Surgery: Integumentary System

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This section contains information to help providers bill for surgical procedures related to the integumentary (skin) system. For additional help, refer to the Surgery Billing Examples section of this manual.

Port Wine Hemangiomas: Argon Laser Treatments

Medi-Cal coverage of argon laser treatment of skin lesions is limited to the treatment of port wine hemangiomas of the face and neck. The following CPT® procedure codes are to be used to bill argon laser treatment of port wine hemangiomas:

CPT Code	Description
13131	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; (1.1 thru 2.5 cm)
13151	Repair, complex, eyelids, nose, ears and/or lips; (1.1 thru 2.5 cm)

Nail Debridement

‹‹CPT codes 11720 (debridement of nail[s] by any method[s]; one to five) and 11721 (debridement of nail[s] by any method[s]; six or more) must be billed in conjunction with a primary diagnosis code indicating the following:››

- A systemic disease or disorder of the feet that significantly impairs the ability to walk
- An infection to the toe, nail or foot

Claims must also include ICD-10-CM code B35.1 (tinea unquium) as the secondary diagnosis code.

These services require a *Treatment Authorization Request* (TAR).

Podiatrists submitting claims for CPT codes 11720 or 11721 must include the referring physician's name and provider number in the *Name of Referring Provider or Other Source* field (Boxes 17 and 17B) of the *CMS-1500* claim or the referring physician's provider number in the *Attending* field (Box 76) of the *UB-04* claim.

Microvascular Free Flaps: Billing "By Report" Required

The following CPT procedure codes require "By Report" billing.

CPT Code	Description
15756	Free muscle or myocutaneous flap with microvascular anastomosis
15757	Free skin flap with microvascular anastomosis
15758	Free fascial flap with microvascular anastomosis

An operative report must be attached to the claim to permit appropriate pricing and avoid denial. In addition, claims will be denied if these procedures are billed with any codes other than codes 15756, 15757 and 15758.

Implantation

CPT Code	Description
15778	Implantation of absorbable mesh or other prosthesis for delayed closure of defect(s) (i.e., external genitalia, perineum, abdominal wall) due to soft tissue infection or trauma

Epidermal Autografts: "Add-on" Codes

Reimbursement for codes 15151 (tissue cultured epidermal autograft, trunk, arms, legs; additional 1 cm^2 to 75 cm^2) and 15156 (tissue cultured epidermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; additional 1 cm^2 to 75 cm^2) are limited to once per session, same provider. Claims for more than once per day must include a statement in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) that the procedure was not performed during the same session.

Destruction of Benign or Pre-Malignant Lesions

When billing for the destruction of benign or pre-malignant lesions in any location, the appropriate CPT code and modifier combinations are required. These are some examples:

CPT Code	Modifier	Description
17000	AG	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); first lesion
17003	51	‹‹Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); second through 14 lesions, each››
17004	AG	‹‹Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); 15 or more lesions›› **Note:** Specify the quantity in the *Remarks* field [Box 80]*IAdditional Claim Information* field [Box 19]

Note: Surgeries for the destruction of lesions performed in an inpatient setting must be billed by the surgeon on the *CMS-1500* claim.

Billing Two or More Lesions: Not Exceeding 14

Providers should bill code 17003 in addition to 17000 for two or more lesions (not exceeding 14).

Refer to the *Surgery Billing Examples* section in the appropriate Part 2 manual for an example showing how to bill for two or more lesions (not exceeding 14).

Billing 15 or More Lesions

CPT code 17004 must be billed “By Report” with modifier AG when billing for 15 or more lesions. Code 17004 is a stand-alone code. It is not appropriate to bill code 17004 in addition to codes 17000 and 17003. Although the number of lesions removed exceeds one, enter a “1” in the *Service Units/Days or Units* box of the claim. Specify the number of lesions removed in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim.

Refer to the *Surgery Billing Examples: CMS-1500* section in the appropriate Part 2 manual for an example showing how to bill for 15 or more lesions.

Bio-Engineered Skin Substitutes

‹‹Bio-engineered skin substitutes are billed with CPT codes 1044T thru 1049T and select HCPCS codes in the ranges A2001 thru A2016, A2018 thru A2045, A4100, G0681 thru G0684, Q4101 thru Q4105, Q4107 thru Q4136, Q4151, Q4154, Q4158, Q4159, Q4160, Q4165 thru Q4206, Q4208 thru Q4222, Q4224 thru Q4242, Q4245 thru Q4373, Q4375 thru Q4380, Q4382 thru Q4429, Q4431 thru Q4433, Q4435 thru Q4440 as specified below.››

Authorization

‹‹The following CPT and HCPCS codes require a *Treatment Authorization Request* (TAR) by the physician or podiatrist:

1044T thru 1049T››
A2001 thru A2045
A4100
G0681 thru G0684
Q4101 thru Q4105
Q4107
Q4108
Q4110 thru Q4114
Q4116 thru Q4118
Q4121 thru Q4128
Q4130 thru Q4136
Q4151
Q4154
Q4158
Q4159
Q4160
Q4166 thru Q4206
Q4208 thru Q4222
Q4224 thru Q4230
Q4232 thru Q4242
Q4245 thru Q4373
Q4375 thru Q4380
Q4382 thru Q4429
Q4431 thru Q4433
Q4435 thru Q4440

The majority of these HCPCS codes are used to bill for the treatment of wounds, skin ulcers and burns. For unique indications, providers should refer to the following “Usage” subheading.

Usage

Apligraf (HCPCS code Q4101) is indicated for applications at least three weeks apart, not to exceed a total of four applications.

Integra (HCPCS code Q4104) is indicated for one application. Repeat application to the same wound as appropriate only if there has been measurable response to the first application. Treating the same wound again in less than one year is not medically appropriate.

Grafix (HCPCS codes Q4132 and Q4133) tissue matrices, derived from amnion and chorion, provide a rich source of viable, multipotent mesenchymal stem cells and growth factors native to the tissue matrix and integral for tissue repair. Grafix CORE (HCPCS code Q4132) provides normal skin for use as treatment for wounds, skin ulcers and burns. Grafix PRIME (HCPCS code Q4133) provides support to normal skin.

Billing

The following codes must be billed “By Report with an invoice attached. All skin substitute codes are reimbursable only when billed in conjunction with a CPT procedure in the range of 15271 thru 15278:

‹‹1044T thru 1049T››

A2011 thru A2013

A2019 thru A2045

A4100

G0681 thru G0684

Q4117

Q4122 thru Q4128

Q4130

Q4134 thru Q4136

Q4158 thru Q4160

Q4166 thru Q4171

Q4173 thru Q4185

Q4187 thru Q4194

Q4197

Q4198

Q4200 thru Q4206

Q4208 thru Q4222

Q4224 thru Q4230

Q4232 thru Q4242

Q4245 thru Q4373

Q4375 thru Q4380

Q4418

Q4419

Q4421 thru Q4429

Q4382 thru Q4433

Q4435 thru Q4440

Apligraf must be billed with one of the following ICD-10-CM diagnosis codes: E10.40 thru E10.49, E10.621 thru E10.628, E11.40 thru E11.49, E11.621 thru E11.628, E13.40 thru E13.49, E13.621 thru E13.628, I83.001 thru I83.029, I83.201 thru I83.229 or L97.101 thru L97.929.

If a second Apligraf disk is used (by billing more than 44 units for HCPCS code Q4101), the provider must submit medical justification for the same recipient, same date of service, or the claim for the second disk will be denied.

Integra must be billed with appropriate ICD-10-CM diagnosis codes for late effect of burns (T20.00XA thru T32.99).

Dermagraft must be billed with ICD-10-CM diagnosis codes E10.40 thru E10.49, E10.621 thru E10.628, E11.40 thru E11.49, E11.621 thru E11.628, E13.40 thru E13.49 or E13.621 thru E13.628.

‹‹Concurrent Optical and Magnetic Stimulation (COMS) Therapy

Providers may be reimbursed for the following COMS services:

Table of CPT Codes for COMs Services

Code	Description
0906T	Concurrent optical and magnetic stimulation (COMS) therapy, wound assessment and dressing care; first application, total wound(s) surface area less than or equal to 50 sq cm
0907T	Concurrent optical and magnetic stimulation (COMS) therapy, wound assessment and dressing care; each additional application, total wound(s) surface area less than or equal to 50 sq cm››

Legend

Symbols used in the document above are explained in the following table.

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.