

Dermatology Coding Alert

Closures: Simple, Intermediate, Complex Closures: A Many-Layered Coding Decision

Dermatologist's documentation is the key.

All closures aren't created equal; one of the nuances of coding these procedures is knowing how to distinguish one type from another. Read on for our experts' advice on how to assess the three closure levels and assign the best codes.

Remember 'Simple' Doesn't Mean 'Easy'

A simple repair involves primarily the dermis and epidermis. It might involve subcutaneous tissues, but not deep layers.

Draw the line: How do you know when a closure might involve subcutaneous layers but is still considered a simple repair? Your provider's documentation is the key. The difference is whether the wound is closed in layers or just a single layer, experts note. The provider might decide to include the subcutaneous layer in the closure but does so by bringing the needle through the dermis into the subcutaneous and back. That results in a single-layer closure rather than closing the subcutaneous layer first and then the dermis/epidermis second in separate closure techniques.

But "simple" doesn't mean the repair is something anyone could do. Simple repairs involve one-layer closure, which helps set them apart from a standard E/M procedure. Simple repair also includes local anesthesia, and chemical or electrocauterization of wounds not closed.

For example, if your dermatologist uses adhesive strips to close a laceration, consider it an E/M service that you'll report with the best-fitting choice from codes 99201-99205 (Office or other outpatient visit for the evaluation and management of a new patient ...) or 99211-99215 (Office or other outpatient visit for the evaluation and management of an established patient ...). Most Steri-strip applications are done by nursing staff; but even if the physician applies them, they're included in the E/M service.

If, however, your dermatologist uses sutures, staples, or tissue adhesives to close the laceration, consider it a separate procedure. Choose your code from 12001-12007 (Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities [including hands and feet] ...) or 12011-12018 (Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes ...), based on the lesion's location and size.

Measuring tip: "For excision of soft tissue tumors, measure the repair itself, which is generally much larger than the actual tissue being removed," says **Pamela Biffle, CPC, CPC-P, CPC-I, CCS-P, CHCC, CHCO**, owner of PB Healthcare Consulting and Education Inc. in Austin, Texas.

Better bet: Measure the repair when the closure has been completed, Biffle says.

Medicare exception: Guidelines change when your physician performs a single-layer laceration repair using a tissue adhesive on a Medicare patient. You'll report G0168 (Wound closure utilizing tissue adhesive[s] only) instead of reporting standard CPT® codes. If your physician uses sutures instead of tissue adhesive for Medicare patients, turn back to the standard suture/repair codes.

Go Deeper With Intermediate Repair

When you see the term "intermediate repair," it means your physician performed one of two things:

- Layered closure of one or more deeper layers (subcutaneous and superficial fascia/non-muscle) in addition to skin; or
- Single-layer closure of heavily contaminated wounds requiring extensive cleaning.

Find your intermediate repair codes at 12031-12037 (Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities [excluding hands and feet ...]); 12041-12047 (Repair, intermediate, wounds of neck, hands, feet and/or external genitalia ...); and 12051-12057 (Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes ...).

Wound cleaning doesn't automatically equal an intermediate-level repair, however. Most lacerations will have some degree of particulate matter removed. In order to assign an intermediate repair, the work involved in removing the matter must be extensive and above what is considered normal removal or cleaning.

In other words: If you classify a procedure as intermediate because of the contamination level and cleaning, be sure you have the documentation to back it up. Carriers will want notes regarding how extensive the wound was, the level of work involved in cleaning, and the amount of time spent on the procedure.

Look for any verbiage that will help describe the extra work involved. The use of words like "extensive," "heavily contaminated," "large," or "copious amounts" of particulate matter or debris will all help the carrier understand that the cleaning is above and beyond that of a normal wound preparation.

Sort Through Complex Repair Choices

Complex repair procedures are more than multilayered closure and include a wide range of possibilities such as scar revision or involved debridement. Complex repair generally includes extensive undermining, stenting, or retention sutures. Complex repair is very time-consuming.

The complex repair codes are broken into more families, helping your coding be more accurate:

- 13100-13102 □ Repair, complex, trunk ...
- 13120-13122 □ Repair, complex, scalp, arms and/or legs ...
- 13131-13133 □ Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet ...
- 13150-13153 □ Repair, complex, eyelids, nose, ears and/or lips ...
- 13160 □ Secondary closure of surgical wound or dehiscence, extensive or complicated.

Consider more than layers when you think it's time to report complex repair codes. Your physician's documentation should include notes about correcting a defect, performing extensive tissue debridement, or even creating a defect in order to repair a problem. For example, plastic surgeons tend to perform many complex repairs because the wounds they close often require a lot of preparation with undermining, retention, and debridement of large skin areas. Many times they use a layered closure technique.

What it's not: Sometimes your physician might perform lesion excision as part of a complex repair. The repair codes do not include excision, so in those situations you'll report separate codes for the excision and repair. Excision of lesions is not included in complex repair and therefore would be coded separately. However, intermediate or complex closure of a lesion removal (benign or malignant) is not included as part of lesion removal, either. As long as the closure is intermediate or complex, you should also apply a separate charge for the closure.

Example: Your physician removes a 2.5 cm benign lesion (including margins) from the patient's mid-back. He closes the wound in layers after extensive irrigation and undermining of tissues. When filing the claim, you should report 11403 (Excision, benign lesion including margins, except skin tag [unless listed elsewhere], trunk, arms or legs; excised diameter 2.1 to 3.0 cm) for lesion excision and 13100 (Repair, complex, trunk; 1.1 cm to 2.5 cm) for complex repair.

Final advice: Look at the provider's closure description and do not code by the wound description. Many providers may describe a complex wound but then close it with a simple technique.