To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP.

Table of Contents

Related Clinical Coverage Policies
Refer to https://medicaid.ncdhhs.gov/ for the related coverage policies listed below:
1G-2, Skin Substitutes
1-O-3, Keloid Excision and Scar Revision

1.0 Description of the Procedure, Product, or Service

Major advances in care of burn patients have resulted in marked decreases in mortality and morbidity, especially with massive burns. In addition to survival, the current focus in burn care is on improving the long-term function and appearance of the healed or replaced skin cover as well as quality of life.

1.1 Monitoring of Interstitial Fluid Pressure

As subeschar edema develops under burn tissue, tissue pressure increases which decreases venous return, thus impairing arterial flow making escharotomy necessary. Monitoring of interstitial pressure is a necessary procedure in a patient with severe full thickness burns to detect muscle compartment syndrome. Compartment pressures may need to be taken several times a day and in numerous locations to determine if a fasciotomy should be performed. Failure to diagnose compartment syndromes and act appropriately can result in loss of digits, or limbs, and can contribute to loss of life.

Usually the pressure measurement number itself is not used as an absolute indication but is compared with previous measurements and any clinical evidence of nerve compression, i.e., tingling, increased pain, decreased sensation, or vessel compression. Motor nerve dysfunction is more difficult to assess given the fact that muscle damage may be impossible to distinguish from nerve damage. Excessive tissue turgor is the single most useful sign of underlying muscle damage and the need for fasciotomy.

1.2 Escharotomy

An escharotomy is an incision made through the eschar (dead tissue) into the fat layer below to relieve pressure. It is a surgical procedure performed by the physician, with the surgical wound covered by a dressing. Often an escharotomy is necessary in circumferential (burned all the way round) second and third degree burns of the arms, hands, legs and chest. The need for an escharotomy usually occurs within the first 12 to 48 hours following burn injury. The pressure from the edema can cause constriction of the veins, arteries and nerves of the arms and legs, just like a tight tourniquet. In circumferential burns of the chest, the pressure from the edema can prevent the patient from adequately expanding his or her chest wall to breathe.

1.3 Fasciotomy

Fasciotomy is a surgical procedure in which the fascia is cut to relieve tension or pressure that limits circulation to an area of tissue or muscle. Fasciotomy is a limb saving procedure when used to treat acute compartment syndrome.

Acute limb compartment syndrome is a surgical emergency characterized by raised pressure in an unyielding osteofascial compartment. Sustained elevation of tissue pressure reduces capillary perfusion below a level necessary for tissue viability, and

irreversible muscle and nerve damage may occur within hours. Causes include trauma, revascularization procedures, burns, and exercise. Regardless of the cause, the increased intracompartmental pressure must be promptly decompressed by surgical fasciotomy.

1.4 Skin Grafting

1.4.1 Autograft

Autografting involves taking skin from an unburned part of the patient's body (donor site) and placing it on the burn wound. After excision, skin grafting may be done if the burn injury is not too extensive. Skin grafting may be postponed until the excised wound bed is healthier. More than one surgical procedure may be necessary depending upon the extent and location of the burns. If more than one surgery is necessary, temporary skin coverage is needed to protect the wound until final grafting or healing takes place.

Most full thickness and sometimes partial thickness burn injuries require excision and skin grafting. When the excised wound bed is ready for skin grafting, the autograft is used to cover the defect.

Partial thickness burns cause blisters and damage all of the epidermis and part of the underlying dermis. These burns usually heal on their own when treated with cleaning and bandaging, however if they are extensive or in a sensitive area, such as the face, they may benefit from the use of cellular wound dressings. These temporary coverings help prevent infection and fluid loss until autografting can be performed. These products may also allow surgeons to take thinner grafts because not as much dermis is required in the autograft.

Full-thickness burns completely destroy both the epidermis and the dermis, and may even damage the underlying flesh and bones. The body is unable to heal itself properly because there are no healthy cells to regenerate. These burns require surgery to replace damaged skin with healthy skin, a process known as grafting. If these wounds are not treated, the body attempts to close them by forming scar tissue that contracts over time, leading to disfigurement and loss of motion in nearby joints.

Surgeons use partial thicknesses of healthy skin from another part of the person's own body (autografting) as a permanent treatment for burn wounds. When the skin damage is so extensive that there is not enough healthy skin available to graft initially, surgeons may use cellular wound dressings.

1.4.2 Allograft

An alternative to autografting is to use skin from another person (allograft) or from another species (xenograft) as a temporary covering to protect the wound. (Refer to Clinical Coverage Policy 1G-2, Skin Substitutes.)

Allografting is more common than xenografting. Allografting uses skin from cadaveric donors, and provides the temporary natural protection of human skin. Xenografts of pigskin are sometimes used if allografts are not available. Xenografts of pigskin are in plentiful supply. Pigskin is the xenograft source that is most anatomically similar to human skin.

1.5 Definitions

None Apply.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(*The term "General" found throughout this policy applies to all Medicaid policies*)

a. An eligible beneficiary shall be enrolled in the NC Medicaid Program *(Medicaid is NC Medicaid program, unless context clearly indicates otherwise*);
b. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.1.2 Specific

(***The term "Specific" found throughout this policy only applies to this policy***)

a. Medicaid

None Apply.

2.2 Special Provisions

2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. **42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]**

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

b. **EPSDT and Prior Approval Requirements**

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide,* and on the EPSDT provider page. The Web addresses are specified below.

   NCTracks Provider Claims and Billing Assistance Guide: https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html

   EPSDT provider page: https://medicaid.ncdhhs.gov/

3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.

3.1 General Criteria Covered

Medicaid shall cover the procedure, product, or service related to this policy when medically necessary, and:

a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;

b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and

c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by Medicaid

None Apply.

3.2.2 Medicaid Additional Criteria Covered

None Apply.

4.0 When the Procedure, Product, or Service Is Not Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.

4.1 General Criteria Not Covered

Medicaid shall not cover the procedure, product, or service related to this policy when:

a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0;**
b. the beneficiary does not meet the criteria listed in **Section 3.0;**
c. the procedure, product, or service duplicates another provider's procedure, product, or service; or
d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by Medicaid

None Apply.

4.2.2 Medicaid Additional Criteria Not Covered

None Apply.

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.

5.1 Prior Approval

a. Medicaid shall not require prior approval for burn treatment injury diagnoses.
b. Medicaid shall require prior approval for scar revisions. The provider shall obtain prior approval before rendering scar revisions. Refer to clinical coverage policy 1-O-3, *Keloid Excision and Scar Revision* at https://medicaid.ncdhhs.gov/.

5.2 Prior Approval Requirements

5.2.1 General

The provider(s) shall submit to the Department of Health and Human Services (DHHS) Utilization Review Contractor the following:

a. the prior approval request; and
b. all health records and any other records that support the beneficiary has met the specific criteria in Subsection 3.2 of this policy.

5.2.2 Specific

None Apply.

5.3 Additional Limitations or Requirements

None Apply.

6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

a. meet Medicaid qualifications for participation;
b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

Providers who meet Medicaid's qualifications for participation and are currently enrolled with the N.C. Medicaid program are eligible to bill for escharotomy, fasciotomy, and skin grafting when the procedure or service is within the scope of their practice.

6.2 Provider Certifications

None Apply.

7.0 Additional Requirements

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.

7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

8.0 Policy Implementation/Revision Information

Original Effective Date: January 1, 1974

Revision Information:

Date	Section Revised	Change
4/1/07	Attachment A	Billing unit limitations were revised for CPT codes 15001, 15101, 15121, 15171, 15301, 15321, and 16036.
5/1/07	Attachment A	Added UB-04 to acceptable claim forms.
1/1/12	Throughout	Updated standard DMA template language
1/1/12	Attachment A	Updated CPT codes
7/1/10	Throughout	Policy Conversion: Implementation of Session Law 2009-451, **Section 10.32 "NC HEALTH CHOICE/PROCEDURES FOR CHANGING MEDICAL POLICY."**
1/1/12	Throughout	To be equivalent where applicable to NC DMA's Clinical Coverage Policy # 1G-1 under Session Law 2011-145
5/29/12	Throughout	Technical changes to merge Medicaid and NCHC current coverage into one policy.
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.
07/01/2018	Section 1.0	Added 1-O-3 Keloid Excision and Scar Revision to the Related Clinical Coverage Policies.
07/01/2018	Subsection 5.1 b	Added reference to the Clinical Policy 1-O-3 Keloid Excision and Scar Revision policy for prior approval of scar revisions.
07/01/2018	Attachment A, Section C	Removed reference to Billing Units.
07/01/2018	Attachment A, Section E	Removed the CPT codes and billing units from this policy. Restored the template language.
03/15/2019	Table of Contents	Added, "To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after November 1, 2019, please contact your PHP."
03/15/2019	All Sections and Attachments	Updated policy template language.
12/31/2019	Table of Contents	Updated policy template language, "To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP."
12/31/2019	Attachment A	Added, "Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines".
06/01/2023	All Sections and Attachments	Updated policy template language due to North Carolina Health Choice Program's move to Medicaid. Policy posted 6/1/2023 with an effective date of 4/1/2023.

Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid:

A. Claim Type

Professional (CMS-1500/837P transaction)

Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.

B. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.
If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

Unlisted Procedure or Service
CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.

D. Modifiers

Provider(s) shall follow applicable modifier guidelines.

E. Billing Units

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).

F. Place of Service

Inpatient Hospital, Outpatient Hospital, Ambulatory Surgery Center, Office.

G. Co-payments

For Medicaid refer to Medicaid State Plan:
https://medicaid.ncdhhs.gov/meetings-notices/medicaid-state-plan-public-notices

H. Reimbursement

Provider(s) shall bill their usual and customary charges.
For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/