// DERM CODING CONSULT

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NEWSBRIEFS

Appeal Claims
We have had positive feedback from the sample letters that have appeared in previous issues of *Derm Coding Consult*. One of our Academy members responded that he had used the sample letter found in the September 1998 issue regarding E/M and biopsy for three appeals. All three appeals achieved positive results with proper reimbursement. Sample appeal letters are also available for inappropriate application of the multiple surgery rule, inappropriate bundling of excisions and repairs, and denial of claims for separate diagnostic skin biopsy and/or frozen section pathology on the same date as services for Mohs micrographic surgery in the June 1999 issue of *Derm Coding Consult*.

Twenty-five percent to forty percent of denied or bundled claims that merit appeal are not appealed. We continue to urge members to look carefully at Explanation of Medical Benefit statements and appeal those claims that contain inappropriate bundling or denied services that would have been paid had the services been done on different dates.

Inappropriate Bundling Examples
The Academy's Non-Medicare Reimbursement Task Force continues to collect examples of inappropriate bundling. In order for the sample to be useful, the following is needed: a copy of the claim and a copy of the EOMB with the personal information eradicated, any appeal letter you have sent, and any response to that appeal. If you have policy statements associated with the denial, we would be interested in receiving those as well. Please mail examples of inappropriate bundling to Barbara Dolan, Private Sector Manager, at the Academy address. We are unable to respond to each example, but are assembling the examples according to the insurance carrier responsible for the bundling. In some cases, state or regional dermatology societies are meeting with the local insurance medical directors to try to solve the inappropriate bundling problem. The Academy can assist you in preparing for those meetings. Additional meetings with national insurance organization medical directors to discuss inappropriate bundling and claims processing are currently being planned.

NOTE: As representatives from the dermatologic community meet with appropriate directors of various medical plans, we caution you regarding legal ramifications. Continue to conduct your meetings to avoid any misinterpretation of a violation of anti-trust requirements, or any perception of collusion of any kind.

E/M Guidelines Update
There have been no new developments in the E/M arena since the June 1999 issue of *Derm Coding Consult*. We are still awaiting a response from HCFA regarding the process. We encourage you to become familiar with the newly proposed guidelines and begin planning implementation. The last issue of *Derm Coding Consult* addressed the proposed guidelines. Currently, either the 1995 or the 1997 guidelines are accepted, however the proposed revisions are simpler and less ambiguous.

AMA Private Sector Advocacy
The American Medical Association has established an advocacy group to assist in private sector issues. Their objectives are to assist AMA members in: identifying and altering abusive and unfair contracting provisions and management practices; increasing physician negotiating leverage; and to identify and respond to emerging trends and issues. Contact the Private Sector Advocacy (PSA) group at (800) 262-3211 or through the AMA Web site (www.ama-assn.org) by selecting Policy and Advocacy and clicking on Private Sector Advocacy.

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SCHERING DERMATOLOGY
PARTNERSHIP PACT™ PROGRAM

Derm Coding Consult is funded by an educational grant from the Dermatology Products Division of Schering Pharmaceuticals

Documentation Basics

The proposed documentation guidelines list the documentation basics. These basics are listed as the principles of documentation that apply to all medical treatment regardless of the setting. These basics are straightforward and will assist you in the compliance program in your practice. You may wish to review a few of your medical records keeping the list of documentation basics in mind.

- The medical record is a tool of clinical care and communication. As such, the importance of communication is noted. If another physician needed to treat the patient in your absence, would the communication in the medical record be sufficient for continuity of care?
- The medical record is to be complete and legible. Review a sampling of your medical records. Are the entries too abbreviated and unreadable? Do you have a master list of physician and staff initials and of abbreviations in your policy manual that are standard to your practice?
- Chief complaint and/or the reason for the encounter, pertinent history, examination findings, including previous test results are documented. The clinical impression or diagnosis, treatment plan, date and identity of provider are to be documented.
- The reason for the encounter, i.e., chief complaint, with rationale for requested diagnostic testing or other services should be clear from the medical record. If not specifically documented, the information should be easily inferred.
- Past and present diagnoses and conditions should be accessible to the treating and/or consulting physician. This information would be particularly necessary in a consulting situation.
- Appropriate risk factors affecting the patient's health should be identified and documented.
- Documentation of the patient's progress, response or lack of response to treatment, change in treatment plan, instructions, follow-up care, and current diagnosis should be complete.
- Documentation in the patient medical record should support the ICD-9-CM and AMA/CPT codes reported on the insurance claim form. Review by a clinical peer would easily substantiate the proper use of the diagnosis and procedure codes.
- Medical records confidentiality according to medical ethics and the law should be fully maintained.

Newsbriefs *from page 1*

Derm Coding Consult Back Issues

All the issues of this publication are available on the Academy's Web site (www.aad.org). Click on Professional Information, then click on Socioeconomic Issues. The issues are listed in chronological order and any or all may be downloaded. The files are in PDF format, requiring Acrobat Reader. Follow directions for downloading if Acrobat Reader is not on your system.

According to hits on our Web site, the two most popular issues recently have been September 1998 and December 1998. The September issue contained information regarding CPT modifier –25, with a sample letter to carriers and the December issue contained CLIA information, Q & A's, and an index of topics covered in all past issues.

Share Publication

This publication is useful as an educational tool to assist members and their staff in coding issues. Please share this publication with the staff members that work in the coding and reimbursement areas of your practice.

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editor's notes:

Coding and reimbursement issues are an evolving process. It is important to keep issues of *Derm Coding Consult* and most important to share with your staff involved with coding and reimbursement issues. Please note that the information provided in each issue is provided to the best ability and knowledge at the time of publication.

mission statement:

Derm Coding Consult is published quarterly (March, June, September and December) to provide up-to-date information on coding and reimbursement issues pertinent to dermatology practice.

visit *derm coding consult* at: **www.aad.org**

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The Academy continues to receive questions regarding when to code using the biopsy code 11100 rather than a shave code, 11300 series, or an excision code, 11400/11600 series. The intent of the procedure is the key to the code chosen.

When a patient presents with a lesion, what is the reason for the procedure? If a portion of the lesion is removed to identify the lesion and/or determine whether additional treatment is necessary, then the biopsy code, 11100, would be appropriate. If the procedure is to be done to remove the lesion, then the method of removal would drive the choice of the proper procedure code, either the shave removal or excision code. Intent is the key to selecting the proper code.

Terminology is an important factor in documentation, especially in an audit situation. For example: if the documentation in the medical record states shave excision of 0.4cm benign lesion of the left upper arm, and code 11400 is reported, it is possible, upon audit, of downcoding to code 11300. According to CPT, shave **removal** is the removal of epidermal and dermal lesions without full-thickness dermal excision by transverse incision or horizontal slicing, codes 11300 - 11313. Shave "excision" is not a CPT term and may be misleading. If in fact the lesion was removed by shave technique, the documentation should agree. Shave codes do not require suture closure. The CPT descriptor for benign lesion excision, codes 11400 - 11471, is full-thickness removal, through the dermis. These excision codes include simple (non-layered) closure, however a full thickness excision that is not closed, is still properly coded with an excision code. Code 11400 has a physician work relative value unit (RVU) of 0.91, with a total RVU of 1.89, and code 11300, a physician work RVU of 0.51 with a total RVU of 1.20. The documentation should clearly state what procedure was performed and the technique used.

Sometimes carriers or physicians confuse skin biopsy procedures with shave removals or excisions, or have misinterpreted CPT descriptors for these procedures. The result may be inappropriate payment or inaccurate claim processing for these procedures.

CPT code 11100 "biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed (separate procedure); single lesion", does not mean that a skin biopsy which does not require closure may be downcoded by a carrier to a shave removal code such as 11300 or 11305. While wounds from shave procedures do not require suture closure, neither do skin biopsies. The parenthetic "(including simple closure)" in the skin biopsy descriptor just means that if a biopsy wound is closed, the physician may not bill a separate simple repair code for the biopsy site in addition to code 11100. Regardless of whether a punch biopsy is sutured or left open, the code (11100) should be the same.

Shave removal may be performed with various types of sharp instruments such as scalpel, razor blade, curette or scissors to tangentially remove epidermal and dermal lesions without a full thickness dermal excision. The fact that the lesion may be completely removed at the upper dermis, mid dermis, or even deep dermis level does not make the procedure an "excision". CPT has reserved the term "excision" for the 11400 and 11600 code series to help distinguish them from the shave removal codes. The fact that tissue may be submitted for pathology examination following complete removal with either a shave technique or full thickness excision does not make these procedures "biopsies" to be coded as 11100, skin biopsy.

These procedures are appropriately coded with the shave removal 11300 series, or the excision 11400 or 11600 series, which most closely describes the procedure performed by site and size. Similarly, it is fair and consistent that small lesions 0.5cm or less removed with a shave procedure, e.g., code 11300,11305 or 11310 and also sent for pathology may be coded as shave removals rather than 11100, even though the latter has a slightly higher RVU.

The importance of accurate documentation cannot be stressed enough. The documentation must support the code or codes reported.

As stated in previous issues of *Derm Coding Consult*, it is recommended that the submission of the claim be held until the pathology report is received. By having the proven pathology diagnosis, an accurate code can be assured.

Destructions

Destruction of a benign lesion would be coded using code 17000 for the first lesion, 17003 for the second through fourteen lesions, each, or 17004 for fifteen or more lesions. Code 17003 is an add-on code meaning that it can only be reported in conjunction with code 17000. Thus, destruction of eight benign lesions would be reported on the HCFA 1500 form as follows:

17000
17003, 7 units

Recently, there have been calls regarding carriers who are not reimbursing properly for code 17003. The usual problem is the failure of carriers to recognize multiple units of code 17003. Staff need to be alert to detect such underpaid claims and not write off balances that are due. Appeal those claims using the CPT code book and this publication to support your appeal.

Again, there is the issue of selecting the proper code, i.e., destruction, shave, or biopsy. As stated before, the intent and the procedure performed determine the selection of the code. The documentation in the medical record must support the code reported.

see **Biopsy/Shave/Excision**, *page 4*

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AAD Welcomes Norma Border

Dear *Derm Coding Consult* Reader,

Let me take this opportunity to introduce myself as your new editor of *Derm Coding Consult*. I'm happy to bring over twenty years of health care industry experience to the American Academy of Dermatology's Department of Socioeconomic and Practice Issues.

My primary responsibilities for the last sixteen years have included working directly with HCFA on medical policy and practice reimbursement issues as well as liaison activities with state and federal legislators and regulators. It has always been my charge to be sensitive and responsive to the problems and issues that impact members and to aggressively pursue equitable resolutions. I have a successful track record with government and health industry work groups, developing effective methods for identifying and resolving policy and operational issues.

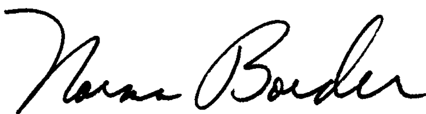
At heart, I'm a problem-solver and a writer. In 1989, combining the two talents, I co-authored How To File Your Medicare/Medigap Claims: The SPEEDCLAIM Way to Quicker Payments. Although out-of-print now, the book was designed to help Medicare beneficiaries and their family members navigate the claims filing maze. It was a labor of love for my own aging family members.

As contributing editor and columnist for five years for *The Claims Advisor*, published by the National Association of Claims Assistance Professionals, Inc., I was happy to provide members with what they considered the primary benefit of membership, timely information on health care industry issues.

It's a privilege and an honor to assume the role of editor for *Derm Coding Consult* from the capable hands of Diane Krier-Morrow. I know you find your practice environment constantly buffeted by payer whims and national payment policy winds. I look forward to the challenge of providing you with timely and consistent information on coding and reimbursement issues.

I look forward to "getting to know you!" Please feel free to contact me at my direct line (847) 240-1814, or fax me at (847) 330-1120 with any coding or reimbursement items you'd like clarified and addressed in future issues of *Derm Coding Consult*.

Best Regards,



Norma L. Border, Manager
Coding and Reimbursement

Global Period

The global period describes the number of days during which all routine services related to the procedure are included in the payment of the original procedure. Again, this includes routine services, such as suture removal and/or checking surgery site. Any services that are complications or unrelated to the procedure are billable by using the correct procedure or service code and the correct modifiers. Use modifier –24 for an unrelated E/M service, and modifier –79 for an unrelated surgical service during the postoperative global period.

Medicare global days are published in the *Federal Register*. The global days applicable to dermatology procedures are 0, 10, and 90 days. Some examples of Medicare global days are listed below.

Procedures with 0 global days are:
11100, 11101 - biopsy of skin
11300-11313 - shave removal
11719-11740 - nail procedures
11900-11901 - intralesional injections
17304-17310 - Mohs' micrographic surgery
99201-99xxx - E/M codes

Procedures with 10 global days are:
10040-10180 - acne surgery; incision and drainage
11200 - skin tags
11400-11446 - benign excision
11600-11646 - malignant excision
12001-13152 - repairs
17000, 17004 - benign destruction
17260-17286 - malignant destruction

Procedures with 90 global days are:
14000-15401 - flaps and grafts

Global days for some carriers may differ from Medicare's global days. Be sure you are aware of the global days for the specific carriers. Global days and global policies should be considered in a managed care contract.

Biopsy/Shave/Excision *from page 3*

In order to report destruction of a malignant lesion, codes 17260-17286, a pathology report identifying the malignant lesion must be present in the medical record. The pathology report does not need to accompany the claim, but must be available to support the code billed. If a previous biopsy of a portion of a lesion confirmed a malignant lesion, (basal cell carcinoma or squamous cell carcinoma), the subsequent definitive destruction procedure does not require any additional tissue to be submitted for pathology. However, if the previously biopsied lesion is excised, it is standard practice to submit the excised specimen for pathology to check that margins were adequate.

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We are fortunate to have a group of Academy members that give of their time to represent dermatology in the Medicare arena. The DERMCAC members are dermatology representatives to the Medicare Carrier Advisory Committees. Each state Carrier Advisory Committee meets quarterly, and your DERMCAC attends those meetings representing dermatology in your state.

The DERMCACs meet as a group at the Annual Meeting and at the summer Academy meeting. During these meetings, the group shares information of common interest. By keeping current with Medicare issues locally and nationally, our DERMCACs are valuable to our organization.

The DERMCAC representative is selected by the state dermatologic organizations. In some states an alternate DERMCAC has also been named. If you have an interest in serving dermatology in this capacity, contact the president of your state organization.

To contact your DERMCAC regarding an issue, we recommend that you send the appropriate documentation explaining the issue via fax. The DERMCAC can then review the issue and contact you. An asterisk (*) indicates the alternate DERMCAC.

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	*J. Kevin Poitras, M.D.	301-881-6782	301-585-3376
	*William Sawchuk, M.D.	703-534-2874	703-532-7211
Puerto Rico	Ana L. Colon de Jimenez, M.D.	787-753-7615	787-763-1454

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I am still confused about pathology coding. Please explain.

Pathology CPT codes 88304 and 88305 include the accession, examination and report. Therefore, if only a portion of the code is performed, the appropriate modifier must be used.

Example 1: Dermatologist prepares slide, interprets slide, and prepares report – code 88304 or 88305. The global service has been performed by the dermatologist.

Example 2: The tissue is sent to an independent laboratory for slide preparation. The slide is read by the dermatologist who then prepares the report. In this instance the laboratory does the technical component and the dermatologist performs the professional component. Modifier –TC is appended to the code indicating the technical component and modifier –26 indicates the professional component. The proper coding would be: 88304 –26 and 88304 –TC; or 88305 –26 and 88305 –TC. Note, billing the technical component to Medicare must be the exact charge the laboratory charges for the slide preparation.

Example 3: The tissue is sent to the laboratory for slide preparation, interpretation and report. The report is received by the dermatologist. The dermatologist reports the global service, indicating that this service was done by an outside laboratory by code 88304 –90 or 88305 –90. The outside laboratory information would need to be reported on the claim form. This billing is appropriate only for non-Medicare claims. Managed care organizations may have specific rules regarding billing for pathology global service.

See article regarding Pathology Coding in June 1998 issue of *Derm Coding Consult*.

What is the proper coding for telangiectasia of the face?

Telangiectasia are usually destroyed. Thus, the 17000 codes are appropriate. If the destruction is done by laser, the laser codes 17106-17108 are **not** appropriate. These codes are to be used for vascular proliferative lesions only. Since telangiectasia are usually asymptomatic, treatment may be classified as cosmetic and thus a non-covered service and reported by using HCPCS code A9270.

Was there a change in code 15000?

The 1999 descriptor of code 15000 no longer includes the language 'including excision of lesion'. Thus, when an excision of a lesion precedes a grafting procedure, the appropriate excision code, 11400 series or 11600 series, should be reported. If the grafting is done on a day other than the day of the excision, the appropriate modifier should be appended, such as modifier –58, if the same physician does the graft within the ten day global period after the excision.

When should modifier –51 be used and when should modifier –59 be used?

The AMA/CPT descriptor of modifier –51 indicates that this modifier is used on the subsequent procedure(s) when multiple procedures are performed by the same provider during the same encounter. Modifier –59 indicates that the service performed was independent of other procedure(s) on the same day by the same provider. Some carriers are no longer requiring modifier –51. Medicare carriers require modifier –59 to be used on one of the codes of the code pairs listed in the Correct Coding Initiative. Knowing the specific carrier's rules will aid you in submission of clean claims. Unfortunately some private carriers have not yet implemented the –59 modifier which has resulted in the inappropriate bundling of separate services for their subscribers.

THANK YOU for the questions that have been submitted in response to the June, 1999 issue of *Derm Coding Consult* survey. We will do our best to address the issues raised in future issues.

HCFA hosted Conference

HCFA hosted a telephone conference on August 12 for State Medical Societies and National Physicians Organizations. One of the agenda items was the issue of Y2K.

All Medicare contractors have been required by HCFA to offer testing to providers. This testing will permit the provider to be assured that all claims will be submitted accurately after January 1, 2000. Contact your carrier to arrange for testing if you have not already done so. If you utilize a billing service, be sure their system will be able to submit your claims properly as of January 1. In testing that contractors have previously done, many of the errors were due to inadequate hardware and not the software.

Services provided after January 1 will be reimbursed according to the year 2000 fee schedule. However, payments will not be made prior to January 17.

Contact HCFA at 1-800-958-4232 for carrier name and phone number.

It's time to begin thinking about coding resources for 2000. Current coding material is vital to submitting "clean" claims. Advise your practice management staff to review your material and update as needed.

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AAD CLIA Compliance Manual being reprinted

As the result of continued high demand, we are temporarily out of stock on the *CLIA '88 Laboratory Manual*, originally made available to members in 1993.

As valuable and *timely* today, nearly 7 years after its first release, the CLIA Compliance Manual provides you with a customizable, full-featured compliance plan for your office. CLIA inspectors regularly advise dermatologists applying for certification to contact the Academy for a copy. Members have consistently identified the *Manual* as one of the most valuable products offered by the Academy.

Reprinting the *Manual* is underway and we expect the *Manual* to be available for shipping shortly. As the cost of reprinting is not currently supported by outside funding, the Academy must charge $75.00 to cover the cost of reprinting the *Manual*.

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