AAPC

CPCD®

Certified Professional Coder in Dermatology

STUDY GUIDE

2026

2026

Specialty Study Guide: CPCD®

DERMATOLOGY

AAPC

Contents

2026 Specialty Study Guide: CPCD® Introduction

The *Specialty Study Guide: CPCD®* is designed to help dermatology coders, billers, and other medical office professionals prepare for the CPCD® examination. This guide is by no means comprehensive. Your primary resource for the exam will be your years of hands-on experience in coding for dermatology services.

Healthcare in the 21st century is complex and requires expertise in proper coding to obtain payment for procedures, services, equipment, and supplies. Becoming a CPCD® shows your expertise in dermatology coding. Membership in AAPC lends integrity to your credentials and provides a large network of coders for support and allows you access to continuing education opportunities. The *Specialty Study Guide: CPCD®* is designed to provide an overall review of coding and compliance information for the more experienced coder, as well as for someone preparing for the CPCD® examination.

We will review the importance of using the coding guidelines within ICD-10-CM and CPT® as well as emphasize the importance of correct Evaluation and Management (E/M) leveling. You will need 2026 versions of ICD-10-CM, CPT®, and HCPCS Level II code books. These are the books you will need for the study guide and the CPCD® exam, as well.

ICD-10-CM Coding

Proper diagnostic coding not only reports the medical necessity of procedures performed, but also contributes to data that determines health policies for tomorrow. Because physicians have traditionally been paid by CPT® code values, coders have sometimes given little importance to correct ICD-10-CM coding. Regulatory trends show that diagnoses will play a larger role in reimbursement in the future. It is important to code correctly so you are prepared for that day.

We will discuss the major topics of diagnosis coding for dermatology. The examinee must become familiar with the *ICD-10-CM Official Guidelines for Coding and Reporting*. The examinee must know how to select the appropriate ICD-10-CM codes as well as the proper sequencing of diagnosis codes when more than one diagnosis code is required to report a patient's condition(s). Understand the conventions, general coding guidelines and chapter specific guidelines in the ICD-10-CM code book.

Evaluation and Management Coding

Office visits consume a lion's share of the physician's time in most practices, and consequently represent the largest revenue source. Compliance is an increasing concern at practices, and the E/M material will focus on the E/M services for dermatology and underscore the importance of modifier use. An understanding of the AMA E/M guidelines and subsection notes is an important foundation for accurate code selection that is provided in your CPT® code book.

An E/M calculator is provided for the online exam (https://www.aapc.com/codes/em-calculator) and your CPT® code book provides a Medical Decision Making (MDM) table to level an E/M service.

CPT® Coding

Surgical procedures specific to dermatology will be discussed in this section. Special attention will be given to the guidelines and parenthetical phrases associated with procedures. Understanding CPT® coding conventions will be helpful as well. The examinee must be able to select the appropriate CPT® codes and sequence the codes correctly when multiple procedures are performed. CPT® codes are sequenced based on the most complex or labor-intensive procedures. The codes with the highest RVUs (Relative Value Units) are sequenced first.

Top 10 Missed Coding Concepts

We will review the top 10 missed coding concepts for the CPCD® certification exam. The list is not presented in any specific order. The information is determined after an evaluation by AAPC's exam department of the commonly missed questions on the exam.

Practice Exam

The practice exam and the exam itself were written by coders with extensive experience in dermatology. The practice exam mimics the format and structure of the CPCD® certification exam.

AAPC has developed specialty credentials to enable coders to demonstrate superior levels of expertise in their respective specialty disciplines. Here is information on the CPCD® credential:

- CPCD® stands alone as a certification with no prerequisite that the examinee holds a CPC®, COC®, or CIC® credential.

- Exams aptly measure preparedness for "real world" coding by being entirely operative/physician-note based. These operative (op) notes are redacted op notes from real dermatology practices.

The CPCD® examination tests your knowledge of coding concepts, anatomic principles, and coding guidelines only. When you take this exam, remember that individual payer rules are not a consideration when choosing the right answer. Unless it is specifically stated in the case note or exam question that the patient is covered by Medicare, you should follow the CPT® coding guidelines.

The exam tests competency. The candidate most qualified to pass the exam will be proficient in understanding:

- Medical terminology and anatomy
- Medical physiology
- Teaching physician guidelines
- Incident-to guidelines
- Split/Shared services
- HIPAA regulations
- Proper use of an Advance Beneficiary Notice (ABN)
- ICD-10-CM coding
- E/M code selection using the AMA CPT® E/M guidelines
- CPT® coding for common procedures
  - 10000 Series
  - 20000 Series
  - 40000 Series
  - Laboratory and Pathology
  - Radiology
  - Medicine
  - Category III codes
- CPT® and HCPCS Level II modifier usage
- HCPCS Level II coding

Familiarity with practical coding and the coding books is essential, as time is an important element in successfully completing the exam. Approach the exam as you would approach your work—by demonstrating coding abilities essential to success. This is not a general aptitude test, and each question has a specific goal for measuring your competency. The practice exam within the *Specialty Study Guide: CPCD®* course is highly representative of the subject matter and level of difficulty you will encounter in the full-length exam.

Test Answers and Rationales

The final chapter in the book contains the answers to the practice exam. Accompanying each answer is a rationale that explains the coding guidelines contributing to selecting the right answer. These rationales should help you understand what is needed to successfully approach and answer questions on the real exam, because they allow you a glimpse into the minds of the test's creators.

Examinees passing the CPCD® certification examinations will receive recognition in AAPC's monthly magazine *Healthcare Business Monthly* and receive a diploma suitable for framing.

About AAPC

AAPC was founded in 1988 in an effort to elevate the standards of medical coding by providing training, certification, ongoing education, networking, and recognition.

AAPC provides medical coding certification exams for coders in physician practices and the outpatient/facility environment. AAPC has expanded beyond outpatient coding to include training and credentials in documentation and coding audits, inpatient hospital/facility coding, regulatory compliance, and physician practice management. The purpose of AAPC coding certifications is to test an examinee's knowledge of coding principles and proficiency in coding accurately and efficiently. AAPC examinations measure a coder's skill of both coding accuracy and efficiency.

AAPC Member Code of Ethics

Members of AAPC shall be dedicated to providing the highest standard of professional service for the betterment of healthcare to employers, clients, vendors, and patients. Professional and personal behavior of AAPC members must be exemplary.

It shall be the responsibility of every AAPC member, as a condition of continued membership, to conduct themselves in all professional activities in a manner consistent with ALL of the following ethical principles of professional conduct:

- Integrity
- Respect
- Commitment
- Competence
- Fairness
- Responsibility

Adherence to these ethical standards assists in assuring public confidence in the integrity and professionalism of AAPC members. Failure to conform professional conduct to these ethical standards, as determined by AAPC's Ethics Committee, may result in the loss of membership with AAPC.

Introduction to ICD-10-CM Coding Guidelines

The National Center for Health Statistics (NCHS) developed ICD-10-CM (International Classification of Diseases, 10th Revision, Clinical Modification) in consultation with a technical advisory panel, physician groups, and clinical coders to assure clinical accuracy and utility. ICD-10-CM coding guidelines are developed by the Centers for Medicare & Medicaid Services (CMS) and the NCHS. Healthcare providers must begin using the most recent ICD-10-CM code revisions on October 1 of each year, with no "grace period" to transition to the changes.

All versions of the ICD-10-CM code book typically include the *ICD-10-CM Official Guidelines for Coding and Reporting*. These guidelines are an invaluable source for diagnosis coding information and provide instruction supplemental to that found in ICD-10-CM Alphabetic Index and Tabular List of the ICD-10-CM code book.

ICD-10-CM codes are "utilized to facilitate payment of health services, to evaluate utilization patterns, and to study the appropriateness of healthcare costs," according to the Official Guidelines. Ongoing, case-by-case success in achieving these goals requires an open line of communication between the coder and the documenting physician.

The Official Guidelines note, "A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures." Each ICD-10-CM code assigned must be supported by documentation linked to that particular claim (individual dates of service must "stand alone"), and coders must be mindful not to assume or extrapolate information from the medical record (for instance, coding a condition as "acute" when it isn't documented as such).

The Official Guidelines are divided into four sections:

- Section I lists ICD-10-CM Conventions, General Coding Guidelines, and Chapter Specific Guidelines.
- Section II explains the Selection of Principal Diagnosis. The Uniform Hospital Discharge Data Set (UHDDS) defines the principal diagnosis as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."
- Section III gives rules for Reporting Additional Diagnoses (diagnoses, in addition to the principal diagnosis, that affect the patient's care).
- Section IV provides Diagnostic Coding and Reporting Guidelines for Outpatient Services. These include information about coding signs and symptoms, when to report chronic diagnoses, the use of 4th and 5th code digits, ambulatory surgery, routine outpatient prenatal visits, and more.

General Tips for Using ICD-10-CM

Use the Alphabetic Index and Tabular List of the ICD-10-CM code book together. When attempting to select an ICD-10-CM diagnosis code, begin by searching for the main term—such as "lesion," "burn," etc.—in the Alphabetic Index. Follow all cross-references and "see also" entries. When you have located the code you are seeking, turn to that code in the Tabular List. Be sure to pay close attention to disease definitions, footnotes, color-coded prompts, and other instruction. Read all supplemental information completely to be certain you are choosing the correct code. Always select a diagnosis to the highest level of specificity supported by the available documentation.

The first-listed diagnosis should describe the most significant reason for the procedure or visit. The first-listed diagnosis will be reflective of the patient's chief complaint. Relevant co-existing diseases and conditions, as well as related history or family history conditions, are reported as secondary diagnoses. When coding preexisting conditions, make sure the assigned diagnosis code identifies the current reason for medical management. Do not report conditions that no longer exist, or do not pertain to the visit.

Many patients will have numerous chronic complaints. Report a chronic complaint diagnosis only when that chronic condition is treated or becomes an active factor in the patient's care.

Always select ICD-10-CM codes to the highest level of specificity supported by documentation. For example, diagnosis coding for fractures of the wrist and hand requires a 5th character (which specifies location), a 6th character (which specifies laterality and whether the fracture is displaced or nondisplaced), and a 7th character (which specifies the episode of care). If this information is not documented, appropriate code selection is impossible. You should work with your provider to ensure that the information necessary for proper coding is always noted.

General ICD-10-CM Guidelines

Signs/Symptoms and Confirmed/Unconfirmed Diagnoses

Use of codes that describe signs and symptoms are acceptable when the provider has not established a related, definitive diagnosis. Report only confirmed diagnoses. Uncertain diagnoses described as "probable," "possible," "suspected," "likely," "rule out," "consistent with," "compatible with," etc., are not coded. Code the highest level of certainty known, using codes that describe known signs, symptoms, abnormal test results, etc.

For example, if a patient has a breast mass and the provider suspects breast cancer, you should not report breast cancer as the diagnosis. Instead, report the signs and symptoms, such as breast mass, that prompted the exam. If testing later confirms cancer, only then should you report the cancer diagnosis.

For outpatient encounters for diagnostic tests that have been interpreted by a physician, and the final report is available at the time of coding, report any confirmed or definitive diagnosis(es) documented in the interpretation. If a definitive diagnosis is known, do not code related signs and symptoms as additional diagnoses. That is, if the test is positive, you report the findings. For tests interpreted as "normal" code the condition, symptom, or sign that necessitated the diagnostic study.

In rare occurrences, a test is ordered without a clear indication of reason, and the ordering physician is not available to gather enough information prior to treating the patient. In such a case, you will want to confirm with the order for the physician's reason(s) that the test was ordered.

When you are provided with both a preoperative and postoperative diagnosis, always report the postoperative diagnoses codes if the pre- and postoperative diagnoses differ.

Signs and symptoms attributable to a definitive diagnosis should not be reported separately. Cite additional signs and symptoms beyond the primary diagnosis only when those signs and symptoms are not integral to the disease process. Report only those additional conditions that affect treatment, and that the provider documents for the current visit.

For example, a patient presents with shortness of breath. The next day, the physician determines the patient has pneumonia, but he feels that the shortness of breath may be due to a cardiac condition. In such a case, you may still report the shortness of breath as a sign and symptom with pneumonia because the physician has documented reason to believe that the conditions are unrelated.

Above all, do not extrapolate or assume information. Select codes only from what is apparent in the available documentation.

Acute vs. Chronic

The doctor makes the determination as to when a condition becomes chronic. Coders will select an appropriate code for acute or sub-acute (primary) versus chronic (secondary) based on the available documentation. For example, a torn meniscus (S83.2-) will become an internal derangement of knee (M23.-) after a defined period of time.

If a patient's condition is both acute/sub-acute and chronic, and a single code does not describe this combination, the ICD-10-CM code book provides instruction that you would report the acute (sub-acute) code as first-listed, with the chronic code secondary.

Sequela (Late Effects)

Sequela (late effects) codes are usually reported as secondary diagnoses, with the effect or reason for the visit as primary. There is no time limit (such as 90 days, one year, etc.) in which late effects can occur.

Sequela (late effects) of cerebrovascular disease fall specifically to category I69, which indicate conditions classifiable to I60-I67 (hemorrhage, occlusion, and stenosis, etc.) as the cause of sequela (late effects). Guidelines indicate that the late effects include neurologic deficits caused by cerebrovascular disease and may be present from the onset or may arise at any time after the onset of the condition—classifiable to categories I60-I67. A code(s) from category I69 may be assigned on a health case record with codes from I60-I67 if the patient has a current cerebrovascular accident (CVA) and deficits from an old CVA.

Some of the codes in category I69 that specify hemiplegia, hemiparesis, and monoplegia also identify whether the dominant or nondominant side is affected. If the dominance is not stated (right-handed, left-handed, or ambidextrous), and the classification does not indicate a default, then the following applies:

- For ambidextrous patients, the default is always dominant.
- If the left side is affected, the default is nondominant.
- If the right side is affected, the default is dominant.

Multiple Conditions Reported with a Single Code

In some cases, ICD-10-CM will employ a single code to describe two or more conditions concurrently, such as a primary diagnosis with an associated secondary process (manifestation), or a primary diagnosis with an associated complication. Code

Evaluation and Management Coding for Dermatology

This chapter examines the documentation requirements for the evaluation and management (E/M) codes used by physicians and non-physician practitioners (NPPs) to bill for their services.

The E/M documentation requirements chapter is designed to provide a detailed approach to the accurate identification of documentation elements as they are defined by the American Medical Association (AMA) Guidelines for E/M services. The goal of this material is to offer the necessary insight to develop proficiency and correct technique to accurately select levels of E/M services for the exam. This material is not meant to influence policy, rather to refer to as coding guidelines for the CPCD® exam.

This chapter should be reviewed with the CPT® guidelines for E/M services found in the current CPT® code book. This guide is a general summary that explains commonly accepted aspects of selecting E/M codes. The goal is that, after completing your training, you will be confident that you will not under or over code a visit.

An Introduction to the Documentation Requirements Associated with E/M Services

The E/M Documentation Guidelines (DGs) have perhaps inspired more discussion than any other non-clinical topic based in the industry. In an ever-increasing effort to ensure that correct payments are made for visits and consultations, Medicare and the AMA have been working together for well over a decade. In 1992, Medicare transitioned to the Resource-Based Relative Value Scale (RBRVS) physician payment system and the AMA introduced E/M codes in CPT® to report visits and consultations.

By 1994, in response to confusion and the inaccurate interpretation of the codes, the Office of Management and Budget mandated that Medicare adopt DGs to expand the definition that was, at that time, only provided by CPT®. Medicare and the AMA jointly developed this initial set of E/M DGs which were deployed in 1995 and became known as the 1995 Documentation Guidelines or DGs. As auditing showed a pattern of continued misuse of the E/M Codes, the 1995 DGs were criticized as unfair to specialists because they seem to account for extended single system examinations with as much weight as limited multiple system exams.

Within two years, the E/M DGs were revised to improve physician and provider understanding and payment accuracy by extending the definitions to include specialty specific guidance. This set of DGs was scheduled to replace the 1995 DGs and became known as the 1997 DGs. The only problem was that the physician community loudly objected to the 1997 DGs. They were criticized as burdensome with documentation requirements that were too detailed and very difficult to achieve. Medicare decided to not replace the 1995 DGs but to instead allow physicians and providers to choose between the 1995 and the 1997 DGs.

In 2021, in an attempt to simplify the guidelines, the AMA changed the descriptions of the Office or Other Outpatient E/M Services codes 99202-99215. In addition, guidelines for the use of these codes were printed in the CPT® code book. The guidelines added in the 2021 CPT® code book were specific to Office or Other Outpatient E/M Services. In 2023, the AMA expanded the use of the guidelines introduced in 2021 to other E/M categories, eliminating the need for the 1995 and 1997 DGs.

Documentation Guidelines

There are three general principles regarding documentation to ensure credit can be thoroughly verified. It is important to follow these rules of thumb:

1. Documentation should be legible to someone other than the documenting physician or provider and their staff.
2. The date of service, name of the patient, and the name of the provider of service should be easily demonstrated by the documentation.
3. The documentation should support the nature of the visit and the medical necessity of the services rendered.

For most E/M visits, the provider performs three main components: history, exam, and medical decision making (MDM). The history directs the provider to troubleshoot the chief complaint based on an interview with the patient. The exam portion is the provider's physical exam and evaluation of the patient. The MDM includes the provider's assessment and plan.

The guidelines for E/M Services, along with the code descriptors, indicate that a "medically appropriate history and/or physical examination, when performed" is included in the service. While the history and exam should be documented, they are not used in the determination of the level of the code.

The guidelines also include pertinent definitions for terms necessary to understand when determining the level of MDM. You should read through the definitions provided in your CPT® code book and refer back to them as we go through the MDM components below.

The E/M guidelines provide instructions for selecting the appropriate level of service based on either of the following:

1. The level of the MDM as defined for each service; or
2. The total time for E/M services performed on the date of the encounter.

The provider can determine to support the E/M level of the visit based on MDM or time on a case-by-case basis. Regardless of which element is used to determine the level of visit, documentation should support the medical necessity of the visit. Payers may also have regulations on when MDM or total time is used.

Determining the Medical Decision Making (MDM)

The MDM most accurately reflects the amount of work a provider performs during an E/M service. Four levels of MDM are recognized: straightforward, low, moderate, and high. The level of MDM directly correlates to a level of service.

EXAMPLE: OFFICE VISIT MDM TO CODE CORRELATION

New Patient Code	Established Patient Code	Level of MDM
	99211	N/A 99211 is reported for services that typically do not require the presence of a provider. As such, the concept of MDM does not apply to code 99211.
99202	99212	Straightforward
99203	99213	Low
99204	99214	Moderate
99205	99215	High

To adequately determine the level of visit, the MDM is selected based on three components:

1. The number and complexity of problems addressed at the encounter;
2. The amount and complexity of data to be reviewed and analyzed; and
3. The risk of complications and/or morbidity or mortality of patient management.

To determine the levels of these components appropriately, the definitions provided in your CPT® code book must be understood. Using a grid method, we will discuss each component. Be sure to refer back to the definitions listed in the E/M Guidelines as needed.

Number and Complexity of Problems

The number and complexity of problems identifies the nature of the presenting problem and is based on the relative difficulty level in making a diagnosis. For the problem to be considered in the number of problems, the problem must be addressed within that encounter.

Per CPT®, symptoms may cluster around a specific diagnosis and each symptom is not necessarily a unique condition. Comorbidities/underlying diseases, in and of themselves, are not considered in selecting a level of E/M services unless they are addressed, and their presence increases the amount and/or complexity of data to be reviewed and analyzed or the risk of complications and/or morbidity or mortality of patient management. The final diagnosis for a condition does not, itself, determine the complexity or risk, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition. Multiple problems of lower severity may, in aggregate, create higher risk due to interaction.

The final diagnosis alone does not determine the complexity or risk to the patient. The documentation should be reviewed for comorbidities or underlying diseases that are addressed that increase the level of risk to the patient. Simply listing a chronic illness in the documentation is not sufficient. The documentation should indicate that the provider addressed the conditions during the encounter or that the condition contributed to the severity of the case.

When a patient sees multiple providers for different aspects of their care, you may see a physician document the condition is being managed by another provider. When the documentation only states that the patient has the condition and that it is being treated by another provider, it is not considered for the leveling of the visit. If there is additional documentation showing assessment or care coordination regarding that diagnosis, other than the statement of the condition being treated by another provider, it is then considered toward the level of service.

TESTING TECHNIQUE

Read through the entire note to get an understanding of the conditions that are addressed and analyzed during the visit. Simply relying on the chief complaint will not always give an accurate description of the number and complexity of problems for the encounter.

There are four levels identified under the number and complexity of problems addressed; minimal, low, moderate, and high. As demonstrated by the table below, the level of Number/Complexity of Problems Addressed increases as the difficulty of the patient's health increases.

Top 10 Missed Coding Concepts on CPCD® Examination

The concepts discussed are not in a particular order. The tips provided below are based on the AAPC exam department observations of the most missed coding concepts.

1. **Proper ICD-10-CM code selection for Nevus:** There are many types of nevi such as: malignant nevus, dermal nevus, dysplastic nevus, etc. Verify the coding for the Nevus by first going to the ICD-10-CM Alphabetic Index to take you to the correct code for that type of nevus. For example, in the ICD-10-CM Alphabetic Index look for Nevus/malignant referring you to see Melanoma. Look for Nevus/dysplastic referring you to see Neoplasm/skin/benign.

2. **Consultation rules according to CPT® and CMS:** According to CPT® guidelines, a consultation may be reported only when all three of the following conditions are met:

   1. A request for an opinion or advice is made by a physician, other qualified health care professional, or an appropriate source for evaluation of a specific problem or condition.
   2. The consulting provider may initiate diagnostic or therapeutic services during the consultation or at a subsequent visit.
   3. A written report is sent back to the requesting provider.

   If any of these elements is missing—such as the absence of a documented written report—the service cannot be coded as a consultation. CPT® also specifies that patients, family members, attorneys, insurance companies, and social workers cannot request a "consultation"; these encounters must be reported using non-consult E/M codes.

   Additionally, CMS no longer reimburses consultation codes. For Medicare patients, report the appropriate office/outpatient or hospital care codes instead. Do not assume a patient has Medicare based solely on age; in exam scenarios, Medicare coverage will always be clearly stated in the case or the question.

3. **Incision Drainage Simple vs Complicated:** The determination of simple/single I&D vs. complex/multiple I&D can vary among payers in how the documentation should be indicated to appropriately select the correct I&D code. For purposes of the certification exam, documentation that supports a complicated I&D can include the placement of a Penrose latex drain, gauze strip packing to allow continued drainage, or require a surgical closure.

4. **When to report and not report an E/M with minor procedures:** To report an E/M service along with a minor procedure on the same day, the E/M must be significant and separately identifiable beyond the usual pre- and post-procedure work.

   When a patient arrives specifically for a planned minor procedure, you typically report only the procedure, unless a new or unrelated problem requires additional evaluation. For example, if a patient comes in for a scheduled lesion excision but also reports a new abdominal rash that the provider evaluates and treats, both the E/M service and the procedure may be coded. Remember that minor procedures always include a certain level of evaluation, so examining the surgical site alone does not justify a separate E/M code. Therefore, if the patient presents strictly for the planned procedure, only the procedure code should be billed without the E/M code.

5. **AMA E/M Guidelines for Selecting the Level for the Risk of Complications and/or Morbidity or Mortality of Patient Management:** Risk is measured based on the physician's determination of the patient's probability of becoming ill or diseased, having complications, or dying between this encounter and the next planned encounter. The E/M guidelines indicate that the risk of complications and/or morbidity or mortality of patient management is distinct from the risk of the condition itself. The risk is based on the management decisions for the patient made by the reporting provider as part of the encounter. Minor surgeries without identified patient or procedure risk factor or over the counter medication is a low level of risk.

6. **Debridement:** Debridement codes are selected based on the size and depth of the debridement. When multiple wounds are debrided, add together the sum of wound surfaces of the same depth. Wounds of different depths are reported separately. For example, the provider performs debridement including the subcutaneous and dermis for two wounds on the patient's lower leg, measuring 4 sq. cm and 10 sq. cm. Because the wounds are of the same depth, add the two wounds together

(14 sq. cm) and report 11042. If the wound measuring 4 sq. cm involved the subcutaneous and the dermis, and the wound measuring 10 sq. cm involved muscle, report 11043, 11042-59.

7. **Unna boot:** The application of an Unna boot is reported with 29580. If the Unna boot is applied on the same date of service as debridement, only report the debridement. The Unna boot application is included when performed on the same date of service as the debridement. If the Unna boot is applied on a different date of service, it can be reported.

8. **Proper ICD-10-CM code selection for NOS versus NEC:** Not Otherwise Specified (NOS) is selected when there is not enough documentation to select a more specific code. For example, codes that are unspecified (e.g. L20.9 is for unspecified atopic dermatitis).

   Not Elsewhere Classifiable (NEC) is selected when specific information is documented for the diagnosis, but there is not an existing ICD-10-CM code to report it. Meaning a specific type of dermatitis was provided, but there is not a specific code to report it and it will be coded as "other specified", L20.89.

9. **Modifiers for multiple excisions:** When multiple excisions are performed that are reported with the same CPT® code, append modifier 59 to identify the procedures were performed on different sites. If multiple excisions are performed reported with different CPT® codes, append modifier 51. Because the different CPT® codes identify different sites and sizes, it is clear there are separate lesions; therefore, modifier 51 is appropriate. Some payers may require modifier 59 instead of modifier 51. For exam purposes, append 59 when the procedures are bundled or the same CPT® code is reported for multiple excisions. Append modifier 51 when different CPT® codes are reported and there are no bundling conflicts.

10. **Biopsy:** When more than one biopsy is performed by different techniques during the same encounter, only one primary biopsy code is reported and the add-on codes for the other techniques are used. Refer to the CPT® guidelines in how different biopsy techniques are reported in the same encounter.

AAPC continuously evaluates and enhances our certification exams throughout the year. As AAPC continues to enhance the certification exams, we are beta testing the inclusion of a fill-in-the-blank item type on our certification exams. To prepare you for both item types (multiple choice and fill-in-the-blank), we have provided two versions of this practice exam. The same questions are on both versions of the Test Your Knowledge practice exam; however, the last three cases on this version of the practice exam are fill-in-the-blank. If you prefer to test using the multiple-choice item type for all the cases, use practice exam B.

The following questions will test your comprehension of the information covered in this study guide. The answer key is used for both versions of the Test Your Knowledge practice exams.

Version A

CASE 1

Operative Report

Preoperative Diagnoses:

1. Open wound, nose.
2. Personal history of squamous cell carcinoma, nose.

Postoperative Diagnoses:

1. Open wound, nose.
2. Personal history of squamous cell carcinoma, nose.

Procedures Performed: Full-thickness skin graft, 1.5 cm sq.

Anesthesia: Local, using 3 cc of 1 percent Lidocaine with epinephrine.

Estimated Blood Loss: Less than 3 cc.

Indications for Surgery: The patient is a 58-year-old white woman who underwent Mohs excision of a squamous cell carcinoma on the right side wall of her nose by Dr. X. In the morning of September 4, Dr. X called requesting us to help with the closure. We were able to do so that same morning. The patient had a full-thickness wound on the right side wall of her nose measuring about 1.5 cm in greatest diameter. I discussed with her local flap reconstruction versus a skin graft. She has had a skin cancer removed recently from the mid-line area of her nose and she also has a skin cancer on her right lower eyelid that was planned to be removed. I felt she did not have adequate tissue to allow for a local flap closure, and I recommended a skin graft. I pointed out to her that we could always go back and do a flap if the skin graft is not acceptable. I marked her preauricular area on the right for the donor site. I felt this would be apt for donor site, it was behind her hair-bearing skin, which was important to her. I drew my best guess for the resultant scar from the donor site and we proceeded.

Description of Procedure: The patient received 1 g of IV Ancef. The face was prepped and draped in sterile fashion after we had infiltrated both areas of her nose and her donor site with a local anesthetic. We tried to keep Betadine out of the wound of her nose. We irrigated the area of her nasal wound and I roughed the area up a bit using a sponge. I trimmed just a little bit of skin to help with a contour of the defect in her nose and then a full-thickness skin graft was harvested from her right preauricular area. This was defatted using scissors and was inset into the nasal wound using 5-0 plain gut suture. It then was placed in the skin graft and a Bolster was placed over the skin graft using Xeroform and 5-0 nylon. The donor site in front of her ear had

meticulous hemostasis achieved using Bovie cautery and this wound was closed in layers using 4-0 Monocryl and 6-0 Prolene. Loupe magnification was used. The patient tolerated the procedure well.

1. What is the first listed CPT® code for this patient encounter?

   A. 15240
   B. 15120
   C. 15260
   D. 15135

2. What is the first listed ICD-10-CM diagnosis code for this encounter?

   A. S01.20XA
   B. S08.811A
   C. S01.20XS
   D. S01.23XA

3. Which of the following statements is true regarding loupe magnification?

   A. The use of magnifying loupes indicates a modifier 22 should be appended to the procedure.
   B. The use of magnifying loupes will not affect reimbursement.
   C. The use of magnifying loupes is reported separately if nerve anastomosis is performed.
   D. Report 69990 for use of magnifying loupes.

CASE 2

Preoperative Diagnoses: Pigmented lesion of right lip and submucosal lesion of left lip.

Procedure Performed: Biopsy of right lip lesion and excision of left lip lesion.

Description of Procedure: The patient's lips were examined. The sites of the lesions were prepped with Betadine and they were injected with 1% Lidocaine with 1:100,000 epinephrine, taking care to aspirate prior to injection. A 15-blade scalpel was then used to make an incisional biopsy on the right lip lesion. Hyfrecator was used for hemostasis. Antibiotic ointment was then applied. The patient tolerated the procedure well. Attention was then turned to the left lip site. This was prepped with Betadine. A 15-blade scalpel was used to make an incision in the mucosa overlying the lesion. The lesion was found at this point to be adherent to the overlying mucosa. Therefore, the incision was converted to an elliptical type. The mucosa and the underlying lesion were then sharply dissected out from the surrounding tissue using an iris scissors. The lesion was handed off the field. Hyfrecator was used for hemostasis. The lesion was then closed using 4-0 chromic for the deep layer followed by 5-0 Prolene for the skin. Antibiotic ointment was applied. The patient tolerated the procedure well.

After reviewing the answers and rationales, if you have further questions, please send them to: mct@aapc.com

CASE 1

Operative Report

Preoperative Diagnoses:

1. Open wound, nose.
2. Personal history of squamous cell carcinoma, nose.

Postoperative Diagnoses:

1. Open wound, nose. [1]
2. Personal history of squamous cell carcinoma, nose.

Procedures Performed: Full-thickness skin graft, 1.5 cm sq. [2]

Anesthesia: Local, using 3 cc of 1 percent Lidocaine with epinephrine.

Estimated Blood Loss: Less than 3 cc.

Indications for Surgery: The patient is a 58-year-old white woman who underwent Mohs excision of a squamous cell carcinoma on the right side wall of her nose by Dr. X. In the morning of September 4, Dr. X called requesting us to help with the closure. We were able to do so that same morning. The patient had a full-thickness wound on the right side wall of her nose measuring about 1.5 cm in greatest diameter. I discussed with her local flap reconstruction versus a skin graft. She has had a skin cancer removed recently from the mid-line area of her nose and she also has a skin cancer on her right lower eyelid that was planned to be removed. I felt she did not have adequate tissue to allow for a local flap closure, and I recommended a skin graft. I pointed out to her that we could always go back and do a flap if the skin graft is not acceptable. I marked her preauricular area on the right for the donor site. I felt this would be apt for donor site, it was behind her hair-bearing skin, which was important to her. I drew my best guess for the resultant scar from the donor site and we proceeded.

Description of Procedure: The patient received 1 g of IV Ancef. The face was prepped and draped in sterile fashion after we had infiltrated both areas of her nose and her donor site with a local anesthetic. We tried to keep Betadine out of the wound of her nose. We irrigated the area of her nasal wound and I roughed the area up a bit using a sponge. I trimmed just a little bit of skin to help with a contour of the defect in her nose and then a full-thickness skin graft was harvested from her right preauricular area. [3] This was defatted using scissors and was inset into the nasal wound using 5-0 plain gut suture. It then was placed in the skin graft and a Bolster was placed over the skin graft using Xeroform and 5-0 nylon. The donor site in front of her ear had meticulous hemostasis achieved using Bovie cautery and this wound was closed in layers using 4-0 Monocryl and 6-0 Prolene. Loupe magnification was used. The patient tolerated the procedure well.

[1] Primary Diagnosis.

[2] Indication of the size of the repair.

[3] Harvesting the skin graft from the ear to repair the defect to the nose.

1. **Answer:** C. 15260

   Rationale: This is a full-thickness free graft, with skin harvested from the right preauricular area and transplanted to the nasal wound, identified by site (nose) and size (1.5 sq. cm) (15260). Look in the CPT® Index for Skin Graft and Flap/Free Skin Graft/Full Thickness 15200-15261. Code 15260 includes direct closure of the donor site.

2. **Answer:** A. S01.20XA

   Rationale: The graft repairs an open wound of the nose immediately following the excision of a neoplasm performed by another physician. In the ICD-10-CM Alphabetic Index, look for. This code requires a 7th character to identify the episode of care. Verify code selection in the Tabular List.

3. **Answer:** B. The use of magnifying loupes will not affect reimbursement.

   Rationale: Instructions under Operating Microscope in CPT® state, "Do not use 69990 for visualization with magnifying loupes or corrected vision." Modifier 22 reports increased procedural services when the work is greater than usually required, and documentation must support the increased work. While use of magnifying loupes can be indicative of microscopic work, loupes are generally used in procedures that already would be characterized in this manner. Loupes are never separately reported.

CASE 2

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Procedure Performed: Biopsy of right lip lesion and excision of left lip lesion.

Description of Procedure: The patient's lips were examined. The sites of the lesions were prepped with Betadine and they were injected with 1% Lidocaine with 1:100,000 epinephrine, taking care to aspirate prior to injection. A 15-blade scalpel was then used to make an incisional biopsy on the right lip lesion. [1] Hyfrecator was used for hemostasis. Antibiotic ointment was then applied. The patient tolerated the procedure well. Attention was then turned to the left lip site. [2] This was prepped with Betadine. A 15-blade scalpel was used to make an incision in the mucosa overlying the lesion. The lesion was found at this point to be adherent to the overlying mucosa. Therefore, the incision was converted to an elliptical type. The mucosa and the underlying lesion were then sharply dissected out from the surrounding tissue using an iris scissors. [2] The lesion was handed off the field. Hyfrecator was used for hemostasis. The lesion was then closed using 4-0 chromic for the deep layer followed by 5-0 Prolene for the skin. [3] Antibiotic ointment was applied. The patient tolerated the procedure well.

[1] Biopsy performed on the right side of the lip.

[2] The removal of portion of the lip on the left side involving the mucosa and surrounding tissue.

[3] Primary closure of the lip.

4. **Answer:** B. 40510 (RVU 14.71)

   Rationale: In this case, more than one procedure is performed. The provider performs an excision of submucosal tissue of the left lip, with no mention of flap, which is reported with 40510. He also performs a biopsy of the lip. Multiple procedures are listed in RVU order, with the highest RVUs listed first. The excision of the lesion has higher RVUs in this case.

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