Internal Medicine Coding Alert

READER QUESTION ~ Use Biopsy Code for Diagnostic Removal

Question: The physician saw an established patient with a patch of rough skin on his forearm. Using a punch tool, she took a 2-mm sample of the skin for testing and closed the site in simple interrupted fashion. (The pathology report came back as keratoderma.) During the encounter, the patient also complained of frequent headaches. Notes indicate that the physician provided level-two evaluation and management service to address the headaches. How should I report this encounter?

New York Subscriber

Answer: Since the biopsy and the E/M were for separate problems, you can report a procedure code and an E/M code on the claim.

On your claim, you should,

• report 11100 (Biopsy of skin, subcutaneous tissue and/or mucous membrane [including simple closure], unless otherwise listed; single lesion) for the skin biopsy.

• link 701.1 (Keratoderma, acquired) to 11100 to represent the patient's rough skin.

• report 99212 (Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem-focused history; a problem-focused examination; straightforward medical decision-making) for the E/M.

• attach modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) to 99212 to show that the E/M and biopsy were separate services.

• link 784.0 (Headache) to 99212 to represent the patient's headaches.