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Excised lesions are coded by diameter

Q Would the excision of a single lesion for a diagnosis of VIN III be excision of a malignant lesion?

A No. A diagnosis of VIN III means that the patient has an intraepithelial neoplasia, and the diagnostic code would be 233.3, carcinoma in situ of the vulva. However, VIN III leads to invasive cancer in only about 4% of women, so this condition is considered preinvasive, not cancerous.

Unless the physician has indicated in the operative note that a simple partial vulvectomy was performed (eg, with more extensive lesions), I would pick codes that represent a benign or premalignant lesion.

If the lesion was excised, the code choice would be one of 11420 through 11426 (excision, benign lesion including margins, except skin tags [unless listed elsewhere], scalp, neck, hands, feet, genitalia; excised diameter [. . .]). Each code in this series specifies a different lesion diameter (≤0.5 cm up to >4.0 cm); you would select the code based on the greatest clinical diameter of the lesion plus the margin required for complete excision.

If the lesion was destroyed, the code 56501 (destruction of lesion[s], vulva; simple) or 56515 (destruction of lesion[s], vulva; extensive) would be reported instead.

Code for hemorrhage depends on timing

Q Could you clarify the ICD-9 coding difference between secondary postpartum hemorrhage and third-stage postpartum hemorrhage?

A The third stage lasts until the entire placenta has been delivered. Therefore the diagnosis code for third-stage postpartum hemorrhage (666.0X) means that the baby was delivered, but that sometime before 24 hours elapsed, retained placenta caused bleeding. Secondary postpartum hemorrhage (666.2X) occurs more than 24 hours after delivery due to retained placenta.

Note that the code 666.1X, other immediate postpartum hemorrhage, is bleeding within the first 24 hours of delivery, but after delivery of the placenta.

Use -58 modifier only when D&C is planned

Q If a patient delivered vaginally but had to have a dilation and curettage for retained placenta, can I use a modifier -58 (staged procedure) or -78 (related procedure)?

A If the patient required the postpartum curettage after she left the delivery suite, the modifier -78 (return to the operating room for a related procedure during the postoperative period) would be the correct modifier. If the curettage occurred while she was still in the delivery suite, the correct modifier would be -51 (multiple procedures). You can only use -58 (staged or related procedure or service by the same physician during the postoperative period) when the procedure was planned ahead of time, was more extensive than the original procedure, or was a therapeutic procedure following a diagnostic procedure, and of course never if the procedure occurs at the same operative session as the delivery. ■

Ms. Witt, former program manager in the Department of Coding and Nomenclature at the American College of Obstetricians and Gynecologists, is an independent coding and documentation consultant. Reimbursement Adviser reflects the most commonly accepted interpretations of CPT-4 and ICD-9-CM coding. When in doubt on a coding or billing matter, check with your individual payer.

FAST TRACK

Because VIN III leads to invasive cancer in only about 4% of women, it is considered preinvasive, not cancerous