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.

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
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.
**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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**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?
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.

### 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.

### Calculating Physician Work RVUs

**Question:**
I am confused about how to count RVUs particularly for bilateral procedures such as the bilateral breast reduction
surgery. Is the RVU assigned to the code 19318 for one breast or for a bilateral procedure? So for example if the work RVU for 19318 is say 33.12, and I did only one breast would I have performed 33.12 RVUs of work? And similarly if I did a bilateral surgery would I have now done 66.24 RVUs of work? I’m not sure my hospital is capturing my RVUs accurately and I really want to understand this.

Answer:

You are very wise to learn how RVUs impact your compensation – I wish more physicians would. My colleague, Sarah Wiskerchen, just wrote an article about RVU compensation that was published in the *Journal of Medical Practice Management* that I think is mandatory reading for every surgeon. First, the RVUs you cite above are the CPT code total RVUs. Physician compensation plans should be based on physician work RVUs, not total RVUs. The physician work RVUs for 19318 are 16.03 in 2013 and that is for a unilateral procedure as described by the code.

Billing for bilateral procedures generally occurs in two types of format: 1) Line-item format listing each CPT code on a separate line and modifier 50 on the second code (19318, 19318-50) and billing your full fee for each procedure, and 2) Bundled format listing the code on a single line with modifier 50 and doubling your fee (19318-50). Payors reimburse 50% of the allowable for the second side/bilateral procedure so in both formats your payment would be 150% of the allowable.

Your compensation formula likely includes modifier adjustments so that you would receive credit for 16.03 work RVUs for the first side and 8.02 work RVUs for the second side for a total of 24.05 work RVUs for the bilateral procedure.
Calculating Size for Codes

Question:
I’m new to coding. My doctor and I have a disagreement on how to calculate the size for the adjacent tissue transfer codes (140xxx). The doctor says there was a 16.5 cm by 7 cm wound that he did an adjacent tissue transfer to close. I think I should use a code for a 23.5 square centimeter code because 16.5 plus 7 equals 23.5. My physician said we are to multiply the numbers so it would be 115.5 square centimeters. Who is right?

Answer:
Your physician is right. Area is measured in square centimeters and obtained by multiplying the length times the width of the wound. You will use 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.

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.