



Derm Coding Consult

Published by the American Academy of Dermatology Association

[Volume 16 | Number 2 | Summer 2012]

Clarification of Biopsy Measure 224

Dermatologists who report at least three quality measures to Medicare's Physician Quality Reporting System (PQRS) in 2012 will be eligible for a bonus payment of 0.5 percent of their total Medicare Part B allowed charges. There are four dermatology-appropriate measures in 2012; three of the measures, 137, 138, and 224, will largely continue as measures from the 2011 program. Measure 224, overutilization of imaging studies in melanoma, however, has changed to include all melanoma patients, regardless of the melanoma stage.

Measure 265, biopsy follow-up, has been added to the program. Measure 265 measures the percentage of patients whose biopsy results have been reviewed and communicated to the primary care/referring physician and to the patient by the performing physician. To satisfy this measure, the biopsying physician must: review the biopsy results with the patient, communicate those results to the primary care/referring physician, track communication in a log, and document the tracking process in the patient's medical record. This measure applies to all patients undergoing a biopsy, regardless of diagnosis.

The dermatologist is always responsible for communicating the biopsy results to the PCP, even if the patient is not referred. There is a system exclusion built into measure 265 in the instance that the patient does not have a PCP. The basis for the development of this measure falls under the Care Coordination project within the National Priorities Partnership, which is convened by the National Quality Forum. In all forms of communication, "appropriate administrative, technical, and physical safeguards" should be used, per HIPAA requirements. Mailers and phone calls are considered appropriate forms of communication if the communication method is agreed upon with the patient and only necessary (according to HIPAA standards) information is given.

2010 PQRS Performance (all reporting methods) – Other Specialties by Comparison

SPECIALTY	# PARTICIPATING	# EARNING INCENTIVE	% EARNING INCENTIVE	MEAN INCENTIVE EARNED	MEDIAN INCENTIVE EARNED
Dermatology	1,725	1,451	84.1%	\$7,462.06	\$4,910.12
Rheumatology	1,386	994	71.7%	\$3,515.70	\$2,640.73
Urology	2,888	1,752	60.7%	\$4,583.05	\$3,912.59
Internal Medicine	22,715	15,844	69.8%	\$2,226.27	\$1,537.27
Ophthalmology	8,144	5,216	64.0%	\$7,750.95	\$6,182.11

A dermatologist wishing to participate in PQRS must report at least three measures. Therefore, he or she only needs to report three of the four dermatology-appropriate measures to qualify. All of the quality measures must have at least one eligible instance for a dermatologist to qualify for the incentive. Additionally, a greater than zero percent performance rates for all three measures is necessary to qualify for the incentive payment. This means that you must perform the measure on at least one patient per measure to qualify for the incentive payment. Each of the four dermatology measures can only be reported via electronic registry, for a full year reporting period (January 1 -December 31, 2012). ❖

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IMPORTANT Please Route to:

Dermatologist Office Mgr Coding Staff Billing Staff

Letter from the Editor

Dear *Derm Coding Consult* Reader,

Spring is in the air, trees are in full bloom, and everyone is busy preparing for a summer filled with activity. This is a great time of year for practices to take advantage of office spring cleaning activities. One of items on the staff "to do" list could be the evaluation of record storage and record destruction. It is good practice to set aside a week every year to clean up record storage. This is vital if you are still working in a paper environment as storage space is a premium for most offices. Dermatology offices planning on implementing an electronic health record have found that maintaining up to date record storage is essential to making the transition from paper to electronic health records.

Spring is also the perfect opportunity for the *Derm Coding Consult* staff to address issues that remain pivotal to operating a practice. In this edition of *Derm Coding Consult*, staff answer commonly asked questions in the format of FAQ's, included the new CMS NCCI file used to determine proper modifier placement, and clarified member questions regarding the new PQRS biopsy follow-up measure 265.

My goal as editor is to include topics relevant to current dermatology practice. I often hear from AAD members and office staff that *Derm Coding Consult* is considered a valued practice tool. In an effort to continue delivering the most up to date and informative information, please continue to provide your input and questions. Listening to members helps staff keep a finger on the pulse of today's evolving dermatology practice.

Best,



Cynthia A. Bracy, RHIA, CCS-P

Comments/suggestions can be sent directly to dcc1@aad.org.

New NCCI Coding Edit Format!

CMS developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims. Effective April 1, 2012, CMS will no longer publish the Mutually Exclusive edit table since all active and deleted edits will appear in the single Column One/Column Two Correct Coding edit file on each website.

Prior to this recent change, procedure edits have been assigned to either the Column One/Column Two Correct Coding edit file or the Mutually Exclusive edit table based on the criterion for each edit. The Mutually Exclusive edit table included edits where two procedures could not be performed at the same patient encounter because the two procedures were mutually exclusive based on anatomic, temporal, or gender considerations. The NCCI edit file included edits to assist billing and coding staff in assigning the appropriate modifier 59 and 25 and when a modifier is not allowed to be appended to a code pair.

CMS has simplified and consolidated the two edit tables into the Column One/Column Two Correct Coding edit file which will streamline the billing process. It will now only be necessary to search the Column One/Column Two Correct Coding edit file for active or previously deleted edits. Staff will no longer need to conduct a code pair search in two separate data tables.

***The edits previously contained in the Mutually Exclusive edit file are NOT being deleted but are being moved to the Column One/Column Two Correct Coding edit table.**

For more information the Column 1 & 2 Edits can be found on CMS website:

<http://www.cms.gov/apps/ama/license.asp?file=/Medicare/Coding/NationalCorrectCodInitEd/downloads/ccipra.zip> ❖

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Editor's Notes:

The material presented herein is, to the best of our knowledge accurate and factual to date. The information and suggestions are provided as guidelines for coding and reimbursement and should not be construed as organizational policy. The American Academy of Dermatology/Association disclaims any responsibility for the consequences of actions taken, based on the information presented in this newsletter.

Mission Statement:

Derm Coding Consult is published quarterly (March, June, September and December) to provide up-to-date information on coding and reimbursement issues pertinent to dermatology practice.

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New Medicare Influenza Vaccine Q Codes

The Centers for Medicare & Medicaid Services (CMS) no longer recognizes or reimburses CPT Code 90658 Influenza Virus Vaccine, Split Virus for flu shots. This has been in effect since January 1, 2011. There are currently five separate influenza vaccine HCPCS codes to distinguish between the brand-names of influenza vaccines for governmental tracking purposes. Make sure to use these new codes when billing the flu vaccine.

*The HCPCS code G0008 Administration of Influenza Virus Vaccine must still be used for the administration of the flu vaccine for Medicare patients.

THE NEW HCPCS MEDICARE FLU VACCINE CODES

Q2035 Afluria Vaccine: Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Afluria)

Q2036 Flulaval Vaccine: Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Flulaval)

Q2037 Fluvirin Vaccine: Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Fluvirin)

Q2038 Fluzone Vaccine: Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Fluzone)

Q2039 NOS (Not Otherwise Specified) Vaccine: Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Not Otherwise Specified)

****New Medicare codes distinguish between vaccine brands***

REIMBURSEMENT RATES

The national average for Medicare payment allowance may vary by geographical location and you will need to check the CMS Fee Schedule for your correct reimbursement rate. HCPCS codes Q2035 & Q2039 do not have national payment limits and will be determined by the local Medicare carrier.

Please refer to the CMS Physician Fee Schedule at:
http://www.cms.gov/PhysicianFeeSched/01_overview.asp ❖

Highmark Medicare Services Name Change!

Highmark Medicare Services officially changed their name to Novitas Solutions Inc. on March 30, 2012. Novitas Solu-

tions Inc. has received several questions from providers regarding the transition. Providers are concerned about how this will affect claim submissions and payments.

These questions and Novitas Solutions Inc. responses are noted below:

Q: Once Highmark Medicare Services transitions its name to Novitas Solutions, Inc., will providers need to change any information that is submitted in our electronic files (i.e. payer IDs, submitter IDs)?

A: No. Information that is submitted in your electronic file will not be changing. You will not be assigned new payer or submitter IDs.

Q: When do I start using the name Novitas Solutions instead of Highmark Medicare Services on my claims?

A: Billers/Submitters should begin using Novitas Solutions on claim submissions immediately.

Q: Do I need to inform my vendor, clearinghouse or billing service of this name change?

A: Yes. Your vendor, clearinghouse or billing service may have written a script that you invoke when you submit claims or retrieve reports. Changes to the script may be needed due to this name change.

Q: Will claims continue to be paid timely during the name transition? Will interest be paid if claims are not paid timely?

A: The name change will not impact claims processing timeliness or the rules governing when interest is paid.

Q: How will the website be changed and will we need to change our bookmarks?

A: The Novitas Solutions website address is <https://www.novitas-solutions.com>. Since we are using an automatic forwarding process from our previous www.highmarkmedicare.com website, your existing bookmarks should all function as usual and take you to the proper location. We do, however, suggest that you erase and replace them, once you have been redirected to the new site pages. The visual appearance, aside from a new company logo, will remain unchanged and content and functionality from the current site will still be available to you.

Q: Will mailing addresses and telephone numbers change?

A: No. Novitas Solutions mailing address and telephone numbers are not being changed at this time. Should those changes occur, we will announce updates through web alerts and listserv notices.

Q: Will Novitas Solutions e-mail addresses change?

A: As a result of our name change, we do expect email addresses to change. However, those changes will not occur until later in 2012. We will announce any changes to email addresses through web alerts and listserv notices.

— see **HIGHMARK** on page 4

Highmark Medicare Services Name Change!

— continued from page 3

Q: Does this change the way I enroll/perform updates to my enrollment?

A: If you are using the CMS PECOS Web application to complete your enrollment, CMS will be changing the drop down menu for contractor selection from “Highmark Medicare Services” to “Novitas Solutions.” The time frame for that change is not yet known. Until CMS makes our name change to PECOS, please continue to select Highmark Medicare Services in the drop down menu. All other enrollment activities remain the same.

Q: Are the forms for enrollment changing?

A: No. The forms are created and maintained by CMS. Changing our name will not impact the enrollment forms.

Q: Does the name change affect where I send my enrollment forms?

A: No. Currently all forms will continue to be mailed to:

**Provider Enrollment Services
Novitas Solutions
P.O. Box 890157
Camp Hill, PA 17089-0157 ❖**

Sign PECOS Electronically!

Dermatologists can save time and expedite the review of their application by using internet-based PECOS. Internet-based PECOS (Provider Enrollment, Chain, and Ownership System) allows providers to submit and sign Medicare enrollment applications electronically. Utilizing the electronic signature feature does not change who is required to sign the application.

1. Organizational Provider applications submitted via internet-based PECOS will require the user completing the application to provide an email address for the authorized signer of the application as part of the submission process. The authorized signer will be directed to follow the instructions in the email and electronically sign the application. This applies to applications using the following forms:

- 855-A for Institutional Providers;
- 855-B for Clinics, Group Practices, and Certain Other Suppliers, and
- 855-S for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers

2. Individual Provider applications repetitive that do not include new reassignments may be e-signed as part of the submission process. This applies to applications using the following forms:

- 855-I for Physicians and Non-Physician Practitioners, and
 - 855-O for Eligible Ordering and Referring Physicians and Non-physician Practitioners
- Any Individual Provider application (855-I) containing new reassignments (855-R) can be electronically signed as part of the submission process; however, you must select the Authorized Official / Delegated Official (AO/DO) for the Organization that is accepting the reassignment and enter that official's email address. The official then will be required to follow the instruction in the email and electronically sign the application.

If a provider opts to sign with a traditional wet signature, they can simply follow the current process of printing and signing the certification statement and mail the completed/signed form to the appropriate contractor.

Questions concerning a system issue regarding PECOS should be referred to the CMS EUS Help Desk at 866-484-8049 or EUSupport@cgi.com. ❖

FAQ's

Q) I have a quick general question about the HIPAA agreement. We recently had a pt refuse to sign it. Does this mean that we can't bill her insurance because we can't release her dx codes or chart note if requested? I'm under the assumption this is the case, but wanted to find out for sure before I bill the patient.

A) The form is an acknowledgment of the privacy practice not an authorization for use in processing claims or any information in regard to treatment/payment/operations (TPO). Refusal to sign does not negate sharing information for TPO purposes as patient signature is not a part of the HIPAA mandate at this time. Make a notation in the patient chart to reflect refusal to sign and the date of occurrence. Please make sure the patient understands what the privacy notice relates to and what it excludes - this is contained within the body of the notice but may need to be further explained verbally since they are refusing to sign.

The law requires physicians, hospital, or other health care providers covered by HIPAA to ask patients to state in writing that they have received the notice. The provider will ask the patient to sign a form stating that they received the notice that day.

- The law does not require the patient to sign the “acknowledgement of receipt of the notice.”
- Signing does not mean the patient agreed to any special uses or disclosures of their health records.
- Refusing to sign the acknowledgement does not

— see FAQ on page 5

FAQ's

— continued from page 4

prevent the entity from using or disclosing health information as the Rule permits it to do.

- If the patient refuses to sign the acknowledgement, the provider must keep a record that they failed to obtain an acknowledgement from the patient.

<http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html>

Q) The CPT 15271 states that the skin substitute is placed over the wound and sutured or stapled into place. Our provider is using steri strips with Mepitel and Meglisorb and Mepilex. Would this be correct to use the code 15271 with this?

- A) According to the revised 2012 skin substitute codes, it would not be appropriate to use these codes as skin substitutes for your scenario of using steri strips with Mepitel and Meglisorb and Mepilex. From the description, these are wound dressing and not skin substitutes such as homograft, allograft, xenograft. The skin substitute grafts code explanation states – *'requires a non-autologous human skin (dermal or epidermal, cellular and acellular) grafts (eg. Homograft, allograft), non-human skin substitute grafts (i.e. xenograft), and biological products that form a sheet scaffolding for skin growth. These codes are not to be reported for application of non-graft wound dressings (e.g., gel, ointment, foam, liquid) or injected skin substitutes.'*

There are no CPT codes for an application of dressing. This activity is included in the surgical package. Skin substitutes for Medicare can only be used in specific circumstances. Check with your Medicare contractor for their Local Coverage Determination (LCD) for more information.

Q) Patient presented with a lesion of uncertain behavior and an excision of the entire lesion is performed. How can I bill this service?

- A) Selection of the appropriate excision code is determined by three parameters: location, maximum excised diameter (which includes the margin) and lesion type, i.e., benign or malignant. When the lesion is clearly benign (e.g. cyst, lipoma, prior biopsy of benign neoplasm), the excision can be coded as benign at the time of surgery using CPT codes 114xx. However, when there is a prior biopsy showing malignancy of lesion, the excision can be coded as malignant at the time of surgery using CPT codes 116xx.

It is not appropriate to code a lesion of uncertain behavior as malignant before pathology confirmation is available as this is considered as incorrect coding should the lesion be found to be benign

upon histopathologic examination. It is therefore recommended that if a lesion is not clearly defined and documented to be either benign or malignant, coding and billing should be delayed until the histopathology has been confirmed.

Q) How long are we required to keep explanations of benefits forms once the information is recorded into our computer system? Also, how long do we keep superbills and encounter forms after the information makes it to the computer for billing purposes?

- A) There are two primary record types that exist in a medical practice—medical records and financial records. The former should be retained as long as there is professional liability exposure and the latter as long as there is IRS audit exposure. Superbills, encounter forms, and EOBs are not considered primary records of either category and can be destroyed after they are inputted into the billing system. Therefore, retention should be based on the business needs of the practice. For example, if the originals may be of help when following up on denied claims, it may be worthwhile to retain them for a minimum of one year. ❖

[H1] Coding Clarification: Laser Treatment of Psoriasis (96920-96922)

[T]Psoriasis is a chronic skin disease that generally includes erythematous silver-scaled indurated plaques. Psoriasis can be managed with a broad array of topical, physical, and systemic therapies. The application of ultraviolet light is one of the physical modalities that have been used for over a century to treat psoriasis. The use of targeted 308nm monochromatic ultraviolet B (UVB) excimer lasers allows focused treatment of psoriatic lesions without exposing uninvolved areas to this high intensity collimated beam of ionizing radiation.

[CPT Parent Code]96920 Laser treatment for inflammatory skin disease (psoriasis); total area less than 250 sq cm

[CPT Child Code]96921 250 sq cm to 500 sq cm

[CPT Child Code]96922 over 500 sq cm

[T]Codes 96920, 96921, and 96922 are exclusively reserved for laser treatment of psoriasis. The energy delivery to tissue with these lasers is far greater than that obtained with non-laser non-coherent narrow or broadband hand-held (UVB) light source devices. The use of non-coherent, non-laser hand-held devices including excimer lamps may be reported with CPT codes 96900, *Actinotherapy (ultraviolet light)*,

— see [H1] CODING CLARIFICATION on page 6

[H1] Coding Clarification: Laser Treatment of Psoriasis (96920-96922)

— continued from page 5

96910, *Photochemotherapy; (Goeckerman treatment) or petrolatum and ultraviolet B*, or 96912, *Photochemotherapy; psoralens and ultraviolet A (PUVA)*.

In general, it would not be appropriate to report a code from the 96920-96922 series for treatment of conditions other than psoriasis. From a CPT coding perspective, code 96999, *Unlisted special dermatological service or procedure*, should be reported for laser treatment of inflammatory skin lesions other than psoriasis. The reporting of codes 96920-96922 for treatment of any condition other than psoriasis would be a specific payer coverage determination. For reimbursement or third party payer policy issues, please contact your local third party payer. ❖

Weathering the 5010 Storm

On April 2, 2012 the Centers for Medicare & Medicaid Services (CMS) has extended the date for providers to be compliant with HIPAA electronic data interchange (EDI) Version 5010 to July 1, 2012. Health plans, clearinghouses, providers and software vendors have been making steady progress. CMS reports that the Medicare Fee-for-Service (FFS) program is currently reporting successful receipt and processing of over 90 percent of all Part B claims in the Version 5010 format with commercial plans reporting similar numbers.

The biggest change offices need to be aware of is post office boxes or lockbox addresses will not be acceptable in the new 5010 version.

- A complete nine-digit ZIP code is required. 0000 or 9999 will not be recognized as place holders.
- The nine-digit ZIP codes must be listed on the claim. Using the five-digit ZIP code may cause your claim to be rejected.

Another change is that patients given an individual insurance identification number must be noted as a subscriber.

- If the family health plan provides each dependent child with an ID number you must list their name and ID number instead of listing them as a dependent.

Most frequently reported problems testing 5010 include:

- Practice management and/or billing systems that showed no problems during the testing phase with their Medicare Administrative Contractor (MAC) reject claims during the production phase.
- Issues with secondary payers accepting 5010 transmitted data

- Crosswalk NPI numbers not being recognized
- MACs “losing” claims
- Old submitter validation information not being transferred
- Certain “not otherwise specified” claims being denied because they do not have a description on the claim
- Spontaneous payment of re-submitted claims without explanation for initial rejection
- Unsuccessful claims processing without explanation cited for rejection

If you have not already felt the impact of these challenges, you soon will. In the next month or two, almost all providers can expect to see claims held up due to rejections. Here are a couple of helpful tips:

- Know what new claims data is needed for the 5010 format. While your PMS vendor or clearinghouse can help convert your claims to meet 5010 compliance, they can only work with the data your practice provides. If new requirements, like the nine-digit Zip code and billing provider address, are not submitted at all, your claim cannot be converted and sent. For examples of what new data is required, you can visit: https://www.cms.gov/Versions5010andD0/01_overview.asp#TopOfPage
- Monitor your rejections both at the EDI level and in your remittance advice (EOB), where claims are adjudicated at the payer. This will help you track the progress of your claims and identify and address issues early to avoid delays in reimbursement.

The Medicare FFS program has stated that they will continue to host provider calls to address outstanding issues related to Medicare programs and systems. The Medicare Administrative Contractors (MACs) will also continue to work closely with clearinghouses, billing vendors or health care providers requiring assistance in submitting and receiving Version 5010 compliant transactions.

Dermatologists experiencing difficulty reaching their MAC are encouraged to send a message describing their issue to ProviderFeedback@cms.hhs.gov with “5010 Extension” in the subject line. CMS will address concerns on an individual complaint basis. ❖



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In The Know.....

Coding for Incision and Drainage (I&D)

Did you know that it is incorrect to report CPT code 10060 – *Incision and drainage of abscess (e.g. carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle or paronychia); simple or single* when the healthcare provider only uses a needle to puncture an abscess and allows the abscess to drain on its own without any incision or aspiration of the abscess fluid into the syringe?

CPT Code 10060 - *Incision and drainage of abscess* includes **both** the **incision** and **drainage** of an abscess, therefore it is inappropriate to use this code when no incision is performed.

The cutting of or into body tissue(s) or organ(s) is referred to as an incision. Skin and soft-tissue infections, including cutaneous abscesses are most commonly treated by incision and drainage (I&D) procedures (**10060-10140, 10180**).

There are eight incision and drainage (I&D) codes in the Integumentary System section of the Current Procedural Terminology (CPT) code book (**10060-10140, 10180**). Most of these I&D procedures include a code for **simple** procedures and another code for **complicated** procedures. It is important to note that code **10060** should be reported for a simple or single I&D procedure and code **10061** should be reported for a complicated or multiple I&D procedure(s). Even though the terms **simple** and **complicated** are not specifically defined in CPT, the choice of code is based on individual provider judgment based on the level of difficulty involved in the I&D procedure. Therefore, if a simple I&D procedure is performed on multiple lesions, the appropriate code is **10061**.

NOTE: Pay close attention to the medical record documentation for the procedure in order to differentiate between an I&D and an aspiration biopsy. An aspiration biopsy is reported using CPT code 10160. The difference between an I&D and an aspiration biopsy is that the aspiration biopsy includes the introduction of a bore needle with syringe into the fluid space to aspirate the fluid.

Now you are in the know!

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Published by the American Academy of Dermatology Association



Distribution of *Derm Coding Consult* is made possible through support provided by Amgen Pfizer.