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Dermatology Coding Alert

Melanoma: Stop Melanoma Coding Errors Before They Spread

If the dermatologist gets down to the fascia, would you still stick with an integumentary code? Those answers and more below.

Skin cancer is the most common form of cancer, according to the American Cancer Society. The rates of melanoma have been rising over the last 30 years, and the ACS estimates that 76,380 new cases will be diagnosed in 2016. Some of those will surely be in your practice.

Are you ready for the challenges of melanoma coding? Or do you still frequently ask one of the questions below? Read on for our expert answers.

Question: Should we bill melanoma treatments using the skin or musculoskeletal codes?

Answer: Even if the dermatologist removes tissue down to but not including the fascia, you should only report the procedures with a code from the integumentary CPT® series.

Example: The dermatologist re-excises a melanoma of 11 cm by 3.3 cm (excised diameter) on the patient's left upper arm. The surgeon removed tissue down to, but not including, the fascia. The defect required an intermediate repair.

You should code this using the appropriate codes from the CPT® Integumentary Section, such as 11604 (Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 3.1 to 4.0 cm) for the excision, and 12034 (Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities [excluding hands and feet]; 7.6 to 12.5 cm) for the repair.

Even though the dermatologist went below the integumentary layer, you would not report a CPT® code from the musculoskeletal section, such as 24075 (Excision, tumor, soft tissue of upper arm or elbow area, subcutaneous, less than 3 cm).

Here's why: Because the case is for a melanoma, you're dealing with a skin lesion, not a soft tissue tumor, so you should use the skin codes.

"Melanoma can spread unlike basal cell carcinoma, or be so large as to require an excision that does require going through the fascia and possibly removing soft tissue," explains **Pamela Biffle, CPC, CPC-P, CPC-I, CPCO,** owner of PB Healthcare Consulting and Education Inc. in Austin, Texas. "Melanoma does spread to lymph nodes and other organs. Basal cell carcinoma is never deeper than skin."

Important: "The fascia is a boundary between the integumentary codes and the soft-tissue ones," Biffle says. "One may only use the soft tissue codes if tissue below the fascia has been removed."

Question: Can we bill repair separately after a melanoma excision?

Answer: Sometimes. Malignant lesion excision codes include simple repair, but you can additionally code for an intermediate or complex repair if the surgeon documents that type of closure.

What's the difference? A simple repair generally includes a single-layer closure. But when you see the term "**intermediate repair**," it means your physician performed one of two things:

- Layered closure of one or more deeper layers (subcutaneous and superficial fascia/non-muscle) in addition to skin; or

- Single-layer closure of heavily contaminated wounds requiring extensive cleaning.

Complex repair procedures are more than multilayered closure and include a wide range of possibilities such as scar revision or involved debridement. Complex repair generally includes extensive undermining, stenting, or retention sutures. Complex repair is very time-consuming.

"Tissue transfers such as Z-plasty and W plasty include the excision, since tissue must be removed to obtain the repair," Biffle notes.

Some coders may find this challenging, warns Biffle what they consider a complex repair may turn out to be a tissue transfer.

Do this: What you need to know to bill the closure is the longest dimension of the wound. This is likely to be quite a bit longer than the excision itself, because surgeons often create an elliptical excision, which is needed for a clean closure. You will identify the total length of the repair and choose the intermediate repair code that matches that length.

For instance: The dermatologist creates an elliptical excision 6 cm long surrounding a 2.5 x 1.5 x 1.0 cm lesion excision with 1 cm margins on the scalp. You should report the intermediate repair with CPT® code 12032 (Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities [excluding hands and feet]; 2.6 cm to 7.5 cm) in addition to the excision code (11604, Excision, malignant lesion including margins, trunk, arms or legs; excised diameter 3.1 to 4.0 cm).

On average nationally, CPT® code 11604 alone brings $319.73 in a non-facility, according to the Medicare Physician Fee Schedule. Reporting 12032 separately brings in an additional $307.20.

These rules for closure coding apply for excision of benign and malignant lesions of both the integumentary system (114xx-116xx) and the musculoskeletal system for lesions such as lipomas (e.g., 21011, Excision, tumor, soft tissue of face or scalp, subcutaneous; less than 2 cm). The only difference is that you can only separately report complex repair with muscle/soft tissue lesions, while you can separately report intermediate and complex repair with integumentary lesions.

Question: Is the diagnosis coding different for in situ melanoma vs. malignant melanoma?

Answer: Once upon a time, it wasn't but that time is past.

The ICD-9 diagnosis codes for malignant melanoma of skin (172.x) did include "melanoma in situ" But effective Oct. 1, 2015, the code set for malignant melanoma of skin expanded considerably. In addition to more specificity in body location (for example, different ICD-10 codes for melanoma on right and left eyelids), the new diagnosis codes will distinguish between malignant melanoma and melanoma in situ.

Example: Under ICD-10, you have these expanded options for a malignant melanoma of the eyelid:

- C43.10 Malignant melanoma of unspecified eyelid, including canthus
- C43.11 ...right eyelid, including canthus
- C43.12 ... left eyelid, including canthus
- D03.10 Melanoma in situ of unspecified eyelid, including canthus
- D03.11 ... right eyelid, including canthus
- D03.12 ... left eyelid, including canthus.

Tip: Just as in ICD-9, your first stop when coding for a neoplasm in ICD-10 is the Neoplasm Table. You'll find the table just after the end of the Alphabetic Index in your coding manual, rather than under "N" in the Alphabetic Index.

Question: Can we report adjacent tissue transfer separately from melanoma repair?

Answer: No. In cases involving adjacent tissue transfer to close a repair after a melanoma excision, you can only report one CPT® code: the tissue transfer itself. That code includes the excision, so you cannot report it separately.

Example: The dermatologist excises a melanoma of the face and closes using adjacent tissue transfer. You may be tempted to code both 14040 (Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; defect 10 sq cm or less) and 11643 (Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 2.1 to 3.0 cm). You should report only 14040 for the closure using existing tissue transfer.