Dermatology Coding Alert

Your Top-3 Foreign-Body Removal Questions Answered

Refresh your 10120 and 10121 coding with our primer

Before you report any foreign-body removal proce-dures, look for documentation details on how many foreign bodies the physician removed and from where he removed them, because you may miss details related to the extent of the procedure that will cut your pay.

Take a look at these three frequently asked questions to determine whether you know how to decipher the most appropriate foreign-body removal code, repair code, and any modifiers that you shouldn\'t overlook:

Question 1: What should I report if the dermatologist explores a wound to remove a foreign body but does not find a foreign body to remove?

You shouldn\'t report codes for foreign-body removal (10120 and 10121, Incision and removal of foreign body, subcutaneous tissues; simple or complicated) in this scenario because the dermatologist didn\'t remove any foreign body.

Some coders might report 10120 or 10121 and append modifier -52 (Reduced services), but be warned that your reimbursement will not reflect the amount of work your dermatologist performed, says **William J. Conner, MD**, physician at Meridian Medical Group, a multi-specialty practice in Charlotte, N.C.

So if the dermatologist performed an extensive procedure, your pay will not reflect the extensive work.

Look to 20100 for Multiple Removals

You should report multiple removals of foreign bodies with codes 20100-20103. In these situations, your physician documents that he explored multiple wounds in the separate anatomic sites specified by the wound exploration codes.

Though the physician may remove foreign bodies when he completes wound exploration, the foreign-body removal codes (10120 and 10121) do not specify separate anatomic sites or multiple penetrating wounds.

Example: Suppose a patient was running when he tripped and fell. As a result, he had small rocks and debris embedded under the skin of his wrist.

In this instance, you can report exploration codes 20100-20103, depending on location (e.g., 20100, Exploration of penetrating wound [separate procedure]; neck; or 20101, ... chest). Otherwise, you should select an unlisted-procedure code appropriate to the area of exploration (such as 25999, Unlisted procedure, forearm or wrist) and provide supporting documentation explaining the extent of the exploration that the physician completed and the reason for the procedure.

Bonus: The carrier will note the unlisted-procedure code and flag the claim for individual consideration. To help the insurer determine payment, compare the procedure to another, similar procedure of about the same extent or difficulty.

For example, you might compare when a physician explores a nonpenetrating wound to when he explores a penetrating wound at the same location, Conner says.

Question 2: If the dermatologist removes a foreign body, such as glass or a splinter, from a patient and sutures the wound, should we bill 10120 for the foreign-body removal and 12011 for the simple repair?

Most insurance companies consider 10120 (Incision and removal of foreign body, subcutaneous tissues; simple) to include the repair, just as CPT states that excision of skin lesions (11400-11446 and 11600-11646) includes simple closure or repair.

If you report 12011 (Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less) in your claim, your carrier will deny your claim, says **Mandy Duncan, CPC**, coding specialist at Surgical Associates PC in Birmingham, Ala.

But if the physician completes a more complicated procedure - for example, the foreign-body removal requires dissection of the underlying tissues - you should report 10121 (... complicated), Duncan says.
In most cases like this, your dermatologist performed an E/M examination in addition to the foreign-body removal, and you should bill separately for the E/M (99201-99205 for a new patient, or 99211-99215 for an established patient), Duncan says.

You should report 10120 along with the appropriate-level E/M office visit code with modifier -25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) appended. Modifier -25 tells the insurer that the E/M visit is separate from the foreign-body removal, Duncan says.

Question 3: The physician removed a sharp foreign body from the patient with forceps. Should I use the foreign-body removal code 10120? And does the physician have to make an incision for the procedure code to count?

You should report 10120 in this scenario, according to CPT. If the foreign body created an \"incision\" upon entry, coding options vary because not every practice has the same philosophy about which code you should report. Some practices might think the foreign body made the incision, while others might only consider the physician\'s use of a scalpel to remove the foreign body an incision, Conner says.

Your practice should decide what constitutes an incision. But, when the dermatologist removes a foreign body, in most cases the physician must make small incisions during the removal procedure, so incisions are often a necessary but also separate part of the package, Conner says, and you should report the incision separate from the foreign-body removal.

Remember: For more extensive foreign-body removals, you should report the code for complicated foreign-body removal (10121).

Warning: Make sure your physician knows the importance of including thorough details when he completes his foreign-body removal documentation, because vague notes can undermine your full reimbursement, says **Lori Sorenson, CPC**, coding specialist at Deaconess Billings Clinic Health Center in Billings, Mont.