DERM CODING CONSULT

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Newsbriefs

AAD meets with CIGNA

On January 5, American Academy of Dermatology representatives met with CIGNA's Vice President of Health Policy, Rachelle Dennis-Smith, M.D. and Neal Fischer, M.D., CIGNA of Illinois associate medical director to discuss access to dermatopathology services, inappropriate claims processing and CIGNA's 11/1/99 national prior authorization policy. Representing the Academy were Marianne O'Donoghue, M.D., Clay Cockerell, M.D. and James A. Zalla, M.D., who chaired the meeting. Dr. Zalla is a member of the American Medical Association CPT Editorial Advisory Panel and on the AMA Correct Coding Policy Committee. Observing on behalf of the AMA were Mark Segal, M.D., VP of coding and medical information systems and Lisa Kaplan, JD, Sr. Attorney for the AMA private sector advocacy group. AAD representatives and staff came away from the meeting with a sense of real responsiveness and cooperation from CIGNA. Barb Dolan, AAD Manager for private sector advocacy feels that the groundwork has been laid for effective communication and resolution of a number of long-standing problems. One area of absolute agreement was that Mohs surgery is exempt from modifier –51 and should be reimbursed at 100 percent. CIGNA leadership found the discussion of coding for Mohs surgery in *Derm Coding Consult* was particularly helpful in clarifying the issue.

California and Ohio DERMCAC Success: AK LMRP

Lenore Kakita, M.D. and Kathleen Adair, M.D., after much discussion and work with the Transamerica Occidental Life Insurance Co. (TOLIC) medical directors, (and assisted by other AAD members) succeeded with their arguments to significantly improve the frequency of care for AK's and reduce some of the documentation burden on dermatologists. The new TOLIC Medicare LMRP for treatment of actinic keratoses was published in the December Medicare regional bulletin and is effective February 1, 2000 for the following ten states: Alaska, Arizona, Colorado, Hawaii, Nevada, North Dakota, Oregon, South Dakota, Washington, Wyoming and Southern California. It removes the proposed limit of two visits per year for AKs. However, if dermatologists are seeing patients more than the prevailing 98% (4x's a year) or 99% (6x's a year), then documentation of one or more predisposing conditions must be recorded in the medical record.

In Ohio, Steven Gootblatt, M.D., medical director for Nationwide's Medicare operations notified Brett Coldiron, M.D., president of the Ohio Dermatologic Association, that he has accepted the recommendations of the Ohio Carrier Advisory Committee (CAC) members regarding the classification of actinic keratoses for local medical review policy purposes. Actinic keratoses will be recognized as premalignant lesions within the continuum of squamous cell carcinoma requiring treatment "with destructive methods being the standard of care." The letter caps efforts by George Haney, M.D. and Thomas G. Olsen, M.D. the DERMCAC representative and alternate for Ohio, who made their presentation on AK's at the December 8th Ohio CAC meeting.

AAD Discusses National AK Policy with HCFA

On January 12th, American Academy of Dermatology President Darrell S. Rigel, M.D. along with Thomas G. Olsen, M.D. AAD DERMCAC Chair and John Barnes, Associate Executive Director/AAD Government Affairs Office met with HCFA to discuss development of a national "decision memo" which would declare actinic keratoses dangerous and in need of treatment. This effort would not preclude continuing efforts by AAD toward a future national Medicare policy on AKs. However, HCFA publication of a decision memo would assist the Academy and DERMCAC representatives throughout the country in working with local carriers for consistency in local medical review policy language (LMRP) and to eliminate outliers. While HCFA remains committed to national medical policy issuances that are based on clinical outcome studies, HCFA made tacit admission that control group requirements would be unethical in dealing with the potential threat of untreated malignancies resulting from "observation" of AK's.

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Letter from the Editor

Dear *Derm Coding Consult* Reader,

We've moved into the new century with far less fuss than anticipated. Y2K has become a non-issue for most of us. But I believe the vast collective "we" was well served in making the required assessments and updates necessary to meet it.

The American Academy of Dermatology will continue to set milestones throughout the year. I hope to meet and share some of them with you at the Annual Meeting in San Francisco this month. Do stop by the Resource Center and say hello. We appreciate the ongoing feedback we receive from all of you. We hope to resolve some of the questions and correspondence generated by the December issue.

We thought now would be a good time to update and reiterate coding requirements of Mohs Micrographic surgery procedures. Although we've responded to your specific questions, it hasn't been addressed comprehensively since the June 1997 issue of Derm Coding Consult. Our editorial advisory board member, John A. Zitelli, M.D. has provided a wonderfully cogent article we hope you find right on the mark.

The draft revised Evaluation and Management Guidelines are still in limbo with no test dates set by HCFA yet. However, information on the revised pilot HCFA instructions on consultations are included in this issue. Published last August, they clarify and simplify when consultation services are provided and billed. In addition, we are addressing the need to demonstrate medical necessity when submitting evaluation and management and surgical service codes for the same day.

The Academy continues to meet with the major payers to educate and advise on key dermatology issues, including: bundling, access to dermatopathologists and appropriate multiple procedure reductions.

Hope to See You in San Francisco!

Norma L. Border, Editor

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United Health Care: Unresolved Issues

Since AAD representatives met with UnitedHealth Group in April 1999, the Academy has pursued clarification on a number of UHC issues. In his January 7 letter, Richard A. Justman, M.D., national medical director for UHC, provided an update to James A. Zalla, M.D. on several of the issues raised at the above meeting. The UnitedHealth Group claims system no longer applies multiple procedure reductions to CPT 17304. In addition, bundling of CPT 17304 with CPT 12052 or CPT 13132 does not occur under the new UHC reimbursement policy governing these codes. Dr. Justman advised that denial of intermediate or complex repair codes is now limited to benign lesions of 0.5 cm or less. UHC is still researching and will address the alteration of E&M service codes from new patient to established patient codes (CPT 99202/99203 to 99213/99214) which occurrs when a surgical code for the patient is entered before the E&M code for services on the same day. However, this is contingent on future programming enhancements.

It is still a disappointment that UHC has chosen not to recognize use of –59 Modifier for identification of distinct procedural services. Per Dr. Richard Justman, UHC National Medical Director, there is concern regarding "a great deal of variation in its use among providers." However, UHC is doing data analysis and intends to revisit the issue of excisional biopsies with pathology done by a Mohs surgeon prior to performing Mohs' surgery on the same day.

Atlas of Cancer Mortality

The National Cancer Institute has published a new "Atlas of Cancer Mortality in the United States, 1950-94." The new atlas graphically indicates the geographic patterns of cancer deaths in over 3000 counties for over 40 cancer types, including melanomas of the skin. The maps provide statistical data for men and women as well as white and black population groups. Single copies of the Atlas can be ordered without charge from the NCI Cancer information service at 1-800-4 CANCER and viewed on line at http://www.nci.nih.gov/atlas.

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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 Clarifies Consultation Requirements

With less fanfare than it deserved, HCFA issued revised instructions clarifying the conditions and simplifying the documentation requirements for physician consultations (MCM 14-3, Section 15506, 8/99 Trans. 1644). Medicare will pay for a consultation regardless if treatment is initiated providing the new consult criteria are met.

The new requirements for Evaluation and Management consultation services for CPT codes 99241-99275, are:

1. the consult is provided by a physician whose opinion or advice on the evaluation and management of a specific problem is requested by another physician or other appropriate source;
2. the request for a consultation from an appropriate source and the need (condition, symptom, presenting problem requiring evaluation) for consultation must be documented in the patient's medical record; and
3. a written report of the consultation findings is provided to the referring physician.

The consulting physician may initiate diagnostic or therapeutic services during the initial consult or at a subsequent visit. Subsequent visits would be reported as an established patient visit such as CPT 99211-99215.

HCFA's primary example of a consultation is an internist seeing an established patient with a history of hypertension and diabetes mellitus who notices a new skin lesion. The internist sends the patient to a dermatologist to have the lesion evaluated. The dermatologist examines the patient as requested and removes the lesion which pathology determines to be an early melanoma. The dermatologist dictates and forwards the report to the internist detailing his evaluation and treatment of the patient. (Please note, in earlier instructions, HCFA used the above as an example of a referral.)

Transfer of Care/Group Practice Consults
An exception would be those situations where the referring physician transfers the full care of the patient at the time of the referral and the receiving physician documents approval of care in advance. However, transfers of care are fairly rare in dermatology practice. Should this occur, the office visit would be for a new patient rather than a consult. The new instructions also permit payment for a consultation if one physician in a group practice requests a consultation from another doctor in the same group practice, providing the above three requirements are met.

Documentation is Key
HCFA is concerned that too many consultation activities, requests and reports, are done over the phone with insufficient documentation in the medical record. Every effort should be made to put consultation requests in writing, such as a request card initialed by the attending physician, a faxed request with signature, or a request via prescription pad. Whatever the vehicle, the original or a photocopy should be included in the medical record preceding the consultation. However, standing orders in a medical record for consultations do not meet the request criteria. To close the documentation loop, the written report of the consultation should be sent to the requesting physician AND included in the patient's medical record at the consulting physician's office.

In the absence of a written request, it is extremely important that the details of the request be included at the start of the consultation in the medical record and recapped in the written report to the attending physician, e.g., "At the request of Dr. Does N. Noderm, I am examining Mr. N. Flamd in consultation for an extensive rash on the right upper chest."

Pre and post-op consultations
Payment will be made for the appropriate consultation code for a pre-operative consultation for a new or established patient performed by any physician at the request of a surgeon as long as all of the requirements for billing the consultation codes are met. However, consultation codes are not appropriate for subsequent post operative management of the patient's condition(s). Established patient codes would be used for any required follow-up.

Payment will be made for a post-operative consultation if the surgeon requests a physician who has not seen the patient for a pre-operative consultation to provide an evaluation and recommendations for management of a specific condition. However, if the surgeon asks the physician to take responsibility for the management of an aspect of the patient's condition during the post operative period this does not qualify as a consultation. These services are not billable as a consultation because the surgeon has not requested an opinion or advice in treating the patient. In this instance, the services are categorized as concurrent care and should be billed with the appropriate level of visit codes for a new or established patient.

Patient Initiated Second Opinion
If a patient initiates a consultation request regarding the need for surgery, diagnostic or therapeutic procedures, such a consultation is covered by Medicare. In the event that physicians have differed on the first or second opinion, a third opinion may be sought and covered by Medicare as a consultation. Confirmatory consultation codes are CPT 99271 thru 99275.

Please remember to thank your Schering representative for support of this publication.

Coding for MOHS Micrographic Surgery *by John A. Zitelli, MD*

The CPT codes for Mohs surgery (17304-17310) are unique and often misunderstood. They are the only CPT codes that combine the services of both surgery and pathology together in a single code. The Health Care Finance Administration (HCFA), the American Medical Association (AMA), and many third party payers have worked together to assign fair Resource based Value Units (RVU's) to these CPT codes and define policies that result in fair reimbursement for the services that are described by these codes. This article will explain these codes, the policies for their use, the rationale for the policy decisions, and provide reference for the explanations so that providers and third party payers can both understand and agree upon proper coding and reimbursement for Mohs surgery.

Introduction

Mohs Micrographic surgery requires that a single physician act both as the surgeon and the pathologist. If either of these responsibilities are delegated to another physician, the use of CPT codes 17304 through 17310 is not appropriate.[1]

CPT 17304

This code describes the first stage of Mohs surgery. This includes the "pre-service" work of explaining the procedure, obtaining informed consent and preparation of the patient for surgery including anesthetizing the lesion. The "intra-service" work includes debulking or gross removal of all tumor, excision of the first Mohs layer, color coding of the specimen and mapping, complete routine histologic preparation of all specimens, and microscopic examination by the surgeon. The "post-service" work includes the evaluation of the wound and discussion of wound care instructions.[2] It is important to understand these components of physician work and their relation to RVU's because they influence the reimbursement policies.

One common coding problem for Mohs surgery relates to the definition of "specimens" in a single layer. CPT 17304 includes reimbursement for up to five specimens. That means that a layer can be cut into as many as five pieces before processing as frozen sections. The map will reflect the number of pieces. Any number of specimens greater than five should be billed separately (see CPT 17310) for each specimen.

Routine stains, (H & E or toluidine blue), are included in reimbursement for CPT 17304 and cannot be billed separately. However, special stains or procedures such as immunoperoxidase stains (CPT 88342) or decalcification procedures (CPT 88311) may be billed separately.[3]

When two or more separate tumors are treated on the same day, CPT 17304 is used for the first stage of each tumor. The –59 modifier may be used to indicate that this is a distinct procedural service on a separate unrelated tumor, but the –51 modifier should not be used.[4,5] However, some carriers may require the use of other modifiers, such as –76.

Reimbursement for CPT 17304 should not be reduced when submitted as a second tumor or when submitted with other procedures such as reconstruction. CPT 17304 is not subject to the Multiple Surgery Reduction Rule (MSRR).[5,6,7] The rationale for this policy is that there is little or no reduction in work when two or more tumors are removed with Mohs surgery or when Mohs surgery is performed on the same day as other procedures. The MSRR reduces reimbursement for two procedures on the same day when there is overlap in the pre-service and post-service work. The intra-service work does not overlap but, for many procedures is less than 50% of the total work. Therefore, most procedures are reduced 50% when performed on the same day. However, the work for Mohs surgery differs significantly from other procedures because the majority of work (76%) is intra-service work. The pathology portion of Mohs surgery constitutes a large portion of the intra-service work and the pathology services are not subject to the multiple surgery reduction rule. Furthermore, there is very little duplication in the pre-service work because of unique evaluation and discussions of separate lesions. Similarly, there is no duplication in the post-service work because there are zero post-op days in the global period. Therefore, with little or no overlap when two or more Mohs procedures are performed, these codes are not subject to the MSRR.

CPT 17305 and 17307

These codes describe the second and subsequent stages of Mohs surgery to trace out and excise microscopically visible tumor. The RVU's already reflect the reduction in work compared to CPT 17304 and therefore, these codes are not subject to the MSRR and do not need the –51 modifier when submitted.[5] CPT 17307 is used with the appropriate multiplier for each stage when four or more stages of Mohs' surgery are necessary. When Mohs surgery on a single tumor carries over to another day, the first layer of the subsequent day should continue with the original series (i.e., the second day starts with CPT 17305, 17306 or 17307).

CPT 17310

This code represents the incremental increase in work for both surgery and pathology when unusually large tumors are treated. The code for each layer (CPT 17304-17307) includes reimbursement for processing up to five tissue specimens or blocks of tissue from each layer. For any layer that requires more than five blocks or specimens, CPT 17310 should be used with the appropriate numerical multiplier to indicate the number of specimens greater than five in that layer. For example, if the first layer of Mohs resulted in seven specimens, five of these seven specimens would be included in the reimbursement for CPT 17304, but CPT 17310 would be submitted twice to represent the additional two specimens.[8,9]

CPT 11100 – Skin biopsy on the same day as Mohs surgery
A biopsy of a skin lesion for which Mohs surgery is planned is necessary in order for the physician to determine the diagnosis.

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Coding for MOHS Micrographic Surgery *continued from page 4*

If the diagnosis is confirmed by biopsy within 60 days before Mohs surgery, no further biopsy is allowable. However, if no biopsy has been performed or no histologic diagnosis is available using reasonable effort, a biopsy may be done and reimbursed on the same day as Mohs surgery. The –59 modifier should be used with the biopsy (CPT 11100) and pathology (CPT 88331) codes to allow for separate payment. The –59 modifier is also appropriate when a separate skin lesion, other than the lesion for which Mohs surgery is performed, is biopsied on the same day as Mohs surgery.[3,10] This is consistent with Medicare policy that reimbursement should be made for any diagnostic procedure that is medically necessary when done on the same day as the surgical procedure, if the diagnostic procedure would have been paid if it were done on a different day. An example is a breast biopsy done for the diagnosis of breast cancer followed immediately after frozen section diagnosis by lumpectomy or mastectomy.

It is not appropriate to bill for a biopsy or frozen section with Mohs surgery for routinely reviewing the histopathological features of the tumor if a prior biopsy has been performed.

CPT 88331

Diagnostic pathology by frozen section is reimbursed separately from Mohs surgery only when a biopsy is performed before Mohs surgery as noted above, or for pathology on separate lesions. If two or more separate lesions or biopsy sites are reported, then CPT 88331 is to be submitted with the numerical multiplier (i.e., 88331 X 2). CPT 88332 is to be used only when a contiguous specimen is cut into tissue blocks and is reported for each additional block from the same tissue specimen.[11]

Reconstruction

Wounds after Mohs surgery are sometimes allowed to heal without reconstruction and therefore, no RVU's for reconstruction are included in the reimbursement for Mohs surgery. If reconstruction is necessary, then the repair codes (simple, intermediate, complex, flaps or grafts) should be submitted separately.[1] When claims for Mohs surgery and reconstruction are submitted, the repair is not reduced by 50% because it is usually the highest paying code and is paid at 100%. However, even if the full reimbursement for reconstruction or repair is lower than Mohs surgery, it should not be reduced because there is no overlap of work with reconstruction and Mohs surgery. The rationale for this decision is that reconstruction is performed in a separate operative session requiring all of its calculated pre-service, intra-service, and post-service work. This separate session requires new patient consent, new anesthesia, fresh instruments and supplies, wound preparation including hemostasis and wound edge debridement. Mohs surgery has a zero day global period and there is no overlap with the post-service work of reconstruction. Therefore, with no overlap in the calculation of total work or practice expense RVU's, reconstruction is allowed at 100%.

Evaluation and Management

E&M services on the same day as Mohs surgery are allowable if they are for an initial consultation, an initial new patient visit, or the E&M service that includes the decision to perform surgery.[12] If an allowable E&M service is performed with Mohs surgery alone, or with a repair with less than a 90 day global period (i.e. complex repair), then the E&M service should be submitted with the –25 modifier.[13,14,15,16] If an allowable E&M service is performed with Mohs surgery and a major surgical reconstruction (90 day global period, i.e. flap or graft), then the E&M service should be submitted with a –57 modifier. A separate diagnosis is not required to reimburse for the initial E&M, or the E&M service associated with the decision to perform surgery.[13]

E&M services after Mohs surgery may be allowed depending on the global period of the service associated with Mohs. If Mohs surgery was performed without repair and the patient returns for a wound check, the E&M service is allowable because there are no RVU's in the CPT 17304-17310 series for follow-up visits as reflected in a zero day global period. However, if a flap or graft was performed, then all routine follow-up care within the 90 day post-op period is included in the original reimbursement, and no further E&M services are allowed. The exceptions to this rule are for complications that require a return to the operating room, defined as a room dedicated to the performance of surgical procedures.

see Coding for MOHS, *page 6*

Questions and Answers

Q. What is the correct ICD-9-CM code for dysplastic nevus?

A. Dysplastic nevi are considered precancerous lesions that exhibit features such as irregular borders and are asymmetrical. There is not a specific ICD-9-CM code for dysplastic nevus. Thus, ICD-9-CM code 238.2, neoplasm of uncertain behavior, is the commonly used code for dysplastic nevus.

Uncertain behavior indicates that a definite distinction between benign and malignant cells cannot be certain. This may be due to neoplastic changes that are occurring in the lesion.

Defining New and Established Patients

Response prepared by Allan S. Wirtzer, M.D., Sherman Oaks, CA., and James A. Zalla, M.D., Florence KY

Q. What constitutes a new patient?

A. There has been conflicting information. In one correspondence, we were advised that if no codable service had been performed in three years, the patient would be considered a new patient. On the other hand, a recent AMA publication, *cpt Assistant*, indicated that even a phone call or a prescription refill could be considered a service that would prevent the patient from being considered new. This issue is currently being addressed by the AMA CPT Editorial Panel to clarify the definition for CPT 2001.

Coding for MOHS Micrographic Surgery *continued from page 5*

This E&M service requires a –78 modifier.[10] If an E&M service is performed within the global period that is unrelated to the routine post-op care, then a –24 modifier must be used with the E&M code.[13]

Indications for Mohs Surgery
Some Medicare carriers have adopted or modified a model policy for Mohs surgery developed by a Carrier Medical Director Surgery Clinical Workgroup in 1997 that limits the indications for Mohs surgery.[3] After this work group completed its policy, it has been documented that Mohs surgery is more cost effective than many common methods for the treatment of skin cancer (i.e. radiation therapy, excision in a hospital or outpatient surgery center with or without frozen section control) and is comparable to routine office excision.[17] With both cost and effectiveness in mind, Mohs surgery is cost effective for all skin cancers requiring excision, and should be considered when making the decision to perform surgery, or authorizing reimbursement for Mohs surgery.

Mohs Surgery in the Hospital or Ambulatory Surgery Center
Reimbursement to the surgeon for Mohs surgery in these settings is reduced to reflect a reduction in practice expense. The RVU's and reimbursements are listed in the facility based RVU's published by HCFA in the Federal Register.[18]

Reviews and Appeals
When claims are denied repeatedly, some providers give up even when the insurer is wrong. Instead, providers should use this information to support their position in telephone and personal hearings, or appeals. For Medicare claims, you may appeal to the Administrative Law Judge for claims with a value greater than $500. One can also appeal to the regional HCFA Director for Medicare claim problems.

The Federal Register can be found on HCFA's homepage.
1. Go to HCFA homepage (http://www.hcfa.gov)
2. Click on "Medicare"
3. Click on "Professional/Technical Information"
4. Select Medicare Payment Systems
5. Select Physician Fee Schedule.

CPT 2000 Printing Errors

cpt Assistant, December 1999 issue states that some printing errors have occurred in *CPT 2000*. There were no errors cited in the Integumentary section. If dermatologists have any suggestions or revisions to improve the index in CPT, AMA staff would welcome such input. Please send any suggestions to Norma Border at AAD. Fax 847-330-1120 or email to: nborder@aad.org.

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Challenging Modifier –25 Denials *by Norma L. Border*

Despite a long-standing policy clarification from HCFA and clear guidance in the CPT 2000 Appendix A for appropriate use of Modifier –25, there have been an increasing number of denials for it's use with evaluation and management services (E&M) by Medicare carriers in specific locales. I believe this reflects an unfamiliarity with the type and nature of E&M services as well as greater frequency of office-based procedures provided to Medicare beneficiaries by dermatologists. However, in the 11/2/99 Federal Register, HCFA published that it intends to review surgical procedures with a global period of XXX in relation to current modifier –25 usage and identify those codes where use of the –25 modifier may be mandated in future. While HCFA has committed to seeking review of these codes from physician specialty societies, I feel it is important that AAD members be able to deal pro-actively with this issue.

Keep AAD Informed

First, may I solicit your ongoing cooperation in sharing any Medicare carrier correspondence or publications which include a reiteration of or additional requirements for use of Modifier –25. Please feel free to send me denial information, as well as medical review hearing and appeals correspondence. (Please be sure that staff blocks specific patient identification information to maintain privacy and confidentiality.)

Exercise Your Appeal Rights

Second, if you are experiencing an increase in denied services involving E&M services as well as surgical procedures on the same day, each of these denials should be appealed as part of your rights as a participating Medicare provider. The sample letter provided in the September 1998 *Derm Coding Consult* can be easily modified to reflect the specific circumstances of the claim(s) in question. The letter should also be modified to include patient information: name, HIC#, date of service, supporting patient record data, etc.. We will be revisiting the Medicare appeals mechanisms open to participating physicians in the June 2000 *Derm Coding Consult* with additional sample letters.

Documentation Key to Effective Appeals

Third, in challenging Carrier denials related to Modifier –25 use, be prepared to support the request for review not only with surgical report information but also with the appropriate level of documentation in the patient record to support that the E&M service provided was unequivocally **"...**a significant, separately identifiable E&M service above and beyond the usual pre-operative and post-operative care associated with the procedure that was performed." (CPT 2000 Appendix A)

DERMCAC Can Help

Fourth, most of the credit for successful resolution of specific problems with a Medicare Carrier must go to the efforts of the DERMCAC representatives and alternates in your state who work tirelessly with the Medicare Carrier Medical Director (CMD) in educating them to the impact of HCFA instruction and policy on the practice of dermatology. As Medicare claims payment issues develop in your area, keep your DERMCAC representative informed and work with him or her to generate effective meetings with the CMD to address and resolve specific issues. The current list of AAD DERMCAC representatives can be found in the September 1999 *Derm Coding Consult*.

Easy Access to *Derm Coding Consult*

All the *Derm Coding Consult* articles, Q&A's and model letters are available to Academy members and their office staff from the web site at www.aad.org. At the AAD home page, you may click on either the Professional Information or Members Only icons at the top of the page or the same text categories at the bottom of the page. On the Professional Information or Members Only page, scroll down and click on Socioeconomic Issues and on the following screen select Derm Coding Consult. You'll be able to select the last four issues of *Derm Coding Consult* or go further back into the *Derm Coding Consult* Archives.

You can print selected copies or pages of *Derm Coding Consult* from the AAD web site. These are available as Portable Document Format (pdf) files. However, you will need a current version of Acrobat Reader from Adobe in order to do so. Acrobat Reader can be downloaded FREE directly from Adobe, accessed from the AAD web site either from the bottom of the AAD Home Page or at the bottom of the *Derm Coding Consult* web page. Just follow the instructions to click here. You will be connected to www.adobe.com. The software is safe and free, but you will need to answer five short questions. This software is in general distribution and the same download capability is available from the Medicare web site at www.hcfa.gov.

If you are missing one or more back issues of *Derm Coding Consult*, this will enable you to print off any missing copies and keep your reference binder up to date. If you are having a particular coding or billing problem, check the December 1999 issue which includes the Topic Index for ALL prior issues of *Derm Coding Consult*. You'll be able to check out every pertinent article to resolve that coding issue. Derm Coding Consult on-line can be your quickest reference for resolving coding and billing problems.

Be sure to check out the AAD web site at
www.aad.org

Medical Necessity

As documentation continues to be an important issue, medical necessity plays a major role.

From the 1999 Policy Compendium of the American Medical Association comes the following definition of medical necessity:

> "Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is:
>
> 1) in accordance with generally accepted standards of medical practice
> 2) clinically appropriate in terms of type, frequency, extent, site, and duration; and
> 3) not primarily for the convenience of the patient, physician, or other health care provider. "

For Medicare billing, a service that is not medically necessary indicates that the claim submitted did not substantiate the need for such service or that the service has not been proven effective. The patient may not be billed for services that were denied due to "not medically necessary" unless the patient was provided with a written notice prior to the service being rendered that the service may not be approved. With the written notice having been signed by the patient, the patient may then be billed for the service.

Your Medicare Manual and/or Medicare bulletins should have information on medical necessity as well as waiver of liability provisions. Be sure to read this information carefully so you will know when you can or cannot bill the patient. Also, become familiar with the information regarding elective surgery.

A service deemed "non-covered" by Medicare is a service that is never allowed or reimbursed by Medicare. Such a service would be billed directly to the patient. Non- covered services would include any service of a cosmetic nature. Cosmetic services are never allowed by Medicare and need not be submitted to Medicare. However, should a patient request a non-covered service be submitted to Medicare, do use ICD-9-CM code V50.8, elective surgery for purposes other than remedying health states, other, or V50.9, and HCPCS procedure code A9270, non-covered item or service. The Medicare Manual (§2300 and §2329) states, "Cosmetic surgery or expenses incurred in connection with such surgery are not covered" and " Services 'related to' non-covered services (e.g., cosmetic surgery. ….), are not covered services under Medicare." Thus, if a lesion is removed for cosmetic purposes and the lesion is sent to pathology, the pathology service is also a non-covered service.

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