Codify
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Home Health ICD-9/ICD-10 Alert

Coding 101: Don't Make This Open Wound Mistake

A referral for care of an 'open wound' isn't always what it seems.

Open wounds bring case mix points, so of course you'll want to take credit for the care you provide them. But if you're too quick to report a wound as "open" you may be making a risky code choice.

First, it's important to understand what an open wound means for coding purposes. In ICD-9 coding logic, open wounds and trauma wounds that penetrate the integumentary system are the same thing wounds caused by accident or violence. This includes wounds caused by animal bites, avulsions, cuts, lacerations, punctures and traumatic amputations.

Traumatic wounds, burns, and post-operative complications are Skin 1 case mix diagnoses, says **Jan McLain, RN, BS, LNC, HCS-D, COS-C, BCHH-C,** with **Adventist Health System Home Care** in Port Charlotte, Fla. These diagnoses earn points in all equations when listed as primary or secondary in the top six diagnosis slots for the clinical domain in the HHRG as well as for nonroutine supplies (NRS).

Problem: When you code incorrectly for a superficial wound as an open wound, you're up-coding which results in over payment.

Many coders are confused by the term "open wound." If you're coding for a dehisced surgical wound, or a Stage IV pressure ulcer where you can see down to the bone, you might think that you're coding for an open wound, but when you follow ICD-9 coding guidelines, you know that's an incorrect assumption. Surgical wounds don't count as open wounds.

Another area that can trip up coders is coding for a patient who had an open fracture. Even when your patient has an open fracture diagnosis, it's not appropriate to assign an open wound code. Instead, look to aftercare codes such as V54.16 (Aftercare for healing traumatic fracture of lower leg) to indicate the fracture.

Watch Referral Language

Take care when a referral mentions that you'll provide care for a patient's "open wound." This language can lead you to use a trauma code when it's not appropriate. Hospital referrals often refer to a wound as an "open wound," regardless of the cause.

Instead, read the medical record carefully to identify the correct wound type. Then select the code that matches your patient's wound type. Your code should reflect the cause of the original wound. You should only code for a trauma wound if the original cause of the wound was trauma.

Bottom line: Don't rely solely on referral information. Be sure to assess and review additional medical record documentation. The correct selection of the ICD-9 code to identify the etiology of the wound extends beyond the reimbursement world, but has a huge clinical effect as well, McLain says. "Once the etiology of an open wound is determined, this etiology must be communicated to all clinicians involved in the care of the wound to allow for the appropriate wound care products to be selected."

Coding example: Your new patient was referred to home health for aftercare of an abdominal surgical wound following

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an open approach colectomy due to colon cancer. Don't be tempted to list 879.2 (Open wound of abdominal wall, anterior, without mention of complication) for this patient because you can see that the wound is open with the wound bed observable.

Instead, if the wound has been left open to heal by secondary intention, you can code for it with V58.42, (Aftercare following surgery for neoplasm), says **Judy Adams, RN, BSN, HCS-D, HCS-O,** with **Adams Home Care Consulting** in Asheville, N.C.

You'll also want to use caution when you think the wound is showing signs of complicated healing. For example, suppose the wound incision was initially closed with sutures or staples and has since separated. This wound may exhibit dehiscence, but you'll need confirmation from the physician before you can list a dehiscence code, Adams says.

Straight from the source: Section I.B.18 in the Official ICD-9-CM Guidelines for Coding and Reporting states the following under Complications: "Code assignment is based on the provider's documentation of the relationship between the condition and the care or procedure. The guideline extends to any complication of care, regardless of the chapter the code is located in. It is important to note that not all conditions that occur during or following medical care or surgery are classified as complications. There must be a cause and effect relationship between the care provided and the condition, and an indication in the documentation that it is a complication. Query the provider for clarification, if the complication is not clearly documented."

The dehiscence codes 998.3x (Disruption of wound) are Skin 1 case mix codes, Adams points out. Because these codes can add 8-20 case mix points, your agency runs the risk of an upcoding accusation when you report them, unless you have documentation from the physician that the wound is indeed dehisced.

If the wound is infected, as stated or confirmed by the physician, you would list 998.59 (Other postoperative infection) with an additional code for the infectious organism, if known. Be sure to also list a code for the patient's colon cancer unless it has been documented as resolved, in which case you would list V10.05 (Personal history of malignant neoplasm; large intestine).

Another scenario: When the physician documents dehiscense or disruption of a surgically repaired traumatic wound or laceration, should you code for it as a traumatic open wound or as dehiscense of a surgical wound? Code for this wound with 998.33 (Disruption of traumatic injury wound repair) which is also a Skin 1 case mix code and provides points toward NRS, McLain says.

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