

Dermatology Coding Alert

Wound Repair: 12001 or 14000? Choose Wisely Between Tissue Transfers and Wound Repairs

3 steps help your dermatologist get the reimbursement he deserves.

When a dermatologist closes a wound, it's easy to gravitate toward the repair codes (12001- 13006). But if the documentation shows that the dermatologist performed a tissue transfer (14000-14302), those codes might be more appropriate, and more lucrative. Follow these three steps to make sure you're coding accurately, ethically, and profitably.

1. Get to Know the Difference Between Transfers and Repairs

For wound closure procedures, you'll first need to decide between wound repair codes 12001-13160 and adjacent tissue transfer codes 14000-14302 (Adjacent tissue transfer or rearrangement ...).

The basics: In simplest terms, if your surgeon only cleans and sutures the wound you'll choose a simple, intermediate, or complex repair code (12001-13160).

However: Intermediate and complex repairs may require freeing tissue as well, says **Pamela Biffle, CPC, CPC-P, CPC-I, CCS-P, CHCC, CHCO**, owner of PB Healthcare Consulting and Education Inc. in Austin, Texas. "What the average coder needs to look for is the word 'plasty' or 'flap,'" she says.

If your surgeon documents that he freed tissue from around the wound and rearranged it to cover and repair the wound area, you're dealing with a tissue transfer and need to turn to 14000-14300.

The wound repair/closure CPT® codes 12001-13160 describe direct wound closure employing sutures, staples, or tissue adhesives (cyanoacrylate), say experts. The tissue transfer CPT® codes 14000-14302 are used for the repair of traumatic wounds and for the excision of a lesion (benign or malignant) and the repair of the resulting "primary defect" (and the resulting "secondary defect") by adjacent tissue transfer or rearrangement (including Z-plasty, W-Plasty, V-Y plasty, rotational flap, random island flap, or advancement flap).

Other types of flaps are reported two other places in CPT®: "Flaps (Skin and/or Deep Tissues)" (15570-15738) and "Other Flaps and Grafts" (15740-15776). Traumatic wounds that incidentally result in one of these configurations are not reported with these codes.

Tip: One easy way to determine if your dermatologist performed a tissue transfer is to look for a flap creation that results in a "secondary defect" in addition to the "primary defect" of the wound itself. The primary defect is the one being repaired, and the secondary defect is the defect created by lifting or removing the adjacent tissue.

The size and how this secondary defect is repaired will depend on the type and location of flap and the size of the primary defect as to whether the secondary defect can itself be closed primarily or may be need a separate skin graft for closure.

Keep in mind that you can separately report any skin grafting necessary for closure of the secondary defect, as follows:

- 15100-15136 for autologous skin grafts
- 15150-15157 for autologous tissue-cultured epidermal grafts
- 15040 for autologous keratinocytes and dermal tissue harvesting for tissue cultured skin grafts
- 15271-15278 for acellular dermal replacement.

Bottom line: During a procedure described by 12001-13160, the dermatologist will not create a secondary defect. Undermining a wound without an additional incision(s) is not considered as an adjacent tissue transfer, experts say.

2. Determine Overall Area and Location

Once you determine that your dermatologist performed a tissue transfer, you'll need to narrow down your code selection by determining the total area of the primary and secondary defects, according to CPT® instructions.

After adding up the affected area, look at the repair's anatomical location to narrow your choices even further.

Example: Your dermatologist removes a lesion measuring 2 cm x 2 cm from a patient's back including margins. To repair this primary defect, the surgeon creates a flap measuring 4 cm x 2.5 cm.

To determine the total area, add together the area of the primary defect ($2 \times 2 = 4$ sq cm) and the area of the secondary defect ($4 \times 2.5 = 10$ sq cm) for a total area of 14 sq cm. In this case, you should choose 14001 (Adjacent tissue transfer or rearrangement, trunk; defect 10.1 sq cm to 30.0 sq cm) for a repair totaling 14 sq cm on the back.

Remember: When you're reporting tissue transfers, you should report each repair separately. This is different from wound repair coding using 12001-13160. For wound repairs, CPT® instructs you to use one code to describe the repair, even if it involves more than one wound.

This is not true of adjacent tissue transfers, however. Multiple wounds repaired in the same anatomic location and with the same classification (simple, intermediate, or complex) are grouped together by adding the all the lengths of repair into the same CPT® descriptor. This is not true for adjunct tissue transfer.

How it works: For each adjacent tissue transfer repair, report one code based on the defect's size.

3. Skip Separate Lesion Removal Coding

You should not separately report any lesion removals your surgeon performs during a tissue transfer procedure. The excision of the benign lesion (CPT® 11400-11446) or of the malignant lesion (CPT® 11600-11646) is not separately reported with the tissue transfer codes (CPT® 14000-14302). Both CPT® and CMS/Correct Coding Initiative guidelines reinforce this guidance.

Exception: If your surgeon performs an excision on a separate day from the tissue transfer, you may report the procedures separately. You might see this scenario if your surgeon is waiting for the pathology report to be sure the lesion margins are clear before closing the operative wound. If the tissue transfer occurs during the excision's 10-day global period, append modifier 58 (Staged or related procedure or service by the same physician during the postoperative period) to the tissue transfer code.