

Eli's Rehab Report

Keep Cool When Coding for Burn Rehabilitation Services

More than 2 million burns occur in the United States each year, over 100,000 of which require rehabilitation and often pain management treatment. New technology and upgraded patient training have improved patient burn care, and PM&R practices are seeing more of these patients than ever. The coding can be confusing, however, because burn treatment has its own code series (16000-16030), and many physiatrists lose revenue by coding for burn care using standard E/M codes. Knowing when to use burn codes and the proper codes for pain management and physical and occupational therapy can help streamline your billing process and reduce denials.

Don't Limit Your Options

"There is the misconception that the burn treatment codes in the 16000 series are reserved for trauma or initial burn care only," says **Paula Fillari, RN, CCRN**, staff nurse IV in the rehabilitation department at the Bothin Burn Center at St. Francis Hospital in San Francisco. "We use these codes when patients return for burn care, even after they've been discharged."

Many physiatrists are the primary rehabilitation caregivers after a burn patient has been discharged. They take over much of the debridement and wound dressing, administer pain management, and prescribe physical and occupational therapy.

Codes 16000-16030 represent services from initial treatment of first-degree burns through dressings and debridement of large burns. For example, if the physiatrist changed the dressings and debrided a small burn in the office without anesthesia, he or she would bill 16020 (dressings and/or debridement, initial or subsequent; without anesthesia, office or hospital, small), which pays about \$70. If the physiatrist coded for the service using the level-three E/M code ([CPT 99213](#)), he or she would have collected about \$55. The burn care codes pay better and are more accurate.

Determining the Burn Size, Rule-of-Nines Key

CPT classifies burn codes according to the total burn size. It's important to know how CPT defines whether a burn is small, medium or large. In some cases, the physiatrist treats the patient after the burn has been treated in the hospital, where a burn size designation has already been established. However, some physiatrists face the task of evaluating a burn for the first time.

CPT is not specific regarding "small," "medium" and "large" burn wounds, leaving that to the clinical judgment of the physician. But the CPT descriptors offer some idea of the burn size criteria. The descriptor for a medium burn gives the example of "whole face or whole extremity," whereas the descriptor for large burn offers the example of "more than one extremity."

Physiatrists who treat burn patients in the rehabilitation stages should remember the "rule of nines" when choosing the size of the burn to code, if the size hasn't already been determined by the treating hospital or physician.

The TBSA (total body surface area) is calculated by using the criterion that divides the body into fractions of 9 percent. For example, in an adult the head is worth 9 percent, each arm is worth 9 percent, the front of the trunk is worth two units of 9 percent (for a total of 18 percent), the back of the trunk is also worth two units of 9 percent (for a total of 18 percent), and each leg is worth 18 percent, leaving 1 percent left for the genital area.

For the "rule of nines," many carriers use the measurement of 4-1/2 percent of a body segment to denote a small wound, 4-1/2 to 9 percent to denote a medium wound and greater than 9 percent for a large wound.

However, Fillari says, "If the burn size has already been designated, indicate on your chart what the original treating team chose. But code according to the percentage of the original burn that is still unhealed, since that's the only section that you are actually debriding and dressing. If you are still treating the entire burn, code according to the original size."

For instance, a patient presents to a physiatrist for pain management and debridement on a burn of the entire left arm. When the patient was hospitalized, the burn was classified as comprising 9 percent of her TBSA, but only 2 percent of the original burn is still considered an open wound. Therefore, the physiatrist would code using 16020, debridement for a small burn, but he would indicate in his chart that the burn was originally a medium burn and that the patient has made significant progress. The burn severity will also be addressed in the diagnosis code, explained below.

Pain Management With Burn Care

Suppose the physiatrist treats the wound and offers pain management on the same visit. A patient presents with a small burn of her forearm, which is healing well but needs dressing and debridement. For this, the physiatrist codes 16020. The patient also has severe pain in her forearm, so the physiatrist performs a trigger point injection into the arm, which is coded as 20550 (injection, tendon sheath, ligament, trigger points or ganglion cyst).

Although both 16020 and 20550 are starred procedures, both can be billed on the same day when medically necessary. Because they are not bundled together by the CCI edits and are not related to one another, there is no need to add modifier -59 (distinct procedural service) to the claim.

If a patient presents to the physiatrist after the burn has healed but still has severe pain in the affected area, you would not bill the burn care codes. If the physician performed an E/M service, the appropriate E/M code should be billed. If a pain management procedure took place as well (99211-99215), the practice should add modifier -25 (significant, separately identifiable E/M service by the same physician on the same day) to the E/M code. This demonstrates that the E/M service was performed in addition to the pain management procedure, which would be demonstrated by separate documentation of history, exam and medical decision-making.

Diagnosis Codes for Burns

Although most burn patients who see the physiatrist for posttraumatic rehab have already been assigned an ICD-9 code, that diagnosis may not remain accurate. The severity and size of the burn will change as the burn is treated and heals. To report burns properly, the physiatrist needs a minimum of two codes.

The diagnosis codes for burns are listed in category 940-949 of ICD-9-CM. The first code is selected by location and severity of the burn (i.e., first degree, second degree, etc.), and the second details the extent of the burn (TBSA affected and percent over third degree). Because coders rely on the physiatrists' documentation to code correctly for burn treatment, the physician must be very descriptive in the chart notes.

Codes 941-945 describe both the location and severity of the burn(s). The first three digits of the code indicate the location of the burn on the body. For example, burns on the upper limbs use the 943 series of codes, adding a fourth digit that describes the severity. If the patient received a second-degree burn with blisters and epidermal loss on the upper limb caused by a candle, the diagnosis code is 943.2. A fifth digit should then be added to provide added specificity by indicating the specific site of upper limb. If the second-degree burn was on the shoulder, it is coded as 943.25. A full listing of fourth and fifth digits is in the ICD-9 manual under the corresponding burn code numbers.

Choosing the Second ICD-9 Code

The second diagnosis code for a burn patient is always 948.xx (burns classified according to extent of body surface involved). Code 948 categorizes burns according to the extent of the total body surface involved. The fourth digit demonstrates the total percentage of the body surface area burned, and the fifth digit accounts for the percentage of third-degree or higher burns to the body, if applicable.

The 948 code for the patient burned on the shoulder by a candle would be 948.00 because less than 10 percent of the body was burned and less than 10 percent of the burn was a third-degree burn.

When coding multiple burn sites, keep in mind that you should use 948.xx only once on the claim because it is reporting the **total** body surface area affected. That means you add the percentages together for **all** burns to arrive at the fourth digit and then add only the percentages that were for third-degree or worse burns to arrive at the fifth digit.

Therapy for Burn Patients

"Because burn care is individualized according to a variety of patient needs, the therapy for burn rehab really runs the gamut using all of the different modalities for all different types of burns," Fillari says. "Most commonly, the patient will be seen for therapeutic exercises (97110), gait training (97116), or activities of daily living (97535), usually between one and three times a week at the beginning of their rehabilitation."

Normally, all of these codes can be billed together on the same day, whether they are performed by the same therapist or by several therapists as part of the team. For instance, a patient with an ankle burn received 15 minutes of range-of-motion exercises with a physical therapist to promote strength and mobility in her ankle. She then met with an occupational therapist for 30 minutes of activities for daily living training. The therapy practice could bill one unit of 97110 and two units of 97535 together without problems if the services were approved by the treating physician, were medically necessary, and were part of the current treatment plan.

Diagnosis Codes for Burn Therapy

Physical and occupational therapists should not code their claims using the burn diagnosis codes outlined above. Therapists should always code the actual problem they are treating. This is correct coding and is usually the only way to get reimbursed for most therapy modalities. The majority of carriers do not list the burn ICD-9 codes as covered diagnoses for therapeutic exercises (97110), but they usually list such diagnoses as limb pain (729.5), joint pain (719.40-719.49), difficulty in walking (719.79) and other conditions associated with burn rehabilitation.

Even though the ICD-9 code to support treatment of the burn will be based on the problem it is causing (pain, gait disturbance, etc.), the therapy plan should always include the history of the burn and treatment to date.