2020 Updates to Coding Guidelines: Differentiating Intermediate from Complex Repairs

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AAD Council on Practice Management
Intermediate & Complex Repair Workgroup

Arriving on January 1, 2020

Updates to Intermediate and Complex Repair Coding Guidelines

Repair (Closure)

- Updated coding guidelines
- Distinction between intermediate and complex repair procedures

How Did We Get Here?

2015 RUC RAW Review
- Repair codes identified as potentially misused; CPT request AAD to write CPT Assistant Article

2016 AAD Submits CPT Assistant Article
- Specialty submitted CPT Assistant Article to CPT Assistant Editorial Board

CPT Editorial Board Concerns with CPT Assistant Article
- Editorial Board concerned article did not address differences between the two procedures
- Concluded article will not help appropriate code use; Recommend submission of CCA

How Did We Get Here? cont’d

October 2016
- CPT Editorial Panel decline to publish specialty society submitted CPT Assistant Article
- Cited article did not provide clear distinction on difference between intermediate and complex repair procedures

February 2017
- CPT Editorial Panel requests specialty society to submit code change application (CCA) for consideration at May 2018 Panel meeting

May 2018
- Specialty societies (AAD, ASDS, ACMS, SID) submit code change proposal
- CPT Editorial Panel requests distinct and clear distinctions between intermediate and complex repair for further consideration during the September 2018 Panel meeting

September 2018
- CPT Editorial Panel revised and updated intermediate and complex repair coding guidelines
- Includes simple illustration to define what is considered “extensive undermining”

CPT Rationale for New Guidelines

12031 - 13153
- Previous integumentary repair coding guidelines had ambiguity causing inappropriate reporting of intermediate and complex repair services

Specific clarification for the coding guidelines
- Updated guidelines are intended to provide clarity to the distinction between intermediate and complex repair services
Simple Repair

No changes to coding guidelines for simple repair; Simple closure of any defect resulting from surgical procedure is always included in the procedure service and is not separately reportable.

Requires wound closure with sutures, staples or tissue adhesives. Secondary intention healing alone following any procedure, including Mohs surgery, does not qualify as a simple repair.

2020 Intermediate Repair: Definition

Includes the repair of wounds that, in addition to simple repair, require layered closure of one or more of the deeper layers of subcutaneous tissue and superficial (non-muscle) fascia, in addition to the skin (epidermal and dermal) closure.

2020 Intermediate Repair: Definition continued

Includes limited undermining (defined as a distance less than the maximum width of the defect, measured perpendicular to the closure line, alone at least one entire edge of the defect). Single-layer closure of heavily contaminated wounds that have required extensive cleaning or removal of particulate matter also constitutes intermediate repair.

2019 Complex Repair: Definition

Includes the repair of wounds requiring more than layered closure, viz, scar revision, debridement (e.g., traumatic lacerations or avulsions), extensive undermining, stents or retention sutures. Necessary preparation includes creation of a limited defect for repairs or the debridement of complicated lacerations or avulsions.

2020 Complex Repair: Definition

Includes the repair of wounds that, in addition to the requirements for intermediate repair, require at least one of the following: exposure of bone, cartilage, tendon, or named neurovascular structure; debridement of wound edges (e.g., traumatic lacerations or avulsions); scar revision, debridement (e.g., traumatic lacerations or avulsions).

Complex Repair: Select documentation

When applicable, document

- Exposed bone: e.g., skull
- Exposed cartilage: e.g., lateral nasal cartilage, ear cartilage
- Exposed tendon: e.g., dorsal hand(s) extensor tendon(s)
- Named neurovascular structure: e.g., supratrochlear artery and nerve, auriculotemporal nerve with superficial temporal artery
extensive undermining (defined as distance equal to or greater than the maximum width of the defect, measured perpendicular to the closure line along at least one entire edge of the defect); involvement of free margins of helical rim; vermilion border, or nostril rim; placement of retention sutures.

Necessary preparation includes creation of a limited defect for repairs or the debridement of complicated lacerations or avulsions. Complex repair does not include excision of benign (11400-11446) or malignant (11600-11646) lesions, excisional preparation of a wound bed (15002-15005) or debridement of an open fracture or open dislocation.

Complex repair undermining is defined as:
- Undermined distance less than the maximum width of the defect, measured perpendicular to the closure line, along at least one entire edge of the defect.

Intermediate repair undermining is defined as:
- Undermined distance less than the maximum width of the defect, measured perpendicular to the closure line, along at least one entire edge of the defect.

Documentation must include:
- Extensive undermining done along at least one wound edge
- Maximum width of defect perpendicular to line of closure
- Width of undermining done, or undermining was equal to or greater than the maximum width of defect

Complex repair undermining is defined as:
- Distance equal to or greater than the maximum width of the defect, measured perpendicular to the closure line, along at least one entire edge of the defect.
What should the medical record documentation include?

- Location of defect and repair
- Type of repair performed
- Maximum width of defect perpendicular to the line of closure
- Undermining of one or both sides, less than the maximum defect width (state width); or equal to or greater than the maximum width along one entire edge
- Describe the layers that are closed, closure type e.g. interrupted, mattress etc.
- Length of repair

Sample Complex Repair Medical Record Documentation

Left cheek with maximum defect width of 2.2 cm was repaired linearly following an excision of adjoining standing cones.

Extensive undermining, 2.4 cm beyond the entire medial edge of the defect, was done.

Layered closure was done with 5-0 absorbable buried dermal-subcutaneous stitches followed with 6-0 nylon vertical interrupted surface stitches. The final length of closure measured 6.2 cm.

National Correct Coding Edits

- Medically Unlikely Edits (MUEs) for the repair codes have been determined
- Multiple procedures on the same date of service are still likely to be reduced under the multiple surgical reduction rule (MSRR)
  - Add-on codes need not be further discounted
  - However, payers can choose to discount payment for any reason despite CMS/NCCI guidelines
  - Check with specific payer guidelines, adhere if instructed to append modifier to add-on codes

National Correct Coding Initiative (NCCI) Edits

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MUE Edits/MAI Indicators

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MAI = 2 Based on policy, not appealable
MAI = 3 Based on “clinical benchmarks,” appealable
Intermediate Repair

Patient presents with melanoma in situ on the left arm

Excision area is prepped per protocol. Excision performed down to muscle fascia, with excision length of 5.5 cm

Wound is closed with 4-0 polyglactin subcutaneous sutures to reduce tension along the line of closure.

Surface wound is then closed with 8-0 nylon interrupted stitches.

Good wound approximation is achieved. Sterile pressure dressing is placed, instructions for wound care provided and reviewed with patient.

You Report:

CPT 12032

Excision of Subcutaneous Soft Connective Tissue Tumors

Excision of subcutaneous soft connective tissue tumors includes simple or intermediate repair.

Extensive undermining done for the purpose of excising the tumor is included in the soft tissue and subfascial tumor excision definitions.

Guidelines: Extensive undermining done for the purpose of excising wound edges is separately reportable.

Multiple Intermediate Repairs, Same Anatomic Classification: First Repair

Patient presents with atypical nevi on right upper arm and mid-back

Upper arm nevus is excised down to the level of subcutaneous fat with excision length of 0.8 cm

Wound is closed with 2-0 polyglactin subcutaneous sutures to reduce tension along the line of closure.

Surface wound is then closed with 3-0 nylon interrupted stitches.

CPT Code 12031

Multiple Intermediate Repairs, Same Anatomic Classification: Second Repair

Patient presents with atypical nevi on upper back

Same patient, atypical nevus on upper back

Excised down to the level of subcutaneous fat with excision length of 2 cm

Wound is closed with 2-0 polyglactin subcutaneous sutures to reduce tension along the line of closure.

Surface wound is closed using 5-0 nylon interrupted stitches.

CPT Code 12032

What do the coding guidelines say???

CPT Wound Repair Coding Guidelines

When multiple wounds are repaired, add together the lengths of those in the same classification and from all anatomic sites that are grouped together into the same code descriptor.

Our patient:

Patient wounds are classified under the same code descriptor and anatomic classification.

Correct Coding:

Repair size on the arm should be added to that on the trunk.

Total repair size is reported with single code.

Arm repair: 0.8 cm

Back repair: 2.0 cm

Total repair: 2.8 cm

CPT Code 12032: repair, intermediate, trunk and/or extremities 2.6 cm to 7.5 cm

Mohs surgery; Complex Repair and a Biopsy

Suspicious lesion on right cheek; invasive squamous cell carcinoma on the right superior helix.

Right cheek lesion is biopsied using tangential technique; diagnostic frozen section done and interpreted on site.

Mohs surgery performed to the malignant lesion on the right helix and closed with complex repair.

Line of closure measures 2.4 cm

You report 17311; 13151; 11102

What is wrong with claim submission?
Mohs surgery; Complex Repair and a Biopsy Coding Guidelines

**Tangential Biopsy**
If a biopsy of a suspected skin cancer is performed on the same day as Mohs surgery, report a diagnostic skin biopsy code with modifier 59.

**Complex Repair**
If a repair is performed, report with separate repair, flap or graft code.

**Correct Coding**
- 17311
- 11102-59
- 13151-59*
- 88331-59
* -59 modifier per NCCI edit

**Mohs surgery with Complex Repair**
BCC of the glabella treated with Mohs surgery. Final surgical defect is 0.9x2.1 cm. Repair options discussed with patient. Considering defect size and medical necessity, complex repair is determined as best option using a BSS blade, the margins are incised and drawn down to the subcutaneous fat. Burrow’s triangles are removed with sharp scissors dissection.

**No Changes to Adjacent Tissue Transfer (ATT) Guidelines**
- Lesion excision
  - Included in the ATT procedure (11400 – 11646)
  - ATT includes Z-, W-, V-Y-plasty, rotation flap, random island flap, advancement flap
  - When applied to repair lacerations, procedure must be performed by the surgeon
- Undermining
  - When performed to achieve closure, without additional incisions, does not constitute ATT; see complex repair codes 11100 - 11360
- Secondary defect closure
  - When performed to achieve closure without additional incisions, does not constitute ATT; see complex repair codes 11100 - 11360
  - When performed as an additional procedure
  - Measure primary and secondary defect to determine appropriate code
  - "Defect" means primary defect (resulting from the excision) and secondary defect (resulting from flap defect)

**Intermediate Repair**
- Undermining
  - Intermediate repair undermining is defined as:
  - Undermined distance less than the maximum width of the defect, measured perpendicular to the closure line, along at least one entire edge of the defect.

**Complex Repair**
- Undermining
  - Extensive undermining is defined as:
  - Distance equal to or greater than the maximum width of the defect, measured perpendicular to the closure line, along at least one entire edge of the defect.

Documentation must include:
- Extensive undermining done along at least one wound edge
- Maximum width of defect perpendicular to line of closure
- Width of undermining done, or undermining was equal to or greater than the maximum width of defect
Questions / More Information

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