Dermatology Coding Alert

3 Tips Help You Report 99201 With 17000 Codes

Recoup $100 for your E/M and wart removal procedures

When your dermatologist performs an E/M service with wart removal, you can report both the E/M and wart removal if the E/M service was a significant and separately identifiable service. But always check with your carrier before you append modifier -25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) to the E/M code.

Take a look at the following three tips to help you report these services accurately so your practice won\'t miss out on about $40 for **CPT 99201** and $65 for 17000 or more, according to national averages indicated in the 2004 Physician Fee Schedule.

1. Know When You Should Charge an E/M

Each insurer has its own guidelines for office visits (99201-99215, Office or other outpatient visit ...) and wart removal (17000-17111, Destruction, benign or premalignant lesions), says **Susan D. Sajdyk, CPC**, a dermatology billing specialist at Memorial Physicians Inc. in Marysville, Ohio. So, knowing whether to appeal an E/M denial is difficult unless you know that the service deserves payment.

You should report the office visit (99201-99215) in addition to the procedure when the dermatologist performs a significant, separately identifiable E/M service from the wart removal.

Example: If a patient comes in for an initial wart removal visit, you should charge an E/M service, Sajdyk says: \"The physician has to examine the area, discuss treatment options and perform the removal.\" But when the patient comes in for another treatment and the dermatologist doesn\'t do anything other than the re-treatment, don\'t report an office visit, she adds.

Tip: If you want to prove to your payers that the E/M is a significant, separately identifiable service, encourage your dermatologists to write different paragraphs for the office visit and wart removal, Sajdyk says.

What you can look for: Documentation should include the history, physical examination, assessment and plan in one paragraph, coding experts say. The second paragraph should describe the wart\'s location, appearance, and removal method. And, the notes should include a diagram of the affected body parts to fill any potential loopholes in your documentation.

If it\'s your first time billing a particular insurer, send in the chart notes with the diagram. \"That way, you\'ll know right off the bat whether the payer is going to deny the claim,\" Sajdyk says.

Another tip: Keep a chart of insurers that routinely deny the same-day E/M, expert coders tell us. When a patient whose carrier bundles the E/M into the office visit comes in for wart removal, you can inform him that the insurer will probably deny the service. In this case, you may bill the patient for the charge if your contract allows.

2. Append Modifier -25 to the Office Visit

Although many insurers, including Medicare, require modifier -25 on claims for same-day E/Ms and procedures, not all payers mandate using the modifier. If the dermatologist does something not related to a wart, such as evaluating dermatitis (692.9, Contact dermatitis and other eczema; unspecified cause), you should use modifier -25 on the E/M,

Sajdyk says.

Wart removal and E/M example: During a dermatological checkup, a 30-year-old established male patient complains of a bump on his hand. The dermatologist offers to remove the wart with cryotherapy. The patient agrees, and the physician applies liquid nitrogen to the common wart and informs him that the wart will probably fall off in about a week.

You should report 17000 (Destruction [e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement], all benign or premalignant lesions [e.g., actinic keratoses] other than skin tags or cutaneous vascular proliferative lesions; first lesion) for the common wart removal. You should append modifier -25 to 99395 (Periodic comprehensive preventive medicine reevaluation and management of an individual ...; 18-39 years) for the evaluation and management service to show that the office visit is a significant and separately identifiable service from 17000.

Watch out: Some payers, such as Amerihealth HMO, set up their computer systems automatically to reject any E/M procedure claims that do not contain modifier -25, says **Susan Callaway, CPC, CCS-P**, an independent coding consultant and educator in North Augusta, S.C. Medicare also requires modifier -25 to denote that the dermatologist performed work that was necessary based on the patient\'s condition and resulted from the wart removal, says **Dalrona Harrison, RN, BS, CCS-P, CPC**, associate director for precertification and authorization at Preferred Health Systems in Wichita, Kan.

3. Know When to Report Separate Diagnoses

CPT and Medicare do not require different diagnoses to use modifier -25, Callaway says. **Hint:** To avoid later accusations of inappropriate coding, don\'t \"tweak\" ICD-9 coding, she says. You should instead code accurately. If a definitive diagnosis is not available, you can report based on symptoms.

If separate diagnoses exist, such as acne (706.1, Diseases of sebaceous glands; other acne) and viral warts (078.10, Other diseases due to viruses and Chlamydiae; viral warts, unspecified), use them. Reporting different diagnoses can cut down on insurance company scrutiny, says **Paula Walczyk**, office manager at Family Health Partners in Davenport, Iowa.