#### The Skin You're In

Written and Presented by Susan Ward, CPC, CPC-H, CPC-I, CEMC, CPCD, CPRC



1

#### Disclaimer

- The information you are receiving today is based on the experience and knowledge of the presenter. Opinions may vary regarding scenarios presented. This presentation is for educational and informational purposes only.
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#### Additional Disclaimer

 The content in this presentation is at times graphic. Please know that I will try to warn those of you that have weak stomachs when those particular slides are going to been shown.



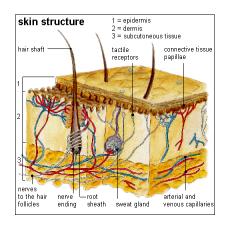
3

#### We Will Discuss ...

- Anatomy of the skin
- Biopsies
- Coding Lesions Malignant vs. Benign
- Coding Repairs
- Flaps & Grafts
- Mohs Micrographic Surgery
- Modifiers
- Diagnostic Coding Issues



## Anatomy of the Skin





5

## Diagnosis

- Neoplasms
  - Abnormal growth not necessarily cancerous
  - Check your Neoplasm table
  - Remember that a mass is not a neoplasm



#### Neoplasms

- Benign Non-Cancerous (216.x)
- Malignant Cancerous (173.x)
- Melanoma Cancerous (172.x)
- Ca in Situ Self Contained (232.x)
- Uncertain Behavior Could go either direction (238.2)
- Unspecified Unknown status (239.2)



7

#### Neoplasm of Uncertain Behavior (238.2) vs Neoplasm of Unspecified Nature (239.2)

We have received numerous comments questioning our instruction to use ICD-9 239.2 Neoplasm of unspecified nature, bone, soft tissue and skin, rather than the apparently preferred 238.2 Neoplasm of uncertain behavior of other and unspecified sites and tissues, skin. This issue has been discussed at length over the period of time the policy and subsequent drafts have been published. Given that the entire ICD-9 235-238.9 achieve their diagnoses <a href="mailto:based on histologic examination">based on histologic examination</a>, these codes are not to be used for lesions removed for a *concern* of *possible* malignancy, but rather only once a pathologic examination has been completed which has this diagnosis as its conclusion. Therefore - especially since the literature clearly supports the notion that a definitively-diagnosed malignant melanoma should not be the subject of a shave biopsy - we choose to retain the current LCD language: "While it is recognized that some diagnoses resulting from a shave biopsy will at times be melanoma, the diagnosis at the time the procedure was performed would most likely be 239.2, Neoplasm of unspecified nature; Bone, soft tissue, and skin, and this would be the appropriate code."

Noridian Medicare <a href="https://www.noridianmedicare.com">www.noridianmedicare.com</a>
LCD policy <a href="https://www.cms.gov/mcd/results.asp?show=all&t=20109115340">https://www.cms.gov/mcd/results.asp?show=all&t=20109115340</a>



## Biopsy

- Per CPT® published by the AMA, code:
  - 11100 for your first lesion
  - +11101 of each additional
  - Biopsy of eyelid is 67810
  - Biopsy of external ear is 69100
    - All codes include a simple closure

Photographs to follow



9

This Patient has a history of Basal Cell Carcinoma and has a suspicious lesion on her left cheek.



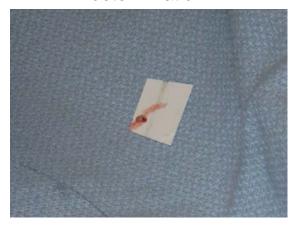
After being prepped and cleaned with Betadine, the surgeon proceeds with a punch biopsy of the lesion.





11

## The excised lesion is sent to pathology for determination.





The excision site is then closed and the patient will return in a week for suture removal and to review the pathology report.



13

## Coding Lesion Excision

- Skin Tags
  - 11200 up to and including 15 lesions
  - -+11201 each additional 10 lesions
- Shaving Lesions
  - -11300 11313
    - Please note size and location determine code selection
    - This does not require suture closure



## Coding Lesion Excision

- Measuring and Coding of Lesion Removal
  - Per CPT® Excision is defined as full thickness removal of a lesion, including margins.
  - Code selection is based on measuring the greatest clinical diameter of the lesion plus the narrowest margins required for complete excision.

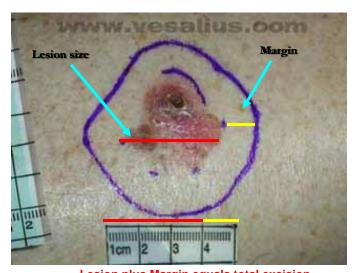
Photograph to follow



15







Lesion plus Margin equals total excision
Lesion with margins is measured prior to lesion being removed

## Coding Lesion Excision

- Benign or Malignant (11400 11646)
  - Code selection is based on:
    - Diagnosis (Pathology)
    - Location
    - Excised size with narrow margins



## Benign Lesions

- 11400 11406
  - Trunk, arms, or legs
- 11420 11426
  - Scalp, neck, hands, feet, or genitalia
- 11440 11446
  - Face, ears, eyelids, nose, lips, or mucous membrane



19

## Malignant Lesions

- 11600 11606
  - Trunk, arms, or legs
- 11620 11626
  - Scalp, neck, hands, feet, or genitalia
- 11640 11646
  - Face, ears, eyelids, nose, or lips



## Repairs

- Repair (Closures)
  - Simple (12001 12021)
    - Superficial, epidermis or dermis
  - Intermediate (12031 12057)
    - Layered, deeper layers of sub-q tissue
  - Complex (13100 13160)
    - Scar revision, debridement, undermining

**CPT**<sup>®</sup> describes Repairs as follows:



21

## Simple Repair

- Used when the wound is superficial.
   Typically involves the epidermis or dermis without significant involvement of the deeper structure of the skin.
  - A ONE layer closure



#### Intermediate Repair

- Includes the repair of wounds, that, in addition to what is described in a Simple Repair, require layered closure of one or more of the deeper layers of subcutaneous tissue and superficial (non-muscle) fascia, in addition to the skin closure.
- Single layer closure of heavily contaminated wounds that have required extensive cleaning or removal of particulate matter also constitutes the use of Intermediate Repair codes.



23

## Complex Repair

- Includes the repair of wounds requiring more than layered closure, such as scar revision, debridement, extensive undermining, stents or retention sutures. Necessary preparation includes creation of a defect for repairs or the debridement of complicated lacerations or avulsions.
- Remember: Complex Repairs do NOT include the excision of benign or malignant lesions.



**OPERATIVE PROCEDURE:** Excision BCC chest with excised diameter of

1.4cm and complex repair of 2.1cm wound.

ANESTHESIA: 1% Lidocaine with epinephrine

COMPLICATIONS: None

**INDICATIONS FOR SURGERY:** The patient has a Basal Cell Carcinoma of the chest . The area of the mass was marked and then I marked my planned excision and the best guess at the resulting scar was drawn. The patient observed these marks in a mirror to understand the surgery and agree on the location and I proceeded.

**PROCEDURE:** The area was infiltrated with local anesthetic. It was prepped and draped in sterile fashion. The chest lesion was excised as drawn, into the subcutaneous fat. Meticulous hemostasis was achieved using light pressure. Dog ears were excised from the wound along with undermining to optimize wound closure; the wound was closed in layers using 3.0 Monocryl, 4.0 Monocryl, and 5.0 Prolene. The patient tolerated the procedure well.

Code this scenario!



25

## Flaps & Grafts

- Flaps (14000 14350)
  - Also known as Z-plasty, W-plasty, Rotation Flap
  - Measured in square cm
    - 14300 was deleted in 2010
      - 14301 any area defect 30.1 sq cm to 60.0 sq cm
      - +14302 each additional 30.0 sq cm or part thereof
- Grafts (15040-15431)
  - Split Thickness or Full Thickness
  - Allograft or Xenograft



#### Adjacent Tissue Transfer

As described per CPT®; excision (including lesion) and/or repair by adjacent tissue transfer or rearrangement.

Skin graft necessary to close secondary defect is considered an additional procedure. The primary defect resulting from the excision and the secondary defect resulting from flap design to perform the reconstruction are measured together to determine code selection.



27

#### Code This....

**PROCEDURE:** The area was infiltrated with local anesthetic. It was prepped and draped in sterile fashion. The back lesion was excised as drawn, into the subcutaneous fat. Suture was used to mark the specimen at its superior and lateral tip, and this was labeled 12 o'clock. Meticulous hemostasis was achieved using light pressure. The planned rhomboid flap was incised as drawn. It was then elevated with the full-thickness and subcutaneous fat. The flap was then rotated into the defect and the donor site was closed. The 2.8 cm² rhomboid flap was inset in layers using 3.0 Monocryl, 4.0 Monocryl, and 5.0 Prolene. The patient tolerated the procedure well.



#### **Grafts**

- STSG Split Thickness Skin Grafts (Autograft)
- FTSG Full Thickness Skin Grafts (Autograft)
- Allograft (Donor Graft)
- Xenograft (Porcine Graft)



29

## Surgical Prep

- Codes came into play in 2007 for Surgical Prep
  - 15002 Per 100 sq cm or 1% of body area of infants for trunk, arms and legs
    - +15003 Each additional 100 sq cm
  - 15004 Per 100 sq cm or 1% of body area of infants for face scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits
    - +15005 Each additional 100 sq cm



# Split Thickness & Full Thickness Skin Grafts

- Code range for STSG
  - 15100 (Trunk, arms and legs)
  - 15120 (Face, scalp, eyelids, mouth, neck, ears, orbits genitalia, hands, feet and/or multiple digits)
- Code range for FTSG
  - 15200 (Trunk)
  - 15220 (Scalp, arms and legs)
  - 15240 (Forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and feet)
  - 15260 (Nose, ears, eyelids and lips)



31

#### Remember Our Patient

A full thickness excision of skin and subcutaneous fat down to fascia was performed.

Graphic photograph to follow





The defect was partially closed by undermining and placing subcutaneous sutures.







A split thickness graft was used to cover the remaining defect. The dermatome is shown set for a thin (15/1000 in) graft.





A Dermatome is used for a autograft.

The thigh donor site is shown. The donor site is temporarily covered with a epinephrine-soaked gauze and then with an occlusive, non-adherent occlusive sheet.





The graft was meshed at a 2:1 ratio to allow drainage of serum and blood, but was not expanded when placed.







The graft now in place was sutured with the tails left long to tie over a bolster.



43



The bolster was tied in place to prevent graft movement and fluid (blood, serum) collection beneath the graft. The bolster was removed at 7 days, and there was a complete take. The final pathology showed the lesion to be 0.70 mm in greatest depth.

Surgeon: Janette Alexander



45



## Allograft

 Application of a non-autologous human skin graft from a donor to a part of the patient's body.



47

## Xenograft

 Application of a non-human skin graft or biologic wound dressing (pigskin or porcine tissue) to a part of the patient's body.



#### **Destruction**

# Destruction, Benign or Pre-malignant Lesions

- Destruction by laser surgery, electrosurgery, cryosurgery, chemosurgery or surgical curettement
- 17000 First lesion (Actinic Keratoses)
- +17003 Second through 14th lesion; each
- 17004 15 or more lesions
- 17106 17108 Cutaneous vascular proliferation
- 17110 Up to 14 lesions (Not Skin Tags) (Warts)
- 17111 15 or more lesions



49

#### **Destruction**

#### Destruction, Malignant Lesions, Any Method

- Destruction, malignant lesion, (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement)
- 17260 17266 Trunk, arms or legs
- 17270 17276 Scalp, neck, hands, feet or genitalia
- 17280 17286 Face, ears, eyelids, nose, lips or mucous membrane



#### Mohs Procedures

 As defined by CPT® Mohs micrographic surgery is a technique for the removal of complex or illdefined skin cancer with histologic examination of 100% of the surgical margins. It requires a single physician to act in two integrated but separate and distinct capacities: Surgeon and Pathologist.



51

#### Mohs Procedures

- The surgeon removes the tumor tissue and maps and divides the tumor specimen into pieces. Each piece is embedded into an individual tissue block for histopathologic examination.
- Coders must have a good understanding of the difference between "stage" and "tissue block."
  - Stage refers to the removal of a layer of tissue
  - The "stage" is then divided into "tissue blocks"



