

# One Little Lesion -- so Many Choices

Save to myBoK

by Robert S. Gold, MD, and Margi Brown, RHIA, CCS, CCS-P, CPC

## Part 1 of 2: The CPT Aspect

Concentrating on lesions in the integumentary system, this article provides some basic and user-friendly information for the coder to have at hand in the day-to-day world of coding.

Coding for lesions in the integumentary system requires a good understanding of the skin and its layers, the different types of lesions and procedures, the guidelines, the areas of potential confusion, and really good documentation. Many codes are available for lesions. In order to choose the correct code, coders need clear documentation by the physician and the necessary chart reports.

The integumentary system includes the code range 10021–19499, with the subsections including the skin, subcutaneous, and accessory structures, nails, pilonidal cyst, repair-closure, destruction, and the breast.

## Understanding the Layers

*Stedman's Medical Dictionary* defines the integument as

1. The enveloping membrane of the body; includes, in addition to the epidermis and dermis, all of the derivatives of the epidermis, hairs, nails, sudoriferous and sebaceous glands, and mammary glands.
2. The rind, capsule, or covering of any body or part.

The skin is an organ of the body, just like the lungs, heart, or kidneys. It has multiple functions ranging from protection from dehydration or from external noxious forces (e.g., solar rays, dusts, pollens) to maintaining homeostasis through its sweat glands. It includes other appendages as well, including hair, nails, and breasts. It is a layered structure, with specific components and functions for each layer.

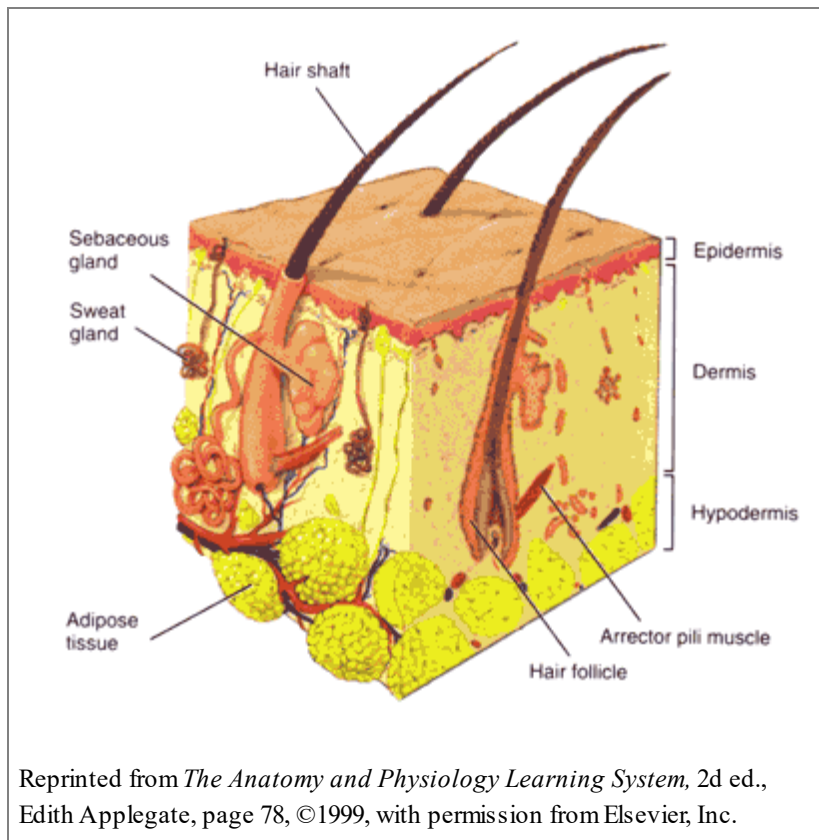
Skin is composed of an epidermal layer that consists of the most external, cornified layer, then the deeper strata with the stratum basale, and the columnar cells from which all of the more superficial layers are derived. These layers, which protect us from external forces, produce moles, melanomas, epidermal inclusion cysts, and visible scars from surgery or injuries. This is also where the nerve endings exist for pain, heat, cold, and touch.

The dermis contains hair follicles, the oil (sebaceous) and sweat glands, and carries nutrition to the epidermis. The sebaceous cysts and other dermal processes such as neurofibromas, fibromas, and some neuromas come next.

Beneath this layer is the fat—the subcutaneous tissue, which is the major component of breasts and love handles. Codes 214.0 and 214.1 lipomas come from this layer. Within the subcutaneous fatty layer exists a superficial fascia layer. In some parts of the body, this has a special name, such as Scarpa's fascia in the groin. In some parts of the body, this layer has muscle tissue in it, such as the platysma muscle of the face and neck. These layers exist in the integumentary system.

At the lower extreme, we find the deep fascia. The deep fascia, the strong connective tissue layer, is part of the musculoskeletal system. It envelops the muscles, connects over bones, and contributes to ligamentous attachments of muscles to the bones. This is no longer in the integumentary system.

Fascia is a fibrous tissue network located between tissue layers. There are two layers of fascia—the superficial layer, which is in the integumentary system, and the deep layer, which is in the musculoskeletal system. Be aware of where the physician is operating when he or she refers to fascia.



### Watch the Wording

The integumentary section has many qualifiers. Depending on these qualifying terms or adjectives and the site, the code may not be inclusive to this system, but may be pertinent to other systems such as the musculoskeletal, male or female genital system, eyelids, or external ears.

For example, neuromas, muscle hernias, and tendon lesions may all have the appearance of skin lesions—until the incision is made. The pathology report becomes an integral part of assigning the appropriate codes in this area. Coding choices are now expanded to other body systems. A few differences between the integumentary (1xxxx codes) and musculoskeletal systems (2xxxx codes) are the type and depth of the lesion. Integumentary excision for benign or malignant lesions of the skin and differentiated from biopsy or shaving of lesions is defined as full-thickness, which is through the dermis. The musculoskeletal system includes narrative descriptions of excision tumor of soft tissue, superficial or deep, subcutaneous, or deep, subfascial, or intramuscular.

For the most accurate code assignment, documentation should clearly identify:

- Disposition of lesion (benign, premalignant, or malignant)
- Type of lesion
  - Lesion
  - Skin tags
  - Callus or hyperkeratotic
  - Cyst
- Quantity
  - Each (each separate or each additional)
  - Single, multiple, or any number
- Site (single site or a range of sites)
- Size
  - Measurement
  - Small, medium, or large

- Severity (simple, complicated, or extensive—complicated may include: having a drain or packing placed in the wound; deep abscess; infection; large or deep area; extensive time; or ligation of blood vessels to stop hemorrhage)
- Inclusive (with or without)
- Depth (deep, skin, or subcutaneous)
- Procedure
  - Incision, excision, or biopsy
  - Incision and drainage
  - Paring or cutting
  - Shaving
  - Destruction
- Type of closure
  - Simple
  - Layered or intermediate
  - Complex
  - Grafting or other reconstructive

### Integumentary Lesion Codes

Paring/cutting benign hyperkeratotic lesion	11055–11057
Biopsy	11100–11101
Removal of skin tags	11200–11201
Shaving	11300–11313
Excision benign skin lesions	
Trunk, arms, legs	
Scalp, neck, hands, feet, genitalia	11400–11406
Face, ears, eyelids, nose, lips, mucous membrane	11420–11426
	11440–11446
Excision skin, and subcutaneous tissue, hidradenitis	
Axillary	11450–11451
Inguinal	11462–11463
Perianal, perineal, umbilical	11470–11471
Excision malignant skin lesions	
Trunk, arms, legs	11600–11606
Scalp, neck, hands, feet, genitalia	11620–11626
Face, ears, eyelids, nose, lips	11641–11646
Destruction	
Benign or premalignant lesions	17000–17250
Malignant lesions	17260–17286

Source: American Medical Association. CPT 2004. Chicago: AMA, 2003.

### Overview of Procedures

Procedures will vary according to the lesion and the above-listed qualifiers. Not all lesions will be removed by excision or fall into the excision categories.

- **Paring**—peeling, usually done for corns, calluses, or hyperkeratotic lesions. The three codes in this section encompass a single lesion, two to four lesions, and more than four lesions.
- **Curettage**—scraping
- **Incisional biopsy**—diagnostic test in which a portion or small piece of tissue is removed from a lesion. CPT includes a note for 2004 stating that obtaining tissue for pathologic examination is not reported separately when it is followed by excision of that lesion.

- **Excisional biopsy** is the same as excision—remove entire lesion for examination of the border of lesion and surrounding normal skin
- **Punch biopsy**—a punch tool cuts through the subcutaneous layer removing a circular core from the center of the lesion. Note: a lesion may be totally excised with a biopsy punch, so be aware of the pathology.
- **Shaving or shave biopsy**—transverse incision or horizontal slice made through the skin that just passes below the depth of the lesion. With this procedure for epidermal or dermal lesions, there is not a full-thickness dermal excision and no closure is required, which is different from excision. Here the technique determines the code assignment.

### Converter for Lesion Coding

0.3937 in. ....	1 cm.
1 in. ....	2.54 cm.
0.16 sq. in. ....	1 sq. cm.
1 sq. in. ....	6.452 sq. cm.

### Lesion Excision Guidelines

For excision lesions, closures can vary. When a simple repair is performed after excision of a lesion, this is included in the excision lesion code and is not coded separately. If a more extensive repair is performed, such as adjacent tissue transfer (codes 14000–14350), this would be the only code used and includes the excision lesion code. All other closures such as layered/intermediate, complex, or reconstructive closures, including skin grafts, are coded in addition to the excision lesion code.

Excision lesion codes include the administration of the local anesthesia, simple closure, and a full-thickness through-the-dermis removal of the lesion.

In 2003 the code selection for measurement was expanded to include not only the largest diameter of the lesion, but also the margins. The formula is:

lesion excised diameter = lesion greatest clinical diameter of  
the lesion itself + the most narrow margins.

This should be documented in the operative or procedure report.

Report each lesion excision separately if a separate excision is made for each lesion removed. If two lesions are removed with one excision, only one excision of lesion code is reported. Do not add the diameters of the lesions if more than one lesion is excised and report just one lesion excision code. This guideline refers to repairs of lacerations of similar depth.

Coding for malignant lesions (11600–11646) includes an additional guideline. When a frozen section is performed and an additional excision is required during the same operative episode, only one code is reported for the final widest excised diameter. If a re-excision is performed at a subsequent operative episode then the appropriate code is used with a modifier 58, staged procedure. For diagnostic coding purposes, if a malignant lesion was excised first and the patient returns for a re-excision for positive margins, the re-excision is reported as though it were the original malignant lesion. Report the lesion as malignant even though the pathology report may indicate the re-excision reveals no residual tumor.

In part 2, we will discuss the diagnosis aspect of integumentary lesion coding including information on lipomas and their confusions.

**Robert S. Gold** ([DCBAInc.com](http://DCBAInc.com)) is CEO and **Margi Brown** ([codebrown@bellsouth.net](mailto:codebrown@bellsouth.net)) is senior consultant at DCBAInc.

#### Article citation:

Gold, Robert S., and Margi Brown. "One Little Lesion: So Many Choices. Part 1 of 2: The CPT Aspect." *Journal of AHIMA* 75, no.10 (Nov-Dec 2004): 64-66.

## Driving the Power of Knowledge

Copyright 2022 by The American Health Information Management Association. All Rights Reserved.