

The CBDs of Chronic Wound Care - Coding, Billing and Documentation

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- Wounds vs. Ulcers
- Acute vs. Chronic Wounds
- Coding and Billing Treatment Modalities
- Coding and Billing Treatment Modality Combinations
- Managing Unpaid Claims
- Documentation



- Wound - A wound is an acute disturbance of tissues by an external force.
 - Superficial
 - Open
 - Complexity
- Ulcer - An ulcer is defined as a gradual disturbance of tissues by an underlying etiology/pathology.

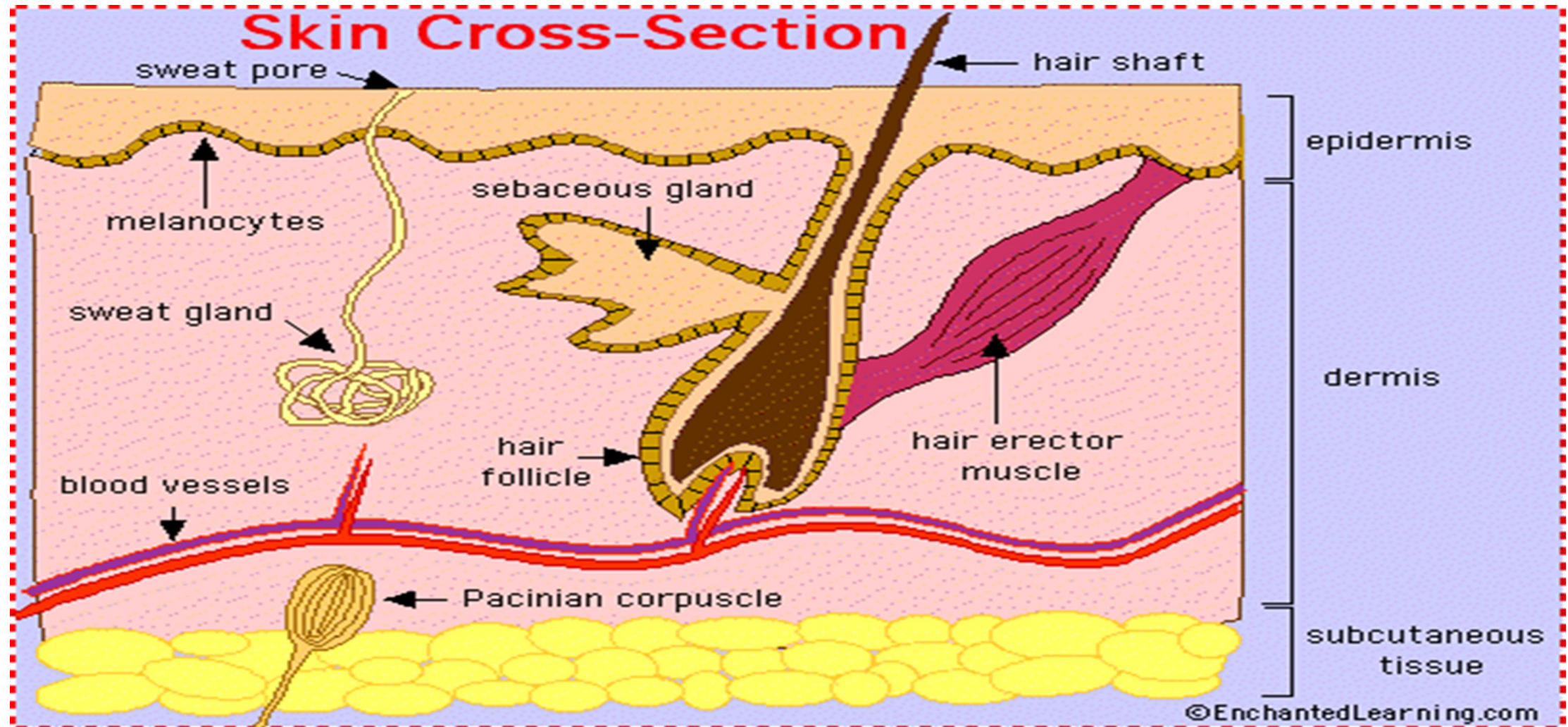


Chronic wounds (ulcers) are classified as to their etiology, such as:

- Diabetic Foot Ulcer (DFU)
- Venous Leg Ulcer (VLU)
- Pressure ulcer

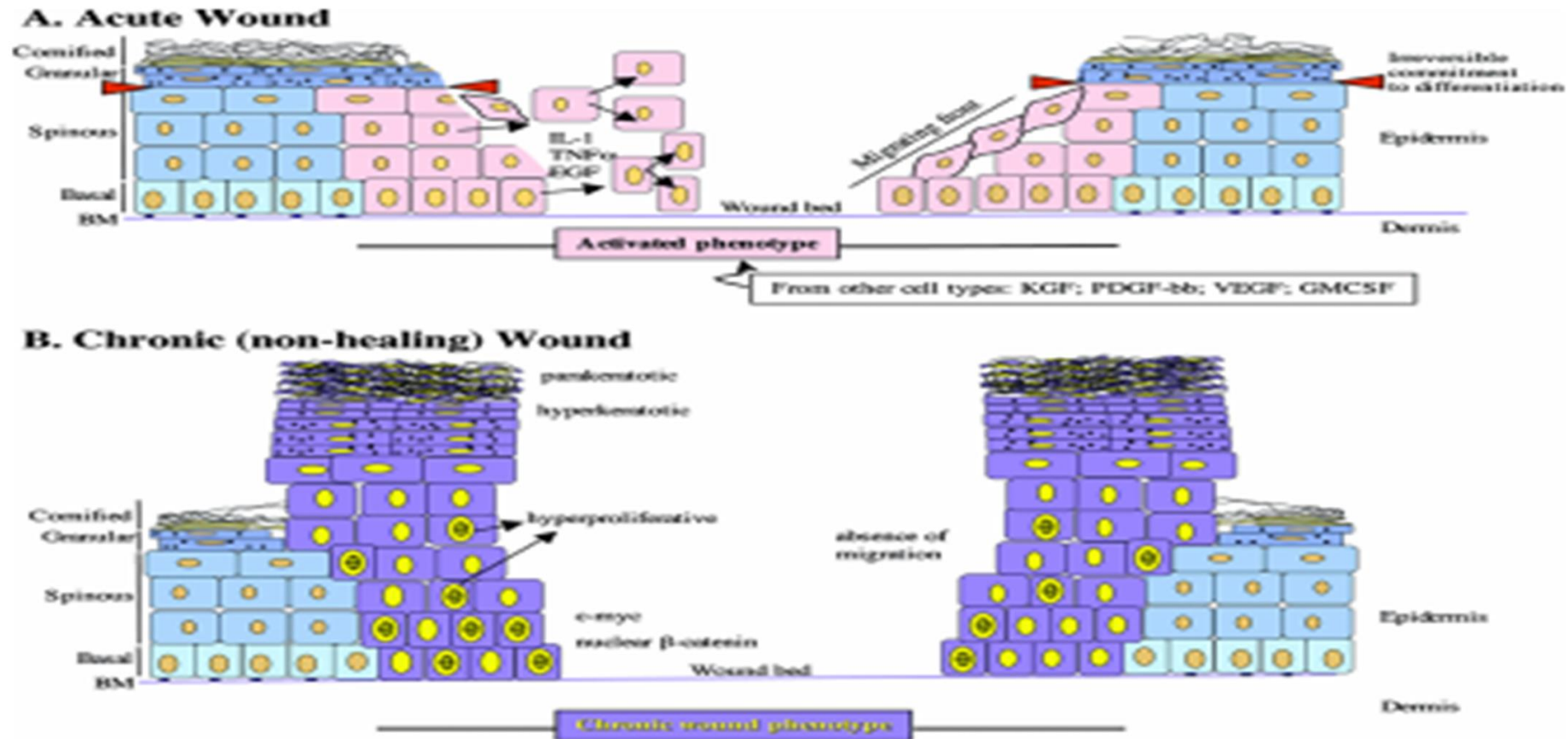
In addition, we see chronic wounds that have arisen from failed surgical closures (dehiscence)

Skin Anatomy and the Healing Cascade



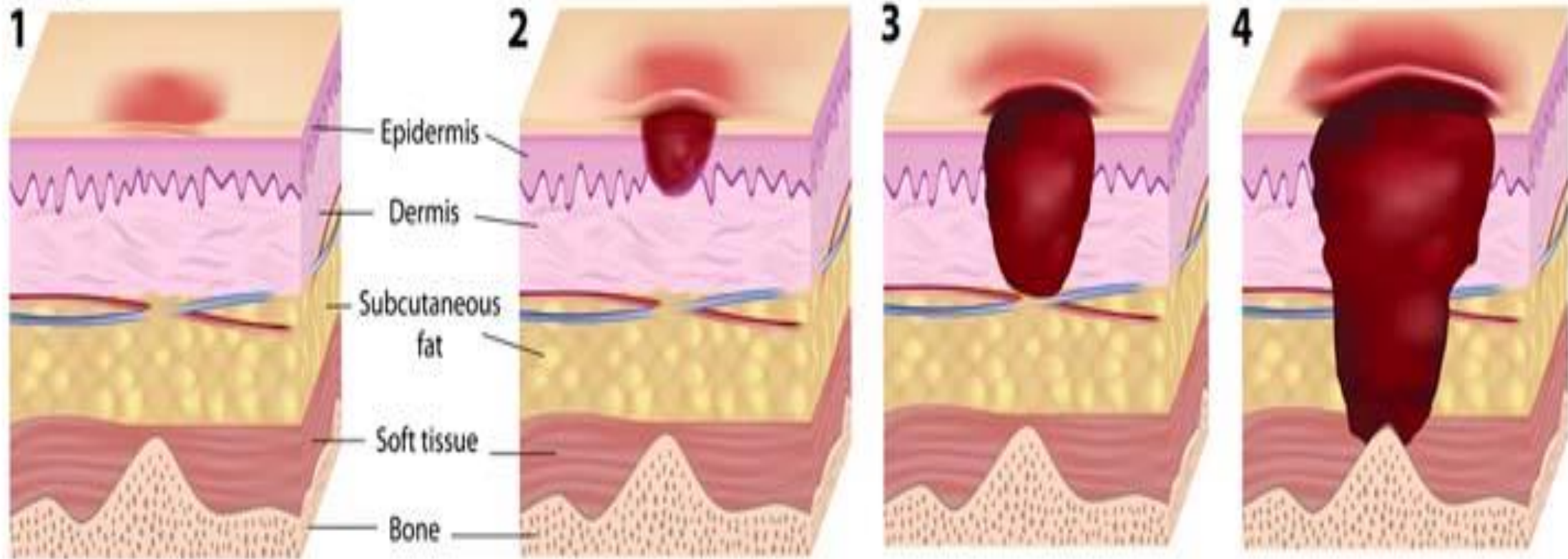


Chronic vs. Acute Wounds





Stages of Pressure Sores





- All pressure ulcers must be staged. Pre ICD-10-CM, coding for Pressure Ulcers required two codes, one for Pressure Ulcer diagnosis and location and one for the Pressure Ulcer Stage.
- ICD-10-CM now combines the Pressure Ulcer location and Stage in one code.



Stage IV Pressure Ulcer –
right heel



- ICD-10 Codes are found in the L chapter, beginning with L89
- L89.6-- Pressure ulcer of heel
- L89.61- Pressure ulcer of right heel
- L89.614 Pressure ulcer of right heel, stage IV

L	89	6	1	4
Integumentary	Pressure Ulcer	Heel	Right Heel	Stage IV



- L89.15 – Pressure ulcer of the sacrum
- L89.510 – Pressure ulcer of the sacral region, unstageable
- L89.511 – Pressure ulcer of the sacral region, stage 1
- L89.512 – Pressure ulcer of the sacral region, stage 2
- L89.513 – Pressure ulcer of the sacral region, stage 3
- L89.514 – Pressure ulcer of the sacral region, stage 4
- L89.519 – Pressure ulcer of the sacral region, unspecified stage



- *Reverse or downstaging* doesn't accurately characterize what's occurring in the ulcer. Stage III and IV pressure ulcers heal by filling in with granulation (scar) tissue—not new dermis and subcutaneous tissue. Therefore, the staging system definitions can be used only one way—as the wound progresses—and not in reverse, as the wound heals. A stage IV pressure ulcer can't become a stage III, stage II, or subsequently stage I ulcer. When a stage IV ulcer is healing or healed, it should be classified (documented) as a healing or healed stage IV pressure ulcer—not a stage I or stage 0 pressure ulcer.



Venous Leg Ulcer

- First code the underlying etiology and then the stage (*per ICD-10 -CM guidelines*)

Caused by:

- Impaired/compromised circulation



Some Underlying Etiologies of Venous Leg Ulcers



- Chronic venous hypertension with ulceration of right lower extremity (I87.311)
- Chronic venous hypertension with ulceration and inflammation of left lower extremity (I87.332)
- Type II Diabetes Mellitus with other skin ulcer (foot) (E11.622)
- Postphlebitic syndrome with ulcer (I87.01-)
- Postphlebitic syndrome with ulcer and inflammation (I87.03-)



- Most common diabetic complications:

- Neuropathy

- Foot ulcers





- Diabetes Mellitus (DM) due to underlying conditions
- E9 Drug or Chemical induced diabetes mellitus
- E10 Type I diabetes mellitus
- E11 Type II diabetes mellitus
- E13 Other specified diabetes mellitus



- E--.0 DM with hyperosmolarity
- E--.2 DM with kidney complications
- E--.3 DM with ophthalmic complications
- E--.4 DM with neurological complications
- E--.5 DM with circulatory complications
- E--.6 DM with other specified complications
- E--.8 DM with unspecified complications
- E--.9 DM without complications

Code Also:



- **L97.1 – thigh only**
- **L97.2 – calf**
- **L97.3 – ankle**
- **L97.4 – heel and midfoot**
- **L97.5 – other part of foot**
- **L97.8 – other part of lower leg**
- **L97.9 – unspecified part of lower leg**
- L97.101 – unspecified thigh, skin only**
- L97.211 – right calf, skin only**
- L97.322 – left ankle, fat exposed**
- L97.423 – left heel/midfoot, muscle**
- L97.501 – other part of unspecified foot, skin only**
- L97.814 – other part right lower leg, bone**
- L97.909 – unspecified part of lower leg, unspecified severity**



Wagner Scale

- ▶ Commonly used by podiatrists; wounds graded based on depth of ulcer and presence of infection or necrosis
- ▶ Developed for diagnosis and treatment of dysvascular foot, especially for diabetic and neuropathic ulcers
- ▶ 6 grades, 0–5 in order of severity of breakdown
 - Grade 0: Pre-ulcerative lesions, healed ulcers, presence of bony deformity; Skin is intact
 - Grade 1: Superficial ulcer without subcutaneous involvement
 - Grade 2: Penetration through the subcutaneous tissue; may expose bone, tendon, ligament, or joint capsule
 - Grade 3: Osteitis, abscess or osteomyelitis
 - Grade 4: Gangrene of digit
 - Grade 5: Gangrene of foot requiring disarticulation/amputation



- Wound Cleansing/Dressing Changes
- Compression
- Total Contact Casting
- Paring or Cutting
- NPWT
- MIST Therapy
- Excision (Pressure Ulcers)
- Debridement
 - Surgical, Selective, Non-Selective
- Grafts/Flaps
- Preparation of Site
- Skin Replacement Surgery
- Hyperbaric Oxygen Treatment



- **Facility**

- No CPT code, E/M charge based on facility leveling tool criteria



- **Physician Office**

- No CPT code (nurse visit 99211 eliminated in 2021)
- If seen by physician then E/M per documentation



- Used in the treatment of venous leg ulcer or other Peripheral disease where edema is problematic.

CPT – 29581 Application of multi-layer compression system; leg, below knee, ankle and foot





- CPT 29445

Application of rigid
total contact leg cast





- No national or local coverage determinations for total contact casting (CPT 29445)
- Best Practice Recommendation:
 - Anatomic site
 - Description of condition/ulcers
 - Application number
 - If a subsequent application, document worsening, static or improving status
 - Product used, lot number, etc.



CPT 11055 – Paring or cutting of benign hyperkeratotic Lesions [e.g. corn or callus]; single lesion

CPT 11056 - ; 2 – 4 lesions

CPT 11057 - ; more than 4 lesions

Paring or Cutting (11055-11057)

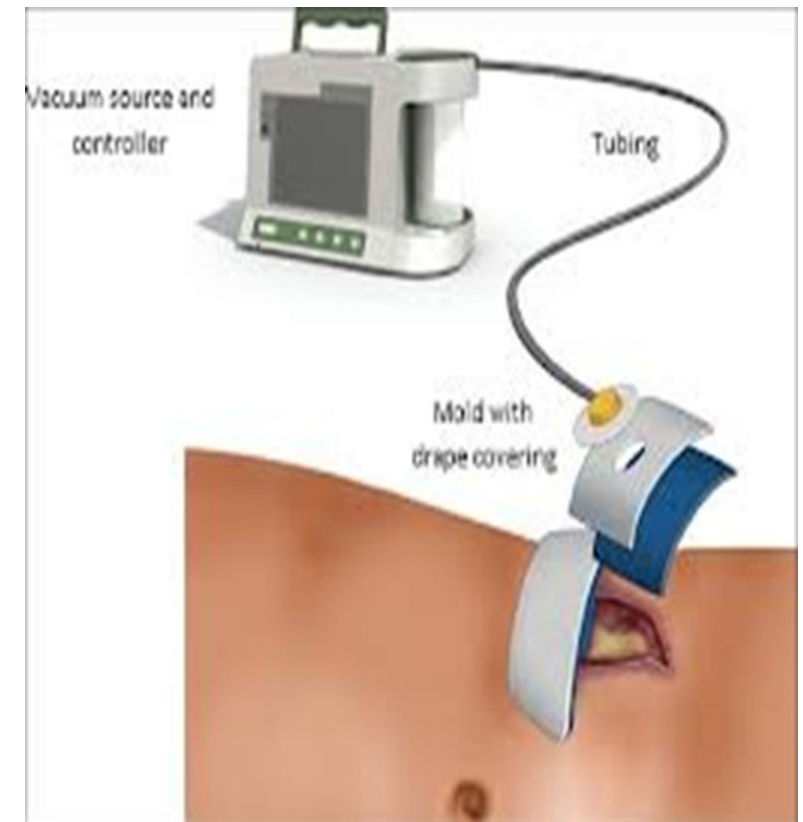
- Removal by scraping or peeling
 - e.g., Removal of corn or callus
- Codes indicate number: 1, 2-4, 5+



Negative Pressure Wound Therapy



- CPT 97605 – **DME**, total wound surface area less than or equal to 50 sq cm
- CPT 97606 – greater than 50 sq cm



Negative Pressure Wound Therapy

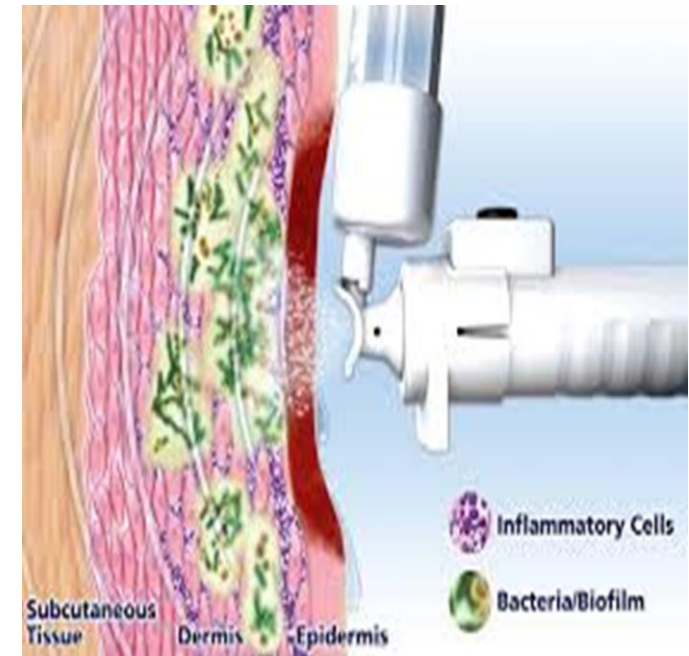


- CPT 97607 – ***non DME***, disposable, less than or equal to 50 sq cm
- CPT 97608 – greater than 50 sq cm





- CPT 97610 – Low frequency, non contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day





- There should be documented improvements in the wound(s) evident after six MIST treatments.

Improvements include documented reduction in pain, necrotic tissue, or wound size or improved granulation tissue. Continuing MIST treatments for wounds demonstrating no improvement after six treatments is considered not reasonable and necessary. No more than 18 services of low frequency, non-contact, non-thermal ultrasound (MIST Therapy) within a six-week period will be considered reasonable and necessary. Also, Low Frequency, Non-Contact, Non-Thermal Ultrasound treatments would be separately billable if other active wound management and/or wound debridement is not performed.



- CPT 10060
 - Incision and drainage of abscess (carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single
- CPT 10061
 - ; complicated or multiple





Sharp surgical debridement is the method of choice

- Involves the use of a
 - Scalpel
 - Scissor
 - other sharp instrument
- CPT 11042 – 11047
- Removes vital tissue in addition to non-vital tissue!





Debridement

- Debridement is defined as the removal of foreign material and/or devitalized or contaminated tissue from or adjacent to a traumatic or infected wound until surrounding healthy tissue is exposed. This LCD applies to debridement of localized areas such as wounds and ulcers. The mere removal of secretions, cleansing of a wound, does not represent a debridement service.

Documentation Requirements



At least ONE of the following conditions must be present and documented:

- Pressure Injury, Stage II, III or IV,
- Venous insufficiency ulcers,
- Arterial insufficiency ulcers including diabetic lower extremity ulcers,
- Dehisced wounds,
- Wounds with exposed hardware or bone,
- Neuropathic ulcers,
- Neuroischaemic ulcers,
- Diabetic Foot Ulcer(s)
- Complications of surgically created or traumatic wound where accelerated granulation therapy is necessary which cannot be achieved by other available topical wound treatment.



Should deep tissue pressure injury or Stage II injury progress to Unstageable, Stage III or Stage IV requiring debridement then documentation supporting this must be included in the medical record

Evidence of improvement includes measurable changes (decreases) of some of the following:

Drainage (color, amount, consistency)

Inflammation

Swelling

Pain

Wound dimensions (diameter, depth, tunneling)

Necrotic tissue/slough



1. Appearance of the ulcer
2. Anesthesia used (or not – if not, why?)
3. Instrument used (must be cutting, surgical instrument)
4. TYPE OF TISSUE DEBRIDED/REMOVED/CUT AWAY/EXCISED...
5. Bleeding and its control
6. Dressing used
7. Patient tolerance to the procedure
8. Discharge instructions



Debridement may be categorized as selective or non-selective:

- Selective debridement refers to the removal of specific, targeted areas of devitalized or necrotic tissue from a wound along the margin of viable tissue. Occasional bleeding and pain may occur. The routine application of a topical or local anesthetic does not elevate active wound care management to surgical debridement. Selective debridement includes selective removal of necrotic tissue by sharp dissection including scissors, scalpel, and forceps; and selective removal of necrotic tissue by high-pressure water jet. Selective debridement should only be done under the specific order of a physician.



- Found in the Medicine Section of the CPT manual
- CPT 95797 – Debridement (e.g., high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (e.g. fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm) including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; first 20 sq cm or less
- CPT +95798 - ; each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)



Use of Evaluation and Management (E/M) Codes in Conjunction with Debridement(s)

- Patients who have chronic wounds may frequently have underlying medical problems that require concomitant management in order to bring about wound closure. In addition, patients may require education, other services, and coordination of care both in the preoperative and postoperative phases of the debridement procedure. An E/M service provided and documented on the same day as a debridement service may be covered by Medicare only when the documentation clearly establishes the service as a "separately identifiable service" that was reasonable and necessary, as well as distinct, from the debridement service(s) provided.

Debridement – Non-Selective



- CPT 97602 – Removal of devitalized tissue from wound(s), non-selective debridement, without anesthesia (e.g., wet-to-dry moist dressings, enzymatic, abrasion, larval therapy), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session.



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FOOT ULCER MANAGEMENT (LARVAL DEBRIDEMENT)





A patient with chronic venous hypertension presents to the office for ongoing wound care of a venous leg ulcers of bilateral lower legs. The one on the right leg measures 2.5 x 6.0 cm and the one on the left leg measures 4.0cm x 8.0cm with inflammation.

The doctor debrides left leg ulcer after applying Lidocaine gel 2.0% to both of the ulcers, using a curette. He removes subcutaneous tissue, controls bleeding with pressure and applies the dressing. On the right leg the doctor performs a selective debridement, also using a curette. The ulcer is dressed and the patient is discharged in good condition.

Apply the appropriate codes for diagnoses and treatment.



A patient with to the office for ongoing wound care of a Stage III pressure ulcer of the occiput. He is generally bed ridden and comes to the wound center via ambulance. The ulcer measures 8.0 x 4.0 cm. and there is undermining.

The doctor surgically debrides the ulcer after applying Lidocaine gel 2.0% to the ulcer, using a curette. He removes subcutaneous tissue, brisk bleeding is controlled with pressure and silver nitrate. A dressing is then applied and the patient is discharged in good condition.

Apply the appropriate codes for diagnoses and treatment.



A patient with to the office for ongoing wound care of a **Stage III pressure ulcer of the occiput**. He is generally bed ridden and comes to the wound center via ambulance. The **ulcer measures 8.0 x 4.0 cm**. and there is undermining.

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CHECK YOUR KNOWLEDGE #2



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Apply the appropriate codes for diagnoses and treatment.

32 sq cm (8 x 4) = 11042 x 1 and 11045 x 1

L89.813

Preparation of Surgical Site



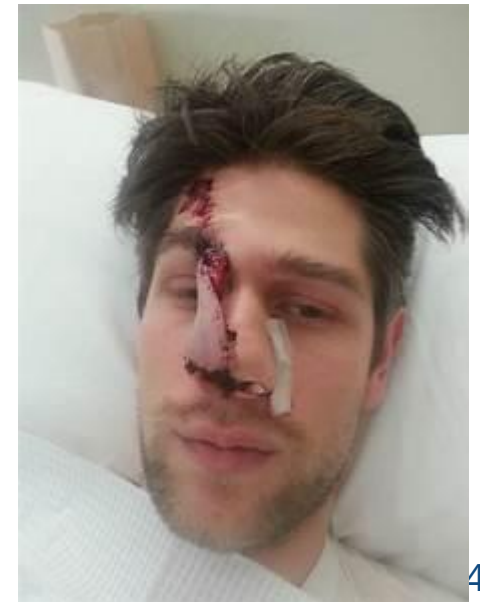
- CPT 15002 Surgical preparation or creation of a recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children
- CPT +15003 ; each additional 100 sq cm, or part thereof, or each additional 1% of body area of infants and children
- CPT 15004 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, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or 1% of body area of infants and children
- CPT 15005 ; each additional 100 sq cm, or part thereof, or each additional 1% of body area of infants and children



- Easily mistaken for debridement
- Verbiage is key
- Meticulous detail of wound description and removal of tissue imperative



- Grafts
 - Autograft – from the same body
 - Homograft – from a human
 - Xenograft – from another specie
- Flaps
 - Direct – Lifted from one part of the body and transferred to another part of the body
 - Tubed/Pedicle – a part of the graft remains attached
 - Rotational flap – the skin is rotated 180 degrees





- Regions listed in CPT refer to the recipient area (not the donor area) when a flap is being attached in a transfer or to a final site.
- Regions listed refer to a donor site when a tube is formed for later transfer or when a delay of flap occurs prior to the transfer.
- CPT codes 15733-15738 are described by donor site of the muscle, myocutaneous, or fasciocutaneous flap
- Codes 15570-15738 do not include extensive immobilization (e.g., large plaster casts and other immobilizing devices are considered additional separate procedures).
- A repair of a donor site requiring a skin graft or local flap is considered an additional separate procedure.

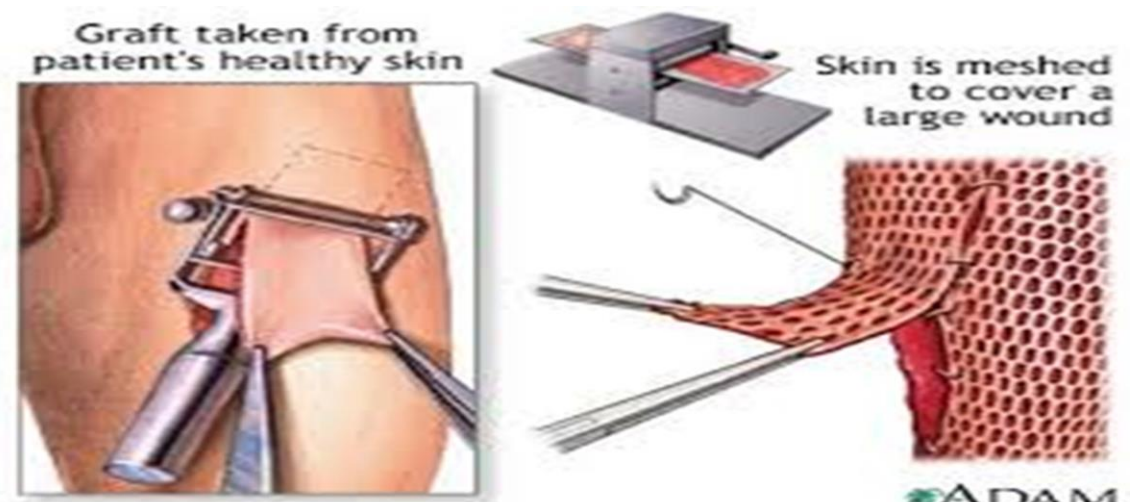
Skin Replacement Surgery - Autografts



- Autografts/tissue cultured autografts
 - Autografts – include the harvest and/or application of an autologous skin graft. Repair of the donor site requiring skin graft or local flaps is reported separately
 - Removal of current graft and/or simple cleansing of the wound is included, when performed

Select the appropriate CPT code from 15040 – 15261 based on:

- Type of autograft
- Location of defect
- Size of defect



Skin Replacement Surgery – Skin substitute grafts



- Skin substitute grafts
 - Include non-autologous human skin (dermal or epidermal, cellular and acellular) grafts (e.g., homografts, allografts), non human skin substitute grafts (i.e., xenografts), and biological products that form a sheet scaffolding for skin growth.
 - Removal of current graft and/or simple cleansing of the wound is included, when performed



Select the appropriate skin substitute application CPT code from 15271 – 15278 based on:

- Location of defect
- Size of defect



- **CPT**

- **DESCRIPTION**

- 15271 APPLICATION OF SKIN SUBSTITUTE 1ST 25 SQ CM, TRUNK/ARMS/LEGS
- 15272 ; EA ADD 25 SQ CM, TRUNK/ARMS/LEGS
- 15273 APPLICATION OF SKIN SUBSTITUTE 1ST 100 SQ CM, TRUNK/ARMS/LEGS
- 15274 ; EA ADD 100 SQ CM, TRUNK/ARMS/LEGS
- 15275 APPLICATION OF SKIN SUBSTITUTE 1ST 25 SQ CM, HANDS/FEET/DIGITS
- 15276 EA ADD 25 SQ CM, HANDS/FEET/DIGITS
- 15277 APPLICATION OF SKIN SUBSTITUTE 1ST 100 SQ CM, HANDS/FEET/DIGITS
- 15278 ; EA ADD 100 SQ CM, HANDS/FEET/DIGITS



<u>HCPCS II</u>	<u>DESCRIPTION</u>
• Q4100	Skin Substitute, NOS
• Q4106	Dermagraft, per sq cm
• Q4112	Cymetra, injectable, 1cc
• Q4145	Epifix, injectable, 1mg
• Q4181	Amnio wound, per sq cm
• Q4198	Genesis amniotic membrane, per sq cm
• Q4237	Cryo-cord, per sq cm
• Q4255	Reguard, for topical use only, per sq cm

Documentation for Skin Replacement Surgery



Novitas Local Coverage Determination (LCD): Application of Skin Substitutes (L35041) 9/13/2018

- The documentation must support that the service was performed and must be included in the patient's medical record. This information is normally found in the history and physical, office/progress notes, hospital notes, and/or procedure report. 6. The medical record must clearly show that the criteria listed under the Covered Indications and Limitations sections have been met, as well as, the appropriate diagnosis and response to treatment.
- The documentation must support the need for skin substitute application and the product used.
- A description of the wound(s) must be documented at baseline (prior to beginning conservative treatment) relative to size, location, stage, duration, and presence of infection, in addition to type of treatment given and response. ◦ This information must be updated in the medical record throughout treatment.

Documentation for Skin Replacement Surgery



Novitas Local Coverage Determination (LCD): Application of Skin Substitutes (L35041) 9/13/2018

- Wound description must also be documented pre and post treatment with the skin substitute graft being used.
- If obvious signs of worsening or lack of treatment response is noted, continuing treatment with the skin substitute would not be considered medically reasonable and necessary without documentation of a reasonable rationale for doing so.
- Documentation of smoking history, and that the patient has received counseling on the effects of smoking on surgical outcomes and treatment for smoking cessation (if applicable) as well as outcome of counselling must be in the medical record.
- The amount of utilized and wasted skin substitute must be clearly documented in the procedure note with the following minimum information:



- The patient returns to the doctor's office for the 3rd skin substitute application to his chronic non healing diabetic foot ulcer on his left heel.
- After the appropriate examination and preparation, the doctor places a piece of Dermagraft in the ulcer of the left heel. The ulcer measures 4cm x 3.5cm. This is an improvement over last week. The piece of Dermagraft is 5.0 x 7.5cm. After the application, a pressure dressing is applied and the patient is discharged to return in one week. The waste is placed on another patient.
- Please apply the correct application and product codes. Indicate what is used and what is wasted of the Dermagraft.



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CHECK YOUR KNOWLEDGE



- The patient returns to the doctor's office for the 3rd skin substitute application to his chronic non healing diabetic foot ulcer on his left heel. The fat layer is exposed and debrided before placing the Dermagraft.
- After the appropriate examination and preparation, the doctor places a piece of Dermagraft in the ulcer of the left heel. The ulcer measures 4cm x 3.5cm. This is an improvement over last week. The piece of Dermagraft is 5.0 x 7.5cm. After the application, a pressure dressing is applied and the patient is discharged to return in one week. The waste is placed on another patient.
- Please apply the correct application and product codes. Indicate what is used and what is wasted of the Dermagraft.
- 15275 JC KX x 14 (1 unit = 1 sq cm) used
- 15275 JW KX x 23.5 wasted – or was it?
- L97.422, E11.621

Hyperbaric Oxygen Treatment





- **Acute carbon monoxide intoxication** - Carbon monoxide poisoning occurs when carbon monoxide builds up in your bloodstream. When too much carbon monoxide is in the air, your body replaces the oxygen in your red blood cells with carbon monoxide. This can lead to serious tissue damage, or even death.
- **Decompression illness** - Decompression sickness, also called generalized barotrauma or the bends, refers to injuries caused by a rapid decrease in the pressure that surrounds you, of either air or water.
- **Gas embolism** - Gas embolism is a diving disorder suffered by underwater divers who breathe gases at ambient pressure
- **Gas gangrene** - Gas gangrene is most often caused by bacteria called *Clostridium perfringens*



- **Acute traumatic peripheral ischemia.** HBO therapy is a valuable adjunctive treatment to be used in combination with accepted standard therapeutic measures when loss of function, limb, or life is threatened. Trauma to a limb, leading to direct tissue damage plus local hypoxic conditions from resulting edema, causes acute traumatic peripheral ischemia.
- **Crush injuries and suturing of severed limbs.** As in the previous conditions, HBO therapy would be an adjunctive treatment when loss of function, limb, or life is threatened. Crush syndrome is a medical condition characterized by significant systemic symptoms resulting from toxins released by crushed muscle tissue.
- **Progressive necrotizing infections (necrotizing fasciitis)** Necrotizing soft tissue infections (NSTI) are characterized by rapidly progressive infection that causes tissue necrosis with associated sepsis and multisystem organ failure.

HBO Approved Diagnoses (Novitas LCD for HBO L35021 4/1/2018



- **Acute peripheral arterial insufficiency** – a condition caused by insufficient blood flow, usually to the extremities.
- **Preparation and preservation of compromised skin grafts** (not for primary management of wounds),
- **Chronic refractory osteomyelitis**, unresponsive to conventional medical and surgical management – osteomyelitis is an infection of the bone, usually caused by pyogenic bacteria or mycobacteria.
- **Osteoradionecrosis** as an adjunct to conventional treatment - Osteoradionecrosis is an extremely serious complication for patients requiring tooth extraction after radiation therapy, and the risk does not appear to diminish with time
- **Soft tissue radionecrosis** as an adjunct to conventional treatment - Soft tissue radionecrosis refers to the delayed effects of radiation therapy which result in tissue breakdown from the impaired blood supply radiation damaged tissue



- **Cyanide poisoning**
- **Actinomycosis**, only as an adjunct to conventional therapy when the disease process is refractory to antibiotics and surgical treatment - a bacterial infection that occurs most often in the face and neck. Symptoms of actinomycosis include a neck mass, jaw or face pain, and formation of pockets of pus (abscess).
- **Diabetic wounds of the lower extremities** in patients who meet the following three criteria:
 - Patient has type I or type II diabetes and has a lower extremity wound that is due to diabetes;
 - Patient has a wound classified as Wagner grade III or higher; and
 - Patient has failed an adequate course of standard wound therapy.



- Law requires a physician be present for supervision of the patient(s) while undergoing HBO therapy.
 - Define “present”
- CMS says only that the physician must be “readily available”
 - Define “readily available”

Where is the wound center/office?
Define “campus”





- Facility - Medicare patients billed with HCPCS G0277 for each 30 minute interval of HBO
- Physician - 99183 with unit of 1 for each patient (supervision only)
- Commercial claims billed with CPT 99183 and only 1 unit



Novitas: LCD Hyperbaric Oxygen (HBO) Therapy (L35021) 4/1/2018

- Documentation that a trained emergency response team is available and that the setting provides the required availability of ICU services that could be needed to ensure the patient's safety if a complication occurred.
- The documentation present in the clinical record must provide an accurate description and diagnosis of the medical condition supporting that the use of HBO is reasonable and medically necessary. The medical documentation must include but is not limited to the following:
 - An initial assessment, which includes a history and physical that clearly substantiates the condition for which HBO is recommended. This should also include any prior medical, surgical or HBO treatments.
- Documentation of the procedure (logs) including ascent time, descent time and pressurization level. There should be a treatment plan identifying timeline and treatment goals.



- Physicians' progress notes that describe the physical findings, type(s) of treatment(s) provided, number of treatments provided, the effect of treatment(s) received and the assessment of the level of progress made toward achieving the completion of established therapy goals. Physician-to-physician communications or records of consultations, additional assessments, recommendations or procedural reports. Laboratory reports (cultures or Gram stains) that confirm the diagnosis of necrotizing fasciitis are required and must be present as support for payment of HBO. X-ray findings and bone cultures confirming the diagnosis of osteomyelitis are required and must be present as support for payment of HBO. Documentation to support the presence of gas gangrene as proven with laboratory reports (Gram stain or cultures) and X-ray. Documentation of date and anatomical site of prior radiation treatments. Documentation supporting date of skin graft and compromised state of graft site.



For diabetic wounds of the lower extremity, the Wagner classification of the wound and the failure of an adequate course (at least 30 days) of standard wound therapy must be documented at the initiation of therapy: ▪ Documentation must include criteria and exam consistency to establish the diagnosis of a Wagner's grade III wound. Documentation of standard wound care in patients with diabetic wounds must include: assessment of a patient's vascular status and documentation of correction of any vascular problem sufficient to impair wound healing in the affected limb; documentation of optimization of nutritional status; documentation of optimization of glucose control; documentation of debridement by any means to remove devitalized tissue; documentation of maintenance of a clean, moist bed of granulation tissue with appropriate moist dressings; documentation of efforts for appropriate off-loading; and documentation of necessary treatment to resolve any infection that might be present.

- Failure to respond to standard wound care occurs when there is no documentation of measurable signs of healing for at least 30 consecutive days post optimization for healing. The medical record must include, at a minimum, a wound evaluation at least every 30 days during administration of HBO therapy.

CHECK YOUR KNOWLEDGE!



- A patient comes to the wound center for her first Hyperbaric Oxygen Treatment. After she is dressed and reviews the safety measures with the nurse she is ready to enter the monoplace chamber.
- Treatment begins: 8:17am as descent to pressure
- Treatment ends: 10:15am ascended to room atmosphere
- Code the HBO Treatment for both the doctor and the facility

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Physician – 99183 x 1
Facility – G0277 x 4 (total treatment time = 1 hour 58 minutes /30 = 3 units and 38 minutes)



- 25 Significant, separately identifiable evaluation and management (E/M) service by the same physician on the same day of the procedure or other service
- 58 Staged or related procedure or service by the same physician during the postoperative period
- 59 Distinct procedural service
 - New X subset: XS, XP, XE, XU
- 77 Repeat procedure by another physician
- 79 Unrelated procedure or service by the same physician during the postoperative period
- GY used to indicate a Medicare service is statutorily not covered and you do not have a signed ABH
- JC May be required to indicate skin substitute used as graft
- JW May be required to indicate skin substitute wasted
- KX May be required to indicated the product was handled, prepared, and applied according to the manufacturers' instructions

The Claim is Clean – but not Paid...Ask Yourself



- Did you verify the patient's benefits?
 - Did you get the pre-authorization or pre-certification?
 - Do your ICD-10-CM codes support the services reported?
 - Are your units reported appropriate to the service or product?
 - Have you appended the appropriate modifiers?
 - Is your provider appropriate to the service?
-
- Work your exception reports for each batch submitted immediately!
 - Work your Remittance Advices reports **daily!**
 - Pay attention to your Ageing Reports – work them monthly



Thank You!

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