Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: 11640-11646 Demystified: Can You Conquer These Excision Coding Scenarios?

Referrals, unexpected findings, and multiple excisions -- check out these case studies to learn how the experts handle them.

Coding all services involved in a lesion removal can quickly lead you into "gray" areas, such as determining whether you should report a separate E/M service when performing minor excisions in the office.

Use these three case studies to understand how you should handle confusing lesion coding scenarios.

Case Study 1: Referral With Simple Excision

A family physician (FP) refers a patient to your dermatologist for excision of a "mole" on the patient's left cheek. The dermatologist suspects that the mole is a small basal cell carcinoma (which is later confirmed by pathology). She performs an excision to remove the lesion, which measures 0.9 cm with margins, in the office. She then closes the wound via simple repair and releases the patient.

How to code: In this case, you would probably report the excision alone (11641, Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 0.6 to 1.0 cm).

Because the referral was for specific removal, there is no billable E/M service, especially if the dermatologist can identify the lesion by simple exam.

The bottom line: All procedures include a minimal E/M, so unless the dermatologist can provide documentation for a significant, separately identifiable E/M service above and beyond that usually included in the excision, you are limited to reporting the excision only.

Case Study 2: Referral With Unexpected Findings

In the next instance, the FP refers the patient to the dermatologist for a skin lesion removal. This time, the dermatologist views the lesion as potentially more serious and not diagnosable by simple exam.

The dermatologist performs a thorough exam and biopsy to determine the nature of the lesion. The biopsy returns positive for malignancy, and the dermatologist schedules the patient for excision at a later date in the operating room.

How to code: First, you should report the biopsy (11100, Biopsy of skin, subcutaneous tissue and/or mucous membrane [including simple closure], unless otherwise listed; single lesion).

In this case, if the dermatologist documents a significant, separately identifiable E/M service, you can report an E/M code (for example, 99203, Office or other outpatient visit for the evaluation and management of a new patient ...). This was not a simple evaluation; the dermatologist had to spend considerable time with the patient.

Good advice: "Since this was a referral I would probably use a new patient code," says **Pamela Biffle, CPC, CPC-P, CPC-I, CCS-P, CHCC, CHCO,** owner of PB Healthcare Consulting and Education Inc. in Austin, Texas, "or include a statement that the patient had previously seen the dermatologist for an unrelated issue."

You should append modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) to the E/M code to distinguish the E/M service as significantly above that included with the biopsy.

On the later date of the excision, you will report the excision (e.g., 11644, ... excised diameter 3.1 to 4.0 cm), as well as any allowable wound repair (e.g., 12052, Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm).

Case Study 3: 1 Lesion, Multiple Excisions

The dermatologist suspects squamous cell carcinoma and excises the lesion in the office. The pathology report returns later showing positive margins -- meaning that the dermatologist did not remove all the malignancy and must excise additional tissue. The dermatologist schedules an additional excision for wider margins in the OR and takes a frozen section. This time the pathology report returns negative.

How to code: Report the initial excision (for example, 11642), as well as any allowable wound repair and E/M services (if appropriate) that the dermatologist provides in his office.

For the additional excision on a later day in the OR, report another excision code as appropriate to the size of the tissue removed (for example, 11643, ... excised diameter 2.1 to 3.0 cm), as well as any allowable wound repair.

If the re-excision took place during the initial procedure's (11642) global period (within 10 days of the initial procedure), you must append modifier 58 (Staged or related procedure or service by the same physician during the postoperative period) to the lesion excision code.

The dermatologist will want to excise all malignant tissue on the first try, but if he doesn't, he'll have to go back as many times as necessary to ensure he has provided adequate margins.

Diagnosis tip: If the dermatologist excises a malignant lesion and must re-excise the same lesion to ensure adequate margins, you should use the same diagnosis for the re-excision as you did for the initial excision, even if the pathology report for the re-excision returns negative for malignancy, according to AMA recommendations.