Outpatient Facility Coding Alert

Skin Care: Know What to Look for to Peel off the Ambiguity of Skin Coding

Look into the elements of skin procedures before coding.

Although there have been no recent changes in dermatology codes, it can still be difficult to choose the right code because of the many factors involved. While coding skin procedure codes you need to take into account the size, the type of removal, location of the lesion, pathologic results and your provider's intent.

Distinguish Between Biopsy, Shave, and Excision

You first need to know the distinct difference between shave, biopsy and excision. A careful review of the word shave simply states, "removal." That means the lesion was removed by shaving. A biopsy is when only a portion of a lesion, tissue, or skin is removed in order to obtain a diagnosis. Taking a portion of a lesion is not removing it.

Make sure that your operative note is consistent with what you charge. Don't use terms such as a "shave biopsy removal" or "incisional biopsy" when you are actually doing a shave removal. A biopsy is a biopsy and a shave removal is just that, a shave removal.

By definition, an excision should extend through the full thickness of dermis to the level of the subcutaneous tissue. Regardless of the fact that the pathologist used words, "completely excised," a shave that remains within the dermis cannot be reported as an excision.

When coding for dermatitis conditions (such as suspected psoriasis or contact dermatitis), remember to categorize the specimens you collect for lab tests as biopsies even if the sampled lesions are entirely removed using a shave technique. Never forget to list your suspected diagnosis in your clinical notes. However, you should bill using diagnosis code 709.9 (Unspecified disorder of skin and subcutaneous tissue) for unspecified disorder of skin and subcutaneous tissue. If you use the code for psoriasis, for example, the payer may deny the claim, as they might ask why you did a biopsy if you already knew the diagnosis.

If your physician removes and "cures" a symptomatic seborrheic keratosis via a shave technique, you can appropriately bill the procedure as a shave. Nonetheless, if you cannot determine whether a lesion is a seborrheic keratosis or a melanoma and you do a full thickness excision because of concern about melanoma, you can bill for excision. But it is inappropriate to excise seborrheic keratoses when you are certain of the diagnosis. It is often appropriate to remove them because of symptoms, but only via the shave technique.

Remember this bit of useful information for billing shaving and biopsy claims:

- There are only two biopsy codes versus 12 shave removal codes.
- If the lesion (e.g., nevi, seborrheic keratosis, and warts) is larger than 0.5 cm/d, then reimbursement is greater in seven (11302, 11303, 11307, 11308, 11311, 11312 and 11313) out of the 12 codes versus the two biopsy codes.

Seize the Size for Rightful Claims

Excision is full-thickness lesion removal through the dermis. The excision codes are divided by size, which is determined by the diameter of the lesion plus the size of the margin required for a complete excision. For example, for the excision of a benign lesion of the trunk, arms, or legs, the following options are available:

- 11400, Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs;

excised diameter 0.5 cm or less

- 11401, ... excised diameter 0.6 to 1.0 cm
- 11402, ... excised diameter 1.1 to 2.0 cm
- 11403, ... excised diameter 2.1 to 3.0 cm
- 11404, ... excised diameter 3.1 to 4.0 cm
- 11406, ... excised diameter over 4.0 cm.

Report Repair by Categorizing

CPT(R) codes for wound repair, or closure, are first separated into categories for simple, intermediate, and complex procedures.

A simple repair (12001-12021) involves only the skin, and simple repair is included with excisions. This is typically a one-layer closure, so it should be a fairly superficial wound that might involve the epidermis or dermis or superficial subcutaneous skin. Local anesthesia is included in the codes and can be used for electric or chemical cautery of wounds that are not closed, but sealed. If the physician only uses an adhesive to close a wound, it would be included in the appropriate E/M level code.

An intermediate repair (12031-12057) involves one or more deeper layers of subcutaneous tissue and superficial fascia, in additional to the epidermal and dermal closure.

When a wound repair procedure involves one or more layers of tissue as well as extra work, like debriding a heavily contaminated wound or conservative revision of heavily traumatized edges, coders will report a code for complex repair (13100-13160). These codes do not include excision of lesions, either benign or malignant, nor excisional preparation of the wound bed.

Repair codes are further categorized by the anatomical site and the size of the repair. For simple repairs, the anatomical sites are separated by:

- Scalp, neck, axillae, external genitalia, trunk, and/or extremities (including hands and feet)
- Face, ears, eyelids, nose, lips, and/or mucous membranes.

For intermediate repairs, codes are separated by:

- Scalp, axillae, trunk, and/or extremities (excluding hands or feet)
- Neck, hands, feet, and/or external genitalia
- Face, ears, eyelids, nose, lips, and/or mucous membranes.

For complex repairs, the sites are:

- Scalp, arms, and/or legs
- Forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet
- Trunk
- Eyelids, nose, ears, and/or lips.

For multiple wounds during a single encounter, coders should add the size of the wounds in the same categorization (e.g., simple, intermediate, complex) and the same anatomical groups together and report the code(s) that represent the total length of the closure.

For example, a physician performs a simple repair of a 0.8 cm superficial wound of the left ear and of 1.1 cm of the nose. The coder should report 12011 (Simple repair of superficial wounds of face, ears, eyelids, nose, lips, and/or mucous membranes; 2.5 cm or less).

If the physician repairs wounds at different levels or in anatomic groups, coders should report the codes separately, adding modifier -59 (Distinct procedural service). While coders may think to append modifier -51 (Multiple procedures), you cannot report this in a hospital outpatient setting. Review your Local Coverage Determinations (LCDs) and other payer-specific information for instructions on modifier use and other rules regarding all wound care procedures.

The maximum reportable length for simple and intermediate repairs is "over 30 cm," but add-on codes are included for complex repair procedures. Coders should report those for each additional 5 cm greater than 7.5 cm.

For example, a physician performs a complicated wound closure of the scalp measuring 9.3 cm. Coders would report 13121 (Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm) and add-on code 13122 (... each additional 5 cm or less [List separately in addition to code for primary procedure]).

Pay attention: Coders should also note that in 2014, the AMA deleted code 13150 (Repair, complex, eyelids, nose, ears, and/or lips; 1 cm or less) to align those anatomical sites with the others for complex repair that begin at 1.1 cm.

Skin replacement procedures include the surgical preparation as well as the placement of autografts, which use the skin from the same patient, or skin substitutes.

The surgical preparation codes report the initial services for preparing a clean and viable wound surface for placement of a graft, flap, skin substitute, or negative pressure wound therapy.

This may include release of a scar contracture, or band. The CPT(R) Manual includes base codes for different anatomical groups, such as:

15002 (Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar [including subcutaneous tissues], or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children) for the trunk, arms, or legs

15004 (Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar [including subcutaneous tissues], or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or 1% of body area of infants and children) for the face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits.

These codes are reported for the first 100 sq cm of the surface area, with associated add-on codes for each additional 100 sq cm. These sizes are based on the total surface area of the wound created. Coders can add multiple wounds in the same anatomic group together.

Takeaway point: Focusing on the different elements of skin related procedures and following a diplomatic approach to choosing the right codes will help to generate a faster and more accurate claim.