# Coding and Reimbursement of Primary Care Biopsy and Destruction Procedures

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Current medical practice requires physicians to accurately report services provided to patients. Billing for destruction of benign and malignant lesions and for surgical, needle, and endoscopic biopsy procedures involves the selection of specific 1992 Current Procedural Terminology (CPT) codes. Payment for these procedures by third-party payers often requires the *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD-9-CM) coding for neoplastic lesions. This review explains the proper codes to use in identifying common biopsy and destruction procedures performed by primary care physicians. The Health Care Financing Administration's relative value units and one state's published Medicaid payment rates are included for each procedure code. Instructions for selecting site-specific biopsy and destruction codes are provided.
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The histopathologic examination of tissue provides practitioners with additional information to establish or confirm a diagnosis.[1] Surgical biopsy is frequently performed to obtain tissue for histologic analysis. Biopsy techniques include surgical, needle, and endoscopic procedures. Surgical excisional biopsy denotes the complete removal of a lesion; surgical incisional biopsy signifies that only a sample of a lesion is removed.[2] Needle biopsy involves removal of tissue and fluids from subcutaneous masses, internal organs, and cysts. Endoscopic biopsy is accomplished with alligator-type side-biting forceps or by brushing technique.[2]

Primary care physicians perform destruction procedures on abnormal tissue and benign and malignant lesions. The 1992 publication of *Physicians' Current Procedural Terminology* identifies the most common destruction methods as chemical, electrocautery, electrodessication, cryosurgery, and laser ablation.[3] Lesions frequently destroyed include condylomata, papillomas, molluscum contagiosum, herpetic lesions, flat warts, milia, and other benign or malignant lesions.[3–5] Normal tissue may also require ablation if it interferes with body function or grows to excess.

With the refinement of biopsy and destruction techniques and the discovery of new treatment procedures, many new procedure codes have been created.[3] The billing of procedures is complicated by extensive reporting rules for third-party payers. This review describes the codes used to report biopsy and destruction procedures commonly performed by primary care physicians. Relative value units created by the Health Care Financing Administration (HCFA) and one state's published Medicaid payment schedule are included for each code. These procedure codes can be incorporated into office fee schedules to improve reporting to third-party payers.

## CPT and ICD-9-CM Coding

Current medical practice requires physicians to accurately report services provided to patients. Unfortunately, physicians lose 10% to 30% of potential annual income because of improper reporting of services.[6] Standard terminology allows physicians and third-party payers to "speak the same language." The 1992 publication of Current Procedural Terminology (CPT) is the most widely accepted and current listing of descriptive terms and identifying codes used to report medical services and procedures.[3]

Excellent resources are available to provide basic instruction to physicians who are unfamiliar with basic coding principles.[6–9] Physicians may obtain new CPT books every December to examine annual coding changes.[6] Reimbursement rules for individual third-party

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Table 1. Coding and Sample of Reimbursements for Surgical Biopsy Procedures, Excisional or Incisional

| 1992 CPT Code† | Biopsy Procedure Description | 1992 Total RVUs‡ | 1992 NC Medicaid Allowable§ ($) |
|---|---|---|---|
| 11100 | Skin, subcutaneous tissue, or mucous membrane biopsy including closure—*not otherwise listed* | 1.24 | 34.79 |
| 11101 | Biopsy, each additional lesion | 0.65 | 16.16 |
| 27613 | Biopsy, soft tissue of leg or ankle area, superficial | 3.04 | 32.18 |
| 27614 | Biopsy, soft tissue of leg or ankle area, deep | 8.36 | 119.20 |
| 25065 | Biopsy, soft tissue of forearm or wrist, superficial | 3.40 | 15.49 |
| 25066 | Biopsy, soft tissue of forearm or wrist, deep | 5.93 | 30.32 |
| 24065 | Biopsy, soft tissue of upper arm or elbow, superficial | 3.07 | 27.41 |
| 24066 | Biopsy, soft tissue of upper arm or elbow, deep | 8.52 | 89.40 |
| 21920 | Biopsy, soft tissue of back or flank, superficial | 3.06 | 33.14 |
| 21925 | Biopsy, soft tissue of back or flank, deep | 6.85 | 48.62 |
| 19101 | Incisional biopsy of breast | 6.23 | 158.38 |
| 57500* | Biopsy of cervix, single or multiple, with or without fulguration, *without* colposcopy | 1.75 | 37.37 |
| 69100 | Biopsy of external ear | 1.57 | 27.41 |
| 58100* | Endometrial biopsy, suction type | 1.59 | 38.81 |
| 67810* | Biopsy of eyelid | 2.46 | 50.86 |
| 27040 | Biopsy, soft tissue of pelvis or hip area, superficial | 4.31 | 14.90 |
| 27041 | Biopsy, soft tissue of pelvis or hip area, deep | 13.13 | 32.18 |
| 27323 | Biopsy, soft tissue of thigh or knee area, superficial | 3.91 | 32.18 |
| 27324 | Biopsy, soft tissue of thigh or knee area, deep | 8.03 | 66.49 |
| 40490 | Biopsy of lip | 2.14 | 34.17 |
| 38500 | Biopsy or excision of superficial lymph node(s) | 4.98 | 62.00 |
| 40808 | Biopsy, vestibule of the mouth | 1.84 | 39.93 |
| 20200 | Biopsy of muscle, superficial | 2.90 | 42.58 |
| 21550 | Biopsy, soft tissue of neck or thorax | 3.13 | 31.70 |
| 54100 | Biopsy of penis, cutaneous | 2.77 | 28.61 |
| 56100* | Biopsy of perineum | 1.83 | 53.64 |
| 23065 | Biopsy, soft tissue of shoulder area, superficial | 3.15 | 15.51 |
| 23066 | Biopsy, soft tissue of shoulder area, deep | 5.56 | 30.32 |
| 41100 | Biopsy of tongue, anterior two-thirds | 2.59 | 45.97 |
| 57100* | Biopsy of vaginal mucosa, simple | 1.81 | 47.74 |
| 57105 | Biopsy of vaginal mucosa, extensive, requiring suture | 3.73 | 178.60 |
| 56600* | Biopsy of vulva | 1.51 | 30.19 |

**Surgical procedures identified by a star, or asterisk, in the 1992 CPT.*
†*From* Physicians' Current Procedural Terminology.[3]
‡*From Department of Health and Human Services Medicare fee schedule.*[10]
§*From North Carolina Title XIX Fee Schedule Master List.*[12]

*CPT denotes Current Procedural Terminology; RVUs, relative value units; NC, North Carolina.*

payers vary from state to state, and physicians should contact local carriers for specific instructions.

Starred surgical procedures are identified in the 1992 CPT.[3] These small surgical services involve variable preoperative and postoperative services, and generally are not billed as a surgical package. If a starred surgical procedure is performed during a visit involving significant services unrelated to the procedure, then a visit may be billed in addition to the procedure. If the procedure constitutes the major service at that visit, the visit is not billed in addition to the procedure.[3]

Some third-party payers have reduced allowable reimbursement for starred procedures, anticipating that a fee will also be charged for the visit. The Medicare

Table 2. Office Biopsy Procedures for Which Additional Supply Charges May be Reimbursed by Medicare*

| CPT Code† | Biopsy Procedure |
|---|---|
| 19101 | Incisional biopsy of the breast |
| 20200 | Biopsy of muscle, superficial |
| 38500 | Biopsy (or excision) of lymph node |
| 43202 | Esophagoscopy with biopsy |
| 43239 | Upper gastrointestinal endoscopy with biopsy |
| 45380 | Colonoscopy with biopsy |
| 85102 | Bone marrow biopsy |

**From Department of Health and Human Services Medicare fee schedule.*[10]
*†From 1992* Physicians' Current Procedural Terminology.[3]

program has indicated that a charge for a visit will be reimbursed in addition to a procedure only when the physician performs a significant, separately identifiable evaluation and management service.[10] These visits require a diagnosis code different from the diagnosis code associated with the procedure, and a −25 modifier must be added to the visit code.[10] While the Medicare program is no longer differentiating starred from nonstarred procedures for reimbursement purposes, other third-party payers may reimburse for visits when a starred procedure is performed.

Biopsy procedures commonly performed by primary care physicians are listed in Tables 1, 2, 3, and 4. Primary care surgical destruction procedures are listed in Tables 5, 6, 7, and 8. The procedures listed were chosen for their applicability 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 not included in this review.

The 1992 total relative value units (RVUs) shown in the tables represent the work value assigned to visits and procedures by the HCFA.[10] These RVUs 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 because of geographic modifiers and the impact of the Historic Payment Base.[11]

The 1992 North Carolina Medicaid allowable represents the published payment schedule for services provided to Medicaid patients in that state.[12] Both the 1992 total RVUs and the North Carolina Medicaid payment schedule values are included because they are part of the

Table 4. Coding and Method of Reimbursement for Endoscopic Biopsy Procedures

| 1992 CPT Code† | Biopsy Procedure Description | 1992 Total RVUs‡ | 1992 NC Medicaid Allowable§ ($) |
|---|---|---|---|
| 46606 | Anoscopy with biopsy | 1.28 | 35.76 |
| 52204 | Cystourethroscopy with biopsy | 5.26 | 150.19 |
| 45380 | Colonoscopy with biopsy/brushing | 9.49 | 414.83 |
| 45331 | Flexible sigmoidoscopy (fiberoptic) with biopsy/brushing | 3.31 | 125.37 |
| 43202 | Esophagoscopy with biopsy/brushing | 5.74 | 357.61 |
| 43239 | Upper gastrointestinal endoscopy with biopsy/brushing | 7.62 | 463.67 |
| 57454* | Colposcopy with biopsies | 2.89 | 106.23 |
| 45302 | Proctosigmoidoscopy with brushing | 1.74 | 53.64 |
| 45305 | Proctosigmoidoscopy with biopsy | 2.08 | 51.15 |

**Surgical procedure identified by a star, or asterisk, in the 1992 CPT.*
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*‡From Department of Health and Human Services Medicare fee schedule.*[10]
*§From North Carolina Title XIX Fee Schedule Master List.*[12]

*CPT denotes Current Procedural Terminology; RVUs, relative value units; NC, North Carolina.*

Table 3. Coding and Method of Reimbursement for Needle Biopsy Procedures

| 1992 CPT Code† | Biopsy Procedure Description | 1992 Total RVUs‡ | 1992 NC Medicaid Allowable§ ($) |
|---|---|---|---|
| 85102 | Bone marrow biopsy, needle or trocar | 2.65 | 84.86 |
| 19100* | Needle biopsy of breast | 1.75 | 39.19 |
| 38505 | Needle biopsy of superficial lymph node | 2.54 | 36.35 |
| 20206* | Biopsy, muscle, percutaneous needle | 2.19 | 49.34 |
| 42400* | Biopsy of salivary gland, needle | 1.75 | 52.44 |
| 60100* | Biopsy, thyroid, percutaneous needle | 2.24 | 52.78 |
| 88170 | Fine-needle aspiration with or without preparation of smears, superficial tissue (eg, thyroid, breast, prostate) | 1.42 | 70.01 |

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*§From North Carolina Title XIX Fee Schedule Master List.*[12]

*CPT denotes Current Procedural Terminology; RVUs, relative value units; NC, North Carolina.*

Table 5. General Destruction Codes for Benign Lesions and Sample Reimbursements

| 1992 CPT Code† | Destruction Method Description | 1992 Total RVUs‡ | 1992 NC Medicaid Allowable§ ($) |
|---|---|---|---|
| | Destruction of benign facial or premalignant lesions, any site (not proliferative vascular lesions) | | |
| 17000* | One lesion | 1.15 | 19.88 |
| 17001 | Second and third lesion (each) | 0.42 | 18.67 |
| 17002 | Over three lesions, each additional lesion | 0.31 | 7.13 |
| 17010 | Complicated lesion(s) | 1.61 | 53.68 |
| | Destruction of benign nonfacial lesions (not proliferative vascular lesions) | | |
| 17100* | One lesion | 0.98 | 14.26 |
| 17101 | Second lesion | 0.32 | 9.28 |
| 17102 | Over three lesions, each additional lesion up to 15 lesions | 0.20 | 5.48 |
| 17104 | 15 or more lesions | 2.20 | 17.68 |
| 17105 | Complicated lesions | 1.15 | 73.90 |
| | Miscellaneous destructions, benign lesions | | |
| 17110* | Destruction of flat warts, milia, or molluscum, up to 15 lesions | 1.04 | 18.35 |
| 17200* | Electrosurgical destruction of skin tags up to 15 lesions | 1.10 | 6.24 |
| 17201 | Electrosurgical destruction of skin tags, each additional 10 lesions over 15 lesions | 0.56 | 10.12 |
| 17250* | Chemical cauterization of granulation tissue (not to be used with an excision) | 0.93 | 11.66 |

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public record. These values can be compared with payment schedules in other localities. Because private and federal third-party payers often reimburse greatly different amounts for visits and procedures, it is not recommended that only the Medicare and Medicaid payment schedules be used for setting fees.

Most third-party payers now require a corresponding diagnosis code for any medical service reported.[6,13] Standardized diagnosis coding is available through the *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD-9-CM) system.[14] Diagnosis coding for biopsy or destruction procedures frequently involves describing neoplastic growths of tissue that may be benign or malignant. Neoplasm codes are listed in the ICD-9-CM in the *Neoplasm, neoplastic* section of the Index to Diseases.[14] For each anatomic site, there are six possible code numbers describing the lesion as a primary malignancy, secondary malignancy, cancer in situ, benign neoplasm, neoplasm of uncertain behavior, or unspecified neoplasm.[14] Physicians performing surgical procedures should be familiar with this section of the ICD-9-CM Index.

Third-party payers generally deny reimbursement for a service performed for a "rule-out" diagnosis. Because biopsies are frequently performed to rule out cancer, the diagnosis code should identify another reason for performing the procedure. Patients whose neoplasm is mislabeled malignant may have problems with future medical insurability; therefore, physicians should not describe an uncertain lesion as a malignancy. If a neoplasm code cannot be applied to a biopsy procedure, a physician may choose to describe a symptom. For example, a colonoscopic biopsy of abnormal colonic mucosa (45380) could be billed with the diagnosis code for rectal pain (569.42) or abdominal pain (789.0).

Destruction procedures may be performed on lesions that are suspect for cancer. The corresponding diagnosis code should not reflect a malignancy unless the patient has biopsy-proven cancer. Symptoms may be described when a neoplasm code cannot be applied to a destruction procedure. For example, a patient presents with a tender, bleeding seborrheic keratosis on his back (diagnosis code 702). The lesion avulsed before he arrived, and a visual diagnosis is impossible; the physician performs an electrosurgical destruction to the base. A diagnosis code of 782.0 (tenderness or altered sensation of skin) or 782.9 (other symptom involving the skin) may be selected.

## Surgical Biopsies

When a surgical biopsy is indicated, a physician must decide whether to do a biopsy of part of a lesion or to

excise the entire lesion. Specific excision codes may provide a more accurate description of the procedure performed, as well as bring higher reimbursement than certain biopsy codes. While some biopsies do involve removal of the entire lesion, physicians should use CPT codes that provide the most accurate description of the procedure performed.

Many offices have not expanded their billing systems to include the specific CPT biopsy codes listed in Table 1. Fee schedules that list only the skin biopsy codes 11100 and 11101 may severely limit reimbursement for such procedures. The charges for 11100 may be appropriate for a punch biopsy of the skin, but may not accurately reflect the work performed in more involved procedures.

The value of specific code selection can be seen in the example of a biopsy of a nodule deep in the thigh. If a physician used code 11100 in billing for this biopsy, Medicaid in North Carolina would pay $34.79 and Medicare would pay $38.44 (1.24 RVUs × $31 conversion factor). If the specific code 27324 was selected, Medicaid would pay $66.49 and Medicare would pay $248.93 (8.03 RVUs × $31). The reimbursement from Medicare and many third-party payers would be substantially greater using the more specific code.

Table 1 provides examples of North Carolina Medicaid payment rates exceeding Medicare payment rates ($178.80 as compared with $115.63 for CPT code 57105). Other third-party payers may have significantly different reimbursement values for selected procedures. The Blue Shield Index lists 5.0 RVUs for biopsy of the penis (54100),[15] compared with 2.77 RVUs listed in the Medicare fee schedule.

Shaving or horizontal slicing of lesions for biopsy is reported using codes 11060 to 11062.[3] Multiple shave biopsies are reported with only one code that reflects the number of procedures performed.[3] This is different from the reporting of multiple lesion destructions, which frequently requires additional codes for each additional procedure.

Most third-party payers include the administration of local anesthesia as part of the surgical procedure. The 1992 CPT includes simple closure in the description of the biopsy codes 11100 and 11101. Third-party payers may reimburse supply costs or tray charges (99070) in addition to a procedure. The 1992 Medicare fee schedule eliminated payment for surgical trays for laceration repair, but may reimburse for surgical trays used for selected office biopsy procedures (Table 2).[10]

Most third-party payers limit the reimbursement when multiple procedures are performed on the same day.[6,16] Many pay only one half of the usual reimbursement fee for the second surgical procedure.[10,16] When reporting multiple procedures, the procedure with the highest value (highest RVUs) should be reported first. The −51 modifier (secondary surgery) should be applied to other procedures reported. Some Medicare carriers will reduce the payment of the third and fourth biopsies to 25% of the full payment schedule.[10]

When complications develop after a biopsy procedure, physicians may choose to bill the patient for services related to the complications. Reimbursement for follow-up visits may be denied by third-party payers who follow global surgical payment rules. Medicare only reimburses complications that require a return trip to the operating room following a surgical procedure.[10] Physicians should contact local third-party payers for more specific instruction.

## Needle and Endoscopic Biopsy Procedures

Needle biopsy procedures commonly performed by primary care physicians are listed in Table 3. Occasionally, a physician must choose between two CPT codes that describe similar biopsy procedures, such as the percutaneous needle biopsy of the thyroid gland (60100*) and fine-needle aspiration of the thyroid gland (88170).[3] Certain third-party payers may reimburse an office visit in addition to a starred surgical procedure such as 60100*. Medicare will only pay for an office visit in addition to the biopsy procedure when a −25 modifier is applied to the office visit code and a separately identifiable evaluation and management service is provided.[3,10]

Endoscopic biopsy procedure codes are listed in Table 4. A colonoscopy procedure (45378) is not billed in addition to a colonoscopy with biopsy (45380). The Medicare relative value system includes the value of the colonoscopy procedure (8.48 RVUs) in the higher code that includes the biopsy (9.49 RVUs).[10] In this example, only 1.01 RVUs (about $31.31) are added for the actual biopsy procedure performed.

Medicare has indicated that physicians generally should not bill for a visit the same day as an endoscopic procedure if the patient was evaluated in a prior evaluation and management service.[10]

## Benign Destructions

Benign lesion destruction procedures (Table 5) are classified as premalignant or facial lesion destructions (17000* to 17010), or nonfacial lesion destructions (17100* to 17105). Codes in either category may be reported for any method of destruction, and the administration of local anesthesia is included in the procedure.

Table 6. General Destruction Codes for Malignant Lesions (any method of destruction) and Sample Reimbursements

| 1992 CPT Code† | Destruction Site and Size | 1992 Total RVUs‡ | 1992 NC Medicaid Allowable§ ($) |
|---|---|---|---|
| | Trunk, arms, or legs | | |
| 17260* | Lesion diameter 0.5 cm or less | 1.61 | 29.24 |
| 17261 | Lesion diameter 0.6 to 1.0 cm | 2.06 | 37.41 |
| 17262 | Lesion diameter 1.1 to 2.0 cm | 2.85 | 51.76 |
| 17263 | Lesion diameter 2.1 to 3.0 cm | 3.23 | 107.49 |
| 17264 | Lesion diameter 3.1 to 4.0 cm | 3.53 | 214.57 |
| 17266 | Lesion diameter over 4.0 cm | 4.27 | 357.61 |
| | Scalp, neck, hands, feet, genitalia | | |
| 17270* | Lesion diameter 0.5 cm or less | 1.79 | 32.95 |
| 17271 | Lesion diameter 0.6 to 1.0 cm | 2.68 | 49.34 |
| 17272 | Lesion diameter 1.1 to 2.0 cm | 3.20 | 89.40 |
| 17273 | Lesion diameter 2.1 to 3.0 cm | 3.77 | 115.62 |
| 17274 | Lesion diameter 3.1 to 4.0 cm | 4.71 | 108.61 |
| 17276 | Lesion diameter over 4.0 cm | 5.86 | 357.61 |
| | Face, ears, eyelids, nose, lips, mucous membrane | | |
| 17280* | Lesion diameter 0.5 cm or less | 2.06 | 37.41 |
| 17281 | Lesion diameter 0.6 to 1.0 cm | 3.10 | 56.30 |
| 17282 | Lesion diameter 1.1 to 2.0 cm | 3.70 | 67.20 |
| 17283 | Lesion diameter 2.1 to 3.0 cm | 4.81 | 87.36 |
| 17284 | Lesion diameter 3.1 to 4.0 cm | 6.28 | 114.05 |
| 17286 | Lesion diameter over 4.0 cm | 8.16 | 298.01 |

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Laser destruction of cutaneous vascular proliferative lesions is coded separately.

Application of the benign destruction codes is demonstrated in the following example of a patient who undergoes electrodessication and curettement of four actinic keratoses on the face. These procedures are reported as 17000* for the first, 17001 for the second, 17001 for the third, and 17002 for the fourth lesion. If the actinic keratoses are on the forearm, the same four codes apply because they are premalignant lesions. A large actinic lesion extending from the front to behind the pinnae could be reported as a complicated destruction (17010) because of the size and tissues involved.

Another example would be a patient with five seborrheic keratoses on the back who undergoes cryotherapy destruction of the lesions. These procedures are reported as 17100* for the first, 17101 for the second, 17102 for the third, 17102 for the fourth, and 17102 for the fifth lesion. The second and third premalignant or facial destruction procedures are reported with the second code in that category (17001); only the second benign nonfacial destruction procedure is reported with the second code in that category (17101). When 15 or more benign nonfacial lesions are destroyed, only the code 17104 is reported.[3]

Table 5 lists four miscellaneous benign lesion destruction codes used by primary care physicians. The destruction (any method) of up to 15 small lesions such as flat warts, milia, or molluscum contagiosum is reported with code 17110*. The reporting of the electrosurgical destruction of skin tags varies with the number of procedures performed. The first 15 destructions are billed with 17200*, and each additional 10 lesions are billed with 17201. The electrosurgical destruction of 42 skin tags is reported with code 17200* for the first 15, 17201 for the next 10, and 17201 for the next 10, and 17201 for the next 7. The surgical excision of skin tags is reported with codes 11200 and 11201.

A physician may occasionally perform chemical cauterization of granulation tissue; examples include cauter-

Table 7. Specific Anatomic Site Destructions of Non-Anorectal Lesions, by Code and Method of Reimbursement

| 1992 CPT Code† | Destruction Procedure Description | 1992 Total RVUs‡ | 1992 NC Medicaid Allowable§ ($) |
|---|---|---|---|
| 68135* | Destruction of lesion, conjuctiva | 2.70 | 75.80 |
| 67850* | Destruction of lesion of lid margin (up to 1 cm) | 2.64 | 101.32 |
| 43258 | Upper gastrointestinal endoscopy for ablation of tumor or mucosal lesion | 10.74 | 804.63 |
| 41850 | Destruction of dentoalveolar (gum) lesion | —‖ | 33.24 |
| 40820 | Destruction of lesion or scar of vestibule of the mouth | 1.96 | 20.26 |
| 42160 | Destruction of lesion, palate or uvula | 3.61 | 20.21 |
| 54050* | Destruction of simple lesion(s) of the penis, chemical | 1.68 | 20.77 |
| 54055 | Destruction of simple lesion(s) of the penis, electrodessication | 1.96 | 28.77 |
| 54056 | Destruction of simple lesion(s) of the penis, cryosurgery | 1.86 | 33.14 |
| 54057 | Destruction of simple lesion(s) of the penis, laser surgery | 3.61 | 33.37 |
| 54065 | Destruction of extensive lesion(s) of the penis | 5.36 | 101.32 |
| 42808 | Destruction (or excision) of lesion of pharynx | 5.32 | 172.04 |
| 57061 | Destruction of simple vaginal lesion(s) | 2.30 | 44.14 |
| 57065 | Destruction of extensive vaginal lesion(s) | 7.05 | 145.89 |
| 56501 | Destruction of simple vulvar lesion(s) | 2.25 | 59.13 |
| 56515 | Destruction of extensive vulvar lesion(s) | 5.88 | 131.91 |

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*‡From Department of Health and Human Services Medicare fee schedule.*[10]
*§From North Carolina Title XIX Fee Schedule Master List.*[12]
*‖No values published.*

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ization at the base of an umbilical stump in a newborn or on the vaginal cuff after hysterectomy. This procedure is reported with the code 17250*; cauterization should not be reported in association with an excision procedure.[3]

## Malignant Destructions

The codes for destruction of malignant lesions are described in Table 6. These codes are reported for destruction procedures on biopsy-proven malignancies, and should be accompanied by the appropriate diagnosis codes.

Malignant destructions are coded by size and location.[3] Destruction of a 2.5-cm lesion on the chest wall is coded 17263, whereas destruction of the same-sized lesion on the neck is coded 17273. Facial lesions generally receive the highest reimbursement; scalp, neck, hands, feet, or genitalia lesions receive the second highest; and lesions on the trunk, arms, or legs receive the least reimbursement. The 1992 total RVUs listed in Table 6 reflect this reimbursement pattern.

Table 6 identifies lower reimbursement from the North Carolina Medicaid program for codes 17284 and 17274, compared with code 17264.[12] This may reflect an error in the calculation of the allowable amount. Physicians should monitor surgical procedure reimbursements from the major third-party carriers in their area. Errors are occasionally noted, and correction may improve reimbursements.

## Specific Anatomic Site Destructions

Specific anatomic site destruction codes are listed in Tables 7 and 8. Specific codes generally provide higher reimbursement than the general benign lesion codes listed in Table 5. For example, a patient with a small papilloma on the palate undergoes cryosurgical destruction of the lesion. If the code 17100* was reported, Medicare would reimburse $30.38 (0.98 RVUs × $31.00). If the specific code 42160 was chosen, then Medicare would reimburse $111.91 (3.61 RVUs × $31.00). The North Carolina Medicaid program would pay an additional $5.95 for the specific code.

The knowledge of third-party reimbursement schedules aids in choosing between two codes that accurately describe a procedure. For example, cryotherapy destruction is performed on a patient with four extensive condylomata of the penis. If these procedures are reported as separate benign destructions (17100*, 17171, 17102,

Table 8. Specific Anatomic Site Destructions of Anorectal Lesions, by Code and Method of Reimbursement

| 1992 CPT Code† | Destruction Procedure Description | 1992 Total RVUs‡ | 1992 NC Medicaid Allowable§ ($) |
|---|---|---|---|
| 46900* | Destruction of simple lesion anus, chemical | 2.37 | 15.04 |
| 46910* | Destruction of simple lesion anus, electrodessication | 2.66 | 18.27 |
| 46916 | Destruction of simple lesion anus, cryosurgery | 2.67 | 22.25 |
| 46917 | Destruction of simple lesion anus, laser | 4.27 | 22.04 |
| 46924 | Destruction of lesion(s) anus, extensive, any method | 6.04 | 203.63 |
| 46934 | Destruction of internal hemorrhoids, any method | 5.47 | 112.78 |
| 46935 | Destruction of external hemorrhoids, any method | 4.47 | 50.54 |
| 46936 | Destruction of internal and external hemorrhoids, any method | 7.07 | 151.62 |
| 46937 | Cryosurgery of rectal tumor, benign | 5.76 | 151.62 |
| 46938 | Cryosurgery of rectal tumor, malignant | 7.85 | 221.63 |
| 46940 | Currettage or cauterization of anal fissure | 3.06 | 157.35 |
| 45320 | Proctosigmoidoscopy with ablation of tumor | 4.65 | 149.01 |
| 45336 | Flexible sigmoidoscopy with ablation of tumor or mucosal lesion | 6.34 | 149.01 |
| 45383 | Colonoscopy with ablation of tumor or mucosal lesion | 12.09 | 536.42 |

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*CPT denotes Current Procedural Terminology; RVUs, relative value units; NC, North Carolina.*

and 17102), the Medicaid program in North Carolina reimburses a total of $34.50. This reporting may undervalue the work performed in the procedure. If the site-specific code 54065 is reported, then $101.32 is reimbursed.

Site-specific codes may be reported for malignant lesion destructions; the size of the lesion may suggest using a site-specific code rather than a malignant destruction code. For example, an elderly woman has a biopsy-proven squamous cell carcinoma of the vulva. If the lesion is 0.4 cm in diameter, then code 17270* will yield $55.49 from Medicare (1.79 RVUs × $31.00). If the lesion is 1.4 cm in diameter, code 17272 will yield $99.20 from Medicare (3.20 RVUs × $31.00). The site-specific code 56501 reimburses $69.75 (2.25 RVUs × $31.00), and provides greater reimbursement only if the lesion is very small.

Reimbursements for anorectal destruction procedures vary according to the method and site of destruction (Table 8). Simple anal lesions may be destroyed with chemical methods (46900*), electrodessication (46910*), cryosurgery (46916), or laser ablation (46917). The North Carolina Medicaid program reimburses $50.54 for the destruction of external hemorrhoids (46935), $112.78 for the destruction of internal hemorrhoids (46934), and $151.62 for the destruction of both external and internal hemorrhoids (46936). Physicians are reminded to select the CPT code that provides the most accurate description of the procedure performed.

## Summary

Physician use of specific CPT biopsy and destruction codes should improve reimbursement for these commonly performed procedures. The specific codes identified in this review can be incorporated into physician's office fee schedules. Each biopsy or destruction procedure performed should have a corresponding ICD-9-CM diagnosis code. Use of the *Neoplasm* section of the ICD-9-CM Index will improve diagnosis coding for these procedures. Biopsy procedure codes are classified by surgical, needle, or endoscopic procedures. Benign destruction codes are divided into facial or premalignant lesion procedures and nonfacial procedures. The malignant destructions are coded by size and location. Site-specific codes generally provide higher reimbursement than the general biopsy or destruction codes.

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References

1. Vasarinsh P. Clinical dermatology: diagnosis and therapy of common skin diseases. Stoneham, Mass: Butterworth, 1982:43–4.
2. Hardy JD. Hardy's textbook of surgery. 2nd ed. Philadelphia: JB Lippincott, 1988:230–2.
3. American Medical Association. Physicians' Current Procedural Terminology 1992. Chicago: American Medical Association, 1992.
4. Habif TP. Clinical dermatology: a color guide to diagnosis and therapy. 2nd ed. St Louis: CV Mosby, 1990.
5. Hainer BL. Electrosurgery for cutaneous lesions. Am Fam Physician 1991; 44(suppl):81S–90S.
6. Knaus GM. Coding and reimbursement for family physicians. Kansas City: 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. Department of Health and Human Services. Medicare program; fee schedule for physician's services. Federal Register, November 25, 1991; 56(227):59502–819.
11. Zuber TJ, Jones JG. Physician payment reforms and family physicians [letter]. JAMA 1992; 267:2034–5.
12. 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.
13. Salmon PM, Smith PC. The most common reasons Medicare rejects claims. Physician's Manage 1991; (February):44–55.
14. Jones MK, Brouch KL, Allen MM, Aaron WS, eds. St Anthony's ICD-9-CM code book. Alexandria, Va: St Anthony Publishing, 1991.
15. Blue Cross and Blue Shield of North Carolina. Blue Shield index. Durham: Blue Cross and Blue Shield of North Carolina, 1990.
16. St Anthony's coding for physician reimbursement. Alexandria, Va: St Anthony Publishing, 1991:1–8.

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Other topics are welcome. Abstracts must be submitted by *November 1, 1992*. For more information, contact:

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