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Internal Medicine Coding Alert

4 Tips Help Repair Your Laceration Coding

Experts show you when to use intermediate repair codes

When it comes to laceration repair coding, internal medicine coders may be costing their internists proper reimbursement and not even know it. Coders often resort to simple repair codes (12001-12021) when they could easily - and more accurately - report intermediate services (12031-12057). Before you report another laceration service, review these four tips offered by coding experts.

1. Look for layer descriptions in your physician's chart notes.

To properly choose between simple (12001-12021) and intermediate (12031-12057) repair codes, you'll have to rely on your internist's chart notes to make the right selection. To make your job easier, encourage your physician to use specific terms to describe the kind of laceration he or she repaired. This way, you can more easily select the appropriate code, says **Catherine Brink, CMM, CPC**, president of HealthCare Resource Management Inc. in Spring Lake, N.J.

For example, if your internist describes a 2.2-cm wound as superficial and notes that the wound primarily involves the epidermis or dermis, or subcutaneous tissues without significant involvement of deeper structures, he will probably perform a simple one-layer closure. In that case, you could report 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).

On the other hand, when your internist performs intermediate repair, he or she treats wounds that include the simple repair services. This work requires layered closure of one or more deeper layers of subcutaneous tissue and superficial fascia, Brink says. Sometimes internists fail to mention intermediate repair or how many layers they closed.

Your physician should use terms such as "deeper layers of subcutaneous and superficial (nonmuscle) fascia," "layered closure" or "deep layer suturing" to indicate that he or she performed an intermediate repair.

Let's say your internist sutures a deep subcutaneous scalp wound that requires layered closure, but he fails to report that in his notes. More than likely, you will not know that your physician performed an intermediate repair. So, you will use 12001 instead of the more accurate and higher-paying 12031* (Layer closure of wounds of scalp, axillae, trunk and/or extremities [excluding hands and feet]; 2.5 cm or less).

2. Document extensive cleaning to up complexity.

Make sure your internist documents the extent of debridement he or she performs. Although intermediate repair usually requires layered closure, you can report appropriate intermediate codes if your physician performs a single-layer closure of heavily contaminated wounds that require extensive cleaning or removal of particulate matter, according to CPT guidelines.

But your physician may forget to include the cleaning details when recording laceration services. Therefore, you would not know that the repair qualifies for an intermediate repair code and will use a simple repair code instead.

For example, after a skating accident, a patient presents to your internist with a 7.6-cm gash on his right knee and shin. Because the accident occurred on a gravelly road, the cut contains a lot of gravel and dirt, which requires your physician to thoroughly clean the wound. If your internist writes "Sutured 2.7-cm wound, knee/shin" and fails to include "extensive debridement," you might report 12002* (... 2.6 cm to 7.5 cm), which contains 4.24 relative value units (RVUs) and reimburses on the Medicare Physician Fee Schedule at $155.99, instead of the more accurate 12032* (... 2.6 cm to 7.5

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cm). Because 12032 has 5.6 RVUs and pays $206.02, this error would sacrifice $50 ($206.02 - $155.99 = $50.03) in payment.

3. Get to know the multiple-laceration formula.

Although reporting a single or intermediate repair may now seem simple, learning the multiple-laceration formula will require you to ratchet up your coding skills. So, don't be so fast to blame poor chart notes for all of your coding mistakes. To effectively report laceration services and receive proper reimbursement, you must know how to bill what the chart report contains, says **Marti Geron, CPC, CMA, CM**, coding and reimbursement manager, the University of Texas Southwestern, in Dallas.

When you combine several repairs, you must base them on repair class, such as simple or intermediate, and the anatomic site. To report several repairs, first tally the number of wounds in the same classification. If the wounds occur in the same anatomic area, such as the knee or stomach, and your physician assigns them the same repair class, such as simple or intermediate, add the repairs together for one total.

Pay attention to CPT body groupings, because these may change according to a repair's class. For instance, CPT includes hands, feet and/or extremities in the same anatomic site for simple repairs (12001-12007). The intermediate repair codes for extremities (12031-12037) exclude hands and feet, however.

For example, your internist repairs a 3.2-cm superficial wound on a patient's right hand and a 5.4-cm simple laceration on the patient's arm. Because your internist classifies the wounds in the same class and in the same anatomic site grouping, you should total the measurements (3.2. cm + 5.4 cm = 8.6 cm) and report one code: 12004* (... 7.6 cm to 12.5 cm), Brink says.

4. Use -51 to report dissimilar lacerations.

Typically, not all patient wounds will be located in the same anatomic site, so you'll need to know how to report dissimilar lacerations. When you report such lacerations separately, make sure you use the proper modifier on the right code.

CPT specifies that you should list the more complicated laceration repair as the primary procedure and the less complicated as the secondary procedure when you assign codes for repairs in different classifications or groupings. To further emphasize to payers that you're reporting multiple procedures, you could append modifier -51 (Multiple procedures) to the subsequent code, such as 12001, for instance. Based on multiple-procedure rules, the payer may reduce payment for the secondary procedure by 50 percent. Be sure to check with your payer for specific guidelines when reporting multiple procedures.

Be careful when you append -51 to a code. The more complicated procedure will have more RVUs and a higher reimbursement rate than the less complicated procedure. Therefore, reversing the order will lessen your practice's revenue, Geron says.

For example, suppose your internist treats a patient with three cuts: a 2.8-cm superficial wound on his left shoulder, a 1.1-cm simple laceration on his left ear, and a 3.9-cm wound on his knee that requires layered closure. To code this treatment, follow the earlier classification and grouping recommendations. First look at the two repairs that require simple closure. Although the shoulder and ear wounds fall in the same class, they are not in the same anatomic group. So, you should separately report each repair. For the 2.8-cm simple repair on the shoulder, you should assign 12002. For the 1.1-cm superficial ear laceration, you should use 12011* (Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less). You should assign 12032 for the intermediate knee repair, Geron says.

Even though you have determined the appropriate codes, your work is not over - you still need to put them in the right order. Start with the most complicated procedure, which contains the most RVUs: 12032. All subsequent codes will require modifier -51 to indicate they are multiple procedures. The next two codes, 12011 and 12002, contain the same

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RVUs (4.24). Therefore, as your second code, you may list 12011-51 or 12002-51.

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