Codify
BY AAPC

Outpatient Facility Coding Alert

Dermatology: Don't Fall for the DSAP Diagnosis Trap When Coding Porokeratotic Lesion Excision

Know that misdiagnosis can be common up front.

Your surgeon treats a patient with a fairly large, circular keratotic lesion on a patient's right ankle. That sounds like a simple enough case, but read on to see what trials await you as you zero in on the proper diagnosis and procedure codes.

Focus on Diagnosis

The patient presents with a 0.9 cm lesion on the right ankle that appears hyperkeratotic. Suspecting a wart (078.1, Viral warts) or actinic keratosis (702.0, Actinic keratosis), the surgeon treats the lesion.

The patient returns three months later because the lesion has returned. It is now 1.3 cm in diameter and consists of a "plaque" surrounded by a ridge-like border. The surgeon removes the lesion and sends the specimen to pathology. The pathology report reveals a classic cornoid lamella, which is a thin vertical column of parakeratosis in the epidermal stratum corneum that makes up the outer "ring" of the lesion.

Based on the clinical presentation and pathology report, the surgeon diagnoses the condition as a porokeratotic lesion.

No surprise: The surgeon's initial mis-diagnosis in this case is not unusual. Physicians "may confuse [porokeratosis] with warts or with 'seed corns,' or might refer to the lesions as 'IPKs' (intractable plantar keratosis), but they're not really the same thing," says Arnold Beresh, DPM, CPC, of Peninsula Foot and Ankle Specialists PLC in Hampton, Va.

Problem: No specific ICD-9 exists for porokeratotic lesions, but you can safely report 701.1 (Keratoderma, acquired) for the condition. This case involves an isolated lesion, so don't make the mistake of reporting 692.75 (Disseminated superficial actinic porokeratosis [DSAP]) as the diagnosis. Although DSAP is a form of porokeratosis, it is a specific condition typified by a large number of lesions scattered about sun-exposed limbs.

Account for Treatment Services

On the initial visit, the surgeon treated the lesion with curettage followed by a topical acid application.

The best code to use for destroying a skin lesion with acid is 17110 (Destruction [e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement], of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions), says **Pamela Biffle, CPC, CPC-P, CPC-I, CCS-P, CHCC, CHCO**, owner of PB Healthcare Consulting and Education Inc. in Austin, Tex. Also note that the code describes "surgical curettement" in addition to "chemosurgery," so 17110 fully captures the surgeon's work.

Caution: Although the surgeon pares away a portion of the lesion before applying acid, you should not report 11055 (Paring or cutting of benign hyperkeratotic lesion [e.g., corn or callus]; single lesion) in addition to 17100. Medicare's Correct Coding Initiative (CCI) bundles these two codes, so you should not report them together for the same lesion.

Code excision: On the patient's second visit, the surgeon excises the 1.3 cm lesion with 0.2 cm margins (1.7 cm excised lesion size). Because the final diagnosis is porokeratosis, which is a benign skin lesion, you should report the surgeon's work as 11402 (Excision, benign lesion including margins, except skin tag [unless listed elsewhere], trunk, arms or legs; excised diameter 1.1 to 2.0 cm).

Watch diagnosis: Porokeratosis is considered a pre-malignant condition and may develop into squamous cell or basal cell carcinoma. If the pathology report identifies one of these conditions, you should code the surgeon's excision as 11602 (Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 1.1 to 2.0 cm) instead of 11402.