Shannon O. DeConda, CPC, CPC-I, CEMC, CMSCS, CPMA, CRTT
DoctorsManagement, LLC

Auditor: Shannon O. DeConda, CPC, CPC-I, CPMA, CEMC, CMSCS, CRTT
DoctorsManagement, LLC

Mrs. DeConda is the founder and President of NAMAS (National Alliance of Medical Accreditation Services), as well as a DoctorsManagement LLC partner managing the Coding and Reimbursement Department. As an experienced auditor and educator, Mrs. DeConda is sought after as a national speaker whose teaching style promotes an easy-to-learn and informative atmosphere—using a hands-on learning approach. Over 18 years with national and local consulting experience, she has helped doctors improve their bottom line, coding standards, and reimbursement processes. She is a frequent speaker at national and state seminars, providing business presentations and instructing medical professionals on accounting and reimbursement. Mrs. DeConda resides in the city of Knoxville, Tennessee, with her husband Chris and her three children, Spencer, Shakia, and Sarah.

GLOBAL SURGICAL PACKAGE—Let’s get deeper than knowing what’s included
DOCUMENTATION REQUIREMENTS—What is the most relevant and the required components
MEDICAL NECESSITY—The golden key to all medical services
MODIFIER USAGE—Auditing the modifier usage with the OP Report
NCCI Edits—Ensuring all of the billed services are truly billable
MEDICAL POLICIES—The second layer to a surgical audit
The patient presents to the office on 12-17-2011 and the provider informs the patient that they need to undergo a total knee replacement. The patient consents to the surgery, but does not want the procedure until after the holiday season is over. Surgery is scheduled for 1-20-2012 to best accommodate the patient.

Patient returns to providers office on 1-18-2012 for re-evaluation.
The patient returns today for follow up of her right chronic knee pain. She has been increasing the amount of Advil she is using for pain that breaks through prior to dosage timing of hydrocodone. She states that the pain today seems increased due to the damp cold weather and actually rates the pain as a 9 today. She also complains of pain radiating down the right leg into the ankle region, but has no noted numbness or tingling. She has had no fever, increased swelling, double vision, other musculoskeletal complaints, unstable sugars (known diabetic), and no rashes or skin infections.

I reviewed her PFSH with her and noted that she smokes 2 packs a day, but she advises that she has been able to decrease to 1 pack per day. Ms. Jones additionally comments that her mother did have some troubles with anesthesia during one surgical encounter and I suggested that she be sure to provide more information regarding this to the anesthesiologist at her pre-operative consult with them.

On exam, the patient’s weight is noted to have increased 12 pounds from her last visit. She is noted to have swelling of the right knee, but no redness or discoloration. Her gait is guarded and her ROM is diminished.

Impression: OA of the right knee

The patient appears to still be a viable candidate for the procedure. Her knee, as suspected, is worsening since just her last visit and the additional weight may be further impacting this issue as well.

I will see her in the OR on 1-20-2012. Please additionally refer to the Admit H&P performed today as well for any other pertinent information.

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**PRE-OPERATIVE SERVICES**

- Is an admit H&P billable?
- Why did the patient present to the office today?
- Does the documentation support the service as billable?
- What documentation do we use to audit the E&M portion of the encounter?

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**INTRA-OPERATIVE SERVICES**

PAGES 2-6 OF YOUR HANDOUT
<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Date of Service</th>
<th>Exam/Procedure</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Doe</td>
<td>12/4/2013</td>
<td>Physical Exam</td>
<td>Normal</td>
</tr>
<tr>
<td>Jane Smith</td>
<td>12/4/2013</td>
<td>Blood Pressure</td>
<td>Normal</td>
</tr>
</tbody>
</table>

Notes:
- Physical Exam: All vitals within normal range.
- Blood Pressure: Systolic 120, Diastolic 80.
• Beware of the pitfalls
• Are templates an exception on surgical services?
• Does the documentation include all of the necessary components?

Re: medical fee for service/Bill

Refer to CMS-1500 claim form
Refer to the coding sheet
Refer to the OP Report
Basic OP Report Requirements

The operative report is the provider’s account of the surgical service. The documentation should not just account for the details of how the procedure was done, but it should additionally support the medical necessity of why the service was performed. Additionally, the documentation should include information regarding anything that made the encounter not “cookie-cutter” that would support the medical necessity of the modifier usage.

• Refer to packet for specific details of the operative report

Modifiers for Intra-Operative Services

Page 8 of Your Handout
Are the assist services supported since the documentation includes “proof” that an assist was used in the case?

The auditor did not find an OP report or any other documentation as authored by Mr. King. Is the service supported?

Since the patient’s BMI is noted as being obese, this fact as reported above will support the use of the -22 modifier.
Let's Challenge the Rules:
• Patient reports to office 7 days post-op and is noted to have a red irritated surgical site with drainage.
• Dr. Snyder rounds on a patient status-post total hip replacement and she is noted to be anemic and in need of a transfusion.
• During an on-site visit with an orthopedist, the auditor notes that fluid is withdrawn off of the knee of a patient that recently underwent a total knee replacement.
• Pain management provider managing post-operative pain.
NCCI Edits

• The auditor should be sure to have their NCCI edits when performing audits on government payer claims.
• When performing an audit on commercial carrier claims, the auditor should refer to any type of edits that the individual carrier may recognize.
• Some commercial carriers use the NCCI edits, but the auditor should verify this information.

NCD/LCD Policies

Medical policies contain valuable information which may be of help to an auditor that may be auditing a different service/specialty for the first time. As experienced auditors/coders we often refer to the medical policies, but for what information? The covered diagnosis codes…do you know what other valuable information is found in an LCD?
The treatment of choice for malignant skin lesions that includes a variable margin of surrounding tissue in order to eradicate microscopic tumor cells, which may have spread beyond the visible borders of the lesion.

Medicare will consider the excision of a malignant skin lesion including margins (procedure codes 11600-11646) medically necessary when a pathology report verifies the existence of a malignancy.

The medical record/progress note should indicate the removal of a malignant or an ambiguous, but moderate to high suspicion level with a corresponding pathology report. The size and location of the lesion should be documented in the operative report.
Miscellaneous Housekeeping Guidelines

• Dictation
• Timeliness
• Back up report
• Signature Requirements

Questions? Comments?
Surgical Auditing

This session will provide a hands-on workshop for auditing surgical records. Attendees should expect to cover utilization of the NCCI edits for surgical auditing, medical necessity and appropriateness, the basic auditing steps of the a surgical record, the global surgical package, and time will be spent reviewing some of the gray areas that are a bit less defined by rules and guidelines. This session will not be a review of what the rules and guidelines are, but rather a practicum of them. The content reviewed will be presented in a format that will be appreciated by the seasoned surgical auditor/coder, Compliance officer, as well as an individual that may be newer to the surgical side of medicine.

Surgical Services

While E&M (Evaluation & Management) services tend to be the most audited physician’s service, and the largest volume of claims billed, surgical services represent most of the codes found in the CPT manual. From the beginning of the integumentary code, 10021 all the way through to the audiology section ending with 69990.

An auditor must be familiar first and foremost with medical abbreviations, terminology, and anatomy relevant to the specialty of the provider being audited. These topics will not be covered during today’s session, but there are excellent resources available to assist with familiarization of each.

The tools that will assist the auditor that will be reviewed in today’s session are:
- Global surgical package
- Documentation requirements
- Medical necessity
- Modifier usage
- NCCI edits
- Policy coverage determinations

This session is based on the assumption that the attendee is familiar with these terms and the basic rules, as these will not be discussed in great depth. Today’s session is the application of each.

Global Surgical Package

The basics of the package remind us that the preoperative, intraoperative, and postoperative components all make up the global surgical package, but even though there are hard and fast rules regarding the global surgical package there are always cases that seem to challenge the rules.

Preoperative Services:
Let’s apply auditing rules to preoperative services with the following scenario:
- The patient presents to the office on 12-17-2011 and the provider informs the patient that they need to undergo a total knee replacement. The patient consents to the surgery, but does not want the procedure until after the holiday season is over. Surgery is scheduled for 1-20-2012 to best accommodate the patient.
The patient returns to the clinic on 1-18-2012, and during the encounter the provider documents the following:

The patient returns today for follow up of her right chronic knee pain. She has been increasing the amount of Advil she is using for pain that breaks-through prior to dosage timing of hydrocodone. She states that the pain today seems increased due to the damp cold weather and actually rates the pain as a 9 today. She also complains of pain radiating down the right leg into the ankle region, but has no noted numbness or tingling. She has had no fever, nausea/vomiting, double vision, other musculoskeletal complaints, unstable sugars (known diabetic), and no rashes or skin infections.

I reviewed her PFSH with her and noted that she smokes 2 packs a day, but she advises that she has been able to decrease to 1 pack per day. Ms. Jones additionally comments that her mother did have some troubles with anesthesia during one surgical encounter and I suggested that she be sure to provide more information regarding this to the anesthesiologist at her pre-operative consult with them.

On exam, the patient’s weight is noted to have increased 12 pounds from her last visit. She is noted to have swelling of the right knee, but no redness or discoloration. Her gait is guarded and her ROM is diminished.

Impression: OA of the right knee
Knee pain

The patient appears to still be a viable candidate for the procedure. Her knee, as suspected, is worsening since just her last visit and the additional weight may be further impacting this issue as well.

I will see her in the OR on 1-20-2012. Please additionally refer to the Admit H&P performed today as well for any other pertinent information.

CHALLENGING THE PREOPERATIVE PACKAGE RULES:
- Is an Admit H&P a billable service?
- Why did this patient present to the office today?
- Does the documentation support that this service is a billable encounter?
- What documentation do we use to audit the E&M portion of the encounter?

Intra-Operative Services
Most auditors and coders alike tend to think that services rendered as part of the intraoperative services are standard or somewhat “cookie-cutter” in nature. The services consist of opening the site, performing the service, and closing the site. Coding can at times be difficult to assign to complicated cases. Surgeries, such as spine cases that have a large number of codes that can be assigned, are at times difficult to code, but auditing the services may not be quite so daunting. When auditing the surgical service, the codes have been provided—it is now up to the auditor to evaluate the codes to judge if the services rendered support the codes that were billed.
Additionally, the “cookie-cutter” appearance of the surgical services disappears with modifier usage. The modifier says why this case was different than what is explained as the norm for the service billed. The auditor should be familiar with what the expectation of work performed is based on CPT description. This will enable an auditor to more readily identify cases that are not of the normal type.
1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLX LUNG OTHER
X (Medicare) (Medicaid) Sponsor’s SSN (Member ID #)

2. PATIENT’S NAME (Last Name, First Name, Middle Initial)
Brown, Michelle

5. PATIENT’S ADDRESS (No., Street)
11225 Main Street

6. PATIENT’S RELATIONSHIP TO INSURED
Self

7. INSURED’S ADDRESS (No., Street)
11225 Main Street

11. INSURED’S POLICY GROUP OF FECA NUMBER

13. INSURED’S OR AUTHORIZED PERSONS SIGNATURE
I authorize release of any medical or other information necessary to
treat this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNATURE ON FILE DATE 6-16-2011

14. INSURED’S SOCIAL SECURITY NUMBER
AGCF1598521

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3, 4 to Item 24E by Line)
1. 574.20
2. 575.10

24. A. DATE(S) OF SERVICE FROM

26. PATIENT’S ACCOUNT NO.

27. ACCEPT ASSIGNMENT

28. TOTAL CHARGE
$ 773.31

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS
Mark Rogers, MD

32. SERVICE FACILITY LOCATION INFORMATION
EAC Hospital
1234 Medical Drive
Nashville, CA 45366

33. BILLING PROVIDER INFO & PH.
EAC Hospital
1234 Medical Drive
Nashville, CA 45366

3691234753 X

DATE 06/16/2011
### Coding Information

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>47563</td>
<td>Laparoscopy, surgical; cholecystectomy with cholangiography</td>
</tr>
<tr>
<td>47564</td>
<td>Laparoscopy, surgical; cholecystectomy with exploration of common duct</td>
</tr>
<tr>
<td>47570</td>
<td>Laparoscopy, surgical; cholecystoenterostomy</td>
</tr>
<tr>
<td>47579</td>
<td>Unlisted laparoscopy procedure, biliary tract</td>
</tr>
<tr>
<td>99140</td>
<td>Anesthesia complicated by emergency conditions (specify) (List separately in addition)</td>
</tr>
</tbody>
</table>

### ICD-9

<table>
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<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>574.2</td>
<td>Calculus of gallbladder without mention of Cholecystitis</td>
</tr>
<tr>
<td></td>
<td>Bilary: Calculus NOS; Colic NOS; Calculus of cystic duct; Cholelithiasis NOS; Colic (recurrent) of gallbladder; Gallstone (impacted)</td>
</tr>
<tr>
<td>574.2</td>
<td>Calculus of gallbladder without mention of Cholecystitis or obstruction</td>
</tr>
<tr>
<td>574.21</td>
<td>Calculus of gallbladder without mention of cholecystitis, with obstruction</td>
</tr>
<tr>
<td></td>
<td>other cholecystitis; cholecystitis - without mention of calculus; NOS - without mention of calculus; chronic - without mention of calculus. Excludes: That with: choledocholithiasis,</td>
</tr>
<tr>
<td>575.1</td>
<td>choledocholithiasis and cholelithiasis, cholelithiasis</td>
</tr>
<tr>
<td>575.1</td>
<td>Cholecystitis, unspecified</td>
</tr>
</tbody>
</table>
Date of Operation: 06-16-2011

Preoperative Diagnosis: Cholecystitis and cholelithiasis
Postoperative Diagnosis: Same

Operation Performed: Laparoscopic cholecystectomy with intraoperative cholangiography

Surgeon: Mark Rogers, MD

Indications:
This patient is a 49-year-old lady with symptomatic gallbladder disease and gallstones. She was taken to the operating room, placed on the operating table in supine position, given a general anesthetic, prepped with Betadine scrub and solution and draped to expose the abdomen. A small incision was made in the upper portion of the umbilicus after anesthetizing with Maracaine. It was carried with cautery down to the fascia. Traction sutures were placed on each side of the midline and the fascia was opened with cautery. The peritoneum was opened between clamps with scissors and blunt port was placed in the abdomen and held in place with traction sutures and used to insufflate the abdomen. A 10-12 port was placed in the upper midline and two #5 ports were placed laterally. The gallbladder has some adhesions and these were taken down and the gallbladder was placed on some tension. It wanted to leak because it was very taut so we put a needle in and withdrew most of the bile. The cystic duct was identified and dissected free, clipped near the gallbladder. A small incision was made in the cystic duct, held in place with partially applied clip, used to obtain a cholangiogram which was normal. The clips were removed. The cystic duct catheter was removed. The cystic duct was carefully doubly clipped proximally and transected between the last two clips. The artery was then doubly clipped proximally and singly clipped distally and cut between the sets of clips. The gallbladder was then removed with cautery. The camera was transferred to the upper port and grasping forceps were brought in through the umbilical port to grab the gallbladder and withdraw it out of the abdomen. It was a little intrahepatic. The umbilical port was replaced. The abdomen was re-inflated. Hemostasis was achieved in the gallbladder bed with cautery, irrigated, and suctioned clean. We did put some Histoacryl soaked in Maracaine into the gallbladder bed. The two #5 ports were removed and the abdomen was deflated. The two #5 ports were removed and the abdomen was deflated. The upper port was removed and no bleeding was noted in any of the three ports. The umbilical port was removed and the abdomen was completely deflated. The umbilical fascia was closed with a figure-of-8 and simple suture of #0 Vicryl suture. The upper port did not require fascial closure. The subcutaneous tissues of the two larger incisions was closed with interrupted #000 Vicryl and then all of the skin incisions were closed with running #4-0 Monocryl subcuticular suture. Benzoin and Steri-Strips were applied. Tonsil sponge was placed in the umbilicus and Tegaderm dressing was place over the incision.

The patient tolerated the procedure well.

Mark Rogers, MD
Basic OP Report Requirements

The operative report is the provider’s account of the surgical service. The documentation should not just account for the details of how the procedure was done, but it should additionally support the medical necessity of why the service was performed. Additionally, the documentation should include information regarding anything that made the encounter not “cookie-cutter” that would support the medical necessity of the modifier usage.

An operative report should always include the following:

1. Date of the procedure: The date of the procedure and according to JCAHO standards the time of the procedure must be documented on the OP report.

2. Pre- and post-operative diagnoses: The preoperative diagnosis often times maybe the signs and/or symptoms that is prompting the need for the procedure. The preoperative diagnosis should be the defining indication for the procedure performed.
   When audited the post-operative diagnosis should represent any findings of the procedure (if applicable).

3. Procedures Performed: The procedure(s) that were performed should be clearly documented on the operative report and should accurately reflect the services performed in the body of the operative report. This section of the OP report should be used to give the coder tips and advice as to where to start with coding the procedure, but often times some coders make the mistake of coding only from this portion of the note. The body of the note will contain the critical details that may include things such as altered anatomy or increased work that add to the complexity of interpreting the documentation.

4. Type of anesthesia: This information is often documented in the operative note, but it is not a required component.

5. Blood loss/Blood Replacement: This information is also not a required component, but may add to the complexity of the medical necessity of the case. However, this statement alone would not be enough to support, but would additionally require that the provider explain in their documentation the complications created, if applicable.

6. Surgeon: All providers who participated in the case must be listed in the operative note. This includes resident physicians, assist at surgery, as well as staff surgeons.

7. Details: The procedure details should be as specific as possible and should include the patient's position, the approach or approaches used the specific organ, structure, or area being operative upon. Be specific in your documentation. It cannot be assumed that something was performed simply because it is the way the procedure is usually done. Just as unusual approaches and findings must be specifically documented, so must standard approaches and findings. The details should also include information regarding any type of guidance that was used in order to perform the procedure.

8. Findings: The findings of the procedure are a required element of the OP report. The findings are not required to be marked with a heading or defined as such. It may be included in the details of the OP report and should include information such as: unexpected findings, the size of tumors or lesions, complications, extra work involved in the procedure and other key information that can have an impact on patient care and the medical necessity of the procedure and/or modifiers used.

9. Signatures: Only electronic or authentic signatures are acceptable. All providers who documented any part of the operative note should sign the record. It should be possible to identify who documented each element of the note and, if any changes or amendments were made, who made them and when.
Modifiers for Intra-Operative Use

Modifiers are an indicator to an auditor that the case was somehow different than the standard CPT description of the procedure. Therefore, the auditor should be reviewing the OP report to identify what made the procedure different to substantiate the medical necessity.

Here are some of the most commonly used (but not all) surgical modifiers accompanied with details that the auditor should be reviewing for to support their use.

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>The OP report should include evidence of what the increased work was, and additionally the cause of the increased work.</td>
</tr>
<tr>
<td>50</td>
<td>The documentation should specifically state details of the procedure for each side. Only in limited situations should an auditor allow documentation such as, &quot;same procedure was performed bilaterally&quot; to support this service.</td>
</tr>
<tr>
<td>52</td>
<td>Details of the OP report should explain what about this specific procedure was reduced based on the expectations of the code descriptor.</td>
</tr>
<tr>
<td>53</td>
<td>When a procedure must be discontinued the auditor should find documentation that is inclusive of how much of the procedure was performed and why the procedure was stopped.</td>
</tr>
<tr>
<td>58</td>
<td>It is not necessary that the prior surgical service specifically indicate it was a staged procedure, but the documentation of the procedure being audited should account for why this is a continuation or another staging of the procedure.</td>
</tr>
<tr>
<td>59</td>
<td>Since this modifier is an unbundling modifier and will lead to additional reimbursement that would otherwise not be allowed, it is important that the documentation indicate how the service can be identified as needing to be unbundled.</td>
</tr>
<tr>
<td>80</td>
<td>Assist-at-surgery services must be supported by documentation within the OP report of what the assist did during the procedure.</td>
</tr>
</tbody>
</table>

Modifiers affect claim payment, and any variable that affects reimbursement must be supported within the documentation.

Now let's put that knowledge to work:

**OP Report Heading:**

- **Patient:** Joe Bella
- **Date:** January 18, 2012
- **Procedure:** Right TKR
- **Pre-Operative Diagnosis:** OA Right Knee
- **Post-Operative Diagnosis:** same
- **Surgeon:** Anita Sharp, MD
- **Assisting surgeon:** T. Blake King, FNP
- **BMI:** 47
1. Are the assist services supported since the documentation includes “proof” that an assist was used in the case?
2. The auditor did not find an OP report or any other documentation as authored by Mr. King. Is the service supported?
3. Since the patient's BMI is noted as being obese, this fact as reported above will support the use of a modifier -22?

Post-Operative Services
What makes a service not related to the global surgical package? Post-operative services are identified as being services that are part of “routine” post-operative care. Therefore, the auditor would be evaluating post-operative services that are billed with an unbundling modifier during the global services to identify what makes them not routine during this encounter.

CMS has many rules regarding the global package, but one statement in particular is the source of controversy regarding additionally billable and non-billable services. Per CMS in the Claims Processing Manual services that are additional billable include: *Visits unrelated to the diagnosis for which the surgical procedure is performed, unless the visits occur due to complications of the surgery.*

However, this rule can also simplify post-operative services as well. A good rule of thumb is that if the diagnosis that is assigned to the encounter changes from the surgical diagnosis, the visit is additionally billable.

Let’s challenge the rules:
- Patient reports to office 7 days post-op and is noted to have a red irritated surgical site with drainage.
- Dr. Snyder rounds on a patient status-post total hip replacement and she is noted to be anemic and in need of a transfusion.
- During an onsite visit with an orthopedist, the auditor notes that fluid is withdrawn off of the knee of a patient that recently underwent a total knee replacement.
- Pain management provider managing post-operative pain.

NCCI Edits
The auditor should be sure and have their NCCI edits when performing audits on government payer claims. When performing an audit on commercial carrier claims, the auditor should refer to any type of edits that the individual carrier may recognize. Some commercial carrier use the NCCI edits, but the auditor should verify this information.

When the auditor has identified a surgical procedure in which the services are shown as bundled, the documentation of the encounter must appropriately support why the modifier should be used for the additional reimbursement. Modifiers -50 and -59 would be the modifiers that would most frequently be used in association with the NCCI edits. Therefore, as long as the auditor can interpret the NCCI table, and knows what documentation is needed to support the use of the un-bundling modifiers, the edits should be a routine part of auditing.
National/Local Determination Policies

Certain procedures are deemed only payable when they meet medical necessity as outlined by the payer policies. Most carriers have their medical policies available on their website. When performing an audit the auditor must be sure to refer to the policy that is specific to the geographic area and the specific carrier’s medical policies.

Medical policies contain valuable information which may be of help to an auditor that may be auditing a different service/specialty for the first time. As experienced auditors/coders we often refer to the medical policies, but for what information? The covered diagnosis codes... do you know what other valuable information is found in a LCD?

Local Coverage Determination (LCD) for Excision of Malignant Skin Lesions (L29170)

Contractor Information

Contractor Name: First Coast Service Options, Inc.
Contractor Number: 09102
Contractor Type: MAC - Part B

LCD Information

Document Information
LCD ID Number: L29170

Primary Geographic Jurisdiction: Florida
Oversight Region: Region IV
Original Determination Effective Date: For services performed on or after 02/02/2003

Contractor's Determination Number: 11600

Original Determination Ending Date

AMA CPT/ADA CDT Copyright Statement
CPT codes, descriptions and other data only are Copyright 2011 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS Clauses Apply. Current Dental Terminology,(CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. © 2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

CMS National Coverage Policy
N/A

Revision Effective Date: For services performed on or after 10/01/2011
Revision Ending Date
Indications and Limitations of Coverage and/or Medical Necessity
A skin lesion is any alteration in the normal skin architecture. Lesions can be benign, pre-malignant or malignant. The most common malignant lesions are Basal Cell Carcinomas (BCC), Squamous Cell Carcinomas (SCC) and Melanomas.

Four of the most common methods of treatment of malignant skin lesions are:

- Surgical excision,
- Electrodesiccation (tissue destruction by heat),
- Radiation therapy, or
- Cryosurgery (tissue destruction by freezing)

The treatment of choice for malignant skin lesions is complete excision that includes a variable margin of surrounding tissue in order to eradicate microscopic tumor cells, which may have spread beyond the visible borders of the lesion.

Medicare will consider the excision of a malignant skin lesion including margins (procedure codes 11600-11646) medically necessary when a pathology report verifies the existence of a malignancy.

When a lesion is excised that is a neoplasm of uncertain morphology (e.g., melanoma vs. dysplastic nevi), choose the correct CPT code based on the manner in which the lesion is excised rather than the final pathological diagnosis. The CPT code should reflect the knowledge, skill, time and effort that the provider invests in the excision of the lesion. For example, an ambiguous, but low-suspicion lesion might be excised with minimal surrounding, grossly normal skin/soft tissue margins, as for a benign lesion. This would be most appropriately reported using the excision of benign lesion codes 11400-11446. An ambiguous, but moderate to high suspicion lesion would be excised with moderate to wide surrounding grossly normal skin/soft tissue margins, as for a malignant lesion. This type of excision would be most appropriately reported using the excision of malignant lesion including margins codes 11600-11646.

Coding Information

Bill Type Codes:
Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

Revenue Codes:
Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

<table>
<thead>
<tr>
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<td>99999</td>
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### CPT/HCPCS Codes

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<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>11600</td>
<td>EXCISION, MALIGNANT LESION INCLUDING MARGINS, TRUNK, ARMS, OR LEGS; EXCISED DIAMETER 0.5 CM OR LESS</td>
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<tr>
<td>11601</td>
<td>EXCISION, MALIGNANT LESION INCLUDING MARGINS, TRUNK, ARMS, OR LEGS; EXCISED DIAMETER 0.6 TO 1.0 CM</td>
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<tr>
<td>11602</td>
<td>EXCISION, MALIGNANT LESION INCLUDING MARGINS, TRUNK, ARMS, OR LEGS; EXCISED DIAMETER 1.1 TO 2.0 CM</td>
</tr>
<tr>
<td>11603</td>
<td>EXCISION, MALIGNANT LESION INCLUDING MARGINS, TRUNK, ARMS, OR LEGS; EXCISED DIAMETER 2.1 TO 3.0 CM</td>
</tr>
<tr>
<td>11604</td>
<td>EXCISION, MALIGNANT LESION INCLUDING MARGINS, TRUNK, ARMS, OR LEGS; EXCISED DIAMETER 3.1 TO 4.0 CM</td>
</tr>
<tr>
<td>11606</td>
<td>EXCISION, MALIGNANT LESION INCLUDING MARGINS, SCALP, NECK, HANDS, FEET, GENITALIA; EXCISED DIAMETER 0.5 CM OR LESS</td>
</tr>
<tr>
<td>11620</td>
<td>EXCISION, MALIGNANT LESION INCLUDING MARGINS, SCALP, NECK, HANDS, FEET, GENITALIA; EXCISED DIAMETER 0.6 TO 1.0 CM</td>
</tr>
<tr>
<td>11621</td>
<td>EXCISION, MALIGNANT LESION INCLUDING MARGINS, SCALP, NECK, HANDS, FEET, GENITALIA; EXCISED DIAMETER 1.1 TO 2.0 CM</td>
</tr>
<tr>
<td>11622</td>
<td>EXCISION, MALIGNANT LESION INCLUDING MARGINS, SCALP, NECK, HANDS, FEET, GENITALIA; EXCISED DIAMETER 2.1 TO 3.0 CM</td>
</tr>
<tr>
<td>11623</td>
<td>EXCISION, MALIGNANT LESION INCLUDING MARGINS, SCALP, NECK, HANDS, FEET, GENITALIA; EXCISED DIAMETER 3.1 TO 4.0 CM</td>
</tr>
<tr>
<td>11624</td>
<td>EXCISION, MALIGNANT LESION INCLUDING MARGINS, SCALP, NECK, HANDS, FEET, GENITALIA; EXCISED DIAMETER OVER 4.0 CM</td>
</tr>
<tr>
<td>11640</td>
<td>EXCISION, MALIGNANT LESION INCLUDING MARGINS, FACE, EARS, EYELIDS, NOSE, LIPS; EXCISED DIAMETER 0.5 CM OR LESS</td>
</tr>
<tr>
<td>11641</td>
<td>EXCISION, MALIGNANT LESION INCLUDING MARGINS, FACE, EARS, EYELIDS, NOSE, LIPS; EXCISED DIAMETER 0.6 TO 1.0 CM</td>
</tr>
<tr>
<td>11642</td>
<td>EXCISION, MALIGNANT LESION INCLUDING MARGINS, FACE, EARS, EYELIDS, NOSE, LIPS; EXCISED DIAMETER 1.1 TO 2.0 CM</td>
</tr>
<tr>
<td>11643</td>
<td>EXCISION, MALIGNANT LESION INCLUDING MARGINS, FACE, EARS, EYELIDS, NOSE, LIPS; EXCISED DIAMETER 2.1 TO 3.0 CM</td>
</tr>
<tr>
<td>11644</td>
<td>EXCISION, MALIGNANT LESION INCLUDING MARGINS, FACE, EARS, EYELIDS, NOSE, LIPS; EXCISED DIAMETER 3.1 TO 4.0 CM</td>
</tr>
<tr>
<td>11646</td>
<td>EXCISION, MALIGNANT LESION INCLUDING MARGINS, FACE, EARS, EYELIDS, NOSE, LIPS; EXCISED DIAMETER OVER 4.0 CM</td>
</tr>
</tbody>
</table>

### ICD-9 Codes that Support Medical Necessity

**Procedure Codes 11600-11606**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>172.5</td>
<td>MALIGNANT MELANOMA OF SKIN OF TRUNK EXCEPT SCROTUM</td>
</tr>
<tr>
<td>172.6</td>
<td>MALIGNANT MELANOMA OF SKIN OF UPPER LIMB INCLUDING SHOULDER</td>
</tr>
<tr>
<td>172.7</td>
<td>MALIGNANT MELANOMA OF SKIN OF LOWER LIMB INCLUDING HIP</td>
</tr>
<tr>
<td>173.5</td>
<td>UNSPECIFIED MALIGNANT NEOPLASM OF SKIN OF TRUNK, EXCEPT SCROTUM - OTHER SPECIFIED MALIGNANT NEOPLASM OF SKIN OF TRUNK, EXCEPT SCROTUM</td>
</tr>
<tr>
<td>173.59</td>
<td>UNSPECIFIED MALIGNANT NEOPLASM OF SKIN OF TRUNK, EXCEPT SCROTUM - OTHER SPECIFIED MALIGNANT NEOPLASM OF SKIN OF TRUNK, EXCEPT SCROTUM</td>
</tr>
<tr>
<td>173.6</td>
<td>UNSPECIFIED MALIGNANT NEOPLASM OF SKIN OF UPPER LIMB, INCLUDING SHOULDER - OTHER SPECIFIED MALIGNANT NEOPLASM OF SKIN OF UPPER LIMB, INCLUDING SHOULDER</td>
</tr>
<tr>
<td>173.69</td>
<td>UNSPECIFIED MALIGNANT NEOPLASM OF SKIN OF LOWER LIMB, INCLUDING HIP - OTHER SPECIFIED MALIGNANT NEOPLASM OF SKIN OF LOWER LIMB, INCLUDING HIP</td>
</tr>
<tr>
<td>173.7</td>
<td>UNSPECIFIED MALIGNANT NEOPLASM OF SKIN OF LOWER LIMB, INCLUDING HIP - OTHER SPECIFIED MALIGNANT NEOPLASM OF SKIN OF LOWER LIMB, INCLUDING HIP</td>
</tr>
<tr>
<td>195.1</td>
<td>MALIGNANT NEOPLASM OF THORAX</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>-----------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>195.2</td>
<td>MALIGNANT NEOPLASM OF ABDOMEN</td>
</tr>
<tr>
<td>195.3</td>
<td>MALIGNANT NEOPLASM OF PELVIS</td>
</tr>
<tr>
<td>195.4</td>
<td>MALIGNANT NEOPLASM OF UPPER LIMB</td>
</tr>
<tr>
<td>195.5</td>
<td>MALIGNANT NEOPLASM OF LOWER LIMB</td>
</tr>
<tr>
<td>195.8</td>
<td>MALIGNANT NEOPLASM OF OTHER SPECIFIED SITES</td>
</tr>
<tr>
<td>198.2</td>
<td>SECONDARY MALIGNANT NEOPLASM OF SKIN</td>
</tr>
<tr>
<td>198.81</td>
<td>SECONDARY MALIGNANT NEOPLASM OF BREAST</td>
</tr>
<tr>
<td>232.5</td>
<td>CARCINOMA IN SITU OF SKIN OF TRUNK EXCEPT SCROTUM</td>
</tr>
<tr>
<td>232.6</td>
<td>CARCINOMA IN SITU OF SKIN OF UPPER LIMB INCLUDING SHOULDER</td>
</tr>
<tr>
<td>232.7</td>
<td>CARCINOMA IN SITU OF SKIN OF LOWER LIMB INCLUDING HIP</td>
</tr>
<tr>
<td>232.8</td>
<td>CARCINOMA IN SITU OF OTHER SPECIFIED SITES OF SKIN</td>
</tr>
<tr>
<td>238.2</td>
<td>NEOPLASM OF UNCERTAIN BEHAVIOR OF SKIN</td>
</tr>
</tbody>
</table>

**Procedure Codes 11620-11626**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>172.4</td>
<td>MALIGNANT MELANOMA OF SKIN OF SCALP AND NECK</td>
</tr>
<tr>
<td>172.6</td>
<td>MALIGNANT MELANOMA OF SKIN OF UPPER LIMB INCLUDING SHOULDER</td>
</tr>
<tr>
<td>172.7</td>
<td>MALIGNANT MELANOMA OF SKIN OF LOWER LIMB INCLUDING HIP</td>
</tr>
<tr>
<td>173.40 - 173.49</td>
<td>UNSPECIFIED MALIGNANT NEOPLASM OF SCALP AND SKIN OF NECK - OTHER SPECIFIED MALIGNANT NEOPLASM OF SCALP AND SKIN OF NECK</td>
</tr>
<tr>
<td>173.60 - 173.69</td>
<td>UNSPECIFIED MALIGNANT NEOPLASM OF SKIN OF UPPER LIMB, INCLUDING SHOULDER - OTHER SPECIFIED MALIGNANT NEOPLASM OF SKIN OF UPPER LIMB, INCLUDING SHOULDER</td>
</tr>
<tr>
<td>173.70 - 173.79</td>
<td>UNSPECIFIED MALIGNANT NEOPLASM OF SKIN OF LOWER LIMB, INCLUDING HIP - OTHER SPECIFIED MALIGNANT NEOPLASM OF SKIN OF LOWER LIMB, INCLUDING HIP</td>
</tr>
<tr>
<td>184</td>
<td>MALIGNANT NEOPLASM OF VAGINA</td>
</tr>
<tr>
<td>184.1</td>
<td>MALIGNANT NEOPLASM OF LABIA MAJORA</td>
</tr>
<tr>
<td>184.2</td>
<td>MALIGNANT NEOPLASM OF LABIA MINORA</td>
</tr>
<tr>
<td>184.3</td>
<td>MALIGNANT NEOPLASM OF CLITORIS</td>
</tr>
<tr>
<td>184.4</td>
<td>MALIGNANT NEOPLASM OF VULVA UNSPECIFIED SITE</td>
</tr>
<tr>
<td>184.8</td>
<td>MALIGNANT NEOPLASM OF OTHER SPECIFIED SITES OF FEMALE GENITAL ORGANS</td>
</tr>
<tr>
<td>187.1</td>
<td>MALIGNANT NEOPLASM OF PREPUCE</td>
</tr>
<tr>
<td>187.2</td>
<td>MALIGNANT NEOPLASM OF GLANS PENIS</td>
</tr>
<tr>
<td>187.3</td>
<td>MALIGNANT NEOPLASM OF BODY OF PENIS</td>
</tr>
<tr>
<td>187.4</td>
<td>MALIGNANT NEOPLASM OF PENIS PART UNSPECIFIED</td>
</tr>
<tr>
<td>187.7</td>
<td>MALIGNANT NEOPLASM OF SCROTUM</td>
</tr>
<tr>
<td>195</td>
<td>MALIGNANT NEOPLASM OF HEAD FACE AND NECK</td>
</tr>
<tr>
<td>195.3</td>
<td>MALIGNANT NEOPLASM OF PELVIS</td>
</tr>
<tr>
<td>195.4</td>
<td>MALIGNANT NEOPLASM OF UPPER LIMB</td>
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<td>195.5</td>
<td>MALIGNANT NEOPLASM OF LOWER LIMB</td>
</tr>
<tr>
<td>198.2</td>
<td>SECONDARY MALIGNANT NEOPLASM OF SKIN</td>
</tr>
<tr>
<td>198.82</td>
<td>SECONDARY MALIGNANT NEOPLASM OF GENITAL ORGANS</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>------------------------------------------------------------------</td>
</tr>
<tr>
<td>232.4</td>
<td>CARCINOMA IN SITU OF SCALP AND SKIN OF NECK</td>
</tr>
<tr>
<td>232.6</td>
<td>CARCINOMA IN SITU OF SKIN OF UPPER LIMB INCLUDING SHOULDER</td>
</tr>
<tr>
<td>232.7</td>
<td>CARCINOMA IN SITU OF SKIN OF LOWER LIMB INCLUDING HIP</td>
</tr>
<tr>
<td>232.8</td>
<td>CARCINOMA IN SITU OF OTHER SPECIFIED SITES OF SKIN</td>
</tr>
<tr>
<td>233.30 - 233.39</td>
<td>CARCINOMA IN SITU, UNSPECIFIED FEMALE GENITAL ORGAN - CARCINOMA IN SITU, OTHER FEMALE GENITAL ORGAN</td>
</tr>
<tr>
<td>233.5</td>
<td>CARCINOMA IN SITU OF PENIS</td>
</tr>
<tr>
<td>233.6</td>
<td>CARCINOMA IN SITU OF OTHER AND UNSPECIFIED MALE GENITAL ORGANS</td>
</tr>
<tr>
<td>238.2</td>
<td>NEOPLASM OF UNCERTAIN BEHAVIOR OF SKIN</td>
</tr>
</tbody>
</table>

**Procedure Codes 11640-11646**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>140.0 - 149.9</td>
<td>MALIGNANT NEOPLASM OF UPPER LIP VERMILION BORDER - MALIGNANT NEOPLASM OF ILL-DEFINED SITES WITHIN THE LIP AND ORAL CAVITY</td>
</tr>
<tr>
<td>172</td>
<td>MALIGNANT MELANOMA OF SKIN OF LIP</td>
</tr>
<tr>
<td>172.1</td>
<td>MALIGNANT MELANOMA OF SKIN OF EYELID INCLUDING CANTHUS</td>
</tr>
<tr>
<td>172.2</td>
<td>MALIGNANT MELANOMA OF SKIN OF EAR AND EXTERNAL AUDITORY CANAL</td>
</tr>
<tr>
<td>172.3</td>
<td>MALIGNANT MELANOMA OF SKIN OF OTHER AND UNSPECIFIED PARTS OF FACE</td>
</tr>
<tr>
<td>172.8</td>
<td>MALIGNANT MELANOMA OF OTHER SPECIFIED SITES OF SKIN</td>
</tr>
<tr>
<td>173.00 - 173.09</td>
<td>UNSPECIFIED MALIGNANT NEOPLASM OF SKIN OF LIP - OTHER SPECIFIED MALIGNANT NEOPLASM OF SKIN OF LIP</td>
</tr>
<tr>
<td>173.10 - 173.19</td>
<td>UNSPECIFIED MALIGNANT NEOPLASM OF EYELID, INCLUDING CANTHUS - OTHER SPECIFIED MALIGNANT NEOPLASM OF EYELID, INCLUDING CANTHUS</td>
</tr>
<tr>
<td>173.20 - 173.29</td>
<td>UNSPECIFIED MALIGNANT NEOPLASM OF SKIN OF EAR AND EXTERNAL AUDITORY CANAL - OTHER SPECIFIED MALIGNANT NEOPLASM OF SKIN OF EAR AND EXTERNAL AUDITORY CANAL</td>
</tr>
<tr>
<td>173.30 - 173.39</td>
<td>UNSPECIFIED MALIGNANT NEOPLASM OF SKIN OF OTHER AND UNSPECIFIED PARTS OF FACE - OTHER SPECIFIED MALIGNANT NEOPLASM OF SKIN OF OTHER AND UNSPECIFIED PARTS OF FACE</td>
</tr>
<tr>
<td>173.80 - 173.89</td>
<td>UNSPECIFIED MALIGNANT NEOPLASM OF OTHER SPECIFIED SITES OF SKIN - OTHER SPECIFIED MALIGNANT NEOPLASM OF OTHER SPECIFIED SITES OF SKIN</td>
</tr>
<tr>
<td>195</td>
<td>MALIGNANT NEOPLASM OF HEAD FACE AND NECK</td>
</tr>
<tr>
<td>198.2</td>
<td>SECONDARY MALIGNANT NEOPLASM OF SKIN</td>
</tr>
<tr>
<td>230</td>
<td>CARCINOMA IN SITU OF LIP ORAL CAVITY AND PHARYNX</td>
</tr>
<tr>
<td>232</td>
<td>CARCINOMA IN SITU OF SKIN OF LIP</td>
</tr>
<tr>
<td>232.1</td>
<td>CARCINOMA IN SITU OF EYELID INCLUDING CANTHUS</td>
</tr>
<tr>
<td>232.2</td>
<td>CARCINOMA IN SITU OF SKIN OF EAR AND EXTERNAL AUDITORY CANAL</td>
</tr>
<tr>
<td>232.3</td>
<td>CARCINOMA IN SITU OF SKIN OF OTHER AND UNSPECIFIED PARTS OF FACE</td>
</tr>
<tr>
<td>232.8</td>
<td>CARCINOMA IN SITU OF OTHER SPECIFIED SITES OF SKIN</td>
</tr>
<tr>
<td>238.2</td>
<td>NEOPLASM OF UNCERTAIN BEHAVIOR OF SKIN</td>
</tr>
</tbody>
</table>
Diagnoses that Support Medical Necessity
N/A

ICD-9 Codes that DO NOT Support Medical Necessity
N/A

| XX000 | Not Applicable |

ICD-9 Codes that DO NOT Support Medical Necessity Asterisk Explanation
Diagnoses that DO NOT Support Medical Necessity
N/A

**General Information**

**Documentation Requirements**
The medical record/progress note should indicate the removal of a malignant or an ambiguous, but moderate to high suspicion lesion with a corresponding pathology report. The size and location of the lesion should be documented in the operative report.

Appendices

**Utilization Guidelines** It is expected that these services would be performed as indicated by current medical literature and/or standards of practice. When services are performed in excess of established parameters, they may be subject to review for medical necessity.

Sources of Information and Basis for Decision


Advisory Committee Meeting Notes This Local Coverage Determination (LCD) does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the contractor, this LCD was developed in cooperation with advisory groups, which includes representatives from numerous societies.

Start Date of Comment Period

End Date of Comment Period

Start Date of Notice Period 10/01/2009

Revision History Number 2
Revision History Explanation Revision Number:2
Start Date of Comment Period:N/A
Start Date of Notice Period: 10/01/2011
Revised Effective Date: 10/01/2011

LCR B2011-101
September 2011 Connection

Explanation of Revision: Annual 2012 ICD-9-CM Update. For CPT codes 11600-11606 deleted diagnosis codes 173.5, 173.6, and 173.7. Added new diagnosis codes 173.50-173.59, 173.60-173.69 and 173.70-173.79. For CPT codes 11620-11625 deleted diagnosis codes 173.4, 173.6 and 173.7. Added new diagnosis codes 173.40-173.49, 173.60 173.69 and 173.70-173.79. For CPT codes 11640-11646 deleted diagnosis codes 173.0, 173.1, 173.2, 173.3 and 173.8. Added new diagnosis codes 173.00-173.09, 173.10-173.19, 173.20-173.29, 173.30-173.39 and 173.80-173.89. The effective date of this revision is based on date of service.

Revision Number: 1
Start Date of Comment Period: N/A
Start Date of Notice Period: 10/01/2009
Revised Effective Date: 08/28/2009

LCR B2009-091
September 2009 Update

Explanation of Revision: Under the “ICD-9 Codes that Support Medical Necessity” section for procedure code range 11640-11646, added ICD-9-CM code 198.2. In addition, updated the “Sources of Information and Basis for Decision” section. The effective date of this revision is for claims processed on or after 08/28/2009 for dates of service on or after 02/02/2009 for Florida and for dates of service on or after 03/02/2009 for Puerto Rico/Virgin Islands

Revision Number: Original
Start Date of Comment Period: N/A
Start Date of Notice Period: 12/04/2008
Revised Effective Date: 02/02/2009

December 2008 Bulletin

This LCD consolidates and replaces all previous policies and publications on this subject by the carrier predecessors of First Coast Service Options, Inc. (Triple S and FCSO).

For Florida (00590) this LCD (L29170) replaces LCD L6490 as the policy in notice. This document (L29170) is effective on 02/02/2009.

08/27/2011 - This policy was updated by the ICD-9 2011-2012 Annual Update.

11/21/2011 - For the following CPT/HCPCS codes either the short description and/or the long description was changed. Depending on which description is used in this LCD, there may not be any change in how the code displays in the document:
11600 descriptor was changed in Group 1
11601 descriptor was changed in Group 1
11602 descriptor was changed in Group 1
11603 descriptor was changed in Group 1
11604 descriptor was changed in Group 1
11606 descriptor was changed in Group 1
11620 descriptor was changed in Group 1
11621 descriptor was changed in Group 1
11622 descriptor was changed in Group 1
11623 descriptor was changed in Group 1
11624 descriptor was changed in Group 1
11626 descriptor was changed in Group 1
11640 descriptor was changed in Group 1
11641 descriptor was changed in Group 1
11642 descriptor was changed in Group 1
11643 descriptor was changed in Group 1
11644 descriptor was changed in Group 1
11646 descriptor was changed in Group 1

Reason for Change

Related Documents
This LCD has no Related Documents.

LCD Attachments
There are no attachments for this LCD.

All Versions
Updated on 11/21/2011 with effective dates 10/01/2011 - N/A
Updated on 09/12/2011 with effective dates 10/01/2011 - N/A
Updated on 09/08/2009 with effective dates 08/28/2009 - 09/30/2011
Updated on 11/30/2008 with effective dates 02/02/2009 - N/A
Read the LCD Disclaimer
Printed

Miscellaneous Housekeeping Guidelines
The operative report must be written or dictated immediately after an operative or other high risk procedure. An organization's policy, based on state law, would define the timeframe for dictation and placement in the medical record. CMS policy indicates that documentation should be generated immediately and considers entries that are 24 hours later as “late-entries.” The most important issue is that there needs to be enough information in the record immediately after surgery in order to manage the patient throughout the postoperative period.

The “rough draft” of the OP report could be a hand written note, and is not expected to include all of the specifics of the case, but enough documentation to support what service was performed and that the service was actually performed for continuity of patient care. Additionally, this information may support the services for billing in instances of lost or missing transcription. At minimum this type of progress note should include:
- Patient name and date of service
- The name of the primary surgeon and any assistants used
- Details of the procedure(s) performed
- Findings associated with the procedure
- Estimated blood loss specimens removed (continuity of care)
- Post operative diagnosis

The term immediately after surgery is defined by The Joint Commission as "upon completion of surgery, before the patient is transferred to the next level of care". This is to ensure that pertinent information is available to the next caregiver.
## Coding Information

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>29877</td>
<td>Arthroscopy, knee, surgical; debridement/shaving of articular cartilage (chondroplasty)</td>
</tr>
<tr>
<td>29879</td>
<td>Arthroscopy, knee, surgical; abrasion arthroplasty (includes chondroplasty where necessary) or multiple drilling or microfracture</td>
</tr>
<tr>
<td>29880</td>
<td>Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed.</td>
</tr>
<tr>
<td>29881</td>
<td>Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed.</td>
</tr>
<tr>
<td>29882</td>
<td>Arthroscopy, knee, surgical; with mediscus repair (medial OR lateral)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>836.2</td>
<td>Other tear of cartilage or meniscus of knee, current</td>
</tr>
<tr>
<td></td>
<td>Tear of: cartilage (semilunar) - current injury, not specified as medial or lateral, meniscus - current injury, not specified as medial or lateral</td>
</tr>
<tr>
<td>717.7</td>
<td>Chondromalacia of patella</td>
</tr>
<tr>
<td></td>
<td>Chondromalacia of patellae</td>
</tr>
<tr>
<td></td>
<td>Degeneration (softening) of articular cartilage of patella</td>
</tr>
</tbody>
</table>
Surgery Center of Asheville  
125 South Way Lane  
Asheville, SC 11528  

Operative Report  

Patient Name: Jones, Heather  
Patient ID: 45328  
Dictating Physician: King, Joseph  
Date of Procedure: 1/7/2012  

Preoperative Diagnosis: Right knee medial meniscus tear  
Postoperative Diagnosis: Right knee medial meniscus tear with lateral meniscus tear and patellofemoral chondromalacia grade 3.  

Procedures Performed: Right knee arthroscopic partial, medial, and lateral meniscectomies with patellofemoral chondroplasty shaving.  

Surgeon: King, Joseph, MD  

Anesthesia: General  

Medical Indications: The patient is a 56- Year old female complaining of progressively worsening right knee pain. She notes pain for last several months without specific injury. She has been treated with injections, activity modifications, medications without significant lasting relief. She feels her symptoms are progressively worsening. On physical exam, she had range of motion from full extension to 120 degrees of flexion with medial joint line tenderness, increased MclMurray, and no ligamentous laxity. Radiographs revealed narrowing in the medial compartment with preservation of cartilage space. MRI revealed a medial meniscus tear. Due to the patient’s symptoms, radiographic appearance, and physical findings, she was felt to be a candidate for operative intervention.  

Description of Procedure: After preoperative informed consent, the patient was admitted and taken to ASC where successful general anesthetic was applied. She received 1 g Ancef intravenously preoperatively. Her right lower extremity was then prepped and draped in the usual sterile orthopedic fashion after tourniquet had been placed proximally outside the sterile field over padding. A diagnostic arthroscopy was performed through the standard arthroscopic portals. The outflow was in the superior lateral portal, the scope inflow and the inferolateral portal, and probe in the inferomedial portal. Examination of the suprapatellar pouch revealed no abnormalities. Examination of the patellofemoral joint revealed grade 3 chondromalacia of the undersurface of the patella. All loose cartilage fragments were debrided with arthroscopic shaver taken care to preserve all normal cartilage. Patellar tracking was
central. The scope was placed in gutters revealing no bucket-handle meniscus tear and no loose body. The arthroscope was placed in the medial compartment revealing a medial meniscus tear and no loose body. The arthroscope was placed in the medial compartment revealing a medial meniscus tear. This was debrided back to stable rim utilizing combination of arthroscopic shavers and biters. Following debridement, the residual rim was noted to be entirely stable without additional tear or extension. She did have grade 2 chondromalacia with few areas of grade 3 and a few loose cartilage fragments were debrided with the arthroscopic shaver taking care to preserve the normal cartilage. The scope was then placed in the notch revealing an intact interior cruciate ligament. The scope was placed in the lateral compartment revealing fraying of the lateral edge of the lateral meniscus. This similarly was debrided back to a stable rim utilizing combination of arthroscopic shavers and biters. She had grade 2 changes of with none on the left femoral condyle. All instruments were then removed from the knee and it was irrigated with copious amounts of saline. The portals were closed with nylon suture after 0.25% Marcaine was infiltrated into the knee for postop pain relief. A sterile dressing was applied.

The patient tolerated the procedure well without complications. Estimated blood loss less than 10 cc. The tourniquet was not used.

**Postoperative Plan:** The patient was taken to recovery room in stable condition. She will be discharged home after meeting the same-day surgery criteria. She will be weight-bearing as tolerated with crutches. She was given a prescription for Lortab as needed for pain as well as enteric-coated aspirin for DVT prophylaxis. She will follow up with me in 10 to 14 days or sooner for any problems.
OLIVIA THOMPSON
1155 WEST STREET

DATE: 1/12/2012

10A. RESERVED FOR LOCAL USE

14. DATE OF CURRENT ILLNESS/First symptom) OR INJURY(Accident) OR PREGNANCY (LMP):

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE:

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION:

17. NAME OF REFERENCING PROVIDER OR OTHER SOURCE:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: (Relate Items 1, 2, 3 or 4 to item 24E by Line)

24. A. DATE(S) OF SERVICE FROM TO:

D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)

E. DIAGNOSIS POINTERS

F. CHARGES

22. MEDICAID RESUBMISSION CODE

23. PRIOR AUTHORIZATION NUMBER

29. TOTAL CHARGE

30. BALANCE DUE

NPI

FEDERAL TIN NUMBER: 1598520847

SIGNATURE ON FILE

SIGNATURE ON FILE

HOSPITALIZATION DATES RELATED TO CURRENT SERVICES:

OUTSIDE LAB?

109.00 1

542.00 1

413.00 1

1064.00

1064.00

DATE: 1/12/2012

SIGNATURE ON FILE

SIGNATURE ON FILE
## Coding Information

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99213</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of 3 key components: An expanded focused history; An expanded focused examination; Medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>12032</td>
<td>Repair, Intermediate, wounds of scalp, axillae, truck and/or extremities (excluding hands and feet); 2.6 cm to 7.5 cm</td>
</tr>
<tr>
<td>12034</td>
<td>Repair, Intermediate, wounds of scalp, axillae, truck and/or extremities (excluding hands and feet); 7.6 cm to 12.5 cm</td>
</tr>
<tr>
<td>12035</td>
<td>Repair, Intermediate, wounds of scalp, axillae, truck and/or extremities (excluding hands and feet); 12.6 cm to 20.0 cm</td>
</tr>
<tr>
<td>11424</td>
<td>Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 3.1 to 4.0 cm</td>
</tr>
<tr>
<td>11426</td>
<td>Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter over 4.0 cm</td>
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<tr>
<td>11440</td>
<td>Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.5 cm or less</td>
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<table>
<thead>
<tr>
<th>ICD-9</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>216</td>
<td>Benign neoplasm of skin</td>
</tr>
<tr>
<td></td>
<td>Includes; blue nevus, dermatofibroma, hydrocystoma, pigmented nevus, syringoadenoma, syringoma</td>
</tr>
<tr>
<td>216.4</td>
<td>Scalp of skin and neck</td>
</tr>
</tbody>
</table>
Current Medications: Bactrim Ds, Fish Oil, Zoloft, Benicar HCT
Past Medical History: Family history of skin cancer-NO Personal History of Skin cancer-No HBP
Surgical History: No surgical History documented.
Family History: Non-Contributory
Allergies: Pediozoal
Hospitalization/Major Diagnostic Procedure: No hospitalization history
Review of Systems: SKIN CHECK/SURG: NEGATIVE for rash or any other new or changing skin lesions not listed above. Positive for None other. NEGATIVE for mood changes, malaise, or significant weight loss. Positive for: None other.
Reason for Appointment: 1. I&D scalp

History of Present Illness:
As follows:
Established patient presents today for I&D of the right vertex of the scalp. He states this lesion on the scalp is larger and hard unlike the others that stay small and soft and drain. This does not drain and also causes pain. It has been there for years.

Examination:
Skin exam: General Pleasant, polite, and cooperative to exam. Awake, alert, and oriented to person, place, and time. Neck up exam is of the skin and mucosa of the neck up (neck, face, lips, ears, eyelids, conjunctiva, and scalp).
Physical Examination
There is one 4.0 cm X 3.5 cm tender nodule of the right vertex of the scalp. There is no erythema of the overlying skin.
Assessments
1. Benign Neoplasm of scalp and skin of neck

Treatment:
1. Others
   a. Start Keflex capsule, 500 MG, 1 capsule, orally, QID, 10 days, 40 capsules, refills

Procedures
Excision Lesion:
Site right vertex of the scalp.
Size of Lesion 4.0 cm X 3.5 cm
Suture 3/0 Vicryl, 4-0 Blue Prolene.
Method the lesion was identified and a linear excision was planned and drawn around the nodule with a sterile marking pen. The skin was locally anesthetized and prepped in the usual sterile fashion. Full thickness excision was performed to the level of the deep fat. Meticulous hemostasis was obtained with the electrosurgical device and the defect was closed with 3.0 vicryl and 4-0 prolene. A sterile pressure dressing was applied.

**Post-Op instruction:** The specimen was submitted to pathology for definitive diagnosis. Postoperative instructions were given to the patient both orally and written. The patient was instructed to call the office immediately if they have any problems or concerns. The patient is to return to the office for postoperative visit and suture removal as instructed.

ABX Keflex 500 mg PO QID for 10 days.

**Procedure Codes**
11424- Excision benign SC/NK/HA/FT/GEN 3.1-4.0 CM
12032- LAY SC/AX/TR/EXT >2.6-7.5

**Follow up**
10 days (reason: suture removal)

Electronically signed by David Green, MD on 1/12/2012
HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNION CLAIM COMMITTEE 08/05

Cover Insurance
P.O. Box 133
Asheville, NC 38544

1a. INSURED'S I.D. NUMBER
158820045

4. INSURED NAME (last Name, First Name, Middle Initial)
Doug Phillips

5. PATIENT'S ADDRESS (No., Street)
147 Circle drive

7. INSURED'S ADDRESS (No., Street)
147 Circle drive

Doug Phillips

CITY
Asheville

CITY
Asheville

STATE
NC

STATE
NC

ZIP CODE
35841

ZIP CODE
35841

(845) 7452113

(845) 7452113

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
a. OTHER INSURED'S ID NUMBER OR GROUP NUMBER

b. OTHER INSURED'S DATE OF BIRTH
SEX MM DD YY
M F

c. EMPLOYER'S NAME OR SCHOOL NAME

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous)

b. AUTO ACCIDENT? PLACE (State)

b. OTHER INSURED'S ID NUMBER OR GROUP NUMBER

b. EMPLOYER'S NAME OR SCHOOL NAME

c. INSURANCE PLAN NAME OR PROGRAM NAME

11. INSURED'S POLICY GROUP OF FFCA NUMBER

a. INSURED'S DATE OF BIRTH
SEX MM DD YY
M F

b. EMPLOYER'S NAME OR SCHOOL NAME

c. INSURANCE PLAN NAME OR PROGRAM NAME

c. IS THERE ANOTHER HEALTH BENEFIT PLAN?

If yes, return to and complete item 9-12.

SIGNED

SIGNATURE ON

DATE 1/12/2012

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM

17. NAME OF RE REFERRING PROVIDER OR OTHER SOURCE

17a. NPI

17b.

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB?

22. MEDICAID RESUBMISSION CODE

23. PRIOR AUTHORIZATION NUMBER

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

(Explain unusual circumstances)


A. DATE(S) OF SERVICE FROM

B. PLACE OF SERVICE

C. PROCEDURES, SERVICES, OR SUPPLIES

D. I. M.

E. DIAGNOSIS

F. CHARGES

G. DAYS PER UNIT

H. EPISON FAMILY PLAN

I. ID DUAL

J. RENDERING PROVIDER ID #

25. FEDERAL TAX ID NUMBER

SSN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT

28. TOTAL CHARGE

29. AMOUNT PAID

30. BALANCE DUE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS

42518

45218

X

X

YES

NO

$ 2550.00

$ 2550.10

$ 2550.10

32. SERVICE FACILITY LOCATION INFORMATION

Heart Hospital INC
143 Heart lane
Asheville, NC 38548

Heart Hospital INC
143 Heart lane
Asheville, NC 38548

Frank White, M.D.

NUCC Instruction Manual available at: www.nucc.org

WCMS-1500CS

APPROVED OMB 0938-0999 FORM CMS-1500 (03/05)
## Coding Information

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<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>36005</td>
<td>Injection procedure for extremity venography (introcustion of needle or intracatheter)</td>
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<tr>
<td>36101</td>
<td>Introduction of catheter, superior or inferior vena cava</td>
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<tr>
<td>36011</td>
<td>Selective catheter placement, venous system; first order branch (e.g. renal vein, juglar vein)</td>
</tr>
<tr>
<td>75820</td>
<td>Venography, extremity, unilateral, radiological supervision and interpretation</td>
</tr>
<tr>
<td>75822</td>
<td>Venography, extremity, bilateral, radiological supervision and interpretation</td>
</tr>
<tr>
<td>37187</td>
<td>Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance</td>
</tr>
<tr>
<td>37188</td>
<td>Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance, repeat treatment on subsequent day</td>
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<table>
<thead>
<tr>
<th>ICD-9</th>
<th>Description</th>
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<tbody>
<tr>
<td>453.4</td>
<td>Acute venous embolism and thrombosis of deep vessels of lower extremity</td>
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<tr>
<td>453.41</td>
<td>Deep vein thrombosis NOS, DVT NOS</td>
</tr>
<tr>
<td>453.41</td>
<td>Acute venous embolism and thrombosis of deep vessels of proximal lower extremity</td>
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<td>Femoral, Iliac, Popliteal, Thigh, Upper leg NOS</td>
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<tr>
<td>453.42</td>
<td>Acute venous embolism and thrombosis of deep vessels of distal lower extremity</td>
</tr>
<tr>
<td>453.42</td>
<td>Calf, Lower leg NOS, Peroneal, Tibial</td>
</tr>
</tbody>
</table>
Patient Name: Doug Phillips
Account: 45218
Ordering Physician: Frank White, M.D.

Indication for Procedure: The patient is a very nice 64 year old gentleman with extensive deep vein thrombosis and phlegmasia cerulean dolens of his right leg. We did an EKOS drip catheter on him last night and then brought him back today for additional thrombectomy.

Procedure in Detail: After consent, the patient was brought to the cardiac catheterization laboratory, sterilely prepped and the procedure followed. A 6-French sheath was exchanged out sterilely in the lesser saphenous vein on the right leg. We did an initial venogram. We could still see we had some thrombus in the IVC and the common iliac vein. The rest of the vein was 100% declotted. Then, we went up with a 15 cm Trellis catheter. We did a single Trellis run of the IVC and the common iliac vein on the right with an additional 10 mg of TPA. That gave us a very nice result and the procedure was ended.

Results: Previously, the entire deep femoral system was completely occluded on the right side. It is now 100% open at the popliteal, femoral vein, common femoral vein and external iliac level. At the common iliac vein into the IVC, there was about 50% thrombus removal initially with the EKOS and post the Trellis run, we were able to improve that to about 85% to 90% with excellent flow.

Assessment: Successful thrombectomy of the inferior vena cava and the entire deep vein system on the right.

Plan: At this point, we will continue him on Lovenox and Coumadin. He still has some thrombus noted in the left iliac vein system, even though he is not clinically suffering on the left side and considering this is his second event, I would probably consider him for long-term Coumadin.

Frank White, M.D.