Focus On
Lacerations

Length
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Complexity
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Repair Material
Establish Medical Necessity
There are two broad categories of reimbursement in emergency medicine. One is for the cognitive work involved in patient care, which is represented by the Evaluation and Management (E/M levels 99281 - 99285) and critical care 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.

Lacerations are some of the most common procedures performed by emergency physicians: appropriate documentation and coding will ensure that you are fairly reimbursed for performing these important procedures. Lacerations are assigned CPT codes based upon three elements: length, location and complexity. Your documentation should accurately reflect each of these elements in order to allow the coder to assign the appropriate CPT code for the service.

**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, measure the repaired wound and make sure you report the length including tenths of centimeters to ensure appropriate reimbursement. The payment can take a big jump based on a small increase in length. For instance, *Layered closure of wounds of scalp, axillae, trunk and/or extremities*:

- CPT 12031 (2.5 cm or less): Approximately 4.5 RVUs
- CPT 12032 (2.6 cm - 7.5 cm): Approximately 5.5 RVUs

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

A 20% increase in RVUs simply by measuring correctly!

**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. For example, *the lengths of intermediate repairs of the hands and feet are summed and reported as one CPT code, but the lengths of repairs from different groupings of anatomic sites (eg. nose and scalp) are reported separately using two CPT codes. Furthermore, lengths of different classifications (eg. intermediate and complex repairs) are not added together.*
Wound repairs are classified as Simple, Intermediate or Complex.

**Simple repairs** are the most common repairs performed in the ED. This description is used for repairs that are superficial; e.g., involving primarily epidermis or dermis, or subcutaneous tissues without significant involvement of deeper structures, and require simple one layer closure. If there is more than one layer of closure then the repair would typically be coded as intermediate.

**Intermediate repairs** include wounds that require layered closure of one or more of the deeper layers of subcutaneous tissue, in addition to the skin (epidermal and dermal) closure. In day-to-day practice, when you place deep absorbable sutures (even just one) clearly document the dual layer closure and your work will be recognized with additional RVUs. For example, A 6.0 cm single layer repair is assigned approximately 2 RVUs while the same repair using a layered technique yields approximately 5.5 RVUs. Failure to document or code for a dual layer closure will result in a simple repair classification and a loss of approximately 3.5 RVUs.

In addition to dual layers, there is another way to be classified as and capture the high RVUs associated with intermediate repairs. Single-layer closure of heavily contaminated wounds that have required extensive cleaning or removal of particulate matter also constitutes intermediate repair. If you are repairing a heavily contaminated wound make sure to document the presence of extensive debris/cleansing and have your work recognized with the intermediate repair codes.

**Intermediate Repair Alert!** Make sure to document placement of deep sutures or extensive removal of particulate matter.

**Complex repairs** involve wounds that in addition to multi-layer repair require extensive undermining, creation of a defect, complex revision, or retention sutures.

Wound repairs are also classified by their anatomic location. Simple repairs (CPT 12001 - 12018) have two major groups of locations that are categorized together. Any repairs in these areas of the same type should have their lengths summed. For example, if separate laceration repairs of a hand and foot are done, their lengths should be summed and reported as one repair.

Simple repairs:
- Scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet). For example, a simple hand laceration of 2.5 cm or less is reported with CPT 12001, and if 2.6 cm - 7.5 cm with CPT 12002.
- Face, ears, eyelids, nose, lips and/or mucous membranes

Intermediate repairs (12031-12057) have three major groups of locations that are categorized together:
- Scalp, axillae, trunk and/or extremities (excluding hands and feet)
- Neck, hands, feet and/or external genitalia
- Face, ears, eyelids, nose, lips and/or mucous membranes

Keep in mind that location really does matter! A 5.2 cm scalp laceration coded as 12002 yields 2.1 RVUs while a 5 cm laceration of the forehead is reported with code 12014 and produces 2.5 RVUs.
Wound closures using sutures, staples or tissue adhesives (e.g. 2-cyanoacrylate), either individually or in combination with each other are reported using the CPT wound repair codes for most payers. An exception is for Medicare. Single layer closures utilizing tissue adhesive are reported with a special unique Medicare G code, which can have a significant impact on reimbursement. Medicare pays approximately $25 for a straight Dermabond type repair while the lowest level laceration repair code reimburses roughly $100.

Establish Medical Necessity

Whenever possible, be sure to document at least two diagnoses when laceration repairs are performed. Without supporting documentation and accurate diagnosis reporting, many payers will unfairly bundle your laceration repair with the level of service and not pay for the E/M service that you provided.

For example, document finger injury and finger pain in addition to the finger laceration diagnosis. Providing additional diagnoses helps to support reimbursement for the cognitive work of a separate E/M level if performed.

Tips to Optimize Reimbursement

• Document length
  - 2.6 cm vs. 2.5 cm
• Document location
  - Face vs. scalp
• Deep sutures
  - Intermediate Repair
• Extensive debridement
  - Intermediate Repair
• Multiple diagnoses
  - Ensure you are paid

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