Eli's Rehab Report

Version 12.1 Update: Avoid Denials by Checking Out These Edits For Wound Care, Injection and Moderate Sedation

Find out how NCCI affects both 97602-97606 and 11004-11006

The National Correct Coding Initiative (NCCI), version 12.1, parcels out new edits that affect rehab practices--and you won't always separate them with a modifier.

Separate Anatomic Locations Require Separate Codes

If you're using cutting-edge wound care techniques in the office, you'll want to make sure you note these new edits. You'll find that NCCI 12.1 made active wound management codes 97602-97606 components of 556 different codes on April 1, including many codes from the integumentary system surgery section.

Codes 97602-97606 also became components of a large number of lesion destruction, replantation, fracture care, amputation and neuroplasty codes. You can use a modifier (such as modifier 59, Distinct procedural service) to override almost all of those edits.

Example: Your provider performs a partial-thickness debridement of a wound on the patient's left shoulder (11040, Debridement; skin, partial thickness) and then performs negative wound care therapy (97605, Negative-pressure wound therapy [e.g., vacuum-assisted drainage collection], including topical application[s], wound assessment, and instruction[s] for ongoing care, per session; total wound[s] surface area less than or equal to 50 square centimeters) on a small, chronic stage-four pressure ulcer on the patient's right heel.

You should report both 11040, the code for the debridement, and 97605, the code for the negative-pressure wound therapy, because your provider performed the two wound services in different anatomic locations, meaning the new edit would not apply. Be sure to add modifier 59 to 97605.

Modifier 59 Needs Documentation

"Remember it's OK to use the 59 modifier if documentation warrants the need," says **Annette Grady, CPC, CPC-H,** an independent healthcare consultant and officer on the American Academy of Professional Coders' National Advisory Board in Bismarck, N.D.

Because modifier 59 has been under OIG scrutiny, many coders worry about overusing it. "The key is that no two patients are the same, and there are always circumstances that warrant a different procedure or service due to special circumstances," Grady says.

Meanwhile, 97602-97606 also became mutually exclusive with debridement codes 11000, 11010-11012 and **CPT 11720 - 11721** , and burn treatment codes 16000-16035. You can override those edits, however, with a modifier.

In other words, as of April 1, don't bill 97602 (Removal of devitalized tissue from wound[s], nonselective debridement, without anesthesia [e.g., wet-to-moist dressings, enzymatic, abrasion], including topical application[s], wound assessment, and instruction[s] for ongoing care, per session) with 11010 (Debridement including removal of foreign material associated with open fracture[s] and/or dislocation[s]; skin and subcutaneous tissues) through 11012 (... skin, subcutaneous tissue, muscle fascia, muscle, and bone).

Know Carriers' Methods

If you try to report these procedures separately without supporting documentation, your payer will likely only pay the lesser-valued procedure.

Carriers are already denying claims for negative- pressure wound therapy codes 97605-97606 along with a debridement, says **Suzan Hvizdash, BSJ, CPC,** physician education specialist at UPMC Presbyterian-Shadyside in Pittsburgh.

No Modifier Allowed

But you won't be able to use a modifier to override most of the edits that make 303 other codes into components of 97602-97606, including virtually every code from the anesthesia section of the CPT manual. This means that if your physiatrist provides any anesthesia to the patient to ease the wound debridement, you won't be able to report the anesthesia separately.

In addition, a number of codes became components of excision and debridement codes 11004-11006:

• excision and debridement codes 11000 and 11010-11044
• abscess incision and drainage codes 10060-10061
• trigger point injection codes 20552-20553.

Also, 11004 (Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft-tissue infection; external genitalia and perineum) became a component of 11005 (... abdominal wall, with or without fascial closure). For example, if your physiatrist debrides wounds on both the patient's abdomen and genitalia, you'll report only 11005.

You Can Override Anesthetic Injection Edits

Not all of NCCI 12.1's edits are bad news. You will be able to use a modifier to override edits that make anesthetic injection codes 64400-64470, 64475, 64479 and 64483 components of wound management codes 97602-97606. This makes sense because the descriptions for these wound care management include the phrase "without anesthesia."

Example: Your provider performs a wet-to-dry dressing change for a slow-healing forearm wound (97602) and also injects the trigeminal nerve (64400, Injection, anesthetic agent; trigeminal nerve, any division or branch) with an anesthetic for the patient's painful tic douloureux (350.1, Trigeminal neuralgia).

In this case, you would be able to code for both services, but you would need to add modifier 59 to 64400 to indicate that the injection was distinct from the dressing change.

You'll also be able to override edits making injection codes 90772 and 90774-90775 components of 97602-97606. Physiatrists don't normally report a code like 90772 (Therapeutic, prophylactic or diagnostic injection [specify substance or drug]; subcutaneous or intramuscular) alongside a wound care code like 97602, but if your documentation shows these were two separate and distinct procedures, you could possibly use a modifier (such as 59) to separate these edits.

But you can't use a modifier to override edits that make 97602-97606 mutually exclusive with wound care management codes 97597-97598, and 97602-97606 mutually exclusive with each other. All of these codes represent skilled selective debridement, meaning that you should report only the most accurate code based on your provider's method.

For example, the physiatrist may have removed devitalized tissue (97597-97598) or provided negative- pressure wound therapy (97605-97606). In other words, he wouldn't perform both of these at the same time.

See How NCCI Handles Moderate Sedation Codes

Your physiatrist may use moderate sedation when performing spinal injections, but so far, no Medicare carriers have decided to pay for the new moderate sedation codes (99143-99149). That hasn't stopped NCCI 12.1 from applying new edits to 99143-99149 just in case.
For instance, as of April 1, you'll need a modifier to bill for moderate sedation along with any E/M codes. Keep in mind:

You should apply a modifier (such as modifier 25, Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) on the E/M code, not the moderation sedation code, when your physiatrist sees the patient for an unrelated condition, such as sleep disorders or depression.

Note: You'll also need a modifier (such as 59) if you want to bill for moderate sedation with intracatheter introduction code 36000, hydration code 90760, and almost all of the new injection codes. These new NCCI edits match the CPT guidelines for moderate sedation codes as to what services payers consider included with the new codes.

For example, a provider would need to perform 90772 (Therapeutic, prophylactic, or diagnostic injection [specify substance or drug]; subcutaneous or intramuscular) at a different session on the same day to be able to bypass this edit with the new sedation codes.