Common coding errors can mean lost profits when using EMRs

By Inga Ellzey

The movement toward quality EMRs for dermatologists is great. It will help providers have better notes and legible accounts of the patient-physician encounter, and it will also help with ICD-9 and CPT coding. In the end, however, providers still have to know what they did in the exam room, realize whether it is a chargeable event, and if it is, choose from an array of codes.

The EMR is not the end-all cure-all if the provider is walking down the incorrect coding path. The EMR will only document what buttons the provider touches or keys in, it cannot say, "Hey, you just did an intermediate repair, why didn't you charge for it?"

In this article, I will summarize some of the more important and common coding mistakes made by dermatologists. These mistakes add up and can frequently make the difference between profit and loss, the ability to purchase new equipment, buy a new car or put some extra money away for retirement. Let's make sure you are not giving away your hard-earned profit.

Shave, biopsy, excision

No. 1 on the list of mistakes that can cost practices significant lost revenue is miscoding and billing for a biopsy, when what was actually done was a shave removal or an excision.

Forget intent! Document what you actually did, and bill based on what you documented. If you remove a lesion by either shaving or excision, it is not a biopsy!

Of course, you want to have histological confirmation of what the lesion is. But when that scalpel hits the skin, ask yourself, "What actually occurred?" Did you shave remove the lesion via tangential posturing of the scalpel and in the process try to get as much of the lesion as you could — in essence, complete removal of the tissue? If the lesion comes back benign, you would consider the lesion treated? If you answer yes, then this is a shave removal. Could it grow back? Of course it could. So could a basal cell carcinoma you excised. Just because it could grow back does not change your excision of the BCC to a biopsy. As a result, your documentation should
state, "Shave removal of an enlarging, hyperpigmented X.X cm/d lesion of the back. Base of the lesion was electrodesiccated and then pressure dressing was applied."

What if the pathology report comes back as malignant? Then, because you had followed the shave removal by destruction of the base, you can bill the initial "shave removal" as a destruction using CPT codes 17260-17286, depending on the location and size of the lesion. Can you go back and do a more aggressive surgery because of the diagnosis? Of course. You can go back and ED & C the lesion more aggressively, or excise. If either of these options is chosen during the 10-day postoperative period, you just add modifier 58 to the second procedure (e.g., the destruction of the excision).

If you did not destroy the base of the lesion after a shave removal, then you can only charge the shave removal codes (e.g., codes 11300-11313), regardless of the diagnosis on the pathology report.

Again, you can treat the lesion if you feel additional treatment is needed. If the lesion were malignant or perhaps a dysplastic nevus, you would want to go ahead and treat the lesion by excision. No matter what the subsequent treatment would be, you would not need a modifier on the second, subsequent surgery because the shave removal codes have -0- postoperative days.

Of course, if other surgical services have been done on the day that shave removals were performed, then the postoperative days of those other services could put this second, follow-up procedure into a postoperative period. In this instance, the additional surgery would need modifier 79.

Moreover, if you "remove" a nevus with a punch biopsy, this is not a punch biopsy — it is a full thickness excision. You select a punch that encircles the nevus and you punch it out by going through the full thickness of the dermis into the fat. If the lesion comes back benign, you would consider this fait accomplis. Your documentation should indicate, "Excision down to fat of a 5 mm/d hyperpigmented highly suspicious of a dysplastic nevus or malignant melanoma."

If the lesion is dysplastic or a melanoma, you would do further work and just add modifier 58 if performed during the postoperative period.

Regardless of whether you treat the lesion with shave removal or excision down to the fat, both of these are removals, and not biopsies.

Also, because the diagnosis on the pathology report is one of the determining factors for which CPT code you will bill, always hold shave removals and excisions for pathology confirmation.

**Postop complications**

No. 2 on my list of money losers is not charging for postoperative complications. Many providers think they cannot bill anything during the postoperative period, when the truth is that surgical services that must be performed during a postoperative period resulting as a complication to the surgery are billable and payable. The key is the use of modifier 79, the appropriate CPT code that describes the surgery, and a matching ICD-9 code.

This modifier's definition is as follows: 79 — Unrelated Procedure or Service by the Same Physician During the Postoperative Period: The physician may need to indicate that the
performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79. (For repeat procedures on the same day, see modifier 76.)

**Modifier 79 rules**

This modifier is used only for surgical services during the postoperative period. The postoperative period starts the day following the surgical service; the next day starts at 12:01 a.m.

**NOTE:** If the procedure is performed to resolve a complication that occurs on the same day as the surgery, then modifier 79 would not be appropriate. Modifier 79 is used only during a postoperative period, which starts one second after midnight the day following the procedure.

This modifier is also used to reflect an unrelated surgical service during the postoperative period. Surgical complications that result in another procedure are not considered related to the initial surgery, as they are not a considered part of the original surgical package (which only includes the normal, uncomplicated follow-up care).

Complications such as hematomas, wound dehiscence and postoperative bleeding are considered unrelated to the surgical service since the CPT code is unique and the diagnosis is different from the neoplasm codes. Modifier 79 is appropriate for these situations (see box).

### 'No-charge' visits

Third on my list of costly billing mistakes is the "no-charge" visit when an E/M visit is legally and ethically billable. Here are some common examples:

**1. The patient had three benign nevi removed by shaving (e.g., codes 11301, 11302 and 11311).** The patient returns after one week to have the areas checked for infection and healing and to review the pathology results. The visit was a "no-charge." Argument: Since the shave removal codes have 0 postoperative days, all follow-up visits should be charged. Typically, this visit would be a 99212 or 99213 depending on documentation and/or time spent counseling. Many providers feel that the added charge would anger the patients and there would be another copayment due from the patient adding to the expense of the procedure. You mitigate the patient "anger" if they expected the copayment when they left and made the follow-up appointment. This can easily be accomplished by a short note that is given to the patient when the follow-up appointment is made:

"Dear Valued Patient:

We are scheduling a return office visit in one week to check on your surgical site(s) for signs of infection, non-complicated healing and to review the pathology results with you. We expect a positive outcome, but in the event the lesion(s) removed require additional treatment, those options will be discussed with you at this time also. Because this follow up visit is not included in your surgical fee, please be prepared for a copayment at the time of this follow up visit next week."
2. Billing "no-charges" for follow up skin cancer patients. Many skin cancer patients have excisions and closures with only an intermediate or complex closure. That would put the postoperative period at 10 days. Frequently, when patients come back at two weeks, four weeks, three months or six months postop, these visits are frequently billed as a "no-charge" by the provider. If the 10-day postoperative period has expired, then all follow-up visits relating to the excised cancer site are billable visits and should not be a "no-charge" encounter.

I recently did a consultation for a large dermatology group and after my on-site educational training session, we ran some numbers on the frequency of "no-charges" that the group of eight providers charged for these types of scenarios. When we added up the total, the amount was more than $57,000 in lost revenue (not including the lost copayments). That loss almost covered the cost of their practice administrator’s salary!

3. Failure to bill the proper level of care. There are so many providers that under-code because they are afraid that they will be audited. I see providers that never bill a 99214, 99203, or they bill all visits as a 99212s. Many never bill an office visit on the day they do surgical services — ever. All of these represent horrific losses that not only result in lost practice revenue; they also result in costs to the practice that must absorbed, costs that take profit away from other practice services. There is no patient visit that costs the practice zero dollars.

Every patient encounter has fixed costs that must be subsidized by the charges incurred by the patient when seen (e.g., staff, phones, computers, paper, electricity, land costs and more). Therefore, to avoid losing money and start being paid for what you actually do, here are a few tips:

- Learn how to document for the level of care you provide. Do not under-code thinking that this will keep you out of audits. Not true. You end up as an outlier if 100 percent of your services are billed at 99212. Target ... audit! They will check your records to find out why so many 99212.
- Consider a quality electronic medical record to help you document your services accurately and completely. There is so much new technology out there that can make charting an E/M visit as easy as using your cell phone. Contact me at (800) 318-3271 for some recommendations, or you can contact Mark Kaufman from the American Academy of Dermatology’s committee on EMR certification.
- Run your E/M visit utilization at least quarterly against the Medicare utilization charts for your specialty to see where you are over- or under-coding; both can contribute to revenue loss.

I can go on and on with other practice revenue loss "centers," but for now, if you just correct the problems addressed in this article, you will find significant "found" dollars in your practice without seeing one more patient in 2011. What could make more sense?

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**Note:** CPT code 13160 has a 90-day postoperative period, while the others all have 10 postoperative days in the global period.