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Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: 3 Questions You Must Ask When Coding Decubitus Ulcers

Poor documentation could cost you $150 per debridement

You won't always use an excision code when reporting decubitus ulcer removals. Rather, you should know the location and depth of the wound, as well as whether the physician closed the wound. To make it easy on yourself, ask these three questions:

Question 1: Did the Physician Close the Wound? By answering this question, you're attempting to narrow your code selection to either an excision or a debridement procedure.

If the physician closes the wound, you should report an excision (15920-15958). In this case, the physician will clear the wound of infection prior to closing. On occasion, the physician will also remove underlying structures (generally a bony protuberance, such as the coccyx) at the same time.

If the physician leaves the wound open, you should report a debridement (11040-11044). The physician may choose to leave the wound open in the hopes that healthy tissue will grow over the site of the ulcer. This method may require that the physician perform subsequent debridements over time as the wound heals. Only if there are no signs of infection will the physician perform an excision and close the wound.

Decubitus ulcers, commonly known as bedsores, pressure sores or pressure ulcers, occur because of local interference with circulation, and usually appear over a bony prominence at the sacrum, hip (trochanter), heel, shoulder or elbow.

Question 2: For Excision, What's the Location and Closure Method? You must choose an appropriate excision code according to the location of the ulcer, as follows:

Coccygeal - 15920-15922

Sacral - 15931-5937

Ischial - 15940-15946

Trochanteric - 15950-15958

Note: For an unlisted location, you may choose 15999 (Unlisted procedure, excision pressure ulcer). See CPT for a complete list of code definitions.

Don't forget about ostectomy: In some cases, the above codes also describe removal of underlying bony structure (ostectomy), which may also if become infected, says **M. Trayser Dunaway, MD, FACS**, a general surgeon in private practice in Camden, S.C. For example, 15931 describes excision of a sacral pressure ulcer, while 15933 describes the same procedure but with further removal of bone below the site of the ulcer.

Closure type matters: You must choose between at least two codes to describe the type of closure the physician used for each ulcer location. The first code (for instance, 15920, Excision, coccygeal pressure ulcer, with coccygectomy; with primary suture) describes closure by sutures, while the second code (for example, 15922, ... with flap closure) describes

a closure using skin flaps.

Question 3: How Deep Was the Debridement? When assigning debridement codes, you must know the depth of the tissue the physician removed. This information is crucial, because without supporting documentation, you can only report the most superficial debridement code (11040, Debridement; skin, partial thickness). But if the physician actually debrided all the way to muscle and bone (11044), and you only report 11040, you could lose up to $150 in payment simply because the documentation wasn't sufficient.

Make sure the medical record is complete: When debriding an ulcer, the physician should note not only the location of the ulcer but also the depth/layers of the debridement (partial thickness, 11040; full thickness, 11041, subcutaneous, 11042; subcutaneous and muscle, 11043; or subcutaneous tissue, muscle and bone, 11044).

Tip: Report Muscle/Skin Grafts Separately. When the physician closes a sacral, ischial or trochanteric ulcer excision using muscle flaps or skin grafts, you should report a separate code to describe the closure, according to CPT guidelines.

For example, the physician excises an ischial pressure ulcer with ostectomy. She then closes the operative wound using muscle flap. To report the excision, you should use 15946 (Excision, ischial pressure ulcer, with ostec-tomy, in preparation for muscle or myocutaneous flap or skin graft closure). Per CPT instructions, you may report the muscle flap closure separately using 15734 (Muscle, myocutaneous, or fascio-cutaneous flap; trunk).

Apply -58 for Debridements Following 11044

If the physician performs 11043 or 11044 and reports subsequent debridements within the global period of the initial surgery, you must append modifier -58 (Staged or related service by the same physician during the postoperative period) to the subsequent debridement codes.

Example: The physician debrides a pressure sore above the coccyx, also removing muscle and bone to clear infection. You report 11044. Several weeks later -- within the global period of 11044 -- the physician must perform a subcutaneous debridement to remove additional diseased tissue. You should report this procedure using 11042-58.

Note: The global period for 11043 is 10 days, as opposed to 90 days for 11044.

Don't worry about -58 for 11040-11042: Because codes 11040-11042 include zero global days, you need not append modifier -58 to any subsequent debride-ments following these procedures.

For example, the physician performs a full-thickness debridement, followed 10 days later by a partial-thickness debridement. Report the first procedure 11041. Report the second procedure 11040 with no modifiers attached.

Avoid Active Wound Care Codes for Physicians

Never use active wound care codes 97601 (Removal of devitalized tissue from wound[s]; selective debridement, without anesthesia [e.g., high-pressure waterjet, sharp selective debridement with scissors, scalpel and tweezers], including topical application[s], wound assessment, and instruc-tion[s] for ongoing care, per session) and 97602 (... ; non-selective debridement ...) to report physician management of decubitus ulcers. CPT includes these codes to describe debridements as performed by licensed nonphysician practitioners, such as physician assistants, nurse practitioners and clinical nurse specialists.

Physicians should instead rely on debridement codes 11040-11044 to report wound care, according to the AMA's CPT Changes 2001: An Insider's View. And, you should never report 97601/97602 and 11040-11044 at the same time.