Destruction or Excision: What's Happening in Your Dermatology Office?	
Questions	**Answers**
Webinar Subscription Access Expires December 31.	
Doc excises a "pendunculated gluteal mass" with a full-thickness elliptical excision measuring 3x2 cm.This requires layered closure of sub-q tissue and skin. The pathology comes back as a large acrochordon. Benign lesion codes exclude skin tags, but the skin tag codes do not usually require layered closure. Am I still stuck with the 11200?	Good question, I would first look at why the surgeon took the patient to surgery, was this a painful mass and the concept of it being a skin tag was not thought of? Even though pathology came back as a skin tag, this appears to be a bit more then just a skin tag, so I would be comfortable reporting a excision code with the intermediate closure, knowing that I will most likely have to appeal with my payer.
If a physician performs an excision of a skin tag (0.6 - 1cm) that requires intermediate closure, what would be the most appropriate CPT code(s)?	Skin tags do not require closure, again going back to the question I just answered, in dealing with skin tags they are just "sliced" off the skin, why would your surgeon be excising the skin tag in a direction that would need a intermediate closure?
I have a physician starting to do cosmetic procedures in our office. Do you have any advice on what "special" codes to use so patient could not try to bill insurance? For example Botox - what "special" code would you use to administer the drug?	I have actually created special codes to track any non-billable cosmetic procedures that may be done in the office for tracking purposes only. This also allows the patient to have a receipt for services, but eliminates the possibility of the patient submitting to their insurance company for payment.
shave bx and whole lesion removed use 113XX?	Shave biopsy is a biopsy... shave removal is where you would use the 113xx code set. Verbage in the documentation is the key to the correct code selection, whole lesion removed via ?? Excision or Shave? Changes codes with the answer

procedure note says granular area right septum of nose biopsied w cup forceps. is this proc coded 11100 or 30100?	CPT says if the biopsy is intranasal then you report 30100, if the biopsy is done and is considered superficial or on the skin of the nose then you would report the 11100.
shave bx and whole lesion removed use 113XX?	Shave biopsy is a biopsy... shave removal is where you would use the 113xx code set. Verbage in the documentation is the key to the correct code selection, whole lesion removed via ?? Excision or Shave? Changes codes with the answer
Modifier 58 can be used when a second surgery is performed in the postoperative period of another surgery when the subsequent procedure was: ▪ planned or “staged” or ▪ more extensive than the original procedure; or ▪ for therapy following a surgical procedure; or ▪ for the reapplication of the cast within the 90-day global period. - So modifier 58 would not be appropriate during the 10 day global?	Modifier -58 is used frequetly in the 10 day global period, especially when it deals with burn victims and debridement.
If the provider excises a skin cancer on the forearm & then goes to repair it, but can't quite get it closed. He uses the dog ears in the middle, to get it repaired 7 completely closed. Is this considered a graft & cc repair? How would you code this? Thanks	I am not sure of your question, but if you are asking if your provider is using the "left over" skin excised when doing the closure to assist in closing, I would have a problem coding that as a skin graft. I would look at that as a intermediate or possibly complex closure depending on the documentation.
susan, can you give a compliant example of documentation for 11100?	I would direct you to the CPT book for those guidelines, the choice really comes down to the documentation the physician uses and the intent.

Should we code Malig Destruction based by size of lesion OR based on the lesion after curretage before electrodesication.	If I understand your question correctly, you should always document the size prior to any treatment or prep for treatment. This is your providers responsibility to put the size in the documentation
If a patient has warts (destruction with pencil cautery) there were 16 total destroyed..would the codes be 17000 and 17111?	17111 for destruction of 15 or more lesions, code 17000 is for pre-malignant lesions such as actinic keratosis
what are the key terms to look for to support intermediate repair documented by a PCP? Some of my PCP's just say 'intermediate repair' with very little further documentation. Thank you, Lillian Maric and Sandra Osborn.	I will look for different suture materials used and also how "deep" the laceration or defect is before determining if it is a simple, intermediate or complex repair. Provider documentation of "intermediate repair" on compliance side most likely would not fly with me. I would want more information within the note that states what I said before... types of suture materials used, are they into the dermis, Sub Q tissue, Facia... that is more of what I am looking for in making that determination
Do you recommend holding all excisions and biopsies until pathology is back for correct diagnosis coding? Or would you leave the benign with the unknown diagnosis	Biopsies I have no problem with submitting with a 239.2 dx, but excision I ALWAYS wait for the pathology report I need to know what was removed for the correct code
if destruction of 16 warts would codes be 17000 and 17111 only?	The only code you would report for the warts would be 17111 for destruction of 15 or more lesions, code 17000 is for pre-malignant lesions such as actinic keratosis

Regarding codes 17260-17286, what is the proper way of measuring the destruction? after the lesion is destructed and curattement is done, do we measure then?	Measurement of any lesion is done prior to destruction or excision.
Would you consider using modifier 22 on 17111 if 70 warts are treated at one time?	You can certainly try to use modifier -22 in that scenerio, though to have a patient sit still for the destruction of 70 warts.. WOW..
i have been instucted in the past that coding from pathology is more appropriate. not sure if i missunderstood but are we not to code from path for size and only code from pay to determine malignant or benign	Coding from the pathology ONLY for the diagnosis is fine. What is not good or even justified in audits is coding the size of the lesion from the pathology report
so if the doctor's report is missing lesion size, can we default to the size reported in the path report? If there are multiple shavings, should we report the largest piece be reported as the overall lesion size if lesion size is missing in the note?	If your provider is not documenting size then you have no option but to code to the lowest size in the code set (i.e. 11440) This would also be the same for Shave removal. Any code set that requires size and location to be documented should have that information in the procedure note. This is a MAJOR compliance issue.

We have a lot of patients that voice their concern on the charge of the 17000 any suggestion as to what to say in regards to the cost for "just one lesion" we also have complaints because these codes are considered 'surgery' which falls under patients deductibles. Would it be appropriate to have pt's sign a consent form for these types of treatments?	Yes I would be sure to review with the patient their benefits as it relates to procedures done in your office. In the perfect world patients would understand how their healthcare benefits work. Anytime your practice is performing a procedure on a patient it is in your best interest to have them sign a consent form, even if the procedure is considered simple, along with that you can explain that this is considered by thier insurance company as a surgical procedure.
is 238.2 Neoplasm of uncertain behavior of skin, the slide says dysplastic, can you explain the difference with dysplastic and uncertain behavior?	Dysplastic is uncertain behavior, meaning that there are pre-cancerous cells in the tissue. It is recommened that these lesions be removed because they can possibly become a skin cancer later
i have been instucted in the past that coding from pathology is more appropriate. not sure if i missunderstood but are we not to code from path for size and only code from pay to determine malignant or benign	Coding from the pathology ONLY for the diagnosis is fine. What is not good or even justified in audits is coding the size of the lesion from the pathology report
FOR IPL WE USE 17999 UNLISTED?	I would first look at the code set of 96900-96999, if the service you are providing is not listed there then you would actually need to report the 96999
Do you have a document or web link that states a post-op complication can not be billed as an E/M with modifier 24?	Surgical Guidelines within your CPT book

Billing for injection of keloid s/p excision w/i global. OK to bill j3301? 11900 billing would not be allowed since w/i globsl, right?	I would need more information, what was excised? The keloid? Then if the keloid was excised why is it being injected.
Is 67840 coded "per lesion"?	That would be correct, CPT 67840 would be per lesion excised with no closure or with simple closure
Here's the scenario: Dermatologist intends to perform a biopsy. Ultimately, excises or destroys the lesion (same session, prior to receiving path report). Would you code the procedure as a Biopsy? Or would you code it as an Excision or Destruction (of Benign or Malignant lesion based on pathology)?	If I am understanding your question, then what you are saying is your Derm takes a biopsy of a suspicious lesion and when pathology comes back it indicates "with clear margins". The intent of the provider at the time was to biopsy the lesion and you would report the biopsy code.
I believe you just stated that 15 benign destructions are filed with 17004. Wouldn't you use 17000 and 17003 x 14. 17004 would be for 16 lesions, wouldn't it?	If you look at 17004, this is for 15 or more lesions. If we destroyed 14 lesions then you would report 17000, 17003 x13.
Modifier 57 doesn't really apply to dermatology as the repairs are done in conjuction with a procedure and not always anticipated.	There are times when a patient may present to the office on Monday for a office visit, and because of a opening in the surgical schedule on Tuesday they have surgery on Tuesday. This would be a time where modifier -57 would come into play.
DO PAYERS REQUIRE 2 DX FOR 17110-17111 078 + PAIN EXAMPLE	This is a payer specific question that I am unable to answer. Each payer has their own guidelines that apply, please check with your payer guidelines to see if it would be required to report two diagnostic codes.

Could you use 51 modifier instead of 59 if the insurance doesn't accept the 59 modifier or just not bill the procedure if it is considered bundled?	If the codes are bundled then you should NOT be coding it anyway, that could be taken as abuse. Always check with your payers and check the NCCI edits
Modifier 58 cannot be used for unrelated procedures during a post-operative session. Separate sites would be unrelated.	I am sorry I do not understand your question. You are correct that one would not use -58 if it is unrelated to the original surgery, there are times when during the original surgery a biopsy is done with the intent that they patient will return to the OR if the biopsy comes back positive, therefore making it a planned return.
When a dr does multiple separate and distinct procedures, how to you append the 59 modifier? By lowest rvu value?	You always list your codes in RVU order with the highest RVU listed first, then you would apply modifiers on subsequent line items if warranted by documentation
We have four that have participated in this webinar today. How do we get the the CEU info for the others?	The CEU code is the same for all of your participants
I thought this seminar was to also address the correct way to code skin substitutes?	I appologize for not address that information as promised, please feel free to contact me through the AAPC and I will be more than happy to help you out.
What would be the most appropriate diagnosis code and excision code for a AJMH?	Atypical Junctional Melanocytic Hyperplasia or AJMH would be coded as 238.2