DERM CODING CONSULT

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Newsbriefs

Local Medical Review Policies on the Web

Melanie Combs of HCFA's Office of Financial Management/ Program Integrity Group announced on March 29th that 80% of the Local Medical Review Policies (LMRP) developed by the Medicare Carriers are now available for review on the internet. According to Combs, www.LMRP.net is being implemented and maintained for HCFA by an independent contractor. While the Web site has a search capability, it requires a familiarity with current Medicare Carrier jurisdictions to identify specific state coverage limitations or requirements. The Web site will carry only published LMRP's, not those in draft form or under discussion by the Carrier Advisory Committee (CAC).

HCFA has also hired an outside contractor to review and analyze current LMRP's to identify outliers and work with local providers to resolve LMRP's that differ sharply from those developed in other states and regions. LMRP's do not have the same binding authority as HCFA regulations or instructions. However, this is one area where HCFA Central Office has given a certain level of autonomy to the Carrier Medical Directors.

AAD members have found that the most effective way to deal with individual carrier LMRP problems is to work with their Dermcac representative. Meetings can be arranged with the Carrier Medical Director and should include participation by the state dermatologic or state medical society. Consideration should also be given to inviting the appropriate HCFA Regional Office to participate if the Medicare Carrier is reluctant or uncooperative.

HCFA Centralizes Coordination of Benefits

HCFA has awarded a multi-year contract to Group Health, Inc. (GHI) of New York to take over all the data collection, database management and reporting of all health insurance coverage information for Medicare beneficiaries. The goal is to make it easier and quicker for Medicare providers and beneficiaries to determine if Medicare should be the secondary payer for beneficiary services. Beneficiaries were able to access a new 800 number as of April 1, 2000. Medicare providers will be able to use the same number, 800-999-1118 as of October 1, 2000 to verify beneficiary billing information or to report recent changes in primary payer status. GHI will ensure that the primary payer, whether Medicare, an employer group health plan (EGHP) or a liability insurer, pays first. GHI will also make sure that claims information is transferred automatically to a secondary payer.

GHI will be in charge of the Initial Enrollment Questionnaire sent to all new Medicare beneficiaries to determine the availability of health insurance other than Medicare. GHI will also coordinate the ongoing employer information data match between IRS, SSA and HCFA for working beneficiaries and spouses who have full coverage under an EGHP. The use of a single contractor should over time reduce and then eliminate conflicting information on other available insurance for beneficiaries.

HCFA Issues Corrections to MFS

On April 11th, HCFA issued a correction to the Final Rule for the Medicare Physician Fee Schedule for calendar year 2000. The document corrects a number of technical errors that appeared in the November 2, 1999 Final Rule. Of interest to dermatologists is the inclusion of AMA/Specialty Society RVS Update Committee recommendations for recognition of appropriate supplies with CPT 17276 Destruction of Malignant Lesion over 4.0 cm. HCFA had accepted the recommendation but deleted what was thought to be duplicate gauze, etc. from the language of the final rule. This correction will have minimal impact on reimbursement for CPT 17276.

Errors Delay Carrier Implementation of CCI Version 6.1

Implementation of the latest update package of Correct Coding Initiative edits, version 6.1, has been delayed. A sharp-eyed dermatologist, Dr. Ira Schlesinger of Delray Beach,

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in this issue

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Letter from the Editor

Dear *Derm Coding Consult* Reader,

It was good to meet so many of you in the Resource Center at the Annual Meeting in San Francisco! We sincerely hope to meet many more of you at the Summer Academy in Nashville!

We get a lot of questions regarding the Medicare Part B Appeals process. For that reason, this issue of *Derm Coding Consult* recaps the Carrier Review and Fair Hearing procedures in some detail. Don't forget, the physician and the beneficiary are entitled by law to access to the Medicare appeals process. Exercising your right as a physician to request review of a denied claim does not create any flags or black marks in the Carrier's system against you.

The best tactic for dealing with a flurry of denied claims is to turn around and request a review on each of them. One of Medicare's best kept secrets is that so few physicians challenge Medicare denials AND that each time you push a denied claim to the next appeal level, you double the probability that it will be paid!

We've also learned that dermatologists are reluctant to push denied claims to the Administrative Law Judge review level. Don't be. Especially in situations where the carrier may be applying restrictive local medical review policies (LMRP's) to recoup overpayments, recourse to an ALJ hearing may be your best source for real relief. The ALJ is not required to recognize HCFA or Carrier procedures and instructions. Their decisions are based solely on Medicare law and regulations and therefore provide broader interpretation on payment issues.

We've asked dermatologists who have successfully appealed claims at the ALJ level to share that information. An ALJ decision that sets aside a LMRP in one Carrier jurisdiction may prove a valuable argument in another carrier jurisdiction. We look forward to receiving this information from you and will let *Derm Coding Consult* readers know the results of your input.

Looking forward to seeing you in Nashville!

Norma L. Border, Editor

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Florida spotted the problem in edit tables released by the Florida Medicare carrier in anticipation of the originally scheduled April 1, 2000 implementation date. The edit modifier for CPT 11100 biopsy, had changed from 1 (which allows the use of appropriate CPT modifiers and submission with other surgical procedures performed on the same date of service) to 0 (which would preclude the use of appropriate CPT modifiers).

AAD staff worked with the AMA CPT department to get clarification from the Medicare Carrier, Administar which is in charge of maintaining and updating the Correct Coding Initiative edit package nationally. Administar acknowledged that there were indeed errors in the version 6.1 package. On detailed review Administar staff discovered that over 3,782 edits required correction. The implementation of version 6.1 had been delayed at least until May 1, 2000. Administar will be making the necessary corrections and re-issuing the update to the Medicare Carriers.

Idaho Dermcac Success

At the AAD Annual meeting in San Francisco, Paul Brooke, M.D. of Idaho Falls, ID and Randall Burr, M.D. of Meridien, ID identified a series of coding problems with Regence Blue Shield of Idaho (RBSI), the Medicare Carrier for Idaho. In December 1999, RBSI had initiated a series of medical review policies that were a significant departure from accepted AMA CPT coding practice and guidelines. These changes included: a) bundling of layered, intermediate and complex closures; b) downcoding of excisions based on pathology measurement rather than in vivo measurement of the lesion; and c) bundling of repair codes into excisions of malignant lesion codes.

Drs. Brook and Burr worked with James A. Zalla, M.D., new chair of Dermcac, in preparing for a meeting with RBSI on March 21, 2000 in conjunction with the Idaho Medical Society to discuss and resolve these issues. As a result of this meeting, Robert K. Seehusen, M.D., CEO of the Idaho Medical Society was happy to report to Idaho dermatologists that RBSI has agreed to address and resolve each of the issues raised.

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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.

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Standards of Ethical Coding Released by AHIMA

The American Health Information Management Association (AHIMA) has revised and released its *Standards of Ethical Coding*. Initially developed in 1991, this latest update recognizes the mounting pressure on health care organizations to comply with regulations governing payment for health care services and the necessity of curbing fraud and abuse. The purpose of the *Standards* is to ensure that coding practices adhere to the highest possible ethical standards. In addition to AHIMA, the cooperating parties to the new coding standards are the American Hospital Association, the Health Care Financing Administration and the National Center for Health Statistics.

In brief, these updated *Standards of Ethical Coding* call on coders to: support the importance of accurate and consistent coding practices; adhere to ICD-9-CM and CPT coding conventions, guidelines and any other official coding rules for mandated standard code sets; as well as use their skills and knowledge of currently mandated coding and classification systems to select the most appropriate diagnostic and procedural codes. In addition, the AHIMA Guidelines exhorts coders to assign and report codes that are clearly and consistently supported by physician documentation as well as to consult physicians for clarification and additional documentation to resolve ambiguities in the data in the health record, and above all, should not change codes or the narrative for codes on the billing abstract so that the meanings are misrepresented.

The *Standards of Ethical Coding* encourage coders that in those instances where payer policies conflict with official coding rules, those guidelines should be obtained in writing whenever possible and reasonable efforts should be made to educate the payer. The Academy aggressively pursues such meetings with payers through its Private Sector Advocacy and Dermcac committees. The *Standards* place the responsibility on coders, as members of the health care team, to educate physicians and other clinicians by advocating proper documentation practices as well as furthering specificity to reflect the acuity, severity and occurrence of clinical events. Finally, professional coders are encouraged to participate in the development of coding policies, to maintain and enhance their own coding skills and strive to ensure optimal and appropriate payment for services rendered by health care practitioners and facilities.

Editor's Note: Ultimate responsibility for the correct identification of a medical service or procedure and assignment of the most appropriate diagnostic and procedural codes remains that of the physician providing or supervising the service.

Medical Policy Update

Acne LMRP's Differ

In the December 1999 issue the statement was made that Medicare does not recognize the diagnosis of acne as a medically necessary indication for treatment, although Medicare does cover treatment of rosacea.

We received a statement from a member who suggested we retract the answer as it was incorrect. After reviewing Medicare policies, that member's Medicare carrier does not have a policy on treatment of acne. However, many other Medicare carriers do have a policy. The policies do vary in their content.

Of those carriers that have a policy for the treatment of acne, the key issue is medically necessary treatment vs. cosmetic treatment. It is imperative that you are versed on your carrier's policies. Even if your carrier does not have an acne policy and a cosmetic acne service is performed, that cosmetic service should not be billed to Medicare. Be sure to have the patient sign a waiver of liability when performing a cosmetic service.

E/M Visit with Procedure

The Academy maintains the position that if a significant and separate evaluation and management (E/M) service is provided in addition to a procedure, both the service and the procedure are billable. In order to bill an E/M service, for a new patient all three key components must be met and for an established patient two out of the three key components must be met. The key components are:

- History
- Examination
- Medical Decision-making

If an established patient returns for evaluation of sun damaged skin and two of the three key components are met, it certainly is appropriate to bill for the E/M service even if a procedure is done. The appropriate E/M code would be appended with the modifier –25. Assuming two actinic keratoses are noted and treated via destruction, 17000 + 17003 would be reported along with the separate E/M code, e.g. 99212-25.

The documentation in the medical record should clearly support the E/M level of service reported as well as the procedure performed. A tip for reviewing the medical record: if the documentation for the procedure is taken away, the remaining documentation must support the E/M code reported.

In response to the issue of reporting E/M procedures, the Academy received a letter from Mr. Terrence L. Kay, Director, HCFA/Division of Practitioner and Ambulatory Care, in February. Mr. Kay states, "If in addition to the procedure the physician also provides significant separately identifiable E/M services beyond the usual preoperative and postoperative services associated with the procedure, such services should be billed with modifier –25, and are separately payable.

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Medicare Appeals – Worth the Effort

Too few dermatologists are routinely using the Medicare Part B Appeals process to challenge coverage or payment denials by the Medicare carrier. The appeals process is one of your "rights" as a participating Medicare provider. Choosing to appeal a claim does not create any kind of a flag within the Carrier's claim system and does not single you out for additional review or scrutiny by the Carrier.

Non-Participating Appeal Rights

If you have chosen not to participate in the Medicare program, you are still entitled to appeal a Medicare denial if you, as a nonparticipating physician, practitioner, or supplier took assignment for a specific service. You may also appeal a Medicare determination, if as a nonparticipating physician not taking assignment, you suddenly find yourself held liable for indemnification under §1842(l)(1)(A), Waiver of Liability.

Less than one percent of all Part B denied claims are ever challenged by either the beneficiary or the physician. However, in those instances where a claim is appealed, over 76.9% are overturned in favor of the beneficiary and results in payment to the physician. This percentage goes up incrementally each time a claim is raised to the next appeal level.

At minimum, it is worth the paper, time and stamp to appeal a coverage or payment denial, including partial payments. There are a total of five levels of appeal available: Request for Review, Carrier Fair Hearing, Administrative Law Judge, Medicare Appeals Council and finally Federal Court.

Request for Review: At each step of the appeal process, the request must be in writing. Discussing a denied claim or a partial payment with the customer service department or with your provider relations representative will not serve to initiate any formal review of a denied claim. Requests for Review should be sent as soon as possible after a claim has been denied. You have six months from the date of the denial to request a review. However, a claim that has been returned as incomplete is not eligible for the appeal process.

Use a simple form letter on office stationary. Be sure the letter is dated and addressed to the correct office at the Medicare Carrier. Provide the beneficiary's name, Health Insurance Claim Number (HICN) or Medicare Card number, the date of service and specific service that was denied or only partially paid. Be clear in stating that you are requesting a review of the attached claim because you disagree with the denial. If you simply request an explanation of the coverage or payment determination, the carrier does not have to treat it as a request for review. Give the reason(s) why you consider the denial decision incorrect and state what additional information is being provided to justify a payment decision on this claim.

Only you can decide on the documentation that best supports your claim. Nevertheless, you may want to consider the following as additional information to include: lab or path results, medical history, documentation of severity or acute onset, consultation reports, operation reports, billing forms, referrals, plan of treatment, copies of communications between physician and/or beneficiary, hospital, carrier laboratory, etc. Any letter to the Carrier that explicitly asks that further action be taken on a claim or that clearly indicates dissatisfaction with the initial determination on a claim must be considered as a request for review. Be sure that the dermatologist or an appropriate representative of the provider signs the letter.

The Carrier must ensure that when a Request for Review of a denied claim is received, the claims reviewer cannot be the same individual who made the denial determination. The Request for Review requires the carrier to make a determination responding to the specific issues you raised. It cannot just be an explanation of general Medicare Part B payment principles.

The carrier may request additional information from you to facilitate the review. Respond promptly to these requests. If you don't have additional information or don't respond within thirty days, the carrier will make the new determination based on the information they have. Carrier decisions on Requests for Review must be rendered within 45 days of receipt of the request.

Carrier Fair Hearing: If the Carrier's initial determination is upheld as a result of your Request for Review, you still don't have to take "No" for an answer. If you still disagree with the Carrier and the amount of the denial is at least $100, you can request a Carrier hearing. These can now be scheduled and conducted over the phone as well as conducted at the carrier location. However, the request for a Carrier Hearing must be submitted in writing.

Section 1842(b)(3)(C) of the Social SecurityAct (SSA) provides that a physician who accepts assignment has the same right as the beneficiary to appeal a carrier determination. A claimant who requests a hearing has the right to be represented by a representative of his choice. Therefore, the notice of a review decision notifies the physician of his right to a hearing if $100 or more is in controversy, a statement of the issue in

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

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controversy, the method of requesting a hearing, the time limit for requesting it, and the right to send a representative, or to have a decision based on the record.

Types of Hearings: The nature of the hearings differ only with respect to the burden they impose on claimants, the method of presenting testimony, the speed with which they can be conducted, and a decision rendered. In terms of development, the use of consultants, consideration and evaluation of the facts, the hearings are similar. The purpose of the hearing is to arrive at the correct determination.

A. In-Person Hearing — This is the traditional hearing. The physician and/or representative is afforded the opportunity to present both oral testimony and written evidence supporting the claim, and refuting or challenging the information the carrier used to deny the claim before the Carrier Hearing Officer(HO). This is guaranteed by regulations. Nevertheless, an in-person hearing may not always be what you want, because it is time-consuming, inconvenient, or unnecessary. Therefore, you may request one of the other hearing forms.

B. Telephone Hearing — A telephone hearing offers a convenient and less costly alternative. They differ from in-person hearings in eliminating the need for you to appear. Oral testimony is presented and the opportunity exists for oral challenge. Like in-person hearings, telephone hearings are not for everyone. You may elect not to present oral testimony. In this instance, on-the-record decision is an available alternative.

C. On-the-Record (OTR) Decisions — On-the-record decisions are identical to those rendered in the hearings described above except that oral testimony is not presented. Its major advantage is the speed with which it can be held and a decision rendered. The decision is based on the facts which are in the file, including any additional information obtained by, or furnished to, the Carrier Hearing Officer.

Use the Carrier Hearing process to your advantage to settle a controversy involving benefits under Part B, the reasonableness of charges; whether services were medically necessary; whether items and services furnished were covered; or whether payment can be made under the waiver of liability provision. However, the Hearing Officer may not make determinations with respect to any issue or factor for which HCFA has sole responsibility, such as: whether or not an individual is entitled to coverage under supplementary medical insurance (Part B); whether or not an independent laboratory, portable X-ray supplier or outpatient physical therapy clinic furnishing services meets the conditions for coverage of services; or issues related to hospital insurance benefits under Part A.

Opportunity to Challenge Overpayment Determinations: Because the hearing decision is based on all available and material information, the HO considers all aspects (i.e., technical and coverage of services) relating to the claim. Pursuant to §1870(b) of the SSA, the Secretary of the Department of Health and Human Services decides whether a physician or supplier is without fault with respect to an overpayment. The Secretary delegates this decision-making authority to the Hearing Officer. A physician has the right to appeal the overpayment determination. Therefore, the HO considers whether a physician or supplier is without fault if the Carrier held the physician liable for refunding an overpayment. If the HO finds the physician or supplier is not without fault, the HO rules on the amount of the overpayment. With an In-Person or Telephone Hearing, the opportunity is present to negotiate overpayment amounts and repayment schedules with the assistance of a practice management consultant or your attorney.

The Medicare Carrier must acknowledge the hearing request as soon as possible, but no later than 10 days after receipt. The Carrier instructions specifically state that if, while preparing a hearing file, the carrier sees that the claim is payable in full, the Hearing Officer can dismiss the claim and order the carrier to pay it, rather than incur the cost of the hearing process. You should submit any new relevant evidence within 30 calendar days. The carrier must conduct the requested telephone or in-person hearing within 120 days, as required by law. Unlike current TV courtroom shows, the verdict is not rendered at the time of the Hearing. Whether the Hearing is conducted in person, over the phone or on the record, the decision of the Hearing Officer is always communicated in writing within ten days after the hearing.

Advice to Dermatologists: Remember, Medicare law provides that a physician who accepts assignment has **the same rights** as the beneficiary to appeal a carrier determination. With good medical record documentation to support services identified by appropriate CPT and ICD-9-CM coding, you can effectively challenge Carrier denials.

Come to Academy 2000 in Nashville and visit the AAD Resource Center!

Correct Coding Initiative

As you know, modifiers are necessary to by-pass the Medicare CCI edits. The appropriate modifiers to use are –58, –59, and the anatomic modifiers for eyelids (E1-E4), hand digits (F1-F9, FA), foot digits (T1-T9, TA) and LT, RT. The use of such modifiers conveys that the services performed have not been unbundled, but that separate services were indeed performed.

When a biopsy (CPT 11100) is done at the same time as another procedure, modifier –59 indicates that the biopsy is independent of the other procedure performed. For example: a biopsy of a lesion of the right hand and excision of a .6 cm basal cell carcinoma of the right upper arm would be coded 11100 –59 and 11601. Without the modifier –59, the payer would assume that both procedures may have been performed on the same lesion.

HCFA and Administar determined in 1998 that modifier –59 could be placed on either code. All carriers are expected to recognize modifier –59 on either member of a code pair. If you experience bundling by a Medicare carrier that does not recognize the –59 modifier or the Medicare staff says the modifier should be only on a certain member of the code pair, that is incorrect. Such carriers should be advised to contact Administar for clarification.

An in-depth article on HCFA's Correct Coding Initiative was presented in the June 1997 issue of *Derm Coding Consult*. Do review that article for more detailed information. Remember that you can access that particular issue as well as all issues of *Derm Coding Consult* on the AAD Web site (www.aad.org). Click on Professional Information, Socioeconomic Issues, and *Derm Coding Consult* to download issues.

ACTION REQUEST

Share your positive ALJ Hearing decision with your dermatology colleagues!

If you have successfully pushed a claims issue to the ALJ Hearing level, please fax or mail a copy of the ALJ decision or directive letter to the AAD:
c/o Norma Border
Socioeconomic & Practice Issues
(847) 330-1120 Fax

We'll maintain ALJ Decision Letters as we do the Local Medical Review Policies, and make them availabel to AAD members, providing precedent and support on similar cases.

Tell It To The Judge

There are times when the only way to get satisfaction regarding Medicare claims payment is to "tell it to the Judge," an Administrative Law Judge (ALJ). Beneficiaries and physician providers are entitled to request that a claim or series of related claims that equal or exceed $500 be appealed to an ALJ. The ALJ is an employee of the Social Security Administration. These hearing officials are assigned to the Office of Hearings and Appeals. The ALJ conducts evidentiary hearings on appeals from Medicare Part B determinations. The ALJ Hearing is a quasi-judicial administrative hearing conducted by a Federal ALJ that results in a new decision by an independent reviewer.

You have to have challenged the denial decision on these claims at the first two levels of carrier review before you can take it to an ALJ. However, in those situations where you are: subjected to an unusually restrictive LMRP, targeted for additional review based on modifier or CPT code parameters, or identified by the carrier attempting to recoup what it claims are over-payments, an ALJ Hearing may be your best court of last resort. It finally moves the review of the facts beyond the direct administrative control of the Medicare Carrier.

To the appealing physician or beneficiary's advantage, the ALJ is bound only by the laws and regulations governing Medicare and Social Security. The ALJ is not required to consider any HCFA or local carrier established procedures or policies, including local medical review policies (LMRP's).

A dermatologist can qualify to request an ALJ Hearing if he or she is: a participating physician that always takes assignment on services performed for Medicare beneficiaries; a nonparticipating physician who takes assignment for a specific service; or a nonparticipating physician not taking assignment but held liable for indemnification under §1842(l)(1)(A), waiver of liability. As with all Medicare Part B Appeals, the request for an ALJ Review must be in writing.

To meet the "Amount In Controversy" requirement for the ALJ level of review, the provider or beneficiary may appeal the difference between the amount charged the beneficiary less any amount allowed and/or paid by the carrier, less any remaining Part B Cash Deductible. To meet the amount in controversy requirement of $500, a beneficiary or provider may combine any series of claims for Part B services as long as the appeal is timely filed for all claims at issue and the claims are properly at the level of the appeal requested.

In order to combine claims in an appeal to an ALJ, each claim has to have gone through the prior appeal steps: 1) Part B Review - The first level of appeal following denial of a claim; and 2) Fair Hearing - An independent determination on the claim rendered by a Carrier Hearing Officer (HO) if the amount in controversy is at least $100 (see page 4, Carrier Fair Hearing section).

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Tell It To The Judge

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If you have submitted claims to the review and fair hearing levels and the denials have been upheld, the Carrier must advise you of your right to ALJ review. You must make the request for an ALJ Hearing within 60 days after receiving adverse notice from the Carrier Hearing Officer. ALJ Hearing requests can be filed with the Carrier or to any Social Security Office.

An ALJ can not only require the Carrier to make payment on these claims; he or she also has the power to instruct a carrier to discontinue adverse policies or actions. Decisions by an ALJ can also set precedent for use by other ALJ's in reviewing similar cases as do the actions of Appellate, Federal or State justices influence the subsequent decisions in other districts or jurisdictions.

FY2001 Carrier Changes

On April 28, 2000, HCFA announced major changes in Medicare Part B Carrier contracts for five states: California, Connecticut, Minnesota, Mississippi and Virginia. For Southern California, Transamerica Occidental advised HCFA that it was not interested in renewing its Medicare Part B contract which expires on September 30, 2000. United HealthCare (UHC) also advised HCFA in February that it planned to discontinue participation as a Medicare Carrier for Connecticut, Minnesota, Mississippi and Virginia.

National Heritage Insurance Company of Northern California (NHIC) will begin processing Medicare Part B claims for the entire State of California on October 1, 2000. NHIC, by taking over Part B claims processing from Transamerica for Southern California, will serve an additional 1.7 million beneficiaries and 33,000 more providers.

Blue Cross and Blue Shield of Florida, doing business as First Coast Service Options, will take over Part B claims processing from UHC for the State of Connecticut. Wisconsin Physician Service (WPS) will be the new Medicare Part B Carrier for the State of Minnesota. WPS is the current Medicare Carrier for Illinois, Wisconsin and Michigan with field offices in those states and locally assigned Carrier Medical Directors. In recent press releases, United HealthCare and WPS have voiced their commitment to work for a smooth claims processing transition for Minnesota providers.

Blue Cross and Blue Shield of Alabama, doing business as Cahaba Government Benefits Administrators will take over the UHC Part B Contract in Mississippi. Cahaba is currently the Medicare Part A and Part B contractor for Alabama and the Medicare Carrier for Georgia. TrailBlazer Health Enterprises, Inc., a subsidiary of South Carolina Blue Cross and Blue Shield will replace UHC as Medicare Carrier in Virginia. TrailBlazer is also the Medicare Carrier for Delaware, Maryland, Texas, Northern Virginia and Washington, D.C.

Sterling New HCFA M+C Plan

On May 5, 2000 HCFA approved Sterling Life Insurance Company, a subsidiary of AON as the first Medicare+Choice Private Fee for Service Plan (PFFS). Authorized under the Balanced Budget Act of 1997, PFFS provides an alternative to traditional Medicare to beneficiaries in seventeen predominantly rural states. A PFFS Plan includes contracted Medicare providers but also pays the traditional Medicare fee schedule rate for the service locality by any "deemed" provider, a Medicare participating physician or facility.

Sterling Option 1 plan enrollees must live within the designated Plan coverage states. However, a beneficiary may go to any Medicare participating facility for service. This makes Sterling Option 1 the first Medicare+Choice PFFS plan to provide essentially national coverage for its enrollees. The enrollment card for Sterling Option 1 will have an exclusive contact number for providers, 1-888-858-8550 as well as the Sterling Web site at www.sterlingplans.com, that will provide full information on how to submit claims to the Bellingham Washington claims processing center.

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Specifically, RBSI has agreed to the following:

1) discontinue review of claims for closure classification unless there is an indication of systematic misuse of the intermediate and complex closure codes;
2) follow CPT guidelines for measuring and coding of excised lesions;
3) reporting of re-excisions should adhere to the recommendations of the 1998 AAD Classification and Coding Task Force, using a CPT code to reflect malignancy and a diagnostic code reflecting personal history of malignancy;
4) appropriate recognition of CPT 17310 as an add-on code, not subject to multiple surgery rule.

RBSI also agreed that the affected Idaho dermatologists could resubmit previously denied claims for appeal under the negotiated guidelines.

Be sure to check out the

AAD web site at

www.aad.org

The E/M service does not have to be unrelated to the procedure and the same diagnosis is not sufficient reason to deny payment for the E/M service." Mr. Kay's letter supported the 1993 memorandum from Kathleen Buto. Ms. Buto's memo stated, "It has come to our attention that some carriers are not paying for such **separately identifiable** services unless they are 'unrelated' to the procedural service. This is not correct. A documented, **separately identifiable** related service is to be paid for. We would define related as being caused or prompted by the same symptoms or conditions."

In a response to an AAD member regarding this issue, Dr. James Zalla, Past-Chair of Classification and Coding Task Force stated, "In my opinion from a coding perspective, it is appropriate to code for a separate E/M service when an established patient returns for evaluation of sun damage." Again, documentation of the service provided is of utmost importance.

Update on AMA Proposed E/M Guidelines

During the last National Physician Specialty Group Conference Call on Monday, May 15th, Paul Rudolf, M.D., HCFA/Center for Health Plans and Providers (CHPP) advised that HCFA is in process of scheduling a Public meeting in June on the proposed guidelines. Hopefully, the meeting will provide an update on HCFA's plans regarding the implementation of the AMA Proposed Revised E/M documentation guidelines as well as a forum for discussion of their implementation. These revised guidelines would offer a simpler mechanism for determining the level of medical decision-making. The AMA has consistently argued against the use of counting or numerical formulas to determine the elements present in the documenation of an evaluation and management service.

Dr. Rudolf said that HCFA has almost completed its technical review of the proposed guidelines. HCFA has also publicly committed to a pilot study on use of the AMA proposed guidelines. HCFA would like to avoid the confusion generated by the publications of the 1994/5 and 1997 documentation guidelines. According to Dr. Robert Berenson, Director/CHPP, "We are taking time to review the guidelines, test the response and burdens, and we will educate physicians and Medicare carriers on the revised documentation requirements." However, HCFA has not announced where or when such a pilot study will be conducted. At this point in time, Carriers have been instructed to use either the 1994/5 or 1997 guidelines when reviewing claims, depending on which guideline is most advantageous for the physician.

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