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CHAPTER III
SURGERY: INTEGUMENTARY SYSTEM
CPT CODES 10000-19999
FOR
NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL
FOR MEDICARE SERVICES

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Chapter III
Surgery: Integumentary System
CPT Codes 10000 - 19999

A. Introduction

CPT coding of the integumentary system includes coding narrative for services performed by a number of specialties. While the coding system is oriented toward dermatological procedures, the dermatological aspects of the practice of plastic surgery are covered as are the dermatologic elements (particularly closure, tissue transfer, grafts, adjacent and distant flaps) of multiple surgical procedures, especially radical or mutilative surgical procedures. Integumentary procedures are also often performed in staged fashions due to the sophistication of services rendered.

Generally, integumentary procedures include incision, biopsy, removal, paring/curettement, shaving, destruction (multiple methodologies), excision, repair, adjacent tissue rearrangement, grafts, flaps, and specialized services such as burn management and Mohs' Micrographic Surgery.

When a column one code describes other column two codes, all of which were performed, the column one code should be used rather than listing the individual column two codes. Additionally, because of the technical advances and changes in technology, standard medical practice should be as accurately reflected in CPT coding as possible. The CPT code should reflect what transpires in a standard surgical setting. Necessary services performed in order to accomplish a more comprehensive service are included in the CPT code describing the more complex service.

B. Evaluation and Management (E&M) Services

Medicare Global Surgery Rules define the rules for reporting evaluation and management (E&M) services with procedures covered by these rules. This section summarizes some of the rules.

All procedures on the Medicare Physician Fee Schedule are assigned a Global period of 000, 010, 090, XXX, YYY, or ZZZ. The global concept does not apply to XXX procedures. The global period for YYY procedures is defined by the Carrier. All procedures with a global period of ZZZ are related to another procedure, and the applicable global period for the ZZZ code is determined by the related procedure.

Since NCCI edits are applied to same day services by the same provider to the same beneficiary, certain Global Surgery Rules are applicable to NCCI. An E&M service is separately reportable on the same date of service as a procedure with a global period of 000, 010, or 090 under limited circumstances.

If a procedure has a global period of 090 days, it is defined as a major surgical procedure. If an E&M is performed on the same date of service as a major surgical procedure for the purpose of deciding whether to perform this surgical procedure, the E&M service is separately reportable with modifier -57. Other E&M services on the same date of service as a major surgical procedure are included in the global payment for the procedure and are not separately reportable. NCCI does not contain edits based on this rule because Medicare Carriers have separate edits.

If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier -25. NCCI does contain some edits based on these principles, but the Medicare Carriers have separate edits. Neither the NCCI nor Carriers have all possible edits based on these principles.

Procedures with a global surgery indicator of “XXX” are not covered by these rules. Many of these “XXX” procedures are performed by physicians and have inherent pre-procedure, intra-procedure, and post-procedure work usually performed each time the procedure is completed. This work should never be reported as a separate E&M code. Other “XXX” procedures are not usually performed by a physician and have no physician work relative value units associated with them. A physician should never report a separate E&M code with these procedures for the supervision of others performing the procedure or for the interpretation of the procedure. With most “XXX” procedures, the physician may, however, perform a significant and separately identifiable E&M service on the same day of service which may be reported by appending modifier –25 to the E&M code. This E&M service may be related to the same diagnosis necessitating performance of the “XXX” procedure but cannot include any work inherent in the “XXX” procedure, supervision of others performing

the “XXX” procedure, or time for interpreting the result of the “XXX” procedure. Appending modifier –25 to a significant, separately identifiable E&M service when performed on the same date of service as an “XXX” procedure is correct coding.

C. Anesthesia

With limited exceptions Medicare Anesthesia Rules prevent separate payment for anesthesia for a medical or surgical service when provided by the physician performing the service. The physician should not report CPT codes 00100-01999. Additionally, the physician should not unbundle the anesthesia procedure and report component codes individually. For example, introduction of a needle or intracatheter into a vein (CPT code 36000), venipuncture (CPT code 36410), or drug administration (CPT codes 90760-90775) should not be reported when these services are related to the delivery of an anesthetic agent.

Medicare may allow separate payment for moderate conscious sedation services (CPT codes 99143-99145) when provided by the same physician performing the medical or surgical procedure except for those procedures listed in Appendix G of the *CPT Manual.*

Local anesthesia including local infiltration, regional blocks, mild sedation, and all other anesthesia services except moderate conscious sedation reportable as CPT codes 99143-99145 are not separately reportable by a physician performing a medical or surgical procedure.

Billing for "anesthesia" services rendered by a nurse or other office personnel (unless the nurse is an independent certified nurse anesthetist, CRNA, etc.) is inappropriate as these services are “incident to” the physician’s services.

It is a misuse of therapeutic injection or aspiration CPT codes to report administration of local anesthesia for a procedure. For example, it is a misuse of CPT codes 10160 (puncture aspiration), 20500-20501 (injection of sinus tract), 20526-20553 (injection of carpal tunnel, tendon sheath, ligament, trigger points, etc.), 20600-20610 (arthrocentesis) to report administration of local anesthetic for another procedure.

In the postoperative period, patients treated with epidural or subarachnoid continuous drug administration may require daily

hospital adjustment/management of the catheter, dosage, etc. (CPT code 01996). This service may be reported by the anesthesiologist. The management of postoperative pain by the surgeon who performed the procedure, including epidural or subarachnoid drug administration, is included in the global period services associated with the operative procedure. If the only surgery performed is placement of an epidural or subarachnoid catheter for continuous drug administration, CPT code 01996 may be reported on subsequent days by the managing physician.

D. Incision and Drainage

Incision and drainage services, as related to the integumentary system, generally involve cutaneous or subcutaneous drainage of cysts, pustules, infections, hematomas, seromas or fluid collections. In cases where, in the course of an excision of a lesion, an area of involvement is identified which requires drainage, either as a part of the procedure or in order to gain access to the area of interest, coding/billing for incision and drainage of this fluid collection would be inappropriate if the excision or other procedure is performed in the same session.

Example: A patient who presents with a pilonidal cyst may require simple incision/drainage or may require an extensive excision. In the former case, the appropriate CPT coding is 10080 (or 10081 if complicated). If the pilonidal cyst is excised, while it is obvious that drainage from the cyst will occur in the course of its excision, the appropriate coding is CPT code 11770 (or 11771 or 11772, depending on the complexity), not CPT codes 10080 and 11770. If it is evident that an extensive cellulitis is present around the cyst preventing the complete procedure from being accomplished, it may be reasonable to bill for CPT code 10080, then, after perhaps a week of antibiotic therapy, complete the procedure using 11770-78 (Return to the operating room for a related procedure during the postoperative period.) The nature of the treatment should be driven by medical decision making rather than by coding conventions.

1. Procedure codes such as incision and drainage of hematomas (e.g., CPT Code 10140) are not to be reported if reported during the same session or at the same site as an excision, repair, destruction, removal, etc.

2. Codes describing services necessary to address complications, such as CPT code 10180 (incision and drainage, complex, postoperative wound infection) should not be submitted for services rendered at the same surgical session that resulted in the complication. If performed in conjunction with the primary procedure, it would be included in the primary, column one, procedure. For example, if a patient has undergone a thoracotomy and a necrotizing pneumonia with empyema develops, it may be necessary to perform a lobectomy through the previous incision. The reason for the surgery is to perform the lobectomy; therefore the lobectomy code should be reported. Since the drainage of the empyema is necessary to accomplish the lobectomy, it would be inappropriate to bill for CPT code 10180 (incision and drainage). On the other hand, if the patient would only require drainage of a thoracotomy wound infection (without lobectomy) and it is determined to be medically necessary to place a gastrostomy tube at the same time, the CPT code 10180 could be reported with the appropriate gastrostomy tube placement code.

E. Lesion Removal

For a given lesion, only one type of removal is reported, whether it is destruction (e.g., laser, freezing), debridement, paring, curettement, shaving or excision. CPT definition describes the nature of each of these forms of removal. CPT definition also defines the lesions (specifically full thickness excision) by lesion diameter. In the case where an initial attempt using a less invasive procedure is followed by a more invasive lesion removal, the more complex procedure used would be appropriately reported, but not both procedures. Additionally, multiple codes describing destruction of a lesion are not to be reported for a given lesion; if multiple distinct lesions are removed using different methods, an anatomic modifier or modifier -59 would be used to indicate a different site, a different method or a different lesion. The distinct location of the lesions should be reflected in the medical record.

A lesion biopsy represents a partial removal of a lesion and is frequently performed as a part of a lesion excision in order, for example, to procure a pathological specimen. Generally, a part of, or the entire lesion is submitted for biopsy. When a biopsy is performed as part of a lesion removal, it is part of the overall procedure and is not to be considered as a separate procedure.

If a biopsy is performed on a separate date at a separate session, and subsequently a definitive procedure is performed, the biopsy code may be reported, followed by a separate removal code, indicating the different dates of service.

Tissues removed are often submitted for surgical pathological evaluation; in some cases, physicians qualified in dermatopathology may perform these evaluations. These codes generally include CPT codes 88300-88309 (surgical pathology). Additionally, when the physician is asked to review slides obtained from another physician's excision, and subsequently performs additional removal/biopsy, a separate code for review of outside slides is not reported, i.e. CPT code 88321, in addition to an evaluation and management service. The decision to perform surgery is generally based on an evaluation and management service which includes review of prior records including tissues, slides, etc.) The dermatopathology evaluation must be medically necessary and reasonable. When lesions of like nature (e.g., multiple seborrheic keratoses) are encountered, removal of multiple lesions is frequently accomplished at the same operative session. If it is determined to be medically necessary to separately submit the lesions for pathologic evaluation, documentation of the precise location of each separately submitted lesion must be present. If multiple lesion specimens are submitted as a collective group without documentation specifying locations sufficient to differentiate the source of each specimen, then the surgical pathology code should be submitted as one specimen (one unit of service) even if the specimens were subsequently separated.

Lesions or margins obtained during Mohs' Micrographic Surgery should not be coded under the surgical pathology codes. The definition of Mohs' Micrographic Surgery includes the services defined by the surgical pathology codes (CPT codes 88300-88309) and excision codes (CPT codes 11600-11646 and 17260-17286). These procedure codes are part of the Mohs' Micrographic Surgery CPT codes (17304-17310). Billing separately for one of the above pathology and/or one of the excision codes is inappropriate. It is recognized that a Mohs' surgeon may find it necessary to obtain a diagnostic biopsy in order to make the decision to perform surgery. When a diagnostic biopsy is necessary, it may be reported separately. Modifier -58 may be utilized to indicate that the diagnostic biopsy and Mohs’ Micrographic Surgery are staged or planned procedures.

Lesion removal, by whatever method (usually excisional), may require simple, intermediate, or complex closure and, in unusual circumstances, tissue transfer procedures. When the lesion removal requires only bandaging, strip closure or simple closure (see CPT definition of simple closure), this is included in the lesion excision and is not to be reported separately.

Accordingly, CPT codes 12001-12021 (simple repairs) are considered part of the lesion removal codes. Intermediate and complex closures, when medically necessary, may be coded separately. In the case of Mohs' Micrographic Surgery (CPT codes 17304-17310) all necessary repairs may be coded.

In the course of destruction, excision, incision, removal, repair, or closure, debridement of non-viable tissue surrounding a lesion, injury or incision is often necessary to accomplish the primary service. The debridement codes (e.g., CPT codes 11000, 11040-11042) are not to be reported separately, as this service is necessary as a part of the total procedure according to standard medical practice.

CPT codes describing intralesional chemotherapy (CPT Codes 96405, 96406) refer to injection of chemotherapeutic agents into one or multiple lesions. CPT codes 11900 and 11901 describe non-specific intralesional injection(s) into one or more lesions. While one or the other code may be appropriate for a given service, both lesion injection codes are not to be reported together (unless separate lesions are injected with different agents, in which case modifier -59 should be attached to the intralesional injection code). The CPT codes 11900, 11901 (injection, intralesional) are not to be used for local anesthetic injection in anticipation of chemotherapy or any other definitive service performed on a lesion or group of lesions. Local anesthesia is considered a part of the definitive procedure. These intralesional CPT injection codes (96405, 96406, 11900 and 11901) are included in the following list of CPT codes if the injection represents local anesthesia:

11200 - 11201 (Removal of skin tags)
11300 - 11313 (Shaving of lesions)
11400 - 11471 (Excision of lesions)
11600 - 11646 (Excision of lesions)
12001 - 12018 (Repair - simple)
12020 - 12021 (Treatment of wound dehiscence)

12031 - 12057 (Repair - intermediate)
13100 – 13160 (Repair - complex)
11719 - 11762 (Trimming, debridement and excision of nails)
11770 - 11772 (Excision of pilonidal cysts)
11765 (Wedge excision)

F. Repair and Tissue Transfer

When lesional excision is of such an extent that closure cannot be accomplished by simple, intermediate, or complex closure, other methodology must be employed. Frequently adjacent tissue transfer or tissue rearrangement is employed (Z-plasty, W-plasty, flaps, etc.). This family of codes, (CPT codes 14000-14350), involves excision with adjacent tissue transfer and correlates to excision codes. Excision CPT codes (11400-11646) and repair CPT codes (12001 – 13160) are not to be separately reported when CPT codes 14000-14350 are reported. On the other hand, skin grafting performed in conjunction with these codes may be separately reported if it is not included in the specific code definition. In the case of closure of traumatic wounds, these codes are appropriate only when the closure requires the surgeon to develop a specific adjacent tissue transfer; lacerations that coincidentally are approximated using a tissue transfer technique (e.g., Z-plasty, W-plasty) should be reported with the more simple closure code. Debridement necessary to accomplish these tissue transfer procedures is part of the column one procedure performed. Separate debridement CPT codes (11000, 11040-11042) or repair CPT codes (12001-13160) would be inappropriately reported with these CPT codes (14000-14350) for the same lesion/injury. Procurement of cultures or tissue samples as a part of a closure are included in the closure code and are not to be separately reported.

G. Grafts and Flaps

Free skin grafts are coded by type (split or full), location, and size. For a specific location, a primary code is defined and followed by a supplemental code for additional coverage area. As a result of this coding scheme, for a given area of involvement, the initial code is limited to one unit of service; the supplemental code may have multiple units of service depending on the area to be covered. Because, for a specific area, only one type of skin graft is typically applied, the primary free skin graft CPT codes (15100, 15120, 15200, 15220, 15240, 15260) are

mutually exclusive to one another. If multiple areas require different grafts, a modifier indicating different sites should be used (anatomic or modifier -59).

Generally, simple debridement of a skin wound (CPT codes 11000, 11040-11042) in anticipation of a skin graft is included in the skin graft (CPT codes 15050-15431). When the graft is performed after excisional preparation of a wound, CPT code 15000 (surgical preparation) may be reported separately. CPT code 15000 is not to be used to describe debridement of infected skin, nor is its use indicated with other lesion removal codes.

1. CPT code 67911 describes the "Correction of lid retraction;" a parenthetical notation is added advising that, if autogenous graft materials are used, tissue graft codes 20920, 20922 or 20926 can be reported. Accordingly, all other procedures necessary to accomplish the service are included.

2. Flap grafts (CPT codes 15570-15576) include excision of lesions at the same site (CPT codes 11400-11646).

H. Breast (Incision, Excision, Introduction, Repair and Reconstruction)

Because of the unique nature of procedures developed to address breast disease, a section of CPT (19000-19499) is set aside for such services.

Fine needle aspiration biopsies, core biopsies, open incisional or excisional biopsies, and related procedures performed to procure tissue from a lesion for which an established diagnosis exists are not to be reported separately at the time of a lesion excision unless performed on a different lesion or on the contralateral breast. However, if a diagnosis is not established, and the decision to perform the excision or mastectomy is dependent on the results of the biopsy, then the biopsy is separately reported. Modifier -58 may be used appropriately to indicate that the biopsy and the excision or mastectomy are staged or planned procedures.

Because excision of lesions occurs in the course of performing a mastectomy, breast excisions are not separately reported from a mastectomy unless performed to establish the malignant diagnosis before proceeding to the mastectomy. Specifically CPT codes 19110-19126 (breast excision) are in general included in all

mastectomy CPT codes 19140-19240 of the same side. However, if the excision is performed to obtain tissue to determine pathologic diagnosis of malignancy prior to proceeding to a mastectomy, the excision is separately reportable with the mastectomy. Modifier –58 should be utilized in this situation.

Use of other integumentary codes for incision and closure are included in the codes describing various breast excision or mastectomy codes. Because of the frequent need to excise lymph node or muscle tissue in conjunction with mastectomies, these procedures have been included in the CPT coding for mastectomy. It would be inappropriate to separately report ipsilateral lymph node excision in conjunction with the appropriate mastectomy codes. However, sentinel lymph node biopsy is separately reported when performed prior to a localized excision of breast or a mastectomy with or without lymphadenectomy. Open biopsy or excision of sentinel lymph node(s) should be reported as follows: axillary (CPT codes 38500 or 38525), deep cervical (CPT code 38510), internal mammary (CPT code 38530). (CPT code 38740(axillary lymphadenectomy; superficial) should not be reported for a sentinel lymph node biopsy. Sentinel lymph node biopsy of superficial axillary lymph node(s) is correctly reported as CPT code 38500 (biopsy or excision of lymph node(s), superficial) which includes the removal of one or more discretely identified superficial lymph nodes. By contrast a superficial axillary lymphadenectomy (CPT code 38740) requires removal of all superficial axillary adipose tissue with all lymph nodes in this adipose tissue.)

In the circumstance where a breast lesion is identified and it is determined to be medically necessary to biopsy or excise the contralateral lymph nodes, use of the biopsy or lymph node dissection codes (using the appropriate anatomic modifier, -LT or -RT for left or right) would be acceptable. Additionally, breast reconstruction codes that include the insertion of a prosthetic implant are not to be reported with CPT codes that describe the insertion of a breast prosthesis only.

The CPT coding for breast procedures generally refers to unilateral procedures; when performed bilaterally, modifier -50 would be appropriate. This is identified parenthetically, where appropriate, in the CPT narrative.

I. Add-on Codes

There are a number of supplemental CPT codes known as “add-on” codes defined in the *CPT Manual*. The following is a listing of add-on codes present in the integumentary section of the *CPT Manual*. Although, not all-inclusive, the add-on code must be used in combination with the primary CPT code or the add-on code cannot be reported.

Primary CPT code	***Add-on CPT code***
11000 (Debridement up to 10%)	*11001 (Each additional 10%)*
11200 (Removal of skin tags, up to and including 15 lesions)	*11201 (Each additional 10 lesions)*
11730 (Avulsion of nail plate)	*11732 (Each additional nail plate)*
15100 (Split Graft, 100 sq.cm. or less)	*15101 (Each additional 100 sq.cm.)*
15240 (Full Thickness Graft 20 sq.cm. or less)	*15241 (Each additional 20 sq.cm.)*

J. General Policy Statements

1. In this Manual many policies are described utilizing the term “physician”. Unless indicated differently the usage of this term does not restrict the policies to physicians only but applies to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. In some sections of this Manual, the term “physician” would not include some of these entities because specific rules do not apply to them. For example, Anesthesia Rules and Global Surgery Rules do not apply to hospitals.

2. With few exceptions the payment for a surgical procedure includes payment for dressings, supplies, and local anesthesia. These items are not separately reportable under their own HCPCS/CPT codes. Wound closures utilizing adhesive strips, topical skin adhesive, or tape alone are not separately reportable. In the absence of an operative procedure, these types of wound closures are included in an E&M service.

3. Repair/closure of a surgical incision, CPT codes 12001-12018, is not separately reported from other surgical procedures. The closure is an intricate part of the surgical procedure performed. As noted previously, simple closure of dermatologic excisions is included in the dermatologic procedure.

4. CPT codes 15851 - 15852 refer to suture removal and dressing change under anesthesia. These codes are not to be reported when a patient requires a general anesthesia for a related procedure (e.g., a return to the operating room for complications where an incision is reopened necessitating removal of sutures and redressing). Additionally, these codes, particularly CPT code 15852, are not to be reported with a primary procedure performed under general anesthesia.

5. Drug administration services (CPT codes 90760-90775) are not separately reportable by the physician performing an operative procedure for drug administration during the operative procedure.

Under the OPPS drug administration services related to operative procedures are included in the associated procedural HCPCS/CPT codes. Examples of such drug administration services include, but are not limited to, anesthesia (local or other), hydration, and medications such as anxiolytics or antibiotics. Providers should not report HCPCS/CPT codes C8950-C8952, 90772 or 90773 for these services.

Medicare Global Surgery Rules prevent separate payment for postoperative pain management when provided by the physician performing an operative procedure. HCPCS/CPT codes 36000, 36410, 37202, 62318-62319, 64415-64417, 64450, 64470, 64475, and 90760-90775 describe some services that may be utilized for postoperative pain management. The services described by these codes may be reported by the physician performing the operative procedure only if provided for purposes unrelated to the postoperative pain management, the operative procedure, or anesthesia for the procedure.

If a physician performing an operative procedure provides a drug administration service (HCPCS/CPT codes 90760-90775, C8950-C8952) for a purpose unrelated to anesthesia, intra-operative care, or post-procedure pain management, the drug administration service

(HCPCS/CPT codes 90760-90775, C8950-C8952) may be reported with an NCCI-associated modifier.

6. Fine needle aspiration (FNA) (CPT codes 10021, 10022) should not be reported with another biopsy procedure code for the same lesion unless one specimen is inadequate for diagnosis. For example, an FNA specimen is usually examined for adequacy when the specimen is aspirated. If the specimen is adequate for diagnosis, it is not necessary to obtain an additional biopsy specimen. However, if the specimen is not adequate and another type of biopsy (eg, needle, open) is subsequently performed at the same patient encounter, the other biopsy procedure code may also be reported with an NCCI-associated modifier.

7. The NCCI edits with column one CPT codes 11055-11057 (Paring or cutting of benign hyperkeratotic lesions) each with column two CPT codes 11720-11721 (Nail debridement by any method) are often bypassed by utilizing modifier -59. Use of modifier -59 with the column two CPT code 11720 or 11721 of these NCCI edits is only appropriate if the two procedures of a code pair edit are performed for lesions anatomically separate from one another or if the two procedures are performed at separate patient encounters. CPT codes 11055-11057 must not be used to report removal of hyperkeratotic skin adjacent to nails needing debridement.

8. The NCCI edits with column one CPT codes 17000 and 17004 (Destruction of benign or premalignant lesions) each with column two CPT code 11100 (Biopsy of single skin lesion) are often bypassed by utilizing modifier -59. Use of modifier -59 with the column two CPT code 11100 of these NCCI edits is only appropriate if the two procedures of a code pair edit are performed on separate lesions or at separate patient encounters. Refer to the *CPT Manual* instructions preceding CPT code 11100 for additional clarification about the codes 11100-11101.

9. The NCCI edit with column one CPT code 11719 ((Trimming of nondystrophic nails) and column two CPT code 11720 (Nail debridement by any method, one to five nails) is often bypassed by utilizing modifier -59. Use of modifier -59 with the column two CPT code 11720 of this NCCI edit is only appropriate if the trimming and the debridement of the nails are performed on different nails or if the two procedures are performed at separate patient encounters.

10. If the code descriptor of a HCPCS/CPT code includes the phrase, “separate procedure”, the procedure is subject to NCCI edits based on this designation. CMS does not allow separate reporting of a procedure designated as a “separate procedure” when it is performed at the same patient encounter as another procedure in an anatomically related area through the same skin incision, orifice, or surgical approach.