AHIMA
Distance Education

Wound Care Coding

Audio Seminar/Webinar

April 24, 2008

Practical Tools for Seminar Learning

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The faculty has reported no vested interests or disclosures regarding this presentation.

Faculty

Gloryanne Bryant, RHIA, CCS

Gloryanne Bryant is corporate senior director of coding HIM compliance for CHW, where she is responsible for coding and documentation compliance of 40 acute care facilities and a variety of other non-hospital healthcare entities in three states. Ms. Bryant has over 28 years of experience in the HIM profession. She is a sought-after national speaker and author, and serves as a catalyst for change in healthcare.

Ella L. James, RHIT, CPHQ

Ella James is the director of corporate health information management and corporate health information security privacy officer for the Hospital for Special Care in New Britain, Connecticut, a 228-bed long-term acute care hospital. Ms. James currently chairs the National Association of Long Term Hospitals (NALTH) coding committee and has worked extensively with the cooperating parties to develop coding guidelines for the long-term acute care industry.

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Goals & Objectives

- **Attendees will … gain an understanding on clinical knowledge and how to code specific ICD-9-CM diagnosis codes related to wound care services**
- **Attendees will … enhance their knowledge on the requirements for proper documentation and CPT coding**
- **Attendees will … review some case examples/scenario's**
- **Attendees will … create an action plan listing opportunities for improvement, etc.**

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Polling Question

Have you had an audit on your hospital outpatient wound care services within the last year (with internal or external)?

***1 Yes**

***2 No**

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Outpatient Wound Care Diagnosis and Documentation

- ICD-9-CM codes represent the "condition for the for encounter" or the reason for care - physician documentation
  - MD order/requisition
    - Have a standardized form
    - Often need a new or updated MD order with diagnosis

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ICD-9-CM Coding

- In the outpatient setting, the term first-listed diagnosis is used instead of principal diagnosis
- When determining the first-listed diagnosis, the coding conventions of ICD-9-CM and general and disease specific guidelines take precedence over the outpatient guidelines
- The diagnoses may not be established at the time of the initial encounter/visit. It may take two or more visits before the diagnosis is confirmed
- Begin the search for the proper ICD-9-CM codes by using the Alphabetic Index first, then move to the Tabular List to eliminate coding errors

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Notes/Comments/Questions

ICD-9-CM Coding

- Documentation should describe the patient's condition, using terminology which includes specific diagnoses as well as symptoms, problems, or reasons for the encounter

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ICD-9-CM Coding

- List first the ICD-9-CM code for the diagnosis, condition, problem, or other reason for encounter/visit that is chiefly responsible for the services provided
- List additional or secondary codes that describe any coexisting conditions
  - In some instances, the first-listed diagnosis may be a symptom when a diagnosis has not been established by the physician

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Notes/Comments/Questions

ICD-9-CM Coding

- **Do not code diagnoses documented as "probable", "suspected," "questionable," "rule out," or "working diagnosis" or other similar terms indicating uncertainty**

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Examples - Diagnosis

- **Reason for the encounter/visit – use actual diagnosis**
  - **do not use V58.89 Encounter for procedure and aftercare –- obtain the acute diagnosis or condition (ie. wound, ulcer, burn and the site)**
    - **V67.59 Admission for other follow-up – Do not use**
    - **The MD referral must give a clinical reason/diagnosis/sign or symptom for the visit**
- **Diagnosis/condition**
  - **Decubitus ulcer on the heel, history of diabetes**
    - **707.07**
    - **250.00**

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Notes/Comments/Questions

ICD-9-CM Coding

- **Code all documented conditions that coexist at the time of the encounter, and require or affect patient care treatment or management**
- **Do not code conditions that were previously treated and no longer exist**
- **History codes (V10-V19) may be used as secondary codes if the condition or family history has an impact on current care or treatment**

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ICD-9-CM Coding

- **Superficial injuries such as abrasions or contusions are not coded when associated with more severe injuries of the same site**

Outpatient services coding and reporting guidelines 10/1/2007.

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Notes/Comments/Questions

ICD-9-CM Coding

- **When a primary injury results in damage to peripheral nerves or blood vessels, the primary injury is sequenced first with additional code(s) from categories 950-957, Injury to nerves and spinal cord, and/or 900-904, Injury to blood vessels**
- **When the primary injury is to the blood vessels or nerves, that injury should be sequenced first**

Outpatient services coding and reporting guidelines 10/1/2007.

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Diagnosis Coding - Burns

- **Current burns (940-948) are classified by**
  - **depth**
  - **extent**
  - **agent (E code)**
- **Burns are classified by depth as**
  - **first degree (erythema)**
  - **second degree (blistering)**
  - **and third degree (full-thickness involvement)**
- **Highest degree of burn is sequenced first**

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Diagnosis/Condition

- **Diagnosis/condition (ICD-9-CM codes) – assigned by the HIM Coding Department**
  - **"Wound" – open**
  - **"Diabetes" diagnosis - specific**
  - **Nursing cannot provide a diagnosis from which we code from; the MD (or PA/NP) must provide this information.**

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Diagnosis Coding - Diabetes

- **Decubitus ulcer of the heel, due to diabetes type II**
  - **250.80 *Diabetes with other specified manifestations***
  - **707.07 *Decubitus ulcer, heel***
  - **Note: that DM has specific manifestations that must be documented to identify the underlying disorder or cause and code correctly**
  - **Follow ICD-9-CM coding guidelines**

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Diagnosis Coding - Skin Ulcers

- **Patients can develop more than one ulcer at various sites with different stages of severity.**
  - **Decubitus ulcers, also known as pressure sores and bedsores**
- **Multiple codes from category 707, Decubitus ulcer, may be assigned when a patient has multiple ulcers of more than one site**
- **Decubitus ulcer codes includes superimposed infection**

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Diagnosis Coding - Cellulitis

- **Cellulitis is an acute infection of the skin and soft tissues that commonly results from a break in the skin, such as a puncture wound, laceration, or ulcer. Cellulitis of the skin is classified to category 681, Cellulitis and abscess of finger and toe, and category 682, Other cellulitis and abscess**
  - **Indicate the organism if available**
  - **Abscess and lymphangitis are included in the code for cellulitis of the skin.**
- **The diagnosis of cellulitis must be documented by the physician in order to assign it**

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Diagnosis Coding - Cellulitis

- **Patient is seen primarily for treatment of the open wound:**
  1. **Code for open wound, complicated**
  2. **Cellulitis is assigned as secondary**
- **Patient has a minor wound and is seen specifically for the cellulitis:**
  1. **Cellulitis**
  2. **open wound, complicated**

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Diagnosis Coding - Osteomyelitis

- **Diabetic Osteomyelitis**
- **250.8x, Diabetes with other specified manifestations**
- ***731.8, Other bone involvement in diseases classified elsewhere***

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Diagnosis Coding - Osteomyelitis

- "It is important to recognize that not all ulcers in diabetic patients are diabetic ulcers. Diabetic ulcers of the foot generally start on the toes and move upward. Diabetic ulcers do not usually start on the heel. Ulcers of the heel are almost always decubiti"
- Physician documents that the heel ulcer is a decubitus ulcer, which progressed to osteomyelitis and gangrene
  1. 785.4, Gangrene
  2. 730.07, Acute osteomyelitis, Ankle and foot
  3. 250.70, Diabetes with peripheral circulatory disorders

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Diagnosis Coding - Osteomyelitis

- "If the physician indicates diabetic osteomyelitis, or the patient has both diabetes and acute osteomyelitis and no other cause of the osteomyelitis is documented
  1. 250.80, Diabetes with other specified manifestations
  2. 731.8, Other bone involvement in diseases classified elsewhere
  3. 730.0X, Acute osteomyelitis

- ICD-9-CM assumes a relationship between diabetes and osteomyelitis when both conditions are present, unless the physician has indicated in the medical record that the acute osteomyelitis is totally unrelated to the diabetes

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Diagnosis Coding – Wound Complication

- **997.62**
  - **Infection, Amputation Stump**
- **998.32**
  - **Disruption, operation wound**
- **998.83**
  - **Non-healing surgical wound**
- **998.59**
  - **Mechanical complication due to artificial skin graft/decellularized Allodermis**

Watch the indexing in ICD-9-CM and the clinical documentation

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Primary Diagnosis – HIM Coding via MD Order

- **Reason for the encounter - meet Medical Necessity (compliance)**
  - **Primary or first listed diagnosis**
  - **MD order or referral is key**
- **Medical diagnostic reason for the encounter should also be assigned to provide medical necessity justification**

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Secondary Diagnosis via the MD Order

- **Any secondary diagnosis - obtain from the MD order or requisition note, other supporting documentation**
  - **MD H&P or assessment**
- **Physicians need to understand the diagnostic requirements of the LCD (Local Coverage Determination).**

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Primary and Secondary Diagnosis

- **If nursing is taking a verbal order, they need to ask for the specific diagnosis.**
  - **Ask if it is related or secondary to diabetes or other condition as this can impact the code assignment.**
  - **Coding a diagnosis from the MD order is acceptable.**
  - **Claim denial can result from a nonspecific ICD-9-CM code or a code that does not meet medical necessity for the treatment being provided.**

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Notes/Comments/Questions

Integrate Systems for a Successful Wound Care

- Central Scheduling
- Registration
- Department/Office Visit
- Charge Sheet/Encounter Form
- MD order
- Daily charting
- Charge Description Master (CDM)
  - Materials Management
  - Pharmacy
  - Finance
- Coding
- Billing
  - Denial Mgmt
- Corporate Compliance
- Etc...

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Wound Care Process and Work Flow Success Tips

- Review scheduling, registration, purchasing, pharmacy, chargemaster, coding, and billing processes
- Review paperwork flow-from referral to claim submission, to revenue audit
  - Make every effort to obtain a wound care specific electronic medical record that will service both the outpatient dept. and the physicians

NOTE: In some outpatient departments (with state-of-the-art wound care specific medical records), the coders have more time to serve as educators and auditors!

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Wound Care Process and Work Flow Tips (cont'd)

- **Decide if you will submit claims "per visit" rather than a monthly series claim**
- **Verify patient's actual diagnosis, not just the reason for the visit, that is captured on the claim/UB**
- **Review and update the role of the HIM coder and the role of the department ChargeMaster to generate CPT codes**
- **Quarterly update the ChargeMaster (CDM)**
  - **Be sure it is thorough and inclusive**
  - **Check OPPS rule annually**
- **Daily charge reconciliation**
  - **Missed charges**
  - **Charge corrections**

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Resources for Wound Care Coding

- **Outpatient and HIM Departments should/must purchase and review ICD-9-CM, CPT®, and HCPCS books every fall.**
- **Also AMA CPT Assistant and AHA Coding Clinic on HCPCS – subscriptions**
- **Review OPPS Final Rule**
- **Keep up with FI policies and NCDs**

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Notes/Comments/Questions

Documenting the Care

- It is important to be accurate, consistent and timely in documenting skin breakdown regardless of the cause (pressure, arterial or vascular insufficiency).
  - Nursing
  - Physical Therapist
  - Physician
  - Other
- Often many wounds that heal at slow rates
- Careful documentation of changes and improvement
- Review and update clinic visit criteria check that it represents the work performed by the staff
- Clinicians should not leave important information out of the assessment process.

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Documenting the Care

- Having good documentation is critical and forms/templates can be developed to assist
- Actual details of the wound(s) must be in the medical record:
  - Size, length, width, depth (measurements)
  - Color, odor
  - With or without drainage
  - Improvement/change in wound
- Include what you observe about the wound even if you don't know the correct terms or don't know where the information belongs in the assessment.

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Notes/Comments/Questions

Some Documentation Specifics —Wound Care

- Onset and duration: Knowing if a wound is chronic or acute will help with treatment and outcome planning.
- Size: All wounds must be measured in centimeters for length (vertically), width (horizontally) and depth.
- Edema: The presence of edema can indicate underlying diseases and can be a sign of infection.
- Periwound: Assessment must include inspection of the surrounding tissues.
- Undermining: Undermining indicates the presence of a cavity under the periwound that is caused by shear forces.
- Tunneling: A tunnel is a tract or sinus extending into the underlying tissues from any point in the wound bed.

Include in on-going treatment notes, or progress notes.

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Some Documentation Specifics —Wound Care

- Exudate: Record the amount (none/min/mod/copious), color (red/greenish-blue/yellow-clear) and odor.
- Necrotic tissue: Necrotic tissue is non-viable tissue and is black-brown (eschar) or yellow (slough).
- Granulation tissue: The development of granulation tissue is the goal for full thickness wounds. This area of the wound will look red and beefy and should increase in size with each wound re-evaluation.

Include in on-going treatment notes, or progress notes.

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Notes/Comments/Questions

Capturing Wound Care Services or Treatment Via "CODES"

- Do you have a policy those CPT codes within the surgical range (10000-69999) must be coded by a trained coder or allow for oversight by HIM Coding??
  - Don't be CDM dependent, there must be documentation to support the charge/code
    - Validation
- CPT codes are assigned and appear on the claim/UB (bill) and payment is based upon them.
  - Under OPPS resulting in an APC
- Guidelines and rules exist for the assignment of code(s).
  - OPPS – via CMS

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Capturing Services or Treatment Via "CPT codes"

- Evaluation and Management (E&M) CPT codes – visits
- Medicine CPT Codes – physician and nonphysician codes (include wound care management and PT)
- Surgical CPT codes – surgical procedures
  - 10000-69999
- HCPCS codes for supplies, devices

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Wound Care Management Physician & Non-Physician Providers - CPT Codes

- 97601 Removal of devitalized tissue from wound(s); selective debridement, without anesthesia (eg, high pressure waterjet, sharp selective debridement with scissors, scalpel and tweezers), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session (as of 2004)
  - This is to be used when non-physicians perform the procedures.
  - Clinical documentation should be clear, concise and detailed.

Code 97601 WAS DELETED FOR 2005

- **97602 Removal of devitalized tissue from wound(s); non-selective debridement, without anesthesia (eg, wet-to-moist dressings, enzymatic, abrasion), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session**
  - **Clinical documentation should be clear, concise and detailed within the medical record**

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Description Of Active Outpatient Wound Care Management – Non-Selective

- **Non-selective Debridement, as described by CPT 97602, is the gradual removal of loosely adherent areas of devitalized or necrotic tissue from a wound. This technique of removing devitalized tissues includes preparation of the area to be debrided in order to soften and loosen the dead tissue. This can be achieved by irrigating the wound using various hydrotherapy techniques.**
- **The actual removal of necrotic tissue through the use of non-selective debridement techniques could involve use of the whirlpool or pulsatile lavage, wet to dry and wet to moist dressing applications, and/or applications of enzymes, which are all used to facilitate the gradual removal of areas of necrotic tissue.**

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CPT 97602 Lay Description

- **97602 The health care provider performs wound care management to promote healing using non-selective debridement techniques to remove devitalized tissue. Non-selective debridement techniques are those in which both necrotic and healthy tissue are removed. Non-selective techniques, sometimes referred to as mechanical debridement, include wet-to-moist dressings, enzymatic chemicals, and abrasion. Wet-to-moist debridement involves allowing a dressing to proceed from wet to moist, and manually removing the dressing, which removes both the necrotic and healthy tissue. Chemical enzymes are fast acting products that produce slough of necrotic tissue. Abrasion involves scraping the wound surface with a tongue blade or similar blunt instrument…**
- **Code 97602 is used to describe non-selective debridement performed without the use of anesthesia and should not be reported in addition to codes 11040 - 11044.**

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CPT Coding – Active Wound Care Mgmt

97597-97598

- **The health care provider performs wound care management by using selective debridement techniques to remove devitalized tissue without anesthesia. Selective techniques are those in which the physician has complete control over which tissue is removed and which is left behind. Selective techniques include high-pressure waterjet with or without suction, and sharp debridement techniques using scissors, a scalpel, or forceps.**
- **Another newer method of selective debridement is autolysis, which uses the body's own enzymes and moisture to re-hydrate, soften, and finally liquefy hard eschar and slough. Autolytic debridement is accomplished using occlusive or semi-occlusive dressings that keep wound fluid in contact with the necrotic tissue. Types of dressing applications used in autolytic debridement include hydrocolloids, hydrogels, and transparent films. Wound assessment, topical applications, instructions regarding ongoing care of the wound, and the possible use of a whirlpool for treatment are included in these codes. Report 97597 for a total wound surface area less than or equal to 20 sq. cm and 97598 for a total wound surface area greater than 20 sq. cm. Report the appropriate code per session.**

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Wound Care Visit for Dressing Change – Product Usage

- **Watch the documentation carefully for product names used in dressing**
- **Some promote the healing process others assist with debridement**
- **AQUACEL® Ag - first antimicrobial dressing:**
  - Immediate and sustained antimicrobial activity
  - *Pseudomonas aeruginosa* , *Staphylococcus aureus*, methicillin-resistant *Staphylococcus aureus* (MRSA), vancomycin-resistant *Enterococcus* (VRE)
  - Locks bacteria within the gelled AQUACEL® Ag fibers7 away from the wound bed.
- **Alginate dressings – from seaweed, and are highly absorbent, biodegradable alginate dressings**
  - Cleanse a wide variety of secreting lesions
  - High absorption is achieved via strong hydrophilic gel formation
  - Alginate dressings promotes healing and the formation of granulation tissue
- **Meet and talk with your wound care department about their products they use and what is the clinical purpose/rationale**

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Wound Care Management – Autolytic Debridement

- **Autolytic debridement = the process the body undertakes to remove dead tissue**
- **During autolysis, enzymes present in the wound have the effect of liquefying non-viable tissue.**
- **Physicians foster autolytic debridement by utilizing moist wound dressings. By maintaining a moist wound environment, the body is able to use its own processes to eliminate devitalized tissue.**
- **Products that are conducive to autolysis include hydrocolloids, transparent films, and hydrogels.**
- **Autolysis can be used on its own, after surgical debridement, or in conjunction with enzymatic or mechanical debridement.**
- **Autolysis is helpful for patients who cannot tolerate other forms of debridement.**

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OPPS Payment – Addendum B 2008

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
97597	Active wound care/20 cm or <	CH	T	0015	1.4595	92.96		18.59
97598	Active wound care > 20 cm	CH	T	0015	1.4595	92.96		18.59
97602	Wound(s) care non-selective	CH	T	0015	1.4595	92.96		18.59
97605	Neg press wound tx, < 50 cm	CH	T	0013	0.7930	50.51		10.10
97606	Neg press wound tx, > 50 cm	CH	T	0015	1.4595	92.96		18.59

Know the OPPS Status indicators ie "T"

Multiple Discounted APC Payment

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OPPS Status Indicator & Descriptions - 2008

- **A** Services furnished to a hospital outpatient that are paid under a fee schedule or payment system other than ambulance services; clinical diagnostic laboratory; non-implantable prosthetic and orthotic devices; EPO for ESRD patients; physical, occupational and speech therapy; routine dialysis services for ESRD patient provided in a certified dialysis unit of a hospital; diagnostic mammography; screening mammography.
- **B** Codes that are not recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x, 13x and 14x).
- **C** Inpatient only procedures
- **D** Discontinued codes
- **E** Item, codes and services that: (a) are not covered by Medicare based on statutory exclusion, (b) that are not covered by Medicare for reasons other than statutory exclusion, (c) that are not recognized by Medicare, but for which an alternate code for the same item or service may be permitted, (c) for which separate payment is not provided by Medicare.
- **F** Corneal tissue acquisition; Certain CRNA service; and Hepatitis B vaccines
- **G** Pass-through drugs and biologicals

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OPPS Status Indicator & Descriptions - 2008

- **H** Pass-through device categories; Brachytherapy sources; and Radiopharmaceuticals agents
- **K** Non-pass-through drugs, biologicals and radiopharmaceutical agents
- **L** Influenza vaccine; Pneumococcal Pneumonia vaccine
- **M** Items and services non billable to the fiscal intermediary
- **N** Items and services packaged into APC rates
- **P** Partial hospitalization
- **Q** Packaged services subject to separate payment under the OPPS payment criteria
- **S** Significant service, separately payable
- **T** Significant service, multiple procedure reduction applies
- **V** Clinic or emergency department visit
- **X** Ancillary service
- **Y** Non-implantable durable medical equipment

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Negative Pressure Wound Therapy CPT Codes

97605-97606

- The health care provider performs negative pressure wound therapy (NPWT) with vacuum assisted drainage collection to promote healing of a chronic non-healing wound, including diabetic or pressure (decubitus) ulcer. This procedure includes topical applications to the wound, wound assessment, and patient or caregiver instruction related to on-going care per session. Negative pressure wound therapy uses controlled application of subatmospheric pressure to a wound. The subatmospheric pressure is generated using an electrical pump. The electrical pump conveys intermittent or continuous subatmospheric pressure through connecting tubing to a specialized wound dressing. The specialized wound dressing includes a porous foam dressing that covers the wound surface and an airtight adhesive dressing that seals the wound and contains the subatmospheric pressure at the wound site. Negative pressure wound therapy promotes healing by increasing local vascularity and oxygenation of the wound bed, evacuating wound fluid thereby reducing edema, and removing exudates and bacteria. Drainage from the wound is collected in a canister.
- Report 97605 for a wound(s) with a total surface area less than or equal to 50 sq. cm. Report 97606 for a wound(s) with a total surface area greater than 50 sq. cm.

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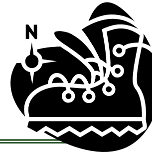
Unna Boot CPT Code



CPT 29580 Unna Boot

- The physician applies an Unna boot to the leg of a patient. An Unna boot is typically used to treat or prevent venostasis dermatitis or ulcers of the lower leg. It is also used to control postoperative edema like that resulting from an amputation. The physician prepares this semirigid dressing by first making a paste of zinc oxide, gelatin, and glycerin. This is applied to the skin of the leg. A spiral or figure eight bandage is wrapped evenly over the leg. Paste is then reapplied and further bandages are applied in the same fashion until the desired rigidity is obtained. Elastic bandages are often added to the dressings for reinforcement. The dressing is typically replaced at least once a week or more often as needed.

Check with your FI regarding coverage and who this can be performed by. Many FIs have established policies regarding this, excluding a multi-layered high graduated compression dressing from this code. Recent AHA HCPCS (1st Qtr 2007) guidance stated multi-layered high graduated compression dressing is 29580.

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Surgical Debridement for Wound Care - CPT Codes

Surgical Debridement Codes:

- 11040 Debridement; skin, partial thickness
- 11041 skin, full thickness
- 11042 skin, and subcutaneous tissue
- 11043 skin, subcutaneous tissue, and muscle
- 11044 skin, subcutaneous tissue, muscle, and bone
  - Documentation must clearly represent these procedures
    - Instruments used, removal of tissue, muscle, or bone, and depth of debridement
  - These surgical codes are "designed" to reflect physician services
  - Review PM A-02-129 - January 2003
  - NGS (FI) states this should not be performed by Physical Therapists… so be sure to check with your FI

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Surgical Debridement Depth

- Watch and use caution with terminology for these procedures:
  - "Debridement of skin"
  - "Debridement down to the muscle"
  - "Debridement of the muscle"
  - "Debridement down to the bone"
  - "Debridement of the bone"

Document the Removal…of

Educate physicians!

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Excisional Debridement — CPT Procedure Codes 11040–11042 Key Documentation Elements

- Clinical documentation should always be specific, clear, concise and accurate.
- Always document legibly.
- Sign, date and time all orders.

CPT 11040 Debridement - skin, partial thickness

Procedure description: The physician surgically removes partially necrotic or dead skin. The physician used a scalpel, curette or dermatome to remove a superficial layer of the affected skin. The epidermal layer is moved with the underlying dermis remaining intact. The partial thickness of skin is excised until viable, bleeding tissue is encountered. A topical antibiotic is placed on the wound. A dressing is applied over the site.

Report CPT 11041 is Debridement same as above for ***skin, full thickness***.

Report CPT 11042 is Debridement same as above but which includes ***skin and subcutaneous tissue***.

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Excisional Debridement— CPT Procedure Codes 11043–11044 Key Documentation Elements

- Clinical documentation should always be specific, clear, concise and accurate.
- Always document legibly.
- Sign, date and time all orders.

CPT 11043 Debridement; Skin, subcutaneous tissue, and muscle

Procedure description: The physician surgically removes necrotic skin, underlying tissue, and muscle. The physician uses a scalpel, curette or dermatome to remove/excise the affected tissue into the muscle. The dissection is continue until until viable, bleeding tissue is encountered. Depending on the size the closure may be immediate or delayed. The wound may be packed open with sterile gauze and may require delayed reconstruction.

Report CPT 11044 is Debridement same as above but when the *bone is also debrided*.

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What's Included In Surgical Procedures

- **Removing the dressing**
- **Cleansing the wound area**
- **Anesthesia**
  - **Local injection of lidocaine**
- **Assessing/evaluating for the procedure**
- **Performing the procedure**
- **Application of the new dressing**
- **Post procedure instructions**

Do not add an E&M to the procedure due to these elements. They are inclusive in the procedure CPT code.

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68128 Federal Register / Vol. 71, No. 226 / Friday, November 24, 2006 / Rules and Regulations

Response: We initially solicited comment as to whether a distinction between new and established visits was necessary because we were planning to transition to G-codes and did not want to unnecessarily create codes for both new and established visits. However, because hospitals will continue to bill CPT codes for CY 2007, they must continue to distinguish between new and established patients, according to the CPT code descriptor. Therefore, these codes will continue to be payable under the OPPS for CY 2007. The AMA defines an established patient as "one who has received professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years." To apply this definition to hospital visits, we stated in the April 7, 2000 final rule with comment period that the meanings of "new" and "established" pertain to whether or not the patient already has a hospital medical record number. If the patient has a hospital medical record that was created within the past 3 years, that

patient is considered an established patient to the hospital. The same patient could be "new" to the physician, but an "established" patient to the hospital. The opposite could be true if the physician has a longstanding relationship with the patient, in which case the patient would be an "established" patient with respect to the physician and a "new" patient to the hospital.

Because hospitals will be reporting CPT codes for CY 2007, they must continue to distinguish between new and established patients, according to the CPT code descriptor. However, it

Medicare OPPS – Final Rule for 2007

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OPPS Definition of New vs. Established – E&M

New and Established Patient

Solely for the purposes of distinguishing between new and established patients, **professional services** are those face-to-face services rendered by a physician and reported by a specific CPT code(s). A new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.

An established patient is one who has received professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.

Per CMS: *The meaning of "new" and "established" pertain to whether or not the patient already has a hospital medical record number in the past three years.*

Review and update clinic E&M visit criteria check that it represents the work performed by the staff

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E&M "Guiding Principles" – Facility (OPPS)

(1) The coding guidelines should follow the intent of the CPT code descriptor in that the guidelines should be designed to reasonably relate the intensity of hospital resources to the different levels of effort represented by the code (65 FR 18451).

(2) The coding guidelines should be based on hospital facility resources. The guidelines should not be based on physician resources (67 FR 66792).

(3) The coding guidelines should be clear to facilitate accurate payments and be usable for compliance purposes and audits (67 FR 66792).

(4) The coding guidelines should meet the HIPAA requirements (67 FR 66792).

(5) The coding guidelines should only require documentation that is clinically necessary for patient care (67 FR 66792).

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E&M "Guiding Principles" – Facility (con't)

(6) The coding guidelines should not facilitate upcoding or gaming (67 FR 66792).

(7) The coding guidelines should be written or recorded, well documented, and provide the basis for selection of a specific code.

(8) The coding guidelines should be applied consistently across patients in the clinic or emergency department to which they apply.

(9) The coding guidelines should not change with great frequency.

(10) The coding guidelines should be readily available for fiscal intermediary (or, if applicable, MAC) review.

(11) The coding guidelines should result in coding decisions that could be verified by other hospital staff, as well as outside sources.

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OPPS 2008 Packaging

- **Two types of packaged services**
  - **Unconditionally packaged status "N"**
    - **Know the definition**
    - **You still charge/code for the service!**
  - **Conditionally packaged status "Q"**
    - **Know the definition**

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Wound Care – Chargeable Items and Revenue Capture

- **Make sure these are documented and charged when provided, included on the charge encounter form:**
  - **Infusion & Injections – new rules in 2007**
  - **Transfusion**
  - **Blood Glucose Checks**
  - **Pharmacy/drugs (via Pharmacy)**
  - **Skin Replacement and Skin Substitutes (Graft) Materials – use HCPCS code(s)**
  - **Etc. (Lab, Radiology, EKG charged via ancillary depts.) - discuss with the departmental leadership**

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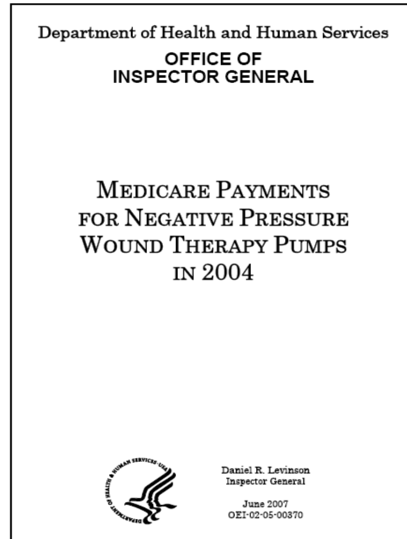
Notes/Comments/Questions

OIG Negative Pressure Wound Therapy Report '07


Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE PAYMENTS FOR NEGATIVE PRESSURE WOUND THERAPY PUMPS IN 2004

Daniel R. Levinson
Inspector General

June 2007
OEI-02-05-00370

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OIG Negative Pressure Wound Therapy Report (cont'd)

- **The pump is a portable or stationary device used for the treatment of ulcers or wounds that have not responded to traditional wound treatment methods**
- **Medicare covers the pump and its supplies under Part B as durable medical equipment**
- **Medicare-allowed payments for the pump increased 444 percent between 2001 and 2005, from $25 million to $136 million**
- **This increase raises concerns about whether the pump is being prescribed appropriately**
- **Findings indicate that claims for the "pump" did not meet Medicare coverage criteria**

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Notes/Comments/Questions

OIG Wound Care – Surgical Debridement Report '07

Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

MEDICARE PAYMENTS FOR
SURGICAL DEBRIDEMENT
SERVICES IN 2004

Daniel R. Levinson
Inspector General

May 2007
OEI-02-05-00390

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OIG Report

- Surgical Debridement along with an E&M
- Surgical Debridement documentation
- Surgical Debridement utilization
  - "Medicare covers and pays for surgical debridement services furnished by physicians and other licensed practitioners within the scope of their practice under State law. In some States, this includes Non-Physician practitioners, such as nurse practitioners and physicians' assistants. For the purposes of this report, we refer to all practitioners as physicians."

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OIG Report

- **Per the OIG Report – Cases were miscoded "were billed with a surgical debridement code that did not accurately reflect the level of tissue, muscle, or bone removed during the debridement. For example, the medical record indicated that tissue was debrided to (but not including) muscle, yet physicians billed CPT 11043—debridement of skin, subcutaneous tissue, and muscle."**
- **Need greater internal scrutiny of the clinical documentation. Need to make sure the "to" versus "into" or "including" level of tissue documentation is stated clearly.**

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WOUND CARE CLINIC: Case #1

SUBJECTIVE DOCUMENTATION: The patient returns to the hospital Wound Healing Center for follow-up on the diabetic ulcer under the right foot first metatarsal-phalangeal joint (seen 4 days prior). The patient did get his vascular angiogram and the transcutaneous oxygen test done. The patient did finish his antibiotics. The patient did see his cardiologist Dr. --- who said according to the angiogram he needs to have an opening up of the artery from the abdominal aorta down into the right extremity, The patient states that Dr. --- told him that if he does not have improvement in his blood flow improved or the surgery performed he is at 100% risk of losing that limb.

OBJECTIVE: The patient does have full-thickness ulceration with exposed bone on the plantar aspect of the right first metatarsal-phalangeal joint. Wound which measures 4.6 x 3.8 x 0.1 cm, has no sinus tract, no tunneling, and no undermining. There is a moderate amount of serous exudate. There is no granulation tissue. Exam is positive for a medium amount of yellow slough and a large amount of black necrotic eschar. The treatment was subcutaneous tissue debridement. The size, description. location as stated above.

(continued)

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WOUND CARE CLINIC: Case #1

PROCEDURE: The physician utilizes tissue nippers on the thickened and dry eschar and subcutaneous tissue was carefully debrided and excised from the wound to avoid any pulling of this skin down into a good healthy tissue around the borders. This was into the subcutaneous tissue. The technique was clean. Anesthesia none. Instrument was scalpel and tissue nippers. Blood loss none. Bleeding did not require any control. Culture and sensitivities were retaken to determine if the MRSA has been eradicated because the patient is off antibiotics. Continue dressings with the Aquacel Ag, the patient tolerated the procedure well.

ASSESSMENT: Patient with diabetes with neuropathy, peripheral vascular disease and full-thickness ulceration underneath the first metatarsal-phalangeal joint right foot.

PLAN: We will continue with local wound care. Recommend he does get the angioplasty to increase blood flow to the right leg to help with healing. The patient is not a candidate for hyperbaric unfortunately due to cancer. The patient will watch for any signs of infection. If any occur, the patient is to call the clinic and/or go the emergency room. The patient to follow-up in the clinic in 1 week.

> What CPT Code(s) would be charged/coded for this encounter?

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WOUND CARE CLINIC: Case #2

SUBJECTIVE DOCUMENTATION: The patient is a 73-year-old female here for recheck of left plantar foot ulceration. She has a new ulcer on her right great toe. The patient denies any pain over the last week except for the rt toe. No aggravating factors. No limitation of her daily activities. She is taking Tylenol for pain. She has not changed her meds since her last visit and has not been to the hospital since her last visit.

OBJECTIVE: Vital Signs: Show temperature 99.1, respiratory rate 16, pulse 82, blood pressure 108/60. General: Alert, oriented times 3. No acute distress. Comfortable.

Wound # I Left plantar foot size 0.2 x 0.2 x 0.1 cm. This is a grade 3 ulceration.

Wound # 2: Right great toe size 0.3 x 0,2 x 0.1 cm. This is a grade 3 ulceration as well.

Please note the general wound assessment which I have reviewed and concur with for further wound measurements and descriptions.

IMPRESSION:

1. Wounds as above,

2. Diabetes mellitus type 2, controlled.

3 Peripheral vascular disease.

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WOUND CARE CLINIC: Case #2

PLAN & TREATMENT BY PHYSICIAN:

1. Please note informed consent on chart. Using aseptic technique and a number 15 scalpel the wound # 2 was debrided of yellow fibrinous material for a partial-thickness debridement. The patient tolerated the procedure well, Minimal bleeding is controlled with pressure. There were no complications noted. The patient did not require any anesthesia due to her neuropathy.

2. Please note informed consent on the chart, wound #1. Using aseptic technique Oasis wound matrix was applied in a sterile fashion for stage 2 of 10. The Oasis (25 sq cm) Surgically fixed to wound with Steri-Strips and moistened with sterile saline and then covered with Tegaderm Ag times 1 week.

3. Tegaderm to the right great toe times 1 week.

4. Patient to follow-up in 1 week for recheck

> What CPT Code(s) would be charged/coded for this encounter?

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Summary

- **Outpatient wound care or burn care documentation needs to be specific and detailed**
- **Need an MD order/referral**
- **Encourage wound care physicians to diagnose the patient and correctly get the diagnosis on the chart before he/she leaves the exam room Assign ICD-9-CM diagnosis**
- **Use established hospital E&M leveling criteria (for OPPS)**
  - **Put in writing**
  - **Update annually**
- **Develop a charge encounter form**
- **Verify that all necessary codes are in the CDM**

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Notes/Comments/Questions

Summary

- Charge reconciliation – daily
- Watch over utilization of E&M with procedures and utilization of surgical debridement
- Develop documentation forms/template
- Meet and talk with wound care clinicians
- Educate all clinical staff on this specific documentation and charging issues
  - Request assistance from your hospital HIM Coding Staff or Department
- Audit at least once per year more often as the rules and codes change

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Resource/Reference List

- Coder's Desk Reference
- OPPS Final Rule 2008
- OPPS Addendum B
- 2008 AMA *CPT® Current Procedural Terminology*
- AMA *CPT Assistant*
- 2008 OIG Work Plan
- HCPCS Book

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Notes/Comments/Questions

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Notes/Comments/Questions

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Appendix

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