Codify
BY AAPC

Dermatology Coding Alert

Coding Quiz Answers: Check Your Lesion Removal Savvy

Read our experts' opinions on coding these scenarios.

Answer 1: Referral With Simple Excision

How to code: In this case, you would probably report the excision alone (17000, Destruction [e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement], premalignant lesions [e.g., actinic keratoses]; first lesion).

Because the referral was for specific removal, there is no billable E/M service, especially if the dermatologist can identify the lesion by simple exam,

The bottom line: All procedures include a minimal E/M, so unless the dermatologist can provide documentation for a significant, separately identifiable E/M service above and beyond that usually included in the excision, you are limited to reporting the excision only.

Answer 2: Referral With Unexpected Findings

How to code: First, you should report the biopsy (11100, Biopsy of skin, subcutaneous tissue and/or mucous membrane [including simple closure], unless otherwise listed; single lesion).

In this case, if the dermatologist documents a significant, separately identifiable E/M service, you can report an E/M code (for example, 99203, Office or other outpatient visit for the evaluation and management of a new patient ...). This was not a simple evaluation; the dermatologist had to spend considerable time with the patient.

Good advice: "Since this was a referral I would probably use a new patient code, and not a code from the consultation section," says **Pamela Biffle, CPC, CPC-P, CPC-I, CPCO**, owner of PB Healthcare Consulting and Education Inc. in Austin, Texas, "or include a statement that the patient had previously seen the dermatologist for an unrelated issue."

You should append modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) to the E/M code to distinguish the E/M service as significantly above that included with the biopsy.

On the later date of the excision, you will report the excision (e.g., 11644, ... excised diameter 3.1 to 4.0 cm), as well as any allowable wound repair (e.g., 12052, Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm).

Answer 3: 1 Lesion, Multiple Excisions

How to code: Report the initial excision (for example, 11642), as well as any allowable wound repair and E/M services (if appropriate) that the dermatologist provides in his office.

For the additional excision on a later day, report another excision code as appropriate to the size of the tissue removed (for example, 11643, ... excised diameter 2.1 to 3.0 cm), as well as any allowable wound repair.

Remember: You only calculate the amount of tissue removed at this procedure, say Biffle: "The size of the original lesion has no bearing on the second service which may be smaller than the original."

Since the re-excision took place during the initial procedure's (11642) global period (within 10 days of the initial

procedure), you must append modifier 58 (Staged or related procedure or service by the same physician during the postoperative period) to the lesion excision code.

The dermatologist will want to excise all malignant tissue on the first try, but if he doesn't, he'll have to go back as many times as necessary to ensure he has provided adequate margins.

Diagnosis tip: If the dermatologist excises a malignant lesion and must re-excise the same lesion to ensure adequate margins, you should use the same diagnosis for the re-excision as you did for the initial excision, even if the pathology report for the re-excision returns negative for malignancy, according to AMA recommendations.