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Outpatient Facility Coding Alert

Coding Basics: 16000-16036: Avoid Burns Coding Meltdowns With This Advice

Map your way to accurate skin percentages with the "Rule of Nines."

If you're reporting 16000-16036 codes, you might be forfeiting pay more than $900 for separately reimbursable procedures, because procedures such as skin grafts are not included in these codes. Our coding experts offer these three tips for improving your burn treatment reimbursement.

Tip 1: Size Determines Anesthesia Code Choice

If the doctor only debrides a burn, you should select an initial treatment code from the 16000-16030 series.

Note: First-degree burns will never require debridement, says **Pamela Biffle, CPC, CPC-P, CPC-I, CCS-P, CHCC, CHCO**, owner of PB Healthcare Consulting and Education Inc. in Austin, Texas. For first-degree burns, select 16000 (Initial treatment, first-degree burn, when no more than local treatment is required) when the physician tends to burns affecting only the epidermis.

For more extensive burns, you must choose among codes 16020 (Dressings and/or debridement of partial-thickness burns, initial or subsequent; small [less than 5% total body surface area]), 16025 (... medium [e.g., whole face or whole extremity, or 5% to 10% total body surface area]), or 16030 (... large [e.g., more than 1 extremity, or greater than 10% total body surface area]).

Don't miss: To find the percentage of involved skin, use the "Rule of Nines." According to the rule:

- head and neck, the right arm, and the left arm each equal 9 percent;
- the back trunk, front trunk, left leg, and right leg each equal 18 percent (the front and back trunk are divided into upper and lower segments, and each leg is divided into back and front segments, each equaling 9 percent);
- genitalia equals 1 percent.

Select the treatment code based on that percentage.

One more thing: Make sure the dermatologist clearly states the size of the affected area(s) in the documentation to support any code selection.

Tip 2: Claim Skin Grafts When Applicable

Codes 16000-16036 describe treatment of the burn surface only, so you may report skin grafts if the physician performs them.

You should select the appropriate skin graft code(s) from the 15100- 15777portion of CPT® not doing so could undermine your reimbursement and cause your practice to lose well-deserved pay.

Example: The doctor treats a patient with third-degree burns on the left arm. He uses a free, full-thickness graft of 40 sq cm to close the wound.

Solution: In this case, you should report 15220 (Full-thickness graft, free, including direct closure of donor site, scalp,

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arms, and/or legs; 20 sq cm or less), as well as +15221 (...each additional 20 sq cm, or part thereof [List separately in addition to code for primary procedure]).

With 23.21 RVUs, Medicare carriers should reimburse 15220 at $789.67 in a non-facility, after multiplying by the 34.023 conversion factor. Add to that $141.54 for +15221 (4.16 RVUs) for a total reimbursement of $931.21.

One more thing: Report 15002-15005 (Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar [including subcutaneous tissues], or incisional release of scar contracture ...) as appropriate when the physician surgically prepares the recipient site.

However: According to the Correct Coding Initiative (CCI), "you can only use the treatment codes or the site prep codes at one time so use the most appropriate code," notes Biffle.

Tip 3: Treat Subsequent Sessions as Staged Procedures

For follow-up procedures, you may have to append modifier 58 (Staged or related procedure or service by the same physician during the postoperative period).

Example: A patient returns to your office every Wednesday for six consecutive weeks. During those visits, the physician continues to treat the burn. You should code these visits with the appropriate CPT® code (16020-16036) with modifier 58. Your choice of code in this case depends on the total percentage of body surface the physician treats.

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