Dermatology Coding Alert

FAQ: 4 Answers Clear Up Your Scar Revision and Related Excision Dilemmas

Use modifier 59 for 2-site procedures.

Before you try to recoup any scar revision pay, you need to know how to establish medical necessity for aftercare procedures and how to report tissue transfers. If you're having trouble recouping scar revision pay, you may need a refresher on how to establish medical necessity for aftercare procedures and how to report tissue transfers.

Here are four frequently asked questions to help you master scar revision coding basics.

Question #1: Should you claim reimbursement for all scar revision procedures, even when the scar does not impair the patient?

Answer: No. Most payers will not cover cosmetic scar revisions, so you should make sure the dermatologist establishes medical necessity for the procedure.

In many cases, 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 dermatologist remove the carcinoma. The scar that forms as a result of that excision impedes the patient's speech and eating, and therefore the dermatologist decides that the removal is medically necessary.

The dermatologist removes the scar, which is 2 centimeters long. You should report the procedure based on the location of the carcinoma that the dermatologist removed and the size of the excision. Measure each excision "at the widest diameter, including any margins," explains **John F. Bishop, PA-C, CPC, CGSC, CPRC,** president of Bishop & Associates in Tampa. So you would report 11442 (Excision, other benign lesion including margins, except skin tag [unless listed elsewhere], face, ears, eyelids, nose, lips, mucous membrane; excised diameter 1.1 to 2.0 cm), coding experts say.

In the situation above, the scar revision is cosmetic but the revision is part of the aftercare process.

With appropriate documentation including details on how the scar impeded the patient, payers should reimburse this procedure based on medical necessity under the circumstances despite the cosmetic nature of the procedure, experts say.

Question #2: Should you always report an adjacent tissue transfer code with your scar revision code?

Answer: No. 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.

Make sure your dermatologist documents the complete repair if he initiated the procedure.

Tip: 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, you should not determine the correct code for adjacent tissue transfer according to the length of the wound but rather by the area of the defect (in square centimeters) and location.

Scar removal may also require tissue transfers when scars occur after a 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.

If the wound is more serious and requires complex repair, report 13151 (Repair, complex, eyelids, nose, ears, and/or lips; 1.1 cm to 2.5 cm). "Complex repair generally includes extensive undermining, stenting, or retention sutures," says **Jill M.**

Young, CPC, CEDC, CPC-IM, with Young Medical Consulting in East Lansing,

Mich. "Complex repair is very time-consuming."

Question #3: If the dermatologist performs an excision and a simple repair on two different sites, should you append modifier 59 to the second procedure?

Answer: Yes. The only time you should bill excision and repair codes together is if the dermatologist performs an excision and a simple repair on two different sites. In this instance, you should append modifier 59 (Distinct procedural service) to the second procedure because the dermatologist performed repairs on two different sites.

Question #4: If the dermatologist performs an adjacent tissue transfer, can you bill a lesion removal?

Answer: No. 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.

If you report adjacent tissue repair, the tissue transfer includes the repair, so don't bill separately for the tissue repair.

You should 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 30.0 sq cm).

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 14301 (Adjacent tissue transfer or rearrangement, any area; defect 30.1 sq cm to 60.0 sq cm) and add-on code +14302 (Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof [List separately in addition to code for primary procedure]) regardless of the location on the body.