Coding Shoulder Melanoma

August 7, 2014

Question:

My doctor documented the following: Excision of a 1.5 cm melanoma from the shoulder with wide undermining to advance the tissues and a layered closure. Can we use an adjacent tissue transfer code, 14000, for this procedure?

Answer:

No. “Wide undermining to advance tissues” is not an appropriate use of an adjacent tissue transfer code. Use a complex repair code (131xx) instead of the adjacent tissue transfer code; you may also report a CPT code for the skin lesion removal (e.g., 116xx).

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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**Excision of Uncertain Behavior Lesion**

July 10, 2014

**Question:**

I excised a skin lesion and the pathology came back as a giant pigmented nevus. ICD-9 says this is “uncertain behavior,” 238.2. Which CPT code do I use – malignant (116xx) or benign (114xx)?

**Answer:**

Great question! It is most appropriate to use the excision of benign skin lesion CPT code (114xx) for excision of uncertain behavior skin lesions.

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**Removal of IMF Wires and Arch**
Bars

June 26, 2014

Question:

Thank you, Kim, for coming to our practice recently. We really learned a lot from you! I forgot to ask this question. I do not usually bill for the removal of the IMF wires and arch bars postop in the office since I have always been told it is included in the original surgical code 21453. However, my colleagues have been advising me to use 20670 (w/ or w/o -58) for this removal. So, before I start following their coding advice, I thought I should check with you.

Answer:

Thank you so much for your kind words! We had a great session – it was enjoyable. You are correct to not bill for removal of the IMF wires and arch bars postop when done in your office. This activity is included in the global package for 21453; if you put on the IMF wires/arch bars you are expected to take them off. That said, if you took the patient back to the OR, then you could bill 20670 (you will append modifier 58 since it was planned or anticipated that you’d remove the arch bars during the global period). However, removal in the office is included in your payment for the initial surgical procedure.

Microdermabrasion Coding

June 12, 2014

Question:
What is your recommendation for the proper CPT-4 coding for microdermabrasion? Many of my colleagues use the codes for dermabrasion (15780-15783). I have also seen unlisted codes used (17999, 96999). Thank you.

Answer:

There is not a specific CPT code for “microdermabrasion” because generally this is considered a cosmetic procedure and not billed to insurance. A CPT Assistant from December 2003 states: “Code 15783 is for “superficial” abrasion and uses the example of tattoo removal. However, tattoo pigment is embedded in the dermis and abrasion treatment of tattoo abrades into the dermis and always causes bleeding. Microdermabrasion treatment is not an epidermal procedure, nor is there an existing code that describes epidermal abrasions. The depth of injury for microdermabrasion to the epidermis is more like that of a superficial chemical peel, such as a glycolic acid peel. Therefore, the appropriate code to report for microdermabrasion is code 17999, Unlisted procedure, skin, mucous membrane and subcutaneous tissue.”

We concur with the advice to use an unlisted code if you have medical necessity and the service will be billed to insurance. But be sure to obtain written prior authorization from the payor because, as previously mentioned, it’s generally considered a cosmetic procedure.

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**Closure After Lumpectomy**

May 15, 2014

**Question:**

I will frequently do a Wise pattern breast reduction on a
breast after a lumpectomy; then I do a breast reduction on the contralateral breast. Is it appropriate to report code 19318 (Reduction mammoplasty) or should I use 19366 for Breast reconstruction with other technique? Or maybe I can use both codes for each side?

**Answer:**

Actually, 19366 cannot be used in your scenario because a mastectomy was not performed. The breast reconstruction codes are used only for reconstruction after a mastectomy procedure and not for closure of a lumpectomy defect. Therefore, you will use only 19318 with modifier 50. Remember, some payors want line-item reporting of the codes (19318 and 19318-50) while other payors recognize the single line method as two procedures (19318-50). Be sure to bill the appropriate format to ensure you’re paid the accurate amount.

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Carpal Tunnel Release and Splint

May 1, 2014

**Question:**

We put on a splint after a carpal tunnel decompression procedure and my coder says we can separately bill 29125 for the short arm splint. I wouldn’t think we could bill this. What do you think?

**Answer:**

You’re right – placement of the splint (or even cast after a fracture repair) is included in the global surgical package
for the decompression procedure (CPT 64721 or 29848) and is not separately reported.

Adjacent Tissue Transfer

April 17, 2014

Question:

We billed an excision of malignant lesion CPT code and an adjacent tissue transfer CPT code and only got paid for the lesion removal. How can we get paid for both services?

Answer:

The excision of a skin lesion code (114xx, 116xx) is included in the adjacent tissue transfer codes (14000-14302) when performed on the same lesion/defect. Therefore, the malignant skin lesion excision should not have been billed. If you’ve “unbundled” the codes by billing both the lesion removal and adjacent tissue transfer then you should refile a corrected claim billing only the adjacent tissue transfer code. However, if the lesion was at a separate site from the adjacent tissue transfer and the two procedures were in no way related to each other, then you should have been paid for both. You should refile a corrected claim with modifier 59 (distinct procedural service) on the lesion removal code to show the lesion was distinctly separate from the adjacent tissue transfer service.
Excision of Lymph Node/Breast Reconstruction

April 3, 2014

Question:

Sometimes when I do a breast reconstruction I find a lymph node or two that I excise to access blood vessels and complete the procedure. I have never billed for this but one of my partners says he always bills. So who is right – me or my partner?

Answer:

Removal of lymph nodes as you describe it is part of the exposure and is included in the breast reconstruction code; therefore, you would not separately report a lymph node removal code such as 38530.

Excision of a Skin Lesion

March 6, 2014

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.