ENSIGN SERVICES

POSTette: Therapist Role for Wound/Skin Care

References: State Practice Acts; MAC LCD's; CMS; APTA, AOTA, ASHA

The Therapists role in the interdisciplinary management of wound care is an important one. Therapy involvement is needed at various clinical facility meetings (e.g., skin meetings) when patients with wound care issues are discussed to determine appropriate rehab intervention.

Physical Therapist Role

Physical Therapist's (PT's) role in wound care involves treating patients and designing programs that prevent pressure injuries. In addition, PTs:

- That perform wound care are required to demonstrate competency prior to performing wound care (preferably upon hire and annually as established by the company). **NOTE:** Always follow the discipline-specific practice acts for each state.
- Consults with the clinical team about appropriate wound interventions for the patient.
- Perform sharp debridement (Refer to state practice act for guidelines.)
- Perform hydrotherapy (pulsed lavage or whirlpool) for the purposes of debridement
- Perform CPI (Closed Pulse Irrigation) for the purpose of debridement
- Perform modalities that enhance wound healing (i.e., ultrasound, electrical stimulation, and non-thermal infrared – using evidence-based practice guidelines) – **LCDs may have specific guidelines**.
- Assess for pressure relieving devices
- Develop and train positioning programs
- Perform functional mobility retraining

PT intervention is appropriate when any of these exist:

- Necrotic material is present in the wound bed.
- The wound is a stage 3 or 4 pressure injury.
- The Rehab potential is good to meet stated goals.
- The wound has an impaired healing process* **(*** Normal wound healing occurs in four to six weeks. If the onset has been greater than 30 days with traditional nursing interventions, and the wound has not demonstrated significant healing, PT services may be indicated.)

The wound intervention is concluded when:

- The wound is closed.
- The wound is no longer making significant progress despite changes to the treatment plan.

NOTE: In June 2000, the APTA passed a position statement stipulating that selective **sharp debridement be performed exclusively by physical therapists, not by PTAs.** Sharp debridement, because of its clinical complexity and the sophistication of judgment required to perform it, precludes delegation to PTAs or others. Frequent communication with the wound care interdisciplinary team is crucial. The treating Physical Therapist needs to work closely with the treatment Nurse or Charge Nurse. When the PT POC includes wound care, a best practice may be to have the treatment Nurse and PT do joint weekly measurement and staging of the wounds to ensure that documentation in the medical record is consistent.

Remember: Reimbursement for PTs providing wound care changes frequently. Refer to your state practice acts, payer source and/or intermediary guidelines.

From APTA:

*Active Wound Care Management Codes **97597-97598***

To summarize, both the wound care management and debridement CPT codes sets are meant for cases in which the healing of the wound is by secondary intention. Wound debridement codes are intended for acute wounds that are debrided of devitalized tissue, while active wound care management codes are intended for cleansing and promoting healing in chronic wounds. Debridement is measured in total depth and surface area, going from skin level down to the bone, while wound care management is limited to surface area only, generally does not go below skin level, and can be performed repeatedly as needed.

***97597** Debridement (e.g., high pressure waterjet with/ without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (e.g., fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; first 20 sq cm or less*

97598 *each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure) (Use 97598 in conjunction with 97597)*

Clinical Example (97597)
A 58-year-old woman presents for follow-up care with a pressure ulcer on the left plantar heel. The wound measures 3.5 cm x 3.0 cm x 1.0 cm. She previously underwent extensive debridement. It is determined that the wound edges and the wound bed are viable with granulations but covered with an adherent proteinaceous slough, fibrin, and debris. After review, it is determined that the patient's wound would benefit from selective active wound care management.

Description of Procedure (97597)
The wound status, classification, size, location, drainage, and depth are documented. Inspect for and document sinus tracts, undermining, odor, and the quality of the wound bed tissue. Inspect and palpate the surrounding skin, wound edge, and exposed soft tissue. Topical or local anesthesia is administered, as needed. Cleanse the wound thoroughly, utilizing high-pressure water jet. Remove the proteinaceous slough, fibrin, and debris covering the wound bed with curette, scalpel, and forceps or scissors until healthy tissue is visualized. Ensure hemostasis.

Clinical Example (97598)
A 28-year-old man presents with a chronic open wound on the right lower leg 3 cm above the medial malleolus. The patient previously underwent extensive debridement of the necrotic soft tissue at the site. The wound currently measures 6.3 cm x 5.2 cm x 2.2 cm. The wound bed is granulating but covered with adherent, yellow proteinaceous slough and fibrous tissue. A moderate amount of serosanguineous drainage is noted. X-rays are unremarkable for bone changes. After examining the wound, it is determined that selective active wound care management would be appropriate.

Description of Procedure (97598)
Additional topical or local anesthesia is administered, as needed. Additional wound cleansing is performed, including additional removal of proteinaceous slough, fibrin, and debris covering the wound bed with curette, scalpel, and forceps or scissors until healthy tissue is visualized.

NOTE: Log 97598 for each occasion of 20 sq cm after the initial 20 sq cm

EXAMPLE: If you have an area that is 60 sq cm
Log codes as follow:
97597 x 1
97598 x 2

Minimum Documentation Requirements:
The medical record must include a plan of care containing treatment goals and physician follow-up. The record must document complicating factors for wound healing as well as measures taken to control complicating factors when debridement is part of the plan. Appropriate modification of treatment plans, when necessitated by failure of wounds to heal, must be demonstrated.

The patient's medical record must contain clearly documented evidence of the progress of the wound's response to treatment at each visit. This documentation includes, at a minimum:

- Current wound volume (surface dimensions and depth).
- Presence (and extent of) or absence of obvious signs of infection.
- Presence (and extent of) or absence of necrotic, devitalized or non-viable tissue.
- Other material in the wound that is expected to inhibit healing or promote adjacent tissue breakdown.

What to include in the intervention documentation:
- Debridement is selective
- Total wound(s) surface are in 'square centimeters' being debrided, including location site(s)
- Depth (or grade), appearance of wound(s)
- Type of tissue or material debrided, amount and quality of debris prior to removal
- Procedures and methods used, sharp instrument used
- If multiple wounds are treated each should have the above components documented and have clear reference to which wound is being described
- Instruction(s) for ongoing care

POSTette: Therapist Role for Wound/Skin Care

References: State Practice Acts; MAC LCD's; CMS; APTA, AOTA, ASHA

Electrical Stimulation (ES) and Electromagnetic Therapy (ET) (Diathermy): These modalities are appropriate for use with some wounds**.**

NOTE: Most LCD's will not cover ES and ET for the same wound.

The following are codes appropriate when using these modalities for wound care:

G0281: Electrical stimulation (unattended), to one or more areas, for chronic stage 3 and stage 4 pressure injury, arterial injuries, diabetic injuries and venous stasis injuries not demonstrating measurable signs of healing after 30 days of conventional care. **It is important to note that G0281 is the only code that may be used for E-stim for wound care.

G0329 (Electromagnetic Therapy for Wounds): Electromagnetic therapy (Diathermy), to one or more areas for chronic Stage 3 and Stage 4 pressure injuries, arterial injuries, diabetic injuries, and venous stasis injuries, not demonstrating measurable signs of healing after 30 days of conventional care.

The use of Electrical Stimulation for wounds or Electromagnetic Therapy for wounds needs to have the following clearly documented:

- Wound being treated is Chronic Stage 3or 4
- 30 days of other conventional interventions were attempted without success.
- The onset of the wound should be clearly documented in the note, and must be supported by documentation in the chart from other disciplines
- Physician examines (in person) the wound every 30 days and documents the visit

Additional documentation tips:

- Total wound(s) surface are in square centimeters being debrided
- Depth (or grade), appearance of wound(s)
- Type of tissue or material being treated
- Procedures and methods used
- If multiple wounds are treated, EACH should have the components documented and have clear reference to which wound is being described
- instruction(s) for ongoing care

Occupational Therapist Role

- If an Occupational Therapist is certified in active wound care and permitted by state practice acts, see Physical Therapist Role.
- Wound care patients should be screened/ assessed by an Occupational Therapist (OT) for positioning, range of motion (ROM) impairments, and the need for splints and/or a restorative nursing program.
- If the patient is losing weight, OT should determine if an adaptive feeding program is needed.

Speech-Language Pathologist Role

- Speech-Language Pathologists should screen/ assess wound care patients to determine any barriers with adequate nutrition intake for wound healing.

Wound/Skin Program Tips:

- Obtain a copy of skin report
- Review all patients w/wounds:
  - Support surfaces in place & used correctly
  - Mobility status
  - Positioning
  - Self-feeding deficits
  - Diet consistency considerations
  - Stage 3 & 4
  - Necrotic tissue present
  - Rehab intervention
  - Chronic Non-healing wounds

Note: For specific wound care documentation requirements refer to payer guidelines including MAC Local Coverage Determinations (LCD's).