

A Potpourri of Things to Do Correctly

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PRACTICE POINTS

- A biopsy is not separately reportable when another procedure was done at the same site on the same day (eg, shave, excision, destruction).
- Use site-specific biopsy codes when their localization is more precise than the general skin biopsy.
- A simple nail clipping for culture or periodic acid–Schiff stain is not a nail biopsy and should not be separately reported from the evaluation and management component of the visit.

When you pick up the *Current Procedural Terminology (CPT)* manual and read it, you may wonder what certain terms mean and how they may be looked at by payers and auditors. As your eyes glaze over from reading mind-numbing descriptions, a few points should be obvious, but conversations with friends, colleagues, and US Office of Inspector General and Centers for Medicare & Medicaid Services forensic investigators have convinced me that it is time for a refresher.

Excisions

For excisions (11400–11646), size is easy to determine. You measure the longest diameter of the lesion and the smallest margin required based on your judgment. The sum of the diameter and twice the margin is your lesion size. For benign lesions, the margin can be as small as 0 to 1 mm. For malignancies, it might be 5 to 9 mm for a melanoma in situ, 1 cm or more for an invasive melanoma with similar margins for squamous cell carcinoma, and somewhat less than 1 cm for basal cell carcinomas and more than 1 cm for Merkel cell carcinomas or spindle cell neoplasms. Unlike the shave removal codes (11300–11313), which do not involve subcutaneous tissue, an excision is at least full thickness through the dermis, which means a clever auditor would expect to see at

least some fat on sections in most cases. Assuming you are through to fat, you may or may not close the wound. If you close the wound in a nonlayered manner, the repair is included and is not separately reportable. If you need to perform an intermediate layered closure (12031–12057) to get optimal function and cosmesis, the repair is separately reportable, as is a complex repair (13100–13163), which often includes wide undermining and other factors that differentiate it from an intermediate repair. If a more demanding repair is needed, you might use an adjacent tissue transfer (14000–14061), but the excision is included and not separately reportable. Skin grafts, most commonly split-thickness grafts, do not include the excision, which can be reported separately; direct closure of the graft donor site also is included.

There are times when you may delay a repair for medical reasons, which you would document in the medical record, but if you systematically delay a repair overnight to avoid the multiple procedure payment reduction, you may become “a person of interest,” which is a bad thing.

The shave removal codes (11300–11313) do not require repair and hemostasis is included. The size of the lesion determines the size of the lesion reported, and margins are not included. Hemostasis is included in the value of the CPT code and is not separately reportable.

It is not uncommon for a patient, usually one well known to you, to present with another skin cancer that has classic clinical findings. You review options with your patient and proceed to take one of the following approaches.

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Option 1: You can tangentially remove or curette the tumor bulk and send the specimen for pathology review. At the same time, you curette and cauterize the base. In this case, you should hold your bill and await pathology. If the lesion is malignant, you would report the appropriate malignant destruction code (17260–17286) only. If it is benign, you would report a biopsy based on site or a benign destruction (17110) if for some reason the destruction was medically necessary. If it is an actinic keratosis, you could report either a biopsy or a premalignant destruction (17000).

Option 2: You perform a full-thickness excision of the lesion with a margin to remove it and send the specimen for pathology review. You should hold your bill and await pathology. If the lesion is malignant, you would report the appropriate malignant excision (11600–11646) and repair as discussed above. If it is benign, you would report the appropriate benign excision (11400–11446) and repair as discussed above.

If a shave, excision, or destruction is performed, a biopsy of the tissue should never be reported separately simply because the tissue may be sent to the laboratory. In other words, a biopsy is not separately reportable when another procedure was done at the same site on the same day.

Biopsy

Biopsies come in 2 varieties: general and site specific. All dermatologists are familiar with the basic skin biopsy codes 11110 and 11101 (biopsy of skin, subcutaneous tissue and/or mucous membrane [including simple closure], unless otherwise listed). Many are not aware of site-specific biopsy codes that often are more appropriate and should be used when their localization is more precise than the general skin biopsy.

Biopsies of the nail unit (eg, plate, bed, matrix, hyponychium, proximal and lateral nail folds) are reported using CPT code 11755. A simple nail

clipping for culture or periodic acid–Schiff stain is not a nail biopsy and should not be separately reported from the evaluation and management component of the visit.

The lip biopsy code (40490) is used appropriately when the vermilion is sampled, not the skin around it. If the skin and vermilion are contiguously sampled, only report 40490. Specific codes exist for the vestibule of the mouth (40808), the anterior two-thirds (41100) and posterior one-third (41105) of the tongue, the floor (41108) and roof (42100) of the mouth, and the salivary glands by needle (42400) or by incision (42405).

The penis can be biopsied on the surface (54100) or deep structures can be sampled (54105), though the latter is uncommon in dermatology practices. The vulva can be sampled with codes comparable to general biopsy, with 54605 for the first biopsy and 54606 used for each additional one.

An incisional biopsy of the eyelid margin is reported with 67810, while conjunctival biopsy is reported with 68100; 68510 describes a lacrimal gland biopsy. The ear, not to be left out, has its own biopsy codes, with 69100 for the external ear and 69105 for the auditory canal.

Clipping of hair or tape stripping of skin (similar to nail clipping described above) are not biopsies and are not separately reportable, as the work involved is considered incident to the cognitive visit taking place.

Final Thoughts

These points should all be fairly straightforward—yes, the skin biopsy includes mucosa, but if a mucosal site such as the mouth has a more specific code, then that code is correct—and the simplest test for the clinician is to ask yourself, “If I were reviewing the claim, what would I expect to see?” As always, document what you do, do what you document, and report that which is medically necessary.