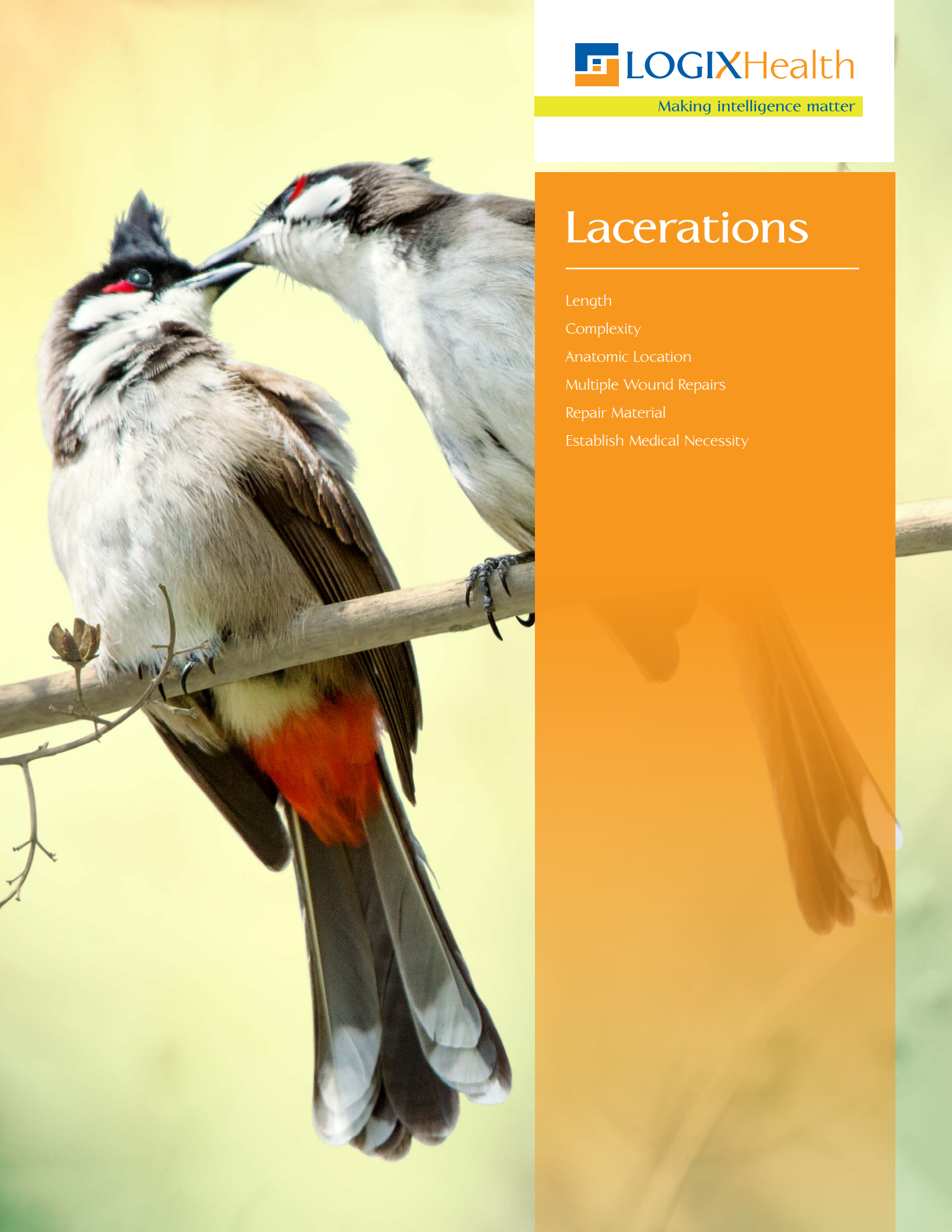

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Lacerations

Length

Complexity

Anatomic Location

Multiple Wound Repairs

Repair Material

Establish Medical Necessity

Identify Your Revenue Opportunities

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LOGIX TIP #43

There is a 20% difference in RVUs between a 2.5 cm and a 2.6 cm laceration repair.

Introduction

There are two broad categories of reimbursement in emergency medicine. One is for the cognitive work involved in patient care, which is represented by evaluation and management codes. The other category is for procedural services, which when documented and coded properly often result in significant and meaningful additional reimbursement over and above the E/M service.

Laceration repairs are some of the most common procedures performed by emergency physicians, and appropriate documentation will ensure fair reimbursement for performing these important procedures. Lacerations are assigned CPT codes based upon three elements:

1. Length
2. Location
3. Complexity

Documentation should accurately reflect each of these elements to allow the coder to assign the appropriate CPT code for the service.

CPT 12002
- 2.6 cm simple finger laceration
- **Approximately 1.8 RVUs**

CPT 99283
- Level 3 ED Visit
- **Approximately 2.1 RVUs**

Length

Wound repairs are categorized by length, and should be documented in centimeters. Increasing RVUs are associated with increasing repair length. Common categories are:

- 2.5 cm or less
- 2.6 cm to 7.5 cm
- 7.6 cm to 12.5 cm
- 12.6 cm to 20.0 cm
- 20.1 cm to 30.0 cm
- Over 30.0 cm

Regardless of whether the laceration is curved, angular, or linear, be sure to measure and document the repaired length (to the tenths of a centimeter) to ensure appropriate reimbursement. The RVUs can take a big jump based on a small increase in length.

For example, consider layered closure of wounds of scalp, axillae, trunk and/or extremities:

- 2.5 cm or less: CPT 12031 (approximately 4.5 RVUs)
- 2.6 cm - 7.5 cm: CPT 12032 (approximately 5.6 RVUs)

A 20% change in RVUs simply by measuring correctly!

Remember to Measure!
Measure all lacerations. Going from 2.5 cm to 2.6 cm often results in a substantial increase in reimbursement.

Complexity

Documentation of the complexity of the repair, in addition to the length is needed to determine the appropriate service to report. Complexity is determined by the repair technique.

There are three categories of complexity: Simple, Intermediate and Complex. There is an increase in RVUs as complexity increases:

- **Simple repair**: Simple repair complexity is assigned to a single layer closure that does not require extensive cleaning of a heavily contaminated wound.
- **Intermediate repair**: Intermediate repair complexity is assigned to a layered closure or a single layer closure that requires extensive cleaning of a heavily contaminated wound.
- **Complex repair**: Complex repair is assigned to a multi-layer repair **that also involves** one of the following: exposure of bone, cartilage, tendon or named neurovascular structure; significant tissue debridement of wound edges (e.g., traumatic lacerations or avulsions); extensive undermining; involvement of free margins of helical rim, vermillion border, or nostril rim; placement of retention sutures.

CPT 12002
- 5 cm simple forearm laceration
- **Approximately 1.8 RVUs**

CPT 12032
- 5 cm forearm laceration that requires single layer closure of heavily contaminated wound with extensive cleaning
- **Approximately 5.6 RVUs: *Over a 300% Increase!***

CPT 12011
- 2 cm lip laceration that requires single layer closure
- **Approximately 1.6 RVUs**

CPT 13101
- 2 cm lip laceration involving the vermillion border requiring layered closure
- **Approximately 7.3 RVUs**

Anatomic Location

The final determining factor for laceration CPT code assignment is the anatomic location of the repair. Laceration repair codes are grouped by location and therefore documenting the specific location is important. For example, a forehead laceration and scalp laceration have meaningfully different RVU values.

CPT 12001
- ≤2.5 cm simple scalp laceration
- **Approximately 1.3 RVUs**

CPT 12011
- ≤2.5 cm simple forehead laceration
- **Approximately 1.6 RVUs**

Multiple Wound Repairs

When multiple wounds are repaired, the lengths of those repairs that are in both the same complexity classification (Simple, Intermediate or Complex) and the same anatomic site grouping are added together. The best practice for documenting multiple repairs is to document each repair separately.

Repair Material

Wound closures using sutures, staples or tissue adhesives (e.g., 2-cyanoacrylate), either individually or in combination with each other are reported using the typical CPT wound repair codes with one exception. Single layer closures utilizing tissue adhesive alone are reported with a HCPCS code (G0168) for Medicare and are assigned a payment of approximately $15. Documentation should clearly indicate if sutures or staples are used in addition to tissue adhesives as these more involved repairs are typically assigned intermediate complexity.

Establish Medical Necessity

It is important to document all appropriate diagnoses for the patient encounter. Providing appropriate diagnoses is needed to demonstrate the medical necessity of the E/M service as well as the separate procedure. For example, document knee contusion and knee pain when appropriate in addition to a knee laceration diagnosis.

Tips to Optimize Documentation

- Measure lacerations
  - Be aware of ranges: 2.6 cm vs 2.5 cm
- Document location
  - Face vs. scalp
- Document complexity
  - Intermediate repair
    - Layered closure
    - Extensive cleaning of heavily contaminated wound
  - Complex - Layered closure **with**:
    - Exposure of deeper structures (cartilage, tendon, bone, etc.)
    - Wounds requiring significant debridement of biologic tissue
    - Involvement of the helical rim, vermillion border, or nostril rim
- Document if there was extensive removal of particulate debris from a heavily contaminated wound
  - Intermediate repair
- Multiple appropriate diagnoses
  - Establish medical necessity for E/M services

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