**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.

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**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.

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**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.

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**Adjacent Tissue Transfer**

April 17, 2014

**Question:**

We billed an excision of malignant lesion CPT code and an adjacent tissue transfer CPT code and only got paid for the lesion removal. How can we get paid for both services?

**Answer:**

The excision of a skin lesion code (114xx, 116xx) is included in the adjacent tissue transfer codes (14000-14302) when performed on the same lesion/defect. Therefore, the malignant skin lesion excision should not have been billed. If you’ve “unbundled” the codes by billing both the lesion removal and adjacent tissue transfer then you should refile a corrected claim billing only the adjacent tissue transfer code. However, if the lesion was at a separate site from the adjacent tissue transfer and the two procedures were in no way related to each other, then you should have been paid for both. You should refile a corrected claim with modifier 59 (distinct procedural service) on the lesion removal code to show the lesion was distinctly separate from the adjacent tissue transfer service.
Excision of Lymph Node/Breast Reconstruction

April 3, 2014

Question:

Sometimes when I do a breast reconstruction I find a lymph node or two that I excise to access blood vessels and complete the procedure. I have never billed for this but one of my partners says he always bills. So who is right – me or my partner?

Answer:

Removal of lymph nodes as you describe it is part of the exposure and is included in the breast reconstruction code; therefore, you would not separately report a lymph node removal code such as 38530.

Excision of a Skin Lesion

March 6, 2014

Question:

When coding for excision of a skin lesion (114xx, 116xx), do I use the size on the pathology report to determine the correct CPT code?

Answer:

The most accurate measurement, according to CPT, is when the lesion has not yet been excised and is still on the patient.
The specimen reduces in size when it is in formalin. So reporting a CPT code with the size listed on the pathology report may result in a lower CPT code being billed and a loss of revenue.

**Suture Removal**

February 20, 2014

**Question:**

Is there a CPT code for removing sutures in the clinic?

**Answer:**

It depends on who put in the sutures. If you put them in and the repair was "intermediate" or "complex" per CPT guidelines, then you cannot charge for removing them because CMS has assigned a 10-day global period to these codes. If you put in the sutures but the repair performed was "simple," then you may charge an E&M service (e.g., 99212). If someone else put them in (e.g., ER doctor) and the patient is sent to you for suture removal, only then you may report an E&M service (e.g., 99201, 99212).

**Billing 19380 and 20926**

February 6, 2014

**Question:**
Is it ok to bill 19380 (Revision of reconstructed breast) and 20926 (Tissue grafts, other (eg, paratenon, fat, dermis) together for excising excess skin on the breast as well as harvesting/injecting fat into multiple breast defects on the same side?

Answer:

No, 19380 would cover all procedures you describe. Remember, 19380 should not be used unless reconstruction is complete. You’d never report a revision (19380) with a tissue expander exchange procedure (11970, 19342).

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**Nipple Reconstruction**

January 23, 2014

Question:

My surgeon is performing bilateral nipple reconstruction with skate flaps and full thickness skin grafts. She would like to use codes 19350 (nipple/areola reconstruction) billed on two lines with LT/RT and 59 modifiers, 15200 (full-thickness graft) on two lines with LT/RT and 59 modifiers and again 15002 (surgical preparation) on two lines with LT/RT and 59 modifiers. We are getting reimbursed for both 19350 but only one 15200 and one 15002. Are we doing something wrong? Why aren’t we getting paid for all these procedures?

Answer:

The code for nipple/areola reconstruction, CPT 19350, includes any and all procedures necessary to reconstruct the nipple/areola including harvesting and placing of grafts. Therefore, it would not be appropriate to separately report
codes for grafts such as 15200. It also would not be appropriate to report a wound/scar excision code such as 15002 as this activity is included in 19350. So I would write off the charges for 15200 and 15002 and I would not separately bill these codes with 19350 in the future.

Also, 19350 accepts modifier 50 per Medicare and most payors. So it should not be necessary to use modifier 59. There are two ways to use format your claim using modifier 50:

1) **Line-item format:** listing the code on two separate lines and modifier 50 is appended to the second code.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>19350</td>
<td>1 unit $your single fee</td>
</tr>
<tr>
<td>19350-50</td>
<td>1 unit $your single fee</td>
</tr>
</tbody>
</table>

OR

2) **Bundled format:** listing the code on one line with modifier 50 but doubling your fee

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>19350-50</td>
<td>1 unit $double your single fee</td>
</tr>
</tbody>
</table>

Medicare recognizes format 2 (bundled) and will pay 150% of the single code allowable. Other payors may want format 1 (line-item).

**Rib Resection with Breast Reconstruction**

January 9, 2014

**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.