

DERM CODING CONSULT



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News Briefs

CMS Issues National Coverage Policy on Actinic Keratoses

After over five years of concerted effort by the Academy, on July 19, 2001, the Center for Medicare and Medicaid Services (CMS formerly HCFA) issued a national coverage determination on Medicare coverage for treatment of actinic keratoses. The full text of the memo is available at www.hcfa.gov/coverage which:

- (1) describes actinic keratosis (AK) and methods of managing this skin lesion;
- (2) reviews the history of Medicare's coverage of management of actinic keratosis and provides a timeline of recent activities;
- (3) presents and analyzes the relevant scientific and clinical data related to actinic keratosis; and
- (4) delineates the reasons for making a positive national coverage decision.

CMS AK Decision

"The Coverage Issues Manual will be revised to indicate that Medicare will cover the destruction of actinic keratosis, without restrictions based on lesion or patient characteristics, using surgical or medical treatment methods, including but not limited to:

- cryosurgery with liquid nitrogen,
- curettage,
- excision, and
- photodynamic therapy.

CMS expects that practitioners will maintain sufficient information, as required under 42 CFR § 424.5(a)(6)³⁷, to enable them to demonstrate entitlement to Medicare reimbursement for covered procedures and services."

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Medicare Revises Advance Beneficiary Notice

The Centers for Medicare and Medicaid (CMS, formerly HCFA) has made significant changes to the Advance Beneficiary Notice (ABN). In response to ongoing complaints from physicians regarding the tone and complexity of the ABN form, CMS committed to revise it as part of the Physician Regulatory Initiative Taskforce (PRIT) efforts to reduce the administrative burden on doctors. Simplifying the advance beneficiary notice was among the top five priority issues recently identified by doctors for HCFA to address and was given a fast track development.

The ABN form is given annually to millions of Medicare beneficiaries before they receive a medical service that Medicare may not pay for. The new one-page version of the form, has been redesigned to make it more readable and easier for the Medicare beneficiary to understand. The revised form is available on the HCFA Web site at <http://www.hcfa.gov/regs/prdact95.htm>. The new ABN form may also be photocopied from page 7 of this publication and put into immediate use.

In April, beneficiaries, health care providers and others were requested to send their comments on the new ABN to the Office of Management and Budget (OMB). OMB approved the revised Notice for use in June. The revised form will be published in the Medicare Carriers Manual in late August. However, CMS has advised the Academy as well as other medical specialty societies that doctors may begin using the new form at once.

"Advance notices are given out each year to beneficiaries who may not know whether Medicare will pay for their particular medical service," HHS Secretary Tommy G. Thompson said. "We heard suggestions and recommendations that helped us improve these forms so Medicare beneficiaries know what the paper they are given really means."

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Letter from the Editor

Dear *Derm Coding Consult* Reader:

This issue is chock full of good news! We have a National Coverage Policy Decision for treatment of actinic keratoses! Finally, one consistent Medicare decision that recognizes AK's as pre-cancerous and does not prescribe patient or treatment parameters. Look for details on the wording of the Medicare Coverage Issues manual on this in the December issue.

Based on negative feedback from almost forty medical specialty societies, the Center for Medicare and Medicaid Services (CMS), formerly HCFA has dropped further development on the Aspen Systems "clinical example" project and will take at least a year to re-assess the entire Evaluation and Management Documentation Guidelines (EMDG) initiative.

In addition, CMS has issued the Guidelines for the HIPAA Privacy Regulations. I've reviewed them and for the most part the Guidelines demonstrate a "common sense" approach to the handling of protected health information (PHI). Don't believe all the consultant hype and scare tactics on how difficult HIPAA Privacy compliance will be. Odds are the simple consent form you are currently using with your patients will meet the HIPAA requirements. The inherent respect and discretion dermatologists and their staff have for the person and personal information of the patients they serve will also prove an asset.

Bottomline, as a health care provider, **dermatology practices have until April 14, 2003** to determine if they are HIPAA compliant and to make the common sense changes necessary to do so. The Academy is part of a coalition of twelve medical specialty societies that have already contracted for the preparation of a comprehensive HIPAA Privacy Compliance Manual that will include sample policies, checklists and forms. The manual is being prepared by a well known health care consulting firm that specializes in legal and compliance issues. The manual should be available to Academy members in early 2002.

Best regards,



Norma L. Border, Editor

Coding Update

Coding for Repairs

According to AMA/CPT, excisions (114xx and 116xx) include simple repair. However, intermediate and complex repairs are separate procedures and may be billed. Medicare rules vary from AMA/CPT directives. See articles regarding repairs in *Derm Coding Consult* December 2000, page 4 and June 1998, page 7.

When reporting an adjacent tissue transfer (14xxx), remember that the excision of the lesion is included and cannot be billed additionally. If an excision is performed on a different lesion at another site, that excision would need to be reported with a -59 modifier according to the Correct Coding Initiative.

Correct Use of CPT 15000

From *Derm Coding Consult*, September 1999

Q. Was there a change in code 15000?

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

From *AMA cpt Assistant*, April 1999

Q. What is the appropriate use of CPT code 15000?

- A. CPT code 15000 was revised in CPT 1999 and is now intended to be reported for the surgical preparation or creation of a recipient site by excision of open wounds, burn eschar or scar. This code has been revised to clarify the inclusion of excision preparation of burn wounds (scars), including tangential excisions. Code 15000 has also been revised to be body surface size dependent, to include excision preparation of the first 100 sq centimeters (or fraction thereof) in the treatment of adults or one percent (or fraction thereof) of the body area of infants and children under ten years of age.

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Norma L. Border, M.A.
Editor, *Derm Coding Consult*
American Academy of Dermatology

Vernell St. John, CPC, CDC
Assistant Editor, *Derm Coding Consult*
American Academy of Dermatology

Address Correspondence to either:
James A. Zalla, M.D., or Ronald L. Moy, M.D.
Editorial Board *Derm Coding Consult*
American Academy of Dermatology
930 N. Meacham Road
Schaumburg, IL 60173-4965

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 them with your staff involved with coding and reimbursement issues. Please note that the information provided in each issue is 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.aadassociation.org/coding.html

ICD-9-CM codes are updated annually on October 1 and the updated codes should be used on claims filed beginning October 1. However, both the old and new codes are acceptable through December 31. Beginning January 1, claims will be rejected if invalid ICD-9-CM codes are submitted.

Program Memorandum AB-01-91 issued on June 28, 2001 directs carriers to emphasize the importance for providers to use the most recent version of the ICD-9-CM coding book and to code to the highest level of specificity.

The following changes listed in the Program Memorandum should be noted in the Tabular Addenda:

Revise	690	Erythematous squamous dermatosis Excludes: seborrheic keratosis (702.11-702.19)
Add	692	Contact dermatitis and other eczema 692.7 Due to solar radiation Excludes: sunburn due to other ultraviolet radiation exposure (692.82) 692.71 Sunburn
Add		First degree sunburn
Add		Sunburn NOS
Revise		692.72 Acute dermatitis due to solar radiation Excludes: sunburn (692.71, 692.76-692.77)
New code	692.76	Sunburn of second degree
New code	692.77	Sunburn of third degree
Add	692.8	Due to other specified agents 692.82 Dermatitis due to other radiation Tanning bed
Revise	692.89	Other Excludes: sunburn (692.71, 692.76-692.77)
Revise	706	Diseases of sebaceous glands 706.3 Seborrhea Excludes: seborrheic keratosis (702) dermatitis (690.10) keratosis (702.11-702.19)

The updated entries in the Index to Diseases and Injuries Addenda reference the new and revised codes as noted in the Tabular Addenda. Additions and revisions are made to the entries under Burn; Dermatitis; Effect, adverse, NEC; Radiation effects or sickness; and Sunburn.

Remember to update encounter forms as well as software with new and revised codes.

Code 15000 is no longer an add-on code and therefore may be reported when grafting is not recommended or will be delayed for a subsequent session.

CPT code 15000 should not be reported for the excision of benign (11400-11471) or malignant lesions (11600-11646), which are reported according to the morphology of the lesion.

Specimen Handling

There are three codes in CPT having to do with specimen handling. The descriptive text preceding these codes states they are an adjunct to the basic services rendered. Thus, these codes are reported in addition to the basic service.

99000 – Handling and/or conveyance of specimen for transfer from the physician’s office to a laboratory

99001 – Handling and/or conveyance of specimen for transfer from the patient in other than a physician’s office to a laboratory (distance may be indicated)

99002 – Handling, conveyance, and/or any other service in connection with the implementation of an order involving devices (eg, designing, fitting, packaging, handling, delivery or mailing) when devices such as orthotics protectives, prosthetics are fabricated by an outside laboratory or shop but which items have been designed, and are to be fitted and adjusted by the attending physician.

However, AMA *cpt Assistant* in February 1999 responded to a question regarding the appropriate use of code 99000. AMA’s comment was: **“From a CPT coding prospective, code 99000, Handling and/or conveyance of specimen for transfer from the physician’s office to a laboratory, is intended to be reported when the physician incurs costs to handle and/or transport a specimen to the laboratory (eg, via messenger service). If the specimen is picked up by the laboratory staff at no additional cost to the physician, it would not be appropriate to report CPT code 99000.”**

In October 1999 *cpt Assistant*, AMA further clarified the use of code 99000. Referring to the February response, AMA stated: **“.....many of our readers pointed out a second use of this code that is also correct, and reflects the most typical use. Code 99000 is also intended to reflect the work involved in the preparation of a specimen prior to sending it to a laboratory. Typical work involved in this preparation may include centrifuging a specimen, separating serum, labeling tubes, packing the specimens for transport, filling and lab forms and supplying necessary insurance information and other documentation.”**

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**Please thank your
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E & M Medicare Data

Each year, Medicare publishes the Part B Extract and Summary System (BESS) data for physician/supplier services reported to Medicare for reimbursement. The National Claims History (NCH) Repository carries complete Part B data for all beneficiaries. Data from the NCH Part B Physician/Supplier claims are used to develop the Physician/Supplier Procedure Summary (PSPS) Master File and the Focused Medical Review (FMR) Master File which are the sources for the Part B data that populate BESS. The data does not provide beneficiary or provider specific data. It contains summary data only.

Prior to May 1984, the data collected by HCFA (now called Center for Medicare & Medicaid Service - CMS) did not provide all the Part B data HCFA felt was necessary. Thus, additional files were submitted by carriers annually for supplemental data. This data was extracted from Medicare claims processing and was used to create in 1984 the Part B Medicare Annual Data (BMAD). BMAD was replaced by BESS in 1991 to establish a system of continuous data extraction instead of annual data extraction.

The BESS data for the evaluation and management (E/M) codes lists the top thirty five provider groups reporting E/M services. The graphs accompanying this article are taken from the 2000 Medicare BESS data, comparing dermatologists level of services reported to all specialties.

Compare these graphs to those that appeared in the June issue of *Derm Coding Consult* on the level of E/M services provided by the respondents to a survey appearing in the December issue. Both sets of data regarding dermatologists use of E/M codes are very similar.

Documentation in the medical record drives the level of service reported. Be sure that the documentation supports the code reported. And again, either the 1994 or 1997 Documentation Guidelines are acceptable to CMS.

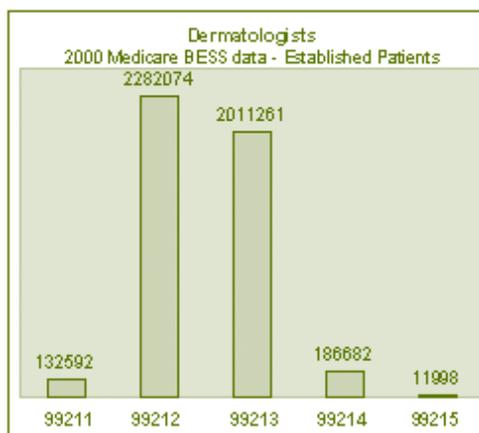
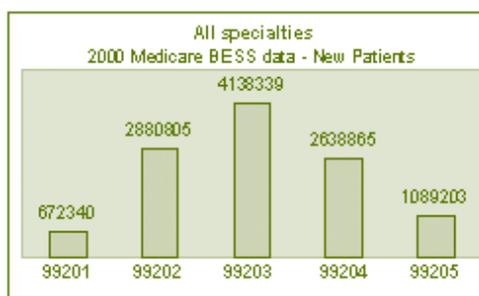
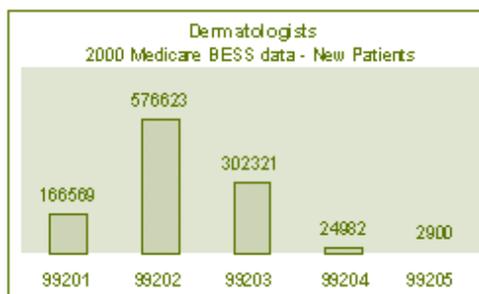
(See related information on E/M documentation guidelines update on page 5.)

The number at the top of each bar is the volume per code.

Web Access in the Dermatology Office

Access to the Medicare carrier Web site is a valuable asset in the provider office. From that site, one can retrieve the Local Medical Review Policies (LMRP), and read or print the Carrier bulletins/newsletters. Keeping up to date with the Medicare rules and regulations electronically is advantageous.

Derm Coding Consult, including all back issues, are available on the AAD/AADA Web site. Other benefits of Web access in the office include monitoring the latest program memoranda from CMS as well as access to the Medicare Manuals.



CMS Drops EMDG Project

Thomas Grissom, newly appointed Director of the Center for Medicare Management announced that CMS has in essence “dropped” current efforts to pursue development of clinical examples under the Aspen Systems Project. CMS had stated that it was working within current AMA CPT definitions to develop and implement simplified Evaluation and Management Documentation Guidelines(EMDG). The aim was to find a solution to the physician community’s concerns over the existing but disparate 1994-95 and 1997 E&M Documentation Guidelines. Grissom commented that the agency has “spun it’s wheels, with no results to date.” He also advised that CMS will suspend all work on E&M documentation until they have had the opportunity to evaluate the situation.

In June 2000, HCFA shared new draft guidelines with physicians at a Town Hall meeting. AADA reviewed and provided comment on several problem areas and suggested modifications. In addition, there was extensive critical testimony at the Physician Payment Advisory Committee (PPAC) meeting. Paul Rudolf, MD, JD, in charge of the Aspen Project had reassured specialty society representatives that practicing physicians would be a part of the development of clinical vignettes and would participate in pilot testing. However, efforts by the Academy to be included in the Aspen Project were rejected.

In June, thirty-nine medical specialty societies “signed-on” to an American Medical Association letter to Thomas A. Scully, Administrator, of the Centers for Medicare and Medicaid Services (CMS) strongly urging that CMS:

“take the next year to re-examine the imposition on physicians of burdensome evaluation and management (E&M) documentation guidelines, as well as its commitment to the development of “clinical examples.” Our organizations and CMS have spent considerable time and effort attempting to determine what constitutes adequate documentation guidelines, yet little progress has resulted... The development of clinical examples by CMS and its contractor, Aspen Systems are seriously flawed and need to be scrapped. Today, more than sixty percent of physicians continue to regard Medicare’s documentation guidelines as the major paperwork burden originating from CMS.”

New Regulatory Task Force on Coding/Documentation of Services

In follow-up to the AMA letter, Grissom advised that Secretary Thompson will shortly announce several new regulatory task forces — one of which will specifically address concerns on the E&M Guidelines. CMS will ask for participation and representation from all interested medical societies. The goal of the new task force will be to resolve chronic problems with coding and documentation to ensure correct compensation and reimbursement of physician services.

More on Correct Coding Initiative

The only sure way to know which code(s) should be appended with modifier –59 is to have a copy of the Correct Coding Initiative (CCI). The CCI listing gives indicators which directs the Medicare carrier on the use of modifier –59. The indicators and their definition are:

- 0 – modifier is not accepted and if used will not bypass the edit
- 1 – modifier is allowed and will bypass the edit
- 9 – modifier is not specified; (created so no blank space would be in indicator field).

The following modifiers when appended to codes will bypass the CCI edits:

E-1 – E4, FA, F1 – F 9, TA, T1-T9, LT, RT, -25, -58, -59, -78, -79, -LC, -LD, -RC, and -91.

Read the descriptor for each of these modifiers in the modifier section of your CPT book.

Modifier –59 is **never** used with the evaluation and management (E/M) services CPT 99201-99499. Nor is it ever used with CPT 77427.

Modifier –59 was established because a carrier may not be able to identify the services performed as separate services. By using the modifier –59, the carrier will know that the procedure reported was a distinct, separate service on the same date of service by the same physician.

For example, a destruction of a malignant lesion performed on the same date by the same physician as an excision of a malignant lesion. The carrier needs to know that these procedures were performed on separate lesions, thus a modifier is necessary. According to the Medicare Carrier’s Manual directions, **if** location modifiers are used, these would bypass the edit. However, modifier –59 appended to the appropriate code according to the CCI listing would also bypass the edit.

If you have appealed claims because of a denial due to CCI, the carrier will not change the initial determination if the modifier indicator is “0”. However, if the reviewer determines that the use of a modifier appended to either code would have been appropriate, the reviewer may change the initial determination only **if** the modifier indicator is “1”.

The Medicare Carrier Manual Part 3 was updated regarding the Correct Coding Initiative with Transmittal #1703, dated May 4, 2001. You may access this transmittal at (http://www.hcfa.gov/pubforms/14_car/3btoc.htm). This transmittal can be viewed and printed without having to download the whole manual.

HCPCS changes for 2002

Program Memorandum B-01-30 was issued in April regarding HCPCS codes. The effective date of this memorandum is January 1, 2002. The changes affect codes that providers bill to Medicare to obtain denials for non-covered items and services in order to submit to the secondary payer. You may read it in its entirety at:

<http://www.hcfa.gov/pubforms/transmit/B0130.pdf>

Modifier GX – Service not covered by Medicare will be **deleted**. Some carriers have been requiring the use of this modifier, while others haven't recognized it.

HCPCS Code A9270 – Non-covered item or service remains a valid code, however, the status is being changed to "not valid for Medicare". This is a status only change as this code has not and will not be reimbursed by Medicare.

Added codes are:

Q3015 – item or service statutorily non-covered, including benefit category exclusion, (used only when no specific procedure code available)

Q3016 – item or service not reasonable and necessary, (used only when no specific procedure code available)

If specific codes are available in either situation, they must be used. The new codes, Q3015 and Q3016 are used only when specific codes are not available.

Added modifiers are:

GY – Item or service statutorily non-covered

GZ – Item or service not reasonable and necessary

When a specific code is available, one of the above modifiers would be added to the code in the appropriate situation. These modifiers inform Medicare that the provider is aware that the item or service is: 1) statutorily non-covered, or 2) not reasonable and necessary.

Information to explain why items or services are being submitted must be reported. An example of explanation would be, "Claim submitted to received denial for secondary payer."

The use of the GA modifier is necessary when reporting Q3016 or GZ modifier. The GA modifier tells that carrier that you have had the beneficiary sign a waiver of liability, and that statement is in the patient's medical record.

The carriers are directed by this program memorandum to publish a reminder regarding these HCPCS changes in the last bulletin in 2001. Thorough reading of your carrier publications is critical. They should be read by all staff who are involved in coding and reimbursement.

Do remember that if a service or an item is statutorily excluded, (i.e., a non-covered service such as a cosmetic service), from the Medicare program, it need not be submitted to Medicare. However, if you submit the service be sure you follow the correct coding as stated in this article.

Medicare Offers Electronic Reimbursement

Although most physicians and other healthcare providers submit Medicare claims electronically, the percentage of those who **receive** Medicare reimbursement electronically is substantially smaller. The Center for Medicare and Medicaid Services (CMS) advises that whether you are a dermatologist with a solo practice or the CFO of a large community hospital, all registered Medicare providers may apply for electronic funds transfer (EFT). Even participating providers who still submit paper claims may be reimbursed electronically.

Electronic Funds Transfer (EFT) is a form of direct deposit that allows the transfer of Medicare payments directly from a Medicare contractor's bank to a provider's bank account. EFT is similar to other direct deposit operations such as paycheck deposits and offers a safe, modern alternative to paper checks.

EFT Advantages

Signing up for Medicare EFT can:

- Reduce the amount of paper in your office
- Save staff time and the hassle of going to your bank to deposit Medicare checks
- Eliminate the risk of your Medicare paper checks being lost or stolen in the mail
- Access your money faster. Many banks credit direct deposits within 2 days of payment

Signing up for EFT

If you are already enrolled as a participating Medicare provider, simply contact your Medicare carrier provider relations department for an EFT enrollment form. Any additional qualifications and terms will be detailed by your Medicare contractor. Your Medicare contractor will handle the rest. In as little as 2 weeks, you could be receiving your Medicare payments hassle-free, via EFT.

If you are not currently a Medicare provider but are considering joining the program, effective July 1, 2001, all Medicare contractors will include an EFT authorization form in the Medicare enrollment package. Additional information about EFT will be posted on www.hcfa.gov.

News Briefs

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CMS Conclusions

Individual clinical decisions regarding the routine removal of AK are supportable via the review of the medical evidence. There is a consensus that immunosuppressed individuals, people with a prior history of skin cancer, and people with AKs of the lips, nose, ear or eyelid are at increased risk of developing SCC. The available scientific evidence does not allow for the identification of additional lesion and/or patient characteristics that would place individuals at a higher risk of developing invasive SCC.

Patient's Name: _____ Medicare # (HICN): _____

ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these health care items or services.

We expect that Medicare will not pay for the item(s) or service(s) that are described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, **Medicare probably will not pay for –**

Items or Services:

Because:

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully.**

- Ask us to explain, if you don't understand why Medicare probably won't pay.
- Ask us how much these items or services will cost you (**Estimated Cost: \$ _____**), in case you have to pay for them yourself or through other insurance.

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **SIGN & DATE** YOUR CHOICE.

Option 1. YES. I want to receive these items or services.

I understand that Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare. I understand that you may bill me for items or services and that I may have to pay the bill while Medicare is making its decision. If Medicare does pay, you will refund to me any payments I made to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Medicare's decision.

Option 2. NO. I have decided not to receive these items or services.

I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay.

Date

Signature of patient or person acting on patient's behalf

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

OMB Approval No. 0938-0566 Form No. CMS-R-131-G (June 2001)

Medicare Revises *continued from page 1*
Advance Beneficiary Notice

A dermatologist may notify a beneficiary that Medicare probably will not pay for a cosmetic service or item. If the beneficiary still wants to get that service, the beneficiary will be asked to sign an agreement that the patient will pay for the service if Medicare does not pay for it. The revised form alerts beneficiaries they need to decide whether they want to receive medical items or services which may not be reimbursable by Medicare.

A major objection to the prior ABN was the tone of its language which seemed to imply that the physician was suggesting medically unnecessary services. The new form clarifies to the beneficiary that:

“Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, Medicare probably will not pay” for the item or service.

The form also advises the beneficiary to ask for a further explanation if it is unclear why Medicare probably will not pay and to check how much the item or service will cost, either out-of-pocket or through other insurance. The beneficiary then is asked to check one of two options, and sign and date the form.

Coding Update *continued from page 3*

The example given discusses venipuncture performed in the office. In addition to coding for the venipuncture, “99000 should be reported when the physician’s office centrifuges the specimen, separates the serum and labels, and packages the specimens for transport to the laboratory.”

Medicare does not pay for this code as it is classified as a bundled service. However, this code is reimbursable by many of the insurance companies.

Order Coding Books Now

CPT 2002 will contain more than 700 code changes. Also included will be the new Category II and Category III codes. The Category II codes are for performance measurement. The Category III codes are for emerging technologies.

As performance measurements, CPT Category II codes will be identified by a 5-digit number with the letter in the last position. These codes are optional use codes and will not be assigned physician work value. They are not required for correct coding.

As emerging technologies, CPT Category III codes are used only for data collection purposes on assessing new procedures and services. These codes will likewise be alphanumeric with the letter in the last position. The additional instructions in the 2002 CPT book will guide you in the use of these two new code sets.



American Academy of Dermatology
P.O. Box 4014
Schaumburg IL 60168-4014

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