Pain-free Wound Care Coding

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Wound care diagnoses and procedures can be challenging to code. In order for coders to code them correctly, clinicians must document diagnoses and procedures appropriately and thoroughly. Open communication between coders and clinicians can help facilitate better documentation.

Inpatient and outpatient coders must understand the nuances of wound care coding, including the ICD-9-CM and CPT coding guidelines, local coverage determinations, and national coverage determinations. Understanding these various guidelines will help coders more accurately code wound care diagnoses and procedures.

Phases of Wound Healing

The wound healing process is a complex series of events that begins the moment an injury occurs and can continue for weeks, months, or years, depending on the severity of the wound, the treatment rendered, and the individual's health.

The first phase of the process is the inflammatory phase, which begins immediately after the injury and lasts two to five days. During this time, the wound bleeds, a clot forms, and phagocytic cells make their way to the wound to clean out the debris.

The next phase, the proliferative phase, can last anywhere from two days to three weeks. During this phase, new skin cells and capillaries form that build the foundation (i.e., collagen) upon which new tissue grows.

The remodeling phase completes the wound healing process. Collagen forms beneath the skin to increase the tensile strength of the wound (although scar tissue is less than 80 percent as strong as original tissue). This final phase can take up to two years.

Wound Care Diagnosis Coding

Causes of open wounds vary and can include burns and other trauma, diabetes complications, pressure ulcers, cellulitis, and various other sources.

Burn diagnosis codes (940–948) are classified according to depth, extent, and agent (E code). First-degree burns affect only the outer layer of the skin and cause pain, redness, and swelling. Second-degree (partial-thickness) burns affect both the outer and underlying layer of skin, causing pain, redness, swelling, and blistering. Third-degree (full-thickness) burns are the most severe burns and extend into the deeper tissues, causing white or blackened, charred skin that may be numb.

All burns are coded with the highest degree of burn sequenced first. If a patient has multiple burns of the same local site (e.g., arm) but of varying degrees, only the highest burn degree is coded.

Diabetic neuropathy (250.6X) and diabetic peripheral vascular disease (250.7X) often cause foot ulcers that require extensive wound care. Diabetic foot ulcers caused by diabetic neuropathy with insults to the feet due to loss of sensation as well as those caused by peripheral vascular disease are coded first to the appropriate diabetes code (250.6X or 250.7X) and then to the ulcer code (707.0X). Gangrene (if present) is coded next (785.4). Additional codes for other diabetic manifestations may also be assigned, such as polyneuropathy or peripheral angioplasty.

If information does not indicate whether the ulcer is due to peripheral vascular disease or polyneuropathy, code 250.8X, Diabetes with other specified manifestations, should be assigned.

It is important to note that all ulcers in diabetic patients are not diabetic ulcers; if there is a question as to linkage, coders should consult the physician. Diabetic ulcers of the foot generally start at the toes and move upward. Diabetic ulcers do not

usually start on the heel.

Ulcers of the heel are almost always decubiti. If the physician indicates diabetic osteomyelitis, or the patient has diabetes and acute osteomyelitis and no other cause of the osteomyelitis is documented, coding professionals should assign the following codes: 250.80, Diabetes with other specified manifestations, type II, or unspecified type, not stated as uncontrolled; 731.8, Other bone involvement in diseases classified elsewhere; and 730.0X, Acute osteomyelitis.

ICD-9-CM assumes a relationship between diabetes and osteomyelitis when both conditions are present, unless the physician indicates that the acute osteomyelitis is unrelated to the diabetes.

Pressure ulcers are classified according to site and stage. The most common sites of pressure ulcers are areas with bony prominences, such as the elbow, upper back, lower back, hip, buttock, ankle, and heel.

The stages of pressure ulcers are:

- I: a reddened area on the skin that, when touched, is "nonblanchable" (does not turn white).
- II: the skin blisters or forms an open sore. The area around the sore may be red or irritated. There is partial-thickness skin loss involving the epidermis or dermis.
- III: the skin breakdown looks like a crater. There is full-thickness skin loss involving damage or necrosis of subcutaneous tissue.
- IV: the depth of the ulcer is down to the muscle and bone and tendons and joints.

When coding pressure ulcers, both the site (707.00–707.09) and the stage (707.20–707.25) must be coded, with the site sequenced first.

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 categories 681, Cellulitis and abscess of finger and toe, and 682, Other cellulitis and abscess. A secondary code identifying the organism should be assigned, if known.

Abscess and lymphangitis are both included in the code for cellulitis of the skin and should not be coded separately. When coding cellulitis associated with an open wound, both the cellulitis and the open wound are coded, with the circumstances of admission determining the sequencing.

Other circumstances that might require wound care include postoperative infections, nonhealing postsurgical wounds, disruption of operation wounds, and skin graft complications. Coding professionals should review the clinical documentation thoroughly to determine if the wound is caused by a complication, which would require a code from category 997 or 998 to be sequenced first.

Wound Care Procedure Coding

Treatment options for the various types of open wounds are just as numerous as the multitude of diagnoses. On the inpatient side, differentiating between excisional and nonexcisional debridement can be a challenge for the coder. From the outpatient perspective, one wound care service might include an evaluation and management CPT code for the visit, medicine CPT codes for wound care management and physical therapy (physician and nonphysician), surgical CPT codes, and HCPCS codes for supplies and devices.

In ICD-9-CM procedure coding, excisional debridement involves surgical removal or cutting away and is coded to 86.22. Nonexcisional debridement may include brushing, scrubbing, washing, and other mechanisms that do not involve surgical removal of tissue and is coded to 86.28.

Active wound care management codes are found in the medicine section of CPT (97597–97606). Codes 97597 and 97598 are assigned for selective wound debridement, which includes high-pressure waterjet and sharp selective debridement with scissors, scalpel, or forceps.

Nonselective wound debridement is coded to 97602 and includes wet-to-moist dressings, application of enzymes, and abrasion techniques that facilitate the gradual removal of areas of necrotic tissue. Another method of nonselective debridement is

autolysis, which uses the body's own enzymes and moisture to rehydrate, soften, and liquefy hard escar and slough.

The final two codes in this subcategory describe negative pressure wound therapy, such as vacuum-assisted drainage collection (97605–97606). Negative pressure wound therapy uses controlled application of subatmospheric pressure to a wound, which promotes healing by increasing local vascularity and oxygenation of the wound bed, evacuating wound fluid, reducing edema, and removing exudates and bacteria.

Surgical debridement codes (11040–11044) are assigned according to the instruments used; the tissue, muscle, or bone removed; and depth of debridement. Coders should review documentation carefully to determine the appropriate surgical debridement code. Incision and drainage codes (10060–10180) are assigned according to the type of lesion involved (e.g., hematoma, abscess).

Skin grafts may be recommended for burns, nonhealing ulcers, skin cancer surgery, and other large wounds. Skin grafts are classified in CPT according to the type of graft used, size of graft in square centimeters, and the location of the skin graft (recipient site). CPT specifies four types of grafts: autografts (15040–15157), acellular dermal replacements (15170–15261), allografts (15300–15366), and xenografts (15400–15431).

Hyperbaric oxygen treatments are another form of wound care treatment. These sessions are reported with code 99183. E/M services and procedures (e.g., wound debridement) that are provided in conjunction with a hyperbaric oxygen treatment session should be reported separately.

Another common type of wound care treatment is the Unna boot (29580). The Unna boot is a compression dressing consisting of a paste, primarily made of zinc oxide, that is applied under and over a gauze bandage. It is used for treatment of ulcers, burns, and other disorders.

A new CPT code has been added in 2010 to report multilayered wound compression treatment. The new code is 29581, Application of multilayer venous wound compression system, below knee.

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