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Dermatology Coding Alert

Laceration Repair: 5 Tips to Stitch Up Your Laceration Repair Coding Errors

Information particularly location, length, and type of repair provides the power to get to the right CPT® code.

CPT® includes several rules with numerous variables to guide coding for wound repair or closure. You must consider wound severity and location to determine the appropriate code from the repair section. And variables such as depth of the wound, method of closure, and degree of contamination of the site can complicate your choice further. However, you can greatly simplify even the most confusing scenarios by using these five tips from our experts.

Tip 1: Determine the Location

Within each level of repair, CPT® further classifies wounds according to anatomic location. Note that these categories are not identical for each repair level, says **Todd Thomas, CPC, CCS-P**, President of ERcoder, Inc. in Edmond, Okla.

Example: For simple repairs, CPT® groups the scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet) together as covered by 12001-12007.

For intermediate repairs, 12031-12037 describe layered closure of wounds of scalp, axillae, trunk and/or extremities excluding hands and feet, while 12041-12047 apply for repair of wounds to neck, hands, feet and/or external genitalia.

For complex repairs, the subclassifications are still more precise, with separate sections for trunk; scalp, arms and/or legs; forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet, etc.

Tip 2: Consider Wound Severity

After you have determined that the repair or closure codes apply and the location of the wound, you must assess the severity of the wound itself, says Thomas.

CPT® classifies repairs as simple, intermediate or complex, according to wound depth, with each category receiving its own complement of codes.

Simple repairs are superficial wounds that involve primarily epidermis or dermis, or subcutaneous tissues without significant involvement of deeper structures, according to CPT®. Additionally, CPT® stresses only simple, one layer, primary suturing is required. Physicians will refer to these as single-layer closures. CPT® code range 12001-12021 covers such repairs, which include local anesthesia and chemical or electro-cauterization of wounds left unclosed.

Intermediate repairs are more extensive and involve one or more of the deeper layers of subcutaneous tissue and superficial (non-muscle) fascia, in addition to the skin (epidermal and dermal) closure, according to CPT®. If the physician mentions layered closure, you probably have an intermediate repair.

A single-layer closure may qualify as an intermediate repair if the wound is heavily contaminated and requires extensive cleaning or removal of particulate matter. A common example of this is repair of road rash wounds that result from falling on gravel, blacktop or concrete surfaces, says Thomas.

CPT® code range 12031-12057 describes intermediate closures.

Complex repairs involve more than layered closure, such as extensive undermining, stents or retention sutures. If the physician mentions repair to the depth of muscle or deeper, it's probably a complex repair.

Complex repairs are often reconstructive procedures and include creation of a defect to be repaired (for instance, excision of the scar and subsequent closure). Such repairs do not, however, include excision of lesions.

Coding for complex repairs differs slightly from coding for other wound repairs. With complex repairs, CPT® assigns add-on codes for each additional 5 cm beyond 7.5 cm. You may bill multiple units of these add-on codes when necessary.

Report complex repairs using code range 13100-13160.

To determine the level of repair, pay close attention to the operative report. Single-layer closures are generally simple unless the physician has noted extensive cleansing of the wound, in which case they may be intermediate. Dual-layer closures are considered as intermediate. Extensive revision or repair of traumatic lacerations or avulsions are considered complex, says Thomas.

Tip 3: How Was It Closed?

Before you can code for wound closure, you must determine if the wound repair or closure codes apply.

If the doctor determines that the severity of the laceration does not warrant stitches, staples, or tissue adhesive, and instead closes the wound using Steri-strips or butterfly bandages, however, you may report only the appropriate E/M service code, as supported by the chart documentation.

According to CPT®, codes 12001-13160 designate closure utilizing sutures, staples, or tissue adhesive (such as 2-cyanoacrylate), either singly or in combination with each other, or in combination with adhesive strips. Although CPT® does not differentiate among stitches, staples and tissue adhesive, and the coding does not change regardless of the physician's method of closure, Medicare has different rules, Thomas warns.

Effective January 1, 2000, a new HCPCS code, G0168 (Wound closure utilizing tissue adhesive[s] only), was established for Dermabond or other tissue adhesive applications. G0168 is defined as "wound closure utilizing tissue adhesive(s) only." The rationale for this code and its RVU assignment is based on FDA data that show wounds closed with tissue adhesives take, on average, one-quarter of the time needed to close a wound with traditional method of treatment, including use of wound closure tapes. As a result, the payment for repair using adhesives is less than one using sutures.

For 2016, the Medicare facility payment for code 12001 (Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities [including hands and feet]; 2.5 cm or less) is $45.47 while the payment for G0168 is $28.64, says Thomas.

Caution: Adhesive strips alone don't qualify for wound repair. If the physician closes the wound using adhesive strips only, you may not report the repair or closure codes. Instead, you would report wound closure using adhesive strips as the sole repair material as a part of any E/M service the physician provides.

This creates a divergence between CMS policy and CPT® rules as well as a difference in code choice for simple versus intermediate or complex repairs. For non-Medicare patients, you'll code for a simple laceration repair with adhesives with the applicable 12xxx CPT® code. If it is an intermediate or complex closure code for it with the appropriate CPT® code, regardless of whether adhesives was used or not.

But for Medicare patients, you'll code for a simple laceration repair with adhesives with G0168, and an intermediate or complex closure with the appropriate CPT® code regardless of whether adhesive was used or not, since sutures would

be used for the deeper layers, explains Thomas.

Tip 4: Measure It and Add It Up

In addition to severity (depth) and anatomic location, CPT® groups repair and closure procedures according to the size (length) of the wound.

Example: Code 12001 describes simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less, whereas 12004 (Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities [including hands and feet]; 7.6 cm to 12.5 cm) describes repair of the same severity and location, but of 7.6 cm to 12.5 cm length.

Remember: Reporting should be based on the size of the wound. Under the "Repair (Closure)" section, the first instruction for coding is to report the size of the repaired wound. It is important to note that depending on the type of repair performed, some wounds will have a final defect size that is greater than the original defect size. Base your CPT® code assignment on the documented wound size, which is typically performed after cleaning of the wound and prior to repair, Thomas warns.

Don't Forget To Combine Similar Repairs When Indicated

After you have determined the location, length, classification, and means of closure for all individual repairs or closures, add together the lengths of the various wounds at each identical level of severity and classified anatomic location to arrive at a total length. CPT® treats all wounds at the same level of severity and anatomic subcategory as a single wound, says Thomas.

Tip 5: Consider the Global Period

Medicare rules for simple repairs can differ from those for intermediate and complex codes. Medicare changed the payment policy for simple laceration repairs starting in 2011 by changing the global surgical package from ten days to zero days. Since then, the follow-up visit for a wound check and suture removal is no longer included in the payment for suturing, stapling or using tissue adhesives on superficial wounds primarily involving the epidermis or dermis without deeper damage.

This change came about in part because Medicare officials did not believe it was typical for emergency department patients to return to the ED where the sutures were placed to have them removed ten days later, says **Caral Edelberg, CPC, CPMA, CAC, CCS-P, CHC**, Chief Executive Officer of Edelberg+Associates in Baton Rouge, La.