



# IMA INSIGHTS

## Debridements: High on the RAC's Radar

To our Healthcare Clients and Friends:

In this edition of *IMA Insights* we discuss an issue that everyone is starting to lose sleep over - the RAC Attack on debridements. In the FY 2007 RAC Status Document, the RAC recouped over \$36 million relating to this issue alone (84% of the take back was done by the New York RAC). That is up from the \$13.9 million recouped in FY 2006 – an eye opening 161% increase. The remainder of this *IMA Insights* will provide you with some background on the issue, update you on the last OIG report on this issue, and discuss what you should do to prepare for the RAC's Attack on debridements and how to protect your revenues.

### BACKGROUND

Over \$25 billion is spent annually on wound care in the United States. Between five and seven million Americans are affected each year by at least one form of chronic wound and the incidence of these wounds is increasing at approximately 10 percent a year. A component of wound care is the performance of surgical debridements to assist in the treatment and healing of wounds. These surgical debridements are described as the removal of necrotic or unhealthy tissue from a wound using a sharp instrument. This process promotes wound healing by the removing of sources of infection and other barriers. With the increase of needed wound care treatments, the submitting of claims to Medicare for surgical debridements is also on the rise and has become the focus of not only RAC Auditors but also a component of the OIG's 2008 Work Plan.

In May of 2007 the OIG released a work product entitled "Medicare Payments for Surgical Debridement Services in 2004." This work product was a result of an audit conducted to determine the extent to which Medicare Part B surgical debridement services in 2004 met Medicare program requirements.

According to the OIG, between 2001 and 2005, Medicare Part B payments for surgical debridements increased from \$140 million to \$202 million (a 44 percent increase). The OIG's review found that 64 percent of the surgical debridement services in 2004 did not meet Medicare program requirements, resulting in approximately \$64 million in improper payments. Their determinations included:

- Services billed with a code or modifier that did not accurately reflect the service provided.
- Services billed that had no documentation or insufficient documentation to determine whether the services were medically necessary or were coded accurately.
- Services performed and billed that were not medically necessary.

As a result of this report, the OIG made recommendations for improvement to the Centers for Medicare and Medicaid Services (CMS). Those recommendations included:

- The strengthening of program safeguards to prevent improper payments for surgical debridement services.
- The conducting of additional medical reviews.
- Educating providers.
- Developing of National Coverage Determinations (NCD) or Local Coverage Determinations (LCD).
- Launching of appropriate actions related to miscoded, insufficiently documented and medically unnecessary services.

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### ISSUES

#### Documentation Requirements (As suggested by the OIG)

There are five CPT codes for surgical debridement which are based on the level of skin, tissue, muscle or bone removed. These CPT codes are:

- 11040 Debridement; skin, partial thickness
- 11041 Debridement, skin, full thickness
- 11042 Debridement; skin and subcutaneous tissue
- 11043 Debridement; skin, subcutaneous tissue, and muscle
- 11044 Debridement; skin, subcutaneous tissue, muscle and bone.

There are many Carrier specific LCDs describing wound care services and providers need to be diligent in acquiring and understanding these LCDs. In general, the documentation should include the indications for the procedure, the type of anesthesia if and when used, the narrative of the procedure that describes the wounds and the details of the debridement procedure. The documentation must verify the surgical excision of tissue (not just "scraping" even with the use of a sharp instrument. The following is the OIG's summarization of the required documentation after they reviewed multiple LCDs:

- Describe the medical condition, including current treatment diagnosis and all relevant diagnoses, of the patient.
- Describe the wound sufficiently to document medical necessity for the service, including the size and depth of the wound.
- Document the presence and extent of or absence of signs of infection and/or the presence and extent or absence of necrotic, devitalized, or non-viable tissue.
- Describe the method of debridement or wound care prescribed (excisional vs. non-excisional).
- Include the depth (of tissue) and level of debridement or type of wound care to support the CPT code billed.
- Description of the character of the wound before and after debridement.
- Describe all dressings and/or treatment.

Document the progress of the wound, including factors that would complicate normal healing, and the response of the wound to treatment.

#### The RAC's Review Criteria

The RAC Attack on debridements included a complex review of "excisional debridements" that were performed and according to the RAC resulted in the identification of incorrect coding. Below is a summary of the RAC's process for evaluating this issue:

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1. The provider assigned a procedure code of 86.22 (Excisional debridement of wound, infection or burn).
2. The medical record documentation stated "debridement was performed" or "wound was sharply debrided".

The RAC references the Coding Clinic 1991Q3, which states "Unless the attending physician documents in the medical record that an excisional debridement was performed (Definite cutting away of tissue, not minor scissors removal of loose fragments), debridement of the skin should be coded to 86.26 (non-excisional debridement of skin). According to the RAC, any debridement of the skin that does not meet the criteria noted above or is described in the medical record as debridement and no other information is available should be coded as 82.22.

**The RAC's Conclusion** – They determined that these types of claims were incorrectly coded and issued repayment request letters totaling \$36 million.

### INSIGHTS

So how do you ensure that your hospital is safe from OIG audits and RAC reviews of debridements? As always, the answer is accurate and complete documentation and coding. Providers need to require a collaborative effort between the physicians and the HIM department. The utilization of a thorough "query process" is an effective way to improve the accuracy of the coding and medical record documentation. A query process will greatly assist in understanding unique clinical occurrences. Providers should develop a standard format for a query form that is easy to use and appropriate for responses. Providers should also develop their own policies and procedures regarding the documentation of the query response in the medical record. Continued training and education surrounding the complexities of this area will be valuable to prevent further errors in coding and omissions in documentation.

The provider community will continue to hear more "noise" about debridements as the national RAC program is rolled out across the country. Don't immediately invest all of your RAC preparedness resources into this issue alone because the money you have at risk varies significantly depending on the RAC assigned to you (assuming the trends from the demonstration project continue). As noted earlier, the RACs took back \$36 million for this issue in FY 2007. However, only \$3.2 million and \$2.5 million were taken back by the California and Florida RACs respectively. Understanding the "hot button" issues of your specific RAC needs to be taken into consideration before you invest your hospital's RAC preparedness resources. Failure to plan accordingly will result in potentially wasting resources on an issue that may *not* be high on *your* RAC's radar.

With the imminent expansion of the RAC program coupled with a continued focus by the OIG, providers need to re-focus on this issue to ensure that large numbers of claims are not taken back by the RAC. Where do you start?

1. Determine who is going to be involved with the project (i.e., corporate compliance, HIM, legal counsel, RAC specialists, etc.).
2. Only look back as far as October 1, 2007 (which is how far back the RAC will be allowed to go under the national program rules).



**IMA  
Consulting**

Two Christy Drive, Suite 219  
Chadds Ford, PA 19317

Phone: 484.840.1984  
Fax: 484.840.0124

**Toll Free: 866.840.0151**

**Visit our Website:**  
[www.ima-consulting.com](http://www.ima-consulting.com)

**Robert J. De Luca,  
Partner**

**Kimberly Hollingsworth,  
Partner**

**Mary Ann Holt,  
Partner**

**Anthony J. Scarcelli, Jr.,  
Partner**

**Robert D. Sutton,  
Partner**

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3. Develop a data mining approach to identify the number of claims at risk.
4. Develop a sampling methodology to utilize in the selection of claims to be reviewed.
5. Pull the necessary records, evaluate the supporting documentation, and make the necessary corrections.

Most importantly, don't forget to also identify those claims where you may have left money on the table. Yes, the RACs claim they look for underpayments and that they return underpayments to providers; however, we all know that this is not a reality. The best way to protect your revenue stream from a RAC Attack or OIG take back is to be proactive in reviewing your supporting documentation to ensure that if your records are ever requested and reviewed that you have a comfort level that your claims are clean (i.e. no material RAC or OIG revenue take backs).

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We are pleased to have had the opportunity to provide this information to you. If you have any questions regarding this issue, please do not hesitate to contact either Lucinda Rook at (484) 574-6433, or myself at (215) 669-3988.

Yours very truly,

*Tony*

Anthony J. Scarcelli, Jr.  
Partner

**ANNOUNCEMENTS**

**IMA Consulting will host booth #1756** at the 2008 HFMA ANI: The Healthcare Finance Conference, June 24-25 at the Mandalay Bay Convention Center in Las Vegas, NV.

**Tony Scarcelli, IMA Consulting Partner**, will be presenting at the 2008 HFMA ANI on the topic of **Recovering Transfer DRG Underpayments**, session number E11, a Thursday, June 26th breakout session.

**IMA Consulting to sponsor the HFMA CFO Boot Camp** at the 2008 HFMA ANI: The Healthcare Finance Conference at the Mandalay Bay Convention Center in Las Vegas, Nevada on June 23-26, 2008.