Coding and Reimbursement of Primary Care Debridement and Excision Procedures

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Current medical practice requires physicians to accurately report services provided to patients. Patient billing for debridement and excision procedures involves the selection of specific 1992 *Physicians' Current Procedural Terminology* codes. Although a site-specific surgical procedure code often yields higher reimbursement than a general procedure code, physicians should select the code that most accurately reflects the procedure performed.

This review identifies the codes used to report destruction and excision procedures performed by primary care physicians. Included in this review are skin debridement, burn debridement, excision of benign and malignant lesions of the skin and subcutaneous tissue, cyst and ganglion excision, nail excision, anorectal lesion excision, shave, paring, and skin tag excision procedures, and foreign body removal. The Health Care Financing Administration's relative value units and one state's published Medicaid payment rates are included for each procedure code. Instructions are provided for selecting between multiple coding options when more than one code describes the service provided.

Key words. Insurance, health, reimbursement; debridement; fees and charges.
J Fam Pract 1992; 35:663-672.

Primary care physicians are frequently called on to provide debridement and excision procedures for patients in the office setting. Pories and Thomas[1] have suggested that office surgery performed by the patient's family physician has outstanding potential owing in part to the comprehensive care, follow-up, and cost-effectiveness provided.

Modern medical practice requires physicians to accurately report the services provided to patients. The 1992 *Physicians' Current Procedural Terminology* (CPT)[2] is the most widely accepted and current listing of descriptive terms and identifying codes used to report medical services and procedures. Many general and specific codes have been created to describe surgical procedures performed.

This review describes the codes used to report debridement and excision procedures commonly performed by primary care physicians. Procedures included in this review are skin debridement, burn debridement, benign and malignant lesion excision of the skin and subcutaneous tissue, cyst and ganglion excision, nail excision, anorectal lesion excision, shave excision, paring, skin tag excision, and foreign body removal. Relative value units (RVUs) created by the Health Care Financing Administration (HCFA)[3] and one state's published Medicaid payment schedule[4] are included for each code. These procedure codes can be incorporated into office fee schedules to improve reporting to third-party payers.

The coding of debridement and excision procedures can be complicated by multiple reporting options. Physicians may report an excision procedure as a biopsy, even when the lesion is completely excised.[5] Excision procedures also may be described by general or site-specific codes in the 1992 CPT.[2] The reader is referred to the coding instructions provided in our first paper.[5] Additional resources are available to provide basic instruction to physicians unfamiliar with basic coding principles.[6-9]

The procedure codes listed in this review were chosen for their possible application to family practice; family physicians may perform procedures not listed, and should consult the CPT index in the back of the CPT book for specific codes.[2]

The 1992 total RVUs represent the work value assigned to visits and procedures by the HCFA.[3] These relative value units may be used as a guide to establish fees. The HCFA has established a $31 conversion factor that can be multiplied by the RVUs to estimate payment from the Medicare program for a particular service. Actual Medicare payments will vary from state to state

Submitted, June 9, 1992.

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 ISSN 0094-3509

Table 1. Common Debridement Procedures

1992 CPT Code†	Procedure Description	1992 Total RVUs‡	1992 NC Medicaid Allowable§ ($)
11000*	Debridement of extensive eczematous or infected skin, up to 10% of the body surface	1.42	27.07
11001	Each additional 10% of the body surface	0.77	59.60
11040	Debridement of skin, partial thickness	1.10	95.22
11041	Debridement of skin, full thickness	1.62	122.81
11042	Debridement of skin and subcutaneous tissue	2.04	122.82
11043	Debridement of skin, subcutaneous tissue, and muscle	4.37	131.12
11044	Debridement of skin, subcutaneous tissue, muscle, and bone	6.10	149.01
16000	Initial local treatment, 1st degree burn	1.33	13.63
16020*	Dressing and debridement of small burn, without anesthesia	1.22	22.65
16025*	Dressing and debridement of medium burn, without anesthesia	2.46	28.39
16030*	Dressing and debridement of large burn, without anesthesia	2.83	55.50
26035	Decompression of fingers or hand after injection injury (grease gun)	15.19	382.05

**Starred surgical procedures as listed in the 1992 CPT.*
†From Physicians' Current Procedural Terminology.[2]
‡From Department of Health and Human Services Medicare fee schedule.[3]
§From North Carolina Title XIX Fee Schedule Master List.[4]

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because of geographic modifiers and the impact of the historic payment base.[10]

Most third-party payers now require a corresponding diagnosis code for any medical service reported.[5,6] Standardized diagnosis coding is available through the *International Classification of Disease, 9th Revision, Clinical Modification* (ICD-9-CM) system.[11] Diagnosis coding for debridement and excision procedures frequently involves describing neoplastic growths of tissue. Neoplasm codes are listed in the ICD-9-CM in the "Neoplasm, neoplastic" section of the Index to Diseases.

General Debridement Procedures

The general debridement procedure codes are listed in Table 1. When large areas of the skin are infected or involved with eczema, code 11000* is reported for the debridement of the first 10% of body surface area, and code 11001 for each additional 10% of body surface area debrided.[2]

Codes 11040 through 11044 are used for reporting skin and subcutaneous tissue debridement procedures. The specific code selected depends on the depth of the tissue involved. Relative value units assigned for these codes vary from 1.10 for a partial thickness skin debridement (11040) to 6.10 for the debridement of skin, subcutaneous tissue, muscle, and bone (11044).[3]

Debridement Procedures of Burn Injury

The codes for reporting burn treatment provided by primary care physicians are listed in Table 1. These codes refer to the local debridement and treatment of burned body surfaces only.[2] If additional medical care is required in the management of burn patients, these evaluation and management services can be reported by attaching the "−25" modifier to the visit code. (See Zuber and Purvis.[5(p 435)])

**A star, or asterisk, is used in the 1992 CPT (and in this article) to identify codes of small surgical procedures that involve variable preoperative and postoperative services and generally are not billed as a surgical package.*

Table 2. Nail Excision and Debridement Procedures

1992 CPT Code†	Excision Procedure Description	1992 Total RVUs‡	1992 NC Medicaid Allowable§ ($)
11700*	Manual debridement of 5 or less nails	0.69	17.23
11701	Each additional nail up to 5	0.50	11.47
11710*	Electric grinder debridement of 5 or less nails	0.69	16.08
11711	Each additional nail up to 5	0.42	11.47
11730*	Avulsion of nailplate, partial or complete, single	1.69	18.72
11731	Avulsion of the second plate	0.99	9.49
11732	Each additional nailplate (above 2)	0.67	4.76
11740	Evacuation of subungual hematoma	0.83	19.58
11750	Excision of nail and nail matrix, partial or complete, for permanent removal	4.16	98.20
11765	Wedge excision of skin of nail fold	1.28	17.29

**Starred surgical procedures as listed in the 1992 CPT.*
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The initial treatment of first degree burns that require only local therapy is reported with code 16000. Burn treatment codes 16020* through 16030* are used to report the initial or subsequent visits. The dressing and debridement of a small burn area is reported with starred code 16020*; a medium burn area is reported with the code 16025*; a large burn area is reported with code 16030*. Some third-party payers still routinely pay for an office visit in addition to a starred surgical procedure. A small burn area describes injury to the skin on less than one entire extremity. A medium burn area is defined as thermal injury involving the skin of the entire face or an entire extremity.[2] A large burn area involves more than one extremity.

Burn treatment that requires general anesthesia is reported with codes 16010 and 16015.[2] Burn treatment codes not requiring anesthesia are listed in Table 1. If a burn requires skin grafting, the skin graft codes (15100 through 15650) are used.[2] Physicians should list the percentage of body surface involved and the depth of the burn whenever reporting burn treatment services to third-party payers.

Nail Excision and Debridement Procedures

The nail excision and debridement procedure codes are listed in Table 2. Physicians performing nail debridement (nail trimming) procedures report their services using the manual procedure codes (11700* and 11701) or the electric grinder procedure codes (11710* and 11711). Generally, up to 10 nail debridements can be reported at a visit. Manually debriding 10 toenails deformed by onychomycosis would be reported as 11700* for the first five, and 11701 five times for each additional nail up to 10. Physicians should contact local third-party payers for rules regarding the reimbursement of nail debridements. Many payers will only reimburse these codes under special circumstances, such as in cases of patients with coexisting diabetic vascular disease.

If the local Medicare carrier has determined that nail debridement is a noncovered service, physicians may be reimbursed for this procedure by the Medicare patient. A Medicare patient requesting this service should sign a waiver on the day of service, indicating that the patient accepts financial responsibility for the noncovered service.

Traumatized nails often require removal. To report the removal of the first nail plate, CPT code 11730* is used. The code 11731 is used for the second nail plate removal, and 11732 for each additional removal procedure.[2] When a laceration damages the nail bed, 11730* may be used to report the nail removal and 11760 to report the repair of the nail bed.

Physicians have multiple treatment options for ingrown toenails. Physicians may perform an incision and drainage procedure (10060* or 10061), a wedge exci-

Table 3. Excision of Benign Lesion of Skin and Subcutaneous Tissue (unless listed elsewhere)

1992 CPT Code*†	Excision Procedure Description	1992 Total RVUs‡	1992 NC Medicaid Allowable§ ($)
	Trunk, arm, or leg excision		
11400	Lesion up to 0.5 cm	1.53	38.13
11401	Lesion 0.6 to 1.0 cm	2.11	45.50
11402	Lesion 1.1 to 2.0 cm	2.68	53.83
11403	Lesion 2.1 to 3.0 cm	3.32	66.08
11404	Lesion 3.1 to 4.0 cm	3.89	72.73
11406	Lesion over 4.0 cm	5.19	93.71
	Scalp, neck, hand, foot, or genitalia excision		
11420	Lesion up to 0.5 cm	1.67	35.86
11421	Lesion 0.6 to 1.0 cm	2.38	52.88
11422	Lesion 1.1 to 2.0 cm	2.89	53.88
11423	Lesion 2.1 to 3.0 cm	3.76	61.58
11424	Lesion 3.1 to 4.0 cm	4.34	66.82
11426	Lesion over 4.0 cm	6.15	92.93
	Face, ear, eye, nose, lip, or mucous membrane excision		
11440	Lesion up to 0.5 cm	1.94	48.88
11441	Lesion 0.6 to 1.0 cm	2.63	54.92
11442	Lesion 1.1 to 2.0 cm	3.19	55.27
11443	Lesion 2.1 to 3.0 cm	4.25	63.41
11444	Lesion 3.1 to 4.0 cm	5.24	61.02
11446	Lesion over 4.0 cm	6.74	92.02

**There were no starred surgical procedures among these CPT codes.*
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sion of the skin of the nail fold (11765), or a more complete excision procedure (11750).[2] The partial or complete excision of nail and nail matrix (11750) should involve the excision or destruction of the nail matrix for permanent removal. Code 11750 describes the highest reimbursed nail procedure for paronychia, yielding $128.96 (4.16 RVUs × $31.00) from Medicare and $98.20 from the North Carolina Medicaid program.

Excision of Lesions of Skin and Subcutaneous Tissue

The office fee schedules of physicians who perform dermatologic surgery should include the benign and malignant lesion excision codes listed in Tables 3 and 4. The benign lesion excision codes are used to report the excision of scarred, fibrous, inflammatory, congenital, or cystic lesions of the skin or subcutaneous tissues.[2] The benign lesion excision codes in Table 3 are not used for other procedures more specifically described or otherwise listed in the CPT. For example, the benign lesion excision codes should not be substituted for the skin tag excision codes (11200* and 11201).

Both the benign and malignant lesion excision codes are categorized by size and location. The excision of a 1.8-cm benign lesion on the trunk is reported with code 11402, while the excision of the same lesion on the hand is reported with code 11422. Facial lesions generally receive the highest reimbursement; lesions of the scalp,

Table 4. Excision of Malignant Lesion of Skin and Subcutaneous Tissue

1992 CPT Code*†	Excision Procedure Description	1992 Total RVUs‡	1992 NC Medicaid Allowable§ ($)
	Trunk, arm, or leg excision		
11600	Lesion up to 0.5 cm	2.51	52.44
11601	Lesion 0.6 to 1.0 cm	3.57	72.71
11602	Lesion 1.1 to 2.0 cm	4.22	87.31
11603	Lesion 2.1 to 3.0 cm	5.03	150.51
11604	Lesion 3.1 to 4.0 cm	5.66	160.21
11606	Lesion over 4.0 cm	7.02	182.38
	Scalp, neck, hand, foot, or genitalia excision		
11620	Lesion up to 0.5 cm	2.89	79.06
11621	Lesion 0.6 to 1.0 cm	4.03	122.63
11622	Lesion 1.1 to 2.0 cm	4.93	158.40
11623	Lesion 2.1 to 3.0 cm	5.84	157.35
11624	Lesion 3.1 to 4.0 cm	7.28	188.34
11626	Lesion over 4.0 cm	8.58	178.80
	Face, ear, eyelid, nose, or lip excision		
11640	Lesion up to 0.5 cm	3.45	103.84
11641	Lesion 0.6 to 1.0 cm	4.74	142.60
11642	Lesion 1.1 to 2.0 cm	5.75	167.62
11643	Lesion 2.1 to 3.0 cm	7.10	216.43
11644	Lesion 3.1 to 4.0 cm	8.78	229.82
11646	Lesion over 4.0 cm	11.37	251.28

**There were no starred surgical procedures among these CPT codes.*
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neck, hand, foot, or genitalia, the second highest; and lesions on the trunk, arm, or leg, the least reimbursement. The 1992 total RVUs listed in Tables 3 and 4 reflect this reimbursement pattern.

Table 4 reveals lower reimbursement from the North Carolina Medicaid program for a 4.5-cm malignant scalp lesion excision (11626) compared with a smaller malignant lesion excision in the same location (11624) or a similar malignant lesion excision on the trunk (11606).[4] This may reflect an error in the calculation of the allowable amount. Physicians should monitor surgical procedure reimbursements from the major third-party payers in their area. Errors are occasionally noted, and correction may improve reimbursements.

When completely excising a skin or subcutaneous lesion of uncertain pathology, the physician has several billing options. The procedure can be billed immediately as a biopsy. The biopsy codes, however, are generally reimbursed less than the excision codes. The physician can guess whether the lesion is benign or malignant. Guessing will result in some lesions being incorrectly overcharged as a malignant lesion, and some being incorrectly undercharged as a benign lesion. Also, incorrectly labeling a patient with a malignancy can cause undue anxiety and possibly affect the patient's future insurability.

Correct billing of lesions of uncertain pathology can be achieved by delaying the billing until the pathology report returns. Offices can sequester charge slips until the correct pathologic diagnosis is available. Delayed billing has the drawback of possible interference with cash flow.

Table 5. Shave Excision, Paring, and Skin Tag Excision Procedures

1992 CPT Code†	Procedure Description	1992 Total RVUs‡	1992 NC Medicaid Allowable§ ($)
	Shave excision procedures		
11060*	Shave excision of a single lesion	0.64	—
11061	Two to four lesions	1.02	—
11062	More than four lesions	1.48	—
	Skin paring and curettement procedures		
11050*	Paring or curettement of a single lesion	0.86	18.87
11051	Two to four lesions	1.28	27.68
11052	More than four lesions	1.38	35.76
	Skin tag excision procedures		
11200*	Excision of skin tags, up to 15	1.22	26.74
11201	Each additional ten lesions	0.46	10.88

**Starred surgical procedures as listed in the 1992 CPT.*
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Delayed billing, however, offers the advantages of correct procedure billing, correct diagnosis application, avoidance of overbilling, and fewer third-party payer audits. Pathology laboratories often assist with the rapid reporting of results. Correct ICD-9-CM codes also are applied once the pathology results return.

A physician occasionally may perform an excision of an unusual or complicated benign lesion. The codes listed in Table 3 may be modified to reflect a complicated benign lesion excision procedure. For example, a 1.5-cm lesion is noted on the skin of the posterior pinna. During the excision, the physician removes tissue down to the cartilage, and then frees up surrounding skin to the top of the pinna to allow for a primary closure. A modifier, −22 or 09922, could be added to the excision code 11442 to reflect the unusual or complicated procedure.[2] If an adjacent tissue transfer, Z-plasty, or advancement flap was used to close the wound, then code 14060 would reflect both the excision and closure procedure.[2]

Shave Excision, Paring, and Skin Tag Excision Procedures

The codes used for shave excision, paring, and skin tag excision procedures are listed in Table 5. Paring and curettement procedures describe the treatment of benign hyperkeratotic skin lesions with or without chemical cauterization or local anesthesia. Paring procedures do not extend through the stratum corneum.[2] The paring code is selected by the number of paring procedures performed.

Shave excision procedures sharply incise or slice epidermal or superficial dermal lesions without performing a full-thickness dermal excision.[2] Suture closure may be used but is not necessary for these wounds. The costs of local anesthesia, chemical cauterization, and electrocauterization are included in the amount reimbursed for this procedure. Shave excision procedures also are coded according to the number of procedures performed. For example, five or more shave excision procedures are reported with the single code 11062. Three paring and curettement procedures are reported with code 11051.

Skin tag excision codes are different from codes for skin tag destruction procedures.[5] The billing of skin tag excisions may involve the reporting of multiple codes, unlike the reporting of shave excisions and paring procedures. The first 15 skin tags that are excised are reported with code 11200*, and each additional 10 lesions are reported with code 11201.[2] For example, the excision of 34 skin tags is reported as 11200*, 11201, and 11201.

Site-Specific Tumor Excision Procedures

The excision of a tumor may be reported with the site-specific codes listed in Table 6. Site-specific tumor exci-

Table 6. Site-Specific Tumor Excision Procedures

1992 CPT Code*†	Excision Procedure Description	1992 Total RVUs‡	1992 NC Medicaid Allowable§ ($)
22900	Abdominal wall tumor, subfascial (dermoid)	10.74	214.57
27618	Ankle or leg tumor, subcutaneous	7.74	53.38
27619	Ankle or leg tumor, deep or subfascial	13.48	298.01
19120	Breast cyst, fibroadenoma, tumor, nipple lesion, or aberrant tissue (1 or more)	8.78	181.02
25075	Forearm or wrist tumor, subcutaneous	6.49	54.98
25076	Forearm or wrist tumor, deep or subfascial	9.70	177.22
24075	Upper arm or elbow tumor, subcutaneous	6.44	50.08
24076	Upper arm or elbow tumor, deep or subfascial	10.93	238.40
21930	Back or flank soft tissue tumor	10.29	298.01
26115	Finger or hand vascular malformation or tumor, subcutaneous	6.35	52.33
26116	Finger or hand vascular malformation or tumor, deep or subfascial	10.04	214.57
28043	Foot tumor, subcutaneous	5.63	52.44
28045	Foot tumor, deep or subfascial	9.39	298.01
41825	Gum (dentoalveolar) tumor, no repair	3.04	664.91
41826	Gum (dentoalveolar) tumor, simple repair	4.76	720.32
27047	Hip and pelvis area tumor, subcutaneous	9.88	46.48
27048	Hip and pelvis area tumor, deep or subfascial	11.44	214.57
27327	Thigh or knee tumor, subcutaneous	7.40	51.56
27328	Thigh or knee tumor, deep or subfascial	10.66	375.49
21555	Neck or thorax soft tissue tumor, subcutaneous	6.26	51.12
21556	Neck or thorax soft tissue tumor, subfascial	10.24	268.21
23075	Shoulder area tumor, subcutaneous	4.54	54.83
23076	Shoulder area tumor, deep or subfascial	11.92	238.40
57135	Vaginal cyst or tumor	5.23	171.14

**There were no starred surgical procedures among these CPT codes.*
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sion codes generally provide higher reimbursement than the general benign and malignant lesion excision codes listed in Tables 3 and 4. The codes in Table 6 apply only to true tumor growths; these codes are not used to report inflammatory, fibrous, scarred, congenital, or cystic lesions.[2]

If a physician reports the excision of a 1.8-cm lipoma in the subcutaneous tissue of the forearm with the benign excision code 11402, Medicare reimburses $83.08 (2.68 RVUs × $31.00) and the North Carolina Medicaid program reimburses $53.83. If the procedure were reported with the site-specific tumor excision code 25075, Medicare would reimburse $201.19 (6.49 RVUs × $31.00) and the North Carolina Medicaid program would reimburse $54.98. The site-specific excision code would improve the reimbursement from Medicare by 142%.

Physicians frequently perform excisional biopsies. If a lesion is totally excised, then the tumor excision codes in Table 6 may be reported. Partial excisions generally

Table 7. Cyst and Ganglion Excision Procedures

1992 CPT Code*†	Excision Procedure Description	1992 Total RVUs‡	1992 NC Medicaid Allowable§ ($)
42810	Brachial cleft cyst or vestige, in skin or subcutaneous tissues	7.98	172.13
19120	Breast cyst(s) or other lesion(s) of breast	8.78	181.02
26160	Finger or hand lesion of tendon sheath or capsule	6.03	146.13
28090	Foot lesion of tendon sheath or capsule	7.98	181.50
30124	Nasal dermoid cyst, skin or subcutaneous tissue	4.73	33.24
42408	Sublingual salivary cyst (ranula)	8.47	161.52
28092	Toe lesion of tendon sheath or capsule	6.08	107.28
57135	Vaginal cyst (or tumor)	5.23	171.14
25111	Wrist ganglion (dorsal or volar), primary	7.40	191.94
25112	Wrist ganglion (dorsal or volar), recurrent	9.24	163.49
11770	Simple pilonidal cyst or sinus	5.97	302.44
11771	Extensive pilonidal cyst or sinus	11.16	302.44
11772	Complicated pilonidal cyst or sinus	12.83	382.64

**There were no starred surgical procedures among these CPT codes.*
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require less work, and are reimbursed at slightly lesser values if billed as a biopsy. The biopsy of the forearm lipoma in the example above could be reported with code 25065; this biopsy code would yield only 47% of the Medicare payment ($95.17) provided by the tumor excision code 25075.

A few site-specific excision codes apply to the removal of a cyst or a tumor. Code 57135 reports the excision of a cyst or tumor of the vagina. Code 19120 describes the excision of one or more breast cysts, fibroadenomas, tumors, duct lesions, or aberrant tissue growths. Both site-specific codes 26115 and 26116 apply to the excision of tumors and vascular malformations in the hand or finger.[2]

The 1992 CPT lists additional codes describing tumor excision procedures that primary care physicians may perform. More radical procedures involving wide excision of soft tissue or bone are identified by anatomical site in the CPT book.[2]

Cyst and Ganglion Excision Procedures

Primary care physicians commonly perform incision and drainage procedures on cystic lesions. When performing more extensive excision procedures on cystic lesions, physicians should report the excision codes listed in Table 7. The cyst excision procedures generally involve more work than incision procedures, and receive higher reimbursement. Physicians who perform ganglion excisions should become familiar with the site-specific ganglion removal codes (Table 7).

A clinical example for the application of these codes involves a patient who presents with a recurrent, uncomplicated pilonidal cyst. Incision and drainage of this cyst (10080*) would yield $27.07 from the North Carolina Medicaid program. If the physician chose to excise the diseased tissue, reimbursement for 11770 would be for $302.44 from that same third-party payer.[4]

The excision of a ganglion at the wrist (either volar or dorsal) is reported with either code 25111 or 25112,[2] based on whether the ganglion is primary or recurrent. Despite possible higher reimbursement from selected third-party payers for one code over another, physicians are urged to choose the code that most accurately reflects the procedure performed.

Table 8. Anorectal Excision Procedures

1992 CPT Code†	Excision Procedure Description	1992 Total RVUs‡	1992 NC Medicaid Allowable§ ($)
46220	Excision of a single anal tag	2.38	41.72
46221	Rubber band hemorrhoid ligation	2.30	61.39
46230	Excision of external hemorrhoidal tags	3.64	47.39
46250	Complete external hemorrhoidectomy	8.08	280.93
46255	Simple external and internal hemorrhoidectomy	11.07	310.27
46260	Complex external and internal hemorrhoidectomy	14.78	417.65
46320*	Enucleation/excision of external thrombotic hemorrhoid	12.52	33.85
46945	Internal hemorrhoid ligation, one procedure	4.01	21.16
46946	Internal hemorrhoid ligation, multiple procedures	5.42	22.16

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Table 9. Removal of Foreign Bodies

1992 CPT Code†	Foreign Body Removal Procedure Description	1992 Total RVUs‡	1992 NC Medicaid Allowable§ ($)
10120*	Subcutaneous tissues, simple	1.80	20.17
10121	Subcutaneous tissues, complicated	3.96	54.37
20520*	Muscle or tendon sheath, simple	2.72	55.33
20525	Muscle or tendon sheath, deep or complicated	6.09	108.36
25248	Exploration of the deep tissues of the forearm or wrist	7.91	178.80
24200	Upper arm or elbow area, subcutaneous	2.46	2.38
24201	Upper arm or elbow area, deep	8.28	178.80
69200	External auditory canal, without anesthesia	1.29	18.92
65205*	Conjunctiva, superficial	1.44	19.20
65210*	Conjunctiva, embedded (subconjunctival)	1.73	25.42
65220*	Corneal, without slit lamp	1.57	15.03
65222*	Corneal, with slit lamp	1.84	21.45
67938	Eyelid, embedded	1.94	101.32
28190*	Foot, subcutaneous	2.63	29.80
28192	Foot, deep	7.04	178.80
28193	Foot, complicated	8.55	268.21
41805	Gum (dentoalveolar), embedded in soft tissue	2.22	22.16
27086*	Pelvis or hip area, subcutaneous tissue	2.60	55.25
27087	Pelvis or hip area, deep tissue	12.90	298.01
27372	Thigh or knee area, deep	9.25	214.57
40804*	Mouth vestibule, embedded, simple	1.94	106.68
30300*	Intranasal	1.58	13.68
55120	Scrotum	7.13	89.40
23330	Shoulder, subcutaneous	2.55	29.80

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Anorectal Excision Procedures

Anorectal excision procedures performed in the primary care physician's office are listed in Table 8. Anorectal or endoscopic destruction procedures are reported with different codes.[5]

The excision of a single anal tag is reported with code 46220. The excision of multiple external hemorrhoidal tags is reported with code 46230. Hemorrhoid excision procedures are reported by site (external or internal) and by the complexity of the surgical procedure required (simple or complex). Hemorrhoidectomy procedure codes that report extensive hemorrhoid procedures including fissurectomy or fistulectomy are not included in this review.

Reimbursement based on hemorrhoid excision codes varies greatly with the work performed. The enucleation or excision of an external thrombotic hemorrhoid (46320*) is reimbursed $78.12 (2.52 RVUs × $31.00) by Medicare and $33.85 by the North Carolina Medicaid program. A complete external hemorrhoidectomy is reimbursed $250.48 (8.08 RVUs × $31.00) by Medicare and $280.93 by the North Carolina Medicaid program.

Suture ligation of internal hemorrhoids is reported with codes 46945 and 46946. Although the rubber band

ligation procedure is similar, the rubber band ligation procedure should be reported with code 46221.[2]

Foreign Body Excisions

Foreign body removal procedures often are reported incorrectly in the primary care office. Physicians may report only an office visit, and delete the excision procedure. Commonly performed foreign body removal procedure and codes are listed in Table 9.

General codes exist for reporting foreign body removal from the subcutaneous tissues and muscle. For example, a simple foreign body removal from the subcutaneous tissues is reported with code 10120*, while complicated subcutaneous excisions are reported with 10121. General codes for foreign bodies excisions from muscle or tendon sheaths are 20520* (simple procedures) and 20525 (deep or complicated procedures).

Foreign body excisions may be reported as site-specific removal procedures. These site-specific codes generally reimburse more than the general codes. For example, a patient sits on a sewing needle and the foreign body penetrates into the muscle of the buttock. The exploration and removal of the needle could be reported with the general code 20525, yielding $186.62 (6.02 RVUs × $31.00) from Medicare and $108.36 from the North Carolina Medicaid program. If this procedure were reported with the site-specific code 20787, Medicare would reimburse $399.90 (12.90 RVUs × $31.00) and the Medicaid program would yield $298.01.

Physicians are frequently called upon to remove foreign bodies from the foot. The removal of a superficial splinter in the foot could be billed with the general code 10120*, yielding $55.80 (1.80 RVUs × $31.00) from Medicare.[3] The site-specific code 28190* would yield 46% more from Medicare. If this splinter extended into the deep tissues of the foot, the site-specific code 28192 would yield 78% more from Medicare than the general code 10121.

Primary care physicians frequently perform simple foreign body removal procedures on the head. Table 9 lists commonly performed procedures involving the eyes (65205* to 65222*), nose (30300*), ears (69200), and mouth (41805).[2] Some third-party payers anticipate that an office visit will be billed in addition to a starred surgical procedure code. Medicare only allows a visit code with a −25 modifier when a separate evaluation and management service is performed in addition to the procedure.

Summary

The reimbursement of office debridement and excision procedures is influenced by proper CPT code selection. Physicians are urged to consider the many reporting options outlined in this review. Site-specific debridement and excision codes generally provide higher reimbursement. Physicians should select the code that most accurately reflects the procedure performed.

Acknowledgment

The authors thank Melissa Boyd of East Carolina University for transcription assistance.

References

1. Pories WJ, Thomas FT. Office surgery for family physicians. Stoneham, Mass: Butterworth, 1985:xiv.
2. American Medical Association. Physicians' Current Procedural Terminology 1992. Chicago: American Medical Association, 1992.
3. Department of Health and Human Services. Medicare program; fee schedule for physician's services. Federal Register, November 25, 1991; 56(227):59502–819.
4. Rate Setting Section. Division of Medical Assistance, North Carolina Department of Human Resources. North Carolina title XIX fee schedule master list. Cary, NC: Electronic Data Systems, 1991.
5. Zuber TJ, Purvis JR. Coding and reimbursement of primary care biopsy and destruction procedures. J Fam Pract 1992; 35:433–41.
6. Knaus GM. Coding and reimbursement for family physicians. Kansas City, Mo: American Academy of Family Physicians, 1990.
7. Farber L. Medical Economics encyclopedia of practice and financial management. Oradell, NJ: Medical Economics Books, 1988.
8. Knaus GM. Getting paid for what you do. Willowbrook, Ill: Professional Management Corporation, 1989.
9. American Medical Association. CPT assistant. Chicago: American Medical Association, winter 1990–1991.
10. Zuber TJ, Jones JG. Physician payment reforms and family physicians [letter]. JAMA 1992; 267:2034–5.
11. Jones MK, Brouch KL, Allen MM, Aaron WS, eds. St Anthony's ICD-9-CM code book. Alexandria, Va: St Anthony Publishing, 1991.