DERM CODING CONSULT

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Medicare Carrier Apologizes for "Educational" Error

In late September, Trailblazer Health Enterprises, LLC., the Medicare carrier for Delaware, Maryland, and the District of Columbia, launched a new program to educate providers. This was Trailblazer's first step in implementing HCFA's new Medical Review: Progressive Corrective Action Program announced in August via HCFA Program Memo AB-00-72. The Medical Review: Progressive Corrective Action Program requires Medicare Carriers to review current statistical data to determine if there are billing aberrancies and to initiate an education program before conducting pre-pay audits.

Trailblazer developed two letters, the first was to go to the vast majority of dermatologists with information on the new program and –25 Modifier usage. The second letter was to be sent only to a very small number of dermatologists that Medicare statistics revealed were using –25 Modifier on almost every Medicare claim submitted.

Letters were sent to every dermatologist in DC, DE and MD re-stating Medicare policy regarding use of the –25 Modifier. However, the letter sent to dermatologists in these service areas advised "When we statistically identify a physician's practice as potentially aberrant, we must define the reason for the aberrance…review your medical records to determine if the services meet the criteria for billing these codes." Instructions were also included for submitting overpayments back to Medicare.

Sandra Read, M.D., DERMCAC representative for DC and Brenda Berberian, M.D., President of the DC Dermatology Society contacted AAD to initiate a coordinated response. The DERMCAC representatives in Delaware and Maryland,

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Medicare Fee Schedule 2001

The Medicare Fee Schedule for 2001, published in the November 1, 2000 Federal Register held no major surprises for dermatologists. Of key interest, is the slightly higher than expected Conversion Factor (CF) of $38.2581 for 2001. This increase of almost 4.5% puts the basic unit of Medicare physician reimbursement $1.64 higher than the 2000 CF of $36.6137.

BBA Transition Continues

This is the third year of the Balanced Budget Act (BBA) transition from charge-based to resource based relative value units (RB/RVS) for practice expense. The practice expense relative value units (PE/RVU) are a mix of 25% charge based and 75% RVU based factors. In 2002, the Medicare Fee Schedule will be 100% RVU based for all factors: physician work, practice expense and malpractice. In addition to the transition-based PE/RVU changes, dermatology will see an offset of one percent to the anticipated 5% increase as a result of changes to practice expense inputs and changes resulting from HCFA's incorporation of 1999 Medicare utilization data.

PEAC Refinement Work to Continue

HCFA is very pleased with the progress of the practice expense refinement process achieved under the AMA Practice Expense Advisory Committee (PEAC). The PEAC developed standardized supply packages for evaluation and management as well as consultation services. The MFS 2001 reflects the refinements to practice expense inputs for almost twenty-two percent of Medicare allowed charges for physician services. HCFA and the AMA/Specialty Society RVS Update Committee has voted to continue the practice expense refinement process through the MFS 2002 regulatory cycle.

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Letter from the Editor

Dear *Derm Coding Consult* Reader,

You'll find that the Medicare Physician Fee Schedule for 2001 will bring an average nine percent increase to Medicare reimbursement of dermatology services. While there was some shaving away at office visit practice expense, the larger than predicted increase for the Sustainable Growth Factor (SGR) as well as HCFA adoption of AMA/RUC recommendations on physician time resulted in a larger than anticipated increase in the Medicare Conversion Factor.

Psoriasis Task Force Special Survey

The Academy is working with the National Psoriasis Foundation to present practice expense data to the AMA/ Practice Expense Advisory Committee to re-evaluate the clinical labor, medical supplies and equipment costs for providing phototherapy services to psoriasis patients. In order to persuade HCFA to adjust these costs, AAD has sent out Practice Expense Direct Input surveys to those dermatologists and dermatology departments that provide this service. The quickest way to improve reimbursement for phototherapy services and guarantee access for psoriasis patients is to submit good survey data at the next AMA/PEAC meeting.

HIPAA – Promised Improvements

This issue of Derm Coding Consult will provide you with more detail regarding the Health Insurance Portability and Accountability Act: Administrative Simplification provisions. There is more than a window of opportunity with HIPAA to streamline health claims handling. HIPAA is an open door that the health care payers have to go through FIRST.

Seasons Greetings

Best wishes for a joy-filled Holiday Season for you and yours from me, the Socioeconomic and Practice Issues Department and everyone in the AAD Graphics and Communications Departments who help us bring you Derm Coding Consult every quarter. And Happy New Millennium (really!)

Norma L. Border, Editor

CPT 2001 Update

There are few changes in the Integumentary portion of AMA/ CPT 2001. The two new codes established (15342 and 15343) are graft codes for the application of skin substitute/neodermis. (See article on page 4.) The directives regarding repairs appearing in the new AMA/CPT code book clearly state that intermediate or complex repairs are reported in addition to an excision of a lesion.

The definition of an established patient has been clarified to represent face-to-face contact with the physician. Thus, if a physician refills a prescription within the three years prior to seeing a patient in the office, the patient visit would be coded as a new patient visit. You will find this definition in the Evaluation and Management Guidelines of the new CPT book.

Also, there has been some refinement in the descriptors for KOH exam and for fungus cultures as performed by dermatologists. These refinements will clarify specimem sources as isolates from skin, hair, or nail and clarify that the KOH may be for fungi or for ectoparasites, eg., scabies. Please read the newly revised descriptors for codes 87101 and 87220.

For all specific changes to CPT 2001, refer to Appendix B in the CPT book that lists all the additions, deletions and revisions for 2001.

Note the symbols used in CPT.

▲ = Revised Code
● = New Code
✱ = Service Includes Surgical Procedure Only
⃠ = Modifier "-51" Exempt
▶◀ = New or Revised Text
✚ = Add-on Code

There is much information in CPT to assist you in proper coding. It is advisable to spend some time reading the new CPT book so that you will be coding correctly and filing clean claims.

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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

Recent HCFA Announcements

2001 Medicare Part B Deductible

The Medicare Part B deductible for Medicare patients will remain at $100.00 for calendar year 2001. Most Part B services are subject to the annual deductible and coinsurance (percentage of costs that the enrollee must pay) which are set by statute under the Social Security Act. For full text of the 2001 Medicare Part A and Part B Premium and Deductible information contained in HCFA PM AB-00-98, go to www.hcfa.gov/pubforms/progman.htm and go to Program Memos. Please remember that physicians may not waive efforts to collect the Part B deductible from their Medicare patients.

Carrier Toll-free Phone Service for Providers

HCFA has directed all contractors of Medicare services to provide toll-free telephone lines for all providers nationwide. HCFA is requiring carriers to provide toll-free service in order to reduce each provider's cost of doing business with Medicare. When this program becomes effective, providers won't have to pay for a long distance call to speak to a Medicare carrier representative. Be aware that although carriers were provided with funding to implement the new 800 or 888 numbers, it did not provide funding for any increase in provider service representatives. Dermatologists and staff will be able to call the carrier toll free, but this won't reduce or eliminate busy signals or hold time in trying to discuss a claim with a provider representative. Note that this directive doesn't affect the telephone lines for electronic submission of claims.

The carriers are required to publicize this service to their providers as soon as the toll-free service is operational. Carriers are to include the toll-free number on bulletins, provider education materials and other printed material (such as remittance advices) as well as on their Web site. The transition from toll-lines to toll-free lines has been delayed somewhat due to the recent strike by Verizon telecommunications workers. Watch your monthly Medicare carrier newsletter regarding the announcement of this cost saving service.

Participating / Non-participating Physician Enrollment

The status of your participation with Medicare will remain the same as last year unless you submit the required forms to either participate or withdraw from participation. The necessary forms to do either can be downloaded at www.hcfa.gov/pubforms/progman.htm (see Program Memo B-00-53, October 20, 2000). The participation/enrollment forms must be postmarked prior to January 1, 2001. Enrollment information along with the 2001 Medicare fee schedule was sent to each provider of Medicare services mid-November.

New Participating Physician Directory Websites

According to the Program Memo, Medicare Carriers will not be printing hard copies of the Medicare Participating Physician Directories but will be making them available on their Web site. HCFA is also establishing an Online Participating Physician Directory. This new directory was launched on the HCFA Medicare Web site (www.medicare.gov) on November 17th. All participating physicians with their address and specialty are listed in this online directory.

The information for this directory will come from the UPIN (Unique Physician Identification Number) database. If you are a participating physician, you should have received a letter from Medicare regarding this directory and indicating your correct information. If there are errors in the information listed on either the Carrier or the Medicare Web sites, submit a request for a correction to your local Carrier in writing. Corrections and changes to the Carrier and national Medicare Web site will be reflected on the Web sites, the month after changes are submitted to the UPIN registry.

Medicare Fee Schedule 2001

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Challenges to Derm Practice Expense Data

HCFA received comment that contended that the practice expense per hour did not appear logical, objective or consistent among specialties and that the total practice expense per hour for dermatology is almost two times greater than for gastroenterology. HCFA responded that specialties are likely to have differences in practice expense per-hour for direct and indirect costs. Responding to the use of dermatology as an example, HCFA argued that dermatologists are generally office-based, while gastroenterology services are provided in the hospital.

HCFA Review of Destruction Codes

In response to another comment regarding apparent anomalies in RVU values assigned to CPT 17000, 17003 and 17004, HCFA has re-examined the current CPEP inputs. The inputs for labor and equipment for these codes appear to be appropriate. However, HCFA is looking for specific recommendations from AAD and the PEAC to address and refine the CPEP supply lists for these codes over the next few months.

Unna Boot Supplies

The Academy requested clarification as to whether or not Unna boot supplies would be separately billable as CPT 29580 was included in a list of codes where supplies are now identified as separately billable. HCFA responded that because Unna boot is used for treatment of cases other than fractures, the supplies are not separately billable.

HCFA Simplifies Equipment Categories

HCFA is attempting to clarify and simplify equipment categories. In prior years practice expense direct inputs have listed medical equipment as well as overhead equipment. HCFA intends to place all equipment into a single category and assume for practice expense purposes that every listed piece of equipment is used 50% of the time for specific procedures. Combining medical and overhead equipment into one category will not eliminate any equipment from the practice expense calculations.

New CPT Coding for Skin Substitute

Apligraft® is a wound application product that is FDA approved for the treatment of noninfected partial and full-thickness venous leg ulcers due to venous insufficiency. The use of Apligraft® may be appropriate for those ulcers that have been present for more than one month and have not responded to conventional ulcer therapy.

Two new codes have been established by AMA/CPT for reporting the application of skin substitute. The 2001 AMA/CPT codes and definitions are:

CPT 15342 .... Application of bilaminate skin substitute/neodermis; 25 sq. cm.

CPT 15343 .... each additional 25 sq. cm. (List separately in addition to code for primary procedure)

(Use CPT 15343 in conjunction with code 15342)

The CPT guidelines for Free Skin Grafts state that CPT 15000 would be used for initial wound preparation. These new CPT codes replace the HCPCS codes that have been used for tissue cultured skin grafts. The codes being replaced are:

G0170 ..... Application of tissue cultured skin grafts, including bilaminate skin substitutes or neodermis, including site preparation, initial 25 sq. cm.

G0171 ..... Application of tissue cultured skin grafts, including bilaminate skin substitutes or neodermis, including site preparation, each additional 25 sq. cm.

In June, HCFA issued Program Memorandum B-00-30, instructing Medicare carriers to provide payment **for the product as well as the procedure code**. The HCFA PM states that the practice expense portion of these two codes (G0170 and G0171) does not include payment for a skin graft product, such as Apligraft®.

The product codes, which are carrier priced, are:

Q0183 ..... Dermal tissue, of human origin, with and without other bioengineered or processed elements, but without metabolically active elements, per sq. cm.

Q0184 ..... Dermal tissue, of human origin, with or without other bioengineered or processed elements, with metabolically active elements, per sq. cm.

Q0185 ..... Dermal and epidermal tissue, of human origin, with or without bioengineered or processed elements, with metabolically active elements, per sq. cm.

The example given by HCFA was, "If a physician used Apligraft® on a vascular wound measuring 20 square centimeters, then the proper coding would be G0170 plus 20 units of Q0185."

However, the 2001 Medicare Fee Schedule 2001 in the November 1, 2000 *Federal Register* **does not** address the issue of the product codes. The text states that the new codes were crosswalked from the G0170 and G0717 codes with no mention of the use of Q0184 or Q0185. Be sure to watch your carrier newsletters for any additional information on the use of these codes. In addition, the June HCFA PM states that carriers should always determine whether the procedure was reasonable and medically necessary and that requesting medical records may be necessary in making the determination. It is important that the documentation in the medical record supports the code(s) reported.

CPT 2001 - Coding for Repairs

AMA/CPT 2001 has added text that more clearly identifies the proper coding of repairs with excision codes. The added text preceding the benign and malignant excision codes indicates that closure by intermediate or complex repair is to be reported separately. It also states that the appropriate excision code (CPT 11400-11446 or 11600-11646) is reported **in addition to** the intermediate (CPT 12031-12057) or complex (CPT 13100-13153) repair code. Simple repairs (CPT 12001-12018) are included in the excision codes. The added text defining complex repair states:

"Complex repair does not include excision of benign (CPT 11400-11446) or malignant (CPT 11600-11545) lesions."

This descriptive text may be used to provide supporting documentation to those carriers that attempt to bundle excisions and repairs inappropriately.

Adjacent tissue transfers or rearrangements codes (CPT 14000-14350) include the excision of the lesion. It would be incorrect to report an excision code (CPT 11400-11446 or 11600-11646) when the repair of the site was accomplished by an adjacent tissue transfer or rearrangement.

When an excision of a lesion site requires skin graft, the appropriate graft code is reported in addition to the lesion excision code (CPT 11400-11446 or 11600-11646). CPT 15000 is **not** used to report the lesion excision.

Medicare Rules Differ Slightly

For Medicare, the excision of a benign lesion .5cm or less includes simple, intermediate, or complex repair. If the benign lesion is greater than .5cm, medically necessary intermediate or complex repair is allowable. The excision and repair of malignant lesions follow CPT guidelines. Do note that the medical record should indicate why an intermediate or complex repair was necessary. (See *Derm Coding Consult* June 1998, page 7.)

HIPAA – This Could Be the Start of Something Good!

On Aug 17th, the first set of regulations implementing the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA) were published in the *Federal Register*. These regulations adopt a set of national standard electronic transactions and require all health plans, clearinghouses, and providers that do business electronically to use these standards. National standards for electronic health care transactions will reduce the administrative burden on health care providers and health plans. These standards must be in use by October 2002.

Entities Required to Use the Standards

HIPAA Administrative Simplification requires that all private sector health plans (including managed care organizations and ERISA plans, but excluding small self administered plans) and government health plans (including Medicare, Medicaid programs, the Military Health System for active duty and civilian personnel, the Veterans Health Administration, and the Indian Health Service programs), all health care clearinghouses, and any health care providers that choose to submit or receive transactions electronically are required to use these standards. These covered entities must use the standards when conducting any transaction covered by HIPAA. A health care clearinghouse may accept nonstandard transactions for the sole purpose of translating them into standard transactions for sending customers and may accept standard transactions and translate them into nonstandard transactions for receiving customers. Providers are not required to use electronic transactions; but if they do they must use the standards. When HIPAA is fully implemented, a dermatologist will be able to submit the same electronic claim format to any government or private health plan in the country, greatly simplifying the process of electronic claims submission for providers.

Under HIPAA, the Secretary of HHS established national electronic standards for the following eight administrative and financial health care transactions:

1. Health claims or encounter information
2. Eligibility for a health plan
3. Referral certification and authorization
4. Health claim status
5. Enrollment and disenrollment in a health plan
6. Health care payment and remittance advice
7. Health plan premium payments
8. Coordination of benefits

In addition to claims, all of the HIPAA transactions will have a standard electronic format that must be accepted and responded to by all health care payers. HIPAA opens the door to quicker, easier, direct, on line interaction with health payers to establish enrollment status, patient eligibility, pre-certifications, referral authorizations as well as status on submitted claims. HIPAA will eliminate local coding requirements and eliminate the plethora of hardcopy attachments that to date have severely limited the number and type of claims that can be easily submitted electronically.

The onus and legislative penalties are on the health care payers to be HIPAA compliant within the next twenty-four months. That compliance includes the requirement to accept AMA/CPT-4 with all it's modifiers as well as ICD-9-CM. Payers whose systems cannot handle all of the above, will not be in compliance and could be subject to monetary penalties.

Dermatology practices that are currently filing claims electronically should request their billing service or software vendor to advise when the service or vendor plans to be HIPAA compliant. All medical billing software applications will have to be modified to achieve HIPAA compliance. Anticipate that there may be additional fees for updating existing software. Note: HIPAA standardization will eliminate the necessity of clearinghouses that currently reformat data into payer acceptable files.

Dermatology practices who are not happy with current software or billing service, or are not filing the majority of their claims electronically, should research software or billing service vendors for the office. The federal requirement of these Administrative Simplification standards eliminates the current confusion of trying to find a billing system or service that can interface with the majority of your patients health care plans. HIPAA makes it simple: one electronic format for all payers. The primary information source on HIPAA: Administrative Simplification is the Department of Health and Human Services HIPAA web site at http://aspe.hhs.gov/admnsimp. These new HIPAA standards will make electronic data interchange (EDI) a viable and preferable alternative to paper transactions.

Late Medicare Increase to Mohs and Pathology Codes

HCFA, in a final update to the 2000 Medicare Fee Schedule, increased practice expense values for these codes and changed the total reimbursement rate effective back to January 1, 2000. The affected Mohs surgery codes are: CPT 17304, 17305, 17306 and 17310. The pathology codes are: CPT 88304, 88304-TC, 88305, 88305-TC. Please note that CPT 88304-26 and CPT 88305-26 are **not** included in this fee schedule adjustment. While detailing the required RVU update changes in HCFA PM B-00-40, the memo does not mandate carriers to automatically make adjustments to providers who submitted claims for these service codes. However, it does require carriers to adjust any claims brought to their attention by providers.

Dermatologists will need to follow local carrier guidelines in recouping the additional reimbursement. If your carrier newsletter/bulletin hasn't given you directions regarding this issue, contact your Medicare carrier provider representative for instructions.

OIG Finalizes Small Practice Compliance Plan

On September 25th, the Office of the Inspector General (OIG) issued its final guidelines for individual physicians and small group practices voluntary compliance program. In 1999, the AMA/Physician Socioeconomic Study indicated that 51 percent of dermatologists still maintain individual practices, while another 23 percent are in private dermatology group practices, and 25 percent are employed in multi-specialty group practices.

Compliance planning to assist practices working with Medicare and private sector carriers to avoid mistakes in billing and coding is accepted as a guiding principle and goal of the OIG's efforts. Having reviewed the draft guidelines for single and small groups, AAD commented to the OIG that many of their earlier expectations were too burdensome for small practices. Many of the more onerous provisions identified by AAD have been removed from the final rules.

The OIG relaxed the medical record audit recommendations from the earlier compliance guidelines for larger group practices. While a minimum of 20 medical records were suggested to be audited per quarter for larger practices, new guidelines for single and small-group practices suggest a level of five to 10 charts per quarter.

Recognizing at last the limitations of staffing in a small practice, the OIG suggests that ideally one person in the practice should be responsible for the coordination of compliance activities, and now allows that more than one person can be responsible for the various aspects of compliance – chart audits, personnel training, accepting and responding to compliance issue complaints. With the new guidelines, compliance management can also be outsourced to a local individual who is responsible for compliance planning for more than one practice.

In comment on the OIG proposed rule, AAD took special issue with member concerns that innocent billing errors, such as duplicate claims processing, would be construed as fraudulent practices within a federal compliance audit. In the final guidelines, the OIG stated that "there appears to be significant misunderstanding within the physician community regarding the critical difference between what the government views as innocent 'erroneous' claims on the one hand, and 'fraudulent' (intentionally and recklessly false) health care claims on the other. To address these concerns, OIG emphasizes that it does not disparage physicians.

"In our view, the great majority of physicians are working ethically to render high quality medical care and to submit proper claims. In addition, under the law, physicians are not subject to criminal, civil or administrative penalties for innocent errors or negligence. The Government's primary enforcement tool, the civil False Claims Act, covers only offenses that are committed with *actual knowledge* of the falsity of the claim *reckless disregard,* or *deliberate ignorance* of the falsity of the claim," advised OIG Inspector General June Gibbs Brown.

The new guidelines suggest that the physicians focus on their most likely risk areas: coding and billing; reasonable and necessary service; documentation; and improper inducements, kickbacks, and self-referrals.

The AAD encouraged the OIG to continue to involve the medical community in the development of improved, uniform educational materials and manuals, particularly for individual and small group practices. This becomes essential for practices, in light of the coming implementation components of the Health Insurance Portability and Accountability Act (HIPAA).

In June 1999, the Academy — with the help of a practice management consulting firm — developed the *Model Dermatology Compliance Program* and makes it available to members on the AAD Web site, www.aad.org. Over 2,000 dermatology practices have downloaded the manual and almost 1,800 hard copies have been distributed to date.

For more information about the OIG Compliance Program, visit the Office of the Inspector General Web site at www.dhhs.gov/progorg/oig/new.html. You can also call the OIG Public Affairs Office at (202) 619-1343. AAD Members may also contact staff members Barbara Dolan, manager, private sector advocacy, at (847) 240-1799, fax (847) 330-1120, e-mail bdolan@aad.org, or Norma Border, manager, coding and reimbursement at (847) 240-1814, e-mail nborder@aad.org.

Coding for pathology services update

The article on page 7 in *Derm Coding Consult*, September 2000, stated, "….that a pathology report must be dictated in the patient's record." Concerns have been raised by members regarding this statement.

We will provide additional information on this issue in the next *Derm Coding Consult*. If you have particular guidelines from a carrier regarding pathology reports, please feel free to share those guidelines with us. Fax to Norma Border at 847-330-1120.

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Ronald Goldner, M.D., Peter Panzer, M.D. and Scott Panzer, M.D. were also alerted regarding the content and tone of the Trailblazer letter.

The letter was discussed in detail at the October Carrier Advisory Committee meetings held in DC and MD in October. Trailblazer staff reiterated the educational intent of the letter. However, the subsequent DC Dermatology Society meeting, Trailblazer admitted that the letter developed for the small number of doctors over-using –25 modifier had been sent to every dermatologist in the area! Although Trailblazer acknowledged the error at the meeting, the DERMCAC representatives pressed for a more tangible response. On October 30th, Trailblazer issued letters of apology to all the dermatologists in the area.

Quick action by the DERMCAC representatives as well as the DC Dermatology Society, who collectively pushed for a discussion of the issue directly with the Carrier Medical Director, resulted in a successful resolution to a painful situation for dermatologists in DC, DE and MD.

New ICD-9-CM Codes

Several new ICD-9-CM diagnosis codes became effective October 1, 2000. These new codes will aid in reporting more specific diagnoses. You will remember that there were no ICD-9-CM coding changes last year due to the concerns of Y2K.

The new ICD-9-CM codes in the integumentary section are:

692.75 Disseminated superficial actinic porokeratosis (DSAP)
707.10 unspecified ulcer of lower limb
707.11 ulcer of thigh
707.12 ulcer of calf
707.13 ulcer of ankle
707.14 ulcer of heel and midfoot
707.15 ulcer of other part of foot
707.19 ulcer of other part of lower limb
727.83 plica syndrome

Refer to the listing in ICD-9-CM regarding the use of the new codes. By definition, 707.1 is not used for decubitus ulcers. Thus the new ulcer codes would fall under 707.1 (ulcer of lower limbs, except decubitus) and may be used for ulcers of the specified sites of the lower limbs other than decubitus ulcers.

Be sure that you have a 2001 edition of ICD-9-CM. Claim denials based on inadequate ICD-9-CM codes are costly to your practice.

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