

DERM CODING CONSULT



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News Briefs

NY Carrier Updates Benign Lesion LMRP

After intensive effort by New York dermatologists, Medicare carrier Empire Blue Cross and Blue Shield announced at the New York State Society of Dermatology Annual meeting on May 10th, that the local medical review policy (LMRP) for benign lesions has been revised. Congratulations to the New York State Society of Dermatology as well as DERMCAC Representative, Herbert Hochman, MD and Carl Leichter, MD for their success in resolving the numerous problems with the Empire LMRP.

The revised LMRP no longer includes actinic keratoses under benign lesions. In addition, it permits treatment of symptomatic benign lesions for all those previously listed as well as the following additional ICD-9-CM codes: 216.0-216.9, 238.2 as well as 455.9, 701.9, 744.1 and 757.39. The list of recognized CPT procedures for treatment of symptomatic benign lesions has also been expanded to include CPT 11200, 11201, 17106, 17107, 17108. However, CPT 11055, 11056 and 11057 have been deleted. The revised policy is effective as of April 30, 2001. The revised LMRP is available on the Medicare Carrier web site at www.empiremedicare.com.

New Advanced Beneficiary Notice

HCFA has requested comment on a revised and simplified "Advance Beneficiary Notice (ABN)." The ABN is one of the Medicare regulatory requirements identified by dermatologists as creating rather than resolving problems when providing a cosmetic or non-covered service. ABN's are required whenever a service will likely not be paid by Medicare. Beneficiaries find the current wording confusing and dermatologists often find it offensive.

The new one page form is designed to be more readable and easier to understand. The notice includes the following proposed draft wording "Medicare does not pay for all of your health care costs...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 service}. The form also allows beneficiaries to simply mark yes or no to indicate whether or not they still want the service and then sign and date the form.

OIG Medicare Audit Report

The annual level of improper Medicare payments has dropped by almost fifty percent since 1996 according to the audit report issued by The Office of the Inspector General (OIG) for the Department of Health and Human Services (DHHS). Acting DHHS Inspector General Michael Mangano commented that 93 percent of all Medicare payments are error-free. Based on statistical samples, OIG estimates improper Medicare benefits totaled \$11.9 billion, or 6.8 percent of the \$713.6 billion in Medicare fee-for-service payments. These payments range from inadvertent mistakes to outright fraud. OIG commended the Health Care Financing Administration for closely monitoring the Medicare program and instituting corrective actions. Mangano has called for "continued vigilance...to ensure that providers maintain adequate documentation supporting billed services, bill only for services that are medically necessary, and properly code claims." However, Mangano wanted to reassure physicians that the OIG "is not targeting honest providers who make honest mistakes."

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Letter from the Editor

Dear *Derm Coding Consult* Reader:

The new Health Care Financing Administration Evaluation and Management Draft Guidelines (EMDG) project is still moving along...slowly. HCFA and the Aspen Systems team are no longer developing clinical vignettes to ensure comparability of claims review but are now compiling "examples." The latest project report suggests HCFA will begin some kind of pilot testing by fall. HCFA has also announced its intention to open the project at a later point to comment from those specialties not included in the initial phase.

I'm glad you all enjoyed the information on usage levels for Evaluation and Management Codes from the HCFA Part B Extract and Summary System (BESS) 1999 data, especially the comparison of office visit levels with other specialty societies. I received almost a hundred responses to the mini-survey on page 8. As promised, we've arrayed the data you provided on office visit levels of service for December 2000 in this issue.

The Academy successfully presented over thirty integumentary codes for validation of practice expense data at the AMA Practice Expense Advisory Committee (PEAC) meeting in March. The aging Clinical Practice Expert Panel (CPEP) data has been reviewed and in many cases, now reflects new standard supply packages as well as re-affirming clinical labor requirements. We will be defending the destruction code series, CPT 17XXX at the August meeting of the PEAC in Chicago.

If you receive an American Medical Association/Specialty Society RVS Update Committee DIRECT PRACTICE EXPENSE RVS Update Survey from the Academy, please read the instructions carefully and respond as quickly as possible. Each response, and yours in particular, is important to the continued success of the Academy's practice expense validation efforts. It is the best way to ensure that dermatology retains the almost twenty percent gains over the last four years in practice expense relative value units under the Medicare RBRVS system.

Best regards,



Norma L. Border, Editor

Local Medical Review Policies

Why are local medical review policies (LMRP) important to you? Carrier reimbursement hinges on what is contained in an LMRP. A claim may be denied because the diagnosis reported was not one that was listed as a covered diagnosis in the LMRP. Similarly, the documentation in the medical record must meet the criteria specified in the LMRP for establishing medical necessity for the procedure reported.

The following are examples of LMRPs:

- Actinic Keratosis
- Destruction of Benign Skin Lesions
- Destruction of Cutaneous Vascular Lesions
- Destruction of Malignant Lesions
- Mohs Micrographic Surgery
- Photochemotherapy, Psoralens, and Ultraviolet A
- Removal of Benign or Premalignant Skin Lesions
- Removal of Benign Skin Lesions
- Routine Foot Care
- Skin Grafting
- Skin Procedures for Hyperkeratosis
- Treatment of Psoriasis
- Ultraviolet Light Therapy

When a claim is denied, it is important to read the message on the Explanation of Medical Benefits (EOMB) as to why the denial. The denial may have occurred simply because of the lack of the appropriate modifier. However, it may have occurred due to an LMRP that states that the reported diagnosis was not a covered diagnosis for the procedure reported.

Local Medical Review Policies as well as the draft policies may be found on the Medicare carrier Web sites. Comparisons can be made of LMRPs of other carriers as all the LMRPs are found on the Web (www.lmrp.net). There is always a comment period before a draft policy becomes effective. It is important to monitor those draft policies and submit appropriate comments.

Should you have concerns regarding any of your Carrier's LMRPs, contact the Dermatology Representative to the Medicare Carrier Advisory Committee (DERMCAC) in your state. The DERMCAC's were listed in the September 1999 issue of *Derm Coding Consult*, with an update to the list in the September 2000 issue.

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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 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.aad.org/coding.html OR www.aadassociation.org/coding.html

E & M CODING SURVEY RESULTS

Thanks to all of you who responded to the Evaluation and Management Coding Survey that appeared on Page 8 of the March 2001 issue of *Derm Coding Consult*. The survey asked the following questions: 1) Who assigns the level of evaluation and management code? 2) How is the level of evaluation and management service determined? and 3) For the month of December 2000, indicate the number and level of service provided for new patients, established patients, office consultations and hospital consultations. Responses were received from close to 100 practices.

The survey response rate indicates the ongoing level of dermatology interest and concern in Evaluation and Management Coding. Dermatology is a unique specialty that focuses on separate parts of one system, the integumentary system. The current 1994 and 1997 E&M Documentation guidelines as well as the draft HCFA guidelines are more reflective of other specialties that focus on one or more body systems.

CPT 2001 Appendix D contains 40 vignettes for dermatology that reflect a dermatologic setting for each level of evaluation and management service recognized by CPT. These vignettes can assist in accurately determining the dermatologic care for all levels of evaluation and management services, that are supported by appropriate documentation.

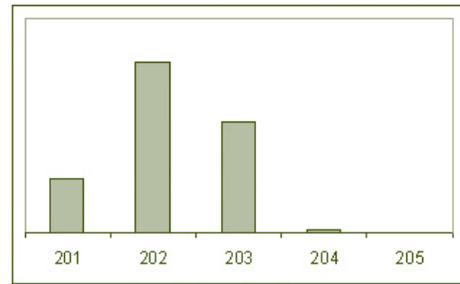
Ninety-four percent (94%) of the survey responses indicated that the level of evaluation and management code is determined or selected based on the physician's knowledge of E&M coding. Six percent (6%) of the survey respondents rely on coding templates for selecting the proper code.

The primary components of an E&M service are: patient history, physical examination, medical decision-making, counseling, coordination of care, and nature of the presenting problem. The first three are considered the key components that contribute to establishing the level of evaluation and management provided by the dermatologist at any given office visit. In establishing the level of an evaluation and management service, time is the last of seven components.

The documentation in the medical record must support the level of E&M service reported. Thus the level of service performed is substantiated by the documentation in the medical record. At this time, either the 1994 or the 1997 Documentation Guidelines are accepted by HCFA. Review the comparison of these guidelines in the September 2000 issue of *Derm Coding Consult* on-line at www.aad.org/coding.html.

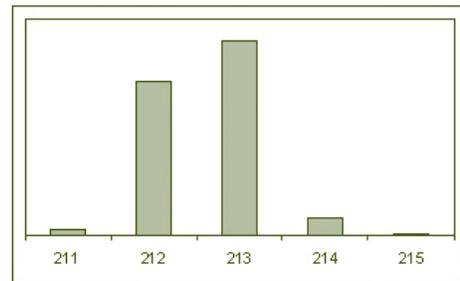
The following four graphs show the levels of service reported according to the survey responses. Each graph represents the code levels reported for that particular evaluation and management code category.

New Patients – CPT 99201 to 99205



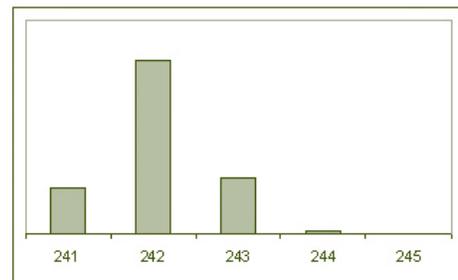
AADA/HPP Derm Coding Consult Survey
Data from December 2000

Established Patients – CPT 99211 to 99215



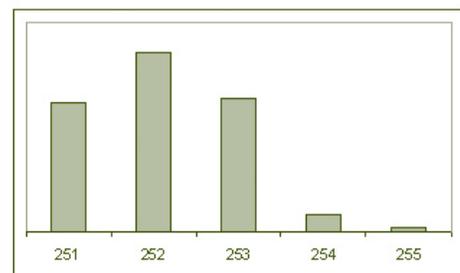
AADA/HPP Derm Coding Consult Survey
Data from December 2000

Consultations, New or Established Patients CPT 99241 to 99245



AADA/HPP Derm Coding Consult Survey
Data from December 2000

Initial In-Patient Consultations CPT 99251 to 99255



AADA/HPP Derm Coding Consult Survey
Data from December 2000

Physician Regulatory Issues Team (PRIT)

In 1998, HCFA's Administrator, Nancy-Ann Min DeParle, initiated the Physicians' Regulatory Issues Team (PRIT) to address the allegations that physicians must understand and comply with an extraordinary number of Medicare regulations. The PRIT – and HCFA – believe that the Medicare program can help to alleviate this feeling. HCFA has pursued the questions from the perspective of practicing physicians – “What are the Medicare requirements that practicing physicians need to know, which do they consider burdensome, and why?” The American Academy of Dermatology submitted comments to PRIT in March 2001.

PRIT has engaged the physician community and identified a number of issues that HCFA believes can be addressed on a “fast-track” basis to improve HCFA's responsiveness to the daily concerns of practicing physicians. AADA is pleased that three of the primary issues for dermatologists are included in the top five most needed quick fixes:

1. National coverage policy for pre-operative evaluations;
2. National coverage policy for follow-up visits for cancer patients;
(This would hopefully address dermatology coding issues for follow-up with malignant melanoma as well as basal and squamous cell carcinoma patients.)
3. Simplifying the Advance Beneficiary Notice (ABN);
4. Revision of the medical necessity form; and
5. Consistent, national guidelines regarding laboratory services.

PRIT learned that physicians do not distinguish among various sources of regulation, such as HCFA, the Office of the Inspector General (OIG), the Department of Justice (DOJ) and others. HCFA has discovered just how difficult it is for physicians to compile and track regulations due to changes caused by Congress and HCFA's decision timelines. Two regulatory areas were recurrently mentioned: Evaluation and Management documentation guidelines, and efforts by HCFA, the OIG, and the DOJ to combat fraud and abuse. These issues have generated a significant sense of both real and perceived burden.

HCFA has assessed physician educational needs. Reports from the Lewin Group and Barents Group, and a pilot study between HCFA's Atlanta Regional Office and First Coast Service Options, indicated that physicians seek better education and training about the Medicare program. HCFA intends to take advantage of new technologies, leverage resources by partnering with other involved parties, and work to produce and distribute pertinent, clear, and consistent educational materials in the most effective way possible. PRIT's suggestions to HCFA: minimize pages and paperwork; create rules that are streamlined, straightforward and well communicated; and balance oversight processes against the importance or precision of each given rule.

Status of Medicare: 2001 Report

Each year the Trustees of the Medicare trust funds report on the funds' current status and their projected condition over the next 75 years. The most significant implication of these findings is that Medicare needs to be reformed and strengthened at the earliest opportunity. The near-term financial condition of Medicare has improved since last year's report, but the program continues to face substantial financial challenges. The long-term financing gap is large, and closing that gap will require innovative solutions that can also present opportunities to strengthen the Medicare program.

Solutions to Medicare's financial problems also provide the opportunity to enhance the quality of medical care by tapping into the tremendous potential for improvements in underlying health care productivity. Medicare costs per enrollee are projected to rise faster than wages and eventually will place larger demands on the Federal budget and beneficiaries.

Although the short-term solvency of Medicare has improved, the most significant change is that health care costs per capita are assumed to increase at a faster rate. This has the effect of substantially raising the long-term cost estimates for both the Medicare Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) programs and represents a more realistic assessment of likely long-term cost growth.

Costs for the Medicare Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) programs combined will grow from 2.3 percent of gross domestic product (GDP) today to 4.5 percent in 2030 and 8.5 percent in 2075. By comparison, total HI and SMI revenues (excluding interest) will only grow from 2.4 percent of GDP today to 3.7 percent in 2030 and 5.3 percent in 2075. Medicare spending is ultimately projected to exceed the costs of Social Security.

The Supplementary Medical Insurance Trust Fund, which pays physician bills and other outpatient expenses, is projected to remain adequately financed into the indefinite future — but only because current law sets financing each year to meet next year's expected costs. Over time, this will require a rapidly growing share of general revenues and substantial increases in beneficiary premiums. The Supplementary Medical Insurance part of Medicare is financed largely by payments from Federal general revenues supplemented by the monthly premiums charged beneficiaries (\$50.00 in 2001).

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

Medicare Coordination of Benefits

The goal of the Medicare Coordination of Benefits (COB) initiative is “to assure that claims are paid right the first time, every time.” HCFA believes that careful focus on COB issues, including Medicare as Secondary Payer (MSP) ensures that both Medicare and health care professionals are providing quality customer service. Good COB practices in the office will streamline the payment process as well as maintain the integrity of the Medicare Trust Funds.

The purpose of the COB/MSP program is to identify all the health benefits available to a Medicare beneficiary and to coordinate the payment process to prevent mistaken payment of Medicare benefits. The COB program involves the collection, management, and reporting of other insurance coverage. Information on eligibility and benefits entitlement is obtained from the HCFA COB central file and is used to facilitate accurate payment. As a participating Medicare physician, your office administration plays a critical role in securing accurate and current health insurance information from your Medicare patients. This assures that payments will be made correctly the first time, minimizing costs and administrative efforts incurred by your staff.

HCFA has assigned COB data collection tasks to the Coordination of Benefits (COB) contractor, who’s responsibility is to consolidate the activities that support the collection, management and reporting of all other health insurance coverage for Medicare beneficiaries. This COB database provides a complete picture of a beneficiary’s eligibility and the availability of other health insurance that is primary to Medicare.

HCFA requires ongoing assistance in streamlining this data collection process and suggests that an updated insurance profile should be requested from patients at least quarterly. With the advent of HIPAA privacy and confidentiality standards in 2003, patient consent for release of information will be standardized as well. A few minutes spent updating COB information on a regular basis as patients are checking in, can later save administrative time and money by reducing the number of instances where claims are returned because the Medicare COB file has identified another insurer as primary payer.

PhotoDynamic Therapy Thank You

Thanks are due to everyone who responded to the photodynamic therapy survey on CPT code 965XX. The dual surveys on physician time and practice expense are requirements for submission to the AMA RBRVS Specialty Society Update Committee. The AAD and presenters, Brett Coldiron, MD and Stacy Smith, MD appreciate the effort and input provided by dermatologists utilizing the new photodynamic therapy modality.

Key questions to ask are:

- Does the patient have any group health plan coverage based upon his/her current or former employment?
- Does the patient have any group health plan coverage based upon his/her spouse’s or another family member’s current or former employment?
- Is the patient receiving Department of Labor black lung disease benefits?
- Is the patient receiving workers’ compensation benefits?
- Is the patient receiving treatment for an injury or illness for which another party could be held liable or is covered under automobile no-fault insurance?

The answers to these questions will help your staff complete and submit claims to the correct primary insurance payer.

Frequently Asked Medicare COB/MSP Questions

Q. What methods, aside from the claim submission, are used to obtain Medicare COB and Medicare Secondary Payer information from a beneficiary?

A. Beneficiaries are sent an MSP Initial Enrollment Questionnaire (IEQ) approximately three (3) months before they are eligible for Medicare. Medicare Secondary Payer (MSP) information is also obtained through a data match comparing information from the Internal Revenue Service/Social Security Administration/Health Care Financing Administration.

Q. How does the dermatologist benefit from Coordination of Benefits?

A. Physicians and other suppliers can maximize their reimbursement and reduce their administrative cost when health insurance is properly coordinated.

Q. How do I know if Medicare is the primary or secondary payer?

A. You don’t have to make that determination. Medicare will determine who is the primary payer once all benefit information is received.

Q. What happens if I submit a claim without the other insurer’s information?

A. The claim will be paid but you will be requested to complete an MSP development questionnaire. If, as a result of this process, a Medicare Secondary Payer (MSP) situation is identified, Medicare will review its payments and may initiate recovery of the conditional payments. Recovery will be sought from providers, beneficiaries, or other parties that have legal obligation to repay Medicare. The claim must be reprocessed to reflect Medicare as the secondary payer. The Medicare provider or supplier must secure information about other health coverage insurance to bill the other insurer.

Correct Coding Initiative

The Correct Coding Initiative (CCI) was established by the Health Care Financing Administration (HCFA) to develop uniform correct coding methods to control improper coding so that Medicare Part B claims are paid appropriately. Modifiers, used correctly, are appended to a code to identify those services which were performed and were not unbundled services. Historically, many Medicare Carriers have had numerous edits in place to detect improper coding. However, there continue to be inconsistencies among carriers regarding the structure and application of such edits. Between October 30, 2000 and February 12, 2001 over 57,000 coding edit combinations have been added to CCI. Not all of these are applicable to dermatology and CCI edits impact specialties differently.

Basic principles of correct coding include services that are integral to the procedure performed. It would be inappropriate to bill these services separately as they are included as common activities according to acceptable medical/surgical practices. Such services would include:

- prepping of skin, including cleansing and shaving;
- positioning and draping patient;
- sedative administered by physician performing the procedure;
- local, topical or regional anesthesia administered by physician performing the procedure; and
- complete documentation of pre, intra, and post-surgical services.

Incorrect coding can be due to unintentionally unbundling services because of lack of understanding of correct coding. Intentional unbundling is when a provider manipulates the procedure codes in order to maximize reimbursement.

Examples of unbundling are:

1. fragmenting a service and coding each component as a separate service; or
2. reporting separate services instead of the comprehensive code.

The Correct Coding Edits (CCE) consist of two sections of codes:

Mutually Exclusive Procedures – Column 1 and Column 2. A code in Column 2 will not be reimbursed when reported on the same date by the same provider as a code listed in Column 1, unless modifier –59 is appended.

Comprehensive and Component Procedures – Column 1 and Column 2 a component code listed in Column 2 will not be reimbursed when reported on the same date by the same provider as a code listed in Column 1, unless modifier –59 is appended.

The Correct Coding Initiative policies state that the modifier may be used with either a Column 1 or a Column 2 code. However, some Carriers expect the modifier to be placed on the Column 2 code. Utilize the anatomic modifiers, such as E1, F1, F5, LT, RT, in describing the area of the procedure, as an alternative to –59

Following the AMA/CPT guidelines as well as carrier guidelines will assist you in correct coding practices and filing clean claims. If the code (column 1 or 2) to which you append the modifier works for your Medicare carrier, there is no need to change.

The following are some examples to assist you with HCFA Correct Coding Edits compliance. Please note that these examples apply to Medicare claims and not to private insurance carriers.

- append –59 to skin biopsy (11100) when any other integumentary procedure is performed on a different lesion at the same operative session
- append –59 to shave (113xx) when procedure is performed at the same operative session as a destruction of benign lesion (17000)
- append –59 to excision of benign lesion (114xx) when procedure is performed at the same operative session as a destruction of benign lesion (17000)
- append –59 to excision of malignant lesion (116xx) when procedure is performed at the same operative session as a destruction of benign lesion (17000)
- append –59 to destruction of malignant lesion (172xx) when procedure is performed at the same operative session as a destruction of benign lesion (17000)
- append –59 to excision of malignant lesion (116xx) when procedure is performed at the same operative session as a destruction of malignant lesion (172xx)
- append –59 to intralesional injection(s) (11900 or 11901) when procedure is performed at the same operative session as a shave, excision, or destruction (113xx, 114xx, 116xx)

In order to avoid denied claims triggered by CCI edits, it is important for dermatologists to know and comply with the carrier's requirements regarding the utilization of modifiers. More information on HCFA's Correct Coding Initiatives policies and edits are included in *Derm Coding Consult*, June 1997 on the AAD or AADA web sites:

www.aad.org/coding.html OR
www.aadassociation.org/coding.html

If you have questions regarding CCI edits or the appropriate application of modifiers, please contact Vernell St. John at 847-240-1815 or e-mail her at vstjohn@aad.org.

Update on Modifier -25 Recognition

According to the 1998 American Medical Association survey of all payers, 75% of payers that use the RBRVS, recognize modifier -25; 92% recognize modifier -26 (professional component), 89% recognize modifier -51 (multiple procedures) and 81% recognize modifier -22 (unusual procedural services). Of particular concern to dermatologists is the accurate recognition and use of modifier -25,

for significant and separately identifiable evaluation and management services by the same physician on the same day of the procedure or other service.

However, the American Academy of Dermatology continues to encourage appropriate recognition of correct coding policies by meeting with specific insurers to educate them regarding dermatologic service coding. Through this intensive effort, AAD representatives to the Private Sector Advocacy Task Force and DERMCAC have been able to report:

- Following an AAD meeting, in March 1999, with **United Healthcare**, United indicated that in April 1999, CPT modifier -25 is recognized in its own Health Plans; the national accounts system was updated to recognize modifiers in April 2000.
- Following an AAD meeting in November 1999 with **Aetna/U.S. Healthcare**, Aetna began recognition of modifier -25 for all its HMO products nationally in 2000. It is expected that by the first quarter of 2001, all Aetna products including PPO products, will recognize modifier -25.
- **Empire BC of NY** recognizes all modifiers.
- The Health Care Financing Administration's **Medicare** program recognizes all CPT modifiers.
- Following a meeting with **CIGNA** January 2000, CIGNA announced in April 2000 that it would recognize modifiers -25 and -57, in addition to other modifiers currently recognized such as modifier -51. The claims policy statement that was announced in Fall of 2000 recognizes modifier -25 for new patient and consultation visits, but for established patient visits documentation is required with modifier -25.
- For the University Physicians Network (UPN) patients, **PHS** recognizes CPT modifiers -25, -57, and -59.
- Following a meeting with **Blue Cross Blue Shield of South Carolina** in August 1999, BC/BS of South Carolina announced that it would permit payment of office visits with modifier -25 for a separate and identifiable E/M service, when accompanied by a destruction code. BC/BS of South Carolina covers state residents and national contracts, such as its contract with WalMart, and other health purchasers with headquarters in South Carolina.
- **Coventry Health Plan** covers modifiers -24, -25, -57 and -59 without documentation when billed appropriately. Documentation is required for CPT 99213-99215 billed with preventive services.

With the scheduled implementation of the Health Insurance Portability and Accountability Act by 2003, all health payers accepting claims electronically will be required to recognize CPT and all its modifiers. However, recognition of a modifier still does not guarantee that a given payer will reimburse for all services identified by modifiers.

Attention Anthem Providers

The American Academy of Dermatology has requested a meeting with Anthem Blue Shield in July to discuss current dermatology claims issues. AAD is aware of a growing number of complaints since January. If you are experiencing problems with claims submitted to Anthem, you can assist AAD in preparing for this meeting. Please mail cover letter with a description of the problem as well as a photocopy of the claim submitted to Anthem with the Anthem explanation of payment or denial attached. Dr. Zalla would like to receive as many examples as possible. Mailed examples are better than faxed materials because they provide better copies. The patient's last name should be blacked out to abide by privacy and confidentiality requirements. The claim and remittance copies should be mailed to:

James A. Zalla, MD
Dermatology Associates of Northern Kentucky, P.S.C.
256 Main Street
Florence, KY 41042

News Briefs *continued from page 1*

New Needle Stick Regulation in Effect

The US Department of Labor (DOL) has revised the Occupational Safety and Health Act (OSHA) to require health care employers to select safer needle devices as they become available in order to ensure the safety of health care clinical staff from the danger of blood born pathogens. The revised OSHA regulation is a direct result of passage of the Needlestick Safety and Prevention Act passed unanimously by Congress and signed by President Clinton last November.

The Centers for Disease Control (CDC) estimates that safer medical devices could prevent 62 to 88 percent of all sharps injuries in hospital settings. Safer sharps are considered appropriate engineering controls, the best new strategy for health care worker protection.

Contact your medical supplier for information on available product(s). The new blood born pathogens standard was published in the Federal Register, January 18, 2001 and became effective 90 days later on April 18, 2001.

M+C To Comply With Local Medical Review Policies

Medicare+Choice organizations (M+COs) are required to provide their Medicare enrollees with those services that are covered under Medicare and available to other fee-for-service Medicare beneficiaries residing in the geographic area covered by the Medicare+Choice plan. As of February 2001, about 5.6 million people have chosen to be in a Medicare+Choice plan. In total, 39 million people have Medicare.

In accordance with federal regulations, Medicare M+COs must comply with HCFA national coverage decisions as well as the "local medical review policies" (LMRPs). Under the new Benefits Improvement & Protection Act of 2000 (BIPA), an M+CO offering a Medicare+Choice plan in an area with more than one local carrier with applicable local medical review policies is able to elect the LMRP for the area that is most beneficial to the Medicare+Choice enrollees.

All finalized Medicare Carrier local medical review policies may be found on the HCFA sponsored Web site at www.lmrp.net. This web site is updated quarterly. LMRPs finalized by the local contractor between the quarterly updates may be found on the local contractor's web site that you may also access from the "Contractor Site" directory through the LMRP web site.

Handy Health Resource Web Sites

HIPAA Administrative Simplification: Information on implementation of the electronic standards as well as the patient privacy requirements from the source!
<http://aspe.os.dhhs.gov/admsimp/>

Want to be able to view the page just like it was printed? You can download the FREE Adobe Reader Software for reading PDF formatted files (including Derm Coding Consult) This is also downloadable from the AAD and HCFA web sites. www.adobe.com/products/

Need to know what your State law says?
www.alllaw.com/state_resources

Want to know more about ICD-9-CM? Check out the US clearinghouse for issues on using ICD-9-CM from the American Hospital Association Central Office on ICD-9-CM at www.icd-9-cm.org.

Want to learn more about existing and new Medicare programs and provider instructions? Log onto the Medicare Learning Network at www.hcfa.gov/medlearn.

When you find a web site that's particularly helpful and information, don't forget to add it to your favorites list in Internet Explorer or bookmark it in Netscape.



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