Dermatology Coding Alert
The practical adviser for ethically optimizing coding, payment, and efficiency in dermatology practices

CPT® 2012 Update

New Codes Abound for Skin Substitutes

Plus: Check out time guidelines for initial observation codes.

Have you ever wished that CPT® would simplify the skin substitute graft codes? Then you’ll be in luck as of Jan. 1, when the new manual will offer eight new codes to take the place of the 15300-15431 range. These changes and many more can be found in the pages of the new edition of the CPT® manual, with codes that take effect on Jan. 1, 2012.

Code Skin Substitutes by Location and Size, Not Type

No matter what type of skin substitute your physician uses — allograft, acellular dermal allograft, tissue cultured allogeneic dermal substitute skin substitute, tissue cultured allogeneic dermal substitute, xenograft, or acellular xenograft implant — you’ll turn to the new “Skin Substitute Grafts” section in CPT® 2012.

Old way: Prior to Jan. 1, 2012, you would pick your skin substitute code based on what type of skin substitute the dermatologist used. For example, for an allograft, you would report 15300-15321 (Allograft skin for temporary wound closure ...); for a tissue cultured allogeneic skin substitute, you would report 15340-15366 (Tissue cultured allogeneic skin substitute ...).

2012 way: Starting next January, you’ll pick the code based only on the wound site and size, from the new code range 15271-15278 (Application of skin substitute graft ...).

Trunk, arms, or legs: For a wound to the trunk, arms, or legs, look to codes 15271-15273 (Application of skin substitute graft to trunk, arms, legs ...). If the wound is smaller than 100 sq cm, you’ll report 15271 (... total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area) for the first 25 sq cm of graft, and add-on code +15272 (... each additional 25 sq cm wound surface area, or part thereof [List separately in addition to code for primary procedure]) for each additional 25 sq cm.

For a wound to the trunk, arms, or legs 100 sq cm or larger, you’ll look to 15273 (... total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children) for the first 100 sq cm of graft, and +15274 (... each additional 100 sq cm wound surface area or part thereof ...) for each additional 100 sq cm thereafter.

Other areas: For wounds to other bodily areas, such as the face, mouth, genitalia, hands, or feet, check out codes 15275-15276 (Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits ...). You’ll use 15275-15276 (... total wound surface area up to 100 sq cm ...) for wounds up to 100 sq cm,
and 15277-15278 (… total wound surface area greater than or equal to 100 sq cm …) for larger wounds.

Similar to +15272 and +15274, +15276 and +15278 are add-on codes, representing graft applications larger than those described in the initial codes (15275 and 15277, respectively).

Observation Time Guidelines Could Help You Out

When CPT® 2011 debuted the subsequent observation care codes 99224-99226, many coders were left scratching their heads at the fact that those new codes featured typical times associated with them, even though the initial observation care codes 99218-99220 don’t have typical times. The new edition of your CPT® manual, which takes effect on Jan. 1, will remedy that problem, with the addition of the following typical time guidelines:

- 99218 — …Physicians typically spend 30 minutes at the bedside and on the patient’s hospital floor or unit
- 99219 — …Physicians typically spend 50 minutes at the bedside and on the patient’s hospital floor or unit
- 99220 — …Physicians typically spend 70 minutes at the bedside and on the patient’s hospital floor or unit.

Although the specific reasons for the CPT® committee’s inclusion of these codes won’t be crystal clear until the AMA’s November CPT® Symposium, it looks like the addition of typical times could open the door for coding based on time.

“There are only two ways that you can use time as a basis for selecting an E/M code,” says Barbara J. Cobuzzi, MBA, CPC, CENTC, CPC-H, CPC-P, CPC-I, CHCC, president of CRN Healthcare Solutions, a consulting firm in Tinton Falls, N.J. “If counseling/coordination of care takes up 50 percent or more of the visit, and if the code has a typical time associated with it. So by these codes now having a time reference, it sounds like we may have a way to reference time used if counseling or coordination of care takes up at least 50 percent of a visit. In addition, this could open the door to collecting for prolonged service times if the time the doctor spends exceeds 30 minutes more than the allotted time, and the visit notes are documented as such,” Cobuzzi adds.

New 2012 Modifier May Not Mean Extra Pay

It isn’t every year that CPT® adds new modifiers for your coding and billing needs, so when you see a new one gracing the pages of your 2012 manual, you might get excited — but don’t rejoice just yet.

Modifier 33 (Preventive service) went into effect on Jan. 1, 2011, but it didn’t make it into the 2011 CPT® book due to publishing deadlines, so the modifier will be making...
its first appearance in the 2012 manual. According to CPT®, the modifier should be appended “when the primary purpose of the service is the delivery of an evidence based service in accordance with a US Preventive Services Task Force A or B rating in effect and other preventive services identified in preventive services mandates.”

**ICD-9 Coding**

### 700 Basics: Take the Rough Edge Off Corn and Callus Coding

Will you know what to do when these little-known terms show up in your doctor’s documentation?

For dermatologists treating the skin of a patient’s foot, one of the most commonly coded diagnoses is corns (and calluses). The condition has a slew of confusing names that may be hard to find — or may not even be in your coding book — and could quickly derail your claims.

Deciphering all of the corn and callus terminology can be especially difficult if you work for several physicians and each one has his own way of naming the same thing, or if you’ve recently started working at another practice. But you no longer have to be in the dark over a callus-related term that comes your way.

**Familiarize Yourself With the Jargon**

You may recognize the word “clavus,” since the ICD-9 corn/callus code 700, *Corns and callosities; includes callus, clavus*, names it up front. But here are a few more related words that many dermatologists use interchangeably in their notes that you should keep in mind:

- Clavi (the word for more than one “clavus”)
- Keratosis
- Keratoma
- Hyperkeratosis
- Intractable plantar keratosis (may be abbreviated as “IPK”)
- Heloma
- Callosity
- Tyloma
- Tylosis
- Durum (this term refers to “heloma durum,” which is considered a “hard corn”).

**Watch out:** “Tylosis” could lead you down the wrong coding path if you’re not careful. The ICD-9 index in the front of the coding book leads you to several options, such as 757.39 (Other specified anomalies of skin; other; includes accessory skin tags, congenital; congenital scar: epidermolysis bullosa; keratoderma [congenital]), and this is the wrong path for a basic corn or callus. Your best bet when you encounter this term in the documentation is to ask the dermatologist to clarify the condition.

**ICD-10:** Once ICD-9 converts to ICD-10 in October, 2013, code 700 will no longer be valid. Instead, you would report ICD-10 code L84 (*Corns and callosities*). The deadline for using ICD-10 is Oct. 1, 2013, with no grace period, stresses...
Pat Brooks, RHIA, senior technical advisor with the Centers for Medicare and Medicaid Services.

Master the Definitions

If you’re still unsure about your dermatologist’s everyday description of these common conditions, learning the definitions of “corn” and “callus” will help.

- A corn is a small, horny area of the skin caused by local pressure (e.g., a shoe or hosiery) irritating the tissue over a bony prominence.

Corns usually occur on a toe, where they form “hard corns.” “Between the toes, pressure can form a soft corn of macerated skin, which often yellows.

- A callus is localized thickening and enlargement of the horny layer of the skin due to pressure or friction. Generally, calluses as well as corns can cause pain, and soft-tissue inflammation may occur around the base of the lesion.

Knowing these definitions is also helpful if you plan to ask the dermatologist for clarification.

Example: You’re struggling with how to code a patient diagnosis that describes a “keratosis” of the bottom of the great toe and the heel. You’ve learned the synonyms for corns/calluses and remember that this is another name for a callus, but you notice that another nearby code has the same word in its descriptor: 701.1 (Keratoderma, acquired; Keratosis [blennorrhagica]).

You ask the dermatologist for more details about the patient’s condition so you can code it properly, and he describes a basic thickening of the skin because of bad shoes. Referring back to the definitions, now you know that it’s just a callus and you can code it as 700.

If the condition were keratosis blennorrhagica, the dermatologist would have described a scaly rash that is associated with Reiter’s syndrome, and this would tell you to code something other than 700, which is for a mere callus.

But if a diagnosis brings you to the 701.x series (Other hypertrophic and atrophic conditions of skin), pay special attention to the definitions under each code.

The definitions can help you verify whether the doctor is using the corn/callus term as a synonym or for a more specific description of the condition.

E/M

HPI Know-How Helps You Catch Level 4 and 5 E/M Opportunities

Beware of CPT® and Medicare differences when counting HPI elements.

Not accurately accounting for the history of present illness (HPI) documented by your dermatologist could result in missing appropriate opportunities to report level 4 or 5 E/M visits. Ensure you’re not missing higher paying possibilities by reviewing this guide to capturing HPI elements.

Brush Up on What Qualifies as an HPI Element

HPI is one of the three parts comprising an outpatient E/M history. It describes the patient’s present illness or problem, from the first sign/symptom to the current status, and typically drives a provider’s decisions about the physical examination and treatment.

“The information gathered during the physical exam (PE) portion of a patient’s evaluation often only shows a very limited picture of the patient’s problem. However, speaking with a patient and gathering the history of the patient’s problem” can help fill out the picture, explains Amanda S. Stoltman, CCS-P, compliance coder at Urology Associates in Muncie, Ind.

Start counting: HPI also will often determine the level of service you’ll report. You’ll count the HPI elements to help you determine which level of service you can report. There are seven or eight HPI elements, depending on which source you are following. For Medicare, the eight elements are as follows:

» Location
» Quality
» Severity
» Duration
SPECIALTY ALERTS


In contrast: CPT® lists only seven HPI elements in the E/M Services Guidelines, with duration not making the list.

Therefore, for Medicare and payers following its guidelines, you should consider duration and timing separately. With payers that follow AMA rules, however, be aware that they don’t consider duration and timing to be two separate elements. Rumor has it this may change in a future edition of CPT®, though. Keep an eye out for 2012 revisions.

Start Counting to Differentiate Brief, Extended

There are two different types of HPI: brief and extended. If your dermatologist documents one to three HPI elements, then he performed a brief HPI. When you have a brief HPI you won’t be able to code any higher than a level two new-patient E/M (99202, Office or other outpatient visit for the evaluation and management of a new patient …), regardless of the encounter’s other specifics. For an established patient, a brief HPI can support up to and including 99213 (Office or other outpatient visit for the evaluation and management of an established patient …) (assuming other requirements are met).

The reason is that with only a brief HPI, the highest possible history level is “expanded problem focused,” according to the 1995 and 1997 documentation guidelines (assuming the visit meets the other history elements).

Alternative: When your dermatologist documents four or more HPI elements, you have extended HPI. Your physician must achieve an extended HPI for you to consider a detailed or comprehensive history. An extended HPI is a requirement for 99203-99205 (new patients) and 99214-99215 (established patients).

Example: “An extended HPI would include (especially if the patient is doing poorly) the length of time the current problem has been going on, what seems to make the problem better or worse, if it is worse during a particular portion of the day, the severity, and if the patient has any other signs/symptoms,” Stoltman says.

Caution: An extended HPI does not guarantee a higher level E/M code, but it does make reporting it possible. Ensure your dermatologist has met the other required elements of service before choosing these high-level codes. “Make sure your doctors obtain and document as much information as possible to allow billing a higher level E/M,” says Ruth Borrero, claims analyst at Prohealth Care in Lake Success, N.Y. However, remember that medical necessity for collecting that information is a key element of supporting the code you choose.

Ensure the Provider Documents the HPI

Remember that the physician must be the one who obtains the HPI. He cannot use or report the information obtained only by his staff. Your dermatologist must personally obtain, refine, add to, complete, and document the HPI if he expects to receive credit and reimbursement for services where the HPI becomes critical to scoring the E/M level of care.

Any employee in your practice, or even the patient himself, can document part of the history, Borrero says. In fact, the E/M service documentation guidelines state that ancillary staff may obtain and record the review of systems (ROS) and/or past family social history (PFSH).

However, documentation guidelines require that the information obtained by others must be attested to. Specifically E/M guidelines state, “To document that the physician reviewed

(Continued on next page)
the information, there must be a notation supplementing or confirming the information recorded by others.”

Reminder: “The physician, or other licensed provider, needs to reference the information provided,” Stoltman warns.

“Since the HPI should be the driving force behind the type of evaluation provided to a patient and treatment options, the HPI most definitely should only be documented by the physician.”

**Reader Questions**

Include Dressings in Debridements

**Question:**
Can our practice be reimbursed for the surgical dressing (supplies) of a partial-thickness burn?

**Georgia Subscriber**

**Answer:**
Medicare and most private carriers already factor supplies such as surgical dressings into the value of debridement codes. In these cases, you cannot recoup additional reimbursement using any codes.

Some commercial carriers may accept 99070 (Supplies and materials [except spectacles], provided by the physician over and above those usually included with the office visit or other services rendered [list drugs, trays, supplies, or materials provided]) or A4550 (Surgical trays) for supplies such as surgical dressings. But these carriers are also likely to require an itemized list of costs and charges. The research involved in determining those costs and charges may cost more than any reimbursement you may obtain.

**Example:**
A new 67-year-old female Medicare patient comes in for a consultation because she’s concerned about a growth on her left arm. The dermatologist does a full history and exam and decides to perform a biopsy. In this case, you would report 11100 (Biopsy of skin, subcutaneous tissue and/or mucous membrane [including simple closure], unless otherwise listed; single lesion) and 99243-25 (Office consultation ...).

If you’re wondering how to distinguish between a “major” and a “minor” surgery, look at the global period. If it’s zero, you shouldn’t even consider modifier 57. Reserve modifier 57 for major surgeries, in which the global period is 90 days — but make sure the surgery wasn’t prescheduled, or you’ll be looking at a denial.

Check with your private payers for their rules, but know that many of them mirror what Medicare says on this issue.

**25 or 57? Don’t Mix Modifiers**

**Question:**
I’m always at a loss on whether to use modifier 25 or modifier 57 when the dermatologist unexpectedly finds the need to do a biopsy of a minor growth during a consultation E/M. What is an example of when these individual modifiers are appropriate?

**Oregon Subscriber**

**Answer:**
Modifiers 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) and 57 (Decision for surgery) are easily confused, but the distinguishing factor is that Medicare restricts modifier 57 to major surgeries.

So, if you go with your example in which the dermatologist performs a regular E/M and decides to remove a minor growth, even though it’s a “surgery” you should use modifier 25 on the E/M (and report the biopsy code as well).

**Example:**
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Check with your private payers for their rules, but know that many of them mirror what Medicare says on this issue.

**Know Your State Laws, Payer Rules Before Sending Patient to Collections**

**Question:**
I work in a physician’s office handling the collection of past due copays, deductibles, and coinsurance as well as the coding and claims. Can I send extremely delinquent accounts to the credit bureau or a collections agency even if the patient is paying a few dollars a month if the practice didn’t agree to a payment plan?

**Washington Subscriber**

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**Answer:**
Yes, you can send information about delinquent accounts to collections agencies and/or credit bureaus — even if the patient is making a token attempt to pay up. If the patient is following a repayment schedule that you haven’t approved, then you have the right to insist on a quicker repayment.

**How it works:** If a patient is paying a small amount every month that was not approved, many practices do send them to collections, and the collection agency may or may not report them to the credit bureau.

You should check your own state’s laws and payers’ or carriers’ requirements, and make sure that your office has policies governing how it handles debts. Most offices have policies in place that show what monthly payments they will accept. If you bill patients, and they send in only a partial payment, it’s best to call them to arrange a set plan rather than just accepting whatever they pay.

**Note:** You, the original creditor attempting to collect a debt, have more rights than a third-party collector, such as a collection agency. Once you’ve turned over the account to a collection agency, then you should direct all payments to the collection agency. If the patient sends money directly to your office, you need to notify the collection agency about that payment. Most likely, your contract with the collection agency will specify how you report this payment and explain how the collection agency will obtain its cut of the money.

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**Collect Surgical Deductibles Up Front**

**Question:**
*We often have patients who don’t pay their deductible after surgery. Is there a recommended way to collect these payments up front?*

**South Dakota Subscriber**

**Answer:**
Yes, you may collect a deductible upfront. The first step is to confirm the deductible amount with the payer. Insurance verification services now make it possible for practices to determine if a patient has met his deductible, or how much deductible remains unpaid. Others provide just information on what the total annual deductible is. This information may also be found online. You usually can access updated information before the patient’s scheduled procedure.

**Pointer:** Before settling on the deductible due, check to see if the patient has Medigap coverage or other secondary insurance that will cover a portion of the payment. Then contact the patient to communicate what his responsibility may be. Try to speak with the patient about collecting the deductible several days, or even weeks, before the procedure, rather than on the day of the procedure.

Make sure you tell the patient where you obtained the information about his deductible, and let him know that the amount is an estimate based on the services your physician expects to perform. Otherwise, you may receive calls from patients after procedures saying they don’t owe any additional fees because they have already paid up front.

Always emphasize that the amount you are collecting is just an estimate, and after their insurance pays, you will adjust the payment amount, which may result in a partial refund or additional monies owed. Some practices use a written surgical fee estimate, which they provide to the patient.

If you cannot collect up front from a patient, you’re left with two options: reschedule the procedure or perform the procedure and hope the patient pays you afterwards when you send a bill. Many practices are opting for rescheduling, especially if the case is elective.

The last option to consider would be setting up a payment plan to allow the patient to pay off the amount due over time — an option, granted, which may leave you with a balance to write off.

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You Be the Coder

**Full-Thickness Graft**

*(Question on page 85)*

**Answer:**
When the dermatologist takes the graft from a different area than the defect site, you should report the graft. In this case, the dermatologist harvests the graft from the ear to close a nose defect. So, you should report the graft with 15260 (*Full-thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; 20 sq cm or less*), based on the graft’s type (full), the defect’s location (the nose), and its size (3 cm).

You should also assign the appropriate excision code (11643, *Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 2.1 to 3.0 cm*).
Dermatology

We would love to hear from you. Please send your comments, questions, tips, cases, and suggestions for articles related to Dermatology coding and reimbursement to the Editor indicated below.

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