Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Orthopedics: Bolster Closure Coding With These Expert Tips

Here's how the definition of complex repair changed recently.

Though broken bones, torn ligaments, and cracked clavicles are at the top of most orthopedists' to-do lists, wound closures are also of great importance. And ortho coders need to understand the various nuances to ensure their coding is correct.

During their presentation at the HEALTHCON Regional 2021 in Charleston, South Carolina, we got the word on wound closure from **Sandy Giangreco Brown, BS, CHC, RHIT, CCS, CCS-P, CPC-I, COBGC, COC, PCS,** and **Kim Heuy, MJ, CPC, CPCO, COC, CHC, CCS-P, PCS**.

Here's what they had to say.

Single Layer (Usually) Means Simple Repair

For simple repairs, the wounds involve "primarily epidermis or dermis or subcutaneous tissue without significant involvement of deeper structures," Brown and Huey explained. Simple repairs always involve uncomplicated one-layer closures.

You'll code simple repairs with the following codes, depending on encounter specifics:

- 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) through 12007 (... over 30.0 cm)
- 12011 (Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less) through 12018 (... over 30.0 cm)

Intermediate Repair Must Surpass Simple Definition

For intermediate repairs, the wounds are characterized by all of the traits of simple repairs, plus "layered closure of one or more layers or heavily contaminated wound. It can be a single layer, but need extensive cleaning or removal or particulate matter," Brown and Huey said.

You'll code intermediate repairs with the following codes, depending on encounter specifics:

- 12031 (Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.5 cm or less) through 12037 (... over 30.0 cm)
- 12041 (Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 2.5 cm or less) through 12047 (... over 30.0 cm)
- 12051 (Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less) through 12057 (... over 30.0 cm)

Beware Bundles When Considering Simple, Intermediate

In an orthopedic practice, you won't be coding for a number of your provider's simple or intermediate repairs.

Why? In orthopedic surgery, virtually all of the simple or intermediate repairs will be bundled into the surgical code. If the patient reports with an open fracture, the provider will almost certainly have to perform wound closure in addition to fracture repair. If these repairs are simple or intermediate, they are typically bundled into the surgical code.

Best bet: Keep it simple; go to the provider for questions about any wound closure, regardless of complexity, that you have questions about. Given the number of uncoded wound closures you're likely to come across in your coding, it's better safe than sorry.

Possible Exception Lies in Different Anatomical Areas

Wound repair closure is usually only coded separately if it is the only procedure your provider performed. It bundles into almost all musculoskeletal procedures performed at the same site.

So, if the provider performs a 4.5 cm intermediate wound closure on a patient's left leg - and it is the only service the provider performs - you could report 12032 (Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.6 cm to 7.5 cm) with modifier LT (Left side) for the service.

More likely: A patient needs wound closure in an area different from the primary surgery area. If the provider performs a simple or intermediate wound closure in an area unrelated to the surgical procedure, you might be able to code it separately. For example, if the provider performs fracture care on a patient's left leg and also performs intermediate wound closure on the patient's left elbow, you might be able to code for both.

Best bet: Check with your provider if you have any questions about coding a simple or intermediate wound closure along with a surgical service.

Code Complex Repairs Separately? Maybe

Complex wound closure coding is where things get … well, complex. However, you need to study complex closure rules the most carefully, as they are the most likely to be coded in addition to a surgical procedure in the same anatomic area.

When your provider performs a complex wound closure, you'll choose from the following codes, depending on encounter specifics:

- 13100 (Repair, complex, trunk; 1.1 cm to 2.5 cm) through +13102 (… each additional 5 cm or less (List separately in addition to code for primary procedure))
- 13120 (Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm) through +13122 (… each additional 5 cm or less (List separately in addition to code for primary procedure))
- 13131 (Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm) through +13133 (… each additional 5 cm or less (List separately in addition to code for primary procedure))
- 13151 (Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm) through +13153 (… each additional 5 cm or less (List separately in addition to code for primary procedure))

There are some complexities when determining whether you can report the repair on the same site as another surgery, however.

Complex repair starts with layered closure and then gets more involved. How involved the repair gets will be the element that determines whether you might be able to report a complex repair code in addition to any other portions of the surgical package.

Most common: If there is undermining in order to create a larger defect in the surgical area, you might be able to report a separate complex repair. Complex closure can also be billed when the surgeon creates the defect: for example, a scar revision.

When you report a complex repair, be sure to document the layered closure and the extra work required for the complete closure.

Complex repairs must include "repair of wounds needing … debridement, extensive undermining, etc.," said Brown and Huey. "Necessary preparation includes creation of a limited defect for repairs or debridement of complicated lacerations or avulsions.

"This [complex closure] doesn't include excision of benign or malignant lesions, excisional prep of a wound bed, or debridement of an open fracture or open dislocation," they said.

Sounds complicated enough? Well, the rule for complex closure was updated in 2020 - with a few new requirements. According to Brown and Huey, complex wound closure claims require documentation of at least one of the following:

- Exposure of bone, cartilage, tendon, or named neurovascular structure;
- Debridement of wound edges (traumatic lacerations, avulsions, etc.);
- Extensive undermining (Per CPT® manual, "A distance greater than or equal to the maximum width of the defect, measured perpendicular to the closure line along at least one entire edge of the defect.");
- Involvement of free margins of helical rim, vermillion border, or nostril rim; or
- Placement of retention sutures.

Remember: "Scar revision is not automatically considered a complex repair," Brown and Huey warned.