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Internal Medicine Coding Alert

CCI 20.2 Update: New CCI Policies For Multiple Skin Lesion Destruction Codes

CCI also adds new bundles for reporting two E/M services together.

Hold your horses if you are planning on reporting two E/M codes for the same patient on the same calendar date of service. The latest version 20.2 of the Correct Coding Initiative (CCI) edits that came into effect on July 1, 2014, includes new edit bundles that do not allow you to report these services together. You also need to apply caution when planning on reporting skin lesion destruction codes with excision codes.

Summary: In CCI 20.2, effective July 1, 2014, there are 20,729 new edit pairs. While there are only 212 terminations, there's a net gain of 20,517 new edit pairs for a total of 1,334,994 active edit pairs in the database. There are 107 changes to the modifier indicator, and of these, 90% went from 1 (you can use a modifier if appropriate) to 0.

Reporting Destruction Codes With Excision Here's What You Need to Do

If your internist performs destruction of a premalignant lesion and in the same session removes another benign or malignant lesion by excision, you will need to be cautious while reporting the appropriate CPT® codes for both the procedures. Your clinician might use cryosurgery, laser surgery, electrosurgery, chemosurgery, or surgical curettement for the destruction.

The new set of CCI edits have brought in additional code bundles that do not allow you to report both the procedural codes together for the same patient on the same calendar date of service. However, since the modifier indicator for these code edits is '1,' you can unbundle the codes if you use a suitable modifier. The modifier that you will have to append to the code in column 2 (which in this case is the excision codes) is 59 (Distinct procedural service).

The column 1 destruction CPT® codes that are included in the version 20.2 of the edits are 17000 (Destruction [e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement], premalignant lesions [e.g., actinic keratoses]; first lesion) and 17004 (...15 or more lesions).

The column 2 codes for these code bundles include the CPT® codes in the following code ranges:

- 11300 - 11313 (Shaving of epidermal or dermal lesions)
- 11400 - 11471 (Excision-benign lesions on the skin)
- 11600 11646 (Excision-malignant lesions on the skin)

"What's new in CCI 20.2 is the edits involving 17004 in column 1," notes an expert. "Most of the edits involving 17000 in column 1 and the three code families highlighted above pre-date CCI 20.2. It's unclear why CMS has not instituted the corresponding 17004 edits until now," he adds.

In addition: Apart from the code bundling with excision procedures, the destruction codes, 17000 and 17004 are also bundled with other destruction CPT® codes. The destruction codes in the column 2 of these edits are reported for destruction procedures on malignant lesions of the integumentary system (17260-17286). Again, the modifier indicator for this code bundling is also '1,' which means you can unbundle the codes by using the modifier 59. You append the modifier to the destruction codes in the range 17260-17286.

Example: An established 66-year-old male patient presents to your physician with complaints of a painful skin eruption in the area of the chest. Your internal medicine specialist examines the patient and observes that the lesion is about one cm in diameter and is round and mobile. He arrives at the diagnosis of a benign epidermoid cyst. During the

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examination, your clinician also notes that the patient has 16 lesions of actinic keratosis in the areas of the forearms. He proceeds to remove the epidermoid cyst by performing an excision and destroys the other skin lesions by surgical curettage.

What to report: You report the excision of the epidermoid cyst using 11401 (Excision, benign lesion including margins, except skin tag [unless listed elsewhere], trunk, arms or legs; excised diameter 0.6 to 1.0 cm) and you report the surgical curettement of the lesions of actinic keratosis with 17004. Since CCI edit bundles the code 11401 into 17004, you append the modifier 59 to 11401.

Get Cautious Reporting Two E/M Services on Same Calendar Date of Service

Although it is usual for you to report only one E/M code for a patient visit on one calendar date of service, there are instances when you will have to report more than one E/M code for the same patient on the same calendar date of service.

As stated in section 30.6.5 of chapter 12 of the Centers for Medicare and Medicaid Services (CMS) Medicare Claims Processing Manual, "Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician. If more than one evaluation and management (face-to-face) service is provided on the same day to the same patient by the same physician or more than one physician in the same specialty in the same group, only one evaluation and management service may be reported unless the evaluation and management services are for unrelated problems."

So, if your physician or two of your physicians evaluate the patient twice (typically at different times) on the same calendar date service for unrelated problems, you may report two E/M codes for the two distinct encounters. The version 20.2 of the CCI edits bundles office/outpatient new patient E/M codes (99201-99205) with established patient codes (99211-99215). Also, lower level established patient codes are bundled into a higher level established patient code.

For example, a level two established patient code (99212) is bundled into a level two new patient code (99202) and other new patient office/outpatient E/M codes. Another example of this bundling between established patient codes is a level three established patient code (99213) being bundled into a level four or level five established patient code (99214 or 99215).

Modifier indicator: Even though you face edits when trying to report two office visit E/M codes for a patient on the same calendar date of service, you can report both the codes for the patient separately. You are permitted to do this because the modifier indicator for the above mentioned code bundles is '1,' which means you can unbundle the codes by using a modifier. The modifier that you will have to use with the column 2 code is 25 (Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service).

Example: An established 70-year-old female patient returns to your provider after suffering a skin laceration while trying to climb into a vehicle. The patient had earlier visited your physician for a scheduled E/M visit to check on high blood-sugar levels and a decubitus ulcer. Since the evaluation of the skin laceration is in no way related to her earlier visit and represents a significant, separately identifiable E/M service, you may report it with a separate E/M code.

If the first visit was reported with 99213 and the second visit warranted you to report 99212, you will have to report 99212 with the modifier 25 appended.

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