NATIONAL ALLIANCE OF MEDICAL AUDITING SPECIALISTS

Dermatology & Wound Care Services

Presenter:
Sara San Pedro CPC, CPMA, CEMC, CCP-P
AHIMA Approved ICD-10 CM&PCS Trainer/Ambassador

NATIONAL ALLIANCE OF MEDICAL AUDITING SPECIALISTS

Objectives

- The Surgical Package and modifiers
- Common wound care services
  - Coding and Documentation
- LCDs, NCDs and NCCI edits
- CPT updates for 2015
- ICD-10
  - Documentation requirements
  - New coding rules

NATIONAL ALLIANCE OF MEDICAL AUDITING SPECIALISTS

Surgical Package

- The AMA and CMS definitions are not quite the same
  - CMS Surgical Package
    - Global Days
    - Minus versus Major
      - Minor procedures don't require a formal, separate report
    - Decisions for surgery
    - NCCI
      - Used to prevent "unbundling" of services (e.g., lab panels)

NATIONAL ALLIANCE OF MEDICAL AUDITING SPECIALISTS

Surgical Package

- Pre-operative
  - Minor procedures (Modifier -25)
    - Day of surgery
  - Major procedures (Modifier -57)
    - Day of and day before surgery
- Intra-operative
- Post-operative
  - Minor procedures
    - 0-10 days
  - Major procedures
    - 90 days

NATIONAL ALLIANCE OF MEDICAL AUDITING SPECIALISTS

Surgical Package

- Not included in Surgical Package
  - Initial decision for surgery (25/57)
  - Other MD services (different specialty/group)
  - Visits unrelated to surgical diagnosis (24)
  - Immunosupression management (24)
  - Diagnostics (i.e. x-rays, labs)
  - Repeat procedures (76/77)
  - Complications following surgery (78)
  - Unrelated surgical procedures (79)
  - Staged/Related procedures (58)
  - Distinct procedures (59)

NATIONAL ALLIANCE OF MEDICAL AUDITING SPECIALISTS

Facts on modifier -25

- False statements:
  - Can always be used when procedure was not planned
  - Can always be used when diagnoses are different
  - Can never be used when diagnoses are the same
- Modifier -25 indicates *"on the day of a procedure, the patient's condition required a significant, separately identifiable E/M service, above and beyond the usual pre and post operative care associated with the procedure or service performed"*

NATIONAL ALLIANCE OF MEDICAL AUDITING SPECIALISTS

Surgical modifiers

- 22 – Increased procedural services
  - Describe 'unusual' or increased details, additional time
- 58 – Staged/Related, same physician during post-op
  - Global starts over, paid full fee
- 59 – Distinct procedural service
  - Refer to NCCI edits (attempt other modifiers first)
  - Often utilized when performed at different site, session
- 62 – Co-surgeon
  - 62.5% of allowable
- 78 – Unplanned return to OR, same physician, related procedure
  - Global not impacted, intraoperative portion allowed only
- 79 – Unrelated procedure, same physician during post-op
  - Modifier -24 for unrelated E/M visits
- 80 – Assistant surgeon
  - 16% of allowable

NATIONAL ALLIANCE OF MEDICAL AUDITING SPECIALISTS

Active Wound Care

- Involves evaluating, management and treatment of non-healing wounds
- Non-healing wounds
  - Chronic pressure, arterial, diabetic or venous stasis ulcers
  - 2nd and/or 3rd degree burn wounds
  - Trauma/surgery induced infected open wounds
  - Wounds with necrotic/eschar tissue
  - Wounds healing by secondary intention

NATIONAL ALLIANCE OF MEDICAL AUDITING SPECIALISTS

Active Wound Care

- Includes:
  - Assessment and management
  - Cleansing the wound
  - Simple debridement (not the same as excisional debridement)
  - Removal and reapplication of dressings
- Wound care involves evaluation, management and treatment of the wound(s) therefore it is inappropriate to report and E/M CPT code in addition to wound care (debridement, application of Unna boot, etc.)
  - Exception: evaluation and documentation of a significant, separately identifiable service from the wound care service
    - Service would need to be a condition not related to the scheduled visit and would require further medical treatment.

NATIONAL ALLIANCE OF MEDICAL AUDITING SPECIALISTS

Documentation

- There must be an order by the physician or other qualified healthcare personnel
- Services must be reasonable and necessary
- Onset and duration should be recorded to determine whether the wound is chronic or acute
- Size, including depth, length and width
- Status of healing and presence of any infections or edema

NATIONAL ALLIANCE OF MEDICAL AUDITING SPECIALISTS

Debridement LCD

- L31705 (Palmetto GBA)
  - Applies to surgical debridement and selective debridement codes (11042-11047; 97597-97598)
    - Specific documentation requirements
    - Utilization Guidelines
    - List of Diagnosis codes that support Medical Necessity

NATIONAL ALLIANCE OF MEDICAL AUDITING SPECIALISTS

Debridements (11000-11044)

- If the provider debrides skin at a single site, then continues to the subcutaneous tissue and then the muscle, only the most extensive code (CPT 11043 debridement, muscle and/or fascia) is to be reported
- Documentation must support the intensity (depth) of the debridement
- If the provider does not document depth, the lowest level must be selected (partial-thickness)
- When reporting debridement of multiple sites, the secondary code is reported with modifier 59

NATIONAL ALLIANCE OF MEDICAL AUDITING SPECIALISTS

Wound Care

- Selective Debridement (CPT 97597 and 97598)
  - Documentation should state a clear description of instruments used (waterjet, scissors, etc.)
  - Thorough objective assessment of wound including drainage, color, texture, temperature, vascularity, condition of surrounding tissue and size of the area targeted for debridement
  - For Medicare there must be necrotic tissue
- Non-Selective Debridement (CPT 97602)
  - Documentation should state type of technique utilized (wet-to-moist, abrasion, etc.)
  - Thorough objective assessment of the wound including drainage, color, texture, temperature, vascularity, condition of surrounding tissue and size of the area targeted for debridement

NATIONAL ALLIANCE OF MEDICAL AUDITING SPECIALISTS

Debridement

- Surgical Debridement (11042-11047) – more extensive debridement of the underlying soft tissue and/or bone
  - Generally the initial debridement service where there is necrotic tissue with subsequent services being selective debridement
  - Documentation should state the depth of the debridement at each service to support the coding.

NATIONAL ALLIANCE OF MEDICAL AUDITING SPECIALISTS

Debridement

- Medicare does not consider maintenance of a wound to be a debridement service.
  - Dressing changes, etc.
- Selective and non-selective debridement codes are not reportable with surgical debridement on the same day for the same wound
- Non-selective debridement is mutually exclusive to selective debridements
- When excisional debridement is reported, the chart must describe clearly the tissue as being cut away and removed with sharp tools.
  - Per AHA 2nd Quarter 2004 Coding Clinic
    - "In excisional debridement a scalpel is used to remove devitalized tissue.. Involves cutting outside or beyond the wound margin"

NATIONAL ALLIANCE OF MEDICAL AUDITING SPECIALISTS

Debridement

- Code selection is based on the depth of the tissue removed and the total surface area of a single wound or, if multiple wounds sum of the surface area of those wounds that are the same depth.
  - Depth and diameter of the "total" area debrided (post debridment).
    - The surface area debrided which may be different than the size of the wound itself
- Documentation should include the appearance of the wound (depth, stage, characteristics, etc); type of tissue removed; improvement of measurable changes

NATIONAL ALLIANCE OF MEDICAL AUDITING SPECIALISTS

Compression Dressing

- Used to treat edema and ulcers
- Control swelling and promote circulation
  - Unna boots (29580)
  - Multi-layer compression system application
    - Leg (below knee) including ankle and foot (29581)
    - Thigh and leg, including ankle and foot (29582)
    - Upper arm and forearm (29583)
    - Upper arm, forearm, hand and fingers (29584)

NATIONAL ALLIANCE OF MEDICAL AUDITING SPECIALISTS

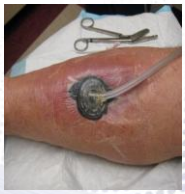
Compression Dressing

- Debridement only is reported when compression dressing applied during the same encounter as debridement
- Applications may be performed by nursing or non-physician providers when within their scope of practice incident-to physician services
- Dressings are integral to debridement services and not separately reimbursable
- Bilateral applications append 50 modifier
  - Some FI/MACs require LT or RT

NATIONAL ALLIANCE OF MEDICAL AUDITING SPECIALISTS

Negative Pressure Wound Therapy

- Used on non-healing wounds which have not responded to wound care.
- Aka "wound vac"
- CPT 97605-97606, G0456-G0457)
- 97605-97606 are NPWT services related to the DME benefits
- G0456-G0457 are NPWT services unrelated to durable medical equipment benefits.
- Reportable once for the total wound surface



NATIONAL ALLIANCE OF MEDICAL AUDITING SPECIALISTS

Negative Pressure Wound Therapy

- When performed with debridement, NCCI considers NPWT mutually exclusive to selective and non-selective debridement
  - No modifier allowed for NPWT services with non-selective debridement
  - Modifier is allowed for NPWT with selective debridements when appropriate.
    - Documentation that services were performed at different anatomical sites

NATIONAL ALLIANCE OF MEDICAL AUDITING SPECIALISTS

CPT 2015 NPWT

- CPT 97607 and 97608
  - Added for 2015 for negative wound pressure therapy that utilizes disposable, non-durable equipment
  - 97607 for wounds with a total surface area less than or equal to 50 sq cm
  - 97608 for wounds with a total surface area greater than 50 sq cm
- CPT 97605 and 97606 have been revised for 2015 to include the phrase "DME"

NATIONAL ALLIANCE OF MEDICAL AUDITING SPECIALISTS

Hyperbaric Oxygen Therapy

- The modality where the entire body is exposed to oxygen under increased atmospheric pressure
- Used for:
  - Decompression sickness, Acute carbon monoxide intoxication, Gas gangrene, Necrotizing Fasciitis, Etc.
- National Coverage Determination (NCD) 20.29

NATIONAL ALLIANCE OF MEDICAL AUDITING SPECIALISTS

Hyperbaric Oxygen Therapy

- Adjunct therapy after no measurable signs of healing for a minimum of 30 days of treatment with standard wound care
- During HBO therapy, wounds must be assessed at least every 30 days
- Not covered by Medicare if there is no measurable improvement after 30 days of HBO therapy

NATIONAL ALLIANCE OF MEDICAL AUDITING SPECIALISTS

Hyperbaric Oxygen Therapy

NCD – 20.29

Indications and Limitations of Coverage

A. Covered Conditions

Program reimbursement for HBO therapy will be limited to that which is administered in a chamber (including the one man unit) and is limited to the following conditions:

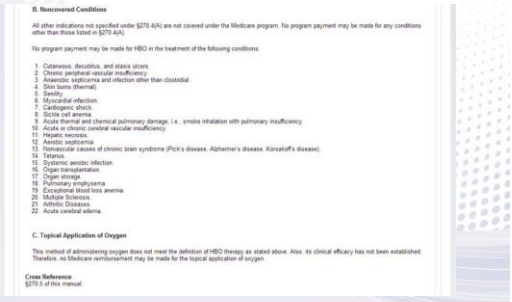
1. Acute carbon monoxide intoxication.
2. Decompression illness.
3. Gas embolism.
4. Gas gangrene.
5. Acute traumatic peripheral ischemia. HBO therapy is a valuable adjunctive treatment to be used in combination with accepted standard therapeutic measures when loss of function, limb, or life is threatened.
6. Crush injury or suturing of severed limbs. As in the previous conditions, HBO therapy would be an adjunctive treatment when loss of function, limb, or life is threatened.
7. Progressive necrotizing infections (necrotizing fasciitis).
8. Acute peripheral arterial insufficiency.
9. Preparation and preservation of compromised skin grafts (not for primary management of wounds).
10. Chronic refractory osteomyelitis, unresponsive to conventional medical and surgical management.
11. Osteoradionecrosis as an adjunct to conventional treatment.
12. Soft tissue radionecrosis as an adjunct to conventional treatment.
13. Cyanide poisoning.
14. Actinomycosis, only as an adjunct to conventional therapy when the disease process is refractory to antibiotics and surgical treatment.
15. Diabetic wounds of the lower extremities in patients who meet the following three criteria:
    a. Patient has type I or type II diabetes and has a lower extremity wound that is due to diabetes;
    b. Patient has a wound classified as Wagner grade III or higher; and
    c. Patient has failed an adequate course of standard wound therapy.

The use of HBO therapy is covered as adjunctive therapy only after there are no measurable signs of healing for at least 30 –days of treatment with standard wound therapy and must be used in addition to standard wound care. Standard wound care in patients with diabetic wounds includes: assessment of a patient's vascular status and correction of any vascular problems in the affected limb if possible, optimization of nutritional status, optimization of glucose control, debridement by any means to remove devitalized tissue, maintenance of a clean, moist bed of granulation tissue with appropriate moist dressings, appropriate off-loading, and necessary treatment to resolve any infection that might be present. Failure to respond to standard wound care occurs when there are no measurable signs of healing for at least 30 consecutive days. Wounds must be evaluated at least every 30 days during administration of HBO therapy. Continued treatment with HBO therapy is not covered if measurable signs of healing have not been demonstrated within any 30-day period of treatment.

NATIONAL ALLIANCE OF MEDICAL AUDITING SPECIALISTS

Hyperbaric Oxygen Therapy

NCD – 20.29



B. Noncovered Conditions

All other indications not specified under §270.4(A) are not covered under the Medicare program. No program payment may be made for any conditions other than those listed in §270.4(A).

No program payment may be made for HBO in the treatment of the following conditions:

1. Cutaneous, decubitus, and stasis ulcers.
2. Chronic peripheral vascular insufficiency.
3. Anaerobic septicemia and infection other than clostridial.
4. Skin burns (thermal).
5. Lipid burns.
6. Myocardial infection.
7. Cardiogenic shock.
8. Sickle cell anemia.
9. Acute thermal and chemical pulmonary damage, i.e., smoke inhalation with pulmonary insufficiency.
10. Acute or chronic cerebral vascular insufficiency.
11. Hepatic necrosis.
12. Aerobic septicemia.
13. Nonvascular causes of chronic brain syndrome (Pick's disease, Alzheimer's disease, Korsakoff's disease).
14. Tetanus.
15. Systemic aerobic infection.
16. Organ transplantation.
17. Organ storage.
18. Pulmonary emphysema.
19. Exceptional blood loss anemia.
20. Multiple Sclerosis.
21. Arthritic Diseases.
22. Acute cerebral edema.

C. Topical Application of Oxygen

This method of administering oxygen does not meet the definition of HBO therapy as stated above. Also, its clinical efficacy has not been established. Therefore, no Medicare reimbursement may be made for the topical application of oxygen.

Cross Reference
§270.5 of this manual.

NATIONAL ALLIANCE OF MEDICAL AUDITING SPECIALISTS

Intralesional Injections (11900-11901)

- Intralesional injections of non-chemotherapeutic agents.
  - Chemotherapeutic agent intralesional injections (96405-96406)
  - Two intralesional injection codes should not be reported together unless separate lesions are injected with different agents
    - Use modifier 59

NATIONAL ALLIANCE OF MEDICAL AUDITING SPECIALISTS

Skin replacement surgery

- CPT 15002 – 15005 (Skin preparation)
  - Code based on location and size of resulting defect
  - For multiple wounds sum the surface area of wounds grouped within the same code descriptor
  - CPT 15002 or 15004, wounds up to and including 100 sq cm
    - CPT 15003 or 15005, each additional 100 sq cm
- CPT 15040 – 15261 (Autografts)
  - Code based on location and size of resulting defect
  - Measurements apply to size of recipient area
  - For multiple wounds sum the surface area of wounds grouped within the same code descriptor
  - Repair of donor site requiring skin graft or local flaps reported separately
  - Do not report Debridement (97602) unless:
    - Gross contamination requires prolonged cleansing
    - Appreciable amounts of devitalized/contaminated tissue are removed
    - Debridement is carried out separately without immediate primary closure

NATIONAL ALLIANCE OF MEDICAL AUDITING SPECIALISTS

Skin replacement surgery

- CPT 15271 – 15278 (Skin substitute grafts)
  - Code based on location and size of defect
  - For multiple wounds sum the surface area of wounds grouped within the same code descriptor
  - Do not report Debridement (97602) unless:
    - Gross contamination requires prolonged cleansing
    - Appreciable amounts of devitalized/contaminated tissue are removed
    - Debridement is carried out separately without immediate primary closure
  - Add on code +15777 (Implantation of biologic implant)
    - Implants for soft tissue reinforcement
    - For mesh, porcine small intestine submucosa other CPT codes are used

NATIONAL ALLIANCE OF MEDICAL AUDITING SPECIALISTS

NCCI Edits

- Skin Replacement Surgery and Skin Substitutes (15002-15431)
  - Classified by size, location of recipient site and type of graft or skin substitute
  - One primary site per area with add on codes for larger sized wounds
  - Primary graft/skin substitute codes are mutually exclusive since only one type of graft/skin substitute can be used on a single anatomic site
    - If multiple sites require different types of grafts/skin substitutes, the different CPT codes should be reported with 59 modifier

NATIONAL ALLIANCE OF MEDICAL AUDITING SPECIALISTS

Destruction

- CPT 17000 – 17004
  - Premalignant Lesions
  - Code based on number of lesions
- CPT 17106 – 17250
  - Benign Lesions
  - Code based on size of surface area or number of lesions
- CPT 17260 – 17286
  - Malignant Lesions
  - Code based on location and diameter of lesion
- Includes laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement

NATIONAL ALLIANCE OF MEDICAL AUDITING SPECIALISTS

Repairs

- Wound closure utilizing sutures, staples or tissue adhesives
- Steri-strips alone should be reported with E/M codes
- Simple wounds does not always equal simple repair
- CPT definitions
  - Simple – Single layer closure
  - Intermediate – Closure of subcutaneous tissue/superficial fascia OR single layer closure of heavily contaminated wounds that require extensive cleansing
  - Complex – Closure of wounds requiring more than layered closure
    - Scar revision, debridement, extensive undermining
  - When more than one classification of wound is repaired, list the more complicated as the primary and less complicated as secondary with modifier -59

NATIONAL ALLIANCE OF MEDICAL AUDITING SPECIALISTS

NCCI Edits

- Biopsy with more extensive procedure
  - Only separately reportable under certain circumstances
    - Separate lesion, report with modifier 59
    - Biopsy is for immediate pathologic diagnosis before performing the more extensive procedure, the biopsy may be reported with modifier 58 on the more extensive procedure.
      - Physician must clearly document that either there were distinct anatomic sites for the biopsies versus the more extensive procedure **OR** that the physician waited for the pathology results prior to performing the more extensive procedure

NATIONAL ALLIANCE OF MEDICAL AUDITING SPECIALISTS

NCCI Edits

- Lesion Removal
  - Only one method of removal may be reported for a single lesion
    - If removal is begun with one method but converted to another for completion, the CPT code describing the completed procedure should be used
  - If multiple lesions are removed through the same incision, a single excision should be reported by combining the sizes of all the lesions
    - i.e. 3 adjacent lesions removed through one single incision
- Lesion Removal
  - Excision of benign lesions (excised diameter 0.5 cm or less) includes simple, intermediate or complex repair which should not be reported separately

NATIONAL ALLIANCE OF MEDICAL AUDITING SPECIALISTS

NCCI Edits

- Mohs Micrographic Surgery (17311-17315)
  - Includes:
    - Skin Biopsy (11000-11001; 11600-11646; 17260-17286)
    - Pathology (88300-88309; 88329-88332)
      - Pathology should not be reported separately
  - Biopsy for diagnosis prior to the Mohs Micrographic surgery, the biopsy and frozen section (88331) may be reported separately with the 59 modifier
  - Repair is separately reportable

NATIONAL ALLIANCE OF MEDICAL AUDITING SPECIALISTS

CPT 2015

- Moh's Micrographic Surgery
  - Updated parenthetical reference
    - If additional special pathology procedures, stains or immunostains are required, see 88311-88314, 88342

NATIONAL ALLIANCE OF MEDICAL AUDITING SPECIALISTS

NCCI Edits

- Repair and Tissue Transfers (12001-14350)
  - Adjacent tissue transfer procedures include excision (11400-11646) and repair (12001-13160)
  - Debridement necessary to perform a tissue transfer procedure is included in the tissue transfer coding
  - Only one repair of a single site may be coded, therefore only the most extensive repair should be coded, therefore simple-complex repairs are incidental to adjacent tissue transfer
  - Skin grafts necessary to close a secondary defect are an additional procedure.
    - These codes do not apply when direct closure or rearrangement of traumatic wounds incidentally results in a defect
    - The goal of the physician must be to perform an adjacent tissue transfer

NATIONAL ALLIANCE OF MEDICAL AUDITING SPECIALISTS

NCCI Edits

- Photochemotherapy (96910-96913)
  - May not be reported with 99211 for services performed by a nurse or technician to examine the patient prior to a subsequent procedure for burns or reactions prior to treatment.
    - Physician may report a separately identifiable, medically reasonable E&M service on the same day with a 25 modifier

NATIONAL ALLIANCE OF MEDICAL AUDITING SPECIALISTS

ICD-10

Neoplasms (C00-D49), Skin & Subcutaneous Tissue(L00-L99) and Injuries (S00-T88)

NATIONAL ALLIANCE OF MEDICAL AUDITING SPECIALISTS

Code Structure

NATIONAL ALLIANCE OF MEDICAL AUDITING SPECIALISTS

Neoplasms (C00-D49)

- Changes in ICD-10 primarily Organizational
  - Includes all Neoplasms
  - In situ neoplasms located before benign
  - 5th character added for extranodal and solid organ sites for lymphomas, Hodgkin's and Non-Hodgkin's disease
  - Heading Changes
  - Melanoma in situ (D03)

NATIONAL ALLIANCE OF MEDICAL AUDITING SPECIALISTS

Skin (L00-L99)

- Greater code specificity
  - Furuncle and carbuncle had the same code in ICD-9, now have distinct codes in ICD-10
  - Abscess and cellulitis had the same code in ICD-9, now have distinct codes in ICD-10
- Greater site specificity
- Laterality
- Contact dermatitis must be documented as:
  - Allergic or Irritant
  - Causal substances are more specific
- Burn classifications
  - Thermal or Corrosive
- Episode of care
  - Initial, Subsequent or Sequela

NATIONAL ALLIANCE OF MEDICAL AUDITING SPECIALISTS

Pressure Ulcers (L89-)

- Stages (Coding Guideline 1.c.12.a.1)
  - Combination codes that identify the site and stage
  - Severity
    - Stages 1-4
    - Unspecified
    - Unstageable
  - Assign as many codes as needed to capture all pressure ulcers present

NATIONAL ALLIANCE OF MEDICAL AUDITING SPECIALISTS

Injuries (S00-T88)

- Code Extensions
  - Most codes have 7th character extensions
  - Most categories have three extensions
    - A – Initial encounter
    - D – Subsequent encounter
    - S – Sequela

NATIONAL ALLIANCE OF MEDICAL AUDITING SPECIALISTS

References

- CPT Manual, Published by AMA 2014
- NAMAS, Medical Audit Reference Guide 2014
- NCCI Manual, Integumentary System Section
- NCCI Manual, Medicine Section
- Understanding Medicare's NCCI: Logic and Interpretation of the Edits, Published by AMA
- https://www.noridianmedicare.com
- http://www.cms.gov/medicare-coverage-database/details/lcd

NATIONAL ALLIANCE OF MEDICAL AUDITING SPECIALISTS

National Alliance of Medical Auditing Specialists

10401 Kingston Pike, Knoxville, TN 37922
P: 1-877-418-5564 F: 1-865-531-0722
Web: www.NAMAS.co Email: namas@namas-auditing.com

NATIONAL ALLIANCE OF MEDICAL AUDITING SPECIALISTS

CEU# 38862UGN