CODING Q&A

# Proper Coding for Skin Tag Removal, Workers Comp Issues, and Off-Hour Visits

DAVID STERN, MD, CPC

**Q. Are you able to bill the following two codes together with a modifier: 17110 (Destruction [e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement], of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions) 17111 (15 or more lesions)?**

*- Question submitted by Julie Briggs*

A. These are mutually exclusive codes. You can use 17110 if the physician destroys 14 or less benign lesions (usually warts). If you destroy 15 or more lesions, then use 17111. You may *not* report both these codes for the same patient on the same day.

**Q. Do you use this same method for coding CPT codes 11200 and 11201 for removing skin tags?**

A. The CPT coding is quite different for removal of skin tags. For skin tag removal, you code 11200 for removing the first 15 lesions, and then you add code 11201 for removal of each additional 10 lesions. Thus, the payors expect you to use 11200 along with 11201, and you many even code 11201 multiple times on a single visit.

**Q. How do I code for the removal of 24 skin tags? Could I round up and use code 11201 (along with 11200) even though the provider only removed an additional nine skin tags, so she did not quite remove the required "additional 10 lesions?"**

A. For removal of the first 15 skin tags, use code 11200, then for removing the additional nine skin tags code with 11201-52. The modifier-52 signifies "reduced services," indicating that the physician removed additional skin tags, but did perform a portion (i.e., removal of nine, rather than 10, skin tags) of the work that the actual code includes.

**Q. If we shave off a skin tag, should we code the procedure with CPT code 11300 (shaving of epidermal or dermal lesion...)?**

A. You should use code 11200 for any sharp excision (including shaving) of skin tags.

**Q. In addition to the diagnosis code for the injury, do I use V71.3 (observation following accident at work) for each follow-up visit for injuries covered under the workers compensation act of my state?**

*- Question submitted by Shanin Skinner, Ontario, OR*

A. No; this code is not intended for use with routine follow-up visits for workers compensation cases. You should reserve the code V71.3 for injuries or possible injuries that require observation of the patient, rather than for rechecks of work comp injuries. I am unaware of any payors that are requiring providers to use this code.

This code could be used, for example, for a patient who needed to be held for observation after contact with a pesticide or other toxic substance, such as carbon monoxide.

**Q. If a patient is covered under the workers compensation act and is treated for two separate injuries, can you bill two E/M codes for the separate injuries or is it just one billing for multiple injuries? For example, an employee injured her neck while lifting a patient, and she injured her ankle when she tripped over a leg of a chair.**

*- Name withheld, California*

A. According to CMS guidelines, you would only code a single CPT. However, many work comp payors will accept completely separate documentation for two separate visits and two separate E/M codes for these visits if these visits are for separate work comp injuries.

*Continued on page 36.*

**David Stern** is a partner in Physicians Immediate Care and chief executive officer of Practice Velocity. Dr. Stern and Frank H. Leone, MBA, MPH, are scheduled to speak at a pair of half-day seminars, Urgent Care: 40 Ways to Increase Profitability, in Tampa and Boca Raton, FL July 25 and 26. For more information about the seminars, call Megan Montana at (800) 666-7926, extension 13. Dr. Stern may be contacted at *dstern@practicevelocity.com*.

Conversely, prospects that bring up personal challenges are more likely to be responsive to solutions that help them (i.e., save them time and/or make them look good).

*"You should not minimize the potential importance of a prospect's self-interest."*

2. You now not only know that your solution should include an appeal to their self-interest or survival, but you have a pretty good line on what their personal "hot buttons" are. The sales process is all down hill from there.

Once the importance of personal issues has been uncovered, you should craft your benefit statement accordingly. In most instances you should address both the professional impact and personal impact sides. The art comes in determining the respective emphasis to place on each side of the continuum.

For example:

- **Heavy "company" orientation**
  *"I am confident that our unique, computerized focus on return-to-work outcomes will provide your company with the best chance to reduce unnecessary costs and enhance the health status of your workers."*
- **Company/personal blend**
  *"I am confident that our approach serves two vital purposes: we emphasis early return-to-work, thus reducing unnecessary lost work time and your workers' compensation-related costs while at the same time allowing you to spend more time addressing other important issues."*
- **Heavy personal orientation**
  *"I believe that our injury/illness prevention programs and focus on early return-to-work will dramatically reduce the time that you have to spend on such cases, thus providing you with more time for other matters and making your life a lot easier."*

In summary, you should not minimize the potential importance of a prospect's self-interest. Learn to assess the degree of such self interest, and craft recommendations and benefit statements accordingly. ■



**Q. When researching our corporate A/R, I found a pattern of drug screens being skipped over for payment. Most of the drug screens that were not being paid were "post-accident" drug screens affiliated with a workers compensation visit. We have never billed workers compensation insurance for drug screens, but usually charge it on a separate ticket and bill either the lab or the company. Does workers compensation insurance normally pay for drug screens associated with an injury visit? Do they have to be billed on the workers compensation claim?**

*- Question submitted by Julie Galens, Accent Urgent Care & After Hours Pediatrics, PA, Cary, NC*

**A.** You are absolutely right! Drug screens should *not* be billed to a work comp carrier and should be billed directly to the employer (or payor designated by the employer) for these tests. Generally, these are invoiced separately from worker's compensation claims on a monthly invoice that includes all employer-paid services for that specific employer. Employers usually (but not always) want these incident testing drug screens to be invoiced along with other employer-paid services, such as post-offer physicals, ethanol breath tests, etc.

If you are billing with this method and not receiving payment, check with the corporate clients, confirm that they do want you to perform post-accident drug screens, and inform them that if they want you to continue performing this service, they must pay their claims on a timely basis.

**Q. My doc (urgent care) thinks that Medicare may now be allowing 99051 (evening/weekend/holiday code) in 2008. Is this true? I spent 45 minutes on the phone with Medicare this afternoon and they didn't seem to know.**

*- Name withheld, Indiana*

**A.** For Medicare, nothing has changed; Medicare does not reimburse for 99051. Do not bill this code to Medicare.

Your doctor, however, may have been referring to Indiana Medicaid, which will reimburse for this code. The Indiana State Medical Society explains the appropriate billing code for evening, weekend, and holiday hours as follows:

> "Procedure code 99051—Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service, providers may bill a maximum of one unit per patient per day. Evening hours are defined as routinely scheduled after 5 p.m. in the prevailing time zone. Providers may only bill for the following holidays, which represent days when physician offices are generally closed for the day: New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, and Christmas Day. When billing for 99051, please document in the medical chart the time, date, or holiday, as applicable." ■