

DERM CODING CONSULT



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NewsBriefs

Major Derm Issues In 2004 Medicare Fee Schedule

The 2004 Medicare Fee Schedule (MFS) has five issues of major concern for dermatology:

- A CMS proposal to make the physician work relative value units the same for the excision of benign or malignant skin lesions with the same excised diameters from the same area of the body;
- A -4.2 percent decrease in the physician payment update;
- Decreases in payment for photochemotherapy services due to CMS reclassification or removal of topical medications from the practice expense (PE) inputs for CPT 96910-96913;
- A decrease in payment for photo dynamic therapy caused by topical medications reclassification as well as use of a different PE scaling factor (CPT 95657); and
- CMS proposal to rebase and revise the Medicare Economic Index (MEI).

AADA has successfully marshaled all its efforts to educate CMS on the serious inequities created by valuing the work of benign and malignant excisions the same. The Academy's comment letter on the proposed rule challenged this decision with clinical examples relating the relative differences in the work involved. AADA also worked in concert with the American College of Surgeons, the Mohs College, the American Society of Dermatologic Surgery, the American Society of Plastic Surgeons, the American Academy of Family Physicians and the American College of Physicians who shared our concerns with the impact of this proposal. Fortunately, CMS has withdrawn this proposal and will retain established different work RVUs for benign and malignant excisions.

The 04 MFS proposal includes an anticipated -4.2% decrease in Medicare reimbursement and continues to drop until 2008, according to CMS estimates. Medicare beneficiaries and their physicians are forced to repeatedly turn to Congress to resolve these yearly problems with the fee schedule. This update situation would be worse today if not for congressional action late last year.

Congress has not yet resolved the fundamental, systemic flaws in the Medicare physician payment update formula:

- Linking Medicare physician fees to the Gross Domestic Product (GDP) which does not accurately reflect changes in the cost of caring for Medicare patients;
- Including the costs of Medicare-covered outpatient drugs and biologicals in setting the SGR expenditure target for physicians' services, even though these items are not physicians' services and therefore, under the formula, inappropriately lead to decreases in the annual payment update;
- Inadequately accounting for changes in the volume of services provided to Medicare patients due to new preventive screening benefits, national coverage decisions that increase the demand for services (such as the national coverage decision for actinic keratoses), a greater reliance upon drugs to treat illnesses, and a greater awareness of covered health benefits and health practices due to educational outreach efforts; and
- Improperly accounting for the costs and savings associated with new technologies.

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Letter from the Editor

Dear *Derm Coding Consult* Reader:

Derm Coding Consult is back in your hands! My thanks to all those dermatologists and practice management staff who called looking for the missing Spring and Summer issues. The combined Spring/Summer issue is included with this mailing. Expect the Winter edition to reach you in early December.

While funding issues have hindered distributing *Derm Coding Consult* in hard copy to all of you, it is and will continue to be available each quarter at www.aadassociation.org/coding.html. You may also access all of the back issues of *Derm Coding Consult* in an easy to print .pdf format at the same location.

All of the articles are indexed each year in the December issue and the latest index can be found in December 2002 issue.

In addition to *Derm Coding Consult*, the Academy is proud to announce the publication of the *AAD's 2004 Coding and Documentation Manual: A Guide for Dermatology Practices*, a comprehensive, easy to use resource that illustrates coding and clinical information to help minimize coding errors and reduce claim denials. (See page 8 for information on ordering.)

The Coding and Documentation Manual includes not only the 2004 CPT Codes pertinent for dermatology, but also the current E&M coding and documentation requirements, an easy to use alphabetic index to ICD-9-CM, and the HCPCS Level II codes. We've designed it to give you all the coding comments you've looked for in *Derm Coding Consult* in one easy to use, dermatology specific manual. The Academy will be updating the Coding and Documentation Manual each year to provide you with the latest CPT, ICD and HCPCS changes. We welcome your comments and suggestions for information that you would like included in future editions.

Best regards,



Norma L. Border, Editor

CMS Cancels Automatic 03 MFS Adjustments

CMS determined in late June (based on the logistics problems identified by the Medicare Carriers) that it would NOT require them to go forward with an automatic mass adjustment and recoupment of "overpayments" that resulted from the delayed implementation of the 2003 Medicare Fee Schedule. In those instances where an overpayment exists, physicians will not receive a "Demand" letter. In addition, Medicare beneficiaries will not receive copies of the "Demand" letters. CMS and Carriers realized the unnecessary confusion this would have caused. However, if the dermatology practice brings to the attention of the Medicare carrier that an incorrect payment for January or February 2003 was received, the carrier will process such an adjustment.

CMS Posts Correct Coding Initiative (CCI) Edits On Line

The Centers for Medicare & Medicaid Services (CMS) announced on September 2, 2003, that the National Correct Coding Initiative (NCCI) edits have been posted on the CMS Web site. Previously these edits were only available for purchase thru the NTIS subscription service. Making these edits available on the Web site is the most recent effort by CMS to reduce burdens on physicians.

There are two databases, one for the Column 1 and Column 2 codes (previously labeled Comprehensive/Component Edits) and one for the Mutually Exclusive Edits. The files are quite large, thus they are in a zipped format. Also on the Web page are links to NCCI question and answers, Medicare Carrier Manual entry regarding NCCI edits and to the NCCI Policy Manual for Medicare Part B Carriers.

The NCCI edits may be found at www.cms.hhs.gov/physicians/cciedits/default.asp. They are posted in an Excel spreadsheet format in numerical order. The spreadsheet includes the effective date of the edit, a deletion date, if applicable, and the modifier status.

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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

New Medicare Utilization Data for E&M

Medicare has released the 2002 Medicare Part B Extract and Summary System (BESS) utilization data. This data is derived from the physician/supplier services reported to Medicare for reimbursement. Listed by AMA/CPT codes, this is summary data only. However, the following reflects E&M service utilization by dermatologists for 2002.

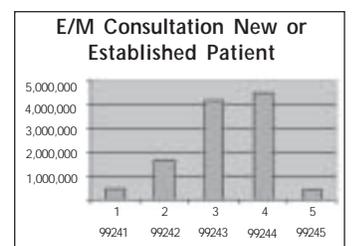
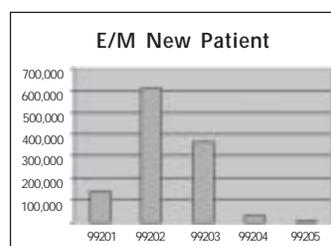
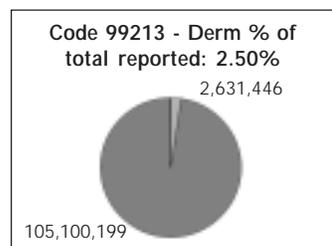
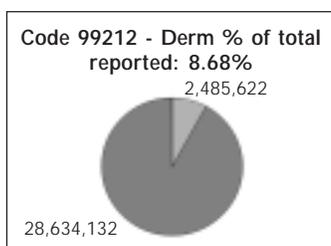
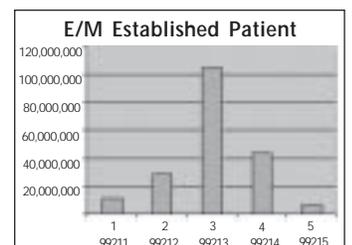
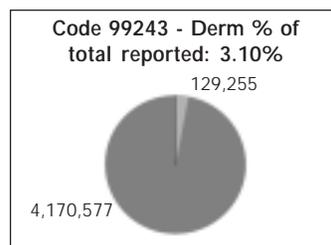
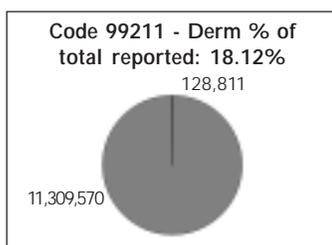
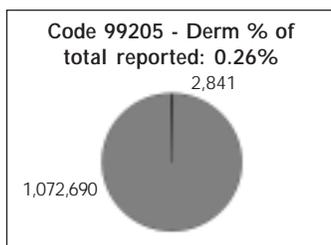
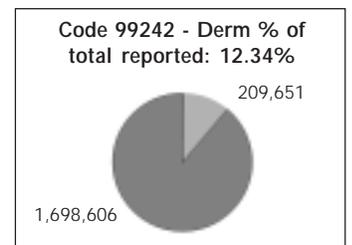
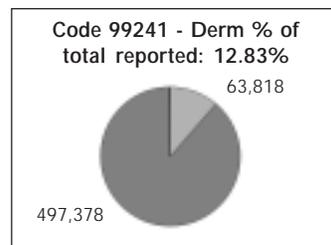
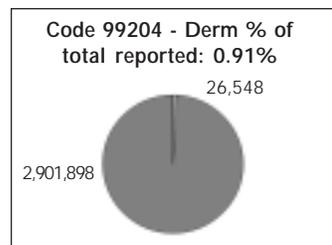
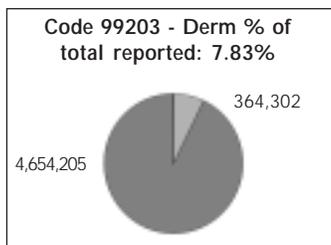
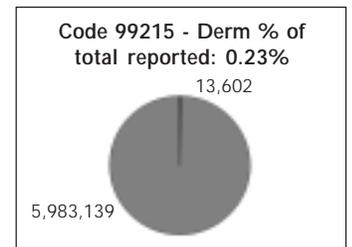
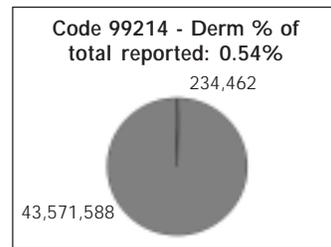
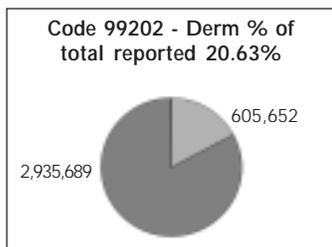
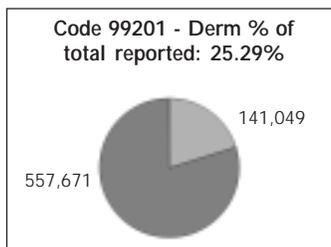
In the BESS utilization data, the total number of services per AMA/CPT code is given, with a breakdown of the number of times that code was reported by each specialty. The percent per specialty is also given. For example: CPT 99213 was reported 105,100,199 times by all specialties. However, dermatologists reported this code only 2,631,446 times or 2.50% of the total utilization for this code. In contrast, CPT 17000 was reported 4,625,009 times by all specialties with dermatologists reporting the code 3,770,420 times which represents 81.72% of the total utilization for that code.

The pie charts that follow are based on the 2002 BESS data and give additional insight as to what E&M service codes dermatologists are reporting. Bar graphs reflect all specialties combined.

(See related information on BESS data and E/M codes.)

2002 Medicare Evaluation and Management Services

CPT	All Specialities	Dermatology	Derm % of total
New Patients			
99201	557,671	141,049	25.29%
99202	2,935,689	605,652	20.63%
99203	4,654,205	364,302	7.83%
99204	2,901,898	26,548	0.91%
99205	1,072,690	2,841	0.26%
Established Patients			
99211	11,309,570	128,811	18.12%
99212	28,634,132	2,485,622	8.68%
99213	105,100,199	2,631,446	2.50%
99214	43,571,588	234,462	0.54%
99215	5,983,139	13,602	0.23%
Consultations			
99241	497,378	63,818	12.83%
99242	1,698,606	209,651	12.34%
99243	4,170,577	129,255	3.10%
99244	4,508,300	12,972	0.29%
99245	421,678	0	0.00%



2004 ICD-9-CM UPDATE

There are no major code changes of interest for dermatology in the latest annual update to International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM). However, a new code a dermatology practice might find useful is: *V58.65 Long-term (current) use of steroids*.

The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) is based on the World Health Organization's (WHO) Ninth Revision, International Classification of Diseases (ICD-9). ICD-9-CM is the official system of assigning codes to diagnoses and procedures associated with hospital utilization in the United States. The WHO ICD-9 is used to code and classify mortality data from death certificates.

The ICD-9-CM consists of:

- a tabular list containing a numerical list of the disease code numbers in tabular form;
- an alphabetical index to the disease entries; and
- a classification system for surgical, diagnostic, and therapeutic procedures (alphabetic index and tabular list)

ICD-9-CM is the tool to use to find the most accurate diagnoses codes that establish medical necessity for the procedures performed in the dermatology practice. The National Center for Health Statistics (NCHS) and the **Centers for Medicare and Medicaid Services** are the U.S. governmental agencies responsible for overseeing all changes and modifications to the ICD-9-CM.

The 2004 updates for ICD-9-CM codes were released in the Centers for Medicare Services (CMS) Program Memorandum AB-03-091, published on June 20, 2003. The ICD-9-CM code updates become effective on October 1, 2003. Medicare carriers are directed in the memorandum to accept both the old and the new codes from October 1, 2003, through December 31, 2003.

To learn more about ICD-9-CM, go to the National Center for Health Statistics' Web site at www.cdc.gov/nchs/about/otheract/icd9/abtcd9.htm

The National Center for Health Statistics (NCHS) and the **Centers for Medicare and Medicaid Services** are the U.S. governmental agencies responsible for overseeing all changes and modifications to the ICD-9-CM.

Keep Up-to-Date with Carrier LMRPs

CMS continues to cut costs on provider education. As a result, most Medicare Carriers are severely limiting the number of provider bulletins they issue each year, or they have eliminated mailing them completely! However, the money saved in postage is being used to make each carrier's website more informative for dermatologists and derm practice administrative staff. Your Medicare carrier's LMRP information is available on their Medicare website.

In the March 2002 issue of *Derm Coding Consult*, an article on Local Medical Review Policies provided Web addresses for accessing carrier LMRPs. Those Web addresses are no longer valid. CMS has now included all the local carrier LMRPs on their database Web site, www.cms.hhs.gov/mcd. However, draft LMRPs may still be viewed at www.draftlmp.net. In addition, each Medicare Carrier Web site has a listing of their own LMRPs.

To insure accurate claims filing, it is very important that you are familiar with your Carrier's LMRPs. An LMRP explains when a service will be covered, as well as when it is considered a reasonable and necessary service.

The content of a local medical review policy (LMRP) consists of:

- Description of the procedure or service
- 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

If you find you disagree with the information contained in an LMRP or in it's classification of a service as covered or non-covered, there is a reconsideration process available for final LMRPs. Any part of the policy or the whole policy may be reconsidered. The requirements of the process are the same as in the development of a new LMRP. Requests for reconsideration are based on:

- Published evidence derived from clinical trials or studies;
- General acceptance by the medical community;
- Scientific data or research studies published in peer-reviewed medical journals; or
- Consensus of expert medical opinion

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Update on Unna Boot Billing

Coding for procedures performed in conjunction with casting and strapping can be confusing because the instructions for using this code in the physician's office setting differs from what is permitted in the outpatient hospital setting.

The Center for Medicare Service's (CMS) surgical package concept involves very specific instructions related to the packaging of supplies. While the use of the Unna boot is a form of taping or strapping, it must be distinguished from the taping and strapping that uses *nonmedicated* material to provide structural support for the lower extremity.

An Unna boot is used to treat varicose ulcers of the lower extremities due to vascular insufficiency. It is a yielding, boot-like dressing applied to the lower extremity. It consists of layers of gauze impregnated with Unna's paste (15% zinc oxide in a glycolgelatin base). The reimbursement for this code *includes the supplies and the service*.

For Dermatologists who perform Unna boot applications, the place of service will be the office or clinic setting, where it is covered when personally performed by, or incident to the physician.

When billing for Unna Boot application, it is advisable to check your Medicare Carrier's local medical review policies (LMRP) for applicable medical necessity issues and utilization guidelines.

CPT 29580 code represents a surgical procedure and while it carries no follow up days, a visit is not reimbursable on the same day, *unless the visit represents a significantly separately, identifiable service*. An evaluation and management code can be billed in addition, when the *initial* evaluation of the condition leading to apply the Unna boot is done. Subsequent evaluation and management codes for established patients should not be billed when repeat Unna boot application is done, unless an unrelated E/M service is also performed. In this case a modifier 25 would be appropriate.

Use RT or LT modifiers to indicate the affected leg when the application is unilateral. If this service is bilateral it would be reported as a single line item code 29580-50, using the bilateral modifier 50 instead of RT and LT. CPT 29580 is subject to the multiple surgery reduction rule and a second procedure would have its reimbursement reduced by 50%.

For removing Unna boots, the only CPT descriptor, 29700 specifically states codes for cast removals should be employed only for casts applied by another physician. The appropriately documented evaluation and management code would be billed when the physician removes the Unna boot.

Derm Coding Consult is also available online at
www.aadassociation.org/coding.html

Derm Practice Enhancement with Non Physician Providers

Defining NPPs

Non Physician providers can be physician assistants, clinical nurse specialists and nurse practitioners. In the US, physician assistants and nurse practitioners function in similar roles. Both can diagnose, treat and prescribe. The training of a PA is general in nature, similar to that of a medical school curriculum. All PAs learn primary care and rotate through other specialties. Nurse Practitioners, and Clinical Nurse Specialists, on the other hand, have traditionally been trained in one specialty (e.g., cardiology), and come from nursing backgrounds and can practice independently, which PAs have not done.

Physician assistants are interdependent, semi-autonomous clinicians practicing in partnership with physicians. This relationship allows them to staff clinic offices, provides on-call service in the practice, deliver care in rural areas (in most states, the physician partner need not be physically present for the PA to practice).

It is the setting and the specialty that determines how the two professions practice, rather than legislative or professional regulations.

State Level Governance

State Laws or regulations govern the NPP's scope of practice in the State where the services are performed. Nurse Practitioners (NP), Clinical Nurse Specialists (CNS), and Physician Assistants (PA) may apply for individual provider numbers for direct billing purposes. All covered services rendered may be billed using the NPPs direct provider number.

Rather than bill directly for services provided, NPPs may provide services "incident to" a physician's professional service and bill accordingly for those services. "Incident to" services are defined as services commonly furnished in a physician's office which are "incident to" the professional services of a physician and are limited to situations in which there is direct physician personal supervision.

Billing for NPP Services

Even though a NPP may be licensed under state law to perform a specific medical procedure and may be able to perform that medical procedure without physician supervision and have the service separately covered and paid by all criteria must be met for those services to be covered as "incident to". Reimbursement is based on 100% of the physician fee schedule amount. Services provided "incident to" are billed under the physician's provider number.

All the following requirements must be met before a NPP may bill under the "incident to" provision:

- The services would be recognized as physician's services, if furnished by a doctor of medicine or osteopathy (MD or DO), as described in the MCM 14-3 Chapter 2, S. 2050. The services are performed by a clinical professional who meets all the NPPS qualifications, and

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Q. An established patient presents with non-symptomatic skin tags in the neck area. Patient states that these tags don't bother her at all, but she just doesn't like them and wants them removed. The dermatologist explains to the patient that Medicare will not cover cosmetic services and there is no medical reason that these skin tags need to be removed. The patient is adamant that she wants them taken off! The skin tags are removed, patient is happy and pays for the service. Patient has not signed an ABN, which is unnecessary in the case of cosmetic services. However, a family member calls later and requests that a claim be sent to Medicare for this service. How should this situation be avoided?

A. The above scenario can easily be avoided by the use of the **"Notice of Exclusions from Medicare Benefits" (NEMB)** form, see page 7. This form advises Medicare beneficiaries prior to a service that Medicare will not pay for the service. By having the beneficiary read and sign the form prior to treatment, one can avoid the claim submission request at a later date.

Medicare does not require providers to use the NEMB form. However, this form is useful in advising beneficiaries of services that are never covered by Medicare. An Advanced Beneficiary Notice (ABN) is not appropriate in the case of cosmetic services that are never a covered benefit.

Some dermatologists are still concerned that it is difficult to determine under what circumstances an ABN should be completed. ABNs are designed to be given when the physician expects, or is certain, that Medicare will deny payment for an item or service, either on the basis of the exclusion for lack of medical necessity or on one of the few other statutory bases that trigger ABNs (viz., custodial care, a hospice patient determined not to be terminally ill, a home health patient who is not homebound or requiring intermittent skilled nursing care, and DMEPOS in the case of unsolicited telephone calls, lack of a supplier number, and failure to get an advance determination of noncoverage).

Dermatologists should be knowledgeable about Medicare coverage rules on the basis of Medicare publications and professional relations activities as well as on the bases of their own experience with the Medicare program and their local medical standards of practice.

A dermatology practice may develop their own form for cosmetic or non-covered services. However, if the NEMB is used, the only alterations one can make are in the header and footer of the document. The header may be customized with the physician identifying information, the date, patient name and Medicare number. The footer should include the date, patient name and patient signature line.

When presenting the NEMB to the patient, the information requested on the form will need to be completed along with checking the appropriate box for the service(s) involved.

An electronic copy of NEMB form may be downloaded from: www.cms.hhs.gov/medlearn/cms20007_eng_Jan03.pdf

When a beneficiary signs an ABN and becomes liable for payment, there are no Medicare charge limits which apply to the supplier's, physician's, or provider's charges. Medicare fee schedule amounts and balance billing limits do not apply. The amount of the bill in such cases, therefore, is a matter between the provider and the beneficiary.

If a service is statutorily excluded by Medicare, but patient insists that a claim be filed, have the patient sign the ABN and submit the claim with a GY modifier. The claim will be denied and the patient will be responsible for payment.

For additional information, check out CMS Medlearn info available at: www.cms.hhs.gov/medlearn

NewsBriefs

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Photochemotherapy

The AADA is disappointed that after successfully presenting photochemotherapy CPT codes 96910-96913 to the PEAC in January, 2001, these codes have once again been inappropriately reduced in value. CMS has repriced steroid cream and anthralin ointment, two topical drugs required during the treatment. The AADA will submit updated pricing information for these items as well as statements explaining that each is not to be categorized as "self-administrable."

Photodynamic Therapy

The scaling factors that CMS uses to adjust estimated costs for individual procedures to match estimated aggregate costs show that payment for photodynamic therapy (PDT) CPT 95657 will be drastically reduced in 2004. CMS is now using the dermatology scaling factor (0.54) for supplies instead of the all physician average (1.29). However, CMS will, at AADA urging CMS reinstate the ability to bill for the light activating agent under the appropriate J code, as of January 1, 2004.

The Medicare Economic Index (MEI)

CMS proposes to rebase the Medicare Economic Index (MEI) thereby assigning different weights to work, practice expense, and malpractice premiums that would shift the share of RVUs going to each of these categories. The impact of this proposal will be reflected in the data tables accompanying the final rule.

AADA is very concerned about the role of the MEI and the Sustainable Growth Rate (SGR) in determining the update in Medicare physician payments. There is statistical evidence that physician salaries and benefits go down in the SGR system while non-physician employee compensation, wages, salaries, and benefits rise. In addition, dermatology practice expense direct input items have been steadily increasing at a time when CMS data and re-pricing implies that the cost of materials and supplies are going down. These trends reinforce our concerns with the update formula's inability to fairly recognize the current cost of providing care to Medicare patients.

NOTICE OF EXCLUSIONS FROM MEDICARE BENEFITS

There are items and services for which Medicare will not pay.

- Medicare does **not** pay for all of your health care costs. Medicare only pays for covered benefits. **Some items and services are not Medicare benefits and Medicare will not pay for them.**
- When you receive an item or service that is **not** a Medicare benefit, **you are responsible to pay for it**, personally or through any other insurance that you may have.

The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them yourself.

Before you make a decision, you should read this entire notice carefully.

Ask us to explain, if you don't understand why Medicare won't pay.

Ask us how much these items or services will cost you (**Estimated Cost: \$** _____).

Medicare will not pay for: _____
_____;

1. Because it does not meet the definition of any Medicare benefit.

2. Because of the following exclusion * from Medicare benefits:

- | | |
|---|--|
| <input type="checkbox"/> Personal comfort items. | <input type="checkbox"/> Routine physicals and most tests for screening. |
| <input type="checkbox"/> Most shots (vaccinations). | <input type="checkbox"/> Routine eye care, eyeglasses and examinations. |
| <input type="checkbox"/> Hearing aids and hearing examinations. | <input type="checkbox"/> Cosmetic surgery. |
| <input type="checkbox"/> Most outpatient prescription drugs. | <input type="checkbox"/> Dental care and dentures (in most cases). |
| <input type="checkbox"/> Orthopedic shoes and foot supports (orthotics). | <input type="checkbox"/> Routine foot care and flat foot care. |
| <input type="checkbox"/> Health care received outside of the USA. | <input type="checkbox"/> Services by immediate relatives. |
| <input type="checkbox"/> Services required as a result of war. | <input type="checkbox"/> Services under a physician's private contract. |
| <input type="checkbox"/> Services paid for by a governmental entity that is not Medicare. | |
| <input type="checkbox"/> Services for which the patient has no legal obligation to pay. | |
| <input type="checkbox"/> Home health services furnished under a plan of care, if the agency does not submit the claim. | |
| <input type="checkbox"/> Items and services excluded under the Assisted Suicide Funding Restriction Act of 1997. | |
| <input type="checkbox"/> Items or services furnished in a competitive acquisition area by any entity that does not have a contract with the Department of Health and Human Services (except in a case of urgent need). | |
| <input type="checkbox"/> Physicians' services performed by a physician assistant, midwife, psychologist, or nurse anesthetist, when furnished to an inpatient, unless they are furnished under arrangements by the hospital. | |
| <input type="checkbox"/> Items and services furnished to an individual who is a resident of a skilled nursing facility (a SNF) or of a part of a facility that includes a SNF, unless they are furnished under arrangements by the SNF. | |
| <input type="checkbox"/> Services of an assistant at surgery without prior approval from the peer review organization. | |
| <input type="checkbox"/> Outpatient occupational and physical therapy services furnished incident to a physician's services. | |

*** This is only a general summary of exclusions from Medicare benefits. It is not a legal document. The official Medicare program provisions are contained in relevant laws, regulations, and rulings.**

This notice explaining exclusions from Medicare benefits is published by the Centers for Medicare & Medicaid Services.

Derm Practice Enhancement with Non Physician Providers

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- that a NPP is legally authorized to perform those services in the state where they were performed.
- The NPP must be an employee of the physician.

Initiating Patient Care

The initial visit (for that condition) must have been a direct, personal, professional service furnished by the physician to initiate the course of treatment of which the services being performed by the NPP is an incidental part.

There must be direct personal supervision by the physician as an integral part of the physician's personal in-office service. The physician must be physically present in the same office suite and be immediately available to render assistance if that becomes necessary;

The physician has an active part in the ongoing care of the patient. Subsequent services by the physician must be of a frequency that reflects his/her continuing active participation in, and management of, the course of the treatment.

The NPPS physician supervisor (or a physician designated by the supervising physician or employer as provided under State law or regulations) is primarily responsible for the overall direction and management of the NPPs professional activities and for assuring that the services provided are medically appropriate for the patient. The physician supervisor or physician designee need not be physically present when the NPP provides a service to a patient and may be contacted by telephone if necessary, *unless State law or regulations* require otherwise.

Keep Up-to-Date with Carrier LMRPs

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The reconsideration process is open to providers and beneficiaries. Follow your Carrier's guidelines in the process involved for reconsideration.

To avoid surprises in a final LMRP, the draft LMRP is made available for public comment prior to finalization. You may monitor the draft policies on your Carrier's Web site and comment as appropriate. If you find a problem with a draft or finalized LMRP, please alert the AADA DermCAC representative in your state, who will be happy to raise any questions on the LMRP policy with the appropriate Carrier Medical Director.

Frequently a Carrier's bulletin/newsletter may publish updates to existing LMRPs. It is important to read carefully all the Carrier publications to keep apprised of any changes to LMRPs. Knowing exactly what your Carrier's policies state will enable you to submit correct claims and avoid denials.

CMS now includes all local carrier LMRPs on their database Web site,

www.cms.hhs.gov/mcd

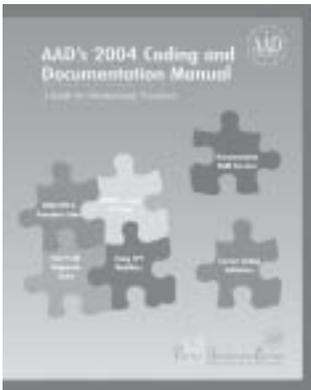
However, draft LMRPs may still be viewed at

www.draftlmp.net

Make Coding Quick and Easy...

AAD's 2004 Coding and Documentation Manual: A Guide for Dermatology Practices

is a comprehensive, easy-to-use resource that illustrates coding and clinical information to help **minimize coding errors** and reduce claim denials, as well as assist dermatologists and their billing staff in submitting accurate claims to **improve the process of reimbursement**.



Included in this manual:

- **2004 CPT Codes** with full official descriptions for procedure codes that are vital to a dermatology practice.
- Updated **E/M Codes** with principles of E/M coding guidelines and recommendations for physician documentation requirements as well as skin-examination templates.
- **ICD-9-CM Diagnosis Codes** in alphabetic order with detailed descriptions of each major clinical category pertinent to dermatology.
- **HCPCS Level II Codes** of drugs and lab tests used in a surgical and/or dermatopathological office setting.
- Modifiers that help explain and enhance coding accuracy.
- **FAQ's** on coding and documentation are noted throughout the text.
- Excerpts from the American Academy of Dermatology's Guidelines of Care and Policies as they pertain to specific coding and documentation issues.

Need to find a code quickly?

Included in your purchase of the manual is **AAD's Quick Coder** that makes frequently used codes easy-to-find. Available on a double-sided laminated card, this handy reference is the perfect resource to save you time in locating common dermatologic codes.



4 Ways to Order!

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