DERM CODING CONSULT

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HIPAA Privacy Rule Update

The Department of Health and Human Services (DHHS) has proposed additional changes to the HIPAA Privacy Rule to clarify privacy requirements, without hindering efficient access to health care services. **The initial rule still requires covered entities (including health care providers) to be in compliance with the electronic standards provisions by October 16, 2002 and with the privacy provisions by April 14, 2003.** The proposed modifications to the privacy rule are designed by DHHS to ensure that the HIPAA protections for patient privacy are implemented in a manner that maximizes privacy while not compromising either the availability or the quality of medical care. AADA will submit comment to DHHS on these revised requirements.

Consent Requirement Changes

The proposed modifications address some of the key problem areas with the initial rule. The consent requirement has been eliminated from those situations where obtaining it would interfere with the prompt and efficient delivery of health care services. The change will eliminate the problems identified with pharmacists filling initial prescriptions, referrals to specialists, providing care instructions over the phone and emergency medical situations. The consent requirement would be eliminated only for uses or disclosures for treatment, payment and health care operations (TPO).

This change would eliminate any barriers that would delay or block patient access to care. Consent would be modified to asking patients to simply acknowledge receipt of the provider's policy regarding patient privacy rights and practices.

Oral Communication

The proposal keeps the original oral communication and "minimum necessary" requirements but will make it clear that physicians may freely discuss patient care with other health care professionals without fear that they will violate the regulation if overheard. As long as a covered entity met the minimum necessary standards and took reasonable safeguards to protect individual health information, incidental disclosures — such as another patient overhearing a fragment of conversation — would not be an impermissible disclosure. In addition, the proposed rule would no longer require physicians to track each time medical information is released under a patient's written authorization.

Business Associates

Under HIPAA, health care providers will need to have contract agreements with any entity with which they exchange health information. The proposed rule now provides a model agreement that will make it easier to put these agreements in place. It will also give all covered health entities, including physicians, up to an additional year to facilitate phasing in contract changes.

Marketing

In response to consumer concerns that the marketing provisions in the current HIPAA rule do not protect individuals' privacy, the proposal would explicitly require covered entities to first obtain the individual's specific authorization before sending them any marketing materials. At the same time, the proposal would permit doctors and other covered entities to communicate freely with patients about treatment options and other health-related information, including disease-management programs.

Parents and Minors

The proposal clarifies that state law governs disclosures to parents. In cases where state law is silent or unclear, the proposed changes would preserve state law and professional practice by permitting a health care provider to use discretion

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Letter from the Editor

Dear *Derm Coding Consult* Reader:

First, my apology that the first issue of *Derm Coding Consult* for 2002 is reaching you later than scheduled. I'll offer as reason, the sudden appearance of the revised HIPAA Privacy Rule as well as the late release of the HIPAA Electronic Standards Extension Request and Model Compliance Plan information on March 29th. I believe the revised HIPAA privacy requirements are generally more reasonable and hopefully will be less onerous to implement for the average dermatology practice.

Second, please note the change to the *Derm Coding Consult* masthead. As a result of the Academy's reorganization and as a function of the Health Policy and Practice department, *Derm Coding Consult* is published by the American Academy of Dermatology Association (AADA). The mission of AADA is "the promotion of the educational and professional… interests of dermatology patients and the field of dermatology."

Third, I was immensely pleased to find *Derm Coding Consult* valued so highly by eighty-two percent of AAD/AADA members as reflected in the results of the 2001 Member Needs Assessment Survey! Please be sure to thank your Schering Laboratories sales representative for Schering's on-going and valued partnership in this educational effort.

Fourth, AAD/AADA are now located in our new building! It has been thoughtfully designed to create a harmonious and healthy work environment for all of us. This is my open invitation to each of you to come visit us whenever the opportunity permits.

Best regards,

Norma L. Border, Editor

Medicare database error corrected

There was a change in the Medicare Physician Fee Schedule Database to CPT code 17004 in late Fall of 2001. The change was to the multiple procedure status (m/s) of 17004. This status indicates that payment adjustment may be applied to a code.

Previously, code 17004 had a status of "0" which meant that there were no payment adjustments applied. That is, if 17004 was reported on the same day as another procedure, there was no multiple surgery rule adjustment to the payment of 17004.

When we began receiving calls regarding decreased reimbursement to code 17004 when performed with another procedure, we discovered that the m/s status of 17004 had been changed to "2". This change in status resulted in the standard payment adjustment rules for multiple procedures, 100% allowed for the highest valued procedure, with 50% allowed for the subsequent procedures.

This change in status had occurred without any notice or communication from Medicare.

A letter was sent to the director of Medicare regarding this issue and requesting a reversal of this change. We received a response indicating that the change in the database was an inadvertent error and that the database m/s indicator is correctly "0".

The First Update to the 2002 Medicare Physician Fee Schedule Database, Program Memorandum Transmittal AB-02-018 was published February 8, 2002, with an effective date of January 1, 2002. This update shows the m/s indicator for code 17004 as "0". You may view this memo at: **http://www.hcfa.gov/pubforms/transmit/AB02018.pdf**

CMS also indicated that Carriers do not need to search their files for any claims that were paid incorrectly, thus the Carrier is not required to make adjustments automatically. Carriers are to adjust those claims that are brought to their attention by the provider. For reimbursement of those incorrectly paid claims, you will need to call those to your Carrier's attention following any guidelines your Carrier may have regarding the re-processing of a previously paid claim.

Address Correspondence to either:
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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

Claims for cosmetic procedures

With the changes to the codes for 2002, we have received numerous inquiries regarding the billing for cosmetic services. No longer can physician providers use HCPCS code A9270 to report non-covered services as that code is used for durable medical equipment providers. There are specific modifiers that are to be used for Medicare claims. See *Derm Coding Consult* December 2001, page 4, for information regarding the use of these new modifiers.

When a service is provided to a Medicare beneficiary that is excluded from services covered by Medicare, a provider is not obligated to submit a claim for that service. Those services that are considered non-covered services by Medicare are services that are cosmetic services or not medically necessary.

CMS recently published a draft Advance Beneficiary Notice (ABN) form CMS-R-131-X for services not covered by Medicare. However, on February 26, 2002, CMS decided that this new form was unnecessary and withdrew the form. For services that are not covered by Medicare, ABNs are not required, but physicians may voluntarily have the patient sign some type of ABN. CMS states that some type of an ABN may be given to a patient for services that are never covered by Medicare with the reason box stating that "Medicare never pays for this service". It would not be necessary to submit a claim for that service to Medicare.

You may also read about ABNs on the Medicare Learning Network **www.hcfa.gov/medlearn/refabn.htm**

Local Medicare carriers may have specific guidelines regarding filing claims for non-covered or cosmetic services. If so, that information will have been published in the carrier bulletin/newsletter, or is in the carrier manual. One must be aware of specific guidelines of the carrier so that if claims are submitted, they are submitted according to the carrier's directives.

Billing Medicare without appropriate modifiers for procedures that are non-covered or cosmetic services is considered fraud. Most carriers have benign lesion policies which clearly state when it is medically necessary to remove a benign lesion, and the documentation required to support the medical necessity of the procedure.

If you participate in managed care plans, you must be aware of what the contracts say regarding cosmetic services.

The use of an ABN must not be confused with the informed consent form. The ABN is used to establish patient financial responsibility for services rendered. The informed consent signed by the patient indicates that the patient understands the procedure to be performed and any possible side effects and/or consequences.

Medicare Practice Expense Lawsuit Victory

On January 1, the method for calculating the practice expense component of the Medicare physician fee schedule became fully effective, at last, after a four-year phase-in period. The new method takes into account the higher office overhead expenses incurred by dermatologists and other specialists that furnish care to beneficiaries primarily in an office setting.

Although the new method is now completely in place, it did not always seem as if this point would be reached. Within days of enactment of the Balanced Budget Act of 1997, a law that authorized the new practice expense method, a group of mostly surgical specialty groups petitioned the U.S. District Court for the Northern District of Illinois, Eastern Division to invalidate the new practice expense method that was developed by the Secretary of Health and Human Services to implement the law. The District Court rejected the plaintiffs' case on the grounds that the new method reflected a reasonable interpretation of the practice expense provisions in the BBA'97.

The plaintiffs then appealed this decision to the U.S. Court of Appeals for the Seventh Circuit. The appeal case was argued on November 2, 2000 and decided on January 28, 2002. The appellate court upheld the lower court's ruling and decisively rejected the arguments presented by the plaintiffs. As the decision itself states: "We do not find the petitioners' arguments persuasive." It is hoped that this resounding victory for the new practice expense method will finally lay to rest attempts to reverse the method for making practice expense payments to physicians participating in the Medicare program.

This legal victory is especially gratifying for American Academy of Dermatology Association members. The AADA, along with its partners in the Practice Expense Fairness Coalition, filed legal briefs in both lawsuits in support of the DHHS and the practice expense method. In addition, dermatologists overall recognized an increase in Medicare income as a result of the practice expense policy. Under the new method, dermatologists have experienced approximately 20 percent increase in Medicare income over the four year transition period.

Please contact Laura Saul Edwards, Assistant Director for Federal Affairs, at 202-842-3555 or ledwards@aad.org if you have questions about the new practice expense method or the practice expense lawsuits.

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

DERMCAC

DERMCACs (Dermatology representatives to the Medicare Carrier Advisory Committee) are appointed by the individual state dermatologic societies. They keep current on issues of importance that may affect coding and reimbursement for services provided by dermatologists. When there is a reimbursement issue with a specific Medicare Carrier, the DERMCAC in the particular state works directly with the Carrier Medical Director in resolving the issue.

DERMCACs play an important role in the Local Medical Review Policies (LMRP) process. The DERMCAC attends the Carrier Advisory Committee (CAC) meeting on a quarterly basis and monitors LMRPs that would be pertinent to dermatology and provides appropriate comments.

DERMCACs meet as a group at the AAD Annual Meeting and at the summer meeting. We are sincerely appreciative of the time the DERMCACs take from their practices to attend these meetings as well as the quarterly CAC meetings. Their participation is most important to all dermatologists. We say THANK YOU to those of you who currently are DERMCACs and to those who have served as DERMCACs in the past.

To contact your DERMCAC regarding an issue, please send the appropriate documentation explaining the issue via fax. The DERMCAC can then review the issue and contact you. An asterisk (*) indicates the alternate DERMCAC.

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Alabama	Gwendellyn McLean, M.D.	205-879-5456	205-879-9290
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Montana	Jeffry Goldes, M.D.	406-442-2064	406-442-3534
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Local Medical Review Policies

Medicare Contractors are private insurance companies that contract with HCFA to process Medicare claims. These Contractors are most commonly referred to as Medicare Carriers. Medicare Carriers are responsible to review and adjudicate claims according to services that are covered services by Medicare Part A or Part B. Thus only the claims for services that are covered services are to be paid by the Medicare Carriers.

The two types of Medicare coverage policies are Local Medical Review Policies and National Coverage Decisions. The National Coverage Decision most recently affecting dermatology was for the treatment of actinic keratoses. Local Medical Review policies are specific to Medicare Carriers for the individual geographic location covered.

Local medical review policies (LMRP) are developed to provide guidance to providers regarding coverage of services. LMRPs are developed by the Carrier Medical Directors and are required to be consistent with any national model policies or National Coverage Decisions. The LMRP may, however, be more detailed or specific than the national guidance document. The LMRP may not be in conflict with any National Coverage Decision. CMS (HCFA) reviews LMRPs to ensure that they are consistent with National Coverage Decisions. An LMRP explains when a service will be covered, as well as when it is considered a reasonable and necessary service.

The content of LMRPs consist of:

- Description of the policy
- Indications and limitations of coverage
- Covered ICD-9-CM diagnosis codes
- Reasons for non-coverage
- Sources of information
- Reference to any national policies, if applicable
- Coding guidelines
- Documentation guidelines
- Additional comments
- Effective date of policy
- Date of any updates to policy

Carriers' developmental process of LMRPs must be open to the public per CMS guidelines. A draft LMRP is developed, made available to the public, and public comments are solicited. Each Medicare Carrier lists their draft LMRPs on their Web site*, and electronic or written comments are accepted. The comments are reviewed and edits made by the Carrier Medical Director and the Carrier Advisory Committee (CAC) before the final LMRP is approved.

(*Regence Blue Cross Blue Shield of Utah does not have a Medicare Web site for providers. Utah providers should refer to monthly Medicare bulletins for any information on LMRPs or draft LMRPs.)

Providers must be aware of their Medicare Carrier's LMRPs. The coverage policy as stated in an LMRP will determine whether a service provided will be covered and/or deemed medically necessary.

There are LMRPs that are especially pertinent to dermatology. One example is a policy on the Removal of benign skin lesions. Not all carriers have such a policy, but for those that do, providers must know exactly what their particular policy states. The criteria listed in the policy will determine whether the service provided will be reimbursed by the Medicare carrier.

Other examples of LMRPs that a carrier may have pertinent to dermatology are:

- Actinic keratosis
- Bilaminate skin substitute
- Cosmetic surgery
- Grenz ray therapy
- Modifier -25
- Mohs Micrographic Surgery
- Mycotic nails
- Pathology services
- Photochemotherapy/Phototherapy/PUVA
- Routine foot care
- Unna boot
- Venipuncture

Thorough reading of your Carrier's monthly newsletter/bulletin will keep you informed on the latest coverage issues. Billing staff must also be aware of any Medicare coverage directives from your Carrier.

For further information on Local Medical Review Policies and National Coverage Decisions, refer to the Web sites listed below.

www.hcfa.gov/coverage/8a2.htm

www.hcfa.gov/medicare/mr/lmrp.htm

www.lmrp.net

www.draftlmrp.net

www.hcfa.gov/coverage/8b3-t4.htm
(National Coverage Decision - Actinic Keratoses Treatment)

In the June 2001 issue of *Derm Coding Consult* (page 4), we reported on the Physician's Regulatory Issues Team (PRIT). PRIT was established early in 2001 by the Centers for Medicare & Medicaid Services (CMS) to address issues that were particularly burdensome for physicians. The latest update from this group was issued on November 26, 2001. This article will summarize issues that are of particular concern to dermatologists.

Many of the issues identified by PRIT have information posted on CMS (HCFA) Web sites. The sites provide information for beneficiaries as well as providers.

Advance Beneficiary Notices (ABN)

An updated ABN was published in the September 2001 issue of *Derm Coding Consult*. This form may be used, but currently it is not mandatory. Mandatory use of the new form will take effect later this year, after CMS publishes instructions for the use of the new form. It is important to note that the new forms include a general ABN as well as an ABN for laboratory services.

The ABNs, general use (CMS-R-131-G) and laboratory services (CMS-R-131-L), may be found on the following site: **http://www.hcfa.gov/medlearn/refabn.htm**.

CMS (HCFA) also has some "frequently answered questions" posted at **http://www.hcfa.gov/medlearn/faqabns.htm** to answer beneficiaries' questions about ABNs.

Coverage/Payment of Follow-Up Visits for Cancer Patients

Preliminary investigation by PRIT indicated that payment for such services were an issue with only a few carriers. However, they are collecting additional information regarding this issue to determine an appropriate course of action.

If you are having difficulty in reimbursement by your Medicare Carrier for follow-up visits for patients with a history of skin cancer or malignant melanoma, please advise Vernell St. John or Norma Border at the Academy.

Eligibility Determination

CMS issued a Program Memorandum (Transmittal AB-01-137) in September 2001 allowing Carriers to release eligibility information to providers over the telephone. This action was in response to physician's concerns over determining the type of Medicare plan covering a beneficiary.

Due to HIPAA privacy requirements, the provider must give the following before the eligibility information may be released by the Carrier:

- Beneficiary last name and first initial
- Beneficiary date of birth
- Beneficiary Health Insurance Claim number
- Beneficiary gender.

A Carrier may choose to limit the number of inquiries per call.

Physician Supervision of Medical Residents

The requirements for physicians supervising residents has been cause for confusion. In reviewing this issue, PRIT discovered the issue had two parts:

1) supervision requirements,

2) documentation requirements.

Work is being done on this issue, including input from the Practicing Physicians Advisory Council (PPAC). We will be watching for further developments in this area.

Medicare Rules

There were concerns from physicians regarding finding the right information about Medicare requirements. Through PRIT some additional assistance has been made available. This includes:

— Toll free numbers for Medicare carriers for provider use;

— New Education material is available at **www.hcfa.gov/medlearn,**

— Answers to frequently asked questions at **www.cms.gov.**

A Medicare Basics manual is being developed with a target release date of Spring 2002. This manual is also to be available on CD-Rom.

In summary, CMS is working diligently to address concerns of physicians to reduce burdens. All the updates on PRIT, are available at:
http://www.hcfa.gov/medlearn/pritproj.htm

HIPAA Privacy Rule Update

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to provide or deny a parent access to such records as long as that decision is consistent with state or other law.

Uses and Disclosures for which Authorizations Are Required

The proposal would also allow the use of a single type of authorization form to get a patient's permission for a specific use or disclosure that otherwise would not be permitted under the Privacy Rule. Patients would still need to grant permission in advance for each type of use or disclosure, but the proposal would eliminate the need for different types of forms to obtain that advance permission.

Need Comments on Alternatives to De-Identification

DHHS is seeking comments on establishing a limited data set that does not include directly identifiable information but in which certain identifiers remain. In addition, to further protect privacy, the Department proposes to condition the disclosure of the limited data set on a covered entity's obtaining from the recipient a data use agreement. The recipient would agree to limit the use of the data set for the purposes for which it was given as well as not to re-identify or contact any individual.

Further information about the proposed rule is available on the Department of Health and Human Service Web site at **http://www.hhs.gov/ocr/hipaa/**.

How To Request Extension on HIPAA Electronic Transactions and Code Set Standards

Physicians whose practice operations will not be compliant with the HIPAA Electronic Transactions and Code Set standards by 10/16/02, have until October 15, 2002 to submit a request for an extension. The Centers for Medicare and Medicaid Services (CMS) are trying to make this as simple as possible.

General instructions on how to request the extension as well as a "fill in the blank" Model Compliance Plan can be downloaded from **http://www.cms.hhs.gov/hipaa**. CMS is also implementing an on-line filing capability for extension requests and compliance plans that will provide a confirmation number for each extension issued.

Submission of the extension request with a completed Compliance Plan will move the compliance due date for the provider to October 16, 2003. The American Academy of Dermatology Association is in process of distributing full instructions and the CMS model compliance plan to all AAD/AADA members.

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