DERM CODING CONSULT

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newsbriefs

AAD/NPF Phototherapy Presentation

At the January AMA/Practice Expense Advisory meeting, Mark Lebwohl, M.D., Chair of the AAD Psoriasis Task Force, Daniel M. Siegel, M.D., co-chair of the AAD/RBRVS Task Force and Gail Zimmerman, Executive Director of the National Psoriasis Foundation presented updated clinical labor time, medical supplies and medical equipment for phototherapy services. The presentation was based on the survey response data supplied to the Academy by over thirty-five dermatology practices providing phototherapy services. The results of the presentation await review by the AMA/RBRVS Committee and its recommendations to HCFA for changes to the reimbursement rate in the 2002 Medicare Physician Fee Schedule.

Bush Reg Freeze May Impact HIPAA Regs

As it's first act, the new Bush Administration issued Executive Orders to all Executive Branch departments putting any regulation of the outgoing Clinton administration on hold for review. The order covers any final regulation published on or after December 1, 2000 that was not implemented in December. Caught in the regulatory freeze are the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Confidentiality regulations. As originally published, these regs must be implemented by February 26, 2003. At minimum, the Bush Executive Order will delay any implementation a minimum of thirty days to sixty days, allowing the incoming Cabinet and department heads to review the impact of the regulation against the new Administration's agenda. Those regulations that are required by law to be published before a specific date may be exempt from the Executive Order, but it's unclear if the HIPAA Regs will be exempted.

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correct coding initiative

Paul Rudolf, M.D., Medical Officer/HCFA, announced during a recent HCFA National Specialty Society Conference call that Carriers have been instructed to place Version 6.3 of the Correct Coding Initiative (CCI) on an indefinite hold. However, to date we have not seen a HCFA program memorandum on this issue. This version of CCI includes a number of edits that bundled sixty-six E&M codes as well as CPT 92002-92014 into over 800 surgical procedures with XXX global as of October 30, 2000. The CCI edits require the use of the –25 Modifier with certain E&M codes billed at the same time as a procedure with an XXX global period, e.g., 99211 and 96910. Per Rudolf, the same edits were also contained in CCI version 7.0. All of the affected edits are suspended as of January 26, 2001 and the suspension is retroactive to October 30, 2000.

Although this edit package had received a preliminary review by the AMA Correct Coding Policy Committee (CCPC), the edit package was distributed to the Medicare carriers for installation without sufficient notice regarding these edits to either the Carriers or to the Medicare providers. Most carriers installed the edits as required by October 30th. HCFA is reviewing the edits and a number of them may be re-installed, but no earlier than July 1, 2001.

This suspension does not affect:

1) any edits involving E&M services that were implemented prior to October 30, 2000 in earlier versions of CCI, or

2) any other edits involving E&M services implemented in versions 6.3 or 7.0.

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Derm Coding Consult is funded by an educational grant from the Dermatology Products Division of Schering Pharmaceuticals.

letter from the editor

Dear *Derm Coding Consult* Reader:

Please keep me posted on any carrier or insurer local medical review (LMRP) policy changes to either benign lesion or actinic keratoses (AK) treatment and billing policies. We have received reports of payers disallowing services for the removal of AK's because these are not clearly identified on the ICD-9-CM code list related to the CPT 1700X policy. The Academy will continue to pursue a National Coverage Policy Decision from HCFA for Medicare payment policy for treatment of AK's. In the mean time, dermatologists, with the assistance of their DERMCAC representatives and state dermatology societies, are pressing to clarify these issues with Carrier and insurer Medical Directors.

The U.S. Senate approved without much dissension, the nomination of ex-Wisconsin Governor Tommy Thompson as the new Secretary of the Department of Health and Human Services. He has an extremely successful track record on health and welfare issues in Wisconsin. At press time, the list of potential candidates for the new Administrator of the Health Care Financing Administration is getting longer without a clear front-runner.

Take a moment to review your own coding patterns in comparison to the latest update to the twenty-five top dermatology codes compiled from HCFA 1999 Part B claims data. While there are certainly no surprises on the surgical codes, there are some interesting variants between dermatology and national array of Evaluation and Management codes. Please complete the short E&M code survey on Page 8 and fax it back to us by April 5th and we will share the results with you in the June issue.

Looking forward to seeing you at the Annual Meeting in Washington D.C.!!

Best regards,

Norma L. Border, Editor

cpt 2001 update

New vs. Established Patient

In the 2001 AMA/CPT, text has been added to the Evaluation and Management (E/M) Services Guidelines that clarifies the definition of a new patient. The revised text now reads:

> "Solely for the purposes of distinguishing between new and established patients, **professional services** are those face-to-face services rendered by a physician and reported by a specific CPT code(s)."

A new patient is further defined as a patient *who has not received professional services within the past three years from the physician* or a physician of the same specialty within the group practice. Previously AMA/CPT had defined a new patient as a patient who had not received *any* professional services for the past three years.

AMA/CPT has also clarified the issue of whether or not an E&M service can be billed as a new vs established patient in those instances where one physician is covering for another physician. CPT 2001 now states that the service provided by the covering physician would be reported the same as if the service was provided by the physician who was not available.

The March 2000 issue of *Derm Coding Consult* included a Q&A regarding a new patient. The previous definition indicated that the refilling of a prescription was considered a service. Therefore, the addition of this new "face-to-face" definition clarifies that telephone prescription refills do not affect the distinction of new vs. established patient in reporting evaluation and management services.

HCFA definition of new patient

In the HCFA Transmittal 1690 of January 5, 2001 for the Medicare Carriers Manual, HCFA states that a new patient means a patient who has not received any professional services from the physician within the previous 3 years. HCFA further directs that if a professional component of a previous procedure is billed within the 3 years, but that **no** evaluation and management service is provided, the patient remains a new patient. The transmittal states, "An interpretation of a diagnostic test, …, in the absence of an evaluation and management service does not affect the designation of a new patient."

Address Correspondence to either:
James A. Zalla, M.D., or Ronald L. Moy, M.D.
Chair, 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 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

newsbriefs

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Of primary concern to dermatologists are the HIPAA regulation's security requirements. It makes it the responsibility of health care providers entrusted with individual health information to protect it against deliberate or inadvertent misuse or disclosure. The final regulation requires every health care provider to establish clear internal procedures to routinely protect patients' privacy, including designating a specific individual to establish and monitor the health care provider's privacy practices and related employee training. The Department of Health and Human Services has expanded the definition of "protected health information (PHI)" to include ALL health information – paper, electronic and oral.

William Braithewaite, M.D., the DHHS Senior Advisor of Health Information will bring AAD members up to date on HIPAA and HCFA implementation steps. Dr. Braithewaite will be making presentations during the Annual Meeting in Washington, D.C. to the DERMCAC meeting, Young Physicians forum, and the Residents Fellows Committee meeting. HCFA will also be posting up-to-date information on their new HIPAA OnLine information at the following web site, http://hipaa.hcfa.gov.

US/SBA Defines "Small" Health Care Providers

As of December 18, 2000, the U.S. Small Business Administration has increased the parameters for its definition of a "small" health care business to make it easier for various categories of providers, including physicians, to participate in government procurement, government contracts as well as the Small Business Administration assistance and loan services. Information on the full range of US/SBA services is available at http://www.sba.gov/

The increase is the result of a US/SBA review of the current economic characteristics of health care industry firms. The agency adopted a revenue standard of $7.5M for outpatient facilities, physician offices and clinics. This is an increase of $2.5M and the increase will benefit over 5000 small health provider businesses. This move by the US/SBA is in sharp contrast to the DHHS/Office of Inspector General's reluctance to clarify or quantify the definition of "small" as it applies to the OIG Individual and Small Practice Compliance Guidelines in their October 5, 2000 regulation for the voluntary program.

Please thank your Schering-Plough representative for sponsorship of *Derm Coding Consult.*

correct coding initiative

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Per Dr. Rudolf any claims submitted and denied as a result of this edit package may be submitted as appeals to the Carrier for re-adjudication. Carriers will not automatically reprocess claims denied as a result of these CCI edits.

Dermatologists should review any claims that have been denied based upon these edits. The Explanation of Medicare Benefits (EOMB) may say: "…service denied/reduced because this procedure is not paid separately" or "Payment is included in another service received on the same day." If the denied E&M service meets the criteria for "significant and separately identifiable," the claims should be resubmitted for adjustment to the carrier with the –25 Modifier on the E&M service code. Although the –25 Modifier will not be required by HCFA at this time, appending it in these situations is correct.

HCFA will be working with the American Medical Association and other medical specialty societies to educate physicians on appending the –25 Modifier to E&M codes when billing with surgical procedures performed on the same day that have an XXX global period, i.e., the global period concept does not apply. HCFA is re-evaluating this edit package and it will not be re-installed until there is sufficient notice and education of carriers and providers. This would be no sooner than July, 2001.

HCFA is developing an educational program that will include guidance to carriers and direct them to publish information regarding these edits in their provider bulletins. HCFA also announced intentions to develop a National Policy Decision clarifying that the same diagnostic or ICD code may be billed for an E&M and another procedure for the same patient on the same day of service.

phototherapy thank you

Thank you to everyone who responded to the phototherapy survey on CPT codes 96910, 96912 and 96913. It is long and extremely detailed as required by the AMA Practice Expense Advisory Committee. The AAD and National Psoriasis Foundation (NPF) presenters , Mark Lebwohl, M.D., and Gail Zimmerman, Executive Director of NPF, are deeply appreciative of the generosity of dermatologists and their phototherapy staff in researching and providing this information.

The availability of this solid practice-based information on clinical staff time, extensive supplies and updated phototherapy equipment were invaluable in preparing and presenting this information at the February AMA/PEAC meeting. Similar practice expense surveys will be distributed this Spring for validation of key integumentary procedures.

Pathology Issue Recap

Derm Coding Consult, September 2000 article **Coding for Pathology Services** included the following paragraph:

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

A number of AAD members were concerned over use of the phrase "must be dictated." In the December 2000 issue, we alerted members that we would provide additional information and further clarification regarding the **Medicare** requirements on reporting pathology results.

We discovered that Medicare carriers vary in their statements on surgical pathology. Some carriers have established local medical review policies (LMRP), some provide operational statements and some have issued educational material relating to surgical pathology.

Specific Carrier Policies

The Nevada Medicare News Bulletin (September, 1998) states: "Pathology reports should substantiate that the specimen examined was one included under the reported procedure code. Since the unit of service for each code is the actual specimen, there should be a separate report in your records for each specimen."

First Coast Service Options Inc., the Medicare carrier for Florida, has issued a Medical Policy Procedure that states the following under Documentation Requirements: "In the event of a post-payment review request, documentation should include a pathology report reflecting the procedure performed."

In addition, Palmetto GBA, the South Carolina carrier, aside from the documentation issue, has a separate Dermatopathology policy. This policy states that when an independent laboratory furnishes both the technical and professional component, the laboratory—not the dermatologist—would bill the global service.

It is important for dermatology practices to know exactly what the Medicare carrier's policies are regarding pathology reporting and/or documentation requirements. The carrier Web site should have a listing of these Medical Review Policies. However, all the published local medical review policies for all Medicare carriers are now listed in a searchable format at the HCFA-sponsored Web site www.lmrp.net.

We also asked two dermatopathologists, Clay Cockerell, M.D. and Thomas G. Olsen, M.D. for their comments.

"In clarifying the phrase, 'must be dictated'", Dr. Cockerell said, "this really means that there must be some record that complies with the local carrier regulations. It [the report] does not have to be 'dictated' per se, but simply created either by a computer generated software package, typing, or written notes."

Dr. Olsen stated: "For a dermatologist reading his/her own slides (performing the professional component of CPT 88304/88305), the following two requirements must be met:

1. CLIA approval as a high complexity laboratory;
2. Must have pathology report or record (written or dictated) of pathology reading which includes but not limited to: patient name, accession number, anatomical site, date of reading, and diagnosis in the medical record."

Dr. Olsen also reiterated the importance of knowing the requirements of the carriers.

Please note that the AAD *Model Dermatology Compliance Program* contains specific elements on survey and monitoring tools that are required for documentation. These elements are identified by an asterisk in the manual. The question, "Is the pathology report documented and present in the medical record" is preceded by an asterisk and appears in relation to the biopsy, excision, shave, and malignant destruction codes. This is also applicable for adjacent tissue transfers, grafts and Mohs codes.

medicare & you 2001

Did you know ... **Medicare & You 2001**, HCFA's annual beneficiary education booklet, received the Vice President's Plain Language Award on January 5, 2001? This award recognizes federal employees who write regulations and government documents in plain language that is easy to understand. **Medicare & You** has an easy-to-read design and layout, readable type, lots of white space, uses active voice, short sentences, lists, charts and common, everyday words except for necessary technical terms.

Limited supplies of **Medicare & You 2001 - Physician Edition** copies are still available from HCFA. To request up to 25 copies, call 1-800-MEDICARE. To request more than 25 copies, fax your request with quantity and shipping address to HCFA at 410-786-1905.

Visit the
AAD Resource Center!
Booth 1769

new prompt payment regs from dol

The Department of Labor (DOL), at Clinton White House direction, released new Employee Retirement Income Security Act (ERISA) regulations for the administration and enforcement of claims processing, appeals procedures and prompt payment for all employer group health plans (EGHP). It will require major health insurers or managed care organizations administering EGHP's to comply with these new regulations. However, DOL does not have the authority to "regulate" prompt payment and these regs do not replace or supercede State prompt payment legislation.

While Patient Bill of Rights legislation languished in Congress, the issuance of these new regulations is a strong step in the right direction. Major insurers or managed care organizations who administer ERISA plans will be required to:

1. make faster decisions on initial claims within thirty days and appealed claims within ninety days;
2. abide by special "72 hour" rules for expedited review of "urgent care" claims;
3. extend the time periods for patients to appeal denied claims to 180 days;
4. designate different reviewers for handling of appeals;
5. consult with relevant health professionals on claims appeals requiring medical decision making;
6. allow enforcement of claimants rights through the courts;
7. facilitate timely action by insurers on "concurrent care reviews" for patients receiving a course of treatment who face early termination of benefits or have need of extended care;
8. fully disclose coverage parameters, including a full disclosure of the plan's claim processing and medical review procedures; and
9. provide more information about the reasons for a denied claim and the criteria and rules applied by the plan in making the denial determination.

The new provisions will be applicable for claims filed under an ERISA plan on or after January 1, 2002. The regulation was published on November 21, 2000 and is not included under the Executive Order signed by President Bush on January 20, 2001, placing a sixty-day delay on all other DHHS regulatory implementation dates.

cpt 2001 errata issued - mohs

AMA has issued a listing of errors that occurred in its initial publication of *CPT 2001*. The listing includes an errata for CPT 17304, Mohs Micrographic Surgery. CPT 17304 was omitted inadvertently from Appendix F. Appendix F lists those codes that are exempt from Modifier –51 but are not specifically designated as Add-on codes. Please note that the other Mohs codes **are** included in Appendix F. This omission to Appendix F will be corrected in *CPT 2002*.

cpt coding system as hipaa national standard

The Department of Health and Human Services (DHHS) selected the AMA/Current Procedure Terminology (CPT) as the standard code set for reporting health care services in electronic transactions. DHHS is committed to working with the medical societies and health care industry to eliminate local codes required by payers and transition all participants to the national standards.

The HIPAA Electronic Standards final rule names CPT *with all its codes and modifiers* as well as the HCFA Common Procedure Coding System (HCPCS) as the code set for: physician services, physical and occupational therapy services, radiological procedures, clinical laboratory tests, other medical diagnostic procedures, hearing and vision services, as well as transportation services including ambulances.

HIPAA requires that by January 1, 2003 any insurer receiving or transmitting health information electronically must accept the HIPAA standard formats and standard code sets or face non-compliance penalties.

medicare update

Top Dermatology Codes

The top dermatology services, ranked in order of frequency, listed below are derived from the HCFA Part B Extract and Summary System (BESS) data released in 2000 based on 1999 data. The frequency ranking of the integumentary surgical codes is not a surprise to dermatologists. However, the relative office visit (Evaluation and Management) frequency ranking for dermatologists differs significantly from the frequency ranking for these same services as reported by all specialties.

Evaluation and management services are determined by the levels of history, physical examination and medical decision making provided and documented in the patient medical record. (See related article in the September issue of *Derm Coding Consult*.)

To determine whether or not your dermatology practice procedures and office visits are comparable to the national and dermatology billing frequencies, consider doing a simple tally on the submission of these codes to Medicare (or to all payers) from your practice for a month. (See survey on page 8.)

The physician work RVUs are listed for each code. However, note that total non-facility RVUs are derived from the total of physician work RVUs, practice expense RVUs, and malpractice RVUs. (See related article on page 7.)

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top derm codes by frequency from 1999 medicare bess data

Rank	CPT Code	# billed by Derms	% of total # billed	Descriptor	Phys Work RVU
1	17003	9,324,657	91.75	Destruction, benign or pre-malignant lesion (any method), 2-14 lesions, each	0.15
2	17000	3,061,971	83.40	Destruction, benign or pre-malignant lesion (any method), 1st lesion	0.60
3	99212	2,215,983	7.60	Office visit, established patient	0.45
4	99213	1,930,708	2.18	Office visit, established patient	0.67
5	88305	1,692,478	15.05	Surgical pathology, level IV, gross and microscopic examination	0.75
6	11100	1,145,475	88.43	Biopsy of skin, single lesion	0.81
7	99202	562,390	19.54	Office visit, new patient	0.88
8	11101	472,108	92.82	Biopsy of skin, each addtl. lesion	0.41
9	99203	303,249	7.49	Office visit, new patient	1.34
10	17004	256,640	89.54	Destruction, benign or pre-malignant lesion, 15 or more	2.79
11	99214	200,956	0.57	Office visit, established patient	1.10
12	99201	166,434	23.78	Office visit, new patient	0.45
13	17304	154,731	94.23	Mohs surgery, first stage, up to 5 specimens	7.60
14	17281	139,347	94.73	Destruction of malignant lesion, 0.6 to 1.0 cm	1.72
15	99211	129,454	1.47	Office visit, established patient	0.17
16	11301	122,574	83.37	Shaving of epidermal or dermal lesion, trunk arms legs, 0.6 to 1.0 cm	0.85
17	17262	109,078	96.65	Destruction of malignant lesion, 1.1 to 2.0 cm	1.58
18	11311	99,247	82.74	Shaving of epidermal or dermal lesion, face ears eyelids lips, 0.6 to 1.0 cm	1.05
19	17282	91,787	95.30	Destruction of malignant lesion, face ears eyelids lips, 1.1 to 2.0 cm	2.04
20	17261	91,137	95.56	Destruction of malignant lesion, 0.6 to 1.0 cm	1.17
21	17305	87,220	94.11	Mohs surgery, second stage, up to five specimens	2.85
22	11900	80,477	85.63	Injection, intralesional up to 7 lesions	0.52

comparison of national (all) vs. dermatology e&m service frequency ranking

Derm Rank	Natl. Rank	CPT Code	Descriptor	Physician work RVU
1	3	99212	Office visit, established patient	0.94
2	1	99213	Office visit, established patient	1.32
3	7	99202	Office visit, new patient	1.62
4	6	99203	Office visit, new patient	2.39
5	2	99214	Office visit, established patient	2.06
6	10	99201	Office visit, new patient	0.93
7	4	99211	Office visit, established patient	0.52
8	8	99204	Office visit, new patient	3.47
9	5	99215	Office visit, established patient	3.06
10	9	99205	Office visit, new patient	4.38

How the Medicare Fee Schedule Works – 2001

As every dermatologist knows, as of January 2, 1992, Medicare has reimbursed physicians on the basis of a national fee schedule. The Medicare allowed charge for physician services is the **lower** of the actual charge or the fee schedule amount. Medicare reimburses the following services on a fee schedule basis:

- Professional services (including attending physician's services furnished in teaching settings) of doctors of medicine and osteopathy, doctors of optometry, podiatry, dental surgery, dental medicine and chiropractors;
- Non-physician practitioner services including those provided by a nurse practitioner, physician assistant and a clinical nurse specialist with respect to services they are authorized to furnish under state law as of January 1, 1998;
- Supplies and services covered incident to physician's services other than drugs covered as incident to such services;
- Physical and occupational therapy furnished by therapists in independent practice;
- Diagnostic tests other than clinical laboratory tests;
- Radiology services; and
- Monthly capitation payment (MCP) for physician's services associated with continuing medical management of end stage renal disease (ESRD) services.

Computing the Medicare Fee Schedule

The key to understanding Medicare reimbursement is in understanding how the Resource Based/Relative Value System (RB/RVS) formula works. Every service and procedure has a CPT code. Every CPT code has been assigned a set of Relative Value Units (RVUs) to reflect the resource or value of physician work, practice expense and malpractice expense associated with providing that service. New CPT codes and recommendations of revised RVUs for existing CPT codes are presented on an ongoing basis to HCFA and to the American Medical Association committees charged with this responsibility.

The Medicare Fee Schedule amount is calculated for each procedure or service based on the following:

RVUw = a relative value for physician work;
RVUpe = a relative value for practice expense (clinical labor, supplies, and medical equipment);
RVUm = a relative value for malpractice premium expense.

For each of the relative value categories above, there is also a geographic practice cost index (GPCI, pronounced "gypsy") that is applied to adjust the RVU's to reflect specific payment localities. The Medicare Fee Schedule amount you receive in payment for a specific service from your local Medicare carrier differs from the national fee schedule because of the impact of the cumulative GPCI's in your area for each of the following:

GPCIw = physician work;
GPCIpe = practice expense, and
GPCIm = malpractice expense.

The calculation formula for the Medicare Fee schedule is:

[(RVUw x GPCIw) + (RVUpe x GPCIpe) + (RVUm x GPCIm)] x CF = MFS Amount

Translating MFS Formula to Dollars

The Conversion Factor (CF) is the dollar figure that converts the formula into a fee. The CF was established by the initial Medicare Fee Schedule legislation and is subject to annual adjustment based on a number of economic indices. The CF for the Medicare Fee Schedule is released by HCFA each November when the final rule is published. The Conversion Factor has risen from $31.001 in 1992 to $38.2581 for 2001.

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.

Impact of BBA Transition on MFS

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 at the close of the BBA transition period, the Medicare Fee Schedule will be 100% RVU based for all factors: physician work, practice expense and malpractice.

Making Changes to RB/RVS

Recommendations for changes to the physician work RVUw are presented by medical specialty societies to the AMA/Specialty Society RBRVS Update Committee (RUC) at their quarterly meetings. Recommendations for changes to the practice expense RVUpe are presented by medical specialty societies to the AMA/Practice Expense Advisory Committee (PEAC) at their quarterly meetings. Recommendations accepted by the AMA/RUC – PEAC Committees are submitted to HCFA in July of each year as comment to the Proposed Rule for the Medicare Fee Schedule for the next calendar year. The American Academy of Dermatology has representation on each of these committees. The Academy representatives have successfully submitted data to the PEAC supporting increased RVUpe values for phototherapy services. In addition, the RVUpe values for over fifty integumentary codes are being presented for validation at future PEAC meetings.

evaluation and management coding survey

Please respond to the following questions regarding the coding of Evaluation and Management (E&M) office visit services in your practice:

1. Who assigns the level of evaluation and management code?

_____ Dermatologist
_____ Registered Nurse
_____ Licensed Practical Nurse
_____ Medical Assistant
_____ Coder; Certified _____ Y ____ N
_____ Certified by whom _____
_____ Billing service
_____ Other, please specify _____

2. How is the level of service determined?

_____ Use of a template
_____ Knowledge of coding
_____ Reference text, Please specify _____
_____ Other, please specify _____

3. The total E/M services you provided in December 2000 _____
How many were provided at each level?

New Patient		Established Patient		Consult Office		Consult Hospital	
99201	_____	99211	_____	99241	_____	99251	_____
99202	_____	99212	_____	99242	_____	99252	_____
99203	_____	99213	_____	99243	_____	99253	_____
99204	_____	99214	_____	99244	_____	99254	_____
99205	_____	99215	_____	99245	_____	99255	_____

Please fax back your response by 4/05/01 to: Vernell St. John at (847) 330-1120.

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