Coding of Multiple Wound Repairs, Coding an E/M, IV Infusion, Coding of the Comprehensive Metabolic Panel

■ DAVID STERN, MD, CPC

Q. We have a patient with several lacerations to both of his hands. On his left hand, we sutured a total of three lacerations that have a grand total of 3.5 cm and on his right hand, we sutured one laceration with a total of 3.0 cm. What is the best way to code this?

A. Assuming that all the procedures were simple wound repairs, you would simply add the lengths of each repaired wound together then code for a simple wound repair of the hand of the resulting length summation:

- 12001 Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities. (including hands and feet); 2.5 cm or less.
- 12002 Simple repair... ; 2.6 cm to 7.5 cm
- 12004 Simple repair... ; 7.6 cm to 12.5 cm
- 12005 Simple repair... ; 12.6 cm to 20.0 cm
- 12006 Simple repair... ; 20.1 cm to 30.0 cm
- 12007 Simple repair... ; over 30.0 cm

You would sum wound repair lengths if all wound repairs were in the specified anatomic locations for the same code range and of the same complexity.

You would sum the wound lengths only for the wounds that are in any of the specified anatomical locations: that is, "scalp, neck, axillae, external genitalia, trunk, or extremities (including the hands and feet)." Wounds outside of these anatomic areas would be coded separately.

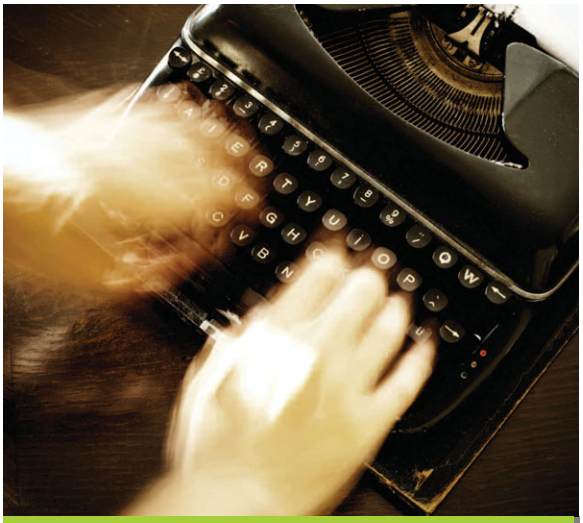
In addition, you should never sum the length of wound repairs for wound repairs of different complexities, even if the repair is in the same anatomic location. For example, for a patient with a 2-cm simple repair of a laceration on the back and a 6-cm complex repair of a laceration on the back, you should code each separately as 12001 (Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less) and 12042 (Layer closure of wounds of neck, hands, feet and/or external genitalia; 2.6 cm to 7.5 cm). You would not sum the lengths of the repairs because the repairs were not of the same complexity. ■

David E. Stern is a certified professional coder. He is a partner in Physicians Immediate Care, operating 18 clinics in Illinois, Oklahoma, and Nebraska. Dr. Stern was a Director on the founding Board of UCAOA and has received the Lifetime Membership Award of UCAOA. He serves as CEO of Practice Velocity (*www.practicevelocity.com*), providing software solutions to over 750 urgent care centers in 48 states. He welcomes your questions about urgent care in general and about coding issues in particular.

Q. I work in a hospital-owned urgent care center and would like to know what is correct when coding an E/M with 96370. I've been told to simply add Mod-25 to E/M and bill the medicine. It also depends on who the payors are. Some insurance companies will pay for the injection and some will not. Can you please clarify the correct coding?

A. The code (93670) you mention is for subcutaneous (SQ) (not intravenous [IV]) infusion. Thus, it would very rarely be used in urgent care. It should never be used:

- if the infusion was actually performed IV;
- if the infusion was not at least for 91 minutes. Note: For therapeutic infusions of 15 minutes or less, you should simply code for a SQ injection, i.e., 96372, Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular. For infusions of 16 – 90 minutes, you should code with 96369 alone.
- if the infusion was for hydration (most common reason in urgent care for infusions); or
- if 96369 is not coded for the first hour. The code 96370 is an add-on code to code for hours subsequent to the first hour. Code with 96369 for the first hour, then add code 96370 for each subsequent hour. ■



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CODING Q & A

Q. What codes can our urgent care center use for infusions?

A. The codes below can be used for different infusions in urgent care. Specifically note that the codes for infusion fall into two basic categories. Hydration is separated from the codes for therapeutic, prophylactic, and diagnostic.

Hydration Administration Codes

- 96360 Intravenous infusion, hydration; initial, 31 minutes to 1 hour. If the total infusion time is 30 minutes or less, then you should not use this code.
- 96361 Each additional hour. Only use this code as an add-on code to 96361. It is added once, if the total infusion time is 91 to 120 minutes. It (96361) would be added a second time if the total infusion time is 121 to 180 minutes.

Therapeutic, Prophylactic, and Diagnostic Administration Codes

- 96365 Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour
- 96366 Each additional hour
- 96367 Additional sequential infusion, up to 1 hour
- 96368 Concurrent infusion
- 96369 Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); initial, up to one hour, including pump set-up and establishment of subcutaneous infusion site(s)
- 96370 Each additional hour

Q. We want to build a panel in our EMR, so that we can code the correct CPT code for each individual component of the Comprehensive Metabolic Panel (CMP). This will increase the revenue for performing a CMP by approximately ten-fold. However, a biller in our company does not believe that this is compliant. Is he correct?

A. Your biller is correct. Billing for each individual item in the CMP separately would be an example of unbundling. Unbundling refers to the practice of billing separately for individual codes in a situation when a single code exists that could include all of the individual codes. The Centers for Medicare & Medicaid Services has found this practice to be non-compliant and would consider billing this way to be fraudulent. ■