Dermatology Coding Alert

READER QUESTIONS: Don't Rely on Non-ASC-List Payment

Question: I code for an ambulatory surgical center (ASC). The dermatologist's documentation supports codes 11401, 11601 and 12031. But these codes aren't on the ASC list of approved codes. Should I still report them?

Arkansas Subscriber

Answer: This is a sticky situation--correct coding requires you to report the appropriate codes for the services the physician performed, but regulatory guidelines tell you those services won't get reimbursed.

Medicare won't pay you for codes that aren't on the ASC-approved list, and most other payers follow suit. So, you can have all the documentation of medical necessity in the world, and your facility probably still won't earn payment for codes 11401 (Excision, benign lesion including margins, except skin tag, trunk, arms or legs; excised diameter 0.6 cm to 1.0 cm), 11601 (Excision, malignant lesion including margins, trunk, arms or legs; excised diameter 0.6 to 1.0 cm), and 12031 (Layer closure of wounds of scalp, axillae, trunk and/or extremities; 2.5 cm or less).

Certainly you shouldn't report codes that the documentation doesn't support, and there is no harm in reporting codes that your documentation supports. You might not expect payment, but you can still report the codes whether they're on the ASC list or not.

Exception: If you're billing a private payer, check your contract. Not all payers follow Medicare guidelines on this matter, and you will benefit from finding out whether your facility's contract with a specific payer allows reimbursement for non-ASC-list procedures.

Some insurers set up separate reimbursement for non-list codes, usually at a percentage of the hospital's charge amount for the procedure.

Smart move: Physicians receive additional reimbursement for performing procedures at ASCs (including non-list procedures), and they should contribute some of that payment to the facility. You should have contracts with your physicians that stipulate the amount of this reimbursement. If your facility allows physicians to perform these services without compensating you, a critical auditor could construe the practice as enticement.