Coding for Full-Thickness Skin Grafts

July 24, 2014

Question:

Patient has a large skin cancer on the nose. I excised it and repaired the wound with a full thickness skin graft. Donor site for the skin graft was the ear, which was closed by mobilizing skin flaps. We billed 11643 for the excision and 15260 for the graft. Is this correct?

Answer:

Yes, the excision of skin lesion is not included in the full-thickness skin graft codes like it is included in the adjacent tissue transfer codes. You may report a code for the excision of lesion (116xx, depending on size of the lesion plus most narrow margins) as well as for the full thickness skin graft (15260). The primary closure is included in 15260 and not separately reported.
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Answer:

Yes, the excision of skin lesion is not included in the full-thickness skin graft codes like it is included in the adjacent tissue transfer codes. You may report a code for the excision of lesion (116xx, depending on size of the lesion plus most narrow margins) as well as for the full thickness skin graft (15260). The primary closure is included in 15260 and not separately reported.

Complex Closure

July 24, 2014

Question:

Our surgeon performed a complex repair to close the wound following a mastectomy she performed. We were wondering if this is separately reportable.

Answer:

Thanks for your inquiry. Your question is actually a common one we are asked, so it’s a great time to make it a Coding Coach question. The mastectomy procedure includes a simple, intermediate and complex closure, as do all major procedures. While the surgeon may spend additional time and attention to achieve the most aesthetic closure as possible, this work of the complex repair is inclusive to the mastectomy.
Adjacent Tissue Transfers

July 24, 2014

Question:

If my doctor does more than one adjacent tissue transfer, do I add them together and bill one code or do I bill them separately?

Answer:

No, you do not add them together and bill one code. The adjacent tissue transfer (ATT) or rearrangement CPT codes 14000-14302 are reported per defect. Therefore, you will have one code for each defect you close with an ATT.

Thrombectomy and Follow-Up Angiogram Coding

Question:

We billed percutaneous thrombectomy (37184) for extraction of a clot and an associated completion angiogram (75898). Payors keep denying the angiogram. Is there a way to get this paid?

Answer:

Per CPT, percutaneous thrombectomy, 37184, includes all fluoroscopic guidance, including completion angiograms. Therefore, 75898 should not be separately reported.
**Bone Wax**

**Question:**

What is the CPT code for bone wax used to control bleeding at the surgical site?

**Answer:**

Thanks for your inquiry. Bone wax, filler, or any product used to control bleeding at the surgical site is inclusive to the surgical procedure and is not separately reportable.

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**Is Physician Presence Required to Report CPT Code 22310?**

**July 24, 2014**

**Question:**

Our neurosurgeon saw a patient in the office and diagnosed the patient as having a vertebral body fracture. The neurosurgeon ordered a brace to be applied, which was done when she was not present in the office. She wants us to report CPT code 22310, but we are saying that in order to bill this, the surgeon must be present for the application of the brace. Is this correct, or can she report 22310 just for diagnosing the fracture and ordering the brace?
CPT code 22310 reads “Closed treatment of vertebral body fracture(s), without manipulation, requiring and including casting or bracing.” The surgeon **must** be present for the application or personally apply the brace to report this code.

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**Providing Exposure For a Spine Procedure? What’s the Correct Code?**

**Question:**

I provide the retroperitoneal exposure for a neurosurgeon colleague for an anterior spine procedure. My partner went to the SVS coding course and tells me this is co-surgery. I have been billing 49010 for the exploratory laparotomy, retroperitoneal, since that is what I am doing and I have been getting paid without any problem. What is the correct coding for this situation?

**Answer:**

Your partner is correct and confirms the value of attending a coding course! The anterior spine procedure performed by the neurosurgeon, typically an anterior lumbar interbody fusion (22558), is valued for the approach, the procedure, and the closure. Therefore, you are doing a distinct part of that CPT code and are therefore acting as a co-surgeon. Reporting 49010 is essentially double billing the approach. To code this correctly, both you and the neurosurgeon should report 22558-62 for this work.
Is Physician Presence Required to Report CPT Code 22310?

Question:

Our surgeon saw a patient in the office and diagnosed the patient as having a vertebral body fracture. The surgeon ordered a brace to be applied, which was done when the surgeon was not present in the office as the surgeon had to emergently leave the office to go to the ER. He wants us to report CPT code 22310, but we are saying that in order to bill this, he must be present for the application of the brace. Is this correct, or can he report 22310 just for diagnosing the fracture and ordering the brace?

Answer:

This is a great question. CPT code 22310, reads “Closed treatment of vertebral body fracture(s), without manipulation, requiring and including casting or bracing.” The surgeon must be present for the application or must personally apply the brace to report this code. The bracing is an integral part of the work associated with the payment for this CPT code.

Submucous Resection of the
Inferior Turbinates

July 10, 2014

Question:

My physician and I disagree about the correct use of CPT code 30140 SMR of inferior turbinates. I have told him that he needs to document removal of bone, but he doesn’t agree and hasn’t been documenting this. Please help!

Answer:

You both are correct! In the submucous resection of the inferior turbinate (SMR) procedure, CPT 30140, the documentation should state that the physician entered or incised the mucosa and removed or reduced some of the bone and/or soft tissue. If he/she is reducing tissue volume only, without an incision, then an ablation code (30801 or 30802) is likely the correct code to use depending on whether it is superficial or intramural (i.e., submucosal). The submucous resection code (30140) of the inferior turbinate is a unilateral code, and may be appended with modifier 50 when performed bilaterally.

Remember, per CPT coding instructions, 30801, 30802 and 30930 (fracture inferior turbinate(s), therapeutic) are not to be reported with CPT 30130 (Excision inferior turbinate, partial or complete, any method) or 30140.