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 (…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.

Epidermal Autografts: "Add-on" Codes

Reimbursement for codes 15151 (tissue cultured epidermal autograft, trunk, arms, legs; additional 1 cm2 to 75 cm2) 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	second through 14 lesions, each
17004	AG	15 or more lesions (specify the quantity in the *Remarks* field [Box 80]**/***Additional 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 HCPCS code C1849 and select HCPCS codes in the ranges Q4100 thru Q4136, Q4151, Q4154, Q4159, Q4160, Q4165 thru Q4198, Q4200 thru Q4206, Q4208 thru Q4222, Q4226 thru Q4242 ‹‹and Q4244 thru Q4255›› as specified below.

Authorization

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

C1849
Q4100 thru Q4108
Q4110 thru Q4114
Q4116 thru Q4118
Q4121 thru Q4128
Q4130 thru Q4136
Q4151
Q4154
Q4159
Q4160
Q4166 thru 4198
Q4200 thru 4206
Q4208 thru Q4222
Q4226 thru Q4242
‹‹Q4244 thru Q4255››

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.

Dermagraft (HCPCS code Q4106) is reimbursable for treatment of full-thickness, diabetic foot ulcers with greater than six-weeks duration, which extend through the dermis, but without tendon, muscle, joint capsule or bone exposure. Dermagraft should be used in conjunction with standard wound care regimens and on patients who have adequate blood supply to the involved foot. Dermagraft is indicated for a once weekly application, not to exceed a total of eight applications.

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:

C1849

Q4100

Q4117

Q4122 thru Q4128

Q4130

Q4134 thru Q4136

Q4159

Q4160

Q4166 thru 4171

Q4173 thru Q4185

Q4187 thru Q4194

Q4197

Q4198

Q4200 thru Q4206

Q4208 thru Q4222

Q4226 thru Q4242

‹‹Q4244 thru Q4255››

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.

‹‹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.