The Skin You’re In

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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 be shown.

We Will Discuss …

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

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 based on histologic examination, 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.”
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

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.

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.

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
Lesion size
Margin

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

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® describes Repairs as follows:

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.

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.

**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.

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)

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)

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.
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
Allograft

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

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

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 ill-defined 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.

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”
Stage and Tissue Blocks

Stage

- 1st Block
- 2nd Block
- 3rd Block
- 4th Block
- 5th Block
- 6th Block

Step 1: The roots of a skin cancer may extend beyond the visible portion of the lesion. If these roots are not removed, the cancer will recur.

Step 2: The visible portion of the tumor is surgically removed.

Step 3: A layer of skin is then removed and divided into sections. The Mohs surgeon will then examine these sections with dyes and markers under a microscope to see if the tumor is in the sections. A map of the surgical site is then drawn.

Step 4: The undermined and adjacent skin areas are then microscopically examined for evidence of remaining cancer.

Step 5: If cancer cells are found under the microscope, the surgeon marks this location onto the "map" and returns to the patient to remove another layer of skin—just like a puzzle, where the cancer cells remain.

Step 6: The removal process stops when there is no longer any evidence of cancer remaining in the surgical site. Because Mohs surgery removes only tissue containing cancer, it ensures that the healthy tissue is kept intact.
Questions???

Thank you!!

Your CEU code is …