Wound Repair Documentation Reminders

- Document repaired wounds *accurately*
  - Measure and record in centimeters, whether curved, angular or stellate
  - Include materials used to close (sutures / staples / adhesives) either singly or in combination with each other, or in combination with adhesive strips
  - Wounds closed utilizing adhesive strips as sole repair are billed as EM code only

- Document if the wound is *superficial* – simple repair
  - e.g., involving primarily epidermis or dermis, or subcutaneous tissues without significant involvement of deeper structures, and requires simple one layer closure;
    - This includes local anesthesia and chemical or electro cauterization of wounds not closed

- Document a single layer closure of heavily contaminated *wound if it requires "extensive"* cleaning or removal of particulate matter as it qualifies for intermediate repair
  - Include specific language "Extensively cleaned if applicable"

- *Intermediate repair procedure notes* in addition to documentation listed in #2 above, requires
  - Documentation of 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

- *Documentation for Complex repair* should include
  - Repair of wounds requiring more than layered closure, viz., scar revision, debridement (e.g., traumatic lacerations or avulsions), extensive undermining, stents or retention sutures
  - Preparation includes creation of limited defect for repairs or the debridement of complicated lacerations or avulsions
  - Document the involvement of nerves, blood vessel and tendons

- When *multiple wounds are repaired*
  - Document each repair separately
  - Your coders will combine by anatomic sites and bill the appropriate procedure codes

- *Decontamination and/or debridement*
  - Considered separate procedure only when
    - gross contamination requires prolonged cleansing,
    - when appreciable amounts of devitalized or contaminated tissue are removed, or
    - when debridement is carried out separately without intermediate primary closure and your procedure note includes documentation

- *Extensive debridement*
  - Document procedure note of subcutaneous tissue, muscle fascia, muscle, and/or *bone*

Splint Documentation Reminders

- Routinely document when a splint is applied to include
  - Type of splint (short arm, long leg, finger, etc.)
  - Who applies splints (by me, by nurse, by ortho tech, by EDP (Emergency Dept. Provider)
  - Post splint assessment include note "Placement check & NV intact"