Dermatology Coding Alert

Sort Out Your AK Chemical Peel Denials by Focusing on Diagnoses and Documentation

Your best defense? An ABN -- but don't forget to apply modifier GA, GY, and GZ.

Using chemical peels for the treatment of conditions such as actinic keratoses? If you're having trouble receiving payment, you're not alone. Experts say the culprit may be your diagnoses.

Get to the bottom of your denied claim by examining the applicable CPT and ICD-9 codes and highlight these details in your dermatologist's documentation.

First, Familiarize Yourself With Valid CPT Codes

Peels have come a long way since their last CPT update in 1994, with different methods of application yielding different results ranging from mild erythema to a complete shedding of the stratum corneum, notes **Karen Hurley, CMM, CPC, LE,** president of HPMSI and owner of Karen Hurley Skin Care in Waldorf, Md. That means you've got to make certain you've got to apply the right CPT code in the right circumstance.

The procedure of chemical peeling refers to a controlled removal of varying layers of the epidermis and superficial dermis with the use of a "wounding" agent, such as phenol or trichloroacetic acid (TCA), say Web sources. Although it is commonly used to treat photoaged skin, (e.g., correcting pigmentation abnormalities, solar elastosis, and wrinkles), chemical peeling has also been used as a treatment for multiple actinic keratoses when treatment of individual lesions is not doable. Experts dub laser resurfacing and chemical peel with trichloroacetic acid as highly safe with limited morbidity.Codes 15788 (Chemical peel, facial; epidermal) and 15789 (Chemical peel, facial; dermal) both pertain to facial areas, while 15792 (Chemical peel, non-facial; epidermal) and 15793 (Chemical peel, non-facial; dermal) describe non-facial areas.

Aside from these, you might also report 17360 (Chemical exfoliation for acne). Also, you might examine the more general codes 17000-17004 (Destruction of premalignant lesions), which pertain to destruction by any method.

Watch Out for These Diagnosis Mistakes

If you receive a denial, check whether your dermatologist administered chemical peel treatment for the purpose of necessity or cosmetic reasons. Important: You should always code the diagnosis your physician provides for the chemical peel, says Hurley.

For instance, suppose the dermatologist did the chemical peel for actinic keratoses (702.0). Did you accidentally report 702.19 (Other seborrheic keratosis) which represents non-symptomatic seborrheic keratosis? CMS considers the removal of 702.19 as cosmetic unless the growth is bleeding, painful, intensely itchy, purulent, or impairs the patient's function in some other way.

On the other hand, "actinic keratoses (AK) are precancerous and always medically necessary. Because there are non-surgical treatments for AK, there may be coverage decisions based on the type of treatment rather than the diagnosis, as is often seen," says **Pamela J. Biffle, CPC, CPC-I, CCS-P, CHCC, CHCO,** owner of PB Healthcare Consulting and Education Inc in Watauga, Texas. For instance, dermatologists may treat AK using cryosurgery with liquid nitrogen, topical drug therapy, and curettage. Just the same, Medicare accepts less-popular methods of treatment, including dermabrasion, excision, laser therapy, photodynamic therapy (PDT), and chemical peels.

Complete Your Report on AK to the Last Detail

Your dermatologist can document the destruction of actinic keratoses in a number of ways -- but if it's incomplete, then that can lead to coding mistakes. Physicians commonly use diagrams enclosed in their progress notes where they can freely mark the body parts where AK is located. Then, they indicate whether theyremoved the AK or not in the assessment report.

Imperative: Make sure that your dermatologist indicates medical necessity for this procedure in his operative report. "Medical necessity should be met in order for you to charge this procedure. Without it, it will be denied," says **Doreen A. Bauer Smith, RHIT,** coding specialist, Dermatology/Womens' Health, University of Minnesota Physicians in Minneapolis,. She adds that an "invaluable tool" in her day-to-day work is checking out the CMS Web site when encountering a doubtful situation.

The Web site provides the LCD (local coverage determination) for your region.

Also, your dermatologist shouldn't forget to document where in a patient's body the AKs are located, as well as the exact number treated, says **Janet McDiarmid, CPC, MPC, CMM, AFC, APC, CCP,** McDiarmid Consultants LLC, past president of the American Academy of Professional Coders.

Cover Your Bases by Explaining Coverage

Don't be caught holding the bag if the patient's payer does not reimburse chemical peel treatments. "It would be a good idea to explain to a patient prior to therapy, there is no guarantee of insurance coverage until after the health plan reviews the claim. If the physician feels strongly that it is a treatment for a premalignant condition -- such as actinic keratoses -- then waiting for the health plan reimbursement may be appropriate, depending on practice policy," Hurley says.

Fallback: If you're not sure that your claim is solid, have the patient sign a waiver of benefits (advanced beneficiary notice or ABN) prior to having the service. That way, the patient pays at the time the dermatologist performs the service.

How an ABN works: Hurley explains the steps you have to take when resorting to an ABN for a Medicare patient. "Submit the claim with the appropriate ABN modifier and wait for possible consideration. If the payer reimburses the claim, your practice would then owe the patient a refund. If the payer denies the claim, you'll have your ABN to protect your right to keep the patient's payment." The ABN modifiers include:

• GA (Waiver of liability statement on file) indicates the provider expects Medicare will deny a service as not reasonable and necessary and that the beneficiary has signed an ABN that is on file;

• GY (Item or service statutorily excluded or does not meet the definition of any Medicare benefit) indicates the service provided to the beneficiary is statutorily noncovered and not a Medicare benefit;

• GZ (Item or service expected to be denied as not reasonable and necessary) indicates the provider expects Medicare will deny a service as not reasonable and necessary and the beneficiary has not signed the ABN.