



## Coding basics for residents: Diagnostic and procedural coding

By Faith C. M. McNicholas, RHIT, CPC, CPCD, PCS, CDC

Following our discussion in the last issue of *Directions in Residency* about the ins and outs of evaluation and management (E/M), and the importance of documentation and its impact on coding, billing, and reimbursement, we will now delve into the importance of accurate diagnostic and procedural/surgical coding.

The Current Procedural Terminology (CPT®) system, developed by the American Medical Association (AMA), provides a standard language and numerical coding methodology to accurately communicate the medical, surgical, diagnostic, and therapeutic services provided by qualified health care providers. The CPT descriptive terminology and associated code numbers provide the most widely accepted medical nomenclature used to report medical procedures and services for processing claims, conducting research, evaluating health care utilization, and developing medical guidelines and other forms of health care documentation.

The good news is that of the more than 7,000 available CPT codes, dermatology uses only about 400 on a routine basis. These are primarily classified under the Surgery/Integumentary and the Evaluation and Management Services sections.

**CPT® has been designated as a national standard for identifying and billing procedural services. All health care providers as well as health care payers are required to use the CPT coding system to communicate billing and payment information for health care services.**

Let's now discuss the basics of diagnostic and procedural/surgical and the importance of succinct, yet detailed documentation with a specific focus on its impact on reimbursement for services provided in a dermatology setting.

### Procedural/surgical services

For most of the codes, dermatologists will need to report the diagnostic and procedural/surgical services rendered to their patients that are contained in the Integumentary section of the AMA CPT coding manual. Because the Integumentary section in the coding manual includes procedures and/or surgeries for the whole body system, it is important that you pay the utmost attention to the code descriptor(s) and

see **CODING** on p. 3



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ensure that the appropriate code(s) that describe the service, rendered to its highest specificity, is chosen for not only the procedure or surgery but also the correct anatomic area and size (where applicable).

The table below includes the bulk of the procedural/surgical codes listed in the Integumentary section that will be used during your career in dermatology.

List of Integumentary Procedure Codes					
CPT Code	Code Descriptor	CPT Code	Code Descriptor	CPT Code	Code Descriptor
10040	Incision and drainage	11000	Debridement, skin	11042	Debridement, wound
10180		11001		11045	
11055	Paring/durettement	11102	Skin biopsy	11200	Removal of skin tags
11057		11107		11201	
11300	Shave removal	11400	Excision, benign lesion	11600	Excision, malignant lesion
11313		11471		11646	
11719	Trimming, debridement, and excision of nails	11770	Pilonidal cyst	11900	Introduction
11762		11772		11954	
12001	Repair, simple	12020	Treatment of wound dehiscence	12031	Repair, intermediate
12018		12021		12057	
13100	Repair, complex	14000	Adjacent tissue transfer	15002	Grafts and flaps
13160		14350		15777	
15780	Miscellaneous procedures	16000	Burn treatment	17000	Destruction, benign, premalignant, and malignant lesions)
15951		16036		17286	
17311	Mohs surgery	21011	Biopsy, excision – soft tissue		
17315		28047			

## CPT code descriptors

Dermatology, by nature of the services provided, is a very complex specialty. Because many dermatology services can and are usually rendered using different methods and/or a combination of various techniques, there may be a need to report multiple CPT codes describing similar services. This is frequently necessary to accurately reflect the service(s) performed.

While often only one procedure/surgery is performed during a patient encounter, multiple procedures may also be performed during a single encounter. In the latter case, the pre- and post-procedure work does not have to be repeated. Therefore, the appropriate code or codes describing the multiple services rendered should be reported.

## Add-on CPT codes

On top of understanding the primary procedure/surgical CPT codes, the coding manual also includes codes for procedures that are performed in addition to the primary procedure. These additional procedures are designated as “add-on” codes and are always reported in addition to the primary procedure when performed. All add-on codes are exempt from the multiple procedure reduction rule (MPRR) concept as these procedures cannot be reported as stand-alone codes. They are also exempt from the use of modifier 51 — multiple procedures. This basically means that as a dermatologist, the additional procedure's pre- and post-procedure work is not repeated because the services are performed during the same encounter.

Add-on codes in the CPT codebook can be readily identified by a ‘+’ (plus) symbol placed before the code and specific descriptor nomenclature which includes phrases such as “each additional” or “list separately in addition to primary procedure,” e.g.

CPT Code	Descriptor	Add-on CPT Code	Descriptor
11102	Tangential biopsy of skin (e.g., shave, scoop, saucerize, curette); single lesion	+11103	Each separate/additional lesion (list separately in addition to code for primary procedure)
11104	Punch biopsy of skin (including simple closure, when performed); single lesion	+11105	Each separate/additional lesion (list separately in addition to code for primary procedure)
11106	Incisional biopsy of skin (e.g., wedge) including simple closure, when performed; single lesion	+11107	Each separate/additional lesion (list separately in addition to code for primary procedure)
17000	Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettment), premalignant lesions (e.g., actinic keratoses); first lesion	+17003	Second through 14 lesions, each (list separately in addition to code for first lesion)
17311	Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (e.g., hematoxylin and eosin, toluidine blue)	+17312	Each additional stage after the first stage, up to five tissue blocks (list separately in addition to code for primary procedure)

see **CODING** on p. 4

## Keep up on coding



*Dermatology World* features monthly updates on billing and coding in *Cracking the Code*. Visit [www.aad.org/dw](http://www.aad.org/dw) to read the latest.

### Separate procedures

Just when you thought things couldn't get any more complicated, the CPT coding manual throws CPT codes designated as 'separate procedure' in the mix. In a nutshell, you will notice that some of the procedures or services you perform are commonly carried out as an integral component of the total service or procedure. As such, the services are listed and can be identified in the CPT codebook by the inclusion of the term "separate procedure." The codes designated as "separate procedure" should not be reported in addition to the code for the total procedure or service of which it is considered an integral component. For example, CPT coding guidelines state that debridement is considered a separate procedure only when gross contamination requires prolonged cleansing, when appreciable amounts of devitalized or contaminated tissue are removed, or when debridement is carried out separately without immediate primary closure.

However, when a procedure or service that is designated as a "separate procedure" is performed independently or considered to be unrelated or distinct from other procedures/services provided at the same time, it may be reported by itself, or in addition to other procedures/services by appending modifier 59 to the specific "separate procedure" code to indicate that the procedure is not considered to be a component of another procedure, but is a distinct, independent procedure. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries).

### AMA CPT surgical package definition

Services provided to patients — by their very nature — are variable. As such, CPT codes that represent a readily identifiable surgical procedure includes, on a procedure-by-procedure basis, a variety of services.

In defining the specific services "included" in a given CPT surgical code, the following services are always included in addition to the operation, per se:

- Local infiltration, metacarpal/metatarsal/digital block or topical anesthesia;
- Subsequent to the decision for surgery, one related to the evaluation and management (E/M) encounter on the date immediately prior to or on the date of procedure (including history and physical);
- Immediate post-operative care, including dictating operative notes, talking with the family and other physicians or other qualified health care professionals;
- Writing orders;
- Evaluating the patient in the post-anesthesia recovery area;
- Typical postoperative follow-up care.

**Coding tip: Supplies and materials (e.g., sterile trays/drugs), over and above those usually included with the dermatological procedure(s) practice expense and rendered are not reported separately.**

### Reporting more than one procedure

As a dermatology resident, there may be circumstances when you will have to perform more than one procedure/service on the same date of service, during the same session, or during the post-operative period (subject to the "surgical package" concept). In these circumstances, you will need to report one or more CPT modifiers to circumvent what is known as the National Correct Coding Initiative (NCCI) and prevent the services from being bundled resulting in non-payment.

**Note:** When a definitive surgical procedure requires access e.g. abscess, hematoma, seroma, etc. (CPT code 11770 – excision of pilonidal cyst), separate services like drainage (CPT code 10080 – incision and drainage) are not separately reportable.

### Mutually exclusive procedures

Some dermatology procedures may frequently require multiple approaches to achieve an intended outcome that is best for the patient. For the purpose of CPT code reporting, clusters of CPT codes describing the various approaches (e.g., shave, excision, and destruction) are available. These approaches are generally mutually exclusive of one another for the same lesion, and therefore, are not to be reported together for a given encounter.

When a circumstance arises for a dermatologist to use multiple approaches to achieve the intended outcome, only the definitive, or most comprehensive, service performed can be reported. However, when separate lesions are treated, each procedure is separately reported with the appropriate CPT codes and modifiers.

### Importance of medical record documentation

As discussed in our E/M article in the last issue, the Centers for Medicare and Medicaid Services (CMS) state that medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history including past and present illnesses, examinations, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient and is an important element contributing to high-quality care.

Accurate, appropriate, and succinct medical record documented can reduce many of the "hassles" associated with claims processing and may serve as a legal document to verify the care provided, if necessary. At the very least, dermatologists must ensure that the procedural/surgical documentation includes:

- Location;
- History of the condition being surgically treated;
- Description of the lesion may include symptoms;
- The intent (diagnostic or therapeutic) for performing the procedure;
- The technique used to perform the procedure;
- Medically necessary reasoning for choosing the appropriate procedure;

To assist dermatology residents to become experts in procedural/surgical coding, documentation, and billing, the Academy has developed web-based procedural coding resources that provide you a detailed understanding of dermatology specific coding and documentation examples. **DR**

## Coding resources for 2020



Find practical tips, tools, quizzes, and videos about common dermatologic coding issues at the Academy's new Coding Resource Center at [www.aad.org/coding-resource-center](http://www.aad.org/coding-resource-center).

## Race for the Case

By Jesse Hirner, MD, and Kara Braudis, MD



A 24-year-old female presents for a one-year history of wrinkling of her palms that seems to occur after about two minutes of water contact. It occurs daily when showering, and in situations where her hands are immersed, (such as washing dishes). It is sometimes accompanied by pain. The patient has no known medical problems and takes an oral contraceptive, but no other medications. This does not occur on her soles. Photos demonstrate the patient's palms after several minutes of immersion in water.

1. What should this patient be screened for?
2. What is the most common treatment used for this condition?
3. In addition to the above, what other associations have been reported?



Respond online with the correct answers at [www.aad.org/RaceForTheCase](http://www.aad.org/RaceForTheCase) for the opportunity to win a \$25 Starbucks gift card!



**Jesse Hirner, MD** is a medical dermatology fellow in the department of dermatology at Brigham and Women's Hospital.



**Kara Braudis, MD**, is a dermatopathologist at the University of Missouri.

## Answers to last issue's Race for the Case

In the last issue we presented a case by Andres Label, MD, a PGY-2 at Hospital Aleman, in Buenos Aires, Argentina.

An 8-year-old girl with no significant medical history returned from a family trip to Brazil the week prior to presentation. She was referred to dermatology for evaluation of an erythematous linear plaque with tense blisters involving the right arm and hand. She had no systemic symptoms and felt well overall.



1. **What is the diagnosis?** Phytophotodermatitis due to lime juice – fucocouramins + UVA light (320-400nm). Other common causes of phytophotodermatitis include celery, parsley, hogweed, parsnips, figs, Balsam of Peru. Most frequent topical phototoxicity reaction:
  - Occurs in children in areas of skin exposed to light
  - Occurs within 24 hours of the exhibition
  - Erythema, edema, blisters, linear distribution
  - Residual residual pigmentation as a possible complication
2. **What other entities can be considered in the differential diagnosis?** Lymphangitis, chemical burn, cutaneous larva migrans. Another consideration would be linear morphea.
3. **What are the treatment options?** Mid-strength topical steroids and high SPF (sun protection factor) for future prevention.

## Race for the Case: Winner (Fall 2019)

Congrats to Ankur Lal, MD, a first-year dermatology resident at VMCC in New Delhi. He provided the most accurate responses to the last case in the shortest amount of time.

## Head and neck lesions of the infant

by Tara Oetken, MD

Diagnosed by exam and history		
Accessory Tragus	Skin-colored papule anterior to the normal tragus. Bilateral in ~10-20% of cases.	Many associated genodermis, however most children are completely normal.
Cephalohematoma	Subperiosteal hematoma. More common after prolonged labor, instrument assisted deliveries. Develop in the first hours after birth. Do not cross the midline. Spontaneous resorption and resolution over several months.	Complications include calcifications, hyperbilirubinemia, and infection
Caput Succedaneum	Localized edema. Boggy mass of the scalp with varying degrees of bruising and necrosis. Cross the midline. Spontaneously resolves over 48 hours.	No treatment needed. Sometimes permanent alopecia can occur (halo scalp ring)
Deep Infantile Hemangioma	Skin-colored to bluish, soft, freely mobile nodule which appears weeks to several months after birth and continues to grow for ~ 1 year.	May be difficult to distinguish from vascular malformation (more common on the extremities), and U/S may be needed.
Encephalocele	Soft mass that can enlarge with crying. May transilluminate. Compressible.	Often seen with other neurologic abnormalities. When suspected, imaging and referral to neurosurgery should be prompt.
Juvenile Xanthogranuloma (JXG)	Yellow/red/orange papule on the head.	~20% present at birth. Can have extracutaneous involvement, MC is eye, second MC is lung. If associated with NF-1, > 20x increased risk of JMML. Resolve on their own.
Leptomeningeal Cyst	Pulsatile non-tender mass at site of previous head trauma.	
Lipoma	Skin-colored, soft, rubbery subcutaneous nodule(s). Most commonly on the neck, shoulders, back, abdomen.	Can be seen in infancy, but more common after puberty.
Nasal Glioma	Firm, non-compressible, non-pulsatile mass that does not transilluminate.	Often mis-diagnosed as infantile hemangioma due to erythematous color and prominent telangiectasia.
Pilomatricoma	Hard subcutaneous mass, often skin to bluish in color. May ulcerate.	Cheeks and eyebrows are common locations. If multiple lesions present, associations include Gardner Syndrome, Myotonic Dystrophy and Rubenstein-Taybi.
Pilar Cyst	Slowly growing, skin-colored, mobile subcutaneous mass. Often more than one lesion	Small subset are AD inherited. Lack granular cell layer on path.



**Tara Oetken, MD**, is a PGY-4 dermatology resident at the University of Arkansas for Medical Sciences (UAMS), in Little Rock, Arkansas.



## Head and neck lesions of the infant

by Tara Oetken, MD

Diagnosed with imaging and biopsy		
Dermoid Cyst	Firm, non-compressible, non-pulsatile subcutaneous lesions. MC location is the lateral eyebrow. Other common locations include medial eyebrow/nasal bridge.	Those on the nose or midline scalp are at higher risk of having intracranial extension. Imaging is required prior to surgical excision.
Eosinophilic Granuloma	Focal tender painful swollen mass.	Self resolving variant of Langerhans cell histiocytosis.
Infantile Myofibromatosis	Firm, skin colored to vascular appearing, subcutaneous nodule. MC locations are head, neck, trunk and upper extremities.	Most common fibrous tumor of infancy. Lesions w/o visceral involvement tend to involute in 1-2 years.
Melanotic Neuroectodermal Tumors of Infancy	Rare. Usually present in the 1 <sup>st</sup> year of life as rapidly growing, non-mobile, non-ulcerative bluish/black mass. Most common in the anterior maxilla but cases in the skull and extremities are reported. Normally painless and benign, but malignant transformation is reported in ~6-7%	MRI is preferred imaging. Treatment is complete surgical resection.
Neuroblastoma	Red to bluish, firm, asymptomatic nodules. If rubbed will blanch and have erythematous rim due to catecholamine release.	Skin metastasis are present in ~1/3 of cases.
Rhabdomyosarcoma	Painful, rapidly growing. Appearance can vary from small nodule to large vascular like plaque.	Rare in skin but can present as a metastasis. Head and neck are the most common sites of presentation

### References

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### Boards Fodders online!



In addition to this issue's Boards Fodder, please check out the special edition of our new online Boards Fodder exclusive.

**Biologics Update 2019** by **Elise Craig, MD**, is a comprehensive update of our former dermatology biologics chart with several of the latest biologics included. You can view, download, or print any of our Boards Fodder charts at [www.aad.org/boardsfodder](http://www.aad.org/boardsfodder). More than 100 charts are now available!

### Got Boards?



*Directions in Residency* is currently accepting submissions for new Boards Fodder charts for 2020. Get published, impress your friends, and help out your fellow residents. Contact Dean Monti, [dmonti@aad.org](mailto:dmonti@aad.org) with your chart ideas.



**Latanya T. Benjamin, MD, FAAD, FAAP**, is associate professor of pediatric dermatology at Florida Atlantic University in Boca Raton, Florida.

## Clinical Pearls

*Clinical Pearls help prepare residents for the future by providing them with top tips from experts about what they should know about a specific subject area by the time they complete their residency.*

### Pediatric considerations

By Latanya T. Benjamin, MD, FAAD, FAAP

**Pearl #1: You don't have to hurt children to treat (cure) molluscum contagiosum.** There are many practitioners whose 1st line treatment for MC is a physical modality, such as spot application with liquid nitrogen or curettage. Whenever possible, my preference is always chemical over physical destruction for the treatment of the molluscum contagiosum virus (a poxvirus) in the pediatric population. Physical destruction tends to be poorly tolerated in children making painless chemical destruction ideal. For example, cantharadin is a topical agent that has a painless ease of application, is effective in nature, with high parental satisfaction [1]. Its application can be taught to other health care practitioners. I recommend having a reputable compounding pharmacy compound it as a 0.7% topical solution. Cantharadin, if applied properly, can offer an effective cure with little to no complication.

**Pearl #2: Listen to parents!** Sometimes, chief complaints may seem trivial or a parent over-anxious but always pursue their concern. I have diagnosed invasive melanomas in a 6-year-old child with a new 2mm pink spot beneath the right orbit and a 15-year-old Hispanic male with a changing mole on the scalp, both of which were pointed out by a concerned parent. These vital diagnoses were made because I heard the concerns of a parent. Aggressive skin cancers, albeit rare, do occur in childhood.

**Pearl #3: Damp wraps not wet wraps.** Most every resident will be taught or witness the valuable technique of wet wraps utilized in the inpatient setting. The role and benefit of wet wraps for the management of atopic dermatitis is well known [2]. However, this typically evokes skepticism when first discussed with parents to try at home. Since communication is key, I recommend introducing the term "damp wraps" to parents to better convey the proper application technique. How you introduce new concepts to the family and patient as a unit largely affects compliance and their willingness to try.

**Pearl #4: Seek out opportunities to see pathology in various ethnic skin.** Cutaneous findings and clinical presentations can be highly variable in skin of color. For example, darker skin can make it harder to appreciate inflammatory dermatoses. Atopic dermatitis

may appear as small monomorphic xerotic papules over the trunk rather than the more common presentation of weeping erythematous eczematous plaques in the classic locations in young children. In the next 30 years, the U.S. Census Bureau projects that nearly 50% of the U.S. population will be comprised of people with skin of color. Since the demographics are changing, keep up with available nationwide training opportunities to assist your ability to make accurate diagnoses and enhance patient care in this population. Overall, increased exposure, educational sessions, and training in dermatology residencies will serve you well [4].

**Pearl #5: Avoid unnecessary general anesthesia in procedural dermatology for young pediatric patients.** Unfortunately, many parents have come to me after a plastic surgeon or adult dermatologist recommended to perform laser or a simple excision under general anesthesia. The FDA advisory warns against the repeated use or lengthy use of general anesthesia and sedation drugs during surgeries or procedures in children younger than three years because it may affect the development of children's brains [4]. With various techniques, many pediatric laser and surgical pediatric procedures can be safely, efficiently, and successfully accomplished in an office setting [5]. A full understanding can save you time in a busy practice setting. **DR**

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If you have suggestions for topics or content for Clinical Pearls, contact Dean Monti at [dmonti@aad.org](mailto:dmonti@aad.org)



## Resident Life

### Making life more bearable

By Karan Lal, MD

There has been a lot of controversy about sunscreen use especially amongst families with children. We do our best in clinic to educate families and children who come to our clinic about sun protection and sunscreen use, dispelling the myths, but it can be hard to reach a wider local audience. Every year the children's hospital at the University of Massachusetts medical center hosts a teddy bear clinic. This is a multidisciplinary event with medical professionals from all fields including dermatology, plastic surgery, child life, etc. Its purpose is to teach families and children about health care but with a focus on children's teddy bears. Here UMass Dermatology has a chronic presence and promotes sunscreen use, sun protection, and healthy outdoor practices. Medical students, residents, and faculty teach kids about applying sunscreen on their teddy bears in hopes that they will use sunscreen on themselves. **DR**



**Pictured from left to right** are Shray Amin (medical student), Karan Lal, DO, MS (chief resident), Esmeralda Valois (residency coordinator), Katherine Su, MD (first year dermatology resident), and Alice Tan (medical student).

### Scary good.



Dermatology residents at the University of Iowa lived out their ultimate Disney fantasies depicting their favorite villains this past Halloween. In reality, however, these residents are not villains at all, but instead involved in giving back to the community. Many of them work at the Iowa City Free Medical Clinic and they organize at least two free AAD SPOTme® cancer screenings each year, a tradition since 1998.

**What's going on  
in your residency  
program?**



Send your photos and  
accomplishments  
to Dean Monti at  
[dmonti@aad.org](mailto:dmonti@aad.org).

## Several big reasons residents should attend AAD's 2020 Annual Meeting in Denver!



### S042 - Resident Jeopardy!

This dynamic, fast-paced take on the classic television show, "Jeopardy," presents challenging self-assessment trivia where teams compete to test their knowledge of dermatology! The session is open to all Annual Meeting attendees. Audience members can attend and self-assess. Everyone has fun!

**Sunday, March 22; 1- 4 p.m.**

### C002 - Conquer the Boards: An Experiential Review

This Certification Exam Prep Course is a hands-on experience where attendees take a simulated, shortened version of the American Board of Dermatology certification exam. Attendees will be able to increase their comfort with the exam format, while practicing time management, and identifying areas of weakness in their knowledge base.

**Friday, March 20; 9 a.m. - 4 p.m.**

### S020 - Derm Rapid Fire: Putting Residents at the Center of QI Initiatives

The session will cover topics of pressing interest, including patient satisfaction, models of peer review, workplace violence, and tele dermatology. The resident winners of the annual AAD Resident and Fellow QI Award will present on cutting edge quality improvement initiatives. A dozen speakers who combine dermatology, internal medicine, and emergency medicine perspectives will provide the foundation for the leadership skills professionals will need to optimize patient care and mitigate potential safety issues in the workplace.

**Saturday, March 21; 3 - 6 p.m.**

### S038 - Residents and Fellows Symposium

At each Annual Meeting of the American Academy of Dermatology, an Everett C. Fox, MD Memorial Lecture Award is granted to the most outstanding clinical and laboratory research abstracts submitted by a dermatology resident or fellow.

**Saturday, March 21; 1 - 4 p.m.**



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### F106 - High Yield "Power Hour" for Residents

This forum is designed for dermatology residents who seek to achieve a comfort level with five high-yield topics encountered during training. Image-based learning will focus on: 1) procedural dermatology, 2) medical dermatology kodachromes, 3) pharmacology, 4) high yield dermatopathology, and 5) testing clinical skills of applied knowledge in dermatology.

**Sunday, March 22; 3:30 - 5:30 p.m.**



### S048 - Boards Blitz

This interactive session will provide key points and tips for identifying and answering questions on the digital image portion of the certification/recertification exams.

**Monday, March 23; 9 a.m. - 12 p.m.**

### AAD Career Networking Event!

If you're hunting for a dermatology job or are about to graduate, we highly recommend you do not miss the AAD Career Networking Event! The AAD Career Networking Event is a great, high-energy event where you'll meet over 50 employers face-to-face in a dedicated two-hour setting. Drinks will be provided as you meet and mingle with potential employers from all over the country and network with other dermatologists.

Register today to stay in the know! <https://resources.healthcareers.com/aad-career-networking-event-registration>

Friday, March 20; 4:30-6:30 p.m.

Hyatt Regency Denver

4th Floor, Capitol Ballroom 4/5/6/ **DR**



### Who doesn't need some dermpath review?



Register for these sessions taking place at the Annual Meeting:

#### C007 - Basic Self-assessment of Dermatopathology Slide Review

Saturday, March 21;  
7:30 a.m - 9:30 a.m

#### C008 - Basic Self-assessment of Dermatopathology Slide Review

Saturday, March 21;  
10 a.m. - 12 p.m.

#### C010 - Basic Self-assessment of Dermatopathology Slide Review - Discussion

Saturday, March 21;  
1 pm. - 4 p.m.

### There's a lot more to learn!



Search for Annual Meeting scientific sessions online:  
[www.aad.org/member/meetings/am2020/program/search](http://www.aad.org/member/meetings/am2020/program/search)



## Inside this Issue



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Hopefully coding is starting to become a bit clearer than muddy water at this point. In this column I want to augment our feature article by touching on some of the most common modifiers used in dermatology. First, let's cover the 59 modifier. The purpose of a 59 modifier is to be able to report two different procedures performed on the same patient, at the same visit, by the same provider. For example, if you were to biopsy a patient and freeze a lesion, one of the codes would need to be given a 59 modifier or it would not be reimbursed. Previously you had to look at the NCCI edits to determine which code should get the 59 modifier, however starting July 1, 2019, a modifier can be placed on either of the code combination.

A 59 modifier should not be added if you are doing multiple biopsies as the new biopsy codes are only billed using one primary code and the additional biopsies are billed using the appropriate add-on code. Unless specifically instructed by a payer, add-on codes do not require a modifier as they have already been adjusted to accommodate the overlapping work. For example, if you perform two shave biopsies the correct coding would be 11102 and +11103, not 11102-59.

Because of the popularity of the 59 modifier there are now 4 subdivisions with XS (separate structure) being the most commonly used by dermatologists. (Check payer preference on use of X[ESPU] modifiers.)

Next, let's talk about the 25 modifier. The purpose of this modifier is to be able to bill an E/M code in addition to a procedural code during the same encounter. For example, if a patient comes to clinic and has a wart which you freeze, moles, and seborrheic dermatitis, you would need to add a 25 modifier to your E/M code to signal that in addition to the destruction code, you performed a visit which would stand apart from the procedure performed. It is important to remember that when you bill for a procedural code, all of the history, physical exam, and medical decision making for that lesion is included in the procedure code and will not count for the separate E/M code. So, if you want to bill an E/M code and a procedural code you need to make sure your other documentation can "stand alone" separate from your procedure. This is just the tip of the modifier iceberg but hopefully will give you confidence to explore them more at [www.aad.org/member/practice/coding/modifiers!](http://www.aad.org/member/practice/coding/modifiers!) **DR**

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