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4 Rules Repair Your Laceration Coding

Experts reveal when to report intermediate repair codes

If you resort to simple repair codes (12001-12021) when you could easily -- and more accurately -- report intermediate services (12301-12057), you may be losing reimbursement and not even know it.

You can get the laceration repair coding payment you deserve by knowing when to report higher-paying intermediate laceration repairs. Use the following four expert coding recommendations to get started:

1. Look for Layer Descriptions

When choosing between simple (12001-12021) and intermediate (12031-12057) repair codes, encourage your physician to use specific language. 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 physician documented a 2.2-cm superficial wound that primarily involved the epidermis, dermis or subcutaneous tissues without significant involvement of deeper structures, he probably performed a simple one-layer closure. In this case, you would 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, if your physician performs an intermediate repair, he treats wounds that include the simple repair services but also require layered closure of one or more deeper layers of subcutaneous tissue and superficial fascia, Brink says.

Hint: Look for the key phrase, "layered closure." Other terms that may signal an intermediate repair include "deeper layers of subcutaneous and superficial (nonmuscular) fascia," "layered closure" or "deep layer suturing."

2. Get Down and Dirty to Up Complexity

Although intermediate repair usually requires layered closure, you often can report intermediate codes when your pediatrician performs a single-layer closure of heavily contaminated, or "dirty," wounds. According to CPT guidelines, extensive debridement or cleaning of wounds as part of a repair qualifies the service as intermediate.

Your physician may forget to include the cleaning detail when documenting laceration services. Explain to your physician that omitting these details could easily cost him $50 per repair.

For example: After a skating accident, a patient presents 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 debris. Your physician thoroughly cleans the wound before performing a single-layer repair. If she documents "sutured 2.7-cm wound, knee/shin" and fails to include "extensive debridement," you would report 12002 (... 2.6 cm to 7.5 cm). The average fee for 12002 according to the 2004 Physician Fee Schedule is roughly $78. The average fee for 12032 (... 2.6 cm to 7.5 cm) -- the intermediate repair code you could have reported had the documentation included "extensive debridement" -- is approximately $147 -- a nearly $70 difference.

3. Know the Multiple-Laceration Formula

Ratchet up your coding skills: You may have mastered how to identify intermediate repairs, but you still have to learn how to categorize multiple lacerations.

To effectively report laceration services and receive proper reimbursement, you must know how to bill all of the services the chart report contains, says **Marti Geron, CPC, CMA, CM**, coding and reimbursement manager at the **University of Texas Southwestern** in Dallas.

When your physician documents several repairs in one patient encounter, you have to identify each repair class (such as simple or intermediate), and the wound's anatomic site. To code multiple repairs, first tally the number of wounds in the same classifications. If the wounds that fall into the same classification occur in the same anatomic area, such as the knee, add the repairs together for one total.

For example: If your physician repairs a 3.2-cm superficial wound on a patient's right knee and a 5.4-cm simple laceration on that same knee, 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 for Dissimilar, Unbundled Lacerations

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 and the right code.

CPT guidelines specify that you should list the more complicated laceration repair as the primary procedure when you assign codes for repairs in different classifications or groupings. To inform payors that you're reporting multiple procedures, you should append modifier -51 (Multiple procedures) to the subsequent code, such as 12001, for instance. Based on Medicare multiple-procedure payment rules, the payor may reduce payment for the secondary procedure by 50 percent. Remember to list the most complicated, highest paying procedure first without modifier -51 so you will receive 100 percent of the greatest fee.

For example: Suppose your physician 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 required layered closure. Following the classification and grouping recommendations, 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, report 12002. For the 1.1-cm superficial ear laceration, report 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.

Put the codes in order starting with the most complicated procedure (the one with the greatest RVUs), 12032. Next list 12011 and 12002 and append modifier -51 to each of these codes.

Be careful: For payors that follow the National Correct Coding Initiative (NCCI), make sure to check whether the edits bundle the laceration codes that you are reporting. If NCCI bundles the laceration codes, you should use modifier -59 (Distinct procedural service) to indicate a separate site and override the edits instead of using modifier -51.

Suppose that in the above example the boy instead has a 2.8-cm superficial wound on his left shoulder (12002) and a 2.6-cm simple laceration on his right check (12013, ... 2.6 cm to 5.0 cm). In this case, because NCCI bundles 12013 into 12002, you should append modifier -59 to the component code (12013-59) to indicate a separate injury. Thus, both lacerations are separately reportable.