# Internal Medicine Coding Alert

## Reader Question: Laceration Repair Procedure Requires Appropriate Diagnosis Codes

**Question:** Our internist recently reviewed a 21-year-old established male patient who had received a laceration from a nail. The wound was in his right cheek and it was abut 1.5cms long. The physician repaired the laceration by suturing the wound. What code(s) should I report for this patient?

Illinois Subscriber

**Answer:** You have not mentioned how deep the laceration was. Assuming that the laceration was not too deep and your clinician just placed simple suture to repair the wound, you will have to report the CPT® code 12011 (Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less) for this procedure that your clinician performed.

In addition, you may be able to report an appropriate E/M code for the evaluation of the patient, if the documentation supports that the evaluation and management of the patient was significant and separately identifiable from the laceration repair. Since the patient was an established patient to the practice, you will have to report the most appropriate established E/M code with the modifier 25 appended for this encounter.

You will also have to support the CPT® code and the E/M code that you are reporting using appropriate diagnosis codes for the encounter. For this encounter, you will need to report S01.411A (Laceration without foreign body of right cheek and temporomandibular area, initial encounter) and W45.0XXA (Nail entering through skin, initial encounter) as your diagnosis codes.