Dermatology Coding Alert

Is Your Everyday Coding In Sync With Payer Rules? Take Our Quiz to Find Out

2 quick scenarios let you brush up on re-excision and measurement skills.

Lesion excision coding is one of the mainstays for dermatology, but frequently-changing carrier guidelines mean you need to pay close attention to each claim. Check out the following scenarios and coding advice to ensure you're reporting procedures correctly.

1. Re-Evaluating Narrow Margins

Scenario: Patient A came to your office to have a suspicious-looking lesion removed. The pathology report showed a malignant lesion. Your physician performs an additional excision within the first procedure's global period to ensure the removal includes clear margins. How should you report the encounter to your payer?

Answer: Because your physician never knows for certain whether a lesion is malignant or benign when he removes it, wait for the pathology report before coding. "Coders are taught to use the most accurate code possible when sending a claim," says **Joseph Lamm,** office manager with Stark County Surgeons in Massillon, Ohio.

"While a doctor may be reasonably certain that a lesion is benign or malignant based on her extensive experience, the final word is based on the pathology report." Choose from the 116xx section (Excision, malignant lesion) to report the excision because of the malignancy.

Once you select the appropriate code, list it twice -- you're reporting two excisions and should consider both malignant even if the second pathology report is negative. "A re-excision of the area would require modifier 58 (Staged or related procedure or service by the same physician during the postoperative period) on the CPT code if it was done within the global period," says Lamm.

Note: CPT indicates that you should use only one code to report the additional excision and re-excision(s) required for complete tumor removal. "To me, that says that the additional excision and any further re-excisions should not be billed until pathology shows complete excision of the tumor," Lamm says. "I read it as the additional excision and re-excisions should be billed based on the width necessary from the original wound (i.e., not taking into account the lesion and margins from the initial excision)."

2. Counting Correct Measurements

Scenario: Your dermatologist excises a benign lesion from Patient B's scalp. The greatest clinical diameter of the lesion is 2.4 cm, and the procedure required margins of 0.4 cm on each side. How should you bill the procedure?

Answer: According to CPT guidelines, an excision is defined as full-thickness (through the dermis) removal of a lesion, including margins (your physician should measure the lesion and margins before excision). Excision codes include simple (non-layered) closure. "A key in dermatology is that the excision must capture the size of the lesion and the size of the defect to accurately pick a code," explains **Jennifer Swindle, CPC, CPC-E/M, CPC-FP, RHIT, CCP-P,** director of coding and compliance for PivotHealth LLC in Brentwood, Tenn.

The lesion in this case is 2.4 cm. Once you add 0.8 centimeters for the margins, you reach a total measurement of 3.2 cm. You'll report code 11424(Excision, benign lesion including margins, except skin tag [unless listed elsewhere], scalp, neck, hands, feet, genitalia; excised diameter 3.1 to 4.0 cm).

Checkpoint: "That's a pretty big lesion, so the surgeon might have used layered closure," Lamm says. "If it's indicated in the documentation, you should code for it along with the lesion excision." Also append modifier 51 (Multiple procedures) because the closure is related to the excision.