Coding Debridement Procedures

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Coding debridement procedures can be difficult-even for the most experienced coding professional. Recent studies have documented inappropriate coding of debridement procedures that have resulted in millions of dollars in overpayments.

This article offers guidance on the appropriate codes for debridement procedures and answers some common questions associated with appropriate code assignment for debridement procedures.

Guidelines for Correct Coding

The American Hospital Association has published extensive guidelines in Coding Clinic that outline the appropriate assignment of the debridement codes. The 1988 fourth quarter Coding Clinic revised the code for debridement of wound, infection, or burn to differentiate excisional and nonexcisional procedures related to treatment of devitalized tissue.

Code 86.22, Excisional debridement, was defined as the "surgical removal or cutting away of devitalized tissue, necrosis, or slough," which could be performed in the operating room, emergency room, or at the patient's bedside.[1]

Code 86.28, Nonexcisional debridement, was defined as the "nonoperative brushing, irrigating, scrubbing, or washing away of devitalized tissue, necrosis, or slough," including snipping of tissue followed by Hubbard tank therapy.[2]

The second quarter 2000 *Coding Clinic* noted that an excisional debridement could be coded when performed by a nurse, therapist, physician assistant, or physician. (This advice superseded previously published advice.)

The first quarter 2004 *Coding Clinic* further defined excisional debridement to involve cutting outside or beyond the wound margin in removing devitalized tissue. Documentation should clearly indicate that the procedure involves cutting outside or beyond the wound margin.

Inappropriate Use of 86.22

Concern over the appropriate code assignment for debridement procedures arose after the Centers for Medicare and Medicaid Services (CMS) published a November 2006 report titled "CMS RAC Status Document."

Section 306 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 directed the Department of Health and Human Services to demonstrate the use of recovery audit contractors (RACs) in identifying Medicare underpayments and overpayments and recouping Medicare overpayments. As shown in the table "Examples of Debridement Services with Overpayments," below, the RAC program identified incorrect coding where the provider billed for excisional debridement but the medical record documentation failed to support code assignment.

Quality improvement organizations (QIOs) have also identified coding errors associated with excisional debridement. As part of their responsibilities for the Hospital Payment Monitoring Program, QIOs review inpatient records monthly that are randomly selected by CMS.[3] An analysis of these case reviews demonstrates the significance of the issue. The use of code 86.22, Excisional debridement, in the hospital inpatient setting affected 24 CMS DRGs.[4]

Examples of Debridement Services with Overpayment

CMS found that coding for excisional debridement resulted in millions of overpayments in fiscal year 2006.

Inpatient Hospital Services	Overpayments Collected (in Millions)
Skin graft and/or debridement for skin ulcer or cellulitis (DRG 263)	$3.9
Wound debridement and skin graft, exc. hand, for musculoskeletal and connective tissue disease (DRG 217)	$13.9

Source: CMS. “CMS RAC Status Document.” November 2006. Available online at www.cms.hhs.gov/RAC.

In addition to reviewing records for short-term acute care hospitals, QIOs also review a random sample of records from long-term care hospitals. The table “Total and Sampled Medicare Claims of CMS DRGs Affected by 86.22,” above, illustrates the total volume of Medicare fee-for-service, inpatient claims related to CMS DRGs affected by code 86.22. It also includes the number of claims sampled and the projected, net dollar error amounts for federal fiscal year 2005.

It is evident from the data that long-term care hospitals billed a substantially higher percentage of claims for CMS DRGs affected by code 86.22 than short-term acute care hospitals in fiscal year 2005. In addition, long-term care hospitals had a higher percentage of sampled claims in error for CMS DRGs affected by code 86.22, as well as a higher projected net dollar error amount.
Analysis of the error claims from the surveillance samples led CMS to add excisional debridement as a target area of the Program for Evaluating Payment Patterns Electronic Report (PEPPER). PEPPER is a summary of paid claims data related to areas or CMS DRGs noted to be at high risk for payment error, provided by QIOs to short-term acute care and long-term care prospective payment system hospitals. Analysis of PEPPER data helps hospitals enhance their compliance activities by focusing on potential problem areas.

Total and Sampled Medicare Claims of CMS DRGs Affected by 86.22

Facility Type	Total Claims With or Without 86.22	Claims With 86.22	% of Total Claims with 86.22	% of Sampled Claims with Error	Projected Net Error Amount (in Millions)
Short-Term Acute Care Hospital	214,960	65,739	30.6%	4.3%	$ 4.3
Long-Term Care Hospital	7,343	5,792	78.9%	13.9%	$ 7.9

Source: TMF Health Quality Institute. “National Short-Term Acute-Care Hospital Payment Error Surveillance Sample; Long-Term Care Hospital Surveillance Sample; Fiscal Year 2005.” Austin, Texas, 2007. Unpublished data.

Best Practices for Coding

Documentation stating “excisional debridement” is not enough to code excisional debridement. The medical record must contain supporting documentation. For example, coders should look for details on the procedure, including instruments used, the extent and depth of the procedure, if there was a definite cutting away of tissue, and if the cutting of tissue was outside or beyond the wound margin.

There are gray areas that can be problematic. For example, physician documentation that just states a wound was “debrided to normal bleeding tissue” or documentation noting that “bleeding was observed” may require a physician query in order to clarify the procedure that was performed.

Several issues of *Coding Clinic* provide further guidance:

- It is appropriate to assign a procedure code based on documentation by a nonphysician professional when that professional provides the service; this only applies to procedure coding where there is documentation to substantiate the code.[5, 6]
- Do not assign additional codes for debridement when these procedures are an integral part of the total procedure performed. A debridement carried out in conjunction with another procedure is often, but not always, included in the code for the procedure. Index entries and inclusion notes provide guidance.[7, 8]
- Instructional notes within ICD-9-CM's tabular list will direct the coder to look elsewhere when the debridement extends beyond the skin and subcutaneous tissue.[9]
- If there is no ICD-9-CM index entry under debridement or guidance provided in the tabular entry for the site debrided, the coder should look in the index under other terms such as excision or destruction of lesion of that site. For example, the code for debridement of soft tissue is found in index under excision, lesion, soft tissue (83.39).[10]
- Assign only a code for the deepest layer of debridement when multiple layers of the same site are debrided.[11]

HIM professionals can take a number of additional steps to substantiate the assignment of code 86.22:

- Maintain a current collection of references. The most important are the ICD-9-CM Volumes I, II, and III, the AHA Coding Clinic for ICD-9-CM, and the ICD-9-CM Official Guidelines for Coding and Reporting.
- Maintain and continually update processes and procedures related to complete, accurate, and timely medical record documentation.
- Audit and monitor identified discharges related to assignment code 86.22 in the overall compliance program. Long-term care hospitals should review PEPPER data on a consistent basis and observe for trends related to the billing of 86.22, as this is a PEPPER target area.
- Participate in coding roundtables and other educational opportunities to discuss issues regarding coding of 86.22; invite physician and other appropriate nonphysician provider staff to participate.

Best Practices for Physician Queries

Ensuring the accuracy of code assignment requires a collaborative effort between the physician (and for code 86.22, possibly nonphysician providers) and the HIM department. The query process is an effective "mechanism for improving the quality of coding and medical record documentation and capturing complete clinical data. The goal of the query process should be to improve physician documentation and coding professionals' understanding of the unique clinical situation, not to improve reimbursement."[12]

Hospitals should develop a standard format for a query form designed to ensure clarity, consistency, and appropriateness of responses. Open-ended questions are preferable; queries that appear to lead the physician (or nonphysician provider) to provide a particular response could lead to allegations of inappropriate upcoding.

Hospitals should also develop policies and procedures concerning clinical conditions and documentation situations that warrant a request for clarification. Medical and HIM staff should work collaboratively to develop specific clinical criteria for a valid query. Policies should be developed regarding documenting the query response in the medical record.

Frequent queries related to incomplete, conflicting, or ambiguous documentation concerning code 86.22 could provide an opportunity for process improvement and may indicate a need for provider or staff education regarding the documentation requirements and coding guidelines for accurate code assignment.

Notes

1. American Hospital Association (AHA). *Coding Clinic* fourth quarter (1988).

2. Ibid.

3. Krushat, W. M., and A. J. Bhatia. "Estimating Payment Error for Medicare Acute Care Inpatient Services." *Health Care Financing Review 26,* no. 4 (2005): 4, 39–49.

4. TMF Health Quality Institute. “LT PEPPER Users Guide.” Appendix-DRGs Affected by Procedure Code 86.22. October 2007. Available online at www.hpmpresources.org/LinkClick.aspx?fileticket=tNZ%2fjwfL5AI%3d&tabid=1059&mid=1052.

5. AHA. *Coding Clinic* second quarter (2000): 9.

6. AHA. *Coding Clinic* fourth quarter (2004): 138–139.

7. AHA. *Coding Clinic* third quarter (1995): 12.

8. AHA. *Coding Clinic* second quarter (2005): 3–4.

9. AHA. *Coding Clinic* first quarter (1999): 8–9.

10. AHA. *Coding Clinic* second quarter.

11. AHA. *Coding Clinic* first quarter.

12. Prophet, Sue. “Developing a Physician Query Process.” *Journal of AHIMA 72,* no. 9 (2001): 88I–M.

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