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Eli's Rehab Report

Disregarding Debridement Type? Expect a Claim Denial

Find out what 1 source cited as the most common therapist error

If you're reporting wound care codes frequently, as practices with physical therapists often do, an audit of your debridement claims could cost your practice dearly if you're not coding correctly. Check yourself by avoiding these four common mistakes.

Watch out: In November 2005, Blue Cross/Blue Shield of Tennessee audited claims for **CPT 97597** (Removal of devitalized tissue from wound[s], selective debridement, without anesthesia [e.g., high-pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps], with or without topical application[s], wound assessment, and instruction[s] for ongoing care, may include use of a whirlpool, per session; total wound[s] surface area less than or equal to 20 square centimeters). The audit found that therapists' documentation "lacked the specific information needed to support wound debridement."

Check out the following top-four debridement coding mistakes and ensure that you're not heading for debridement denial.

Mistake 1: Reporting the Wrong Code

If you report one of the surgical debridement codes (11040-11044), you'll quickly notice a claim denial based on your PT specialty code on the claim. That's because only physicians and nonphysician practitioners (such as a physician assistant or nurse practitioner) should use the surgical debridement codes "because these codes are for physician services," says **John Bishop, PA-C, CPC,** president of Bishop and Associates in Tampa, Fla.

Right way: Physical therapists should use the newer wound care codes (97597-97598). "The only debridement code we use in our rehab setting is 97597," says **Gregg Macek**, director of rehabilitation at Barrington Orthopedic Specialists Ltd. in Hoffman Estates, Ill.

"We employ mostly OTs and PTs, and most of the wounds they work on are minimal in size," Macek says.

Mistake 2: Ignoring Proof of Debridement Type

The Tennessee Blue Cross/Blue Shield audit indicated that some records simply stated "sharps," "dull" or "mechanical" to describe the debridement type, but auditors were not able to determine from these terms whether the debridement was selective.

Medicare local coverage determinations (LCDs) usually list the type of debridement covered under 97597, but most echo the policy of HGSAdministrators (a Part B carrier for Pennsylvania), which allows the following debridement methods under 97597:

• Superficial sharp debridement: This includes scalpel, scissors and tweezers/forceps.

• High-pressure water jet: During this procedure, the therapist submerges the wound in water, such as in a whirlpool, sometimes with an additive agent for cleansing.

• Lavage (nonimmersion hydrotherapy): This is an irrigation device, with or without pulsation, that PTs use to loosen debris within a wound.

Mistake 3: Failing to Prove Medical Necessity

All Medicare payers require a thorough description of the patient's wounds to prove medical necessity for the debridement. Take the lead from Alabama Blue Cross/Blue Shield's policy, which requires the following details in the documentation during the PT's initial wound evaluation:

- Description(s) (such as deep pressure ulcer, infected postoperative wound, etc.)
- Grade, if applicable (such as grade IV)
- Location(s)
- Measurement(s) (total wound size and total surface area debrided)
- Drainage, odor and tissue appearance
- Previous treatment(s) of wounds
- Pertinent medical history (such as diabetes, paraplegia, etc.)
- Goals for treatment
- Instructions for ongoing care, including caregiver education
- Copy of physician referral.

Mistake 4: Exceeding Frequency Guidelines

Both Medicare and private payers limit how often you can report 97597 and 97598 (... total wound[s] surface area greater than 20 square centimeters). For example, Cigna Government Services' policy states, "The utilization of CPT codes 97597 and 97598 is not expected to be more frequent than once a week."

If the PT deems more frequent services medically necessary, he must document the need for additional wound care. And "if the debridement of chronic ulcers requires more than eight numbers of service [visits] to promote healing, the rationale and medical necessity for more frequent services must be clearly documented in the medical record" as well, the policy states.