Common coding mistakes

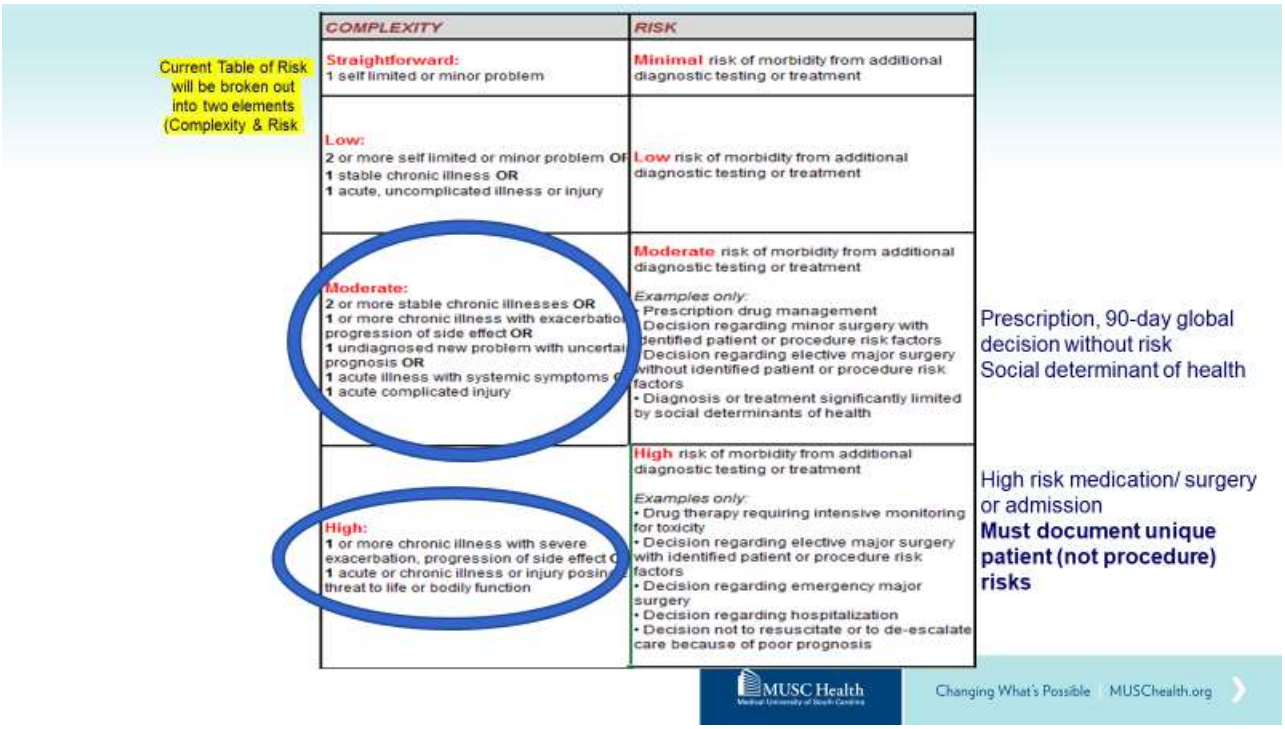
New E&M rules

Straight forward (level 2 New or Established): 1 minor problem (example: seb K)

Low (level 3 New or Established): 1 stable problem (example: localized eczema doing well on TAC)

Moderate (level 4 New or Established): 2 stable, 1 worsening, 1 new of uncertain prognosis + Prescription, or social determinant of health or decision to perform-90 day global procedure in a patient with no unique risk factors
(Examples: acne flare plus new medication; new rash plus addressing patient transportation issue)

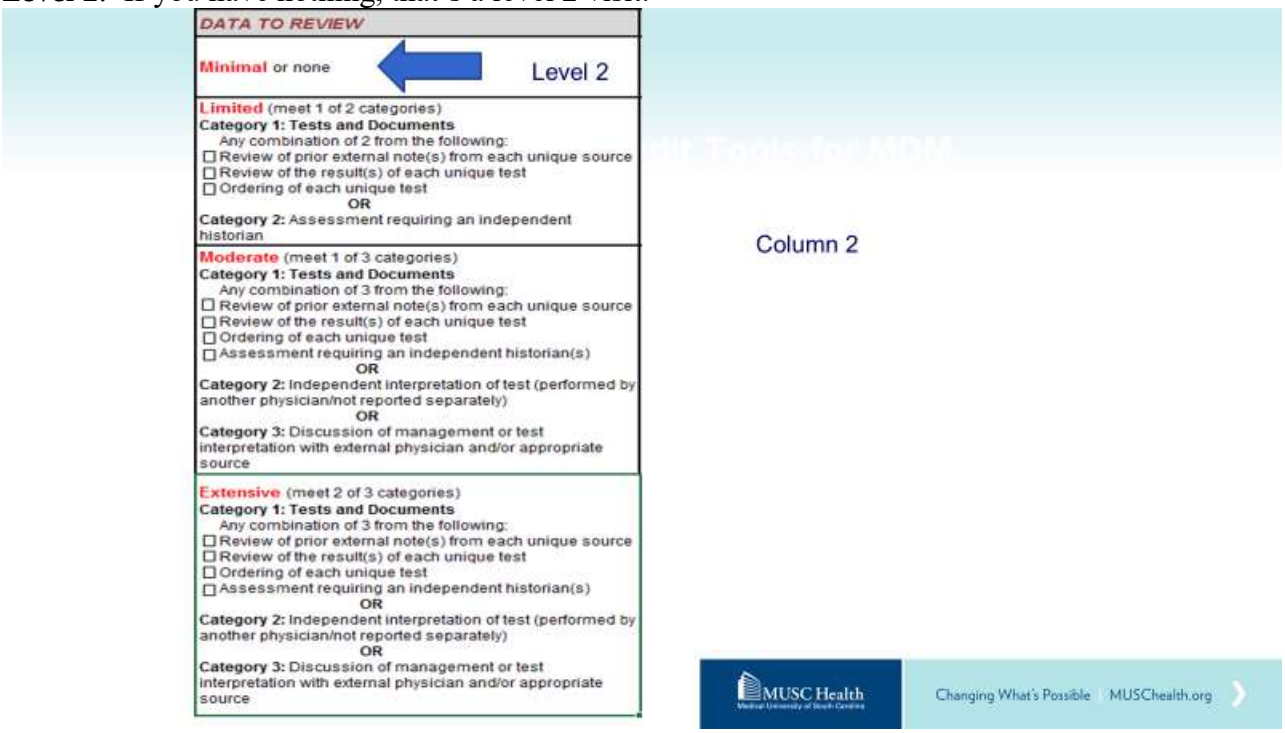
High (level 5 New or Established): Severe exacerbation or risk to life or limb + high risk medication, decision to perform 90 day global surgery with documented additional patient risk factor, or decision to admit to hospital
(Examples: Severe eczema prescribed cyclosporine; Pemphigus treated with azathioprine, new melanoma with excision and decision to perform adjacent tissue transfer in a patient who takes aspirin)



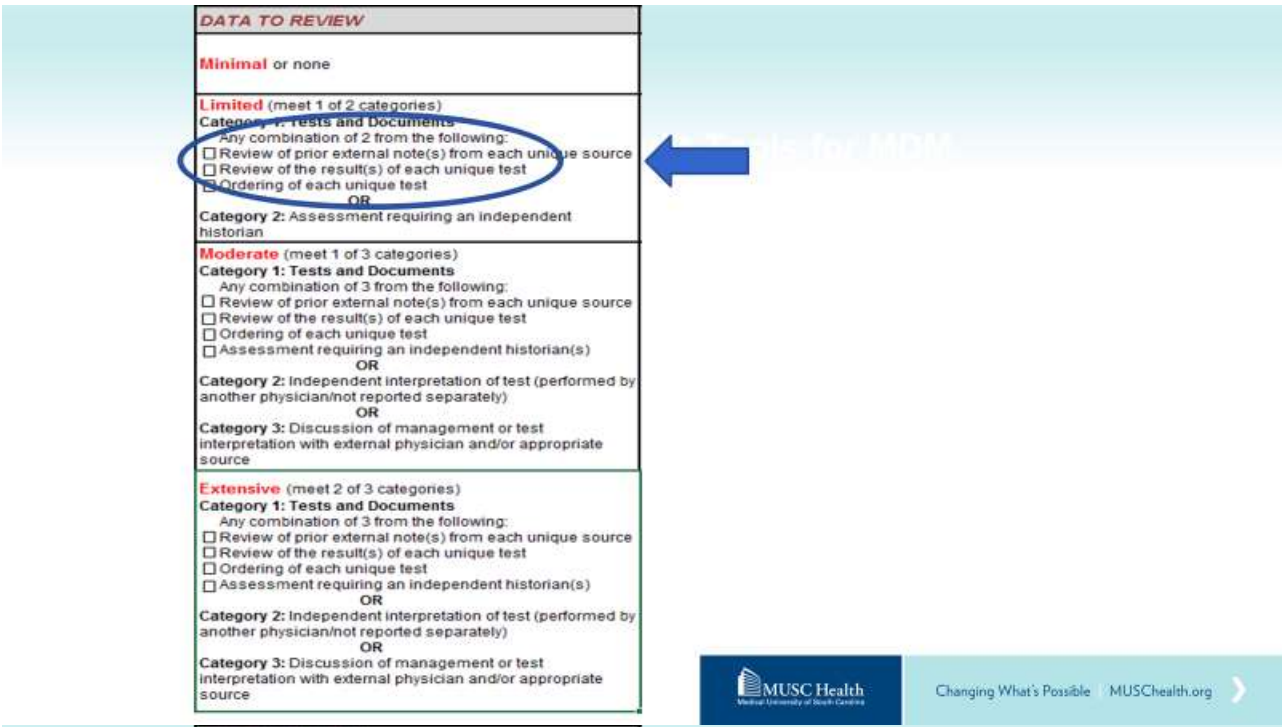
When a medication is not prescribed or social determinant of health addressed, we may need to dive into the more complicated "Data to Review" category for coding.

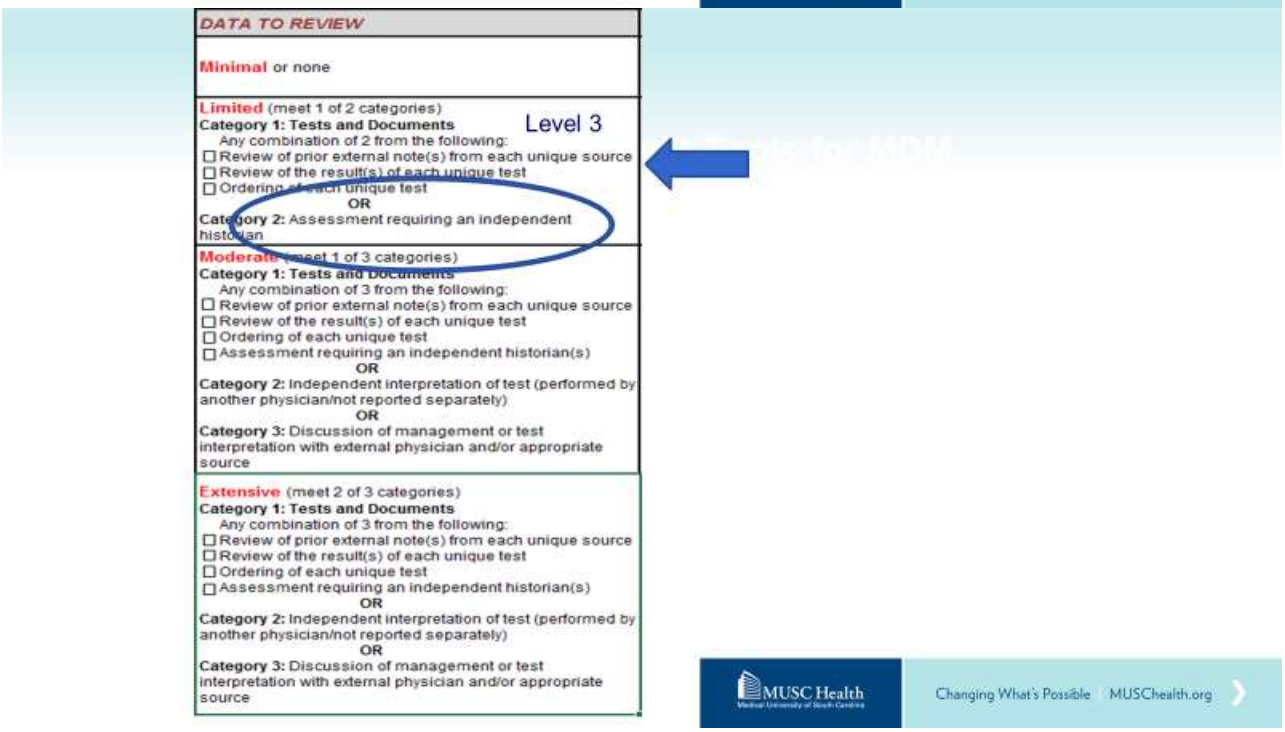
Assuming you have a new life threatening problem (level 5 under category 1), but you prescribe nothing and address no social determinant of health, don't decide to admit or do a 90 day global procedure . . .

Level 2: If you have nothing, that's a level 2 visit.



Level 3: If you document getting history from an independent historian *OR* review external notes *and* lab *OR* review external note *or* lab + order a test





Level 4: If you document getting (<u>history from an independent historian</u> *or* <u>order a test</u> *and* review <u>external notes and lab</u>) *OR* independently <u>interpret outside test</u> in the context of the clinical presentation *OR* <u>discuss management with an external provider</u>

DATA TO REVIEW
Minimal or none
Limited (meet 1 of 2 categories) **Category 1: Tests and Documents** Any combination of 2 from the following: ☐ Review of prior external note(s) from each unique source ☐ Review of the result(s) of each unique test ☐ Ordering of each unique test **OR** **Category 2:** Assessment requiring an independent historian
Moderate (meet 1 of 2 categories) **Category 1: Tests and Documents** Any combination of 3 from the following: ☐ Review of prior external note(s) from each unique source ☐ Review of the result(s) of each unique test ☐ Ordering of each unique test ☐ Assessment requiring an independent historian(s) **OR** **Category 2:** Independent interpretation of test (performed by another physician/not reported separately) **OR** **Category 3:** Discussion of management or test interpretation with external physician and/or appropriate source
Extensive (meet 2 of 3 categories) **Category 1: Tests and Documents** Any combination of 3 from the following: ☐ Review of prior external note(s) from each unique source ☐ Review of the result(s) of each unique test ☐ Ordering of each unique test ☐ Assessment requiring an independent historian(s) **OR** **Category 2:** Independent interpretation of test (performed by another physician/not reported separately) **OR** **Category 3:** Discussion of management or test interpretation with external physician and/or appropriate source

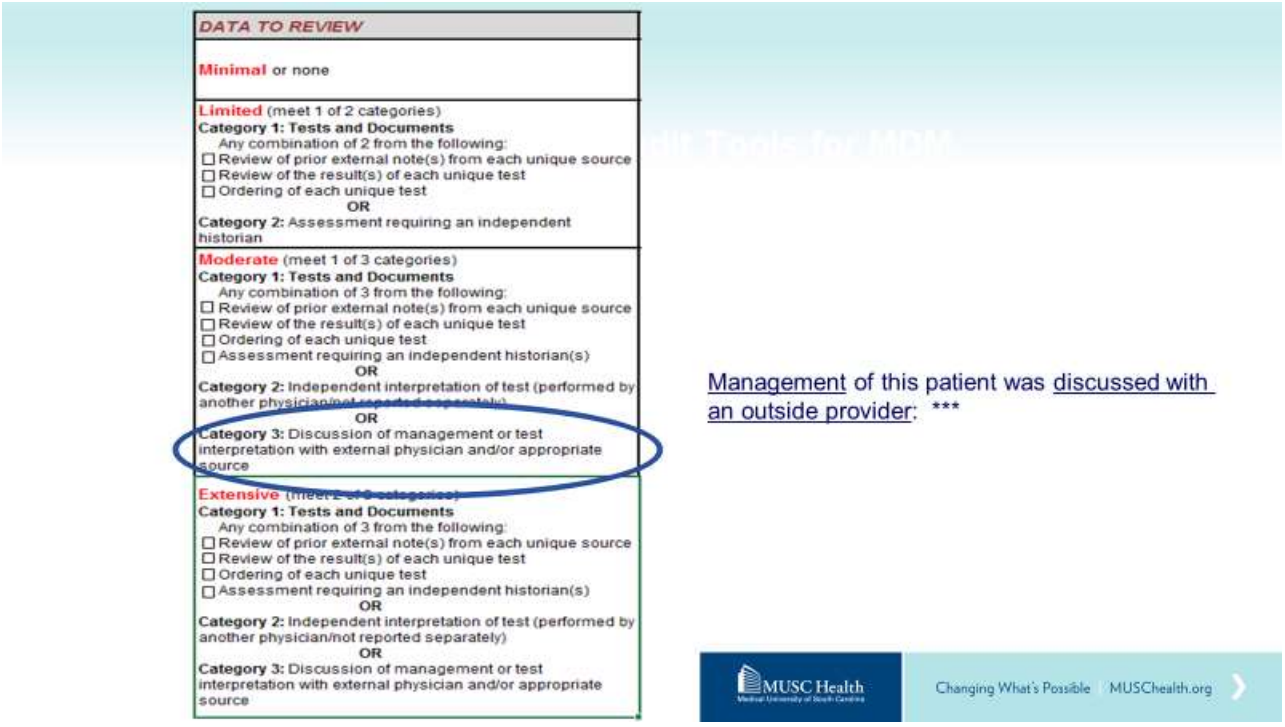
External notes and labs were reviewed
Additional history was elicited from an independent historian

OR

External notes and labs were reviewed
Additional test was ordered

DATA TO REVIEW
Minimal or none
Limited (meet 1 of 2 categories) **Category 1: Tests and Documents** Any combination of 2 from the following: ☐ Review of prior external note(s) from each unique source ☐ Review of the result(s) of each unique test ☐ Ordering of each unique test **OR** **Category 2:** Assessment requiring an independent historian
Moderate (meet 1 of 3 categories) **Category 1: Tests and Documents** Any combination of 3 from the following: ☐ Review of prior external note(s) from each unique source ☐ Review of the result(s) of each unique test ☐ Ordering of each unique test ☐ Assessment requiring an independent historian(s) **OR** **Category 2:** Independent interpretation of test (performed by another physician/not reported separately) **OR** **Category 3:** Discussion of management or test interpretation with external physician and/or appropriate source
Extensive (meet 2 of 3 categories) **Category 1: Tests and Documents** Any combination of 3 from the following: ☐ Review of prior external note(s) from each unique source ☐ Review of the result(s) of each unique test ☐ Ordering of each unique test ☐ Assessment requiring an independent historian(s) **OR** **Category 2:** Independent interpretation of test (performed by another physician/not reported separately) **OR** **Category 3:** Discussion of management or test interpretation with external physician and/or appropriate source

The following outside biopsy or test was interpreted in the context of the patient's presentation: ***
Interpretation: ***



Level 5: If you document:
(External notes and labs were reviewed (each lab and external note counts separately)
Additional history was elicited from an independent historian
OR
External notes and labs were reviewed
Additional test was ordered)

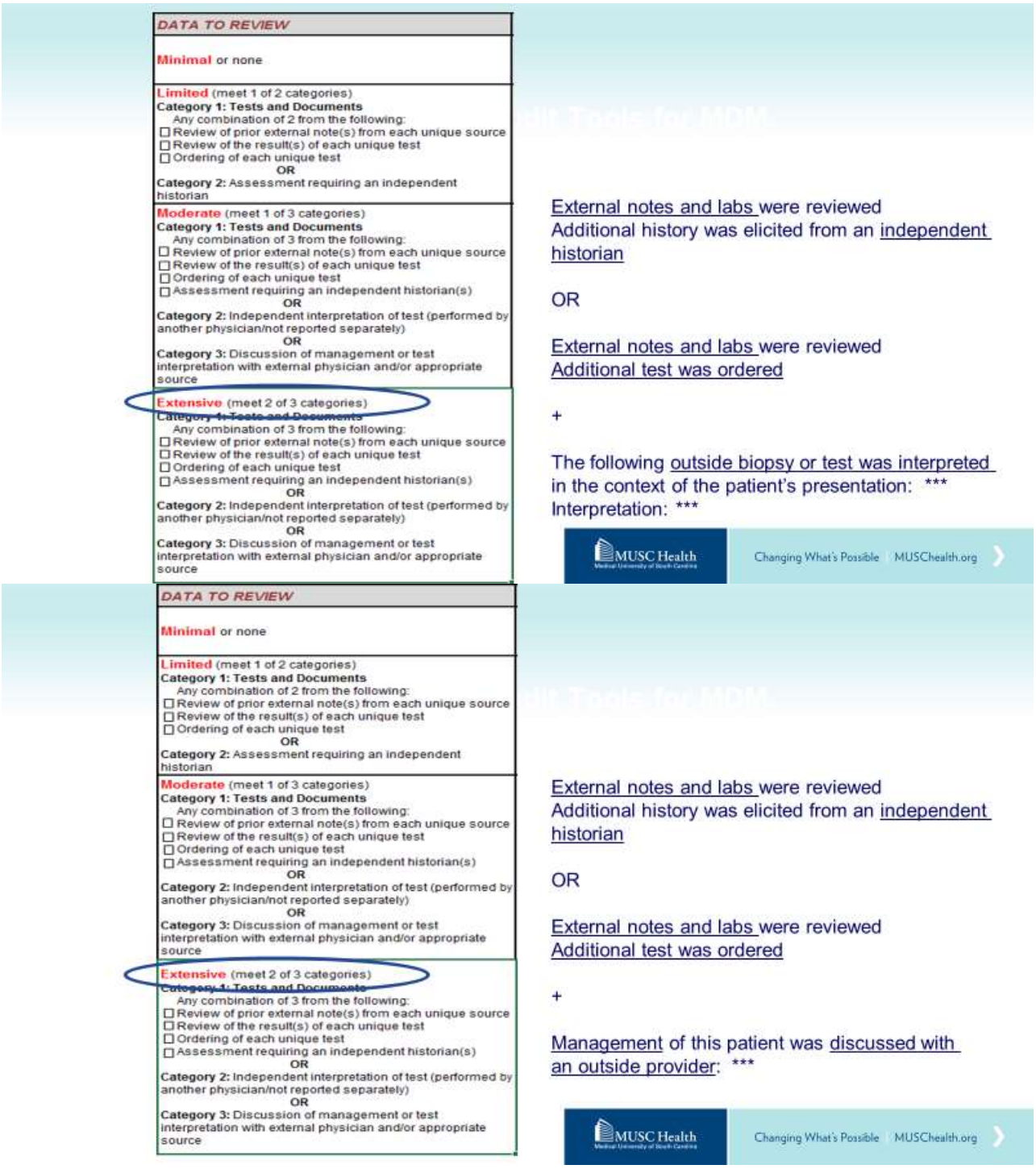
+
The following outside biopsy or test was interpreted in the context of the patient's presentation: ***
Interpretation: ***

OR

(External notes and labs were reviewed
Additional history was elicited from an independent historian
OR
External notes and labs were reviewed
Additional test was ordered)

+
Management of this patient was discussed with

an outside provider: ***



Dot phrases can help: Each provider will have to enter the dot phrase, then edit the note to make it appropriate and unique for each patient encounter. These are not intended to be stand-alone documentation but rather to remind you of what is needed in each category. ONLY USE THIS IF THERE IS NO HIGHER LEVEL OF SERVICE ESTABLISHED IN COLUMN 3 (RISK).

.Data3:
The following was necessary during this visit:
History from an independent historian
OR
Review of external notes *and* lab
OR
Review external note *or* lab + ordering a test

.Data4: The following was necessary during this visit:
History from an independent historian *or* order a test *and* review external notes and lab
OR
Independent interpretation of an outside test in the context of the clinical presentation
OR
Discussion of management with an external provider

.Data5: The following was necessary during this visit:
External notes and labs were reviewed and additional history was elicited from an independent Historian and the following outside biopsy or test was interpreted
in the context of the patient's presentation: ***
Interpretation: ***
OR
External notes and labs were reviewed and an additional test was ordered and the following outside biopsy or test was interpreted in the context of the patient's presentation: ***
Interpretation: ***
OR
(External notes and labs were reviewed and additional history was elicited from an independent historian and management of this patient was discussed with
an outside provider: ***
OR
External notes and labs were reviewed and an additional test was ordered and management of this patient was discussed with an outside provider: ***

Heads exploding yet? Just remember that all you need for a 4 is 1 new problem of uncertain prognosis OR 2 stable OR 1 worsening + prescribe or address a social determinant of health. Consider data reviewed (column 2) ONLY if columns 1 and 3 don't establish appropriate level of service.

V codes – important because they explain the medical necessity of some services (example: they differentiate routine preventive skin cancer screening from medically necessary full body exams. Medicare does not pay for the former.)

- V10.82 Personal history of melanoma
- V10.83 Personal history of other skin CA
- V16.8 Family Hx CA
- V19.4 Family hx skin condition
- V58.41 Planned postop wound closure
- V58.69 Long term use of high risk medication

New patient

- Patient has not received any professional services within the last three (3) years from the physician or a physician of the same specialty who belongs to the same practice group.

Established Patient

- Patient has received professional services within the last three years from the physician or another physician from the same specialty who belongs to the same practice.

Consultation (Payers other than Medicare)

- Seen at the request of another physician or provider for evaluation and management (documented)
- E&M documented
- Documentation of communication back to the referring physician
- Regardless of whether new or established

January changes:

- Documentation of medically appropriate history and physical examination will still be required; however, the documentation will not factor into the determination of the overall E/M level of service choice.
- Altering the definition of the time element for codes 99202-99215 from typical face-to-face time to the total time spent by the physician on the day of the encounter.
- Specific times associated with each E/M service code are noted in the table below:

2021 office visit E/M service codes: Time

New Patient E/M Code	2021 Total Time	Established Patient E/M	2021 Total Time
99201	**Code Deleted**	**99211**	**Time Component removed**
99202	**15 – 29 minutes**	**99212**	**10 – 19 minutes**
99203	**30 – 44 minutes**	**99213**	**20 – 29 minutes**
99204	**45 – 59 minutes**	**99214**	**30 – 39 minutes**
99205	**60 – 74 minutes**	**99215**	**40 – 54 minutes**

Time = Total time on the date of the encounter
(Before face-to-face, during face-to-face, after face-to-face)

Time

- **Total time** is considered both face-to-face and non-face-to-face time personally spent by the physician and/or non-physician clinician on the day of the encounter
    - Includes time spent performing activities that require the physician or non-physician clinician but does not include time in activities normally performed by clinical staff
- Total time may include counseling and/or coordination of care but is no longer the only determining factor for choosing a time-based level of service

Coding Basics

Document Clearly

- All components of E&M
- Location and size of lesions, what was done, why it was done (valid indication for procedure)
- Submit only medically necessary services (that includes elements of the history and physical – example: It would be inappropriate to do a full ROS and full skin exam for a child with a wart).

Ultimate Goal of Coding

- Accurate capture of the medically necessary work actually provided for medically necessary conditions
- Fair reimbursement for those services

New biopsy codes

The new biopsy codes are reported based on method of removal including:

- Tangential biopsy (11102 and 11103)
- Punch biopsy (11104 and 11105)
- Incisional biopsy (11106 and 11107

11102 Tangential biopsy of skin (e.g., shave, scoop, saucerize, curette) single lesion.
+11103 each separate/additional lesion (List separately in addition to code for primary procedure).

11104 Punch biopsy of skin (including simple closure, when performed) single lesion.
+11105 each separate/additional lesion (List separately in addition to code for primary procedure.

11106 incisional biopsy of skin (e.g., wedge) (including simple closure, when performed) single lesion.
+11107 each separate/additional lesion (List separately in addition to code for primary procedure).

For combinations, only one of the 3 primary codes is reported plus add on codes for additional biopsies. Report the primary code with the highest RVU value (incisional > punch > tangential)

Sampling of stratum corneum only, by any modality (e.g., skin scraping, tape stripping) does not constitute a skin biopsy procedure and is not separately reportable.

Destruction codes

- 17000 series: AK, large cell acanthoma, actinic cheilitis, porokeratosis
- 17110: Up to 14 benign lesions
- 17111: 15 or more benign lesions (stand alone)

Destruction codes

Excision and Repair Codes

- Each excision is reported separately. Repairs are reported as a sum of the lengths within grouped body zones. The groupings differ for intermediate and complex closure. Our charge capture in EPIC now reflects the correct groupings.
- CPT 2001 specifically states that repair by intermediate or complex closure should be reported separately for skin excisions. Simple closure is already included in payment (bundled with the code).
  - 11400 – 11446
  - 11600-11646
- CPT 2003: Excision includes the margins (benign and malignant)
  - Measurement of lesion and the most narrow margin is made prior to excision
- Malignant tumor excisions continue to be worth more because of the greater risk, pre and post-service work involved. Only 50% of payment relates to the procedure itself. 50% relates to risk, pre-op couseling and post-op counseling as well as bundled follow-up visits in the global period.
- Soft tissue excisions (including deep lipomas) already include intermediate closure, and layered closure would only be reported separately in rare cases with complex closure (wide undermining) is necessary.
- Medicare bundles complex closure with benign excisions under 0.5 cm, Aetna bundles it up to 1 cm. Both will pay for the closure if a copy of the record and a letter of medical necessity are included.
- Medicare stops paying for procedures after 5 (excisions, closures and destructions other than add on codes count towards the 5). They will pay for the additional procedures only if a copy of the record and a letter of medical necessity are included.
- Medicare stops paying when the unpublished MUE limits are reached for duplicates of any procedure. MUEs are not published, but hover around 5 for most of the procedures we do. They will pay for the additional procedures if they are medically necessary and listed on separate lines instead of one line with quantity (do this ONLY when exceeding the MUE because of medical necessity). Each line of the claim is adjudicated separately.

Flap Closure

- Per CPT 2004: Defect includes primary and secondary defects
- Square cm area of primary plus secondary defect if single repair, separate if distinct repairs

Adjacent Tissue Transfer

- Bundles the excision of malignant or benign.
- Do not code separately for the excision

Skin Biopsy

- CPT 2004: Distinct procedure unrelated to other services provided the same day
- Precludes inappropriate bundling by payers
- Excision of a BCC, specimen sent to lab
  - Do not code biopsy separately
- Excision of a BCC on cheek, biopsy of lesion on nose, both specimens sent to lab
  - Code biopsy separately

Mohs

- CPT 2003: Appropriate to code for preoperative biopsy on the same date as Mohs if the biopsy interpretation determines the subsequent treatment
- Code skin biopsy 11102-11107 and frozen section pathology 88331 with -59 (see details above).

Lab

- CPT 2001: KOH (87220) redefined as Tissue examination of skin, hair or nails for fungi or ectoparasites
- Frozen section (88331) clarified as first block, single specimen

Laser

- CPT 2003: Inflammatory skin disease (psoriasis)
- 96920-96922 based on square cm

What Has Not Changed?

- CPT defines procedures

- RUC determines value
  - Physician Survey Data (time and follow-up visit utilization)
  - Practice Expense (large part of code)
- Physicians are responsible for selecting diagnosis and procedure codes
- Should be selected with the highest degree of specificity

Correct Coding Initiative

- On January 1, 1996, the Medicare program implemented the "Correct Coding Initiative," employing nearly 83,000 code edits, in an attempt to eliminate unbundling or other inappropriate reporting of CPT codes.

Mutually exclusive codes

- Represent services that cannot reasonably be performed in the same session.
- "Comprehensive" code will be paid and the "component" code disallowed.

Medically Unlikely Edits

- CMS stops paying when multiples of a procedure exceed the MUE

Modifier 59

- **Definition: Distinct Procedural Service**
- Modifier 59 is used to clearly designate when distinct, independent and separate multiple procedures are provided. The procedure must not be a component of another procedure. **CMS now uses XS.**
  - Different procedures or surgeries
  - Surgery on different sites or organ systems
  - Separate incision/excision
  - Separate lesions

Modifier 79

- **Distinct Procedural Service during a post-operative period**
- Modifier 79 is used to clearly designate when distinct, independent and separate multiple procedures are provided. The procedure must not be a component of another procedure.
  - Different procedures or surgeries
  - Surgery on different sites or organ systems
  - Separate incision/excision
  - Separate lesions

Modifier 78

- **Definition: Return to the operating room for a related procedure during the postoperative period.**
- Use this modifier when the subsequent procedure is related to the first and requires the use of the operating room during the post-operative global period. Report the proper CPT® code for the procedure performed at the operative session. Do not use the procedure code for the original surgery unless the identical procedure is repeated.
- If more than one procedure is performed in the global period, the Medicare percent is applied **after** the multiple procedure reductions are applied. Documentation is required if billing an unlisted or by report procedure. Modifier 78 should be applied to each related code that is billed post-operatively.

Modifier 25

- **Definition: Significant and Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service.**
- Modifier 25 is used to describe ***separate, distinctly identifiable*** services from other services or procedures rendered during the same visit. Always attach the modifier to the evaluation and management code.

Modifier 24

- **Definition: Unrelated Evaluation & Management Service by the same Physician during a PostOperative Period.**
- Separate, unrelated service was performed during the global period of the surgical procedure.

Modifiers 24 and 25

- The CPT definition of modifier -25 states that an E/M service may be prompted by the system or condition for which a separate procedure or service is needed
- Does not require a separate diagnosis

Modifier 50

- **Definition: Bilateral Procedure, as for Unna boots**

Modifier 51
Definition: Multiple Procedures

- After the first eligible procedure is reimbursed at 100% of our usual and customary allowance, the remaining procedures are reimbursed at 50% up to five procedures. No documentation is required. After the fifth procedure, the procedures will be considered 'by report' and documentation is then required.

Modifier 52

- **Definition: Reduced Services.**
- This modifier can be used in two different ways:
- To report when services were not completed in its entirety.

Modifier 53

Definition: Discontinued Procedure

- Do not use this code to report the elective cancellation of the procedure prior to administration of anesthesia and/or surgical preparation of the patient in the operating room suite.
- When there is no comparable code for establishing reimbursement, Medicare pre-op, post-op and intra-op percentages will be used to determine reimbursement.

Modifier 57

Definition: Decision for Surgery

- **90 day global procedures (For 10 day global procedures, the decision to perform surgery does NOT justify a separate E&M). The 10 day global period starts at midnight tonight. A 90 day global period started at midnight the day before).**

Modifier 62

- **Definition: Two Surgeons.**
- Co-Surgery is the cooperation of two surgeons doing a surgery within the same body cavity with a single primary goal, with each of the two surgeons applying their individual skills to achieve that single goal, while assisting each other.
- Co-surgery may also apply to procedures that require two or more surgeons, neither acting as an assistant to perform the total procedure(s). It may also apply when a surgical procedure involves two or more surgeons performing parts of a single procedure or related procedures simultaneously, e.g., heart transplant, bilateral orthopedic or vascular procedures.
- Each surgeon must bill using the same CPT codes, with modifier 62.

Modifier 66

- **Definition: Surgical Team**
- Team surgery is the coordinated efforts of several surgeons often of different specialties performing highly complex procedures in the same surgical setting.
- Team surgery may also refer to distinct, unrelated procedures on different body areas or organ systems using distinctly different CPT codes.
- Each surgeon will bill using the procedure code describing their portion of the total treatment; using modifier 66 attached to the procedure code.

- For qualified procedures, each surgeon will be reimbursed for the procedure he/she performed at 100% of the allowable.

Mohs Codes

- Complex or ill-defined tumors
- Single physician is both surgeon and pathologist
  - Do not report 88305 separately
- Repair still reported separately
- No longer 51 exempt

Biopsy on same day as procedure

- Biopsy on same day as procedure can be billed separately IF no prior histologic confirmation was present if it is interpreted prior to the subsequent proceured and determines the subsequent procedure (example – frozen section biopsy prior to Mohs, excision or destruction can be reported separately).
  - Must determine subsequent procedure
  - Report biopsy code, 88331
  - 59 to override CCI edit

Mohs Codes

CMS policy:

Medicare is aware that a biopsy of the skin lesion for which Mohs' surgery is planned is necessary in order for the physician to determine the exact nature of the lesion(s) to be removed. The National Correct Coding Initiative does not permit payment for the biopsy and the Mohs' surgery on the same lesion, in the same operative session, on the samedate of service. It is NOT appropriate to report the 59 modifier (distinct procedural service) when the biopsy and Mohs' surgery is performed on the same lesion, in the same operative session, on the same date of service. The -59 modifier should be reported when a biopsy or excision of lesion is performed in situations other than stated above (see below for frozen section biopsy same day as procedure). The use of CPT codes 17311-17315 is reserved for the surgeon who removes the lesion and prepares and interprets the pathology slides. The surgical pathology codes 88300-88309 and 88331-88332 and 88342 are part of the Mohs surgery and are bundled into 17311-17315. The surgeon should not append Modifier 59 to these pathology codes unless they pertain to a

separate biopsy/excision that does not involve Mohs surgery.

CPT 17311: Moh's micrographic technique, including removal of all gross tumor, surgical excision to tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg. Hematoxylin and eosin, toluidine blue), head, neck, hands, feet genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; first stage, up to 5 tissue blocks.

CPT 17312 (Add-on code): Each additional stage after the first stage, up to 5 tissue blocks (List separately in addition to code for primary procedure)

CPT 17313 : Moh's micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stains(s) (eg. Hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; first stage, up to 5 tissue blocks

CPT 17314 (Add-on code): Each additional stage after the first stage, up to 5 tissue blocks (List separately in addition to code for primary procedure)

CPT 17315 (Add-on code): Moh's micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stains(s) (eg. Hematoxylin and eosin, toluidine blue), each additional block after the first 5 tissue blocks, any stage (List separately in addition to code for primary procedure)

Mohs Surgery and Skin Biopsy:

The Mohs micrographic surgery CPT codes include skin biopsy and excision services (CPT codes11102-11107, 11600-11646, and 17260-17286). However, if a suspected skin cancer is biopsied for pathologic diagnosis prior to proceeding to Mohs micrographic surgery, the biopsy (CPT codes 11102-11107) and frozen section pathology (CPT code 88331) may be reported separately utilizing modifier 59 or 58 to distinguish the diagnostic biopsy from the definitive Mohs surgery. Although the CPT Manual indicates that modifier 59 should be utilized, it is also acceptable to utilize modifier 58 to indicate that the diagnostic skin biopsy and Mohs micrographic surgery were staged or planned procedures. Repairs, grafts, and flaps are separately reportable with the Mohs micrographic surgery CPT codes.

In order to allow separate payment for a biopsy and pathology on the same day as MMS, the -59 modifier is appropriate:

- when the lesion for which Mohs surgery is planned has not been biopsied within the previous 60 days; or

- when the surgeon cannot obtain a pathology report, with reasonable effort, from the referring physician; or
- when the biopsy is performed on a lesion that is not associated with the Mohs surgery.

- 17311-17315
  - Includes first routine stain (H&E or Toluidine blue)
  - Additonal special stains or immunostains use 88311 (decalcification), 88314 (special stain), 88342 (immunostain per antibody, not per block or slide), add -59
- 17315: Each block after first 5
  - Used for any body site
- 88314: Additional non-routine special stain (in additon to toluidine blue or H&E)
  - Add -59 to override CCI edit