

MEDICARE COMPLIANCE

RAC Reviewers Hit Hard on Debridement; Five Elements Must Be Documented

The tension between two competing needs — to have all documentation before coding charts and to keep reimbursement rolling in — creates compliance vulnerabilities for hospitals, particularly in high-risk areas like debridements.

Which one will prevail in the competition will become apparent soon, as debridement-related MS-DRGs are facing complex medical review by two recovery audit contractors, and the other two RACs may join the party as well.

“Medical records departments are constantly hammered to reduce the ‘DNFB,’” an acronym for “discharged not final billed,” says Donna Pizzulli, executive vice president for Cybergistics Records Management in Neptune, N.J. The term refers to claims that have not been submitted yet because coders lack the documentation necessary to code charts, even though the patient has left the hospital.

As the DNFB rises and reimbursement is not received in a timely manner, the CFO becomes unhappy. “It is big-time pressure. Coders are coding incomplete charts. Everybody does it, whether it’s electronic or paper [charts],” she says. Against that backdrop, the higher-paying version of debridement — excisional debridement — is easy prey for incomplete documentation and the overpayments that stem from it.

To code for excisional debridement, there must be five documentation elements in the operative report or description of the procedure, Pizzulli says. If any are missing, coders or clinical documentation improvement specialists should query physicians for elaboration or clarification of the patient’s treatment (see sample, p. 3). But that may increase the DNFB. Feeling the heat to get charts coded and out the door, coders either downcode to non-excisional debridement, which may deprive the hospital of deserved reimbursement, or assign the excisional debridement code without all five elements. “Ninety percent [of errors] are documentation issues,” Pizzulli contends. Connolly Consulting, the RAC for Region C (which includes 15 states in the south and southwest), is now conducting DRG validation for 14 debridement MS-DRGs, including skin graft and/or debridement for skin ulcer or cellulitis with complications/comorbidities (MS-DRG 574); skin graft

and/or debridement for skin ulcer or cellulitis with major CC (573); and skin graft and/or debridement for skin ulcer or cellulitis without CC/MCC (575). CGI, the RAC for Region B (which includes seven midwestern states), is validating nine excisional debridement MS-DRGs, including wound debridements for injuries without CC/MCC (MS-DRG 903), wound debridements for injuries with MCC (901) and wound debridements for injuries with CC (902). DRG validation is the process of evaluating whether documentation supports the diagnosis, procedure and discharge disposition and determining if codes have been grouped to the correct DRG (*RMC 12/14/09, p. 1*). It does not address the necessity of inpatient admissions.

More Options Exist Under MS-DRGs

When RACs reviewed and recouped millions of dollars in debridement overpayments during the three-year RAC demonstration, which ended in March 2008, they targeted only a handful of DRGs. Since then, CMS implemented severity-based DRGs, expanding the number of DRGs from 538 to 745 and breaking them down to a much greater extent by secondary diagnoses. “The list has gotten larger because of the MS-DRG changes that burst the twins into triplets in addition to adding totally new DRGs,” Pizzulli says.

Physicians perform debridement to remove necrotic, infected tissue from wounds and burns and promote healing and new tissue growth. There are two categories of debridement:

(1) *Non-excisional (ICD-9-CM code 86.28) is not a surgical procedure.* It involves the non-operative brushing, scrubbing, whirlpool or washing of devitalized tissue, necrosis or slough. However, minor snipping and maggot therapy are included in the description, Pizzulli says.

(2) *Excisional debridement (ICD-9-CM code 86.22) requires the surgical removal or cutting away of necrotic or devitalized tissue.* This procedure may be performed in the operating room, emergency department or at the patient’s bedside, she says. “To be in compliance, it is essential that physician documentation support the use of 86.22,” Pizzulli says. RACs will recoup

money for excisional debridement unless the magic word “excisional” is in the medical record, she says.

To support use of the 86.22 code, the following five elements must be documented:

- ◆ The technique used (e.g., scrubbing, brushing, washing, trimming, or excisional);
- ◆ The instruments used (e.g., scissors, scalpel, curette, brushes, pulse lavage etc.);
- ◆ The nature of the tissue removed (slough, necrosis, devitalized tissue, non-viable tissue, etc.);
- ◆ The appearance and size of the wound (e.g., fresh bleeding tissue, viable tissue, etc.); and
- ◆ The depth of the debridement (e.g., skin, fascia, subcutaneous tissue, soft tissue, muscle, bone).

Physicians may drop the ball on one or more of these elements in terms of documentation. For example, the operative report may never mention the word excisional or the physician may state that “large amounts of

necrotic fascia over the sacrum was debrided” without saying how deep he or she went, she says.

When physicians don’t include all this information, Pizzulli recommends “coding it to the best-case scenario in terms of accuracy and financial ramifications. But put a bill-hold on it. Then query the doctor and have the doctor re-review the medical records and give you the appropriate documentation.” And warn coders not to take shortcuts. “You don’t get a second bite at the apple when the RAC comes,” she notes. “But you do when you are coding in real time because you can go back and get the documentation that you need.”

The good news is that reducing debridement errors doesn’t require you to move mountains, which is the case in other areas. “Debridements are cut and dried,” Pizzulli says. “There are five things to document. You’ve got to get those buckets complete — the instrument used, how deep you went, etc. — and then you’re golden.” And decision making in this area is objective;

Improving the Query Process for Debridement

Because debridement is a popular target of recovery audit contractors, hospitals should ensure that coding and documentation are accurate and complete before dropping Medicare bills. Physician queries are often a necessary part of the process. This query was developed by Donna Pizzulli, executive vice president of Cybergistics Records Management in Neptune, New Jersey. Contact her at dp@cybergisticsllc.com.

Sample Physician Query Excisional vs. Non-excisional Debridement

Patient Name: _____ MR#: _____
 Physician: _____ Discharge Date: ___/___/___
 Coder: _____ Contact #: _____
 Query Date: ___/___/___

Accurate documentation is required to meet compliance, accuracy of coding/billing and reflection of severity of illness. There is documentation of a debridement in this admission, but clarification is needed.

Documentation Reminder: Debridement (excisional versus non-excisional)

When documenting a debridement done in the Operating Room, at bedside, Emergency Department, or treatment room, the following information must be documented in the medical record. Items checked were documented; however further information is required related to the non-checked items:

- The technique used (e.g., scrubbing, brushing, washing, trimming, or excisional)
- The instruments used (e.g., scissors, scalpel, curette, brushes, pulse lavage etc.)
- The nature of the tissue removed (slough, necrosis, devitalized tissue, non-viable tissue, etc.)
- The appearance and size of the wound (e.g. fresh bleeding tissue, viable tissue, etc.)
- The depth of the debridement (e.g., skin, fascia, subcutaneous tissue, soft tissue, muscle, bone)

This procedure was: ___ Excisional Debridement _____ Non-excisional debridement

Please provide specific information on the areas that have **not** been checked and document this information in the patient’s medical record or via this form below, which will become a permanent part of the patient’s medical record.

Without this documentation, we must code the procedure as non-excisional and you should not bill for an excisional debridement procedure.

The justification for payment to the medical facility and to the physician is the medical record. The provider’s signature block on the CMS 1500, used for submitting claims for services, states: “I certify that services shown on this form were medically indicated and necessary for the health of this patient.” If the codes submitted do not match the services documented in the patient’s medical record, reimbursement can be affected under the guidelines of the federal False Claims Act. CMS seeks complete, legible, understandable and concise documentation that will support the medical necessity of treatments being provided.

either a debridement is excisional or it's not. Physicians can argue endlessly about the definition of "septicemia" or whether a diagnosis was present on admission, for example, but excisional debridement is not very subjective, she says.

Pizzulli says hospitals should identify the physicians who perform excisional debridement — they are surgeons and usually a limited number of them — and do a 15-minute targeted education session on debridement documentation. Or prepare a documenta-

tion guideline and send it to the doctors performing debridements.

Finally, get case management or clinical documentation improvement specialists involved on the front end. Have them work with physicians to improve their documentation on a real-time basis before patients are discharged and the records are sent to the health information management department.

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