Successful documentation of wound care

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Providers are often surprised at how pages upon pages of documentation in a patient's health record can result in few reportable diagnosis and/or procedure codes, which often fail to capture the complexity of the patient's condition. However, providers need to be aware of the implications of coding. As healthcare data become increasingly digital through initiatives such as **meaningful use**, coded data not only impact reimbursement but also are increasingly used to represent the quality of care provided. Here's a closer look at how documentation and coding work in the context of wound care.

Coding 101

The Health Insurance Portability and Accountability Act of 1996 includes a provision referred to as *administrative simplification*, which establishes a standard for the reporting of healthcare data by healthcare setting. The inpatient hospital setting, which bills to Medicare Part A, must use the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) under direction of the U.S. Department of Health and Human Services for the reporting of both diagnoses and medical interventions (procedures). The outpatient setting, which includes hospitals, physician offices, and clinics, uses Volumes I and II of ICD-9-CM to report diagnoses, but uses Current Procedural Terminology codes, Fourth Edition (CPT-4), to report medical interventions. Consequently, the documentation for accurately reporting a *diagnosis code* is the same for both inpatient and outpatient settings, but the documentation to support *wound care treatment* will vary by setting because the two different code sets have different documentation requirements.

ICD-9-CM codes are in place until October 1, 2015, when the code set changes to ICD-10-CM, which is the 10th revision of the International Classification of Diseases code set developed by the World Health Organization that was clinically modified for use in the United States. Several different types of wounds can be captured within both code sets, so documentation should clearly reflect the type of wound being evaluated or treated.

Coding a wound

One of the first distinctions to be made when classifying the type of wound is whether it's traumatic or nontraumatic. (Traumatic wounds aren't covered in this article because they are less vulnerable to denials compared to other types of wounds.)

A chronic wound can be further categorized as a pressure ulcer, nonhealing chronic ulcer, or nonhealing surgical wound. In the case of a nonhealing surgical wound, the provider must document a cause-and-effect relationship between the medical intervention (surgery) and the wound; for example, "abdominal wound status post gallbladder surgery."

The ICD-9-CM code set captures the stage of a pressure ulcer, and the ICD-10-CM code set captures both the stage of a pressure ulcer and the status of other nonhealing chronic ulcers. The following descriptions can be used to differentiate types of nonhealing chronic ulcers:

- Limited to skin breakdown
- With fat layer exposed
- With necrosis of muscle
- With necrosis of bone.

It's important to note that staging isn't used to describe these types of nonhealing chronic ulcers, even though the descriptions are similar to pressure ulcer stages. For accurate code assignment, the best practice is for the provider to identify the cause of the nonhealing chronic ulcer, such as diabetes or peripheral vascular disease.

For the purpose of coding, the provider is an independent licensed practitioner, who can be a physician, nurse practitioner or a physician assistant. The provider must document the diagnosis of a wound and its location, including laterality (distinguishing wounds on the left side of the body from those on the right side; required by ICD-10-CM), specifying the type of wound and its cause when applicable. As long as the diagnosis of a pressure ulcer is made by the provider, its associated stage can be obtained from the documentation of other clinicians, such as a bedside nurse, wound care nurse, or physical therapist. Common descriptions such as "pressure ulcer with blister" or "pressure ulcer with full-thickness skin loss" can be translated into the applicable stage. A diagnosis code is reported only once on a claim, so the coded stage of a pressure ulcer is based on its highest stage while the patient is in the hospital. For example, if a patient was admitted with a stage I pressure ulcer that evolved into a stage III pressure ulcer during hospitalization, the stage of the pressure ulcer should be coded as a stage III.

Hospitals can be penalized with de-

Documentation and HACs

Hospital-acquired conditions (HACs) are conditions that the Centers for Medicare & Medicaid Services (CMS) has deemed avoidable. CMS and most other insurers won't reimburse hospitals for these conditions when they develop after admission, so it's vital that providers perform extensive skin-integrity assessments on admission to identify any and all pressure ulcers, regardless of the stage. Frequently, a provider doesn't document a pressure ulcer unless it requires treatment, so it isn't uncommon for documentation of a pressure ulcer to occur on day 3 or later when it has progressed from stage I or II to a later stage. In this situation, reimbursement would be denied. By documenting the presence of the pressure ulcer on admission, providers can ensure that hospitals receive reimbursement because CMS doesn't penalize organizations when a pressure ulcer progresses from a stage I to a stage III or IV after admission.

creased reimbursement and poor quality scores when a pressure ulcer develops after admission to the hospital. In particular, pressure ulcers classified as stage III or IV can increase hospital inpatient reimbursement because they are considered major complication conditions (MCCs), but only if the patient already had a pressure ulcer in the same location regardless of its stage when admitted. Stage III and stage IV pressure ulcers are considered by Medicare to be hospital-acquired conditions (HACs) when they develop during a hospital stay. (See *Documentation and HACs*.) Some pressure ulcers can't be staged because the depth of the wound is obscured. Frequently, these types of wounds will require debridement to facilitate healing, and it's important to update the stage of the ulcer after debridement. Although some wound care staging guidelines may suggest an unstageable wound is synonymous with a stage III pressure ulcer, this suggestion could increase the risk of audit vulnerability because the code set allows classification as "unstageable."

Debridement and coding

Inpatient coding (both ICD-9 and ICD-10) differentiates between excisional and nonexcisional debridement. Excisional debridement results in higher reimbursement because it's considered a surgical procedure, thereby increasing reimbursement, regardless of where the procedure is performed during the hospital admission (for instance, at the bedside, in the emergency department, in the operating room). It's important to note that "sharp" debridement, which is the outpatient terminology, isn't synonymous with "excisional" debridement. For an excisional debridement to be coded as such, it must be specifically described by the person performing the procedure as "excisional," not "sharp," and include the type of instrumentation used (such as scalpel or scissors) as well as the technique, which must be cutting or snipping of devitalized or necrotic tissue.

The documentation should describe the size of the wound both before and after excisional debridement because the procedure should result in an increased wound margin and the presence of revitalized tissue. Lastly, the documentation should clearly describe the depth of the excisional debridement using such terms as "down to and including" to the applicable layer of tissue.

A team approach

The ability of an organization to obtain reimbursement is essential for its financial success. By ensuring proper documentation, providers can work as a team with coders so that organizations receive the reimbursement they deserve. ■

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