



August 2, 2024

Ms. Nicole Marcos
Designated Federal Official (DFO)
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244–1850

RE: File Code CMS–1826–N

Dear Ms. Marcos:

The Alliance of Wound Care Stakeholders (“Alliance”) is a nonprofit multidisciplinary trade association representing physician specialty societies, clinical and patient associations whose mission is to promote quality care and access to products and services for people with wounds through effective advocacy and educational outreach in the regulatory, legislative, and public arenas. Our members possess expert knowledge in complex chronic wounds, and in wound care research. These clinicians treat patients with wounds in all settings – including the hospital outpatient arena. A list of our members can be found on our website: (www.woundcarestakeholders.org).

The Alliance has two separate topic areas which we would like to address. These include:

- Skin substitutes – or more appropriately referred to in our letter as cellular and/or tissue-based products (“CTPs”)
- Total Contact Casting

Skin Substitutes/Cellular and/or Tissue Based Products For Skin Wounds

The Alliance requests that the Hospital Outpatient Payment Panel vote to recommend to CMS the following specific CTP related changes:

1. CMS should
 - assign the existing CPT® add-on codes (15272, 15276, 15274, and 15278) and HCPCS codes (C5272, C5276, C5274, and C5278) to appropriate APC groups allowing for separate payment and
 - issue an exception to separately pay for these add-on codes.
2. CMS should realign both the high-cost and low-cost application procedure codes to higher paying APC groups that reflect the current average sales prices of all CTPs. Manufacturers are required to submit ASP pricing and this pricing should be used to map to an appropriate APC for all CTPs whether they are issued a HCPCS “A” code or “Q” code.

3. CMS should assign the CPT and HCPCS codes for the same size wound, regardless of anatomical location on the body, to the same APC groups.
4. CMS should assign all new CTPs with either “Q” or “A” HCPCS codes, to the low-cost APC groups until a manufacturer provides cost information to CMS.
5. CMS should not assign CTPs that are not in sheet form (e.g., gel, powder, ointment, foam, liquid, or injected) to any APC group because these products are not allowed to use the current application codes of 15271-15278 or C5271-C5278, which drives the APC group assignment. CTPs that are not in sheet form track to services and procedures such as clinic visits and debridement of chronic wounds and therefore should not map to any APC.

We appreciate that the Panel has approved these recommendations over the past few years and request that they once again approve them, as CMS has not yet adopted and implemented any of them. These recommendations stem from patient access issues which are related to the prohibitive costs that hospital outpatient departments (HOPDs) incur if they provide medically necessary CTPs to patients with larger wounds/ulcers. The result is that patients are not receiving care for larger-sized wounds in HOPDs, causing issues with access to care and significant health equity concerns.

The rationale CMS cited for not adopting these in the CY 2023 and CY 2024 Medicare Hospital Outpatient PPS Final Rule responses are concerning. Therefore, we are not only providing the rationale for your consideration but also our concerns with the rationale provided in CMS’s Response to Comments in order to provide further clarification on these recommendations.

1. CMS Should Assign The Existing CPT® Add-on Codes (15272, 15276, 15274, and 15278) and HCPCS codes (C5272, C5276, C5274, and C5278) To Appropriate APC Groups Allowing For Separate Payment And Issue An Exception To Separately Pay For These Add-on Codes.

Rationale for Recommendation

The first barrier to access relates to the packaging of the add-on codes. When the payment for CTPs was packaged into the payment for the application, the add-on codes were also packaged. Because the add-on codes represent wounds and ulcers that require the purchase of additional product or a larger product, patients with wounds/ulcers larger than 25 sq. cm. up to 99 sq. cm. and wounds/ulcers greater than 100 sq. cm. are not being offered medically necessary CTPs in the HOPDs. The reason for this is that the packaged OPPS rates for the base codes are not adequate to allow the HOPDs to purchase the sizes of CTPs necessary to apply to wound/ulcer sizes that are aligned with the add-on code descriptions.

To remedy this issue, the Alliance **urges the Panel to recommend that CMS issue an exception to separately pay for the CTP application add-on codes.** The allowance of payment for the add-on codes is an easy remedy for CMS to implement and there has been precedent set by CMS providing this exception to other procedures which require the purchase of additional product (e.g., chemotherapy).

Additionally, the Alliance **recommends that APC groups 5053, 5054 and 5055 be retained but additional APC groups should be created to appropriately address the costs to purchase the appropriate amount of**

product for wounds/ulcers 26-50 sq. cm., 51-75 sq. cm., 76-99 sq. cm., and each additional 100 sq. cm.

Again, currently, the CPT codes are assigned to APCs based on the wound size - smaller wounds (under 25 sq. cm) or larger size wounds (over 100 sq. cm). The current system makes CTPs for patients, with wounds /ulcers that are in between 25 sq. cm. and 100 sq. cm. as well as those over 100 sq. cm., cost-prohibitive for HOPDs since they are not reimbursed for the extra product that would be needed to treat the patient's medically necessary wounds/ulcers.

In order to appropriately pay HOPDs now for the various sizes of products required for the wounds and most importantly, so that patients with larger wounds can gain medically necessary access to CTPs, each base code for the application of the products must track to separate APC groups and each add-on code must also track to separate APC groups. The OPPS payment rates for the add-on code APC groups should include payment for the additional product that must be purchased. CMS has often stated in their regulations that the cost of the product is significant. In fact, roughly 50% of the payment is for the product and therefore not an insignificant piece. If it was insignificant, not allowing separate add on code payment would not be harmful. However, as CMS stated, the product's cost is significant, and HOPDs can not incur the loss to provide the product to the patient. As a result, patients are being harmed as they have to seek care in different sites of service to obtain the necessary care for their larger sized wounds that is also creating health equity repercussions as a result. In 2023, The Journal of Medical Economics published the study "Chronic wound prevalence and the associated cost of treatment to Medicare beneficiaries: changes between 2014 and 2019," which demonstrated that since the beginning of the packaging of CTPs in the hospital outpatient department, care has shifted to the physicians' office for the treatment of larger sized wounds. Patients should not be penalized by needing to go to other sites of service to obtain treatment for their larger sized wounds - but sadly they are. Again, the Alliance recommends that each base code for the application of the products track to separate APC groups and each add-on code track to separate APC groups. The OPPS payment rates for the add-on code APC groups should include payment for the additional product that must be purchased.

If CMS is not agreeable to this recommendation, as they have not been for the past several years, we recommend that the HOPD be allowed to bill separately for the additional product necessary (in addition to the APC payment for the application) to allow them to afford the purchase of the extra product required to treat the larger wounds/ulcers.

CMS needs to reimburse HOPDs for additional product used for larger sized wounds. The Alliance recommends that the way to do this is to assign the existing CPT® add-on codes (15272, 15276, 15274, and 15278) and HCPCS codes (C5272, C5276, C5274, and C5278) to appropriate APC groups allowing for separate payment and issue an exception to separately pay for these add-on codes

Concerns Related to CMS's Response to Comments

We have concerns with the statements made by CMS in the 2023 and 2024 OPPS final rules and believe the Agency applied faulty logic for the reasons that it did not accept the recommendations of the Panel.

CMS's policy to unconditionally package add-on code procedures has had the following ramifications: it completely undermined the AMA CPT coding framework; it has not ensured that HOPDs are reimbursed for all medically necessary services performed; and it ultimately has impacted Medicare beneficiary access to important medically necessary and indicated CTPs in HOPDs which in turn is also creating a wider divide in health equity.

As stated above, the lack of access to care in the HOPD discussed above, has been demonstrated in the Journal of Medical Economics, “[Chronic wound prevalence and the associated cost of treatment in Medicare beneficiaries: changes between 2014 and 2019](#).” (This study is included as an attachment to these comments.). The key findings of the study which validates the shift from patients being treated in the HOPD to the physician’s office are:

- **Shifts in site-specific spending:** HOPD fees saw the largest reduction (\$10.5 billion to \$2.5 billion) although home health agency expenditures decreased from \$1.6 billion to \$1.1 billion. Physician offices saw an increase from \$3.0 billion to \$4.1 billion and durable medical equipment increased from \$0.3 billion to \$0.7 billion.
- **Decreasing overall cost:** Despite the increase in prevalence, healthcare expenditures associated with chronic wound care *decreased* over the study period. The researchers used three different methods to estimate expenditures. Regardless of the method used, there was a reduction in expenditure, with the most conservative method showing a decrease from \$29.7 billion to \$22.5 billion. This is particularly surprising since overall Medicare [costs increased](#) over the same time frame.
- **Shifts in wound types and cost:** The largest changes were increases in arterial ulcers (0.4% to 0.8%) and skin disorders (2.6% to 5.3%), although the authors suggest that the movement from ICD-9 to ICD-10 over the study time period may factor into the changing prevalence of certain types of wounds. As in 2014, surgical wound complications were the most expensive in 2019, with pressure ulcers the second most expensive. For most wound types there were decreases in expenditures, but the “generic” chronic ulcers and venous leg ulcers registered small-to-moderate increases.

Packaging all add-on codes is indiscriminate, does not promote payment accuracy or advance patient care and creates not only barriers to access but health equity concerns. However, the allowance of payment for the add-on codes – as recommended by this Panel - is an easy remedy for CMS to implement and there has been precedent set by CMS providing these types of exceptions (i.e. chemotherapy).

Yet, CMS has stated that since the OPPS is a prospective payment system and that CTP products are packaged into the payment for their application, “paying separately for add-on codes defeats the goals of such a payment system” and “a prospective payment system is not intended to discourage providers from rendering medically necessary care to patients.” We disagree.

We submit that CMS’s logic is flawed since procedures that require the purchase of a product should receive special considerations. The CMS response may be true for procedures, such as debridement, but cannot be logically applied to procedures that have advanced therapy products packaged into them. **CMS continues to erroneously believe that HOPDs are reimbursed adequately when they treat a patient with a wound/ulcer larger than 25 sq cm. This is simply wrong.** In fact, most hospital administrations prohibit purchase of product for chronic ulcers greater than 28 sq. cm.

As we have stated multiple times, when the AMA work group revised the procedure codes for the application of CTPs, it carefully selected the base codes and add-on codes based on the typical wound/ulcer sizes. Unfortunately, when CMS originally packaged the CTP products into the procedure codes, the Agency **did not include adequate product costs** into the application procedure base codes. In fact, the Alliance of Wound Care Stakeholders has presented CMS with data over the years to show that product costs are and continue to be

higher than the allowable amounts in the packaged rates. However, CMS did not correct the inadequate product costs included in the application base codes, which was further compounded when CMS also packaged the add-on codes. The incorrect product allowable in the base codes and the packaged add-on codes have prevented access to CTPs to patients with wounds/ulcers between 26 and 99 sq. cm. and larger than 100 sq. cm. That is why most patients with those size wounds/ulcers do not have the opportunity to receive CTPs in HOPDs. Therefore, this system is discouraging HOPDs from rendering medically necessary care due to inadequate reimbursement for larger-sized wounds.

This is further highlighted in the following example as presented to CMS:

In addition, CMS stated in its response to the recommendations: *“A substantial portion of the cost of a skin substitute graft application procedure is the graft skin substitute product itself, and the cost of the skin substitute graft products is reflected in the cost of the overall procedure.”* CMS is correct that the substantial portion of the cost of the CTP application procedure **is the cost of the product itself**. However, **the cost of the product is NOT adequately reflected in the computed cost for the primary procedures, and there is NO cost afforded to the add-on codes**. This is a significant issue and one that the Panel also has recognized and has repeatedly requested CMS to address.

Furthermore, CMS erroneously stated that *“facilities are making a profit on the products being used to treat smaller sized wounds and those financial gains even out the losses for product used on the larger sized wounds.”* **This is simply wrong**. Since CMS requires providers to purchase the right size product to match the wound/ulcer size, the **HOPD does not experience much, if any, financial gain when they apply CTPs to wounds/ulcers less than 25 sq. cm. because the allowable amount did not originally and still does not**

cover the costs for small size CTPs. This data was provided to CMS by the Alliance multiple times in comment letters and meetings with the Agency. Therefore, it is illogical to assume that the financial gain (which is none-to-little) for small size wounds/ulcers will offset the huge financial loss that the HOPDs would experience if they purchase product for wounds/ulcers between 26 and 99 sq. cm. and larger than 100 sq. cm with no additional payment.

Because precedent has been set in other areas in which exceptions have been made allowing payment for the add-on codes in OPPS, **the Alliance respectfully requests the Panel to once again support the Alliance recommendation that CMS assign the existing CPT add-on codes (15272, 15276, 15274, 15278) and HCPCS codes (C5272, C5276, C5274, and C5278) to appropriate APC groups, and to issue an exception for separate payment of the CTP application add-on codes.**

2. CMS Should Realign Both The High-Cost And Low-Cost Application Procedure Codes To Higher Paying APC Groups That Reflect The Current Average Sales Prices Of All CTPs.

CMS should realign both the high-cost and low-cost application procedure codes to higher paying APC groups that reflect the current average sales prices of all CTPs. To accomplish this, CMS should use the ASP of all CTPs (products assigned “Q” and “A” HCPCS codes). This will help appropriately map to the correct APC. Because inaccurate product costs were built into the packaged payment for the application of CTPs, the HOPDs have been unable to purchase most low-cost CTPs, even for small sized wounds/ulcers. This improper payment has existed now for 11 years. Now that all CTP manufacturers are required to submit the ASPs for their products, CMS should have adequate pricing information to build actual CTP prices into the application procedure base codes and add-on codes. Once that is accomplished, CMS should realign the CTP application procedure base codes and add-on codes to APC groups that reflect the HOPDs’ true costs.

Since mapping procedure codes to the appropriate APC groups is within this Panel’s charter, the Alliance requests that this Panel recommend that CMS realign the application of CTP base codes and add-on codes to appropriate APC groups that reflect current prices of high-cost and low-cost CTPs. CMS can easily accomplish this by using the existing ASP data to calculate the actual costs for all the CTPs with “Q” codes and “A” codes assigned to the high-cost and low-cost groups. By using the actual reported ASP information, CMS should reassign the packaged application base codes and add-on codes to APC groups that reflect current prices, not the inadequate prices that were used by CMS eleven years ago.

Concerns Related to CMS’s Response to Comments

CMS does not agree with the use of ASP pricing and stated in the response to comments, “we do not believe this is a feasible approach for CY 2024, and it appears to be a different approach to pricing one group of packaged supplies as compared to how all other packaged supplies are priced in the OPPS”. We couldn’t agree more – it should be a different approach because CTPs are not supplies – surgical or any other type of supply. These products are adhered to the wound – they are not removed. Furthermore, it is mandated by law that ALL CTPs report their ASPs. In fact, CMS just held a webinar on ASP reporting for CTPs. No packaged supply is required by law to submit ASP pricing. CTPs are. Finally, this product class also has regulatory requirements placed on them that NO other supply has, specifically, tissue tracking requirements. There are

rigorous requirements that clinics have to adhere to in order to pass their Joint Commission accreditation inspections. These include but are not limited to documenting:

- Who delivered the CTP
- What time the CTP was delivered
- What condition the CTP arrived
- How the CTP is being stored
- Where they are stored
- Monitoring and logging daily temperatures in storing the CTP
- Each staff member who has come into contact with each tissue needs to be tracked and documented
- Maintain a 10-year record retention of the CTP applied

HOPDs are in jeopardy of losing their accreditation based on failure to comply with these requirements. No supply has the same type of documentation requirements as CTPs or have any specifically identified Joint Commission requirements as stringent as CTPs. The reason – CTPs are not supplies and are not treated as such through the accreditation process.

The rationale for not using ASP pricing to assign APC groups is misguided as CTPs are not surgical supplies and are already required to submit ASP pricing to CMS. As such, the Alliance requests that the panel recommend that CMS realign both the high-cost and low-cost application procedure codes appropriate APC groups that reflect the current ASP of all CTPs – especially since ASP reporting is required by all CTP manufacturers.

3. CMS Should Assign The CPT And HCPCS Codes For The Same Size Wound, Regardless Of Anatomical Location On The Body, To The Same APC Groups.

Rationale for Recommendation

Another access issue relates to the anatomic location of the wound/ulcer and the APC group that CMS has assigned to the application procedure code. The APC group assignment should be the same for the same size wound/ulcer whether the ulcer is located on the leg or foot, since the same resources and amount of product must be purchased. However, that is not how CMS has assigned the APCs.

This example illustrates why this is problematic:

Both Patient A and Patient B have chronic ulcers. Patient A has a 100 sq. cm. ulcer on the leg and Patient B has a 100 sq. cm. ulcer on the foot. The application to Patient A should be coded to 15273 which is assigned to APC 5055. The application to Patient B should be coded to 15277 which is incorrectly assigned to APC 5054. Because the same amount of product must be purchased for the 100 sq cm ulcer on the foot, as for the leg, 15277 should be assigned to APC 5055.

HOPDs cannot afford to manage 100 sq cm wounds on the foot. Therefore, patients with large foot ulcers are denied access to treatment while patient with large leg ulcers receive the treatment.

Concerns Related to CMS's Response to Comments

Unfortunately, CMS's response is incorrect, and thus, CMS's Response to Comment is faulty. In the response to comments in the CY 2024 final rule, CMS indicates that the current codes describing the application of high-cost graft skin substitutes for wounds less than 100 cm² (CPT codes 15271 and 15275) have been assigned to the same APC (5054), and the current codes describing the application of low-cost graft skin substitutes for wounds less than 100 cm² (HCPCS codes C5271 and C5275) have been assigned to the same APC (5053). Because they are currently included in the same APC, the OPSS payment for them is the same; and this payment policy is consistent with the recommendation from the HOP Panel and other commenters. This statement is correct and has not been the subject of the comments being provided. However, the application CTPs for wounds that are 100 cm² on the trunk, arms, and legs (CPT code 15273/C5273) has been assigned to a higher-paying APC (APC 5055) than the APC assignment for the code describing the application of CTPs for wounds 100 cm² on the face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hand, feet, fingers, and toes (CPT code 15277/C5277), which is assigned to APC 5054. The 5054 assignment is inappropriate.

It is concerning that CMS does not understand that the same resources and amount of product are used on a patient with the same sized wound located in a different part of the body. Perhaps there is a thought by the Agency that it is easier to apply a CTP to a smaller part of the body. However, it is not easier. 15277/C5277 and 15273/C5273 should be mapped to the same APC – 5055.

Since 2021, the Panel has agreed that CMS should assign APCs for the same size wound regardless of the anatomical location on the body so that 15273/C5273 and 15277/C5277 should be assigned to APC 5055 and 15271 and 15275 should continue to be assigned to APC 5054. As such, the Alliance once again **requests that the Panel recommend that CMS should assign APCs for the same size wound regardless of the anatomical location on the body so that 15273 and 15277 be assigned to APC 5055, and 15271 and 15275 continue to be assigned to APC 5054** as the same resources are used regardless of anatomic location of the wound.

4. CMS Should Assign All new CTPs, With Either “Q” or “A” HCPCS Codes, to the Low-Cost APC Package Until the Manufacturer Provides Cost Information to CMS.

Beginning in 2013 when CTPs were packaged in the HOPDs, CMS mapped CTPs assigned HCPCS “Q” codes into an appropriate APC group based on pricing data that had to be submitted by the manufacturer. CMS identified the pricing information that it required the manufacturer to submit to determine the placement of the product in the high or low-cost group. If the cost was not provided to CMS, the product was automatically placed in the low-cost group. CMS currently places some CTPs assigned “Q” codes into the high or low-cost package based on the Median Unit Cost (MUC) or the Per Day Cost (PDC) and then the product is mapped to an appropriate APC group.

CMS began to issue HCPCS “A” codes to CTPs with FDA 510(k) clearance and has automatically placed certain A code products (those assigned a HCPCS A2XXX code) into the high-cost package without receiving any pricing data to validate their placement in the higher APC grouping while other CTPs not being issued HCPCS A2XXX codes are required to submit pricing information for placement.

The Alliance is concerned with this action by the Agency for the following reason: **CMS is not following its own guidance on this issue and there is a lack of consistency in the placement of product into an appropriate APC. The mapping of CTP products to the appropriate APC group should be based on the assignment of the product to either the high or low-cost package - which is determined by pricing data provided by the manufacturer.**

By automatically placing the CTPs assigned certain “A” codes (those assigned A2XXX) into the high-cost APC group without receiving pricing information from the manufacturer, CMS is potentially paying high-cost rates for CTPs that are actually low-cost. As such, the Alliance requests that this Panel recommend to CMS that the Agency place all CTPs into the high or low-cost package by appropriately mapping each CTP to the correct APC group using pricing data.

Specifically, **CTPs that are issued HCPCS A2XXX codes should not automatically be assigned to the high-cost package and potentially map to an incorrect APC group without providing appropriate pricing data.** The methodological placement of a CTP with a HCPCS A2XXX code into the high or low-cost package should be based on the MUC or PDC just like CTPs that are issued HCPCS “Q”. Not only would this be equitable, but CMS would be following its own guidance. **The notion that “A” codes are “different” from other CTPs is factually not correct.** There are current 510(k) products that have HCPCS “Q” codes and newer ones that now have two types of HCPCS “A” codes being issued.

Concerns Related to CMS’s Response to Comments

In their response to comments CMS stated the following to address the issue of HCPCS codes being issued A2XXX codes not being required to provide pricing and automatically being placed in the high cost group:

- We decided on an approach that would ensure that any graft skin substitute product that could potentially have been described by deleted HCPCS code C1849 be included in the high-cost group.
- We want to ensure that graft skin substitute products that were described by HCPCS code C1849 or could potentially be described by HCPCS code C1849 would be granted time to develop the cost data necessary to allow us to determine if the product should stay in the high-cost group
- Having products with both biological and synthetic elements leads to difficulty defining which of the products assigned to the A2XXX series would be considered “synthetic” and described by HCPCS code C1849.
- We will assign to the high-cost group any skin substitute product that is assigned a code in the HCPCS A2XXX series including new products without pricing information.

CMS has on multiple occasions in rulemaking stated that products within the C1849 code (synthetic CTPs) are and should be classified as CTPs. The Alliance agrees that they are CTPs. Since the agency considers synthetics as CTPs then they should be treated like all other CTPs that came before that subclass of products entered the marketplace. All CTPs prior to synthetics coming into the market-place – were assigned HCPCS Q codes and mapped to appropriate APCs after submitting pricing data. To treat any other CTP differently is wrong. Moreover, CMS also justifies this distinction by saying that any product that could have been described by the C1849 code and were issued a HCPCS A2XXX should automatically be placed in the high-cost bucket. Yet, none of these products should have received A codes but rather they should all have been issued Q

codes which would have taken care of CMS' issues in trying to define and classify the products currently and that will be coming in to the market in the future. Finally, CMS states that, products in the C1849 are being granted time to develop the cost data necessary to allow CMS to determine if the product should stay in the high-cost group. If one is to follow the CMS logic then ANY new CTP that comes into the market place should be assigned to the high cost group without providing any cost data – which clearly is not their intent nor is that a reality. All other products are required to provide pricing data in order to be mapped to an appropriate APC. Any product assigned a A2XXX code should be required to do so as well.

As such, the Alliance once again requests that the panel recommend that all CTPs in the market place – regardless of whether they are “synthetic”, “synthetic with biologic components” or products that do not have any synthetic components should provide necessary pricing data to determine appropriate APC placement. CMS should assign all new CTPs, with either “Q” or “A” HCPCS codes, to the low-cost APC package until pricing is provided by the manufacturer.

5. CMS Should Not Assign CTPs That Are Not In Sheet Form (e.g., Gel, Powder, Ointment, Foam, Liquid, or Injectable) To Any APC Group.

CMS should not assign CTPs that are not in sheet form (e.g., gel, powder, ointment, foam, liquid, or injectable) to any APC group because these products are not allowed to use the current application codes of 15271-15278 or C5271-C5278, which drive the APC group assignment. CTPs that are not in sheet form track to services and procedures such as clinic visits and debridement of chronic wounds. CTPs that are not in sheet form (i.e. gel, powder, ointment, foam, liquid, or injectable) do not align with the American Medical Association's application of CTP coding directions. Furthermore, Medicare does not currently cover or pay for any CTP not in sheet form. As such, these products should not be assigned to any APC group.

The Alliance requests that this Panel recommend to CMS to stop assigning CTPs not in sheet form to any high-cost or low-cost APC group as it is not appropriate.

CMS has indicated that they are already doing this – but this is not correct. There are still products not in sheet form being assigned to APC groups. Therefore, the Alliance requests that the Panel recommend to CMS that they ensure that CTPs not in sheet form not be assigned to a high or low-cost APC.

Total Contact Cast (TCC)

CPT coding guidance allows for debridement (codes [11042-11047](#), [97597- 97598](#))) and application of TCC (CPT 29445) on the same date of service. These codes should map to APC 5052-5053/5102. The CPT Assistance Guidance states, "Code [29445](#), *Application of rigid total contact leg cast*", is the appropriate code to report for the total contact cast application. A TCC is used to reduce the pressure and/or shear forces on a lower extremity wound, typically on the plantar surface. The cast improves the ability of the wound to heal. **If a wound debridement is performed (codes [11042-11047](#), [97597- 97598](#)), any primary or secondary dressing materials used to cover the wound would be included in the debridement and would not be separately reported. However, a TCC is not considered a wound dressing and is not included in the debridement procedure.** Therefore, the cast application should be coded in addition to the code for the appropriate level of debridement, if performed, and should appropriately be mapped to APC 5102. This is a significant issue, one in which the Alliance has been addressing for several years.

The Alliance recommends that the Panel recommend that hospital outpatient departments get paid the separate APC for the TCC (APC 5102) when a debridement is performed on the same date of service.

Conclusion

The Alliance appreciates consideration of the Panel requesting CMS to move forward with these recommendations. Adopting these recommendations will assure that HOPDs can provide the necessary access to CTPs for Medicare beneficiaries and ensure that payment is adequate for providers to treat their patients as well as ensure that TCC is accessible and being appropriately reimbursed.

Thank you for your consideration.

Sincerely,

A handwritten signature in black ink that reads "Marcia Nusgart R. Ph." The signature is written in a cursive, flowing style.

Marcia Nusgart, R.Ph.
CEO, Alliance of Wound Care Stakeholders