Codify
BY AAPC

Outpatient Facility Coding Alert

You Be the Coder: Learn the Strategy for Coding Skin Lesion

Question: Mr. Johns was referred by the family physician to one of our physicians for a skin lesion removal from the forehead. The physician viewed the lesion as potentially more serious and not diagnosable by simple exam. So he performed a thorough exam and biopsy to determine the nature of the lesion. The biopsy result was positive for malignancy and the excision was rescheduled at a later date in the operating room. How do I code?

Kentucky Subscriber

Answer: You should report the biopsy with the code 11100 (Biopsy of skin, subcutaneous tissue and/or mucous membrane [including simple closure], unless otherwise listed; single lesion). Your diagnosis according to ICD-9 is 709.9 (Unspecified disorder of skin and subcutaneous tissue). When your diagnosis system changes to ICD-10, you'll report L98.9 (Disorder of the skin and subcutaneous tissue, unspecified) instead.

In this case, if the physician documents a significant, separately identifiable E/M service, you can report an E/M code (for example, 99213, Office or other outpatient visit for the evaluation and management of an established patient ...). You should append modifier 25 (Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional 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 (for instance, 11644, ... excised diameter 3.1 to 4.0 cm), as well as any allowable wound repair (such as 12052, Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 to 5.0 cm). Had the closure involved only a simple closure, you would not have reported the closure, as payers consider simple closures inclusive to lesion excisions.

Had the wound closure involved a "flap" which, in reality, was an adjacent tissue transfer, you would report 14040 (Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less) or 14041 (Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10.1 sq cm to 30.0 sq cm). The lesion removal would not have been coded nor charged. Instructions before the adjacent tissue transfer section in CPT® indicates that lesion removal is considered site preparation and is therefore considered incidental to the adjacent tissue removal.