Dermatology Coding Alert

Stay Out of These Common Biopsy Coding Pitfalls and Boost Claims Accuracy

Go beyond 11000 to 'site' specific codes, which can net $25 or more.

If you automatically assign 11100 when your dermatologist specifies the biopsy site, you could be forfeiting deserved pay.

Site-specific codes increase coding accuracy. Plus, they pay more than the most widely used code, 11100 (Biopsy of skin, subcutaneous tissue and/or mucous membrane [including simple closure], unless otherwise listed; single lesion).

Don't Miss More Pay for More Work

Site-specific biopsy codes tell the payer that the dermatologist performed a biopsy at a specific site, rather than a generic integumentary based biopsy (11000). A sitespecificbiopsy code also represents a more complicated procedure than 11000 does.

Result: 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.

Tip: If the dermatologists in your practice often forget that there are site-specific biopsy codes, you can help them remember by including a list of the site-specific biopsies on your encounter form to jog their memory. To get you started, add these two specific codes.

Example 1: 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 $25 more for the procedure on the patient's lip than if you had reported 11100 because this biopsy required more work from the dermatologist, notes **Pamela Biffle, CPC, CPC-I, CCS-P, CHCC, CHCO,** owner of PB Healthcare Consulting and Education in Watauga, Texas.

Medicare assigns 3.35 non-facility relative value units (RVUs) to 40490, which, multiplied by the $36.0846 conversion factor, leads to $120.88 in reimbursement. Compare this to $95.26 for 11100 (2.64 RVUs). Often, dermatologists take extra steps in a biopsy of the lip, including the use of a chalazion clamp to control bleeding.

Example 2: A patient with a pigmented lesion of the nail bed presents to your practice. The dermatologist suspects trauma but feels he should perform a nail bed biopsy to rule out melanoma.

Your first thought in coding this scenario might be to bill 11100. But you should instead bill 11755 (Biopsy ofnail unit [e.g., plate, bed, matrix, hyponychium, proximal and lateral nail folds] [separate procedure]).

Code 11755 is more accurate and also pays approximately $25 more than code 11100 (3.35 non-facility RVUs x $36.0846 = $120.88), says Biffle. When a dermatologist performs a nail bed biopsy, he cuts through the plate, biopsies the nail bed, and may suture the wound. This process is much more complicated than a typical skin biopsy.

Report Multiple Biopsies for Separate Sites

When your dermatologist performs multiple biopsies, you need a tool to unlock the claim's payment. Clarify the

circumstances to the payer using modifiers.

Example: The dermatologist performs a biopsy of a lesion on a patient's arm. He performs another biopsy on the patient's eyelid during the same visit.

Solution: Because your dermatologist specifies the site in the detailed documentation, you can see that the documentation justifies reporting 11100 for the biopsy on the patient's arm and 67810 (Biopsy of eyelid) for the second biopsy.

Wait for Path Report to Choose Dx

You should always wait until the pathology report comes back to choose the proper codes to report, even though this will not always affect the CPT code you will wind up choosing.

Reason: The biopsy specimen's pathology will affect the ICD-9 code you report, but most CPT procedure codes are not based on the specimen's results. "There are a few CPT codes which are linked to specific diagnoses (for instance, excision of benign and malignant lesions), but overall CPT is about what you did; ICD-9 is about the outcome or the reason for it," explains **Marcella Bucknam, CPC, CCS-P, CPC-H, CCS, CPC-P, COBGC, CCC,** manager of compliance education for the University of Washington Physicians Compliance Program in Seattle.