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Welcome to the December issue of Maxim Coding Corner<sup>SM</sup>! As a leader in the HIM industry, [Maxim Health Information Services](#) is committed to providing you with coding-related topics that matter to you. This month, we are focusing on coding for lesion excision and destruction. Read on below to learn more and be sure to look for information at the end of this article about our new [Ask a Coding Question](#) feature!

#### **Lesion Excision and Destruction**

There are many minor skin procedures that are performed in a medical office or facility outpatient setting. The following are some general guidelines for selecting the appropriate codes for excision and destruction of skin lesions.

#### **Lesion Excisions**

**Benign Lesions (11400 – 11471)**

**Malignant Lesions (11600 – 11646)**

A skin lesion is an area of the skin whose appearance has changed. Lesions are either non-cancerous (benign) or cancerous (malignant). It is very important to know the pathological diagnosis of a lesion to determine what code to select. Examples of benign lesions are moles (nevi), sebaceous cysts, warts, seborrheic keratoses, skin tags and pigmented lesions. Examples of malignant lesions include basal cell carcinoma, squamous cell carcinoma, and melanoma.

To properly code lesion excisions the following must be determined:

- Site of lesion
- Size of lesion
- Type of lesion
- Number of lesions
- Method of removal (biopsy, excision, destruction)
- Type of closure
- Type of repair

Code selection is determined by measuring the greatest clinical

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diameter of the apparent lesion plus the margins required for complete excision (lesion diameter plus the most narrow margins required equals the excised diameter.) The measurement of the lesion plus margins is made prior to excision. The excision code is determined by the diameter described above --not the specimen sent to pathology. A common coding *error* is adding the measurements of two or more lesions to determine the code used. Each lesion should be coded separately.

Excision codes include simple closure and local anesthesia. No additional codes are assigned for closure of wound, unless the closure requires intermediate or complex repair. In those cases, an additional code would be required from the respective code categories.

If an adjacent tissue transfer is performed in conjunction with a lesion excision, the lesion excision is bundled into the code for the adjacent tissue transfer procedure; and therefore would not be coded separately. Only the adjacent tissue transfer code is reported.

When a malignant lesion has been excised and a re-excision is performed to ensure that the entire lesion has been removed, the code assigned is based on the second final widest excised diameter required for complete tumor removal at the same operative session. This would be appropriate even if the pathology report revealed no malignant process was present.

### **Shave Removal (11300 – 11313)**

Dermal or epidermal lesion shaving should be reported with codes 11300-11313. The "shaving" procedure is epidermal and/or dermal lesion removal without a full thickness dermal excision by transverse incision or horizontal slicing. The tissue removal does not support a biopsy and should not be coded as such.

Shave removal can be reported for benign or malignant lesions. The measurement of the actual lesion's location and size is necessary for proper code selection. Local anesthetic and electrocautery of the wound is included. Closure is not necessary with shave removal

### **Destruction of Lesions Benign or Premalignant (17000 – 17250) Malignant (17260 – 17286)**

CPT guidelines define destruction as the ablation of benign, premalignant, or malignant tissue by any method, including electrosurgery, cryosurgery, laser and chemical treatment. This is *not* removal by excision or shaving of skin lesions using surgical instruments such as a knife, scalpel or other similar tools.

Codes 17000 - 17004 are used for the destruction of premalignant lesions by laser surgery, electrosurgery, cryosurgery, chemosurgery, or surgical curettement. These codes are reported

according to the number of lesions treated. Code 17000 is used for the first lesion, with 17003 coded for *each* additional lesion, up to 14 lesions. Code 17004 is used for 15 or more lesions, and is *not* reported in conjunction with 17000 – 17003.

Destruction of benign lesions other than skin tags or cutaneous vascular proliferative lesions is coded using 17110 and 17111. Code 17110 is used for destruction of 1–14 lesions, while code 17111 is for 15 or more lesions.

Destruction of malignant lesions by any method is described with codes 17260 – 17286. Similar to excision of lesions, the codes used for destruction of malignant lesions are based on the site and size of the lesion.

**References:**

*CPT Professional Edition 2009*

*CPT Assistant, August 2000, Volume 10, Issue 8, pages 5-6 and 12*

*CPT Assistant, August 2009, Volume 19, Issue 8, pages 7 and 10-11*

## **Ask a Coding Question**

**Have a coding-related question that you would like to get answered by an MHIS coding expert?** Visit our new "[Ask a Coding Question](#)" page to submit your question for review. If your question is selected as the **Coding Question of the Month**, a full answer will be posted on our website for you and all MHIS website visitors to reference!

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