Codify by AAPC

# Part B Insider (Multispecialty) Coding Alert

## LESION CODING QUIZ ANSWERS :Check Out How You Fared in Our Lesion Coding Quiz

Determine whether you've got top-notch lesion coding skills -- or whether you need a refresher.

Last week we tested your lesion coding savvy -- now compare your answers with these from our experts.

Doctor Takes Narrow Margins

Question 1: Your surgeon performed a benign lesion removal, without taking wide margins because he expects it to be benign. However, the pathology comes back as a malignant lesion. The surgeon then has to go back and perform an additional excision within the global period of the first procedure. How should you code the first service and the subsequent service to your payer?

Answer 1: "Since it was unknown whether the lesion was malignant or not when the first procedure was performed, you would code that procedure out of the 114xx section, (Excision, benign lesion)," says **Andrea M. Noward,** billing coordinator in the department of surgery at the University of Toledo.

"Since the pathology report came back as malignant and the physician had to perform an additional excision, you would code that procedure from the 116xx section, (Excision, malignant lesion)."

Add modifier: "A re-excision of the area would require a 58 modifier (Staged or related procedure during the postoperative period) on the CPT code if it was done within the global period," says **Joseph Lamm,** office manager with Stark County Surgeons in Massillon, Ohio.

Note: CPT indicates that you should use only one code to report the additional excision and re-excision( s) required for complete tumor removal. "To me, that says that the additional excision and any further re-excisions should not be billed until pathology shows complete excision of the tumor," Lamm says. "I read it as the additional excision and reexcisions should be billed based on the width necessary from the original wound (i.e., not taking into account the lesion and margins from the initial excision)."

Know How to Measure Lesion

Question 2: The physician excises a benign lesion from a patient's scalp. The greatest clinical diameter of the lesion is 2.2 cm, and the procedure required margins of 0.3 cm on each side. Which codes should you bill?

Answer 2: "According to CPT, an excision is defined as full-thickness (through the dermis) removal of a lesion, including margins, and includes simple (non-layered) closure when performed," says **Sharon Stephenson, CCS,** with Richland Parish Hospital in Delhi, La. "The measurement of the lesion plus margin is made before the excision."

If the lesion is 2.2 cm and you add 0.6 centimeters for the margins, you would end up with 2.8 cm, resulting in the use of code 11423 (Excision, benign lesion including margins, except skin tag [unless listed elsewhere], scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm). "With a lesion of that size I would also add that you should check for any layered closure (intermediate or complex), which can be coded separately," Stephenson says.

Test Yourself With Op Note

Question 3: For the operative note provided in last week's Insider, you should report the following CPT codes:

• 11400 x 3 -- Excision, benign lesion... trunk, arms or legs; excised diameter 0.5 cm or less

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- 11401 x 10 -- ... 0.6 to 1.0 cm
- 11402 -- ...1.1 to 2.0 cm
- 11420 -- Excision, benign lesion...scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less
- 11441 -- Excision, other benign lesion...face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.6 to 1.0 cm.

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