Coding the "Spot Check": Part 1

Alexandra Flamm, MD; Daniel M. Siegel, MD, MS

PRACTICE **POINTS**

- Clear documentation that reflects your thought process is an important component of effective coding and billing.
- Include *Current Procedural Terminology*–defined language within documentation to help ensure appropriate reimbursement and decrease the risk of audits.

The updated outpatient evaluation and management (E/M) coding paradigm went into effect in January 2021, with level of visit being based on time or medical decision making (MDM). This article discusses how to effectively utilize this coding structure to correctly document for the "spot check," a common encounter within dermatology.

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On January 1, 2021, the *Current Procedural Terminology* (CPT) evaluation and management (E/M) reporting rules changed dramatically, with "bullet counting" no longer necessary and the coding level now based on either the new medical decision making (MDM) table or time spent on all activities relating to the care of the patient on the day of the encounter.[1] This is described in the *CPT Professional Edition 2023*, a book every practitioner should review annually.[2] In particular, every provider should read and reread pages 1 to 14—and beyond if you provide services beyond standard office visits. These changes were made with the intent to simplify the process of documentation and allow a provider to spend more time with patients, though there is still a paucity of data related to whether the new system achieves these aims.

The general rule of reporting work with CPT codes can be simply stated—"Document what you did, do what you documented, and report that which is medically necessary" (David McCafferey, MD, personal communication)—and you should never have any difficulty with audits. Unfortunately, the new system does not let an auditor, who typically lacks a medical degree, audit effectively unless they have a clear understanding of diseases and their stages. Many medical societies, including the American Medical Association[3] and American Academy of Dermatology,[4] have provided education that focuses on how to report a given vignette, but specific examples of documentation with commentary are uncommon.

To make your documentation more likely to pass audits, explicitly link parts of your documentation to CPT MDM descriptors. We offer scenarios and tips. In part 1 of this series, we discuss how to approach the "spot check," a commonly encountered chief concern (CC) within dermatology.

Scenario 1: A Funny-Looking New Spot

A 34-year-old presents with a new spot on the left cheek that seems to be growing and changing shape rapidly. You

Dr. Flamm is from Department of Dermatology, Penn State Health Milton S. Hershey Medical Center, Pennsylvania. Dr. Siegel is from the Department of Dermatology, SUNY Downstate Medical Center, Brooklyn, New York, and the VA New York Harbor Healthcare System, New York, New York.
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Correspondence: Alexandra Flamm, MD, Penn State Hershey Medical Center, Department of Dermatology, 500 University Dr, Hershey, PA 17033 (Alexandra.f.flamm@gmail.com).
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examine the patient and discuss treatment options. The documentation reads as follows:

- CC: New spot on left cheek that seems to be growing and changing shape rapidly.
- History: No family history of skin cancer; concerned about scarring, no blood thinner.
- Examination: Irregular tan to brown to black 8-mm macule. No lymphadenopathy.
- Impression: rule out melanoma.
- Plan: Consent, biopsy via shave technique. Lidocaine hydrochloride 1% with epinephrine, 1 cc, prepare and drape, hemostasis obtained, ointment and bandage applied, and care instructions provided.

As was the case before 2021, you still need a CC, along with a medically (and medicolegally) appropriate history and physical examination. A diagnostic impression and treatment plan also should be included.

In this situation, reporting is straightforward. There is no separate E/M visit; only the CPT code 11102 for tangential biopsy is reported. An *International Classification of Diseases, Tenth Revision* code of D48.5 (neoplasm of uncertain behavior of skin) will be included.

Why no E/M code? This is because the biopsy includes preservice and postservice time and work that would be double reported with the E/M. Remember that the preservice work would include any history and physical examination related to the area to be biopsied.

Specifically, preservice work includes:

> Inspect and palpate lesion to assess surface size, subcutaneous depth and extension, and whether fixed to underlying structures. Select the most representative and appropriate site to obtain specimen. Examine draining lymph node basins. Discuss need for skin biopsy and biopsy technique options. Describe the tangential biopsy procedure method and expected result and the potential for inconclusive pathology result. Review procedural risks, including bleeding, pain, edema, infection, delayed healing, scarring, and hyper- or hypopigmentation.[5]

Postservice work includes:

> Instruct patient and family on postoperative wound care and dressing changes, as well as problems such as bleeding or pain and restrictions on activities, and follow-up care. Provide prescriptions for pain and antibiotics as necessary. Advise patient and family when results will be available and how they will be communicated. The pathology request form is filled out and signed by the physician. Complete medical record and communicate procedure/results to referring physician as appropriate.[5]

The Takeaway—Procedure codes include preservice and postservice work. If additional work for the procedure is not documented beyond that, an E/M cannot be included in the encounter.

Scenario 2: What If We Don't Biopsy?

A 34-year-old presents with a new spot on the left cheek that seems to be growing and changing shape rapidly. You examine the patient and discuss treatment options. The documentation reads as follows:

- CC: New spot on left cheek that seems to be growing and changing shape rapidly.
- History: No family history of skin cancer; concerned about scarring, no blood thinner.
- Examination: Irregular tan to brown to black 8-mm macule. No lymphadenopathy.
- Impression: rule out melanoma.
- Plan: Review risk, benefits, and alternative options. Schedule biopsy. Discuss unique risk factor of sebaceous peau d'orange skin more prone to contour defects after biopsy.

When determining the coding level for this scenario by MDM, 3 components must be considered: number and complexity of problems addressed at the encounter (column 1), amount and/or complexity of data to be reviewed and analyzed (column 2), and risk of complications and/or morbidity or mortality of patient management (column 3).[1] There are no data that are reviewed, so the auditor will assume minimal data to be reviewed and/or analyzed (level 2, row 2 in the MDM table). However, there may be a lot of variation in how an auditor would address the number and complexity of problems (level 1). Consider that you must explicitly state what you are thinking, as an auditor may not know melanoma is a life-threatening diagnosis. From the perspective of the auditor, could this be a:

- Self-limited or minor problem (level 2, or minimal problem in the MDM table)?[1]
- Stable chronic illness (level 3, or low-level problem)?[1]
- Undiagnosed new problem with uncertain prognosis (level 4, or moderate level problem)?[1]
- Acute illness with systemic symptoms (level 4, or moderate level problem)?[1]
- Acute or chronic illness or injury that poses a threat to life or bodily function (level 5, or high-level problem)?[1]
- All of the above?

Similarly, there may be variation in how the risk (column 3) would be interpreted in this scenario. The treatment gives no guidance, so the auditor may assume this has a minimal risk of morbidity (level 2) or possibly a low risk of morbidity from additional diagnostic testing or treatment (level 3), as opposed to a moderate risk of morbidity (level 4).[1]

The Takeaway—In the auditor's mind, this could be a straightforward (CPT codes 99202/99212) or low-level (99203/99213) visit as opposed to a moderate-level (99204/99214) visit. From the above documentation, an

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auditor would not be able to tell what you are thinking, and you can be assured they will not look further into the diagnosis or treatment to learn. That is not their job. So, let us clarify by explicitly stating what you are thinking in the context of the MDM grid.

Modified Scenario 2: A Funny-Looking New Spot With MDM Descriptors to Guide an Auditor

Below are modifications to the documentation for scenario 2 to guide an auditor:

- CC: New spot on left cheek that seems to be growing and changing shape rapidly.
- History: No family history of skin cancer; concerned about scarring, no blood thinner.
- Examination: Irregular tan to brown to black 8-mm macule. No lymphadenopathy.
- Impression: rule out melanoma (undiagnosed new problem with uncertain prognosis).
- Plan: **Discuss risks, benefits, and alternatives, including biopsy (decision regarding minor surgery with identified patient or procedure risk factors) vs a noninvasive gene expression profiling melanoma rule-out test. Patient prefers the latter.**

In this scenario, the level of MDM is much more clearly documented (as bolded above).

The number and complexity of problems would be an undiagnosed new problem with uncertain prognosis, which would be moderate complexity (column 1, level 4).[1] There are no data that are reviewed or analyzed, which would be straightforward (column 2, level 2). For risk, the discussion of the biopsy as part of the diagnostic choices should include discussion of possible scarring, bleeding, pain, and infection, which would be considered best described as a decision regarding minor surgery with identified patient or procedure risk factors, which would make this of moderate complexity (column 3, level 4).[1]

Importantly, even if the procedure is not chosen as the final treatment plan, the discussion regarding the surgery, including the risks, benefits, and alternatives, can still count toward this category in the MDM table. Therefore, in this scenario with the updated and clarified documentation, this would be reported as CPT code 99204 for a new patient, while an established patient would be 99214.

Scenario 1 Revisited: A Funny-Looking New Spot

Below is scenario 1 with enhanced documentation, now applied to our procedure-only visit.

- CC: New spot on left cheek that seems to be growing and changing shape rapidly.
- History: No family history of skin cancer; concerned about scarring, no blood thinner.
- Examination: Irregular tan to brown to black 8-mm macule. No lymphadenopathy.
- Impression: rule out melanoma (undiagnosed new problem with uncertain prognosis).
- Plan: Discuss risks, benefits, and alternatives, including biopsy (decision regarding minor surgery with identified patient or procedure risk factors) vs a noninvasive 2 gene expression profiling melanoma rule-out test. Patient wants biopsy. Consent, biopsy via shave technique. Lidocaine hydrochloride 1% with epinephrine, 1 cc, prepare and drape, hemostasis obtained, ointment and bandage applied, and care instructions provided.

This documentation would only allow reporting the biopsy as in Scenario 1, as the decision to perform a 0- or 10-day global procedure is bundled with the procedure if performed on the same date of service.

Final Thoughts

Spot checks are commonly encountered dermatologic visits. With the updated E/M guidelines, clarifying and streamlining your documentation is crucial. In particular, utilizing language that clearly defines number and complexity of problems, amount and/or complexity of data to be reviewed and analyzed, and appropriate risk stratification is crucial to ensuring appropriate reimbursement and minimizing your pain with audits.

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