Dermatology Coding Alert

3 Tips Help You Report 99201 With AK Codes

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

When your dermatologist performs an E/M service with AK removal, you can report both the E/M and lesion removal if the E/M service was a significant and separately identifiable service.

Caveat: 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 lesion removals (17000-17111, Destruction, benign or premalignant lesions). 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 AK removal, says **Maureen Ripley**, office and billing manager at the Ellerin Medical & Cosmetic Dermatology Center in Burlington, Mass., especially if the patient is new to your practice. "If a new patient presents, there's a complete new patient evaluation, because it doesn't make sense to try to treat something without a full background," she says.

Along with the appropriate E/M code, report "any diagnoses that come with that examination, which are probably more than just the AK," Ripley says.

Example: If a patient comes in for an initial AK visit, you should charge an E/M service, since the physician has to examine the area and discuss treatment options. But when the patient comes in for another treatment and the dermatologist doesn't do anything other than the re-treatment (or the light-exposure portion of photodynamic therapy), don't report an office visit.

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 AK removal.

What to look for: Documentation should include the history, physical examination, assessment and plan in one paragraph, coding experts say. The second paragraph should describe the AK'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.

2. Append Modifier 25 to the Office Visit

Standard procedure is to attach modifier 25 to any E/M code you report on the same day as a procedure code, Ripley says. 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 the AK, such as evaluating dermatitis (692.9, Contact dermatitis and other eczema; unspecified cause), you should use modifier 25 on the E/M.

Lesion removal and E/M example: During a dermatological checkup, the dermatologist discovers an AK on the hand of a 30-year-old established male patient. The dermatologist offers to remove the lesion with cryotherapy. The patient agrees, and the physician applies liquid nitrogen to the AK.

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 cryotherapy. You should append modifier 25 to the evaluation and management service to show that the office visit is a significant and separately identifiable service from 17000.

3. Know When to Report Separate Diagnoses

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