Mo’ Money Less Problems

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Disclosure

- I have consulted or spoken for AbbVie, Arcutis, Dermavant, Verrica, Sanofi, Leo, UCB, Lilly, Pfizer, Galderma, Janssen and Advanced Solution on the topics of Atopic Dermatitis, Prurigo Nodularis, Alopecia Areata, Psoriasis, Molluscum and wound healing
- The information discussed today is unbranded and has received no commercial support from these entities
- All the information presented here is my own and does not reflect the opinions or views of Forefront Dermatology

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The Golden Rules

- Document what you do, and code for what can be supported by your documentation

- Do not bill based on "feels" - we did not invent the game but it is our job to play it well: Take care of the pennies and the dollars will take care of themselves

- This means the two minute seb derm visit is a level 4 & don't feel bad about it because the fifteen minute thorough skin check is still a level 3

- Be open to addressing all of a patient's concerns, bringing up findings you see incidentally and offering treatments

- Sometimes we need the "spot check" but always feel free to offer the FBSE

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So What's Normal?

- Knowing avg numbers helps with self-eval and ability to look for improvement
- Avg collection per patient is $150-200; this can range $250-300 for those who do more cosmetics or mohs as well
- Typical biopsy rate for skin cancer rule out is 40% of lesions biopsied come back malignant; other study: of all biopsies avg NNB to get a malignancy was 7.5 but when cancer is suspected then NNB is just 3
- Should have up to 35% new patients and if higher then your patients are not returning
- Payor mix and fee schedules vary by practice and geography, so we can only control what we can control

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Medical Optimization

With new MDM, the level 4 is king in derm

- medical condition(s) + rx management

* Chronic exacerbated condition not at treatment goal

- any derm condition that has been present for 1 year or has a natural course over a year (even if waxes and wanes)
- "Not at treatment goal" can be based on patient or physician perception

*Two stable chronic conditions at treatment goal

- history of a skin cancer does count as a chronic stable condition
- SK, angioma, lentigo, benign nevi, etc is a doubtful

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Medical Optimization

Common misconceptions:

Improved or unchanged condition = stable

- in fact a patient can be 99% improved but if their goal or your goal is complete clearance then they are “chronic exacerbated not at goal”

Sending rx or refilling rx is enough

- need official counseling blurb from EMR (if not available can free text: “benefits and risks reviewed with patient” or “SER”

You have to send an rx

- Discussing prescription benefits/risks counts even if declined

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Medical Optimization

The basic FBSE is a level 3 but can potentially be 4 in the setting of other medical condition with rx management

- should not pressure patients into treating but if you see something say something

- if you do treat, include in HPI: e.g. if you notice acne and rx tretinoin during FBSE then write "patient complains of facial bumps" into HPI

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Medical Optimization

Common Rx treatments for incidental chronic conditions:

- Topicals in acne/rosacea
- Field therapy in actinic skin damage
- Rx for AGA
- Non-hydroquinone compounded lightening cream for dyschromia
- Glycopyrrolate compounded for hyperhidrosis
- Hydrocortisone 2.5% + ammonium lactate for itchy xerosis/hyperkeratosis
- Topicals for seb derm

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Medical Optimization

For level 5 - best to use time during date of service instead of MDM unless you are referring patient to the ER

- high risk for audit in derm even in situation where it is appropriate based on outpatient MDM

For surgical consultation - skin cancer can be an “acute complicated injury” because it has multiple treatment options and potential for morbidity/mortality.

- Discussion of tx options also counts as level 4 with any risk factors or risks associated (DM, anticoagulation, immune suppression, etc)

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Medical Optimization

If presenting for eval (specialty or second opinion) and being sent back to a primary dermatologist then that is a consultation (for privately insured)

General complexity of visit:

- Add immunosuppressed status as dx code for patients with DM, medication induced, cancer, HIV, etc to support overall complexity of a particular visit

- code all other chronic skin conditions you note on exam even if not treated (if discussed e.g tinea pedis, psoriasis)

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Procedural Optimization

For better or worse this is a major component of our revenue

We are the experts in cutaneous procedures

If something can be ameliorated more quickly then offer to the patient (e.g ILK for LSC)

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Procedural Optimization

If people come for a single procedure or “spot of concern” and you notice anything else even just actinic damage and counsel/recommend sunscreen SPF greater than 30, then technically it is a level 3 office visit too

- Don't need to fish for this, but it naturally happens

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Procedural Optimization

For certain conditions typically treated with procedure can discuss and document medical management and patient refusal as well to secure level IV

- extensive AKs with field tx
- verruca vulgaris with topicals
- inflamed cyst treated with I&D, ILK and abx

Some recommend a different code for EM and procedure to ensure they both get covered

- e.g. if you do ILK for psoriasis you may code injection it under “pruritus” or “lichen simplex chronicus”

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Procedural Optimization

R21 added can be “new unknown diagnosis of uncertain prognosis” to meet level IV in many instances where you biopsy and/or treat empirically in addition to clinical impression

- E.G. patient with widespread eczematous rash biopsied “ eczema vs MF” treated with triam ointment bid x 2 weeks

Often i’ll just add a second suspected diagnosis

- E.g same situation as above except I add dx of atopic dermatitis and treat with triam ointment bid x 2 weeks

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Procedural Optimization

Document symptoms of benign lesions to justify procedures:

- cryo, electrodessication, shave removal, excisions
- covered if itchy, painful, bleeding, etc
- This should be in the HPI and in the plan as best practice

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Destructions

There are special codes for some sites of destruction. These include the anus, penis, vulva, and eyelid margin

The anogenital codes are separated into simple vs extensive and these terms are not clearly defined. You should use your judgement and justify in your documentation when you use the extensive code

- can do both genital, anal, and body code in the same visit
- can code condyloma > verruca to minimize denials
- technically perineum and scrotum don't count as special site

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Destructions

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Destructions

Destruction of malignant requires pre and post-op sizes (does not include margin)

- Can actually bill this if a spot is clinically cancerous and patient refusing biopsy just document appropriately with dermoscopy and exam findings

Coding for Destructions - Malignant Lesions

Trunk or Extremities	Scalp, neck, hands, feet, genitalia	Face, ears, eyelids, nose, lips, mucous membranes	Lesion diameter
CPT Code			
17260	17270	17280	0.5 cm or less
17261	17271	17281	0.6 to 1.0 cm
17262	17272	17282	1.1 to 2.0 cm
17263	17273	17283	2.1 to 3.0 cm
17264	17274	17284	3.1 to 4.0 cm
17266	17276	17286	Over 4.0 cm

Intent: ablation of malignant tissue
Method: any method of destruction– electrosurgery, cryosurgery, laser & chemical treatment
Codes are defined by;
- anatomic site
- lesion diameter

- Closure is not usually not required
  - with/without curettement
- Includes local anesthesia
- Pathology report identifying malignancy must be available to report code

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Biopsies

Some sites on the body have their own biopsy codes which may reimburse more than usual, so it is worth looking these up. Sites include the external ear, eyelid, lip, nail unit, penis, vulva or perineum, and tongue

- Eyelid difficult because needs to involve margin to count; not worth fudging this!

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Biopsies

I strongly recommend biopsying rashes, especially if you even think about needing systemic tx:

- I have had too many AD and Pso visits that end up being the opposite or a different condition

- Many “world expert” clinicians have been fooled on exam alone

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Don’t Forget The Shave Removal

- Use these codes if your intention is to remove the entire lesion and not just sample it BUT it is ok to send for path of course!
- Comment on symptoms requiring removal; for coverage necessary because otherwise might just be a biopsy; still code d48.5
- Should use for all pigmented lesion biopsies per many experts

Coding for Shave Removals

Codes grouped anatomically;

Trunk or extremities

CPT Code	Defined by size of tissue removed
11300	0.5 cm or less
11301	0.6 to 1.0 cm
11302	1.1 to 2.0 cm
11303	Over 2.0 cm
Scalp, neck, hands, feet, genitalia	
11305	0.5 cm or less
11306	0.6 to 1.0 cm
11307	1.1 to 2.0 cm
11308	Over 2.0 cm
Face, ears, eyelids, nose, lips, mucous membrane	
11310	0.5 cm or less
11311	0.6 to 1.0 cm
11312	1.1 to 2.0 cm
11313	Over 2.0 cm

Intent: Therapeutic removal of lesion
Histopathology: May be done incidentally
Depth: Not through the dermis

- The entire lesion or only the noxious portion of the lesion is removed
- Reported for either benign or malignant lesions
  - Removal of benign asymptomatic benign lesions may be considered cosmetic
- Measure the lesion prior to removal
- Does not usually involve suture closure
- Includes local anesthesia and chemical/ electrocauterization
- Code represents a single lesion, report a separate code for each lesion
- Shave removals that intentionally go beyond the dermis should be reported with an excision code

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Don’t Forget The Shave Removal

Biopsy/Removal/Excision Codes – Intent, Intent, Intent

Shave Removal - shaving a cutaneous lesion in its entirety through the dermis with the intent to remove the entire visible lesion with a small margin of normal skin. Must report pre op size, margin, and post-op size and bill the code based on the PRE OP lesion size. At the base of a shave removal should be pin point bleeding +/- fat globules poking through.

11102 - shave - $113

TRUNK, ARMS OR LEGS

11300 - LESION DIAMETER 0.5 CM OR LESS - $114

11301 -LESION DIAMETER 0.6 TO 1.0 CM - $140

11302 - LESION DIAMETER 1.1 TO 2.0 CM - $165

11303 - LESION DIAMETER OVER 2.0 CM - $183

SCALP, NECK, HANDS, FEET, GENITALIA

11305 -LESION DIAMETER 0.5 CM OR LESS -$115

11306 - LESION DIAMETER 0.6 TO 1.0 CM - $143

11307 - LESION DIAMETER 1.1 TO 2.0 CM - $168

11308 - LESION DIAMETER OVER 2.0 CM - $176

FACE, EARS, EYELIDS, NOSE, LIPS, MUCOUS MEMBRANE

11310 - LESION DIAMETER 0.5 CM OR LESS $130

11311 - LESION DIAMETER 0.6 TO 1.0 CM - $130

11312 - LESION DIAMETER 1.1 TO 2.0 CM - $189

11313 - LESION DIAMETER OVER 2.0 CM - $219

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Multiple Procedure Reduction Rule

Typically in MPRR: 100% of 1st and 50% of every subsequent

Rarely it's 100% of 1st, 50% of 2nd and 25% thereafter (Medicaid and similar plans)

Up to 7 typically reimbursed, beyond that often uncovered

Loophole is to have a mix of shave removal and biopsy by shave method

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Excisions

If you remove an entire lesion using a punch biopsy tool, this as an excision and not a biopsy; also no such thing as “excisional biopsy” or “punch excision”

Almost never a reason to do an “incisional biopsy” because you can just shave removal or excise

Up to 5 mm, 6-10 mm, 1.1-2 cm, 2.1-3 cm, 3.1-4 cm, over 4 cm

Code d48.5 for excising dysplastic nevi or other benign lesions

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Excision

EXCISION - BENIGN LESION

11400 Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.5 cm or less - $140

11401 Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.6 to 1.0 cm - $173

11402 Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 1.1 to 2.0 cm - $190

11403 Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 2.1 to 3.0 cm - $217

11404 Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 3.1 to 4.0 cm - $248

11406 Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter over 4.0 cm - $351

11420 Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less - $141

11421 Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.6 to 1.0 cm - $176

11422 Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm - $198

11423 Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm - $225

11424 Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 3.1 to 4.0 cm - $258

11426 Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter over 4.0 cm - $366

11440 Excision, other benign lesion including margins (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.5 cm or less - $158

11441 Excision, other benign lesion including margins (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.6 to 1.0 cm - $192

11442 Excision, other benign lesion including margins (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 1.1 to 2.0 cm - $213

11443 Excision, other benign lesion including margins (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 2.1 to 3.0 cm - $250

11444 Excision, other benign lesion including margins (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 3.1 to 4.0 cm - $311

11446 Excision, other benign lesion including margins (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter over 4.0 cm - $422

EXCISION - MALIGNANT LESION

CPT Code Description

11600 Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 0.5 cm or less - $233

11601 Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 0.6 to 1.0 cm - $277

11602 Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 1.1 to 2.0 cm - $299

11603 Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 2.1 to 3.0 cm - $343

11604 Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 3.1 to 4.0 cm - $383

11606 Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter over 4.0 cm $552.83

11620 Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less - $235

11621 Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 0.6 to 1.0 cm - $279

11622 Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm - $310

11623 Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm - $365

11624 Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 3.1 to 4.0 cm - $412

11626 Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter over 4.0 cm - $500

11640 Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 0.5 cm or less - $243

11641 Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 0.6 to 1.0 cm - $288

11642 Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 1.1 to 2.0 cm - $328

11643 Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 2.1 to 3.0 cm - $389

11644 Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 3.1 to 4.0 cm $482

11646 Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter over 4.0 cm - $632

Don’t Forget The Soft Tissue Excision

You can use soft tissue excision codes for lipoma and other lesions not connected to epidermis

Keep in mind that these codes include an intermediate repair so you should only bill a separate repair if it is complex

Use code D48.1 or d49.2 to minimize denials

Codes as under or over 2 or 3 cm depending on location

- The smaller code actually covered more than the larger one: If you have very large sq masses you may be forced to use benign excision code in office setting

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Don't Forget The Soft Tissue Excision

Code				Setting
EXCISIONS				
21011	Tumor, soft tissue of face or scalp	Subcutaneous	Less than 2 cm	YES
21012			2 cm or greater	NO
21013		Subfascial	Less than 2 cm	YES
21014			2 cm or greater	NO
21555	Tumor, soft tissue of neck or anterior thorax	Subcutaneous	Less than 3 cm	YES
21552			3 cm or greater	NO
21556		Subfascial	Less than 5 cm	NO
21554			5 cm or greater	NO
[illegible]	tissue of back or flank	Subcutaneous	Less than 3 cm	YES
[illegible]			3 cm or greater	NO
[illegible]		Subfascial	Less than 5 cm	NO
[illegible]			5 cm or greater	NO
23075	Tumor, soft tissue of shoulder area	Subcutaneous	Less than 3 cm	YES
23071			3 cm or greater	NO
23076		Subfascial	Less than 5 cm	NO
23073			5 cm or greater	NO
24075	Tumor, soft tissue of upper arm or elbows area	Subcutaneous	Less than 3 cm	YES
24071			3 cm or greater	NO
24076		Subfascial	Less than 5 cm	NO
24073			5 cm or greater	NO
25075	Tumor, soft tissue of forearm and/or wrist area	Subcutaneous	Less than 3 cm	YES
25071			3 cm or greater	NO
25076		Subfascial	Less than 3 cm	NO
25073			3 cm or greater	NO
26115	Tumor or vascular malformation, soft tissue of hand or finger	Subcutaneous	Less than 1.5 cm	YES
26111			1.5 cm or greater	NO
26116		Subfascial	Less than 1.5 cm	NO
26113			1.5 cm or greater	NO
27047	Tumor, soft tissue of pelvis and hip area	Subcutaneous	Less than 3 cm	YES
27043			3 cm or greater	NO
27048		Subfascial	Less than 5 cm	NO
27045			5 cm or greater	NO
27327	Tumor, soft tissue of thigh or knee area	Subcutaneous	Less than 3 cm	YES
27337			3 cm or greater	NO
27328		Subfascial	Less than 5 cm	NO
27339			5 cm or greater	NO
27618	Tumor, soft tissue of leg (lower) or ankle area	Subcutaneous	Less than 3 cm	YES
27632			3 cm or greater	NO
27619		Subfascial	Less than 5 cm	NO
27634			5 cm or greater	NO
28043	Tumor, soft tissue of foot or toe	Subcutaneous	Less than 1.5 cm	YES
28039			1.5 cm or greater	YES
28045		Subfascial	Less than 1.5 cm	YES
28041			1.5 cm or greater	NO
BIOPSIES (EXCISIONAL)				
21550	Soft tissue of neck or thorax	N/A	N/A	YES
21920	Soft tissue of back or flank	Superficial	N/A	YES
21925		Deep		YES
23065	Soft tissue of shoulder area	Superficial	N/A	YES
23066		Deep		YES
24065	Soft tissue of upper arm or elbow area	Superficial	N/A	YES
24066		Deep		YES
25065	Soft tissue of forearm and/or wrist	Superficial	N/A	YES
25066		Deep		NO
27040	Soft tissue of pelvis and hip area	Superficial	N/A	YES
27041		Deep, subfascial or intramuscular		NO
27323	Soft tissue of thigh or knee area	Superficial	N/A	YES
27324		Deep, subfascial or intramuscular		NO
27613	Soft tissue of leg or ankle area	Superficial	N/A	YES
27614		Deep, subfascial or intramuscular		YES

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HS Excision

Cpt 11450 aka “excision of sweat gland lesion axilla”

11462 for “excision of sweat gland lesion inguinal”

11470 for “excision of skin and subcutaneous tissue for hidradenitis, perianal, perineal, or umbilical”

Should be billed under HS ICD L73.2 not d48.5

The size does not matter

Simple or intermediate repair is bundled

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Procedural Consultation

Biopsy or excision is a minor procedure: if no risk factors at all then is level 3 category but if patient at higher risk of bleeding based on anticoagulation or infection based on immunosuppression then may be a level 4

- This only matters if you are recommending the procedure for a future visit

- If recommending excision for future visit + patient have a risk factor of any sort then may be level 4 (especially if you explain benefits and risks of rx such as 5FU)

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Repairs

Higher risk for audit compared to other procedures

CLCs are under scrutiny; a 50/50 split of intermediate and complex repairs is reasonable

Don’t be the person billing 100% complex repairs and if you are then DOCUMENT, DOCUMENT, DOCUMENT

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Repairs

Classification – Intermediate Repairs

Scalp, axillae, trunk, extremities		Neck, hands, feet, external genitalia		Face, ears, eyelids, nose, lips, mucous membranes	
Code	**Length**	**Code**	**Length**	**Code**	**Length**
12031	2.5 cm or less	**12041**	2.5 cm or less	**12051**	2.5 cm or less
12032	2.6 cm to 7.5 cm	**12042**	2.6 cm to 7.5 cm	**12052**	2.6 cm to 5.0 cm
12034	7.6 cm to 12.5 cm	**12044**	7.6 cm to 12.5 cm	**12053**	5.1 cm to 7.5 cm
12035	12.6 cm to 20.0 cm	**12045**	12.6 cm to 20.0 cm	**12054**	7.6 cm to 12.5 cm
12036	20.1 cm to 30.0 cm	**12046**	20.1 cm to 30.0 cm	**12055**	12.6 cm to 20.0 cm
12037	Over 30.0 cm	**12047**	Over 30.0 cm	**12056**	20.1 cm to 30.0 cm
				12057	Over 30.0 cm

Codes are defined by;

- Three anatomic grouping categories
- Total length of repair

- When multiple intermediate repairs are performed
  - Only one code from each anatomic grouping can be reported

- In addition to simple repair of skin requires
  - Layered closure of deeper layers of subcutaneous tissue superficial fascia with limited undermining
- Or
  - A single layer closure of heavily contaminated wounds requiring extensive cleaning or removal of particulate matter
- Reportable in addition to biopsies and excision
  - with exception soft tissue biopsies and excisions (CPT code 20XXX series)

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Repairs

Classification – Complex Repairs

Trunk	Scalp, arms/legs	Forehead, cheeks, chin, mouth, neck axillae, genitalia, hands/feet	Eyelids, nose, ears, lips	Length of repair *(report repairs less than 1.1 cm as an intermediate repair)*
Code	**Code**	**Code**	**Code**	
13100	**13120**	**13131**	**13151**	1.1 cm to 2.5 cm
13101	**13121**	**13132**	**13152**	2.6 cm to 7.5 cm
+13102	**+13122**	**+13133**	**+13153**	each additional 5 cm

Codes are defined by;

- Four anatomic grouping categories
- Total length of repair

- When multiple complex repairs are performed
  - Only one code from each anatomicgrouping can be reported

- In addition to intermediate repair, requires at least one of the following
  - Extensive undermining
  - Involvement of free margins of helical rim, vermilion border, or nostril rim
  - Exposure of bone, cartilage, tendon or named neurovascular structure
  - Debridement of wound edges
  - Placement of retention sutures
- Reportable in addition to biopsies and excision

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Repairs

Most commonly complex repairs are for smaller lesions (under 2 cm) by undermining the diameter at least on one side

Repairing a laceration is also complex as long as you debride the wound edges

Retention suture is not strictly defined outside of "goal to remove tension from the epidermis of a closure" but possibilities are fascial plication vs. pulley stitch

Technically all cysts/lipomas removed through a small ellipse entail extensive undermining beyond the size of defect but this does not count

For purse string: diameter x 3.14 = length

Can use glue for tops and that counts as epidermal closure as do staples

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Don’t Forget Your Injections And 11 Blade

These procedures are both good for the patient in terms of favorable SE profile and covered if there is medical necessity

I&D and Intralesional injection

I&D

10040 Acne surgery, milia cyst drainage - $130

10060 Incision and drainage of abscess (carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single $155

10061 Incision and drainage of abscess (carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); complicated or multiple $235

10140 Incision and drainage of hematoma, seroma or fluid collection - $188

10160 Puncture aspiration of abscess, hematoma, bulla, or cyst - $140

Intralesional Injection

11900 - injection less than 7 - $65

11901- injection more than 7 - $85

96405 - Chemo intralesional up to 7 - $93

96406 - Chemo intralesional > 7 - $150

64650 -Chemodenerv eccrine glands - $98

Don’t forget J code for substance you are injecting!

J3301 = Kenalog 10 mg

J9190 = Fluorouracil

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I&D

Simple vs complex (would bill complex if requires breaking up loculations to drain however open to interpretation)

There is a special code for pilonidal cysts

Use 10140 code for any hematoma/Seroma/digital myxoid cyst

- Can use the 10140 code for nail unit hemorrhage also

Table 1

CPT Code	Description	MPFS Average Reimbursement
10080	Incision and drainage of pilonidal cyst; simple	$184.32
10081	Incision and drainage of pilonidal cyst; complicated	$276.48
21501	Incision and drainage, deep abscess or hematoma, soft tissues of neck or thorax	$465.83
23930	Incision and drainage, upper arm or elbow area; deep abscess or hematoma	$369.72
25028	Incision and drainage, forearm and/or wrist, deep abscess or hematoma	$543.59
26010	Drainage of finger abscess; simple	$272.88
26011	Drainage of finger abscess; complicated (eg, felon)	$402.48
26990	Incision and drainage, pelvis or hip joint area; deep abscess or hematoma	$649.43
27301	Incision and drainage, deep abscess, bursa, or hematoma, thigh or knee region	$696.23
27603	Incision and drainage, leg or ankle, deep abscess or hematoma	$545.75
42700	Incision and drainage, abscess; peritonsillar	$194.04
54700	Incision and drainage of epididymis, testis and/or scrotal space (eg, abscess or hematoma)	$222.84
56405	Incision and drainage of vulva or perineal abscess	$111.60
56420	Incision and drainage of Bartholin's gland abscess	$124.92
67000	Blepharotomy, drainage of abscess, eyelid	$276.48
69000	Drainage external ear, abscess or hematoma; simple	$190.80
69005	Drainage external ear, abscess or hematoma; complicated	$217.08
69020	Drainage external auditory canal, abscess	$234.36

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Coding for Administration of Injectables

Codes are defined by;

- Type of injection
  - Subcutaneous / intramuscular
  - Intralesional
- Purpose of administration
  - Therapeutic/prophylactic/diagnostic
  - Destruction
  - Antineoplastic

- Subcutaneous / Intramuscular administration
  - Reported once per "stick"
  - Report drug separately
- Intralesional administration
  - Reported based on number of lesions injected
- Payer policy determines coverage of administration
  - Check with payer for specific coverage

	CPT Code	Injection type
Other than antineoplastic administration	96372	Therapeutic, prophylactic, or diagnostic, subcutaneous or intramuscular
	11900	Intralesional; up to and including 7 lesions
	11901	more than 7 lesions
Antineoplastic administration	96401	Chemotherapy administration, subcutaneous or intramuscular; non-hormonal
	96405	Chemotherapy administration; intralesional, up to and including 7 lesions
	96406	more than 7 lesions

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Debridement

Skin and subcutaneous tissue - based on area size

Can use for chronic wounds or hypertrophic granulation tissue

Can be sharp like curette for wounds or loop electrocautery for granulation tissue

11042 – Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less +11045 – each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)

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New kid on the block - G2211

Add-on code for "complex care coordination" and reimburses around $18

"Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition"

Use for chronic conditions that require longitudinal care +/- co-management

Cannot be used in a visit with a 25 modifier

Certainly can use for conditions being treated with a biologic, advanced systemic, or other medication which requires "high risk medication monitoring" but many also using in our more basic conditions such as seb derm, rosacea, etc depending on severity and follow up schedule

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Modifiers

Everyone's FAVORITE!

Modifier 59 is typical for multiple procedures

- however if two procedures are coded the exact same eg destruction malignant on the cheek and then on the forehead for lesions in the same size class then you have to use the 76 modifier because the 59 alone will get rejected (common denial)

Modifier 58 is necessary for re-excision of a positive margin or unexpected finding within the global period or else it will be denied

- basically anything relating to the original procedure requiring further intervention within the global period

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