Codify
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Internal Medicine Coding Alert

Four Elements Crucial to Payment For Removal of Skin Lesions

To report the removal of skin lesions, the method of removal, size and location of the lesion, and whether the tissue was benign or malignant are the crucial elements needed to select the proper CPT code. There may be variation, however, among local payers regarding the modifiers that are used for reporting the removal of multiple lesions.

Three Methods of Removal

There are numerous types of skin lesions and a variety of ways to remove them. But there are three methods of removal that internists primarily employ:

1. Shaving is the sharp removal by transverse incision or horizontal slicing to remove epidermal or dermal lesions without a full-thickness dermal excision, according to CPT. The descriptions of the codes for shaving (11300-11313) all include local anesthesia and chemical or electrocauterization to close the wound.

2. Excision is defined as the full-thickness (through the dermis) removal of a lesion, according to CPT. Local anesthesia and a simple (non-layered) closure are included in the descriptions of both the excision of benign lesion codes (11400-11446) and the excision of malignant lesion codes (11600-11646).

3. Destruction means the ablation of benign, premalignant or malignant tissues by any method, with or without curettement. This could include electrosurgery, cryosurgery, laser or chemical treatment. Lesions that might be removed in this manner include condylomata, papillomata, molluscum, contagiosum, herpetic lesions, warts, milia, or other benign, premalignant (e.g., actinic keratoses) or malignant lesions. Local anesthesia is included in the description of the codes for the destruction of benign or premalignant lesions (17000-17250) and malignant lesions (17260-17286). No wound closure is necessary with this type of removal.

Maximum Width Reported as Size

The size of a lesion is measured by its diameter, states the fall 1995 issue of CPT Assistant. The diameter is the length of a straight-line segment that passes through the center of a figure, especially of a circle or sphere. If the lesion is asymmetrical or irregular, the maximum width can be reported as the size of the lesion, says **Carol Ethridge, CPC,** coding specialist at Baptist Health Centers, a practice management group for more than 75 medical practices in Birmingham, Ala.

If the dimension of the lesion is 3x4x5 cm, you would go with the highest measurement, which would be 5 cm in this case, she explains. Its only the lesion itself that is measured, even if the internist does remove some of the skin surrounding the lesion.

Because reimbursement is higher for larger lesions, it is important that the measurement of the lesion be taken from the patients medical record and not the pathology report, says **Kathy Pride, CPC, CCS-P,** coding supervisor for Martin Memorial Medical Group, a multispecialty physician group in Stuart, Fla. Lesions that are shaved or excised are sent to the pathology lab for analysis. While the pathologist may note the size of the lesion in the lab report, the specimen has often shrunk by that time and may be smaller than when the internist removed it.

The code also will be determined by the location of the lesion, which will fall into one of the following three areas:

1. trunk (includes chest and back), leg or arms

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2. scalp, neck, hands, feet, genitalia
3. face, ear, eyelids, nose, eyes, mucous membrane

Pathology Report Says Benign or Malignant

The final determinant to correct coding for lesion removal is whether the lesion is benign or malignant. When removal is by destruction, the internist must note the status of the tissue prior to the procedure because there wont be a sample left to send to the pathologist afterward. Shaving is the only removal method where it is not necessary to know whether the lesion is malignant to determine the CPT code, but Pride believes that the status of the tissue should be indicated by the diagnosis code.

I wait for the pathologists final determination before coding a lesion benign or malignant, says Pride. Thats the only item that I code from the pathologists report.

Coding Multiple Removals Will Vary by Method

Coding for the removal of multiple lesions depends on the method of removal. The CPT codes for removal of benign lesions by destruction have the number of lesions built into the definition. The removal of the first benign lesion is reported with 17000 (destruction by any method, including laser, with or without surgical curettement, all benign or premalignant lesions; first lesion). The removal of lesions two through 14 are reported with 17003 (...second through 14 lesions; each), and the removal of 15 or more lesions with 17004 (...15 or more lesions).

If three benign lesions are removed by destruction during the same session, 17000 should be reported first, and 17003 reported two times to account for the second and third lesion. Code 17003 is always reported in combination with 17000.

If 17 benign lesions are removed by destruction during the same session, only 17004 should be reported; this code is never reported in combination with 17000 and 17003, according to CPT.

For removal by shaving, excision and destruction, each lesion should be reported separately. But the particular modifiers used to report the multiple removals will vary according to the payer.

To report the excision of two benign lesions (one 0.7 cm in diameter, the other 1.2 cm.) on the arm, Pride suggests first using 11302 to report the 1.2 cm lesion because it is the largest and using 11301 with modifier -59 (distinct procedural service) to report the 0.7 cm lesion. When removing multiple lesions, I use modifier -59 to report procedures done in the same area of the body and different areas of the body, Pride says.

Ethridge uses modifier -59 to report multiple lesion removals in different parts of the body, but uses modifier -51 (multiple procedures) to report multiple removals in the same area of the body. In the previous example, Ethridge would use 11302 to report the larger lesion and 11301 with modifier -51 to report the 0.7 cm lesion.

Limited Coverage for Benign Lesions

Several state Medicare payers have been limiting coverage of the removal of benign skin lesions because they believe 17000 is overused. The local medical review policy of Nationwide, the Part B Medicare carrier for Ohio and West Virginia, is similar to several others and states that [r]removal of certain benign skin lesions that do not pose a threat to health or function is considered cosmetic and as such is not covered by the Medicare program.

The local medical review policy of First Coast Service Options, the Part B Medicare carrier for Florida, limits medical coverage mainly to patients who present with actinic keratosis, a scaly, cutaneous lesion caused by chronic sun exposure, that either has changed in appearance, is located on the nose, ear or eyelids, or has not responded to topical treatments. The removal of benign lesions other than actinic keratosis is not considered a medical necessity except when the lesion is on an area of the body where it is constantly irritated (such as the bra line) or if the lesion obstructs vision or a bodily orifice.

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The use of modifiers to report the multiple removals of skin lesions and the medical coverage issues surrounding the procedure will vary from state to state. Internists should contact their local payers to get specific coding and medical coverage policy instructions.

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