

DERM CODING CONSULT



Published by the American Academy of Dermatology Association

Volume 6, Number 4

December 2002

NewsBriefs

2003 Medicare Fee Schedule: No News is Good News?

As *Derm Coding Consult* goes to press, there is no news from the Centers for Medicare and Medicaid Services (CMS) on an anticipated publication date for the 2003 Medicare Fee Schedule Final Rule (03 MFS). CMS is over thirty days late in publishing the final rule. CMS is obligated to publish the Medicare Physician Fee Schedule sixty days prior to its implementation. Current expectations are that this delay in publishing the regulation will also require a corresponding delay in the effective date for the 03 Medicare Fee Schedule to sometime in early February.

This unusual situation will also have some ripple effects. In the absence of a published final rule with the 03 MFS, it is anticipated that Medicare Carriers will continue to pay physicians at the 2002 Medicare Fee Schedule levels until the sixty day notice requirement is met. It may be reasonable to hope that the delay in publication of the 03 MFS could give the new 108th Congress time for the U.S. Senate to finish work on the legislative fix already passed in the House.

In addition to a delayed date for implementing the 03 MFS, CMS staff has also commented (in the context of the National Physician Open Door Forum monthly conference calls) that this may also impact and extend the due date for Medicare Par/Non-Par enrollment for 2003. The Academy will apprise members of any information on an enrollment extension as soon as it becomes available.

Without the enactment of a legislative fix before the effective date of the 03 Medicare Fee Schedule, there will be a -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.

CIGNA Agreement Announced

CIGNA Healthcare announced on November 26th that it has reached an agreement to resolve bill payment claims brought on behalf of physicians and other health care providers in state and federal courts. This agreement includes implementing key changes to its practices and procedures to make it easier for doctors to do business with CIGNA.

CIGNA announced that it will now:

- Post additional explanations of its claim coding and other payment policies on its website;
- Establish e-mail procedures that will enable physicians and providers to make inquiries regarding fee schedules and obtain claim coding information;
- Appoint a third party administrator to review certain denied claims from 1/1/1996 to determine if they should have been paid;
- Establish a \$10M "prompt pay fund" to compensate physicians and providers for claims that have failed to be processed within CIGNA timeliness standards;
- **Discontinue requirement for physicians to submit medical records to support payment for office visits on the same day as separately billed surgeries or other procedures;** and

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Letter from the Editor

Dear *Derm Coding Consult* Reader:

In my twenty years in health policy, there has never been this long a delay in the publication of the Medicare Fee Schedule! As I write this, the Centers for Medicare and Medicaid Services is well over a month late! Everyone knows that the final rule as rumored will not make anyone happy. The four-year transition to a resource-based RVU reimbursement for practice expense effectively cushioned Dermatology from the cuts other specialties have already experienced. However, without Congressional intervention, physicians will see an average drop of over \$2.00 per RVU per procedure for 2003.

There is the possibility of a "fix" by the new 108th Congress. A legislative proposal that would provide a simple 2% increase cleared the House of Representatives. The White House, as well as DHHS/CMS are supportive of a legislative fix that would provide a modest but positive increase in the 2003 Medicare Conversion Factor. The Academy will be looking to our members for their continued grassroots support when Congress reconvenes in early January.

In the mean time, take comfort in the new AMA CPT instructions for measuring the size of an excised lesion. At last there is a clear recognition of the differing levels of work required for benign and malignant lesions (see article and updated lesion illustrations on pages 4 and 5).

The Health Policy and Practice Department as well as the Academy will lose the Valued contributions of Barbara Dolan, Manager/Private Sector Advocacy as of December 31st. She has been the primary resource on HIPAA implementation for the last two years and key to the development of the HIPAA Privacy and Security Manuals. Barb is retiring and moving to the wilds of western Illinois. She will be missed and we wish her all the best!

Best regards,



Norma L. Border, Editor

Private Sector Update

United Health Care Networks, effective October 12, 2002, has programmed its national claim system to recognize CPT Modifier -59 Distinct Procedural Service. This will allow appropriate recognition of distinct services performed on the same day. In addition, United Health Care has also reviewed the list of dermatology add-on codes and concur that these codes should not be subject to the multiple surgery reduction rule.

AMA Coalition Educates Aetna and Cigna on CPT Use

The Chief Executive Officers of Aetna, Inc. and Cigna Corp. have each received a letter from the American Medical Association and twenty-two other medical specialty societies (including AADA) which voices the collective deep concern about whether Aetna and Cigna have a "proper understanding, (regarding the) interpretation and use of CPT." The letters take particular issue with the insurers downcoding, bundling and lack of recognition of CPT Modifiers. In addition, Aetna was cited for failure to recognize add-on codes as well as utilizing a multiple surgery reduction policy that is not consistent with Medicare.

Cigna and Aetna were also cited for failure to recognize and adopt particular CPT codes which have resulted in uncompensated care to their respective insureds.

This letter was taken as an educational step by AMA. However, both companies have been advised to "discontinue current practice of referencing CPT codes, guidelines and conventions as justification for denying compensation for the care" given Aetna and Cigna's apparent misunderstanding of common CPT usage. The AMA will continue to monitor complaints and actively confront the misapplication of CPT codes, guidelines and conventions by insurers.

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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 accurate to our 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

2003 CPT Changes

The new AMA CPT book includes changes that affect coding of dermatology services. A major change is in the coding of excisions. It is essential to have current coding books in your practice.

Excision Coding

The revised descriptor of the excision codes in AMA CPT 2003 says **excised diameter**. This replaces the previous term "lesion diameter". The instructions state that the excised diameter would include the most narrow margins for complete excision of the lesion and the measurement should be done prior to the excision. Be sure to read the entire directives regarding the excision codes.

Example:

11400 Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; **excised** diameter 0.5 cm or less

11401 **excised** diameter 0.6 to 1.0 cm

This same text and format is applicable to all excision codes, benign and malignant in the integumentary section.

The new terminology will be especially welcome when reporting a re-excision of a lesion based on a pathology report indicating that the margins are not clear. The re-excision size will be selected on the excised diameter of the procedure. If the re-excision is performed during the global period be sure to append Modifier -58.

During an operative session, if frozen sections determine that additional margins must be excised, one CPT code would be reported based on the final excised diameter.

See the related article on pages 4-5.

Mohs Coding

The descriptor of the Mohs code 17304 has been revised to include the text stating that the first routine stain is included in the Mohs procedure. Text has also been added regarding separately reportable additional stain codes 88311-88214, 88342 when performed during the Mohs surgery session.

Code 17310 was made an add-on code. The descriptor has been revised to state that code 17310 should be reported for each additional specimen over five for any stage.

17304 Chemosurgery (Mohs micrographic technique), including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and complete histopathological preparation **including the first routine stain (eg, hematoxylin and eosin, toluidine blue)**; first stage, fresh tissue technique, up to 5 specimens.

(If additional special pathology procedures, stains or immunostains are required, use 88311-88314, 88342)

17310 **each additional specimen after the first 5 specimens, fixed or fresh tissue, any stage (List separately in addition to code for primary procedure)**
(Use 17310 in conjunction with codes 17304-17307)

Laser Treatment

New codes have been established for laser treatment for inflammatory skin disease. Note that these codes are listed in the Medicine section of CPT as opposed to the destruction of lesions section. The descriptor indicates that these codes are used only for the laser treatment of inflammatory skin disease (psoriasis). The code reported is selected on the size of the area treated.

96920 Laser treatment for inflammatory skin disease (psoriasis); total area less than 250 sq cm

96921 250 sq cm to 500 sq cm

96922 over 500 sq cm

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ICD-9-CM Update

New codes effective October 1, 2002 were listed in the September issue of *Derm Coding Consult*. These diagnosis codes must be used beginning January 1, 2003. The official guidelines for coding and reporting of ICD-9-CM are available on the AMA Web site. The notice on the site states that the guidelines have been approved by the Cooperating Parties and the Editorial Advisory Board for ICD-9-CM.

The guidelines include the following points:

1. Use both alpha and tabular (numeric) indices in selecting a proper code
2. Code to the highest level of specificity, using 3, 4, or 5 digits as appropriate
3. Signs and symptoms codes are appropriate when a definitive diagnosis has not been established
4. Signs and symptoms integral to a disease should not be coded additionally
5. Follow guides for multiple coding for a condition, such as "use additional code" or "code first"
6. Do not code diagnoses which are documented as "probable", "rule/out" or "suspected".

Specific guidelines for neoplasms include:

1. If histological term is documented in the alpha index, reference that first, then see the Neoplasm table
2. If malignant neoplasm has been excised or eradicated and no further treatment to the site is necessary, code V10, personal history of malignancy is to be used; V10.82 Personal history of malignant melanoma of skin, or V10.83 Personal history of other malignant neoplasm of skin.

Be sure you are using the most current ICD-9-CM codes, and that they have the necessary additional digits if appropriate.

Changes to Descriptors for Excision of Benign and Malignant Lesions

by James A. Zallia, MD

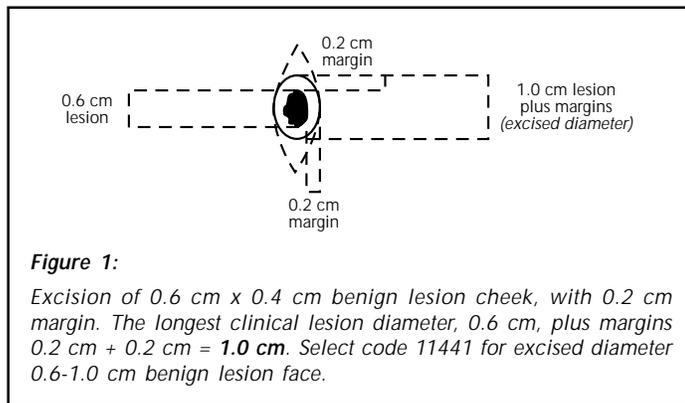
The AMA CPT Editorial Panel, based on recommendations from the Integumentary Work Group, recognized that CPT descriptor changes were needed to address the significant difference in physician work when certain tumors require much wider margins of excision than other tumors of the same clinical size. Rather than the current descriptor which bases code selection for excision of benign and malignant lesions only on the lesion size, the new descriptor which includes the lesion plus the required margin for the “excised diameter” is a simple solution that can be consistently applied.

At the November 2001 meeting, the CPT Editorial Panel accepted this proposal in conjunction with a new series of clinical illustrations. These clinical illustrations reflect the common scenarios for excision of benign and malignant lesions to show how the excised diameter would be measured. Great care was taken to clarify the language as to what is meant by excised diameter and margins, as well as the caution that measurements should be made prior to the skin excision, because the skin’s elasticity usually causes the excised area to expand to a larger defect after the incisions are made.

The term “excised diameter” is redefined to simply add the closer margin to that same clinical lesion’s longest diameter. For many lesions, especially benign lesions that require smaller margins of excision, the same CPT code would still be used with the revised definition as is used with the current definition.

Measuring and Coding the Removal of a Lesion (Illustrations)

For example, in the following clinical illustrations, Figure 1 is a 0.6 mm lesion excised with a 0.2 mm margin. It would still be coded as 11441.



Similarly, in Figure 2, the addition of the margin to the lesion size still does not change the current code (CPT 11403) to a higher code for this benign lesion, since required margins are usually small.

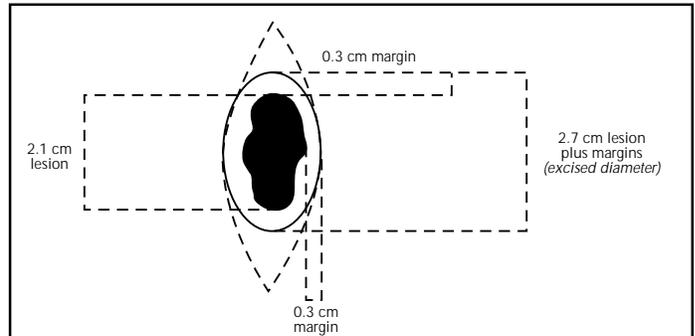
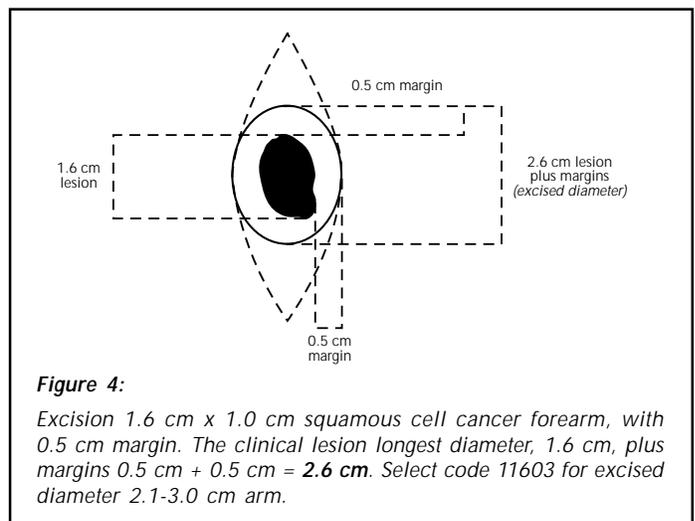
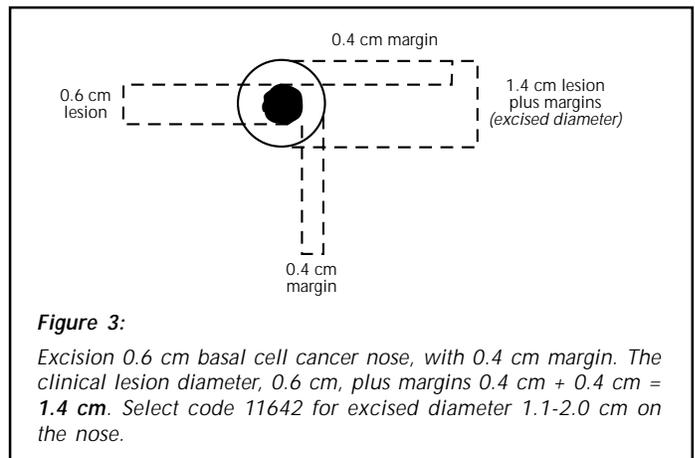


Figure 2:
Excision of 2.1 cm x 1.1 cm congenital nevus chest, with 0.3cm margin. The clinical lesion longest diameter, 2.1 cm, plus margins 0.3 cm + 0.3 cm = **2.7 cm**. Select code 11403 for excised diameter 2.1-3.0 cm trunk.

However, for the excision of malignant lesions that require variably larger margins, it would be expected that some lesions would now measure into the next code size range, as seen in Figure 3 and Figure 4.



Changes to Descriptors for Excision of Benign and Malignant Lesions

by James A. Zallia, MD

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Figures 5 and 6 reflect the significantly greater margins of excision required for the treatment of a melanoma with resulting CPT codes of 11603 and 11606, respectively. Code selection based historically on actual lesion measurement underestimated physician work involved in melanoma excisions of this type. Hence the necessity to refine the CPT descriptor.

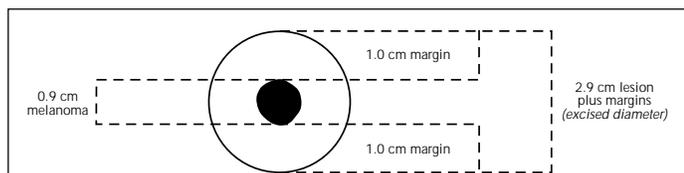


Figure 5:

Excision 0.9 cm malignant melanoma leg, with 1.0 cm margin. The clinical lesion diameter, 0.9 cm, plus margins 1.0 cm + 1.0 cm = 2.9 cm. Select code 11603 for excised diameter 2.1-3.0 cm leg.

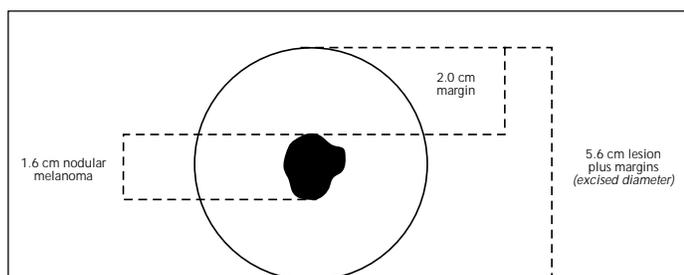


Figure 6:

Excision 1.6 cm x 1.4 cm nodular melanoma, 2.8 mm thickness back, with 2.0 cm margin. The clinical lesion longest diameter, 1.6 cm, plus margins 2.0 cm + 2.0 cm = 5.6 cm. Select code 11606 for excised diameter over 4.0 cm malignant lesion trunk.

Re-excisions are illustrated in Figures 7 and 8. Figure 7 shows a re-excision at the same operative session and Figure 8 should a re-excision at a subsequent operative session. If the re-excision occurs within the global period of the original procedure, remember to add modifier -58.

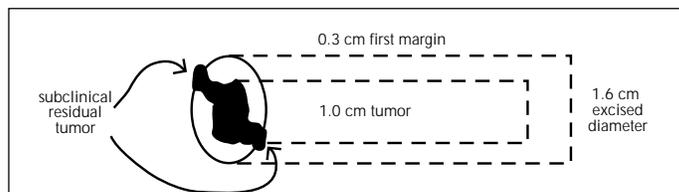
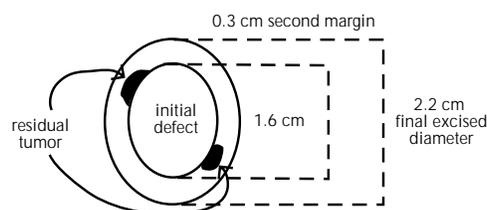


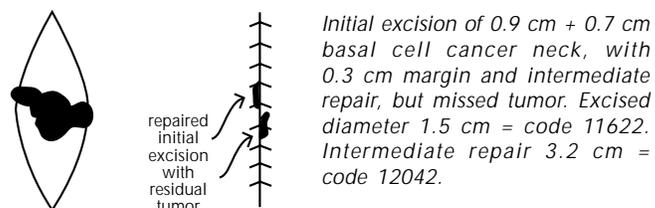
Figure 7: Re-excision at same operative session.

Initial excision of 1.0 cm + 0.6 cm basal cell cancer forehead, with 0.3 cm margins missed the subclincal margin at two sites. Initial excised diameter = 1.6 cm.

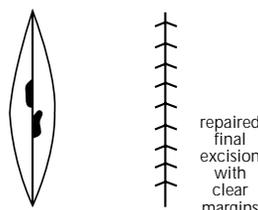


Re-excision of original 1.6 cm excised diameter with additional margins 0.3 cm + 0.3 cm = 2.2 cm final excised diameter. Select code 11643 for malignant excision face 2.1-3.0 cm.

Figure 8: Re-excision at subsequent operation session.



Initial excision of 0.9 cm + 0.7 cm basal cell cancer neck, with 0.3 cm margin and intermediate repair, but missed tumor. Excised diameter 1.5 cm = code 11622. Intermediate repair 3.2 cm = code 12042.



Re-excision of residual tumor with additional margins 0.3 cm + 0.3 cm and including linear scar with ellipse 3.2 cm x 0.7 cm. Code subsequent re-excision malignant lesion neck, with code 11621 (0.6-1.0 cm) plus intermediate repair 3.2 cm code 12042

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

Major Changes to Derm Coding in 2003!
Be Sure to Order New CPT Code Books!

HIPAA — Sharing Patient Information with AADA

Every health organization and practice is moving closer to the HIPAA Privacy Standard compliance deadline of April 14, 2003.

HIPAA Privacy Standards compliance requires that dermatology practices exercise vigilance in any situation where protected health information (PHI) may be shared with an outside entity. This applies when you request assistance from the AADA/Health Policy and Practice (HPP) in resolving claims filing problems.

HPP does not want to be your business associate under HIPAA. HPP will implement HIPAA compliant procedures in regard to requests for review and comment on patient medical records, claims forms, remittance information and correspondence. These are considered non-routine disclosures. Therefore, the dermatology practice that is covered entity under HIPAA should:

- develop reasonable criteria for determining, and limiting disclosure,
- release only the minimum amount of PHI necessary to accomplish the purpose of a non-routine disclosure.

The HIPAA Privacy Rule requires dermatologists to make their own assessment of what PHI is reasonably necessary for treatment, payment, and operational purposes and to implement policies and procedures accordingly.

For the purpose of sharing information with other direct and indirect treatment providers, dermatologists need not limit information uses or disclosures.

The **minimum necessary standard** is intended to make dermatologists evaluate their everyday information procedures to prevent unnecessary or inappropriate access to PHI.

In order to assist AADA members with the HIPAA Privacy Rule while continuing to help them resolve coding and reimbursement issues with various payers, please remember:

HPP STAFF DOES NEED: Patient sex (if pertinent), ICD-9-CM diagnostic code(s) for the service, CPT procedure code(s) for the services, CPT modifiers used, and Charge amount, as well as, Fee schedule amount, Participating or non-participating status, Remittance amount, Remittance codes (and payer code explanation).

HPP STAFF DOES NOT NEED: Patient name, address, SS# or Insurance Identification #, Insured Name, Birthdate, or age.

When requesting review of a billing problem by e-mail, fax or mail, please review the documents being sent and apply the de-identification and **minimum necessary standard**.

1. Review the pertinent documentation required: medical record, billing form, remittance advice, correspondence.

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CLIA Clarification

Revision of CLIA Information In Regard to DTM Complexity & Clarification of Proficiency Testing Option

In the June, 2002 issue of Derm Coding Consult we provided a summary of the CLIA regulations for the physician office laboratory titled, "CLIA Quick Facts". Since that time, we have received clarification that office laboratories performing the dermatophyte test medium (DTM) are required to have a "Certificate of Moderate Complexity" not "Physician Performed Microscopy (PPMP)" that we had printed. This is now corrected in the following section on DTM below:

Dermatophyte Test Medium (DTM) Testing

- DTM testing requires either a "Certificate of Moderate Complexity", "Certificate for High Complexity", or "Certificate of Accreditation" depending on the type of test system and will have inspections conducted every 2 years regardless of the formulation or manufacturer claims that this is "exempt".
- The National Committee for Clinical Laboratory Standards NCCLS-M22-A2 provisions were modified in 2001 requiring end-user quality control checks with **each batch of shipment**. Physicians are asked to do this regardless of various claims on eliminating this step by manufacturers.
- End-user quality control is defined as checking each batch or shipment of media for sterility, the ability to support growth, selectivity/inhibition and biochemical response.
- The federal requirement is bi-annual proficiency testing which may be done with one of the four methods listed in this document.
- Physician offices that perform tests of any complexity other than waived, 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.

Proficiency Testing Requirements

Proficiency testing is required biannually for any test kits that are not considered "waived". In the past, AAD/AADA members were offered CME programs that included pictures of slides to qualify for proficiency testing but this was restricted to individual tests and inspectors and is not acceptable for the majority of tests. Thus, we urge members to utilize one of the four methods below to fulfill proficiency testing requirements.

- 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
- Follow up sampling of the tests performed with a confirmatory test
- Statistical analyses of patient outcomes over a six month time span to assure the quality of test methods.

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- Pay interest on fully documented claims that are not paid within 30 days in those locations where interest payments are not required by law.

Per Patrick Welch, President of CIGNA Healthcare, "We are making accommodations in our business practices that will ease the administrative burden on physicians."

2003 CPT Changes

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Modifiers

Changes in 2003 are the elimination of the five digit modifiers, such as 09925. These modifiers had in some instances been used in lieu of the two digit modifiers. Beginning January 1, 2003 only two digit modifiers will be recognized. Modifiers are used to further explain additional circumstances about the service(s) or procedure(s).

HIPAA – Sharing Patient Information with AADA

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2. Patient protected health information (PHI) not essential for HPP review should be blocked out with either a dark marking pen or white out.
3. If the document contains information on more than one patient, make sure that PHI for **all** the patients listed has been blocked.
4. When faxing documentation with PHI for review: please use a **confidentiality disclaimer** on the cover of the fax.

CLIA Clarification

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If you need a copy of the revised "CLIA Quick Facts Sheet", either: 1) write in "CLIA" under "Search" on www.aad.org which will lead you to the hyperlink for "CLIA" and the "CLIA Quick Facts Sheet"; or you may send us a fax request for "CLIA Quick Facts Sheet" to (847)330-1120. It will be faxed to you within 48 hours.



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