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Dermatology Coding Alert

Avoid Common Snafus When Reporting 99212

Modifier -25 protects when it comes to additional brief procedures and E/M

Dermatology practices look to 99212 as a stable, easy source of constant revenue, but misreporting or overlooking this code can deny your practice well-deserved pay.

Use these three scenarios to learn when to report 99212 (Office or other outpatient visit for the evaluation and management of an established patient ... Physicians typically spend 10 minutes face-to-face with the patient and/or family).

Don\'t Forfeit E/M With Other Procedures

When your dermatologist provides services that require very little time in addition to other E/M services to a patient, you shouldn\'t automatically dismiss the possibility of reporting low-level E/M codes in addition to or instead of a procedure code.

Scenario 1: An established patient presents to your practice so your dermatologist can remove five sutures that the patient\'s family physician put in for a lesion he excised. Should you report a low-level E/M code for this procedure?

Answer: If your dermatologist removes sutures while the patient is under anesthesia, you could report either 15850 (Removal of sutures under anesthesia [other than local], same surgeon) or 15851 (Removal of sutures under anesthesia [other than local], other surgeon).

Red flag: In most cases, dermatologists would not use anesthesia to remove sutures. Therefore, in this instance, you should report a low-level E/M (such as 99212), says **Linda Martien, CPC, CPC-H,** National Healthcare Review in Woodland Hills, Calif.

Generally, repair codes include suture removals, so you should not charge separately for suture removal, Martien says. However, when a dermatologist removes sutures put in by another physician (such as the family practitioner in this case), you can charge for the suture removal with the lower-level E/M code, Martien says.

Medicare pays about $35 for 99212, which can add up quickly if your dermatologist performs several 99212 procedures per day.

If your dermatologist wants to bill suture removal at a higher E/M service level, be sure to double-check the documentation to see if he can justify a higher level of decision-making and the additional time he spent with the patient based on medical necessity, Martien says.

Extra: Generally, the medical documentation for hassle-free, quick procedures (such as suture removal) supports only a low-level code like 99212.

But if the removal is part of a visit for another problem (such as a wound-related infection), you should include the suture removal in the E/M visit for the separate problem, which then raises the level of E/M services the dermatologist provides.

Use Modifier -25 With Low-Level Codes

When a patient comes in for a routine check and the dermatologist performs an additional brief procedure, you should

report both the procedure and the E/M appended with modifier -25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service).

Scenario: An established patient comes to see your dermatologist for a routine visit to check for seborrheic keratosis (SK).

The dermatologist examines the patient, educates him on treatment and decides he is low-risk for SK. He completes this examination in less than 10 minutes.
But while the dermatologist speaks with the patient, he notes a suspicious lesion on the patient\'s arm. As a result, the dermatologist decides to biopsy the lesion and send the specimen to pathology.

Answer: In this case, you can report low-level E/M code 99212 to cover the initial examination the dermatologist completed on the patient, says **Carole Violette**, **CPC, CDC,** clinical manager at Yakima Valley Dermatology in Yakima, Wash.

You should also report a diagnosis code (702.11, Inflamed seborrheic keratosis) for the low-risk diagnosis the dermatologist gave the patient, Violette says.

You should report 11100 (Biopsy of skin, subcutaneous tissue and/or mucous membrane [including simple closure], unless otherwise listed; single lesion) for the biopsy of the suspicious lesion on the patient\'s arm that the dermatologist completed, she says.

In this case, there is not a site-specific biopsy code to describe the biopsy of a lesion on an arm. Therefore, 11100 is the most specific code you can report.

Don\'t miss: You should append modifier -25 to the lesser-valued procedure, which in this case would be 99212 ($35 versus $45 for code 11100), Violette says.

You Might Not Report E/M, Even for Established Patients

For an established patient your dermatologist sees several times throughout the year, you may automatically assign 99212 or 99213 - but you could be making a big mistake.

Here\'s a multi-part scenario to help illustrate why you shouldn\'t get too comfortable with these low-level codes.

Scenario, Part A: The patient presents to your practice with a crusty lesion on her left shoulder. Your dermatologist has not seen this patient for two years.
Your dermatologist performs a problem-focused history and a detailed examination and makes a diagnosis of actinic keratosis (AK, 702.0, Actinic keratosis).

The dermatologist recommends removing the lesion, but the patient wants to just watch it for a while.

Hint: The documentation notes straightforward medical decision-making.

Answer: In this instance, you should report 99212 for the low-level, straightforward procedure the dermatologist delivered, Martien says.

Though the dermatologist had not seen the patient for two years, as long as he sees her within three years, carriers still consider the patient as an established patient.

Scenario, Part B: The same patient returns six months later for re-evaluation of the actinic keratosis. The dermatologist again performs a problem-focused history and a problem-focused exam. The lesion has not changed, and again the patient puts off making a decision regarding treatment.

At this time the patient asks the dermatologist to look at her right great toe. She reports increasing pain, redness and tenderness to the nail for the past two weeks. The dermatologist concludes the patient has an infected ingrown toenail.

The dermatologist performs a digital block and performs a wedge excision of the skin of the nail fold. He treats the wound with antibiotic ointment and dresses it. The visit lasts for no longer than 10 minutes.

Answer: In this scenario, you will report 99212 for the E/M service and 11765 (Wedge excision of skin of nail fold [e.g., for ingrown toenail]) for the infected, ingrown nails.

Don\'t forget: You should append modifier -25 to the E/M code to notify carriers that the dermatologist performed two separate procedures, Martien says.

Scenario, Part C: The same patient returns in three months. She decides that she wants the dermatologist to remove the AKs on her shoulder. The dermatologist treats the AK with liquid nitrogen.

Answer: You should only 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) in this instance.

You would not report an E/M service for this visit because the patient presented to your practice to have the dermatologist remove the lesion. There are no key components (such as, history, exam, medical decision- making) to justify reporting an E/M, Martien says.