Placement of Acellular Dermal Matrix in Breast Reconstruction

October 30, 2014

Question:

I did a bilateral tissue expander reconstruction with placement of acellular dermal matrix in the soft tissue for reinforcement. I coded this as 19357-50 and 15777-50 but my biller told me I could not bill 15777 with modifier 50. She said 15777 should only be billed once. Is this true?

Answer:

No, it isn’t true. The CPT guidelines directly underneath 15777 in the manual say: For bilateral breast procedure, report 15777 with modifier 50. Therefore, 15777 may indeed be reported with modifier 50.

Medicare and many payors did not set up their systems to acknowledge 15777 as accepting modifier 50 when the code was introduced in 2012. But after the first 3-6 months most of the payors, including Medicare, were on board and recognize modifier 50 when appended to 15777.

Removing a Portion of a
Tissue Expander

October 2, 2014

Question:

I have attended 3 of your meetings in the past – 2 in Dallas and 1 in Boston – you do a great job! I need a little help on coding something. What is the code for removal of a fill port only? We are not removing the tissue expander at all. We are taking the patient back to the operating room to do this and we are not in a global period. The codes that I keep coming back to are 19499 and 20680. Any recommendations?

Answer:

I would not use 20680 or 20670 since these codes are in the musculoskeletal system and generally meant to be used for removal of orthopaedic/bone implants. I recommend using 11971 (Removal of tissue expander(s) without insertion of prosthesis) with modifier 52 (reduced services) since you are not removing the entire expander.

Reporting 19342 and 11970

September 18, 2014

Question:

Over the past 15 years I have taken numerous courses taught by KZA, as has my staff. We have found you, your colleagues at KZA, and the courses all to be wonderful and very beneficial.

I was wondering if you could help me with a question I have. The last course I took with you had an emphasis on breast
reconstruction coding and that was great. When a patient has an exchange of a tissue expander for a permanent implant and at the same time either a capsulectomy or a capsulotomy, I have been using 19342 instead of the 11970. I’ve thought about billing both codes—19342 and 11970. What do you think? Any suggestions you may have will be greatly appreciated.

Answer:

Good question. The AMA’s CPT Assistant from August 2005 says: “If a temporary tissue expander has been used, it is removed after the skin has stretched sufficiently and replaced with a permanent breast prosthesis during a second operation. This procedure is generally coded 11970, Replacement of tissue expander with permanent prosthesis. Code 11970 is global and includes removal of the temporary expander, which is not to be reported separately. In certain instances, considerable capsular adjustments are necessary to allow proper placement of the prosthesis within the fibrous capsule that has formed around the expander, and with appropriate documentation in the operative report, code 19342 is sometimes used instead of 11970.” Therefore, you would never report 11970 with 19342 for a procedure on the same breast.

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Adjacent Tissue Transfer (14xxx)

September 4, 2014

Question:

I’m reading an operative report and the surgeon says she did “undermining of the incision to close a keloid excision
defect.” She wants to use an adjacent tissue transfer code. This documentation doesn’t seem to satisfy the CPT description. What do you think?

Answer:

We agree with you that the documentation is not sufficient to support an ATT code (e.g., 14xxx). “Undermining” does not constitute use of an adjacent tissue transfer code. CPT says a scar revision is reported using only a complex repair code.

Dog Ears

August 21, 2014

Question:

When abdominal “dog ears” are excised after breast reconstruction surgery, is it appropriate to report the procedure with tissue rearrangement codes 14000 and 14001 when the dog ears have been excised and flaps were developed and rotated to close the wound? Or, is it more appropriate to use the excision of benign lesions codes from the 11400-11406 code series and the appropriate repair codes?

Answer:

First, excision of dog ears is likely considered “cosmetic” and not covered by insurance unless you can provide medical necessity for the service. If you can establish medical necessity and/or the insurance will cover it, then you would use an excision of benign skin lesion code (e.g., 114xx) and typically an intermediate repair code (e.g., 120xx). This procedure as you’ve described it is not an appropriate use of the adjacent tissue transfer code(s).
Coding Shoulder Melanoma

August 7, 2014

Question:

My doctor documented the following: Excision of a 1.5 cm melanoma from the shoulder with wide undermining to advance the tissues and a layered closure. Can we use an adjacent tissue transfer code, 14000, for this procedure?

Answer:

No. “Wide undermining to advance tissues” is not an appropriate use of an adjacent tissue transfer code. Use a complex repair code (131xx) instead of the adjacent tissue transfer code; you may also report a CPT code for the skin lesion removal (e.g., 116xx).

Coding for Full-Thickness Skin Grafts

July 24, 2014

Question:

Patient has a large skin cancer on the nose. I excised it and repaired the wound with a full thickness skin graft. Donor site for the skin graft was the ear, which was closed by mobilizing skin flaps. We billed 11643 for the excision and 15260 for the graft. Is this correct?
Answer:

Yes, the excision of skin lesion is not included in the full-thickness skin graft codes like it is included in the adjacent tissue transfer codes. You may report a code for the excision of lesion (116xx, depending on size of the lesion plus most narrow margins) as well as for the full thickness skin graft (15260). The primary closure is included in 15260 and not separately reported.

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**Excision of Uncertain Behavior Lesion**

July 10, 2014

**Question:**

I excised a skin lesion and the pathology came back as a giant pigmented nevus. ICD-9 says this is “uncertain behavior,” 238.2. Which CPT code do I use — malignant (116xx) or benign (114xx)?

**Answer:**

Great question! It is most appropriate to use the excision of benign skin lesion CPT code (114xx) for excision of uncertain behavior skin lesions.
**Removal of IMF Wires and Arch Bars**

June 26, 2014

**Question:**

Thank you, Kim, for coming to our practice recently. We really learned a lot from you! I forgot to ask this question. I do not usually bill for the removal of the IMF wires and arch bars postop in the office since I have always been told it is included in the original surgical code 21453. However, my colleagues have been advising me to use 20670 (w/ or w/o -58) for this removal. So, before I start following their coding advice, I thought I should check with you.

**Answer:**

Thank you so much for your kind words! We had a great session – it was enjoyable. You are correct to not bill for removal of the IMF wires and arch bars postop when done in your office. This activity is included in the global package for 21453; if you put on the IMF wires/arch bars you are expected to take them off. That said, if you took the patient back to the OR, then you could bill 20670 (you will append modifier 58 since it was planned or anticipated that you’d remove the arch bars during the global period). However, removal in the office is included in your payment for the initial surgical procedure.

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**Microdermabrasion Coding**

June 12, 2014
Question:

What is your recommendation for the proper CPT-4 coding for microdermabrasion? Many of my colleagues use the codes for dermabrasion (15780-15783). I have also seen unlisted codes used (17999, 96999). Thank you.

Answer:

There is not a specific CPT code for “microdermabrasion” because generally this is considered a cosmetic procedure and not billed to insurance. A CPT Assistant from December 2003 states: “Code 15783 is for “superficial” abrasion and uses the example of tattoo removal. However, tattoo pigment is embedded in the dermis and abrasion treatment of tattoo abrades into the dermis and always causes bleeding. Microdermabrasion treatment is not an epidermal procedure, nor is there an existing code that describes epidermal abrasions. The depth of injury for microdermabrasion to the epidermis is more like that of a superficial chemical peel, such as a glycolic acid peel. Therefore, the appropriate code to report for microdermabrasion is code 17999, Unlisted procedure, skin, mucous membrane and subcutaneous tissue."

We concur with the advice to use an unlisted code if you have medical necessity and the service will be billed to insurance. But be sure to obtain written prior authorization from the payor because, as previously mentioned, it’s generally considered a cosmetic procedure.