Dermatology Coding Alert

ICD-10: Follow These Steps for Trouble-Free Burn Dx Coding

Codes include information on location, degree, TBSA, and cause.

Knowing the type and degree of a patient's burn isn't enough to complete the diagnostic picture under ICD-10. You also need to include a code that describes the cause of the burn.

Check the ICD-10 Coding in this Scenario

Scenario: Your patient has a second-degree burn of the left foot from hot bath water.

Step 1: Code the location and degree of the burn.

In ICD-10, you would list T25.222A (Burn of second degree of left foot, initial encounter). Notice that the ICD-10 descriptor includes "left" increasing the level of detail you can report.

Don't miss: In ICD-10, certain codes require you to list a seventh character to provide information about the characteristic of the encounter. If you report only six characters for these diagnoses, you're submitting an invalid code and courting a claim rejection.

When it comes to injuries, you'll list seventh character "D" to indicate a subsequent encounter or "S" to indicate sequela.

Step 2: Report the TBSA

The next step in coding for a burn is to report the portion of the body affected by the burn and the portion affected by third degree burns (total body surface area, or TBSA). The addition of a T31 code is advisable when there is mention of a third-degree burn involving 20 percent or more of the body surface.

In the scenario described above, suppose the patient's burn covers 2 percent of his body. Report T31.0 (Burns involving less than 10% of body surface).

Step 3: Report the Cause of the Burn.

Under ICD-10 there's a third step. You'll need to add the external cause code for how the burn happened to complete your list of diagnoses.

Under ICD-9, most external cause codes or E codes weren't mandatory, says **Lisa Selman-Holman, JD, BSN, RN, HCS-D, COS-C, HCS-O,** consultant and principal of **Selman-Holman & Associates** and **CoDR Coding Done Right** in Denton, Texas. But you did need to list an E code when you're coding for a poisoning caused by a drug or chemical or an adverse effect of a drug taken correctly, she says. Under ICD-10, you list external cause codes for all injuries.

The change is thanks to the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which repealed the SGR and scheduled five, consecutive 0.5 percent increases through Jan. 1, 2019.

That's not all: The Medicare Physician Fee Schedule (MPFS) impacts your potential pay in other ways beyond the overall increase, and also impacts many compliance issues that affect your practice. Read on to let our experts walk you through some MPFS proposals you need to know about.

Celebrate Stalled Incident-To Changes

According to experts, incident-to rules remain unchanged for 2016, despite previous indications to the contrary. That means a non-physician practitioner (NPP) can continue to bill under the national provider identifier (NPI) of a supervising physician (who is present in the office) for 100 percent reimbursement of the Medicare fee schedule. This process is called billing "incident-to," and you can only bill this way for an established patient receiving service under a care plan put in place by a physician in the practice.

Background: In the July 15 proposed Medicare Physician Fee Schedule (MPFS), CMS suggested paying for incident-to services only if the doctor who bills for the incident-to service is the same person who established the care plan.

Final rule: In response to comments regarding the proposed incident-to change, CMS states in the final rule, "The proposed policy was not intended to require that the supervising physician or other practitioner must be the same individual as the physician or other practitioner who orders or refers the beneficiary for the services, or who initiates treatment. Rather, we intended to clarify that under circumstances where the supervising practitioner is not the same as the referring, ordering, or treating practitioner, only the supervising practitioner may bill Medicare for the incident to service."

Important: This nixes a rule change that would have gone into effect on Jan. 1, 2016, says **Michael A. Ferragamo, MD, FACS,** clinical assistant professor at the State University of New York at Stony Brook. "This reversal of the rule change means more NPPs can bill incident-to services directly to Medicare at 100 percent reimbursement when any physician is in the office suite," he adds.

However: "It is important to note that the billing provider must be the physician who supervised the service and is present at the time of the encounter in the office suite," says **Maggie M. Mac, CPC, CEMC, CHC, CMM, ICCE,** AHIMA-approved ICD-10 CM/PCS trainer and president of Maggie Mac-Medical Practice Consulting in Clearwater, Fla. "This is not a change in policy but a clarification and has always been in effect with incident-to billing."

Still relevant: CMS also proposed that the person providing the incident-to service does so in accordance with state law and is licensed to do it. The incident-to provider also cannot have been excluded from any federal health care program or have had their enrollment revoked for any reason. In other words, just because the service is billed under a supervising doctor's number doesn't mean the performing NPP can see the patient if he/she has been excluded from Medicare. These guidelines still apply.

Don't Write Off Global Periods

At the end of 2014, CMS put forth a proposal in the Federal Register that shocked many coding professionals. Under the plan, the current 10-day global codes would transition to 0-day in 2017, and the 90-day global codes will change to 0-day in 2018. "This certainly would have resulted in a pay cut for surgeons," Ferragamo says.

Update: The MPFS final rule notes that the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), enacted earlier this year, prohibits CMS "from implementing the policy established in the CY 2015 PFS final rule with comment period that would have transitioned all 10-day and 90-day global surgery packages to 0-day global periods."

Outlook: "It's hard to say definitively if the removal of global period would be good or bad for physicians as I think there are good and bad aspects," says **Marcella Bucknam, CPC, CPC-I, CCS-P, CPC-H, CCS, CPC-P, COBGC, CCC,** internal audit manager with Peace Health in Vancouver, Wash. "Certainly the potential is there for surgeons to make more money, especially for patients who are very sick and require move follow up or for patients who develop complications. At this time, Medicare bundles all of that." On the other hand, Bucknam says surgeons would need to change their thinking and their documentation, improving the details they include, for post-operative visits or face drastic reductions in reimbursement.

Change may still come: "Unfortunately, we will likely see this pay cut in global payments in the near future," Ferragamo says.

Bucknam agrees: "I do think that CMS will eventually eliminate global periods one way or the other," she says. "Consider

the proposals to bundle payments for hospital care. Hospitals do not have global period for surgery. That is particularly for physicians. If payments are bundled, I think it is likely the global period concept will not apply. There are also some other new payment methodologies that are being tossed about that would work much better if a global period wasn't part of the equation."

CMS action: The 2016 MPFS final rule states that beginning no later than January 1, 2017, CMS will develop a process "to gather information needed to value surgical services from a representative sample of physicians... [including] the number and level of medical visits furnished during the global period and other items and services related to the surgery, as appropriate." Then, "beginning in CY 2019, [CMS] must use the information collected as appropriate, along with other available data, to improve the accuracy of valuation of surgical services under the PFS."