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# HEALTHCON

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# Outpatient Clinic Coding

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# Outpatient Clinic Coding

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- Outpatient Service Guidelines
- Ambulatory Surgery Center
- Wound Clinic
- Pain Clinic

# ICD-10-CM Official Guidelines for Coding and Reporting

## Section IV. Diagnostic Coding & Reporting Guidelines for Outpatient Services

### **A. Selection of first-listed condition**

- In the outpatient setting, the term first-listed diagnosis is used in lieu of principal diagnosis.
- In determining the first-listed diagnosis the coding conventions of ICD-10-CM, as well as the general and disease specific guidelines take precedence over the outpatient guidelines.
- Diagnoses often are not established at the time of the initial encounter/visit. It may take two or more visits before the diagnosis is confirmed.

### **G. ICD-10-CM code for the diagnosis, condition, problem, or other reason for encounter/visit**

- List first the ICD-10-CM code for the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the services provided. List additional codes that describe any coexisting conditions. In some cases the first-listed diagnosis may be a symptom when a diagnosis has not been established (confirmed) by the physician.

### **N. Ambulatory surgery**

- For ambulatory surgery, code the diagnosis for which the surgery was performed. If the postoperative diagnosis is known to be different from the preoperative diagnosis at the time the diagnosis is confirmed, select the postoperative diagnosis for coding, since it is the most definitive.

# ICD-10-CM Official Guidelines for Coding and Reporting

## Section IV. Diagnostic Coding & Reporting Guidelines for Outpatient Services

### **H. Uncertain diagnosis**

- Do not code diagnoses documented as “probable”, “suspected,” “questionable,” “rule out,” or “working diagnosis” or other similar terms indicating uncertainty. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit.

### **I. Chronic diseases**

- Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s)

# ICD-10-CM Official Guidelines for Coding and Reporting

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## Section IV. Diagnostic Coding & Reporting Guidelines for Outpatient Services

### **J. Code all documented conditions that coexist**

- Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management.
- Do not code conditions that were previously treated and no longer exist.
- However, history codes (categories Z80-Z87) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

# Unspecified Codes

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- *If a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for sign(s) and/or symptom(s) in lieu of a definitive diagnosis. When sufficient clinical information isn't known or available about a particular health condition to assign a more specific code, it is acceptable to report the appropriate "unspecified" code (e.g., a diagnosis of pneumonia has been determined, but not the specific type).*

Source: *Official Guidelines for Coding and Reporting;*

*Coding Clinic, 2<sup>nd</sup> qtr, 2013, pg 29-30*

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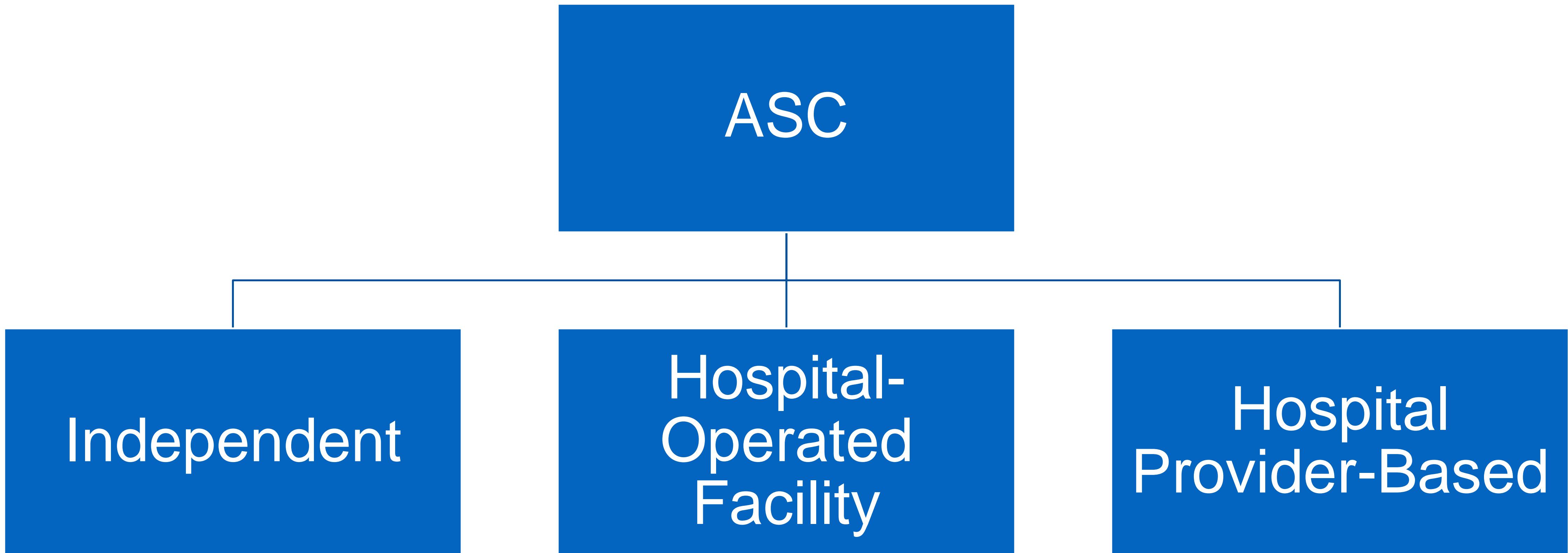
# Ambulatory Surgery Center

# Ambulatory Surgery Center

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- **10.1 - Definition of Ambulatory Surgical Center (ASC)**
- **(Rev. 3031, Issued: 08-22-14, Effective: 01-01-12, Implementation: 09-23-14)**
- An ASC for Medicare purposes is a distinct entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients. The ASC must have in effect an agreement with CMS obtained in accordance with 42 CFR 416 subpart B (General Conditions and Requirements). An ASC is either independent (i.e., not a part of a provider of services or any other facility), or operated by a hospital (i.e., under the common ownership, licensure or control of a hospital). A hospital-operated facility has the option of being considered by Medicare either to be an ASC or to be a provider-based department of the hospital as defined in 42 CFR 413.65.

# Ambulatory Surgery Center



# Ambulatory Surgery Center

## Independent ASC

- Covered surgical procedures identified by CMS annually
- Non-covered procedures
  - Professional services billed by rendering provider
  - Beneficiary liable for facility charges
- Covered ASC facility charges
  - Services that would be covered if furnished on an inpatient or outpatient basis in connection with a covered surgical procedure
    - Recovery rooms, patient prep areas, waiting rooms, and other areas used by patient
    - Services and procedures provided in connection with covered surgical procedure furnished by nurses, technical personnel and others involved in patient care

# Ambulatory Surgery Center

## Hospital-Operated Facility

- Separately identifiable entity separately certified and enrolled in Medicare with a supplier approval and agreement that is distinct from the hospital's Medicare provider agreement
- Physically, administratively, and financially independent and distinct from other operations of the hospital
- Treat costs for the ASC as a non-reimbursable cost center on the hospital's cost report
- Agree to the same assignment, coverage, and payment rules applied to independent ASCs
- Comply with the conditions for coverage for ASCs

# Ambulatory Surgery Center

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## Hospital Provider-Based

- May be on- or off-campus
- Must be an integral part of the hospital, subject to the hospital conditions of participation
- Is not separately enrolled and certified in Medicare or subject to ASC conditions for coverage

# Ambulatory Surgery Center/Department

## Know your guidelines

- Surgical package – services related to the surgery
- Follow-up care
- Supplies and materials
- Appropriate use of modifiers
- Separate procedures – integral component or inclusion of
- Unlisted service or procedure
- Imaging – documentation and report
  
- National Correct Coding Initiative (NCCI)
- National and Local Coverage Determinations (NCD/LCD)

# Ambulatory Surgery Center/Department

Know how to read an op-note

- Patient name, DOS, location, demographics, etc.
- Pre-op/preliminary Dx(s)
- Post-op/definitive DX(s)
- Procedure(s)
- Anesthesia
- Physician(s)
- Body of op-note
- Surgical findings
- Indications for surgery

# Ambulatory Surgery Center/Department

## Common Coding Errors

- Coding from the title descriptions vs body of note
  - other billable procedures
  - multiple procedures when allowed
- Not coding to the highest level of specificity
  - laterality, severity, Anatomical location
- Incorrect or non-specific diagnosis codes
- Unbundling or up-coding
- Modifiers
- Billing for implants
- Billable supplies or equipment usage
- Current/updated codes
- Multiple surgeons and/or assistants

# Ambulatory Surgery Center/Department

## Common Billing/Coding Edits

- Unbundling
- Medical Necessity (dx to procedure)
- Age/gender
- Mutually exclusive
- NCCI
- LCD/NCD
- Code validation (deleted codes)
- Medically Unlikely Edits (MUEs)
- Duplicate/frequency of services
- Modifiers

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# Wound Care Clinic

# Wound Care Clinic

American Diabetes Association

<http://www.diabetes.org/diabetes-basics/statistics/>

Last Reviewed: May 18, 2015

Last Edited: December 12, 2016

- **Prevalence:** In 2012, 29.1 million Americans, or 9.3% of the population, had diabetes.
- **Undiagnosed:** Of the 29.1 million, 21.0 million were diagnosed, and 8.1 million were undiagnosed.
- **New Cases:** 1.4 million Americans are diagnosed with diabetes every year.
- **Prediabetes:** In 2012, 86 million Americans age 20 and older had prediabetes, a condition in which blood glucose levels are higher than normal but are not high enough for a diagnosis of diabetes.
- **Deaths:** Diabetes remains the 7th leading cause of death in the United States in 2010, with 69,071 death certificates listing it as the underlying cause of death, and a total of 234,051 death certificates listing diabetes as an underlying or contributing cause of death.
- **Amputations:** In 2010, about 73,000 non-traumatic lower-limb amputations were performed in adults aged 20 years or older with diagnosed diabetes. About 60% of non-traumatic lower-limb amputations among people aged 20 years or older occur in people with diagnosed diabetes.

# Wound Care Clinic

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## Types of wounds

- Diabetic Foot Ulcers
- Vascular
- Arterial Ulcers – caused by poor circulation
- Diabetic or Neuropathic Ulcers
- Pressure Ulcers (bedsores)
- Small-vessel ulcers
- Other non-healing chronic wounds (surgical, burns, trauma, etc.)

# Wound Care Clinic

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## Types of treatment

- Therapy – to improve circulation
- Edema reduction therapy
- Debridement
- Topical growth factors/skin
- Treatment product substitutes
- Pneumatic compression therapy

# Wound Care Clinic

- Over 70,000 ICD-10-CM codes
  - Type (venous, diabetic, ischemic, pressure, non-pressure, etc.)
  - Laterality (left, right, bilateral)
  - Location
  - Depth
    - Stage of pressure ulcer
    - Depth of non-pressure ulcer (breakdown of skin, fat layer exposed, necrosis of muscle/bone)

# Wound Care Clinic

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Involves thorough review of medical record

- Wound dimensions (length), location (site), complexity
- Wound closure (sutures, staples, or tissue adhesive)
- Chronic diseases
- Procedures or types of treatment
- Photographs
- Progress of wound(s)

# Wound Care Clinic

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## Common Areas of Risk

- Coding Issues
- Inappropriate use of modifier 25
- Poorly documented wound dimensions, or lack of
- Selective vs. nonselective debridement
- Reporting dressing of wounds separate from E/M
- CPT® G0463

# Wound Care Clinic

Section I. Conventions, general coding guidelines and chapter specific guidelines

## B. General Coding Guidelines

### **12. Chapter 12: Diseases of the Skin and Subcutaneous Tissue (L00-L99)**

#### **a. Pressure ulcer stage codes**

- 1) Pressure ulcer stages**

Codes from category L89, Pressure ulcer, identify the site of the pressure ulcer as well as the stage of the ulcer.

The ICD-10-CM classifies pressure ulcer stages based on severity, which is designated by stages 1-4, unspecified stage and unstageable.

Assign as many codes from category L89 as needed to identify all the pressure ulcers the patient has, if applicable.

- 2) Unstageable pressure ulcers**

Assignment of the code for unstageable pressure ulcer (L89.--0) should be based on the clinical documentation. These codes are used for pressure ulcers whose stage cannot be clinically determined (e.g., the ulcer is covered by eschar or has been treated with a skin or muscle graft) and pressure ulcers that are documented as deep tissue injury but not documented as due to trauma. This code should not be confused with the codes for unspecified stage (L89.--9). When there is no documentation regarding the stage of the pressure ulcer, assign the appropriate code for unspecified stage (L89.--9).

- 3) Documented pressure ulcer stage**

Assignment of the pressure ulcer stage code should be guided by clinical documentation of the stage or documentation of the terms found in the Alphabetic Index. For clinical terms describing the stage that are not found in the Alphabetic Index, and there is no documentation of the stage, the provider should be queried.

# Wound Care Clinic

Section I. Conventions, general coding guidelines and chapter specific guidelines

B. General Coding Guidelines

14. Documentation for BMI, **Depth of Non-pressure ulcers, Pressure Ulcer Stages, Coma Scale, and NIH Stroke Scale**

- For the Body Mass Index (BMI), **depth of non-pressure chronic ulcers, pressure ulcer stage**, coma scale, and NIH stroke scale (NIHSS) codes, **code assignment may be based on medical record documentation from clinicians who are not the patient's provider** (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient's diagnosis), **since this information is typically documented by other clinicians involved in the care of the patient** (e.g., a dietitian often documents the BMI, a nurse often documents the pressure ulcer stages, and an emergency medical technician often documents the coma scale).
- **However, the associated diagnosis** (such as overweight, obesity, acute stroke, or pressure ulcer) **must be documented by the patient's provider**. If there is conflicting medical record documentation, either from the same clinician or different clinicians, the patient's attending provider should be queried for clarification.

# Wound Care Clinic

## Types of Debridement

- **Excisional**- chart notes must clearly describe the tissue as being cut away with sharp tools such as scissors, scalpel, forceps, etc. (97597-97598 and 11042-11047)
  - **Superficial Selective Debridement**-down into and including the epidermis and dermis (97597 and 97598)
  - **Surgical Debridement**- More extensive debridement of the underlying tissue
    - Subcutaneous (11042 and 11045)
    - Muscle/Fascia (11043 and 11046)
    - Bone (11044 and 11047)
- **Non-excisional**- removal of devitalized tissues without cutting such as irrigation, scrubbing, washing, etc. (97602)

# Wound Care Clinic

## Wound Debridement Vs Active Wound Care Management

- In most cases, wound debridement is intended for debriding acute wounds of devitalized tissue, while active wound care management is intended for cleansing and promoting healing of chronic wounds.
- Debridement Codes 11042-11047
  - Debridement is the process of removing dead tissue from wounds. It can be accomplished by invasive methods such as scissors, scalpel, and/or forceps.
  - Debridement codes [11042-11047](#) are reported based on depth of tissue that is removed and total surface area of the wound(s).
    - *Depth* is defined progressively from the skin level down through to the bone.
    - *Surface area* is defined as each section of 20 sq cm, or additional part thereof.
    - To report, both criteria of depth and surface area should be met. The operative note or procedure report should document all pertinent information that is required to determine to what depth and how much total surface area is being debrided from a given wound.
  - This code series is for the debridement of wounds when no direct primary closure, such as grafting, is anticipated.
  - Wound care management codes 97597-97602 should not be reported in conjunction with codes 11042-11047 for the same wound.
- **CPT Assistant Archives (4th Quarter 1990 - present) - Copyright American Medical Association**  
**Wound Debridement Vs Active Wound Care Management (October 2016, Volume 26, Issue 10, pages 3, 4, 5, 8)**

# Wound Care Clinic

## Debridement Codes

11042	Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less
+ 11045	each additional 20 sq cm, or part thereof (list separately in addition to code for primary procedure)
11043	Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq cm or less
+ 11046	each additional 20 sq cm, or part thereof (list separately in addition to code for primary procedure)
11044	Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less
+ 11047	each additional 20 sq cm, or part thereof (list separately in addition to code for primary procedure)

# Wound Care Clinic

## Debridement Documentation – What To Look For

- Location (site and laterality)
- Depth to which wound(s) debrided (dermis/epidermis, sub-q, muscle/fascia, bone)
  - Single wound – depth is reported by deepest level of tissue removed
  - Multiple wounds – sum the surface area of wounds at the same depth, but do not combine those from different depths
  - ICD-10-CM and CPT codes need depth documented in order to choose the most specific code.
- Tools used, such as scalpel, scissors, etc.
- Assessment
  - General appearance
  - Progress (improving/worsening)
- Plan of care, next steps

# Wound Care Clinic

## Wound Debridement Vs Active Wound Care Management

- Active wound care management refers to procedures performed to remove devitalized and/or necrotic tissue to promote healing, and may require multiple visits.
  - Code [97597](#) involves debridement of open wound(s) and includes topical application(s); wound assessment; use of a whirlpool, when performed; and instruction(s) for the ongoing care of a wound that has a total surface area of 20 sq cm or less.  
Add-on code [97598](#) is reported for each additional 20 sq cm or part thereof.  
Methods include high-pressure water jet and sharp selective debridement techniques using scissors, scalpel, and/or forceps.
  - Code [97602](#) involves the nonselective removal of devitalized tissue from wound(s), without anesthesia, and includes topical applications and dressings, wound assessment, and instruction(s) for ongoing care, per session.
    - No surface area specified.
- **CPT Assistant Archives (4th Quarter 1990 - present) - Copyright American Medical Association  
Wound Debridement Vs Active Wound Care Management (October 2016, Volume 26, Issue 10, pages 3, 4, 5, 8)**

# Wound Care Clinic

## Wound Debridement Vs Active Wound Care Management

- One additional factor to consider is the surgical preparation code set ([15002-15005](#)).
  - Size-based procedure codes intended to describe burn and wound preparation or incisional or excisional release of scar contracture resulting in an open wound requiring skin grafts.
  - Surgical preparation codes relate to healing wounds by primary intention
    - Debridement and wound management codes relate to healing wounds by secondary intention.
  - CPT guidelines instruct the user to consider wound management codes ([97597](#), [97598](#)) and debridement codes ([11042-11047](#)) in cases in which nonviable tissue is removed from a chronic wound and it is left to heal by secondary intention, and to not report surgical preparation codes [15002-15005](#).
- To summarize:
  - Wound care management and debridement CPT codes sets are meant for cases in which the healing of the wound is by secondary intention.
  - Wound debridement codes are intended for acute wounds that are debrided of devitalized tissue
  - Active wound care management codes are intended for cleansing and promoting healing in chronic wounds.
  - Debridement is measured in total depth and surface area, going from skin level down to the bone
  - Wound care management is limited to surface area only, generally does not go below skin level, and can be performed repeatedly as needed.
- **CPT Assistant Archives (4th Quarter 1990 - present) - Copyright American Medical Association**  
**Wound Debridement Vs Active Wound Care Management (October 2016, Volume 26, Issue 10, pages 3, 4, 5, 8)**

# Wound Care Clinic

## Skin Substitute Grafts

- Includes
  - Non-autologous human skin (dermal/epidermal, cellular/acellular)
  - Grafts (homograft, allograft)
  - Non-human skin substitute grafts (xenograft)
  - Biological products
- Removal of current graft and/or simple cleansing of wound is included, do not report 97602 separately
- 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

# Wound Care Clinic

## Skin Substitute Grafts

Codes are based on anatomical location and size of graft

- Size is measured in square centimeters
- Per CPT® “Add together the surface area of multiple wounds in the same anatomical locations as indicated in the code descriptions. Do NOT add together multiple wounds at different anatomical site groups.”
- Square centimeter measurement applies to adults and children over 10 years old
  - % of body area is used for infants and children under age of 10

# Wound Care Clinic

## Skin Substitute Grafts

Less than 100 square cm-

- 15271- first 25 square cm- trunk, arms (wrist), legs (ankle)
- +15272 (each additional 25 square cm up to 100 square cm)
  
- 15275- first 25 square cm-face, scalp, eyelids, moth, neck, ears, genitalia, hands/feet, digits
- +15276 (each additional 25 square cm up to 100 square cm)

Greater than 100 square cm-

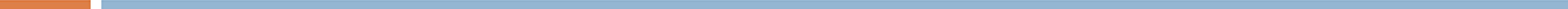
- 15273- greater than or equal to 100 square cm- trunk, arms, legs
- +15274- each additional 100 square cm
  
- 15277- greater than or equal to 100 square cm- face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, digits.
- +15278-each additional 100 square cm

# Wound Care Clinic

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## Evaluation & Management Services

- New vs. Established Patient
  - HX, EXAM, MDM
  - Time-based
- Initial evaluation – separately billed from treatment
  - Subsequent E/M Services
- 25 modifier use



# Pain Clinic

# Pain Clinic

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- Diagnosis may change and get more specific
- Treatments may change based on more specific diagnosis
- Documentation supports Medical Necessity
  - Diagnosis reporting
  - Objective and physical findings

# Pain Clinic

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## Short list of examples

- Phantom Limb Pain
- Central Pain Syndrome
- Other Chronic Pain
- Neck / Back / Limb Pain
- Long-term (current) drug therapy
- Chronic Knee & Joint Pain
- Chronic Muscle Pain
- Headaches / Migraines

# Pain Clinic

## Example: Types of Treatment

- Medications (non-aspirin, NSAIDs, corticosteroids, opioids, etc.)
- Injections
- Nerve blocks
- Electrical stimulation

# ICD-10-CM Official Guidelines for Coding and Reporting

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Section I. Conventions, general coding guidelines & chapter specific guidelines

## **C.6: Diseases of the Nervous System (G00-G99)**

### **b. Pain - Category G89**

#### **1) General Coding Information for pain**

- If the pain is not specified as acute or chronic, post-thoracotomy, postprocedural, or neoplasm related, do not assign codes from category G89, Pain not elsewhere classified.
- A code from category G89 should not be assigned if the underlying (definitive) diagnosis is known, unless the reason for the encounter is pain control/management and not management of the underlying condition.
- When an admission or encounter is for a procedure aimed at treating the underlying condition, the underlying condition should be assigned as the Principal diagnosis. No code from category G89 should be assigned.

# ICD-10-CM Official Guidelines for Coding and Reporting

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Section I. Conventions, general coding guidelines & chapter specific guidelines

**C.6: Diseases of the Nervous System (G00-G99)**

**1) General Coding Information for pain**

**(a) Category G89 Codes as Principal or First-Listed Diagnosis**

- Category G89 codes are acceptable as Principal diagnosis or the first-listed code:
  - When pain control or pain management is the reason for the admission/encounter.
  - When a patient is admitted for the insertion of a neurostimulator for pain control, assign the appropriate pain code as the Principal or first-listed diagnosis.

# ICD-10-CM Official Guidelines for Coding and Reporting

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Section I. Conventions, general coding guidelines & chapter specific guidelines

## **C.6: Diseases of the Nervous System (G00-G99)**

### **1) General Coding Information for pain**

#### **(b) Use of Category G89 Codes in Conjunction with Site Specific Pain Codes**

- **(i) Assigning Category G89 and Site-Specific Pain Codes**
- Codes from category G89 may be used in conjunction with codes that identify the site of pain (including codes from chapter 18) if the category G89 code provides additional information.

# ICD-10-CM Official Guidelines for Coding and Reporting

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Section I. Conventions, general coding guidelines & chapter specific guidelines

## **C.6: Diseases of the Nervous System (G00-G99)**

### **1) General Coding Information for pain**

#### **(b) Use of Category G89 Codes in Conjunction with Site Specific Pain Codes**

- **(ii) Sequencing of Category G89 Codes with Site-Specific Pain Codes**
  - If the encounter is for pain control or pain management, assign the code from category G89 followed by the code identifying the specific site of pain.
  - If the encounter is for any other reason except pain control or pain management, and a related definitive diagnosis has not been established (confirmed) by the provider, assign the code for the specific site of pain first, followed by the appropriate code from category G89.

# ICD-10-CM Official Guidelines for Coding and Reporting

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Section I. Conventions, general coding guidelines & chapter specific guidelines

## **C.6: Diseases of the Nervous System (G00-G99)**

- **4) Chronic pain**
  - Chronic pain is classified to subcategory G89.2.
  - There is no time frame defining when pain becomes chronic pain.
- **6) Chronic Pain Syndrome**
  - Central pain syndrome (G89.0) and chronic pain syndrome (G89.4) are different than the term “chronic pain,” and therefore codes should only be used when the provider has specifically documented this condition.

# Pain Clinic

## Review Documentation For

- Chief complaint and chronologic history of the development of the present pain (location; quality; severity; timing; context; modifying factors and associated signs and symptoms).
- Review of systems.
- Evaluation of the effect of pain on physical and psychological function.
- Past history (include past experiences, illnesses, operations and treatments).
- Family history (pain complaints, degenerative disorders, drug or chemical dependency, alcoholism, drug abuse, depression, anxiety and other psychological disorders).
- Social history.

# Pain Clinic

More Specifically, Look For

- **Acuity**
  - Acute or chronic
- **Cause**
  - Trauma, post-thoracotomy, neoplasm, postprocedural, or other underlying cause if known
- If admission/encounter for pain management or control vs. treatment directed at the underlying condition
- **Site/Laterality** of pain
- Patient compliance / non-compliance
- Use/Abuse/Dependence
  - Medications
  - Drugs or alcohol use
- **Severity**
  - Mild, Moderate, Severe
  - Patient progress

# Evaluation & Management

OUTPATIENT / OFFICE										
New (3 of 3)						Established (2 of 3)				
Hx	PF	EPF	D	C	C	Nurse Visit	PF	EPF	D	C
Ex	PF	EPF	D	C	C		PF	EPF	D	C
MDM	SF	SF	L	M	H		SF	L	M	H
	99201-10	99202-20	99203-30	99204-45	99205-60	99211-5	99212-10	99213-15	99214-25	99215-40

CONSULTATION (3 of 3)					
Hx	PF	EPF	D	C	C
Ex	PF	EPF	D	C	C
MDM	SF	SF	L	M	H
OP	99241-15	99242-30	99243-40	99244-60	99245-80
IP	99251-20	99252-40	99253-55	99254-80	99255-110

# Conclusion

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If it's not documented, it was never done!

- Follow coding guidelines!
- Be familiar with LCDs and NCDs!
- Be familiar with State and Federal regulations!

# THANK YOU

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