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# A review of Next Steps in Derm's most read articles on Legal and Billing & Coding When Starting a Practice

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JOURNAL OF DRUGS IN DERMATOLOGY
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# From the Editor:

Welcome to the Best of Next Steps in Derm! In this quarterly publication, we are pleased to present another one of our most popular articles from 2014, along with a new exclusive article that will help dermatology residents and young physicians get a head start in their careers.

Have you ever felt daunted at the prospect of having to figure out coding for every patient encounter? No need to worry, help is at hand, as Dr. Beth McLellan's original, clear, and comprehensive article explains all the groundwork you'll need for efficient and accurate billing. Designed as a reference tool for those getting comfortable with coding, this article not only outlines the basics but conveniently details specifics such as navigating through history, physical exam and medical decision-making. Detailed charts and tables provide valuable information on common procedures such as biopsies, injections and excisions. Modifiers are made simple with a list and explanation of the most important ones you'll use.

Dr. Hollmig's introductory guide to non-compete provisions will stand you in good stead for understanding the legal language of restrictive covenants – and this rudimentary knowledge will help you negotiate, strategize, and avoid any untoward long-term complications.

We intend for these and the other articles at NextStepsinDerm.com to give you invaluable advice and information that will smooth your way through a wonderful new world of discovery.

Enjoy this issue!

*Daniel M. Siegel MD, MS, Senior Editor*

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# Exclusive Article:

## Medical Coding in Dermatology

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One of the most daunting tasks that new dermatologists face is figuring out how to code for each patient encounter. Coding is not always taught formally in residency, and residents receive a lot of information and tips about coding – not all of it accurate. This article is intended to lay the groundwork for efficient and accurate billing, but the education should not stop here. Seek out coding and billing sessions at conferences, in journals and online. Coding is one of the only things you'll learn in medicine that you can apply to each and every patient encounter, and it takes some studying and practice to become comfortable with it.

### The Basics

Evaluation & Management (E & M) codes are used to bill for office visits and CPT codes are used to bill for procedures. Sometimes, if you perform a procedure in addition to a full office visit or multiple procedures in one visit, you'll need to use modifiers to tell insurance companies that these were all separate events that should be paid. This article will address each of these separately.

Remember to always keep medical necessity in mind and document honestly and accurately. It is not appropriate to do a full skin exam and detailed history on every single follow-up patient in order to bill for higher level visits. You should perform and bill for what you determine to be medically necessary for each patient.

### Evaluation & Management (E & M)

E & M codes are used to bill for office visits and are separated into three main categories: new (99201-99205), established (99211-99215), and consult (99241-99245). A new patient is any patient who has not been seen by a physician (not just you) in the same specialty and same practice in the past three years. If a patient comes back to see you and hasn't been to the practice in four years, that patient would be billed as a new visit even though you have seen them before. Remember, three years is the cut-off.

For consults, you must have a documented request for consultation and report back to the consulting physician. Consults are not covered by all insurance plans; for those you should bill as a new patient instead.

Once you have determined if you are in the category of new, established or consult, you must next determine the level of the visit from 1-5. To do this, you need to consider three elements: the history, physical exam, and medical decision-making. You'll need to meet the criteria for 2/3 of these components for an established patient, and all 3/3 for a new patient or consult. For example, if your history and medical decision-making meet a level 4, but your physical examination only met a level 3 for an established patient you should still bill a level 4 (99214). For a new patient, since you only met a level 4 for 2/3 of the criteria, you should bill a level 3 (99203).

To simplify things, let's eliminate the codes that are not normally used in dermatology. First, the lowest level visits (99201 and 99211) are for nurse visits and should not be used by physicians. Next, because of limitations in the physical exam done in most dermatology visits, we can't usually meet the criteria for new patient visits higher than 99203. This means that for new patient visits (and consults) you are really only deciding between



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two levels: 99202 or 99203 for new patients, and 99242 or 99243 for consults. Most dermatologists do not routinely meet criteria for an established patient 99215. This means that for established patient visits you are really only deciding between three levels: 99212, 99213 and 99214. We've already narrowed it down from 15 possible choices to just seven!

## Three Elements to Consider

### *History*

To simplify this part of the billing, remember the "4-2-1 rule." If you always include a chief complaint, 4 items in your history of present illness (HPI), 2 review of systems (with one related to skin), and 1 past, family or social history, you'll always meet the criteria for a level 3 new patient (99203) and a level 4 established patient (99214), which are the highest levels normally billed in dermatology. Stick to "4-2-1" for all your patients and you'll never have to think about the level of your history again.

Items in the HPI that qualify are: location, quality, severity, duration, timing, context, modifying factors, and associated symptoms. For example, the statement "the patient presents with a 4-day history of a mildly itchy rash on the right arm" meets 4 items in the HPI (severity, associated symptom, location, and duration) – enough for a 99203 or 99214 (assuming all other criteria are met).

### *Physical Examination*

The physical examination is a bit more complicated than the history. There are two sets of criteria – the 1995 and 1997 guidelines. For lower level visits (99202 and 99213), you need to document the exam of the skin (which can be limited) and one other system (saying the patient is alert and oriented and in no acute distress would qualify) using the 1995 criteria. For higher-level visits (99203 and 99214), you should document 12 bullet points (each body part examined is a bullet point) using the 1997 criteria (see Figure 1). The physical exam is often the limiting factor for dermatologists billing the highest levels. Unless you are doing a very thorough examination (including thyroid, lymph nodes, and leg edema) or billing based on time, you probably won't be able to bill higher than a 99203 for new patients. For established patients, we can get to a 99214 using the history and medical decision-making since only 2/3 are needed to meet a given level.

**Possible Bullet Points for Physical Examination by 1997 Criteria**

- 3 vital signs
- Orientation to time/place/person
- Mood and affect
- General appearance
- Scalp and hair
- Head (including the face and neck)
- Eyelids
- Lips
- Chest (including breasts and axillae)
- Abdomen
- Genitalia/groin/buttocks
- Back
- Right arm
- Left arm
- Right leg
- Left leg
- Eccrine/apocrine glands
- Lymph nodes
- Eccrine/apocrine glands
- Lymph nodes

Figure 1

**Medical Decision-Making**
**Step 1: Determine Severity**
*(add points for each problem)*

| Problem | Points |
|---|---|
| Self-limited or minor (up to 2) | 1 |
| Established problem, stable or improved | 1 |
| Established problem, worsening | 2 |
| New problem, no further work-up | 3 |
| New problem, additional work-up | 4 |

Figure 2

**Medical Decision-making**
**Step 2: Assign Risk Level**

| Level of Risk | Presenting Problems |
|---|---|
| Minimal | 1 self-limited or minor problem (e.g. [illegible]) |
| Low | • 2 or more self-limited or minor problems<br>• One stable chronic illness<br>• Acute uncomplicated illness or injury<br>• Skin biopsy<br>• OTC drugs<br>• Bloodwork<br>• Minor surgery without risk factors (cryotherapy) |
| Moderate | • 1 or more chronic illness with mild exacerbation, progression, or side effects of treatment<br>• 2 stable diagnoses<br>• Undiagnosed new problem with uncertain prognosis<br>• Acute illness with systemic symptoms<br>• Prescription drug management |
| High | • 1 or more chronic illnesses with severe exacerbation<br>• Threat to life or bodily function |

Figure 3

**Medical Decision-making**
**Step 3: Determine the complexity based on whichever is lower of the severity and risk**

| Severity Points | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| Level of Risk | Min | Low | Mod | High |
| Overall MDM | Straightforward | Low | Mod | High |
| Level of Service | 99201<br>99202<br>99212 | 99203<br>99213 | 99204<br>99214 | 99205<br>99215 |

Figure 4

**Time-based Coding**

| New | | Established | |
|---|---|---|---|
| 99201 | 10 min | 99211 | 5 min |
| 99202 | 20 min | 99212 | 10 min |
| 99203 | 30 min | 99213 | 15 min |
| 99204 | 40 min | 99214 | 25 min |
| 99205 | 60 min | 99215 | 40 min |

Figure 5



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***Medical Decision-Making***
We have arrived at the most complicated of the three criteria, but this is also sometimes the easiest to meet so don't ignore this one! With practice, this will become second nature. You must begin by determining the "severity" using a point system and the "risk level" for the visit (see Figures 2 and 3). Plug these levels into the third table (see Figure 4) and the lower one will determine which code to use.

## Time-Based Coding

In special situations when you spend a lot of time with a patient but don't meet criteria for a high level visit, you can bill based on time alone and ignore all the other criteria. You must document that more than half the visit was spent directly counseling the patient face-to-face or coordinating care, and you must document the length of the visit (see Figure 5).

## Procedures

There are many different procedures performed by dermatologists and it is not feasible to discuss all of them in detail, however some of the most commonly used codes are described below.

***Biopsies***
One of the most common codes you will use in dermatology is for skin biopsy. In most cases, you should use 11100 for the first biopsy (shave or punch) and 11101 for each additional biopsy. For example, if you perform five biopsies you would bill 11100 and 11101 with a quantity of 4 for a total of 5. When shouldn't you use these codes?

- Use shave removal codes if your intention is to remove the entire lesion and not just to sample it. For example, if a patient has a big irritated, bleeding seborrheic keratosis and you shave it off, your intention is to remove the entire lesion for symptomatic relief. Even if you send it for pathology to confirm your clinical diagnosis, you should still bill this as a shave removal and not a biopsy.

- If you remove an entire lesion using a punch biopsy tool, you can code this as an excision and not a biopsy. For example, if you use a 6mm punch to remove a 5mm epidermoid cyst, you should code this as a benign excision, not a biopsy.

- Some sites on the body have their own biopsy codes, which may reimburse more than 11100, so it is worth looking these up. Sites include the external ear, eyelid, lip, nail unit, penis, vulva or perineum, and tongue.

***Injections***
For most injections, you can use the code 11900 for up to and including seven lesions, or 11901 if you inject more than seven lesions. You should also bill for the medication injected using the J code assigned to that medication. Injections of toxins for hyperhidrosis have separate codes such as 64650 for chemodenervation of both axillae.

***Destruction***
When billing for destruction you need to first determine if you are in the category of benign, pre-malignant (actinic keratosis) or malignant. If benign, you should bill 17110 if you treat up to 14 lesions or 17111 if you treat more than 14 lesions. You must choose one or the other – not both. These codes do not cover skin tags – they have their own code of 11200 for up to 15 lesions and 11201 for 15 or more.

For actinic keratoses, you need to keep track of the number of lesions you treat and bill that specific quantity. The first lesion is always 17000. For lesions 2-14 you should bill 17000 (for the first lesion) and 17003 with the quantity over one that you treated. If you treat 15 or more actinic keratoses, you only bill 17004. For example, if you treat six lesions, you would bill 17000 and 17003 with a quantity of five for a total of six lesions. If you treat 20 lesions, you would only bill 17004 (since it is more than 14).

For destruction of malignant lesions, the billing is based on the size and location of the area treated. If you are performing an electrodessication and curettage, you should measure after you curette but before you electrodessicate.

Just as with biopsies, there are special codes for some sites of destruction. These include the anus, penis and vulva. Some companies that manufacture cryotherapy devices have convenient tables of destruction codes on their websites, which you can use as a quick reference. These anogenital codes are separated into simple vs. extensive, and these terms are not clearly defined. You should use your judgment and justify in your documentation when you use the extensive code. There are also different codes for these areas based on the type of destruction: chemical, cryotherapy, electrodessication or laser.

***Excision***
Excisions are coded based on location, size of

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the lesion, and whether they are malignant or benign. Remember that the size should be the total diameter at the widest part including the margin. For example, a 5mm x 8mm basal cell carcinoma excised with a 4mm margin would be billed as 1.6cm malignant excision (8mm + 4mm + 4mm). Some dermatologists will wait to submit the billing until the pathology is available so that they can bill as malignant if the pathology report shows that.

If you excise more than one lesion in the same size range and location, you must bill for it twice and use a 59 modifier to note that they were separate procedures.

You can use soft tissue excision codes for deeper lesions such as deep cysts and lipomas. Keep in mind that these soft tissue codes include an intermediate repair so you should only bill a separate repair if it is complex.

### *Repairs*

Skin excision codes include a simple repair, and soft tissue excision codes include an intermediate repair. You should only bill for a repair separately if you do something more than what is included: intermediate or complex for skin excisions. A simple repair is a single layer of sutures. An intermediate repair is a layered closure. A complex repair is "more than a layered closure, viz. scar revision, debridement, avulsion, extensive undermining, stents or retention sutures." The term "extensive undermining" is not defined, so you should use your best judgment. If you are doing more than you would in your average closure, then consider billing it as complex. You should state in your documentation why you needed to use a complex repair and what made it complex to support your billing.

If more than one repair falls in the same size range and area, rather than bill that code twice, simply add the lengths together and bill once based on this summed length. For example, if you excise two nevi on the back and perform an intermediate repair on each measuring 2.6cm and 5.5cm, you would add them together for a total length of 8.1cm and bill 12034 (Intermediate repair trunk 7.6-12.5cm).

## Modifiers

This is another area that becomes complicated, however it's important to make sure you are reimbursed for all the work you perform. Some important modifiers to know are listed next, but many more exist.

### *25*

This modifier is used when a procedure and an office visit are performed on the same day. This modifier should be attached to the E & M code for the office visit if the office visit is "above and beyond" what is included in the procedure. For example, if you see a new patient and perform a full skin exam, treat his/her seborrheic dermatitis, and treat a wart with liquid nitrogen, you should bill for an office visit with a 25 modifier and destruction of a benign lesion (17110). If that same patient returns in a month and all you do is treat the wart again, you should bill only for the procedure since your office visit was most likely not above and beyond what is included in that procedure.

### *59*

A 59 modifier is sometimes needed when two procedures are performed during the same visit. This shows the payer that the procedures were distinct and performed on different sites. For example, if you perform a biopsy (11100) and treat an actinic keratosis with liquid nitrogen (17000) during the same visit, you will need a 59 modifier on the biopsy to ensure that you are paid for both procedures. Not all combinations of procedures require a 59 modifier and it is not always easy to know which procedure requires it. For this reason, it helps to have staff who can help you with this one!

### *24*

This modifier should be used when a patient is seen during a global period following a procedure for an unrelated problem. For example, all excisions have a 10-day global period. If a patient has an excision of a basal cell carcinoma and comes in three days later for shingles, a 24 modifier should be attached to the E & M to show the shingles is unrelated to the recent procedure.

### *79*

Similar to the 24, the 79 modifier is used during the global period for a procedure, but is attached to another procedure. For example, if a patient had a skin excision and comes in six days later (within the 10-day global period) and has intralesional kenalog injected for alopecia areata, the 79 modifier should be attached to the intralesional injection code (11900).

## Summary

As you can see, medical billing is not straightforward and is something that you need to study and learn. Seek help, especially at the beginning, to make sure you are billing efficiently and appropriately.



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# Negotiation Tips for Non-Competition Clauses

By S. TYLER HOLLMIG, MD
"Best Of" Next Steps Online
from July 21, 2014

Many physician employment contracts contain non-compete clauses, also known as "restrictive covenants." From our perspective as physicians, the legal language of restrictive covenants may be difficult to understand and somewhat intimidating, yet these clauses are fraught with significant long-term implications. While it is critical to consult with an attorney in reviewing your entire contract, having a rudimentary understanding of the key elements of standard non-compete clauses beforehand may help guide your negotiating strategy.

First, do not assume that your non-compete clause will be unenforceable if challenged. While courts' enforceability determinations vary on a state-by-state (and case-by-case) basis, there are nationwide examples of restrictive covenants being upheld. Furthermore, the time and expense required to fight a non-compete—even if ultimately successful—is typically financially and emotionally draining. As such, it is clearly worthwhile to negotiate your non-compete into acceptable form before signing your contract.

Important elements of typical restrictive covenants include duration, geographic scope, and type of practice. While these elements, at baseline, must be reasonable when considered in light of each other, each can be negotiated and adjusted to your benefit. The duration prong establishes the length of time you cannot practice within the defined geographic radius after leaving your employer; reasonable lengths typically range from one to two years, though lengthier terms are not anomalous. Reducing the duration of your non-compete will permit you to get into a new practice within a reasonable time frame. Geographic scope refers to how far away your new practice must be from your employer. It is critical that you define the areas included in the geographic scope. For example, if your employer is a large medical group with numerous affiliated clinics/hospital sites, define your primary practice site as the sole nexus for any radius restriction. It is also important to define the type of practice covered by the non-compete. If, for example, you are a pediatric dermatologist but are only practicing general dermatology for your current employer, you may be able to leave your group to practice exclusively pediatric dermatology elsewhere.

There are several other provisions of typical non-competes worth considering. A "buy-out" clause specifies the pre-determined amount you (or a willing future employer) must pay to relieve you from the proscriptions of the non-compete covenant. Negotiate as low a monetary value to your "buy-out" as possible. Additionally, consider requesting that your non-compete expire at the end of your initial contract term, thereby enhancing your bargaining power (both with your current employer or potential employers willing to pay the buy-out) when you reevaluate your options in a few years. Finally, be aware of what triggers the restrictive covenant. Some contracts apply the non-compete regardless of who terminated the employment relationship and why it ended. In other words, your employer might be able to terminate you "without cause" (i.e., without your doing anything wrong) and leave you without the ability to take another job within the terms of the covenant. You might therefore request that the non-compete apply only if you quit "without cause" or your employer fires you with "cause." Accordingly, it is crucial to define the term "cause" up front to avoid potential later disputes.

The above is simply a rough introductory guide to understanding non-compete provisions, and is not intended as legal advice. While it is essential that you engage an attorney experienced in health care employment matters to review your entire contract, including your non-compete, you will benefit from any knowledge you can acquire before entering into the process of negotiating your contract (or spending costly hours with an attorney learning the basic principles).

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