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?
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.

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
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.

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**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...
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.

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**Cranioplasty**

May 29, 2014

**Question:**

What is the correct code to bill for a prefabricated polymethylmethacrylate custom cranial implant greater than 5 cm? I, the neurosurgeon, think the code should be 62141 (Cranioplasty for skull defect; larger than 5 cm diameter), but the plastic surgeon who is co-surgeon on this case thinks 62143 (Replacement of bone flap or prosthetic plate of skull) should be billed. The bone flap was taken off due to infection in the global period. The custom implant was put back out of the global period.

**Answer:**

You are correct – the correct code for a new prefabricated cranial implant is 62140 (Cranioplasty for skull defect; up to 5 cm diameter) or 62141 depending on the diameter of the defect. If the original autologous bone flap were being replaced, then 62143 would be appropriate. Alternatively, 62143 would be appropriate if a prefabricated cranial implant were being replaced; but you would use 62140/62141 for the first-time placement of the PMMA implant.
Closure After Lumpectomy

May 15, 2014

Question:

I will frequently do a Wise pattern breast reduction on a breast after a lumpectomy; then I do a breast reduction on the contralateral breast. Is it appropriate to report code 19318 (Reduction mammoplasty) or should I use 19366 for Breast reconstruction with other technique? Or maybe I can use both codes for each side?

Answer:

Actually, 19366 cannot be used in your scenario because a mastectomy was not performed. The breast reconstruction codes are used only for reconstruction after a mastectomy procedure and not for closure of a lumpectomy defect. Therefore, you will use only 19318 with modifier 50. Remember, some payors want line-item reporting of the codes (19318 and 19318-50) while other payors recognize the single line method as two procedures (19318-50). Be sure to bill the appropriate format to ensure you’re paid the accurate amount.

Carpal Tunnel Release and Splint

May 1, 2014

Question:

We put on a splint after a carpal tunnel decompression
procedure and my coder says we can separately bill 29125 for the short arm splint. I wouldn’t think we could bill this. What do you think?

Answer:

You’re right – placement of the splint (or even cast after a fracture repair) is included in the global surgical package for the decompression procedure (CPT 64721 or 29848) and is not separately reported.