Wound Care Management

Adjudication Rule

Abstract

For Members

Billing Rules are the adjudication rules, which are in compliance with official CPT, ICD-CM and HAAD/CCSC coding guidelines.

A billing rule defines the minimum requirements to be met when a service is claimed for a Daman beneficiary in terms of frequency, duration etc. It explains the minimum required documentation to claim a service. It also defines the coverage of a service under a particular insurance plan administered by Daman.

For Medical Professionals

The scope of this guideline is to describe the proper coding and reporting requirements for wound care management.

Daman covers wound care management for all health insurance plans, subject to policy terms and conditions and if billing methodology is clinically appropriate in terms of diagnosis, frequency and duration.

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Wound Care Management

Scope
The scope of this guideline is to describe the proper coding and reporting requirements of wound care. Wounds can be categorized as traumatic and non-traumatic.

- Traumatic wounds are mainly acute (include lacerations, abrasions, cellulitis, burns etc) and chronic (like Ulcers) in nature
- A non-traumatic wound includes surgical wound dehiscence

The ICD coding and CPT coding rules varies according to the nature of wound.

Adjudication Policy

Eligibility / Coverage Criteria
Wound care management is covered for all health insurance plans administered by Daman, subject to policy terms and conditions and if the billing methodology is clinically appropriate in terms of diagnosis, frequency and duration.

Requirements for Coverage
ICD diagnosis coded to highest level of specificity as documented in the medical record of the patient.

Non-Coverage
ICD-9-CM code(s) not covered by the individual’s policy or is/are clinically in-appropriate in terms of diagnosis, frequency and duration.

Payment and Coding Rules
ICD – CM Coding rules are as given below:

1. Coding for Injuries
Code for the most serious injury, as determined by the provider and the focus of treatment is sequenced first.

Billing and documentation requirements:
- Code only those injuries, documented in the medical record.
- Assign a single code for each injury, only when a combination code is not available
- Do not code superficial injuries when associated with more severe injuries of the same site
- Always code E code to show the cause and place of occurrence of the injury

2. Coding for Burns
Burn codes (940-948) are classified by depth, extent and by agent (E code). Burns are classified by depth as first degree (erythema), second degree (blistering), and third degree (full-thickness involvement).

Billing and documentation requirements:
- Code the site, degree and extend of burn, documented in the medical record
- Classify burns of the same local site (three-digit category level, 940-947) but of different degrees to the subcategory, identifying the highest degree recorded in the diagnosis. Non-healing burns are coded as acute burns
- Necrosis of burned skin should be coded as a non-healed burn
- Code 958.3, Post-traumatic wound infection, not elsewhere classified, as an additional code, only if infected burn site is documented
- Category 949, Burn, unspecified, is extremely vague term and should rarely be used

3. Coding for Cellulitis
Coding of cellulitis secondary to superficial injury, burn, or frostbite requires two codes, one for the injury and one for the cellulitis.

Sequencing of codes depends on the circumstances of the admission.

Billing and documentation requirements:
- Code cellulitis only if documented in the medical record
- Code 958.3, Post-traumatic wound infection, NEC, should not be assigned if the infection is identified as cellulitis
- Cellulitis described as gangrenous is classified to code 785.4, Gangrene

4. Coding for Wound Disruption
- 998.31 Disruption of internal operation wound
- 998.32 Disruption of external operation wound

CPT-4 and Service Codes Coding Rules are given below:

1. Debridement
It is the removal of foreign material and/or devitalized or contaminated tissue from or adjacent to a traumatic or infected wound until surrounding healthy tissue is exposed.

Active wound care management
Definition: Debride the wound of devitalized tissue, cleanse the wound, promote coverage of the dermal defect, and to restore function to the tissue and surrounding area. Includes following:
- Selective (97597 – 97598)
- Non selective (97602)
- Negative pressure (97605-97606)
Wound Care Management

- Surgical debridement (Excisional) (11000-11001 and 11042 – 11047)
- Pressure ulcers (15920-15958)
- Burn wounds (16020-16030)

Billing and documentation requirements:

- These codes are normally billed by non-physician professionals (e.g. physician assistants, nurse practitioners, enterostomal therapy nurses, wound care nurses, physical therapists) licensed to perform these procedures. Report these codes by physician only if debridement of skin performed which is limited to epidermis and/or dermis.
- Include assessment of the wound, the technique of debridement (selective or nonselective) with or without the use of minimal anesthesia, cleansing of the wound, dressing of the wound (including application of topical ointments, wound bed protection and bulk dressing), and any patient/family instruction.
- Examination of wound to assess the drainage, color, texture, temperature, vascularity, condition of surrounding tissue, and size of the area to be targeted for debridement of necrotic tissue.
- When debridement is performed, the debridement procedure notes must document tissue removal (i.e. skin, full or partial thickness; subcutaneous tissue; muscle; and/or bone), the method used to debride, and the character of the wound (including dimensions, description of necrotic material present, description of tissue removed, degree of epithelialization, etc.) before and after debridement.
- Do not report both selective and nonselective debridement codes for techniques performed on the same devitalized tissue area(s) of a wound on the same date of service.
- The application and removal of dressings associated with these debridement techniques is considered part of the work associated with the procedures and, therefore, would not be reported separately. If a dressing change is performed without any active wound care management (debridement), then it is not be appropriate to use the wound care management codes to describe the service.
- Generally, 97022 (whirlpool) and 97597/97598 should not be reported during the same encounter, since the whirlpool is a component of the 97597/97598 codes.
- Do not report 97597-97606 codes with 11042 – 11047.
- E/M codes are not usually billed in conjunction with an active wound care management code. Active wound care management code includes the pre-debridement wound assessment, the debridement, and the post-procedure instructions provided to the patient on the date of the service. Only significantly separately identifiable service are performed and reasonable as well as distinct, from the debridement service(s) provided a separate E/M can be claimed.

**Surgical debridement (Excisional)**

Billing and documentation requirements:

- The debridement code submitted should be based on the type and amount and the surface area of tissue removed, not based on the depth, size, or other characteristics of the wound. Document should support coded anatomical site, area of body surface debrided and or extent of tissue or foreign material debrided (e.g. if a wound involves exposed bone but the debridement procedure did not remove bone, CPT code 11044 cannot be billed).
- When performing debridement of a single wound, report depth using the deepest level of tissue removed. In multiple wounds, sum the surface area of those wounds that are at the same depth, but do not combine sums from different depths.
- For debridement of skin, i.e., epidermis and/or dermis only, see 97597, 97598.
- Dressings applied to the wound are part of the service for CPT codes 11000-11001 and 11042-11047 and they may not be billed/reimbursed separately.
- The use of CPT codes 11042-11047 is not appropriate for the following services: washing bacterial or fungal debris from feet, paring or cutting of corns or calluses, incision and drainage of abscess including paronychia, trimming or debridement of nails, avulsion of nail plates, acne surgery, destruction of warts, or burn debridement. Report these procedures, when they represent covered, reasonable and necessary services, using the CPT code that most closely describes the service supplied.
- E/M codes are not usually billed in conjunction with a surgical debridement code. Surgical debridement code includes the pre-debridement wound assessment, the debridement, and the post-procedure instructions provided to the patient on the date of the service. Only significantly separately identifiable service are performed and reasonable as well as distinct, from the debridement service(s) provided a separate E/M can be claimed.
- Codes 11040-11044 are considered complex surgical services performed by physicians.

**Pressure Ulcers**

Billing and documentation requirements:

- Selecting the code depends on, whether it was excision or a debridement.
Wound Care Management

- If physician debrides the ulcer, effectively removing it and allowing the wound to stay open to heal, then code (11040-11044). If the physician excises the ulcer, clears all infection and closes the wound, then the appropriate code from the decubitus ulcer category should be used.
- Pressure ulcer is differentiated by location (coccygeal, sacral, ischial and trochanteric), primary sustrate or flap closure with skin flaps and with or without ostectomy.
- The document should support the anatomical site, flap, graft, closure and or ostectomy.
- E/M codes are not usually billed in conjunction with a pressure ulcer excision code. CPT code includes the pre-debridement wound assessment, the debridement, and the post-procedure instructions provided to the patient on the date of the service. Only significantly separately identifiable service are performed and reasonable as well as distinct, from the debridement service(s) provided a separate E/M can be claimed.
- Dressings applied to the wound are part of the CPT code and need not to be reported.

Burn Wounds (16000-16030)

- The procedure codes 16000-16042 are to be used to report the local treatment of the burn wound itself.
- These codes do not include evaluation and management services. The usual pre- and post-procedural services (e.g. explaining procedures to the patient/family, supervising the positioning and prepping of patient; monitoring stability of the patient, as appropriate; and after care instruction) are included in the procedure code and not reported separately.
- The degree of the burn, percentage of body surface involved (typically using the Rule of Nines should be documented in the patients chart. The depth of the burn also needs to be documented.
- Dressings applied to the wound are part of the CPT code and need not to be reported.

2. Dressing change

Dressing change (for other than burns), under anesthesia (other than local) (15852).

Billing and documentation requirements:
- As per AMA, dressing changes other than under local anesthesia do not have separate CPT codes and are included when an E/M code is reported.
- If a procedure is performed on the same day dressing will be part of that procedure. E.g. Laceration repairs, debridement etc.
- CPT Code 15852 is reported normally when physician changes a dressing on a wound other than a burn while the patient is under sedation or general anesthesia. Document should justify medical requirement for performing dressing under anesthesia. E.g. severe crush injuries where serial tissue debridement is required and also for certain types of infection.

Evaluation and Management Codes:

- When service provided is only a non-surgical cleansing of a wound without sharp debridement, with or without the application of a surgical dressing, the appropriate Evaluation and Management (E/M) codes should be used.
- The selection of the E/M service should be supported by the documentation of the appropriate components; and the non-surgical cleansing of a wound will be considered bundled in the E&M reimbursements, and has no entitlement for separate payment.

3. Service codes for Non-surgical cleansing of a wound (51-01, 51-02 and 51-03)

Billing and documentation requirements:
- Report only when performed in the "Follow up within one week" period, non-surgical cleansing of a wound without sharp debridement with or without local anesthesia.
- Do not report with wound debridement, dressing for burns, and dressing change under anesthesia other than local on the same encounter.

Medical justification for performing such a procedure needs to be documented with the length of surgical dressing applied.

Adjudication Examples

Example 1

Question: Below claim is reported by a network provider to Daman for a Thika patient. Are these services payable?

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>944.13 (ICD-9)</td>
<td>Erythema due to burn (first degree), two or more digits, not including thumb</td>
</tr>
<tr>
<td>948.1 (ICD-9)</td>
<td>10-19% of body burned; third degree less than 10%, not present, or unspecified</td>
</tr>
<tr>
<td>E924.2 (ICD-9)</td>
<td>Accident caused by hot (boiling) tap water</td>
</tr>
<tr>
<td>E849.0 (ICD-9)</td>
<td>Injury or poisoning occurring at/in the home</td>
</tr>
<tr>
<td>16000 (CPT)</td>
<td>Initial treatment, first degree burn, when no more than local treatment is required</td>
</tr>
<tr>
<td>99213 (E/M)</td>
<td>Consultation</td>
</tr>
</tbody>
</table>

Answer: yes, all of the above services are payable as they are clinically appropriate in terms of diagnosis, frequency and duration.
Wound Care Management

Example 2

**Question:** Below claim is reported by a provider to Daman for a UAE Plan patient with the ICD-9 CM codes 924.20, E888.9, and E849.0. The CPT4 codes reported are CPT 15852 & SRVC 10. Can these services be paid?

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>924.20 (ICD-9)</td>
<td>Contusion of foot</td>
</tr>
<tr>
<td>E888.9 (ICD-9)</td>
<td>Unspecified fall</td>
</tr>
<tr>
<td>E849.0 (ICD-9)</td>
<td>Injury or poisoning occurring at/in the home</td>
</tr>
<tr>
<td>15852 (CPT)</td>
<td>Dressing change (for other than burns), under anaesthesia (other than local)</td>
</tr>
<tr>
<td>99213 (E/M)</td>
<td>Consultation</td>
</tr>
</tbody>
</table>

**Answer:** Daman will deny the CPT code 15852, as this service is clinically not appropriate in terms of diagnosis and will be rejected with denial code MNEC-003.

**Denial codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Code description</th>
</tr>
</thead>
<tbody>
<tr>
<td>MNEC-004</td>
<td>Service is not clinically indicated based on good clinical practice, without additional supporting diagnoses/activities</td>
</tr>
<tr>
<td>MNEC-005</td>
<td>Service/supply may be appropriate, but too frequent</td>
</tr>
<tr>
<td>MNEC-003</td>
<td>Service is not clinically indicated based on good clinical practice</td>
</tr>
<tr>
<td>DUPL-002</td>
<td>Payment already made for same/similar service</td>
</tr>
<tr>
<td>PRCE-002</td>
<td>Payment is included in the allowance for another service</td>
</tr>
</tbody>
</table>

**Appendices**

**A. References**

1. CCSC Coding Manual 2012
2. AMA CPT Assistant, 2007
3. AMA CPT Book 2012
4. HAAD Claims and Adjudication Rules V2012-Q2
5. American Health Information Management Association - Audio Seminar/Webinar 2008

**B. Revision History**

<table>
<thead>
<tr>
<th>Date</th>
<th>Change</th>
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<tbody>
<tr>
<td>01-07-13</td>
<td>V 2.0: New template Coding rules updated</td>
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</table>
| 15-07-14 | 1. V 3.0  
2. Disclaimer updated as per system requirements                      |