Excision of Melanoma

Question:
I’ve heard differing advice and hope you will clear up something for me. What CPT code do we use for excision of a melanoma? I’ve heard people say to use the excision of skin lesion code, 116xx, and others tell me to use the soft tissue or radical excision of tumor codes such as 21556 or 21557?

Answer:
Good question. CPT says that a melanoma is a cutaneous lesion and, therefore, an excision/resection should be reported using the excision of malignant skin lesion codes such as the 116xx codes. It is not accurate to report an excision of soft tissue tumor code (e.g., 21555, 21556) or radical resection of soft tissue tumor (e.g., 21557) code for excision of a melanoma.

AV Graft Coding: Basilic Vein Transposition In 2 Stages

Question:
I do a basilic vein transposition for AV access in two stages. The code 36819 is for doing the procedure all in the same time. How do I report it in 2 stages?

Answer:
To report this procedure in 2 stages report, 36821 for stage I, the direct basilic vein to brachial artery transposition, since it is essentially performing an AV fistula. For Stage
II, the superficialization of the patent brachio-basilic vein fistula, report an AV graft revision, 36832. Report 36832 with a 58 modifier since 36821 has a 90 day global. Remember to document in the operative note for 36821 that a staged procedure is planned.

How Do I Calculate The Size of An Adjacent Tissue Transfer Code

Question:

I am inquiring how to calculate the size of a wound to determine which adjacent tissue transfer code should be reported. The surgeon excised a dematofibrosarcoma protuberans of the chest that resulted in a primary and secondary defect documented as a 16.5 x 7. The secondary defect was closed primarily. My surgeon says the size of the defect is 115.5 sq cm and I am saying the wound size is 23.5 sq cm. Who is right?

Answer:

Your surgeon is right. To report adjacent tissue transfers, the wound size is based on square centimeters (sq cm). To determine the total size of the wound defect, the defect size is determined by first multiplying the length times the width of the primary and secondary defects and adding both of them to determine the total defect size when the secondary defect is closed primarily as noted. Report CPT 14301 for the first 60 square centimeters (sq cm), add-on code 14302 for the next 30 sq cm and +14302-59 for the remaining 25.5 sq cm. Alternatively, you may report 14301 and 14302 x 2 units if you...
know that the payor will recognize more than 1 in the units box and reimburse the appropriate amount. Please note, some payors may not require the modifier 59 on the second add-on code.

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**Excision of a Sebaceous Cyst**

**Question:**
What diagnosis code do we use for a sebaceous cyst – is it a “benign neoplasm”?

**Answer:**
Actually, a sebaceous cyst has its own diagnosis code, 706.2, so use of a neoplasm code is not accurate. You’ll use the excision of benign skin lesion CPT code, 114xx, to report the surgical procedure. Remember, many payors do not reimburse for excision of a sebaceous cyst as it may be considered a “cosmetic” procedure.

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**Fluoroscopy**

**Question:**
Can I bill a fluoroscopy code such as 77002-26 when I do a transsphenoidal pituitary tumor removal? Or, how about billing 77003-26 when I do a discectomy?

**Answer:**
Actually, use of fluoroscopy for localization or to help you perform a surgical procedure is included in the global
Bypass Graft Thrombectomy with Revision (35876): What’s Billable?

May 16, 2013

Question:

The physician does bypass with vein (35566). The next day thrombus develops in that vein graft and the physician does a catheter thrombectomy but the graft tears from the thrombectomy and is not repairable. He removes the graft and replaces it with a synthetic graft. Is 35876 (thrombectomy with revision) the only billable code for the services provided on day two?

Answer:

Yes, on day two, 35876 for the thrombectomy and revision is the only code reported. Remember to add a 78 modifier to 35876 for an unplanned return to the operating room for a related procedure.
Carotid – Subclavian Bypass
Before a TEVAR

Question:

I performed a carotid-subclavian bypass with vein in preparation for TEVA that was then performed on a subsequent day. How are these two procedures reported?

Answer:

The carotid-subclavian bypass is reported with 35606 as the first stage of this two stage procedure. Since this has a 90 day global and the TEVAR is preformed within that global period, all the TEVAR codes (main body deployment, catheterization, exposure, etc) would be reported with a 58 modifier to indicate a staged procedure. The operative note for 35606 should document the staged nature of the procedures. No modifier is needed on the 35606, assuming the patient is not already in a global period for an earlier procedure.

Maxillary Sinus Lavage (31000)

Question:

My doctors want to bill 31000 for a maxillary sinus lavage every time they do an endoscopic procedure on the maxillary sinus such as 31256 (endoscopic maxillary antrostomy), 31267 (endoscopic maxillary antrostomy with tissue removal from within the sinus) and 31295 (endoscopic balloon dilation of the maxillary sinus). The lavage is bundled with 31256 and
31267 when I look at Medicare’s Correct Coding Initiative edits but I can bypass the edit using modifier 59 (distinct procedural service). Is it appropriate for us to append modifier 59 to 31000 in these instances? CPT 31000 is not bundled with the balloon dilation code, 31295, so it must be ok to bill both codes.

Answer:

It is not appropriate to append modifier 59 to 31000 just to get the procedure paid. You must meet the criteria for use of modifier 59 in order to use the modifier appropriately and bypass the CCI edits. In these three examples, it is not accurate to separately report 31000 with or without a 59 modifier. The lavage is a lower-valued procedure performed at the same operative session on the same structure (maxillary sinus) and, therefore, would be included in the primary procedure codes of 31256, 31267 or 31295. Do not separately report 31000 for maxillary sinus lavage.

Intraoperative Angiography During Microvascular Flap Surgery

Question:
I am doing this new thing during my microvascular free flap procedures where I do intraoperative fluorescent angiography (Spy) to evaluate tissue perfusion prior to closing the wound. I’m told by the vendor that I can bill CPT 15860 Intravenous injection of agent (e.g., fluorescein) for this in addition to the microvascular free flap code. I’ve tried billing it the last couple of times but I can’t get the insurance company to
pay for it. Please help.

**Answer:**
Anything you need to do to test the vascular flow in flap such as using a Doppler, tissue oximetry, or injecting fluorescein is included in the code for the primary procedure. Checking tissue perfusion and vascular flow is an inherent part of doing a microvascular free flap and not a separately billable procedure.

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**Pituitary Surgery**

**Question:**
My neurosurgeon and an ENT doctor do pituitary surgeries together and the ENT wants to bill 62165 and 61548 together. Is it ok to bill both codes?

**Answer:**
No, it is not appropriate to report both codes together. Choose the single code that best describes what was done and each physician will append modifier 62 (two surgeons, or co-surgery) to that single code.