Briefings on APCs

This month’s coding Q&A

Coding autologous skin cell transplants
Q: For an autologous skin cell transplant, there are two new CPT codes for applications of skin cell suspension autograft (15015 and 15017). What’s the difference?

A: The difference is the anatomical site to which the transplant is being placed. So, when harvesting a skin patch, it could come from anywhere on this patient's body and then they prepare it. And when they apply it—when they actually do that transplant—you have to be very specific as to where it is going.

For the trunk (i.e., the body), arms, and legs, it’s 15015. And, of course, you have an add-on code (+15016) each additional 480 sq. cm if it's a large area.

Use 15017 if it's going to the face, scalp, eyelids, mouth, neck, orbital area, genitalia, hands, feet, or digits (i.e., fingers and toes). Again, you have an add-on code (+15018) for each additional 480 sq. cm.

An autologous skin cell transplant is a wonderful thing. It really helps patients with their psychological acceptance of dealing with a malignancy and then dealing with the defect once the neoplasm has been removed. So, this is the fix for the defect.

Editor’s note: *Information for this answer was provided by* ***Shelley C. Safian, PhD, MAOM, RHIA, CCS-P, CPC-I,*** *an AHIMA-approved ICD-10-CM/PCS trainer, during HCPro’s webinar “2025 ICD-10-CM and CPT Updates for Neoplasms.”*

Prescription drug management during an evaluation and management visit
Q: Can an over-the-counter drug such as ibuprofen, with a provider’s instruction to take at the prescription dosage, be counted as prescription drug management?

A: Generally, yes. This is because the risk involved with a drug generally has to do with its dosage, not whether it was taken as a single prescription-strength pill versus four regular-strength over-the-counter pills. However, payers may have differing opinions.

Q: If a provider and a patient spend time reviewing the pros and cons of particular medications, can this be counted as prescription drug management even if the provider did not end up prescribing the medications in question?

A: Yes. Since the provider made the decision to explore different medications and the benefits or downfalls of each one, this should be counted as prescription drug management. The documentation should detail which drugs were discussed as well as the identified pros and cons specific to the patient’s plan of care.

Editor’s note: *These questions and answers come from HCPro’s elearning course, “Introduction to E/M and Time-Based E/M Code.”*

The difference between extensive and limited debridement
Q: For a shoulder arthroscopy procedure, when is debridement limited and when is it extensive?

A: Some surgeons may be emboldened to bill more of their debridement cases as “extensive,” but these services must be clearly documented as such, with the medical necessity to support them.
To stay compliant and ensure proper payment, coders must clearly understand the difference between the two types of debridement, based on the codes’ CPT descriptors:

- 29822 (Arthroscopy, shoulder, surgical; debridement, limited, 1 or 2 discrete structures [e.g., humeral bone, humeral articular cartilage, glenoid bone, glenoid articular cartilage, biceps tendon, biceps anchor complex, labrum, articular capsule, articular side of the rotator cuff, bursal side of the rotator cuff, subacromial bursa, foreign body(ies)])
- •29823 (Arthroscopy, shoulder, surgical; debridement, extensive, 3 or more discrete structures [e.g., humeral bone, humeral articular cartilage, glenoid bone, glenoid articular cartilage, biceps tendon, biceps anchor complex, labrum, articular capsule, articular side of the rotator cuff, bursal side of the rotator cuff, subacromial bursa, foreign body(ies)])

The CPT manual descriptions for each code makes it clear: if the surgeon debrides one to two “discrete structures” in the shoulder, it would be considered limited (29822). If three or more are debrided, it would be coded as extensive

(29823). Both bone and soft tissue qualify as discrete structures, according to the codes' descriptors.
Further, to qualify for codes 29822 and 29823, the surgeon must document that the following structures were debrided:

- Humeral bone and humeral articular cartilage
- Glenoid bone and glenoid articular cartilage
- Biceps tendon, biceps anchor complex
- The labrum
- Articular capsule
- Articular side of the rotator cuff
- Bursal side of the rotator cuff
- Subacromial bursa
- Foreign body(ies)

Your doctor can support the need for an extensive debridement by clearly describing the conditions of the areas that required treatment and exactly what was done.

Editor's note: *This information was excerpted from 2024 Orthopedic Coding & Documentation Trainer.*
These answers were provided based on limited information. Be sure to review all documentation specific to your own individual scenario before determining appropriate code assignment.