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Procedure Coding for Skin Lesions and Lacerations

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Practical Tools for Seminar Learning

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The faculty has reported no vested interests or disclosures regarding this presentation.

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Objectives

- ◆ **Review CPT® coding guidelines related to excision of skin lesions and treatment of lacerations**
- ◆ **Discuss challenging coding cases related to skin lesion excisions and lacerations repairs**

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Integumentary

- ◆ **Today's review will be focused on the following topics:**
  - • **Excision – Benign Lesions**
  - • **Excision – Malignant Lesions**
  - • **Pilonidal Cyst**
  - • **Repair**
    - • **Simple**
    - • **Intermediate**
    - • **Complex**
  - • **Destruction**

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Integumentary

- ◆ **We won't be able to review these topics today:**
  - • **Paring or Cutting**
  - • **Biopsy**
  - • **Removal of Skin Tags**
  - • **Shaving of Epidermal Lesions**
  - • **Nails**
  - • **Breast and Mastectomy Procedures**

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Clinical Diagnostic Information

- ◆ **Hyperkeratotic Lesions —** hypertrophy of the corneum of the skin (the upper layer of cells — the horny layer); corns and callus
- ◆ **Skin Tags —** Acrochordon or pedunculated papilloma or fibroepithelial polyp; usually a fibrovascular core covered by unremarkable epidermis; occur in 46% of the general population and are associated with diabetes mellitus and pregnancy.
- ◆ **Benign Lesions —** any one of several skin lesions ranging from integumentary lipomas to moles, nevi, warts, sebaceous cysts, seborrheic keratoses, and others.
- ◆ **Malignant Lesions —** basal cell carcinoma, squamous cell carcinoma, melanomas, and metastatic skin lesions.
- ◆ **Pilonidal Cyst —** pilonidal sinus disease; sacrococcygeal fistula; infection near the tailbone; abscess

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Anatomy of Skin and the Lesions That Develop
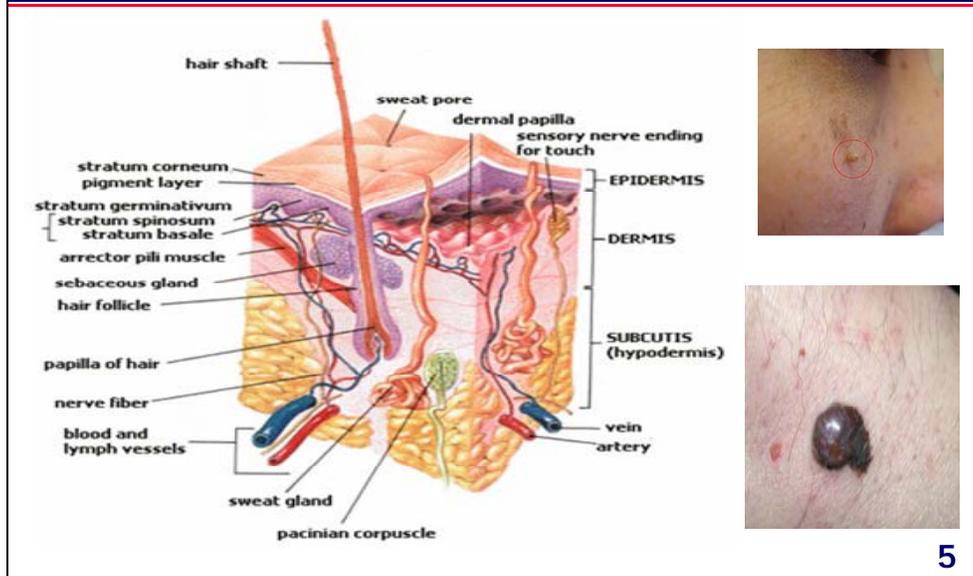
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CPT® Codes and Descriptions

Code Range: 11400 – 11471

Excision – Benign Lesions

11400 Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.5 cm or less

11401 excised diameter 0.6 to 1.0 cm

11402 excised diameter 1.1 to 2.0 cm

11403 excised diameter 2.1 to 3.0 cm

11404 excised diameter 3.1 to 4.0 cm

11406 excised diameter over 4.0 cm

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CPT® Codes and Descriptions

Code Range: 11600 – 11646

Excision – Malignant Lesions

11600   Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 0.5 cm or less

11601   excised diameter 0.6 to 1.0 cm

11602   excised diameter 1.1 to 2.0 cm

11603   excised diameter 2.1 to 3.0 cm

11604   excised diameter 3.1 to 4.0 cm

11605   excised diameter over 4.0 cm

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Procedure Description – Excision

- ◆ **Excision – full thickness (through the dermis) removal of a lesion, including margins and simple repair**

- ◆ **These codes are *not* used for:**
  - • **A biopsy, a shaving of a lesion, or destruction of a benign, pre-malignant, or malignant lesion**
  - • **Excision of a pilonidal cyst**
  - • **Excision of a pressure ulcer**

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CPT® Coding Instructions/Guidance

- ◆ **For excision of a benign or malignant lesion**
  - • **The size of the lesion is determined by adding the size of the lesion at its widest to double the width of the narrowest margin; this size is determined prior to excision**
  - • **The incision size may be larger than the excised lesion and margins**
  - • **Two or more lesions may be removed as a single specimen**
  - • **The surgeon must specify the size of the lesion and margins**

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CPT® Coding Instructions/Guidance

- • **If an adjacent tissue transfer is used to close the defect, the excision of the lesion is not reported separately**
- • **Simple closure is inherent to the procedure**
- • **Intermediate or complex closures are reported separately**
- • **When multiple lesions are excised, use a separate code for each lesion that is excised**
- • **Within each anatomic site, combine the similar repair lengths**

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CPT® Coding Instructions/Guidance

- **Additional instructions for malignant lesions**
  - **If a malignant lesion requires multiple excisions during the same encounter, report one code for the widest excision**
  - **When a subsequent excision is needed at a separate encounter, report a code that represents the size of the entire specimen removed at the subsequent encounter**

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CPT® Coding Instructions/Guidance

- **Documentation by the attending provider is essential.**
- **Treatment for hyperkeratotic lesions, skin tags, or acne is coded elsewhere.**
- **Topical chemotherapy is reported using office visit codes (E&M codes).**

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CPT® Assistant

- **April 2000 – pages 8-9**
  - **Clinical Vignette #1 identifies use of CPT® codes 13132 and 13133**
  - **Clinical Vignette #2 identifies use of CPT® codes 13101 and 13102**
- **November 2002 – page 5**
  - **Excision of skin lesions**
  - **Measuring lesion excision - illustration**
  - **Measuring lesions excised**
  - **Chemosurgery - Mohs technique**
  - **Mohs micrographic surgery**
- **August 2006 – page 10**
  - **Lipoma excision from the right flank**

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Coding Clinic for HCPCS

- **2ND Qtr 2008 – page 5**
  - **Coding the Removal of a Lesion**
    - **Complete documentation includes the size of the lesion as well as the margins excised**
    - **Measurement of the lesion plus the margins should be made prior to the excision**
    - **Pathology reports should not be used in lieu of physician documentation**
    - **Query the physician regarding the size of the lesion as well as the margins excised**

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Outpatient Query Forms – Example

PHYSICIAN DOCUMENTATION QUERY
EXCISION OF LESION(S) CLARIFICATION

Dear Dr: _____: Date: _____

MR #:_____ Patient Name: _____ Admit Date: _____

Documentation clarification is required to meet compliance, accuracy in coding and severity of illness reflection for your patient.

There is clinical documentation present in the medical record for excision of lesions(s).
The following information is needed to assign the correct ICD-9-CM and CPT code(s):

• *SIZE* of the greatest clinical diameter in centimeters plus margins for each lesion excised
• *DEPTH* of the tissue involved for each lesion (e.g., skin, fascia, muscle or bone)
• Type of *CLOSURE* for each lesion (e.g., simple, intermediate or complex)

Clinical indications: _____
H&P: _____ **Operative report:** _____
Nursing Notes: _____ **Progress Notes:** _____

Please document the information in the procedure note or on this form, in the space/box
below as an addendum. (Sign and date all documentation)

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NCCI Manual – Excision of Lesions

- **The HCPCS/CPT® codes for lesion removal include the procurement of tissue from the same lesion by biopsy at the same patient encounter.**

- **CPT® codes 11000-11001 (biopsy of skin, subcutaneous tissue and/or mucous membrane) should not be reported separately.**

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NCCI Manual – Excision of Lesions

- **Multiple lesions submitted for pathological examination as a single specimen, only one CPT® code may be reported.**

- **Separate surgical pathology CPT® code may be reported for each lesion if medically necessary.**

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NCCI Manual – Excision of Lesions

- **Debridement**
  - **Lesion removal**
  - **Incision & Drainage**
  - **Repair**
- **Not Separately Reportable**

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Sebaceous Cyst

- ◆ **Sebaceous cyst on the left**
- ◆ **Infected sebaceous cyst on the right**

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CPT® Codes and Descriptions – Pilonidal Cyst/Destruction

11770 **Excision of pilonidal cyst or sinus; simple**

11771 **Extensive**

11772 **Complicated**
(For incision of pilonidal cyst, see 10080, 10081)

17000 – 17250 **Destruction, Benign or Premalignant Lesions**

17260 – 17286 **Destruction, Malignant Lesions, Any Method**

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Procedure Description – Pilonidal Cyst

- **Excision of pilonidal cyst or sinus;**
  - **Simple: Using a scalpel, the involved tissue is completely excised and the wound is sutured in a single layer**
  - **Extensive: The extensive sinus is above the fascia but has subcutaneous extensions. After excision, the wound is sutured in several layers**
  - **Complicated: The sinus is more complicated and has many subcutaneous extensions. After excision of the involved tissue, local flaps may be required for closure or the wound may be left open**

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Procedure Description – Destruction

- *Destruction: ablation by any method, with or without curettement, not usually requiring closure*
  - **Laser surgery**
  - **Electrosurgery**
  - **Cryosurgery**
  - **Chemosurgery**
- *Curettement:* **removal of material with a curet (curette)**

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Procedure Description – Destruction

- *Pre-malignant lesions (17000 – 17004)*
- *Cutaneous vascular lesions are destroyed with a laser (17106 – 17108) and the resulting scar tissue eventually fades.*
- *Other benign lesions (17110 – 17111)*
- *Chemical cauterization (silver nitrate) of granulation tissue (17250)*
- *Destruction of a malignant lesion by site and size (17260 – 17286)*

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Instruments Used in Destruction & Curettement Procedures

- **A Curette**

- **A Cryoblation probe**
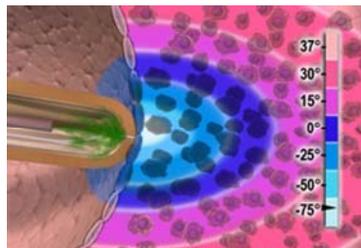
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Case Example #1

What CPT® code would be used for the destruction of 15 premalignant lesions using the laser technique?

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Answer

- ♦ **17004 –** Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses), 15 or more lesions

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Case Example #2

- ◆ **Preoperative Diagnosis:**

  1. Right neck mass **2.** Nasal mass

- ◆ **Postoperative Diagnosis:**

  Benign lesions on both neck and nose

- ◆ **Procedure:**

  Excision of right neck mass and nasal mass

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Case Example #2

- · **Procedure Details:** The patient's right neck was prepped and draped in the usual sterile fashion. The patient was given 1% Lidocaine for local infiltration anesthesia. An elliptical incision was made around the lesion using the #15 blade scalpel. The incision was carried down through the skin and dermis using the scalpel. The 3.5 cm specimen was grasped using toothed forceps and was dissected out circumferentially and excised and sent for pathology. Hemostasis was achieved and the wound was closed using interrupted sutures of 3-0 nylon.

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Case Example #2

- Attention was then turned to the patient's nose. The area was prepped and draped in the usual sterile fashion. The patient was given 1% Lidocaine for local infiltration anesthesia. An elliptical incision was made around the lesion using the #15 blade scalpel. The incision was carried down through the skin and the 2 cm specimen was excised and sent for pathology. Hemostasis was achieved and the wound was closed using interrupted sutures of 3-0 nylon.
- What CPT® code(s) would be assigned?_____

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Answer

- **11424** – benign lesion, 3.5 cm, neck
- **11442-59** – benign lesion, 2 cm, nose

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Case Example #3

- **Pre-op diagnosis: Five lesions: 1 cm right forehead; 1 cm left forehead; 1 cm left temple, 1 cm left hand; broad excoriation on the dorsum of the left hand.**
- **Surgery/Procedure: Excisional biopsy of a lesion on right forehead, left forehead, left temple, and left hand with a 3-mm punch biopsy of the broader lesion on the dorsum of the left hand.**

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Case Example #3

Procedure: With the patient under general LMA anesthesia following sterile prep and drape, initially the left hand lesion was excised and the wound was closed with running 4-0 Prolene subcuticular stitch and some simple 4-0 Prolene sutures. The broad flat area on the dorsum of the hand was biopsied with a punch biopsy. The punch biopsy site was closed with a 4-0 Prolene simple suture.

The lesion on the left forehead was excised using a transverse incision. The deep subcutaneous tissue was closed with 4-0 Vicryl and interrupted 6-0 Prolene simple sutures. The 1-cm raised lesion on the left temple in the hair was then excised; it was closed with skin staples.

The last lesion was a 1-cm lesion on the right forehead which was excised using a transverse incision. The wound was closed with 4-0 Vicryl subcuticular stitch and then some 6-0 Prolene simple stitches on the skin. A sterile occlusive dressing was applied. The estimated blood loss was minimal.

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Case Example #3

Pathology: 5 specimens received

Gross: A. Left hand lesion, 15 x 11 x 4 mm, tan, hemorrhagic slightly encrusted excision. **B.** Large lesion left hand punch biopsy, 3 mm punch, excised at 5 mm. **C.** Left forehead lesion, 16 x 7 x 4 mm excision. **D.** Left temple side of head lesion, 16 x 10 x 5 mm, tan, hemorrhagic, hair-bearing excision. **E.** Right forehead lesion, 22 x 20 x 5 mm excision.

Micro: A, B, C, E -- Squamous cell carcinoma
D – Pigmented Seborrheic Keratosis, Biopsy

What CPT® code(s) should be assigned? _____

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Answer

- **C. 11641 -** malignant lesion, forehead, 0.6 - 1.0 cm
- **E. 11641 - 59 -** malignant lesion, forehead, 0.6 - 1.0 cm
- **D. 11441 - 59 -** benign lesion, temple, 0.6 to 1.0 cm
- **A. 11621 - 59 -** malignant lesion, hand, 0.6 to 1.0 cm
- **B. 11100 - 59 -** punch biopsy, single lesion

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Laceration Repairs

Questions to ask when coding simple, intermediate, and complex repairs:

1. **Into which category does the repair fall (simple, intermediate, complex)?**
2. **What are the measurements of the wound (determined by the longest dimension)?**
3. **Are there multiple repairs? (If so, total the lengths if the wounds are within the same classification.)**

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Laceration Repairs

Questions to ask when coding simple, intermediate, and complex repairs:

4. **Were nerves, blood vessels, or tendons repaired, and not just ligated? (If so, code that repair from appropriate body system.)**
5. **Was a graft or flap used? (If so, do not code as simple, intermediate, or complex repair. Instead, use the graft or flap code.)**
6. **Was a lesion excised? (If so, and a simple repair, code the excision only. If so and intermediate or complex repair, code both the excision and repair.)**

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Laceration Repairs

- Repairs – Simple, Intermediate, and Complex (12001-13160)

- CPT® code is selected based on the length of the closure. If two closures of the same type and within the same 'anatomic category', combine the lengths and use one code.

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Laceration Repairs – Simple

- Simple repair is used when the wound is superficial (e.g., involving primarily epidermis or dermis or subcutaneous tissue without significant involvement of deeper structures) and requires simple one-layer closures.

- If the repair extends into the subcutaneous tissue, you would still use a simple closure if one-layer. Intermediate goes deeper!

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Laceration Repairs – Simple

A Simple Repair

- Does not include the use of adhesive strips, steri-strips or "butterfly" closure. A wound treated by any of these methods should be coded using an evaluation and management code.
- This category of codes also includes the simple closure of wound dehiscence, see CPT® code **12020** and **12021**. For the closure of a wound dehiscence that is complex or extensive see CPT® code **13160**.
    - **12020** Treatment of superficial wound dehiscence; simple closure
    - **12021** Treatment of superficial wound dehiscence; w/packing
    - **13160** Secondary closure of surgical wound or dehiscence, extensive or complicated

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Laceration Repairs – Intermediate

An Intermediate Repair

- Is defined in CPT® as the layered closure of one or more of the deeper layers of subcutaneous tissue and superficial (non-muscle) fascia in addition to the simple repair and includes:
    - Single layer closure of heavily contaminated wounds that require extensive cleaning and removal of particulate matter.
    - The use of two types of suture material is not necessarily indicative of an intermediate repair. If the use of two types of suture material is documented consult with the physician to confirm the type of repair performed.

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Laceration Repairs – Intermediate

- ◆ **Physicians will sometimes refer to a repair as a "plastic closure." Do not assume that a layered or complex repair was performed based on this terminology. Confirm with the physician the type of repair performed.**

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Laceration Repairs – Intermediate

February 2007 *CPT® Assistant:*

Purse String repair of a Mohs surgery defect should be coded with the simple repair codes unless there was extensive undermining.

Extensive undermining could support an intermediate repair.

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Laceration Repairs – Complex

A Complex Repair

- Is defined in CPT® as the repair of wounds requiring more than layered closure, scar revision, debridement, (e.g., traumatic lacerations or avulsions), extensive undermining, stents or retention sutures. It may include creation of the defect and necessary preparation for repairs or the debridement and repair of complicated lacerations and avulsions.

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Laceration Repairs – Complex

A Complex Repair

- Physicians will frequently document lacerations as complex based on the shape or size. However, a "complex" laceration does not always constitute a complex repair. Review the documentation carefully to ensure appropriate assignment of the CPT® code(s).

- The excision of a scar is included in the CPT® code for the complex repair and should not be coded separately. Code only the complex repair.

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Laceration Repairs – Complex

A Complex Repair

- ◆ **For full thickness repair of the lip or eyelid, see the respective anatomical subsections. Procedures on the lips can be found in the digestive system chapter.**

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Extensive Undermining

- ◆ **What is "extensive undermining"?**
  - • **CPT® provides no directives or definitions**
  - • **Assign complex repair codes (13100-13160)**
  - • **Documentation in the medical record must support the use of complex repair codes**
- ◆ **Use of Intermediate and Complex Repairs**
  - • *CPT® Assistant*, **August 2006, pages 1-3**
  - • **Derm Coding Consultant, Fall 2006, pages 7-8**

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Instrumentation

- ◆ **The term instrumentation in the operative report *alone* does not support the assignment of an intermediate or complex repair.**

- ◆ **Instrumentation describes skin stretching devices that are used intraoperatively.**

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Laceration Repairs

- ◆ **Wound repair coding depends on:**
  - • **Type of wound**
  - • **Type of repair**
  - • **If an excision is involved**
  - • **Level of repair**
  - • **Size of wound**
  - • **Number of wounds being repaired**

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Laceration Repairs

- ♦ **When multiple wounds are repaired, add together the lengths of those in the same classification (simple, intermediate or complex) that are also in the same subcategory of codes.**
  - • **For example, a patient having a simple repair of a 2.5cm laceration of the arm and a simple repair of a 2.5cm laceration of the scalp would be assigned CPT® code 12002, simple repair of superficial wounds of the scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6cm to 7.5cm.**
- ♦ **This is only a guideline for the simple, intermediate, and complex repairs.**

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Laceration Repairs

- ♦ **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.**
  - • **For example, you would add together a 3.6 cm simple repair of the abdomen, a 5.2 cm simple repair of the back, and a 2.8 cm simple repair of the chest as one 11.6 cm simple repair to the trunk (12004).**
  - • **12004 Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 7.6 cm to 12.5 cm**
- ♦ **This guideline DOES NOT apply to adjacent tissue transfers.**

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Laceration Repairs

- ◆ **Decontamination and/or debridement is considered a separate procedure only when:**
  - • **Gross contamination requires prolonged cleansing,**
  - • **Appreciable amounts of devitalized tissue are removed or**
  - • **Debridement is carried out separately without immediate primary closure.**
  - • **For example, a patient with multiple wounds of the hand due to a table saw accident. If an intermediate repair is performed on the ring finger and a debridement of the skin is performed on the thumb and index finger, assign a CPT® code for the repair and the debridement.**

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Laceration Repairs

- ◆ **When the excision of a lesion requires an intermediate or complex closure the CPT® code should be based on the size of the defect to be repaired *not the size of the lesion that was excised.***

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Medical Necessity

Medical necessity is also a part of the coding. If there is a very small laceration being repaired, medical necessity for an intermediate or complex repair of that site might be challenged.

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Flaps & Grafts

- **Flaps are attached to the donor site and usually obtained from tissue adjacent to or near the recipient site. Grafts are not attached to the donor site and are most often obtained from tissue remote from the recipient site.**

- **The donor site is where the wound is created by the surgeon—in other words, where the graft/flap material is obtained. The recipient site is where the wound is repaired by the surgeon—in other words, where the graft/flap material is applied.**

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Flaps & Grafts

- ◆ **CPT® classifies these codes by:**
  - • **Type of repair**
  - • **Site of repair (recipient site)**
  - • **Size of repair (square centimeters)**

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Flaps & Grafts

- ◆ **Questions to ask when coding flaps and grafts:**
  - • **Into which category does the repair fall (flap or graft)?**
  - • **If flap, doesn't really matter from a coding perspective what type of flap was used (Z plasty, V-Y, other). If graft, we need to know the type (pinch, split-thickness or full-thickness).**
  - • **What are the measurements of the original wound site (determined by multiplying the dimensions)?**
  - • **Was a lesion excised? (If so for adjacent tissue transfers, do not code the excision since it is included in the repair. If so for skin grafts, code lesion excision codes.)**
  - • **Was there site preparation other than lesion excision?**
  - • **Was the donor site repaired with flap or graft? If so, add that as well.**

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Adjacent Tissue Transfers

- ◆ **Adjacent tissue transfer/rearrangement (ATT) is defined as the transfer of tissue to repair a defect such as traumatic avulsion, or an area where a large defect exists as the result of lesion excision. This procedure involves moving or lifting a normal, healthy section of skin (that remains connected at one or two of its borders) to an adjacent or nearby defect for the repair of the defect.**

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Adjacent Tissue Transfers

Tips

- ◆ **This category of codes includes the excisions of lesions regardless of whether they are malignant or benign. Do not code excisions of lesions at the flap site separately.**

- ◆ **The size and location of the recipient site.**

- ◆ **The repair of the donor site is coded only if local flaps or skin grafting is required. Do not code an intermediate repair of a donor site.**

- ◆ **They do not apply when direct closure or rearrangement of traumatic wounds incidentally result in these configurations.**

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Adjacent Tissue Transfers

Tips

- ◆ **Do NOT total ATT repairs — only simple, intermediate, and complex.**
- ◆ **CPT® code 14300, Adjacent tissue transfer or rearrangement, more than 30 sq cm, unusual or complicated may be reported when the physician performs an unusual or complex tissue transfer or rearrangement. CPT® does not define unusual or complicated; instead, this determination is made by the physician. Code 14300 may be reported for any anatomical area.**

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CPT® Assistant

CPT® Assistant, **July 2000** page 10

- ◆ **If two lesions from the same anatomical classification are removed and both of the created defects require adjacent tissue transfer repairs, the ATTs may be reported for each tissue transfer (eg, flap advancement) performed, provided the defects have distinct margins and are not contiguous.**

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CPT® Assistant

CPT® Assistant **July 2000** page 10
- **Modifier -59 should be appended to any secondary repair code(s) to indicate separate anatomical sites.**
- **Example:**
  - **Lesion is removed from the forehead, resulting in a 5.2 sq cm defect**
  - **Lesion is removed from the neck, resulting in a 7.3 sq cm defect**
  - **Both require rotational advancement flaps to provide closure, then *CPT®* code 14040 would be reported twice, with modifier -59 appended to the second code.**
    - **(Both sites fall into the same anatomic classification as defined by the code descriptor for code 14040, but they do not have contiguous margins and represent separate and distinct defects.)**

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NCCI Manual – ATT

- **When lesion excision is of such an extent that closure cannot be accomplished by simple, intermediate, or complex closure, other methodology must be employed.**

- **Frequently adjacent tissue transfer or tissue rearrangement is employed (Z-plasty, W-plasty, flaps, etc.). This family of codes, (CPT® codes 14000-14350), involves excision with adjacent tissue transfer and correlates to excision codes. Excision CPT® codes (11400-11646) and repair CPT® codes (12001 – 13160) are not to be separately reported when CPT® codes 14000-14350 are reported.**

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NCCI Manual – ATT

- **Skin grafting performed in conjunction with these codes may be separately reported if it is not included in the specific code definition.**

- **In the case of closure of traumatic wounds, these codes are appropriate only when the closure requires the surgeon to develop a specific adjacent tissue transfer; lacerations that coincidentally are approximated using a tissue transfer technique (e.g. Z-plasty, W-plasty) should be reported with the more simple closure code.**

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NCCI Manual – ATT

- **Debridement necessary to accomplish these tissue transfer procedures is part of the column 1 procedure performed. Separate debridement CPT® codes (11000-11042) or repair CPT® codes (12001-13160) would be inappropriately reported with these CPT® codes (14000-14350) for the same lesion/injury.**

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Skin Grafts

- **Skin Replacement – Permanent placement of skin with tissue or graft of healthy skin**
- **Skin Substitute – Temporary replacement of skin with autograft or allograft biomaterial, engineered tissue or a combination of materials**
- **Identify by size and location of the defect (recipient area) and the type of graft <u>or skin substitute</u>; inlcudes simple debridement of granulations <u>tissue</u> or recent avulsion.**

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Skin Grafts

Tips
- **Base coding on:**
- **Type of Graft**
- **Site of Graft**
- **Size of Graft**
- **Okay to code excisions of lesions at the graft site separately. However, per CCI: Flap grafts (CPT® codes 15570-15576) include excision of lesions at the same site (CPT® codes 11400-11646).**

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Skin Grafts

Tips

- The size and location of the recipient site and the type of grafting being performed distinguish skin grafts.
- The repair of the donor site is coded only if local flaps or skin grafting is required. Do not code an intermediate repair of a donor site.
- They do not apply when direct closure or rearrangement of traumatic wounds incidentally result in these configurations.
- Do NOT total Graft repairs – only simple, intermediate, and complex.

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NCCI Manual – Skin Grafts

- For a specific location, a primary code is defined and followed by a supplemental code for additional coverage area. As a result of this coding scheme, for a given area of involvement, the initial code is limited to one unit of service; the supplemental code may have multiple units of service depending on the area to be covered.

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NCCI Manual – Skin Grafts

♦ **Because, for a specific area, only one type of skin graft is typically applied, the primary free skin graft CPT® codes (15100, 15120, 15200, 15220, 15240, 15260) are mutually exclusive to one another. If multiple areas require different grafts, a modifier indicating different sites should be used (anatomic or modifier -59).**

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Case Study 1

Diagnosis: **Basal cell carcinoma of the right nasal ala and multicentric basal cell carcinoma of the top of the left shoulder.**

Operation: **Excision of basal cell carcinoma from the right nasal ala and frozen section control for margins and reconstruction with a quadrilateral focal rotation flap and excision of basal cell carcinoma from the top of the left shoulder and frozen section for margins.**

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Case Study 1

Procedure:

In the supine position and draped in such a manner as to expose the nasal area, the #15 scalpel was used to <u>excise the lesion</u> on the right nasal ala with an ellipse of skin measuring <u>2x1cm</u>. The specimen was sent for frozen section evaluation. Report was that the <u>margin is free of tumor</u>. Consideration was then given to closure of the wound with a full thickness skin graft or a local rotation flap. The patient preferred a local rotation flap and therefore a <u>quadrilateral flap was based laterally and rotated into the defect over the nasal ala</u>. The skin flaps were sutured with interrupted 5-0 nylon suture.

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Case Study 1

The scalpel was then used to <u>excise the lesion</u> from the top of the left shoulder. An ellipse of skin measuring <u>4x2 cm</u> was used for excision and the specimen was tagged at a 12 o'clock margin and sent for frozen section evaluation. Report was that the <u>margin was free of tumor</u>. The wound margins were undermined to allow for eversion and advancement and then <u>approximated with interrupted 4-0 nylon suture</u>. The patient tolerated the procedure well and was taken to the holding area in satisfactory condition.

He was given prescriptions for Darvocet-N 100 and Vibratab 100 mg. He will be able to change the dressing daily and will be seen in the office in 8 days for evaluation and suture removal.

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Case Study 1

What/how to code case study 1:

1st excision = CPT® **11642** (nose excision 2.0 cm)

ATT repair of that excised area = CPT® **14060** (nose ATT up to 10 sq cm)

Since the ATT includes the excision, we lose CPT® 11642 and are left with CPT® 14060 for the nasal excision/repair.

2nd excision = CPT® **11604** (trunk, arms 4.0 cm)

Simple repair is not added to the excision, we only code CPT® 11604.

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Case Study 1

However, the physician didn't document the size of the ATT (add excised area plus repaired area) but it most likely would not make a difference.

Since the lesion excision bundles into the ATT, a modifier **-59** must be appended.

Why wasn't the 2nd lesion repaired with more than simple suturing since it was so much larger than the first lesion?

Cosmetic results are not quite as important on the shoulder.

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Case Study 1

14060 + 11604-59 are the final codes for case study 1.

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Case Study 2

Postop Dx: 15% total body surface area, second and third degree flame burn to the back and left buttock.

Procedure: Tangential excision and soft tissue skin graft to the back.

Technique: The patient was taken to the operating room, intubated in the supine position. He was then rolled to the prone position on the operating table. His back and legs were prepped and draped in the usual sterile fashion. The Weck knife and Humby knife were used to <u>tangentially</u> <u>excise the areas of deep second and third degree burns</u> to his back and a small area on the left buttock.

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Case Study 2

The <u>total grafted area was 1600 sq cm with a split thickness skin graft</u>, 0.010 in thickness, taken from his left and right posterior thigh and hip. All grafts were 2 to 1 meshed. The grafts were brought up to the burn sites and stapled in place with skin staplers. After excellent hemostasis had been achieved with episoap laps, the graft sites were then covered with bacitracin soaked interface and covered with burn fluff which was held in place with a rubber band stent. The left buttock wound was also covered with interface soaked bacitracin and held in place with burn fluff and circumferential m3 soaked suture.

The patient tolerated the procedure extremely well and was taken to the recovery room in stable condition.

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Case Study 2

Tangential excision means a deep burn wound preparation technique which results in a large open area that must be covered.

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Case Study 2

What/how to code case study 2:

Excisional prep for grafting of burn = CPT® 15002 + 15003x15 (excisional prep 100 sq cm + each additional 100 sq cm)

STSG = CPT® 15100 + 15101x15 (STSG 100 sq cm + each additional 100 sq cm)

15100

15101x15

15002

15003x15

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Case Study 3

Procedure: Reconstruction of right cheek Mohs defect with cervicofacial advancement flap and a STSG from the right thigh

Operative Procedure: Under adequate anesthesia with the patient in the supine position, his face and right thigh were prepped and draped in the usual manner. The right cheek defect was carefully debrided and irrigated with saline. A cervicofacial flap was designed and an incision was made in the preauricular area, followed by an incision along the angle of the mandible and the upper neck. Dissection was carried out to release all the loose tissue and advance the flap cephalad.

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Case Study 3

The flap was loosened and elevated and when advanced, <u>covered approximately a third</u> of the initial defect. The flap was then sutured in position with interrupted #3-0 monocryl and #4-0 monocryl.

Attention was then turned to the residual defect, which <u>measured about 8x6cm, and a STSG was harvested</u> from the right thigh measuring 12/1000th of an inch, and left as a sheet that was placed over the temporal and cheek defect. It was <u>quilted into position</u> with interrupted #5-0 monocryl. A compressive dressing was applied circumferentially. The donor thigh area was dressed with opsite. The patient tolerated the entire procedure well and left the operating room in satisfactory condition.

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Case Study 3

What/how to code case study 3:

ATT repair of that excised area = CPT®
14040 (cheek ATT up to 10 sq cm)

STSG repair = CPT® **15120**
(cheek, 100 sq cm)

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Case Study 4

Diagnosis: Upper mid lip with a .5 cm laceration extending from the vermilion border superior. .5 cm mid upper lip buccal laceration, through and through.

Procedure: Wound repaired: buccal membrane, would repaired: skin

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Case Study 4

Technique: The affected area was prepped with shurclens. 1% buffered xylocaine without epinephrine, local block. The laceration was explored to its base. There was no foreign body in the wound. No vascular or nerve injury. There are no signs of a tendon injury. Wound repaired: <u>the skin was closed with 2, 6-0 nylon simple interrupted sutures</u>.

The affected area was prepped with shurclens. 1% buffered xylocaine without epinephrine, local block. The laceration was explored to its base. There was no foreign body in the wound. No vascular or nerve injury. There are no signs of a tendon injury. <u>Buccal membrane repaired with 1, 4-0 vicryl simple.</u>

The patient was referred for f/u 4-5 days.

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Case Study 4

What/how to code case study 4:

This is a tough one because it appears to be one laceration that goes through the depth of the lip, which would be coded CPT® 40652 (repair full thickness lip), but the simple repairs include mucous membranes, so the code to use is CPT® 12011 (simple repair of lip/mucous membrane laceration). Unless the physician provides more clarification.

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Resource/Reference List

- ◆ **AMA**
  - • **CPT® Book 2009**
  - • *CPT® Assistant*
  - • *CPT®* **Changes, An Insider's View**
- ◆ *AHA Coding Clinic for HCPCS*
- ◆ **Ingenix Coders' Desk Reference**
- ◆ **American Academy of Dermatology Association**
  http://www.aad.org/members/publications/_doc/DCC_06_Fall.pdf

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Resource/Reference List

- ◆ **National Correct Coding Initiative Edits**
  http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEHOPPS/list.asp#TopOfPage

- ◆ **The Coding Institute**
  http://codinginstitute.com

- ◆ **Worldwide Wounds**
  www.worldwidewounds.com

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Appendix

Appendix

Resource/Reference List

http://www.aad.org/members/publications/_doc/DCC_06_Fall.pdf

http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEHOPPS/list.asp#TopOfPage

http://codinginstitute.com

www.worldwidewounds.com

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