

Here are some answers to some commonly-asked questions.

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Welcome to Codingline Particulars, a regular feature in Podiatry Management focusing on foot and ankle coding, billing, and practice management issues.

## **Old Injury Repair Coding**

**Q:** A patient with type 2 diabetes, well controlled, presented to the office with a history of a three-week-old chain saw injury to his left foot. The laceration, according to the patient, was "relatively shallow" and did not appear to involve either tendon or bone. The patient self-treated with ointments and bandages. The site, at this point, was infected and open, with cellulitis. A culture was taken in the office and came back as MRSA. The patient was admitted to the hospital for IV antibiotics and wound treatment.

After 72 hours, the wound site appeared significantly less swollen and red. Drainage had not been seen on the dressing for close to 24 hours. The patient was taken to the operating room to explore for any deep abscess (none was found), and a debridement of the wound  $(1.5 \times 6.0 \text{ cm})$ in the subcutaneous level was performed. There appeared to be no overt evidence of infection present. A deep culture was taken and the wound was irrigated with 3L of saline mixed with 500mg of Vancomycin. The skin margins were "freshened" and the laceration was closed.

Please provide all applicable ICD-10 codes, including the cause of the injury and all subsequent diagnoses related to the injury including the infective organism involved. Also, I would appreciate recommendations for CPT coding.

**Response:** Based on your description above, you might want to consider the following diagnosis codes:

S91.312A (laceration without foreign body, left foot)

L03.116 (cellulitis of left lower limb)

Causes of Morbidity (V00-Y99)] of the ICD-10-CM, External Causes of Morbidity." https://www.cms.gov/ Medicare/Coding/ICD10/downloads/ ICD-10QuickRefer.pdf]

But who can resist injury by chainsaw coding? W29.3xxA (contact with powered garden and outdoor hand tools and machinery).

As far as the procedure coding, had you performed both an incision and drainage and debridement in the same wound site, only one procedure would be reportable. Since you

# CPT describes three levels of wound repair: simple, intermediate, and complex.

B95.62 (methicillin resistant staphylococcus aureus infection as the cause of diseases classified elsewhere)

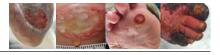
E11.9 (type 2 diabetes mellitus without complications)

The external cause [of injury] code typically need not be added to the billing. According to CMS: "Similar to ICD-9-CM, there is no national requirement for mandatory ICD-10-CM external cause code reporting. Unless you are subject to a state-based external cause code reporting mandate or these codes are required by a particular payer, you are not required to report ICD-10-CM codes found in Chapter 20 [External

did not encounter an abscess in the wound, you are left with debridement coding and/or closure coding.

CPT describes three levels of wound repair: simple, intermediate, and complex. In the scenario presented above, we are looking at either a simple repair or intermediate repair.

"Simple repair is used when the wound is superficial; e.g., involving primarily epidermis or dermis, or subcutaneous tissues without significant involvement of deeper structures, and requires simple one layer closure. This includes local anesthesia and chemical or electrocauteriza-*Continued on page 112* 



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tion of wounds not closed.

Intermediate repair includes the repair of wounds that, in addition to the above, require layered closure of one or more of the deeper layers of subcutaneous tissue and superficial (non-muscle) fascia, in addition to the skin (epidermal and dermal) closure. Single-layer closure of heavily contaminated wounds that have required extensive cleaning or removal of particulate matter also constitutes intermediate repair."

Your choices in procedure coding are:

CPT 12002 (simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/ or extremities [including hands and feet]; 2.6 cm to 7.5 cm or CPT 12042 (repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 2.6 cm to 7.5 cm)

So, can you also bill for the debridement (CPT 11042) if you perform an intermediate repair?

According to CPT guidelines, "Debridement is considered a separate procedure only when gross contamination requires prolonged cleansing, when *appreciable* amounts of devitalized or contaminated tissue are removed, or when debridement is carried out separately without immediate primary closure." [emphasis added]

Make sure your operative report clearly describes what you found and what you did to qualify for the "appreciable" threshold if you are looking to add a debridement code to your laceration coding.

## Dehiscence of Surgical Wound Diagnosis Code

**Q:** I had a patient who lives in a different state show up in my office with a dehiscence of surgical wound that required repair, which I did. Following the procedure, I coded the dehiscence as T81.31S (disruption of external operation (surgical) wound, not elsewhere classified). My clearinghouse is returning the claim as "T81.31S is not a valid diagnosis code".

I have also tried T81.31A and T81.31D with the same results.

Thoughts or recommendations would be appreciated.

**Response:** There are several problems with your coding. First, ICD-10 T81.31- requires both 6th and 7th characters. When you look up T81.31-, you will notice that it does not offer any 6th character choices. Instead, ICD-10 only notes that a 7th character is required. Since all 7th characters must be, by definition, in the 7th charrepairing the dehiscence is follow-up to the initial treatment of the injury, the coding would be T81.31xD.

## Ongoing Debridement Post Amputation

**Q:** If a podiatrist (or vascular surgeon, for that matter) does an amputation, but leaves the amputation site open, is it okay to bill serial debridements post-amputation on the wound

Returning to the operating room to remove a buried surgical screw post-injury is considered follow-up ("D") care to the original active treatment (putting it in).

acter position, you need to insert an "x" in the 6th position as a placeholder, then include the appropriate 7th character in the 7th character position.

The second problem is that you need to understand the definitions of the 7th character options. In this case, the T81.31—code 7th character options are:

A initial encounter D subsequent encounter S sequela

"A" represents performance of active (not follow-up) treatment.

"D" represents performance of follow-up to active treatment, but not itself part of the initial active treatment.

"S" represents a sequela or late effect (complication of a previous injury or illness). You cannot code an "S" (sequela) for complications of surgery.

Consequently, "S" is out. You now have to determine if you are still initially actively treating this injury ("A") or whether you are following up the initial active treatment of the injury ("D"). It should be noted that one of the official examples of active treatment is "surgical treatment". But we also know that not all surgical treatment is active treatment-the example of returning to the operating room to remove a buried surgical screw post-injury is considered follow-up ("D") care to the original active treatment (putting it in). For the sake of this example, presuming your

that is of your creating? If so, what modifier would be appropriate? I see it being routinely billed in my wound center and I am wondering if this is permissible.

**Response:** Yes, it would be permissible to bill for serial debridements in a post-operative global period using a "-58" (staged or related procedure or service by the same physician during the post-operative period) modifier. There are three circumstances that allow for the use of the "-58" modifier:

(a) A planned or anticipated (staged) procedure related to the original surgery;

(b) A more extensive procedure performance related to the original procedure; or

(c) A therapy following a surgical procedure.

An example of (a) would be similar to the scenario you present above. Also, you would use a "-58" modifier on post-operative subsequent application of cast codes. An example of (b) would be the amputation of a digit, progressing gangrene, and the need to do a transmetatarsal amputation. Most foot and ankle specialists do not bill example (c).

You do not apply a "-58" modifier on procedure codes that are unrelated to the original surgery, or in cases of a complication of surgery (unplanned return to the operative room; "-78").

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## Follow-Up for an Amputation—Different Hospital

Q: I have a patient on whom I performed a 5th ray amputation for osteomyelitis and a soft tissue infection right foot. She was followed in a nursing home for several weeks when she was admitted to a hospital on a psych unit because of mental deterioration. That hospital was approximately 20 miles from my office. I was following her there for the still open (healing by second intention) wound.

Can I code CPT 99223 (initial hospital care) with a "-24" modifier to show that even though this is within the global period, the admission was due to a different problem (mental deterioration)? If so, can I put the "-24" modifier on the subsequent hospital E/M codes, too?

Response: Unfortunately, regardless of the place of service, you are following this patient providing her postop care. The "-24" modifier, by definition, is applied to an E/M service code during a post-operative period when that E/M service is unrelated to the surgery. In your particular case, you are seeing this patient to manage her post-operatively. She just happens to inconveniently be in a facility far from your office. The "-24" modifier would not apply here.

#### Hyperbaric Oxygen (HBO) Therapy & Diagnosis Codes

Q: When billing service, CPT 99183 (physician or other qualified health care professional attendance and supervision of hyperbaric oxygen therapy, per session), for a patient in an outpatient wound center, what are the wound diagnoses acceptable to Medicare if the patient is diabetic? We billed E11.621 (type 2 diabetes mellitus with foot ulcer), and L97.419 (non-pressure chronic ulcer of right heel and midfoot with unspecified severity).

Novitas Medicare had denied it for not meeting medical necessity, but the LCD says these codes are correct. What do we need to do to get Medicare to pay?

Response: According to the Novitas LCD on hyperbaric oxygen therapy, for a diabetic ulcer to be covered, the following must be documented:

"Diabetic wounds of the lower extremities in patients who meet the following three criteria:

A) Patient has type I or type II diabetes and has a lower extremity wound that is due to

diabetes:

B) Patient has a wound classified as Wagner grade III or higher; and

C) Patient has failed an adequate course of standard wound therapy."

You should avoid using an unspecified ICD-10 code, if at all possible. Consider one of the following, if appropriate:

L97.412 Non-pressure chronic ulcer of right heel and midfoot with fat layer exposed

L97.413 Non-pressure chronic ulcer of right heel and midfoot with necrosis of muscle

L97.414 Non-pressure chronic ulcer of right heel and midfoot with necrosis of bone

Per ICD-10 guidelines, you would code E11.621 (Type 2 diabetes mellitus with foot ulcer) first. Lastly, review your MAC's LCD to ensure that you qualify to supervise/perform hyperbaric oxygen therapy per LCD requirements. PM

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Dr. Goldsmith of Cerritos, CA is editor of Codingline.com and recipient of the Podiatry Management Lifetime Achievement Award.