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Dermatology Coding Alert

AK Removals: 17000-17111 With 99201 Can Bring In $120

Follow these 3 tips for your E/M and lesion removal procedures.

When your dermatologist performs an E/M service with actinic keratoses (AK) removal, you can report both the E/M and lesion removal if the E/M service was a significant andseparately 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.

You can only consider reporting modifier 25 when coding an E/M service, says **Janet Palazzo, CPC,** coder for a practice in Cherry Hill, N.J. If the procedures you're reporting don't fall under E/M services, it's possible the encounter qualifies for another modifier instead.

Take a look at the following three tips to help you report these services accurately so your practice won't miss out on about $41 for 99201 and $80 for 17000 or more, according to national averages indicated in Medicare's 2011 Physician Fee Schedule.

Tip 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, especially if the patient is new to your practice.

Along with the appropriate E/M code, report any diagnoses that come with that examination, which may include more than just the AK.

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.

Tip 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

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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), premalignant lesions [e.g., actinic keratoses]; 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.

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