# Part B Insider (Multispecialty) Coding Alert

## Malignant, Benign Lesions: All the Same to Medicare - New Codes for Home Cardiac Telemetry, ESRD Care

The 2003 CPT book changed the definitions for excision of benign lesions (11400-11446) and malignant lesions (11600-11646). Now, you report these codes based on the diameter of skin removed, not the size of the lesion. In response, Medicare will pay the same for lesion removal, whether benign or malignant, based on the size of the area removed and the body part.

For example, the work RVUs will be the same for 11402 (Excision, benign skin lesion, trunk, arm or legs with excised diameter 1.1 to 2.0 cm) as for 11602 (the same thing for a malignant lesion). This means a boost for benign and a cut for malignant lesion codes. For example, the 2004 work RVU will be 0.93 for both **CPT 11400** , which has a 2003 work RVU of 0.85, and 11600, which has a 2003 work RVU of 1.31.

In another major change, the Centers for Medicare & Medicaid Services is creating new G codes for home cardiac telemetry monitoring, a major technological advance. It's now possible to discharge patients with heart arrhythmias to the home setting and monitor them at home with similar equipment to hospital monitoring, CMS explains. You can determine, on a real-time basis, whether a patient is having arrhythmias or monitor ongoing arrhythmias by means of a home telemetry station connected to a monitoring station by phone.

Now, the carriers require the professional and technical components of this service to be billed under unlisted-procedure code 93799, but CMS is establishing four new codes, GXXX1-GXXX4. The first of these will have 0.52 physician work RVUs and 0.24 malpractice RVUs, roughly equivalent to existing monitoring code 93268. GXXX2 will have 0.07 malpractice RVUs, similar to 93270, and GXXX3 will have 0.15 malpractice RVUs, similar to 93271. GXXX4 will have 0.52 work RVUs and 0.02 malpractice RVUs, similar to 93272.

CMS said it would have to consider further how to cover the professional component of flow cytometry, in which markers are analyzed on a "panel" basis, not an individual basis. This means that the professional component of the current code, 88180, doesn't accurately reflect the practice of flow cytometry. CMS appealed to the laboratory community to consider whether the coding for the procedure should change. Otherwise, CMS may issue HCPCS codes for the procedure.

CMS also aims to improve the care for end-stage renal disease patients by creating new G codes that allow Medicare to coordinate dialysis payment with the frequency of physician visits. Now, Medicare pays a composite rate to physicians for oversight regardless of the patient's condition or the number of visits. CMS is replacing the monthly dialysis capitation codes (90918-90921) with new monthly codes, GXXX5-GXX16. Physicians will receive more for patients they see four or more times per month than for patients they see less often. These codes aren't billable in a month when the patient is hospitalized.