

DERM CODING CONSULT



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Newsbriefs

CIGNA Modifier Enhancements

CIGNA Healthcare has announced that it intends to implement an enhancement to its clinical claim policy for Modifiers -25 and -57 for all its healthcare products. In a letter to physicians CIGNA is announcing that these modifiers would no longer be limited to the E/M consultation codes. In addition, E/M consultation codes will also no longer require the additional submission of office notes or supporting documentation when billed with additional procedure or service codes. AAD has asked Cigna for further clarification as to whether or not this new policy applies to New Patient office visit codes, CPT 99201 – 99205 as these are not specifically mentioned in the CIGNA letter.

CIGNA claim policy is now more consistent with AMA CPT guidelines as well as Medicare coverage guidelines in recognizing that an E/M service and other procedures provided at the same encounter may be related to the same diagnosis. However, CIGNA is still requiring office notes and supporting documentation when modifiers -25 and -57 are used with Established patient E/M codes. Use of these modifiers for established patients is not intended to be any different for the same services to new patients or consultations, according to AMA CPT.

Medicare Audits

With additional funding from the Balanced Budget Refinement Act (BBRA), the Health Care Financing Administration (HCFA) has increased audits. Pre-payment audit reviews can result in additional focus on codes that have high volume usage. Documentation is a key issue in these pre-payment audits. The documentation must support the code(s) reported. (See related article on Local Medical Review policies, page 3.)

It is important for you to keep your DERMCAC (Dermatology representative to the Medicare Carrier Advisory Committee) advised of auditing activity and any denials that you receive as a result. (DERMCACs were listed in the September 1999 issue of *Derm Coding Consult*. See list of DERMCAC changes on page 3.)

For example, since April, the Medicare carrier for Illinois and Michigan has significantly increased the volume of pre-payment audits of dermatology claims. This included claims for destruction of actinic keratoses. Dermatologists in Illinois and Michigan responded to increased requests for additional information but questioned the purpose and focus. Initial feedback to DERMCACs from the Carrier Medical Directors in both states at the end of May indicated that there were no changes to existing local medical review policies and that this was a system error that would be corrected. However, by mid-June dermatologists were seeing the results of the initial pre-payment audits and an alarming number of denials for destruction of AKs as being medically unnecessary.

In Illinois, Katherine Wier, M.D. raised the issue again at the July CAC meeting with the Illinois Medical Director. While still attributing the problem to an unresolved system edit problem, Illinois dermatologists have been instructed to submit the information on inappropriately denied claims to staff in the carrier medical director's office for investigation and resolution.

Andrew Mitchell, M.D., Michigan DERMCAC, reported mid-July that denials due to the lack of medical necessity had ceased in Michigan. However, pre-payment audits were still occurring.

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Letter from the Editor

Dear *Derm Coding Consult* Reader:

At the Academy's Annual meeting in San Francisco this spring I attended the Private Sector Advocacy Task Force's meeting as well DERMCAC. It was clear that claims submission and billing problems are proliferating regardless of payer. The Academy is fortunate to have articulate and persuasive members who generously give their time and expertise in meetings with payer medical directors and corporate officers. They are committed and persuasive advocates, whose primary goal is to educate these payers on dermatology's distinctiveness as a specialty and recognition of not only the clinical effectiveness but also the cost effectiveness of the care provided.

If you haven't added HIPAA to your current list of known acronyms, you need to do it NOW. The Health Insurance Portability and Accountability Act (HIPAA) was passed in 1996 and its immediate impact was to make it much easier for individuals with employer group health plan insurance to move from one employer to another without losing the umbrella of coverage for themselves and for their family members. The next phase of HIPAA implementation will significantly impact the privacy and confidentiality of patient data in an electronic environment. It will also set standards to simplify and increase the ability of health care practitioners and providers to interact with both government and private payers. The goal of HIPAA's Administrative Simplification mandate is standardized formats for enrollment, eligibility, clinical records, claim submission and remittance advice regardless of payer. It could be a brave new world...but there's still a lot of work for everyone involved. The trick is, become involved now and be able to reap the benefits as they become available. There will be more to come on HIPAA.



Norma L. Border, Editor

AAD Comments on OIG Draft Guidelines for Small Practice Compliance

Despite the Office of the Inspector General's comment that OIG has carefully considered the 83 comments (including AAD) submitted in response to the 9/8/99 OIG solicitation notice, a significant portion of this latest compliance program for individual and small physician practices is obviously lifted verbatim from its earlier facility-oriented programs. This assumes that there is an internal administrative structure of sufficient complexity to effectively allow the small medical practice to segregate the proposed monitoring and audit functions required by such a compliance program.

Should the OIG publish a Final Compliance Plan, it would affect every physician office, regardless of size. Maintenance and documentation of compliance would be an on-going necessity for each physician office.

In his response letter to the OIG, Richard K. Scher, M.D., President of AAD commented, "If the OIG is truly concerned about Medicare program dollars lost as a result of erroneous claims, perhaps the answer is a lot simpler than the construction of an elaborate, labor intensive, "voluntary" compliance plan providing no protection for the effort incurred for the small physician office." Dr. Scher reminded OIG that, "unlike hospitals, home health agencies, skilled nursing facilities, outpatient rehab facilities, hospices, renal facilities and even rural health clinics, a physician who has chosen to participate in the Medicare program is not provided with even a basic instructional manual on Medicare Program requirements that is updated on a regular basis."

In light of both HCFA and the OIG's concerns regarding Medicare program dollar losses, how can it be argued that this is too expensive an effort? In the absence of such an authoritative and mutually binding exposition of Medicare Program requirements and responsibilities, it is myopic of the OIG to suggest that. It would be onerous and increase the responsibility and potential liability for each physician attempting to comply. AAD recommended that serious consideration should be given to rapid development and distribution of a Medicare Participating Physician's Office Manual.

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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

HCFA Proposes New Criteria for Making Coverage Decisions

HCFA has published a notice that sets forth a proposed criteria for establishing Coverage Policy decisions at both the national and local level. In responding to this proposal, the Academy commented that any effort to reform the local coverage review process should include a formal policy for reconsideration of coverage decisions developed and implemented by the local carrier. Under such a process, any clinical group could petition the Carrier Advisory Committee (CAC) for a modification or reversal of a local medical review policy (LMRP). Such a request for reconsideration would be provided to the CAC in writing and would clearly identify any deficiencies in the existing policy, provide justifications for changing that policy, and specific changes sought.

AAD believes that the CAC could serve as a screening tool for the carrier in this new process. The CAC could review and evaluate requests for reconsideration of local carrier policy, and forward it onto the Carrier Medical Director (CMD) with a recommendation. It would be a simple process that utilized existing infrastructure. The creation of a new committee to undertake such a review is not necessary when a better utilization of the CAC is all that is needed. Such a process would also lend fairness, responsiveness and legitimacy to the local coverage process. In addition to creating a new role for the CAC, the Academy believes that local carriers should be held to the same standards as HCFA. These local medical review policy decisions should be evidence-based and reflect the local medical community's standard of care.

While many local coverage decisions are determined in a consultative manner with the CAC and local and state medical societies, often they are not. In 1996, the Florida CAC objected strenuously to the proposed LMRP on actinic keratoses. The Florida State Medical Society and a number of state and national medical specialty societies also expressed their opposition to this policy on the grounds that the policy was without merit on scientific and medical grounds. However, these concerns were dismissed by the CMD. It is hoped that standardizing the process for both local and national coverage decisions will improve the quality and application of medical coverage decisions for Medicare.

DERMCAC Survey on LMRP

We recently polled the DERM-CAC (Dermatology representative to the Medicare Carrier Advisory Committee) members regarding local medical review policies (LMRP) on actinic keratoses, benign lesions, and malignant lesions.

Fifty-eight percent of the states, including District of Columbia and Puerto Rico, have actinic keratoses policies; 56% have benign lesion policies; and less than 10% have malignant lesion policies. A few states have Mohs Micrographic Surgery policies.

Actinic Keratoses Update

On June 6, 2000 the Academy re-activated its request for a National Coverage Policy for the treatment of actinic keratoses. It is our understanding that HCFA intends to publish a National Coverage Policy sometime during the month of September. The National Coverage Policy decision will be made internally at HCFA prior to publication. The Academy has been working closely with HCFA staff to provide them with the most up to date peer reviewed literature on the nature and treatment options for actinic keratoses.

It is important for you to know your Medicare carrier's local medical review policies. These policies indicate when services are covered or non-covered and the indications and limitations of coverage. The policies indicate the appropriate AMA CPT and ICD-9-CM codes that are applicable. Many of your carriers have Web sites and list the local medical review policies on that site. The policies are printed in your Medicare bulletin or newsletter as they become effective. Another Web site for local medical review policies is www.lmrp.net.

DERMCAC Changes

Please note the following changes to the DERM-CAC listing in the September 1999 *Derm Coding Consult*:

<u>NAME</u>	<u>FAX</u>	<u>PHONE</u>
Colorado		
Kathleen Sawada, MD	303-935-5095	303-935-4681
*John Schmidt, MD	719-584-4779	719-543-2211
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C. William Hanke, MD	317-582-8481	317-582-8484
Maine		
Nancy Egan, MD	207-798-4658	207-725-5197
Massachusetts		
Terry Hadley, MD	978-371-9675	978-369-9023
Minnesota		
Cynthia Olson, MD	612-904-4236	612-347-2332
*Peter Lee, MD	n/a	612-946-6983
North Carolina		
*Lauren Gandhi, MD	336-768-8031	336-768-2180
Oregon		
Thomas Kruse, MD	503-375-3643	503-370-7364
District of Columbia		
Sandra Read, MD	202-223-6833	202-223-6830

*indicates alternate

Evaluation and Management Guidelines - Status Quo

Although HCFA has recently released Draft E/M Documentation Guidelines, there is no change to HCFA's position regarding evaluation and management services. HCFA directs its auditors to use either the 1995 or the 1997 guidelines, whichever is the most advantageous to the physician. The following provides you detailed information regarding the differences between the 1995 and the 1997 documentation guidelines. The documentation in the medical record must support the level of service (or the procedure) rendered. The only difference between these two guidelines is in the documentation of the examination.

HISTORY - REQUIREMENTS

Documentation of history is the same in the 1995 and 1997 guidelines. To qualify for a given level of history, all three elements in the table must be met.

History of Present Illness (HPI)	Review of Systems (ROS)	Past, Family, and/or Social History (PFSH)	Type of History
Brief (1-3 elements)	N/A	N/A	Problem Focused
Brief (1-3 elements)	Problem Pertinent	N/A	Expanded Problem Focused
Extended (4+)	Extended (2-9)	Pertinent (1 of any 3)	Detailed
Extended (4+)	Complete (10+)	Complete (1 of any 2 for est. pt.; 1 of all 3 for new pt.)	Comprehensive

Note: An extended HPI is also defined as the documentation of three or more chronic or inactive conditions.

MEDICAL DECISION MAKING - REQUIREMENTS

Documentation of the complexity of medical decision making is the same in 1995 and 1997 guidelines. Two of the three elements in the table below must either be met or exceeded.

Number of diagnoses or management options	Amount and/or complexity of data to be reviewed ^a	Risk of complications and/or morbidity or mortality	Type of decision making
Minimal	Minimal or None	Minimal	Straightforward
Limited	Limited	Low	Low Complexity
Multiple	Moderate	Moderate	Moderate Complexity
Extensive	Extensive	High	High Complexity

Documentation of examination is where the 1995 guidelines differ from the 1997 guidelines. Both guidelines are based on four types of examinations. However, the 1995 guidelines do not define limited examination, nor does AMA CPT. There are no bullets for counting to achieve a level of service in the 1995 guidelines. Thus the vagueness lends itself to the necessity of the auditors being able to utilize both guidelines, whichever is most advantageous to the physician.

TYPES OF EXAMINATION - REQUIREMENTS

Problem Focused	limited examination of affected body area or organ system
Expanded Problem Focused	limited examination of affected body area or organ system and other symptomatic or related organ system(s)
Detailed	extended examination of affected body area(s) and other symptomatic or related organ system(s)
Comprehensive	general multi-system examination or complete examination of a single organ system

DOCUMENTATION OF EXAMINATION - con't

Documentation requirements when using the 1997 guidelines:

<p><u>Level of exam</u></p> <p>Problem focused Expanded problem focused Detailed Comprehensive</p>	<p><u>Perform and document</u></p> <p>one to five elements identified by a bullet at least six elements identified by a bullet at least twelve elements identified by a bullet perform all elements identified by a bullet; document every element in each box with shaded border and at least one element in each box with an unshaded border</p>
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Body areas for the 1997 guidelines are associated with the organ systems and the elements are identified by bullets. The following table lists what is necessary for a skin examination.

System/Body Area	Elements of Examination												
Constitutional	<ul style="list-style-type: none"> Measurement of any three of the following seven vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming) 												
Head and Face													
Eyes	<ul style="list-style-type: none"> Inspection of conjunctivae and lids 												
Ears, Nose, Mouth and Throat	<ul style="list-style-type: none"> Inspection of lips, teeth and gums Examination of oropharynx (e.g., oral mucosa, hard and soft palates, tongue, tonsils, posterior pharynx) 												
Neck	<ul style="list-style-type: none"> Examination of thyroid (e.g., enlargement, tenderness, mass) 												
Respiratory													
Cardiovascular	<ul style="list-style-type: none"> Examination of peripheral vascular system by observation (eg, swelling, varicosities) and palpation (eg, pulses, temperature, edema, tenderness) 												
Chest (Breasts)													
Gastrointestinal (Abdomen)	<ul style="list-style-type: none"> Examination of liver and spleen Examination of anus for condyloma and other lesions 												
Genitourinary													
Lymphatic	<ul style="list-style-type: none"> Palpation of lymph nodes in neck, axillae, groin and/or other location 												
Musculoskeletal													
Extremities	<ul style="list-style-type: none"> Inspection and palpation of digits and nails (e.g., clubbing, cyanosis, inflammation, petechiae, ischemia, infections, nodes) 												
Skin	<ul style="list-style-type: none"> Palpation of scalp and inspection of hair of scalp, eyebrows, face, chest, pubic area (when indicated) and extremities Inspection and/or palpation of skin and subcutaneous tissue (e.g., rashes, lesions, ulcers, susceptibility to and presence of photo damage) in eight of the following ten areas: <table border="0" style="width: 100%; margin-left: 20px;"> <tr> <td>▪ Head, including the face</td> <td>▪ Abdomen</td> <td>▪ Right upper extremity</td> </tr> <tr> <td>▪ Neck</td> <td>▪ Genitalia, groin, buttocks</td> <td>▪ Left upper extremity</td> </tr> <tr> <td>▪ Chest, including breasts and axilla</td> <td>▪ Back</td> <td>▪ Right lower extremity</td> </tr> <tr> <td></td> <td></td> <td>▪ Left lower extremity</td> </tr> </table> <p>NOTE: For the comprehensive level, the examination of at least eight anatomic areas must be performed and documented. For the three lower levels of examination, each body area is counted separately. For example, inspection and/or palpation of the skin and subcutaneous tissue of the right upper extremity and left upper extremity constitutes two elements.</p> <ul style="list-style-type: none"> Inspection of eccrine and apocrine glands of skin and subcutaneous tissue with identification and location of any hyperhidrosis, chromhidroses or bromhidrosis 	▪ Head, including the face	▪ Abdomen	▪ Right upper extremity	▪ Neck	▪ Genitalia, groin, buttocks	▪ Left upper extremity	▪ Chest, including breasts and axilla	▪ Back	▪ Right lower extremity			▪ Left lower extremity
▪ Head, including the face	▪ Abdomen	▪ Right upper extremity											
▪ Neck	▪ Genitalia, groin, buttocks	▪ Left upper extremity											
▪ Chest, including breasts and axilla	▪ Back	▪ Right lower extremity											
		▪ Left lower extremity											
Neurological/ Psychiatric	<p>Brief assessment of mental status including:</p> <ul style="list-style-type: none"> Orientation to time, place and person Mood and affect (e.g., depression, anxiety, agitation) 												

BODY AREAS RECOGNIZED IN 1995 GUIDELINES

- Head, including face
- Neck
- Abdomen
- Genitalia, groin, buttocks
- Each extremity
- Chest, including breasts and axillae
- Back, including spine

ORGAN SYSTEMS RECOGNIZED IN 1995 GUIDELINES

Essentially the same as in the 1997 guidelines.

The 1995 and 1997 guidelines state:

Specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s) should be documented. A notation of "abnormal" without elaboration is insufficient.

Abnormal or unexpected findings of the examination of the unaffected or asymptomatic body area(s) or organ system(s) should be described.

A brief statement or notation indicating "negative" or "normal" is sufficient to document normal findings related to unaffected area(s) or asymptomatic organ system(s).

However, the 1995 guidelines add that the medical record for a general multi-system examination should include findings of about 8 or more of the 12 organ systems.

LEVEL OF SERVICE

Choosing the level of service in both the 1995 and 1997 guidelines is accomplished by the following tables.

New patients – all three key components must be met or exceeded

Level	99201	99202	99203	99204	99205
History	Prob Foc	Ex Prob Foc	Detailed	Comprehensive	Comprehensive
Exam	Prob Foc	Ex Prob Foc	Detailed	Comprehensive	Comprehensive
Decision Making	Straight forward	Straight forward	Low complexity	Moderate complexity	High complexity

Established patients – two key components must be met or exceeded

Level	99211	99212	99213	99214	99215
History	Minimal	Prob Foc	Ex Prob Foc	Detailed	Comprehensive
Exam	Minimal	Prob Foc	Ex Prob Foc	Detailed	Comprehensive
Decision Making	Minimal	Straight forward	Low complexity	Moderate complexity	High complexity

Both the 1995 and the 1997 guidelines indicate that the extent or content of the examination performed are dependent upon clinical judgment and the nature of the presenting problem(s).

All the guidelines may be downloaded from the HCFA Web site (www.hcfa.gov). Select Medicare, select Professional/technical information, and scroll down to the guidelines. See related article (2000 Proposed Evaluation and Management Guidelines), page 7.

2000 Proposed Evaluation and Management Guidelines

A new set of evaluation and management (E/M) documentation guidelines was presented by the Health Care Financing Administration (HCFA) on June 22, 2000. These guidelines are **draft** guidelines and the earliest we could expect to see them implemented is in 2002. Specialty specific vignettes are to be established for the various E/M codes. The draft guidelines are to be pilot tested in early 2001 and then refined along with comprehensive education for providers and staff before final implementation of these new guidelines will occur.

How do these new draft guidelines affect your practice? They simply don't affect you at all at the present time as they are still just draft guidelines.

The goals for the new draft guidelines according to HCFA:

1. develop and implement documentation guidelines that are consistent with current standards for documentation;
2. require what a practicing physician considers clinically appropriate
3. improve consistency of physician coding
4. improve reliability of medical review
5. facilitate accurate payment
6. ensure work equivalency across specialties.

HCFA wants the requirements easier for physicians thus reducing burdens. They also want the guidelines to be clear and unambiguous.

After doing study comparisons of the 1995, 1997, and the proposed 1999 guidelines, the new draft guidelines were based on the 1995 guidelines. Dr. Robert Berenson, HCFA Director of Center for Health Plans and Providers stated that the "cure" of the proposed 1997 guidelines was worse than the disease, as the 1997 guidelines were too complex and too complicated. The 1999 proposed guidelines lacked consistency by reviewers looking at the levels of service provided, whereas the 1995 guidelines yielded more consistent results by reviewers.

In the 2000 draft guidelines, history is similar to the 1995 guidelines history, the examination has three levels with no bullets and no shading, and the medical decision making has three levels, low, moderate, or high complexity.

Following the development of these draft guidelines, HCFA plans to study and modify them prior to publishing the final product. They then will embark upon education before implementation of the guidelines. They have stated that training will be available for physicians and office staff.

The Classification and Coding Task Force has reviewed these draft guidelines. Their concerns were incorporated in the Academy's comment letter to HCFA. Individual physicians may comment directly to HCFA regarding the draft guidelines. Comments should be addressed to: Mr. Terrence Kay, Director, Division of Practitioner and Ambulatory Care, PPG/CHPP, C4-02-06, 7500 Security Boulevard, Baltimore, MD 21244.

Coding for Pathology Services

There have been no recent changes to the CPT coding of pathology services. However, the topic of concern regarding pathology services has to do with laboratory discounts for physicians that stemmed from a recent OIG opinion. See the related article in July 2000 *Dermatology World*, pages 6-7. You may read that article on the AAD Web site (www.aad.org). Either from the Members Only or the Professional Information page, click on Marketplace to find *Dermatology World*. Be sure you know what your Medicare carrier has stated regarding pathology services in their manual and bulletins or newsletters.

The following is a review of the three scenarios for proper pathology coding to comply with Medicare reimbursement rules.

- A. Dermatologist prepares the slide, reads the slide and prepares the pathology report. Bill the appropriate CPT code 88302, 88304 or 88305 following the Medicare fee schedule or the appropriate limiting charge.
- B. Dermatologist sends a tissue to the pathology laboratory for slide preparation only. The laboratory bills the dermatologist for the slide preparation. Dermatologist reads the slide and prepares the pathology report. Bill 88302, 88304 or 88305 with -TC modifier, technical component, charging the exact amount that the pathology laboratory charges for the slide preparation, plus the 88302, 88304 or 88305 with -26 modifier, professional component, with the appropriate Medicare fee or limiting charge amount for the dermatologist service of reading the slide and preparing the report. Include the name and, if possible, the ID# of the lab. Note, the laboratory may bill Medicare directly for the technical component (TC).
- C. Dermatologist sends tissue to the pathology laboratory. Laboratory prepares the slide, reads it and sends written report to the dermatologist. Laboratory bills Medicare directly.

Managed care contracts or other third party payers may have their own rules regarding the billing of pathology services.

Remember that a pathology report must be dictated and in the patient's medical record. Recording of the diagnosis only on the medical record is not sufficient. AMA CPT states that the surgical pathology services include accession, examination, and reporting.

Articles regarding coding of pathology services were previously published in the July 1998 and September 1999 issues of *Derm Coding Consult*.

Be sure to check out the AAD web site!

www.aad.org

AAD Practice Expense Survey Project

At the AAD Annual Meeting in San Francisco, the Section on Health Policy, Practice and Research adopted a Resolution to develop, administer and evaluate the results of an effective practice expense survey. The objective is to provide the Academy with valid information to support physician work values and practice expense calculations used in the Practice Expense Advisory Committee validation process of the Medicare Fee Schedule (MFS). In order to protect the twenty-percent practice expense gains that dermatology has achieved during the PE/RVU transition period from 1998 through 2002, AAD must be prepared to submit updated supplemental practice expense data to HCFA. Academy members have supported development and submission of practice expense data through participation in the CPEP panels in 1996 and 1997. However, the data obtained at that point in time is aging rapidly.

In a June 28th letter from Dr. Scher, AAD provided detailed comment to HCFA on the Criteria for Practice Expense survey data from medical specialty societies to meet the 2002 Fee Schedule requirements for RBRVS validation purposes. Of primary concern is that HCFA clarify that it intends to adopt the less costly and more targeted AMA Practice Expense Survey. The AMA Practice Expense Survey is the basis for most specialty society survey plans at this juncture.

There are a number of survey firms that are capable of providing survey design and/or administration services for such an effort. In order to submit data to HCFA for consideration and inclusion in the 2002 Medicare Fee Schedule, the Practice Expense survey project must be completed no later than May 1, 2001. This will ensure that the survey's impact on dermatology can be assessed and a decision made by AAD regarding the submission of the survey's results to HCFA before the deadline of August 1, 2001.

It is important to all dermatologists that the Academy move confidently to protect the practice expense reimbursement gains that dermatology has achieved during the transition period from 1998 through 2002 for practice expense/relative value units (PE/RVU's) for Medicare reimbursement. The Academy is preparing to gather, evaluate and if appropriate, provide updated supplemental practice expense data to HCFA. Everyone who ultimately participates in this survey process will be contributing to the stability of Medicare reimbursement for all dermatologists. The survey will be conducted by a short telephone interview. Should you be asked to participate in this survey, please realize the importance of your participation. If you have further questions, contact Norma Border at 847-240-1814 or email: nborder@aad.org.



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