Dermatology Coding Alert

Scars: Get Answers on Showing Medical Necessity for Scar Revisions

Tip: You may be able to report tissue transfers as a separate procedure.

If you think it's impossible to get reimbursed for scar revisions, think again. It is possible if you know how to establish that the dermatologist performed the procedure for medically necessary reasons.

Read on for answers to some frequently asked questions about scar revisions.

Question: How do we show medical necessity for scar revisions?

Answer: 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. 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.

Don't miss: Verify that the diagnosis you reported is payable, up-to-date, and accurate. Remember if you're using an ICD-10 code, it must be documented in the patient's record that the patient has that condition.

Question: What if the dermatologist performs a tissue transfer?

Answer: If the scar excision leaves a deficit that is too large or too deep for an intermediate or complex repair, the dermatologist may perform an adjacent tissue transfer. However, note that a revision may not require a complex repair.

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

Tip: If the dermatologist performs tissue transfer procedures to close secondary procedures, you should report the tissue

transfer procedures as an additional procedure.

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.

Question: Can I report scar revision in addition to a biopsy?

Answer: Yes, you can separately report the scar revision in addition to the biopsy (such as 19101, Biopsy of breast; open, incisional) if they occur at different locations. You cannot bill both if the biopsy is in the scar-revision area. You should choose the appropriate code from the range 13100-13102 (Repair, complex, trunk ...) for the scar revision.

Beware CCI: Medicare's Correct Coding Initiative bundles 13100 as a column 2 code to 19101, but you can use a modifier to unbundle the codes, when appropriate. Since the scar revision and biopsy involve different sites on the breast, you can override the edit pair by appending modifier 59 (Distinct procedural service) to 13100.

Regarding the ICD-10 code, you should not report Z41.1 (Encounter for cosmetic surgery) if the scar is caused by a prior surgery. Instead, you should use ICD-10 code L90.5 (Scar conditions and fibrosis of skin) to describe the condition that resulted in the scar revision surgery.

Question: Can we bill a lesion removal along with an adjacent tissue transfer?

Answer: 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 excision or removal of tissue, so don't bill separately for the removal, notes **Pamela Biffle, CPC, CPC-P, CPC-I, CPCO,** owner of PB Healthcare Consulting and Education Inc. in Austin, Texas.