

Billing and Reimbursement Guideline: Lesion Excision Surgery
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Guideline Publication Date: September 1, 2010

Key coding, documentation and reimbursement points include:

- The diagnosis submitted on the claim should be coded to the highest level of specificity.
- The medical record should document the following information regarding the excision procedure(s):
 - Lesion location – codes are selected based on the anatomic location of the lesion. If more than one lesion is removed from the same body area, a modifier 59 is used to identify the separate site. The medical record should identify the precise location either in written terms or in an anatomic diagram.
- Full or partial thickness excision.
- Measurements of the lesion and margin sizes prior to the excision.
- The type of repair or closure used to close the excision should also be documented.
- Simple single layer closure is included on all lesion excisions. This would include simple dressings, strip closures, or adhesives.
- Intermediate and complex repairs may be required and are billable on lesions greater than 0.5 cm.
- The most extensive code is the only code billed for excision. If a less extensive or less complex procedure was attempted but followed by a more invasive procedure, the only procedure billed is the final complex procedure.
- Dermabond closure cannot be billed with repair codes 12001 – 13300 for the same wound site. If one wound is closed with sutures and another with

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Format change, minor edits

Dermabond, a 59 modifier is required to show that this service is unrelated to the first.

- Modifiers 25 or 59 should be used to indicate a separately identifiable service.
- This guideline applies to CMS-1500 claim submissions.
- This guideline applies to place of service 11, 21, 22, 24 and 50.

Please refer to Neighborhood's provider website at <http://www.nhpri.org> for specific provisions by product line.

This guideline is not a guarantee of reimbursement. Plan coverage, eligibility and claim payment edit rules may apply.

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