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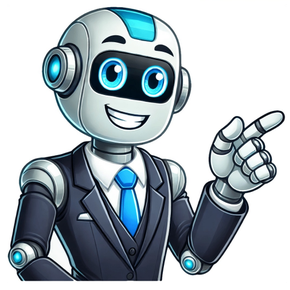

On a CPT® code's hierarchy page, you get to see a medical code's neighbors, including the CPT® codes' official long descriptors. Seeing related codes helps coders choose the correct code, improving their accuracy rate. Click on a blue code to see a sample of a CPT® code's details page. On a CPT® code's hierarchy page, you get to see a medical code's neighbors, including the CPT® codes' official long descriptors. Seeing related codes helps coders choose the correct code, improving their accuracy rate. Click on a blue code to see a sample of a CPT® code's details page. Page 2 On a CPT® code's hierarchy page, you get to see a medical code's neighbors, including the CPT® codes' official long descriptors. Seeing related codes helps coders choose the correct code, improving their accuracy rate. Click on a blue code to see a sample of a CPT® code's details page. Hint: Not all three codes are appropriate for most cases -- find out why. If you code for pediatric urologists, you may see a fair share of hypospadias repair procedures cross your desk. Coding for these procedures can pose a challenge to even seasoned coders. For example: Do you know whether you should report more than one code to accurately describe the procedure? See how your coding stacks up with the experts' by testing your hand at coding this case study from Becky Boone, CPC, CUC, certified reimbursement assistant for the University of Missouri Department of Surgery in Columbia. Review the Surgical Case Preoperative diagnosis: Distal hypospadias Postoperative diagnosis: Distal hypospadias Procedure: Distal hypospadias repair Byers flap Dorsal only flap Indication for Procedure: This is a 7-year-old male with history of distal hypospadias. The family was advised many years ago to have this repaired under anesthesia. However, they were lost to follow-up and did not return for evaluation until the child was much older. They now request that his hypospadias be corrected surgically. The risks and benefits of surgery were explained at length to the patient's family, and they agreed to proceed. Description of Procedure: The patient was brought to the operative suite and placed on the OR table in the supine position. After adequate general endotracheal anesthesia was performed by the anesthesiologist, the patient's genitalia were then prepped and draped in the usual sterile fashion. A holding suture was placed through the glans for retraction. The urethral meatus was somewhat narrow in a subcoronal location. This would dilate up to 8 French, and therefore, part of the lip of the meatus was cut back using a Westcott scissors, and the skin edges were reapproximated using interrupted 7-0 PDS. This now calibrated up to 12 French easily. Holding sutures were placed in the dorsal hooded foreskin. A marking pen was used to mark out the glans collar, and this was brought around ventrally proximal to the urethral meatus. The skin was then incised using a scalpel. The penile shaft skin was then carefully degloved using sharp dissection as well as Bovie cautery for hemostasis. After all the chordee elements were taken down, there was no evidence of any penile curvature. At this point, a vascularized pedicle flap was harvested from the dorsal preputial skin and brought around ventrally through a buttonhole at the base of the pedicle. This would be used later for coverage of the repair. A tourniquet was then placed at the base of the penis for hemostasis. A marking pen was used to mark out the urethral plate on either side of the glans. This was incised deeply with a Beaver blade scalpel. The glans wings were then further developed using a Westcott scissors. Hemostasis was achieved. The urethral plate was then incised deeply in the midline in order to hinge the plate and to allow tubularization of the urethra without tension. The urethra was then tubularized over a 10-French bougie using running PDS suture for a first layer and then interrupted 7-0 PDS for a second layer. The dorsal pedicle flap was then laid over the repair for a third layer of coverage. Hemostasis was then obtained. The glans was then reconstructed in multiple layers using interrupted 6-0 PDS sutures. The edges of the glans collar were trimmed appropriately. The tourniquet was then released, and hemostasis was excellent. There was not sufficient ventral penile shaft skin for coverage, and therefore, Byers flaps were created using dorsal and lateral skin, and less than 10 sq cm of skin coverage was created by interdigitating the skin edges ventrally with interrupted 6-0 PDS suture. The excess foreskin was then removed, and the 10-French Zaontz urethral catheter was then placed per urethra and anchored to the glans using a 5-0 Prolene suture. A sterile dressing was applied. The patient tolerated the procedure well, and he was then transported to the recovery room in stable condition. Coding dilemma: How would you code this procedure? "For this case, my group of pediatric urologists want to bill the following codes together: 54324, 15740, and 14040," Boone says. "They state that they've been to conferences where they are being told that this is appropriate, but I have never coded this way. Can I actually report all three codes for this case and others like it?" No CCI Bundle Isn't a Green Light for Additional Coding When you are considering reporting multiple procedure codes for a surgical encounter, one of the first places you probably should look is at the Correct Coding Initiative (CCI) edits. There are no CCI edit bundling for any of the following codes: 54324 -- 1-stage distal hypospadias repair (with or without chordee or circumcision); with urethroplasty by local skin flaps (eg, flip-flap, prepucial flap) 15740 -- Flap; island pedicle 14040 -- Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less. Caution: "But just because there is no CCI edit saying you cannot report these codes together, doesn't mean you can just automatically report all three codes," warns Michael A. Ferragamo, MD, FACS, clinical assistant professor of urology, University Hospital, State University of New York, Stony Brook. Pay Attention to the Code Descriptors There are other types of bundlings as well that you need to consider. In this case, you should consider what is included in the procedure as noted by the actual description of 54324. How it works: "15740 describes a flap or island pedicle. 14040 is adjacent tissue transfer," explains Jonathan Rubenstein, MD, director of coding and physician compliance for Chesapeake Urology Associates in Baltimore. "52324 describes a 1-stage hypospadias repair and it says it includes local skin flaps as part of its description. So I don't think that it is appropriate to bill 14040 or 15740 separately as they seem to be included in the description of the procedure." Look at similar codes: There are other codes that are similar in terms of the description of local skin flaps and adjacent tissue transfer being part of the main procedure code. For urethral mobilization with flap or tissue transfer, you would just code 54326 (1-stage distal hypospadias repair [with or without chordee or circumcision]; with urethroplasty by local skin flaps and mobilization of urethra), Rubenstein explains. If your urologist truly performs hypospadias repair along with an island flap, it would be more appropriate to report 54328 (1-stage distal hypospadias repair [with or without chordee or circumcision]; with extensive dissection to correct chordee and urethroplasty with local skin flaps, skin graft patch, and/or island flap) than 54324 and 15740, Rubenstein says. Final Coding: Pick Just One The bottom line is that for procedures such as the one described in this case study reporting 54324 alone is really the most appropriate billing just as we suspected from our earlier discussions. Consult your urologist: In reality, your urologist can bill all three codes if he truly believes all three best represent the surgery he performed. There is no CCI edit or other specific guideline that states you cannot report all three. "They can bill whatever they want," Ferragamo says. "That doesn't mean it is necessarily proper coding, and I don't think what they did in the procedures supports coding anything other than 54324. If a payer asks to review the op report, they probably would agree that the documentation does not support more than code 54324." Search The CPC Preparation course teaches physician office coding, such as how to assign the proper diagnosis and procedure codes from operative reports and patient charts. This course also helps to prepare you for the CPC certification exam. The CPB Medical Billing course emphasizes billing and only lightly touches on coding, and will prepare you for the CPB certification exam. This course teaches medical billing and reimbursement issues, such as how to take the codes that have already been assigned by the coder and process a claim form, and how to work with 3rd party payers to make sure the claim is processed correctly. It is important that a coder understands billing issues as it helps to decrease claim denials and increase reimbursement. An understanding of billing will also expand a coder’s career opportunities. Credit will not be awarded for educational activities completed prior to certification. Completing an 80 hour or more classroom course will waive one year experience. A letter or certificate of completion indicating hours completed must be submitted to the AAPC to verify course completion. Completion of either the CPC or COC Preparation online courses will waive 80-hours of coding education which waives one year work experience towards the A removal. The student does not need to submit proof of course completion, AAPC will verify this experience as met once the course is completed. AAPC offers training courses for CPC, COC, and CIC certification preparation. The CPC Prep course teaches physician office coding and helps to prepare a student for the CPC certification exam. The COC Prep course teaches coding for an outpatient hospital/facility setting and helps to prepare a student for the COC certification exam. The CIC Prep course teaches coding for an inpatient hospital/facility setting and helps to prepare a student for the CIC certification exam. These are self-study courses in which students work at their own pace, from home, to complete each course within a 4-month timeframe or less. For students who prefer to take a classroom based course, many AAPC certified instructors teach AAPC curriculum throughout the US. Need education advice? Get a consult with a Career Counselor. Schedule a call to discuss our multi-user products or services for your team. Have a general question? Ask a Customer Success representative. Our phone lines are open Monday through Friday during our regular business hours. Mon - Thu | 7 AM - 5 PM (MST) Fri | 7 AM - 4 PM (MST) Enrollment advisor 1-877-290-0440 Customer service 1-800-626-2633 Businesses 1-844-825-1679 Individual purchases 1-877-524-5027 Need your issue resolved in real time? Start a chat with our customer support team here. Chat with Us Focus on initial versus complication first. When your urologist performs a hypospadias repair procedure on a pediatric patient, there are several codes that could apply, which makes your job a challenge. You’ll start by determining if your urologist is performing an initial repair (54300-54336), a repair of complications (54340-54348), or a repair of a hypospadias cripple (54352). Read on to ensure you know which code set to turn to when coding your urologist’s procedures. 1. Focus on Staging and Meatus Location for Initial Procedures “For hypospadias repairs, the code you use is based on the location of the meatus, what you do surgically, and how many stages will be required to complete the repair,” explains Michael A. Ferragamo, MD, FACS, clinical assistant professor of urology at the State University of New York at Stony Brook. Multi-stage: Once you know your urologist is performing an initial hypospadias repair, you need to scour the documentation to see if he performed a staged procedure. For the first stage of a staged procedure, you’ll report one of the following: 54300 — Plastic operation of penis for straightening of chordee (eg, hypospadias), with or without mobilization of urethra 54304 — Plastic operation on penis for correction of chordee or for first stage hypospadias repair with or without transplantation of prepuce and/or skin flaps. For the second stage, choose from the following codes, based on the repair size: 54308 — Urethroplasty for second stage hypospadias repair (including urinary diversion); less than 3 cm 54312 — ... greater than 3 cm 54316 — Urethroplasty for second stage hypospadias repair (including urinary diversion) with free skin graft obtained from site other than genitalia. Finally, if your urologist performs a third stage, report 54318 (Urethroplasty for third stage hypospadias repair to release penis from scrotum [eg, third stage Cecil repair]). Single stage: If your urologist notes that he performed a single-stage hypospadias repair, you will choose one of the following codes: 54322 — 1-stage distal hypospadias repair (with or without chordee or circumcision); with simple meatal advancement (eg, Magpi, V-flap) 54324 — ... with urethroplasty by local skin flaps (eg, flip-flap, prepucial flap), (use for a Mathieu repair) 54326 — ... with urethroplasty by local skin flaps and mobilization of urethra, (use for Snodgrass/Thiersh repairs) 54328 — ... with extensive dissection to correct chordee and urethroplasty with local skin flaps, skin graft patch, and/or island flap 54332 — 1-stage proximal penile or penoscrotal hypospadias repair requiring extensive dissection to correct chordee and urethroplasty by use of skin graft tube and/or island flap 54336 — 1-stage perineal hypospadias repair requiring extensive dissection to correct chordee and urethroplasty by use of skin graft tube and/or island flap, (use for Duckett repair) These codes differ based on the surgical components of the procedure as noted in the code descriptors as well as the anatomical location of the repair, Ferragamo says. You’ll use 54322 or 54324 for distal repairs, and 54324, 54326, or 52348 for mid-shaft repairs, he adds. Apply 54332 for proximal penile or penoscrotal repairs and 54336 for perineal repair. 2. Switch Code sets for Complication Repair If your urologist is repairing a complication from a previous hypospadias repair, such as a stricture or fistula, you won’t use the codes listed above. Instead, choose from one of the following, based on the complexity of the repair: 54340 — Repair of hypospadias complications (ie, fistula, stricture, diverticula); by closure, incision, or excision, simple 54344 — ... requiring mobilization of skin flaps and urethroplasty with flap or patch graft 54348 — ... requiring extensive dissection and urethroplasty with flap, patch or tubed graft (includes urinary diversion). Exception: If your urologist notes he performed a “repair of a hypospadias cripple,” 54340-54348 don’t apply. Rather, you’ll report 54352 (Repair of hypospadias cripple requiring extensive dissection and excision of previously constructed structures including re-release of chordee and reconstruction of urethra and penis by use of local skin as grafts and island flaps and skin brought in as flaps or grafts). 3. Watch For Additional Reportable Procedures Note that the hypospadias repair codes include many of the component procedures that your urologist may also perform in the same surgical session, and you should not separately report those procedures. For example, if your urologist performs a “Nesbitt procedure,” which is a plastic repair of the penis to correct angulation, you should not separately report 54360 (Plastic operation on penis to correct angulation) along with the hypospadias repair code. There are some procedures that are not included in the primary hypospadias repair codes. For example, if your urologist performs a tunica vaginalis graft for urethroplasty coverage, you can separately report 15740 (Flap; island pedicle requiring identification and dissection of an anatomically named axial vessel) with primary codes 54324, 54326, 54328, 54332, and 54336. However, if he performs a Dartos island flap, you should not separately report 51740 with mid-shaft and proximal hypospadias repair codes 54328, 54332, or 54336, Ferragamo warns. See the box on the right for other procedure codes your urologist may perform. You’ll need to check with your payer to see if you can separately bill for any of the listed procedures. Additionally: If your urologist has to perform extensive reconfiguration of Byar’s flaps or a scrotal flap to cover the urethroplasty, you should report 14040 (Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less) with the hypospadias repair code. For harvesting a buccal graft, report 15240 (Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; 20 sq cm or less) and 15120 (Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children [except 15050]) for a split thickness graft. Example: Your urologist is treating a patient with a mid-shaft penile hypospadias and chordee. He performs a one-stage initial repair with extensive straightening of the chordee, local skin flaps, a buccal mucosal tube urethroplasty, and an artificial erection to gauge the degree of chordee. You should report 54328 for the hypospadias repair. Then, report 15240 for the graft and 54235 (Injection of corpora cavernosa with pharmacologic agent[s] [eg, papaverine, phentolamine]) for the induced artificial erection during the procedure. Attach modifier 51 (Multiple procedures) to 15240 and 54235 if your payer requires that modifier. You will use ICD-9 code 752.61 (Hypospadias). Named vessel is key. Changes to CPT® 2013 "other flaps and grafts" instructions -- along with the code revision -- might simplify your coding for 15740 (Flap; island pedicle requiring identification and dissection of anatomically named axial vessel). But let our experts take the changes a step further to remind general surgery coders just how much there is to know about coding for pedicle flaps, adjacent tissue transfer, island flaps and more. ‘Island Flap’ Means Vessel An island pedicle flap procedure doesn’t change in 2013, but the CPT® code revision emphasizes the nature of the service. An island flap is, by definition, a surgical pedicle consisting predominately of the supplying blood vessels. The code revision doesn’t change that, but it does strengthen the documentation needed to justify reporting 15740. Now the code describes an island pedicle flap "requiring identification and dissection of anatomically named axial vessel," according to the verbiage added to the 15740 code definition in CPT® 2013. No vessel name: That means if your surgeon doesn’t identify the anatomically named axial vessel incorporated into the flap design, you can’t report 15740. Instead: "For random island flaps, V-Y subcutaneous flaps, advancement flaps, and other flaps from adjacent areas without clearly defined anatomically named axial vessels, see 14000-14302," states the new CPT® 2013 text note in the "Other Flaps and Grafts" introduction. Distinguish Flaps Versus Adjacent Tissue Transfer A pedicle flap is a type of nonadjacent tissue transfer that initially remains attached to the donor-site blood supply. The surgeon cuts a "stalk," or pedicle of tissue, that includes a flap the proper size and shape to repair a defect that is not contiguous with the donor site. The surgeon then maneuvers the flap to the repair site, still attached by the pedicle to the donor site, and later cuts the pedicle free. Watch for: You might also see this technique called "attached flap" or "tubed pedicle," which refers to a sub-type that involves stitching together the long sides of the pedicle to form a tube. The codes that describe pedicle flaps, such as 15570-15576 (Formation of direct or tubed pedicle, with or without transfer; ...) can refer to transfers of skin and/or deep tissues from non-adjacent locations, according to Marcella Bucknam, CPC, CPC-I, CCS-P, CPC-H, CCS, CPC-P, COBGC, CCC, audit manager for CHAN Healthcare in Vancouver, Wash. CPT® also includes pedicle flap codes for blood vessels (15740) and for nerve and vascular tissue (15750, Flap; neurovascular pedicle), Bucknam explains. On the other hand: CPT provides different codes for grafts involving tissue transfer from a directly adjacent site: 14000-14302 (Adjacent tissue transfer or rearrangement ...) For instance: If your surgeon creates a subclavian-vein pedicle flap to repair a distant injury to the right axilla, should you report 15740 or 14040 (Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq. cm or less)? "Code 15740 describes a flap or island pedicle; 14040 is adjacent tissue transfer," explains Jonathan Rubenstein, MD, director of coding and physician compliance for a surgery practice in Baltimore. That means you should code the service describe using 15740, not 14040, because the procedure description documents the axial vessel and the creation of a pedicle flap for a non-adjacent site. Combat the #1 denial reason - mismatched CPT-ICD-9 codes - with top Medicare carrier and private payer accepted diagnoses for the chosen CPT® code. View the CPT® code's corresponding procedural code and DRG. In a click, check the DRG's IPPS allowable, length of stay, and more. To plug inpatient facility revenue drains, subscribe to DRG Coder today. Crosswalk to an anesthesia code and its base units, and calculate payments in a snap! Subscribe to Anesthesia Coder today. View matching HCPCS Level II codes and their definitions. By Ken Camilleis, CPC, CPC-I, CMRS An adjacent tissue transfer (CPT® 14000-14350) relocates a flap of healthy skin from a donor site to an adjacent laceration, scar, or other discontinuity. A portion of the flap is left intact to supply blood to the grafted area. Adjacent tissue transfer/rearrangement (ATT/R) may be for repair of traumatic skin wounds, lesion excision, or rearrangement/reconstruction of tissue by Z-plasty, W-plasty, V-Y-plasty, rotation flaps, advancement flaps, or other methods. CPT® assigns ATT/R procedure codes by anatomic site, and by the combined area (in square centimeters) of the defect to be repaired (the primary defect) and the defect created by the tissue transfer (the secondary defect). ATT/R procedures with a total area of more than 30 sq cm are reported using the “any site” codes 14301-14302.
14000 Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less 14001 defect 10.1 sq cm to 30.0 sq cm 14020 Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10 sq cm or less 14021 defect 10.1 sq cm to 30.0 sq cm 14040 Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less 14041 defect 10.1 sq cm to 30.0 sq cm 14060 Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less 14061 defect 10.1 sq cm to 30.0 sq cm 14301 Adjacent tissue transfer or rearrangement, any area; defect 30.1 sq cm to 60.0 sq cm +14302 each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure) 14350 Filleted finger or toe flap, including preparation of recipient site As an example, the surgeon repairs a defect on the chest using ATT/R. The primary defect measures 4 sq cm, while the secondary defect (resulting from creation of the tissue flap) measures 9 sq cm. Per CPT®, “The primary defect resulting from the excision and the secondary defect resulting from flap design to perform the reconstruction are measured together to determine the code.” In this case, total area is 13 sq cm (4 sq cm + 9 sq cm). Because the defect is located on the trunk, the correct code is 14001. Include Same-location Excision, Debridement, and Repairs Per CPT® instructions, ATT/R procedures include excisions at the same location—for instance, to revise a scar or to remove a benign or malignant lesion. CPT® Assistant (July 2008) provides the following example: A physician excises a 1.5 cm lesion on the cheek with an excised diameter of 1.8 cm (primary defect, approximately 3.2 sq cm) and performs an adjacent tissue transfer (flap dimension of 1.4 cm x 3.0 cm, which equals a 4.2 sq cm secondary defect). Based on the total area of the primary and secondary defects (7.4 sq cm) and the location (cheek), the correct code is 14040. The lesion excision is included in the tissue transfer and is not separately reported. In a second example, a patient’s nostril is retracted secondary to a scar. The scar is excised, and an 11 sq cm dorsal nasal flap is used to repair the 2 sq cm defect resulting from the scar excision. Based on the total area (13 sq cm) and location (nose), the correct code is 14061. The ATT/R code includes scar excision at the same location. According to the National Correct Coding Initiative (NCCI) Policy Manual for Medicare Services (chapter 3), “Debridement necessary to perform a tissue transfer procedure is included in the procedure. It is inappropriate to report debridement (e.g., CPT® codes 11000, 11042-11047, 97597, 97598) with adjacent tissue transfer (CPT® codes 14000-14350) for the same lesion/injury.” As well, NCCI edits prohibit separate reporting of related repairs (12001-13160) with ATT/R procedures. The NCCI Policy Manual clearly states, “12001-13160 should not be reported separately with CPT codes 14000-14350 for the same lesion or injury.” Note: Medicare contractors must observe NCCI guidelines, but private payers may reimburse medically necessary complex closures (13100-13160) to repair a secondary defect in addition to an ATT/R. Check with your payer for its policies. Grafts Call for Separate Coding As CPT® Assistant (July 2008) explains, “Sometimes a tissue transfer or rearrangement procedure creates an additional defect that must be repaired. If a skin graft or another flap is necessary to close a secondary defect, this should be reported separately.” The NCCI Policy Manual concurs, stating, “Skin grafting in conjunction with a repair or adjacent tissue transfer is separately reportable if the grafting is not included in the code descriptor of the adjacent tissue transfer code.” For example, the surgeon excises a 5 cm malignant lesion with 0.5 cm margins from the neck (for an excised diameter of 7 cm or 38.5 sq cm). A 64 sq. cm transposition flap is used to close the defect (primary defect + secondary defect = 102.5 sq cm). The flap donor site is partially closed, but there is a remaining 16 sq cm defect, which requires a split-thickness skin graft. To report the ATT/R, begin with 14301, which describes any area 30.1 to 60.0 sq cm. For the remaining 42.5 sq cm (102.5 – 60 = 42.5), report two units of add-on code 14302, which describes each additional 30 sq cm, or part thereof. The lesion excision is included in the adjacent tissue transfer and isn’t coded separately. The split thickness autograft to repair the remaining 16 sq cm defect may be separately reported using 15120 Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children (except 15050). Don’t Over-code Repairs Adjacent tissue transfer codes do not apply when the rearrangement of traumatic wounds incidentally results in an ATT/R configuration (e.g., Z-plasty, W-plasty), according to CPT® guidelines. If the surgeon only debrides and closes a primary defect (for example, using staples, sutures, or adhesives), choose an appropriate repair code (12001-13160). For instance, if the surgeon undermines the adjacent tissue to achieve closure without additional incisions, even if the surgeon advances flaps of skin toward each other, you would report a complex closure (13100-13160), rather than an ATT/R, because the flap advancement by itself is not sufficient to code an ATT/R. Report ATT/R (14000-14350) only if the surgeon freed any tissue from another site or from around the damaged area, and transplanted or rearranged the tissue to overlay and repair the wound. Optimize Adjacent Tissue Transfer/Rearrangement Reimbursement was last modified: February 1st, 2012 by admin aapc