Internal Medicine Coding Alert

Here's Why Multiple Lesions Don't Always Mean Multiple Codes

Under certain conditions, you should add repair areas and report 1 code

When patients develop lesions, they'll often rely on their internists to perform lesion removals in the office -- especially when the internist is their primary-care physician.

These minor surgical procedures can cause major coding headaches if you don't follow our rules for reporting.

Last month, we taught readers how to correctly diagnose lesions as benign or malignant, and how to measure total lesion size. This month, we'll break down exactly how to choose the right CPT codes in different situations. Follow this expert advice to choose the proper lesion excision code for each encounter.

Determine Lesion Type First

On your lesion excision claims, you have to know whether the physician removed a benign or malignant lesion from the patient, says **Pat Strubberg, CPC,** of Patients First Health Care in Washington, Mo. When reporting lesion removal, you should choose from 11400-11471 for benign lesions and 11600-11646 for malignant lesions, he says.

(Note: For more information on deciding whether a lesion is benign or malignant, see "Take 3 Steps to Perfect Your Lesion Excision Claims" in the March issue of Internal Medicine Coding Alert.)

For Coding, CPT Breaks Body Into 3 Areas

Once you confirm whether the lesion is benign or malignant, you should narrow your code choice further based on which area of the body the internist operated on. CPT breaks lesion removal codes into three body areas:

• trunk, arms, legs (11400-11406, 11600-11606)

• scalp, neck, hands, feet, genitalia (11420-11426, 11620-11626)

• face, ears, eyelids, nose, lips, mucous membrane (11440-11446, 11640-11646).

Example: The internist treats a lesion on a patient's right arm. The operative report indicates that the lesion was malignant, its diameter was 1.9 cm at the widest point, and the physician also excised a skin margin of 0.3 cm.

You would add the lesion diameter (1.9) and the margin (0.3 x 2), and the total excision area would be 2.5 cm. On the claim, you should report 11603 (Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 2.1 to 3.0 cm).

Consider 2 Coding Options for Excisions From Same Body Area

There are instances in which the internist removes multiple lesions from the same body area. When this occurs, your coding will depend on the number of incisions the physician makes, says **Sheldrian Leflore, CPC,** revenue management educator with The Coding Group in Carlsbad, Calif.

Single excision: If the physician removes multiple lesions via the same incision site, you should tally the total size of the excision and report one CPT code, Leflore says.

For instance, the internist removes two benign lesions from a patient's neck through the same incision: Each lesion measures 1.0 cm, and there is a 1.0-cm margin between them.

In this scenario, you would add each lesion size and the skin margin, giving you a total excision area of 3.0 cm. On the claim, Leflore says, you should report 11423 (... excised diameter 2.1 to 3.0 cm).

Multiple excisions: Basically, multiple lesions removed via multiple excisions equal multiple excision codes, Leflore says. For example, the internist removes a 1.0-cm benign scalp lesion with a 0.5-cm margin. During the same session, he also excises a 0.5-cm benign neck lesion with a 0.2-cm margin.

Since the internist performed two incisions on the patient (one on the scalp, one on the neck), you'd report a CPT code for each excision:

• report 11422 (... excised diameter 1.1 to 2.0 cm) for the excision of the scalp lesion.

• report 11421 (... excised diameter 0.6 to 1.0 cm) for the neck lesion excision.

• attach modifier 59 (Distinct procedural service) to show that the excisions were separate procedures, because they occurred in different body areas that use the same CPT code family.

If Body Areas Differ, Leave Modifiers Off Claim

When the excisions occur in different body areas that do not use the same CPT code family, things are less complicated for the coder. You'll report two codes in these scenarios, and modifiers are unnecessary, Strubberg says.

Suppose the internist removes a 1.0-cm malignant lesion with a 0.3-cm margin from a patient's lip, then excises a 0.5-cm malignant lesion with a 0.2-cm margin from a patient's neck. On the claim, you would:

• report 11642 (Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 1.1 to 2.0 cm) for the lip lesion excision.

• report 11621 (Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 0.6 to 1.0 cm) for the neck lesion excision.

Report Intermediate or Complex Closure of Wound Site Separately

Simple closure of the excision site is bundled into all of the lesion excision codes, Strubberg says. However, intermediate and complex closure of excision sites may be reported separately, though it is unlikely that an internist would perform this type of closure. When the internist performs an intermediate closure, you'll choose a code from the 12031-12057 code set, Leflore says. For complex closures, you'll choose from the 13100-13153 set.