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DermWorld
directions in residency
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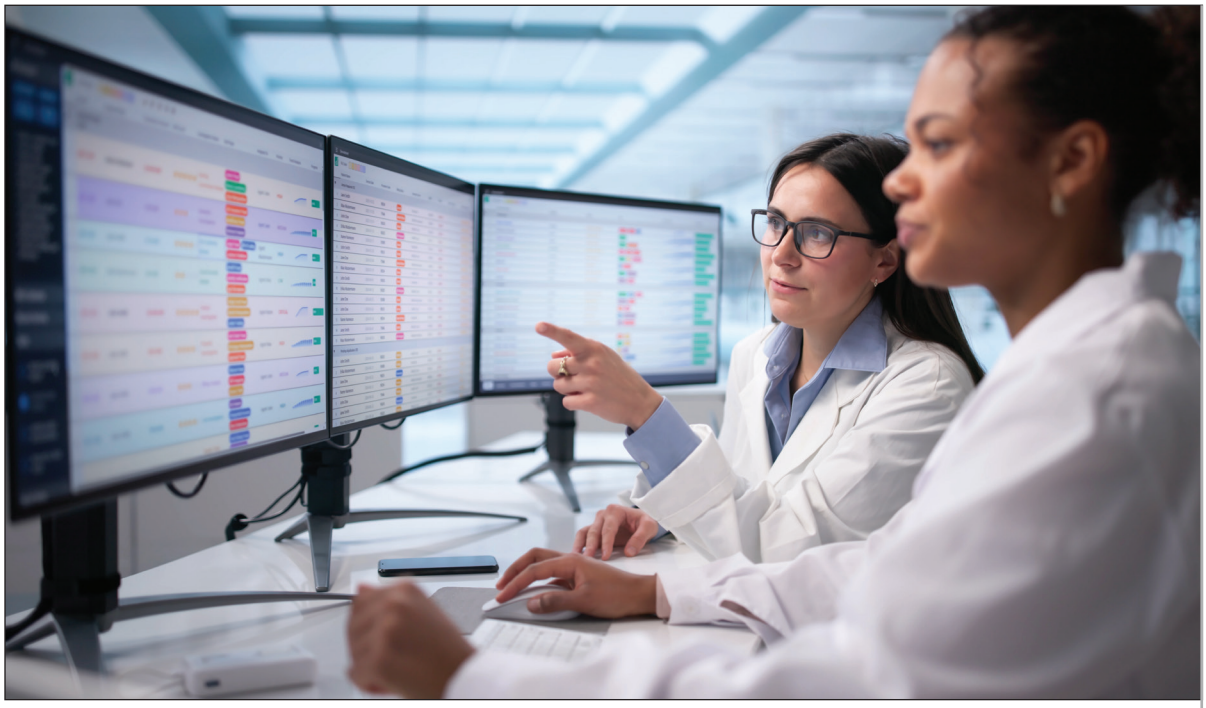

Dermatology coding essentials

By Faith C. M. McNicholas, RHIT, CPC, CPCD, PCS, CDC, Senior Manager, Coding & Reimbursement

In residency and beyond, your ability to deliver excellent patient care will require strong coding and documentation skills — now an essential part of modern medical practice.

With time, you will confidently be able to identify and navigate dermatology-specific CPT®, ICD-10-CM, and Healthcare Common Procedure Coding System (HCPCS) codes and their guidelines, and apply best practices to overcome common coding challenges, support claim payment and optimal reimbursement, and minimize denials and audit risks.

Getting to know ICD-10-CM

The International Classification of Diseases (ICD) is the standard classification for epidemiological and clinical use that is copyrighted and developed by the World Health Organization (WHO). The United States is currently in the 10th revision of this classification system (ICD-10-CM).

These codes provide information on medical necessity as to "why" the service is being performed. While ICD-10-CM codes do not have a dollar value assigned to them, selecting the correct diagnosis code allows payers to determine if the service or procedure reported meets medical necessity and specific payment criteria for the patient's policy and supports payment of the claim. As such, the ICD-10-CM code should uphold the reason for reporting each specific CPT code.

When assigning diagnosis codes, first document the primary reason for the encounter. In some cases, the first listed code may be a symptom or sign until the final diagnosis has been established.

Any additional code(s) to describe coexisting conditions that are addressed during the encounter must be listed as secondary code(s) on the claim form. This includes any conditions that are evaluated, assessed, or treated during the encounter or require continuous monitoring. Any underlying conditions that affect or may impact patient care, treatment, or management must also be documented when addressed during the encounter.

see CODING on p. 3

AAD Coding Resource Center

Visit the AAD Coding Resource Center at **www.aad.org/coding** for more practical tips, tools, quizzes, and videos about common dermatologic coding issues.

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CODING from p. 1

Do not report conditions that were previously treated and no longer exist, except for the history codes. History codes may be reported as an additional code if the historical condition or family history has an impact on current care or treatment.

The ICD-10-CM code structure

Diagnosis codes always begin with an alpha character and are alphanumeric. A complete code may consist of three to seven characters. The first three characters designate the chapter and category of the diagnosis.

The next three characters designate the subcategory and subclassification of the condition or disease. These characters provide greater specificity about the diagnosis, such as etiology, anatomic site, severity, or other vital clinical details.

Category

- **C44**

Other and unspecified malignant neoplasm of skin

Subcategory

- **C44.1**

Other and unspecified malignant neoplasm of skin of eyelid, including canthus

Subclassification

- **C44.11**

Basal cell carcinoma of skin of eyelid, including canthus

Codes

- Alpha-numeric
- Codes may be 3 to 7 characters
  - An incomplete code is invalid

Example

B86	Scabies
L10.0	Pemphigus vulgaris
D22.39	Melanocytic nevi of other parts of the face
C44.112	Basal cell carcinoma of the skin of ***right*** eyelid including canthus
C44.1121	Basal cell carcinoma of the skin of ***right upper*** eyelid, including canthus

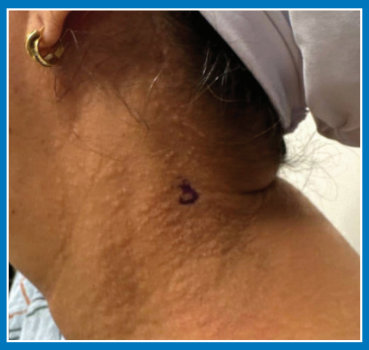
A final note: The diagnosis code is not valid if it has not been coded to the full extent of the characters available in the category. This includes any applicable seventh characters. Submitting incomplete or truncated diagnosis codes will result in claim denials. DR

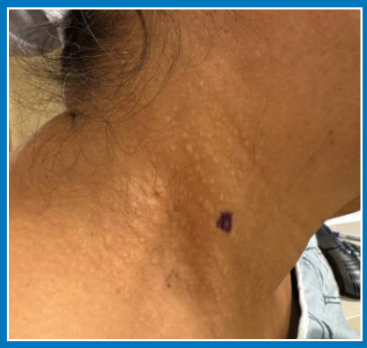
Stephanie Sanchez-Melendez, MD, is a PGY-3 at Boston University Medical Center.

Bilal Fawaz, MD, FAAD, is the assistant program director and an assistant professor of dermatology at the Boston University School of Medicine.

Race for the Case

By Stephanie Sanchez-Melendez, MD, and Bilal Fawaz, MD, FAAD





A 59-year-old woman with a history of fibromyalgia and chronic migraines presented with a two-year history of pruritic papules on the bilateral neck. Treatment with triamcinolone 0.1% cream for one week provided mild improvement in pruritus but did not resolve the lesions. Review of systems was negative for cardiovascular, gastrointestinal, and visual symptoms.

Physical examination demonstrated numerous skin-colored to yellow papules on the neck, some coalescing into a cobblestone appearance. No similar lesions were present elsewhere on the body or oral mucosa.

Biopsies from the right and left neck demonstrated basket-weave keratosis overlying an unremarkable epidermis, slightly decreased elastic fibers in the papillary dermis on elastic tissue stain, and a mild superficial perivascular and interstitial lymphocytic infiltrate with scattered pigment-laden macrophages.

1. **What is the most likely diagnosis?**
2. **Which histopathologic finding is most characteristic of this condition?**
3. **Which diagnosis is the most important clinical mimic of this condition?**
4. **Which histopathologic finding would favor the alternative diagnosis? Which stains would be helpful?**
5. **What conditions are associated with the inherited disorder that clinically resembles this patient's condition?**

Respond with the correct answers at **www.aad.org/RaceForTheCase** for the opportunity to win an Amazon gift card!

Race for the Case winner (Summer 2026)

The winner of the summer 2026 Race for the Case is Antara Afrin, MD, a PGY-4 at Yale Dermatology. Dr. Afrin correctly identified graft vs. host disease (GvHD) in our latest Race for the Case and provided the most accurate responses in the quickest time. Congrats to Dr. Afrin!

You can read more about this case online at **www.aad.org/race-case-answers**. If you can solve the case above, there may be a $100 Amazon gift card in your future, and you will be invited to contribute your very own Race for the Case. Visit **www.aad.org/RaceForTheCase**.

Hand nerve blocks

By Gavin Cardwell, DO, Shannon Hart, DO, and Nathaniel A. Marroquin, DO

Gavin Cardwell, DO, is a PGY-2 at the KCU-GME Consortium/ADCS Orlando Dermatology Residency Program.

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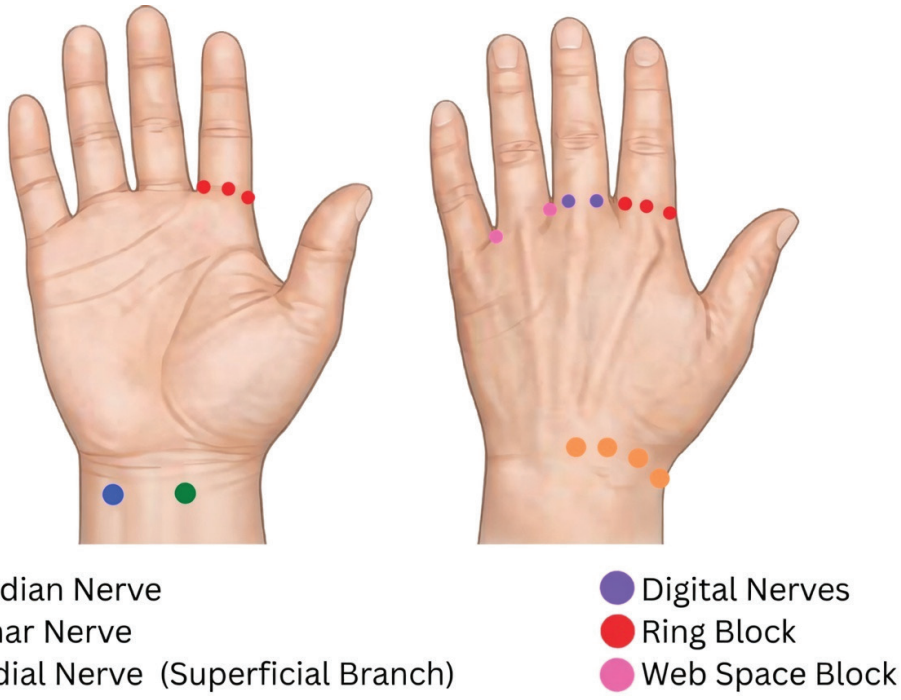
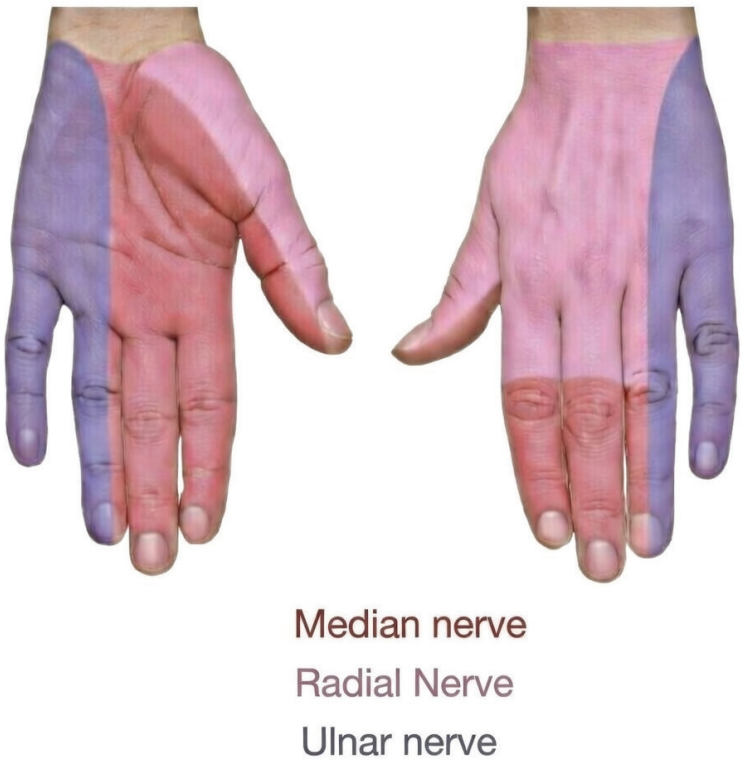
Nerve block injection sites



Cutaneous innervation of the hand



Hand nerve blocks

By Gavin Cardwell, DO, Shannon Hart, DO, and Nathaniel A. Marroquin, DO

Nerve	Sensory distribution	Key landmarks	Injection site & technique	Volume	Complications/ pearls
Median nerve	Palmar thumb, index, middle, radial half of ring finger; nail beds	Palmaris longus tendon, flexor carpi radialis; nerve lies just ulnar to flexor carpi radialis at wrist	At volar wrist crease, insert ulnar to flexor carpi radialis tendon, advance 1-2 cm, aspirate, inject	3-5 mL	Intravascular injection (radial artery nearby), nerve injury, incomplete block if injected too superficial
Ulnar nerve	Small finger and ulnar half of ring finger (palmar & dorsal)	Flexor carpi ulnaris tendon; ulnar artery is radial to nerve	At volar wrist crease, inject radial to flexor carpi ulnaris tendon, depth ~1 cm	3-5 mL	Ulnar artery puncture, nerve injury; always aspirate
Radial nerve (superficial branch)	Dorsal thumb, index, middle (not nail beds)	Radial styloid, anatomic snuffbox	Subcutaneous wheal over radial wrist, from radial styloid dorsally toward midline	3-5 mL	Usually very safe; incomplete coverage common if not wide enough
Digital nerves	Entire finger; each finger has radial & ulnar digital nerves	Base of finger at MCP crease	Inject lateral to flexor tendon on both sides of finger	1-2 mL per side	Caution with epinephrine in peripheral vascular disease; do not exceed 8 mL total volume per digit due to tourniquet effect
Ring block	Entire finger	Proximal finger base	Subcutaneous infiltration circumferentially	5-8 mL	Swelling, do not exceed 8 mL per digit due to tourniquet effect
Web space block	Individual digit	Web space between fingers	Insert into web space dorsally, advance toward palmar surface	2-3 mL	Less painful but sometimes incomplete

References:

1. Bolognia, J. L., Schaffer, J. V., & Cerroni, L. (2024). *Dermatology* (5th ed.). Elsevier
2. Alikhan A, Hocker TL. (2023) *Review of Dermatology* (2nd ed). Elsevier

More study charts online!

There are more Boards Fodder charts online! In addition to the chart in this issue, you can view the **Vasculopathy** chart by Taha Rasul, MD, Benjamin Coope, DO, and Karan Rajalingam, MD, and the **Cutaneous cysts classified by epithelium** chart by Alexandra Stroia, DO, and Stephen Olsen, MD.

These and many more charts can be found at **www.aad.org/boardsfodder**.

Kristen Lo Sicco, MD, FAAD, is associate professor of dermatology and director of the Skin and Cancer unit at NYU Langone Health.

Clinical Pearls

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

Alopecia areata

By Kristen Lo Sicco, MD, FAAD

1. Alopecia areata (AA) impacts a significant number of Americans, and its prevalence among women and patients with skin of color is increasing. AA is a chronic autoimmune disease that affects approximately 7 million people in the United States. Like the eye, brain, and placenta, typically our hair follicular unit is also a protected site with no autoimmune activity, termed "immune privilege." When this privilege is lost, the hair follicle is vulnerable to attack by one's own immune system. Likely a mix between genetics and environmental factors, one may develop AA at virtually any age. While AA may occur in children, adults, women, and men, some research has demonstrated that the prevalence of AA is greater in women as well as in Asian patients, followed by Black, Latino, and white individuals.

2. Prior to 2022, there was no U.S. FDA-approved therapy to treat AA. Now, we have multiple systemic therapies to treat AA. There are three FDA-approved therapies for severe AA — all of which are systemic immunosuppressive oral therapies. Two, baricitinib and deuruxolitinib, are oral JAK 1 and 2 inhibitors approved for the treatment of severe AA in adults. Ritlecitinib, a JAK 3 TEC (tyrosine kinase expressed in hepatocellular carcinoma inhibitor) is approved for the treatment of severe AA in adults as well as adolescents aged 12 and above. Additional studies regarding novel therapies for AA are also ongoing. Research shows that inflammation in AA is systemic and early intervention, especially in more severe subtypes, is vital to optimize results. Emerging research indicates poorer response to oral JAK inhibitor therapy with over four years of a current AA flare. The use of minoxidil in AA may also be considered. Multiple studies have demonstrated the utility of oral minoxidil as an adjunctive agent when combined with oral JAK inhibitors.

3. Pay attention to boxed warnings for oral JAK inhibitors. The boxed warnings for oral JAK inhibitors came from rheumatology literature. These warnings include serious infection, malignancy, MACE (major adverse cardiovascular events), thrombosis, and higher rates of all-cause mortality. It is important to contextualize this given the inherent differences in the rheumatology and dermatology populations. Patients with RA often have a higher baseline risk of cardiovascular risks, including MACE and stroke. Dermatology patients are often younger and overall healthier individuals. Nonetheless, it is important to consider risk factors for potential adverse events prior to initiating a JAK inhibitor.

4. You are your patient's best advocate. Despite FDA approval of multiple therapies to treat AA, patients may still be denied medication coverage or face significant delays when starting therapy. Using scales such as the AASc (Alopecia Areata Scale) can be used during clinic visits as an efficient way of documenting the full disease burden, ultimately with the goal of minimizing barriers to care. It incorporates multiple disease domains, including eyebrow and eyelash involvement, nail changes, as well as patient-reported symptoms, resulting in three severity classes (mild, moderate, and severe).

5. Cranial prostheses, or wigs, are an important aspect of treatment for patients with AA, especially children who often suffer from bullying or isolation. Some patients may not be tolerant of or only partially responsive to therapy. Research shows that AA has a negative quality of life impact on adults as well as children and their families. Adolescents with AA suffer from higher rates of bullying compared to their unaffected peers and girls may experience more bullying and emotional distress. Cranial prostheses are important for those who chose to wear them. However, they remain cost prohibitive for many patients. A letter of medical necessity template should be utilized to most efficiently advocate for your patients, using language such as "cranial prosthesis" and "durable medical equipment." It is also recommended to document AA's psychosocial impacts, disease severity, and recalcitrance to first-line medical therapies. DR

References:

See **www.aad.org/member/publications/more/dir** for references.

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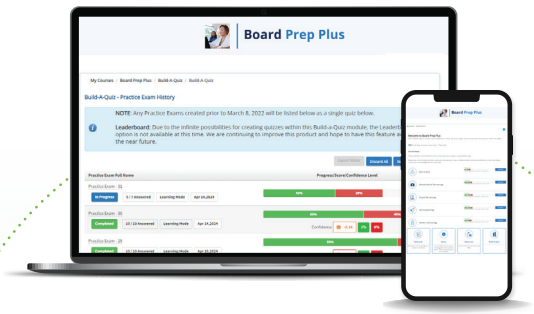

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Inside this Issue

Eric J. Beltrami, MD, is a PGY-4 at Boston University Medical Center.

Born to lump, forced to split

As future dermatologists, we all eventually ask: Am I a lumper or a splitter? In my final year of residency, this is a question I ponder often. Our board exams are notoriously esoteric. Studying board material comprehensively requires splitting of seemingly similar diagnoses into discrete entities. In our daily clinical lives, however, it can be much more efficient and practical to lump dermatoses together that share features or common treatment pathways. This issue of *DermWorld Directions in Residency* makes a compelling case for splitting.

Vasculopathy, reviewed thoroughly in the online version of this issue, demonstrates how splitting can be essential. Thorough workup is often necessary to reach a specific diagnosis. For most vasculopathies, reducing morbidity and mortality is paramount and is best achieved with a targeted diagnosis and therapeutic approach. These conditions serve as reminders that dermatologists are often charged with committing to specific diagnoses, reviewing patients holistically and considering underlying systemic disease that may not be readily apparent to other clinicians.

The value of splitting is not always obvious. This issue's online review of cutaneous cysts features mostly benign entities requiring no intervention. Practically speaking, is it critical to cinch the specific diagnosis for a benign lesion? Epidermal inclusion cyst, pigmented follicular cyst, and milium all exhibit follicular infundibulum differentiation. One could argue these should be lumped into one entity. Conversely, classifying these entities as "infundibular cysts" may represent a lost opportunity to trigger genetic testing for Gardner syndrome or direct immunofluorescence for a subepidermal blistering disorder. Such diagnostic specificity heightens our vigilance to detect less obvious disorders and syndromes.

If you were not yet convinced being a splitter can be practical, the feature on dermatology coding drives home the utility of specificity in our work. It was surprising to learn not only how ICD-10 codes are structured, but that diagnosis codes are only valid if the most specific code available in the respective category is used. The determining factor between insurance claim denial for a treatment or reimbursement for the services rendered could be the specificity of the diagnosis code used in our documentation and billing.

It appears the value of splitting goes far beyond board material. It will follow us in all facets of our careers as dermatologists, even for those of us who would prefer to live by a philosophy of lumping. DR

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