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Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Don't Miss How Closures and Grafts Can Change Your Lesion Coding

Tip: You'll still start with lesion size plus margins.

Lesion excisions might be commonplace for your physician, but that doesn't mean your coding is always cut-and-dried. A coder submitted the following scenario to Codify􏰀use her situation as a way to ensure your own excision claims are on track.

Question: How do we code for multiple skin excisions in the office when frozen sections are done until all margins are clear of cancer? Sometimes it can involve as many as six separate excisions.

The simple answer: When coding for skin excisions, you bill based on the largest final margin size (lesion size plus the margins). Each final lesion excision is separately coded and billed. If the physician completes multiple final lesion excisions of the same size in the same grouping that is covered by the same code, you should bill with either multiple units or by appending modifier 59 (Distinct procedural service) to each of the lesion codes after the first to indicate separate sites.

The correct billing method is determined by how each payer will process the multiple lesion excisions. For example, simple closures are included in lesion excisions. If you're reporting intermediate or complex closures, you add together those of the same type (i.e., all intermediate or all complex closures) that have been performed in the same body area and grouped in the same code set. The total will determine the lesion length and lead you to the correct code.

Caveat: If, however, the physician completes an adjacent tissue transfer, flap, or graft, you do not bill both the excision and closure. Site preparation is included in adjacent tissue transfers, flaps, and grafts. You report the closure but not the lesion excision.

Remember that all excisions and closures aren't simple. Sometimes you can code for more extensive services.

Watch for More Involved Closures

"You can code intermediate layer closures as well as complex closures with lesion excisions, not just adjacent tissue transfers, flaps or grafts," says **Barbara J. Cobuzzi, MBA, CENTC, COC, CPC-P, CPC-I, CPCO,** Vice President of Coding and Consulting at J&S Stark Billing and Consulting, Inc**.**, in Shrewsbury, N.J. "Many times, the closure has a higher RVU than the lesion excision. If you're not paying attention to that, you're missing great opportunity."

Example: A physician may remove a 0.5 cm lesion on the neck and send it for frozen section and it comes back that the margins are still malignant. The physician than excises the margins, expanding the widest margins to 2.7 cm and sends it for frozen section. The margins come back malignant again and the widest margins are expanded to 3.1 cm. That sample was sent for frozen section and it came back as clear.

Code it: Although the physician performed three excisions, because it was a skin lesion, you report the lesion excision only as the largest margin excision, the 3.1 cm. Code 11624 (Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 3.1 to 4.0 cm) applies to the excision of this lesion. Since the lesion excision on the neck was so large, the physician performed a layered cosmetic closure.

Remember: Only simple closures are bundled with lesion excisions. As a result, the layered closure is separately coded and billed. The shape of the lesion excision requires a closure which was 4.3 cm long according to the operative note. You should report the intermediate closure with 12042 (Repair, intermediate, wounds of neck, hands, feet and/or

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external genitalia; 2.6 cm to 7.5 cm). Code 11624 has 9.57 Non-facility RVUs (office) and 12042 has 8.14 Non-facility RVUs (office). Your final coding for the procedure should be:

- 11624
- 12042-51 (Multiple procedures).

Don't Code Too Much for Tissue Grafts

When you file a claim for adjacent transfer tissue transfer (140xx), the work of the lesion excision is included in the graft.

Example: If the defect from the malignant lesion removal could not be closed as a straight closure and an adjacent tissue transfer was required for a good plastic closure, do not code the initial creation of the defect (the removal of the malignant lesion) separately. Only code the defect, no matter how many "flaps" are needed. The physician completed an adjacent tissue transfer closure for a defect sized 4.5 cm x 2 cm, which means the defect size is 9 cm.

Code it: The correct code based on the flap size will be 14040 (Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less).

Remember: Even if the surgeon had to use two or three adjacent tissue transfers (flaps) from different directions, only the 9 cm defect side would be coded and only 14040 would apply, not three times 14040 because adjacent tissue transfers are coded based on the defect.

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