Things Are Not Always As They Seem

FITTING TOGETHER THE PIECES FOR CODING SKIN LESIONS

By Tara Conklin, CPC

Lesions come in all shapes and sizes and can consist of multiple pathologies. At one time or another, your clients will bill for the removal of a lesion. Of course, the removal is only the first part in the proper reporting of these services. Let's look at the puzzle pieces of "skin lesion" reporting.

If you have ever looked at the lesion removal codes in the CPT, you are probably familiar with their structure and context. But if you are not familiar with them, they may be a bit confusing.

Identify the "How" of Removal

We begin with the lesion removal itself. The physician must provide the required information in order for the coder to determine the correct codes for size, location, and method of removal.

First, you need to know the physicians' method of removal. Is he shaving, paring, excising, or just destroying it with laser or liquid nitrogen? Shaving is defined in the CPT as *"sharp removal by transverse incision or horizontal slicing …without a full-thickness dermal excision."* Think of peeling a potato with a knife; the blade cuts along the upper layer of the potato removing the skin but leaving the potato roughly undamaged. Shaving is done in a similar fashion

Paring is similar to shaving and the two are often confused especially when trying to code for them. Paring is defined as *"to cut away the thin layer of something or to reduce by large amount."* The main difference between *"paring"* and *"shaving"* is usually the tool used and how deep the layer goes.

Measure That Lesion

Next, determine the size of the lesion. CPT guidelines tell us the measurement is *"…based on the physicians' judgment."* It's the physician's responsibility to measure the lesion *prior* to cutting. The

reason the lesion is measured before it's removed is that the correct size is based on the actual size of the lesion and the skin margins surrounding it.

Sound confusing? Think of planting a tree. Let's say the root ball is two feet in diameter. You have to create a hole bigger than the root ball in order to fit the tree into the hole and give it room to grow and expand. So you dig a hole four feet wide and put your tree inside. You now have a root ball that is two feet wide with a hole that expands away from the roots one foot all the way around. Proper measurement includes the size of the root ball you planted (two feet) and the amount of space between the root ball and the edge of the hole on the two longest sides (one foot and one foot). In our example, you would have a total size of four feet $(2 + 1 + 1 = 4)$
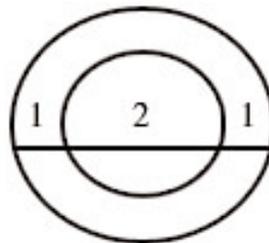
You probably have already guessed the tree is the lesion and the hole represents the margins. Both are necessary for correct measurement. Great, we have our size and we know how he excised it, let's go code it, right?

Hold That Ticket

Hold on eager beaver not quite yet. Before anything is coded you have to know what the physician did with the lesion after it was excised. If he simply discarded the tissue as he was able to determine from gross examination what it was, then feel free to go look up the correct CPT code based on method and type. But if he sent the lesion to

pathology, HOLD THAT TICKET. Even though at first glance it may look benign, as Alice in Wonderland discovered, "things are not always as they seem." Make a folder in the office and use it specifically for charge tickets holding for pathology. It won't hurt to hold a ticket for a few days, but it will hurt if it was coded benign and path came back positive for malignancy.

There are separate code lists in the CPT for excision and destruction of benign and malignant lesions. Bottom line, malignant is more of a risk to the patient and is paid out at a higher rate. The idea in coding is not only to get a fast turn around on the payment but to get the correct reimbursement.

Here's an example. Dr. Frank N. Stein excises a lesion from the forearm that is 2.5 long x 1.3 wide. The margins of this lesion are .5 at the top and .5 at the bottom which is the longest diameter of the lesion. So 2.5 (lesion top to bottom) + .5 (top margin) + .5 (bottom margin) = 3.5 total excised diameter. Dr. Stein turns in his charge ticket with a diagnosis of benign forearm neoplasm 216.6, but sends the lesion off to pathology for final diagnosis. He files a clean claim with CPT code 11404. Two weeks later he receives a payment from Medicare for $184.38 and skips happily to the bank.

However, the pathology report on that lesion comes back one week after excision as *"malignant melanoma."* Had Dr. Stein waited to file his ticket and correctly coded CPT 11604 he would have received a payment of $220.65. That's a $36.27 loss. Even if Dr. Stein catches the mistake and re-files a corrected claim he still loses money in time and man hours working the claim on the backend after the initial submission.

The last thing to keep in mind when coding for lesions is the extent of closure, primarily for surgical excisions.

consumption—to "work" a denial. Since the latter has an unpredictable time variable, the ability to measure and manage the more discrete tasks is lost. If denials are set aside to be worked all together, a time budget can be established for "X" denials per hour and thereby staff productivity can be better anticipated and managed.

Whereas performance benchmarks readily lend themselves to comparison between practices of the same specialty, operations benchmarks are less easily matched between organizations. The latter is primarily a consequence of the diversity of software products used, the wide variety of organizational models employed by billing companies (functional model, client/team model, various hybrids, etc.), the quality and form

(document, scanned image, etc.) of the source material, and a host of other variables. Some software allows for transactions to be entered in batch format (think rows of data into a spreadsheet) rather than page format (think screen-by-screen entry of data into an onscreen "form"); the former is fast, the latter is slow.

Operating benchmarks are essential to understanding and managing employee productivity and accuracy, investigating and devising ways to increase productivity and accuracy, predicting the staffing impact of adding (or losing) a client, and measuring and monitoring operating costs at the functional level. By establishing work standards, billing companies are able to define employee expectations, consider system and automation improvements,

and evaluate the impact of incorporating new workflow approaches, such as incorporating scanning, electronic payment posting, etc.

The chart on page 14 lists ten of the most common and, arguably, important, operations benchmarks.

The third installment of this series will present and discuss common performance benchmarks and will outline typical productivity benchmarks for those elements discussed in this article.

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only! Strict HIPAA policies and procedures must be complied with at home as well as at work. If the employee is transporting documents with protected health information (PHI), be sure those documents are enclosed and protected and the employee takes every caution necessary to transport the documents safely.

A word of caution: determine *which* specific job functions your organization feels comfortable having performed off site—or before you know it, your receptionist will want to work from home, too! NOT! ▲

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Simple suture is included in the lesion removal. However, intermediate and complex repair may be coded in addition to the lesion removal.

It's important to remember that each lesion is coded separately based on size and location. You may have the same code listed more than once or more than one code from a particular code group. Regardless, give each lesion its own CPT code. On the other hand, repairs of the same CPT body group and the same category are only coded once, based on the total length of repairs. For example, if you have two intermediate repairs, one on the neck at 1cm and the other on the forearm at 3 cm, you add the two lengths together since they are in the same code group 12031-12037 for a total repair length of 3 cm. This gives us code 12032. The guidelines for coding both lesions and repairs are in the CPT before each sub-category.

Don't lose out on lesions. It's better to wait until you have all the facts before coming to a verdict. Each puzzle has a specific number of pieces; if you are missing any particular piece you'll never have the whole picture. Get all the pieces to coding your lesions and the payout will be picture perfect. ▲

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