A Guide to Avoiding Common Procedural Coding Mistakes

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PRACTICE **POINTS**

- When multiple biopsy types are performed on the same date of service, only one primary code is reported, along with add-on codes for any additional biopsies.
- When multiple biopsy types are performed on the same date of service, the primary code goes to incisional biopsy if one is performed or punch biopsy if there was no incisional biopsy.

Accurate procedural coding is essential to appropriate reimbursement and regulatory compliance in dermatology. This article reviews commonly misunderstood areas of procedural coding. Key clinical distinctions are highlighted, such as the differentiation between tangential biopsies and shave removals, as well as the bundling rules for adjacent tissue transfers and soft tissue repairs. Additionally, the article offers practical guidance on navigating the National Correct Coding Initiative (NCCI), Medicare payment edits, and the strategic use of modifiers to accurately reflect distinct or staged services.

Accurate procedural coding is essential to appropriate reimbursement and regulatory compliance in dermatology. This article reviews commonly misunderstood areas of procedural coding, including new biopsy codes; coding for shave removals, destruction, excision and repair, and adjacent tissue transfer (flap closure); the National Correct Coding Initiative; Medicare payment edits; Mohs micrographic surgery (MMS) codes; and correct use of key modifiers. Practical guidance is provided to help avoid frequent errors.

NEW BIOPSY CODES

The most common questions about procedural coding relate to the new *Current Procedural Terminology* (CPT) biopsy codes, which are reported based on method of removal. Primary codes include the following:

- 11102: tangential biopsy of skin (eg, shave, scoop, saucerize, curette) for a single lesion
- 11104: punch biopsy of skin, including simple closure, when performed, for a single lesion
- 11106: incisional biopsy of skin (eg, wedge), including simple closure, when performed, for a single lesion

Add-on codes are used for each separate or additional lesion:

- 11103: tangential biopsy
- 11105: punch biopsy
- 11107: incisional biopsy

When multiple biopsy types are performed on the same date of service, only one primary code is reported along with add-on codes for any additional biopsies. The primary code reported should have the highest relative value unit (generally incisional > punch > tangential) plus the add-on codes for additional biopsies performed. Sampling of the stratum corneum only (eg, skin scraping or tape stripping) does not constitute a skin biopsy and is not reportable as a procedure.

SHAVE REMOVAL CODES

Shave removal codes are appropriate when the intent is removal of the entire lesion and there is only dermis remaining at the base of the wound. Tangential biopsy codes are appropriate when the intent is to sample a portion of a lesion for diagnosis. If saucerization of a lesion is appropriate and only fat remains at the base of the wound, the procedure is correctly coded as an excision. If any dermis remains at the base of the wound, the procedure is properly coded as shave removal. Shave codes do not distinguish between benign and malignant lesions and do not include the margin of normal skin, only the diameter of the lesion itself.

DESTRUCTION CODES

Destruction codes include both premalignant and benign lesions and may be reported as add-on codes or stand-alone codes, depending on lesion type and number. The 17000 series is used for destruction of premalignant lesions such as actinic keratosis, large cell acanthoma, actinic cheilitis, and porokeratosis:

- 17000: destruction of the first premalignant lesion

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- 17003: destruction of each additional premalignant lesion (up to 13 lesions); reported in addition to 17000
- 17004: destruction of 15 or more premalignant lesions; reported as a standalone code (not in addition to 17000)

The following codes are used for destruction of benign lesions:

- 17110: destruction of benign lesions (up to 14 lesions)
- 17111: destruction of 15 or more benign lesions; reported as a standalone code (not in addition to 17110)

EXCISION AND REPAIR CODES

Individual excisions are reported separately, while repairs are reported as the sum of the lengths within grouped anatomic zones. The groupings differ for intermediate and complex closures, so be sure to refer to your coding manual. Intermediate or complex closures should be reported separately for skin excisions, whereas simple closures are already included in the excision code and are not reported separately. Excision diameter includes the margins necessary to ensure complete removal of the tumor for both benign and malignant tumors. For neoplasms of uncertain behavior, defer billing until pathology results are available to ensure accurate reporting as either a benign or malignant tumor excision. Lesion size is measured prior to excision and includes the lesion plus the narrowest intended clinical margin; this measurement reflects the width of the excised specimen rather than the length of the repair.

Malignant tumor excisions continue to be worth more because of the greater risk and preservice and postservice work involved. Only about 50% of payment relates to the procedure itself; the other 50% relates to risk and preoperative and postoperative counseling as well as bundled follow-up visits in the global period. That accounts for the difference in compensation for benign vs malignant tumors as well as the 50% multiple surgical reduction for multiple lesions, as the equipment and cognitive portion bundled into the procedure are not separate for each procedure.

Coding for soft tissue excisions (including deep lipomas) already includes payment for intermediate closure, and it would be very unusual for any closure code to be reported separately when a lipoma is excised.

Historically, Medicare has bundled complex closures with benign excisions under 0.5 cm. Medicare also applies medically unlikely edits that may limit payment when more than 5 excisions, closures, or destruction procedures (excluding add-on codes) are reported on the same date of service. Medicare may pay for the additional procedures if a copy of the record and a letter of medical necessity are included.

CODING FOR ADJACENT TISSUE TRANSFER (FLAP CLOSURE)

When reporting adjacent tissue transfers, the total size of the defect includes primary and secondary defects when calculating the area of the flap. The areas of the primary and secondary defects are added together when the flap represents a single repair. The sums are reported separately if they are distinct repairs. Adjacent tissue transfer already includes payment for the excision of malignant or benign lesions. Do not code separately for the excision.

CORRECT CODING INITIATIVE

On January 1, 1996, the Medicare program implemented the National Correct Coding Initiative (https://www.cms.gov/national-correct-coding-initiative-ncci), employing nearly 83,000 code edits, in an attempt to eliminate unbundling or other inappropriate reporting of CPT codes. When procedures are performed on separate and distinct lesions, a modifier is required to bypass the edit that would otherwise deny payment for the second procedure. Medicare publishes lists of paired codes (column 1 paired with column 2). The code in column 2 is the one that requires modifier 59 or 79.

MEDICARE PAYMENT EDITS

Mutually Exclusive Edits

Mutually exclusive edits seek to identify services that cannot reasonably be performed in the same session. The "comprehensive" code will be paid and the "component" code disallowed.

Medically Unlikely Edits

The Centers for Medicare & Medicaid Services stop paying when multiples of a procedure exceed the medically unlikely edits, but payment may be made if accompanied by a copy of the medical record and letter of medical necessity. A common example would be a transplant recipient requiring destruction of many malignant lesions in a single session, exceeding the medically unlikely edits for the procedure.

MOHS MICROGRAPHIC SURGERY CODES

Mohs micrographic surgery codes require that a single physician act as both surgeon and pathologist. Do not report 88305 separately, as the pathology interpretation is already included in the MMS reimbursement. Repairs, grafts, and adjacent tissue transfer are separately reportable with the CPT codes for MMS.

The CPT codes for MMS include skin biopsy and excision services (11102-11107, 11600-11646, and 17260-17286); however, if a suspected skin cancer is biopsied for pathologic diagnosis prior to MMS, the biopsy (11102-11107) and frozen section pathology (88331) may be reported separately utilizing modifier 59 or 58 to distinguish the diagnostic biopsy from the definitive MMS. The biopsy should not duplicate a prior biopsy unless that biopsy result cannot be located; it must be performed before MMS and must determine the subsequent procedure. Although CPT indicates that modifier 59 should be used, it also is acceptable to utilize modifier 58 to indicate that the diagnostic skin biopsy and MMS were staged or planned procedures. This may be appropriate in the following scenarios:

- The lesion for which MMS is planned has not been biopsied within the previous 60 days,
- The surgeon cannot obtain a pathology report, with reasonable effort, from the referring physician, or
- The biopsy is performed on a lesion that is not associated with the MMS.

KEY MODIFIERS AND HOW THEY ARE USED

Modifiers are essential tools in dermatology coding that are used to indicate when procedures or evaluation and management (E/M) services are distinct, staged, bilateral, or related to specific global periods. Correct application ensures accurate reimbursement, prevents claim denials, and reflects the true work performed. The following list summarizes commonly used modifiers and guidance for their proper use.

Modifier 59: Distinct Procedural Service

Modifier 59 is used to clearly designate when distinct, independent, and separate multiple procedures are provided. The procedure must not be a component of another procedure. Examples include:

- Different procedures or surgeries
- Surgery on different sites or organ systems
- Separate incision/excision
- Separate lesions

When code 17000 is paired with the new biopsy codes, modifier 59 is paired with code 17000.

Modifier 79: Distinct Procedural Service During a Postoperative Period

Modifier 79 is used to clearly designate when distinct, independent, and separate multiple procedures are provided. The procedure must not be a component of another procedure. Examples include:

- Different procedures or surgeries
- Surgery on different sites or organ systems
- Separate incision/excision
- Separate lesions

Modifier 58: Staged or Planned Procedure

Modifier 58 is most commonly used when a staged excision is planned in advance or when a positive tumor margin requires further excision during a global period.

Modifier 25: Significant, Separately Identifiable E/M Service

Modifier 25 is defined as a significant and separately identifiable E/M service performed by the same physician on the same day as a procedure or other service. It is used to describe a separate, distinctly identifiable E/M service rendered during the same visit as another procedure. The modifier must be appended to the E/M code. The decision to perform a 0- or 10-day global procedure on the same date of service is already bundled into the payment for the procedure and does not qualify as a separate billable service.

Modifier 24: Unrelated E/M Service During a Postoperative Period

Modifier 24 is defined as an unrelated E/M service performed by the same physician during a postoperative period. It is used when a separate, unrelated E/M service is provided during the global period of a surgical procedure.

Modifiers 24 and 25: Documentation and Distinction

The CPT definition of modifier 25 states that an E/M service may be prompted by the system or condition for which a separate procedure or service is needed. Neither modifier requires a separate diagnosis; however, both require clearly distinguishable cognitive services beyond those typically associated with the procedure itself. This includes evaluation beyond the examination of the lesion, discussion of risks, benefits, and alternatives, and the decision to perform a 0- or 10-day global procedure.

Modifier 50: Bilateral Procedure

Modifier 50 is defined as a bilateral procedure and is used when the same procedure is performed on both sides of the body, such as application of Unna boots. When reporting this modifier, specify the quantity applied. Because Unna boots may be required on the arms as well as the legs, the billing system cannot determine how many were applied unless the quantity is clearly indicated.

Modifier 57: Decision for Surgery

Modifier 57 is reported when an E/M service involves the decision to perform a 90-day global procedure on the same date of service. For 10-day global procedures, the decision to perform surgery on the same day does not justify a separate E/M service. The global period timing begins at midnight, with the 10-day global starting on the day of the procedure and the 90-day global starting the day before the procedure; for example, if an excision is performed today and an adjacent tissue transfer is performed tomorrow, the excision is considered within the global period.

FINAL THOUGHTS

Physicians remain responsible for accurately selecting diagnosis and procedure codes that reflect medically necessary services, and CPT codes continue to define the procedures that are reported. The Relative Value Scale Update Committee determines the value of each procedure based on physician survey data, including time and follow-up visit utilization, as well as practice expense, which represents a substantial portion of each code's value. Our specialty relies on dedicated volunteers who devote significant time and effort to ensuring accurate representation of the work we perform for our patients. When the opportunity arises, please thank them for their service.