Editorial

Mass Destruction

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Medicare strikes again. As many physicians have undoubtedly heard, sweeping changes are being introduced regarding the definition, use, and reimbursement of the destruction codes for benign and premalignant lesions in 2007. Beginning January 1, changes in the American Medical Association CPT® (current procedural terminology) manual will impact the documentation and coding of these procedures.

Why are these changes being made? As you would expect, it is all about the dollars. For a long time, the benign and premalignant destruction codes have been scrutinized by the Centers for Medicare and Medicaid Services (CMS) because of the high volume of billed procedures. According to the American Academy of Dermatology (AAD), over 18 million procedures are billed annually, at a cost of $356 million per year. Of these procedures, 92% are performed and billed by dermatologists.

Let us first examine the changes in definitions. According to a member alert issued by the AAD on October 5, 2006, as of January 1, only premalignant lesions (actinic keratoses) will be billed with the 17000, 17003, and 17004 codes.[1] All benign lesions, including but not limited to condylomata, papillomas, molluscum contagiosum, herpetic lesions, warts (ie, common, plantar, flat), milia, or other benign lesions, will be billed with 17110 and 17111 codes. The major impact for dermatologists is that the billing of warts will change.[1]

As of January 1, the changes reflected in destruction, benign, or premalignant lesion codes (17000–17250) will be as follows[1]:

- Destruction of premalignant lesions
  - 17000: Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement); premalignant lesions (eg, actinic keratoses); first lesion
  - 17003: Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement); premalignant lesions (eg, actinic keratoses); second through 14 lesions, each (list separately in addition to code for first lesion) (use 17003 in conjunction with code 17000)
  - 17004: Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement); (premalignant lesions (eg, actinic keratoses); 15 or more lesions (do not report 17004 in conjunction with codes 17000–17003)
- Destruction of benign lesions
  - 17110: Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement) of benign lesions other than skin tags or cutaneous vascular lesions; up to 14 lesions
  - 17111: Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement) of benign lesions other than skin tags or cutaneous vascular lesions; 15 or more lesions

The AAD noted that while it "did not initiate this code change process, in order to reduce further scrutiny by CMS of dermatology billing of benign and pre-malignant destruction codes the Academy has agreed to the following [described above] CPT Code descriptor changes."[1]

Now we wait for the other shoe to drop. This month, when the Medicare physician fee schedule is released, we will have to see how reimbursement for these codes is altered. I would not predict that it will be a satisfactory outcome for dermatologists.

These changes are certainly unwelcome, both because destructions are an important part of our therapeutic armamentarium and because they provide a significant part of our income. Yes, we treat a lot of actinic keratoses. Unfortunately, people have a lot of actinic keratoses, and cryotherapy is a great therapy. If we are looking to assign responsibility for this situation, I guess we will ultimately have to blame the sun.

The author reports no conflict of interest.

REFERENCE

1. Mandated changes to definition and use of destruction codes for benign and pre-malignant lesions in 2007 [member alert]. Schaumburg, Ill: American Academy of Dermatology; October 5, 2006.