Answers to questions from the 2023 ASPS Coding Course

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This installment of CPT Corner presents answers to the most frequently asked or relevant questions posed by attendees of the virtual ASPS Coding Course held March 17-18. One benefit of virtual events is the increased number of attendees they can allow – the Coding Course saw more than 200 attendees – but one downside is the inability of organizers to address every question. Based on practice patterns, we received a large volume of questions related to breast reconstruction. We strongly recommend review of the December 2020, January/February 2021 and March 2023 CPT Corner columns from *PSN* – each of which takes a deep dive into breast reconstruction while addressing some of the breast-related questions. Some of the breast-related questions not addressed in those columns are included here.

The questions and answers below often are 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, ASPS members can submit their questions through our online coding question submission portal at: *https://plasticsurgery.formstack.com/forms/coding_question_submission_form*.

Can you review the appropriate reporting of the revised Emergency Department Service codes (99281-99285)?
The E/M codes for Emergency Department Services were intended to be used for the provider performing the overall evaluation and management of patients seen in the E.R. This typically would not be a plastic surgeon, as our specialty almost always provides consultative care. Most insurers expect the consulting physician to use the outpatient consult codes (**99241-99245**), although some insurers will only recognize the new or established outpatient codes (**99202-99205** or **99221-99225**). If a patient is being seen in the E.D. out of convenience for the surgeon, then only the new or established outpatient codes should be reported even if the insurer accepts the consultation codes.

If a patient is seen multiple times before an operation to discuss the surgery, are these billable events?
Yes. As long as the patient is not being seen for a preoperative history and physical – or preoperative marking – then the encounter is a billable event with code selection based on the appropriate E&M leveling.

Are 99024 codes supposed to be submitted to insurance companies? I thought these were not paid, but some insurance companies reimburse us while others deny the claim.
CPT **99024** has been suggested as a code for tracking to CMS to support the number of post-op visits within a global period. The code has an attributed wRVU = 0 and does not typically have an associated reimbursement.

Is hospital discharge management included in the global period?
Yes, same-day or later-day discharge of a patient is included if it occurs within the established 0-, 10- or 90-day global period.

Do we need two separate OP notes if the surgeon is doing a case that has an insurance component and a cosmetic component?
No. One operative note is adequate – but it's important to document the portion that is insurance and the portion that is cosmetic. The time component for each portion of the procedure might also need to be documented, as it relates to anesthesia and facility charges.

What do you do if you perform two simultaneous cases, and one is a 90-day global and one is a 0-day global?
90-day global trumps the 0-day global, so care for 90 days is included for both procedures.

What code would you use for isolated diastasis rectus repair?
There is no code for isolated diastasis repair and the recommendation is to use unlisted code **49999**. Preauthorization is often required and might alter the suggested coding for payment in reconstructive cases, since insurance most commonly does not pay for this procedure and considers it cosmetic.

I did a tissue expander, which got exposed and became infected. I took the tissue expander out in the office under local in my minor procedure room. Can I bill that with a -78 modifier? How about in the E.R.?
The CPT description of modifier **-78** is "Unplanned return to the operating/procedure room by the same physician or other qualified health care professional following initial procedure for a related procedure during the postoperative period." It is appropriate to report, but it might be denied as part of the global period, and it could prove difficult to appeal due to the definition of the modifier. However, if performed in an O.R., then modifier **-78** would be appropriate and more likely to be reimbursed. We also appreciate that situations like this don't always make perfect sense based on coding limitations.

How do I bill for the supplies associated with doing nipple tattooing in the office?
The supplies for the procedure are included in the practice expense component of **1192x** and, thus, are not separately billable.

I treated a lesion that I thought was malignant, but the pathology came back as benign. Can I still code for a malignant lesion since I was treating it as "malignant lesion?"
No. If the pathology comes back that the lesion is benign, then it's a benign lesion. If the pathology of the biopsy was malignant and the re-excision showed "scar with no residual lesion," then you still can report the code for the malignant lesion.

I removed an "atypical" lesion and used D48.5 (Neoplasm of uncertain behavior of skin) as the ICD-10 code. Benign or malignant?
Benign.

CPT guidelines say 15771 (Grafting of autologous fat) may be coded with 19380 (Revision of reconstructed breast). Is 15771 always allowed with 19380? I'm getting a denial that these codes have a procedure-to-procedure code pair edit.
Yes, **15771** can be and should be billed with **19380** if both procedures are done in the same setting. This is very clear in the revised CPT introductory language for the breast repair and/or reconstruction section of the CPT book. Unfortunately, there are some instances where there is a disconnect between NCCI and CPT when updates are made. Further, some payers (sometimes with old software or those who have not updated their polices when the CPT book is changed) deny these as being bundled. It should be appealed but is a frustrating problem.

Would you code 19316 or 19318 rather than 19380 when a lift or reduction is done on a reconstructed autologous breast reconstruction, if that is all they do?
This is a grey area – especially with increased nipple-sparing procedures with both implant and flaps. For implant-based reconstruction, if the native nipple is present, then **19316** would be appropriate if a more formal mastopexy is performed. Although for minor nipple-position changes, consider the repair codes to better describe the more limited work. For autologous reconstructions, **19380** is the appropriate codes for these soft-tissue revisions.

At time of tissue expander placement, is it appropriate to report 15734 (Muscle flap, trunk) if the serratus muscle is transposed to close-off the axillary wound, not accommodate a device and made during the mastectomy for SLND (to prevent lymphatic drainage into breast pocket)?
No. Manipulation of the muscle is considered part of the creation of the pocket, and whether used in this situation or to accommodate the device, it is not separately billable.

Are you able to bill for excision of skin margins at the time of a breast reconstruction that was followed by mastectomy same day?
No. If you are closing a mastectomy defect due to insufficient quality of the skin, then the closure is considered part of the mastectomy reimbursement and a co-surgeon or assistant surgeon modifier might be considered. If you perform either an implant or autologous reconstruction, the excision or revision of the skin envelope is considered part of the reconstructive procedure.

Does CPT code 11971 bundle with 19370 or 19371 when removal of an established capsule is necessary and performed?
Technically, there are no PTP edits – however, **19371** includes removal of the capsule and all contents (i.e., the tissue expander). In addition, **11971** (like **19328**/**19330**) includes some capsule excision/scoring/etc. That should not be reported with **19370**.

Does performing an ultrasound-guided nerve block (e.g., TAP block with DIEP) bundle with the primary surgical code?
Yes. Infiltration of local anesthetic (around the operative site or as a block) by the surgeon is bundled with the primary procedure.

Can you please help with reporting 15777 in a bilateral reconstruction?
This has become a grey area and you might have to check with your payor how they want this reported. The National Correct Coding Initiative has a Medically Unlikely Edit limit of reporting quantity = 1, but an adjudication indicator of 3 – so that it can be appealed if necessary.

If a patient wants to remove implants and go flat – or decides to go flat after autologous-flap complication – would it be appropriate to code 19380 as we're performing multiple tasks to bring the breast to its final state (in this case a deconstruction)?
No. Once the reconstructed breast is removed, you cannot "revise the reconstructed breast." The implant/TE removal and capsulectomy codes include soft-tissue revision for closure. For autologous flap removal, the debridement codes or the complex repair codes would be appropriate.

Should we be reporting 15771 for each breast where fat grafting is being performed in the same surgical session or sum the total amount of grafted for both breasts?
You should only code based on total volume, regardless of whether it was placed bilaterally.

Can you describe coding for the excision of lateral chest tissue?
This is another grey area. If one is considering the lateral tissue to be part of the breast, then the excision of that area is part of a breast code (reduction, reconstruction, etc.). However, if the area is being separately considered part of the trunk, then CPT **15839** (excision, excessive skin and subcutaneous tissue – includes lipectomy – other areas) would likely be most appropriate. However, you need to be very clear with preauthorization and/or insurance benefits coverage, as this may be considered cosmetic and not reconstructive.

If the surgeon is changing the plane of implants from sub-pectoral to pre-pectoral, can a flap code be added?
No, the flap code cannot be added. It would be appropriate to report the capsule revision **19370** or capsulectomy **19371**, depending on which is performed. Code **19342** would be used for the new implant, which includes the creation of a new pocket. Manipulation of the pectoralis major muscle is considered bundled with the breast reconstruction codes.

Can you bill for closure of axillary incision after a breast surgeon takes a lymph-node biopsy?
No. The closure of the lymph-node biopsy site is included as part of the lymph-node biopsy and can otherwise be closed by the primary surgeon (even if you decide to perform the closure). Without medical necessity, unbundling between surgeons is also considered fraudulent.

Would 69110 (Excision external ear, partial, simple repair) be appropriate for excision of an accessory tragus which includes ectopic cartilage?
No. Based on the typical pathophysiology, we would instead recommend reporting CPT **42810** (Excision brachial cleft cyst or vestige, confined to skin and subcutaneous tissues). **PSN**

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