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Dermatology Coding Alert

Avoid Terminology Traps in Biopsy and Excision Coding

Knowing when to report excisions instead of biopsies can save you $73

When it comes to reporting biopsy and excision codes to medical payers, you can be caught in a frustrating name game. Is an excisional biopsy an excision or a biopsy? When is a punch biopsy actually an excision?

With some simple guidelines, you can learn how to handle these commonly used -- and frequently miscoded -- terms and ensure that you're reaping full reimbursement for your surgeon's work.

Get Back to the Basics

Before you delve into your dermatologist's notes, you need to know the fundamental difference between a biopsy and excision. In a biopsy, the physician removes only a piece of a lesion, but for an excision, the physician removes the entire lesion mass, along with a margin of healthy tissue.

Mistake: Don't let the ordering of a pathology report always push you toward a biopsy code. "I get a lot of questions about this," says **Linda Martien, CPC, CPC-H**, director of coding operations at National Healing Corporation of Boca Raton, Fla. Many physicians who have excised lesions "may be under the impression that because they're sending [a sample] for a biopsy, that's what they should bill."

While it's true that biopsies generally end in pathology analysis, your surgeon will also typically request a path report for an excised specimen.

If your dermatologist doesn't document whether he removed part or all of a lesion, consider the dimensions of the incision to decide between biopsy and excision, says **Jenny Culjat**, office manager for a practice in Berkeley, Calif. Guideline: CPT defines an excision as a full-thickness (through-the-dermis) removal.

Example 1: A patient presents to your office with a dark brown, multicolored, irregular-shaped 4-mm lesion on his exterior lower lip. The dermatologist removes five millimeters of tissue to full thickness. The path report later determines that the lesion was malignant.

Answer: You should report the procedure as an excision and code 11640 (Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 0.5 cm or less). Reason: The dimensions of the removed tissue indicate that the surgeon removed the entire lesion to full thickness, along with a margin of healthy tissue.

Cost: You'd be losing out on about $73 if you incorrectly coded this procedure as a biopsy with 11100 (Biopsy of skin, subcutaneous tissue and/or mucous membrane [including simple closure], unless otherwise listed; single lesion). Based on the 2006 physician fee schedule, the 4.12 relative value units (RVUs) for 11640 will yield an average nonfacility payment of $149.05. But with 2.09 RVUs, the biopsy code results in an average payment of $75.61.

Tackle Tricky Terminology

Even when you receive more detailed information in an op report, you may need to decipher deceptive terminology to arrive at the proper procedural code.

For example, if you're using biopsy codes to report excisional biopsies, you're most likely leaving money on the table. CPT defines an excisional biopsy as removal of an entire lesion, necessitating excision codes.

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Be careful: In contrast, during an incisional biopsy, the surgeon cuts into the suspect area and removes only a portion of the total lesion. Therefore, biopsy codes are your best choice.

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