Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: 5 Steps To Find The Correct

Tip: Don't forget to report intermediate or complex closures separately

If you think knowing an excised lesion's location and size is enough to select the proper code, you're missing a few important steps.

If a lesion is malignant, you'll need to choose between an excision or destruction code. And remember that CPT doesn't bundle all lesion biopsies and closures with the excision code - you can and should report some separately.

Follow these 5 steps to report the correct excision code every time:

1. Confirm the physician performed a lesion excision.

CPT lists codes for removal of skin tags (11200-11201) and shaving of epidermal or dermal lesions (11300-11313). You may find it hard to choose between the shaving and excision codes because they are both for lesion removal, but there is a clear difference between the two.

Distinction: Shaving involves the removal of skin lesions "without a full-thickness dermal excision," according to CPT. In contrast, CPT defines an excision as "full-thickness (through the dermis) removal of a lesion, including margins." That means lesion excision is a more extensive procedure than lesion shaving.

In addition, CPT lists separate codes for destruction of benign lesions (17000-17250) and malignant lesions (17260-17286). Destruction codes include any method of lesion removal other than excision, says **Linda Martien, CPC, CPC-H,** coding consultant with **National Healthcare Review Inc.** in Woodland Hills, CA. For example, laser surgery, electrosurgery, cryosurgery, chemosurgery, and surgical curettement are all methods of lesion destruction.

2. Determine if the lesion is benign or malignant.

There are separate sets of codes for excision of benign lesions (11400-11471) and excision of malignant lesions (11600-11646). If you are unsure of a lesion's status, ask the physician.

3. Identify lesion location.

CPT categorizes lesion excision codes first by lesion location, and then by lesion size. For excision of benign and malignant lesions you must choose from the following basic location groupings:

1. trunk, arms or legs;
2. scalp, neck, hands, feet, genitalia; or
3. face, ears, eyelids, nose, lips.

4. Select lesion size.

CPT lists excision codes for the following excised diameters:

4. 0.5 cm or less,

5. 0.6 to 1.0 cm,
6. 1.1 to 2.0 cm,
7. 2.1 to 3.0 cm,
8. 3.1 to 4.0 cm, and
9. over 4.0 cm.

When a physician excises a lesion, he also removes a margin of skin surrounding the lesion to make sure all the abnormal cells are gone, Martien explains. You need to calculate the total excised diameter of a lesion by adding the size of the lesion and the size of the margins.

Example: Your physician excises a 1 cm benign lesion on a patient's leg and documents a margin of 0.5 cm. Because the margin is on both sides of the lesion, the total length of the margin is 1 cm. You would therefore calculate a 2 cm excised diameter (1 cm lesion + 1 cm total margins) and report 11402 (Excision, benign lesion including margins, except skin tag [unless listed elsewhere], trunk, arms or legs; excised diameter 1.1 to 2.0 cm) for the excision.

No documented measurements? If your physician doesn't specify the size of the lesion or the margins he excised, you have no choice but to report the smallest measurement code available, which is only 0.5 cm or less, Martien says. The removed lesion may have been much larger than that, so "if your doctor isn't specific in his documentation, he's really hurting himself reimbursement-wise," she adds.

Using the pathology report is a no-no: If the physician didn't document the lesion size in his notes, many coders will check the pathology report to obtain the excision diameter. But the pathologist's measurements could be smaller than the physician's measurements because preserved specimens tend to shrink, Martien says. "I would not use the path report at all - the physician documentation must state the lesion size," she warns.

5. Remember to report intermediate and complex closures separately.

Excision of a skin lesion often causes some defect(s) requiring closure. All lesion excision codes include simple closure, but if the physician performs an intermediate closure (12031-12057) or complex closure (13100-13153) you should report the appropriate repair code separately.

Don't get confused: Many coders get confused because CPT instructs you to report each lesion excision separately, but to report all closures with one code by adding the lengths of all the repairs, Martien says. Remember that you must report a separate excision code for each excised lesion, but only one code for all the closures performed on a group of anatomic sites (for instance, one code for the sum of all repairs on the face, ears, eyelids, nose, lips and/or mucous membranes).

Example: If your physician excises three benign lesions - each with a 2 cm excised diameter - on a patient's hand, you would report 11422 (Excision, benign lesion including margins, except skin tags [unless listed elsewhere], scalp, neck, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm) three times.

If each excised lesion creates the need for an intermediate closure, you would add up the length of the three repairs (2 cm + 2 cm + 2 cm) and report 12042 (Layer closure of wounds of neck, hands, feet and/or external genitalia; 2.6 to 7.5 cm) for the total 6 cm of closures.

Biopsies Can Be Separate, Too

All lesion excision codes include skin biopsy because obtaining some removed tissue for pathologic examination is part of the routine procedure. However, your physician may decide to excise one lesion, but also perform a biopsy on another, separate lesion during the same visit. If this happens, CPT instructs you to report the biopsy code (11100) separately.

Use modifier -59: To get paid for both procedures, you will need to append a modifier -59 (Distinct procedural service) to the biopsy code. The insurance company won't know you are reporting procedures on two separate lesions unless you tell them with a -59, says **Lisa Center, CPC**, quality coordinator with **Freeman Health System** in Joplin, Mo.

Example: Suppose your physician excises a malignant lesion with a 0.5 cm excised diameter on a patient's face, and also performs a biopsy of a lesion on the patient's arm. "You always want to sequence your codes with the most complex procedure first," Martien says. And modifier -59 should always go on the second code and other subsequent codes you report, she adds.

So for this example, you would first report 11640 (Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 0.5 cm or less) and then report 11100 (Biopsy of skin, subcutaneous tissue and/or mucous membrane [including simple closure], unless otherwise listed; single lesion) with a -59 modifier.