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Internal Medicine Coding Alert

Get the Pay You Deserve With Multiple Lesion Removals

Experts say you have to know which modifiers to use

If a patient presents to your internal medicine office for multiple lesion removals, you should report each procedure separately. But don't forget to attach either **modifier -59** (Distinct procedural service) or **modifier -51** (Multiple procedures) to the excision code.

Suppose your physician excises multiple lesions from the same body area; you may want to use modifier -59, depending on your payer's requirements.

Many Medicare carriers consider it better to use modifier -59 to avoid "duplicate" denials or bundling, says George Ward, a billing supervisor for South of Market Health Center in San Francisco.

What to do: The internist excises a 1.0-cm lesion from a patient's arm, and a 3.1-cm lesion from the leg. You should use **11404-59** (Excision, benign lesion including margins, except skin tag [unless list elsewhere], trunk, arms or legs; excised diameter 3.1 to 4.0 cm; distinct procedural service), and **11401** (... excised diameter 0.6 to 1.0 cm).

On the other hand, your payer may require that you attach modifier -51 to the second excision procedure. Append modifier -51 to the lower-valued code because carriers reduce a procedure's payment by 50 percent when you use the modifier.

Strategy: You should always sequence your procedures from the highest- to the lowest-priced procedure code. That way, if Medicare adds modifier -51 for you to the second procedure, you'll get paid for the highest-priced code, internal medicine coding experts say.