Know Your Lesions

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Agenda

- Skin Anatomy
- Diagnosis
- Excision of Lesions
- Repairs

Anatomy
Diagnosis

• Skin cancer is the most common form of cancer in the United States

• More than a million new cases are reported each year

• Incidence is rising faster than any other type of cancer

Diagnosis

• While skin cancers can be found on any part of the body most (about 80%) appear on the face, head, or neck

• The primary cause of skin cancer is ultraviolet radiation - most often from the sun

• Also from artificial sources like sunlamps and tanning booths
Discovery and Diagnosis

Skin Cancer Risk Factors

- Skin is fair and freckles easily
- Light-colored hair and eyes
- Large number of moles, or moles of unusual size or shape.
- Family history of skin cancer or a personal history of blistering sunburn.
- Lot of time working/playing outdoors.
- Live closer to the equator, at a higher altitude, or in any place that gets intense, year-round sunshine.

Diagnosis

BCC

- Basal cell carcinoma is the most common form of skin cancer, affecting 800,000 Americans each year
- The most common of all cancers
- 1 out of every 3 new cancers is a skin cancer
- Most are basal cell carcinomas (BCC)
- These cancers arise in the basal cells, which are at the bottom of the epidermis (outer skin layer)
- More common in men, although more women are getting BCCs than in the past
Diagnosis

SCC

- Squamous cell carcinoma (SCC), the second most common skin cancer after basal cell carcinoma
- Afflicts more than 200,000 Americans each year
- Arises from the epidermis and resembles the squamous cells that comprise most of the upper layers of skin
- SCCs may occur on all areas of the body but are most common in areas exposed to the sun.

Diagnosis

- SCCs usually remain confined to the epidermis for some time
- Will eventually penetrate the underlying tissues if not treated
- Can be disfiguring
- In a small percentage of cases, they spread (metastasize) to distant tissues and organs and can become fatal
- SCCs that metastasize most often arise on sites of chronic inflammatory skin conditions or on the mucous membranes or lips.
**Diagnosis**

**Melanoma**

- Most serious form of skin cancer
- If diagnosed and removed while it is still thin and limited to the outermost skin layer, it is almost 100% curable
- Once the cancer advances and metastasizes (spreads) to other parts of the body, it is hard to treat and can be deadly
- Number of cases of melanoma has increased more rapidly than that of any other cancer over the past 10 years
- Over 51,000 new cases are reported to the American Cancer Society each year

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**Method of Removal**

**CPT Definitions**

Biopsy (11100-11101) - obtaining of tissue for pathologic examination

Destruction (17000-17004, 17110-17111, 17260-17286) – ablation of benign, premalignant or malignant tissues by any method, with or without curettment, including local anesthesia, and not usually requiring closure
Punch Biopsy
In this photograph the patient is having a biopsy done on the cheek. The surgeon is using a punch tool to obtain the sample for diagnostic evaluation.

Biopsy
This is what the sample of the skin looks like after it has been removed from the biopsy tool.
Method of Removal

CPT® Definitions

Shave (11300-11313) – Removal by transverse incision or horizontal slicing to remove epidermal and dermal lesions without a full-thickness dermal excision

Excision (11400-11646) - Full-thickness (through the dermis) removal of lesion, including margins, and includes simple (non-layered) closure when performed

Excision of Lesions

Coding Lesion Excisions (11400-11646)

• Benign vs. Malignant
• Anatomic Site
• Size
• Type of Closure
Benign/Malignant

- **Benign Excisions**
  - 11400-11446

- **Malignant Excisions**
  - 11600-11646

Anatomic Site

**Codes are further broken down by anatomic group**

- xxx00 – xxx06 – Trunk, Arms or Legs
- xxx20 – xxx26 – Scalp, Neck, Hands, Feet, Genitalia
- xxx40 – xxx46 – Face, Ears, Eyelids, Nose, Lips, Mucous Membrane

**Codes are then divided by excised diameter**
  - Must be specific
Lesion with margins is measured prior to lesion being removed.

Lesion plus Margin equals total excision

Excision of Lesions

Excised Diameter = longest part of the lesion plus the most narrow margin necessary for excision.

Example: excision, malignant lesion of the nose, 0.9 cm with skin margins of 0.6 cm. Code 11642.
Example: excision, malignant lesion of the back, 1.0 cm. Code 11606

- Margin (2.0 cm)
- Excised diameter (lesion plus margins): 
  - 1.0 cm + 4.0 cm = 5.0 cm

- 1.0 cm melanoma

Example: excision of benign lesion of neck, 1.0 cm x 2.0 cm. Code 11423

- Margin (0.2 cm)
- Excised diameter (lesion plus margins): 
  - 2.0 cm + 0.4 cm = 2.4 cm

- 2.0 cm x 1.0 cm benign lesion
Template Example

Location: 1) __________________ 2) __________________

1. Size of lesion 1 at greatest diameter: ___________ cm
2. Size of most narrow margin necessary: ___________ cm
3. Size of total margin taken: ___________ cm
4. Excised Diameter (add 1 + 2 above) ___________ cm

Pathology (circle one): Benign | Malignant Pathology

Closure (circle one): Simple | Intermediate | Complex | Other

• If closure is simple, it is bundled into the lesion excision and not separately reportable. If other than simple, repair should be reported separately.

Reminders

• Specific number
• Each documented separately
• Specific size (lesion and necessary margin)
• Specific site
• Repair type
Repair

- The type of closure is important with excision of lesions as simple closures are bundled into the excision codes per CPT® guidelines.
- Intermediate and complex closures are separately reportable.
- When an excision and closure are separately reported, modifier 51 may be necessary when reporting (payer issue).

Repair
(12001-13160)

CPT® recognizes three types of repair:

- **Simple repair** is used when the wound is superficial; e.g., involving primarily epidermis or dermis, or subcutaneous tissues without significant involvement of deeper structures, and requires simple one layer closure. This includes local anesthesia and chemical or electrocauterization of wounds not closed.
Repair
(12001-13160)

- **Intermediate repair** includes the repair of wounds that, in addition to the above, require layered closure of one or more of the deeper layers of subcutaneous tissue and superficial (non-muscle) fascia, in addition to the skin (epidermal and dermal) closure. *Single-layer closure of heavily contaminated wounds that have required extensive cleaning or removal of particulate matter also constitutes intermediate repair.*

Repair
(12001-13160)

- **Complex repair** includes the repair of wounds requiring more than layered closure, viz., scar revision, debridement, (e.g., traumatic lacerations or avulsions), extensive undermining, stents or retention sutures. Necessary preparation includes creation of a defect for repairs (e.g., excision of a scar requiring a complex repair) or the debridement of complicated lacerations or avulsions.
Type of Repair

- CPT® defines a wound closure as a closure “utilizing sutures, staples, or tissue adhesives (e.g., 2-cyanoacrylate), either singly or in combination with each other, or in combination with adhesive strips.

- If adhesive strips (i.e., butterfly) alone are used, then it is bundled in to the E/M service.

Size of Repair

Be careful when coding for size of repair as size ranges are different for each type and site.

- For example, simple repairs of the scalp, neck, axillae, external genitalia, trunk and/or extremities are broken down into the following size ranges:
  - 2.5 cm or less - 12.6 – 20.0 cm
  - 2.6 – 7.5 cm - 20.1 – 30.0 cm
  - 7.6 – 12.5 cm - Over 30.0 cm
Size of Repair

- While simple repairs of the face, ears, eyelids, nose, lips and/or mucous membranes are broken down into the following size ranges

  - 2.5 cm or less
  - 2.6 – 5.0 cm
  - 5.1 – 7.5 cm
  - 7.6 – 12.5 cm
  - 12.6 – 20.0 cm
  - 20.1 – 30.0 cm
  - Over 30.0 cm

When to Add Repairs

- According to the CPT® manual we add together repairs when they are the same classification (simple, intermediate, complex) and the same anatomic grouping (scalp, arms, etc.).
- But, when more than one classification of wound is repaired, they are reported separately. The most complicated repair is listed as the primary procedure and the less complicated is listed as the secondary procedure, with the modifier 51 attached.
Example

- A physician performs the following: 2.4 cm excised diameter benign lesion removal from the back with a 3.0 cm intermediate closure, 3.2 cm excised diameter malignant lesion removal from the abdomen with 3.5 cm intermediate closure, and 1.4 cm excised diameter benign lesion removal from the arm with a 1.5 cm simple closure.

Template Example

Location: 1) ___________________ 2) ___________________
1. Type of repair #1 (see below): ___________________
2. Length of repair #1: ___________________ cm

- Type of Repairs:
  Simple – single layer, no debridement
  Intermediate – deep layers or single layer with debridement
  Complex – significant debridement or undermining | Reconstructive

- If repair same Type (as above) AND same anatomical grouping (12001-12007, 12011-12018, etc) then add together repairs and report 1 code.
- If not same type/same group, then code more complicated first.
Adjacent Tissue Transfer

• Adjacent tissue transfers (ATT) are used to report closure of primary or secondary integumentary defects by relocating a flap of adjacent normal, healthy tissue into a defect, including procedures such as Z-plasty, W-plasty and V-Y-plasty.

• When the ATT is done as a result of a lesion excision, then the excision is bundled into the ATT.

Adjacent Tissue Transfer

• Reporting the size of Adjacent Tissue Transfers is done in square centimeters.

• Note the anatomical areas

• If measurement exceeds 30.0 cm$^2$ see CPT 14301
Example

The patient was taken to the operating room. The area was infiltrated with local anesthetic. With her in the prone position, the back was prepped and draped in sterile fashion. I excised the lesion as drawn into the subcutaneous fat. I then incised the flap as I had drawn it, and elevated the flap with full-thickness of subcutaneous fat. Meticulous hemostasis achieved in the wound and the donor site using Bovie cautery and suture ligature of 4-0 Monocryl suture. The flap was rotated into the defect. The donor site closed, and the flap inset in layers using 2-0 Monocryl, 3-0 Monocryl, 4-0 Monocryl and 5-0 Prolene. Loupe magnification was used. The patient tolerated the procedure well.

Final measurements were 2.2 x 2.0 x 2.0

Example

The forearm was infiltrated with local anesthetic. The left hand and forearm were circumferentially prepped and draped in sterile fashion using ChloraPrep. I then excised the basal cell carcinoma on the left forearm as drawn into the subcutaneous fat, measuring 1.3 cm. Suture was used to mark the specimen at its proximal tip and this was labeled 12 o'clock. Meticulous hemostasis had been achieved using a Bovie cautery. A defect was created to optimize this repair by excising dog ears and thus it was considered a complex repair and the wound was closed in layers using 3-0 Monocryl, 4-0 Monocryl and 5-0 Prolene (5-0 Prolene was used in running suture to better maintain hemostasis). Total closure measured 3.1 cm. Loupe magnification was used throughout the procedure and the patient tolerated the procedure well.

Pathology report indicated Basal Cell Carcinoma with clear margins.
PREOPERATIVE DIAGNOSIS: 1. Dysplastic nevus left radial forearm
2. Dysplastic nevus left ulnar forearm

POSTOPERATIVE DIAGNOSIS: Same.

OPERATIVE PROCEDURE:
1. Excision dysplastic nevus left radial forearm with excised diameter of 0.8 cm and a complex repair of 2.3 cm.
2. Excision dysplastic nevus left ulnar forearm with excised diameter of 2.5 cm and a complex repair of 4.8 cm.

ANESTHESIA: 3cc 1% Lidocaine with epinephrine.

COMPLICATIONS: None

INDICATIONS FOR SURGERY: The patient has dysplastic nevus left radial forearm and left ulnar forearm. The areas were marked for elliptical excision with gross normal margins of 2 mm in relaxed skin tension lines of the respective area and the best guess at the resulting scars was drawn. The patient observed these marks in a mirror to understand the surgery and agree on the location and we proceeded.

PROCEDURE: The areas were infiltrated with local anesthetic. The area was prepped and draped in sterile fashion. The dysplastic nevus left radial forearm lesion was excised as drawn, into the subcutaneous fat. Suture was used to mark the specimen at its radial tip, and this was labeled 12 o’clock. This was sent for permanent pathology. A defect was created to optimize the repair by excising dog ears from the wound and thus, it was considered a complex repair and the wound was closed in layers using 4.0 Monocryl and 5.0 Prolene. The dysplastic nevus left ulnar forearm lesion was excised as drawn, into the subcutaneous fat. Suture was used to mark the specimen at its radial tip, and this was labeled 12 o’clock. This was sent for permanent pathology. A defect was created to optimize the repair by excising dog ears from the wound and thus, it was considered a complex repair and the wound was closed in layers using 3.0 Monocryl and 5.0 Prolene. Meticulous homeostasis was achieved using light pressure. The patient tolerated the procedure well.

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PREOPERATIVE DIAGNOSIS: Suspicious Lesions left cheek, left upper and lower abdomen and right neck

OPERATIVE PROCEDURE:
1. Excision suspicious lesion left cheek with excised diameter of 7 mm with a repair of 1.2 cm.
2. Excision suspicious lesion left upper abdomen with excised diameter of 9 mm with a repair of 1.4 cm.
3. Excision suspicious lesion left lower abdomen with excised diameter of 7 mm with a repair of 1.2 cm.
4. Excision suspicious lesion right neck 3 mm.

ANESTHESIA: 3cc 1% Lidocaine with epinephrine.

INDICATIONS FOR SURGERY: The patient has suspicious lesions of the left cheek, left upper abdomen, left lower abdomen and right neck. Clinical diagnosis of this/these lesions is unknown, but due to the appearance malignancy is a realistic concern. The areas were marked for elliptical excision with gross normal margins of 2 mm in relaxed skin tension lines of the respective areas and the best guess at the resulting scars was drawn. The patient observed these marks in a mirror to understand the surgery and agree on the location and we proceeded.

PROCEDURE: The areas were infiltrated with local anesthetic. They were prepped and draped in sterile fashion. The suspicious left cheek lesion was excised as drawn, into the subcutaneous fat. This was sent for permanent pathology. The wound was closed in layers using 4.0 Monocryl and 6.0 Prolene. The suspicious left upper abdomen lesion was excised as drawn, into the subcutaneous fat. A defect was created to optimize the repair and the wound was closed in layers using 4.0 Monocryl, 5.0 Monocryl and 6.0 Prolene. The suspicious lower abdomen lesion was excised as drawn, into the subcutaneous fat. This was sent for permanent pathology. A defect was created to optimize the repair and the wound was closed in layers using 4.0 Monocryl, 5.0 Monocryl and 6.0 Prolene. Meticulous homeostasis was achieved using light pressure. The patient tolerated the procedure well. Pathology reported indicated left cheek – congenital nevus * abdomen upper and lower compound nevus * neck dysplastic nevus
THANK YOU!!

Resources

- American Cancer Society
- ICD-9-CM 2010
- Dorland’s Illustrated Medical Dictionary, 30th Edition