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Dermatology Coding Alert

CPT® 2012 Update: New Codes Abound for Skin Substitutes

Plus: Check out time guidelines for initial observation codes.

Have you ever wished that CPT® would simplify the skin substitute graft codes? Then you'll be in luck as of Jan. 1, when the new manual will offer eight new codes to take the place of the 15300-15431 range. These changes and many more can be found in the pages of the new edition of the CPT® manual, with codes that take effect on Jan. 1, 2012.

Code Skin Substitutes by Location and Size, Not Type

No matter what type of skin substitute your physician uses -- allograft, acellular dermal allograft, tissue cultured allogeneic dermal substitute skin substitute, tissue cultured allogeneic dermal substitute, xenograft, or acellular xenograft implant -- you'll turn to the new "Skin Substitute Grafts" section in CPT® 2012.

Old way: Prior to Jan. 1, 2012, you would pick your skin substitute code based on what type of skin substitute the dermatologist used. For example, for an allograft, you would report 15300-15321 (Allograft skin for temporary wound closure ...); for a tissue cultured allogeneic skin substitute, you would report 15340-15366 (Tissue cultured allogeneic skin substitute ...).

2012 way: Starting next January, you'll pick the code based only on the wound site and size, from the new code range 15271-15278 (Application of skin substitute graft ...).

Trunk, arms, or legs: For a wound to the trunk, arms, or legs, look to codes 15271-15273 (Application of skin substitute graft to trunk, arms, legs ...). If the wound is smaller than 100 sq cm, you'll report 15271 (... total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area) for the first 25 sq cm of graft, and add-on code +15272 (... each additional 25 sq cm wound surface area, or part thereof [List separately in addition to code for primary procedure]) for each additional 25 sq cm.

For a wound to the trunk, arms, or legs 100 sq cm or larger, you'll look to 15273 (... total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children) for the first 100 sq cm of graft, and +15274 (... each additional 100 sq cm wound surface area or part thereof ...) for each additional 100 sq cm thereafter.

Other areas: For wounds to other bodily areas, such as the face, mouth, genitalia, hands, or feet, check out codes 15275-15278 (Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits ...). You'll use 15275-15276 (... total wound surface area up to 100 sq cm ...) for wounds up to 100 sq cm, and 15277-15278 (... total wound surface area greater than or equal to 100 sq cm ...) for larger wounds.

Similar to +15272 and +15274, +15276 and +15278 are add-on codes, representing graft applications larger than those described in the initial codes (15275 and 15277, respectively).

Observation Time Guidelines Could Help You Out

When CPT® 2011 debuted the subsequent observation care codes 99224-99226, many coders were left scratching their heads at the fact that those new codes featured typical times associated with them, even though the initial observation care codes 99218-99220 don't have typical times. The new edition of your CPT® manual, which takes effect on Jan. 1, will remedy that problem, with the addition of the following typical time guidelines:

- 99218 --... Physicians typically spend 30 minutes at the bedside and on the patient's hospital floor or unit
- 99219 -- ...Physicians typically spend 50 minutes at the bedside and on the patient's hospital floor or unit

- 99220 -- ...Physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit.

Although the specific reasons for the CPT® committee's inclusion of these codes won't be crystal clear until the AMA's November CPT® Symposium, it looks like the addition of typical times could open the door for coding based on time.

"There are only two ways that you can use time as a basis for selecting an E/M code," says **Barbara J. Cobuzzi, MBA, CPC, CENTC, CPC-H, CPC-P, CPC-I, CHCC,** president of CRN Healthcare Solutions, a consulting firm in Tinton Falls, N.J. "If counseling/coordination of care takes up 50 percent or more of the visit, and if the code has a typical time associated with it. So by these codes now having a time reference, it sounds like we may have a way to reference time used if counseling or coordination of care takes up at least 50 percent of a visit. In addition, this could open the door to collecting for prolonged service times if the time the doctor spends exceeds 30 minutes more than the allotted time, and the visit notes are documented as such," Cobuzzi adds.

New 2012 Modifier May Not Mean Extra Pay

It isn't every year that CPT® adds new modifiers for your coding and billing needs, so when you see a new one gracing the pages of your 2012 manual, you might get excited -- but don't rejoice just yet.

Modifier 33 (Preventive service) went into effect on Jan. 1, 2011, but it didn't make it into the 2011 CPT® book due to publishing deadlines, so the modifier will be making its first appearance in the 2012 manual. According to CPT®, the modifier should be appended "when the primary purpose of the service is the delivery of an evidence based service in accordance with a US Preventive Services Task Force A or B rating in effect and other preventive services identified in preventive services mandates."

Part B pay: Unfortunately, you're not likely to get any love from your MACs with this new modifier. According to a Q&A on WPS Medicare's Web site, Medicare does not recognize modifier 33 (www.wpsmedicare.com/part_b/resources/provider_types/awv-faq.shtml).