Dermatology Coding Alert

Documentation Holds the Key for Full Dermatology Pay

Don\'t miss these 4 questions to help you recoup as much as $80

Solid documentation that includes E/M components, body systems, and service levels holds the key for any practice\'s payments because local payers will always turn to documentation when justification of reporting or questionable reimbursements come into play. Supplying too much or too little information could mean reduced or denied compensation.

Helpful: With the help of our coding experts, we\'ve pulled together four questions to ask yourself to make sure your dermatologist\'s documentation meets the grade-A mark.

Question 1: Did your dermatologist specify two of the three E/M components?

To avoid underreporting and underpayment, make sure your dermatologists\' documentation assigns two of the key components to the following daily subsequent care codes for a patient\'s evaluation and management:

1. 99231 -- ... problem-focused interval history, problem-focused exam, straightforward or low-complexity medical decision-making
2. 99232 -- ... expanded problem-focused interval history, expanded problem-focused exam, moderate-complexity medical decision-making
3. 99233 -- ... detailed interval history, detailed exam, high-complexity medical decision-making.

Note: The key components are the history, the exam and the medical decision-making.

When reporting these codes, clearly determine the differences between consult care and established patient care, says **Linda Martien, CPC, CPC-H**, coding expert with National Healthcare Review Inc. in Woodland Hills, Calif.

Martien explains that often dermatologists may make the mistake of not deciphering the difference between these two levels of care.

Solution: You should look for both the request from the requesting physician and the report by the dermatologist back to the requesting physician to ensure that the service was a consult and avoid denials for your consult care.

Question 2: Did the dermatologist report two to seven body systems?

If the dermatologist examines a patient for skin carcinoma, he must examine and document at least two to seven body systems: constitutional, eyes, ears, nose, mouth, and throat; cardiovascular; respiratory; gastrointestinal; genitourinary; musculoskeletal; integumentary (skin and/or breast); neurological; psychiatric; endocrine; and hematologic/lymphatic and allergic/immunologic.
For dermatologists, the most common body systems reported may include constitutional, eyes, ears, nose, mouth, and throat, and of course integumentary (skin and/or breast).

What you should see in the note: Your physician should use phrases such as EYES: pupils equal and reactive to light (PERL); HEART: regular, rate and rhythm (RRR); LUNGS: clear to auscultation (CTA).

Documentation of the skin may include: Palpation of scalp and inspection of hair of scalp, eyebrows, face, chest, pubic area (when indicated); and extremities; and inspection and/or palpation of skin and subcutaneous tissue (e.g., rashes,

lesions, ulcers, susceptibility to and presence of photo damage) in these areas: 1) head and neck; 2) chest, breasts and back; 3) abdomen; 4) genitalia; and 5) extremities

Question 3: Does the documentation identify the appropriate service level?

Attention: To help your dermatologist better understand the service levels, try three steps:

1. Present him with internal and external audits. These audits will show your dermatologists which codes were not allowed based on the documentation reviewed. The audits may also help to illustrate to the doctors what was missing in the original documentation.

2. Review the CMS documentation guidelines with the physician so he will understand what constitutes a level-one, -two or -three standard of care. Sometimes doctors mistakenly assume that if they write enough, Medicare or private carriers will pay for a higher level of treatment. Remember: It\'s the quality of the note, not the quantity.

3. Review the charts to make sure the physician has written or inferred the diagnoses for his patients.

Beware: Underdocumenting can result in undercoding. Downcoding over the course of a year could cost the physician thousands of dollars. And, your carrier may assume that your practice doesn\'t have a true bell curve in its coding practices, and this can signal abuse, says **Carole Violette, CPC, CDC**, clinical manager at Yakima Valley Dermatology in Yakima, Wash. All practices should use a variety of E/M codes, not just middle-of-the-road coding to avoid problems such as downcoding, she says.

Another tip: The old saying \"If it isn\'t documented, it wasn\'t done\" is the best way to avoid abusive billing practices, Violette says.

Question 4: Do your dermatologists know the levels of service?

To help your physicians understand the different levels of service, try using the \"nature of the presenting problem.\"

Since \"low risk\" corresponds to code 99213 (Office of other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three components: an expanded problem-focused history; and expanded problem-focused examination; medical decision-making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem[s] and the patient\'s and/or family\'s needs. Usually the presenting problem[s] are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family), explore with your dermatologists what types of patients you see that might fit into 99213.

Do the same for code 99214 and moderate- to high- risk patients. You might also reference the clinical vignettes provided in CPT -- see Appendix C in your CPT Manual, coding experts say.