Home Health ICD-9/ICD-10 Alert

Coding How-To: Remove Confusion From Dressing Change Coding

Don't list V codes for complicated wounds.

If you're still uncertain about when and in which sequence to report V58.30 (Encounter for change or removal of nonsurgical wound dressing), you could be jeopardizing your risk adjustment. Take a closer look at these codes and learn when and how to report them.

The V58.3 series was revised effective Oct. 1, 2006, replacing old code V58.3 (Attention to surgical dressings and sutures) with three new codes: V58.30, V58.31 (Encounter for change or removal of surgical wound dressing) and V58.32 (Encounter for removal of sutures).

Old way: Prior to the change, you reported V58.3 only when providing care for surgical wounds. The code expansion was intended to "better identify the type of dressing and suture care provided," according to AHA Coding Clinic for ICD-9-CM, Vol. 23, No. 4. But the added detail seems to have increased dressing change coding confusion.

Sequencing Suggestions Raise Questions

Some coding experts advise listing V58.30 as primary and listing the wound as a secondary code. For example, if providing dressing changes for a diabetic ulcer, you would list the following codes:

• M0230a: V58.30;
• M0240b: 250.8x (Diabetes with other specified manifestations); and
• M0240c: 707.1x (Ulcer of lower limbs, except decubitus).

However, others think this sequencing shortchanges the agency providing home care.

When a patient has a diabetic ulcer, the nurse is usually doing a lot more than simply changing or removing the dressings. She is usually educating the patient and caregiver on diabetes management as well as assessing the patient's compliance, says **Lisa Stanley Whitmore, RHIA**, with **Kaiser Permanente Home Health** in San Diego. This viewpoint holds that more accurate sequencing would be:

• M0230a: 250.8x;
• M0240b: 707.1x; and
• M0240c: V58.30.

"Don't list V58.30 as primary," says **Lisa Selman-Holman, JD, BSN, RN, HCS-D, COS-C**, consultant and principal of **Selman-Holman & Associates** in Denton, TX.

Selman-Holman offers this advice based on instruction from the Central Office on ICD-9-CM at the **American Hospital Association**, which recommends reporting V58.30 as the principal diagnosis when the encounter is solely for the change or removal of a nonsurgical wound dressing.

"I like to ask home care coders, 'When caring for a patient with a decubitus ulcer, does your nurse run in, take the old dressing off, put the new dressing on and leave?' " says **Judy Adams, RN, BSN, HCS-D**, with **LarsonAllen** in Charlotte, NC. "Everyone laughs because [providing a dressing change] is not the only thing you do."

"I cannot imagine a home health case where the only thing we do is a dressing change," agrees Selman-Holman.

Bonus: Reporting V58.30 later on in your list of codes can also be a boon for risk adjustment. V codes don't provide any risk adjustment, explains Adams. Filling up M0230 and M0240 with V codes decreases the amount of risk adjustment for outcomes. Only numeric codes provide risk adjustment. Especially when the V code isn't indicating a condition, but a reason for encounter (such as dressing changes), it's best to sequence it at the end of the list.

Complications Bring More Confusion

Assign V58.31 "to wounds that are the result of a surgical procedure, including incision, excision, incision and drainage and wound debridement," Coding Clinic advises. List V58.30 for "wounds that are not the result of a procedure."

But should you use a V58.3x code if the wound is complicated?

ICD-9 coding guidelines generally hold that V codes should not be used if the patient has a complication. When a patient has a complication of medical or surgical care such as infection or wound dehiscence, the **Centers for Medicare & Medicaid Services** instructs home care coders to code the complication rather than listing a V code.

Based on these guidelines, "it seems kind of contradictory to list the V code for attention to wound dressings if you're caring for a pressure ulcer, a diabetic ulcer or a laceration," says Whitmore.

Try this: If you're providing routine care of a nonsurgical wound whether it's a diabetic ulcer, pressure ulcer or some other type of wound that is not the result of a procedure, sequence the code for the wound first and also list V58.30 to describe the dressing change, says Selman-Holman. But if it's a complicated wound, always code for the wound and don't include the dressing change V code, she says.

Coding example: Your patient has a gash in his calf from an accident. The wound has been cleaned out and stitched together. It has a little bit of serous drainage. You will be doing a dressing change.

In this situation, list the following codes, suggests Selman-Holman:

- M0230a: 891.0 (Open wound of knee, leg [except thigh], and ankle; without mention of complication) and
- M0240b: V58.30.

What About V58.32?

Less controversial, but still confusing is V58.32, the new code for removal of sutures or staples. Some home health coders don't feel it's ap-propriate to list this code if it's only for one visit.

But removing staples or sutures would always be for one visit, Selman-Holman says. So list V58.32 as a secondary code and place it at the bottom of your list of codes, she says. If you're going to take the sutures or staples out and that's the reason for your sole visit, it's appropriate to place V58.32 at the bottom of your list of codes, she says.