

Debridement Coding in ICD-10-PCS CONQUER THE CHALLENGE

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Coding for excisional and non-excisional debridement procedures is likely to continue to be under the microscope. This has been a target area for the Revenue Audit Contractor (RAC) and other auditors because debridement procedures are frequently miscoded. All too often, an excisional debridement is coded when the documentation supports only a non-excisional debridement. There is a significant difference in the relative weights of an excisional compared to a non-excisional debridement; the former groups it to a surgical Diagnosis Related Group (DRG) and the latter to a medical DRG. The implementation of ICD-10 did not make the challenge of distinguishing between an excisional and a non-excisional debridement code disappear. The purpose of this article is to provide information that may be helpful when selecting the correct ICD-10-PCS code for a debridement procedure.

Debridement is the removal of devitalized tissue to encourage wound healing and to reduce the likelihood of infection. Two specific types of devitalized tissue include slough and eschar. Devitalized tissue can be removed by surgical, mechanical,

autolytic, biologic, enzymatic or other means.

- The surgical debridement method is coded as an excisional debridement, given sufficient provider documentation.
- The mechanical debridement methods are coded as a non-surgical debridement and include washing, brushing or using hydrosurgery. The Versajet™ system is a hydrosurgery debridement method; a high velocity stream of fluid produces a local vacuum, i.e. the Venturi effect, which removes the dead tissue.

Debridement is broadly classified as either excisional or non-excisional. The term “debridement” in the alphabetic index of ICD-10-PCS Official Coding Guidelines lists:

- Debridement, excisional as the root operation Excision; and
- Debridement, non-excisional as root operation Extraction.

The definition of the root operation Excision is the “cutting out or off, without replacement, a portion of a body part.” The definition of the root operation Extraction is the “pulling or

stripping out or off all or part of a body part by use of force.”

The selection of the type of debridement requires specific documentation from the physician or other health care providers who performed the procedure. An excisional debridement is coded when the health care provider documents “excisional debridement”; this is often referred to as the “magic words” by coding professionals. But even without the “magic words,” if the procedure documentation meets the definition of the root operation “Excision” (cutting out or off, without replacement, part of a body part), then it is still coded as an excisional debridement. Convention A11 of the ICD-10-PCS Official Coding Guidelines specifies that, “it is the coder’s responsibility to determine what the documentation in the medical record equates to in the PCS definitions” (CMS, 2016).

Guideline B3.5 of the ICD-10-PCS Guidelines instructs coding professionals to code only the deepest layer when multiple layers are involved (CMS, 2016). So, it is important for the documentation to indicate the deepest layer of tissue removed. The coding

professional cannot assume that bone was debrided just because the lab report mentions bone fragments.

It is not appropriate to make assumptions when selecting a debridement code. For example, the coding professional cannot assume that an excisional debridement was performed based on documentation of the use of sharp scissors to remove devitalized tissue or other nonspecific terminology, such as “sharp debridement.” When the documentation is unclear, the coding professional must query the provider for clarification.

Coding professionals need specific and detailed information to identify and code the more resource-intensive excisional debridement. The debridement documentation should include:

- Anatomical site (including laterality)
- Type of debridement (excisional or non-excisional)
- Technique used to remove the tissue (scrubbing, cutting, irrigation)
- Instruments used (scalpel, wire, brush, scissors)
- Nature of tissue being removed (devitalized, necrotic, eschar, slough)
- Appearance and size of the wound (wound bed moist and red)
- Depth of the procedure (removed necrotic muscle tissue down to the bone)

When Clinical Documentation Improvement (CDI) education specialist Sharme Brodie teaches new CDI specialists the documentation requirements for debridement, she suggests the mnemonic device “TINA D,” which stands for technique, instrument, nature of tissue, appearance and depth (Brodie, 2016).

The electronic health record (EHR) can create challenges for coding professionals because debridement procedures can be performed in the

TERM	DEFINITION
Devitalized	Tissue that is avascular (dead, necrotic, nonviable).
Granulated	Tissue that often has a rough or grainy texture and red or pink color. This moist tissue appears early during wound healing.
Slough	Devitalized tissue that is often white or yellow in color, but could be tan or green.
Eschar	Devitalized tissue that is most often brown or black in color.

emergency department, the operating room, or patient’s room. Because procedures may be done by nurses or other wound care specialists, not only by surgeons and other physicians, debridement documentation can be located in nursing or wound care notes. EHRs that separate nursing documentation from physician documentation can be problematic, for example, the wound care nurse documentation can be included in the record after the physician has signed off on the record. The record should be locked to prevent the addition of documentation after the physician has completed the record.

Another concern is conflicting documentation, for example, the nurse describes a stage II pressure ulcer but the physician does not document any skin integrity issue, or the nurse describes a wound as “necrotic” and the physician describes the same wound as having “slough.” It is important to have a process for consistent documentation; for best practice, the physician should review the nursing wound care documentation. If the physician does not document an ulcer or other skin integrity issue, then a pressure ulcer stage III or higher could be coded as not present upon admission. It may be possible to have the wound evaluation and treatment documented by the wound care specialist crossover for inclusion in the physician’s documentation, pending review and agreement. Many hospitals have instituted such a documentation

system with physicians cosigning the wound care document.

Coding wound debridement procedures in ICD-10-PCS can be a challenge. Reviewing the ICD-10-PCS Official Coding Guidelines and reading the American Hospital Association’s AHA Coding Clinic for additional guidance helps to refresh coding knowledge. Coding professionals may find it worthwhile to review how the procedure is being documented by their providers and to ask for help remediating documentation deficiencies. When the documentation provides the necessary elements for coding, coding professionals will likely find that they are able to conquer debridement procedure coding challenges.

References

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