DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
Docket Number: M-11-721

In the case of	**Claim for**
Sunrise Family Foot Care Center (Appellant)	Supplementary Medical Insurance Benefits (Part B)
**** (Beneficiary)	**** (HIC Number)
First Coast Service Options (Contractor)	**** (ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated November 23, 2010, concerning wound debridement, physician evaluation and management (E&M), and related services provided to nine beneficiaries between November 11, 2008, and November 10, 2009. In his decision, the ALJ dismissed the request for hearing for one beneficiary for failure to meet the required amount in controversy, and found fully favorably on the coverage issues relating to a second beneficiary. With regard to the remaining seven beneficiaries, the ALJ determined that some or all of the services were not covered by Medicare, or were not separately payable. The ALJ found the appellant liable for the non-covered costs under section 1879 of the Social Security Act (Act) and waived any liability on the part of the beneficiaries.[1]

The appellant has asked the Medicare Appeals Council to review the ALJ's action with respect to coverage and payment for services furnished to six of the seven beneficiaries whose claims the ALJ disallowed in part or full.[2] The appellant's

[1] Sunrise Family Foot Care Center is owned and operated by Sheldon Ross, D.P.M. Throughout the decision, we refer to the appellant using the pronoun "he" which is in reference to Dr. Ross, the representative of the appellant.

[2] A list with the full name and HICN of each beneficiary, as well as each date of service and CPT code at issue, is attached to this decision and will be

request for review forms (DAB-101s) and twelve-page letter setting forth the appellant's contentions (dated January 19, 2011) are entered into the record as Exhibit (Exh.) MAC-1.

The Council reviews the ALJ's decision *de novo*. 42 C.F.R. § 405.1108(a). The Council will limit its review of the ALJ's decision to the exceptions raised by the party in the request for review, unless the appellant is an unrepresented beneficiary. 42 C.F.R. § 405.1112(c).

In each case, the Council agrees with the ALJ's ultimate conclusion that Medicare will not cover the wound debridement services and/or E&M services. However, in each case the Council modifies or supplements the ALJ's decision to set forth the applicable Medicare coverage criteria, and to assess with respect to each beneficiary, based on these criteria, whether the wound debridement services and/or E&M services were medically reasonable and necessary.

DISCUSSION

A. Allegation of ALJ Bias

The appellant asserts in his request for review that the ALJ was biased, or otherwise decided the case in an inappropriate manner. For example, the appellant alleges that the ALJ "merely denied coverage stating his opinion without justifying [the] decision with facts . . . . The Judge has offered no facts here to justify his opinion and therefore it must be assumed it is his personal opinion." Exh. MAC-1, at 4. The appellant also alleges that the ALJ has formulated a personal opinion before reading the evidence provided, considering the oral testimony provided and reading the relevant Medicare policy." *Id.* at 6.

The Council has reviewed the written record and the recording of the ALJ hearing. CD Recording of ALJ Hearing, October 21, 2010. From the record, the recording, and the ALJ's decision, there is ample evidence that the ALJ reviewed all of the documentation and facts and applied the correct legal standard for each beneficiary and each date of service. In those instances where the appellant claims that the ALJ did not read the record, the ALJ did read the record but found it lacking in one or more ways. The ways in which the record was lacking are identified

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sent to the appellant only. To protect his/her privacy, each individual beneficiary will receive a copy of this decision, throughout which he/she is identified by initials only.

in the ALJ's written decision. The Council agrees with the ALJ that the evidence is not sufficient to support many of the appellant's claims. However, the fact that the ALJ found the evidence lacking does not mean that the ALJ did not review the evidence and base his decision on the evidence and applicable law.

There is no indication of bias in the ALJ's handling of the hearing or in the written decision in this case. It is clear that the appellant disagrees with the ALJ's decision. However, the appellant has not identified any prejudice or partiality in the ALJ's handling of the case or the ALJ's decision. *Cf.* 42 C.F.R. § 405.1026 (bases for disqualification of an ALJ). Therefore, the Council finds that the appellant has not shown any bias on the part of the ALJ.

B. Debridement Services

Legal Authorities

As with other services under the Medicare law, section 1862(a)(1)(A) of the Act directs that no payment may be made for services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body part. In addition, as with other areas of Medicare coverage, section 1833(e) of the Act prohibits payment to any provider of services "unless there has been furnished such information as may be necessary in order to determine the amounts due." *See also* 42 C.F.R. § 424.5(a)(6).

A Medicare contractor develops program guidance and may issue a Local Coverage Determination (LCD) for its service area. In this case, First Coast Service Options, Inc. (the contractor) issued LCD L18976 (Debridement Services), which covers services at issue furnished prior to February 2, 2009, and LCD 29128 (Wound Debridement Services), which covers services at issue furnished on or after February 2, 2009.

An ALJ and the Council are bound by statutes, *e.g.* the Act, as well as regulations, National Coverage Determinations (NCDs), and Rulings issued by CMS. 42 C.F.R. §§ 405.1060(a)(4) and 405.1063. Neither an ALJ nor the Council is bound by contractor LCDs or CMS program guidance such as program memoranda and manual instructions, "but will give substantial deference to these policies if they are applicable to a particular case." 42 C.F.R. § 405.1062(a). An ALJ or the Council must explain its

reasoning for not following an LCD or program guidance in a particular case. 42 C.F.R. § 405.1062(b).

LCD L18976 (*Debridement Services)* and LCD 29128 (*Wound Debridement Services*) address coverage for the HCPCS billing codes that apply to debridement services.[3] The LCDs provide similar guidance for wound debridement services, and draw a key distinction between surgical debridement and active wound care management (which includes selective debridement). *Compare* LCD L18976 with LCD L29128. LCD L18976, for example, states in pertinent part:

> *Surgical Debridement (CPT codes 11040-11044*)[4]
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> Surgical debridement is typically used for the treatment of a wound to clear the site and to establish the margins of viable tissue. It is suited for removal of thick, adherent eschar and devitalized tissue in large ulcers. It is also appropriate when there is evidence of infection, sepsis, or osteomyelitis. Bleeding is likely; anesthesia is often required for deeper lesions of neurologically intact skin. Individuals performing it should be licensed to perform surgery.
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> * * *
>
> *Active Wound Care Management*
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> Debridement is indicated whenever necrotic tissue is present on an open wound. Debridement may also be indicated in cases of abnormal wound healing or repair. Debridement techniques usually progress from non-selective to selective but can be combined. Debridement will not be

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[3] LCD L18976 was in effect for services performed from January 1, 2005, through February 1, 2009. In the state of Florida, LCD L29128 replaced LCD L18976 on February 2, 2009, as the policy covering wound debridement services. Since the appellant performed surgical debridement on beneficiaries O.La., S.P-Z., and K.S. during dates of service in which LCD L18976 was still in effect, the Council will discuss whether Medicare coverage criteria as stated in LCD L18976 were met for these respective dates of service.

[4] The Centers for Medicare and Medicaid Services (CMS) has established uniform national definitions of services, codes to represent services, and payment modifiers to the codes. 42 C.F.R. § 414.40(a). The Medicare coding system, Healthcare Common Procedural Coding System (HCPCS) is based on the American Medical Association's (AMA's) Physician's Current Procedural Terminology (CPT).

> considered a reasonable and necessary procedure for a wound that is clean and free of necrotic tissue. This procedure includes wound assessment; debridement; application of creams, . . . and other wound coverings; and instructions for ongoing care. It should be billed no more than once per day, regardless of the number of wounds.
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> *Selective Debridement* ***([CPT codes]*** *97597 & 97598)*
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> For the removal of specific, targeted areas of devitalized or necrotic tissue from a wound along the margin of viable tissue. Occasional bleeding and pain may occur. The routine application of a topical or local anesthetic does not elevate active wound care management to surgical debridement. Selective debridement includes:
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> - Selective removal of necrotic tissue by sharp dissection including scissors, scalpel, and forceps
>
> - Selective removal of necrotic tissue by high pressure water jet

LCD L18976, *LCD for Debridement Services*. The LCD provides that selective debridement is utilized for removal of specific, targeted areas of devitalized or necrotic tissue from a wound along the margin of viable tissue. Occasional bleeding and pain may occur.

The LCD also explains it is not reasonable or necessary to continue a given type of wound care if evidence of wound improvement cannot be shown; such evidence must be documented with each visit.

For both surgical debridement and selective debridement, coverage for wound care on a continuing basis for a given wound in a given patient is contingent upon evidence documented in the patient's record that the wound is improving in response to the wound care being provided. Evidence of improvement includes *measurable changes* in at least some of the following: drainage, inflammation, swelling, pain, wound dimensions (diameter and depth), granulation tissue, and necrotic tissue/slough.

Such evidence must be documented with each visit. A wound that shows no improvement after 30 days requires a new approach, which may include a physician reassessment of underlying infec-

tion, metabolic, nutritional, or vascular problems inhibiting wound healing, or a new treatment approach. *See* LCD L18976.

Modifiers may be appended to HCPCS codes to provide additional information about the services rendered, only if the clinical circumstances justify the use of the modifier. The following modifiers relating to debridement services have been listed by the appellant in this case:

> Modifier "-51" - Multiple Procedures: When multiple procedures, other than E&M services, are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending the modifier 51 to the additional procedure or service code(s).
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> Modifier "-59" – Distinct Procedural Service: Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier -59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician. However, when another already established modifier is appropriate it should be used rather than the modifier -59. Only if no more descriptive modifier is available, and the use of modifier -59 best explains the circumstances, should modifier -59 be used. Modifier code 09959 may be used as an alternate to modifier -59.
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> Modifier "-76" – Repeat Procedure by Same Physician: The physician may need to indicate that a procedure or service was repeated subsequent to the original procedure or service. This circumstance may be reported by adding the modifier -76 to the repeated procedure or service or the separate five digit modifier code 09976 may be used.

HCPCS 2007 (Oct. 27, 2006); HCPCS 2008 (Dec. 27, 2007).

ANALYSIS

Beneficiary **I.E.**
Date(s) of Service (DOS): 6/11/2009 (code 11042-76)

Beneficiary I.E. was seen for stage III ulcers on her right ankle, foot, and heel at a follow-up office visit on June 11, 2009. The beneficiary also had arteriosclerotic lower extremity disease, right and left lower extremities, and venous insufficiency, right leg. Exh. 3, at 133.[5] The appellant billed Medicare for surgical debridement of multiple wounds on this date. *Id.* at 132.

The contractor reimbursed the appellant for debridement services performed on two of the anatomical sites, but denied coverage for the third debridement procedure. On redetermination and reconsideration, the contractor and the Qualified Independent Contractor (QIC) upheld the contractor's initial determination. *Id.* at 106-108, 127-128.

The ALJ agreed with the contractor and the QIC that CPT code 11042-76 should not be covered for this date of service because there was insufficient documentation to show that the procedure was reasonable and necessary. Dec. at 8-9. Specifically, the ALJ noted that the procedure was performed during a follow-up office visit, that the coverage criteria in the applicable LCD requires evidence that the wound is healing, and that no medical documentation from previous visits was present in the file. The ALJ stated that "[a]bsent such documentation, the evidence is insufficient to support the conclusion that wound healing had occurred." Dec. at 9.

The appellant asserts that testimony given at the hearing and information "available to the ALJ through CMS" indicates that the appellant's initial encounter with the beneficiary was June 4, 2009. Exh. MAC-1, at 5. After noting that he performed the beneficiary's initial debridement on June 5, 2009, the appellant contends that there was not enough time between debridement procedures for any appreciable improvement at the wound site. *Id.* Moreover, the appellant asserts that two wound debridement procedures within seven days of one another cannot be considered wound care on a continuing basis. *Id.*

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[5] Unless otherwise noted, the citations in each of the subsections addressing an individual beneficiary refer to the marked ALJ exhibits present in that beneficiary's individual claim file.

The Council concurs with the ALJ that the appellant did not demonstrate that the wound debridement services provided on June 11, 2009, were reasonable and necessary. LCD L29128 requires that "Medicare coverage for wound care on a continuing basis for a given wound in a given patient is contingent upon evidence documented in the patient's medical record that the wound is improving in response to the wound care being provided." LCD L29128. Further, the LCD requires that evidence of improvement "must be documented with each visit." *Id.* As indicated by the ALJ, since this was a follow-up visit, rather than an initial visit, evidence of improvement was required. Without documentation from previous visits that described the wound in question, there was insufficient evidence to demonstrate that wound healing had occurred. Thus, the service coded as 11042-76 does not meet Medicare coverage criteria and therefore is not reasonable and necessary.

Beneficiary **O.Le.**
DOS: 4/6/2009, 4/13/2009, 4/27/2009, 5/11/2009, 5/18/2009, 6/1/2009 (code 11042, with various modifiers)

Beneficiary O.Le. was seen for multiple ulcers on his left and right legs, as well as severe venous stasis dermatitis/ cellulitis on the dates of service indicated above. The beneficiary also had chronic arteriosclerotic lower extremity disease, chronic venous stasis and chronic venous insufficiency. On each date of service at issue, the appellant's office notes classify each encounter with the beneficiary as a "Follow-up Skilled Nursing Visit." Exh. 3, at 297, 536, 570, 602, 619, 636. The appellant billed Medicare for surgical debridement of multiple wounds on each date of service.

After the contractor's redeterminations and the QIC's reconsideration, which each concerned the denial of coverage for various surgical debridement procedures that the appellant furnished to the beneficiary and billed to Medicare, the appellant requested an ALJ hearing regarding the claims that remained denied. *See* Exh. 3, at 516-517 (QIC's list of each claim and outcome on reconsideration); *see also*, ALJ Master File, Exh. 9, at 4-5 (appellant's spreadsheet that includes the services appealed to the ALJ). The ALJ denied Medicare coverage for all appealed wound debridement services on each date of service at issue. Dec. at 10-11. For the first date of service at issue, the ALJ indicated that there must be evidence that a wound is healing in order for the services to be regarded as reasonable and necessary and thus covered by Medicare. Citing a

lack of documentation pre-dating the beneficiary's April 6, 2009, follow-up office visit, the ALJ found that the debridement services on this date were neither reasonable nor necessary. *Id.* With respect to the latter dates of service, the ALJ stated that it did not appear that the various wounds were improving in response to the treatment that the appellant had provided. *Id.* at 11. In support of his opinion about the lack of improvement of the various wounds, the ALJ noted the appellant's testimony at the hearing that the wounds were failing to progress towards healing. The ALJ noted that although the beneficiary was chronically non-compliant in following the appellant's treatment plan, this did not excuse the general expectation that the beneficiary's wounds should heal during continuing treatment. The ALJ also noted that the treatment plan was not appreciably modified to address the beneficiary's lack of wound healing. *Id.*

Before the Council, the appellant asserts that for the first date of service at issue, evidence to show the wounds were healing was unnecessary because the wounds were worsening. For the other dates of service, the appellant asserts that he modified his approach over time in treating the beneficiary, thus complying with the applicable LCD. The appellant contends that the ALJ's statement that the plan of treatment was not modified in any "meaningful way" is a standard that is not required in the applicable LCD. Exh. MAC-1.

The Council concurs with the ALJ that the appellant did not demonstrate that the wound debridement services furnished on April 6, 13, and 27, 2009, May 11 and 18, 2009, and June 1, 2009, were reasonable and necessary. As mentioned previously, LCD L29128 stipulates that coverage is contingent on whether the wound is healing in response to the treatment being provided. The applicable LCD also states that "[a] wound that shows no improvement after 30 days requires a new approach, which may include a reassessment, by a qualified professional, of underlying infection, metabolic, nutritional, or vascular problems inhibiting wound healing, or a new plan of care or treatment method." LCD L29128. The appellant conceded that the beneficiary's various wounds were not healing during the course of treatment, and in fact many of them were worsening. Hearing CD; *see also* Dec. at 11. In this circumstance, the LCD requires a new approach, plan of care, or treatment method to address the non-healing wounds. After careful review of the medical documentation, we find that the appellant did not make any

significant changes in his approach, plan of care, or treatment method used to care for the beneficiary's non-healing wounds.

The beneficiary's examination report for each date of service is included in the evidentiary record. For the dates of service at issue, the "Assessment" section of each examination report describes the podiatrist's impressions of the beneficiary's condition and his opinion on treatment that may promote healing of the wounds. Each "Assessment" is nearly identical in its content. *See, e.g.,* Exh. 3, at 604, 638. Similarly, in the "Plan" section of the examination report, the appellant describes the course of treatment. Although there are a few minor differences within the "Plan" section of the examination report, we agree with the ALJ that the changes are minimal and cannot be considered as a new approach, new plan of care, or new treatment method. Moreover, no detailed information is given in the examination report to indicate the reasoning for the change or how the change will make a difference and improve the condition of the beneficiary's wounds. The applicable LCD states that the "[m]edical record documentation maintained by the performing provider must clearly indicate the medical necessity of the service being billed." LCD L29128. In this case and for the dates of service at issue, the medical documentation did not demonstrate that wound debridement was necessary despite the worsening of the condition of the wounds. Therefore, Medicare will not cover the wound debridement services that were denied by the contractor for dates of service on April 6, 13, and 27, 2009, May 11 and 18, 2009, and June 1, 2009.

Beneficiary **I.M.**
DOS: 7/3/2009 (code 11042-59-76)

Beneficiary I.M. was seen for chronic pressure ulcers on his right and left heels at a follow-up hospital visit on July 3, 2009. The beneficiary was also being seen for moderate chronic, arteriosclerotic lower extremity disease of his right and left lower extremities. Exh. 3, at 26. The appellant billed Medicare for surgical debridement of multiple wounds on this date. *Id.* at 35.

The contractor did not reimburse the appellant for two of the claimed debridement services because it determined that the services at issue were duplicate services. On redetermination and reconsideration, the contractor and the QIC upheld the contractor's initial determination. Exh. 3, at 4-6, 28-30. On

appeal, the ALJ found that the services at issue were not reasonable or necessary. The ALJ noted that the hospital visit in question was identified as a follow-up visit, and that evidence of improvement in the condition of the wounds was required in order for the services to be reasonable and necessary. In his decision, the ALJ indicated that medical documentation from previous visits was not included in the file, and absent such documentation, the evidence was insufficient to demonstrate that wound healing had occurred. Dec. at 9.

Before the Council, the appellant asserts that LCD L29128 allows, in rare instances, for only the prevention of the progression of the wound if the wound is "due to severe underlying debility or other factors such as inoperability" and "is not expected to improve." Exh. MAC-1, at 6 (quoting LCD L29128). The appellant contends that beneficiary I.M.'s condition qualified as a "severe underlying debility" because of complications from end-stage HIV. Exh. MAC-1, at 6. Thus, the appellant asserts, the services should be covered because they were to prevent the progression of the wound. *Id.*

The Council concurs with the ALJ that the appellant did not demonstrate that the wound debridement services provided on July 3, 2009, were reasonable and necessary. As mentioned above, generally Medicare will only cover wound care on a continuing basis if there is evidence in the medical documentation that the wound is healing in response to the treatment provided. *See* LCD L29128. This particular date of service was identified in the medical documentation as a follow-up visit, and as such, the appellant should have previously treated the wounds in question. As the ALJ noted, there was no evidence in the record describing the condition of the wounds at issue, and without medical documentation from previous visits, there was insufficient documentation that the wounds were healing.

The appellant contends that the standard that should be applied in this particular case is not whether the wounds were healing, but whether the treatment provided was preventing the progression of the wounds for wounds that were not expected to improve. We are not convinced by the appellant's argument. There is no evidence in the beneficiary's medical record that the goal of the wound care was to prevent progression of the beneficiary's wounds. Furthermore, the appellant undermines his own argument by statements in the examination report such as "[s]urgical debridement of wound should significantly improve wound healing . . ." and "[t]he patient understands appropriate

wound healing of the ulceration is expected within an appropriate period of time . . . ." Exh. 3, at 27. These statements indicate that the appellant expected improvement in the condition of the wounds and that preventing progression of the wounds was not the goal for this beneficiary. Thus, the services at issue, coded as 11042-59-76, do not meet Medicare coverage criteria and therefore are not reasonable and necessary.

Beneficiary **K.S.**
DOS: 11/11/2008 (codes 11042 and 11042-76)

Beneficiary K.S. was seen for two ulcers, one on her left leg and one on her left ankle, at a follow-up office visit on November 11, 2008. Exh. 3, at 445. The appellant billed Medicare for surgical debridement of both ulcers on this date. *Id.* at 455. Initially, the contractor denied coverage for the debridement procedures. On redetermination and reconsideration, the contractor and the QIC upheld the contractor's initial determination. *Id.* at 422-424, 431-432.

On appeal, the ALJ agreed with the contractor and the QIC that the debridement services were not covered for the November 11, 2008, date of service because there was insufficient documentation to demonstrate that the services were reasonable and necessary. Dec. at 9. As with other beneficiaries discussed in this decision, the ALJ noted that the office visit on the date of service at issue for this beneficiary was a follow-up visit. The ALJ stated that the "relevant coverage determination provides that, in order for such continuing wound care to be reasonable and necessary, there must be evidence that the wound is in fact healing." *Id.* The ALJ further noted that no medical documentation that described previous treatment was present in the beneficiary's claim file and that absent such documentation, he was unable to conclude that the beneficiary's lower extremity wounds were healing.

Before the Council, the appellant asserts that he indicated on the examination report that there was no improvement in the condition of the wounds and that the home health provider failed to follow his orders on properly dressing the wounds. Exh. MAC-3, at 7. The appellant also asserts that he reassessed the problem, addressed the deficiencies in care, and initiated a new plan of care. *Id.*

We agree with the ALJ that the appellant did not demonstrate that the wound debridement services provided on November 11, 2008, were reasonable and necessary. However, we supplement the ALJ's decision concerning this beneficiary by applying the correct coverage determination for the date of service at issue. The only LCD referenced in the ALJ's decision is LCD L29128, *LCD for Wound Debridement Services*. But, as stated earlier in this decision, LCD L18976, *LCD for Debridement Services*, was in effect until February 2, 2009, at which time LCD L29128 replaced the retired LCD as the contractor's policy on debridement services. Despite the reference to the incorrect LCD, the ALJ's conclusion that the services are not covered was correct, in part because LCD L18976 is similar to LCD 29128 in requiring evidence of wound improvement for Medicare to cover the debridement services or if there is no wound improvement, a change in approach to address a non-healing wound. *Compare* LCD L18976 to LCD L29128.

We are not persuaded by the appellant's argument that the services should be covered due to his indication on the report that there was no improvement in the wounds and that the home health provider failed to follow his orders. LCD L18976 is clear that wound improvement that cannot be shown after thirty days requires a new approach, which may include reassessment of the problems inhibiting wound healing. The LCD also requires that medical necessity must be documented in the medical record based in part on evidence that the treatment will make a significant practical improvement in the wound in a reasonable and generally predictable period of time.

In the case of this beneficiary, there is nothing in the record to indicate that there was improvement in the wounds or that the wounds would improve due to the care provided by the appellant. The only documentation in the record is the examination report for the date of service at issue. There is nothing in the record that describes the condition of the wounds, and the treatment provided, on previous dates of service. Additionally, there is no evidence in the record, other than the examination report for the date of service at issue, that indicates that the wounds improved subsequent to the dates of service at issue or that the appellant met the "new approach" requirement specified in the applicable LCD. More detailed information and medical documentation describing how or why the home health provider failed to properly dress the wounds, and the effect this absence in care had on the wounds at issue would have been helpful in our analysis. Also medical records beyond the date of service

in question could have assisted in determining whether the services provided on the date of service were reasonable and necessary. Accordingly, we find that there was insufficient evidence to demonstrate that wound healing occurred, or that a new approach was used that would have made a significant practical improvement in the wounds in a generally predictable period of time.

C. Both Debridement and Evaluation & Management (E&M) services

The appellant's request for review of the ALJ's decision on services to the other beneficiaries involves, in each instance, claims for Medicare coverage of both debridement services and E&M services. This part of the request for review is analyzed below, after a description of the additional legal authorities applicable to E&M services.

Additional Legal Authorities- Evaluation & Management

The following HCPCS (or CPT) codes, for E&M services, are also involved in this case:

99213 – Office or other outpatient visit for the E&M of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient or family.

93923 – Complete bilateral noninvasive physiologic studies of upper or lower extremity arteries, 3 or more levels (e.g., for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental blood pressure).

The following HCPCS modifiers have been listed by the appellant in connection with these services:

> Modifier "-25" - Significant, Separately Identifiable E&M Service by the Same Physician on the Same Day of the Procedure or Other Service: It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E&M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E&M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E&M service to be reported. The E&M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E&M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E&M service. This modifier is not used to report an E&M service that resulted in a decision to perform surgery.
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> Modifier "-26" – Professional Component: Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding 26 to the usual procedure number.

HCPCS 2007 (Oct. 27, 2006); HCPCS 2008 (Dec. 27, 2007).

Beneficiary **O.La.**
DOS: 11/11/2008 (codes 11042 and 99213), 11/20/2008 (code 93923-26), and 11/10/2009 (code 11042-76)

Beneficiary O.La. was seen by the appellant on November 11, 2008, during a follow-up office visit. The appellant billed Medicare for surgical debridement of one stage III wound (CPT code 11042) and an E&M service (code 99213) on this date. Exh. 3, at 272. Subsequently, the beneficiary was seen by the appellant on November 20, 2008, and the appellant billed Medicare for a physiologic study of the beneficiary's lower extremities (code 93923-26). *Id.* at 250. Nearly one year later, on November 10, 2009, the beneficiary visited the appellant for wound debridement and the appellant billed Medicare for surgical debridement of multiple wounds (code 11042-76). *Id.* at 247, 249.

For each date of service, the contractor did not reimburse the appellant for select wound debridement, E&M, and/or diagnostic testing services. On redetermination and reconsideration, the contractor and the QIC upheld the contractor's initial determinations. On appeal, the ALJ found that the services at issue were not reasonable or necessary, and thus, not covered by Medicare.

In his decision, the ALJ noted that all of the services were provided in the context of a follow-up visit, but that no previous treatment notes were provided for the November 11, 2008 date of service, and that the previous treatment notes that were submitted for the November 20, 2008 date of service indicated that no significant healing had occurred. The ALJ also noted that for the November 10, 2009, date of service, in which improvement in the wound was indicated, the previous treatment notes pre-dated this date of service by nearly one year. The ALJ found that the documentation for all three dates of service was insufficient to verify wound healing as required in Medicare coverage criteria. Concerning the E&M code for the November 11 date of service, the ALJ determined that the services specified under the code "were a necessary and normal part of the associated debridement service performed on the same day," and thus the associated claim was not eligible for reimbursement. Dec. at 8. With respect to CPT code 93923, which concerns reimbursement for a non-invasive physiological study, the ALJ stated that "the records submitted indicate that the nature of Beneficiary's condition had already been well established prior to [November 20, 2008]." Dec. at 8. The ALJ also determined that no new concerns were indicated in the beneficiary's medical record that would have justified performing the physiological study. *See id.*

Before the Council, the appellant asserts that on November 11, 2008, the beneficiary's wound required debridement due to infection and arteriosclerotic lower extremity disease. Exh. MAC-1, at 2. The appellant also asserts that a new plan of care was initiated on this date of service. As for the claimed E&M service, the appellant asserts that he included information related to the beneficiary's arteriosclerotic lower extremity disease and sickle cell disease in the orthopedic status, neurologic status, and vascular status of the examination report that is not required for coverage of wound debridement. The appellant contends that the additional information for E&M services unrelated to the wound debridement procedures validates the claim for Medicare reimbursement for code 99213. Concerning

the November 20, 2008, date of service, and the appellant's claim for coverage of CPT code 93923, the appellant argues that the beneficiary's condition and the documentation of the condition met the coverage criteria specified in LCD L6001. *Id.* at 4-5. For the November 10, 2009, date of service, the appellant contends that previous notes are not required as evidence to demonstrate that wound healing has occurred and he asserts that the medical documentation that is in the evidentiary record meets the criteria specified in the applicable LCD. *Id.* at 3-4.

The Council concludes that Medicare will not cover the debridement and E&M services billed by the appellant for the November 11, 2008, and the November 10, 2009, dates of service. We concur with the ALJ that the appellant's documentation did not clearly indicate the medical necessity of the wound debridement service billed for these dates of service. Again, we specify that the applicable LCD for the wound debridement services furnished on November 11, 2008, is LCD L18976. But similar to the LCD that the ALJ referenced in his decision, LCD L18976 requires a provider to use a new approach if wound treatment is ineffective after thirty days. The applicable LCD for the November 10, 2009, date of service, LCD L29128, has the same "new approach" requirement. The applicable LCDs also require a provider to document medical necessity in the medical documentation including an indication that the treatment will make a significant practical improvement in the wound in a reasonable and generally predictable period of time. *See* LCD L18976 and L29128.

As with other beneficiaries discussed in this decision, the appellant fails to indicate that there was improvement in the beneficiary's wound, or that the wound would improve in response to the specified treatment for the November 11, 2008, date of service. For the November 11 visit, there are no treatment notes that describe the condition of the wound, or the treatment provided, on previous dates of service, and there is nothing to indicate that that the wound in question improved subsequent to the date of service at issue. Alternatively, the appellant did not clearly indicate in his examination report or through other medical documentation that a new approach would be initiated. Concerning the appellant's visit to the beneficiary on November 10, 2009, the appellant indicates that there was improvement, but he only makes cursory statements about the condition of the wound. General statements, similar to the statements listed in the examination report about the condition of the "improving"

wound, without documentation providing detailed evidence of improvement, fail to satisfy the criteria for Medicare coverage of continuing wound care and the documentation requirements listed in the applicable LCDs for wound debridement services. Thus, we find that the appellant's documentation does not demonstrate that the wound debridement procedures at issue were medically reasonable and necessary, and therefore the procedures are not covered by Medicare.

Turning to CPT code 99213 billed for November 11, 2008, we agree with the ALJ that the billed services were not eligible for separate reimbursement on this date of service. The appellant's E&M report for this date indicates that the beneficiary had chronic problems with arteriosclerotic lower extremity disease secondary to sickle cell disease, and it contained a detailed dermatologic evaluation of his leg ulcers. The appellant provided a detailed plan of care to address the beneficiary's wound on his left leg. However, the "Assessment" and "Plan" sections of the appellant's reports primarily focus on treatment for the beneficiary's ulcerations, for which E&M of the ulcerations is included in the surgical debridement codes. The appellant asserts that the services provided for the beneficiary's arteriosclerotic lower extremity disease and sickle cell disease were separate and apart from the surgical services performed on the same date. *See* Exh. MAC-1, at 3. But the appellant provides only cursory notes related to conditions other than the beneficiary's stage III ulcer, and merely recommends continuing the same treatment for the lower extremity and sickle cell diseases. Therefore, the Council concludes that the documentation does not demonstrate the need for a separately payable E&M visit.

For the November 20, 2008, date of service, the Council finds that the non-invasive physiological study (CPT code 93923) did not meet the Medicare coverage criteria given in the applicable LCD. The coverage criteria for the diagnostic test at issue is delineated in LCD L6001, *LCD for Noninvasive Physiologic Studies of Upper or Lower Extremity Arteries*. The LCD specifies that Medicare will consider this diagnostic test to be medically necessary for various conditions including "tissue loss defined as gangrene or pregangrenous changes of the extremity, or ischemic ulceration of the extremity occurring in the absence of pulses." LCD L6001. Before the Council, the appellant states that the beneficiary has a documented ischemic ulceration on his left leg as well as non-palpable pulses. However, a review of the medical documentation for November 20, 2008, does not

indicate that the beneficiary suffered from an ischemic ulceration or non-palpable pulses. In fact, the medical record does not indicate a condition such as peripheral arterial disease, which includes symptoms that qualify for the diagnostic test according to the applicable LCD. Moreover, the appellant stated in the examination report that the beneficiary's pulse and blood pressure were stable and that there was no ischemia present. *See* Exh. 3, at 215-216. Thus, we find that the medical documentation does not demonstrate that the non-invasive physiological study was reasonable and medically necessary, and therefore it is not covered by Medicare.

Beneficiary **S.P-Z.**
DOS: 11/18/2008 (codes 11042 and 99213)

Beneficiary S.P-Z. was seen by the appellant on November 18, 2008, during a follow-up office visit. Exh. 3, at 496. The appellant billed for debridement services (CPT code 11042) that were performed to treat a stage III pressure ulcer on the beneficiary's left heel. The appellant also billed Medicare for E&M services (CPT code 99213, modifier -25) related to the beneficiary's chronic venous insufficiency bilateral condition. *Id.* at 506.

Initially, the contractor denied Medicare coverage for the wound debridement and E&M services at issue. On redetermination and reconsideration, the contractor and the QIC upheld the contractor's initial determination. On appeal, the ALJ found that the services at issue were not reasonable and necessary, and thus, not covered by Medicare. In his decision, the ALJ determined that there was not sufficient medical documentation in the evidentiary record to support the conclusion that wound healing had occurred. Dec. at 10. Additionally, the ALJ determined that the services that the appellant billed as E&M services "were a necessary and normal part of the associated debridement services performed that same day" and so they were not eligible for separate reimbursement. *Id.*

The appellant does not raise any specific exceptions to the ALJ's decision concerning the denial of coverage for CPT code 11042 other than the contention that if Medicare does not cover the wound debridement services, it should cover the E&M services furnished on the same date of service. As for the appellant's exceptions regarding the denial of the E&M services, the appellant asserts that the medical record documents the beneficiary's complaints of swelling in both legs, as opposed to

wound debridement services focusing on only the left leg. The appellant also asserts that the "Objective" and "Assessment" sections of the examination report address the swelling in both legs of the beneficiary. The appellant states that the beneficiary was using sequential intermittent compression therapy and this was unrelated to any of the beneficiary's wounds. Exh. MAC-1, at 8-9.

Because the appellant did not raise any exceptions concerning the ALJ's denial of coverage for the wound debridement services, we adopt this part of the ALJ's decision without further comment. As for the E&M services billed by the appellant for beneficiary S.P-Z., we agree with the ALJ that they are not eligible for separate reimbursement. The appellant's description of the beneficiary's complaints of swelling in her feet was addressed mostly as a part of, and not in addition to, the wound debridement services that were furnished on the date of service at issue. In the examination report, the appellant discussed the beneficiary's chronic venous insufficiency in the context of her wound treatment. Further, the appellant instructed the beneficiary to continue the same treatment that she was already following prior to his visit. Similar to the report that was prepared for beneficiary O.La., the appellant provides only cursory notes related to conditions other than the beneficiary's wound on her left foot. Therefore, the Council concludes that the documentation does not demonstrate that Medicare should cover E&M services billed on the same date of service as the wound debridement services.

D. Financial Liability for Non-Covered Charges.

The ALJ determined that the appellant is liable for the non-covered charges, and the beneficiaries' liability is waived, pursuant to section 1879 of the Act. Dec. at 11. The appellant has not contested this determination. Therefore, the Council adopts this part of the ALJ's decision.

DECISION

For the reasons discussed above, the Council modifies the ALJ's decision. The Council finds that the wound debridement services furnished to I.E., O.La., O.Le., I.M., S.P-Z. and K.S., the E&M services furnished to O.La. and S.P-Z., and the diagnostic test furnished to O.La., as discussed above and identified in

Attachment A, are not covered by Medicare. The appellant is liable for the non-covered costs.

MEDICARE APPEALS COUNCIL

/s/ Gilde Morrisson
Administrative Appeals Judge

/s/Constance B. Tobias, Chair
Departmental Appeals Board

Date: June 18, 2012