

Dermatology Coding Alert

Biopsies: Biopsy, Excision, or Shave? Read This Before Coding Your Next Lesion Procedure

Clinical accuracy and deserved reimbursement ☐ up to \$75 per procedure ☐ are at stake.

Biopsies are some of the most common procedures in any dermatology practice ☐ which means that coding pitfalls are also common. Here, our experts answer some of the most frequently asked questions about site-specific biopsies.

Q: What's the difference between an excision and a biopsy?

A: Simply put, when the dermatologist intends to fully remove a lesion, he performs an excision. If the goal is just to take a sample of the lesion for pathology, a biopsy is performed.

Report a biopsy with CPT® code 11100 (Biopsy of skin, subcutaneous tissue and/or mucous membrane [including simple closure], unless otherwise listed; single lesion). Report any additional biopsies with 11101 (...each separate/additional lesion [List separately in addition to code for primary procedure]).

The excision code will depend on the size of the lesion, where it is located, and whether the lesion is malignant or benign. Excision of benign lesions will be coded with a code from the 11400-11446 (Excision, benign lesion...) range; malignant lesions should be assigned a code from the 11600-11646 (Excision, malignant lesion including margins...) range.

Don't miss: Shave removals are another common source of confusion, says **Pamela Biffle, CPC, CPC-P, CPC-I, CPCO**, owner of PB Healthcare Consulting and Education Inc. in Austin, Texas. Report shave removals with CPT® codes 11300-11313 (Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs...), she says.

Q: When should I report a site-specific biopsy code instead of 11100?

A: Any time there is a code that describes the specific site the dermatologist took a biopsy from, you should report that. The 11100 code definition states "unless otherwise listed." That means you should not use 11100 if your surgeon takes a skin biopsy from a specific site that's listed elsewhere in CPT®.

The dermatologist deserves more pay for the higher level of complexity of these site-specific procedures. Your practice is losing income if your dermatologists overlook these site specific codes, which is easy to do because dermatology practices rely on the integumentary section of the CPT® manual.

Example: A patient presents to your practice with a papular lesion of the lip. After the dermatologist examines the patient, he determines that he must perform a biopsy.

In this scenario, you should report 40490 (Biopsy of lip) instead of 11100. As long as the dermatologist notes the site-specific biopsy in the documentation, you should receive approximately \$30 more for the procedure on the patient's lip than if you had reported 11100 because this biopsy required more work from the dermatologist.

Medicare assigns 3.62 non-facility relative value units (RVUs) to 40490, which, multiplied by the 2014 \$35.8228 conversion factor, leads to \$129.68 in reimbursement. Compare this to \$102.45 for 11100 (2.86 RVUs). Often, dermatologists take extra steps in a biopsy of the lip, including the use of a chalazion clamp to control bleeding.

Q: What are some of the site-specific skin biopsy codes I should keep an eye out for?

A: These are some of the common ones, along with the Medicare Physician Fee Schedule non-adjusted payment if

performed outside of a facility (based on RVUs multiplied by the conversion factor). Note that all of these site-specific codes are valued higher than 11100's \$102.45.

- 11755 □ Biopsy of nail unit (e.g., plate, bed, matrix, hyponychium, proximal and lateral nail folds) (separate procedure) [\$134.69]
- 30100 □ Biopsy, intranasal [\$144.01]
- 40490 □ Biopsy of lip [\$129.68]
- 40808 □ Biopsy vestibule of mouth [\$193.08]
- 54100 □ Biopsy of penis (separate procedure) [\$197.03]
- 67810 □ Incisional biopsy of eyelid skin including lid margin [\$171.59].

Q: Should I wait for the path report to choose what code to report?

A: The pathology report would not change which biopsy code you report (however, it would change the excision code; see above). What the pathology report will help determine is the diagnosis code. So for a complete, accurate claim, always to wait for pathology, Biffle advises: "It can change you code □ for example, you think a benign lesion was excised but the path came back malignant."