Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Dermatology Services Impacted Hard by CCI 19.2

Focus on three modifiers for unusual cases.

If you're rusty on when evaluation and management (E/M) services are included in the surgical package, you're in for a rude awakening now that Correct Coding Initiative (CCI) version 19.2 went into effect on July 1.

That's because the number of changes to CCI 19.2 approaches 300,000 code pairs, and "97 percent [of new-edit-pair column one codes] are within the surgical category," according to **Frank Cohen, MPA, MBB**, principal and senior analyst for The Frank Cohen Group in Clearwater, Fla.

What's in column 2? "For column 2 codes, E/M led the pack with almost 95 percent of the total, so we can expect the changes in this release to affect everyone," Cohen states.

Learn New Bundles

Most of the new edit pairs that will affect dermatology practices fall in the integumentary chapter. CCI 19.2 bundles virtually every 10000-level procedure with the majority of E/M codes. You should pay particular attention to the following common procedures that are column one codes bundled with E/M codes in column 2:

- Incision and drainage 10060-10180
- Debridement 11000-11044
- Biopsy 11100-11313
- Lesion excision benign (11400-11471) and malignant (11600-11646)
- Repair simple (12001-12021), intermediate (12031-12057), and complex (13100-13160)
- Adjacent tissue transfer 14000-14350
- Skin replacement surgery 15002-15278
- Flaps and grafts 15570-15776

Beware wound therapy pairs: CCI 19.2 also bundles several of the preceding codes with G0456 and G0457 (Negative pressure wound therapy, [e.g., Vacuum assisted drainage collection] using a mechanically powered device, not durable medical equipment, including provision of cartridge and dressing[s], topical application[s], wound assessment, and instructions for ongoing care, per session...) in column 2.

Recall E/M CPT® Rules for Surgery

To understand why CCI added all these edit pairs, you need look no further than CPT® surgery guidelines, which state that the surgical package includes "one related E/M encounter on the date immediately prior to or on the date of procedure (including history and physical)."

Note that the guidelines also specify that the included E/M service is subsequent to the decision for surgery. In other words, CCI's new edit pairs reflect correct coding generally, you shouldn't separately report an E/M service with a surgical code on the same date of service or within the surgical global period.

Exception: If you have documentation that the E/M service is unrelated to the surgery or results in the decision for surgery, you can separately report the E/M service using an appropriate modifier.

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Don't Miss Modifier Options

Because CCI lists the new edit pairs with a modifier indicator of "1," you can report the bundled pair together by appending a modifier to the column 2 code.

If you have appropriate documentation, you can override the new surgery/E/M edit pairs by using one of the following modifiers:

- 24 – Unrelated evaluation and management service by the same physician or other qualified health care professional during a postoperative period
- 25 – Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of another service or procedure
- 57 – Decision for surgery.

24 rules: You should append modifier 24 to an appropriate E/M code only when an E/M service occurs during a postoperative global period for reasons unrelated to the original procedure.

Modifier 24 tells the payer that the provider is seeing the patient for a new problem. The diagnosis code tells the story, but payers want to have coders put the modifier on the claim to indicate this – perhaps because of the way their edits/flag system is set up.

25 rules: When using modifier 25, you should remember this maxim: If you don't have medically necessary HEM (history, exam, and medical decision-making), you can't bill an E/M.

Because each surgical procedure includes a related E/M, you can only report a distinct E/M using modifier 25 if the physician documents that the patient's condition requires and involves the additional key components of at least a problem-focused E/M service.

57 rules: You might use modifier 57 when your dermatologist performs a procedure and a distinct E/M service for the same patient on the same day. Add modifier 57 to an E/M code when the decision for a major surgery with a 90-day global period is made.

Modifier 57 tells the story that even though there is an E/M and a surgery procedure on this claim form within a day of each other, the E/M is not a pre-op visit. It was the 'decision for surgery' visit and is therefore not bundled into the surgery code package.

Because modifier 57 claims involve an E/M service that results in a decision for surgery, you would expect to see the same diagnosis code for both the E/M and the surgical procedure. The dermatologist would not make a decision for surgery based on a significant problem unrelated to the procedure.