Codify
BY AAPC

Outpatient Facility Coding Alert

Surgical Focus: Follow These 4 Steps to Set Wrist Repair Coding on Track

Be well versed in anatomy to differentiate tendon from nerve codes.

Hand and wrist surgery operative reports can be overwhelming from a coding perspective, particularly when the surgeon performs more than 10 procedures during the session. Here's the key to keeping your claims in order: Have a solid knowledge of anatomy and break down the services by site.

Read the following operative note and determine how you would code the service.

Dig Into the Op Report Summary

The patient had the following injuries:

- A 12-cm complex laceration to the volar right wrist
- Transections of the radial artery, superficial radial nerve, abductor pollicis longus, brachioradialis tendon, middle finger flexor digitorum superficialis, and palmaris longus
- Partial transections of the extensor pollicis brevis, ring finger flexor digitorum superficialis and flexor pollicis longus tendons.

Procedure: The surgeon irrigated and debrided fullthickness skin edges, subcutaneous tissue, muscle and tendon of the left forearm laceration and performed a complex repair of the 12-cm laceration to the forearm. He repaired the radial artery with a reversed vein graft, which he harvested from the volar forearm. Next, he repaired the superficial radial nerve after neurolysis using Neurogen conduit. The orthopedic surgeon then repaired the extensor pollicis brevis (EPB), the abductor pollicis longus (APL), the brachioradialis (BR), the ring finger flexor digitorum superficialis (FDS4), the middle finger flexor digitorum superficialis (FDS3), the palmaris longus (PL), and the flexor pollicis longus (FPL) tendon.

Code the Procedure

Reporting a procedure like this requires a vast knowledge of anatomy. If you don't know whether the extensor pollicis brevis is a tendon, muscle, or nerve, you won't know which code to report. The same goes for all of the other terms in the surgeon's report.

Step 1: Report the artery repair. Typically, you should list the highest-valued procedure first. In this case, the arterial repair code 35236 (Repair blood vessel with vein graft; upper extremity) rates the highest dollar value with with 28.93 RVUs.

Link 35236 to ICD-9 code 903.2 (Injury to blood vessels of upper extremity; radial blood vessels).

According to the American Society of Surgery for the Hand's (ASSH) Global Service Guide for Hand Surgery, harvesting and/or insertion of a vein graft is included in the reimbursement for 35236, so you should not report any additional codes for the vein harvesting.

Step 2: Code wrist tendon repairs. You'll need to crack your anatomy books to determine which codes fall under the wrist tendon section of CPT®, and which are better suited for the hand and finger subheading.

In the wrist section, you'll find the code for the surgeon's work repairing the five tendons in the wrist: 25260 (Repair, tendon or muscle, flexor, forearm and/or wrist; primary, single, each tendon or muscle). You should report five units of

25260 to represent the repairs of the BR, FDS3, FDS4, PL, and FPL tendons.

You'll report two units of 25270 (Repair, tendon or muscle, extensor, forearm and/or wrist; primary, single, each tendon or muscle) to represent the surgeon's repairs of the EPB and APL tendons.

Link both 25260 x 5 and 25270 x 2 to 881.22 (Open wound of elbow, forearm, and wrist, with tendon involvement, wrist).

Step 3: Code nerve repair. You should report 64910 (Nerve repair; with synthetic conduit or vein allograft [e.g., nerve tube], each nerve) with modifier 51 (Multiple procedures) for the superficial radial nerve repair. Link this code to the diagnosis 955.3 (Injury to peripheral nerve[s] of shoulder girdle and upper limb; radial nerve).

Step 4: Don't separately report repair codes per CCI. Because the National Correct Coding Initiative (CCI) bundles 13121 (Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm) into 25260, you should not separately report the complex repair codes. However, if the physician removes an appreciable amount of devitalized or contaminated tissue, you can also report 11043 (Debridement, muscle and/or fascia [includes epidermis, dermis, and subcutaneous tissue, if performed]; first 20 sq cm or less).