CODING Q&A

DME, Benign Lesion Excision, Urgent Care Codes

DAVID STERN, MD, CPC

Q. We currently provide DME to our patients as a courtesy to them and then bill their insurance. We generally get paid by most private insurances, but not by Medicare. Our billing department claims Medicare will never pay for any DME we provide because we are not a DME provider licensed with Medicare. If our billing department is correct, would it be compliant to give DME prescriptions to all patients 65 and over?

A. I am not aware that writing a script would be non-compliant. Your policy is consistent in that you bill any payor that will pay for it.

Another option would be to have the patient sign an Advanced Beneficiary Notice (ABN) for the specific DME that is prescribed. Then you could sell the DME to the patient. The ABN would clearly state that the patient understands that Medicare does not cover the item under your arrangement with Medicare, but that it may be covered if the patient visited a store that is registered with CMS to sell DME.

This information is for educational purposes only. You are encouraged to seek legal counsel before making any decision on this issue. ■

Q. The physician removed a benign lesion from the patient's back and the cutaneous layer was closed with 3 interrupted 4-0 nylon sutures. The lesion before excision was 1.5 cm at its widest and the physician allowed margins of 1.5 cm on both sides. I billed CPT codes 11402 and 12001. Insurance only paid for the excision and not the closure. When can you bill separately for closure when excising a benign lesion?

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A. Excision is defined as full-thickness (through the dermis) removal of a benign lesion of skin, including margins, and includes simple (non-layered) closure when performed. Therefore, you can only bill for the closure if intermediate or complex repair is required. The excision codes are grouped by anatomy and then by size. Codes 11400-11406 are used for the excision of benign lesions of the trunk, arms, or legs. Codes 11420-11426 are used for the excision of benign lesions of the scalp, neck, hands, feet, and genitalia, whereas codes 11440-11446 are used for excision of benign lesions of the face, ears, eyelids, nose, lips, and mucous membrane.

Keep in mind that payors who follow the national correct Coding Initiative (CCI) edits may bundle intermediate and complex repairs into the excision of benign lesions of 0.5 cm or less (11400, 11420, and 11440). You can check the edits at https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html.

You also need to keep in mind that when measuring lesions, you should include the margins in your calculation. In the case you presented, to get the excised diameter, you add the lesion plus the margins, which comes to 4.5 cm and changes the code to 11406.

Codes for Benign Lesion Excision of the trunk, arms, and legs are:

- 11400 – excised diameter 0.5 cm or less
- 11401 – excised diameter 0.6 to 1.0 cm
- 11402 – excised diameter 1.1 to 2.0 cm
- 11403 – excised diameter 2.1 to 3.0 cm
- 11404 – excised diameter 3.1 to 4.0 cm
- 11406 – excised diameter over 4.0 cm

Codes for Benign Lesion Excision of the scalp, neck, hands, feet, and genitalia are:

- 11420 – excised diameter 0.5 cm or less
- 11421 – excised diameter 0.6 to 1.0 cm
- 11422 - excised diameter 1.1 to 2.0 cm
- 11423 – excised diameter 2.1 to 3.0 cm
- 11424 – excised diameter 3.1 to 4.0 cm
- 11426 – excised diameter over 4.0 cm

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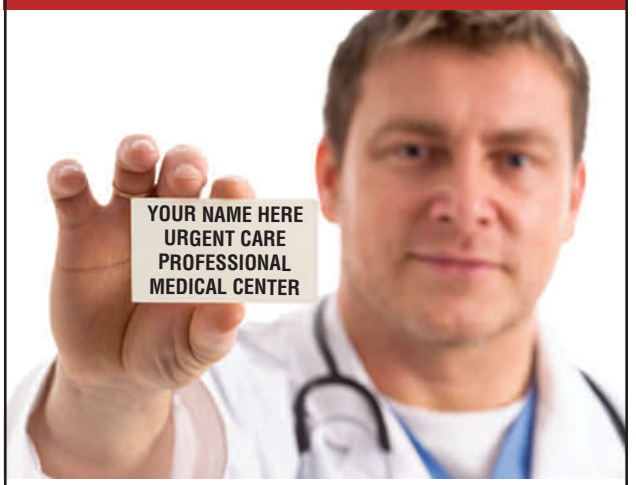

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Codes for Benign Lesion Excision of the face, ears, eyelids, nose, lips, and mucous membrane are:

- 11440 – excised diameter 0.5 cm or less
- 11441 – excised diameter 0.6 to 1.0 cm
- 11442 - excised diameter 1.1 to 2.0 cm
- 11443 – excised diameter 2.1 to 3.0 cm
- 11444 – excised diameter 3.1 to 4.0 cm
- 11446 – excised diameter over 4.0 cm ■

Q. Are the codes 99050 and 99051 urgent care codes per se? If you bill these should you be using Place of Service (POS) 20?

A. These codes are not limited to use in urgent care settings and therefore are not restricted to POS (Place of Service) 20. Code 99050, "Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (e.g., holidays, Saturday, or Sunday), in addition to basic service" can be billed in addition to other services, including an E/M code, for a patient seen outside of regular office hours. Reporting code 99050 requires that your office have posted hours that clearly designate times when the office is open versus closed. For example, your posted office hours are 9:00 a.m. to 4:00 p.m. A patient calls and needs to be seen that day but cannot make it into the office until 6:00 p.m. The provider either stays in the office or leaves and comes back to see the patient. You would be justified in billing code 99050 along with an E/M code because the patient was seen after posted regular business hours. On the other hand, code 99050 does not apply if a patient is seen after normal office hours when the patient arrived during normal hours but was not seen by the provider until after the office's normal closing time.

Code 99051, "Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service" can be billed when the physician sees the patient in the office and provides the necessary services or care during regularly scheduled weekend, evening, or holiday hours. Again, the posted hours should clearly designate times when the office is open versus closed. Evening hours are typically considered to begin after 5:00 p.m. For example, your posted hours are 9:00 a.m. to 9:00 p.m. You can bill code 99051 with the appropriate E/M code for all patients that are seen from 5:00 p.m. to 9:00 p.m. If your posted hours include weekends, you can bill code 99051 for all patients seen on the weekend no matter what time they are seen.

Check each payor's guidelines regarding both codes. Medicare will not reimburse for either code so it is inappropriate to bill a Medicare patient for these codes. ■

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