Third-Party Reimbursement for Lower-Extremity Wound Care

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This article describes the treatment of lower-extremity wounds, specifically foot and ankle ulcerations, in the context of reimbursement for treatments rendered. Therefore, such issues as standard of care, documentation, classification of foot wounds, coding, and reimbursement are discussed. (J Am Podiatr Med Assoc 92(1): 54-58, 2002)

The combination of research, wound care specialization, and public education has resulted in a significant and dramatic improvement in professional treatment of foot and ankle ulcers and the outcomes associated with such treatment. Given the potential for severe morbidity, disability, and even mortality associated with lower-extremity wounds in compromised patient populations, advancements in treatment have led to the development of therapeutic techniques and algorithms that expedite the healing of ulcerations. Unfortunately, while many teaching institutions are adopting accepted and proven treatment programs and algorithms, a significant number of health-care practitioners still follow their individual protocols, which may or may not expedite the healing process in foot and ankle ulcers.

A critical relationship exists between the quality of medical record documentation and the overall quality of care rendered to patients with lower-extremity wounds. Too many findings, and too many factors, influence not only ongoing treatment, but future treatment direction. Medical records that fail to provide some reasonably acceptable level of documentation may ultimately result in unnecessarily prolonged or failed wound healing. The medical record may fall short by failing to provide evidence of important information, such as the lack of healing or closure, the existence of deep wound infection, chronic drainage or odor, or information regarding previous surgical and medical care.

Practitioners who focus on the treatment of foot and ankle ulcers need to provide documentation that not only presents a chronology of pertinent facts, clinical observations, and historical information to refresh the clinician’s memory, but also acts as a valuable resource for any other treating health-care professional requiring access to the information in the medical record. A quality record is essential both for ultimate quality of care and for validating that the claimed services and procedures were medically necessary and were performed. To assist in the adjudication of claims, third-party payers are requesting copies of medical records more frequently, especially in cases of wound care, and this may be a long-term and costly process. The importance of maintaining quality records cannot be overemphasized. Good principles of medical record documentation should include the following:

- A medical record that is complete, accurate, clear, and legible;
- Documentation for each patient encounter that includes, among other details, the date of service, the reason for the encounter, the appropriate history and physical examination pertinent to the clinical findings, condition, the illness present, findings from the review of tests and services, any other applicable findings, an assessment or impression, and a direction or plan of care;
- Clinical findings that, for ulcerations, document the number of wounds, location of each wound, mea-
surement of each wound, and classification of the wound, as well as drainage, odor, and other influencing factors, such as vascular, neurological, biomechanical, musculoskeletal, and dermatologic factors;

- The identification of relevant patient health risks and, for the established patient, progress or interval changes in medical status, findings, or treatment;

- Indication of the physician’s thought processes or medical decision making, either directly stated or indirectly evident in the body of the medical record;

- The dating of all entries and, for each entry, the signature of the examining and treating health-care provider (physician, nurse, or physical therapist, for example); and

- Clear evidence of all information reported on the claim form (diagnoses, procedures, services, and supplies dispensed) and support of that information according to the date of service.

The above list is based on a compilation that was developed jointly by representatives of the Health Care Financing Administration, American Health Information Management Association, American Hospital Association, Managed Care and Review Association, American Medical Association (AMA), and American Medical Peer Review Association, as well as multiple insurance companies.

Third-party payers are obligated to ensure that the services and procedures claimed were performed and were medically necessary, appropriate for the diagnosis, and within the standard of care and scope of provider practice. The medical records and the documentation contained in them are vital so that the payer can appropriately reimburse services and procedures claimed.

**Documentation**

**Grading of Wounds**

Health-care providers should use a clearly identified classification system to classify foot and ankle ulcerations in the medical record. Examples may include such terminology as Grade 2, Wagner Classification, or Grade 2, Stage B, University of Texas Diabetic Wound Classification. Furthermore, clinical findings in the medical record should support the wound classification identified.

**Wound Illustration and Photography**

The continuum of wound status throughout the treatment program is documented primarily as text in the body of the medical record. It should also be documented either with sequential markings on a representative lower-extremity illustration or through a photographic record. The availability of illustrative or photographic evidence of wounds under treatment can make the difference between the reasonably rapid processing of a reimbursement claim and delay or denial of reimbursement of ulcer treatment.

There is no Current Procedural Terminology (CPT) or Health Care Financing Administration Common Procedure Coding System (HCPCS) code for medical photography, although there once was. The expenses associated with a provider’s elective medical photography are considered to be included in the primary services or procedures performed and are not independently reimbursed. If, however, the third-party payer requests or demands photographs, it is recommended that the payer be contacted to confirm the request and establish that such services are above and beyond what is usual and customary for the office. Because the request is mandated by the payer, the provider may elect to submit a claim to the payer for such services with the billing of CPT 99199 (unlisted special service or report) with a “32” modifier (mandated services by a third-party payer) attached.

**Depth of Wound Debridement**

The various wound classification systems focus on the depth of wound involvement and other factors, but they do not indicate the actual depth of debridement performed. The inclusion in the clinical description in the medical record of information on the depth of debridement performed is not only important, it is also critical in validating the level of CPT debridement billed. One of the more frequently used debridement series within the AMA’s CPT is found under the CPT 11040 series of coding. These codes depend on the depth of debridement performed and are discussed below.

**Wound Debridement and Related Procedures and Services**

Third-party reimbursement requirements vary among payers and codes. Without an absolute standard of billing, a universal definition of coding, or uniform guidelines for physicians, reimbursements cannot be expected to be standard, universal, or uniform among payers. Wound care specialists should establish best-treatment protocols within their own offices for ulcer care, and then develop a billing methodology with coding specialists which accurately reflects the treatment using the most accepted, most universal standards of billing available. If a payer denies or modifies
usual and customary claims for services or procedures, the practitioner must be ready to appeal the denial or modification of the billed claim.

**Ulcer Wound Care**

**Debridement, Incision and Drainage, and Incision Codes**

The following codes are used for debridement, incision and drainage, and incision:

CPT 10060 and CPT 10061 (incision and drainage [I&D] abscess). When an abscess is present in the structure of the skin or subcutaneous tissue ulcer site, and the primary treatment is an incision and drainage of the abscess versus debridement of the ulcer, the billing code is CPT 10060 for a simple abscess incision and drainage and CPT 10061 for multiple simple incision and drainages or for a single complicated incision and drainage of the abscess. These codes both have a global period of 10 Medicare follow-up days. An abscess associated with an ulcer that is debrided would generally not be billed independently of the ulcer debridement.

CPT 11000 (debridement of extensively infected skin). This code is reserved for clinical circumstances in which severely infected skin involves wide areas of the foot. This code is not to be used for the casual debridement of ulcers. CPT 11000 has no Medicare follow-up days.

CPT 11040 through CPT 11044 (debridement). This coding series is one of the most commonly used to report claims for debridement services. The codes are defined as follows:

- **CPT 11040** (debridement of partial-skin thickness; no Medicare follow-up days)
- **CPT 11041** (full-skin thickness debridement through the dermis, but not including the subcutaneous tissue; no Medicare follow-up days)
- **CPT 11042** (debridement of skin, and debridement through and including structures within the subcutaneous tissue; no Medicare follow-up days)
- **CPT 11043** (debridement of skin, subcutaneous tissue, and debridement through and including structures within the muscle layer; 10 Medicare follow-up days)
- **CPT 11044** (debridement of skin, subcutaneous tissue, and muscle, including bone; 10 Medicare follow-up days)

Codes CPT 11040 through CPT 11044 demand medical record documentation of the depth of debridement. Failure to document depth of debridement performed for each ulcer may result in the third-party’s payer reducing the submitted coding to the CPT 11040 level or denying the claim altogether.

**CPT 20000** (incision of superficial soft-tissue abscess primarily within the subcutaneous layers of the foot or ankle). The example given in the CPT is an abscess secondary to osteomyelitis. CPT 20000 has 10 Medicare follow-up days assigned to it.

**CPT 20005** (incision of a deep or complicated soft-tissue abscess primarily within the foot or ankle). This code is generally reserved for deep space abscesses, such as those found intermetatarsally. CPT 20005 has 10 Medicare follow-up days assigned to it.

**CPT 27603** (I&D deep abscess, ankle). When an abscess is present deep in the tissue of an ulcer site and the primary treatment is an incision and drainage of the abscess versus debridement of the ulcer, the billing would be CPT 27603. The Medicare follow-up period is 90 days. An abscess present and associated with an ulcer that is debrided generally would not be billed independently of the ulcer debridement.

**CPT 27607** (incision of ankle osteomyelitis or bone abscess). This code is reserved for bone infections or abscesses requiring incision and drainage. CPT 27607 has 90 Medicare follow-up days assigned to it.

**CPT 27640** and CPT 27641 (partial excision of bone, ankle). These are singular bone debridement codes used in “dirty” cases that require excision of the infected bone. The Medicare follow-up period is 90 days.

**CPT 28002** and CPT 28003 (I&D deep bursal space, foot). When an abscess is present within the deep layers of the foot and the primary treatment is an incision and drainage of the site, the billing would be CPT 28002. The Medicare follow-up period is 10 days. If multiple bursal spaces are involved, CPT 28003 would be used. CPT 28003 has a 90-day Medicare follow-up period.

**CPT 28005** (incision of foot bone cortex). This code is reserved for bone infections or abscesses requiring incision and drainage. CPT 28005 has 90 Medicare follow-up days assigned to it.

**CPT 28120** and CPT 28124 (partial excision of bone, foot). These are singular bone debridement codes used in “dirty” cases requiring excision of the infected bone. The specific bone dictates the specific code to use. The Medicare follow-up period is 90 days.

**Bilaminate Skin Substitute**

The 2001 CPT has added two new codes for the application of Apligraf (Novartis Pharmaceuticals Corp,
East Hanover, NJ), bilaminate skin substitute/neo-
dermis. They are CPT 15342 for up to 25 \(\text{cm}^2\) and CPT 15343 for each additional 25 \(\text{cm}^2\). The CPT 15342 has a 10-day Medicare follow-up period. When billing these codes, the surgeon is permitted to also bill (one time) CPT 15000, which is the surgical preparation of the ulcer or wound site to accept the bilaminate skin graft. CPT 15000 has no Medicare follow-up period assigned it.

**Venous Stasis Ulcer Treatment**

The treatment of venous stasis ulcers uses treatment codes that are used for other types of wounds. A key element in the management and healing of venous leg ulcers is the use of compression. The Unna boot has long been used as a compression dressing in the treatment of this type of wound. It has a code of CPT 29580. In July 1999, the AMA’s CPT newsletter stated that a “22” modifier was added to the Unna boot code, stipulating that CPT 29580-22 should be used to represent the application of a graduated sustained high-compression bandage system for the treatment of venous dermal ulcers. This bandaging system is applied to the lower extremity.

**Coding Modifiers**

Since debridement, incision, and drainage may be performed either multiple times or as part of a separately identifiable evaluation and management service, modifiers are used to identify the circumstances for multiple coding submission and to assist in the processing of the claim:

“24” Modifier. A separately identifiable evaluation and management service performed during a global period for a previously performed surgery. Generally this is attached to an evaluation and management code that is wholly unrelated to the previous surgery.

“25” Modifier. A separately identifiable evaluation and management service performed on the same day as a procedure, generally a minor procedure (less than 90-day follow-up period).

“57” Modifier. Identifies the evaluation and management service as critical to making the decision to perform surgery within 24 hours. This is reserved for major procedures (90-day follow-up periods).

“58” Modifier. Staged or more extensive procedure performed during a follow-up period of another procedure. When multiple debridements are expected within the global period of another procedure, a “58” modifier is attached to the new staged procedure. It is very important to document ahead of time the fact that staged or additional procedures are planned. The “58” modifier can also be used when a more extensive procedure is subsequently performed that is related to the previous surgery in a global period. An example would be the initial performance of a digital amputation with subsequent transmetatarsal amputation within the digital amputation global period.

“78” Modifier. This modifier is attached to a subsequent surgical procedure that was performed within the initial global period and necessitated a return to the operating room for a related procedure by the same surgeon.

“79” Modifier. When the procedure is unrelated to the initial procedure within a global period, the subsequent procedure is modified with “79” to separate it from the original procedure’s global period allowance. An example of this would be the performance of a left bunionectomy 6 weeks after a right bunionectomy was performed.

**Active Wound Care Management**

Active wound care codes were added to the CPT in 2001 under the Physical Medicine and Rehabilitation section. While payers may specify which providers (physicians versus ancillary healthcare professionals, such as physical and occupational therapists) can use these codes, CPT does not differentiate provider use. If circumstances warrant it, and the specific payer reimburses physicians for providing the service, foot care specialists should feel comfortable billing for them. The codes are as follows:

CPT 97601 (removal of devitalized tissue from a wound; selective debridement, with or without anesthesia). This includes the use of high-pressure waterjet and/or sharp debridement. Topical applications and dressings are included.

CPT 97602 (nonselective debridement, with or without the use of anesthesia). This includes the use of wet-to-moist dressings, enzymatic debriding, and abrasion. Topical applications and dressings are included.

**Other Graft Materials**

Other biologic wound dressings are also available to cover a wound site and include a variety of porcine materials, which are packaged many different ways. These are classified as xenografts. CPT 15400 is used for these materials and includes the site preparation for the graft.

**Conclusion**

Subspecialization in foot and ankle wound care has resulted in a significant reduction in morbidity, dis-
ability, and mortality associated with ulcers of the lower extremities. New research has led to treatment protocols which have allowed chronic wounds that were previously thought to be cause for amputation to be controlled, reduced, and resolved. The intensity of treatment and the commitment of the physician, ancillary health-care professionals, patient, and family members are necessary to achieve a positive result.

In years past, treatments were a hodgepodge of services and procedures whose true worth could not be documented. Today, in contrast, practitioners have a myriad of treatments that have been shown to reduce the healing period, improve the filling in and closure of wounds, and return patients to meaningful, albeit closely monitored, lives.

As the intensity of treatment has increased, so has the cost of care for lower-extremity wounds. Protocols, developed from research, appeared to support the initial levels of treatment intensity, with a gradual lessening of that intensity as the wound begins to heal. The coding and billing of services, tests, procedures, and supplies associated with wound care seemingly had no direction or uniformity. It is critical that the billing provider and the reimbursing payer understand that every patient with lower-extremity wounds is unique. Approval of services and procedures must be based on benefit coverage, standard of care, medical necessity, and treatment effectiveness. While the costs of wound care are very high, the costs of wounds left untreated are even greater.

Bibliography