Some confusion for home care providers ensued when electrical stimulation (ES) and electromagnetic therapy (EM), which have been proven effective for accelerating wound healing, were approved for Medicare payment under a national coverage determination (NCD). ES involves the application of electrical current directly on the skin in close proximity to the wound. EM, which was approved for payment to treat certain wounds effective July 2004, uses a pulsed magnetic field to induce current.

The NCD and billing guidance contained a list of provider types that could bill for EM and EM that did not include home care agencies, but an EM code was added to the latest home health consolidated billing list released in the Centers for Medicare & Medicaid Services’ (CMS) Transmittal 226. These therapies may be billed to Medicare when used by home health providers to treat wounds if the coverage conditions are met. CMS responded to an inquiry by The National Association for Home Care & Hospice (NAHC) in a letter stating that “EM and ES must be provided by a physical therapist or a physician,” but clarified that “the NCD does not exclude the home as a setting where these services can be provided as long as all other criteria are met.”

Coverage Criteria

Medicare will allow either one covered ES therapy or one covered EM therapy for the treatment of chronic stage III or stage IV pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers if no measurable improvement is evidenced after at least 30 days of standard wound therapy. CMS defines “chronic ulcers” as ulcers that have not healed within 30 days of occurrence, and “measurable signs of improved healing” include a decrease in wound size (either surface area or volume), a decrease in amount of exudates, and a decrease in amount of necrotic tissue.

“Standard wound care” includes:

- optimization of nutritional status;
- debridement by any means to remove devitalized tissue;
- maintenance of a clean, moist bed of granulation tissue with appropriate moist dressings, and necessary treatment to resolve any infection;
- frequent repositioning of a patient with pressure ulcers (usually every 2 hours);
- offloading of pressure and good glucose control for diabetic ulcers;
- establishment of adequate circulation for arterial ulcers; and
- use of a compression system for patients with venous ulcers.

As CMS stated, application of ES and EM must be performed by a physical therapist, physician (or clinician incident to physician services), who also must evaluate the wound and contact the treating physician if the wound worsens. If ES or EM is being used, wounds must be evaluated at least monthly by the treating physician. Furthermore, continued treatment with ES or EM is not covered if measurable signs of healing have not been demonstrated within any 30-day period of treatment. ES and EM must be discontinued when the wound demonstrates a 100%-epithelialized wound bed.

Full details of the coverage criteria can be found in CMS Transmittal 7 (posted online at www.cms.hhs.gov/manuals/pm_trans/R7NCD.pdf).

The question as to whether home care agencies are permitted to bill Medicare for these services was raised in a variety of forums, including CMS Open Door Forums numerous times over the past year. NAHC’s letter from CMS resolves the longstanding confusion caused by earlier billing instructions that limited services to certain provider types. Provided all coverage criteria are met, agencies are permitted to bill for ES, as well as the newly approved EM services, whether provided directly or through contract with a hospital, skilled nursing facility, or rehabilitation center.

CMS Issues New OASIS Guidance for Accurate Coding of Pressure Ulcers

CMS has issued **new guidance** for accurate coding of OASIS Pressure Ulcer Items on its Web site at [www.cms.hhs.gov/oasis/npuap.pdf](http://www.cms.hhs.gov/oasis/npuap.pdf). This guidance is “based on the current advances in wound care research” as issued by the National Pressure Ulcer Advisory Panel (NPUAP) regarding healing status of stage 1 and stage 2 pressure ulcers and states:

“It is the opinion of the NPUAP that stage 1 pressure ulcers that heal to normal-appearing skin are not at increased risk for future ulcer development. Similarly, NPUAP believes that stage 2 pressure ulcers generally heal to nearly normal skin, but may result in some scar tissue formation.

It is our opinion that healed stage 2 ulcers only minimally increase the future risk of pressure ulcers at that location, and do not result in the same increased risk of future ulcerations as does a healed stage 3 or stage 4 pressure ulcer, where the underlying skin architecture is dramatically and permanently altered” (NPUAP, June 30, 2004).

**OASIS Implications**

Based on this opinion, CMS has determined that it is **changing its prior guidance** on healed pressure ulcers delineating that stage 1 or 2 pressure ulcers should not be “reverse staged.” That is, once a patient had a stage 1 or 2 pressure ulcer, it would always have been staged at its worst, regardless of healing, under the prior guidance.

Now, if a patient has a healed stage 1 pressure ulcer (and no other pressure ulcers or skin lesions/wounds), according to the **new guidance**, the response to (M0440) “Does this patient have a skin lesion or an open wound?” should be **No**. If the patient has a healed stage 2 pressure ulcer (and no other

Many patients receive home care before their incisions have healed at the surface, and we lack evidence-based protocols for home management of these wounds. Currently, the best practice is that home wound care be individualized with a focus on promoting healing and preventing infection.

For accurate coding responses for healed stage 3 and healed stage 4 pressure ulcers, the guidance remains unchanged as noted in the *OASIS Implementation Manual* under the assessment strategies for (M0450) “Current Number of Pressure Ulcers.” Because the underlying skin ar-

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**Source:** NAHC Report, August 19, 2004. Reprinted with permission from the National Association for Home Care.