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.

---

**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.

---

**Excision of Uncertain Behavior Skin Lesion**

**Question:**
If my physician excises a lesion and the pathologist says it is a diagnosis that is considered “uncertain behavior” by ICD-9, do I use the benign excision of skin lesion CPT code or the malignant CPT code when I bill?

**Answer:**
Good question! When the diagnosis is categorized with an “uncertain behavior” ICD-9 code, then you will use the excision of benign skin lesion CPT code for the removal.

---

**Rib Resection With Breast Reconstruction**

**Question:**
I did a breast reconstruction with a free flap, actually a DIEP flap, and billed 19364 for the breast reconstruction as well as 21600 for the rib resection. The insurance company paid me for the breast reconstruction but denied payment on the rib resection. I appealed the denial but lost – they said
that the rib resection is included in the breast reconstruction code. Do you agree?

**Answer:**
Yes, we do. And, as a matter of fact, so does CPT. The CPT Assistant, July 2012 specifically states that the rib resection is included in 19364 and should not be separate reported.

---

**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 I should be reported. The surgeon excised a dermatofibrosarcoma protuberans of 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 physician 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.

---

**Removal of K-wire**

**Question:**
I repaired a phalangeal fracture on a patient and placed K-wires. I took them out in the office. Is this billable?

**Answer:**
No, removal of the K-wire is included in your global surgical package of the fracture repair. However, you may bill if you take the patient to the operating room (use modifier 58 if the removal is staged/planned or use modifier 78 if the removal is unplanned for some reason such as infection or bleeding).

---

**Nasal Fracture Repair vs. Rhinoplasty**

**Question:**
I did an open treatment of a nasal fracture repair and septoplasty on a patient who was in a bar fight two years ago on spring break and had his nose broken. He now has nasal airway obstruction and deviated nasal septum as well as displaced nasal bones. I billed 21335 (Open treatment of nasal fracture; with concomitant open treatment of fractured septum) but the insurance company denied it. Did I do something wrong or should I appeal it by sending in pictures?
**Answer:**
The nasal fracture treatment codes (e.g., 21310-21337) are to be used when you are treating an acute fracture, not an old or healed fracture. The rhinoplasty codes (e.g., 30420) are more appropriate when you are treating a healed fracture. You can try to appeal the denial but we suspect the insurance company will not pay for the procedure because they consider it to be “cosmetic.”

---

**Multiple Lesions**

**Question:**
The doctor removed 3 lesions: 1) left upper back, 2) right upper back, and 3) right lower back. Each lesion was closed in layers. I got the pathology results back and they all were malignant, with clear margins, so I’m ready to code the case. Do I have to use one malignant skin lesion excision code since the lesions are all in the same area (trunk)? Meaning, do I add up the measurements of each lesion and bill one code?

**Answer:**
No! Each lesion may be reported separately using a malignant lesion of the trunk CPT code (11600-11606). It is the intermediate repair code that will be the sum (or added up) of the three separate closure lengths (12031-12037).