Answering top questions from the 2024 ASPS Coding Course

"CPT Corner" provides general information, available at the time of publication, regarding various coding, billing and claims issues of interest to plastic surgeons. ASPS is not responsible for any action taken in reliance on the information contained in this column.

By Jeff Kozlow, MD, MS; David Schnur, MD; Bella Avanessian, MD; Eric Payne, MD; and Scott Oates, MD

This month's installment of "CPT Corner" presents answers to the most frequently asked or relevant questions posed by attendees of the virtual ASPS Coding Course, which was held March 15-16. This was the most comprehensive course to date and included most topics related to plastic surgery, including gender-affirmation surgery coding.

As always, we received a large volume of questions related to breast reconstruction. We strongly recommend review of past "CPT Corner" columns from *PSN* – particularly the December 2020, January/February 2021 and March 2023 installments, each of which takes a deeper dive into breast reconstruction.

Past "CPT Corner" articles are easily accessed by pointing your browser to ***https://www1.plasticsurgery.org//ebusiness4/sso/login.aspx***. Also available is a "Coding Resources" section in the "Health Policy" tab of the menu that contains several helpful resources, including a searchable portal for archived articles.

The questions and answers below are often more generic than some specific topics or unique cases that we are asked about during the course. In situations where an operative report is critical to making coding recommendations, we encourage ASPS members to submit their questions through our online coding question submission portal at: *plasticsurgery.formstack.com/forms/coding_question_submission_form*.

The following are some of the questions that were submitted during the course:

I was called to see a consult in E.D. and then the patient was admitted before I saw them. Should I code as an E.R. visit or as an inpatient visit?

In general, the E.R. codes are intended for care directly provided in the E.R. Consultations whether they occur in the E.D. or inpatient setting would be reported with the inpatient consult codes (**99251-99255**) or initial hospital care codes (**99221-99223**). Remember that Medicare does not recognize consultation codes.

For a H&P done morning of surgery because the original is more than 30 days old, is there anything we can bill for these?

The H&P performed the morning of surgery is considered part of the global period (including 0-day global) and not separately reported. The exception would be if the decision of surgery is made that day (i.e., acute trauma with emergency surgery). The E&M service prior to surgery is reported with modifier **-57**.

Can you clarify when to use the -51 vs -59 modifier?

The **-51** modifier is used when multiple procedures are performed and the multiple procedure payment reduction is appropriate (e.g., there are no issues with edits/duplicates between the codes). The **-59** modifier is used to identify when there are pair-to-pair (PTP) edits that would normally disallow the codes if performed at the same site/time. This signifies that the two separate procedures are being appropriately billed and not subject to the PTP edit, since they are separate procedures.

Can you clarify co-surgeon vs. assistant surgeon?

This year's virtual Coding Course hosts (left to right), Jeff Kozlow, MD; David Schnur, MD; Bella Avanessian, MD; Eric Payne, MD; and Scott Oates, MD.

Payment for each co-surgeon is based on the lesser of the actual charges or 62.5 percent of the Medicare Physician Fee Schedule (MPFS) amount. According to CPT, "When two surgeons work together as primary surgeons performing distinct part(s) of a single reportable procedure, each surgeon should report his/her distinct operative work by appending modifier **-62** to the single definitive procedure code." For both surgeons to receive appropriate reimbursement, they must not be assisting each other, but performing distinct and separate parts of the same surgical procedure. If one surgeon is assisting and another surgeon is performing the procedure, then it's appropriate to bill as assistant surgeon with the -80 modifier. The reporting of an assistant for each of two co-surgeons may be accepted when the surgeons are different specialties – but might be challenged if they are within the same specialty.

What if I excise more than one adjacent skin cancer with a single excision, or more than one lipoma through same incision?

If you are removing two adjacent skin lesions with the same excision, then the additive area of the two lesions would be reported. For example, if you are removing a 0.8-cm basal cell and a 1.3-cm adjacent basal cell on the trunk with one excision, then bill as if it were a 2.1-cm lesion with CPT code **11603**. Likewise, if two lipomas are being excised through the same incision then add the diameters of the two together and bill the appropriate code.

How do I bill for scar revision?

Most payors will want it to be billed with the appropriate benign excision and repair codes, but some payors might still want complex repair instead to be billed, and include the excision and closure even if the criteria for a complex repair have otherwise been met. If performing adjacent tissue transfer or ATT (e.g., Z-plasty for burn scar), consider reporting the surgical preparation and ATT family codes. If removing large areas of excess tissue, you might want to preauthorize for the lipectomy family of codes.

How do I code the closure with "purse string" approach in which circular wound is widely undermined and then purse string suture is placed around periphery and used to "cinch" the wound closed?

The purse string is typically a simple repair (and bundled with excision codes). If extensive undermining (defined as undermining greater than the width of the defect over one entire edge) is performed along with purse string, it may be reported as an intermediate repair. The length is based on the diameter of the defect and not the circumference.

When coding excision of a skin cancer of the ear, is it ever appropriate to use CPT 69110 (excision external ear; partial, simple repair), or would these always be integumentary CPT codes?

Yes, there are some special sites that have unique excision/biopsy codes (e.g., ear, lip, genitalia). You might want to do some RVU/reimbursement math based on sizes, since these lesions can be appropriately coded in more than one way.

Can I bill 15002-15005 (surgical preparation codes) with adjacent tissue-transfer codes (14xxx) and complex closures (131xx)?

Surgical prep codes *can* be reported with the ATT codes. Surgical prep *cannot* be reported with complex repair (PTP edits).

What's appropriate coding for paraspinous muscle flaps?

CPT code **15734** (muscle, myocutaneous or fasciocutaneous flap; trunk) is the appropriate code and can be billed once per side. The paraspinous muscles are primarily trunk muscles and avoids the (i.e.) in **15733** that disallows any muscle flap that is not listed in the parenthetical. Although there are technically three muscles within each paraspinous bundle, functionally they are moved as one unit and convention to avoid over-coding. In addition, the skin closure would be considered bundled (both with spine procedure and with flap procedure). Concurrent latissimus and/or trapezius flaps must be clearly documented as separate flaps if performed. Advancing the medial borders of the muscle to the midline because they were freed from the paraspinous muscle is *not* a muscle flap. Documentation must include dissection of the flap and preservation of the blood supply.

Is a keystone flap considered adjacent tissue transfer or fasciocutaneous flap?

Generally, it's coded as an ATT (**14xxx**) unless a single perforator pedicle is isolated and dissected, in which case it could be coded as a flap. A large latissimus dorsi V-Y myocutaneous flap with thoracodorsal pedicle dissection would be properly coded with **15734**.

Does the surgeon need to do injection of the dye in order to code 15860 (Intravenous injection of agent [e.g., fluorescein]) to test vascular flow in a flap or graft?

No – the intravenous injection is not a substantial portion of the procedure, and the surgeon can bill **15860** even if the anesthesiologist does the injection (see "CPT Corner" published in the June 2022 issue of *PSN*).

Can I code for panniculectomy at the time of hernia repair?

The NCCI Manual (Chapter 6) states: "Removal of excessive skin and subcutaneous tissue (panniculectomy) at the site of an abdominal incision for an open procedure including hernia repair is not separately reportable. CPT code **15830** shall not be reported for this type of panniculectomy. However, an abdominoplasty which requires significantly more work than a panniculectomy is separately reportable." This PTP edit may be circumvented with the use of **-59** (or **XP**, **XS**, **XU**) modifiers, but it's advisable to check with your payor first before trying to bill these codes together.

If a patient has a severely comminuted open fracture and the fracture is debrided including bony "fragments" – but I do not manipulate the fracture or use internal fixation – what is the appropriate code(s)?

A debridement of an open fracture including bone (**11012**) would be the appropriate code and does not require an ORIF code to be billed. Removal of foreign bodies are included in **11012** but do not need to be present for it to be billed.

How do you report a fillet flap when performed with a finger amputation?

The only code that should be billed is **14350** (filleted finger or toe flap, including preparation of recipient site). This code includes the debridement and completion amputation.

Is there a code for using a nerve wrap?

No, that would be included in the primary procedure on the nerve (repair, neurolysis, etc).

If while dissecting a posterior tibial artery, I accidentally injure the posterior nerve and immediately repair it, can I code for the repair?

Generally speaking, no. According to NCCI, the treatment of complications of primary surgical procedures is separately reportable only in certain circumstances. The global surgical package for an operative procedure includes all intraoperative services that are a usual and necessary part of the procedure. Additionally, the global surgical package includes all medical and surgical services required of the surgeon during the postoperative period of the surgery to treat complications that do not require a return to the O.R. Thus, treatment of a complication of a primary surgical procedure is not separately reportable if it represents usual and necessary care in the O.R. during the procedure. Examples from CMS are a spleen injury or bowel injury during an intra-abdominal procedure or measures taken to control bleeding.

I performed a scalp flap debulking after a previous free flap procedure. Is 15839 (excision, excessive skin, and subcutaneous tissue; other area) the appropriate code?

It depends on what was done. For a simple excision and closure, use excision of benign lesion codes and the appropriate closure codes. If extensive debulking and readvancement of the flap is performed, then ATT codes (**14xxx**) are appropriate – but be sure to document well.

The description for CPT 42215 (major revision palatoplasty) states the defect will dictate the repair performed. If palatal flaps were used for imbrication and closure of a palatal fistula, and bilateral buccal fat pad flaps were used to buttress the repair, is 14040 separately reportable with CPT 42215 if both techniques were used to repair the fistula?

Yes, that's an appropriate use of the ATT CPT code for buccal fat pad flaps.

If you are doing a rhinoplasty and harvest septum, can you code 30520 (septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft)?
No, if you just use the septum for graft, then don't code for septoplasty (**30520**). Instead, use code **20912** (cartilage graft nasal septum).

Is there a code when using irradiated rib allograft cartilage for repair of nasal vestibular stenosis?
No. There's no separate CPT code for placement of an allograft (off-the-shelf product). The reconstruction performed using this graft should be best described with CPT code 30465, which includes harvest of the spreader grafts. Therefore, if an off-the-shelf product is used instead, this would be included in the CPT code. Use of the graft should be mentioned in the operative report. CPT code **21208** (osteoplasty, facial bones, augmentation-autograft, allograft, or prosthetic implant) can be used when augmenting the nasal bones or dorsum with either prosthetic implant or with an allograft such as a cadaveric rib-cartilage graft. This code requires prior authorization and is frequently denied by third-party payers.

Can I code 15760 (graft; composite e.g., full thickness of external ear or nasal ala, including primary closure, donor area) with 21235 (graft; ear cartilage, autogenous, to nose or ear includes obtaining graft) for harvest of ear cartilage from the same patient, or should I only use code 15760?
Don't use these unless you're performing each of these separate procedures on the same patient. CPT code **15760** is for a composite graft including the skin, subcutaneous fat and cartilage. CPT code **21235** is only cartilage. If performing a composite graft, use only **15760**.

A patient who had breast reconstruction with implants after a mastectomy years ago now has a ruptured left implant. She wishes to have both implants out and not replaced. I plan to remove the implants and do a bilateral mastopexy. Can I bill CPT 19328 (removal of intact breast implant) right and 19330 (removal of ruptured breast implant, including implant contents, e.g., saline, silicone gel) left and 19316 (mastopexy) -50?
Once the breast implants are removed, there's no breast present to perform a mastopexy and, thus, **19316** is not appropriate. If a tissue rearrangement is performed in order to lift the NAC, then ATT should be used – but document well to support ATT.

If I'm performing liposuction as part of a breast reduction technique (not as a separate cosmetic component), how would I report volume of reduction?
It's best to document the milliliter of lipoaspirate with estimate of 1 cc of lipoaspirate (not the total aspirate) = 1 gram of tissue. The insurance company may or may not consider that in deciding whether the weight criteria has been met to reimburse for the procedure.

I'm still confused about how to code 15777 (Implantation of biologic implant [e.g., acellular dermal matrix for soft tissue reinforcement i.e., breast, trunk]) bilaterally. Can you please help?
This is admittedly a confusing topic. The modifier **-59** is, in fact, CCI-valid and thus can be used for **15777**, even though it's an add-on code. Your insurer might want it reported differently though, so be sure you understand what they want. It may be reported with a quantity 2. The modifier **-50** is not CCI-valid. (CPT assistant April 2021)

Does 11971 (removal of tissue expander without insertion of implant) include capsulectomy?
It includes a partial capsulectomy (e.g., use of a curette to remove some of the capsular material). If a complete capsulectomy is performed, code the capsulectomy code (**19371**) which includes removal of the tissue expander. But in this scenario, do not code **11971** in addition to **19371**.

If I performed a capsulectomy and left a small portion of the capsule, can I still code 19371 (peri-implant capsulectomy, breast, complete, including removal of all intracapsular contents)?
Reporting of **19371** requires documentation of complete capsule removal. It's also realized that in some situations, a small area of residual capsule cannot be safely removed. We recommend that surgeons document the size of this small residual area *and* how that area was ablated (e.g., curette, cautery, etc.) to remove the superficial surface. Documentation is key here. If you remove almost all the capsule and document how you ablated the remainder of the capsule, then it's appropriate to report **19371** for the procedure.

If I'm performing tissue-expander breast reconstruction and also placing ADM and performing an auto-derm flap, can the auto-derm flap and ADM be billed in addition to the tissue expander?
Yes, though be sure you document well. If a de-epithelialized autoderm flap is used in addition the ADM, this could be reported separately with adjacent tissue-transfer code(s) (**14000-14350**), as appropriate, based only on the area of the transposed autoderm flap. Depending on the size of the flap, some surgeons consider a **-52** modifier with the larger flaps. In order to meet the criteria for an adjacent tissue transfer, it's important that additional incisions are made within the soft tissue to allow the transposition of the flap to within the breast; that vascularity to the tissue is preserved; and documentation includes how the tissue is transferred to a different location or plan. Neither de-epithelialization alone or a Wise-pattern closure constitutes an adjacent tissue transfer and would be considered bundled with the closure following an implant placement.

Can 15734 (muscle, myocutaneous, or fasciocutaneous flap; trunk) for diastasis repair be reported separately in conjunction with DIEP 19364?
No, there's no additional code for diastasis repair. If you feel there's significant diastasis prior, then consider an unlisted code with the insurer.

I used an arterial and venous interposition graft to increase the length of pedicle for a free flap. Do I use the vein graft code to report this?
Yes – use the repair of artery with the vein graft code twice based on the location of the recipient of your free flap (**352xx**).

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Legislative Update
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vederm substitutes, and deceiving patients about the authenticity of the products used. She pleaded guilty to the charges in November of 2022.

- In March 2022, an Alabama woman was sentenced on felony charges for illegally importing, dispensing and injecting unapproved foreign-source Botox.
- In January 2023, a man in the San Fernando Valley pleaded guilty to selling used and counterfeit medical devices for skin tightening and fat reduction.
- In April 2023, a healthcare company in Massachusetts pleaded guilty and paid more than $2.5 million in fines for purchasing and using Botox labeled only for use in foreign countries.
- In May 2023, a physician in Grand Rapids agreed to a settlement of $135,871.84 for using foreign unapproved Botox.

As evidenced by these examples, the FDA and DEA are actively involved in combatting the proliferation of counterfeit neurotoxins and other illicit drugs in the United States. Their strategies include issuing joint warning letters to online networks selling unapproved and misbranded drugs; enhancing screening at international mail facilities; taking part in large-scale international operations to disrupt darknet trafficking of harmful substances; as well as the investigation and prosecution of individual providers.

Significant crackdowns now occur frequently, involving coalitions of international law enforcement agencies and resulting in record numbers of arrests and the seizure of large quantities of illicit drugs, including counterfeit Botox. This collaborative effort underscores the determination of U.S. authorities to tackle the complex issues of drug counterfeiting and illegal online pharmacies that often bypass regulatory safeguards, thereby putting public health at serious risk. The agencies also focus on enhancing the safety of the U.S. drug market by working closely with other federal and international partners to monitor and intercept illegal drug operations.

In response to these challenges, the FDA emphasizes the importance of sourcing Botox and other medical products exclusively from authorized distributors. They recommend healthcare providers verify the authenticity of the products they purchase and educate themselves on recognizing counterfeit items. By ensuring all medical products used in their practices are FDA-approved, plastic surgeons not only comply with the law but also protect their patients and uphold the standards of medical integrity. **PSN**

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I performed a DIEP flap and did three vein dissections with anastomosis. I know 19364 includes two veins. What CPT is used for the third vein?
Report the code for repair of blood vessel direct – upper extremity (**35206**). Upper extremity is used instead of **35216** (intrathoracic, without bypass), as this code is intended for repair of the intrathoracic great vessels and not appropriate in this situation.

I performed a DIEP flap and lost the flap intraoperatively after almost completing the entire surgery and discarded the flap. Can I still bill for the DIEP?
Yes, if the bulk of the surgery is completed and the flap is lost and removed prior to leaving the O.R., then it is appropriate to bill **19364** and modify with **-52** to account for any work not done (e.g., insetting the flap) and additional postoperative care.

How would I code a breast reconstruction using bilateral stacked free flaps (four flaps)?
CPT code **19364** has an MUE (medically unlikely edit) of 1 and an adjudication indicator of 3. This issue was also addressed in a June 2021 CPT Assistant article with recommendations that **19364** be reported twice with a **-59** modifier on the second code. Authorization with the insurer is critical.

I performed a vertical rectus abdominus myocutaneous flap and transferred it to the thigh. Do I code based on the donor site or the recipient site?
It's based on the recipient site, so **15738** (muscle, myocutaneous, or fasciocutaneous flap; lower extremity) would be the appropriate code.

Save the date for the 2025 ASPS Coding Workshop, which will be held virtually March 14-15. Registration for the event will open in December. **PSN**

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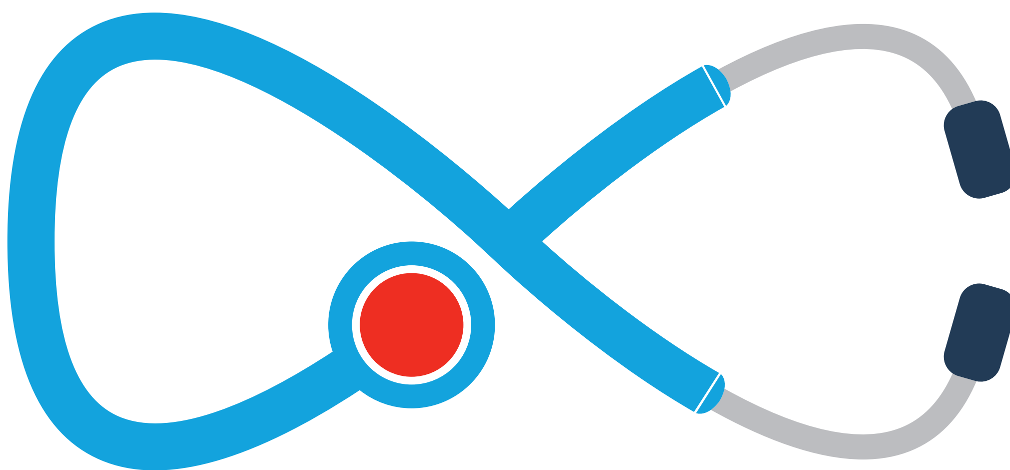

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