Nipple-areolar reconstruction coding can be confusing

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Although only one code for nipple-areolar reconstruction appears in CPT, confusion is sometimes encountered in the proper use of this code since there are many variations in the methods employed for nipple-areolar reconstruction.

Separate code
Nipple-areolar reconstruction is not included in any of the breast reconstruction codes (e.g., TRAM, tissue expanded, latissimus dorsi). When the nipple-areolar complex is reconstructed, the procedure is separately reported with code 19350. For example, during a second-stage breast reconstruction, a tissue expander is replaced with a permanent implant and the nipple-areolar complex is reconstructed. This is reported:

11970 Replacement of tissue expander with permanent prosthesis

19350-51 Nipple-areolar reconstruction

Code 11970 does not include nipple-areolar reconstruction, and it would be inappropriate to bundle the two procedures together.

Global
When code 19350 was first introduced, the only method of nipple-areolar reconstruction was with a local flap and full thickness skin graft. The relative value of 19350 took into account the creation of a nipple mound, as well as the full thickness skin graft for areolar reconstruction.

CPT code 19350 is global and includes all elements necessary to create a nipple mound and an areola: local flap, skin graft, cartilage graft, biologic implant, tattooing, etc. To code and bill for any of these separately is unbundling.

Scenarios

1. A nipple is created with a skate flap, and the areola is reconstructed with a full thickness skin graft.

   This entire procedure is reported with code 19350. The flap is not reported separately (14000), nor is the skin graft (15200). The global code 19350 includes flap elevation and formation of a nipple mound, as well as the full thickness skin graft for areolar reconstruction.

2. A nipple is created with a skate flap.

   Several weeks later, the surrounding skin is tattooed to recreate the areola.

   This entire procedure is reported with code 19350 on the first date of service. The flap is not separately reported (14000), nor is the tattooing (11921). Even though the tattooing is performed at a later date, it’s included in the global code 19350, as it completes the nipple-areolar reconstruction.

3. An ear cartilage graft creates a nipple mound and the tissues are tattooed.

   This entire procedure is reported with code 19350. The cartilage graft is used to create a nipple mound, and is not separately reported (21235). All maneuvers necessary to create a nipple and areola are included in code 19350.

4. No previous nipple-areolar reconstruction has been performed. A 20 sq cm nipple and areola are created via tattooing only.

   This procedure is reported with code 11921, which describes tattooing from 6.1 sq cm to 10 sq cm. An areola of diameter 5 cm is approximately 20 sq cm. Bilateral nipple-areolar reconstruction with tattooing only is reported by total surface area, not with the bilateral modifier 50. The total surface area of tattooing must be documented in the operative report. Thus:

   11921 Nipple-areolar tattooing, first 20 sq cm

   11922 Nipple-areolar tattooing, each additional 20 sq cm

What if a nurse performs the tattooing?

It’s appropriate for a properly trained registered nurse (RN) to perform tattooing as an “incident to” service. Six criteria must all be satisfied in order for the surgeon to bill for her services:

- The physician must have previously established the plan of care for the tattooing (e.g., written an order, described in the operative note or medical record).
- The nurse must be an employee of the billing surgeon.
- Tattooing must be within the RN’s scope of practice based on state nursing licensure guidelines.
- It must be performed in the physician office setting (place of service code 11).
- The billing surgeon must be in the office at the time of the tattooing and must document his/her presence (e.g., co-signs the nurse’s procedure note).
- The tattooing must be the only reconstruction (if the surgeon has already billed for nipple-areolar reconstruction with code 19350, the tattooing is included in the global fee).

Outside the global period

What if a nipple mound has been created via a flap and has been reported with code 19350, but the tattooing takes place after the 90-day global period of code 19350? In general, services performed outside a global period are separately billable, but this is an unusual circumstance.

The surgeon has already billed for a nipple-areolar reconstruction, i.e., 19350 describes both nipple and areolar reconstruction. In this case, the surgeon has reconstructed the nipple mound but has not created an areola (either by skin grafting or by tattooing), so the reconstruction has not been completed. If the surgeon plans to tattoo outside the 90-day global period, the nipple mound reconstruction should be reported as 19350-52. The reconstruction is then “completed” with tattooing which can then be reported with code 11921.

Finding CPT Corner online
We are often asked about obtaining copies of current and previous “CPT Corner” columns. All current columns and most previous columns are available on the ASPS Plastic Surgery Education Network (PSEN) website at psemnetwork.org/resources/cptcorner.

One can see how the entire billing process now becomes very messy. It is more straightforward to report 19350 initially for the entire reconstruction, which includes the tattooing, and not bill separately for tattooing, even if the tattooing occurs after the 90-day global period.

The intent of the global code 19350 is to report, as the descriptor indicates, “nipple/areola reconstruction.” The code includes the procedure performed to reconstruct the nipple as well as the procedure used to reconstruct the areola, whether skin grafting or tattooing, whether immediately or delayed.

This situation is analogous to a lesion excision with a 10-day global period, which is meant to include the procedure and routine postoperative care, including suture removal. If the patient returns for suture removal on postoperative day 11, outside the global period, one would not report or charge for suture removal, as this is included in the lesion excision.

– Dr. Janievis is the Society’s representative to the AMA CPT Advisory Committee.

ICD-10 ALERT
Are You Ready For ICD-10?

ICD-10 is only one year away. Although the official ICD-10 implementation date is Oct. 1, 2014, you should start familiarizing yourself with the new system. There will be no transition period. ICD-9 must be used until Sept. 30, 2014. ICD-10 begins Oct. 1, 2014. Claims submitted with ICD-9 codes for dates of service Oct. 1, 2014, or later will be rejected.

Recall that ICD-10 is an entirely new system, comprising 70,000 diagnosis codes (compared to ICD-9’s 17,000 codes). The current ICD-9 system uses up to five digits. ICD-10 is entirely different: It’s alphanumeric and uses up to seven digits.

What you should be doing now

- Create an implementation planning team.
- Develop a budget for implementation (Information System changes, personnel training, modifying forms, etc.).
- Speak with your software vendors to find out what system upgrades you will need to implement the changes and when they will be available.
- Start familiarizing yourself with the specifics of ICD-10 coding and how it differs from ICD-9 coding.
- Run an ICD-9 frequency report to determine the diagnosis codes billed in your practice in the past year. Start with your top 25 ICD-9 diagnoses and begin to map these to the more specific diagnoses of ICD-10. Remember: There is a much higher level of specificity required in the ICD-10 coding system.
- Many practices will experience a significant delay in cash flow beginning Oct. 1, 2014. You should have cash available to cover approximately three months of practice expenses. If you do not, you need to establish a line of credit prior to Oct. 1, 2014, to cover at least three months of expenses.

ADDITIONAL RESOURCES

2014 ASPS Coding Workshops
Visit plasticsurgery.org or call (800) 766-4955 for locations, dates and registration information.

American Health Information Management Association (“ICD-10”)
ahima.org/icd10

American Medical Association (“ICD-10 Code Set to Replace ICD-9”)
americanmedicalassociation.org/icd10

Centers for Medicare and Medicaid (“Provider Resources”)
cms.gov/ICD10/05a_ProviderResources.aspx#TopOfPage

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