Internal Medicine Coding Alert

Reader Question: Rely on Intent to Report Skin Lesion Removal Code

Question: If our internal medicine specialist removes a skin lesion by shaving it and we send the removed tissue to the lab for analysis, should I report the procedure with the CPT® code for shaving, or should I use a biopsy code?

Michigan Subscriber

Answer: You should base your reporting on the intent of your clinician in performing the procedure. If your internal medicine specialist's primary intent in shaving the lesion was to send the tissue to the lab for analysis, you should report a biopsy code. Depending on the number of lesion(s) your internal medicine specialist biopsied, you can report 11100 (Biopsy of skin, subcutaneous tissue and/or mucous membrane [including simple closure], unless otherwise listed; single lesion) for biopsy of one lesion and report the add-on code +11101 (...each separate/additional lesion [List separately in addition to code for primary procedure]) for every additional lesion removed.

But on the other hand, if your internal medicine specialist shaved the lesion for the primary purpose of removing it and you sent it to the lab for analysis incidental to that procedure, you should report one of the shaving of epidermal or dermal lesion codes depending on the size of the lesion and the area of the body from which it was removed. For this purpose, you will have to report from one of the CPT® codes from the range, 11300-11313.

CPT® guidelines preceding the biopsy codes are instructive in this regard. CPT® states:

During certain surgical procedures in the integumentary system, such as excision, destruction, or shave removals,the removed tissue is often submitted for pathologic examination. The obtaining of tissue for pathology during the course of these procedures is a routine component of such procedures. This obtaining of tissue isnot considered a separate biopsy procedure and is not separately reported. The use of a biopsy procedure code (e.g., 11100, 11101) indicates that the procedure to obtaint issue for pathologic examination was performed independently, or was unrelated or distinct from other procedures/services provided at that time.