Codify
BY AAPC

Internal Medicine Coding Alert

Coding Quiz Answers: Check Your Skin Lesion Removal Coding Know-How

Reporting skin lesion removals performed by your internal medicine specialist can be very straight forward or downright confusing. You should be aware of what codes to report, and when you can report another service such as an E/M with the removal codes.

Scenario 1: Simple Destruction of Keratotic Lesion

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

Because the encounter was specifically for removal and the "mole" was previously diagnosed, there is no billable E/M service.

The bottom line: All procedures include a minimal amount of evaluation and management of the patient, so unless your clinician can provide documentation for a significant, separately identifiable E/M service above and beyond that usually included in the destruction, you are limited to reporting the destruction only.

Scenario 2: Excision 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 your internal medicine specialist 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; your physician had to spend considerable time with the patient. "The physician was presented with an undifferentiated condition requiring a thorough exam and history and leading to some medical decision making on his part. Typically, if that amount of history, exam, and medical decision making is documented, it would substantiate reporting an appropriate E/M code," points out an expert.

You should append modifier 25 (Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service) to the E/M code to distinguish the E/M service as significantly above and beyond whatever evaluation and management might normally be included with the biopsy.

On the later date of the excision, you will report the excision with an appropriate CPT® code (e.g., 11644, Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; 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).

Scenario 3: One Lesion, Multiple Excisions

How to code: Report the initial excision (for example, 11642, ...excised diameter 1.1 to 2.0 cm), as well as any allowable wound repair and E/M services (if appropriate) that your provider performs 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. The size of the original lesion has no bearing on the second service which may be smaller than the original.

If 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 or other qualified health care professional during the postoperative period) to the lesion excision code used at the subsequent encounter. Note that if additional excisions and re-excisions were done at the same session, CPT® advises that you use only one code to report the additional excision and re-excision(s) based on the final widest excised diameter required for complete tumor removal.

Your physician 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 your internist 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.