

Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: When Wound Repair Isn't Enough, Turn to Tissue Transfers--6 Steps Show You How

You won't report lesion excision separately

When the surgeon performs an adjacent tissue transfer (for instance, to close a large or irregular wound following lesion removal), you must be sure to add together the area of both the primary and secondary defect to choose the correct code. But that's only the beginning: Successful tissue-transfer coding requires that you follow at least six steps.

1. Differentiate Transfers From Repairs

When reading physician documentation, you must know what separates tissue transfer (14000-14300) from closures as described by repair codes 12001-13160.

In a nutshell: During simple, intermediate or complex repair (12001-13160), the surgeon cleans and sutures the wound. Adjacent tissue transfer involves freeing tissue from around the wound and literally rearranging it to cover the defect.

Recognize the difference: -For adjacent tissue transfer or rearrangement, you should see the surgeon document that the specific defect, excision or laceration needs surrounding tissue rearrangement to accomplish final closure. These include Z-plasty, W or V-Y plasty, rotation flaps, local advancement flaps, and double pedicle flaps,- says **John Bishop, PA-C, CPC**, president of **Bishop and Associates** in Tampa, FL. -The original tissue maintains its blood supply and is carefully -moved- into position for final wound closure.-

-The easiest method [to differentiate tissue rearrangement from repair] is to identify whether any of the processes described in the CPT Adjacent Tissue Transfer or Rearrangement section guidelines are described (such as Z-plasty and so on),- says **Terri Brame, CPC, CPC-H**, operations manager for the Division of Clinical Revenue at the **University of Washington** department of surgery. -Another tip is that a -primary- and -secondary- defect are addressed.-

Finally, unlike repair as described by 12001-13160, the flap creation during tissue transfer results in a -secondary defect- in addition to the -primary defect- of the wound itself.

-The primary defect is the one being repaired, and the secondary defect is the defect created by lifting the adjacent tissue,- Brame says.

Important: Surgeons may perform an additional closure or skin graft to repair the secondary defect. Usually, surgeons use tissue transfer to minimize scarring when repairing wounds that are too large or deep for a complex repair.

2. Determine Overall Area And Location

To select the appropriate tissue transfer code, you must determine the total area (in sq cm) of the primary and secondary defects, according to CPT instructions. In addition, you must consider the repair's anatomical location (use the inset chart to find the correct tissue transfer code at a glance).

Example: Your surgeon removes a lesion measuring 2 cm x 2 cm from a patient's right forearm. To repair this primary defect, the surgeon creates a flap measuring 4 cm x 2.5 cm. To determine the total area, add together the area of the primary defect ($2 \times 2 = 4$ sq cm) and the area of the secondary defect ($4 \times 2.5 = 10$ sq cm) for a total area of 14 sq cm.

In this case, you should choose 14021 for a repair totaling 14 sq cm on the arm.

3. Consider Each Repair Separately

When reporting tissue transfers, you should consider and code each repair individually, Brame says.

Source of confusion: CPT treats all wound repairs (12001-13160) at the same level of severity (simple, intermediate or complex) and anatomic subcategory as a single, cumulative wound. Therefore, coding for wound repair as described by 12001-13160 often means that you'll use a single code to describe repair of more than one wound.

This is not true of adjacent tissue transfers, however.

Bottom line: For each repair by adjacent tissue transfer, you will report one code. Even if the surgeon uses more than one type of flap to close a defect, you should report each flap separately based on the defect's size.

Exception: You should consider a double-advancement flap as a single procedure, even though it involves creating two flaps.

Example: The surgeon removes two lesions from the right forearm and closes each wound using tissue transfer and a secondary defect of 12 sq cm, for a total of 17 sq cm.

The second closure involves a primary defect of 7 sq cm and a secondary defect of 15 sq cm, for a total of 22 sq cm. In this case, you would choose two units of 14021 rather than a single unit of 14300 because you should report each adjacent tissue transfer separately, even if they occur in the same anatomical region.

4. Include Lesion Removal

You should not report benign or malignant lesion excision (11400-11646) separately when claiming adjacent tissue transfer. Rather, you should consider the lesion removal as included in (bundled to) the tissue transfer, Bishop says. Both CPT and **Centers for Medicare & Medicaid Services** guidelines (as set forth in the National Correct Coding Initiative [NCCI]) confirm this practice.

Example: The surgeon excises a carcinoma of the face (11643, Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 2.1 to 3.0 cm). She closes the excision using adjacent tissue transfer (14040). In this case, you should report 14040 only. The lesion excision (11643) is included in the tissue transfer.

-Staged- exception: If the surgeon performs an excision on a separate (earlier) day from the tissue transfer, you may report the procedures separately. This can occur, for instance, if the surgeon wishes to wait for the pathology report to be sure the margins are clear before closing the operative wound.

But if the tissue transfer occurs during the excision's 10-day global period, you must append modifier 58 (Staged or related procedure or service by the same physician during the postoperative period) to the tissue transfer code.

What about separate locations? NCCI includes a modifier indicator of -1- for the edits bundling 11400-11646 to 14000-14350. You may use modifier 59 (Distinct procedural service) to override the edits when the lesion excision and adjacent tissue transfer occur at different locations, or during separate, distinct operative sessions, says **Barbara J. Cobuzzi**, president of **CRN Healthcare Solutions** in Tinton Falls, NJ.

Example: The surgeon performs a single excision on the right forearm, along with lesion excision followed by adjacent tissue transfer at another location near the elbow.

In this case, you should report the lesion excision followed by adjacent tissue transfer using the appropriate tissue transfer code only (for example, 14021).

You may report the lesion excision only in a separate location using the appropriate lesion excision code (for example, 11601, Excision, malignant lesion including margins, trunk, arms or legs; excised diameter 0.6 to 1.0 cm) with modifier 59 appended.

5. Include Repairs And Debridement, Too

In addition to lesion excision, you should also bundle into adjacent tissue transfers any repairs (12001-13160) or debridement (11000-11042) for the same lesion or injury, Brame says. NCCI bundles 12001-13160 and 11000-11042 to 14000-14300, as outlined in the introductory material of Chapter 3 (-Integument-ary System-) and supported by code pair edits elsewhere. Different location allows for separate payment: If the repair and tissue transfer occur at different locations, you can report the repair separately.

Example: The surgeon removes a lesion from the patient's left cheek, which requires a flap repair. At the same time, he closes a nearby but separate 2.5-cm wound by intermediate repair. In this case, you can report the flap repair (14040) separately from the intermediate repair (12051, Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less). Remember that the flap repair includes the lesion excision at the same site.

6. Report Surgical Prep, Grafts Separately

Bishop confirms that when your surgeon uses a skin graft to close a secondary defect, you may report the procedure in addition to the tissue transfer:

- 15100-15136 for autologous skin grafts
- 15150-15157 for autologous tissue-cultured epidermal grafts
- 15040 for autologous keratinocytes and dermal tissue harvesting for tissue-cultured skin grafts
- 15170-15176 for acellular dermal replacement.

In addition, you may report surgical preparation of the recipient site, when required, using the following codes (as appropriate to location and total area prepared):

- 15002--Surgical preparation or creation of recipient site by excision of open wounds, burn eschar or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children
- +15003--- each additional 100 sq cm or each additional 1% of body area of infants and children (list separately in addition to code for primary procedure)
- 15004--Surgical preparation or creation of recipient site by excision of open wounds, burn eschar or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or 1% of body area of infants and children
- +15005--- each additional 100 sq cm or each additional 1% of body area of infants and children (list separately in addition to code for primary procedure).

Specifically, CPT 2007 instructs, -Codes 15002-15005 describe burn and wound preparation or incisional or excisional release of scar contracture resulting in an open wound requiring a skin graft.-

What constitutes site prep that warrants billing 15002-15005? According to the Sept. 1997 CPT Assistant, -Usually, the untreated site contains uneven layers or multiple layers that pose a problem, not only facilitating the connection of the surfaces (to maximize graft survival) but accommodating the graft to cause minimal visualization of the graft site.-

