2015 General Surgery Survival Guide

Chapter 17: Tissue Transfer

When lesion excision is so extensive that the physician can’t achieve closure by simple, intermediate, or complex means, she generally must rely upon other repair options. Frequently, she’ll use adjacent tissue transfer or tissue rearrangement (Z-plasty, W-plasty, flaps, etc.) using codes from the range 14000-14350.

**Watch bundling issues:** Coding excisions (11400-11471), debridement (11000-+11047*), and simple repairs (12001-13160) are bundled into adjacent tissue transfer.

You can report a skin graft needed to close a secondary defect as an additional procedure, however, and bill for it separately using appropriate code(s) from the following families:

- 15100-+15261 for autologous skin grafts by recipient site
- 15150-+15157 for autologous tissue-cultured skin grafts
- 15040 for autologous keratinocytes and dermal tissue harvesting for tissue-cultured skin grafts
- 15271-+15278 for skin substitute grafts.

**Caution:** When closing traumatic wounds, codes 14000-14350 are appropriate only when the closure requires the physician to develop a specific adjacent tissue transfer. You should report lacerations that coincidentally are approximated using a tissue transfer technique (for example, Z-plasty or W-plasty) with the more simple closure code.

You may report surgical preparation of the recipient site 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 part thereof, 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 part thereof, or each additional 1% of body area of infants and children (List separately in addition to code for primary procedure).
CPT® Codes
• 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 — Adjacent tissue transfer or rearrangement, any area; 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
• 15845 — Graft for facial nerve paralysis; regional muscle transfer
• 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

Help Recover Scar Revision Pay

If a scar excision leaves a deficit that is too large or too deep for a complex repair, the physician may perform an adjacent tissue transfer.

Don't miss: Adjacent tissue transfers include Z-plasty, W-plasty, V-Y-plasty, rotation flaps, advancement flaps, and double pedicle flaps. Make sure your physician documents the complete repair if he initiated the procedure. If he performs tissue transfer procedures to close secondary procedures, you should report the tissue transfer as an additional procedure. Unlike repairs, you would not determine the correct code for this procedure based on the wound's length, but rather by the area of the defect (in square centimeters) and its location on the body.

Extra: Scar removal may also require tissue transfers when scars occur after a secondary defect. "Defect" refers to both the primary and secondary defect. CPT® directs that if the primary defect results from the excision and the secondary defect results from the flap design, you should measure the two excisions together to determine the appropriate code.

Opportunity: Your doctor may also perform an intermediate or complex closure or an adjacent tissue transfer to repair a wound from an excision.

If the wound requires only a simple closure, you should not bill a repair code. If the physician performs a layered, intermediate closure of one or more of the deeper layers of tissue and superficial, non-muscle fascia in addition to the skin (epidermal and dermal) closure, report 12051 (Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less).

If the wound is more serious and requires complex repair (that is, requires extensive undermining, stents, or retention sutures), report 13151 (Repair, complex, eyelids, nose, ears, and/or lips; 1.1 cm to 2.5 cm). The only time you should
bill the two codes together is if the doctor performs an excision and a simple repair on two different sites. In this
instance, you can append modifier 59 (Distinct procedural service) or other appropriate modifier to the second
procedure because the physician performs repairs on two different sites.

**Capture Large Repairs with 14301 - 14302**

When your general surgeon repairs a large defect, e.g., abdominal wall defects greater than 30 sq cm. you may report
them with 14301 (Adjacent tissue transfer or rearrangement, any area; defect 30.1 sq cm to 60.0 sq cm) and +14302
(... each additional 30.0 sq cm, or part thereof [List separately in addition to code for primary procedure]) for these
services. You may come across really massive abdominal wall repairs, much more than a typical ventral hernia - that
require adjacent tissue transfers to cover the defect. In those scenarios, these codes are going to be your man
recourse.

**Does (ATT) Adjacent Tissue Transfer Include Lesion Removal?**

Unlike intermediate or complex closures, you cannot bill lesion removal if the doctor performs ATT (adjacent tissue
transfer), because ATT includes the lesion removal. After the physician excises and debrides the scar, he performs an
ATT to repair the wound.

**Warning:** Anytime you report ATT, the lesion excision is included, so don't separately bill the excision.

Scar excision is also included in ATT, so don't bill scar excision separately, either.

Like the repair codes, the defect's size (in square centimeters) and the location determine the ATT codes. But when
coding a defect that is more than 30 sq cm, report 14300 regardless of the location on the body.

**Make Sure You've Got Defect and Repair Codes Down Pat**

In the past, coders frequently were puzzled when reporting primary and secondary defects. Prior to 2004, the ATT
code (14000) referred to primary and secondary defects, which were both repaired in the ATT procedure. In 2004, the
revised guideline stated that the term "defect" includes the primary and secondary defects. In addition, CPT®
guidelines instruct you that when a skin graft is necessary to close the secondary defect, you should consider the graft
an additional procedure.

CPT® guidelines advise you to add together the sizes of the primary defect resulting from the excision and secondary
defects resulting from flap design. You should therefore select the appropriate transfer code based on the total size of
the sum of the defects.

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