Dermatology Coding Alert

Get 100 Percent Reimbursement for Skin Repairs, Skin Grafts

2 tips to steer clear of add-on code denials

When you report add-on codes for your skin repair and skin graft procedures, watch for two key items in your dermatologist\'s documentation so you can avoid denials:

1. Document the wound size. When you report add-on codes for your skin graft repairs, you must have the measurements of the repair. For example, when the dermatologist repairs a complex wound on the scalp, arms, and/or legs, you report 13121 (Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm). **Warning:** You report +13122 (... each additional 5 cm or less [list separately in addition to code for primary procedure]) for any additional length that is 5 cm or less if the wound is greater than 7.5 cm.

2. Count the number of lesions when you report 15786 (Abrasion; single lesion [e.g., keratosis, scar]). If your dermatologist documents removing more than one lesion, report 15786 with add-on code +15787 (... each additional four lesions or less [list separately in addition to code for primary procedure]) for each additional four lesions or fewer.

Attention: Reporting add-on codes is unlike multiple-procedure reporting because multiple-procedure fees are already reduced.

If you report add-on codes, you can expect 100 percent of the fee for the add-on procedure. You could be paid about $343 for 13121 and $98 for the add-on code 13122, according to the 2004 fee schedule. In addition, bill your units with 13122, says **Lori LeMond, CPC, PMCC-I**, lead coder at Arizona Medical Clinic in Peoria, Ariz.

For example, if your physician performs a complex repair on a 22.5-cm lesion, you report 13121 for the first 7.5 cm and 13122 x 3 for the next 15 cm, LeMond says. When units are billed, you should report them as a single line item on the HCFA claim form. If you list the units separately, she says, you will only get paid for first one and you\'ll be denied the rest as duplicates.

Another caution: Don\'t append modifier -51 (Multiple procedures) to your add-on codes for two reasons. First, add-on codes are modifier-exempt, so you must report the add-on codes in addition to primary procedures/services but never alone, says **Lori Owens, CPC**, insurance supervisor at Ohio Valley Surgical Specialists in Owensboro, Ky. Second, if you append a modifier, you may cut your reimbursement in half.

Self-defense against denials: If you are using add-on codes, you can take a good first step against denial by learning the characteristics of this special class of codes:

1. Never list an add-on code as a primary procedure.
2. Never list an add-on code with modifier -51.
3. Never lower add-on payment as a multiple-surgery reduction, because the add-on fees are already reduced in the fee schedule.

   But ...

4. Always report these codes with another primary procedure code.