Internal Medicine Coding Alert

Winning Ways to Boost Pay-up for Lesions & Closures

Presented by Barbara Johnson

Thank you Mandy and good morning to all for joining us. What I would like to accomplish today is to discuss and help clarify some of the questions that I hear regarding integumentary coding as far as lacerations and/or wounds, talk about how they are closed. The measurements, the anatomical areas, lesions, masses and neoplasms continue to be a big question, particularly the difference between a lesion and a neoplasm, the excision, how to measure them, and whether the biopsy is truly incisional or excisional. We will talk about coding some grafts and flaps and, of course, the adjacent tissue transfers which technically are the flaps. We will then talk some about breast surgery, mastectomy and simple reconstruction and biopsy and then débridement wound versus fractures. Then the new codes for the necrotizing wounds that we see so much, unfortunately, today. We will talk about some of E modifier issues and when and how to use them. The ICD-9 issues, the differences in the diagnostic coding for integumentary system and for lesions and neoplasm and cysts. Then, if we have some time, we can talk a little bit about the explanation of benefits and we do need to review those for appeal or review. Let us start at the beginning with the lacerations and wounds.

The measurement on lacerations and wounds is by anatomical site and is listed in the codes for the closure, the exact site. Multiple lacerations or wounds in the same anatomical site would be added together for a total. If they are in different anatomical sites, then each anatomical as listed in the CPT would be added together and then coded separately from different anatomical sites--and we could be using multiple codes, the 12000 or 13000 series there. Using sutures, staples or tissue adhesive is a primary way of closing lacerations or wounds. We advise using the E/M section if you are doing the adhesive strip closure, then you would have to go with your E/M for that particular service. There are three types of primary closure, a simple closure which would be 12001--12021, the intermediate closure 12031--12057, and then complex closure 13100--13153. These vary as the description and they have gone by the type of a wound or laceration that you have.

A simple closure would be of a superficial wound, usually epidermis or dermis, perhaps subcutaneous issue, which requires a one-layer closure. It does include local anesthesia, chemical or electrocautery of the wounds, and not closed would be included in all of that. Since this does include the local anesthesia, modifier 47 would not apply in this case and we will talk about 47 if we need to towards the end. Intermediate closure would include the wounds that are listed under the simple closure; that requires layered closure, one or more of the deep layers, which would include subcutaneous tissue, superficial non-muscle fascia or it could be a single-layer closure of a heavily contaminated wound that requires extensive cleansing and/or removal of foreign matter. We are all faced with the traumas, the motorcycle accidents, the lacerations containing grass, dirt, rocks, various other particles that would have to be debrided out or washed out with saline and at that point then those single-layer closures would become intermediate closures just due to the complexity of the case and the risk of infection. The complex closure would be used if it required more than a layered closure, it would be scar revision, debridement, extensive undermining, and it could require stents or retention sutures. The complex repair does not include the excision of a lesion being a benign or malignant and I have given you the codes there.

Extensive undermining--which is required for a complex closure--the definition on that is that both sides of the laceration or the wound are cleared of excess tissue underneath the skin layer to bring the edges together without tension and without buckling, so that you have a very smooth closure. There is a difference between just undermining and extensive undermining, how you would know the difference unless your doctor is very specific in his op report? At times, if I have questions whether or not a closure would be intermediate or complex, I have talked with the surgeon and have been able to determine from him or her that the undermining was not extensive and so it would be an intermediate. I have encouraged my physicians and surgeons to always dictate the word 'extensive' if that is what they have done. Physicians can be a little hard to train sometimes, it may be a process that you need to go through to help them

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understand what you are trying to get from them.

The ICD-9 for lacerations and wounds, there are some lacerations codes in the book, but for the most part, you would look at the wounds. Under wounds, you have the regular codes, then you have with tendon and many areas and then complicated. When we talk of a complicated wound, we are talking about either gross contamination from debris or foreign matter in the wound itself, infection which could be present, delayed healing or treatment or foreign bodies in that wound. For lacerations and wounds, you could also be referred to the crush, which is simply under crush, contusions for some wounds, and then under injury, there is a category of superficial, which could be used depending upon what you have there.

Lesions, neoplasms, masses, and cysts, and this is where a lot of confusion comes in. When you look at the CPT book, it only mentions lesions either benign, premalignant or malignant lesions. When you look at the ICD-9 book, there is a bunch of lesion codes, but then also the neoplasm codes, which are broken down by 6 categories. In the CPT, let us say we have the benign lesions and it should actually say neoplasms because of the difference here. Actually, it could either say neoplasms or lesions. For the ICD-9, under neoplasms, we have six different types: malignant which could be primary; secondary which would be your metastatic codes or in situ; and then we have the benign, uncertain behavior and unspecified.

When we talk about a mass, Dorland's describes a mass as a lump or collection of cohering particles. In some instances, a mass could be a lesion or a neoplasm or it could be like a disorder of the skin or the subcu tissue, not necessarily a neoplasm per se. The cyst is a closed epithelium-lined cavity or sac, usually containing liquid or semisolid material. Cysts are generally not neoplastic, there are not neoplasms that are cysts. There are a lot of codes in the ICD-9 that can be used for the cysts, probably the most common would be just a secondary 706.2.

Neoplasm or lesions can be coded from the neoplasm section by anatomical site. If you are scheduling or trying to get authorization for a neoplasm or a lesion to be excised, you may want to use the specified code to start with and then at a later time, you can be more specific on that. Again, you could code from mass or disorder and then cyst would be from the cyst category.

The next slide that I have given you, these actually came from the CPT and it is showing how they are measuring the excision area for coding. For many years we were asked to code by the size of the lesion or tumor. Now, they have expanded that to include margins, which would be of advantage to all of us. Physicians again sometimes will not dictate the size of the excision. If you have a path report, you can use the report to get the size. Remember in preparing the slides for reading and reporting, that the size will have shrunk a little bit, so the concept of under coding could come into play here, but at least on the pathology report, it will give you exact sizes, so you can use that as your guidelines.

The 11400--11406 series, benign lesions including margins, which is, as I mentioned, of the trunk, arms or legs. It starts at 0.5 cm or less and then goes up to over 4.0 cm. The 11600--11606 is the same category, trunk, arms or legs of malignant lesions. It does include also the margins, and starts at 0.5 or less cm and goes to over 4.0 cm. The 11420--11426 includes the scalp, neck, hands, feet, genitalia and the sizes are exactly the same. The 11620--11626, those are the malignant lesions of the scalp, neck, hands, feet, and genitalia, and the sizes are exactly the same. The 11440--11446 include the face, ears, eyelids, nose, lips, and mucous membrane. These are benign lesions, again 0.5 cm or less through over 4.0 cm. Then, the 11640--11646, malignant lesions face, ears, eyelids, nose, lips, etc., the same sizes. These can be coded using the malignant lesion only after the path report is received unless your doctor knows for sure that is what it is.

The excision when includes the local anesthesia and simple closure. If an intermediate closure or a complex closure is accomplished at that time, then that would be coded separately and billed separately, you use the code with the highest unit value codes first and then other ones with a modifier 51. Again, on the margins, you add the diameter of the lesion, neoplasm mass, or cyst and the margins on two sides to give you the size for the excision.

If you are doing multiple lesions, each lesion would be coded separately according to the anatomical site. You could end up with multiple lesions basically in the same anatomical site if they are doing like trunk, arms and legs; or you could have multiple if they are doing trunk, neck, maybe face or something like that, so you would list those individually by the

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anatomical site and then closure would be added together according to anatomical site also and coded if they are intermediate or complex.

The ICD-9 coding issues, tumor is described as any new or abnormal growth, one in which cell multiplication is uncontrolled or progressive. A lesion is described as, and these are all taken from Dorland's Medical Dictionary, any pathological or traumatic discontinuity of tissue or loss of function of any part. This is kind of a confusing definition, but it kind of helps to understand a little bit, I think, the difference. Most of the time, we are only able to use the codes in the CPT that say benign or malignant lesions, but we are coding neoplasms.

The biopsy of skin and subcu tissue and this could be just a simple biopsy, the 11100--11101, biopsy of skin, subcu and/or mucous membrane. It includes the simple closure unless otherwise listed or specified by the surgeon and that would be the 11100 with the one lesion. The 11101 is an add-on code for each additional lesion and it would be listed separately. If you are doing multiple lesions, you will bill that out with multiple units and of course the 11101 could only be used in conjunction with the 11100.

The shaving of lesions, the 11300--11313, these would be epidermal or dermal lesions, which would be superficial. We have a single lesion, trunk, arms or legs. And then a lesions scalp, neck, hands, feet, or genitalia. And then 11310--11313, face, ears, eyelids, nose, lips, mucous membrane. These again are coded by size of the shaving, starting with 0.5 cm or less and then go to over 2 cm. As a general rule, if they are doing shaving of a lesion that is more than 2 cm, they would really have to call it an excision rather than just a shaving.

Debridement, the removal of foreign material or devitalized tissue from or adjacent to a traumatic or infected lesion until surrounding healthy tissue is exposed. And debridement can be done in multiple stages and if the physician is taking the patient back to the OR for multiple stages, if they will dictate in their OP report that this is a staged procedure or staged debridement, then you would bill with a modifier 58 and that would help you reimbursement.

Debridement is considered a separate procedure when gross contamination is present and requires prolonged cleansing or debriding or working out of the material. The CPT codes 11040--11044, these depend on the depth of debridement and they go from just skin, subcu tissue down to bone. The 11010--11012 is debridement of open fractures and this also depends upon the depth of debridement. The 11004--11008 were new codes for 2005 and this is debridement for necrotizing soft tissue infection. The 11004, skin, subcu tissue, muscle and fascia of the external genitalia and perineum. The 11005 is of the abdominal wall, with or without fascial closure. And the 11006 is external genitalia, perineum and abdominal wall, with or without the fascial closure. The biggest problem with these three codes is the fact that these limits us to external genitalia, perineum or abdominal wall, so if you are doing an area other than those three specified, you would have to go back to the 11044, your debridement code.

The 11008 is the removal of prosthetic material or mesh from the abdominal wall for necrotizing soft tissue infection and this would be listed separately as an add-on code. It would be in addition to the code for the primary procedure. And they do recommend that you use the 11008 with either one of the codes from 11004--11006. You would report skin graft or flap separably when that is performed in the same session. If an orchiectomy is performed, then you would use that code, the 54520. If testicular transplantation is performed, then they do recommend the 54680.

ICD-9 for debridement, some of the codes that are recommended for the diagnosis. Of course, we have these cellulitis, 681.XX-682.9. They do recommend also the ulcer codes, the 707-10-707.15. They will also be the skin ulcers. The 728.86 which is necrotizing fascitis--that is probably your more common diagnostic code. 785.4--gangrene and then 910.0--916.1 which would be abrasion or a friction injury. They do also recommend codes for the areas where you might run into frostbite. That is not a big issue in Southern California, but I am sure it is in other parts of country and we need to remember that in our coding and in our various areas, we may run into all of the types of injuries or conditions that may arise.

Debriding open fractures: these were new codes a couple of years ago. They have been very popular, they are very easy to use, very handy and make coding much simpler for the very, very contaminated open fractures that we run into sometimes. These debridement codes include removal of foreign material associated with the open fracture or dislocation. The 11010 is skin and subcu tissue, 11011 would be skin, subcu tissue, muscle fascia and muscle, and then

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11012 is skin, subcu tissue, muscle fascia, muscle and bone. Hopefully, your doctors, you are able to get them to dictate the depth of the debridement that they are doing; regardless of which set of codes you are using, you need to have the debridement depth there. The 11010--11012 are not bundled into the open reduction and fixation of fracture. This would be separately. In some instances--and this is where your RVU books and information come in very handy, the debridement codes may actually be a higher unit procedure than the open reduction and internal fixation of that fracture and so you would bill that as your primary procedure and then the open reduction with your modifier 51. In order to bill those codes, the fracture must be listed as an open fracture, in which the skin is actually broken.

For grafts and flaps. For a graft, the definition is any tissue or organ for implantation or transplantation. A free flap is one that is lifted from the donor site and transferred to recipient site. When it is lifted from the donor site, there is nothing attached to the body. It is completely free. Then the rotational flap--the flap is harvested and rotated to the recipient site and it is less attached to donor site by skin and possibly a little bit of subcu tissue. For the skin grafts, we have the split-thickness skin graft frequently dictated by physicians as an STSG or a full-thickness skin graft FTSG and those codes are in the 15000--15261. A split-thickness graft is the epidermis or the top layer of skin and then the full-thickness would be your deeper layers which would be the epidermis and the dermis. The skin graft, the skin is taken from an area of the body or an extremity and then used to cover a wound. Now, these are coded by the recipient site, by size and by area and the preparation of the recipient site is coded separately from the graft.

I have given you the rule of 9 partially because it becomes very important if you do happen to be doing any burn coding. But also if your doctor fails to give you a size, sometimes the rule of 9s for adults and then also for infants and children under 10, it can kind of help you to understand what they are taking about if they just specify that they have done a graft to the leg or something like that. Hopefully, they are not quite that big, but they can be. In the rule of 9 for children, even though it is called the rule of 9, it does vary a little bit particularly in the legs and I have given you the pictures from the books that give you a description. When we talk about this--the codes for skin graft--it is for children under 10 or infants and so this will give you kind of a breakdown there. When we talk about size, 2.5 cm is 1 inch and it is actually 2.54 cm to get real technical or 25.40 mm and 1 mm is 0.03937 of an inch or 1/25th of an inch. Sometimes, just having something to tell you what the size is helps.

On the split-thickness grafts, those are broken down also by anatomical site and they are the 100 sq cm or less, the 15100 is the 100 or 1% of body area of infants or children under 10 years of age. Then, 15101 is each additional 100 sq cm or less or 1% of body area of infants and children under 10. The add-on code can be used multiple times depending on the size of the graft. The 15120 and 15121 is face, scalp, eyelids, neck, mouth, ears, orbits, genitalia, hands, feet or multiple digits. Again, this is 100 sq cm or less or 1% of the body area and then the 15121 is each additional.

For the full-thickness graft, these are broken down not only by anatomical site, but at 20 sq cm or less and so the 15200 is 20 sq cm or less of the trunk, the 15201 is each additional 20 sq cm. The 15220 is 20 sq cm or less of the scalp, arms, and/or leg and the 15221 is each additional 20 sq cm or less. The 15240 and 15241 is of the forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands or feet and then each additional 20. And then the 15260 and 15261 is of the nose, ears, eyelids or lips and again if you are doing different anatomical sites, you would code those differently. All of these skin graft codes are adult or children under 10 years of age and that would go again by the percentage of body.

The bilaminate skin, which is the skin substitute, 15342 and 15343 is based on 25 sq cm and then each additional. There is no anatomical site on that, so those are the codes just straight through. The allograft, 15350--15351 is 100 sq cm or less and then each additional. An allograft would be, of course, a homograft from another person genetically matched or cadaver, which can be used. The skin graft for the xenograft--and of course the xenograft would be biological non-human and that is also 100 sq cm or less and then each additional 100. Those again are not anatomically specified.

The surgical preparation, the 15000 and 15001 is the 100 sq cm or less or 1% of body area, which would be preparation or creation of recipient site by excision of open wounds, burn eschar or scar (including subcu tissues) and then each additional 100. Those would be billed in addition to the other 15000 codes for the split thickness or full-thickness graft. Those could also be billed as stand-alone codes if you are burn escharotomies or removing burn eschar and if you bill it in conjunction with the skin graft, then the 15000 would require a modifier 51, 15001 would not require a modifier 51.

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The burn eschar is actually a slough of skin or subcu tissue that was produced by the burn and the slough is described as necrotic tissue in the process of separating from the viable portion of the body, kind of like peeling when you have had a sunburn. The tissue transfers or rearrangement codes, the 14000--14300, these again are based on size and anatomical site. They include the preparation of the recipient site for those codes, so the excision including an excision of a lesion is included in that. If the donor site is closed separately, then that is coded separately. And I have given you kind of a little picture here of the z-plasty and the pedicle flaps that you would have an idea of those appear. Again, those are from the book.

The flaps are based on 10 sq cm or less in the anatomical site and then 10.1--30 sq cm and the anatomical sites on those trunk and then scalp, arms or legs and then go to forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands or feet. Then, the 14060 and 14061 are of the eyelids, nose, ears or lips. The 14300 is your unusual or complicated, any area or more than 30 sq cm. In using the 14300, it does not have to be more than 30 sq cm, it could be unusual or complicated simply because of the debridement that would have to be done--that would be included in that if you have a contaminated wound there. The ICD-9 for grafts and flaps would be very similar to those that we have discussed, of course, the 800 series, lacerations, excisional procedures, lesions, neoplasms, cysts, mass or a delayed closure and I have given you the V code there on the delayed closure.

Also, on the lesions, an incisional biopsy is where they have actually just made an incision and taken a piece of the tumor for pathological evaluation; excisional biopsy would be where they removed the entire mass, neoplasm, lesion, cyst, whatever. So some of the procedures, particularly in the breast, it talks about incisional biopsy and excisional biopsy and that brings us up to the breast surgery. I have not gotten into a lot of detail here because this is geared more toward the integumentary system, but I wanted to touch on some of this, but not get into the real in depth work that can be done sometimes in breast reconstruction and that kind of thing.

So, for the breast biopsy, we have the percutaneous needle not using imaging guidance and that is 19100 and the 19101 is an open incisional biopsy, we just explained that. The 19102 is your percutaneous needle biopsy using imaging guidance and then the 19103 is the biopsy by automated vacuum-assisted or rotating biopsy device that uses imaging guidance. The 19120 which is probably the most popular code with surgeons would be the excision of a cyst, fibroadenoma or other benign or malignant tumor, aberrant breast issue, duct lesion, nipple or areolar lesion. Is it open, male or female, one or more lesions, but that would be for one breast. If you are doing both breasts, then you would bill it as a bilateral. The 19125--excision of breast lesion identified by preoperative placement of radiological marker, open, single lesion, that would be the needle localization and most of the time it is called that. Then, 19126 is each additional lesion identified by the radiological marker, needle localization or something like that.

The 19140--mastectomy for gynecomastia; I am noticing that rapidly becoming the procedure of choice for gynecomastia is liposuction and you would have to use the liposuction code for that. It would not be classified as a mastectomy because that would require actually making the incision and excising some tissue. The 19160 would be a partial mastectomy, sometimes referred to as a lumpectomy, quadrantectomy, or segmentectomy depending on your surgeon. When they were trained and how recently they were out of school, their physiology is different sometimes. The 19162 would be your partial mastectomy with axillary lymphadenectomy and it does give you for placement of radiotherapy afterloading balloon or brachytherapy catheters to refer to specific codes.

Mastectomy, simple, complete--19180, this would be an incision around the breast into the axillary lesion and then breast tissue would be dissected from the pectoral fascia and the sternum, this has 14.91 RVUs. The 19182 is your subcutaneous mastectomy and that would be an incision in the inframammary crease and then breast tissue excluding the skin and pectoral fascia is excised and that is 13.48 units. The 19316 is your mastopexy and that is removing excess skin between the nipple and the lower breast and then the nipple and areola are moved to a higher location. If this is done bilaterally, it would be billed with a modifier 50 and if implants are placed at that time, you would use 19340 and 19340 is modifier 51 exempt standalone code as far as that is concerned.

19318--mammoplasty, reduction and this would be where the breasts are actually reduced, the wedges of skin and breast tissue are removed decreasing the size of the breast, the nipple and areola are moved to location for asymmetry and this is a unilateral procedure, though if it is done bilaterally, then you would bill it with the modifier 52. Many carriers for the reduction are asking for 400 or 500 gm of tissue to be removed from each breast. Now 400 gm would be

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about 14 pounds and 500 gm would be about 17 pounds, so you can see where you are going to have quite a difference in weight there. If you are doing this, it is very appropriate both for the mastopexy and the mastoplasty reduction to get an advanced approval from the insurance carrier and if you are doing the reduction, you would want to give an estimate of tissue that would be removed that time in order for them to properly evaluate whether or not this procedure would be covered. Many of these procedures today are being covered by carriers and so it is not uncommon to have them paid at all. And then of course the mastopexy frequently can be done on a patient who has had a mastectomy to equalize out the breasts after reconstruction.

Mandy, I think we can open it up for questions at this time and I would be glad to try and help anyone. As I have said frequently, I do not have all the answers, but I have some tremendous friends who can help, so if I cannot give you an answer today, you can leave your name and phone number and we will get back with you, so that we can properly answer you question.

Thank you Ms. Johnson. Ladies and Gentlemen I would like to remind you that this portion of the teleconference is also being recorded. If you have a question at this time, please press star (*) one (1) on your touchtone telephone. If your question has been answered or you wish to remove yourself from the queue, please press pound (#). Please limit yourself to one question at a time, so that everyone may have a chance to participate. If you have another question, you may reenter the queue by pressing star (*) one (1).

Our first question comes from Nicole Bartley of the Coding Institute, please state your question.

Question (NB): We have several questions that were sent in by e-mail. The first one is regarding punch biopsies. It says Medicare uses the 11100 CPT code, but in the CPT book, it looks like they are more in line with the shaving codes 1113 series, what codes should we be using?

Answer: For the punch biopsy actually your 11100 is your better code. The shaving does require a little bit more tissue and actually what they have done is just shave off using a scalpel, but almost like a razor, just taking the lesion from the skin. They are a little bit different procedures, so as far as the punch biopsy is concerned, I think you better ought to continue using the 11100 series for those. Of course, those are either single lesion or each additional lesion, so if you are doing multiple lesions, you are going to gain area there and gain some reimbursement as far as those units are concerned.

Question (NB): Okay, the second question is regarding an unspecified neoplasm. They were able to find a definition of when to use the unspecified neoplasm codes in ICD-10, but nothing in ICD-9, should they use the definition that is in ICD-10 or should they wait until ICD-9 comes up with a definition of what those codes mean?

Answer: Actually, ICD-10 is not in use much in the United States, it has not been approved yet. Once it is approved--and it would be announced probably in month of September--it will have 24 months before it becomes mandatory, so the definitions that are used in there, while they can be helpful for us understand, do not really apply to ICD-9. ICD-9 is very vague as far as unspecified neoplasms are concerned. The rule of thumb has always been until you have a pathological report, a lesion or neoplasm is unspecified. If your pathological report is unable to determine whether it is benign or malignant, then you could use the uncertain behavior. Only code it as a malignant lesion once the path report says malignant and that is probably your best ground and it is pretty much what it says in ICD-10. Sometimes physicians will want to get a preoperative authorization to excise a lesion, so at that time your best option is to use the unspecified code because you do not really have a path report that is going to tell you malignant or benign. I hope that answers the questions; if not, you can get a hold of the Coding Institute and we will proceed further on that description.

Question (NB): Okay, the next question is that if the doctor does not wait for path, what code should they be using for removal of lesion, the benign CPT codes?

Answer: Yes, definitely; never bill a malignant code until you have a path report that tells you it is malignant. Now, the problem with billing before receiving the path report is that you are going to use a benign code which has fewer units than the malignant code and if it comes back malignant you are going to have to do a secondary or a corrected billing to get the additional reimbursement on that. Realizing that sometimes it takes a while to get past reports back or they

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have to be sent on to other facilities because they are not real definitive, you have a problem sometimes with your contractual agreements in your managed cares because they have to be billed within a certain number of days. So, on those, go ahead and use the benign code, but then put a comment in your remarks section that this claim is being submitted and pending past report and revised claimed maybe submitted at a later date. In that way if it does come back as malignant then you can bill a corrected billing and get the additional reimbursement.

Question (NB): Okay! I have just a couple more here and then we will go ahead and open up to the floor. If the patient comes in for a planned visit for a physician to examine the lesion or bump and physician decided to remove or excise it, can we still bill for an E/M with the excision removal?

Answer: Yes and that is a very interesting thing. If you have a new patient or the patient comes in for a visit and the physician at that time decides to do a biopsy or to remove something, you can bill the E/M service with the modifier 25. Now you would want to specify what the diagnosis is for the E/M service and then of course see the diagnosis for the lesion. If it is a new patient, then yes definitely, always bill the office visit with the modifier 25 because you really could not have a patient come in and do a surgical procedure even just a biopsy without doing an examination and talking with the patient. And that would all be documented in the medical record and so you would have to have the documentation there and then bill it with the 25. Yes there are a lot of conversations and a lot of investigations being done by the Inspector General's office on modifier 25, but as long as you are using it legitimately for a patient who has never been seen or a patient who has not been seen for that particular diagnosis in the past, then to bill the office visit and the surgical procedure, the biopsy or whatever together, using a 25 is very appropriate. Remember to use the 25 for cases where it would be a minor procedure 10 days or 0 days and then use the modifier 57 if it happens to be a major procedure, that is the difference in notes to code.

You have another one in the call?

Question (NB): Yes, the final question asks, if a patient comes in for a visit for a spot on an arm or leg, and upon the physician examining the site, the doctor decides to remove the lesion, is it okay to bill for the lesion removal and E/M as the decision was made at that time of the exam visit.

Answer: Yes that comes under that category. If any time, the physician decides at the time of the exam to do a procedure then you can bill that with a modifier 25. If the patient comes in and the appointment was made to excise the lesion, then unless you have a separate diagnosis you would not bill an E/M service. So I hope that answers those question, if not, you can get hold of the Coding Institute and we will talk further on that.

Are there other questions that we can help Mandy?

Yes, our next question comes from Richard Buckley of Pocono Medical Care. Please state your question.

Question (RB): Yes first the correction on page 37 of 400 grams of breast material be listed one pound not 14 pounds and 500 grams would be very slightly more than one pound and not 17 pounds, there are 453.6 grams.

Answer: Yes, there should be a point in there I am sorry.

Question (RB): That too is wrong even with a point in there. My question is regarding wide local excision of dysplastic nevi and melanomas, for example a melanoma is removed with all pigment being removed comes back a Clark's level three. So there is no melanoma left, however, wide local excision is required according to standards with 2.5 centimeters or margin addition on each side, what would be appropriate coding of that be because there is no lesion left so we cannot go by lesion size, there are simply margins left?

Answer: Actually technically, as long as the initial past report shows not clear margins, then it would still be a malignant lesion.

Question (RB): Well, my question was that the margins are clear, it is out or let us say that we do a biopsy of a 1 millimeter lesion, we do a punch biopsy and it is totally out; however, it comes back at Clark's level IV, obviously,

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requiring a very wide local excision, how do we code that subsequent wide local excision since there is no tumor left?

Answer: Yes, even though there is no tumor left, sense of standard of care would require additional excisions that would be billed as a malignant lesion.

Question (RB): Right! What do we code as far as the size of the excision?

Answer: Again, you would have to have the exact size. If they are doing a 2.5 centimeter excision then you would code it at that area, not go back to the original tumor size what you are going to look at is the size of the excision at that time. The problem there becomes is it really just excising the malignant lesion though further to get the margins or additional skin, if you are doing a very large area and there is a listing in that anatomical site for a radical excision, you may want to look at those codes and the surgeon may feel that those codes are more appropriate. But if you are doing a 2.5 centimeter excision around that 1 millimeter then you would bill it as the 2.5 centimeter.

Question (RB): Thank you. A corollary to that question if you are doing a layer closure, however, I have elected to do something else on the surface such adhesive strips, is that to be billed as a layer closure?

Answer: Yes, the layered closure would be depending on the number of layers that you have done on deeper surfaces and then frequently physicians will use just the adhesive strips to close the skin and that would still come under that.

Comment (RB): Thank you.

Our next question comes from Susan Jason of Vancouver Clinic. Please state your question.

Comment (SJ): Our question was already answered, thank you.

Our next question comes from Amy Power of Massachusetts General. Please state your question.

Question (AP): On layer closures of excisions, can a surgeon simply say layered closure or must you go down to the fascia, must it be stated in the op?

Answer: It should be stated in the op report. Sometimes depending upon how these physicians dictate, they may say a layered closure, but a layered closure really was only one suture in the superficial tissue and then the skin, so you really want to see them dictate the size of the suture for the fascia or muscle and then the different layers. I have gotten my surgeons to actually dictate, you know like, 4.0, 5.0, depending on what type of suture they are using on the different layers and it has made it much easier to code and much easier to get the payment because then if the op report goes to the insurance company, they can see right there the different layers and how they were closed. Does that answer your question Amy?

Question (AP): Does that mean that simply saying deeper layers is not sufficient, it should say fascia?

Answer: It should say fascia yes.

Comment (AP): Thank you.

Our last question comes from Barbara Ogorman of Health Partners. Please state your question.

Question (BO): I would like to ask about using punch biopsy tools to remove a lesion. We see this a lot, they use the tool they state they removed the entire lesion with that tool, would you consider that to be an excision or a biopsy?

Answer: Well, this is a hot seat I am sitting on. Actually, I would consider that an excision because if you do a punch biopsy you are not really taking the entire lesion as a general rule. If you are doing an incisional biopsy you are only taking a portion, if you are doing excision then you were removing the entire lesion; so if they are removing the entire lesion I would call it an excision. Or are they doing a closure?

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Question (BO): Yeah, most of the time, they are saying some kind of closure.

Answer: I would call it an excision. When you look at the 11100, that does include simple closure, but it just specifies biopsy, and in this particular instance that you are giving you are excising even though you are doing it with a punch and so I would feel fairly comfortable billing with an excision code because those are going to be small anyway, so you are not going to have that to code.

Comment (BO): Most often we see something like 4-5 millimeter lesion removed with punch biopsy tool.

Comment: Yes that is just the method they are using instead of a scalpel, so I would bill those as excision. Does that answer your question?

Question (BO): Yes but what if the documentation actually says excisional biopsy?

Answer: Then you will use the excision code.

Question (BO): If they are truly removing the lesion?

Answer: Right, if the are doing a large lesion whether it is benign or malignant, under a lot of the anatomical sites there are codes for excision of superficial or deeper layers or radical excisions of lesions. So sometimes you want to look at those based on the size of the lesion. You know, I have seen lipomas removed from the back that would be 13-14 centimeters, so if you are using the 11406 for that you are kind of cheating your physician if you can use another code that would give you a little bit better reimbursement. So you might want to make yourself well aware of those and kind of look at those sometimes when you are seeing these lesions removed.

Comment (BO): Thank you.

Question (NB): I have got another question.

Comment: Okay.

Question (NB): Do you consider the forehead to be part of the face or the scalp?

Answer: The question asked recently too was do you know where does the neck begin and where does it end. Now you would like to say the hairline, but there you are also going to have the problem of some individuals with receding or missing hairlines and so you kind of have to guide where the hairline might have been. There is nothing in writing that says the forehead is so many centimeters or that kind of thing. If it is a real fine line I think you just kind of have to go with how high up on the forehead it really was, you know if it is above where you feel the normal hairline would have been on the individual or where their hairline is then it would be scalp.

Comment (NB): It sounds like an application thing for the providers for them to really truly determine which it is.

Answer: It is, it really is, and sometimes trying to get the physician to be real specific as to the location is difficult and if there are pictures, that is where those could come in handy. But I have always tried to instruct my physicians and residents to kind of go with what would be the normal hairline and then use that as your break as far as forehead and scalp are concerned. Then, of course, you have the doctor who removes the lesion of the forehead and the scalp. They do not make it quite easy for that at all.

Are there other questions Mandy?

At this time, I would like to turn the program back to you for any closing comments you may have.

I thank you very much for being with me this morning. I have thoroughly enjoyed this, I love talking to people and I love talking about coding. Again, if you have any questions that we have an answer, please get a hold of the Coding Institute

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and we will get those answers for you. I hope you have had a good morning and I hope I have helped you understand some of this coding a little bit better and I do invite you to join us on any of our future teleconferences. I enjoy working with the Coding Institute. They are very easy to work with and they have always been very superior in their product.

Thank you Mandy and thank you Nicole.

This is the conclusion of Winning Ways to Boost Pay up for Lesions & Closures National Teleconference. We hope you enjoyed this session. Please complete your teleconference evaluation form and return it to the Coding Institute at the address listed on the form. Ms. Johnson, the Coding Institute, and I would like to thank you for your attendance. To end this call, simply hang up your phone.

Goodbye.

To view slides please refer to this issues pdf.

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