You Were Audited for What?
Tales From the Trenches

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Conflict of Interest Statement

I have no relevant financial conflicts of interest.
Incoming chair AAD PAPR committee
Chair ACMS Private Sector TF
Advisor, AAD AMA RUC
Insurer chart reviews
Do We Still Need to Learn Coding?

My EHR does my coding for me
Do We Still Need to Learn Coding?

My EHR does my coding for me
EMRs Coding Only As Good As the Programmer
Chart Review Observations

- Triggers that draw chart reviews. (Outliers; High ticket items, Multiple procedures performed in one visit; Recurring procedure on one patient; High percentage use of one procedure code, therapeutic intervention, or diagnosis; Patients who feel their service was not properly coded.)

- Reviews are becoming more and more common. (Insurer pre and post payment reviews, Modifier and E/M use reviews, Medicare Advantage “Care Coordination Reviews”) With EMR, reviews may be done in real time.

- Remember that your one best chance to be paid for what you do is to bill it right the first time (clean claim)
Member Name: 
Provider: 
Date Of Service: 01/28/2016

This letter is in response to a claim received for the patient identified above. Unfortunately we are unable to process this claim because the information submitted was incomplete or requires additional information.

For the following claim, please return this letter, a new claim, reconsideration form with 'previously denied/closed for additional information' checked and the items requested below:

Member Number: 
Patient Control # 
Claim Number: 
Dates Of Service: 01/28/2016 - 01/28/2016
Total Amount Billed:

Service Line 01
Please submit legible medical records for DOS to include but not limited to: Written/Verbal Orders

Service Line 02
Please submit legible medical records for DOS to include but not limited to: Written/Verbal Orders

Service Line 03
Please submit legible medical records for DOS to include but not limited to: Written/Verbal Orders

DL106 NYC
Insurers are Watching

<table>
<thead>
<tr>
<th>Modifier 25 Billing Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Modifier 25 Occurrences:</td>
</tr>
<tr>
<td>Total Modifier 25 Billed Charges:</td>
</tr>
</tbody>
</table>

**BILLING BREAKDOWN**

- Total Dates of Service: 380
- Your Modifier 25 Billing Instances: 289
- Your Modifier 25 Billing Instances %: 76.1%
- Expected Modifier 25 Billing %: 30.5%
- Your Variance from Expected Billing %: 45.5%

**Your Modifier 25 Billing Distribution**

- 76%
- 24%

**Your Modifier 25 Billing Frequency as Compared to Expected**

- 76.1%
- 30.5%
RAC Audit Letter

Review Results Letter – No Findings

Date

RAC Point of Contact
Provider Name
Address 1
Address 2
City, State Zip

Re: Provider Name #123456789
Letter ID: XXXXXX
Issue: Issue Name
NPI: NPI Number
Date of Birth:
Medical Record #: 
Patient Control #: 
Date(s) of Service:
Claim Reference #: 

Dear Medicare Provider,

The Centers for Medicare & Medicaid Services (CMS) has retained CGI Federal Inc to carry out the Recovery Audit Contracting (RAC) program in the State of _________. The RAC program is mandated by Congress and has a primary goal of identifying Medicare improper payments. Improper payments include overpayments and underpayments. Improper payments may occur because of incorrect coding, lack of sufficient documentation or no documentation, use of an outdated fee schedule or billing for services that do not meet Medicare’s coverage and/or medical necessity criteria etc.

Our request for additional medical documentation, detailed in a letter dated xx/xx/xxxx, constituted reopening under §1869(b) (1) (G) of the Social Security Act (the Act) and 42 CFR 405.980(a) (1). Our good cause to reopen the claim, if required by 42 CFR 405.980(b) (2), was described in the request letter,
What is an Outlier?

*Average stages per case by surgeon for head and neck Mohs surgery (CPT 17311)*
Documentation Basics

- Remember not good enough anymore just to indicate what you did. You also have to document why it was medically necessary even if it is obvious to you.
- Documentation must be clear and precise.
- Insurance reviewers are generally not dermatologists and will not give you the benefit of the doubt.
MACs and LCDs for Mohs surgery

- 6 LCDs for Mohs surgery for the MACs (CGS, WPS, FCSO, Noridian, Novitas, Palmetto).
- Each LCD has unique wording and requirements. Coverage of Mohs surgery for specific malignant diagnoses, histologic subtypes, locations, and clinical scenarios varies between LCDs.
- Some LCDs are based directly on the Mohs surgery appropriate use criteria; others have less specific coverage criteria.
MACs and LCDs for Mohs

- To understand the specific documentation requirements of the MAC for a particular state or region, AAD members are encouraged to familiarize themselves with the Mohs surgery LCD of their local MAC.

“New” Mohs Documentation Requirements

- Note should make clear why the lesion will not be (was not) managed by standard excision or destruction technique.
- Operative notes and pathology documentation in the patient’s medical record should clearly show that MMS was performed using accepted MMS technique, in which the physician acts in two integrated and distinct capacities: surgeon and pathologist (therefore confirming that the procedure meets the definition of the CPT code(s)).
- Operative documentation should note: location, number, and size of the lesion(s); number of stages performed; number of specimens per stage. Histology documentation must include the following: (a) First stage: if tumor present, depth of invasion; pathological pattern of the tumor; cell morphology; if present, note perineural invasion or scar tissue. (b) Subsequent stages: if the tumor characteristics are the same as in the first stage, note this fact only. If the tumor characteristics are different from the first stage, describe the differences.
The “Audit Proof” Mohs Note

Mohs Micrographic Surgery Procedure Note

Patient Name:  
Date of Birth:  
Date of Service:  

Case #:  
Account #:  

Diagnosis: Basal cell carcinoma  
Site: Left upper lip

Preoperative size: 7 x 6 mm  
Postoperative size: 15 x 12 mm  
Surgeon: Howard W. Rogers M.D. Ph.D.  
Anesthesia: 1% Lidocaine with epinephrine and bicarbonate as needed.

This lesion was not managed by excision or destruction because tumor had aggressive pathology (morphoeaform type) and tumor was in a critical area for tissue conservation.

The operating physician (Howard Rogers, MD) during the performance of Mohs surgery acted in two integrated and distinct capacities: surgeon and pathologist.

Preparation: The patient was brought into the operating room. After a detailed explanation of the procedure and the possible risks of infection, bleeding, scarring, pain, and tumor recurrence; informed consent was obtained. The patient was lain down on the procedure table. The surgical site was prepped with an antiseptic solution, infiltrated with local anesthetic as above, and draped with sterile sheets. This was repeated for each surgical stage of the procedure.

Procedure:

1. The lesion was aggressively debulked with a scalpel and dermal curet.  
2. A layer of tumor containing tissue with a thin margin of normal appearing tissue was excised.  
3. Hemostasis was achieved with spot electrocoagulation.  
4. The resected tissue was oriented relative to the surgical defect and a map of the defect was drawn. Orientation was aided with hatch marks and staples around the defect.  
5. A pressure dressing of Telfa, gauze and tape was affixed to the defect; the skin was cleansed of antiseptic solution; and the patient was taken back to the waiting room.  
6. The resected tissue was divided into appropriately sized specimens while maintaining orientation relative to the map.
Continued Case Number:

7. The specimens were marked with tissue dyes with corresponding markings of the map.
8. The specimens were individually processed for horizontal frozen sections that allowed the examination of the entire superficial peripheral as well as deep margins.
9. The frozen sections were stained with hematoxylin and eosin and examined by the surgeon for the presence of tumor.
10. If tumor cells were found in any margin, a notation in red was made on the map and the patient was returned to the operating room with additional surgery directed only to the areas still involved with tumor. The preparation and steps 2 – 9 were repeated until no more tumor cells were identified in any of the horizontal frozen section. See attached maps.

Stage 1 (17311) involved examination of microscopic sections of 2 tissue specimen(s). Tumor was found persisting in 2 of the specimen(s).
Stage 2 (17312) involved examination of microscopic sections of 2 tissue specimen(s). The surgical margin was found to be free of tumor.

At this point, no further tumor cells were identified and the tumor excision was considered complete. The patient was brought into the operating room and options for repair of the surgical defect were discussed. Repair of the surgical defect was accomplished by primary closure (see reconstruction note).

Dictated by Howard W. Rogers M.D. Ph.D.
The “Audit Proof” Mohs Note

Patient Name:
Date of Birth: Case #:
Date of Service: Account #:

Diagnosis: Basal cell carcinoma
Site: Right upper lip

<table>
<thead>
<tr>
<th>Stage</th>
<th>Tumor</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>Present</td>
<td>Spindle shaped aggregates of atypical basaloid cells with high nuclear cytoplasmic ratios and peripheral palisading of their nuclei in the dermis. There is desmoplastic stromal pattern.</td>
</tr>
<tr>
<td>1.2</td>
<td>Present</td>
<td>Spindle shaped aggregates of atypical basaloid cells with high nuclear cytoplasmic ratios and peripheral palisading of their nuclei in the dermis. There is desmoplastic stromal pattern.</td>
</tr>
<tr>
<td>2.1</td>
<td>Absent</td>
<td></td>
</tr>
<tr>
<td>2.2</td>
<td>Absent</td>
<td></td>
</tr>
</tbody>
</table>

Howard W. Rogers M.D. Ph.D.
Permanent Section Pathology on Same Day as Mohs Surgery

- If 88305 is reported on the same day, expect an audit or recoupment. Appeals often denied.
- It’s not just Medicare – private insurers are doing it also.
Permanent Section Pathology on Same Day as Mohs Surgery

- If you must...
  - Document the medical necessity of sending pathology specimen
  - 1) A second opinion consultation is required during surgical treatment of melanoma;
  - 2) Further tissue processing is required to assess features of an aggressive, deep, or histologically unusual tumor;
  - 3) Paraffin section evaluation is used to confirm a diagnosis other than what was found on a prior pathology report, upon which Mohs surgery was done;
  - 4) Further tissue analysis is necessary to complete the staging of a tumor so that the need for additional therapy, such as radiation or chemotherapy, can be determined;
  - 5) Unusual findings during frozen section evaluation, or during other portions of the Mohs case, lead the physician to conclude that a second pathologic opinion is necessary;
  - 6) Despite proper processing technique, frozen section interpretation is not sufficient to assess the tissue margin with a high degree of reliability;
  - 7) A biopsy specimen of tumor not previously biopsied is obtained and assessed by frozen section immediately before commencement of Mohs; the pathologic diagnosis is then confirmed by paraffin section; or
  - 8) Special stains are required that are not done on frozen sections but are on paraffin sections.

https://www.aad.org/Forms/Policies/ps.aspx
The 8 Stage Mohs Case

- Billed as 17311 and 17312 x7 units
- 6 units of 17312 are paid and 1 unit is denied as medically unlikely
Medically Unlikely Edits

- The maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service.
- 17311 – 4
- 17312 – 6
- 13731 – 3
- 17314 – 4
- 17315 – 15
- 11101 - 6
Mohs and Immunos

- 2 stage Mohs case is done for melanoma with 7 blocks stained with HMB45. The immunos are billed in addition to the base Mohs codes as 88342 x 7 units.

- All the units of 88342 are denied as medically unlikely.
Changes to Coding for Immunohistochemistry

- **88342** Immunohistochemistry or immunocytochemistry, per specimen; initial single antibody stain procedure
- **88341** each additional single antibody stain procedure
- **88344** each multiplex antibody stain procedure
- Code 88343 has been deleted for 2015
- “G” codes G0461 and G0462 will no longer be reported to CMS
- CMS has instituted DOS limit on 88342 of 3 and clarified per specimen policy
- NCCI has firm interpretation - one mohs layer as a specimen = one unit of 88342
- So the proper coding for immunos on a 2 stage case is actually 88342 x2
Phototherapy Audits

- Recently, BCBS MI demanded payment from dermatologists for 100’s of “upcoded” phototherapy service 96910 which should have been 96900

- The insurer contacted patients directly and asked how services were provided as well as evaluated medical records.
Phototherapy

- **Should be relatively simple**

- **96900** Actinotherapy (ultraviolet light)

- **96910** Photochemotherapy; tar /petrolatum and ultraviolet (Goekerman)

- **96912** Photochemotherapy; psoralens and ultraviolet A (PUVA)

- **96913** Photochemotherapy (Goekerman and/or PUVA) for severe photoresponsive dermatoses requiring at least 4-8 hours of care under direct supervision of the physician (includes applications of medication and dressings)
Phototherapy Medicare Utilization

- **96900** Actinotherapy: 108,314 - $20.78
- **96910** Photochemotherapy: 390,737 - $72.37
- **96912** Photochemotherapy: 26,702
- **96913** Photochemotherapy: 39
Phototherapy Service Definitions

- Disclaimer – my opinion
- CPT 96900 – Actinotherapy - Prior to actinotherapy, no application of tar, petrolatum, or other light enhancing agent occurs in the office.
- CPT 96910 – Photochemotherapy; tar and ultraviolet B (Goeckerman treatment) or petrolatum and ultraviolet B - Prior to photochemotherapy, application of tar, petrolatum, or other light enhancing topical product occurs within office, by staff or patient.
Standard Procedure - written

- What topical agent was applied, if any?
- To what areas the topical product was applied?
- Who applied the topical product?
- If the patient applied the topical, document that assistance was offered and refused?
Eximer Laser Psoriasis Treatment

- **96920** Laser treatment for inflammatory skin disease (psoriasis); total area less than 250 sq cm
- **96921** Laser treatment for inflammatory skin disease (psoriasis); 250 sq cm to 500 sq cm
- **96922** Laser treatment for inflammatory skin disease (psoriasis); greater than 500 sq cm
Laser for Vitiligo

- AMA - Although both vitiligo and focal atopic dermatitis have literature based support for successful outcomes with laser treatments, the 96920-96922 CPT codes are specifically indicated for psoriasis treatments.

- Consequently, one would describe each of the vitiligo laser light treatments with the 96900 Actinotherapy (ultraviolet light) CPT code. One may also choose CPT 96999, Unlisted special dermatological service or procedure.
MAC Site of Service Audits

- OIG report indicated overpayments due to inappropriate site of service payments
- Mohs with same day repair in facility
- Any service for a patient treated in a facility on the same day
- Cover letter indicating that all services were rendered in the office setting along with requested records
Oh what a difference a few words make!

- Shave biopsy done – code 11100  **Denied!!!**
- Skin biopsy done by shave technique – Code 11100  **Paid!!!**
Biopsy of Eyelid

A patient presents with a rapidly growing papule of the lower eyelid. A biopsy is performed and coded 67810.

Is this correct?
Biopsy of Eyelid

- Eyelid biopsy code 67810 has been revised to clarify that eyelid biopsy must include lid margin, tarsal plate or palpebral conjunctiva. Again, typical eyelid skin biopsies would fall under the 11100 skin biopsy code.
Biopsy of Lip

Cutaneous lip biopsies would be better coded 11100.

The 40490 code is designated for lip biopsies done from the vermilion border to the dry-wet junction of the lip.
Procedure Sizing

- The last number of your treatment sizes should be evenly distributed X.0-X.9
- Most excisions and treatments will be in the 0.6 to 3.0 cm range
Malignant Destruction Coding

Patient presents with a 5x8 mm biopsy proven superficial BCC of the chest which is treated by curettage and electro-dessication with 3 passes.

Coding 17261
Dx C44.519
Both AMA and CPT avoid describing exactly how the measurement of malignant destructions are determined. The most reasonable interpretation is that the size is the maximum diameter of the defect after curetting, as it is the curetting that finds and defines subclinical tumor extension. The defect size is 14x10 mm, and the procedure code is 17262.
ELECTRODESICCATION AND CURETTAGE DESTRUCTION OF CUTANEOUS LESION

OPERATIVE REPORT

NAME: ________________________________
DATE OF BIRTH: ____________________________
DATE OF SERVICE: ___________________________
SURGEON: Howard W. Rogers, M.D., PhD.
DIAGNOSIS: ________________________________
MEDICAL NECESSITY: Malignancy, Precancerous growth, symptomatic lesion
FIRST PASS SIZE: ________ cm (Billed lesion diameter)
LOCATION: ____________________________
ANESTHESIA: LIDOCAINE WITH EPINEPHRINE as needed
NUMBER OF PASSES: __________________________
MARGIN: ________________________________

COMMENT: After informed consent was obtained, the patient was positioned on the surgery table in a supine position; the lesional area(s) was prepped with hibiclens, and infiltrated with 1% Lidocaine with epinephrine as above. The lesional skin was curetted in multiple directions with a number 4 dermal curette until all friable tissue was removed. The lesional base and an indicated margin was electrodessicared with a hyfrecator. This procedure was repeated as above. The wound was dressed with vaseline and a pressure dressing. Estimated blood loss was minimal. There were no complications. Wound care instructions were provided for the patient in verbal and written form including a 24-hour telephone number in case of emergency. The patient will follow up in ________________.

Howard W. Rogers, MD PhD
Proper determination of excision size

Greatest clinical dimension of the lesion to be excised.
Proper determination of excision size

Excision size is defined as the greatest clinical dimension of the lesion added to the surgical margins.
Proper determination of excision size

Standing cones don’t count
Re-excision after positive margins

7 days after excision of an infiltrative BCC on the shin, pathological evaluation reveals positive histological margins on the lateral edge of the specimen. The involved margin is re-excised with an additional 4 mm margin. How is this billed?
Bill Re-excisions After Positive Margins Properly

- As for a standard excision, the greatest dimension of the involved margin is the clinical lesion size. The margins are added to the clinical size for excisional procedure code. Of course, a 58 modifier is appended because the procedure is performed within the 10 day post op period of the original excision.
Scenario 1 – Focally Positive Margin

Re-excision Size
Scenario 2 – Largely Positive Margin
Scenario 3 – Extensively Positive Margin

Re-excision Size
ELLIPTICAL EXCISION

OPERATIVE REPORT

NAME: ____________________________
DATE OF BIRTH: __________________
DATE OF VISIT: __________________

PROCEDURE: EXCISION WITH SIMPLE CLOSURE.
SURGEON: HOWARD W. ROGERS, MD PhD

PREOPERATIVE DIAGNOSIS:
MEDICAL NECESSITY OF EXCISION:
MALIGNANT / UNCERTAIN BIOLOGICAL POTENTIAL / SYMPTOMATIC LESION
SIZE OF LESION PREOP: ______CM + ______ MM MARGINS
TOTAL EXCISION SIZE = Preop size plus margin times 2; ______CM
LOCATION:

PERIOPERATIVE MEDICATIONS: NONE
ANESTHESIA: LIDOCAINE WITH EPINEPHRINE; ___________ C.C.

TYPE OF CLOSURE: SIMPLE LINEAR CLOSURE: EPIDERMAL APPROXIMATION WITH
RUNNING _______ PROLENE SUTURES.
FINAL SUTURE LENGTH LINE: ___________CM

COMMENT: After informed consent was obtained, the patient was positioned on the surgery table in a
supine position, the lesional area was prepped with alcohol, and infiltrated with 1% Lidocaine with
epinephrine as above. Thereafter, the skin was prepped with Betadine, and draped with sterile towels.
Using a surgical marking pen, an elliptical design was created to include above indicated margins. Using a
# 15 blade scalpel, an excision was carried out through the full thickness of the skin extending to the
subcutis. Undermining was carried out circumferentially. The specimen was placed in formalin and sent
for routine histopathological evaluation. The cavity from which the specimen was removed was
undermined circumferentially for approximately 1.0 cm and hemostasis was achieved with
electrohyfrecation. Standing cones were excised, such that the wound closure lines would fall into relaxed
skin tension lines of the body. The epidermis was then approximated with suture and technique as above.
Estimated blood loss was minimal. There were no complications. Wound care instructions were provided
for the patient in verbal and written form including a 24-hour telephone number in case of emergency.
The patient will return in ______ week.
Benign Destructions 17111

- Recent audit looked for locations of all the lesions treated.
- Not good enough anymore to record 20 painful warts treated with cryosurgery
Complex Closure

- Patient with BCC on neck undergoes excision with complex linear closure (4.0 cm). The closure is coded 13132.
Do Not Bill Complex Closure Just Because Lesion is on Head / Neck

Complex closure is a repair that requires more than layered closure such as…

- Scar Revision
- Debridement (as of traumatic lacerations)
- Extensive Undermining
- Stents
- Retention Sutures

- REMEMBER MEDICAL NECESSITY!
Do Not Bill Complex Closure Just Because You Are Repairing a Mohs Defect

- Taking standing codes and de-beveling Mohs defect does not constitute debridment
Alteration of Standing Cone Placement (Not Complex)
Complex Closure

- Nose with extensive undermining
Complex Closure

- Padded retention suture bridges to prevent suture pull-through due to high wound tension
Complex Closure Documentation

EXCISION WITH COMPLEX CLOSURE

OPERATIVE REPORT

NAME:________________________
DATE OF BIRTH:________________
DATE OF VISIT:________________

PROCEDURE: EXCISION WITH COMPLEX CLOSURE.
SURGEON: HOWARD W. ROGERS, MD PhD

PREOPERATIVE DIAGNOSIS:
MEDICAL NECESSITY OF EXCISION:
MALIGNANT / UNCERTAIN BIOLOGICAL POTENTIAL / SYMPTOMATIC LESION
Medical Necessity: Lack of locally redundant tissue, High risk of wound dehiscence, Minimal local tissue reservoir, Presence of local free margin to avoid distortion of the nose, eyelid, lip, ear.

SIZE OF LESION PREOP: _______ CM + _______ MM MARGINS
TOTAL EXCISION SIZE = PREOP SIZE + MARGINS X 2: _______ CM
LOCATION:
PERIOPERATIVE MEDICATIONS: NONE
ANESTHESIA: LIDOCAINE WITH EPINEPHRINE: _______ C.C.

TYPE OF CLOSURE: LAYERED CLOSURE WITH _______ PDS BURIED AND DEEP SUTURES AT LEVEL OF NON-MUSCULAR FASCIA, DEEP SUBCUTIS, AND DERMIS. EPIDERMAL APPROXIMATION WITH RUNNING PROLENE SUTURES.
FINAL SUTURE LENGTH LINE: _______ CM

COMMENT: After informed consent was obtained, the patient was positioned on the surgery table in a supine position, the lesional area was prepped with alcohol, and infiltrated with 1% Lidocaine with epinephrine as above. Thereafter, the skin was prepped with Betadine, and draped with sterile towels. Using a surgical marking pen, an elliptical design was created to include above indicated margins. Using a #15 blade scalpel, an excision was carried out through the full thickness of the skin extending to the subcutis. The specimen was placed in formalin and sent for routine histopathological evaluation. The cavity from which the specimen was removed was undermined extensively and circumferentially for approximately 3.0 cm and hemostasis was achieved with electrohyfrecation. This repair required more effort than an intermediate closure because of this extensive undermining. “Dead space” was closed and deep wound edges approximate in a layered fashion using sutures noted above. Standing cones were excised, such that the wound closure lines would fall into relaxed skin tension lines of the body. The epidermis was then approximated with suture and technique as above. Estimated blood loss was minimal. There were no complications. Wound care instructions were provided for the patient in verbal and written form including a 24-hour telephone number in case of emergency. The patient will return in _______ week.
Is it an excision?

Patient complains of rapidly growing tender lesion on left arm.

- Clinical diagnosis – SCC (2.2 cm)
- Shave excision done with 3 mm margins with derma-blade and sent for path
- Path shows well differentiated squamous cell carcinoma with clear margins; the deep margin extends to the deep dermis

Coding 11603
Dx C44.622
Bill Excisions and Shave Removals Appropriately

- Problem – Excision is defined as removal of a lesion into the subcutis. Tangential or shave excision of benign or malignant lesions are covered by 11300 code series.

- Shave removal may vary in depth in the dermis. The complete histological removal of the lesion is irrelevant to the coding (shave versus excision). If the level of removal does not go through the full thickness of the dermis, it is not an excision.

- Difference between a shave removal and a biopsy by shave technique is the intent.
If I say I did an excision, I did an excision!!!

- Don’t think they won’t look at your pathology
ELLIPICAL EXCISION

OPERATIVE REPORT

NAME: __________________________
DATE OF BIRTH: __________________
DATE OF VISIT: ___________________

PROCEDURE: EXCISION WITH SIMPLE CLOSURE.
SURGEON: HOWARD W. ROGERS, MD PhD

PREOPERATIVE DIAGNOSIS:
MEDICAL NECESSITY OF EXCISION:
MALIGNANT / UNCERTAIN BIOLOGICAL POTENTIAL / SYMPTOMATIC LESION
SIZE OF LESION PREOP: __________CM + _______MM MARGINS
TOTAL EXCISION SIZE = Preop size plus margin times 2; __________CM

LOCATION:
PERIOPERATIVE MEDICATIONS: NONE
ANESTHESIA: LIDOCAINE WITH EPINEPHRINE; ___________C.C.

TYPE OF CLOSURE: SIMPLE LINEAR CLOSURE: EPIDERMAL APPROXIMATION WITH
RUNNING ___________ PROLENE SUTURES.
FINAL SUTURE LENGTH LINE: ___________ CM

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for routine histopathological evaluation. The cavity from which the specimen was removed was
undermined circumferentially for approximately 1.0 cm and hemostasis was achieved with
electrohyfrecation. Standing cones were excised, such that the wound closure lines would fall into relaxed
skin tension lines of the body. The epidermis was then approximated with suture and technique as above.
Estimated blood loss was minimal. There were no complications. Wound care instructions were provided
for the patient in verbal and written form including a 24-hour telephone number in case of emergency.
The patient will return in _______ week.
Drug rep came to my office indicating that code 96401 was proper injection code for biologics.
Biologic Injection

- 96401 - Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic

- 96372 - Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular

- J2357 - Injection, omalizumab, 5 mg – will need 30 units for 150 mg dose
Worried about Audits?

☐ Code and document properly
Thank you

rogershoward@sbcglobal.net