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Internal Medicine Coding Alert

CPT ® Coding Strategies: Skin Lesion Removal Reporting: Biopsy and Excision

Hint: Watch for site-specific biopsy codes to report in lieu of skin biopsy.

When your physician performs a removal of a lesion of the skin to send to the lab for pathological studies, you should know when to report a biopsy and when to report an excision code. You should also know if you need to wait for the path report prior to reporting the procedure that the internist performed.

Understand When to Report a Biopsy or an Excision

When your internal medicine specialist performs an excision, it is quite easy to fall into the trap of reporting the procedure with a biopsy. When your physician fully removes a lesion and sends the removed tissue to the lab for histological studies, he performs an excision, and this has to be reported with an excision code even though the tissue was sent to the lab for pathology. On the other hand, if the procedure performed was just to take a sample of the lesion for pathology, you report a biopsy code.

Report a skin lesion biopsy with CPT® code 11100 (Biopsy of skin, subcutaneous tissue and/or mucous membrane [including simple closure], unless otherwise listed; single lesion). Report any separate, additional skin biopsies that your physician performs with 11101 (...each separate/additional lesion [List separately in addition to code for primary procedure]). Provide adequate documentation to let the payer know the location of each biopsy that was performed. Often your physician might draw a picture of the location in the handwritten notes. In an EMR, this can be a challenge, so you should provide a clear verbal description of the location.

If the removal was truly an excision, the CPT® code that you choose to report will depend on the size of the lesion, where it is located, and whether the lesion is malignant or benign. You report excision of benign lesions with a code from the 11400-11446 (Excision, benign lesion...) range; you assign a code from the 11600-11646 (Excision, malignant lesion including margins...) range for malignant lesions.

"CPT® defines 'excision' as full-thickness (i.e. through the dermis) removal of a lesion, including margins," notes **Kent Moore,** senior strategist for physician payment at the American Academy of Family Physicians. "It includes local anesthesia and simple (non-layered) closure when performed," he adds.

Heads up: If your physician performed a shave removal, you will need to report it from the CPT® code range, 11300-11313 (Shaving of epidermal or dermal lesion, single lesion,...). Again, you should note that shave excisions are a technique for removal of a lesion and should not be confused with a biopsy and be reported with a biopsy code.

"Per CPT®, shave removal tends to be limited to epidermal and dermal lesions whereas excision is characterized as full-thickness removal through the dermis. Shave removal includes local anesthesia and chemical or electrocauterization of the wound, which does not typically require suture closure," Moore says.

Report a Site-specific Biopsy Code When it Exists

Any time there is a code that describes the specific site from where your clinician took a biopsy, you should report the more specific biopsy code. The 11100 code definition states "unless otherwise listed." That means you should not use 11100 if your physician takes a biopsy from a specific site that has a specific listing elsewhere in CPT®.

Your physician deserves more pay for the higher level of complexity of these site-specific procedures. Your practice is losing income if your physician overlooks these site specific codes and reports a general code from the integumentary

section of the CPT® manual.

Example: A patient presents to your practice with a papular lesion of the lip. After your physician has examined 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 your physician 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 to be done by your physician.

Medicare assigns 3.68 non-facility relative value units (RVUs) to 40490, which, multiplied by the 2015 $35.7547 conversion factor, leads to $131.58 in reimbursement. Compare this to $104.40 for 11100 (2.92 RVUs).

Additional site-specific codes: These are some of the common site-specific codes that you need to watch out for when the provider performs a biopsy of these sites. Note that all of these site-specific codes are valued higher than 11100's $104.40.

- 11755 Biopsy of nail unit (e.g., plate, bed, matrix, hyponychium, proximal and lateral nail folds) (separate procedure) [$134.80, 3.77 RVUs]
- 30100 Biopsy, intranasal [$144.45, 4.04 RVUs]. For biopsies performed on the skin of the nose, stick to reporting 11100 or 11101 as appropriate.
- 40808 Biopsy, vestibule of mouth [$194.51, 5.44 RVUs]
- 54100 Biopsy of penis (separate procedure) [$201.30, 5.63 RVUs]
- 67810 Incisional biopsy of eyelid skin including lid margin [$173.05, 4.84 RVUs].

Don't Wait For Path Reports to Choose Appropriate Biopsy Code

You need not wait for the pathology report if your physician performs a biopsy as it would not change the biopsy code you will report. However, if the provider performed an excision, it would be better to wait for the path report as this could change the excision code you will choose to report.

The pathology report will help determine the diagnosis (ICD-9-CM or the ICD-10) code to report when acknowledged by your physician. This might change the code that you will report for the excision. For example, you think a benign lesion was excised, but the path came back malignant. Therefore, for a complete, accurate claim, it is wise to wait for the pathology determination before you choose the appropriate excision code.