

# DERM CODING CONSULT



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## NEWSBRIEFS

### File for Your HIPAA Electronic Standards Extension NOW

The Health Insurance Portability and Accountability Act (HIPAA 1996) requires that the Department of Health and Human Services (HHS) establish national standards for the transmission of electronic data and codes sets. These HIPAA Electronic Standards were established by law October 16, 2000, with an original compliance date of October 16, 2002. Last December, President Bush signed the Administrative Simplification Compliance Act (ASCA). ASCA permits covered entities (health plans, clearinghouses, and health care providers **including physicians**) to apply for a one-year delay in complying with the electronic standards, by filing a request for an extension with HHS.

**The model compliance plan extension form must be submitted by a covered entity no later than October 15, 2002.** It provides a one year extension, to October 16, 2003, to become HIPAA compliant on all electronic claims transactions.

If you submit the model compliance plan extension request electronically, HHS will provide an online confirmation number as acknowledgement of your extension. If you mail the extension request, you will not receive an acknowledgement, but HHS has confirmed that you may consider your extension granted. HHS specifically requests that you do not send both an electronic and a paper copy of the model compliance plan. One or the other will suffice.

The model compliance plan extension form should be completed and submitted to CMS as quickly as possible. To

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## 2003 MEDICARE FEE SCHEDULE: GOOD NEWS AND BAD NEWS

As they say, there is good news and there is bad news in regard to the proposed 2003 Medicare Fee Schedule. Taking the bad news first, there is a proposed -4.4% across the board cut to the Medicare update formula. In addition, the change in clinical staff time calculations will negatively impact on the Practice Expense RVUs. The impact will result in a -5 to -7% average reduction in Medicare reimbursement. Some examples of these reductions are as follows: Office Visit, new patient (CPT 99203) has a current total RVUs of 2.54 RVU. The proposed Medicare fee schedule would reduce this to 2.51 RVUs. An office visit for an established patient (CPT 99213) has a current total RVUs of 1.39 RVUs. The proposed Medicare fee schedule would reduce this to 1.38 RVUs.

The 2003 proposal would also alter the method for calculating PE relative value units (RVU) for codes with a Professional Component (PC) and Technical Component (TC) which are outside of the zero physician work pool. It proposes that the TC would be equal to the difference between the global value and the PC, rather than being separately calculated. If this recommended change for deriving TC values is implemented, then Medicare reimbursement for CPT codes 88304 and 88305, Surgical pathology, gross and microscopic examination (Levels III and IV) will be significantly reduced. The PE RVU for CPT Code 88304 would drop .10 RVU overall. However, CPT Code 88305 would drop a substantial .18 RVU overall, with .17 of this decrease coming out of the TC. This means that 2003 reimbursement for CPT Code 88305 services will drop to about \$81.92, a sizable \$11.48 decrease in payment from the 2002 payment level of \$93.40.

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## LETTER FROM THE EDITOR

Dear *Derm Coding Consult* Reader:

**If you haven't already requested the HIPAA Electronic Standards extension, please do it now!!** Requests must be received before October 15, 2002. Everybody (including the Centers for Medicare and Medicaid services and most major health insurers) has either already submitted the extension request or plans to do so shortly. If you don't request the extension and submit the Model Compliance Plan, the Centers for Medicare and Medicaid services can assume you are compliant with the HIPAA Electronic Standards as of October 16, 2002.

**If you haven't already ordered the HIPAA Privacy Standards Manual, please do it now!!** Everything you need to know about the HIPAA Privacy Standards is in the AADA "HIPAA Privacy Standards: A Guide for Dermatology Practices" manual. The latest federal update to the Privacy Standards (issued August 14, 2002) will be available shortly and provided automatically to Academy members who have already purchased the manual.

**The deadline for implementing the HIPAA Privacy Standards is April 14, 2003. There will be no extensions to this due date!**

And if HIPAA isn't enough to worry about, the 2003 Medicare Fee Schedule is not going to make anyone happy. The four-year transition to a resource-based RVU reimbursement for practice expense has cushioned Dermatology from other recent cuts. There is an anticipated drop of over \$2 per RVU in the early DHHS actuary's estimates for the 2003 Conversion Factor!

There is still the possibility of a Congressional "fix." A legislative proposal that would provide a simple 2% increase cleared the House of Representatives in mid-Summer. However, it is subject to a Joint Conference Committee review to resolve differences before a Senate vote. This will be an uphill battle on a crowded Congressional agenda in an election year. The prescription drug proposals are getting the lion's share of Congressional attention. If there is no fix before Congress adjourns its "Lame Duck" session in November, there will be no remedy for next year's cuts, and additional fee schedule cuts are already projected for 2004.

Best regards,



Norma L. Border, Editor

## LOCUM TENENS REQUIREMENTS

What is a physician to do when he or she is going to be away from the practice either for personal reasons such as a vacation, for continuing medical education, or for medical reasons? It is common to retain a "substitute physician" called a locum tenens. The locum tenens is substituting for the regular physician for a period of no more than 60 days.

A claim may be submitted by the regular physician, if assignment is accepted, for services provided by the locum tenens physician. The five basic requirements in billing Medicare for the services of a locum tenens physician are:

1. Regular physician is not available to provide services;
2. Beneficiary seeks services from regular physician;
3. Locum tenens physician is paid by the regular physician for his/her services on a per diem or similar fee-for-time basis;
4. Locum tenens services provided to Medicare patients not to exceed a continuous period of more than 60 days; and
5. HCPCS modifier -Q6 is appended to procedure code furnished by the locum tenens physician.

A locum tenens in a medical group situation must meet the above requirements. However, the Medicare manual states, "Also, a physician who has left the group and for whom the group has engaged a locum tenens physician as a temporary replacement may still be considered a member of the group until a permanent replacement is obtained." Of course, the modifier -Q6 is appended to the procedure codes billed by the locum tenens. Also, the group must keep a record of each service provided by the locum tenens physician along with the locum tenens UPIN number, and provide that list to Medicare if requested. The medical group regular physician's PIN number must be entered on the HCFA-1500 claim form in block 24k when billing services of locum tenens.

If a physician is a member of a group but bills in his/her own name, this physician is viewed as an independent physician in regards to services of a locum tenens physician.

The complete text of the Medicare Carriers Manual regarding locum tenens may be found in Part 3, 3060.7.

Be sure to contact other carriers with which you contract regarding their rules and regulations on services provided by a locum tenens physician.

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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](http://www.aadassociation.org/coding.html)

## RESULTS CLIA OFFICE LABORATORY FAX SURVEY

Thanks to the 56 offices that responded to our survey. We have reviewed all of the comments and responded to individual questions. Please note that these results represent only 1-2% of the circulation of this publication and therefore should not be interpreted as representing the clinical practice of dermatologists in general.

- **89% of overall responding dermatologists have CLIA certificates for Provider-performed Microscopy Procedures (PPMP), Moderately Complexity or Highly Complexity lab procedures**
- 38% of the total have certificates for PPMP Testing
- 34% of the total have certificates for Highly Complex Testing
- 79% perform KOH testing in their offices
- **46% have “no” or “other” mechanism for proficiency testing in place**
- 25% split samples with another physician office laboratory to fulfill proficiency testing requirements
- 20% use CLIA or non-CLIA proficiency testing service

Many respondents complained that the proficiency testing requirements were confusing, especially around KOH testing. Here is information regarding the most common misperceptions:

- KOH is considered a PPMP level of testing that requires a PPMP certificate

- The PPMP certificate requires proficiency testing of a group of samples at a **minimum of twice/year**
- Proficiency testing may be accomplished through 4 avenues: using a CLIA or non-CLIA proficiency testing service; splitting samples with another office laboratory; follow-up sampling of tests with another confirmatory test; or statistical analysis of patient outcomes over a 6 month time span to assure quality of test method.

Recently, we developed a “CLIA Quick Facts” sheet which is on the AAD and AADA Web sites. This was distributed at the Summer Meeting and will also be available at the 2003 Annual Meeting. The focus is to encourage members to develop systems of proficiency testing for KOH testing. CLIA Resources:

- [www.cms.hhs.gov/clia/](http://www.cms.hhs.gov/clia/)
- State CLIA office
- Order AAD/AADA CLIA Manual (call 847-330-0203)
- Contact AAD/AADA Staff: Carol K. Sieck, RN, MSN 847-240-1796 or e-mail [csieck@aad.org](mailto:csieck@aad.org).

## NEWSBRIEFS

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date, over 70,000 covered entities, including the Centers for Medicare and Medicaid Services (CMS), have filed for this extension. The Academy strongly recommends that **ALL** dermatology practices file for this extension!

**If a dermatology practice does not submit a model compliance plan extension form to CMS, it must be compliant with the HIPAA Electronic Health Care Transactions and Code Set Standards by October 16, 2002.**

### HIPAA Electronic Standards Extension Forms

#### To Request Extension On-Line:

The extension form, as well as the instructions for filing and frequently-asked-questions (FAQ), can be accessed online, downloaded and/or completed on line at the following HHS Web site: [www.cms.gov/hipaa/hipaa2/ASCAForm.asp](http://www.cms.gov/hipaa/hipaa2/ASCAForm.asp). You can link directly to this web site from the American Academy of Dermatology Association (AADA) web site at [www.aadassociation.org/HIPAA\\_elect.html](http://www.aadassociation.org/HIPAA_elect.html).

#### To Request Extension By Mail:

If you are unable to access either of the web sites on line, you may fax a request for the HIPAA model compliance plan extension form to AADA on your office letterhead or fax cover sheet. Be sure the request includes both your phone and fax numbers! **Fax your request to (847)330-1120.**

The AADA/Health Policy and Practice department staff will fax back the model compliance plan extension instructions, the extension form and mailing information.

## 2003 MEDICARE FEE SCHEDULE: GOOD NEWS AND BAD NEWS

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Because of the high volume of these services provided by dermatopathologists, the AADA is quite concerned regarding the impact of this proposed change and has urged CMS to delay implementation of this proposal by at least a year, allowing those specialties affected by the change to gather the necessary data to demonstrate the impact on their specialty. We will also encourage CMS to furnish information on how the proposed change affects the specialty mix, frequency and PE per hour data used in calculating Practice Expense RVU values.

### Key Is Conversion Factor

The key to Medicare reimbursement is always the Conversion Factor which CMS does not release until the Final Rule is published in early November. However, the DHHS Office of the Actuary made some initial projections early this year. Any projection will be subject to updates to the various factors in the Medicare Update Formula as well as direct action by Congress.

Remember, the Conversion Factor (CF) X Total Non-Facility RVU = Medicare Fee.

In 2002, the CF = 36.1992 X 1.00 RVU = \$36.20. However, in 2003 the conversion factor is being projected at 34.1355 X 1.00 RVU = \$34.14.

### Projected impact on CPT 17000, 17003, 17004

<b>17000</b>	02 MFS = 62.63	03 MFS = 57.69
<b>17003</b>	02 MFS = 14.48	03 MFS = 13.31
<b>17004</b>	02 MFS = 198.01	03 MFS = 185.01

## ADVANCE BENEFICIARY NOTICE FINAL INSTRUCTIONS

Medicare has issued final instructions for use of the new Advanced Beneficiary Notice (ABN), CMS-R-131-G and CMS-R-131-L. The ABN is a written notice presented to the patient prior to the services and/or procedures by the physician or supplier indicating that Medicare may not pay for the service. Transmittal AB-02-114, a Program Memorandum (PM) issued on July 31, 2002 replaces Transmittal A-01-77 that was issued on July 27, 2001. The effective date of this PM is October 1, 2002. Thus, the mandatory use date of the new ABN forms is October 1, 2002. The CMS-R-131-G form is the general use form and the CMS-R-131-L form is for laboratory services. According to these new instructions, the G form may be used in all situations, but the L form may only be used for laboratory tests.

These final instructions list specific instances when an ABN is **not** required. Cosmetic surgery is included in the list, as well as routine foot care. Therefore, when a cosmetic service is being performed, the ABN form CMS-R-131-G is not required. The instructions do not prohibit a physician or supplier from giving some type of notice voluntarily to beneficiaries for cosmetic services. In these instances however, the CMS-R-131-G should **not** be used. The reason the ABN would not be used is because it contains the language, "Please submit my claim to Medicare." Since cosmetic services are statutorily non-covered services, they do not need to be submitted to Medicare. For such services, the physician or supplier may collect the fee(s) from the beneficiary.

The instructions give examples of when an ABN should be given to a beneficiary. Such an example is giving an ABN to a beneficiary when the service provided is not reasonable and necessary under the Medicare program standards. (Although no specific examples are given in the instructions, the following would be an example: skin tag irritated by necklace — does not meet medical necessity.)

"Routine" ABNs are prohibited. The instructions state that routinely given ABNs are defective notices and will not protect the physician or supplier from liability. The same applies to "generic" ABNs.

There are specific instructions for filling out the ABN forms including format.

### Format requirements are:

1. Italics or fonts that are difficult to read are not to be used in filling in any provider entry blanks or boxes;
  - a. Arial or Arial Narrow font or similar font is recommended
  - b. 10 to 12 font size recommended
2. A Visually high-contrast combination of dark ink on pale background is required;
  - a. black or dark blue ink on white background is strongly recommended
  - b. low-contrast combinations and block shading are prohibited
3. Handwritten insertions must be legible; and
4. Originals and copies of ABNs must be legible and high contrast.

### Completing the ABN form requirements are:

1. **Header** identifying information
  - a. name of billing entity (if group practice, may want to included names of group members)
  - b. address and phone number
  - c. logo, optional
2. **Patient** identifying information
  - a. name entered by physician or supplier
  - b. Medicare number entered by physician or supplier
3. Customizable boxes
  - a. **Items or Services** box
    - i. must be described in detail so patient will understand what services will be provided
    - ii. HCPCS codes alone are not acceptable descriptions
    - iii. a listing of services with check-off boxes acceptable
      - (1) unacceptable to not indicate when service(s) will be provided
  - b. **Because** box
    - i. reason to be given why Medicare may deny payment
    - ii. must be simply and sufficiently stated so that beneficiary will understand reason
4. **Estimated cost**
  - a. may be provided by physician or supplier
  - b. patient may write estimated cost in space
  - c. lack of amount or difference in final cost amount does not invalidate the ABN
  - d. amount estimates may also be provided in the items and services box
5. **Option 1 or 2** box
  - a. may not be pre-selected by provider or supplier
  - b. patient must personally select option
6. **Date**
  - a. entered by beneficiary
  - b. ABN not to be rejected if date is typed or printed
7. **Signature**
  - a. signed by beneficiary
  - b. signed by authorized representative under 42 §CFR 424.36(b)
8. Form copy
  - a. beneficiary retains copy of signed, dated ABN
  - b. physician or supplies retains original signed, dated ABN

You may download the entire ABN final instruction document at: [www.hcfa.gov/pubforms/transmit/AB02114.pdf](http://www.hcfa.gov/pubforms/transmit/AB02114.pdf). This form, which is mandatory on **October 1, 2002** is also printed on page 5.

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

## ADVANCE BENEFICIARY NOTICE (ABN)

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

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

<b>Items or Services:</b>
<b>Because:</b>

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

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

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

<input type="checkbox"/> <b>Option 1. YES. I want to receive these items or services.</b> I understand that Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare. I understand that you may bill me for items or services and that I may have to pay the bill while Medicare is making its decision. If Medicare does pay, you will refund to me any payments I made to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Medicare's decision.
<input type="checkbox"/> <b>Option 2. NO. I have decided not to receive these items or services.</b> I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay.

\_\_\_\_\_ Date

\_\_\_\_\_ Signature of Patient or Person Acting on Patient's Behalf

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

## NEW ICD-9-CM CODES

ICD-9-CM codes are updated annually on October 1 and the updated codes may be used on claims filed beginning October 1. Medicare contractors are required to accept both the old and new codes through December 31. After January 1, claims submitted with invalid ICD-9-CM codes will be rejected. When updating the patient encounter form and other applicable internal forms, be sure to update ICD-9-CM codes so claims submitted are clean claims.

The Program Memorandum AB-02-085 issued on June 20, 2002 directs carriers to emphasize the importance for providers to use the most recent version of the ICD-9-CM coding book and to code to the highest level of specificity. Use 4<sup>th</sup> and 5<sup>th</sup> digits when appropriate. Refer to this Program Memorandum for the total listing of changes to the ICD-9-CM codes.

The following changes to the Tabular List of ICD-9-CM codes in the Program Memorandum especially pertinent to dermatology are:

	454 Varicose veins of the lower extremities		780 General symptoms
New code	454.8 With other complications		780.9 Other general symptoms
Add	Edema	Delete	<del>Amnesia (retrograde)</del>
Add	Pain		<del>Chill(s) NOS</del>
Add	Swelling		<del>Generalized pain</del>
Revise	454.9 <del>Without mention of ulcer or inflammation</del>		<del>Hypothermia, not associated with low environmental temperature</del>
Add	<u>Asymptomatic varicose veins</u>	New code	780.99 Other general symptoms
	Varicose veins NOS		Amnesia (retrograde)
	459 Other disorders of circulatory system		Chill(s) NOS
	459.1 Postphlebotic syndrome		Generalized pain
Add	Chronic venous hypertension due to deep vein thrombosis		Hypothermia, not associated with low environmental temperature
Add	Excludes: chronic venous hypertension without deep vein thrombosis (459.30-459.39)		
New code	459.10 Postphlebotic syndrome without complications		782 Symptoms involving skin and other integumentary tissue
Add	Asymptomatic postphlebotic syndrome	Revise	782.5 Cyanosis
Add	Postphlebotic syndrome NOS		Excludes: newborn (770.83)
New code	459.11 Postphlebotic syndrome with ulcer	New code	795.3 Nonspecific positive culture findings
New code	459.12 Postphlebotic syndrome with inflammation		795.31 Nonspecific positive findings for anthrax
New code	459.13 Postphlebotic syndrome with ulcer and inflammation	Add	Positive findings by nasal swab
New code	459.19 Postphlebotic syndrome with other complication	New code	795.39 Other nonspecific positive culture findings
New sub-category	459.3 Chronic venous hypertension (idiopathic) Stasis edema		998.3 Disruption of operation wound
Add	Excludes: chronic venous hypertension due to deep vein thrombosis (459.10-459.19) varicose veins (454.0-454.9)	New code	998.31 Disruption of internal operation wound
New code	459.30 Chronic venous hypertension without complications	New code	998.32 Disruption of external operation wound
Add	Asymptomatic chronic venous hypertension		Disruption of operation wound NOS
Add	Chronic venous hypertension NOS	V01 Contact with or exposure to communicable diseases	
New code	459.31 Chronic venous hypertension with ulcer	V01.8 Other communicable diseases	
New code	459.32 Chronic venous hypertension with inflammation	New code	V01.81 Anthrax
New code	459.33 Chronic venous hypertension with ulcer and inflammation	New code	V01.89 Other communicable diseases
New code	459.39 Chronic venous hypertension with other complication	V58 Encounter for other and unspecified procedures and aftercare	
	707 Chronic ulcer of skin	Add	V58.4 Other aftercare following surgery
Revise	707.1 Ulcer of lower limbs, except decubitus	Note:	Codes from this subcategory should be used in conjunction with other aftercare codes to fully identify the reason for the aftercare encounter
Add	<u>Code, if applicable, any causal condition first:</u>	New code	V58.42 Aftercare following surgery for neoplasm
Add	Chronic venous hypertension with ulcer (459.31)	Add	Conditions classifiable to 140-239
Add	Chronic venous hypertension with ulcer and inflammation (459.33)	New sub-category	V58.7 Aftercare following surgery to specified body systems, not elsewhere classified
Add	Postphlebotic syndrome with ulcer (459.11)	Add	Note: Codes from this subcategory should be used in conjunctions with other aftercare codes to fully identify the reason for the aftercare encounter
Add	Postphlebotic syndrome with ulcer and inflammation (459.13)	New code	V58.77 Aftercare following surgery of the skin and subcutaneous tissue, NEC
			Conditions classifiable to 680-609

## NATIONAL CORRECT CODING INITIATIVE EDITS

The Correct Coding Initiative (CCI) edits Version 8.1, included some edits regarding complex repair codes that were inappropriate as the edits were for complex repairs of different anatomical sites or for add-on codes.

As Chair of DERMCAC and the Health Care Finance Committee, James A. Zalla, MD sent a letter to AdminaStar Federal, the Medicare contractor in charge of maintaining the Correct Coding Initiative (CCI) edits, expressing concerns about the appropriateness of these edits. AdminaStar Federal has accepted Dr. Zalla's rationale for retaining or deleting the edits. However, the corrections will not appear until CCI Version 8.3 scheduled for October 1, 2002 but the revision will be retroactive.

The edits that will be deleted are those that pertain to different anatomic sites. Should you have had claims denied due to these edits, you will need to resubmit those claims to the carrier after October 1, 2002.

The forty pairs of deleted edits are:

Column 1	Column 2	Column 1	Column 2
13100	13120	13131	13102
	13122		13122
	13131		13150
	13133		13151
	13150		13153
	13151		
13101	13153	13132	13102
	13121		13122
	13122		13152
	13132		13153
	13133		
	13152		
13120	13153	13150	13102
	13102		13122
	13131		13133
	13133		
	13150		
	13151		
13121	13153	13151	13102
	13102		13122
	13133		13133
		13152	13102
			13122
			13133

The edits to be retained are those pertaining to complex repair codes in the same anatomical sites. An example of such an edit would be CPT codes 13100 and 13101.

13100 Repair, complex, trunk; 1.1cm to 2.5cm

13101 2.6cm to 7.5cm

The modifier indicator for these codes is "0", which means that a modifier is not accepted and if used will not bypass the edit. This edit is certainly appropriate since one would not report these codes together on the same date of service.

Repairs in the same anatomical site are added together and reported with the appropriate code.

If you have received any denial of claims based on the current edits for these CPT codes, these claims may be resubmitted to Medicare carriers after October 1, 2002. The adjustments should be made by the Carrier for those claims that you resubmit.

Changes in the 8.2 version of the Correct Coding Initiative effective July 1 — September 30, 2002 affecting integumentary codes pertain to Mohs codes (17304, 17305, 17306, 17307, 17310). The CCI modifier indicator for code 88332 was changes from "1" to "0". The "0" means that no modifier will by-pass the edit.

Code 88332 descriptor is, "each additional tissue block with frozen section(s)".

If you have any questions regarding Correct Coding Initiative, you may contact Vernell St. John, phone: 847-240-1815, fax: 847-330-1120, or email: vstjohn@aad.org.

## CATEGORY III CODES

CPT contains codes that are temporary codes established for emerging technologies, services and procedures. These codes also are used for data collection for services/procedures. Recently, the CPT Editorial Panel agreed to early release of such codes to assist users. Category III codes will be released in July and January on the AMA CPT Web site. They will be published in the subsequent edition of the CPT code book.

Category III codes do not go through the AMA/RUC (Relative Value Update Committee) as there are no relative value work units associated with these codes. Therefore, payment for Category III codes is carrier priced.

A newly established Category III code of particular interest to dermatologists is:

0044T Whole body integumentary photography, at request of a physician, for monitoring of high-risk patients with dysplastic nevus syndrome or familial melanoma

The descriptor of this code clearly states its use. It is to be used for high-risk patients with dysplastic nevus syndrome or familial melanoma and not for routine whole body imaging and at the request of a physician.

Due to CPT Editorial Panel actions, the descriptor language of a Category III code may differ at the time of publication of the CPT code book, or the code may be deleted. Be sure to monitor the AMA Web site for updates on Category III codes as well as noting the text in the current CPT book.

## MEDICARE CLAIMS UPDATE

### Multiple locations

Medicare has issued new text in their Carriers Manual, Part 3, 3101, regarding physicians who provide services in multiple locations. This is especially important for those whose offices are located in different fee schedule pricing localities.

Any claim(s) submitted must clearly list identifying information for the specific location where the service was provided. The claim(s) can be processed through one office, but the location of the provided service is absolutely necessary so that the correct pricing jurisdiction may be applied to the claim.

### Pathology services

A provider may submit a claim for a purchased technical component. However, in purchasing a diagnostic test, the purchaser must perform the interpretation. The physician or supplier that performed the technical component must have a Medicare number. The physician purchasing the test may charge only the price charged by the supplier.

The full text regarding purchasing diagnostic tests may be found in the Medicare Carriers Manual, Part 3, 3060.4.

## DERMATOLOGISTS WITH LOWEST MEDICARE CLAIM DENIAL RATE

A recent analysis of the Medicare Part B Extract and Summary System (BESS) claims denial data for 2000 shows the specialty of dermatology with the lowest denial rate for claims submitted to Medicare. Dermatologists submitted close to 29.5 million claims to Medicare. Of those, less than six percent (5.6 or 1.8 million claims) were denied. Dermatology has the lowest percentage of denials for the twenty-six medical specialties tracked in BESS. The average denial rate for specialists billing Medicare was thirteen percent. Geriatric specialists had the next lowest denial rate of 7.2%.

This denial rate data speaks well for the care and accuracy of claim submissions by dermatology practices, nationally. It is also a compliment not only to Dermatology practices coding and billing staff but also to the Academy's educational efforts, through seminars and *Derm Coding Consult* that have produced this nationally measurable result on behalf of dermatology.



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