Post-Operative Pain Management and Breast Reconstruction

January 4, 2018

Question:
My physician consistently reports CPT 19364 for a breast reconstruction with free flap and 64421 for post-operative pain management and the payors are denying CPT 64421 with Modifier 59. How can I get paid for both procedures? Is there another code I can use?

Answer:
CPT 64421 (Injection, anesthetic agent; intercostal nerves, multiple, regional block) is included in 19364 (Breast reconstruction with free flap) and cannot be reported separately. In addition, both codes are bundled under NCCI and cannot bypass the edit even with Modifier 59. There is not another code you can use to get paid for post-operative pain management as it is included in the breast reconstruction.

*This response is based on the best information available as of 01/04/18.

Complex Closure with a Soft
Tissue Tumor Code

November 30, 2017

Question:
Can I also bill for the complex repair when I’ve also excised a soft tissue tumor like a lipoma in the 21552-21555 series of codes?

Answer:
Actually CPT says these soft tissue tumor codes include the simple or intermediate repair and a complex repair may be separately reported. That said, Medicare and many other payors will not reimburse the code because they consider it to be a primary closure.

*This response is based on the best information available as of 11/30/17.

Debridement Prior to Skin Grafting

November 16, 2017

Question:
I’m taking a patient to the OR for debridement of a dehiscent surgical wound and will skin graft it for closure. I’m looking at getting 11042 (debridement) and the skin graft codes precertified. Is this right?

Answer:
Not exactly. You’re right about the skin graft code(s). However, we do not recommend the 11042 – 11047 codes. These codes are used for wound debridement but only when you are debriding an open wound with no intention of closing it; you expect the wound to heal by secondary intention. In your example, you will be closing the wound. Therefore, the more accurate code is a surgical preparation code (15002 – 15005) for **excision** (note the term is not debridement) of the open wound to prepare a viable wound surface for grafting.

*This response is based on the best information available as of 11/16/17.*

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**Intercostal and TAP Blocks**

November 2, 2017

**Question:**
My doctor documents that she does bilateral intercostal chest blocks as well as bilateral TAP blocks to the abdomen and rectus fascia when she does breast reconstruction procedures. I want to bill for these but my plastic surgeon thinks they are not billable?

**Answer:**
We agree with your surgeon. These services are performed through the same surgical exposure for postoperative pain management; therefore, the services are included in the primary procedure code for the breast reconstruction procedure and not separately billable with injection codes.

*This response is based on the best information available as
**“Stacked” DIEP**

October 19, 2017

**Question:**
What is the code for a “stacked” DIEP flap used for breast reconstruction?

**Answer:**
CPT says 19364 is used for a free flap breast reconstruction of any type. There is not a separate CPT code for a “stacked” DIEP flap reconstruction. Some payors will allow the HCPCS II code S2067; however, some will not pay S2067 but will allow S2068. Get the appropriate code precertified so you know what code is allowed prior to billing.

*This response is based on the best information available as of 10/19/17.*

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**Abdominal Fat Graft**

October 5, 2017

**Question:**
I billed 15770 (Graft; derma-fat-fascia) for an abdominal fat graft. After reviewing my operative report, the insurance company denied the code saying it was wrong. What code should I use?

Answer:
CPT 15770 is a composite graft meaning more all layers – dermis, fat and fascia – are used to repair a defect. In your situation, you used only one layer – fat. Therefore, the correct code is 20926, Tissue grafts, other (eg, paratenon, fat, dermis).

*This response is based on the best information available as of 10/05/17.

Absorbable Implant
September 21, 2017

Question:
I billed 30465 for an injection of a bioabsorbable implant into the lateral nasal wall to repair nasal vestibular stenosis. The insurance company is denying this for “coding issue” and “wrong place of service”. How can I appeal?

Answer:
CPT 30465 says “Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction)” and was introduced into CPT in 2001 – 16 years ago – which is long before the injection procedure was performed. As a point of history, the code was valued to be a hospital/ASC services, has a 90-day global period, is inherently a bilateral
procedure (meaning performed on both sides so modifier 50 may not be used), requires incisions and includes grafting as well as medial osteotomies when performed. Medicare’s physician time table says the code is valued for a median intra-service time of 120 minutes. We do not recommend using 30465 for the office procedure you describe. Rather, we recommend using an unlisted CPT code such as 30999.

*This response is based on the best information available as of 09/21/17.

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**Moderate sedation Denials. How do we get paid for 99153?**

September 7, 2017

**Question:**
We are billing the new moderate sedation codes, but are getting denied on the second 15 minutes, 99153. Almost all our patients have sedation for more than 15 minutes. What are we doing wrong?

**Answer:**
You are doing nothing wrong! The codes you are referencing are listed below. Code 99151 or 99152 are paid without a problem. It’s code 99153 that is the issue. When Medicare valued these new codes as part of the Medicare Physician Fee Schedule, 99152 (or G0500 for GI endoscopy procedures) had an RVU assigned. Code 99153, for the second 15 minutes, (or a minimum of 23 minutes total of sedation) did not have a professional fee value assigned, indicating that Medicare will not pay for...
these additional minutes. Medicare considers all physician work for moderate sedation to be covered by the single code; 99151 (or G0500 for GI endoscopy procedures). Continue to bill per CPT guidelines that allow this second code. Private payors may pay for this code. Write off the Medicare denial.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>99151</td>
<td>Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient’s level of consciousness and physiological status; initial 15 minutes of intra-service time, patient younger than 5 years of age</td>
</tr>
<tr>
<td>99152</td>
<td>initial 15 minutes of intra-service time, patient age 5 years or older</td>
</tr>
<tr>
<td>+99153</td>
<td>each additional 15 minutes intra-service time (List separately in addition to code for primary service)</td>
</tr>
<tr>
<td>G0500</td>
<td>Moderate sedation services provided by the same physician or other qualified health care professional performing a gastrointestinal endoscopic service that sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient’s level of consciousness and physiological status; initial 15 minutes of intra-service time, patient age 5 years or older. Report additional time with 99153 as appropriate. Use only for GI endoscopy procedures for Medicare patients</td>
</tr>
</tbody>
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Paramedian Forehead Flap on Previous Mohs Surgery

August 24, 2017

Question:
My doctor did a division and inset of a paramedian forehead flap on a patient that had Mohs surgery on their nose. Do I code 15620 since the flap was brought from the forehead, or 15630 since the flap was placed on the nose?

Answer:
Good question. If you look at the code descriptors, they state, “Delay of flap or sectioning of flap at...” This means that the code is chosen for where the flap is inset. In your case, the flap was inset at the nose. CPT code 15630 for division and inset at the eyelids, nose, ears, or lips, would be the correct code to report. Don’t forget also that if repair of the donor site requires skin graft or local flap to repair, it is separately reportable. Hope this helps.

*This response is based on the best information available as of 08/24/17.*
Global Period for Surgery. Is it billable?

August 10, 2017

Question:
My patient presented to the ED with an infection at the incision site from a surgery that I did 4 weeks ago. It has a 90 day global. I was on vacation so my general surgeon partner saw the patient and admitted her. What should she bill for this?

Answer:
Since the patient is in a global period for the surgery, this is not billable, by you or any of your partners of the same specialty.

From a billing perspective, you and your partners are a single billing entity. Therefore, you all share the global package of the patient’s surgery.

*This response is based on the best information available as of 08/10/17.*