Eli's Rehab Report

Debridement, Central Motor EP Highlight 2005 CPT Changes

EP codes eliminate the need for unlisted-procedure code and payment hassles

If your physical or occupational therapist performs debridement and regularly reports 97601, then as of Jan. 1, you should strike that from their list of possible choices and add 97597-97598 instead.

In addition to these two new debridement codes, CPT Codes 2005 contains other changes that will impact physical medicine and rehab coders, so make sure you note the following advice from our experts on applying the two new wound care codes, two new central motor evoked potential studies (EP) codes, and the four new acupuncture face-to-face codes.

Get ready now: Keep in mind that for 2005, neither Medicare payers nor practices billing Medicare payers are allowed the usual 90-day "grace period" to transition to the new codes. Beginning on Jan. 1, 2005, you **must** use CPT 2005 exclusively for Medicare payers, according to CMS transmittal 95 (February 2004).

Wound Surface Area Determines the Code

If your physical or occupational therapist regularly performs debridement, you'll have to start paying attention to the surface area.

CPT has deleted 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 instruction[s] for ongoing care, per session) and added two more debridement codes. Pay attention to the new codes' descriptions. They differ by wound surface area - either "less than or equal to" or "greater than" 20 square centimeters of surface area:

97597 - Removal devitalized tissue from wound(s), selective debridement, without anesthesia (e.g., high-pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), with or without topical application(s), wound assessment, and instruction(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area less than or equal to 20 square centimeters

97598 -... total wound(s) surface area greater than 20 square centimeters.

Coding tip: You should rely on the provider's documentation to determine the wound size, says **Tina Zink**, a coder at McKenzie Williamette Medical Services Center in Springfield, Ore., "But if the provider doesn't tell us in the documentation, we revert to the smaller wound size."

Keep in mind: Physicians do not use these codes, and will typically use the integumentary series (10040-19499) for debridement services instead. For example, a physiatrist might use a code from the 11040-11044 series depending on the number of layers he debrides. If he debrides skin, subcutaneous tissue and muscle, you should report 11043 (Debridement; skin, subcutaneous tissue, and muscle).

50 cm Squared Decides Wound Care Codes

When you're deciding which code to use for wound care, you should check your physician's documentation for the size of the wound. CPT added two wound care codes that differ by either "less than or equal to" or "greater than" 50 square centimeters:

97605 - Negative pressure wound therapy (e.g., vacuum-assisted drainage collection), 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 - ... total wound(s) surface area greater than 50 square centimeters.

For Central Motor EP, Turn to 95928/95929

Beginning Jan. 1, you should report 95928 (Central motor evoked potential study [transcranial motor stimulation]; upper limbs) or 95929 (... lower limbs), as appropriate - rather than an unlisted-procedure code - for central motor evoked potential (EP) studies. The new codes join previously listed EP procedures 92585/92586 (auditory EP), 95925-95927 (somatosensory EP) and 95930 (visual EP).

"These new codes allow us to code for interpretation of the motor pathway centrally from the cortex through the spine and on to the peripheral muscle," says **Gloria Galloway, MD,** associate professor of neurology at the Children's Hospital and OSU in Columbus, Ohio, one of the authors of the CPT proposal for codes 95928/95929.

"Motor EP differs from the sensory or SEP codes, which allow interpretation of the sensory tracts and sensory cortical responses," Galloway says. "We know that patients undergoing spinal surgeries are typically at risk for both motor and sensory deficits, so monitoring both pathways makes sense."

Coding advice: You should report a single unit of 95928/95929 for any and all sites that the neurologist tests during a single session. The codes are bilateral. For example, if the physician tests a total of four sites on the upper limbs (two on the right arm and two on the left arm), you would report 95928.

Know which diagnoses and conditions to use with 95928/95929: in the outpatient setting, motor neuron diseases such as amyotrophic lateral sclerosis (335.20) and multiple sclerosis (340).

And neurologists may use central motor evoked potential studies intraoperatively to monitor procedures involving scoliosis instrumentation, intramedullary spinal cord tumors, brain tumor resection, laminectomies or other surgical procedures to repair spondylosis and spinal stenosis, Galloway says.

Therefore, CPT 2005 will allow you to report 95928/95929 in addition to +95920 (Intraoperative neurophysiology testing, per hour [list separately in addition to code for primary procedure]).