Dermatology Coding Alert

4 Questions Help Recover Scar Revision Pay

Verify medical necessity and avoid \'cosmetic\' denials

When your dermatologist performs scar revisions, you should know the scar size, type of removal, and medical necessity -- or you lose out on deserved reimbursement. Experts offer the following four questions to help you determine the best code to report.

1. Is the Procedure an Excision or a Repair?

When the dermatologist removes a scar, you should know whether the service is an excision or a repair: Depending on your situation, you carrier will reimburse one or the other or both. So, if the scar is excised and the dermatologist only did a simple repair, report only the lesion (scar) removal, says **Lisa Jay, CPC**, a coding specialist with Greenwood Surgical and Associates in Greenwood, S.C. If the dermatologist completes a complex or intermediate repair, you should report the repair and excision separately. But if the repair requires a flap (typically, a form of adjacent tissue transfer), you only bill for the repair.

2. Does the Scar Impair Function?

Most payers will not cover cosmetic scar revisions, so you should make sure the dermatologist establishes medical necessity for the procedure. Coding experts ask
a simple question to determine medical necessity: Does the scar impair any function
for the patient?

Most patients with function-impeding scars present with scars around their eyes or mouth. For example, a patient with a basal cell carcinoma on the lip may have the carcinoma removed. The scar that forms as a result of that excision impedes the patient\'s speech and eating, and therefore the removal is medically necessary. The dermatologist removes the scar, which is 2 centimeters long. You report the procedure based on the location of the removal and the size of the excision. In this instance, you report code 11442 (Excision, other benign lesion including margins [unless listed elsewhere], face, ears, eyelids, nose, lips, mucous membrane; excised diameter 1.1 to 2.0 cm), Jay says.

In the situation above, the scar revision is cosmetic but the revision is considered part of the aftercare process. With appropriate documentation, payers should reimburse this procedure based on medical necessity under the circumstances despite the cosmetic nature of the procedure.

3. Is the Tissue Transfer an Additional Procedure?

If the scar excision leaves a deficit that is too large or too deep for a complex repair, the dermatologist 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. But as CPT 2004 states, make sure your dermatologist documents the complete repair if he initiated the procedure. If the dermatologist performs tissue transfer procedures to close secondary procedures, you should report the tissue transfer procedures as an additional procedure, as outlined in recent CPT changes. Unlike repairs, the correct code for this procedure is not determined by the length of the wound 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. CTP 2004 revisions

state that \"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 measure the two excisions together to determine the appropriate code.

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

If the wound only requires a simple closure, you do not bill a repair code. If the dermatologist 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 (Layer closure of 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), says **Lisa Center, CPC**, quality coordinator with Freeman Health System in Joplin, Mo. The only time you bill the two codes together, Center says, is if the dermatologist performs an excision and a simple repair on two different sites. In this instance, you append modifier -59 (Distinct procedural service) to the second procedure because the dermatologist performed repairs on two different site, Center says.

4. Is Adjacent Tissue Transfer Part of the Removal?

Unlike intermediate or complex closures, you cannot bill lesion removal if the dermatologist performed adjacent tissue transfer, because the tissue transfer is part of the lesion removal. After the scar is excised and debrided, the dermatologist performs an adjacent tissue transfer to repair the wound.

Warning: Anytime you report adjacent tissue repair, Jay says, the repair is included in the tissue transfer, so don\'t bill separately for the tissue repair.

You code the tissue transfer procedure as 14041 (Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10.1 sq cm to 30 sq cm). You should not bill for the scar excision, because the excision is included in the tissue transfer.

Like the repair codes, size (in square centimeters) and the location of the defect determine the adjacent tissue transfer codes. However, when coding a defect that is more than 30 sq cm, report 14300 (Adjacent tissue transfer or rearrangement, more than 30 sq cm, unusual or complicated, any area) regardless of the location on the body.