**Placement of Mesh in Breast Reconstruction Procedures**

**Question:**

When performing a TRAM flap single pedicle or other types of breast reconstruction procedures where I close the donor site with mesh, does the breast reconstruction code such as 19367 include the mesh placement for donor site or is it separately billable with code 49568? I was told by a colleague that the mesh code is separately reportable but I just wanted to check with you to be sure before I billed it. Thank you!

**Answer:**

Actually, according to CPT rules, 49568 can only be billed with a hernia repair code so it is not appropriate to report the code with a breast reconstruction procedure code such as 19367. Because 19367 says “including closure of donor site” then placing the mesh is part of the closure and not separately reported. It would not be accurate to report 15777 for mesh placement since it is not a “biologic” as required by the CPT code.

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**Excision of a Skin Lesion**

**Question:**

When coding for excision of a skin lesion (114xx, 116xx), do I use the size on the pathology report to determine the correct CPT code?

**Answer:**
The most accurate measurement, according to CPT, is when the lesion has not yet been excised and is still on the patient. The specimen reduces in size when it is in formalin. So reporting a CPT code with the size listed on the pathology report may result in a lower CPT code being billed and a loss of revenue.

**Implantation of Biologic Code (15777) Issue**

**Question:**
I’m using the new add-on code, 15777, for Alloderm placement when we do a breast reconstruction with tissue expander. However, we are having trouble getting paid on the code when we bill it bilaterally with modifier 50. Can you help?

**Answer:**
Yes, this has been a problem since the code came out in January 2012. CPT says modifier 50 is appropriate on 15777. However, Medicare (and some other payors) did not appropriately set up their payment systems to recognize modifier 50 on 15777. Medicare fixed this issue effective July 1, 2012. You should refile/appeal previous denials and hopefully be paid now.

**Breast Reconstruction**

**Question:**
I’m doing a second stage breast reconstruction revision by
removing the tissue expander and placement of a permanent implant. I got two codes pre-certified, 11970 (Replacement of tissue expander with permanent prosthesis) and 19380 (Revision of reconstructed breast). So I billed those two codes but the insurance company only paid one code, 11970. How can I appeal and also get paid for 19380?

Answer:
Actually, the CPT code for removing a tissue expander and placing a permanent breast implant is reported using only 11970. CPT 19380 is not reported until the patient has undergone final reconstruction and now requires some type of revision.

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**Soft Tissue Tumor Codes**

**Question:**
I removed a lipoma from the chest that was a good size and pretty deep. I’m looking at the excision of benign skin lesion codes (114xx) and they just don’t seem to describe what I did. Please help.

**Answer:**
Good thing you asked for advice because new codes were introduced in 2010 that better describe the procedure you performed. Look at codes 21552 – 21556 to see which code best describes your procedure. The codes are anatomical location-specific (e.g., face/scalp, neck/anterior thorax), depth-specific (e.g., subcutaneous, subfascial), and size-based (in centimeters depending on total excision length).
A Letter From a Private Payor About My E & M Coding. Should I Be Concerned?

Question:
I received a letter from a private payor saying I report a higher percentage of 99204, 99205, 99244 and 99245 services than my peers. The letter advised me to review the E & M requirements for these codes. Should I be concerned?

Answer:
Yes you should! This is essentially a warning letter that your payor is trending your E&M services and has identified you as an outlier with these levels of service in comparison to your peers. You may choose to contact your healthcare attorney to determine next steps. This may include an internal or external review of E&M services that were reported with these E&M codes or perhaps some one-on-one E&M Coding and Documentation education. You should also run a CPT frequency report (may be called a productivity report in your system) and benchmark yourself and your group, if appropriate, to state and national benchmark data. This data is available from the Medicare website or KZA can assist you with our E & M Analyzer.

The Analyzer, provides you with a comprehensive assessment of your E & M coding patterns as compared to your peers and where you might be at risk. Click here to find more information about the E&M Analyzer. Now is the time to act as your payor has already identified they are paying attention.
**Skin Lesion Removal and Closure**

**Question:**
I have a question on lesion removal and closure coding. If two lesions the same size, same diagnosis (e.g., malignant) and same area (e.g., neck) are removed, is the code used twice or are the sizes added together for one code? I have the same question for a repair—same site (per code description), same type of closure (e.g., intermediate) — do we add the lengths together or use the same code twice?

**Answer:**

We cover these exact questions in the AAOHNS/KZA coding courses. Report one CPT code for each lesion removed. Use modifier 59 on the second and subsequent same CPT codes. For example, removal of two malignant lesions of the neck each 1.2 cm in diameter are reported using 11642 and 11642-59. Be careful because some payors (including Cahaba Medicare) require the use of modifier 76 rather than 59 in the situation where more than one of the same CPT codes is billed on the same date of service.

For the repair codes, you will sum the repairs for similar types of repairs (e.g., intermediate, complex) in similar anatomic locations (per CPT code). Bottom line is lesion removal codes are never added together but the wound repair codes may be summed.
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Complex Closure

Question:
One of my doctors wants to bill complex closure codes along with his breast procedure codes (i.e. breast reduction & breast reconstruction). He wants to use them for the closure stating that he is doing a complex layer closure when he closes the patient. He got the idea because he has a “friend who does this and gets paid”. Are we missing out on money because we don’t bill for the complex closure?
Answer:
No, you are not missing out. In fact, your doctor’s friend is not coding correctly. The primary closure (i.e. simple, intermediate, complex) is included in the breast reduction and breast reconstruction procedures and not separately reported.

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**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.