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Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Expert Answers to Top Five Questions Ease Your Integumentary Biopsy Reporting

You may lose up to $75 per procedure for any erroneous reporting.

Whenever your provider sees a patient for skin or skin structure cancer lesions, you should be accurate in reporting biopsies of them. These procedures might be simple, but they can add up to huge losses for you if you miss out on reporting them. Here are answers from experts for the top five most frequently asked questions about site-specific integumentary biopsies.

Q: What's the difference between an excision and a biopsy?

A: Simply put, when the physician intends to fully remove a lesion, he performs an excision. If the goal is just to take a sample of the lesion for pathology, a biopsy is performed.

Report a 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 biopsies with 11101 (...each separate/additional lesion [List separately in addition to code for primary procedure]). "Additionally the location of each biopsy should be clearly supported by documentation," says **Kelly C. Loya, CPC-I, CHC, CPhT, CRMA**, Director of Reimbursement and Advisory Services, Altegra Health, Inc. "Often the physician will draw a picture of the location in the handwritten notes. In EMR, this can be a challenge, so a clear verbal description should be evident."

If the removal was an excision, the CPT® code chosen 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.

Don't miss: Shave removals are another common source of confusion, says **Pamela Biffle, CPC, CPC-P, CPC-I, CPCO**, owner of PB Healthcare Consulting and Education Inc. in Austin, Texas. Report shave removals with CPT® codes 11300-11313 (Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs...), she says. "Remember shave excisions are a technique for removal of a lesion and should not be confused with a biopsy, which is done only to determine the nature of the lesion, but not intended to remove the lesion fully," Loya says.

Q: When should I report a site-specific biopsy code instead of 11100?

A: Any time there is a code that describes the specific site the clinician took a biopsy from, 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 skin biopsy from a specific site that's listed 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 physicians overlook these site specific codes, which is easy to do because skin coding practices rely on 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 3.62 non-facility relative value units (RVUs) to 40490, which, multiplied by the 2014 $35.8228 conversion factor, leads to $129.68 in reimbursement. Compare this to $102.45 for 11100 (2.86 RVUs). Often, oncologists take extra steps in a biopsy of the lip, including the use of a chalazion clamp to control bleeding.

Q: What are some of the site-specific skin biopsy codes I should keep an eye out for?

A: These are some of the common ones, along with the Medicare Physician Fee Schedule non-adjusted payment if performed outside of a facility (based on RVUs multiplied by the conversion factor). Note that all of these site-specific codes are valued higher than 11100's $102.45.

- 11755 — Biopsy of nail unit (e.g., plate, bed, matrix, hyponychium, proximal and lateral nail folds) (separate procedure) [$134.69]
- 30100 — Biopsy, intranasal [$144.01]
- 40490 — Biopsy of lip [$129.68]
- 40808 — Biopsy, vestibule of mouth [$193.08]
- 54100 — Biopsy of penis; (separate procedure) [$197.03]
- 67810 — Incisional biopsy of eyelid skin including lid margin [$171.59].

Q: Should I wait for the path report to choose what code to report?

A: The pathology report would not change which biopsy code you report (however, it would change the excision code; see above). What the pathology report will help determine is the diagnosis (ICD-9-CM) code to report when acknowledged by the treating physician. Therefore, for a complete, accurate claim, it is wise to wait for the pathology determination, Biffle advises: "It can change the code reported. For example, you think a benign lesion was excised but the path came back malignant."