DERM CODING CONSULT

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NewsBriefs

AADA Supports Elimination of 95-97 E & M Documentation Guidelines

The American Academy of Dermatology Association (AADA) has submitted a letter to Tommy G. Thompson, Secretary of the Department of Health and Human Services to share the AADA's strong support for elimination of the Evaluation and Management documentation guidelines in their current form, as recommended by the HHS Advisory Committee on Regulatory Reform. Since the first version of the documentation guidelines was developed in 1992, dermatologists have consistently reported that the guidelines are complex, burdensome, and detract from patient care. AADA agreed with the HHS Advisory Committee on Regulatory Reform assessment that it is time to replace the guidelines with a rational, streamlined method for recording evaluation and management services.

Currently, the Centers for Medicare and Medicaid Services (CMS) is working with the national medical societies and the American Medical Association to devise a proposal for a new structure for documentation of evaluation and management services. The AADA is an active participant in this effort. The new E&M documentation proposal should be completed later this year, and it is expected that the recommendations made in the proposal if accepted by CMS, would be implemented by 2004. In the interim, CMS and the medical societies must agree upon what constitutes sufficient documentation until the new coding structure is in place. Until such time as there is official notification from CMS regarding interim or new E&M documentation

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Quarterly Medicare Updates On-Line

The Centers for Medicare & Medicaid Services (CMS) announced in April via Program Memorandum AB 02-049 that all Medicare providers have a new source for timely Medicare update information on the CMS Web site. The **CMS Quarterly Provider Update** will provide a single source for all Medicare instructions and regulations that impact Medicare providers. The Web site also lists regulations under development, such as the 2003 Medicare Physician Fee Schedule and provides their scheduled publication dates. *In addition, to the extent practical, all new and revised instructions affecting Medicare providers will be implemented 90 days after they are included in the Update.* For example, the instructions listed in the first update have implementation dates of July 1, 2002 or later. There will still be instructions and program changes that will necessitate mid-Quarter publication. However, these will be clearly identified on the Web site.

The information will be released on the first work day of each calendar quarter and may be viewed at: **www.cms.hhs.gov/providerupdate**. The information found on this site includes all recent Medicare regulations published in the *Federal Register* as well as Medicare Coverage Issues Manual changes and Program Memorandums issued. This information is categorized for all who receive payment from Medicare with specific sections for physicians and other health professionals. Monitoring this site and your individual Medicare carrier's Web site will keep you fully informed of any changes in the Medicare program that would affect claims and reimbursement processing.

in this issue

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Letter from the Editor

Dear *Derm Coding Consult* Reader:

The word from our Washington DC office is that the Centers for Medicare Services (CMS) will release the Notice of Proposed Rule Making for the 2003 Medicare Physician Fee Schedule ahead of schedule! The American Academy of Dermatology Association (AADA) staff are prepared to review it in detail and comment accordingly.

However, there are encouraging words coming from the House Ways and Means Committee that a legislative "fix" to the Medicare update formula is making progress. A proposed legislative budget fix for the Physician Fee Schedule would ensure a positive two percent increase to the 2003 conversion factor. Increases for 2004 and 2005 would drop to under two percent. While this is encouraging, we can't lose sight of the issue that before 2006 a "real" recalibration of the Medicare update formula is required or physician reimbursement will face an even steeper "drop-off."

In the meantime, the shortfalls in this year's Medicare Part B contractor claims processing budgets of over $40MM is severely impacting carrier provider education activities. Already carriers are advising physicians that they will not be receiving a hard copy of the fourth quarter Medicare Provider Bulletin and will be expected to down-load and print it off from the Carrier's Web site.

This particular budget crunch should end with the start of the federal government's new fiscal year, as of October 1, 2002. However, it may be time for dermatology practices to give serious consideration to hooking up internet access in the office as a way to ensure that you receive timely and accurate information on Medicare coverage and billing requirements.

Best regards,

Norma L. Border, Editor

CMS Cuts Provider Education

Faced with a $40 million dollar shortfall in the Medicare budget for the handling of an increased volume of Medicare Part B claims, inquiries and appeals, the Center for Medicare Services has instructed their Carriers to shift funds from Provider Education and Provider Representative activities for the balance of fiscal year 2002 (through September 30, 2002). In most cases, at minimum, it means that Carriers will not be printing and mailing copies of their Monthly or Quarterly Provider bulletins to physician offices. Carriers will prepare the information but it will only be made available on their respective Web sites. "If a physician office does not have internet access, they may have to contact their Part B Carrier to request that the 4th Quarter bulletin be faxed to them," according to Stewart Streimer, Director/Provider Billing and Education Group during the June 17th CMS Physician Open Forum conference call.

The Carriers have been given a certain amount of latitude as to which Provider Education services will be cut, but for the most part, it will become increasingly more difficult for physicians to resolve claims or medical review policy issues through the end of FY2002. In some instances, Provider Representatives may be completely replaced by Customer Service Representatives.

Unfortunately, the US General Accounting Office in its recent report to the Senate Committee on Finance on two recent studies examining the interactions between physicians and carriers (*Medicare: Using Education and Claims Scrutiny to Minimize Physician Billing Errors*, GAO-02-778T, May 28, 2002) found that CMS falls far short in meeting the needs of physicians for clear explanations of complex coverage policies and billing requirements.

> *"In summary, … physicians often do not receive complete, accurate, clear or timely guidance on Medicare billing and payment policies."*

CMS cuts to provider education as well as its efforts to put reliable information on its Web site will, in the long run, serve the dual function of making internet access in the medical practice the rule rather than the exception. Office access to the internet expands the practice's ability to find reliable information and Web sites.

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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

NewsBriefs

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guidelines, The 1995 and 1997 documentation guidelines (DGs) remain in effect.

CMS, formerly HCFA, began work with the AMA to develop DGs to supplement and clarify the definitions of E/M services contained in the CPT book (e.g., what are the requirements of an expanded problem focused examination, what are the requirements for moderate complexity medical decision making). HCFA distributed these DGs in September 1995 to Medicare carriers who began educating physicians on the appropriate use of the guidelines. The educational period concluded August 31, 1995. Effective September 1, 1995, these DGs were used for medical review of E/M codes. These initial DGs have subsequently been referred to as the "1995 DGs."

Some specialty societies, including AAD/AADA, criticized the 1995 DGs because the requirements for a complete single system examination were not clear. They felt that medical reviewers rarely gave credit for complete single system exams and, therefore, were not allowing specialists to meet the documentation requirements for high level E/M services. Moreover, it was difficult to ensure work equivalency between multi and single system exams under these guidelines.

In response to these criticisms, HCFA and the AMA, with input from medical specialty societies, developed an alternative set of DGs that was intended to be more useful for single system exams. The alternative set of DGs included ten single system examinations. The definitions for the multi-system examinations were also clarified, and other changes were made. For instance, the required elements in the medical decision-making algorithm were significantly changed. The revised guidelines were reviewed extensively and approved by representatives of most national medical societies. These revised DGs were released in 1997 and have subsequently been referred to as the "1997 DGs."

CMS original intent was to replace the 1995 DGs with the 1997 DGs. However, many practicing physicians strongly objected to the 1997 DGs because they felt that they were too complicated and would detract from patient care. Therefore, in April 1998, CMS instructed Medicare carriers to use both the 1995 and 1997 DGs when reviewing records. **Physicians may use whichever set of evaluation and management documentation guidelines is most advantageous.** Further, CMS is committed to look at alternative sets of guidelines, conduct pilot studies of any further draft guidelines before implementation, and to engage in extensive efforts to educate physicians and carriers on the requirements of the guidelines prior to implementation.

Photodynamic Therapy (PDT) Drug Coverage

On May 8, the Centers for Medicare and Medicaid Services (CMS) issued a letter to inform all Medicare Part B contractors that the generic aminolevulinic acid, (ALA) and/or the Levulan Kerastick may be billed using HCPCS code J7308 in conjunction with the photodynamic therapy procedure (CPT code 96567) and is covered by the Medicare program. CMS stated, "Physicians have discretion in deciding which treatment is most appropriate for the individual patient, and denying the availability of this drug/device therapy is inappropriate." In addition, Medicare covers the destruction of actinic keratoses without restrictions based on lesion or patient characteristics.

The CMS clarification about PDT therapy is necessary because some contractors are improperly denying coverage of this drug. Non-coverage of the aminolevulinic acid, (ALA) is inconsistent with the Medicare national coverage policy for AK treatment, issued November 26, 2001, which makes no distinction between the drug/device used to treat actinic keratoses.

The PDT treatment for AKs includes the application of the photosensitizing drug aminolevulinic acid, (ALA) which is activated by the application of the light source to destroy the actinic keratoses lesions. The FDA has approved this combination of drug/device for the treatment of AKs. See article in the December 2001 issue, page 3, regarding PDT coding.

The Medicare Coverage Issues Manual, MCM Pub. 6, S. 35-101 states:"

> *"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 curretage. Less commonly performed treatments for AKs 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)."*

Prompt action by CMS to enforce the AK national coverage policy is greatly appreciated. If the carrier in your region is denying coverage for PDT therapy, or for the necessary photosensitizing topical drugs, or is otherwise out of compliance with the National Coverage Policy for treatment of AKs, contact Norma Border at 847-330-0230 or nborder@aad.org for assistance.

Advance Beneficiary Notice

An Advance Beneficiary Notice (ABN) is presented to the beneficiary by the provider to inform the beneficiary before the service is performed that Medicare most likely will not pay for that particular service in that instance. Therefore, the beneficiary will be liable for payment for that particular service should Medicare not pay for the service provided.

The Center for Medicare Services (CMS) instructions for the new Advance Beneficiary Notice (ABN) were issued in January 2002 as **draft** instructions. These draft instructions are very comprehensive and can be printed in their entirety (24 pages) from: **www.cms.hhs.gov/medlearn/flp7310.pdf**

The ABN must be specific to the particular service to be provided. In other words, it may not be a generic form. The ABN Form to be signed by the beneficiary must have spaces, blanks or boxes to list the particular service to be provided as well as the reason why Medicare probably will not cover that service. The service and reason for Medicare denial must be written in lay language that the beneficiary will understand. Also, the beneficiary must be notified in advance of the service so that the he or she may "make a rational, informed consumer decision". See Advance Beneficiary Notice (ABN) No. CMS-R-131-G (OMB Approval No. 0938-0566) published in the September 2001 *Derm Coding Consult*, page 7.

An ABN should only be given to a beneficary when the provider has doubt as to whether the particular service will be covered by Medicare. The ABN instructions also state that "blanket" ABNs should not be used. According to the instructions, "Giving ABNs for all claims or items or services is not an acceptable practice."

Examples of services provided to beneficiaries for which an ABN is **not** required include cosmetic surgery. It is important to note that Option 1 of the ABN form states that the claim is to be submitted to Medicare. Therefore, if a cosmetic procedure is to be performed, signing an ABN is unnecessary as cosmetic services are not a covered benefit by the Medicare program and a claim would not be submitted to Medicare.

A provider may choose to provide some type of notice to the beneficiary regarding the cosmetic service to be provided, but the standard ABN form (CMS-R-131-G) should **not** be used in this instance. Information and an example of such a notice may be found at **www.cms.gov/medlearn/refabn.asp**.

Cosmetic services are not a covered benefit of Medicare according to the Medicare rules. Submitting a claim for a cosmetic service to Medicare as a medically necessary service could be considered fraudulent billing. If you are performing cosmetic services, you may choose to give your patients some type of cash receipt.

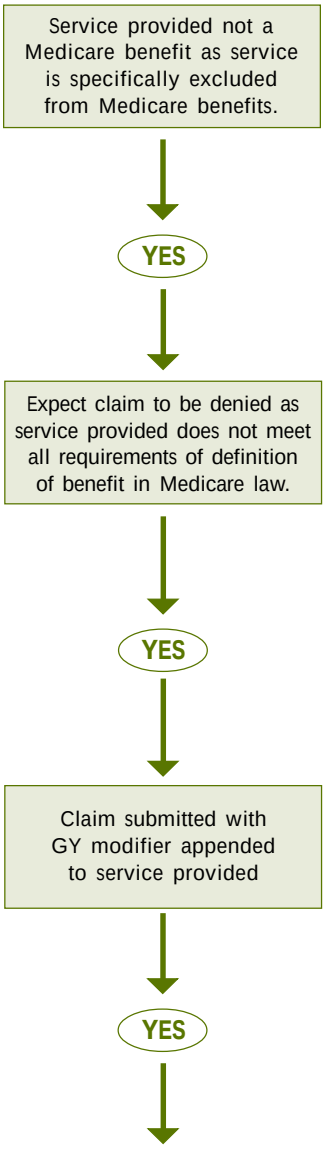
The use of the GA modifier indicates that an ABN has been signed by the patient and it is a part of the patient's medical record. A copy of the signed ABN should also be given to the patient.

continued in box on next page

The following flow charts will guide you in the use of modifiers GY and GZ.

MODIFIER GY

ITEM OR SERVICE STATUTORILY EXCLUDED OR DOES NOT MEET THE DEFINITION OF ANY MEDICARE BENEFIT



RESULTS:
ABN not necessary for services that are statutorily excluded from Medicare benefits.

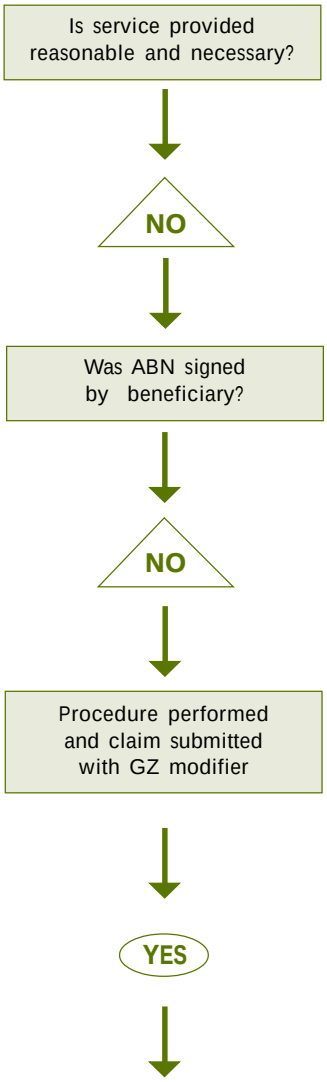
ABN not an issue for these services.

NOTES:
Claim **should** be denied by Medicare. However, if claim **is paid**, the GY modifier is irrelevant.

Beneficiary will be liable for charges.

MODIFIER GZ

ITEM OR SERVICE EXPECTED TO BE DENIED AS NOT MEDICALLY NECESSARY



RESULTS:
Claim will be reviewed by Medicare And **may** or **may not** be denied.

If claim is denied, beneficiary is not liable for payment of service provided.

NOTES:
Use modifier GZ when you know an ABN should have been signed and wasn't to alleviate risk of allegation of fraud and abuse for claiming service provided was medically necessary.

Never use modifier GZ when you expect Medicare to pay for the service provided.

Modifier –59

With the approaching deadlines for the HIPAA Administrative Simplification regulations which state that all carriers are required to recognize the coding standards of AMA/CPT, the correct use of the CPT modifiers becomes more important. Of course, the regulations do not state that the payers must pay based on the AMA CPT codes and related modifiers, only that they have to accept the codes electronically.

After the HIPAA electronic standards deadline of October 16, 2003, health care payers may no longer advise physicians or providers that they "do not accept" any valid AMA CPT code or related modifier. However, until then, it is still important to know the policies of the health care payers on the use of CPT modifiers as the rules currently differ among Carriers.

CPT Modifier –59 was introduced in 1997 and has been required with Medicare's Correct Coding Initiative (CCI) for some time. Now, there are a growing number of private health care payers that are recognizing modifier –59.

Modifier –59 indicates a distinct procedural service. This modifier explains to the Carrier that the service is separate from the other service(s) reported. If a lesion is removed and a skin biopsy of a separate lesion is done during the same encounter, it would be necessary to append modifier –59 to the skin biopsy code (11100) on a Medicare patient.

If the procedure performed is one of the parts of a CCI code pair edit, one procedure would need to be reported with a CPT modifier. For example, destruction of an actinic keratosis performed during the same encounter as a shave removal of a symptomatic seborrheic keratosis would be reported as follows:

17000 11305 –59

Previous articles have appeared in *Derm Coding Consult* regarding modifier –59. (See issues: 9/01, pg 5; 6/01, pg 6; 3/01, pg 1,3; 6/00, pg 1-2, 6; 6/98, pg 2; 6/97, pg 6-7; 3/97, pg 2.) Access these articles at **www.aadassociation.org/coding.html**.

Advance Beneficiary Notice *continued*

Resources for ABNs may be found at the following Web sites:

www.hcfa.gov/medicare/bni/

www.cms.gov/medlearn/flp7310.pdf

www.cms.gov/medlearn/refabn.asp

The current ABNs used are good only until August 31, 2002. The new ABN form must be used beginning September 1, 2002.

See related *Derm Coding Consult* articles in June 2002, page 3 and September 2001, pages 1, 8, (**www.aadassociation.org/coding.html**).

Coding Questions and Answers

The following coding questions and answers reflect the most recent inquiries to AADA/Health Policy and Practice/Coding and Reimbursement staff. Please feel free to contact us at any time with your questions!

Q. May I bill CPT code 11100 (biopsy) and 11601 (excision) for the same lesion during the same encounter?

A. No! The most definitive code for the service provided would be reported. In this case, the excision would be the appropriate code to bill.

Q. Would I use the reduced service modifier –52 when injecting only 5mg of triamcinolone acetonide? The descriptor of HCPCS code J3301 is: Injection, triamcinolone acetonide, 10mg.

A. No modifier is needed. When an amount is stated in the descriptor, any quantity up to that amount is billed as one unit.

Q. I notice that there are site specific biopsy codes in CPT, such as for the eyelid and lip. When is it appropriate to use such site specific codes rather than the skin biopsy code 11100?

A. According to the AMA's publication *Principles of CPT Coding*, if an appropriate site specific biopsy code exists, that code should be reported rather than code 11100. Be sure to refer to CPT for the exact descriptor of a site specific code.

Q. When doing two skin biopsies, do I add modifier –59 to code 11101?

A. No. Code 11101 is an add-on code. Add-on codes are codes that may not be used alone and are never subject to modifiers. Refer to Appendix E in CPT for a list of all add-on codes.

Q. A patient was sent to me for a consultation. During that same encounter, a surgical procedure was performed. May a consultation still be billed?

A. Yes, as long as the requirements are met for the consult. (See *Derm Coding Consult*, March 2000, page 3.) Performing a procedure does not negate the use of a consultation code. Medicare guidelines for consultation permit initiation of treatment at the time of the consult.

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

Multiple Surgery Rule Application Errors on CPT 17004

As noted in the March 2002 Derm Coding Consult (page 2), Carriers received instruction to change the Medicare Physician Fee Schedule Database to apply the multiple surgery (m/s) rule CCI modifier "2" to CPT code 17004, effective January 1, 2002.

Previously, CPT 17004 had a CCI status of "0" which meant that if CPT 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 in early 2002 regarding decreased reimbursement to code CPT 17004 when performed with another procedure, it was discovered that the m/s status of 17004 had been changed to "2". This change in status resulted in the standard multiple surgery payment adjustment rules for multiple procedures being applied to CPT 17004, 100% allowed for the highest valued procedure, with 50% allowed for the subsequent procedures.

On behalf of the Academy, James A. Zalla, MD as chair of Dermcac, sent a letter to the Center for Medicare Services requesting a reversal of this change. CMS responded that the change in the database was an inadvertent error and that the database m/s indicator should be "0".

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

Medicare Carriers were not supposed to activate the incorrect "2" status for CPT 17004 until January 1, 2002. CMS has indicated that Carriers do not need to search their files for any CPT 17004 claims that were paid incorrectly. These errors should only appear on claims with service dates from January 1, 2002 thru March 31, 2002. However, if you received reduced payments for CPT 17004 between October 1, 2001 and December 31, 2001, it indicates the local Carrier may have initialized this edit prematurely.

The Medicare Carriers are not required to make adjustments automatically to any claim with this error. However, they are to adjust/correct those CPT 17004 claims that are brought to their attention by the provider. For reimbursement of those incorrectly paid claims for dates of service from October 1, 2001 thru March 31, 2002, you will need to resubmit these to your Carrier's attention following any guidelines your Carrier may have regarding the re-processing of a previously paid claim and include in your cover letter that these are being re-submitted because payment was reduced as the result of a Medicare administrative error.

Solving Modifier Mysteries

There are AMA/CPT descriptors of modifiers (see AMA/CPT 2002, Appendix A) and there are Carrier's guidelines on when to use modifiers. The bottom line is that you must know the CPT descriptors as well as each Carrier's guidelines regarding the use of CPT modifiers to effectively submit multiple procedures for payment on a single claim. Ignoring either CPT or Carrier requirements will only result in delayed or denied payment.

Modifier –59 Distinct Procedural Service — is now being recognized by some third party payers consistent with the Correct Coding Initiative. Previously this modifier was required only by Medicare.

Modifier –51 Multiple Procedures — is generally not required by Medicare and other payers. It will be applied automatically by the payers software when required.

Modifier –76 Repeat Procedure by Same Physician — is required by some payers when the same procedure code is performed more than once on separate lesions (i.e., 11601, 11601-76, 11601-76). However, this application is not consistent with CPT guidelines.

The only way to be certain what modifier to use is to know what the particular Carrier or payer requires. Consider setting up a billing modifier "quick reference" sheet. List the CPT Modifiers in the left hand column of a large columnar pad.

List the dermatology practice's major payers (one in each column) across the top. For each payer, enter an indicator for each required CPT Modifier in the payer's column to speed up adding required modifiers in the billing process and to ensure better claims submission accuracy.

CMS Issues EMTALA Clarifications

On June 13, 2002, the Centers for Medicare and Medicaid Services (CMS) issued letters to the CMS Regions clarifying a number of EMTALA issues that have been presented by the Specialty Society EMTALA Task Force. CMS recognizes that these changes will permit more optimal use of a limited number of specialists and still meet the intent of the Emergency Medical Treatment and Labor Act (EMTALA) legislation.

Simultaneous "On-Call" — CMS instructions now indicate that it is permissible to allow a specialist to be "on-call" and to provide coverage simultaneously at several hospitals to maximize patient access to specialist care.

Scheduling of Elective Surgery — CMS instructions now indicate that it is permissible for an "on-call" specialist to schedule and perform elective surgeries for his/her own or referral patients, except in the case where he or she is the specialist "on-call" in one of the region's Critical Access Hospitals.

CMS Begins Random Inspections of Physicians' Offices with Waived Testing

On May 3, 2002, the Centers for Medicare & Medicaid Services (CMS) announced that they will begin a new initiative, "designed to help physicians and other providers perform simple tests that provide better care to their patients". While simple or "waived" tests are exempt from regulation under CLIA and typically performed in physician office laboratories, there have been identified problems with the quality of the performance of these tests. CMS will be sending trained surveyors to a small number of physician offices with "waived" labs. These will be selected from a randomized sample of all "waived" labs.

The selected laboratories will be notified in advance of the visit and be encouraged to participate in this educational and quality assurance project. There are no fines or sanctions associated with these surveys. The CMS surveyors are utilizing a purely educational approach in working with lab personnel. A copy of the press release, "CMS Launches Effort to Improve Quality of Laboratories Doing Simple Tests" is available at: **www.cms.hhs.gov/media/press/release.asp?Counter=451**

Following is a recap of current CLIA testing requirements for the most commonly performed tests in a dermatology practice.

KOH & DTM TESTING

To fulfill the CLIA requirement for potassium hydroxide (KOH) OR dermatophytosis (DTM) testing, the physician office must be aware of the following:

- These require a "Certificate for Provider-Performed Microscopy Procedures (PPMP).
- In regard to DTM, the National Committee for Clinical Laboratory Standards NCCLS-M22-A2 were modified in 2001 to require end-user quality control checks with each batch of shipment. Physicians are asked to do this regardless of various claims by manufacturers.
- In regard to KOH or DTM, the federal requirement is bi-annual proficiency testing of PPMP samples, "to assure the validity of patient test results".
- Physician offices that perform PPMP must do the following in addition to proficiency testing: be able to demonstrate processes for quality control, quality assurance, patient test management, and personnel requirements
- Unlike certificates for moderate and high complexity testing, PPMP certificates are not subject to routine inspections unless the provider is performing other moderately complex tests that require a "Certificate for Moderate Complexity".
- Proficiency testing requirements may be accomplished by a variety of methods: enrollment in a proficiency testing program that is or is not approved by the U.S. Department of Health and Human Services, splitting samples with another laboratory, or follow up sampling of the tests performed with a confirmatory test or statistical analyses of patient outcomes over a six month time span to assure the quality of test methods.

NEW NCD on Intravenous Immune Globulin's (IVIG)

CMS has published a National Coverage Decision (NCD) on Intravenous Immune Globulin's (IVIg) for the Treatment of Autoimmune Mucocutaneous Blistering Diseases. This revision to the Coverage Issues Manual (Transmittal 155, Section 45-31) on May 1, 2002, is a national coverage decision (NCD) which is binding on all Medicare carriers, intermediaries, peer review organizations, health maintenance organizations, competitive medical plans, and health care prepayment plans. An NCD that expands coverage is also binding on a Medicare+Choice Organization.

Intravenous immune globulin (IVIg) is a blood product prepared from the pooled plasma of donors. It has been used to treat a variety of autoimmune diseases, including mucocutaneous blistering diseases. It has fewer side effects than steroids or immunosuppressive agents.

Effective October 1, 2002, IVIg is covered for the treatment of biopsy-proven: (1) Pemphigus Vulgaris, (2) Pemphigus Foliaceus, (3) Bullous Pemphigoid, (4) Mucous Membrane Pemphigoid (a.k.a., Cicatricial Pemphigoid), and (5) Epidermolysis Bullosa Acquisita for the following patient subpopulations:

1. Patients who have failed conventional therapy. Contractors have the discretion to define what constitutes failure of conventional therapy;
2. Patients in whom conventional therapy is otherwise contraindicated. Contractors have the discretion to define what constitutes contraindications to conventional therapy; or
3. Patients with rapidly progressive disease in whom a clinical response could not be affected quickly enough using conventional agents. In such situations IVIg therapy would be given along with conventional treatment(s) and the IVIg would be used only until the conventional therapy could take effect.

In addition, IVIg for the treatment of autoimmune mucocutaneous blistering diseases must be used only for short-term therapy and not as a maintenance therapy. Contractors have the discretion to decide what constitutes short-term therapy.

Dermatologists would use HCPCS J1563 to bill for IVIg for the treatment of the above listed clinical conditions.

CLIA Resources: www.hcfa.gov/medicaid/clia/cliahome

Order the AAD/AADA CLIA Manual (available by phoning Alice Bell at 847-240 1823)

Contact AAD/AADA staff Carol K. Sieck, RN, MSN at 847-240-1796 or csieck@aad.org

CLIA Dermatology Practice — Office Laboratory FAX Survey

Please respond to the following questions regarding CLIA Testing Certification Level, laboratory tests performed in your office and proficiency testing method.

1) What is the level of laboratory testing in your office dermatology practice as indicated by your CLIA certificate (check the correct response)?

___ a. Waived
___ b. Provider-Performed Microscopy Procedures (PPMP)
___ c. Moderately complex
___ d. Highly complex

2) Please check each of the current laboratory tests performed at your office?

___ a. fungal cultures, DTM
___ b. fungal cultures, Mycosel & Sabouraud's agar
___ c. KOH
___ d. Cytodiagnosis of Molluscum Contagiosum
___ e. Darkfield Examination
___ f. Ectoparisites
___ g. Histopathology
___ h. Histopathology-Moh's Surgery
___ i. Microscopic Hair Shaft Evaluation
___ j. Staining Procedures, Gram Stain, Wright's Stain, Paragon Multiple Stain, Acid-Fast Stain, Albert's Stain, Anagen Dye
___ k. Tzanck (Cytodiagnostic) Smear
___ l. Virology
___ m. Parasitology
___ n. Mycology
___ o. Bacteriology
___ p. Mycobacteriology
___ q. Other_____

3) Unless your level of office laboratory testing is considered waived, proficiency testing is required twice a year. How are you meeting this requirement (check the method you used most recently)?

___ a. Using CLIA or non-CLIA proficiency testing service
___ b. Splitting samples with another physician office laboratory
___ c. Follow-up sampling of tests with another confirmatory test
___ d. Statistical analysis of patient outcomes over a 6 month time span to assure quality of test method
___ e. N/A Waived only testing
___ f. Don't have a system in place
___ g. Other

PLEASE FAX BACK YOUR RESPONSE BY 8/05/02 TO: Carol Sieck, Practice Management Manager, AAD, 847-330-1120

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