COMPLIANCE TIP

TO: Compliance Alert Distribution List

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SUBJECT: Documenting Removal of Skin Lesions

DATE: June 14, 2016

The documentation for the removal of skin lesions should contain the following elements to allow for proper procedure coding:

**Mechanism of Removal**

Destruction – the ablation of benign, premalignant or malignant tissues by any method (other than shaving or excision), with or without curette, not usually requiring closure. Methods include electrosurgery, cryosurgery, laser and chemical treatment.

Shaving – the sharp removal by transverse incision or horizontal slicing. Removes epidermal and dermal lesions without a full-thickness dermal excision. Suture closure not required.

Excision – Full-thickness removal of a lesion through the dermis and includes simple non-layered closure when performed.

**Important to document mechanism of removal, depth of removal, and type of closure.**

**Tissue Type**

Documentation should indicate the type of tissue being removed. For example, benign, premalignant, malignant, actinic keratosis, skin tag, seborrheic keratosis, verruca vulgaris, malignant melanoma, etc. Some of these tissue types have distinct procedure codes to report (e.g., removal of skin tags) so it is important to include the specific type of tissue being removed.
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Location

Indicate the location of the tissue being removed. If there is more than one lesion being removed, document the different locations as specifically as possible. For example, left forearm, right temple. If multiple, noncontiguous lesions are removed from the same body area, document the body area, side of the body, and the clock position (e.g., left forearm lesion at 3:00, left forearm lesion at 6:00). This will help with modifier application which will distinguish each separate removal.

Some lesion destructions should be reported with procedure codes outside of the Integumentary System section of CPT and are based on the specific anatomic site so it is important to document the location of the tissue removal.

Size

Include size of lesion and size of margins (when applicable).

For lesions which are destroyed, the lesion size should be measured after any curettement is performed.

Size matters for shaving and excisions and should be documented in centimeters.

For removal by shaving, document the lesion diameter in centimeters. The size of any margin removed with the lesion is not considered in the size. Most of the time a margin of tissue is not taken during a shave.

For excisions, the excised diameter consists of the greatest clinical diameter of the actual lesion plus the narrowest margins maintained.

For example, a 1.0 cm lesion is excised and a 2.0 cm margin is maintained on each side of the lesion.

Add these figures together to arrive at the “excised diameter.”

1.0 cm lesion + 2.0 cm margin + 2.0 cm margin = 5 cm

The documentation should include details on the lesion size and each margin or one cumulative figure detailed as the “excised diameter.” Documentation should be specific enough to determine whether the size includes margins or just the lesion itself.
Intent

When deciding between a biopsy, excision, or shaving code, documentation of the physician’s intent is important. The intent of a biopsy is to remove a portion of skin, suspect lesion, or the entire lesion so that it can be examined pathologically.

Often, a physician will remove a lesion that he or she suspects is benign by shaving (and may even use the term “shave biopsy” which is confusing to a coder because no such CPT code exists with this exact verbiage). Although the physician may submit the tissue for biopsy, select an appropriate shaving code rather than the biopsy code (biopsy is included in the shave if performed on the same lesion).

In the case of a suspected malignant lesion, the physician 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, report the biopsy code (11100-11101) and, if circumstances require, the appropriate lesion excision code (11600-11646) if the entire malignant lesion is excised at a later session. Even if the pathology report does not reveal malignancy, report the biopsy code rather than a shaving code because the intent was to obtain sample tissue for examination, not removal. The biopsy codes are used to indicate that the procedure to obtain tissue for pathologic examination was performed independently, or was unrelated or distinct from other procedures performed at the same time.

To clearly document that a procedure is an excision, document “lesion excision” or “lesion removal” in the beginning of the procedure note. This will identify that the intent at the outset was to remove the entire lesion by means of cutting, as opposed to obtaining a sample that incidentally results in the entire lesion being removed.

Please share as appropriate with faculty, residents/fellows, nonphysician practitioners, billing and clinic staff.