Internal Medicine Coding Alert

Reader Questions: Report Skin Biopsies Per Lesion

Question: A new patient reports to the internist for an initial E/M. During the course of a level-two service, the patient complains about an itchy red lesion on his left arm and a raised lesion on his left leg. The internist performs biopsies on both areas using a punch tool. What is the proper code for a punch biopsy?

Montana Subscriber

Answer: The punch biopsy code is 11100 (Biopsy of skin, subcutaneous tissue and/or mucous membrane [including simple closure], unless otherwise listed; single lesion). However, you're selling the claim short if you report only 11100.

Why? Coding of biopsies is per lesion, meaning an add-on code is appropriate for the second lesion. Also, your internist provided a separate E/M service during the encounter, so you should code for that also.

On the claim, report the following:

• 11100 for the first biopsy

• +11101 (... each separate/additional lesion [List separately in addition to code for primary procedure]) for the second biopsy

• 99202 (Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; straightforward medical decision making) for the E/M

• Modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) linked to 99202 to show that the E/M and biopsies were separate services.

-- Answers to You Be the Coder and Reader Questions were reviewed by **Kathy Pride, CPC, CCS-P,** director of government program services for QuadraMed in Reston, Va.; and **Bruce Rappoport, MD, CPC,** a board-certified internist who works with physicians on compliance, documentation, coding and quality issues for Rachlin, Cohen & Holtz LLP, a Fort Lauderdale, Fla.-based accounting firm with healthcare expertise.