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THE LIVANTA CLAIMS REVIEW ADVISOR

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Higher-Weighted Diagnosis Related Groups (HWDRG) Validation: Debridement

This month's issue of *The Livanta Claims Review Advisor* addresses utilizing the correct procedure codes for debridement on Medicare Part A claims. As always, coders must follow proper reporting guidelines. The following guidelines governing the coding of debridement procedures are reviewed based on coding errors Livanta has encountered while performing HWDRG reviews.

Types of Debridement

The most common coding error involving debridement is misidentifying the debridement type (excisional versus non-excisional).

Excisional Debridement

The International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) defines the root operation of excision as "cutting out or off, without replacement, a portion of a body part." According to Taber's Medical Dictionary, debridement is the "removal of dead, damaged, or infected tissue, or foreign material, especially from a wound." Therefore, excisional debridement is defined as "the surgical removal of dead, damaged, or infected tissue." Using a sharp instrument does not always indicate that an excisional debridement was performed. Excisional debridement involves the use of a scalpel to remove devitalized tissue. It is important that physicians and other providers document as much detail as possible to support this procedure.

Below are some examples of what coders might see in an operative report to support the coding of excisional debridement:

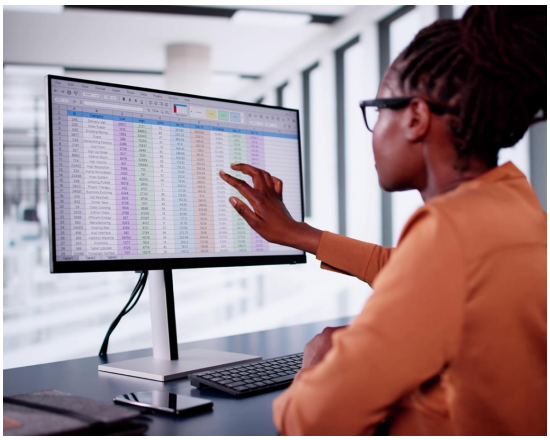
- Cutting away necrotic tissue of a decubitus ulcer using a scalpel
- Excisional debridement of a non-healing surgical wound
- Excisional debridement of necrotizing fasciitis
- Excisional debridement of the proximal femur due to osteomyelitis
- Debridement of a diabetic ulcer described as skin excision
- Abdominal muscle excision to treat a mesh complication

Non-excisional Debridement

Coding Clinic, Third Quarter 2015, page 3 defines non-excisional debridement as "nonoperative brushing, irrigating, scrubbing, or washing of devitalized tissue, necrosis, slough, or foreign material." In most cases, this procedure is coded to the root operation of extraction (pulling or stripping out or off all or a portion of a body part).

Characteristics of Debridement

When coding a debridement procedure, both the approach and depth of the procedure must be considered.



Approach

- External – For debridement of the skin only, the approach is always external.
- Open – When debridement of subcutaneous or deeper tissue is performed, the approach is open. This guidance is from Coding Clinic 4th Quarter 2013, page 120, which states that an open approach is defined as cutting through the skin and any other body layers to expose the site of the procedure. When the site is already exposed, the approach is still classified as open.
- Percutaneous debridement usually involves a joint.

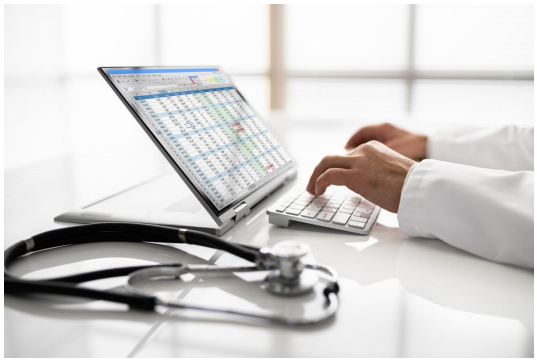
Depth

Choosing the correct depth when coding a debridement is important as this often makes a major difference in reimbursement. Below are some documentation examples specific to depth and the correct way to code them:

- Excisional debridement, left hip wound down to the bone → 0KBP0ZZ (open excision of left hip muscle)
- Sharp debridement of skin ulcer, right lower leg → 0HDKXZZ (extraction, skin, right lower leg, external)
- Excisional debridement into bone, right toe → 0QBQ0ZZ (excision, right toe, phalanx, open)
- Pulse lavage debridement of sacral decubitus, fascia → 0JD90ZZ (extraction, buttock, fascia, open)

- Excised skin of left ankle → 0HBNXZZ (excision left foot skin, external approach)
- Scalpel used to debride left calf ulcer down to fascia → 0JBP0ZZ (excision left lower leg fascia, open)

Applicable Coding Clinic Articles



Second Quarter 2023

- When both excisional and non-excisional debridement are performed at the same site and same level, code only excisional debridement.

Second Quarter 2020

- If an excisional muscle debridement of the sacrum is performed and laterality is not documented, assign codes for both the left and right side.

Third Quarter 2018

- When debridement of the periosteum is documented, it is coded to debridement of the underlying bone.

Third Quarter 2015

- Providers should specifically document the type of debridement. Clear and concise documentation is required to report excisional debridement properly.
- Either the provider must document “excisional debridement,” or the documentation of the procedure must meet the definition of excision.
- Debridement of the bone, fascia, tendon, or muscle cannot be assumed as excisional without further supporting documentation.
- Use of scissors or a sharp instrument to scrape away tissue is not considered an excisional debridement.
- When multiple layers of the same site are debrided, assign a code only for the deepest layer of the excisional (or non-excisional) debridement.

Fourth Quarter 2014

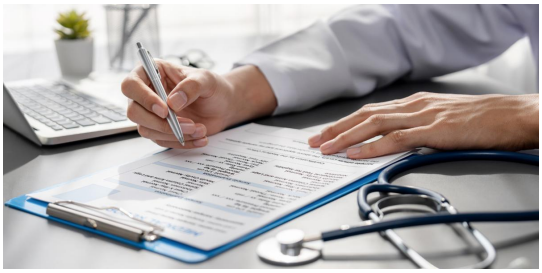
- A debridement done to clean an open wound as part of an open reduction internal fixation is not separately reportable.

Third Quarter 2014

- An “excisional debridement” is coded separately when performed on a deeper level, like the fascia or tendon, when done as part of a skin grafting procedure.

Queries for Type or Depth of Debridement

Without a narrative operative report, a query for the type or depth of debridement does not support a debridement procedure. According to the Joint Commission[1] and federal regulations[2], the following information must be included in an operative report:



- Patient identifiers
- Date of service
- Surgeon name(s)
- Surgical assistant's name(s)
- Procedure(s) performed
- Detailed description of the surgical technique
- Description of findings
- Postoperative diagnosis
- Estimated blood loss
- Specimens removed

1 https://www.jointcommission.org/standards/standard-faqs/ambulatory/record-of-care-treatment-and-services-rc/000001698/

2 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-482/subpart-C/section-482.24

In Conclusion

The presence of a debridement code can significantly increase hospital reimbursement, especially with excisional debridement. For this reason, it is imperative that hospitals educate their surgeons and other providers on the importance of clear, concise, and complete documentation of debridement. It is also important for coders to understand the sometimes subtle differences between these two procedure categories.

About Livanta

Livanta is the national Medicare Claim Review Services contractor under the Beneficiary and Family Centered Care – Quality Improvement Organization (BFCC-QIO) Program. As the Claim Review Services contractor, Livanta validates the DRG on hospital claims that have been adjusted to pay at a higher weight. The adjusted claim is reviewed to ensure that the diagnoses, procedures, and discharge status of the patient reported on the hospital's claim are supported by the documentation in the patient's medical record. Livanta's highly trained, credentialed coding auditors adhere to the accepted principles of coding practices to validate the accuracy of the hospital codes that affect the DRG payment. When needed, actively practicing physicians review for medical necessity and

clinical validity based on the presence of supporting documentation and clinical indicators.

Post-payment review of these HWDRG adjustments is mandated under statute and in CMS QIO Manual: Perform DRG validation on prospective payment system (PPS) cases (including hospital-requested higher-weighted DRG assignments), as appropriate (see §1866(a)(1)(F) of the Act and 42 CFR 476.71(a)(4)).

Read more: CMS, Quality Improvement Organization Manual, Chapter 4 - Case Review **https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/qio110c04.pdf**

Questions?

Should you have questions, please email **ClaimReview@Livanta.com**, or visit the claim review website for more information: **https://www.livantaqio.cms.gov/en/ClaimReview/index.html**