CODING & DOCUMENTATION

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Venipuncture at a follow-up visit

Q What documentation is required when a medical assistant performs venipuncture on a date when the patient is not seen by the physician?

A The documentation should refer to the written lab order by date and location (e.g., "in the 8/31/16 progress note") and list the date of venipuncture, time, site, and patient tolerance of the procedure. All documentation should include the legible signature (written or electronic) and credentials of the individual performing the service.

Debridement of subcutaneous tissue

Q Which CPT code should be reported for debridement of subcutaneous tissue on two separate wounds?

A Code 11042, "Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 cm^2 or less," is reported once for the first 20 square centimeters or less of the combined wound surface measurements. When multiple wounds are debrided at the same level, use the sum of their surface areas in code selection. However, if multiple wounds are debrided at different levels, report separate codes for each wound (e.g., 11042 for debridement of subcutaneous tissue *and* 11043 for debridement of muscle and/or fascia). Code 11045 may be reported for each additional 20 square centimeters.

Body mass index

Q We have been advised that due to new ICD-10 guidelines, codes for body mass index (BMI) should be reported only when the BMI impacts the care of the patient. However, measuring and reporting the BMI is tied to a quality initiative. Can we report BMI codes when the measurement is necessary for this purpose?

A Yes. The BMI code is a status code that may be reported to indicate that a patient's body mass was incorporated into the clinical evaluation of the patient's health status. It is always a secondary code to the primary reason for an encounter (e.g., well-visit, weight loss, obesity, etc.). The latest guidelines did add instructions stating that the BMI codes (Z68.-) should be reported only when they meet the definition of a reportable diagnosis as defined in Section III of the guidelines. However, Section III generally does not apply to outpatient or office services. Clinical guidelines for assessing a patient's BMI support clinically evaluating the result in relation to the patient presentation, comorbidities, etc., and thus support reporting the BMI code.

Stasis ulcers

Q What is the correct diagnosis code for a stasis ulcer?

A Report code I87.2, "Venous insufficiency (includes stasis dermatitis)," when the diagnosis is stasis ulcer without diagnosis of varicosities. You can confirm the correct code category by looking up the term "Ulcer, stasis (venous)" in the alphabetic index. It directs you to "see Varix, leg, with ulcer," which has the subterm "without varicose veins," which specifies code I87.2.

If varicosities are present, codes in category I83, "Varicose veins of lower extremities," may be used for reporting varicosities with ulcers or with ulcers and inflammation. FPM

Editor's note: Some payers may not agree with the advice given. Refer to current coding manuals and payer policies.

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About the Author

Cindy Hughes is an independent consulting editor. Author disclosure: no relevant financial affiliations disclosed. These answers were reviewed by members of the *FPM* Coding & Documentation Review Panel, including Kenneth Beckman, MD, MBA, CPE; Robert H. Bösl, MD, FAAFP; Marie Felger, CPC, CCS-P; Thomas A. Felger, MD, DABFP, CMCM; Emily Hill, PA-C; Joy Newby, LPN, CPC; and Susan Welsh, CPC, MHA.