

DERM CODING CONSULT



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News Briefs

Disappointing 2002 Medicare Fee Schedule

The Centers for Medicare & Medicaid Services (CMS) on November 1, 2001 announced final payment policies and payment rates under the Medicare Physician Fee Schedule. Total payments to physicians are projected to increase by 1 percent in 2002, from \$41.2 billion in 2001 to \$41.7 billion.

The Medicare law requires that the annual update reflect inflation in the costs of medical goods and services, as well as actual spending compared to target spending – the sustainable growth rate or SGR. This Medicare Update formula was adopted by Congress as part of the Balanced Budget Act of 1997. Between 1998 and 2001, the new formula worked well for physicians – the cumulative increase in the update was 15.9 percent compared to a medical inflation increase of 9.3 percent.

However, the formula, which is required to use the new economic data from a slowing economy and high levels of expenditures for physicians' services, has produced a negative update for calendar year 2002. As a result, the factor used to update payment rates for individual services will go down by 4.8 percent, and the conversion factor (CF) will be still lower (5.4% below 2001 levels).

The 2002 Medicare Physician Fee Schedule Conversion Factor(CF) is set at \$36.1992, a drop of \$2.06 per RVU from last year's CF of \$38.2581. (See Impact Table)

According to CMS Administrator Tom Scully, "The law designing the physician update is incredibly prescriptive, and gives us no flexibility in adjusting this multi-year formula. However, in other areas, we are redoubling our efforts to find ways to make the Medicare program work better in other ways for physicians, such as our Physicians' Open Door

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Actinic Keratosis Update

Somewhat faster than anticipated, the Center for Medicare Services (CMS) has published the new Coverage Issues Manual (CIM) instruction on the treatment of actinic keratosis. It provides specific instruction to Medicare Carriers for implementation of the National Coverage Decision (NCD) Policy. It is effective for treatment or services provided on or after November 26, 2001.

The Medicare Coverage Issues Manual, Transmittal #145 was published on October 26, 2001. (See full text of Section 35-101 in box) The text of the new Coverage Issues Manual instruction itself is clear and unambiguous, stating, "Medicare covers the destruction of actinic keratoses without restrictions based on lesion or patient characteristics." However, the wording of the transmittal cover instruction to Medicare carriers is not. It states, "Medicare contractors retain discretion to determine the number of visits considered reasonable and necessary to treat these lesions."

One of the goals of the Academy's five year effort to get Medicare agreement to a national coverage decision (NCD) on actinic keratosis is to eliminate the wide range of carrier local medical review policies (LMRP) which set arbitrary limits on treatment parameters for Medicare patients with AKs. The Academy intends to closely monitor subsequent Medicare carrier implementation of these new instructions.

A National Coverage Decision (NCD) made under §1862 (a)(1) of the Social Security Act is binding on all Medicare carriers, intermediaries, peer review organizations, and other contractors. Under 42 CFR 442.256 (b) an NCD that expands coverage is also binding on Medicare+Choice organizations. In addition, an administrative law judge may not review an NCD. (See §1869 (f)(A)(I)).

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Letter from the Editor

Dear *Derm Coding Consult* Reader:

This issue of *Derm Coding Consult* is definitely a "good news/bad news" mix for dermatologists! In the good news category, the American Academy of Dermatology Association's (AADA) efforts have improved with reimbursement for key Photochemotherapy codes by 117%!

The bad news, falling national economic indicators have severely impacted the Medicare Update factor for 2002. This has dropped the Medicare conversion factor by over \$2.00! The AADA is actively supporting several legislative proposals that may bring relief, but these are linked directly to the broader "economic recovery" proposals struggling through the Congress.

"Good news" is, we have the national coverage decision policy instructions for treatment of actinic keratoses published with an effective date of November 26, 2001. "Bad news" is that the transmittal cover instruction to the Medicare carriers advises "Medicare contractors retain discretion to determine the number of visits considered reasonable and necessary to treat these lesions." This adds an unfortunate element of ambiguity to the implementation of the new instruction. I ask that you keep me advised of any implementation problems that may occur with your Carrier. If additional directives or guidelines are issued by your Medicare carrier, please fax me a copy at 847 330 1120.

A final piece of "good news," AADA has been awarded the AMA CPT 2001 Educational Excellence Award for diligently providing coding information such as *Derm Coding Consult* for member dermatologists! I want to acknowledge and thank all of those Academy members who have served or are currently serving on the *Derm Coding Consult* Editorial Advisory Board. Their contributions to the content of *Derm Coding Consult* are invaluable in presenting accurate information to you, our readers.

I want to sincerely thank each of our Board members for their generosity and insights in serving the AADA in this capacity (see listing below). And I also want to thank those who have served *Derm Coding Consult* so ably in the past, including it's first editor, Diane Krier-Morrow.

Best regards,



Norma L. Border, Editor

CPT 2002 Update

Destruction Descriptor Changes

There has been a change in the descriptors in the destruction codes in the integumentary section of CPT 2002. The deletion of *by any method* is an objective of the CPT-5 project to promote clarity of CPT codes. There are other codes in CPT 2002 that still contain the phrase *by any method*. Those codes will be reviewed through the CPT process for CPT 2003.

The term, *by any method*, has been deleted as an editorial change that does not affect reimbursement in the following codes:

- 17000 Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), all benign or premalignant lesions (eg, actinic keratoses) other than skin tags or cutaneous vascular proliferative lesions; first lesion
- 17004 Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), all benign or premalignant lesions (eg, actinic keratoses) other than skin tags or cutaneous vascular proliferative lesions; 15 or more lesions
- 17110 Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of flat warts, molluscum contagiosum, or milia; up to 14 lesions
- 17260 Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter 0.5cm or less
- 17270 Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 0.5cm or less
- 17280 Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5cm or less

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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.aadassociation.org/coding.html

In these codes, the parenthetical (*eg, laser surgery, electro-surgery, cryosurgery, chemosurgery, surgical curettement*) are included as examples of methods of destruction. Note that “eg” means example thus there may be other types of destructive methods that are used for destroying lesions. Note that the only change to the CPT guidelines regarding destructions is that *including local anesthesia* has been omitted. The definition of the CPT surgical package is defined in the Surgery Guidelines and anesthesia is included in that package.

Other destruction codes affected by the deletion of *by any method* that dermatologists may use are:

- 46924 Destruction of lesion(s), anus (*eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle*), extensive (*eg, laser surgery, electro-surgery, cryosurgery, chemosurgery*)
- 54065 Destruction of lesion(s), penis (*eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle*), extensive (*eg, laser surgery, electro-surgery, cryosurgery, chemosurgery*)
- 56501 Destruction of lesion(s), vulva; simple (*eg, laser surgery, electro-surgery, cryosurgery, chemosurgery*)
- 56565 extensive (*eg, laser surgery, electro-surgery, cryosurgery, chemosurgery*)

Free Skin Grafts

Text has been added preceding the graft codes to clarify coding for autogenous skin grafts vs. autogenous tissue-cultured skin grafts. The added text states:

“Use 15000 for initial wound preparation. Use 15100-15261 for autogenous skin grafts. For autogenous tissue-cultured skin grafts, use 15100-15121. These codes include harvesting of keratinocytes and their subsequent application. Procedures are coded by recipient site. Use codes 15342 and 15343 for application of skin substitute/neodermis. Use modifier ‘-58’ for staged application procedure(s).”

Photodynamic Therapy

A new CPT code has been established for the light application to destroy premalignant and/or malignant lesions.

- 96567 Photodynamic therapy by external application of light to destroy premalignant and/or malignant lesions of the skin and adjacent mucosa (*eg, lip*) by activation of photosensitive drug(s), each phototherapy exposure session

A new J code, J7308, has been assigned for the topical aminolevulinic acid. The appropriate level of evaluation and management code would be reported along with J7308 on the day the photosensitizing agent is applied. The code 96567 would be reported when the patient returns (approximately 14 hours later) for the light application. This code is reported only once for each exposure session regardless of the number of lesions treated.

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ICD-9-CM Coding for Diagnostic Tests

As the HIPAA regulations have designated ICD-9-CM as the standard approved for diagnostic codes, the final rule requires not only the use of ICD-9-CM codes but also the reporting guidelines for these codes as well. CMS Program Memorandum Transmittal AS-01-144 issued September 26, 2001 provides guidance to health care providers regarding the use of ICD-9-CM codes for diagnostic testing. (See full text at <http://www.hcfa.gov/pubforms/progman.htm>)

To determine the appropriate primary ICD-9-CM diagnostic code the following instructions are given.

1. If the provider has a confirmed diagnosis on the basis of a diagnostic test, the provider interpreting the test should code that diagnosis. Signs or symptoms prompting the ordering of the diagnostic test may be reported as well if they are not related to or fully explained by the confirmed diagnosis.

Example given: “A surgical specimen is sent to a pathologist with a diagnosis of ‘mole’. The pathologist personally reviews the slides made from the specimen and makes a diagnosis of ‘malignant melanoma’. The pathologist should report a diagnosis of ‘malignant melanoma’ as the primary diagnosis.

2. Should a diagnostic test be normal or not yield a diagnosis, the sign or symptom prompting the ordering of the test would be reported.
3. If a diagnostic test is ordered in the absence of any sign or symptom, the primary ICD-9-CM code reported would be the appropriate screening code. The results of the test could be reported as additional diagnoses.

Referring providers must provide diagnostic information to the testing entity at the time the test is ordered. Also, the provider treating the beneficiary must be the provider ordering the test. An order may be done by:

- Written document to the testing entity signed by the treating provider delivered by hand, mail or fax;
- Telephone call to the testing entity by the provider or his/her office

Note: The telephone call must be documented by the provider and the testing entity in the beneficiary’s medical record

- E-mail by provider to the testing entity.

ICD-9-CM coding guidelines may be found on the Centers For Disease Control Web site at <http://www.cdc.gov/nchs/datawh/ftpser/ftpicd9/ftpicd9.htm#guide>

Comprehensive Error Rate Testing (CERT)

Program Memorandum Transmittal AB-01-113 issued August 16, 2001 addresses allowed changes to the Comprehensive Error Rate Testing (CERT) regarding prepayment random medical review by carriers. This PM states,

“The FY 2002 Budget and Performance Requirements does not require prepayment random medical review; therefore, all contractors may stop prepayment random medical review on October 1, 2001.”

The PM does not state that a carrier has to stop random prepayment medical reviews; it simply states that they may stop such reviews.

OIG Work Plan for 2002

The purpose of the Office of the Inspector General (OIG) 2002 Work Plan is to improve HHS programs and operations and protect them against fraud, waste, and abuse. OIG accomplishes this task by conducting independent and objective audits, evaluations, and investigations. Information and advice obtained is given to Department officials, the Administration, the Congress, and the public.

The 2002 Work Plan contains the following statements pertaining to provider services that should be carefully noted.

Advance Beneficiary Notices

OIG will examine the use of advance notices to Medicare beneficiaries and their financial impact on beneficiaries and providers. Physicians must provide advance notices before they provide services that they know or believe Medicare does not consider medically necessary or that Medicare will not reimburse. Beneficiaries who are not notified before they receive such services are not responsible for payment. Indications are that practices vary widely regarding when advance beneficiary notices are provided, especially with respect to noncovered laboratory services.

Physicians at Teaching Hospitals

This OIG initiative is designed to verify compliance with Medicare rules governing payment for physician services provided in the teaching hospital setting and to ensure that claims accurately reflect the level of service provided to patients. Previous OIG work in this area suggested that many providers were not in compliance with applicable Medicare reimbursement policies.

Billing for Residents' Services

OIG will determine whether hospitals have properly used residents' physician identification numbers to bill Medicare. Medicare regulations allow residents, who are licensed physicians, to be issued physician identification numbers for purposes of billing Medicare for their services. However, residents may bill Medicare only when they are "moonlighting", which is defined as providing medical treatment, other than in their field of study, in an outpatient clinic or an emergency room.

Physician Evaluation and Management Codes

OIG will determine whether physicians correctly coded evaluation and management services in physician offices and effectively used documentation guidelines. OIG will also assess whether carriers identified any instances of incorrect coding and what corrective actions they took. Medicare payments for evaluation and management codes total approximately \$18 billion per year and account for almost half of Medicare spending for physician services. Since 1992, Medicare has used visit codes developed by the American Medical Association to reimburse physicians for evaluation and management services. Generally, the

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HCPCS 2002 UPDATE

In the September 2001 issue of *Derm Coding Consult* new HCPCS codes per Program Memorandum B-01-30 were addressed. However, CMS has now issued Program Memorandum B-01-58 dated September 25, 2001 that supersedes the B-01-30 memo.

The new Program memo advises that HCPCS codes **Q3015** and **Q3016** will **not** be implemented.

It also clarifies that HCPCS Code **A9270** is a valid code. However its use is now limited to claims submitted by Durable Medical Equipment-Point of Service (DMEPOS) suppliers.

Program Memorandum B-01-58 dated September 25, 2001 also clarifies the use of modifiers: **GA**, **GY**, and **GZ**:

- GA** – indicates the provider expects Medicare will deny a service as not reasonable and necessary and that the beneficiary has signed an ABN and is on file;
- GY** – indicates the service provided to the beneficiary is statutorily non-covered and not a Medicare benefit;
- GZ** – indicates the provider expects Medicare will deny a service as not reasonable and necessary and the beneficiary has not signed the ABN.

Modifier GY and GZ are to be used with a specific HCPCS code. If a specific code is not available, a "not otherwise classified" code (NOC) would be used.

Claims submitted using the GY modifier **may** be auto-denied upon carrier discretion. And, a service submitted with both the GZ and GA modifier will be unprocessable as having an invalid modifier.

Carriers are to address these changes in their Provider Bulletin publications. Be sure to read your carrier's guidelines regarding these updates.

Clarification

In the "Medicare Revises Advance Beneficiary Notice" article on page 1 of the September Issue of *Derm Coding Consult*, the text advises that the "ABN form is given *annually* to millions of Medicare beneficiaries." This information was taken directly from the CMS Press Release regarding the new form. Please be advised that Medicare requires that the Advance Notice to Beneficiaries must be given to each beneficiary at any time when a service may not be considered by Medicare to be reasonable and necessary. The intent of the article was not to imply that this notice is provided only once or only on an annual basis to Medicare beneficiaries.

● Dermatology Gains in Practice Expense RVU's

AADA has brought forward over eighty codes in 2001 to the AMA/Practice Expense Advisory Committee for review and validation of clinical labor time, medical supplies and medical equipment. The following code families were presented at the March and August PEAC meetings:

CPT 12001 thru 12041 – Simple Repairs; CPT 11400-11446 – Excision of Benign Lesions; CPT 11600-11646 – Excision of Malignant Lesions; CPT 11100-11101 – Skin biopsy; and CPT 17260-17286 – Destruction of Malignant Lesions.

Daniel M. Siegel, MD, AAD Representative to the AMA/PEAC successfully proposed validations and updates that refined the CPEP data submitted to CMS in 1996-1997 for clinical labor, medical supply and equipment. In addition, these integumentary codes were also modified to reflect AMA/PEAC approved standard time and/or supply packages. The PEAC also accepted the inclusion of a \$7000 power table in lieu of the standard \$1800 exam table for dermatology procedures. This equipment update will also be included in all subsequent dermatology validation presentations.

In recognition, that the destruction codes include "any method," AADA was also successful in arguing Medicare recognition of the supplies and equipment required to provide electro-surgery and cryosurgery. This will result in incremental increases in practice expense relative value units for any destruction procedure where liquid nitrogen may be used. Medicare staff has accepted the addition of a cryosurgery equipment package totaling \$2706 for all 28 CPT destruction codes.

● News Briefs - Continued

Phototherapy Reimbursement Up by +50%

One of the few bright spots in the 2002 Medicare Fee Schedule is the positive improvement in reimbursement for key phototherapy codes. The 2002 Medicare Fee Schedule (MFS) reflects a **117%** increase for CPT 96910 and 96912 to \$50.67 and \$57.19 as well as a **54%** increase for CPT 96913 to \$84.71. These increases are the result of the successful AADA phototherapy survey responses in late 2000 from dermatologists actively providing phototherapy services that contributed to the successful phototherapy code presentations to the AMA PEAC in January 2001.

Mark Lebwohl, MD, Chair, Department of Dermatology at Mt. Sinai School of Medicine and Gail Zimmerman, Executive Director of the National Psoriasis Foundation effectively demonstrated the great importance of these codes to practicing dermatologists and their patients suffering from psoriasis and other painful, chronic skin conditions. The successful increase in practice expense RVU's for these codes is the culmination of months of diligent effort by the AADA within the RBRVS process.

● Derm Coding Consult wins AMA Award

The AADA was honored by the AMA/CPT Editorial Panel at the Annual Meeting of the AMA/CPT HCPAC Advisors/CPT Editorial Panel held in November. The Specialty Society **2001 Educational Excellence Award** was presented to AADA and accepted by Allan S. Wirtzer, M.D. on behalf of the AADA. This award recognizes the specialty society's endeavors in coding-related education.

Each year the AMA CPT Staff requests that the CPT Editorial Panel and the CPT Advisory Committee members submit nominations for the AMA CPT Educational Excellence Award. It is given to the medical society whose publications and coding education advance physician and staff knowledge and understanding of the AMA CPT Coding system.

James A. Zalla, MD submitted the nomination for the AADA coding courses and the **Derm Coding Consult** newsletter. In his nomination letter Dr. Zalla said, "...I would recommend for consideration of the Awards Committee and AMA staff the publication *Derm Coding Consult* of the American Academy of Dermatology [Association]. Academy staff and members have worked diligently to provide coding related information for member dermatologists in this quarterly publication for the past five years. It is also sent to all the Medicare carrier medical directors."

We would like to acknowledge all of those members who have served or are currently serving on the Editorial Advisory Board. Their contributions to the content of *Derm Coding Consult* are extremely valuable in presenting accurate information to the readers. We sincerely thank these members for their willingness to serve the AADA in this capacity.

The current Editorial Advisory Board consists of: James A. Zalla, MD; Ronald L. Moy, MD; Allan S. Wirtzer, MD; Mervyn L. Elgart, MD; Lenore S. Kakita, MD; James D. Maberry, MD; Pamela Kim Phillips, MD, Stephen P. Stone, MD and John A. Zitelli, MD. Those who have served in the past are: Curtis Hawkins, MD, Randall K. Roenigk, MD and Allison T. Vidimos, MD.

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Derm Coding Consult is available on the AADA Web site (www.aadassociation.org/coding.html).

Please thank your
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for their sponsorship of
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Winner of the 2001 AMA-CPT
Excellence in Education Award

At the Annual Meeting of the CPT Editorial Panel and Advisors held in November, an E/M Workgroup was established to re-visit the E/M codes. This action was taken due to the decision by Centers for Medicare & Medicaid Services (CMS) to cancel the Aspen project.

The purpose of establishing such a workgroup is to:

- Recommend changes in the code descriptors, code criteria, and/or code levels for improving understanding by health care providers;
- Clearly describe physician work and current clinical practice in E/M codes;
- Minimize the need for documentation guidelines and facilitate patient care;
- Minimize financial impact on providers;
- Eliminate physician burden and enhance medical review and claims payment processes.

The workgroup will evaluate the existing E/M codes and make recommendations to aid providers to clearly describe their work. The workgroup will evaluate medical decision-making and time as currently used in E/M coding. Data will be collected by the workgroup to assist in this project. Random sampling of providers will be done. It is of utmost importance that those providers who receive opinion surveys respond timely so their input will be considered.

There are to be nineteen individuals who will comprise this workgroup. Among those included in this workgroup will be AMA/CPT Editorial Panel members plus representatives from specialty societies, CMS, RUC, and PPAC. There should be opportunity for input from all specialties as well as from physicians in this workgroup process.

An initial review of recommendations is to be presented to the CPT Editorial Panel at their August 2002 meeting.

There have been no changes to the E/M codes or documentation guidelines for calendar year 2002. CMS continues to accept either the 1995 or 1997 documentation guidelines. Documentation in the medical record must support the level of service billed. See the article on page 2 of the September 1999 issue of *Derm Coding Consult* for documentation basics that apply to medical record documentation.

codes represent the type and complexity of services provided and the patient status, such as new or established. Revised guidelines were issued in the 1995 and again in 1997. Following the issuance of the 1997 guidelines, providers were told that they could use either the 1995 guidelines or the 1997 guidelines. Revised guidelines are again under development.

Consultations

This OIG study will determine the appropriateness of billings for physician consultation services and the financial impact on the Medicare program from any inaccurate billings. In addition, OIG will determine the primary reasons for any inappropriate billings. In 2000, total allowed charges to Medicare for consultations were \$2 billion.

Initiative and our Physicians Issues Project which aim to free physicians up from paperwork to concentrate on patient care.”

The Academy, while supportive of current legislative proposals to address the impact of this fall in Medicare reimbursement levels, is also concerned that simply “freezing” the Medicare Fee Schedule at the 2001 level would be counter-productive for dermatology. This year, CMS accepted recommendations from the AMA/RBRVS Update Committee and Practice Expense Advisory Committee that includes generally positive modifications to eighty dermatology service codes.

The Academy has signed on to letters of support for the Jeffords-Breaux “Medicare Physician Payment Fairness Act of 2001” that would revise the update by 9/10ths of a percent and result in a modified conversion factor for 2002 of \$37.91. However, this is dependent on the legislation moving forward independently or as part of an economic incentive package.

A modification to the conversion factor would provide CMS, Congress, and providers the opportunity to develop a workable solution to avoid sharp fluctuations in annual Medicare update calculations in the future. It would also avoid the anticipated adverse impacts that will be inflicted on Medicare participating physicians if the current update formula continues to be used in calculating physician payment rates.

Medicare Fee Schedule Impact - 2002 to 2001 Comparison

Four examples of the impact of the CF change for 2002, are:

CPT Description	PhysWork		PractExp		MalPrac		Tot/RVU		New 2002	Old 2001
	02	01	02	01	02	01	02	01	MFS/CF	MFS/CF
11423 – Exc benign lesion	2.17	2.17	3.02	2.93	0.17	0.17	5.36	5.27	\$194.03	\$205.06
17263 – Destr malig lesion	1.79	1.79	1.79	1.72	0.08	0.08	3.66	3.59	\$132.49	\$137.31
99203 – Office visit, new	1.34	1.34	1.07	1.08	0.08	0.08	2.49	2.50	\$90.14	\$95.63
99213 – Office visit, est	0.67	0.67	0.67	0.67	0.03	0.03	1.37	1.37	\$49.59	\$53.40

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The new section of the Coverage Issues Manual states:

"35-101 TREATMENT OF ACTINIC KERATOSIS
(Effective for services performed on and
after November 26, 2001.)

Actinic keratoses (AKs), also known as solar keratoses, are common, sun-induced skin lesions that are confined to the epidermis and have the potential to become a skin cancer.

Various options exist for treating AKs. Clinicians should select an appropriate treatment based on the patient's medical history, the lesion's characteristics, and on the patient's preference for a specific treatment. Commonly performed treatments for AKs include cryosurgery with liquid nitrogen, topical drug therapy, and curettage. Less commonly performed treatments for AK include dermabrasion, excision, chemical peels, laser therapy, and photodynamic therapy (PDT). An alternative approach to treating AKs is to observe the lesions over time and remove them only if they exhibit specific clinical features suggesting possible transformation to invasive squamous cell carcinoma (SCC).

Medicare covers the destruction of actinic keratoses without restrictions based on lesion or patient characteristics."

Appendix F

Appendix F lists the CPT codes that are exempt from the use of modifier -51. The codes that appear in this list have already been reduced and the carrier should not apply further reductions. Inadvertently, code 17304 was left out of that appendix last year. This has been corrected in CPT 2002. Thus, all the Mohs' codes appear in Appendix F as well as code 17004.

NOTE: We are aware of a change in the Medicare database regarding 17004. We are currently addressing that issue and will have more information in the March 2002 issue of *Derm Coding Consult*.

Introduction

Revisions have been made in the Instructions for Use of CPT in the Introduction of CPT 2002. The additional text in the first paragraph states, "Do not select a CPT code that merely approximates the service provided. If no such procedure or service exists, then report the service using the appropriate unlisted procedure or service code."

The last sentence of the second paragraph has the added text, "...or other qualified health care professional."

CPT 2002 Facts

New codes added = 215
Revised codes = 269
Other changes = 425
Total number of CPT codes in 2002 = 8,107



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