

Internal Medicine Coding Alert

Coding Quiz: Test Your Skin Lesion Removal Coding Skills With This Quiz

Check on when you can or cannot report an E/M service.

Reporting a lesion removal that your physician performs might not be as straightforward and simple as it seems. You will have to know what other services you can or cannot report with these lesion removal codes.

Read the following three scenarios, and see if you can decipher the right codes to report for the different lesion removal situations described.

Scenario 1: Simple Destruction of Keratotic Lesion

Your internal medicine physician performs an ablation of a "mole" on the patient's torso. Your internist has previously diagnosed that the mole is an actinic keratosis. He performs cryosurgery to remove the lesion in the office. The chart notes read that the lesion measures 0.8 cm in size. Appropriate ointment and dressings are applied to the treatment site, and the patient is released. No other areas were examined.

What codes would you use to report the procedure that your provider performed?

Scenario 2: Excision With Unexpected Findings

In the next instance, your internist views the lesion as potentially more serious and not diagnosable by simple exam.

Your clinician performs a thorough exam with history and does a biopsy to determine the nature of the lesion. The biopsy returns positive for malignancy, and your physician schedules the patient for excision at a later date.

What code(s) would you report for the procedure performed by your physician?

Scenario 3: One Lesion, Multiple Excisions

Your physician suspects squamous cell carcinoma and excises the lesion in the office. The pathology report returns later showing positive margins — meaning that your internist did not remove all the malignancy and must excise additional tissue. Your clinician schedules an additional excision for wider margins. This time the pathology report returns negative.

What CPT® codes would you report for this scenario?