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 dematofibrosarcoma 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).

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**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).

Tissue Expander Exchange with Revision of Breast Reconstruction

Question:
I did a tissue expander exchange to permanent prosthesis on a patient and she needed a little bit of fat and excess tissue removed at the same time. I billed 11970 (tissue expander
exchange), 19370 (for the capsulotomy) and 19380 (revision of breast reconstruction) but the insurance company wouldn’t pay for 19370 or 19380. I wrote an appeal letter complaining and asked for a re-review. I just got notice that the original denials were upheld. Is the insurance company wrong or did I code it incorrectly?

**Answer:**

It is difficult to make a determination without seeing the actual operative note. But in general, the capsulotomy (19370) is included in the exchange code, 11970, and not separately reported.

Also, 19380 is intended to be used for revision of a previously reconstructed breast. The breast is not considered to be finally reconstructed at the time of the exchange. It is only after the breast has undergone complete reconstruction than we can use 19380.

So it sounds like the insurance company was correct to pay only 11970.