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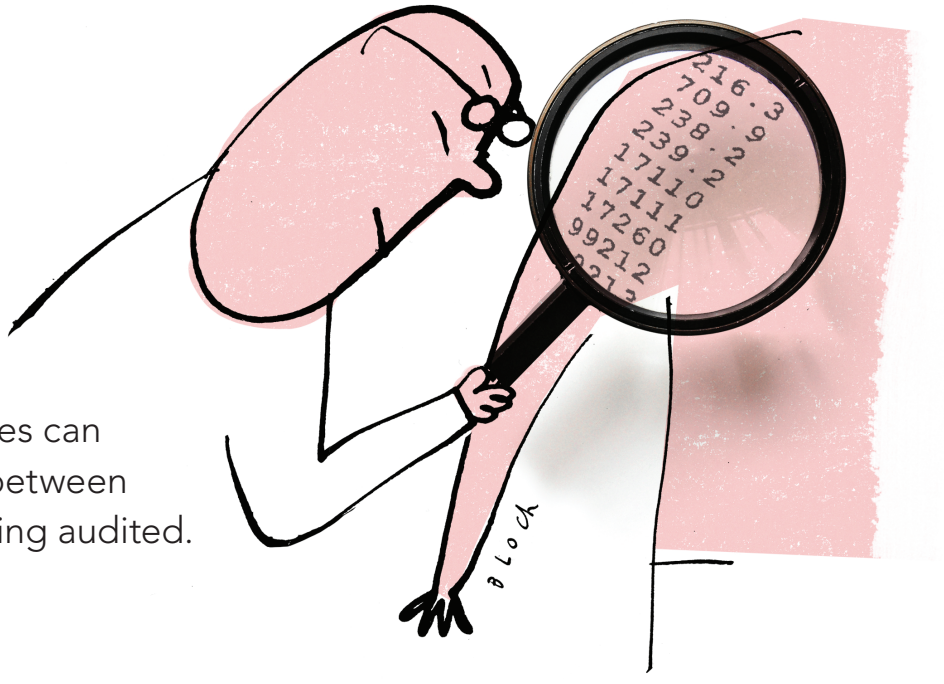
12 Errors to Avoid in Coding Skin Procedures



Using the correct codes can mean the difference between getting paid and getting audited.

Coding and billing for diagnosing and treating skin lesions is rife with potential pitfalls that could lead to delayed payments at best and increased insurer scrutiny or investigation for fraud at worst. Because skin procedure codes take into account the type of removal, the size and location of the lesion, your intent, and pathologic results, documenting your service and selecting the right code can be confusing. This article explains how to avoid some of the most common mistakes in skin procedure coding and provides an encounter form that can help you to more rapidly and accurately report skin-related diagnoses and associated procedures (see the form on page 14).

1 Know the difference between an excision and a biopsy.

An excision is a procedure intended to fully remove a lesion. The specimen should include the lesion and the surgical margins. To qualify as an excision, the procedure must be *full thickness*, which means entirely through the reticular dermis to fat. For example, let's say a lesion appears to be a 4 mm nodular basal cell carcinoma (BCC) or a nevus. An 8 mm punch is used to excise the visible portion of the lesion with apparent 2 mm margins in all directions with the punch carried full thickness. The lesion has been excised. The excision code includes anesthesia and straightforward, simple closure. If the procedure required extensive undermining, a two-layer closure, and removal of excess skin, a separate code for a moderately complex closure should be used.

By contrast, a biopsy is a procedure that samples anything less than a full lesion, even if full thickness ("incisional" rather than "excisional"). For example, sampling a 1 cm suspected squamous cell carcinoma (SCC) at full thickness into subcutaneous fat with a 4 mm punch instrument centrally should be coded as a biopsy. A biopsy code might also be used when sampling one or more of a group of lesions for diagnosis, even if these sample lesions are completely excised, or when taking samples of a dermatitis. ➤

SERGE BLOCH

WHEN A PATIENT ASKS FOR REMOVAL FOR COSMETIC REASONS, MEDICARE, MEDICAID, AND MOST OTHER INSURANCE PLANS DO NOT COVER THE SERVICE.

Complete removal does not necessarily mean that an excision code should be used. When the intent is to entirely remove the pathology by anything less than a full thickness technique, a shave code may be appropriate, even if the pathology report confirms complete removal of the lesion. For example, trying to completely remove a nevus or suspected melanoma via a "scoop" or "saucerization" technique that extends into the deep dermis and not the fat should be coded as a shave removal, not an excision.

Excisions, biopsies, and shaves have their own definitions and uses.

2 Don't overbill for excisions or underbill for re-excisions.

Measure lesions before removal as they tend to change shape afterward.

A primary excision should be billed based on the largest diameter of the lesion plus the narrowest lateral margins. For example, a round 4 mm lesion placed centrally in an 8 mm punch has a lesion diameter of 4 mm and 2 mm margins all around. The excision length for this lesion is 8 mm: 4 mm (lesion) plus 2 mm (one narrowest margin) plus 2 mm (other narrowest margin). For an ovoid lesion measuring 8 mm by 4 mm, removed with 2 mm margins across the short diameter and greater margins at the apices to fashion a fusiform excision closer to the traditional length-to-width ratio of 3:1, the calculation would be 12 mm: 8 mm (lesion) plus 2 mm (narrowest margins counted twice) (see the photo illustration on the next page).

The lesion should be measured preoperatively because tissue tends to change shape or shrink in formalin, which causes pathologic measurement to be generally smaller than the clinical measurement, and some dermapathology laboratories include that information in their reports.

Re-excisions don't generate an added office visit fee.

A re-excision is a procedure on any lesion that has been previously biopsied or undergone an initial excision by you or anyone else. When billing for a re-excision, use the total closed length of the excision to guide your code selection. When a patient presents for a scheduled re-excision, you should bill for the procedure but not the office visit, unless significant, separately identifiable services are provided, in which case you could submit a code for the evaluation and management service with modifier 25.

If re-excision shows no residual malignancy, you should still bill the malignant lesion diagnosis codes, because that was the purpose of the re-excision.

3 Know the difference between biopsy and shave.

When there is a dermatitis, such as suspected psoriasis, contact dermatitis, or Grover's disease, specimens you obtain for pathology should be classified as biopsies even if the sampled lesions are entirely removed using a shave technique. List your suspected diagnosis in your clinical notes, but you should bill using diagnosis code 709.9 for unspecified disorder of skin and subcutaneous tissue. If you use the code for psoriasis, for example, the insurer may reject the claim and ask why you did a biopsy if you already knew the diagnosis.

If you remove and "cure" a symptomatic seborrheic keratosis via a shave technique, that can be appropriately billed as a shave. If you cannot determine whether a lesion is a seborrheic keratosis or a melanoma and you do a full thickness excision because of concern about melanoma, it is legitimate to bill for excision. It is almost always inappropriate to excise seborrheic keratoses when you are certain of the diagnosis. It is often appropriate to remove them because of symptoms, but only via the shave technique. Note that for smaller lesions, biopsy codes may provide greater

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reimbursement than shave codes.

Lines can be blurred. For example, let's say a person has a single papulosquamous plaque, and the differential diagnosis includes SCC and superficial BCC. An attempt to completely remove the lesion via a shave technique is documented. The histology report indicates psoriasis. Because the intent was to evaluate for a suspected malignancy and the lesion was completely removed, documentation would support billing a shave code. A biopsy code also would have been appropriate, but the shave code is legitimate and the reimbursement is greater. It is okay to get paid for what you do!

My research suggests that most dermatologists tend to use the diagnosis code for neoplasm of uncertain behavior of skin (238.2) when biopsying or shaving a lesion of uncertain etiology because of concern about malignancy and billing before the histopathology is known. This remains the appropriate code after histology has returned for dysplastic nevi, sebaceous nevi, and other lesions of uncertain biologic behavior. The other option is to submit the diagnosis code for neoplasm of uncertain nature (239.2). Some coding authorities emphatically recommend this code rather than 238.2, but if you have been using 238.2 without difficulty I wouldn't recommend switching. I have used 238.2 exclusively for years with good results.

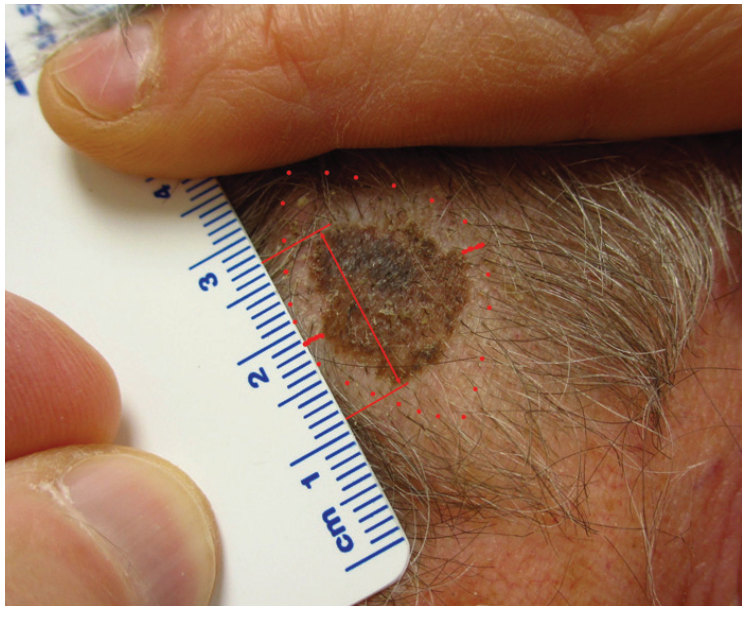
4 Don't upcode destruction of benign lesions or undercode destruction of malignancies.

Molluscum and verrucae are epidermal lesions. On palms and soles, verrucae can be very deep and invaginate the epidermis and even make radiographic impressions on bone. However, even if you inject anesthesia and curette a deep wart on a plantar surface or use any of a variety of methods of removing molluscum, the appropriate code is either 17110 (destruction of benign lesions, 14 or fewer lesions) or 17111 (15 or more lesions), because the billing should be based on what is medically necessary.

When dealing with a malignancy that is curable by cryotherapy alone or by curettage with or without electrodessication or cryotherapy, the procedure often starts with a shave followed by the destructive procedure. You can only bill for one procedure in this case, and the codes for destruction of malignancies pay more than those for shaves or biopsies. For example, Medicare's median nongeographically adjusted payment rate for destroying a 2.5 cm scalp lesion (code

- Some procedures could be billed as biopsies or shaves, but the reimbursement levels are different for each.
- Wart removal is most appropriately billed using destruction codes.
- Bill excisions based on adding their largest diameter with their narrowest lateral margins.

HOW TO MEASURE AN EXCISION LENGTH FOR PROPER CODING



This macular lesion is suspicious for melanoma. Many authorities recommend a 2 mm margin, full thickness, primary excision for diagnosis and initial pathologic staging to guide subsequent re-excision and management. Here, the excision length for billing for the initial excision would be the largest diameter of the lesion, 16 mm (long red arrow), plus the narrowest margins across the narrow diameter of the ellipse (clusters of dots at margins across short axis of ellipse), 2 mm on each side or 4 mm total, for a billed excision length of 2.0 cm (16 mm plus 4 mm). Note that if the lesion needs to be re-excised, the re-excised length for billing will be the final closed length of the suture line. Pathology confirmed this as a melanoma. Thus, malignancy excision codes are appropriate both for the initial excision and re-excision, along with the ICD-9 code for melanoma, scalp (172.4).

DR. GARY FOX

SKIN CARE ENCOUNTER FORM

Patient Name _____ Patient # w/ check digit _____

D.O.B. _____ Date _____

CPT		DESCRIPTION
		OFFICE VISITS
		Established patient
99212		Problem focused
99213		Expanded problem focused
99214		Detailed
99215		Comprehensive [ ] Procedure only
99024		Post-op care
03003		Record release
G8553		E-prescribing **(MEDICARE ONLY)**
		New patient
99201		Problem focused
99202		Expanded problem focused
99203		Detailed
99204		Comprehensive (moderate MDM)
99205		Comprehensive (high MDM)
		CONSULTATIONS
		Referring Dr. _____
99241		Problem focused
99242		Expanded problem focused
99243		Detailed
99244		Comprehensive (moderate MDM)

CPT		DESCRIPTION
		OFFICE PROCEDURES
10040		Acne surgery
11000		Debridement
10060		I & D abscess, single
10061		I & D abscess, complex or multiple
11900		Intralesional injection, up to 7 lesions
11901		Intralesional injection, > 7 lesions
95044		Patch tests _____# of tests
11100		Skin biopsy, single
+11101		Skin biopsy, each add'l (#) _____
11200		Skin tags, up to 15
+11201		Skin tags, each additional 10 lesions
		Destruction premalignant lesions – AKs
17000		First lesion
+17003		2-14 lesions Total: 1+ _____
17004		15 or more lesions
		Destruct benign lesions warts/molluscum/milia
17110		Up to 14 lesions
17111		15 or more lesions
87177		Scabies mount
87220		KOH prep

	≤ 0.5 cm	0.6-1.0	1.1-2.0	2.1-3.0	3.1-4.0	> 4.0
Destruction malignant lesion (curettage, ED&C, cryotherapy)						
Trunk, arms, legs	17260	17261	17262	17263	17264	17266
Scalp, neck, hands, feet, genitals	17270	17271	17272	17273	17274	17276
Face, ears, eyelids, nose, lips	17280	17281	17282	17283	17284	17286
Excision benign lesion						
Trunk, arms, legs	11400	11401	11402	11403	11404	11406
Scalp, neck, hands, feet, genitals	11420	11421	11422	11423	11424	11426
Face, ears, eyelids, nose, lips	11440	11441	11442	11443	11444	11446
Excision malignant lesion						
Trunk, arms, legs	11600	11601	11602	11603	11604	11606
Scalp, neck, hands, feet, genitals	11620	11621	11622	11623	11624	11626
Face, ears, eyelids, nose, lips	11640	11641	11642	11643	11644	11646

Shave lesion	≤ 0.5 cm	0.6-1.0	1.1-2.0	>2.000
Trunk, arms, legs	11300	11301	11302	11303
Scalp, neck, hands, feet, genitals	11305	11306	11307	11308
Face, ears, eyelids, nose, lips, mucous membrane	11310	11311	11312	11313

Two layer closure	≤2.5 cm	2.6-7.5
Scalp, axilla, trunk, extremities excluding hand and foot	12031	12032
Neck, hand, foot, genitals	12041	12042

	≤2.5 cm	2.6-5.0	5.1-7.5
Face, ear, eyelid, nose, lip, mucous membrane	12051	12052	12053

ICD-9		DESCRIPTION
701.2		Acanthosis nigricans
706.1		**Acne vulgaris**
692.9		Acneiform dermatitis
692.72		Actinic cheilitis
702.0		**Actinic keratosis**
995.20		Adverse medical reaction (taken internally)
704.01/.02		Alopecia areata / telogen effluvium
704.09		Alopecia, other
528.5		Angular cheilitis
691.8		Atopic dermatitis
216.____*		**Benign neoplasm (nevus, dermatofibroma)**
694.9 / 709.8		Bullous dermatitis/vesicular eruption
682.9		Cellulitis NOS
380.00		Chondrodermatitis nodularis helicis
		Contact dermatitis
692.4		Chemicals
692.83		Metals
692.6		Plants/poison ivy
692.89		Other contact
692.79		Photodermatitis
692.9		Unspecified cause
700		Corns and callosities
708.3		Dermatographism
709.9		**Dermatosis NOS**
709.00/.09		Dyschromia/melasma & pig purpura
705.81		**Dyshidrotic eczema (hand/foot eczema)**
692.9		**Eczema NOS**
706.2		**Epidermoid cyst/milia/milial cyst**
695.10		Erythema multiforme, NOS
690.8		Erythematosquamous dermatitis
782.1		Exanthem except vesicular
698.4		Factitial dermatitis
701.9		**Fibroepithelial polyp**
704.8		Folliculitis/follicular disease
680.____		Furuncle/carbuncle

ICD-9		DESCRIPTION
695.89		Granuloma annulare
694.8		Grover's
228.01		Hemangioma/cherry angioma
054.9		Herpes simplex w/o complication
705.83		Hidradenitis
705.21		Hyperhidrosis
701.1		Hyperkeratosis
684		Impetigo
695.89		Intertrigo
701.4		Keloid
701.1		Keratoderma, acquired/hyperkeratosis
757.39		Keratosis pilaris
709.09		Lentigo/Lentigo maligna
697.0		Lichen planus
701.0		Lichen sclerosus et atrophicus/morphea
698.3		**Lichen simplex chronicus**
214.1		Lipoma, skin except face
695.4		Lupus erythematous, discoid
172.____*		Malignant melanoma of skin
173.____*		**Malignant neoplasm, skin (BCC/SCC)**
078.0		Molluscum contagiosum
703.8		Nail abnormalities, acquired
238.2		**Neoplasm of undetermined nature**
692.9		**Nummular dermatitis**
110.1		Onychomycosis
686.8		Perleche
696.3		Pityriasis rosea
698.2/.3		Prurigo/nodularis
698.9		**Pruritus NOS**
696.1		**Psoriasis**
686.1		Pyogenic granuloma
695.3		Rosacea/perioral dermatitis
133.0		Scabies
709.2		Scar
706.9		**Sebaceous hyperplasia**

ICD-9		DESCRIPTION
690.10/.11		**Seborrheic dermatitis NOS/capitis**
702.19		**Seborrheic keratosis NOS**
702.11		Seborrheic keratosis, inflamed
692.74		Solar elastosis
454.1		Stasis dermatitis
701.3		Striae
998.83		Surgical wound, nonhealing
448.1		Telangiectasia (spider)
110/.0 /.5 /.3		Tinea capitis/corporis/cruris
110.4 / .2		Tinea pedis/tinea manuum
111.0		Tinea versicolor
707.1 /.8		Ulcer, lower limb/other sites
708.0		Urticaria, allergic
708.1		Urticaria, idiopathic
078.10		**Verruca (viral wart)**
709.01		Vitiligo
998.59		Wound infection/post-op abscess
706.8		**Xerosis cutis**
V16.8		Family history of melanoma
V10.82		Personal history of melanoma
V10.83		**Personal history BCC/SCC**

*** 4th Digits**
- 0 - Lip
- 1 - Eye including canthus
- 2 - Ear (pinna)
- 3 - Face
- 4 - Neck & scalp
- 5 - Trunk, except scrotum
- 6 - Upper extremities, including shoulder
- 7 - Lower extremities, including hip
- 8 - Other specified site

5th Digits
- 1 = BCC
- 2 = SCC
- 0 = Unspecified
- 9 = Other specified

DIAGNOSIS:

IF YOU DON'T HAVE DOCUMENTATION TO SUPPORT THE MEDICAL NECESSITY OF A SERVICE, THEN YOU PROBABLY SHOULDN'T BILL FOR IT.

17273) is $208.31 versus $123.90 for a shave (code 11308) and $103.81 for a biopsy (code 11100). So when histology confirms malignancy, don't cheat yourself – bill for the destruction of the malignancy.

5 Don't submit claims prematurely.

Codes – and payment amounts – may differ depending on whether the pathologic result is benign or malignant. Biopsies and shave removals should be coded and billed immediately because it makes no difference in code selection whether the lesion is benign or malignant. However, for excisions when the differential diagnosis includes malignancy, the claim should be held until you've reviewed the pathology report. Sometimes the pathology is equivocal, such as a dysplastic nevus or atypical junctional melanocytic hyperplasia. Such claims should be billed using diagnosis code 238.2 (neoplasm of uncertain behavior of skin) and a CPT code for an excision with benign findings.

When an obviously benign lesion is being excised because it is causing irritation (e.g., nevus catching during shaving), you could hold the claim until the pathology is known. I usually go ahead and submit the claim with a diagnosis code that indicates it is benign (e.g., 216.3, benign nevus of face) and the appropriate CPT excision code.

6 Know when to bill the patient rather than the insurer.

When a patient asks for removal of a lesion for cosmetic reasons, Medicare, Medicaid, and most other insurance plans do not cover the service. Billing insurance for cosmetic removal of lesions could be deemed fraudulent. Tell the patient before the procedure that it may result in an out-of-pocket expense. Medicare requires an Advance Beneficiary Notice, signed by the patient before the procedure, or beneficiaries cannot be billed for the noncovered service. Consider using a separate encounter form – or even a separate visit – for cosmetic removals. Annotate these forms so that your billing staff knows not to bill insurance.

For benign lesions that are symptomatic or have functional significance, such as skin tags that catch on clothing or seborrheic keratoses that catch on combs, document the reason for removal and bill insurance. I add the secondary diagnosis code of disturbance of skin sensation (782.0) when removing known benign symptomatic lesions. This code is not precise, but I have found no better ICD-9 code to indicate irritancy from skin tags and seborrheic keratoses caused by clothing and other outside factors.

7 Know the global periods.

Excisions have a global period, often 10 days, so suture removal and other routine follow-up care is included in the payment and should not be separately reported. Biopsies and shaves, on the other hand, have no global period, so you can bill for follow-up visits.

8 Know when to use multiple codes – or a single code for multiple lesions.

If treating or destroying multiple benign lesions of the same type, such as verrucae or molluscum (or a combination of both), it does not matter for coding and billing purposes whether you use different methods. For example, you could remove some with shaving, some with cryotherapy, and others with cantharidin or an injection of Candida antigen. The important point is whether there were 14 or fewer lesions (code 17110) or 15 or more (code 17111).

If you biopsy three different lesions, or three different areas of a dermatosis, then the code is 11100 for the first biopsy and +11101 for each additional biopsy. However, if you do shaves and curettage with curative intent, wait for the pathology to return to

Wait for pathology before billing, as benign and malignant lesions generate different levels of reimbursement.

Removing benign lesions requires added justification.

When removing multiple benign lesions, the technique is less important than the number.

verify BCC. Then bill for destruction of three BCCs, using a separate code for each one. Code selection will depend on the size and location of the lesion (codes 17260-17286). If you remove multiple lesions in a single visit by shave or full thickness excising, each should be reported separately with modifier 59 to indicate that these are distinct procedural services provided on the same day.

When treating more than one lesion of the same type on the same area, document well and include a note to the billing staff that these are separate lesions.

9 Know when to do two-layer closures – and bill for them.

Two-layer closures may be necessary to avoid serious scarring or wounds reopening.

Tension on a skin closure suture line not only influences the likelihood of wound dehiscence but also is a factor influencing "railroad tracking" later. Surgeons who incise the skin for deeper procedures are not removing skin. When skin is removed, it needs to be pulled back together, which increases tension at the wound edges. Even with subcutaneous undermining, often the width of excisions is such that there will be significant tension on skin sutures unless absorbable subcutaneous sutures are placed. When a two-layer closure is appropriate, document its rationale and necessity in the dictation and surgical procedural paperwork – and bill for it. Append modifier 59 to the appropriate code for a moderately complex (two-layer) closure based on the site and excision length.

10 Don't overlook medical necessity.

Sending all removed lesions for histopathology can protect you later if the patient develops melanoma.

It is not medically necessary to do a full thickness excision to remove a symptomatic seborrheic keratosis, which is a superficial process, or to cure lesions of molluscum contagiosum, which is an epidermal viral process. Even if you perform excisions of these lesions, it is not appropriate to bill these as excisions.

11 Send everything for histopathology.

You never want to be in a situation where a patient develops metastatic melanoma, has no obvious primary symptoms, and is asked whether he or she has had anything removed (especially anything "pigmented") that was not sent for histopathology. Your word that it was a seborrheic keratosis may not protect you, because sometimes even the world's greatest experts cannot make that differentiation with complete assurance. Histology is your ally and your defense. Skin tags that are soft and absolutely typical, as well as typical verrucae in younger patients, can be exceptions.

12 Don't have documentation? Don't bill.

Photographs are a good way to document medical necessity of procedures.

Many of us have heard the expression, "If it isn't documented, it wasn't done." Although we all know that saying isn't true, if you don't have documentation to support the medical necessity of a service, then you probably shouldn't bill for it.

Photography is an excellent documentation tool. You can capture location and size, provided you include a centimeter ruler in the photo next to the lesion. It also helps to support the medical necessity of the procedure (e.g., demonstrating an ulcerated, pearly lesion with telangiectasia). Of course, photos can also document history of recent onset, change, growth, bleeding, crusting, irritancy, etc.

Be careful

In one of my former jobs, I reviewed insurance claims for skin procedures. As one example of erroneous billing, a primary care physician billed more than $7,000 for excision of molluscum on a single claim. This was eventually recoded to destruction of benign lesions (17111), which typically pays about 2 percent of that amount. In situations like this, the insurer may go back and audit all your recent claims in this category and flag you for auditing going forward. When billing involves a government-sponsored insurance plan, you could also be investigated for waste, fraud, and abuse. You've worked too hard and too long for that. FPM

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