

Eyelid Reconstruction An Oculoplastic Surgical Coding Minicourse

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Part I

INTRODUCTION

An Oculoplastics Q & A article was presented in the July, 2004 issue of OSN. This Minicourse on Eyelid Reconstruction is presented to clarify problems encountered when coding for oculoplastic procedures. In ophthalmic plastic surgery the code selection encompasses different sections of the CPT (Current Procedural Terminology) and one must master codes from the following sections: Integumentary, Musculoskeletal, Eye and Ocular Adnexa and even some of the codes in Nervous System section.

LESION EXCISION

Biopsy. CPT provided clarification in 2003 for when biopsies can be billed in addition to the excision of a lesion with or without reconstruction. Essentially, obtaining tissue for pathologic diagnosis is included in the procedure. It may be billed additionally when it is performed independently or is distinct from other procedures performed at the same operative session, such as biopsy of a lesion not followed by a definitive procedure at a different site on the same date.

There is no such thing in CPT coding as "excisional biopsy". If an excision of a lesion is performed and the specimen or parts of specimen are submitted for pathological diagnosis only the excision should be coded. A newer CPT code found in the eye section is 67810 Incisional biopsy of eyelid skin including lid margin.

Integumentary codes vs Eye and Ocular Adnexa Codes. For simple excision of lesions of the eyelid, it is financially more advantageous to use the codes in the eye section (ie, 67840 rather than 11440 or 11640). Be sure to read the other requirements in CPT for code 67840.

Size determination. This was also clarified in 2003. Excision is defined by CPT as full-thickness (through the dermis) removal of a lesion including margins and includes simple (non-layered) closure. Codes in Integumentary system are listed by size, and the size to be reported is determined by measuring the greatest clinical diameter of the apparent lesion plus those margins required for complete excision. Therefore, the code reported (excised diameter) includes lesion diameter plus the most narrow margins required based on the physician's judgment. The measurement of the lesion plus margin is made prior to excision. An example: if a facial malignant lesion's greatest diameter is 0.9 cm and the superior and inferior margin to be excised are each 0.3 cm then the total size would be $0.9 + 0.6 = 1.5$ cm = CPT code 11642.

Size determination in reference to Adjacent Tissue Transfer and Rearrangement is different from the above in that some sets of codes include excision of lesion(s) and others do not. **All the tissue rearrangement codes (14020-14300) include excision as do the eyelid excision and repair codes (67961 and 67966).** If the excision is not a part of the description of the code and the repair is at a higher level than direct closure, then you can usually code for it. CPT states that for excision of benign or malignant lesions requiring more than simple closure, ie, requiring intermediate or complex closure you may additionally report the intermediate closure codes (12031 – 12057) or the complex closure codes (13100 – 13153).

ADJACENT TISSUE TRANSFER OR REARRANGEMENT

Size determination. In 2004, new guidelines were added to this section since it was felt that significant under-determinations of the size of a defect were being reported. The new guidelines state that for purposes of code selection, the term "defect" includes primary and secondary defects. The primary defect resulting from the excision of lesion, along with the secondary defect resulting from flap design to perform a reconstruction, are measured together to determine the size used in selecting the code.

In eyelid reconstruction the secondary defect may be considerably larger than the primary defect area, especially when large flaps are used.

Frozen section. CPT guidelines instruct that when frozen section pathology reveals margin excisions that are not adequate, a single excision code should be used to report the additional excision and re-excision(s) necessary at the same operative session. When performed on a single day then the code(s) are reported only once, and for the largest

size defect. Re-excision procedures performed to widen margins at subsequent operative sessions should be reported by using the code appropriate to identify the size, location, and type of excision performed. The modifier -58 is appended if the re-excision is performed during the post-operative period of the primary excision procedure.

Procedure definition. Adjacent Tissue Transfer and Rearrangement codes include excision of the lesion. These are the codes to be used for Z-Plasty, W-PLasty, V-Y Plasty, rotation flap (Tenzel flap), advancement flap, double pedicle flap. If these procedures are used in trauma cases, such as laceration repair, the surgeon must create the configuration. These codes are not to be used when closure of a laceration accidentally results in these configurations.

GRAFTS

Additive Procedures. All kinds of grafts (skin grafts, dermal-fat-fascia, ear cartilage etc.) are payable in addition to the reconstructive procedures, unless the code descriptor states that the procedure includes obtaining the graft. When multiple grafts are used they are payable according to multiple surgery payment guidelines. Frequently, however, payment for the second graft is denied and may only be recouped in post payment review. If you are using the same procedure code more than once for reconstruction of the same site, as with placement of multiple composite grafts in an eyelid for example, then the second graft must have modifier -59 appended to it to indicate that this is not a duplicate procedure.

An exception to coding separately for grafts occurs when various conjunctivoplasty procedures are performed - for most of these codes the conjunctival or buccal mucosa graft is included. Ptosis repair using autogenous fascia lata also included the obtaining of the fascia lata in the primary code (67902)

Use of CPT code 15004/5. This code description states: Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues;... It is not usually used with routine excision(s) of lesions or reconstruction as an additional code.

STAGED PROCEDURES

There are only a few staged procedures for ophthalmology and procedure code 67975 (reconstruction of eyelid, full thickness by transfer

of tarsoconjunctival flap from opposing eyelid; second stage) is one of them. Some of the other surgeries in ophthalmic surgery, surgeries are considered as being performed in sessions and are only payable once per treatment, even if performed at different times. This changes constantly and needs to be reviewed annually.

However, second stage eyelid reconstruction, as with a Hughes procedure or Cutler-Beard procedure, is considered a staged procedure and the opening of the eyelids is payable at 100 percent of the allowable if performed in the global period (90 days for Medicare) by appending modifier -58 when the second surgery is performed. Modifier -58 reimburses at 100 percent of the allowable - so be sure you don't erroneously use modifier -78 which only reimburses at 70 percent of the allowable.

EYELID RECONSTRUCTION CODES

Be aware that procedure codes 67961 (Excision and repair of eyelid, involving lid margin, tarsus, conjunctiva, canthus or full thickness, may include preparation for skin graft or pedicle flap with adjacent tissue transfer or rearrangement; up to one-fourth of lid margin) and 67966 (same description but over one-fourth of lid margin) both include the excision of the lesion.

CONCLUSION

Join us next month for Part II – an interactive oculoplastic surgical coding workshop.

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