HHSC is performing a comprehensive review of the Wound Care Management Services benefit for Medicaid clients.

The following is a summary of changes in scope for this policy review:

- Expanded prior authorization and documentation requirements
- Added policy language and limitations for skin substitute grafts and surgical wound preparation
- Added policy language for prior authorization initial requests and wound debridement
- Added two additional pressure injury categories
- Added a new section entitled Dressings and/or Metabolically Active Skin Equivalents
- Changed payment methodology
- Updated terminology

Some policy language that is out of scope for this review is included in this document for context. New policy language has been underlined and deleted language has been struck-through to highlight proposed policy changes.

Note: The current language regarding the Wound Care Management Services benefit can be found in the Texas Medicaid Provider Procedures Manual (TMPPM), Vol 2: Providers Handbook, Sections 9.2.78 Wound Care Management.
1 Wound care management may be a benefit of Texas Medicaid. Wound care management includes the care of acute and chronic wounds, including, but not limited to, open ulcers (venous pressure or diabetic ulcers), fistulas, or erosion of skin related to cancer.

2 Acute wounds are defined as wounds taking less than up to 30 days for complete healing.

3 Chronic wounds are defined as wounds taking more than 30 days for complete healing.

4 Diabetic ulcers are skin lesions associated with clients with Type 1 and Type 2 diabetes mellitus. The majority of all amputations in diabetic clients are preceded by an infected ulcer.

5 Skin ulcers represent the majority of chronic wounds. Skin ulcers include but are not limited to:

5.1 Venous ulcers are also known as venous insufficiency ulcers, stasis ulcers, or varicose veins, and are due to sustained venous hypertension, which results from chronic venous insufficiency and/or an impaired muscle pump.

5.2 Arterial insufficiency ulcers are due to insufficient arterial flow resulting in ischemia and eventual necrosis. Atherosclerosis is the most common cause of arterial ulcers. Other arterial vascular diseases include vasospastic disease and vasculitis. Arterial ulcers are frequently found at the most distal point of arterial perfusion. No drainage is apparent unless the ulcer is infected.

5.3 Pressure ulcers are any skin wound caused by unrelieved pressure resulting in damage to various sections of the skin structure that worsen over time.

Pressure Ulcers Injuries

6 As defined by the National Pressure Ulcer Advisory Panel, “A pressure injury is a localized damage to the skin and/or underlying tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, comorbid conditions, and condition of the soft tissue.”

Pressure Injury Stages

7 Stage 1 Pressure Injury: Non-blanchable erythema of intact skin within a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Stage I may be difficult to detect in individuals with dark skin tones. May indicate "at risk" persons.

8 Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in
the heel. This stage should be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (Marsi), or traumatic wounds (skin tears, burns, abrasions).

9 Stage 3 Pressure Injury: Full thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure injury.

10 Stage 4 Pressure Injury: Full thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage of bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

Additional Categories/Stages

11 Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e., dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.

12 Deep Tissue Pressure Injury: Intact or nonintact skin with localized area of persistent non-blanchable deep red, maroon, or purple discoloration, or epidermal separation revealing a dark wound bed or blood-filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle, or other underlying structures are visible, this indicates a full-thickness pressure injury (unstageable, Stage 3, or Stage 4). DTPI should not be used to describe vascular, traumatic, neuropathic, or dermatologic conditions.

Wound Care Treatment

13 Wound care includes:

13.1 Optimization of nutritional status
13.2 Debridement by any means to remove devitalized tissue
13.3 Maintenance of a clean, moist bed of granulation tissue
13.4 Any necessary treatment to resolve infection that may be present

14 Based on the specific type of wound, wound care may include:

14.1 Use of a compression system for clients with a venous ulcer
14.2 Establishment of adequate circulation for a client with an arterial ulcer
14.3 Frequent repositioning of a client with a pressure ulcer
14.4 Off-loading pressure and good glucose control for a client with a diabetic ulcer

15 Measurable signs of improved healing include:
15.1 A decrease in wound size, either in surface area or volume
15.2 A decrease in amount of exudate
15.3 A decrease in amount of necrotic tissue

16 Wound care must be performed by a licensed health professional qualified to safely and effectively provide the medically necessary care. Providers are expected to exercise clinical judgment in providing the most appropriate care in accordance with their scope of practice as designated by their regulatory/governing boards.

17 Wound care management includes first line and second line therapies. First line wound care is used for acute wounds. If the wound does not improve with first line treatment, adjunctive second line therapy may be used.

First Line Wound Care Therapy

18 First line wound care therapy may include the following:
18.1 Cleansing, antibiotics, and pressure off-loading
18.2 Debridement
18.3 Dressings
18.4 Compression
18.5 Whirlpool for burns

*Cleansing, Antibiotics, and Pressure Off-loading*

19 Wound cleansing helps create an optimal healing environment and decreases the potential for infection by loosening and removing cellular debris and residual topical agents from previous dressings.

20 Wound cleansing agents may include normal saline, commercial wound cleansers, povidone iodine, hydrogen peroxide, or sodium hypochlorite. Cleansing solutions and methods vary based on effectiveness and individual client needs.

21 Systemic or topical antibiotics may be used to prevent or treat wound infections, and aid in the healing of wounds.

22 Pressure off-loading devices such as pillows, boots, mattresses, and protectors, may also be used as part of first line wound care therapy to prevent or relieve pressure on the wound.

*Debridement*

23 Selective debridement consists of the following:
23.1 Conservative sharp debridement
23.2 High pressure lavage to selected areas
Non-selective debridement consists of the following:

24.1 Blunt debridement
24.2 Enzymatic debridement
24.3 Autolytic debridement
24.4 Mechanical debridement
24.5 Hydrotherapy and wound immersion

Wound debridement includes the pre-debridement wound assessment, the debridement, and the post-procedure instructions provided to the client on the date of service.

The following procedure codes may be a benefit for wound debridement:

Table A: Procedure Codes—Wound Debridement

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>11000</td>
<td>11001</td>
</tr>
<tr>
<td>97597</td>
<td>97598</td>
</tr>
</tbody>
</table>

The following procedure codes may be a benefit for debridement of partial-thickness burns:

Table B: Procedure Codes—Debridement of Partial-Thickness Burns

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>16020</td>
<td>16025</td>
</tr>
</tbody>
</table>

Dressings

Wound dressings may include wet and dry dressings. Dressings applied to the wound are considered part of the service for wound debridement.

Metabolically active skin equivalents used in wound care may be considered separate benefits, in addition to the wound debridement procedure, as outlined in this policy.

The following procedure codes may be a benefit for metabolically active skin equivalents:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1-C9250</td>
<td>1-Q4100</td>
</tr>
<tr>
<td>1-Q4107</td>
<td>1-Q4108</td>
</tr>
<tr>
<td>1-Q4116</td>
<td>1-Q4121</td>
</tr>
<tr>
<td>1-Q4130</td>
<td>1-Q4134</td>
</tr>
<tr>
<td>1-Q4143</td>
<td>1-Q4146</td>
</tr>
</tbody>
</table>

Compression
The following procedure codes may be a benefit for compression performed as part of wound care management:

**Table C: Procedure Codes—Compression**

<table>
<thead>
<tr>
<th>Procedure Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>29580</td>
</tr>
</tbody>
</table>

*Whirlpool for Burns*

Whirlpool may be a benefit when used as first line wound care therapy for the treatment of burn wounds.

**Second Line Wound Care Therapy**

Second line wound care therapy is limited to chronic pressure injuries stage \( III \) or \( IV \) or other types of chronic wounds. Second line wound care therapy is covered only after first line therapy has been tried for at least 30 days without measurable signs of improved healing. First line wound care therapy may continue as appropriate, with the addition of second line wound care measures as indicated by the client’s medical condition.

Second line wound care therapy may include:

- **34.1 Whirlpool**
- **34.2 Irrigation, such as pulsatile jet irrigation**
- **34.3 Application of metabolically active skin equivalents/skin substitutes**

**Whirlpool**

Whirlpool is a non-selective hydrotherapy used in the second line treatment of chronic wounds, which may be used in combination with other therapeutic treatments. Whirlpool generates water movement producing massage of body areas impacting surface circulation and loosening nonviable tissue.

**Pulsatile Jet Irrigation**

Pulsatile jet irrigation may be a benefit for the treatment of Stage \( III \) or \( IV \) wounds, when other forms of treatment have failed.

The following procedure codes may be a benefit for removal of devitalized tissue using pulsatile jet irrigation:

**Table D: Procedure Codes—Pulsatile Jet Irrigation**

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>97597</td>
</tr>
</tbody>
</table>

**Skin Substitute Grafts and Surgical Wound Preparation**

The application of skin substitutes may be a benefit for the treatment of pressure injuries stage 3 or 4 or other types of chronic wounds that have failed to respond to standard wound care.
treatment after 30 days.

39.1 A failed response is defined as a wound that has increased in size or depth or has not changed in baseline size or depth, shows no measurable signs of healing improvements after 30 days of appropriate wound-care measures.

40 It is the expectation that a specific skin substitute product will be used for the episode of each documented wound, and compliance with FDA assessments and submitted guidelines for the specific skin substitute product used will be adhered.

41 All wound care services require documentation of the wound, and a comprehensive treatment plan is required to be maintained in the client’s medical record as outlined in the documentation requirements of the policy.

Contraindications for skin substitute grafts

42 Skin substitute grafts are contraindicated in clients with known hypersensitivity to any component of the specific skin substitute graft (e.g., allergy to avian, bovine, porcine, equine products).

43 Skin substitute grafts are contraindicated in clients with inadequate control of underlying conditions or exacerbating factors, and will not be considered reasonable and necessary; such conditions or exacerbating factors include the following:

43.1 Clients with uncontrolled diabetes

43.2 Clients with active infection

43.3 Clients with active Charcot arthropathy of the ulcer extremity

43.4 Clients with vasculitis

43.5 Clients who continue smoking tobacco

44 The following procedure codes may be a benefit for the application of skin substitute grafts and surgical wound preparation:

Table E: Procedure Codes—Skin Substitute Grafts and Surgical Wound Preparation

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>15002</td>
</tr>
<tr>
<td>15050</td>
</tr>
<tr>
<td>15275</td>
</tr>
</tbody>
</table>

Limitations

45 A limitation of 10 skin substitute grafts will be allowed per episode of wound care in a 12-week period of care per rolling year.

46 If more than one specific product is used or product change occurs during the 12-week period of care the expectation remains that the cumulative number of applications will not exceed 10.
The treatment of any chronic skin wound will typically last no more than twelve (12) weeks.

**Surgical Wound Preparation**

It is expected that each wound will require appropriate wound preparation at least once at initiation of care prior to placement of the skin substitute graft.

Repeated use of surgical preparation services in conjunction with skin substitute application codes will be considered not reasonable or necessary and will not be reimbursed.

**Re-treatment of healed wounds**

Retreating healed skin wounds showing greater than 75% in size reduction and smaller than 0.5 square cm is not considered medically reasonable or necessary and will not be reimbursed.

Retreating a venous stasis ulcer or (diabetic) neuropathic foot ulcer within one (1) year of any given course of skin substitute product(s) is considered treatment failure and does not meet reasonable and necessary criteria for re-treatment of that ulcer with a skin substitute product and will not be reimbursed.

Repeat or alternative applications of skin substitute grafts are not considered medically reasonable and necessary when a previous full course of applications were unsuccessful.

Unsuccessful treatment is defined as increase in size or depth of an ulcer or no change in baseline size or depth and no sign of improvement or indication that improvement likely (such as granulation, epithelialization or progress towards closing) for a period of 4 weeks past start of therapy.

**Authorization Requirements**

Prior authorization requests may be submitted to the TMHP Prior Authorization Department via mail, fax, or the electronic portal. Prescribing or ordering providers, dispensing providers, clients' responsible adults, and clients may sign prior authorization forms and supporting documentation using electronic or wet signatures. For additional information about electronic signatures, please refer to the 'Electronic Signatures in Prior Authorizations' medical policy.

Prior authorization (PA) is required for non-emergent wound debridement, procedure codes 2/F-11042, 2/F-11043, and 2/F-11044. A request for PA must be submitted before the procedure is performed.

Prior authorization is also required for the unspecified skin substitute procedure code 1-Q4100.

Requests for prior authorization must be submitted to the Special Medical Prior Authorization (SMPA) unit as follows:

To complete the prior authorization process by paper, the provider must fax or mail the completed “Special Medical Prior Authorization (SMPA) Request Form” to the SMPA unit and retain a copy of the signed and dated form in the client's medical record at the provider's place of business.
56.1.1 Prior authorization requests for traditional Medicaid clients must be submitted by the physician to the Special Medical Prior Authorization (SMPA) department by approved electronic method using the “Special Medical Prior Authorization (SMPA) Request Form.” Documentation supporting medical necessity for the requested procedure must be included with the request. When required, the requests must include the physician’s original signature and the date signed.

To facilitate determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including documentation for medical necessity of the equipment and supplies requested. The physician must maintain documentation of medical necessity in the client's medical record.

The requesting provider may be asked for additional information to clarify or complete a request for the equipment or supply requested.

Requests for prior authorization for wound debridement procedure codes 2/F-11042, 2/F-11043, and 2/F-11044 must include the following documentation:

Location of the wound

Characteristics of the wound, including:

61.1 Dimensions (diameter and depth)
61.2 Drainage (amount and type)
61.3 Related signs and symptoms (swelling, pain, inflammation)
61.4 Presence of necrotic tissue/slough

Wound care treatment plan

For procedure codes 2/F-11043 and 2/F-11044, at least one of the following conditions must also be present and documented:

63.1 Stage III or IV wounds
63.2 Venous or arterial insufficiency ulcers
63.3 Dehisced wounds or wounds with exposed hardware or bone
63.4 Neuropathic ulcers
63.5 Complications of surgically created or traumatic wound where accelerated granulation therapy is necessary but cannot be achieved by other available topical wound treatment.

Wound debridement procedure codes 2/F-11042, 2/F-11043, and 2/F-11044 are not appropriate and will not be prior authorized for:

64.1 Washing bacteria or fungal debris from the feet
64.2 Paring or cutting of corns or calluses
64.3 Incision and drainage of an abscess
64.4 Trimming or debridement of nails, or avulsion of nail plates
64.5 Acne surgery
64.6 Destruction of warts
64.7 Burn debridement

Retroactive authorization (RA) is required for wound debridement procedure codes 2/F-11042, 2/F-11043, and 2/F-11044 performed on an urgent or emergent basis. A request for RA must be submitted by the provider within 14 calendar days, beginning the day after the procedure is performed.

The wound debridement procedure code submitted on the PA or RA request must reflect the level of debrided tissue, i.e., partial-thickness skin, full-thickness skin, subcutaneous tissue, muscle or bone, and not the extent, depth, or grade of the ulcer or wound.

When requesting a PA for the unspecified skin substitute procedure code 1-Q4100, the following information must be submitted with the request:

67.1 The client’s diagnosis.
67.2 Characteristics of the wound, including:
   67.2.1 Location
   67.2.2 Dimensions (diameter and depth)
   67.2.3 Drainage (amount and type)
   67.2.4 Related signs and symptoms (swelling, pain, inflammation)
   67.2.5 Presence of necrotic tissue/slough
67.3 Medical records indicating prior treatment for the diagnosis, the medical necessity of the requested skin substitute, and the wound care treatment plan.
67.4 A clear, concise description of the skin substitute to be applied, and the reason for recommending this item.
67.5 A CPT or HCPCS procedure code, which is comparable to the requested procedure.
67.6 Documentation demonstrating that the requested procedure is not investigational or experimental.

68 The place of service in which the requested procedure will be performed.
68.1 The physician’s intended fee for the requested procedure.

Debridement of partial-thickness burns, procedure codes 2-16020, 2/F-16025, or 2-16030, do not require prior authorization. These procedures may be provided by physicians and qualified non-physician providers.

Prior Authorization/Authorization Requirements

Prior authorization/authorization requests may be submitted to the TMHP Prior Authorization Department via mail, fax, or the electronic portal. The electronic signature technology must meet all applicable federal and state statutes and administrative rules. Electronically-signed documents must have an electronic date on the same page as the signature. Electronic signatures that are generated through an electronic medical record (EMR) or electronic health record (EHR) system that complies with applicable federal and state statutes and rules are acceptable. All electronically-signed transactions and electronically-signed documents must be kept in the client’s medical record.
Prescribing and dispensing providers that utilize electronic signatures must provide a certification that the electronic signature technology that they use complies with all applicable federal and state statutes and administrative rules. Providers who submit a prior authorization/authorization request must also attest that electronic signatures included in the request are true and correct to the best of their knowledge. A hard copy of electronic transactions and signed documents must be available upon request. Stamped signatures and images of wet signatures will not be accepted. Prescribing or ordering providers, dispensing providers, clients’ responsible adults, and clients may sign prior authorization/authorization forms and supporting documentation using electronic or wet signatures.

To complete the prior authorization process by paper, the provider must fax or mail the completed “Special Medical Prior Authorization(SMPA) Request Form to the SMPA unit, and retain a copy of the signed and dated form in the client’s medical record.

To complete the prior authorization process electronically, the provider must complete the Special Medical Prior Authorization (SMPA) Request form requirements through any approved electronic methods and retain a copy of the signed and dated form in the client’s medical record.

To facilitate determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including documentation for medical necessity for the equipment or supplies requested. The physician must maintain documentation of medical necessity in the client’s medical record.

The requesting provider may be asked for additional information to clarify or complete a request.

Retrospective review may be performed to ensure documentation supports the medical necessity of the requested equipment or supplies.

Prior authorization is not required for debridement of partial-thickness burns, procedure codes 2-16020, 2/F-16025, or 2-16030. These procedures may be provided by physicians and qualified non-physician providers.

**Initial Requests**

Prior authorization is required for wound debridement procedure codes 2/F-11042, 2/F- 11043, and 2/F-11044.

Prior authorization/Authorization requests must include all the following documentation:

- **78.1** Location of the wound
- **78.2** Characteristics of the wound, which include all the following:
  - **78.2.1** Dimensions (diameter and depth)
  - **78.2.2** Drainage (amount and type)
  - **78.2.3** Related signs and symptoms (swelling, pain, inflammation)
78.2.4 Presence of necrotic tissue/slough

79 The treating provider (RN, Physician, Physical Therapist) must submit a signed and dated wound care treatment plan or letter of medical necessity that includes all the following documentation:

79.1 The planned interventions for the problem identified

79.2 The treatment goals

79.3 The expected outcomes

80 The signed and dated treatment plan or letter of medical necessity is considered current when signed and dated within 30 calendar days prior to or on the date the procedure is performed for prior authorization requests. When the treatment plan is not signed and dated within 30 calendar days prior to or on the date the procedure is performed, a new treatment plan must be submitted.

81 For retroactive authorization, the signed and dated treatment plan or letter of medical necessity is considered current when signed and dated within 14 calendar days beginning the day after the procedure is performed. When the treatment plan is not signed and dated within the 14-calendar day period, the request will be denied.

82 For procedure codes 2/F-11043 and 2/F-11044, at least one of the following conditions must also be present and documented:

82.1 Stage 3 or 4 wounds

82.2 Venous or arterial insufficiency ulcers

82.3 Dehisced wounds or wounds with exposed hardware or bone

82.4 Neuropathic ulcers

83 Complications of surgically-created or traumatic wound where accelerated granulation therapy is necessary but cannot be achieved by other available topical wound treatment.

84 Wound debridement procedure codes 2/F-11042, 2/F-11043, and 2/F-11044 are not appropriate and will not be prior authorized for:

84.1 Washing bacteria or fungal debris from the feet

84.2 Paring or cutting of corns or calluses

84.3 Incision and drainage of an abscess

84.4 Trimming or debridement of nails, or avulsion of nail plates

84.5 Acne surgery

84.6 Destruction of warts
84.7 Burn debridement

Prior authorization (PA) requests must be submitted by the provider within 30 calendar days prior to or on the date the procedure is performed. When the PA request is not submitted within 30-calendar days prior to or on the date the procedure is performed, the request will be denied.

For prior authorization requests, the physician’s signature date on the SMPA request form is considered current when signed and dated within 30 calendar days prior to or on the date the procedure is performed. When the physician’s signature date is not signed and dated within the 30-calendar day period prior to or on the date the procedure is performed, the request will be denied.

Wound debridement procedure codes 2/F-11042, 2/F-11043, and 2/F-11044 prior authorization requests will be considered for 7 calendar days beginning on the requested procedure date.

Retroactive authorization (RA) is required for wound debridement procedure codes 2/F-11042, 2/F11043, and 2/F-11044 performed on an urgent or emergent basis. A request for RA must be submitted by the provider within 14 calendar days, beginning the day after the procedure is performed. RA requests not submitted within the 14-calendar day period will be denied.

For retroactive authorization (RA) requests, the physician’s signature on the SMPA request form is considered current when signed and dated within 14 calendar days, beginning the day after the procedure is performed. RA requests with the physician’s signature not signed and dated within the 14-calendar day period will be denied.

Prior authorization requests for subsequent debridement will be considered on a case by case basis with documentation of medical necessity. These requests will be reviewed by the Medical Director.

The wound debridement procedure code submitted on the PA or RA request must reflect the level of debrided tissue, i.e., partial-thickness skin, full-thickness skin, subcutaneous tissue, muscle or bone, and not the extent, depth, or grade of the ulcer or wound.

PA and RA requests must be submitted to the TMHP SMPA unit for processing. A PA is not a guarantee of payment. PA and RA requests that are denied by TMHP can be resubmitted to the TMHP Prior Authorization Department by following the denial appeal’s process in the Texas Medicaid Provider Procedures Manual (TMPPM) Section 5: Fee-for-Service Prior Authorizations, 5.8 Prior Authorization Denials Appeal’s Process.

**Documentation Requirements**

For all wound care management services outlined in this policy, documentation supporting the medical necessity of the service must be maintained in the client’s medical records, including the following information:

93.1 Accurate diagnostic information pertaining to the underlying diagnosis or condition as well as any other medical diagnoses or conditions, to include the client’s overall health status.

93.2 Appropriate medical history related to the current wound, including:
93.2.1 Wound measurements to include length, width, and depth, any tunneling or undermining

93.2.2 Wound color, drainage (type and amount), and odor, if present

93.2.3 The prescribed wound care regimen, to include frequency, duration, and supplies needed

93.2.4 Treatment for infection, if present

93.2.5 All previous wound care therapy regimens, if appropriate.

93.2.6 The client’s use of a pressure reducing support surface, mattress or cushion, when appropriate.

Documentation maintained in the client’s medical record must support the level of debridement service provided.

94.1 Fewer than five wound debridements involving removal of muscle or bone are typically required for management of most wounds. Documentation maintained in the client’s medical record must support the number of debridements performed involving muscle or bone.

95 The client’s medical record must include documentation that wound treatments with metabolically-active skin equivalents/skins substitutes (procedure codes listed in Table D) are accompanied by appropriate adjunctive measures and must identify the adjunctive therapies being provided to the client as part of the wound treatment regimen.

96 Services must be provided in accordance with the Food and Drug Administration (FDA) approved package label and applied according to the manufacturer’s instructions for use.

Documentation Requirements

97 In addition to documentation requirements outlined in the Prior Authorization section of this policy, there are additional documentation requirements for wound care management services. For all wound care services outlined in this policy, documentation supporting the medical necessity of the service must be maintained in the client’s medical records, which includes but is not limited to the following information:

97.1 Accurate diagnostic information pertaining to the underlying diagnosis or condition as well as any other medical diagnoses or conditions, to include the client’s overall health status.

97.2 Appropriate medical history related to the current wound, including:

97.2.1 Wound measurements to include length, width, and depth, any tunneling or undermining

97.2.2 Wound color, drainage (type and amount), and odor, if present

97.2.3 The prescribed wound care regimen, to include frequency, duration, and supplies needed

97.2.4 Treatment for infection, if present

97.2.5 All previous wound care therapy regimens, if appropriate

97.2.6 The client’s use of a pressure reducing support surface, mattress or cushion, when appropriate.
98 Documentation maintained in the client's medical record must support the level of debridement service provided.

98.1 Fewer than five wound debridements involving removal of muscle or bone are typically required for management of most wounds. Documentation maintained in the client’s medical record must support the number of debridements performed involving muscle or bone.

99 The client’s medical record must include documentation that wound treatments involving application of skin substitute products (procedure codes listed in Table E) are accompanied by appropriate adjunctive measures and must identify the adjunctive therapies being provided to the client as part of the wound treatment regimen.

99.1 Services must be provided in accordance with the Food and Drug Administration (FDA) approved package label and applied according to the manufacturer’s instructions for use.

100 Documentation maintained in the client’s medical record must support the need for skin substitute applications and the product used.

101 All wound care treatments involving the application of skin substitute products must include but is not limited to the following documentation:

101.1 Wound treatments are accompanied by the appropriate adjunctive measures, and identify the specific adjunctive therapies being provided to the client as part of the wound treatment regimen.

101.2 Clients who use tobacco will have ceased smoking or have refrained from systemic tobacco intake for at least 4 weeks prior to beginning skin substitute applications and during the conservative wound care.

101.3 Adequate circulation/oxygenation to support tissue growth/wound healing must be present as evidenced by physical examination (e.g., Ankle-Brachial Index [ABI] of no less than 0.60, toe pressure greater than 30 millimeters of mercury [mmHg].

102 The wound has a skin deficit at least 1.0 square centimeter (cm) in size.

103 For diabetic foot ulcers, the client’s medical record reflects a diagnosis of Type 1 or Type 2 Diabetes.

104 Partial or full thickness ulcers must have a clean granular base without tendon and or muscle involvement, bone exposure or sinus tracts.

105 Documentation of the wound’s response to the treatment is required at least every 30 days for each treatment episode. The documentation requirements must include measurements of the initial wound, measurements at the completion of appropriate wound care every 30 days, and measurements immediately prior to placement and with each subsequent placement of the skin substitute.

106 Wound care services that include the use of skin substitutes must be provided in accordance with the Food and Drug Administration (FDA) approved package label and applied according to the manufacturer’s instructions for use. Skin substitute products not used within the scope of the FDA’s intended use and indications are considered experimental and or investigational.
All services outlined in this policy are subject to retrospective review to ensure that the documentation in the client’s medical record supports the medical necessity of the service(s) provided.

Reimbursement

Providers are reimbursed for items addressed in this policy by the lesser of:

108.1 The provider’s billed charges
108.2 The published fee determined by HHSC
108.3 Manual price as determined by HHSC, which is based on:

   108.3.1 The manufacturer’s suggested retail price (MSRP) less 18 percent or average wholesale price (AWP) less 10.5 percent, whichever is applicable
   108.3.2 The provider’s documented invoice cost

If manual pricing is used, the provider must request prior authorization and submit documentation of one of the following:

109.1 The MSRP or AWP, whichever is applicable
109.2 The provider’s documented invoice cost

Procedure codes listed in the “Procedure Codes for Metabolically Active Skin Equivalents” table, with the exception of procedure code 1-Q4100, may be reimbursed to physicians and qualified non-physician providers in the office setting, or to hospitals in the outpatient setting.

Procedure codes 1-Q4112, 1-Q4113, and 1-Q4114 may also be reimbursed to ambulatory surgical centers.

Procedure code 1-Q4100 may be reimbursed to physicians and qualified non-physician providers in the office setting only.

Procedure codes listed in the “Procedure Codes for Metabolically Active Skin Equivalents” table, with the exception of injectable procedure codes 1-Q4112, 1-Q4113, and 1-Q4114, are considered part of the debridement performed at an ambulatory surgical center and are not separately reimbursed.

Professional services for selective wound debridement (procedure codes 1-97597 and 1-97598) may be reimbursed to a licensed physical therapist or physical therapy group, when it is determined to be within the provider’s scope of practice, and the service is prescribed by a Medicaid-enrolled supervising physician or qualified non-physician provider.

Metabolically-active skin equivalents/skin equivalents used in wound care are not reimbursed in the home setting.

Wound debridement may be reimbursed using procedure codes 2/F-11000, 2/F-11001, 2/F-11042, 2/F-11043, or 2/F-11044. The procedure code reported must reflect the level of debrided tissue, i.e., partial-thickness skin, full-thickness skin, subcutaneous tissue, muscle or bone, and not the extent, depth, or grade of the ulcer or wound.
Authorization requirements must be met for both non-emergent and emergent debridement (procedure codes 2/F-11042, 2/F-11043, and 2/F-11044) to be considered for reimbursement. Claims for these procedures must include the authorization number on the claim at the time of claim submission.

Debridement of partial-thickness burns may be reimbursed without prior authorization to physicians and qualified non-physician providers using procedure codes 2-16020, 2/F-16025, or 2-16030.

NOTE: Whirlpool provided as a physical or occupational therapy modality is not addressed in this policy. See the “Cross Reference Policies” list for appropriate policy references.

Reimbursement/Billing Guidelines

Professional services for selective wound debridement (procedure codes 1-97597 and 1-97598) may be reimbursed to a licensed physical therapist or physical therapy group, when it is determined to be within the provider’s scope of practice, and the service is prescribed by a Medicaid-enrolled supervising physician or qualified non-physician provider.

All skin substitute products utilized in wound care are considered part of the services provided with procedure codes 15271 through 15278 and are not separately reimbursed.

Wound debridement may be reimbursed using procedure codes 2/F-11000, 2-11001, 2/F-11042, 2/F11043, or 2/F-11044. The procedure code reported must reflect the level of debrided tissue, i.e., partial thickness skin, full-thickness skin, subcutaneous tissue, muscle or bone, and not the extent, depth, or grade of the ulcer or wound.

Authorization requirements must be met for both non-emergent and emergent debridement (procedure codes 2/F-11042, 2/F-11043, and 2/F-11044) to be considered for reimbursement. Claims for these procedures must include the authorization number on the claim at the time of claim submission.

Debridement of partial-thickness burns may be reimbursed without prior authorization to physicians and qualified non-physician providers using procedure codes 2-16020, 2/F-16025, or 2-16030.

NOTE: Whirlpool provided as a physical or occupational therapy modality is not addressed in this policy. See the “Cross Reference Policies” list for appropriate policy references.

The following table contains procedure codes for wound care services:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
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<td>2/F-15278</td>
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</table>

Exclusions

The following services are not a benefit of Texas Medicaid:
125.1 Infrared therapy
125.2 Ultraviolet therapy
125.3 Topical hyperbaric oxygen therapy
125.4 Low-energy ultrasound wound cleaner (MIST therapy)
125.5 Services submitted as debridement, which do not include the removal of devitalized tissue. Examples include removal of non-tissue integrated fibrin exudates, crusts, biofilms, or other materials from a wound, without the removal of tissue.
125.6 Electrical stimulation and electromagnetic therapy
125.7 Greater than ten (10) applications of a skin substitute product(s) for the treatment of a single wound within a 12-week period
125.8 Separately billed repeated use of the skin substitute product after 12 weeks for a single wound or episode
125.9 Skin substitute grafting for partial thickness loss with the retention of epithelial appendages is not covered as epithelium will repopulate the deficit from the appendages, negating the benefit of over grafting
125.10 Skin substitute products not billed concurrently with procedure codes 15271-15278, are not separately reimbursed