Coding the "Spot Check": Part 2

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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 the coding level being based on time or medical decision making (MDM). In part 2 of this series, we describe how to best code an encounter that includes a "spot check" with other concerns.

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When the *Current Procedural Terminology* (CPT) evaluation and management (E/M) reporting rules changed dramatically in January 2021, "bullet counting" became unnecessary and the coding level became 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]

To make your documentation more likely to pass audits, explicitly link parts of your documentation to CPT MDM descriptors. Part 1 of this series discussed how to approach the "spot check," a commonly encountered chief concern (CC) within dermatology, with 2 scenarios presented.[2] 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. In part 2, we describe how to best code an encounter that includes a "spot check" with other concerns.

Scenario 3: By the Way, Doc

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 (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 (GEP) melanoma rule-out

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test. (Based on the decision you and the patient make, you also would document which option was chosen, so a biopsy would include your standard documentation, and if the GEP is chosen, you would simply state that this was chosen and performed.)

As you turn to leave the room, the patient says: "By the way, Doc, can you do anything about these silvery spots on my elbows, knees, and buttocks?" You look at the areas of concern and diagnose the patient with psoriasis.

How would it be best to approach this scenario? It depends on which treatment option the patient chooses.

If you performed a noninvasive GEP melanoma rule-out test, the CPT reporting does not change with the addition of the new problem, and only the codes 99204 (new patient office or other outpatient visit) or 99214 (established patient office or other outpatient visit) would be reported. This would be because, with the original documentation, the number and complexity of problems would be an "undiagnosed new problem with uncertain prognosis," which would be moderate complexity (column 1, level 4). 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 a diagnostic choice should include possible scarring, bleeding, pain, and infection, which would be best described as a decision regarding minor surgery with identified patient or procedure risk factors, given the identified patient concerns, making 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, documentation would best fit with CPT code 99204 for a new patient or 99214 for an established patient. The addition of the psoriasis diagnosis would not change the level of service but also should include documentation of the psoriasis as medically necessary.

However, if you perform the biopsy, then the documentation above would only allow reporting the biopsy, 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. Therefore, with the addition of the psoriasis diagnosis, you would now use a separate E/M code to report the psoriasis. You must append a modifier −25 to the E/M code to certify that you are dealing with a separate and discrete problem with no overlap in physician work.

Clearly you also have an E/M to report. But what level? Is this chronic? Yes, as CPT clearly defines chronic as "[a] problem with an expected duration of at least one year or until the death of the patient."[1,5]

But is this stable progressive or showing side effects of treatment? "'Stable' for the purposes of categorizing MDM is defined by the specific treatment goals for an individual patient. A patient who is not at his or her treatment goal is not stable, even if the condition has not changed and there is no short-term threat to life or function," according to the CPT descriptors. Therefore, in this scenario, the documentation would best fit a chronic illness with exacerbation, progression, or side effects of treatment (column 1, level 4), which is of moderate complexity.[1]

But what about column 3, where we look at risks of testing and treatment? This would depend on the type of treatment given. If an over-the-counter product such as a tar gel is recommended, this is a low risk (column 3, level 3), which would mean this lower value determines the E/M code to be 99213 or 99203 depending on whether this is an established or new patient, respectively. If we treat with a prescription medication such as a topical corticosteroid, we are providing prescription drug management (column 3, level 4), which is moderate risk, and we would use codes 99204 or 99214, assuming we document appropriately. Again, including the CPT terminology of "not at treatment goal" in your impression and "prescription drug management" in your plan tells an auditor what you are thinking and doing.[1,5]

The Takeaway—Clearly if a GEP is performed, there is a single CPT code used—99204 or 99214. If the biopsy is performed, there would be a biopsy code and an E/M code with a modifier −25 attached to the latter. For the documentation below, a 99204 or 99214 would be the chosen E/M code:

- CC: (1) New spot on left cheek that seems to be growing and changing shape rapidly; (2) Silvery spots on elbows, knees, and buttocks for which patient desires treatment.
- History: No family history of skin cancer; concerned about scarring, no blood thinner. Mom has psoriasis. Tried petroleum jelly on scaly areas but no better.
- Examination: Irregular tan to brown to black 8-mm macule. No lymphadenopathy. Silver scaly erythematous plaques on elbows, knees, sacrum.
- Impression: (1) Rule out melanoma (undiagnosed new problem with uncertain prognosis); (2) Psoriasis (chronic disease not at treatment goal).
- Plan: (1) Discuss risks, benefits, and alternatives, including biopsy (decision regarding minor surgery with identified patient or procedure risk factors) vs a noninvasive GEP melanoma rule-out test. Patient wants biopsy. Consent, biopsy via shave technique. Lidocaine hydrochloride 1% with epinephrine 1 cc, prepare and drape, aluminum chloride for hemostasis, ointment and bandage applied, care instructions provided; (2) Discuss options. Calcipotriene cream daily; triamcinolone ointment 0.1% twice a day (prescription drug management). Review bathing, avoiding trauma to site, no picking.

Scenario 4: Here for a Total-Body Screening Examination

Medicare does not cover skin cancer screenings as a primary CC. Being worried or knowing someone with melanoma are not CCs that are covered. However,

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"spot of concern," "changing mole," or "new growth" would be. Conversely, if the patient has a history of skin cancer, actinic keratoses, or other premalignant lesions, and/or is immunosuppressed or has a high-risk genetic syndrome, the visit may be covered if these factors are documented in the note.[6]

For the diagnosis, the *International Classification of Diseases, Tenth Revision,* code Z12.83—"encounter for screening for malignant neoplasm of skin"—is not an appropriate primary billing code. However, D48.5—"neoplasm of behavior of skin"—can be, unless there is a specific diagnosis you are able to make (eg, melanocytic nevus, seborrheic keratosis).[6]

Let's look at documentation examples:

- CC: 1-year follow-up on basal cell carcinoma (BCC) excision and concern about a new spot on the nose.
- History: Notice new spot on the nose; due for annual follow-up and came early for nose lesion.
- Examination: Left ala with flesh-colored papule dermoscopically banal. Prior left back BCC excision site soft and supple. Total-body examination performed, except perianal and external genitalia, and is unremarkable.
- Impression: Fibrous papule of nose and prior BCC treatment site with no sign of recurrence.
- Plan: Reassure. Annual surveillance in 1 year.

Using what we have previously discussed, this would likely be considered CPT code 99212 (established patient office visit). However, it is important to ensure all concerns and treatment interventions are fully documented. Consider this fuller documentation with bolded additions:

- CC: 1-year follow-up on BCC excision and concern about a new spot on the nose.
- History: Notice new spot on the nose; due for annual follow-up and came early for nose lesion. **Also unhappy with generally looking older.**
- Examination: Left ala with flesh-colored papule dermoscopically banal. Prior left back BCC excision site soft and supple. **Diffuse changes of chronic sun damage.** Total-body examination performed, except perianal and external genitalia, and is unremarkable.
- Impression: Fibrous papule of nose and prior BCC treatment site with no sign of recurrence **and heliodermatosis/chronic sun damage not at treatment goal.**
- Plan: Reassure. Annual surveillance in 1 year. **Over-the-counter broad-spectrum sun protection factor 30+ sunscreen daily.**

This is better but still possibly confusing to an auditor. Consider instead with bolded additions to the changes to the impression:

- CC: 1-year follow-up on BCC excision and concern about a new spot on the nose.
- History: Notice new spot on the nose; due for annual follow-up and came early for nose lesion. **Also unhappy with generally looking older.**
- Examination: Left ala with flesh-colored papule dermoscopically banal. Prior left back BCC excision site soft and supple. **Diffuse changes of chronic sun damage.** Total-body examination performed, except perianal and external genitalia, and is unremarkable.
- Impression: Fibrous papule of nose **(D22.39)**[7] and prior BCC treatment site with no sign of recurrence **(Z85.828: "personal history of other malignant neoplasm of skin) and heliodermatosis/chronic sun damage not at treatment goal (L57.8: "other skin changes due to chronic exposure to nonionizing radiation").**
- Plan: Reassure. Annual surveillance 1 year. **Over-the-counter broad-spectrum sun protection factor 30+ sunscreen daily.**

We now have chronic heliodermatitis not at treatment goal, which is moderate (column 1, level 4), and the over-the-counter broad-spectrum sun protection factor 30+ sunscreen (column 1, low) would be best coded as CPT code 99213.

Final Thoughts

"Spot check" encounters are common dermatologic visits, both on their own and in combination with other concerns. With the updated E/M guidelines, it is crucial to clarify and streamline your documentation. In particular, utilize language clearly defining the number and complexity of problems, data to be reviewed and/or analyzed, and appropriate risk stratification to ensure appropriate reimbursement and minimize your difficulties with audits.

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