Tissue Expansion After Mastectomy

Coding breast reconstruction can be difficult, but knowing procedures and diagnoses helps.

By Victoria M. Moll, CPC, CPMA, CPRC
Breast cancer is responsible for the death of one in every 36 women in the United States. Women who undergo a mastectomy to remove malignant tissue are faced with an array of reconstructive options, including flaps and implants. Most commonly, implants are placed in a staged fashion. More insurers are covering these services, but the details of coding a reconstruction can be tricky.

Expansion Follows Mastectomy
Immediately after a patient’s mastectomy, a reconstructive surgeon will evaluate the skin flaps and prepare to insert a tissue expander. Following placement of the expander, the patient will present for subsequent fills of saline until the breast has expanded to the patient’s liking.

CPT® 19357 Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion describes this first stage.

The use of a dermal matrix, such as AlloDerm®, facilitates a higher initial expansion and is additionally billable with add-on code +15777 Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (eg, breast, trunk) (List separately in addition to code for primary procedure).

Insertion of the tissue expander apparatus into the chest wall includes all office visits for progressive expansion within the 90-day global period. Because this process can extend beyond the 90-day global for the initial surgery, any office visits past that period may be billed using the appropriate evaluation and management (E/M) code.

For example, the patient has bilateral tissue expanders with dermal matrix placed on May 1. This surgery is coded 19357-50 and 15777-50. The patient presents for her first fill on June 1, and has subsequent fills on June 17, June 30, and July 19. On Aug. 5 the patient returns again. This service is outside of the 90 day global period for the tissue expander insertion. During her visit for the fill, the physician completes a problem focused history and exam with straightforward medical decision-making. This visit is billed as 99212 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making.

Exchanging Prosthesis Includes Shaping
The tissue expander may serve as the final prosthesis, but the majority of patients have the expander exchanged for a silicone or saline implant. A general exchange of the tissue expander for the permanent prosthesis is reported with 11970 Replacement of tissue expander with permanent prosthesis. However, if extensive capsular work is performed, you may instead report 19342 Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction.

Per CPT® Assistant (January 2013):
… code 11970 includes some minor adjustments to the capsule. However, when significant adjustments are made to the capsule, many of which comprise a significant part of the procedure, and when appropriately documented, code 19342, Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction, may be reported to represent the additional maneuvers that involve more surgeon time and work. For example, sometimes the capsule must be significantly modified, the infra-mammary crease must be lowered or raised, or partial or total capsulectomy must be performed.

Another example of the type of work associated with the use of code 19342 is breast reconstruction with expander in a patient undergoing postoperative expansion. When the tissue expander is replaced, it may be that the capsule is found to be very tight and multiple radial incisions may be required in the capsule to accommodate the permanent prosthesis and form a symmetric contour to the opposite breast. CPT code 11970 alone does not account for this additional work, which is over and above removal of an expander and replacement with a permanent implant.

The provider should document if the capsule was particularly thick or tight to support the extra effort involved for billing the higher service. If this portion falls within 90 days of the expander placement, use modifier 58 to indicate a staged procedure.

Case Scenario 1
“I came down upon the previous scar with the scalpel and excised it as an ellipse. I incised and came down upon the expander, which easily peeled free and was removed. The pocket was washed with antibiotic solution. Under super sterile conditions, the final implant was placed and the wound was stitched closed in a layered fashion.”
In this case, the physician removed the tissue expander and exchanged it for an implant in a straightforward fashion, without any extra work done to the breast or the capsule. CPT® 11970 is the correct code for this procedure.
Coding/Billing: Breast Reconstruction

Case Scenario 2

“Attention was turned to the left breast where the patient had an oncologic mastectomy for breast cancer. The lateral portion of the previous scar was incised with a #15 blade and an ellipse of the tissue was passed off the field. Bovie was used to deepen down to the capsule, and the expander was removed. The capsule was found to be very tight and thick, so multiple radical incisions were made and a complete capsulectomy was performed. The capsule tissue was sent to pathology. The capsule was washed several times with saline and was found to be hemostatic. A high profile textured smooth gel silicone implant was opened and deployed into the pocket before closing the wound in a layered fashion.”

The breast capsule was tight and required radical incisions to remove it in its entirety. Code 19342 would be appropriate due to the extra amount of work involved with the surgery.

Shaping, Tattooing Are Included

Any revision done at this time to properly shape the breast is included in the expander exchange. Because the breast is not fully reconstructed until after all stages are complete, 19380 Revision of reconstructed breast may be reported only when correcting later contour irregularities, deformities, etc. Billing 19380 at the time of an exchange would be like filing an auto claim for a car that’s still on the assembly line.

The nipple is reconstructed in the final stage. Any nipple-areolar reconstruction, such as skate flap, C-V flap, or cartilage graft, may be reported with 19350 Nipple/areola reconstruction. The graft or flap is included in 19350 and may not be billed separately. Nipple tattooing, which can be done as an office procedure, is also included in 19350. Tattooing may be billed only if no other reconstruction has been done on the nipple, or when performing touch-ups. Correct coding in such cases is 11921 Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm for the first 20 square centimeters and +11922 Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; each additional 20.0 sq cm, or part thereof (List separately in addition to code for primary procedure) for each additional 20 sq cm.

For example, a patient presents to her surgeon’s office three years after her breast reconstruction. She previously had bilateral skate flap nipple reconstruction with tattooing, but the tattoos have faded and the patient desires a touch-up. Each nipple is approximately 20 sq cm, equaling a total of 40 sq cm for both nipples. Because nipple tattooing is calculated based on the total size of the areas, this is coded as 11921 and 11922.

Watch Your Diagnosis Placement

Because many payers reimburse breast reconstruction services only in relation to breast cancer, it’s prudent for providers to document current or past history of breast cancer in the operative report. Although there are other applicable diagnoses for these cases, listing a cancer code as primary diagnosis may prevent the claim from hitting insurance edits designed to deny services not meeting that criteria. HBM

<table>
<thead>
<tr>
<th>Common Related Diagnoses</th>
<th>Code</th>
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<tbody>
<tr>
<td>174.0-175.9</td>
<td>Malignant neoplasm of breast</td>
</tr>
<tr>
<td>198.81</td>
<td>Secondary malignant neoplasm of breast</td>
</tr>
<tr>
<td>233.0</td>
<td>Carcinoma in situ of breast</td>
</tr>
<tr>
<td>V10.3</td>
<td>Personal history of malignant neoplasm of breast</td>
</tr>
<tr>
<td>V16.3</td>
<td>Family history of malignant neoplasm of breast</td>
</tr>
<tr>
<td>V45.71</td>
<td>Acquired absence of breast and nipple</td>
</tr>
<tr>
<td>V51.0</td>
<td>Encounter for breast reconstruction following mastectomy</td>
</tr>
<tr>
<td>V84.01</td>
<td>Genetic susceptibility to malignant neoplasm of breast</td>
</tr>
</tbody>
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Victoria M. Moll, CPC, CPCM, CPRC, is a coder for a large physician group. She has over seven years of experience in billing and coding for hospitals, obstetrics/gynecology, transplant services, general surgery, and plastic and reconstructive surgery. She previously worked as a coding instructor at a local technical school, and now serves as education officer in the Allentown, Pa., local chapter.

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Side Matters

CPT® breast procedure codes are unilateral. Providers must document on which side (or both) they are operating. When documenting a bilateral procedure, the physician might describe the first side in full and state that a mirror procedure was done on the other side. If the bilateral procedures are not identical, the process for each side should be detailed in the operative report.

Note that payer requirements may differ regarding application of modifier 50 Bilateral procedure and modifiers LT Left side and RT Right side. Review your individual payer rules when assigning the anatomical modifiers.