Excision of Skin Lesion

January 14, 2016

Question:
I heard you say at a course (you were great, by the way. I learned a lot from you!) that we should wait for a pathology report before billing for excision of skin lesions. Please explain why. This may be why I’m not getting paid.

Also, when is your next plastic surgery coding course?

Answer:
Thank you for your kind words, you made my day! Yes, you’ll need to wait for a pathology report when reporting the excision of skin lesion codes because the CPT code descriptions require the pathology be known. The codes are for removal of benign (114xx) and malignant (116xx) lesions. If you have a previous pathology report showing a malignancy (e.g., biopsy) then you can go ahead and bill the service using the malignant lesion excision code (116xx) without waiting for the pathology report.

Thank you for also asking about our courses. Click here for our 2016 Plastic Surgery Coding courses. I hope to see you soon!

*This response is based on the best information available as of 01/14/16.

Split Thickness Skin Graft

December 17, 2015
**Question:**
The doctor did a split-thickness autograft of the leg. I can’t find the CPT code for this procedure for an adult. I see only CPT codes for infants and children. Can you tell me where the codes for adults are?

**Answer:**
There are two stand-alone codes for split thickness skin grafts:

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>15100</td>
<td>Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children</td>
</tr>
<tr>
<td>15120</td>
<td>Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children</td>
</tr>
</tbody>
</table>

Note that the code descriptors say, “first 100 sq cm or less, or 1% of body area of infants and children.” That means the code applies to both adults and children. If an adult, you’ll use the area in square centimeters documented in the note. If an infant or child, you’ll use 1% of the body area as your guide for coding the area grafted.

*This response is based on the best information available as of 12/17/15.*
Question:

Please resolve an internal debate we’re having in our office. Are the STSG codes chosen based on the recipient or the donor site?

Answer:

Good question, and this is always confusing. CPT says: “Select the appropriate code from 15040-15261 based upon type of autograft and location and size of the defect. The measurements apply to the size of the recipient area.” So you’ll choose the code based on the recipient/defect site and the area (in square centimeters) is of that same site. The two STSG graft codes are 15100 (recipient/defect site is trunk, arms or legs) and 15120 (recipient/defect site is face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits).

*This response is based on the best information available as of 12/03/15.*
Since the new diagnosis codes for absence of the breast includes one specifically for bilateral, will modifier 50 (bilateral procedure) still be required on the CPT code? For example, for bilateral breast reconstruction with a tissue expander and biologic implant, we will use Z90.13 for acquired absence of bilateral breasts and nipples for the diagnosis code. Will we still need modifier 50 on the CPT codes 19357 and 15777?

Answer:

YES! Nothing changes with CPT coding with the implementation of the new diagnosis coding system, ICD-10-CM. So in your example, you’d use 19357-50 and 15777-50 (or 19357, 19357-50, 15777, 15777-50 if the payer prefers each code be listed separately). [Click here](#) to see our newly released webinar for everything you ever wanted to know about ICD-10-CM Coding for Plastic Surgery!

*This response is based on the best information available as of 11/05/15.

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**7th Character Extension in ICD-10-CM**

October 22, 2015

**Question:**

I don’t understand the 7th character extension. Why don’t all codes get the 7th character extension?

**Answer:**
Good question! Only certain categories of codes have the 7th character extension requirement. For plastic surgery, the most common categories of codes include injuries (S codes) and other complications such as capsular contractures (T codes). The 7th character of A or B is for an initial encounter and used as long as the patient is receiving active treatment for the condition (e.g., consultation in the ER, surgery). The 7th character for subsequent encounters (e.g., D, G, K) is used when the patient has completed active treatment and is the recovery or healing phase of the injury.

*This response is based on the best information available as of 10/22/15.

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**Suture Removal**

**October 16, 2014**

**Question:**

I did not operate on this patient but he ended up in my office for suture removal. Isn’t there a code I can bill for removing sutures when placed by another physician?

**Answer:**

There is indeed a code for removal of sutures, but only if you do it in under “anesthesia other than local” (CPT 15851, Removal of sutures under anesthesia (other than local), other surgeon). If you are removing the sutures under local or no anesthesia, then the service is included in your E&M code.
Bilateral Diagnosis Coding and Bilateral CPT Coding for Breast Reconstruction

October 8, 2015

Question:

If I use the new ICD-10-CM code for acquired absence of the breast (Z90.13), do I still need to use the CPT modifier 50 for bilateral procedures when I bill for breast reconstruction procedures (e.g., 19357, 19364)?

Answer:

Good question! Changing diagnosis coding systems from ICD-9-CM to ICD-10-CM does not change anything about CPT coding. The CPT coding system does not change at all with our change to ICD-10-CM for diagnosis coding. So, yes, you will still use modifier 50 or RT/LT or whatever modifiers you were using prior to October 1 to accurately report the bilateral procedure.

*This response is based on the best information available as of 10/08/15.*

Acellular Dermal Matrix Placement for Breast
Reconstruction

September 24, 2015

Question:

I’m doing bilateral tissue expander breast reconstructions and will be using ADM. Is there a separate code for the ADM?

Answer:

Yes, there is. In addition to 19357 (Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion) you can report an add-on code, +15777 (Implantation of biologic implant (e.g., acellular dermal matrix) for soft tissue reinforcement (e.g., breast, trunk)) (List separately in addition to code for primary procedure). You can report both codes bilaterally, with modifier 50.

*This response is based on the best information available as of 09/24/15.

ICD-10-CM for Bilateral Conditions

September 10, 2015

Question:

I noticed that the ICD-10 codes for many conditions are specific for right and left. I also noticed that some conditions have a specific code for bilateral. But what if the patient has bilateral disease but there is not a diagnosis code for bilateral? Should I use an unspecified code?
Answer:

Good question! No, don’t use an unspecified code. The laterality is specified in your documentation, so an unspecified code is inaccurate. If a bilateral code exists and the disorder is documented as bilateral, then the bilateral diagnosis code should be used. But if the documentation states the condition is bilateral, and there is not a bilateral diagnosis code, then use both the right and left codes.

Watch for Kim Pollock’s upcoming webinars on ICD-10 coding for plastic surgery and breast procedures...more information shortly!

*This response is based on the best information available as of 09/10/15.

Holding Claims for Path Reports

August 13, 2015

Question:

Do you advise that we hold our claims for excision of skin lesion procedures until after the pathology report is received? That seems to delay our charges and I want to get them billed quickly!

Answer:

Yes, you need to hold the claim for the excision of skin lesion codes (114xx for benign skin lesions, 116xx for malignant skin lesions) if you do not have a previous
pathology report showing a malignancy. Why? Because the CPT codes for the procedures require the lesion pathology be identified. If you have a biopsy report for the lesion showing a malignancy, then you can go ahead and bill the excision procedure using the malignant CPT (116xx) and diagnosis codes.