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Part B Insider (Multispecialty) Coding Alert

PART B MYTHBUSTER: Know What Wound Repair Includes--And What It Doesn't

Dismantle this common myth to get on the road to correct coding

Myth: Wound repair codes in-clude lesion excisions, and lesion excision reimbursement includes wound repair charges.

Reality: Lesion excision codes can include wound repairs, but this rule is only a one-way street.

You will often see healthcare providers perform wound repairs (12001-13160) alongside lesion excisions and debridement, but you won't always be able to code each procedure independently. In fact, you should never include excision of lesions, whether benign (11400-11471) or malignant (11600-11646), in wound repair. Lesion excision, however, may include wound repair, depending on the type of lesion and the repair's size and/or complexity, says **Linda Martien, CPC, CPC-H**, coding specialist at **National Healing Inc.** in Boca Raton, Fla.

Example: The national Correct Coding Initiative (CCI) bundles intermediate (12031-12057) and complex (13100-13153) repairs to excision of benign lesions of 0.5 cm or less (11400, 11420 and 11440)--presumably because even complex repair of such a small wound does not increase surgeon effort appreciably. But Medicare does not bundle intermediate and complex repairs of excisions for malignant lesions of 0.5 cm or less.

Best bet: Check CCI before you report wound repair in addition to lesion excision. Especially for smaller wounds, you-ll often find that payers bundle the repairs with the excision codes.

Debridement (cleansing and removing devitalized tissue) commonly accompanies wound repair at any level (simple, intermediate or complex), says **John F. Bishop, PA-C, CPC, MS, CWS**, president of Tampa, Fla.-based **Bishop & Associates**. Specifically, wound repair includes debridement unless -gross contamination requires prolonged cleansing, when appreciable amounts of devitalized or contaminated tissue are removed, or when debridement is carried out separately without immediate primary closure,- according to CPT instructions.

Example: A patient falls off a ladder onto concrete and suffers ex-tensive lacerations of varying depths. Several of the wounds require repair/ closure, but they also contain gross contamination (asphalt, dirt, etc.). And significant areas of tissue surrounding wounds on the leg and forearm require trimming.

In this case, the wounds are primarily superficial and qualify as simple or, at best, intermediate repairs. But because the amount of cleansing and tissue removal greatly exceeds that which typically accompanies such repairs, the physician may report debridement separately.

Example 2: A bicyclist falls off of her bike and suffers a minor case of -road rash.-

In this case, wound contamination is greater than that associated with simple repair, but not unusually extensive. Consequently, the physician may choose the intermediate repair codes (due to the contamination) but cannot report debridement separately.

For extensive debridement of soft tissue or bone not associated with open fractures and/or dislocations (as in the first example above), choose the appropriate code from the 11040-11044 range (such as 11043, Debridement; skin, subcutaneous tissue, and muscle).

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For extensive debridement associated with open fractures and/or dislocations, you should select the appropriate code from the 11010-11012 range.

When reporting wound repair and debridement codes together, you must observe two important guidelines, says **Terri Brame, MBA**, **CPC, CPC-H,** principal at **BEST Coders**.

1. Provide documentation to justify the separate debridement codes. The attending physician should note that the wound required extensive debridement and record the area and time involved, as well as the extent of the procedure.

2. Append modifier 59 (Distinct procedural service) to the debridement codes. The modifier tells the payer that the debridement is a separate and distinct procedure, beyond that usually associated with wound repair.

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