Prevent RAC denials: Improve excisional debridement documentation

by Trey La Charité, MD

Every institution reading this column has likely received its first recovery audit contractor (RAC) denials regarding the documentation and coding of excisional debridement procedures (86.22). Our hospital is no exception. While we knew that this procedure was a specific and deliberate target of the RACs, we were not privy to the tactics they would use in an attempt to downgrade these procedures to the nonexcisional code (86.28). We now have a better understanding of the methodology the RACs employ to generate these denials.

The following recommendations are based on our (a 500-bed academic medical center) experiences with the RAC denials we have received thus far for excisional debridements. Each denial, prior to appeal, potentially represents a loss of $1,500–$17,000, depending on the original MS-DRG submitted.

One of my mentors once said that the definition of wisdom is the knowledge gained through the experiences of others without actually having to make those mistakes yourself. My hope is that our experiences will improve your resilience against future RAC recoupment.

Add ‘excisional’ as appropriate

Unfortunately for all medical facilities, the RACs have discovered an AHA Coding Clinic guideline (third quarter 1991, volume 8, number 3, pp. 18–19) that they are using to their advantage. This guideline states that “unless the attending physician documents in the medical record that an excisional debridement was performed ... debridement of the skin should be coded to nonexcisional.”

The RACs have taken this to mean that a procedure must be titled or labeled as an “excisional debridement” in the same way a physician would title any other common procedure such as a central line placement, a thoracentesis, or a lumbar puncture. This represents a recurring problem for our facility as the RACs have quoted this guideline every time an excisional debridement has been coded but not specifically labeled as an “excisional debridement” by the physician.

This documentation requirement represents a substantial culture change for most facilities as physician and physical therapist documentation of these procedures is traditionally minimal at best.

Review Coding Clinic guidance

In addition to this new documentation wrinkle, there are four other components of an excisional debridment that our facility believes should be documented in order to avoid future RAC denials:

1. The location, size, and condition of the wound
2. The depth to which the wound was debrided
3. The removal of devitalized or necrotic tissue
4. A list of the surgical instrumentation used

Although none of us signed up for the aggravation created by the RAC when we elected to pursue careers in medicine, we must implement the strategies necessary to ensure that our facilities’ patient care missions survive in today’s tumultuous healthcare environment.

First, the wound being debrided should have its exact location, size, and condition described in detail. This clearly establishes medical necessity for performing this procedure in the medical record. Although detailed pictures are acceptable (and preferred by some resident physicians), a better approach includes a detailed description of what the wound actually looks like.

Secondly, the depth to which the operator debrides a wound needs to be clearly written or dictated in the procedure note. It is essential to remember that the depth to which the operator debrides a wound must be expressed in terms of tissue layers as opposed to units of measurement such as centimeters or inches. This is because debridements
down to different tissue layers carry different ICD-9-CM codes and, therefore, also carry different reimbursement rates.

Members of your CDI team should encourage your medical staff to be as specific as possible about how far down the operators went during the procedure. Coding Clinic (first quarter 2008, volume 25, number 1, pp. 3–4) provides instruction that “when multiple layers of the same site are debrided, assign only a code for the deepest layer of debridement.”

Codes for these procedures are based on the deepest layer reached, including debridement of the skin and subcutaneous tissue (86.22), fascia (83.39), muscle (83.45), tendon (83.39), and bone (77.60).

Third, the operator must document that he or she removed devitalized or necrotic tissue from the wound. According to Coding Clinic (fourth quarter 1988, volume 5, number 4, p. 5), an “excisional debridement is the surgical removal or cutting away of devitalized tissue, necrosis, or slough.” Also per Coding Clinic (second quarter 2004, volume 21, number 2, pp. 5–6), an “excisional debridement is the definite cutting away of tissue that includes cutting outside or beyond the wound margin.” These guidelines are cited with every excisional debridement denial we have received from the RAC when clear documentation of the removal of necrotic tissue was lacking.

continued on p. 8

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### Sample wound debridement form

<table>
<thead>
<tr>
<th>Name: _____________________</th>
<th>MR #: ____________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encounter #: ______________</td>
<td>Date: ___________</td>
</tr>
<tr>
<td>Debridement indication: ______</td>
<td></td>
</tr>
</tbody>
</table>

**Location and description of wound (length, width, depth, etc.):**

**Type of debridement:**

- ☐ Nonexcisional
  - The nonoperative brushing, irrigating, scrubbing, or washing of devitalized tissue, necrosis, or slough
- ☐ Excisional
  - The surgical removal or cutting away of devitalized tissue, necrosis, or slough

**Was necrotic/devitalized tissue removed?**

- ☐ Yes
- ☐ No

**Instrumentation used (please check all that apply):**

- ☐ Scalpel
- ☐ Forceps
- ☐ Scissors
- ☐ Bovie
- ☐ Curette
- ☐ Other (please specify): ____________________________

**Depth to which wound was debrided:**

- ☐ Skin and subcutaneous tissue
- ☐ Muscle
- ☐ Tendon
- ☐ Bone
- ☐ Other (please specify): ____________________________

**Type of dressing used after debridement:**

______________

**Operator:** ________________

**PAGER #_________ Date & time:__________**

Wound Debridement Medical Records (Dev. 6/10)

*Source: University of Tennessee Medical Center. Reprinted with permission.*
Lastly, the operator should give a list of the exact surgical instrumentation used to perform this procedure, not just that “sharp debridement” was performed. This has become vital as the RACs and other auditors try to routinely exploit the use of the word “sharp” to their benefit. Coding Clinic (second quarter 2004, volume 21, number 2, pp. 5–6) states:

The use of a sharp instrument does not always indicate that an excisional debridement was performed. Unless the documentation describes sharp debridement as a definite cutting away of tissue and not the minor removal of loose fragments with scissors or scraping away tissue with a sharp instrument, assign code 86.28, nonexcisional debridement.

Your CDI program should train your operators to avoid using the word “sharp” in their excisional debridement procedure notes if at all possible; including this word creates fertile ground for unnecessary and avoidable denials.

A possible solution

These new documentation requirements are compounded by the wide variety of medical and surgical services that actually perform the procedure. At my facility, excisional debridements are performed by numerous surgical specialties, including general surgery, trauma surgery, plastic surgery, vascular surgery, and oral maxillofacial surgery. Excisional debridements are also performed by our family practice and OB/GYN physicians, and, of course, our physical therapists working with our wound care service. Further, excisional debridements may be performed in either the inpatient or the outpatient environment.

The institution of a uniform approach to this documentation challenge, however, should be successful. After our first RAC denials for excisional debridements were received and reviewed in the spring of 2010, we developed a simple single-page wound debridement form to be used throughout our institution (view the form on p. 7). The chair of the surgery department and the director of physical therapy services were intricately involved in the creation of this form so that facilitywide operator buy-in would be ensured.

We then held educational sessions with our medical staff and the physical therapy department. These sessions gave specific examples of why denials were received, the financial impact of those denials, and the proposed fix with our new debridement form. The program director for our general surgery residency held a separate educational session for his residents explaining the critical nature of the situation and encouraging them to use the new form.

The form lists the AHA Coding Clinic definitions for excisional and nonexcisional debridements (fourth quarter 1988, volume 5, number 4, p. 5). It also employs a user-friendly check box format for all of the other needed documentation pieces with the exception of the wound description section.

Our hope is that through the use of this form, there can be no question as to what procedure was performed. Unfortunately, as the form has only been in use at my facility since May 2010, I do not yet have any RAC review results to share regarding its effectiveness in preventing denials.

There are several other wound debridement form examples created by other institutions available through the ACDIS website in the Forms & Tools Library. I strongly suggest that your CDI program consider creating such a form. Although the new form will not help with records coded prior to its implementation, it should go a long way in reducing your institution’s future denial liabilities.

The collective goal of CDI programs is to make our medical record documentation as accurate as humanly possible. Although none of us signed up for the aggravation created by the RAC when we elected to pursue careers in medicine, we must implement the strategies necessary to ensure that our facilities’ patient care missions survive in today’s tumultuous healthcare environment.

Editor’s note: La Charité is a hospitalist with the University of Tennessee Hospitalists at the University of Tennessee Medical Center at Knoxville. He is clinical assistant professor with the Department of Internal Medicine and serves as the physician advisor for UTMCK’s clinical documentation integrity program, coding, and RAC response. Contact him at clachari@utmck.edu.