Ensuring Proper Wound Care Service Coding: OIG Highlights Need for Organizations to Assess Wound Care Coding Practices

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This year the Office of Inspector General (OIG) issued two reports relating to wound care services and Medicare payments. As the OIG has included wound care services as part of its 2007 work plan, coding and HIM professionals should review each report and re-assess their organization's coding and reimbursement of these services.

This article reviews each report's findings and outlines ways organizations can ensure wound care services are properly coded and reimbursed.

Surgical Debridement

In late May 2007 the OIG released "Medicare Payments for Surgical Debridement Services in 2004." The study sought to determine the extent to which Medicare Part B surgical debridement services in 2004 met Medicare program requirements.

Surgical debridement services were defined as the removal of dead or unhealthy tissue from a wound using a sharp instrument, such as a curette or scalpel. The purpose is to promote wound healing by removing sources of infection and other impediments.

OIG conducted a medical record review of 368 surgical debridement services from the Centers for Medicare and Medicaid Services' National Claims History file that had a 2004 service date.

The investigation targeted five CPT codes:

- 11040, Debridement; skin, partial thickness
- 11041, Debridement; skin, full thickness
- 11042, Debridement; skin and subcutaneous tissue
- 11043, Debridement; skin, subcutaneous tissue, and muscle
- 11044, Debridement; skin, subcutaneous tissue, muscle, and bone

These codes represent outpatient services provided under Medicare Part B.

The report concluded that 64 percent of surgical debridement services in 2004 did not meet Medicare program requirements, resulting in approximately $64 million in improper payments. Medicare allowed approximately $188 million for surgical debridement services in 2004. Higher cost services were less likely to meet program requirements than lower cost services.

Reviewers determined that 39 percent of surgical debridement services were billed with a code or modifier that did not accurately reflect the service provided. Twenty-nine percent had no or insufficient documentation to determine whether the services were medically necessary or were coded accurately. One percent were not medically necessary.

Every outpatient wound care department, unit, or center should read through the OIG report. An organization's compliance officer or committee must be aware of the report's findings, which directly relate to professional fee service billing and hospital-based outpatient services. The report can be used as a guide to improve wound care coding and reimbursement.

Tips for Improvement

After reviewing the report, HIM professionals should consider the following actions:

- Conduct an audit of 40 to 50 outpatient wound care service records (accounts) where surgical debridement was coded. An outside consulting or auditing firm may be required if the organization does not have the coding expertise internally.
    - Target the assignment of the surgical range of CPT codes.
    - Review the documentation content for the procedure itself.
    - Review for medical necessity and physician orders.
    - Track any utilization pattern or trends (two or three times per week for more than three to four weeks could be a flag).
- Contact the billing service or business office (patient financial services) and ask about any denials on outpatient surgical debridement cases; ask for a list of the accounts.
- Review the charge description master (CDM) and the charge form used in the outpatient wound care department or unit for accuracy.
- Talk to clinical care providers about their understanding of surgical wound care services and documentation requirements.
- Develop a corrective action plan depending on the audit findings.
- Prepare and provide educational material for clinical, coding, CDM, and billing staff on surgical debridement wound care services.
- Discuss the action plan with the compliance officer, director, or committee.
- Rebill (refund) any accounts or encounters where the documentation is not sufficient to support the CPT code charged.
- Check the fiscal intermediary's Web site for any specific guidance of local coverage determination for wound care services.
- Meet with utilization staff and discuss the OIG report and steps to monitor over-utilization within the department, unit, or center.
- Improve charting and documentation forms and dictation and narrative surgical procedure content and details (talk to physicians and other nonphysician providers).
- Re-audit and establish ongoing annual coding and documentation audits and education.

Negative Pressure Wound Therapy Pumps

The June 2007 OIG report "Medicare Payments for Negative Pressure Wound Therapy Pumps in 2004" sought to determine the extent to which claims for negative pressure wound therapy pumps met Medicare coverage criteria and supplier documentation requirements in 2004. The report focuses on outpatient services, particularly the HCPCS codes for supplies and pumps. These codes directly link to the actual service or procedure of negative pressure wound therapy, so clinical and compliance staff need to be aware of this report's findings.

The pump is a portable or stationary device used to treat 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.

The pump is classified as a capped rental item and can be billed on a monthly basis for up to four months, as long as it is considered medically necessary. In certain circumstances, a physician may request an extension after the fourth month. Medicare pays the same amount for the first month as it does for each subsequent month; payments averaged $1,673 per month in 2005.

The report studied the following HCPCS codes:

- E2402, Negative pressure wound therapy pump, stationary or portable
    - A6550, Dressing set for negative pressure wound therapy electrical pump, stationary or portable, each
    - A6551, Canister set for negative pressure wound therapy electrical pump, stationary or portable each
- HCPCS, modifiers:

- EY, No physician or other healthcare provider order for this item or service
- KX, Specific required documentation on file

The following CPT codes correlate to these HCPCS codes:

- 97605, Negative pressure wound therapy including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters
- 97606, Negative pressure wound therapy including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters

Report findings indicate that almost one-quarter of pump claims in 2004 did not meet Medicare coverage criteria, resulting in approximately $21 million in improper payments. Medicare allowed $90 million in 2004 for pumps. An additional $6 million in improper payments were made for supplies associated with these claims.

Reviewers determined that 15 percent of all pump claims in 2004 did not have sufficient documentation to determine whether the claims met Medicare coverage criteria. Another 6 percent of all pump claims were undocumented, while an additional 3 percent were not medically necessary.

Tips for Improvement

HIM professionals should consider the following steps for minimizing compliance risks when reporting negative pressure wound therapy services:

- Conduct an audit of 40 to 50 outpatient wound care service "negative pressure therapy" records (accounts). Talk with the physical therapy department in addition to the designated outpatient wound care department. This may require engaging an outside consulting or auditing firm.
    - Target the assignment of the negative pressure wound therapy HCPCS and CPT codes.
    - Review the documentation content for the services.
    - Review for medical necessity and physician orders.
    - Track any utilization pattern or trends.
- Contact the billing service or business office (patient financial services) and ask about any denials on outpatient negative pressure wound therapy services.
- Review the CDM and charge form for accuracy, specifically HCPCS codes.
- Talk to the clinical care providers about their understanding of negative pressure wound therapy services and documentation requirements as well as the organization's durable medical equipment regional carriers.
- Prepare and provide educational material for clinical, coding, CDM, and billing staff relating to negative pressure wound therapy services.
- Rebill (refund) any accounts or encounter where the documentation is not sufficient to support the CPT or HCPCS code(s) charged.
- Meet with utilization staff and discuss the OIG report and steps to monitor over-utilization within the department, unit, or center.
- Review local medical review policies relating to negative pressure wound therapy.
- Re-audit and establish ongoing annual coding and documentation audits and education.
- Discuss the action plan with the compliance officer or director.

Compliance issues relating to documentation and coding continue to surface, whether charge-driven codes or those assigned specifically by coding professionals. OIG's two reports clearly inform the healthcare community of the areas where problems and issues exist. In addition, the financial risk and exposure is great even for a small outpatient service line.

Organizations must carefully review the OIG reports and take the necessary steps to improve operations, clinical documentation, charging, and coding practices. HIM and coding professionals should take the lead and help those working in outpatient clinical areas. They must stay informed, share information, and be proactive to ensure data integrity for reimbursement.

References

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