Superficially at least, coding wound repairs would seem pretty simple. But a wound isn’t a wound isn’t a wound, and a number of different techniques are used to treat them.

Three factors determine the choice of codes for wound repairs (12001–13160): anatomic site, length of the wound (measured in centimeters), and the type of repair.

Types of Wound Repairs
There are three types of wound repairs:

Simple repairs primarily involve epidermis, dermis, or subcutaneous tissues without significant involvement of deeper structures. One-layer closing and suturing is sufficient to close these superficial wounds. Chemical or electrocauterized wounds are not closed.

Intermediate repairs require layered closure of one or more of the subcutaneous tissues and superficial (nonmuscle) fascia. This is in addition to epidermal and dermal skin closure and single-layer closure of heavily contaminated wounds requiring extensive cleaning or removal of particulate matter.

Complex repairs involve more than layered closure, including possible scar revision, debridement of traumatic lacerations or avulsions, extensive undermining, stents, or retention sutures. They also may include creation of the wound defect and necessary preparation for repairs, or the debridement and repair of complicated lacerations or avulsions.

Describing Wounds
Wounds may be described as curved, angular, or star-shaped. Documentation should be reviewed to determine the length of the wound, regardless of its shape.

The lengths of multiple wounds that were closed using the same type of repair (simple, intermediate, or complex) at a single body site should be added together, and these wounds then should be coded as a single wound. When more than one type of repair is involved, the most complicated repair should be assigned as the principal procedure.

Wound Repair Coding Tips
The following guidelines may help you with the correct coding of wound repair procedures:

- Wounds repaired with adhesive strips, such as steri-strips or butterfly strips, are included in the appropriate evaluation and management (E/M) code (99201–99499). Wounds that are not sutured should not be coded separately.

- The American Medical Association recommends coding wound repairs using skin adhesive(s) as a simple repair of a lesion. Dermabond is a skin adhesive that offers a relatively new alternative to sutures and steri-strips.

- When two types of sutures are used to close a wound, the physician should specify to the coder whether a simple...
or intermediate repair code is appropriate. A simple repair code would be used if an irregularly-shaped wound (such as an elliptical wound) makes it necessary to use two kinds of sutures. On the other hand, if one of the two sutures used is absorbable, such as Vicryl, chromic, gut, or Dexon, the repair probably is intermediate.

**Coding Debridement**

Debridement or decontamination of a wound should be coded separately only if one of the following applies:

- The wound requires prolonged cleansing.
- Appreciable amounts of devitalized tissue are removed.
- Debridement is a separate procedure with no immediate primary closure.

When multiple sites are debrided, each is coded separately.

Codes 11010–11012 are used for coding debridement of open fractures and/or dislocations, and are assigned in addition to the fracture code. The 51 modifier should not be used unless the debridement is separate from the fracture and/or dislocation. The debridement must be extensive, rather than routine, to be coded separately.

**Blood Vessel, Tendon, and Nerve Repair**

Wound repairs that are performed on blood vessels, tendons, or nerves should be indicated with codes from the “Cardiovascular,” “Musculoskeletal,” or “Nervous System” subsections of the CPT manual, respectively.

The ligation of vessels in an open wound, and the simple exploration of exposed nerves, blood vessels, or tendons in an open wound are considered part of the wound repair and should not be coded separately.

Musculoskeletal codes (20100–20103) should be used in cases involving a cross-reference for wound exploration, requiring enlargement of the wound to determine penetration—including removal of foreign bodies, debridement, ligation, or coagulation of minor blood vessels or the subcutaneous tissue, muscle fascia, and/or muscle.

**Coding Self-Test**

When coding wound repairs, coders should make certain that the following questions are addressed:

- How many wounds were repaired?
- What is/are the anatomic site(s)?
- How long is/are the wound(s)?
- What types of repairs were performed?
- Were multiple wounds at the same site treated with the same type of repair?

**Adjacent Tissue Transfers, Flaps, and Grafts**

Adjacent tissue transfers include such procedures as Z-plasty, W-plasty, V-Y plasty, or rotation flaps. They are coded according to the size of the defect. The skin graft required to close the site from which the donated material was taken is considered an additional procedure.

Excision of a lesion prior to repair by adjacent tissue transfer is bundled into the adjacent tissue transfer procedure, rather than reported separately.

Complete documentation must be available to ensure the correct coding of grafts, not only for the current procedure, but also on any staged procedures performed at the site.

Codes for flaps and grafts may or may not include repair of the donor site. It is important to read all of the notes listed under these subheadings: repair-complex; adjacent tissue transfer or rearrangement; free skin grafts; flaps (skin and/or deep tissues); and other grafts.

Skin grafts are identified by the size and location of the defect, and the type of graft—free, pedicle, flap, or other.

Skin-graft codes may be used for both principal and secondary procedures. Certain free skin-graft codes are assigned according to the amount of body area involved. When assigning codes 15000, 15001, 15100, 15101, 15120, and 15121, body percentages should be used for children under the age of 10 and 100-square-centimeter units should be used for patients more than 10 years old.

Codes 15100–15121 should be used for tissue-cultured skin grafts, including bilaminate skin or neodermis. The harvesting of tissue and/or the application of neodermis should not be coded separately. (See “Table 1” on page 3.)

**Source:** *Complete Coding Tutor*, Third Edition, St. Anthony Publishing.
Table 1: Understanding Adjacent Tissue Transfers, Flaps, and Grafts

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z-plasty</td>
<td>Lengthening, straightening, or realigning a scar to help reduce tension on the wound for a better cosmetic result.</td>
</tr>
<tr>
<td>W-plasty</td>
<td>Used for less linear scar/wound repair.</td>
</tr>
<tr>
<td>Advancement flap</td>
<td>The simplest of flaps—stretching nearby skin over a wound.</td>
</tr>
<tr>
<td>V-Y plasty</td>
<td>A V-shaped incision is sutured in a Y shape to lengthen an area of tissue.</td>
</tr>
<tr>
<td></td>
<td>Reversing the sequence results in a shorter area of tissue.</td>
</tr>
<tr>
<td>Rotation flap</td>
<td>Semicircular flap of skin rotated into position over the wound site.</td>
</tr>
<tr>
<td></td>
<td>Also called a transpositional or interpolation flap.</td>
</tr>
<tr>
<td>Pedicle or</td>
<td>Flaps consisting of the full thickness of the skin and the subcutaneous tissue are transferred to a clean tissue bed.</td>
</tr>
<tr>
<td>double-pedicle flaps</td>
<td>Ideal for covering exposed bone and tendon.</td>
</tr>
<tr>
<td>Sliding flap</td>
<td>Transferring a flap to its new position using a sliding technique.</td>
</tr>
<tr>
<td></td>
<td>Similar to an advancement flap.</td>
</tr>
<tr>
<td>Melolabial flap</td>
<td>A flap from the medial cheek is used as a transposition flap to repair a defect on the side of the nose. It is used for deep nasal defects, providing thick subcutaneous skin and fat for rebuilding tissue lost in surgery.</td>
</tr>
<tr>
<td>Kutler procedure</td>
<td>Two flaps are developed, one on each side of the finger, and mobilized toward the fingertip, and sutured to conform to the normal shape of the fingertip.</td>
</tr>
<tr>
<td></td>
<td>An example of a V-Y plasty.</td>
</tr>
<tr>
<td>Split graft</td>
<td>A graft that contains both epidermal and dermal layers; portions of the graft contain only part of the dermal layer.</td>
</tr>
<tr>
<td>Full-thickness graft</td>
<td>A graft that contains an equal and continuous portion of both epidermis and dermis.</td>
</tr>
<tr>
<td>Autograft</td>
<td>Both the donor and recipient sites are from the same individual.</td>
</tr>
<tr>
<td></td>
<td>For replacing damaged tissue.</td>
</tr>
<tr>
<td>Allograft</td>
<td>The donor and recipient are different individuals.</td>
</tr>
<tr>
<td></td>
<td>For temporary coverage until autograft material is available.</td>
</tr>
<tr>
<td>Xenograft</td>
<td>The graft material is of nonhuman origin, such as a graft from a pig.</td>
</tr>
<tr>
<td></td>
<td>For temporary coverage until autograft material is available.</td>
</tr>
<tr>
<td>Pinch graft</td>
<td>A small autograft.</td>
</tr>
</tbody>
</table>

Source: Complete Coding Tutor, Third Edition, St. Anthony Publishing

HCFA Lists ‘Glitches’ in Outpatient PPS and Code Editor

The Health Care Financing Administration published a notice in late August that identified a number of what it called “glitches” in the outpatient prospective payment system (OPPS) standard systems and the Outpatient Code Editor (OCE).

Notwithstanding the problems, HCFA said the OPPS was processing claims well enough to warrant cancellation of its Contingency Plan 1. That plan would have allowed interim payments to providers in the event of the failure of HCFA’s processing systems (see the story beginning on page 1 of the September issue).

Standard System Maintainer Issues
HCFA’s notice identifies several standard system problems, including some that will raise flags for compliance professionals because they are perennial hot buttons in focused compliance reviews. These problems are as follows:

- The fiscal intermediary standard system (FISS) was rejecting as duplicates claims with condition code G0.
- The FISS received error code E6101 from the common working file (CWF) when the sum of revenue...
lines on a claim did not agree with the total charge line. These claims were being rejected to the contractor suspense file until an appropriate fix could be implemented.

- Medicare beneficiaries were not receiving complete deductible and coinsurance information because the Medicare summary notice was not reflecting complete data from surgery claims with two revenue lines that displayed charges on line one but no charges on line two.
- The CWF system was generating an error code in claims involving outlier payments. HCFA explained that suspended claims would be released for normal processing once the problem was resolved.

**OCE Issues**
The following problems were to have been resolved by October 1, 2000:

- **Edit 17 (inappropriate specification bilateral procedure).** The OCE was not rejecting all but one of the bilateral procedures in cases where the same type “T” procedure was reported multiple times on the same line item. However, the OCE functioned correctly when the multiple bilateral procedures were reported on separate line items.
- **Edit 22 (invalid modifier).** The OCE was not set up with a complete list of valid modifiers for ambulance services and positron emission tomography (PET) scans, but HCFA said a fix was implemented in intermediary systems that would deal with this edit.
- **Edits 19, 20, 39, and 40 (mutually exclusive/component of comprehensive procedure that would be allowed if the appropriate modifier were present).** Because the National Correct Coding Initiative (NCCI) Version 6.2 edit table in the current OCE incorrectly includes mental health codes, multiple psychiatric services provided on the same day may be edited incorrectly.
- **Edit 42 (multiple medical visits on the same day, with the same revenue code, without condition code G0).** HCFA instructed providers to bill multiple evaluation and management (E/M) services in the same revenue center on separate line items to avoid having the OCE pay more than one E/M code.
- **Revenue codes without HCPCS.** Because the OCE was assigning line-status indicator “A” (services not paid under PPS) to some revenue codes without a HCPCS code, HCFA advised that the services should be packaged in the PPS payment.
- **ER/Observation.** The OCE was processing claims spanning more than one day (that included ER or observation services) as single-day claims. To avoid this, HCFA advised hospitals that they could submit separate claims for each day of a multiple-day claim containing ER or observation services.
- **Nonpayable HCPCS codes.** The OCE was not assigning a reason code for some nonpayable HCPCS codes.
- **Multiple edits issued for the same HCPCS code.** The OCE was issuing two different edits, instead of one, for some HCPCS codes, potentially slowing payments to providers.

Claims involving the following modifiers are being discounted inappropriately, but HCFA says the problems will be resolved no later than January 2001:

- modifier 52, reduced services
- modifier 76, repeat procedure by same physician
- modifier 77, repeat procedure by another physician
- modifier 79, unrelated procedure or service by the same physician during the postoperative period.

### Table 2: HCFA’s OPPS Reminders

| Hospitals should refer to transmittal 747 of the Hospital Manual for proper reporting of units of service and line-item dates of service. |
| Hospital-based rural health clinics (RHCs) should discontinue billing non-RHC services on the RHC claim (bill type 71X), and should use type-of-bill code 13X or 14X with the hospital’s provider number. |
| Clinical diagnostic laboratory services must be billed with the appropriate HCPCS code. |
| Implantable devices reported with codes such as E0751 and LB600, no longer eligible for payment under the orthotic/prosthetic fee schedule, should be reported under revenue code 278. |
| To avoid rejection of claims containing any of the HCPCS codes that have been removed from the “inpatient-only list” and assigned to ambulatory payment classifications (APCs), hospitals were advised to either hold the claims until October 1, 2000 or submit the claims with the affected codes—followed by an adjustment claim containing all services provided. |
| The electronic remittance advice (ERA) files do contain the APC number assigned at the line, but when the files are run through PC Print, the APC number is not printing on the remits. Providers wishing to review and confirm the APC detail not being printed are advised by HCFA to move to an ERA format. |
Hospital coders should be aware of a program memorandum (PM) that the Health Care Financing Administration issued on August 7 to Medicare fiscal intermediaries (FIs) and contractors, offering “amplified” instructions for effective medical review progressive corrective action (PCA) efforts. The purpose of the PM, according to HCFA, is to facilitate “easy understanding of expectations and basic requirements.”

Effective October 1, 2000, the PM is instructive to providers because it offers likely scenarios that describe how FIs identify and investigate potential billing problems. Consequently, coding staff may want to perform their own medical reviews of claims being submitted for reimbursement, based on some of the seven clinical vignettes listed on page 6. First, however, here is a summary of the instructions contained in PM transmittal AB-00-72:

1. **The decision to conduct a medical review should be data driven.** Data analysis is an essential first step in identifying potential problems in patterns of claims submission and payment. The analysis may range from simple identification of aberrations to more sophisticated examinations of patterns within claims or groups of claims.

2. **“Probe” reviews should be conducted to validate potential problems.** The interim step of examining a small “probe” sample of claims before deploying significant medical resources for a full-blown investigation of potential problems is suggested. This ensures that medical review resources are targeted at identified problem areas. HCFA recommends probe sample sizes of between 20 to 40 claims per provider, and 100 claims distributed among a wider universe of providers in the case of potential systemic problems.

3. **Providers should be subjected only to the number of medical reviews necessitated by the identified problem.** HCFA is instructing intermediaries to target medical review activities at providers or services that place the Medicare trust funds at the greatest risk, consistent with the specifications of the budget and performance requirements (BPRs). Furthermore, HCFA cautions intermediaries that actions imposed on providers must be appropriate to the level of noncompliance found.

4. **Providers should be notified that additional documentation requested is due within 30 days.** In the event that requested documentation is not received within 45 days, contractors are instructed to make a medical review determination based on available medical documentation. They are being instructed not to return the claim to the provider, and to collect overpayments on denied claims. Intermediaries should reverse denied claims on postpayment review so that they do not appear in the Provider Statistical and Reimbursement Report.

5. **The provider’s error rate should be considered in determining a course of action.** For prepayment reviews, determine a provider’s specific error rate by dividing the dollar amount of allowable charges billed in error by the dollar amount of allowable charges for services medically reviewed. For postpayment reviews, divide the dollar amount of services paid in error by the dollar amount of services medically received.

6. **Provider feedback and education is an essential part of problem solving.** When dealing with problems that affect a large number of providers, contractors are instructed to contact medical and specialty societies. When only a small group of providers is involved, the contractors are instructed to give feedback to those providers on the nature of the problem and remedial steps to be taken by both the provider and the contractor. Contractors also are instructed to remove providers from medical review “as soon as possible” after the provider has demonstrated compliance with Medicare billing requirements.
7. All overpayments must be collected or offset as determined by HCFA and the contractor’s procedures.

8. Any potential instances of fraud should be referred to the contractor’s fraud unit. PCA requirements do not apply when a fraud development is initiated.

9. Reviews and educational contacts with providers should be recorded in a Provider Tracking System (PTS). The purpose of the PTS is to coordinate contacts with providers and eliminate redundancy in multiple contacts. PTS contacts are to be coordinated with the contractor’s fraud unit.

10. The results of appeals should be tracked in medical review activities. HCFA tells contractors that it is not an efficient use of medical review resources to deny claims that are routinely appealed and reversed. Instead, contractors are instructed to learn why hearing or appeals officers view specific issues differently, and to discuss appropriate policy, procedure, or strategy changes with their regional officers.

The PM also instructs intermediaries and carriers to educate their providers about PCA concepts through efforts ranging from bulletin articles to incorporating PCA into ongoing medical review training efforts. In addition, HCFA used its PM to offer hospital coders the following “vignettes” of possible medical review efforts, and to suggest administrative actions that staff can initiate to minimize problems. However, this is not a comprehensive list of vignettes or administrative actions, and should be used only as a guide.

1. Twenty claims are reviewed. One claim is denied because a physician signature is missing on the plan of care. The denial reflects 7 percent of the dollar amount of claims reviewed. Judicious use of medical review resources indicates no further review is necessary at this time. Data analysis will determine where medical review activities should be targeted in the future.

2. Forty claims are reviewed. Twenty claims are for services determined to be not reasonable and necessary. These denials reflect 50 percent of the dollar amount of claims reviewed. This launches a 100 percent prepayment review due to the high number of claims denied and the high dollar amount denied.

3. Forty claims are reviewed. Thirty-five claims are denied. These denials reflect 70 percent of the dollar amount of claims reviewed. Payment suspension is initiated due to the high denial percentage and the Medicare dollars at risk.

4. Forty claims are reviewed. Thirty-three claims are denied. These denials reflect 25 percent of the dollar amount of the claims reviewed. The contractor provides feedback to the provider about specific errors made, and educates the provider on the correct way to bill. The contractor initiates a moderate amount (e.g., 30 percent) of prepayment medical reviews to ensure proper billing.

5. Thirty-five claims are reviewed. Thirty claims are denied, representing 75 percent of the dollar amount of the claims reviewed. Many of the denials are because services were provided to beneficiaries who did not meet the Medicare eligibility requirements. A consent settlement offer is made, but declined by the provider. A statistically valid random sample (SVRS) postpayment review is performed and an overpayment is projected to the universe of paid claims. Overpayment collection is initiated.

6. Twenty-five claims are reviewed. Five claims are denied, representing 5 percent of the dollar amount of the claims reviewed. The durable medical equipment regional carrier (DMERC) recognizes this supplier as one who has a significant decrease in billing volume when targeted medical reviews are initiated. The DMERC is concerned that this supplier may be selectively submitting bills when placed on medical review, and chooses to continue some level of prepayment medical review despite the low error rate.

7. Twenty claims are reviewed. Ten claims are denied for lack of complete physician orders, representing 65 percent of the dollar amount of the claims. The regional home health intermediary (RHHI) informed the home health agency (HHA) about the denials and the reason for the denials. In response, the agency owner initiated a mandatory training program for select staff. The HHA was put on 30 percent prepayment medical review. Results of the review indicated an improvement in the error rate to 30 percent (based on dollars denied divided by dollars reviewed). On appeal, nearly all of the denials were overturned. The RHHI consults with the administrative law judge to understand why the cases are being overturned, and consults with the regional office on the next appropriate steps.

Source: HCFA PM, transmittal AB-00-72
The Health Care Financing Administration recently issued a program memorandum (PM) to fiscal intermediaries, clarifying the correct use of modifier 25 under the outpatient prospective payment system (OPPS).

Under the OPPS, payments for diagnostic and/or therapeutic procedures found in code ranges 10040–69990, 70010–79999, and 90291–99140 include the following: taking the patient’s blood pressure and temperature; asking the patient how he or she feels; and getting the patient to sign the consent form. Pathology and laboratory services are not included in this definition of services.

According to HCFA, since payment for the types of services listed above is included in the payment for procedures provided on the same date, it generally is not appropriate to bill for an evaluation and management (E/M) service separately.

However, HCFA notes that there are circumstances under which it is appropriate to report an E/M service code in addition to the procedures provided on the same date—as long as the “key components” of history, examination, and medical decision making have been met.

**Modifier 25 Defined**

In its CPT 2000, the American Medical Association defines modifier 25 as follows:

“Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service.”

The AMA further clarifies correct use of the modifier as follows: “The physician may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient’s condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding the modifier 25 to the appropriate level of E/M service. ...”

**Five Guidelines for Use of Modifier 25**

In the PM, HCFA offers the following five guidelines for the use of modifier 25.

**Guideline 1:** Should a separately identifiable E/M service be provided on the same date that a diagnostic and/or therapeutic procedure is performed, information substantiating the E/M service must be clearly documented in the patient’s medical record to justify use of modifier 25.

**Guideline 2:** Modifier 25 may be appended only to E/M service codes, and only for those within the range of 99201–99499. For outpatient services covered under the OPPS, the relevant code ranges are as follows:

- 99201–99215 Office or Outpatient Services
- 99281–99285 Emergency Department Services
- 99291 Critical Care Services
- 99241–99245 Office or Other Outpatient Consultations

The PM notes that, for reporting services provided by hospital outpatient departments, offsite provider departments, and provider-based entities, all references in the code descriptors to “physician” are to be disregarded.

**Guideline 3:** Medicare requires that modifier 25 always be appended to an emergency department (ED) E/M code (99281–99285) when the service is provided on the same date as a diagnostic medical/surgical and/or...
therapeutic medical/surgical procedure. The following three examples of this guideline are offered.

**Example 1:** A patient is seen in the ED with complaint of a rapid heartbeat. A 12-lead ECG is performed. In this case, the appropriate code(s) from the following code ranges can be reported.

- **99281–99285** Emergency department services with modifier 25
- **93005** 12-lead ECG

**Example 2:** A patient is seen in the ED after a fall. Lacerations sustained from the fall are repaired and radiological x-rays are performed. In this case, the appropriate code(s) from the following code ranges can be reported.

- **99281–99285** Emergency department services with modifier 25
- **12001–13160** Repair/closure of the laceration
- **70010–79900** Radiological x-ray

**Example 3:** A patient is seen in the ED after a fall, complaining of shoulder pain. Radiological x-rays are performed. In this case, the appropriate code(s) from the following code ranges can be reported.

- **99281–99285** Emergency department services with modifier 25
- **70010–79900** Radiological x-ray

HCFA notes that, in this example, if a subsequent ED visit were to occur on the same day, but no additional procedures were performed, it would not be appropriate to append modifier 25 to the subsequent ED E/M code. However, because there were two ED E/M visits to the same revenue center (45X), condition code G0 (G-zero) must be reported in form locator (FL) 24 or the corresponding electronic version of the UB-92 claim form.

**Guideline 4:** Because payment for taking the patient’s blood pressure, temperature, asking the patient how he or she feels, and obtaining written consent is included in the payment for the diagnostic and/or therapeutic procedure, it is not appropriate to report a separate E/M code for these types of services.

**Guideline 5:** When the reporting of an E/M service with modifier 25 is appropriate (that is, when the documentation of the service meets the requirements of the specific E/M service code), it is not necessary for the diagnosis code for which the E/M service was rendered to be different from the diagnosis code for which the diagnostic medical/surgical and/or therapeutic medical/surgical procedure(s) were performed.

**Modifier 25 (The Abridged Version)**

- **Modifier 25** applies only to E/M service codes, and then only when an E/M service was provided on the same date as a diagnostic medical/surgical and/or therapeutic medical/surgical procedure. In other words, modifier 25 does not apply when no diagnostic medical/surgical and/or therapeutic medical/surgical procedures are performed.

- It is not necessary for the procedure and the E/M service to be provided by the same physician/practitioner for modifier 25 to apply in the facility setting. It is appropriate to append modifier 25 to the qualifying E/M service code whether or not the E/M service and procedure were provided by the same professional.

- The diagnosis associated with the E/M service need not be different than that for which diagnostic medical/surgical and/or therapeutic medical/surgical procedures were provided.

- It is appropriate to append modifier 25 to ED codes 99281–99285 when these services lead to a decision to perform diagnostic medical/surgical and/or therapeutic medical/surgical procedures.

**Sources:** HCFA program memorandum, transmittal A-00-40, July 20, 2000; and CPT 2000, American Medical Association, CPT only ©1999, all rights reserved