

Internal Medicine Coding Alert

Cut Through the Confusion of Lesion Excision

The integumentary section of the CPT manual can be tricky for [internal medicine coders](#) who may not access it as frequently as surgical coders. According to **Linda Bishop, CPC, CCS**, corporate compliance officer, Pediatric Management Group at Childrens Hospital, Los Angeles, sequentially follow the steps below to easily locate the proper code.

Step One: Review the Three Layers of the Skin

Understanding the basic anatomy of the skin is crucial to understanding the integumentary section of CPT. These codes reflect the three layers of the integument the epidermis, the dermis and the subcutaneous layer. The epidermis is the layer of skin that is visible to the eye. Corns, calluses and squamous cell cancer all originate in this layer of the skin. Basal cell carcinomas and malignant melanomas originate in this layer. The second layer of skin, the dermis, lies directly beneath the epidermis. The dermis contains hair follicles, sweat glands, sebaceous (oil producing) glands, lymphatic vessels and nerves. One of the main components of the dermis is collagen, which gives the skin its toughness and elasticity. The third and deepest layer of the integument is the subcutaneous layer. This layer contains fat cells, nerves and blood vessels.

Step Two: Determine Removal Technique

Physician documentation should identify the technique used for lesion removal. CPT's definition of some terms may differ from your physician's usage of the same terms. For instance, CPT defines the term "excision" as a "full-thickness (through the dermis) removal of the lesion and includes simple non-layered closure." Thus, any lesion excision that is not "full-thickness (through the dermis)" would not be coded using the lesion excision code series (11400-11646) even though the physician's documentation refers to the procedure as a lesion excision.

Biopsy: A biopsy is defined as removal of a small piece of tissue for microscopic pathological examination. This seems straightforward, but confusion begins to seep in when physicians use the term "excisional biopsy." CPT does not use this term so the coder will have to examine the operative note to determine if an actual full excision of the lesion was performed and sent for biopsy or if only a small portion of a lesion was biopsied.

For instance, if the operative note indicates that the physician made an elliptical incision around the borders of the lesion and excised the full lesion, this would be billed as an excision, not a biopsy, even though the physician's note refers to the procedure as an excisional biopsy. Most skin lesions seen by internists are usually small and will be excised and sent to pathology rather than just biopsied. The biopsy codes are 11100 (biopsy of skin, subcutaneous tissue and/or mucous membrane [including simple closure] unless otherwise listed; single lesion) and 11101 (each separate/additional lesion).

Shaving: CPT defines lesion excision by shaving as "the sharp removal by transverse incision or horizontal slicing to remove epidermal and dermal lesions without a full-thickness dermal excision. This includes local anesthesia, chemical or electrocauterization of the wound. The wound does not require a suture closure." Because only the top layer of the epidermis or dermis is removed, scarring is minimal.

"Physicians try to anticipate the depth of a lesion before they remove it. If they anticipate that the lesion is superficial, then they will go ahead and shave it," says **Michael Haynes, MD**, internist and compliance director for University Medical Associated in Augusta, Ga. Haynes cites seborrheic keratoses as a type of lesion that most physicians would elect to remove by shaving. The shaving codes are 11300-11313 (shaving of epidermal or dermal lesion).

Paring or cutting: Paring or cutting refers to the removal of superficial lesions confined to the top layer of the

epidermis. The internist will use a curette to remove corns and calluses, which are the most common type of benign hyperkeratotic lesions. Parings or cuttings should be reported with 11055-11057 (paring or cutting of benign hyperkeratotic lesion [e.g., corn or callus]).

Destruction: CPT defines lesion destruction as "ablation" or removal of a part "by any method, with or without curettement, including local anesthesia, and not usually requiring closure." Any method is defined to include "electrosurgery, cryosurgery, laser and chemical treatment." Destruction codes can be used for benign, pre-malignant or malignant lesions. Benign or pre-malignant lesions typically treated with ablation include condylomata, papillomata, molluscum contagiosum, herpetic lesions, warts, (common, plantar, flat), milia or atinic keratoses. The destruction codes are 17000-17286 (destruction [e.g., laser surgery, electrosurgery, cryosurgery, chemotherapy, surgical curettement]).

Excision: To use the excision codes there must be documentation that the excision extended through the epidermis down to the dermis and that the wound required closure, usually with sutures or tissue adhesive. If more than a simple closure is required, the closure is billed separately. (See Step five for further discussion of separately billable closures.)

Step Three: Determine the Excision Type

Once you identify the technique, you will need to identify the lesion type. Many, but not all of the lesion-excision codes are chosen based on the pathology of the lesion (benign vs. malignant). Some benign lesions, such as skin tags, have their own CPT codes (11200-11201 removal of skin tags, multiple fibrocuteaneous tags, any area). The following table helps coders select the proper code by technique and lesion type. When using the lesion excision codes, it is often necessary to wait for the pathology report to determine if the benign or malignant code should be used. Additionally, many payers require a pathology report be submitted with biopsies and excision codes.

Step Four: Find the Location, Size and Number

Some lesion excisions are coded based on size and location, others are coded strictly on location, or on the number of lesions excised. The following table can help coders identify the additional information needed to properly code the technique used.

Step Five: Determine the Type of Closure

Most excision codes require suture closure. A single-layer closure, or the placement of sutures in only one layer of skin, is included in the excision codes. However, when the excision extends into the deeper layers of the subcutaneous tissues, a layered closure may be required. Any time a layered closure is needed to close a lesion excision, it may be billed separately in addition to the excision code. Unlike the lesion excision codes, which are billed per lesion, separately billable closure codes are summed and billed once per anatomical area.

For instance, a physician excises a 3 cm lesion on the chin and a 2 cm lesion from the patient's cheek. The physician would bill two codes for the lesion excision 11443 (excision benign lesion, face, 2.1 cm to 3.0 cm) and 11442 (excision benign lesion, face, 1.1 cm to 2.0 cm), but the length of the two closures would be added together and only one code would be used to bill the layered closure, 12052 (layer closure of face, 2.6 cm to 5.0 cm) because the closures are in the same anatomical area.

If the two lesion excisions were in different anatomical areas, two different codes would be used for the closure. For instance, a patient has a 3 cm lesion excised from his chin and a 2 cm lesion excised from his foot. Both lesions require a layered closure. The physician would bill 11443 and 11422 (excision benign lesion, foot, 1.1 cm to 2.0 cm). For the layered closures, he or she would also bill 12052 and 12041 (layer closure, feet, 2.5 cm or less). Because the lesions are in two different anatomic areas, the lengths of the two lesions are not summed and the closures are billed separately.