

# GENERAL SURGERY CODING ALERT

Your practical adviser for ethically optimizing coding reimbursement and efficiency in general surgery practices

SAMPLE

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## Shave Your Claims Mistakes: Not Every Removal Is an Excision

► **Tip: Skip margin calculations for 11300-11313**

When reporting shaving of epidermal or dermal lesions as described by 11300-11313, you must follow a very different set of rules than when you report more familiar lesion excision codes 11400-11646.

More fundamentally, you may not always be clear on when you should select 11300-11313 over the excision codes or, for that matter, a biopsy procedure. Here are the facts you need to discern and properly report shaving procedures.

### Consider Depth to Distinguish Shaving

To differentiate between shaving (11300-11313) and excision (11400-11646), you should consider first and foremost the depth of the removal.

Technically, anytime the surgeon removes skin tissue, an “excision” has occurred. But for coding purposes, CPT narrowly defines an excision as involving “full-thickness (through the dermis) removal of a lesion.”

Shaving, by comparison, involves, “sharp removal ... without a full-thickness dermal excision.” In some cases, the surgeon may remove the raised portion of a benign lesion and allow additional lesion tissue to persist in the dermis.

“Shaving implies a superficial removal,” says **John F. Bishop, PA-C, CPC, MS, CWS**, president of Tampa, Fla.-based Bishop & Associates.

The surgeon’s method to remove a lesion better reveals the difference between shaving and excision. During shaving, the surgeon uses a “transverse incision or horizontal slicing,” as CPT notes, to remove the lesion. In this way, surgical shaving resembles shaving to remove body hair. For instance, the surgeon holds the blade horizontal to the skin and moves it across the lesion, literally shaving it off. Often, in fact, the surgeon will use a razor blade to shave a lesion.

Excision, in contrast, usually involves holding the blade perpendicular to (and thus cutting through) the skin to remove the lesion at a greater depth — for which a scalpel is better suited. In these cases, the surgeon always wishes to remove the entire lesion to the greatest necessary depth.

“You have to read the documentation carefully,” Bishop says. “Physicians may use terms like ‘shave biopsy’ for a procedure CPT might describe as an excision.”

**Bottom line:** Pay attention to the removal’s depth more than the terminology your physician uses.

A final clue that may help you differentiate between shaving and excision is whether the surgical wound required repair, Bishop says. Although excision frequently requires suture or separate repair, shaving “does not require suture closure,” CPT says.

**You’ll see excisions more often:** “General surgeons don’t do a lot of shave removals,” says **M. Trayser Dunaway, MD, FACS, CSP**, a general surgeon, author and educator with Healthcare Value in Camden, S.C. “We typically will completely excise all smallish lesions because we all get a bit nervous about spreading the tumor by a biopsy. When we excise, we may excise with close margins if we’re not sure [about the lesion’s nature]. If necessary, we will return later to take wider margins.”

### For Shaving, Rely on Lesion Size Only

When reporting shaving procedures, you must *not* consider the size of any margin the surgeon removes with the lesion. In fact, the surgeon may not document, or even take, a margin of tissue during a shave. This is a crucial difference from coding for excisions.

CPT groups shaving codes into three categories, as determined by the lesion’s location:

- 11300-11303 — trunk, arms or legs
- 11305-11308 — scalp, neck, hands, feet, genitalia
- 11310-11313 — face, ears, eyelids, nose, lips and mucous membrane.

Within each category, CPT further divides the codes by the lesion’s size. Thus, 11301 applies for a lesion of the trunk, arms or legs measuring 0.6 cm to 1.0 cm, while 11302 applies to a lesion in any of the same locations but measuring 1.1 cm to 2.0 cm. Note once more that these measurements apply to the lesion’s size only and does not include any margin.

### Code per Lesion

The descriptors for 11300-11313 specify “single lesion,” which means that you may report one code for each lesion that the surgeon shaves. If, for instance, the surgeon shaves 16 lesions, you may report an appropriate code for each. But if the surgeon shaves an extraordinary number of lesions during a single session, you may have to submit substantiating documentation.

For example, the surgeon removes by shaving four dermal lesions: one on the left upper arm, measuring 1.0 cm, two on the chest, measuring 1.4 cm and 1.6 cm, and another on the neck, measuring 0.4 cm. In this case, you would report 11301 (*Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.6 to 1.0 cm*) for the upper arm lesion, two units of 11302 (... *lesion diameter 1.1 to 2.0 cm*) to describe shaving of the chest lesions, and one unit of 11305 (*Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less*).

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Bishop says that some payers might prefer that you list each removal as a separate line item, with modifier 59 (*Distinct procedural service*) appended to the second and subsequent codes. In the above example, for instance, this means you would report 11301, 11302, 11302-59 and 11305.

“This is payer-specific, so ask for instructions if you’re unsure,” Bishop says.

## Include Anesthesia, Cauterization

CPT guidelines, reiterated by the AMA in *CPT Assistant* (Vol. 18, Issue 2; Feb. 2008), stipulate that removal of epidermal or dermal lesions using shave technique includes local anesthesia and, if necessary, chemical or electro cauterization to arrest bleeding. You should not attempt to code separately for these services.

Bishop says that the physician may choose freezing or chemical means to cauterize the wound, but as long as the physician doesn’t place stitches or staples, the shave removal codes are still appropriate.

## Watch Out for Biopsy Confusion, Also

Although surgeons may submit samples taken using a shave technique for pathological examination, the results of the exam (whether benign, malignant or uncertain) have no bearing on your CPT coding (although, obviously they matter tremendously for ICD-9 coding). Again, this is in contrast to excisions, which designate separate code ranges for benign and malignant lesions.

Perhaps more important, however, you must be careful not to confuse removal by shaving with biopsy only as described by 11100-11101. In fact, CPT instructions preceding the biopsy codes specifically site “shave removals” as a method to obtain tissue for pathologic examination, which has added to the confusion over how to differentiate 11300-11313 from 11100-11101.

In the end, physician intent matters most, Dunaway says. Often, a surgeon will remove by shaving a lesion that she suspects is benign. Although she may submit the tissue for biopsy, you should still select an appropriate shaving code rather than the biopsy code (biopsy is included in the shave).

In the case of a suspected malignant lesion, however, the surgeon may use shaving to remove a portion of the tissue for examination, with the intent of removing the entire lesion by excision if pathology confirms malignancy. In such a case, you would apply the biopsy code (11100, *Biopsy of skin, subcutaneous tissue and/or mucous membrane [including simple closure], unless*

*otherwise listed; single lesion*) and, if required at a later session, the appropriate code for excision of malignant lesion procedure (11600-11646).

But even if the pathology report did not reveal malignancy in the above case, you would still report the biopsy code rather than a code for removal by shaving. In this case, the intent was to obtain sample tissue for examination, not removal.

For more information on when to report biopsy separately, see Reader Question “Consider Timing, Location, Intent for Skin Biopsy” on page 71 this issue. □

## Revalidation Requires Your Attention — Now

### ► Medicare can pull billing privileges for noncompliance

All practices billing Medicare should act now to get a strong handle on Medicare’s “revalidation process.” For those practices not in compliance, your carrier or fiscal intermediary (FI) may very well pull the plug on your billing privileges.

**Background:** According to CMS ruling 42 CFR 424.515 in the April 21, 2006, *Federal Register*, all Medicare providers must revalidate their Medicare information on file, via a CMS-855 form, within 60 days of receiving a revalidation request from their CMS fiscal intermediary or carrier, say **Lyndean Brick, JD**, senior vice president of Murer Consultants Inc. in Joliet, Ill.

*(Continued on next page)*

## You Be the Coder

### ICD-9 and CPT Link Closely for Burns

**Question:** *In the emergency department (ED), our surgeon saw a 9-year-old girl with blistering burns to the left side of her body. After a level-four E/M, the ED physician treats the child for partial-thickness burns on her entire left arm and left leg. The child had no third-degree burns. How should we code this scenario?*

Tennessee Subscriber

**Answer:** See page 71. □

That sounds simple enough, but many providers have never filed a complete CMS-855 — which can make the revalidation process quite difficult, Brick says.

**But that's not all:** “Generally speaking, after a provider submits a complete CMS-855, either in response to a revalidation request or otherwise, the provider must then revalidate his or her entire CMS-855 filing once every five years — or within 90 days after any change in his or her Medicare provider information,” Brick says.

## Know What CMS Wants

If you're not sure what kind of information you need to have lined up for CMS for revalidation, check out a copy of the Medicare enrollment form online at [www.cms.hhs.gov/cmsforms/downloads/cms855i.pdf](http://www.cms.hhs.gov/cmsforms/downloads/cms855i.pdf). You may see that pieces of this required information are out of date for your practice or facility, and if that's the case, you should fix that fast and submit a fresh 855 form to CMS.

As you update your information, consider consistency a top priority. “One of the biggest problem areas we find is that providers aren't consistent with names, among other things, in their legal documentation,” Brick says.

**Critical:** And now, with national provider identifiers (NPIs) going into full-swing, the practice or facility name

and other information you've filed on your NPI application must match your legal documentation. “Even if one little thing gets out of whack and CMS catches it, its contractors can stop reimbursement,” Brick says.

## Keep an Eye on the Timing

The CMS revalidation process is being enforced over a five-year period that went into effect last year, and the initial revalidation effort focused on Medicare contractors' top-100 billers. “CMS will continue to push forward with its revalidation efforts with smaller organizations as the effort phases in,” Brick says.


**Going forward:** From here on out, anytime you have even the slightest change in your legal information, even something as small as an address change, you need to notify Medicare of that change within 90 days.

**See for yourself:** To view the complete rule, see the April 21, 2006, Federal Register online at [edocket.access.gpo.gov/2006/pdf/06-3722.pdf](http://edocket.access.gpo.gov/2006/pdf/06-3722.pdf). □

## Ask 11 Questions to Assess Your Revalidation Compliance

► *If your answer isn't 'yes' to these items, it's time to make changes*

1. Is the provider's Medicare correspondence address on file current and reliable? If not, the provider may not receive a revalidation request and miss the deadline.
2. Does the provider have processes in place to track pertinent information on new and existing board members and managing employees?
3. Does the provider actively track all practice locations that are billed as provider-based?
4. Is the provider prepared to submit all required supporting documentation with a complete CMS-855, such as legal formation documents, state licenses, IRS tax ID confirmations, certifications, EFT bank account letters, and NPI confirmations?
5. Do the provider's NPIs accurately reflect applicable provider numbers and taxonomy codes, legal business names, etc.?
6. When submitting a revalidation application, does the application accurately reflect all practice locations?
7. Are Section 5's included for all organizational owners and managers, including chain home offices?



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8. Are Section 6's included for all board members and at least one W-2 managing employee?

9. Does the provider retain copies of all Medicare enrollment applications, including initial enrollments, changes of information or ownership, and revalidations?

10. Does the provider file CMS-855 changes of information within 90 days of all changes to practice locations, board members, managing employees, owners, authorized officials, and delegated officials?

11. Does the provider have a CMS-issued provider-based determination for each practice location listed in the 855 (if applicable)?

**Special thanks:** List of questions provided by **Murer Consultants Inc.** □

## **CCI Quick Update:** **Unna Boot Faces New Bundles**

The latest version of the Correct Coding Initiative (14.1) introduces several new bundling edits involving Unna boot application (29580, *Strapping; Unna boot*). Specifically, CCI now bundles several additional integumentary procedures to 29580, including:

- 10061 — *Incision and drainage of abscess; complicated or multiple*
- 10140 — *Incision and drainage of hematoma, seroma or fluid collection*
- 10160 — *Puncture aspiration of abscess, hematoma, bulla or cyst*
- 11000 — *Debridement of extensive eczematous or infected skin; up to 10 percent of body surface.*

The CCI justifies the edits as being consistent with “CPT Manual and CMS coding manual instructions” — that is, the edits merely reinforce longstanding correct coding principles.

However, these edits only apply if the surgeon performs the bundled procedure and places the Unna boot at the same location. Therefore, for instance, if the surgeon placed an Unna boot on the left leg but performed an incision and drainage of a hematoma on the right leg, you could report both 29580 and 10140, with modifier 59 (*Distinct procedural service*) on the latter code to show the separate location.

CCI 14.1 also deletes the edit bundling simple repair codes 12002 and 12004 to Unna boot strapping. Should the surgeon repair superficial wounds of 2.6 cm or more,

even at the same location as placement of the Unna boot (29580), you may now report the wound repair separately, under CCI guidelines. □

## **READER QUESTIONS**

### **Approach Is Crucial for Fistula Repair**

**Question:** *I find two codes in CPT for repair of ileoanal pouch fistula/sinus that differ only according to the approach the surgeon uses. How can I differentiate between the two?*

Minnesota Subscriber

**Answer:** Check the procedure notes carefully. If the surgeon states that during surgical preparation he prepped the abdomen and perineum, that's a tip-off for a combined approach as described by 46712 (*Repair of ileoanal pouch fistula/sinus [e.g., perineal or vaginal], pouch advancement; combined transperineal and trans-abdominal approach*). Be sure that you pay attention,

*(Continued on next page)*

### **News in Brief:**

## **CMS Proposes Big ICD-9 Changes**

Proposed changes to ICD-9-CM for 2009 call for the greatest number of revisions in more than a decade. CMS unveiled, in an April 15 announcement, more than 330 new diagnosis codes.

A few significant additions include codes to identify carcinoid tumors by site, a dedicated category for secondary diabetes mellitus (249), and codes classifying pressure ulcers by stage.

In addition to the 330 proposed diagnosis codes, CMS received requests that another set of more than 120 diagnosis codes be “fast tracked” for inclusion in 2009.

The ultimate decision on how many new codes will appear in the 2009 ICD-9 manual will come when the Final Rule is published in the *Federal Register* in August. All approved 2009 ICD-9 codes will become effective Oct. 1.

*General Surgery Coding Alert* will bring you additional information as it becomes available. For those readers wanting to view the 32-page list of the proposed ICD-9 codes for 2009, contact John Verhovshek at [codewrite@comcast.net](mailto:codewrite@comcast.net). □

however, to where the surgeon then places the incisions. Sometimes, the surgeon will prepare both areas but may revert to a single approach (46710, ... *transperineal approach*), depending on how the exploration unfolds.

**The distinction matters:** If the operative report leaves you any doubts as to which code you should select, ask the surgeon for guidance. In a facility setting, the “double” approach (46712) pays more than 52 relative value units (RVUs) instead of about 25.15 RVUs (a difference of about \$1,000) for 46710. So a mistake could be costly.

**Make the documentation clear:** If you have trouble determining the approach, not only should you ask the surgeon to clarify for you, but you should also ask the surgeon to amend the documentation. If the operative note is unclear to you (who works with the physician all of the time), it will also probably be unclear to any auditor or medical reviewer checking the documentation.

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## Smallest Margin Measurement Matters for Excision

**Question:** *I am confused regarding how to determine lesion size when coding for excisions. For instance, if the surgeon excises a malignant 5-mm, right lateral chest lesion with margins of 7 mm x 17 mm, what is the appropriate code?*

South Dakota subscriber

**Answer:** Your surgeon will often make elliptical excisions in an attempt to bring the skin together more easily during suture and “flatten” or minimize the resulting scars. If you imagine a long, thin scar, for instance, you can see how this would be less noticeable — especially over time — than a more rounded “hole” that the physician cannot suture or close neatly. You can see an illustration of an excision of this type on page 54 of the 2008 AMA *Professional Edition* of the CPT Manual.

You should not let the elliptical, uneven margins confuse you, however. The total amount of skin surface the surgeon removes does not determine the excision code you select.

Rather, under CPT coding instructions, you would determine the correct code by measuring the lesion at its widest point, before excision, and adding to it twice the measurement of the smallest margin (again, before excision).

**In a nutshell:** You should always use the smallest, not the largest, margin when figuring your final code choice.

So, for instance, for a right lateral chest lesion measuring 0.5 cm and with margins 0.7 x 1.7 cm, you would add 0.5 cm (the lesion’s size) to the smallest margin (0.7 cm) multiplied by 2. (CPT descriptors stipulate measurements in centimeters. Because your surgeon documented millimeters in this case, simply move the decimal point one place.) The total measurement would equal 1.9 cm (0.5 + [0.7 x 2]).

For a malignant lesion, the correct code is 11602 (*Excision, malignant lesion including margins, trunk, arms or legs; excised diameter 1.1 to 2.0 cm*).

---

## Watch for Specifics When Selecting Biopsy Code

**Question:** *Our surgeon performed a diagnostic laparoscopy with biopsy for multiple liver lesions. Would 47370 be the correct choice for this procedure?*

Maryland Subscriber

**Answer:** Code 47370 (*Laparoscopy, surgical, ablation of one or more liver tumor[s]; radiofrequency*) is likely not correct in this instance. The descriptor for 47370 stipulates ablation by radiofrequency — while your question makes no mention of radiofrequency and stresses biopsy for study rather than outright destruction or removal (which is the effect of ablation).

The surgeon can achieve the same results using cryosurgery (47381, *Ablation ... cryosurgical*), but this procedure doesn’t fit your description any better.

For a simple diagnostic laparoscopy, your best code choice is 49321 (*Laparoscopy, surgical; with biopsy [single or multiple]*). This code specifies “single or multiple,” so you would report a single unit of 49321 regardless of the number of liver lesions the surgeon biopsies.

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## Zoom In on ‘Targets’ Before Coding Sedation

**Question:** *An established 64-year-old patient complaining of rectal pain and abdominal cramps reports to the surgeon. During a level-four E/M service, the surgeon discovers a foreign body (FB) in the colon. The surgeon then removes the FB via flexible sigmoidoscopy. Due to the patient’s anxiety and pain, the surgeon provides 26 minutes of moderate sedation during the procedure. Can we report the sedation separately?*

Massachusetts Subscriber

**Answer:** You cannot report moderate sedation separately in this case. CPT bundles moderate sedation into all of the colonoscopy codes, so your claim cannot include 99144 (*Moderate sedation services [other than those services described by codes 00100-01999] provided by the same physician performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; age 5 years or older, first 30 minutes intra-service time*).

**How can you tell?** You can easily check if moderate sedation is bundled into a procedure code: Simply look up the code in your CPT manual. If the code has the “⊙” symbol next to it, you cannot report moderate sedation in addition to that code. The code for colonoscopy with FB removal (45379) has such a mark next to it.

In this case, then, you should report:

- 45332 (*Sigmoidoscopy, flexible; with removal of foreign body*) for the colonoscopy
- 936 (*Foreign body in intestine and colon*) linked to 45332 to represent the FB
- 99214 (*Office or other outpatient visit for the E/M of an established patient, which requires at least two of these three key components: a detailed history; a detailed examination; medical decision-making of moderate complexity*) for the E/M
  - 936 linked to 99214 to represent the FB
  - modifier 25 (*Significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service*) linked to 99214 to show that the E/M and FBR were separate services.



## Consider Timing, Location, Intent for Skin Biopsy

**Question:** *How do I know when to report skin biopsy separately with, or in place of, other procedures such as shaving or excision?*

California Subscriber

**Answer:** In general, you may report skin biopsy (11100-11101) separately when the biopsy occurs at a separate location from an excision or other removal, or when the results of the biopsy prompt the more extensive removal by excision or other method.

For instance, if the surgeon excises a lesion on the right hand and biopsies a different lesion (either on the

*(Continued on next page)*

# You Be the Coder

## ICD-9 and CPT Link Closely for Burns

**Answer:** Because your surgeon provided a separate E/M and then treated the patient's burns, you can report a pair of CPT codes:

- 16030 (*Dressings and/or debridement of partial-thickness burns, initial or subsequent; large [e.g., more than one extremity, or greater than 10% total body surface area]*) for the burn treatment.
- 99284 (*Emergency department visit for the E/M of a patient, which requires these three key components: a detailed history; a detailed examination; and medical decision-making of moderate complexity*) for the E/M service, appended with modifier 25 (*Significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service*) to show that the E/M and burn treatment were separate services.

You must be careful when assigning ICD-9 codes for this scenario. Be sure to include codes to represent each burn, as well as a 948.xx code to show the total body surface area (TBSA) of the child's burns.

When choosing the 948.xx code, use the pediatric “Rule of Nines” to calculate TBSA burned:

- The head accounts for 18 percent
- The chest and back each equal 18 percent
- Each arm accounts for 9 percent
- Each leg equals 14 percent.

Therefore, your patient had burns to 23 percent of her body (14 percent [left leg] + 9 percent [left arm] = 23 percent). There were no third-degree burns.

On the claim, you would link all of the following diagnoses to 99284 and 16030:

- 943.29 (*Burn of upper limb, except wrist and hand; blisters, epidermal loss [second degree]; multiple sites of upper limb, except wrist and hand*) for the arm
- 945.29 (*Burn of lower limb[s]; blisters, epidermal loss [second degree]; multiple sites of lower limb[s]*) for the leg
- 948.20 (*Burns classified according to extent of body surface involved; 20-29% of body surface; less than 10 percent or unspecified*) to represent the TBSA burned. □

right hand or elsewhere on the body), the excision and biopsy are separate. You should append modifier 59 (*Distinct procedural service*) to the biopsy code to show that it occurred at a different location from the excision.

Remember, however, that biopsy is a standard practice when removing skin lesions. In most cases, you would not report biopsy of the same lesion separately with an excision or other removal.

In an alternative scenario, the surgeon takes a biopsy by shave technique and submits the sample to pathology for examination. The results reveal a malignant lesion, which the surgeon then removes in its entirety, with margins, by excision.

In this case, the biopsy and excision are again separate because the biopsy led to the decision for the excision. When coding, you will want to append modifier 58 (*Staged or related procedure or service by the same physician during the post-operative period*) to the excision code to show that this was a staged procedure following the biopsy.

The surgeon's intent has a lot to do with distinguishing between a biopsy, for instance, and removal by shaving, excision, etc. The AMA has stressed this point, noting: "The intent of a biopsy is to remove a portion of skin, suspect lesion or entire lesion so that it can be examined pathologically" (*CPT Assistant*, Vol. 14, Issue 10: Oct. 2004). In contrast, "The intent of other integumentary system procedures that involve removal of tissue is different. Generally, they are performed for the purpose of removing the entire lesion."

Because physicians often use the terms "biopsy" and "excision" interchangeably, you may find it useful to question your surgeon on those claims when the terminology and intent are unclear.

— *Technical and coding advice for You Be the Coder and Reader Questions provided by Marcella Bucknam, CPC, CCS-P, CPC-H, CCS, CPC-P, CPC-OBGYN, CPC-CARDIO, manager of compliance education for the University of Washington Physicians and Children's University Medical Group Compliance Program.* □

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