Outpatient Facility Coding Alert

Dermatology: Focus on Diagnosis and Documentation to Successfully Report AK Treatment

Choosing correctly from 15788-15793 is crucial to your claim.

Chemical peels aren't just for cosmetic purposes anymore -- but that doesn't mean reimbursement is a given. Get to the root of denials for your ASC and smooth out future claims by watching three simple things.

Learn Your Different Code Choices

Chemical peels can have results ranging from mild erythema to a complete shedding of the stratum corneum, depending on which method of application the physician uses. Because of that, you need to pay attention to the circumstances to choose the correct CPT® code.

Uses: The term "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). Although chemical peels are commonly used to treat photoaged skin, (e.g., correcting pigmentation abnormalities, solar elastosis, and wrinkles), physicians can also use peels to treat multiple actinic keratoses when treatment of individual lesions is not doable.

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.

The national average payment rates are as follows:

Caution: Don't be tempted to report 17360 (Chemical exfoliation for acne [e.g., acne paste, acid]), for AK treatment, warns **Pamela Biffle, CPC, CPC-P, CPC-I, CCS-P, CHCC, CHCO,** owner of PB Healthcare Consulting and Education Inc. in Austin, Texas. You should also avoid the more general codes 17000-17004 (Destruction of premalignant lesions), which pertain to destruction by any method, as guidelines require you use the most specific code, she says.

Steer Clear of These Diagnosis Mistakes

If you receive a denial, check the diagnosis to learn whether the physician administered chemical peel treatment because of necessity or for cosmetic reasons.

Example: Suppose the physician performed the chemical peel to treat actinic keratoses (702.0). Did you accidentally report 702.19 (Other seborrheic keratosis), which represents non-symptomatic seborrheic keratosis? CMS considers removals represented by 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 are 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 Biffle.

Explanation: Physicians may treat AK using cryosurgery with liquid nitrogen, topical drug therapy, and curettage. Medicare also accepts less-popular methods of treatment, including dermabrasion, excision, laser therapy, photodynamic

therapy (PDT), and chemical peels. Review your local carrier's policies before assuming treatments will be covered, Biffle says.

Remind Physicians to Document Clearly

The physician can document destruction of actinic keratoses in a number of ways -- but incomplete details can lead to coding mistakes.

Work-around: Physicians commonly use diagrams in their progress notes where they can mark the body parts where AK is located, and the exact number treated. Then, they indicate whether they removed the AK or not in the assessment report.

Imperative: Ensure that the physician indicates medical necessity for this procedure in his operative report. The situation must meet medical necessity requirements before you can charge for the procedure. Otherwise, experts say your claim will be denied.

Use ABNs to Boost Bottom Line Chances

Because insurance payment for chemical peels can sometimes be iffy, cover your bases with the patient up front.

Explain prior to the procedure that 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 keratosis -- then waiting for the health plan reimbursement may be appropriate, depending on practice policy.

Fallback: If you're not sure the claim is solid, ask the patient to sign a waiver of benefits (advanced beneficiary notice or ABN) prior to having the service. That way, the patient knows he is expected to pay for the service if his insurance denies coverage.

How an ABN works: Submit the claim with the appropriate ABN modifier and wait for possible consideration. 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.

If the payer reimburses the claim, the patient pays nothing. If the payer denies the claim, you have documentation showing the patient will cover the charges.