Dermatology Coding Alert

How Accurate Is Your Wound Repair Coding?

A simple checklist helps you collect your pay

You can improve your wound repair reimbursement if you understand how to report such services as debridement and the different wound complexity levels. Coding experts offer the following tips for improving your wound repair and closure reimbursement.

Report Debridement Services

Wound debridement is included in the repair when the wound is simple - that is, without involvement of deeper structures (involving the epidermis, dermis or subcutaneous tissues only), says **Linda Martien, CPC, CPC-H**, coding expert at National Healthcare Review Inc. in Woodland Hills, Calif. But you code debridement separately along with the repair when the repair is intermediate and/or complicated, or when the wound requires extensive cleaning or removal of particulate matter, she says. When the closure requires extensive cleaning and/or removal of matter, the repair goes from a simple repair to an intermediate repair, Martien says.

If you are coding for a more complicated procedure that requires staples, sutures or similar closure materials, ask yourself these four questions to help determine the correct coding:

1. Can the repair be classified as simple, intermediate or complex? CPT organizes repair codes by complexity of the treatment. Here\'s a brief list to help you determine the several layers of closure:

1. **Simple repairs** (12001-12021) include superficial wounds of the epidermis or dermis and subcutaneous tissue, requiring one-layer closure. Simple repair is included in most of the excision procedures.

2. **Intermediate repairs** (12031-12057) require additional layered closure of one or more deeper levels of subcutaneous tissue or superficial fascia, excluding muscles.

3. **Complex repairs** (13100-13160) are even more extensive and might include scar revision, extensive undermining, stents or retention sutures.

2. What part of the body is injured? When reporting simple or intermediate repairs, you must also consider that the codes refer to different locations of the body. For instance, codes 12001-12007 refer to simple repairs on the scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet), but codes 12031-12037 refer to intermediate repairs of wounds of the scalp, axillae, trunk and/or extremities (excluding hands and feet).

3. How large is the wound? Once you determine the complexity of the repair and the site of the wound, you assign a specific code reflecting the length of the injury. For example, 12002 refers to a 2.6-cm-to-7.5-cm simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet).

4. Are there multiple wounds? If a patient has multiple wounds on the same body category, then you add the lengths of the wounds together to find the appropriate code. For example, the dermatologist repairs a wound on a patient\'s hand that measures 3.7 cm. The dermatologist also repairs another wound on the patient\'s neck that measures 2.1 cm. You would add up the two areas (3.7 + 2.1 = 5.8 cm) and report 12002 in this example because the sum of the wound lengths falls between 2.6 cm and 7.5 cm and the wounds fall in the same appropriate body category. If the closures are in different body categories or require different levels of repair, each relevant code is reported with modifier -59 (Distinct procedural service).

Modifier -59 Is Key to Multiple-Excision Reporting

But don\'t confuse multiple wound repair with multiple excisions. When reporting multiple excisions, do not \"add together\" the excised diameter of the lesions, as you would add together the lengths of multiple wounds for wound repair. Rather, report each excision independently. \"It\'s more work to excise two 1-cm lesions than a single 2-cm lesion,\" says **Laureen Jandroep, OTR, CPC, CCS-P, CPC-H, CCS**, director and senior instructor for CRN Institute, an online coding certification training center based in Absecon, N.J. \"If you add together the two 1-cm lesions and report it as a single 2-cm lesion, you\'re losing reimbursement and tainting the medical record. What you\'re coding is not an accurate representation of what the physician did.\"

When reporting multiple excisions, you should attach a verifiable diagnosis to each individual removal code. In addition, append modifier -59 to the second and subsequent codes to indicate the separate nature of each lesion and to avoid \"duplication\" denials. For example, if the dermatologist removes three lesions from the left arm - sizes 1 cm (benign), 1.5 cm (benign), and 2.5 cm (malignant) - report 11401 with 216.6 (Benign neoplasm of skin; skin of upper limb, including shoulder), 11402-59 with 216.6, and 11603-59 with 173.6 (Other malignant neoplasm of skin; skin of upper arm, including shoulder). Remember to measure the size based on the margins excised, not just the apparent lesion.

Modifier -25 Reduces Denials When You Report E/M

When a patient sees the dermatologist for a separate condition, you can report both codes, but make sure you append modifier -25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service).

For example, an established patient makes an appointment to see the dermatologist for examination of a suspicious-looking or abnormally acting skin lesion. While the dermatologist is doing the exam (for which the dermatologist will assign an E/M code), the patient mentions that he has a festering thorn in his hand from pruning his roses. In addition to the lesion exam, the dermatologist performs an I&D and removes the thorn from the patient\'s hand. For this encounter, the dermatologist assigns the E/M established patient code with modifier -25 and the I&D code 10120 (Incision and removal of foreign body, subcutaneous tissues; simple). The physician also charges for supplies used, says **Linda Martien, CPC, CPC-H**, coding expert at National Healthcare Review Inc. in Woodland Hills, Calif.

Adequate and accurate charge capture for all procedure charges is essential and requires meticulous documentation, Martien says. This is particularly important when documenting wound care. There are relatively new codes for wound care alone, so be aware of the guidelines that state, \"Procedures are performed to promote healing, and involve selective and nonselective debridement techniques.\" Wound care in the process of treatment of a lesion/wound is included in the procedure, Martien says.