CODING FOR MINOR SURGICAL PROCEDURES

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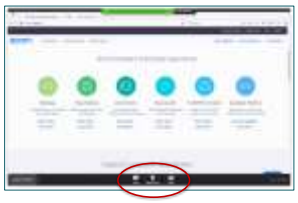

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Agenda--review coding for:

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- Lesion destruction
- Excision of lesions
- Biopsy, shaves
- Foreign body removal
- Repairs
- Joint injections
- Wound care, debridement
- Modifier 25

Lesion destruction

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From CPT: "*Destruction* means the ablation of benign, premalignant or malignant tissues by any method, with or without curettement, including local anesthesia and not usually requiring closure."

Destruction of benign lesions – start with location	
Mouth, eyelid or margin, conjunctiva, vulva, vagina, anus, penis	Skin, all other locations

Benign lesions—defining factors

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Chart on page 3 of handout

- Size of lesion for eyelid and margin
- Simple or extensive for vulva, vagina, anus and penis
- Method for anus and penis
- Type for other lesions, pre-malignant, benign, skin tags

Essential documentation

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- Location
- Method
- Number of lesions, or simple/extensive
- For eyelid/margin, size

Destruction of malignant lesions

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- Selected by size of *lesion not defect*
- Selected by location
- Use for any method of destruction

📖 "The correct code is chosen based on the anatomic area where the lesion is located and the lesion diameter. Use 17260—17286 to report each lesion destroyed and include any method of destruction as previously described." Principles of CPT Coding.

Lesion excisions, benign/malignant

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Benign Lesions	Malignant Lesions
Neoplasms	Neoplasms
Cicatricial (scars)	Basal cell carcinoma
Fibroma	Squamous cell caner
Cutaneous lipoma	Melanoma
Inflammatory lesions	
Congenital lesions	
Cysts	

Coding

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- Select the code based on the size of the excision, not the lesion
- The excision size is the widest clinical diameter of the lesion and narrowest margin
- Each lesion reported separately, unless adjacent and removed with one excision
- Document size of excision and location
- Wait for pathology to select code

Closure after excision

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- CPT allows reporting of intermediate and complex repair
- Simple repair bundled by CPT and NCCI
- CMS/NCCI bundle all repairs
- Bill for both, the repair code may have higher payment than the excision

Select CPT based on pathology

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This is unique to these codes; report shaves, breast biopsies and fine needle aspiration at the time of service

Per Principles of CPT Coding

- If physician notes the lesion is obviously benign, okay to bill benign at time of service
- For re-excision of malignant lesion use excision of malignant lesion codes, even if pathology shows no sign of malignancy

Essential documentation

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- Location
- Size of excision
- Repair, if intermediate or complex

Biopsy and non-excisional shave

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- Punch biopsy is reported with codes 11100 and +11101, although method not defined in CPT
- Use 11100 and +11101 for biopsy of skin, subcutaneous tissue and/or mucous membranes
- Shaving is "sharp removal by transverse incision or horizontal slicing to remove epidermal and dermal lesions without a full thickness dermal excision"

Biopsy and non-excisional shave

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- For excision, full thickness use the excision codes
- Suture closure is usually not performed for a shave biopsy
- Local anesthesia, chemical cauterization or electrocauterization are not reported separately

Removal of a foreign body

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10120 Incision and removal of foreign body, subcutaneous tissues; simple

10121 Incision and removal of foreign body, subcutaneous tissues, complicated

- Requires incision
- No CPT definition of simple or complicated

Removal of a foreign body

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📖 Principles of CPT Coding: "If fascia is penetrated and a foreign body to be removed is within the fascia, subfascia or muscle, use an anatomic-specific code in order to delineate the work effort involved (eg codes 23330, 27086, 28190), to identify the specific service performed, and to identify the location/area (depth/fascia/muscle) that the foreign body was removed from. The physician determines the depth of the foreign body removal in order to decide whether integumentary system or musculoskeletal system CPT codes are appropriate. Documentation must reflect what was performed and verify the code(s) selected."

Removal of a foreign body

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69200 Removal of foreign body from external auditory canal; without general anesthesia

30300 Removal of foreign body, intranasal; office type procedure

67938 Removal of embedded foreign body, eyelid

65205 Removal of foreign body, external eye; conjunctival superficial

Simple repair

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"***Simple repair*** is used when the wound is superficial; eg, 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.

By location

Scalp, neck, external genitalia, axillae, trunk, and/or extremities, including hands and feet
Face, ears, eyelids, nose, lips and/or mucous membranes

Intermediate repair

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"***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."

By location

Scalp, axillae, trunk, and/or extremities
Neck, hands, feet and/or external genitalia
Face, ears, eyelids, nose, lips and/or mucous membranes

Complex repair

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"*Complex repair* includes the repair of wounds requiring more than layered closure, viz., scar revision, debridement (eg, traumatic lacerations or avulsions), extensive undermining, stents or retention sutures. Necessary preparation includes creation of a limited defect for repairs or the debridement of complicated lacerations or avulsions.

By location

Trunk
Scalp, arms and/or legs
Forehead, cheeks, chin, mouth, neck, axillae, genitalia, trunk, hands and/or feet
Eyelids, nose, ears and/or lips

Repair

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- Repairs of the same type (simple, intermediate, complex) and location grouping are added together and reported with a single code
- Repairs of two different types or different locations are reported separately

Essential documentation

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- Location (as defined in the code)
- Type
- Size

Joint injections

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- Do not report ultrasound guidance separately with 20600—20611
- Fluoroscopic, CT and MRI can be reported separately
- Always document medical necessity for guidance
- For ultrasound guidance, there must be a permanent recording and a report

Cerumen removal

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- 69209 for lavage by staff
- 69210 when requires instrumentation by provider

Cerumen removal is covered if there are:

- visual considerations: impacts exam,
- qualitative considerations: hard, dry, irritated, was causing pain, hearing loss or itching
- inflammatory considerations: associated with odor, infection or dermatitis, or
- quantitative considerations: obstructive or copious

Wound care

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Non-selective debridement 97602

- Status indicator of bundled

Non-selective debridement, wound vac DME equipment 97605, 97606

- Wound vac including topical application, assessment, instructions, per session
- Up to or equal to 50 sq cm, or greater than 50 sq cm
- Report only one code: 97606 isn't an add on code

Wound care

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Non selective debridement using wound vac, disposable equipment, 97607, 97608

- Including provision of exudate management system, topical application, wound assessment, instructions for ongoing care, per session, up to or equal to 50 sq cm, greater than 50 sq cm
- Report only one code. 97608 is not an add on code.

Wound care

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Selective debridement, dermis/epidermis

Sharp, selective debridement including topical applications, assessment, instructions for ongoing care

- 97597 first 20 sq cm
- +97598 each additional 20 sq cm or part thereof

Wound care

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- Based on size of area
- Not location specific
- Report 97597 once per session, no matter how many wounds
- Use +97598 based on sq cm.

Wound care

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Debridement by depth

- 11042, +11045 subcutaneous tissue
- 11043, +11046 muscle and/or fascia

(Also codes for bone but not in this handout)

- First 20 sq cm, and add on codes for additional 20 sq cm or parts there of
- Not location specific
- CPT codes out of sequence

Wound care

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Debridement by depth

- When a single wound has multiple depths, report with one code to the deepest depth
- When multiple wounds have the same depth, add together the total sq cm and report one code
- For multiple wounds of different depths, report the deepest first and report additional debridement codes with modifier 59

E/M and a minor procedure

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25 Significant, separately identifiable E /M service by the same physician on the same day of the procedure or other service

- Same day as a procedure, the physician performs an E/M service that is a significant, separate, identifiable service Append modifier 25 to the E/M on the same day as a minor (0 or 10 day global per Medicare).
- Link diagnosis code(s) appropriately to E/M and procedure.

Initial evaluation prior to minor procedure

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A minor surgical procedure is a procedure with **0 or 10** global days

"The decision to perform a minor surgical procedure is <u>included</u> in the payment for the minor surgical procedure…"

From the NCCI manual

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"The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25."

E/M and procedure same day

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Bill both when:

the physician/non-physician practitioner (NPP) needs to evaluate the patient's symptom, condition problem prior to doing the procedure—and both are documented.

E/M and procedure same day

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Bill only the surgical procedure when:

- Only a procedure is documented.
- For a planned procedure.
- For a planned, repeat procedure (such as wound debridement).
- When the medical decision making occurred at a previous visit
- For excision/destruction of small lesions
- Breast biopsy or bronchoscopy scheduled at a previous visit

E/M and fracture care

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- Most fracture care codes have 90 global days, not minor procedures
- Watch out for a few non-displaced, closed fractures with 10 global days: they need modifier 25

Thank you

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DEMYSTIFYING CODING FOR PHYSICIANS

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