Billing and Coding Update

Alexander Miller, M.D.
AAD Representative to the AMA CPT Advisory Committee

October 13, 2018
New Skin Biopsy CPT® Codes

It’s all about the Technique!
SPEAKER:

Alexander Miller, M.D.
AAD Representative to the AMA-CPT Advisory Committee

Chair
AAD Health Care Finance Committee
Arriving on January 1, 2019

New and Restructured Biopsy Codes

Tangential biopsy

Punch Biopsy

Incisional Biopsy
How Did We Get Here?

**CMS CY 2016**

Biopsy codes (11100, 11101 identified as potentially mis-valued; high expenditure

**RUC Survey sent to AAD Members**

Specialty survey results are the only tool available to support code values

**Challenging survey results**

Survey revealed bimodal data distribution; respondents were valuing different procedures

CPT Codes 11100, 11101 referred to CPT for restructuring
Rationale for New Codes

11100; 11101

- Previous skin biopsy codes did not distinguish between the different biopsy techniques that were being used

CPT Recommended technique specification in new biopsy codes

- Will also provide for reimbursement commensurate with the technique used
How Did We Get Here?

**February 2017**
- CPT Editorial Panel deleted 11100; 11101
- 6 New codes created based on technique utilized
- Each technique: primary code and add-on code

**March 2017**
- RUC survey sent to AAD members

**April 2017**
- Survey results presented to the RUC
Biopsy Codes Effective Jan., 1, 2019

- Integumentary biopsy codes 11100, 11101 have been deleted.
- New Skin Biopsy codes: 11102 - 11107, skin only, does not include mucosa.
- Site-specific biopsy codes still applicable.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>11755</td>
<td>Biopsy of nail unit (plate, bed, matrix, hyponychium, proximal and lateral nail folds)</td>
</tr>
<tr>
<td>30100</td>
<td>Biopsy, intranasal</td>
</tr>
<tr>
<td>40490</td>
<td>Biopsy of lip mucosa</td>
</tr>
<tr>
<td>40808</td>
<td>Biopsy, vestibule of mouth</td>
</tr>
<tr>
<td>41100</td>
<td>Biopsy of tongue; anterior two-thirds</td>
</tr>
<tr>
<td>41105</td>
<td>Biopsy of tongue; posterior one-third</td>
</tr>
<tr>
<td>41108</td>
<td>Biopsy of floor of mouth</td>
</tr>
<tr>
<td>54100</td>
<td>Biopsy of penis</td>
</tr>
<tr>
<td>56605</td>
<td>Biopsy of vulva or perineum; 1 lesion</td>
</tr>
<tr>
<td>56606</td>
<td>Biopsy of vulva or perineum, each separate additional lesion</td>
</tr>
<tr>
<td>67810</td>
<td>Incisional biopsy of eyelid skin including lid margin</td>
</tr>
<tr>
<td>69100</td>
<td>Biopsy external ear</td>
</tr>
</tbody>
</table>

All remain unchanged.
**Definition:** Procedure to obtain tissue solely for histopathologic examination

- **Sampling** of a lesion

You want to know what it is on histopathology, so you biopsy it

- **Stratum corneum sampling by any method** (scraping, tape stripping) is **not a biopsy**
Skin Biopsy codes can be reported to indicate:

- that the procedure to obtain tissue was solely for diagnostic histopathologic examination;
- that the procedure was performed independently, or was unrelated or distinct from other procedures/services provided during the same encounter;
- biopsies performed on a different lesion or different site(s) on the same date of service may be reported separately as they are not considered components of other procedures.

During excisions, destructions, or shave removals, tissue submitted for histopathology is a routine component of such procedure(s) and is not reported separately.

Biopsies performed on a different lesion or different site(s) on the same date of service may be reported separately as they are not considered components of other procedures.
Code Criterion is Based on Technique

Biopsy technique is selected based on:

Optimal tissue sampling: consider type of neoplastic, inflammatory or other lesion requiring tissue diagnosis

Three distinct techniques:
three primary biopsy codes; three add-on codes
2019 Skin Biopsy Codes

11102
Tangential biopsy of skin, (eg, shave, scoop, saucerize, curette), single lesion

11103
each separate/additional lesion

11104
Punch biopsy of skin, (including simple closure when performed), single lesion

11105
each separate/additional lesion

11106
Incisional biopsy of skin (eg, wedge), (including simple closure when performed), single lesion

11107
each separate/additional lesion
<table>
<thead>
<tr>
<th>Tangential biopsy</th>
<th>Shave removal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intent</strong>: obtain tissue sample for diagnostic pathologic examination</td>
<td><strong>Intent</strong>: therapeutic removal of epidermal or epidermal-dermal lesion</td>
</tr>
<tr>
<td><strong>Instrument</strong>: sharp blade, such as scalpel, flexible blade, curette</td>
<td><strong>Instrument</strong>: removal with a sharp blade, such as scalpel, flexible blade</td>
</tr>
<tr>
<td><strong>Depth</strong>: may include epidermis only, or epidermis and dermis</td>
<td><strong>Depth</strong>: not through dermis</td>
</tr>
<tr>
<td><strong>Histopathologic tissue evaluation</strong>: always done</td>
<td><strong>Histopathologic tissue evaluation</strong>: may be done</td>
</tr>
<tr>
<td><strong>Two codes only</strong>: primary and add-on</td>
<td><strong>Code selection</strong>: determined by site and lesion size</td>
</tr>
<tr>
<td>Tangential biopsy</td>
<td>Shave removal</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>• Biopsy of an inflammatory dermatosis with the shave technique</td>
<td>• Cosmetic shave removal of an elevated nevus</td>
</tr>
<tr>
<td>• Biopsy of a large atypical pigmented lesion (saucerization or scoop biopsy technique, into deep dermis)</td>
<td>• Shave removal of irritated seborrheic keratosis, irritated nevus</td>
</tr>
<tr>
<td>• <strong>Intent:</strong> obtain an optimal tissue sample for histopathology</td>
<td>• <strong>Intent:</strong> to completely remove the lesion; or to completely remove the noxious portion of lesion</td>
</tr>
</tbody>
</table>
Punch Biopsy (11104, 11105)

**Intent:**
obtain tissue sample for diagnostic pathologic examination using punch instrument

**Full-thickness removal of a skin sample, including simple closure**
Punch penetrates through dermis into subdermal space

**Manipulation of the adjoining skin, such as removal of adjacent standing cones/Burow’s triangles/dog ears is included**

Histopathologic tissue evaluation always done

Two codes only: primary and add-on
11104 11105
Punch Biopsy Example

Punch defect: through dermis

Excision of standing cones included

Simple suturing included
Incisional Biopsy

- **Intent:** obtain tissue sample for diagnostic histopathologic examination
- **Instrument:** sharp blade (not a punch)
- **Depth:** full-thickness tissue sample:
  - penetrates into the subcutaneous space
  - May include large fat tissue sample, if required (eg, panniculitis)
- **Includes:** simple closure
- **Histopathologic evaluation:** always done
- **Two codes only:** primary and add-on

Excision, benign or malignant

- **Intent:** excision of entire lesion, with margins
- **Instrument:** sharp blade
- **Depth:** full-thickness, through dermis
- **Includes:** simple closure
- **Histopathologic evaluation:** usually done
- **Code selection determined by:**
  - Benign vs. Malignant
  - Location
  - Maximum excision diameter
<table>
<thead>
<tr>
<th>Incisional Biopsy</th>
<th>Biopsy, Soft Tissue</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intent:</strong> obtain tissue sample for diagnostic histopathologic examination</td>
<td><strong>Intent:</strong> sampling of tissues deep to skin: subcutaneous, subfascial, intramuscular</td>
</tr>
<tr>
<td><strong>Instrument:</strong> sharp blade (not a punch)</td>
<td><strong>Instrument:</strong> sharp blade</td>
</tr>
<tr>
<td><strong>Tissue sample:</strong> full-thickness skin</td>
<td><strong>Tissue sample:</strong> subcutaneous or subfascial or muscle</td>
</tr>
<tr>
<td>o penetrates into the subcutaneous space</td>
<td>o Skin may not be included</td>
</tr>
<tr>
<td>o Contains skin</td>
<td><strong>Includes:</strong> simple or intermediate repair</td>
</tr>
<tr>
<td>o May include large fat tissue sample, if required</td>
<td><strong>Histopathologic evaluation:</strong> always done</td>
</tr>
<tr>
<td><strong>Includes:</strong> simple closure</td>
<td><strong>Code selection determined by:</strong></td>
</tr>
<tr>
<td><strong>Histopathologic evaluation:</strong> always done</td>
<td>o Location</td>
</tr>
<tr>
<td><strong>Two codes only:</strong> primary and add-on</td>
<td>o Type of biopsy: superficial or deep</td>
</tr>
</tbody>
</table>
2018 vs. 2019 Biopsy Coding

2018

• First biopsy:
  11100
  ➢ each additional:  11101

2019

• First biopsy:
  11106: Incisional
  11104: Punch
  11102: Tangential
  ➢ each additional:
    11107: Incisional
    11105: Punch
    11103: Tangential
Biopsy Coding Hierarchies

- **Incisional biopsy 11106**
  - Additional incisional: 11107
  - Additional Punch: 11105
    - Additional tangential: 11103

- **Punch Biopsy 11104**
  - Additional punch: 11105
  - Additional tangential: 11103

- **Tangential Biopsy 11102**
  - Additional tangential: 11103
Single Technique Biopsy Coding Examples

**Tangential**

*Three tangential Bx:*
11102, 11103x2

**Punch**

*Three punch Bx:*
11104, 11105x2

**Incisional**

*Two incisional Bx:*
11106, 11107
Multiple Biopsies, Different Lesions or Sites

More than one biopsy with different techniques used for each additional lesion

List the highest value base (primary) code first

Additional biopsy add-on codes in order of highest to lowest value
<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Descriptor</th>
<th>Current work RVU</th>
<th>RUC work RVU</th>
<th>CMS work RVU</th>
<th>CMS time refinement</th>
</tr>
</thead>
<tbody>
<tr>
<td>11102</td>
<td>Tangential biopsy of skin, (eg, shave, scoop, saucerize, curette), single lesion</td>
<td>NEW 3 0.66</td>
<td>0.66</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>+11103</td>
<td>Tangential biopsy of skin, (eg, shave, scoop, saucerize, curette), each separate/additional lesion</td>
<td>NEW 0.38</td>
<td>0.29</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>11104</td>
<td>Punch biopsy of skin, (including simple closure when performed), single lesion</td>
<td>NEW 0.83</td>
<td>0.83</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>+11105</td>
<td>Punch biopsy of skin, (including simple closure when performed), each separate/additional lesion</td>
<td>NEW 0.45</td>
<td>0.45</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>11106</td>
<td>Incisional biopsy of skin (eg, wedge), (including simple closure when performed), single lesion</td>
<td>NEW 1.01</td>
<td>1.01</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>+11107</td>
<td>Incisional biopsy of skin (eg, wedge), (including simple closure when performed), each separate/additional lesion</td>
<td>NEW 0.54</td>
<td>0.54</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>
Multiple Biopsies of Different Lesions or Sites

- **Only one primary code is used**, regardless if multiple biopsy techniques used

- When multiple biopsies are done, use one primary code and add-on code(s) appropriate to the additional biopsy techniques used

- Incisional biopsy (11106) is always primary to other biopsy techniques

- Punch biopsy (11104) is always primary when shave biopsy also performed
# Multiple Techniques Biopsy Coding Examples

<table>
<thead>
<tr>
<th>One incisional, one punch, two tangential</th>
<th>Two punch, one tangential</th>
<th>One incisional, two tangential</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 11106 (incisional)</td>
<td>• 11104 (punch)</td>
<td>• 11106 (incisional)</td>
</tr>
<tr>
<td>• 11105 (punch)</td>
<td>• 11105 (punch)</td>
<td>• 11103 (tangential)</td>
</tr>
<tr>
<td>• 11103x2 (tangential)</td>
<td>• 11103 (tangential)</td>
<td>• 11103 (tangential)</td>
</tr>
</tbody>
</table>
# CMS 2019 Proposed RVUs

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
<th>RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>11102</td>
<td>Tangential</td>
<td>.66</td>
</tr>
<tr>
<td>11103</td>
<td>Tangential Add-On</td>
<td>.29 (RUC recommended .38)</td>
</tr>
<tr>
<td>11104</td>
<td>Punch</td>
<td>.83</td>
</tr>
<tr>
<td>11105</td>
<td>Punch Add-On</td>
<td>.45</td>
</tr>
<tr>
<td>11106</td>
<td>Incisional</td>
<td>1.01</td>
</tr>
<tr>
<td>11107</td>
<td>Incisional Add-On</td>
<td>.54</td>
</tr>
<tr>
<td><strong>11100</strong></td>
<td><strong>Deleted Biopsy</strong></td>
<td><strong>.81</strong></td>
</tr>
<tr>
<td><strong>11101</strong></td>
<td><strong>Deleted Biopsy Add-On</strong></td>
<td><strong>.41</strong></td>
</tr>
<tr>
<td>-----------------</td>
<td>-----------------------------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>11100</td>
<td>Biopsy of skin</td>
<td>0.81</td>
</tr>
<tr>
<td>11101</td>
<td>Biopsy of skin add-on</td>
<td>0.41</td>
</tr>
<tr>
<td>11102</td>
<td>Tangential bx skin single lesion</td>
<td>NA</td>
</tr>
<tr>
<td>11103</td>
<td>Tangential bx skin ea sep/addl</td>
<td>NA</td>
</tr>
<tr>
<td>11104</td>
<td>Punch bx skin single lesion</td>
<td>NA</td>
</tr>
<tr>
<td>11105</td>
<td>Punch bx skin ea sep/addl</td>
<td>NA</td>
</tr>
<tr>
<td>11106</td>
<td>Incisional bx skin single lesion</td>
<td>NA</td>
</tr>
<tr>
<td>11107</td>
<td>Incisional bx skin ea sep/addl</td>
<td>NA</td>
</tr>
</tbody>
</table>
National Correct Coding Edits

• Medically Unlikely Edits (MUEs) for the new biopsy codes have been determined
• Multiple procedures on the same date of service are still likely to be reduced under the multiple surgical reduction rule (MSRR)
  ➢ Add-on codes need not be further discounted
    ❖ However, payers can choose to discount payment for any reason in spite of CMS/NCCI guidelines
## 2019 NCCI Edits Examples

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Column 2</th>
<th>Column 1</th>
<th>Column 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Modifier</td>
<td></td>
<td>Modifier</td>
</tr>
<tr>
<td></td>
<td>0=Not Allowed</td>
<td>1=Allowed</td>
<td>9=Not Applicable</td>
</tr>
<tr>
<td>11442</td>
<td>•11102 1</td>
<td>17004</td>
<td>•11102 1</td>
</tr>
<tr>
<td>11442</td>
<td>•11104 1</td>
<td>17004</td>
<td>•11104 1</td>
</tr>
<tr>
<td>11442</td>
<td>•11106 1</td>
<td>17004</td>
<td>•11106 1</td>
</tr>
<tr>
<td>11602</td>
<td>•11102 1</td>
<td>17110</td>
<td>•11102 1</td>
</tr>
<tr>
<td>11602</td>
<td>•11104 1</td>
<td>17110</td>
<td>•11104 1</td>
</tr>
<tr>
<td>11602</td>
<td>•11106 1</td>
<td>17110</td>
<td>•11106 1</td>
</tr>
<tr>
<td>17000</td>
<td>•11102 1</td>
<td>17262</td>
<td>•11102 1</td>
</tr>
<tr>
<td>17000</td>
<td>•11104 1</td>
<td>17262</td>
<td>•11104 1</td>
</tr>
<tr>
<td>17000</td>
<td>•11106 1</td>
<td>17262</td>
<td>•11106 1</td>
</tr>
<tr>
<td>HCPCS/CPT Code</td>
<td>Practitioner Services MUE Values</td>
<td>MUE Adjudication Indicator (MAI)</td>
<td>MUE Rationale</td>
</tr>
<tr>
<td>----------------</td>
<td>----------------------------------</td>
<td>----------------------------------</td>
<td>---------------</td>
</tr>
<tr>
<td>11102</td>
<td>1</td>
<td>2 Date of Service Edit</td>
<td>Date of Service Edit</td>
</tr>
<tr>
<td>+11103</td>
<td>6</td>
<td>3 Date of Service Edit</td>
<td>Date of Service Edit</td>
</tr>
<tr>
<td>11104</td>
<td>1</td>
<td>2 Date of Service Edit</td>
<td>Date of Service Edit</td>
</tr>
<tr>
<td>+11105</td>
<td>3</td>
<td>3 Date of Service Edit</td>
<td>Date of Service Edit</td>
</tr>
<tr>
<td>11106</td>
<td>1</td>
<td>2 Date of Service Edit</td>
<td>Date of Service Edit</td>
</tr>
<tr>
<td>+11107</td>
<td>2</td>
<td>3 Date of Service Edit</td>
<td>Date of Service Edit</td>
</tr>
</tbody>
</table>

MAI = 2  Based on policy;  not appealable
MAI = 3  Based on “clinical benchmarks;” appealable
<table>
<thead>
<tr>
<th>MAI</th>
<th>Impact on Claim</th>
<th>Edit Rationale</th>
</tr>
</thead>
</table>
| 1   | CLAIM LINE EDIT | • These are “claim line edits”  
• Based on CPT code descriptor and is not appealable |
| 2   | DATE OF SERVICE EDIT: POLICY | • These are “per day edits based on policy”  
• Rigorously reviewed and vetted within CMS  
• MAI designation because UOS on the same date of service (DOS) in excess of the MUE value would be considered impossible because it was contrary to statute, regulation or subregulatory guidance.  
• This subregulatory guidance includes clear correct coding policy that is binding on both providers and CMS claims processing contractors.  
• Limitations created by anatomical or coding limitations are incorporated in correct coding policy, both in the HIPAA mandated coding descriptors and CMS approved coding guidance as well as specific guidance in CMS and NCCI manuals.) |
| 3   | DATE OF SERVICE EDIT: CLINICAL | • These are “per day edits based on clinical benchmarks”.  
• If claim denials based on these edits are appealed, contractors may pay UOS in excess of the MUE value if there is adequate documentation of medical necessity of correctly reported units.  
• If contractors have pre-payment evidence (e.g. medical review) that UOS in excess of the MUE value were actually provided, were correctly coded and were medically necessary, the contractor may bypass the MUE for a HCPCS/CPT code with an MAI of “3” during claim processing, reopening or redetermination, or in response to effectuation instructions from a reconsideration or higher level appeal.) |
Questions/More Information

Faith McNicholas
fmcnicholas@aad.org

Peggy Eiden
peiden@aad.org

Cynthia Stewart
cstewart@aad.org
Is this a:

- **Simple repair**
- Intermediate repair
- Complex repair

Simple repair...” requires simple one layer closure.” (CPT 2018)
Intermediate Repair

- Layered closure
- Undermining not required
Complex Repair

Excision of standing cones (Burow triangles, dog ears) **does not justify** a complex repair code.

“Note: Dog ears/Burow's triangles may be included as a part of the complex repair.”

*CPT Assistant*  
August 2006, pg 1

**Complex repair**

- Layered closure plus
- “extensive” undermining, retention sutures, scar revision, debridement (for traumatic lacerations, avulsions)
- **Nothing** is said in CPT about standing cone removal
- Excision of standing cones lengthens the line of closure
- Complex repair codes are stratified via location and length
Excision of redundant skin triangles to generate a fusiform shape for repair does not make it a complex repair.

Why doesn’t the CPT define extensive undermining?
Extensive undermining **DOES NOT** mean Any undermining
CPT®: “Sum of lengths of repairs for each group of anatomic sites.”

Repair, complex, scalp, arms, and/or legs;
Complex Repairs: CPT 13100-13153

Retention Sutures are used to reinforce a single layer closure of atrophic, fragile skin that is unable to support buried dermal sutures.
Modifier 25: Undergoing Insurer Scrutiny and attempts at payment reductions

CPT®: Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service

- Patient’s condition required a significant, separately identifiable E/M
- Service is above and beyond usual preoperative and postoperative care included in a procedure
- Substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported
- E/M service may be prompted by the symptom or condition for which the procedure was provided
- Separate diagnoses are not required
- Service needs to be reasonable and necessary
What is Included in a procedural CPT® code?

• Evaluation of a specific lesion for which a procedure is done
• Decision to perform a minor surgical procedure (0 and 10 day global)
• Certain elements of history pertaining to the lesion for which a procedure is done
• Usual, uncomplicated preoperative evaluation
• Usual, uncomplicated postoperative care
An established patient comes in with a complaint of an asymptomatic, growing plaque on his nose. You generate a differential diagnosis of BCC, adnexal tumor or granulomatous disease. You proceed to biopsy the lesion.

You submit the following billing:

A) Biopsy, 11100 and E/M, 99213
B) Biopsy 11100
C) Biopsy 11100 and E/M 99213.25
D) Biopsy 11100 and E/M 99212.25
E) Biopsy 11100.59 and E/M 99213
What is included in biopsy valuation?

**CPT 11100 (biopsy)**

**Pre-service:** one obtains a pertinent history including previous skin cancer, prior treatments, and sun protection. Indications for the biopsy, expected benefits, and a description of the procedure and its risks are discussed. Consent is obtained and the biopsy tray is prepared.

**Intra-service:** selection of the optimal biopsy site and lesion inspection and palpation, and then the biopsy procedure itself from start to bandaging.

**Post-service:** patient instruction on care and follow-up, charting, and communication with any referring physician.
An established patient comes in with a complaint of an asymptomatic, growing plaque on his nose. You generate a differential diagnosis of BCC, adnexal tumor or granulomatous disease. You proceed to biopsy the lesion.

You submit the following billing:

**Biopsy 11100**

Why only 11100?

*The evaluation focused only upon the biopsied lesion. No other work beyond that included in the 11100 biopsy valuation was done.*
What is included in procedure valuation?

CPT 17260 -17286 (malignant lesion destructions)

**Pre-service:** review of pertinent medical records data, followed by discussion of the treatment options and risks. Obtain informed consent and have the necessary procedure tray prepared.

**Intra-service:** the lesion is inspected, palpated, and its size, location, functional risks, and depth are recorded. Anesthetic is administered and the procedure is done.

**Post-service:** antibiotic ointment and any dressing are applied and pertinent instructions are given. Recurrence risks and the need for follow-up are discussed. Charting, any operative note report, and communication with a referring physician are included.
What is included in procedure valuation?

CPT 17000 and 17110 series (destruction)

*Pre-service (before the destruction is done) work:* includes a review of pertinent medical records data, a discussion of treatment choices, a review of risks of the treatment with the patient, obtaining informed consent, and preparation of necessary equipment.

*Intra-service work:* inspection and palpation of lesions to establish a diagnosis and to specify size, location, depth, and then the actual destruction with liquid nitrogen freezing.

*Post-service work:* application of any antibiotic ointment and dressings, if needed, and post-procedure patient and family instructions. Charting and any communication with a referring physician are included in this work.
“Moreover, where the decision to perform the minor procedure is typically done immediately before the service, it is considered a routine preoperative service and a visit or consultation is not billed in addition to the procedure.”

Medicare Claims Processing Manual, Chapter 12, Section 40.1
Conclusion: all procedures have some built-in E&M component

- The procedure’s E&M component must be separated from any additional E&M provided in order to determine qualification for .25 modifier use and the level of any additional E&M to be billed.

You evaluate a new patient with a history of malignant melanoma. You take a history, do a review of systems, do a complete skin examination plus lips, oral mucosa, conjunctivae, palpate lymph node basins and identify a clinically atypical pigmented lesion on the arm that you excise.

You bill:

A) Excision and repair codes + 99203 E/M code
B) Excision and repair codes only
C) **Excision and repair + 99203.25 E/M code***
D) 99203 only, and schedule the excision for another day, as E/M done on same day as procedure is never covered

Why? Significant, separately identifiable, medically indicated (and documented) service was done beyond that inherent in the excision.

*Some Medicare contractors (e.g., Noridian) do not require appending .25 to a New patient E/M.
How to determine a level of E/M separate from that of a concurrently done procedure?

- Subtract all E/M included in the procedure from the total E/M done
- What is left determines level of potentially billable E/M
- Reminder: the separate service should be reasonable and necessary

You evaluate a new patient with a history of malignant melanoma. You take a history, do a review of systems, do a complete skin examination, palpate nodes and identify a clinically atypical pigmented lesion on the arm that you excise.

<table>
<thead>
<tr>
<th>Nevus E/M Overlap</th>
<th>Separate E/M Related to Chief Complaint: History of melanoma</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examination of atypical nevus, discussion of removal need, plan, care</td>
<td>History, including past melanoma, treatments, interim changes, complaints; Family history Review of systems Complete skin examination and inspection of lips, oral mucosa, eyes, nails Palpation of lymph node basins Discussion of melanoma risks, vigilance and prevention strategies</td>
</tr>
</tbody>
</table>
A patient is referred to you for Mohs surgery. You review pertinent history, evaluate a nasal biopsy-proven BCC and do a 3 stage Mohs excision. You refer the patient out for repair of the defect.

You bill:

A) Mohs surgery first and 2-3 stages: 17311, 17312x2

B) 17311, 17312x2 and 99202.25

C) 17311, 17312x2 and 99202.57

“The initial evaluation focused upon the lesion being treated is usually included in the allowance for a minor surgical procedure.” AAD “Audits on Modifier 25 are Coming” webinar 12/13/2017

Mohs surgery alone is a minor surgical procedure: 0 day global period
# Global Surgical Periods

<table>
<thead>
<tr>
<th>0 Days: Minor Procedure</th>
<th>10 Days: Minor Procedure</th>
<th>90 Days: Major Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biopsy (11100…)</td>
<td>Destruction (17000 - 17286)</td>
<td>Flaps</td>
</tr>
<tr>
<td>Shave removal (11300 – 11313)</td>
<td>Excisions (11400 – 11646)</td>
<td>Grafts</td>
</tr>
<tr>
<td>Debridement (11000, 11011-42)</td>
<td>Repairs (12001 – 13153)</td>
<td>Tissue Expanders</td>
</tr>
<tr>
<td>Mohs (17311 – 17315)</td>
<td></td>
<td>Destruction of Vascular Proliferative Lesion (17106 – 08)</td>
</tr>
</tbody>
</table>

*No modifier is needed when an E/M or a surgical service is done at any day following a zero day global surgical procedure.*
Most Common Modifiers Used During the Global Period

24: Unrelated E/M Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period

25: Significant, Separately Identifiable E/M Service by the Same Physician Or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service

57: Decision for Surgery (refers to E/M service resulting in a decision to perform a 90 day global surgery the day of or day after the evaluation)

79: Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period

58: Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period
Global Surgical Package

• Includes all normal/usual preoperative, intraoperative and postoperative services
• Included postoperative services are limited to the global period
• Payment for the procedure includes usual services within the global period, including wound care/checks and suture removal
• The global period applies to both the surgeon and to physicians of the same specialty in a group practice who may do postoperative care for the patient
Group Practice and Surgical Follow-up

- When services are furnished by a physician of the same specialty within a group practice the services are considered part of the global surgical package. Separate coding/billing is not appropriate.

- If the patient were new to a physician of a different specialty within the group practice or the physician of any specialty were independent of the group practice, then an appropriate E/M office visit would be billable.

## Services included in Global Package

<table>
<thead>
<tr>
<th>Included</th>
<th>Not Included</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Initial evaluation to determine 0 or 10 day global procedure need</td>
<td>• Initial evaluation to determine 90 day global surgery need</td>
</tr>
<tr>
<td>• Treatment of complications not requiring operating room care</td>
<td>• Treatment of complications <em>in the operating room</em></td>
</tr>
<tr>
<td>• Postop visits related to surgery</td>
<td>• Visits unrelated to the diagnosis leading to the surgical procedure</td>
</tr>
<tr>
<td>• Pain management</td>
<td>• Additional treatment unrelated to the surgery</td>
</tr>
<tr>
<td>• Routine surgical site care:</td>
<td>• Staged procedures</td>
</tr>
<tr>
<td>– Dressing changes</td>
<td>• Unrelated procedures</td>
</tr>
<tr>
<td>– Sutures/staples removal</td>
<td></td>
</tr>
</tbody>
</table>


Medicare definition: Operating/Procedure Room

“A place of service specifically equipped and staffed for the sole purpose of performing procedures”

<table>
<thead>
<tr>
<th>OR/Procedure Room</th>
<th>NOT OR/Procedure Room</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Room exclusively used and staffed for procedures/surgeries</td>
<td>• Patient examination room</td>
</tr>
<tr>
<td>• Laser suite</td>
<td>• Multipurpose patient treatment room</td>
</tr>
<tr>
<td>• Your office procedure/surgery room if it meets the definition</td>
<td>• Any location not used exclusively for doing procedures/surgeries</td>
</tr>
</tbody>
</table>

Conclusion: if a postoperative complication requires surgical treatment in the office setting, and that treatment is done in a room used exclusively for procedures/surgeries, then that treatment is billable with an appended .78 modifier.
Steps for Optimal Coding

• Determine level of E/M service &/or Procedure type(s)
• Correlate ICD-10 diagnoses with CPT codes
• Select Modifiers if needed
• Document appropriately to justify billing
CPT and ICD-10 Codes

Correlate CPT code with corresponding ICD-10 code(s)

Example:
Established patient with history of melanoma, evaluated for several lesions
Evaluation established diagnosis, treatment and plan for the following:

<table>
<thead>
<tr>
<th>Dx and Service</th>
<th>CPT Code</th>
<th>ICD-10 Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>H/O MM: Hx, ROS, complete skin exam, nodal palpation, discussion</td>
<td>99213</td>
<td>Z85.820 (Personal Hx MM) L82.1 (SKs found)</td>
</tr>
<tr>
<td>Actinic keratoses</td>
<td>17000, 17003 (or 17004) (destruc.)</td>
<td>L57.0</td>
</tr>
<tr>
<td>BCC, on back</td>
<td>17261 (desctruc., malig., 0.6-1 cm)</td>
<td>C44.519</td>
</tr>
<tr>
<td>Atypical nevus, on chest</td>
<td>11100 (biopsy)</td>
<td>D48.5 (neoplasm, uncertain behav.)</td>
</tr>
</tbody>
</table>

Append modifiers as appropriate
Next step:

- Modifier needed?
- If two or more procedures are done, which one(s) qualify for a modifier?
  - Which codes are primary (no modifier), and which qualify for a modifier?

Multiple procedures: consult National Correct Coding Initiative (NCCI):

- Procedure-to-procedure (PTP or column 1/2) edits
- Medically Unlikely Edits (MUE)
The purpose of the NCCI Procedure-to-Procedure (PTP) edits is to prevent improper payment when incorrect code combinations are reported. The NCCI contains one table of edits for physicians/practitioners and one table of edits for outpatient hospital services. The Column One/Column Two Correct Coding Edits table and the Mutually Exclusive Edits table have been combined into one table and include PTP code pairs that should not be reported together for a number of reasons explained in the Coding Policy Manual. The purpose of the NCCI MUE program is to prevent improper payments when services are reported with incorrect units of service.

https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html

Updated quarterly
# NCCI PTP Example: destruction codes

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
<th>I</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Column 1</td>
<td>Column 2</td>
<td>* = in existence prior to 1996</td>
<td>Effective Date</td>
<td>Deletion Date</td>
<td>Modifier</td>
<td>PTP Edit Rationale</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0 = not allowed</td>
<td>1 = allowed</td>
<td>9 = not applicable</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>* = no data</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>239752</td>
<td>17000</td>
<td>17261</td>
<td>20140701</td>
<td>*</td>
<td>1</td>
<td>Mutually exclusive procedures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>239753</td>
<td>17000</td>
<td>17262</td>
<td>19990401</td>
<td>20050101</td>
<td>1</td>
<td>Mutually exclusive procedures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>239754</td>
<td>17000</td>
<td>17262</td>
<td>20140701</td>
<td>*</td>
<td>1</td>
<td>Mutually exclusive procedures</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Primary code**: Row 1 column A
- **Secondary Code (append modifier)**: Row 1 column B
- **1 = Modifier allowed, both paired payable with modifier (59 &/or 76)**
NCCI PTP Example: Destruction/Biopsy

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Column 2</th>
<th>* = in existence prior to 1996</th>
<th>Effective Date</th>
<th>Deletion Date</th>
<th>Modifier</th>
<th>PTP Edit Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>242543</td>
<td>17261</td>
<td>11100</td>
<td>19970101</td>
<td>*</td>
<td>1</td>
<td>CPT Manual or CMS manual coding instructions</td>
</tr>
<tr>
<td>242544</td>
<td>17261</td>
<td>11600</td>
<td>19960101</td>
<td>*</td>
<td>1</td>
<td>Mutually exclusive procedures</td>
</tr>
<tr>
<td>242545</td>
<td>17261</td>
<td>11601</td>
<td>19960101</td>
<td>*</td>
<td>1</td>
<td>Mutually exclusive procedures</td>
</tr>
</tbody>
</table>

- **Primary code**
- **Secondary Code (append modifier)**
- **1 = Modifier allowed, both paired payable with modifier 59 &/or 76**
You freeze 5 actinic keratoses with liquid nitrogen, biopsy two atypical nevi, one on the back and the other, on the abdomen, and destroy a 1.2 cm wide superficial basal cell carcinoma on the chest with curetting and electrodessication.

Per NCCI PTP edits,
• 17000, 17004 are column 1 codes
• 17562 and 11100 are column 2 codes
• 11101 is not listed in column 2

Conclusion:
• 17000, 17004 are primary to both malignant destruction and to biopsy codes (and to shave removal codes, as well)
• Append .59 modifier to biopsy and malignant destruction codes paired with destruction of actinic keratoses
• **Add-on codes (i.e., 11101, 17003) do not require a .59 modifier**
8 stages of Mohs done on Medicare patient. Your MAC is likely to pay for:

A. All 8 stages, CPT 17311 and 17312x7
B. Only 4 stages, CPT 17311 and 17312x3
C. Only 5 stages, CPT 17311 and 17312x4
D. Only 6 stages, CPT 17311 and 17312x5
E. Only 7 stages, CPT 17311 and 17312x6
Answer: E, Only 7 stages

Why? NCCI Medically Unlikely Edits (MUE)
- Accessible on NCCI website.
- MUE table lists CPT codes, MUE value and MAI number (1, 2 or 3)

https://www.cms.gov/Medicare/Coding/NationalCorrectCodingInitEd/index.html
MUE and MAI for Mohs Surgery

<table>
<thead>
<tr>
<th>HCPCS/</th>
<th>Practitioner Services MUE Values</th>
<th>MUE Adjudication Indicator</th>
<th>MUE Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>644</td>
<td>17311</td>
<td>4</td>
<td>3 Date of Service Edit: Clinical</td>
</tr>
<tr>
<td>645</td>
<td>17312</td>
<td>6</td>
<td>3 Date of Service Edit: Clinical</td>
</tr>
<tr>
<td>646</td>
<td>17313</td>
<td>3</td>
<td>3 Date of Service Edit: Clinical</td>
</tr>
<tr>
<td>647</td>
<td>17314</td>
<td>4</td>
<td>3 Date of Service Edit: Clinical</td>
</tr>
<tr>
<td>648</td>
<td>17315</td>
<td>15</td>
<td>3 Date of Service Edit: Clinical</td>
</tr>
</tbody>
</table>

MUE for 17312 is 6, meaning 6 stages
MAI for 17312 is 3, meaning a date of serviced edit

When the MAI is 3, one may appeal an unpaid claim via a redetermination, and the appeal should be upheld as long as:
• The service was provided
• The service was correctly coded
• The service was medically necessary
“Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances.”
“However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.”

(color accent added)
Practical -59 Modifier Guidelines

• Two or more procedures done during one patient encounter:
  – Look up NCCI edits
  – Determine whether both may be payable if a modifier is used
  – Determine the primary code (Column 1 in NCCI)
  – Determine the secondary code (Column 2 in NCCI)
    • If secondary code has a modifier indicator of 1, then a modifier can be used to bypass the NCCI edit
  – Append -59 &/or -76 modifier to secondary code
“Duplicate” procedures coding

- **Modifier –76** should be appended to procedure(s) or surgical service(s) to indicate a repeat procedure/surgery was performed on the same day for patient management purposes.
  - eg, 11401, 11401.76

- **Modifier –91** should be appended to laboratory procedure(s) or service(s) to indicate a repeat test or procedure performed on the same day for patient management purposes.
  - eg, 88305, 88305.91
Modifier .76 and .91 Use

• Two basal cell carcinomas destroyed: cheek and forehead, 0.7 and 0.6 cm diam.
  – Previously code:
    • 17281, 17281.59
    • **Now code:** 17281, 17281.76

• Histopathology dx. for above lesions:
  – Basal cell carcinoma, cheek & BCC, forehead
  – Previously code:
    • 88305.26, 88305.26
    • **Now code:** 88305.26, 88305.26.91
Correct -59 Modifier Use

<table>
<thead>
<tr>
<th>CPT</th>
<th>Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>99213</td>
<td>25</td>
</tr>
<tr>
<td>11100</td>
<td>59</td>
</tr>
<tr>
<td>11101</td>
<td></td>
</tr>
<tr>
<td>17004</td>
<td></td>
</tr>
</tbody>
</table>

Keep track: does your MAC follow the above NCCI guideline conventions? It may not!
According to the NCCI, 17000 is the Column 1 code and does not need a modifier. 11100 is in Column 2, and would be bundled into the 17000 code, resulting in no payment for the service, unless one uses a modifier appended to 11100. 17003 is an add-on code to 17000 and does not require a modifier.
MLN Matters® MM8863

- -59 is most used modifier
- “Associated with considerable abuse
- ...and high levels of manual audit activity;
- ...leading to reviews, appeals and even civil fraud and abuse cases.”
The CMS Reaction

• Educational initiatives
• Requirement for use of .76 and .91 in lieu of .59 in special circumstances
• Introduction of XE, XS, XP, XU modifiers

TAKE ACTION
Medicare HCPCS Modifiers

- **XE** Separate Encounter, A Service That is Distinct
  - Because It Occurred During A Separate Encounter

- **XS** Separate Structure, A Service That Is Distinct
  - Because It was Performed On A Separate Organ/Structure

- **XP** Separate Practitioner, A Service That Is Distinct
  - Because It Was Performed By A Different Practitioner

- **XU** Unusual Non-Overlapping Service, The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service
“Please note that providers may continue to use the -59 modifier after January 1, 2015, in any instance in which it was correctly used prior to January 1, 2015. The initial CR establishing the modifiers was designed to inform system developers that healthcare systems would need to accommodate the new modifiers. Additional guidance and education as to the appropriate use of the new –X {EPSU} modifiers will be forthcoming as CMS continues to introduce the modifiers in a gradual and controlled fashion. That guidance will include additional descriptive information about the new modifiers. CMS will identify situations in which a specific –X {EPSU} modifier will be required and will publish specific guidance before implementing edits or audits.”

MLN Matters® Number: SE1503 (February, 2015)
Related Change Request Number: 8863
“If it ain’t broke, don’t fix it”