

DERM CODING CONSULT



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NEWSBRIEFS

Medicare Data Base Error Corrected

In early March, the Centers for Medicare and Medicaid Services (CMS) issued an emergency update to the Medicare Physician Fee Schedule Database (Program Memorandum AB-03-035) that has severely impacted payments for Mohs surgery. The change of the CPT 17304, Multiple Procedure Indicator from zero to 1, makes the MOHs code subject to the multiple surgery reduction rule.

CMS, responding to AADA inquiries, has confirmed that there should be no change to the Multiple Procedure Indicator as 17304 is specifically exempted. (Program Memorandum AB 03-070 with this correction was published on May 9, 2003.)

“This is an error and the CMS central office staff is aware of this inconsistency and need for correction, and appropriate instructions will be transmitted to the carriers. Normally, carriers would have up to 60 days to implement update changes, which would mean that they would have to be in effect by July 1, 2003, however I understand some carriers are able to implement these changes sooner”, advised James Zalla, M.D., Chair of the AADA Health Care Finance Committee.

CMS also indicated that Carriers do not need to search their files for any claims that were paid incorrectly, nor will the carriers make adjustments to any Mohs claims that were inappropriately reduced, automatically. Carriers will adjust those claims that are brought to their attention by the Mohs practices. Incorrectly paid claims should be flagged, and resubmitted following any guidelines the local Carrier provides regarding the re-processing of these claims. At minimum, these can be resubmitted to correct an administrative error on the part of CMS.

CMS Will Alert Beneficiaries Re Co-Pay Refunds

The Center for Medicare and Medicaid Services (CMS) intends to ease any patient confusion regarding co-payment refunds linked to late issuance of the 2003 Medicare Fee Schedule (MFS).

The Medicare program will send patients stock messages in their July 2003 Medicare Summary Notices (MSNs) that explain in general why they may have made higher than necessary co-payments for certain January and February claims.

The overpayment problem stems from the delayed 2003 Medicare physician fee schedule, which took effect March 1st. Medicare claims for services provided in January and February 2003 and processed by the local carrier after March 1, 2003, but before July 1, 2003 — will be reimbursed at the 2003 payment rate because of Medicare computer system limitations. Remember, the January and February 03 claims are supposed to be paid under the 2002 MFS, which has a lower conversion factor (\$36.20CF) than the “fixed” 2003 fee schedule (\$36.79CF).

The Medicare program also will send patients copies of the overpayment notices that carriers will send to physicians in July, when any overpayments for January and February 2003 claims will be subject to adjustment. To settle any collected co-payments that were too high, the dermatology practice should take a pro-active approach and contact the patient about issuing a refund or crediting the overpayment to any balance on the patient’s account, advised a CMS spokesperson. CMS also plans to use the www.medicare.gov web site to help notify patients about the co-payment problem.

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LETTER FROM THE EDITOR

Dear *Derm Coding Consult* Reader:

Good News! The Centers for Medicare and Medicaid Services has just published AB 03-070 correcting the multiple surgery indicator for CPT 17304. This is the second time in two years that an instruction has been issued to Medicare Carriers that is inconsistent with the correct application of CPT Guidelines and that has resulted in a severe impact on reimbursement for dermatology services. The Academy has submitted a letter to CMS upper management outlining this issue and strongly urging that CMS introduce a review procedure that will ensure medical specialty societies have an opportunity to review and comment on changes of this magnitude in future.

Not so good news. Although the Medicare Fee Schedule for 2003 benefited from the "fix" by the 108th Congress, physicians are again facing a negative fee schedule adjustment in 2004. The Academy is working hard to offer constructive suggestions for a legislative proposal that would truly fix the Medicare Fee Schedule roller-coaster. The Academy will be looking to our members for their continued grassroots support when Congress considers Medicare reform legislation into the Fall session.

The Health Policy and Practice Department welcomes two new staffers: **Michael Feehan**, Practice Administration Issues Manager (847 240 1824) has primary responsibility on HIPAA implementation, the HIPAA Privacy and Security Manuals as well as the HIPAA "Frequently Asked Questions" section on the AADA web site; **Alice Church, CCS-P**, Coding & Reimbursement Specialist (847 240 1799) is the new Associate Editor for *Derm Coding Consult*, as well as editor for the new 2004 Dermatology Coding Manual that will include CPT, ICD-9-CM and HCPCS customized for dermatology practice use. She is also happy to field questions on coding and billing problems.

Best regards,



Norma L. Border, Editor

CODING Q & A

Q. Is there a specific code(s) for ultraviolet light therapy using a Narrow Band unit?

A. The only codes for administering ultraviolet light are 96910, 96912, and 96913. These codes were recently reviewed by the RUC and the relative value units were increased, thus increasing reimbursement.

Q. We have hired a new physician in our practice and are waiting credentialing by managed care plans with which we contract. How should we currently bill for this physician's services?

A. Until the new physician is accepted or credentialed by the managed care plan(s) he or she may not bill that plan. Furthermore, it would be considered fraud to bill for that physician's services under another physician's ID number. A claim is submitted only by the physician who provided the service.

Q. What is the proper ICD-9-CM code for dysplastic nevus?

A. There is not a specific diagnosis code for dysplastic nevus. Due to the nature of the lesion, it is considered a neoplasm of uncertain behavior. The proper code would be 238.2 — neoplasm of uncertain behavior of skin.

Q. How do we report the re-excision, to clear margins, when pathology yields dysplastic nevus?

A. Based on the new lesion excision descriptors, the re-excision size reported would be based on the size of the margins excised. Due to the fact that a dysplastic nevus is of uncertain behavior, it is not a malignant lesion. Thus, the excision of benign lesion codes would be appropriate and **not** the excision of malignant lesion codes.

Q. If multiple lesions are being excised, is it appropriate to add together the lesion sizes and margins and report one excision code?

A. NO! Each lesion plus the most narrow margin to fully excise the lesion is reported separately. The **only** time lesions may be combined is when through one excision, two lesions are excised. That of course would be when the two lesions are in extremely close proximity and only one excision is required to remove both lesions. In such an instance, the lesion sizes and margins would be added together and reported with one code.

Q. We have received conflicting information regarding the use of modifier -59 in relation to the Correct Coding Initiative (CCI). On which code should be modifier be appended?

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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

NORIDIAN UPDATES “NON-MALIGNANT SKIN LESION REMOVAL” AND “ACTINIC KERATOSIS” POLICIES

Noridian Administrative Services revised its list of payable diagnoses for Non-malignant Skin Lesion Removal Policy, effective February 1, 2003. This Local Medical Review Policy (LMRP) B2002.21 was published in Noridian’s December 2002 News Bulletin. The primary geographic jurisdiction is Alaska, Arizona, Colorado, Hawaii, Iowa, Nevada, North Dakota, Oregon, South Dakota, Washington and Wyoming.

Non-Malignant Skin Lesions

There are three categories of payable diagnoses for CPT codes 11200, 11201, 11300, 11301-11313, 11400-11406, 11420-11426, 11441-11446, 17000, 17003, 17004, 17110 and 17111. Category I codes identify the specific lesion being treated and *establish medical necessity*. Category II codes identify conditions for which *payment is allowed only if the conditions have complications that are in the Category III list*. Diagnoses from List II must be accompanied by diagnoses from the List III for payment to be allowed. The second diagnosis establishes the medical necessity for the carriers allowing payment. **Claims submitted with a diagnosis from the Category II list that does not include a second diagnosis from the Category III list will be denied.**

I. These ICD-9-CM codes identify the lesion being treated and will, by themselves, allow payment:

078.0	Molluscum contagiosum
078.10, 078.19	Viral warts
238.2	Neoplasm of uncertain behavior, skin
374.84	Sebaceous cyst of eyelid
380.00-380.02	Perichondritis of pinna (chondrodermatitis)
686.1	Pyogenic granuloma
698.3	Prurigo nodularis
701.1	Keratoderma (acquired) symptomatic, painful and/or inflamed) use diagnosis code 700 to report non-symptomatic corns and calluses)
701.4	Keloid
702.11	Inflamed seborrheic keratosis

II. These ICD-9-CM codes identify those conditions for which payment is allowed only if the conditions have complications, these being listed in III below.

135	Sarcoidosis (cutaneous)
216.0-216.9	Benign neoplasms of skin (nevi, moles)
221.2	Benign neoplasm of vulva
222.1	Benign neoplasm of penis
222.4	Benign neoplasm of scrotum
448.1	Nevus, non-neoplastic
455.9	Residual hemorrhoidal skin tags
701.4	Hypertrophic scar
701.9	Skin tags
702.19	Other seborrheic keratoses
706.2	Sebaceous cyst
744.1	Accessory auricle
759.39	Other anomalies of the skin

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CIGNA — PROPOSED ILLINOIS SETTLEMENT MOVED TO FLORIDA COURT

In a “setback” for Cigna (as well as Illinois physicians hoping for relief), a federal judiciary panel has ordered that a proposed settlement of a class-action suit in Illinois be transferred to Federico Moreno, a U.S. district judge in Miami who is hearing a separate class-action suit involving the insurer. In the Illinois suit, doctors alleged that Cigna used a program called ClaimCheck to screen their claims for combinations of procedures and then eliminated or reduced payments for some of them, thus paying less than what the doctors billed. Under the settlement, Cigna agreed to pay back claims to 600,000 to 700,000 physicians and other health care providers. Cigna had said that the Illinois settlement also would resolve claims from the Miami suit.

The proposed settlement was estimated to be worth \$50 million to \$60 million by Cigna and up to \$200 million by lawyers for the Illinois doctors. However, the federal judiciary panel decided that Moreno, who has been overseeing the national class-action suit in Miami for nearly three years, was better suited to rule on the proposed settlement than U.S. District Judge G. Patrick Murphy, who had only spent “a few days” on the case in Illinois before Cigna reached a settlement.

The Miami lawsuit alleges that Cigna and seven other HMOs — Aetna, United Healthcare, Coventry Health Care, WellPoint Health Networks, Humana Health Plan, PacificCare Health Systems and Anthem BlueCross BlueShield — delayed or denied reimbursements for health services and rejected claims for necessary medical treatments as part of a racketeering conspiracy. The plaintiffs’ attorneys in the Miami lawsuit had said that the Illinois settlement was “woefully inadequate” for doctors and that Cigna had “inappropriately” reached a quick settlement with the Illinois court while the Miami case was ongoing. Lawyers for the physicians in the Miami case are anticipated to argue that the Illinois settlement should be set aside. Moreno’s decision on the Illinois settlement could take up to an additional six months before any direct relief or payments by CIGNA to physicians.

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

www.cms.hhs.gov/lmrp/default.asp

www.lmrp.net

www.draftlmrp.net

www.cms.hhs.gov/coverage

(National Coverage Decision – Actinic Keratoses Treatment)

Highlights New Final Rules Lab Requirements Quality & Personnel Requirements

CLIA Category	Old Requirement	New Requirement
Quality Control (QC) Effective April 24, 2003	QC performed every 8 hours for non-waived labs	QC performed every day for non-waived labs but include the the detail of the high complexity lab including performance specifications comparable to those established by the manufacturer and including the following: accuracy, precision, reportable range of test results, normal values and any other performance characteristic required for test performance
Patient Test Management Effective April 24, 2003	QC under general requirements based on manufactures instructions	Need to validate accuracy of each non-waived test once prior to testing the specimen with more flexibility for surveyors & individual labs
Procedure Manual Effective April 24, 2003	Lab directors of non-waived labs must approve, sign and date the procedure manual	All new or changed procedures must be reviewed by the lab director and included in the manual before these are performed
Lab Director Requirements Effective February 24, 2003	Lab directors of high complexity labs were required to have either a doctorate degree, board certification or bench experience	Grandfathering of non-board certified individuals with a doctorate degree for who have served or are currently serving a high complexity lab & requires board certification for future doctoral-degreed directors for high complexity testing
Recordkeeping Effective April 24, 2003	Test requisitions were required to have relevant and necessary for accurate and timely testing	At a minimum, the date of the test, patient's name, unique identifier or identification number, sex, age or date of birth and specimen site must be included on test requisitions that route & results back to patient's chart. Also, records must be retained a minimum of 2 years or 5 years depending on the record.
Proficiency Testing Effective April 24, 2003	Required 90% agreement on bi-annual testing	Requires 80% agreement on bi-annual testing
Licensure Effective April 24, 2003	States had jurisdiction over removal of licensure	Federal systems now support states for removal of licensure
Increased Education Resources from CMS Effective Currently	Complex regulatory information often difficult to interpret by the physician specialist	<ul style="list-style-type: none"> • Educational sessions offered from CMS upon request • State Agencies or Regional Office Lab Consultants will provide compliance help per their Web site at www.cms.hhs.gov/CLIA • Accrediting organizations will offer training to individual labs • CDC will offer training and materials through the National Laboratory Training Network phone 800-536-6586.

Preparing for CLIA Inspections

- Review laboratory and testing policies and procedures with staff.
- Organize laboratory records and files to demonstrate quality control and quality assurance.
- Review your personnel files which should include orientation and training if they are participating in specimen collection.
- Locate your proficiency testing records for moderate or high complexity testing only.

Potassium Hydroxide (KOH) Testing

- KOH testing requires a "Certificate for Provider-Performed Microscopy (PPMP)."
- PPMP certificates are not subject to routine inspections unless the provider is performing other moderately complex or highly complex tests.
- The federal requirement is bi-annual testing 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.
- Quality control refers to the specific processes of evaluating each shipment or testing process for accuracy and reliability while quality assurance refers to the global program including policies and procedures to assure overall quality across the total testing process.

CLIA Certificates & Fees

There are four main classifications of CLIA certificates that are granted based on the complexity of the laboratory tests performed	
<ul style="list-style-type: none"> • Certificate of Waiver for labs performing only waived tests. 	<ul style="list-style-type: none"> • \$150/biennial fee
<ul style="list-style-type: none"> • Certificate of Provider-Performed Microscopy Procedures (PPMP) permits microscopy procedures but may also perform waived tests. 	<ul style="list-style-type: none"> • \$200/biennial fee
<ul style="list-style-type: none"> • Certificate of Moderate Complexity permits moderately complex testing but may also perform waived tests. 	<ul style="list-style-type: none"> • biennial fees vary based on number of specialties and annual test volume
<ul style="list-style-type: none"> • Certificate of High Complexity permits all levels of test complexity from high to waived testing. 	<ul style="list-style-type: none"> • biennial fees vary based on number of specialties and annual test volume
<ul style="list-style-type: none"> • Certificate of Accreditation permits all levels of test complexity and is issued on the basis of the laboratory’s accreditation by an accrediting organization approved by CMS. 	<ul style="list-style-type: none"> • biennial fees vary based on number of specialties and annual test volume

Dermatophyte Test Medium (DTM) Testing

<ul style="list-style-type: none"> • 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”.
<ul style="list-style-type: none"> • 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.
<ul style="list-style-type: none"> • 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.
<ul style="list-style-type: none"> • The federal requirement is bi-annual testing proficiency testing which may be done with one of the four methods listed in this document.
<ul style="list-style-type: none"> • 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

<p>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. These are listed in the federal register and acknowledged by CLIA inspectors.</p>
<ul style="list-style-type: none"> • Enrollment in a proficiency testing program that is or is not approved by the U.S. Department of Health and Human Services.
<ul style="list-style-type: none"> • Splitting samples with another laboratory.
<ul style="list-style-type: none"> • Follow up sampling of the tests performed with a confirmatory test.
<ul style="list-style-type: none"> • Statistical analyses of patient outcomes over a six month time span to assure the quality of test methods.

Resources

<ul style="list-style-type: none"> • General information: http://www.cms.hhs.gov/clia/
<ul style="list-style-type: none"> • Categorization of test complexity: Food & Drug Administration Web site http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfCLIA/search.cfm
<ul style="list-style-type: none"> • Order the AAD/AADA CLIA Manual (available by phoning 847-330-1823)
<ul style="list-style-type: none"> • Contact AAD/AADA staff Carol K. Sieck, RN, MSN at csieck@aad.org or 847-330-1796

NOTE: This information reflects the most accurate data at the time this sheet was prepared and updates will be provided periodically.

NEW BIOLOGICS FOR TREATMENT OF MODERATE TO SEVERE PSORIASIS

Biologics show promise for patients in need of a more aggressive therapeutic approach in the treatment of psoriasis. Biologics are an emerging class of drugs engineered from proteins and produced by living cells that work by inhibiting part of the immune response that leads to the inflammatory process in psoriasis. Current treatment regimens for psoriasis and psoriatic arthritis, especially those used for moderate to severe disease, can have significant side effects on the immune system. Biologics may play an important role in quickly treating patients with more severe psoriasis. Some of these biologics are already on the market for treating psoriatic arthritis, rheumatoid arthritis, juvenile rheumatoid arthritis and Crohn's disease.

Biogen's Amevive (alefacept) was FDA approved for the treatment of psoriasis in February 2003. Amgen/Wyeth's Enbrel (etanercept) is on the market for treating psoriatic, rheumatoid and juvenile arthritis. Results from clinical trials for Enbrel showed benefits for psoriasis. FDA approval is expected in 2004. Centocor's Remicade (infliximab) has been approved by the FDA for rheumatoid arthritis and Crohn's disease. Recent studies have indicated its effectiveness in treating psoriasis. Additional studies are ongoing.

If you are considering providing these new biologics to your patients with psoriasis, it would be advisable to check with your local carriers regarding reimbursement for the medication, as well as its administration. Only Amevive has received FDA approval for treating psoriasis. Since Enbrel and Remicade are still being tested in clinical trials, reimbursement could be denied because "their safety and efficacy has not yet been established." The cost of these genetically engineered pharmaceuticals is high.

Injection of Biologicals

Medicare does not pay for both an office visit and intramuscular injection administration. If you bill these together, you risk having the injection service paid (lower reimbursement), the office visit denied, and the balance will have to be written off as a contractual obligation. Do not bill for an office visit unless a significant level of E/M service was provided (and documented) beyond what is included in the administration of the medication. Review of systems, monitoring for complications as well as for the effectiveness of treatment is expected. If no new psoriasis related problems or other distinct diagnostic conditions were addressed, from Medicare's point of view, there would be no justification for billing an office visit in addition to the administration of the biological.

The Medicare Carriers Manual: 15502 D. **Injections and E/M Codes billed separately on the same day of service.** "Advise physicians that CPT code 99211 can not be used to report a visit solely for the purpose of receiving an injection which meets the definition of CPT codes 90782, 90783, 90784 or 90788 if any other physician fee schedule service was rendered. The drugs are billed as J codes, whether or not separately billed. If no E/M service or other service is provided

on the same date as the injection, the injection code is billed."

In the Medicare Fee Schedule Data Base (MFSDDB) the injection codes have a status of "T." *There are RVUs and payment amounts for these services but they are only paid if there are no other services payable under the physician's fee schedule billed on the same day by the same provider. These services are bundled into the physician's services for which payment is made.* (Federal Register, Vol. 67, No, 251 12/31/02 P. 80043)

Infusion of Biologicals

When billing for Remicade, which is administered via infusion, use CPT 90780 (IV infusion for therapy/diagnosis) administered by a physician or under direct supervision of physician, up to one hour. Use the "add on code" 90781, for each additional hour (up to eight hours). The HCPCs code for Remicade is J1745 (infliximab, one unit per 10 mgs infused, if your facility supplied the drug and is seeking reimbursement. Billing for the IV start and/or saline infusion are services considered integral to the procedure and are not separately billable.

Do not bill for an office visit unless a significant level of E/M service was provided beyond what is included in the administration of the medication. Taking vitals and monitoring for complications and the effectiveness of treatment is expected. If no new problems were addressed, there would be no justification for assigning an additional E/M code.

If you administer the medication during the visit that you initially determine the need for Remicade and discuss the process with your patient, then you could bill the E/M and the infusion service. Modifier -25 would be appended to E/M code. Check with your carriers to determine whether or not they consider the infusion bundled into an E/M service.

Enbrel can be self-injected. The MCM (2049.2) states "if a physician gives the patient an injection which is usually self-injected (e.g., Insulin or calcitonin), this drug is excluded from coverage, unless administered to the patient in an emergency situation e.g., (diabetic coma)". CPT 90782 injection IM or subcutaneous) would be the appropriate CPT for the administration of Enbrel.

Coding for infusions of Amevive would be similar to those for Remicade with the exception of the J code. Presently there is no specific J code for Amevive. If you are seeking reimbursement for this medication, the miscellaneous J code (J3590) may be used. Submit a paper claim and documentation when using unlisted codes.

Check with each of your local insurance carriers regarding coverage issues for these medications. Biologicals for the treatment of psoriasis may still be excluded from insurer or managed care coverage as "investigational or experimental" as is often the case with emerging technology.

KNOW THE GLOBAL PERIOD — AND NO POST SURGICAL SURPRISES

Physician reimbursement comes only after a service has been provided and documented, the service is correctly coded and billed, and finally, the carrier makes payment to the provider. While the services any physician provides are by their very nature variable, CPT codes represent readily identifiable surgical procedures which include specific services in addition to the procedure performed.

CMS established a national definition of the global surgical package to

“ensure that payment is made consistently for the same services across all carrier jurisdictions, thus preventing Medicare payments for services which are more or less comprehensive than intended.”

This national global surgery policy became effective in January of 1992. In 2002, in an effort to clarify exactly what is and isn't included in the global surgical package, CPT revised its descriptor language to define the components of the package. The surgical global period includes the actual surgery and any hospital or office visits related to uncomplicated follow-up care for the surgery within the global time limit. The surgical global period does not include postoperative complications (i.e., bleeding or infections) or unrelated services (i.e., services by another specialty).

Become familiar with your contracted insurance carrier policies. Global period guidelines will differ between the various carriers. Medicare's can be found in the Medicare Fee Schedule Data Base (MFSDDB). The MFSDDB, (Table 1.) supplies information relevant to claims processing requirements that have been established for surgical issues. Codes with “090” are major surgeries. Codes with “000” or “010” are minor surgical procedures. Codes with “ZZZ” are add-on codes (that are always billed with a primary procedure, whose global period applies to both codes). “YYY” status means it is carrier priced.

Table 1. – Example of Information in MFSDDB

HCPC	Short Description	PCTC	Global	Bilateral Surg	Mult Surg
11100	Biopsy of skin lesion	0	000	0	2
11101	Biopsy, skin add-on	0	ZZZ	0	0
11300	Shave skin lesion	0	000	0	2
11313	Shave skin lesion	0	000	0	2
11900	Injection into skin lesions	0	000	0	2
10040	Acne surgery	0	010	0	2
10060	Drainage of abscess	0	010	0	2
11200	Removal of skin tags	0	010	0	2
11400	Exc tr-ext b9+marg 0.5 < cm	0	010	0	2
12001	Repair superficial wound(s)	0	010	0	2
14000	Skin tissue rearrangement	0	090	0	2
14001	Skin tissue rearrangement	0	090	0	2
14020	Skin tissue rearrangement	0	090	0	2

The MFSDDB also contains pricing information, payment policy indicators, relative value units for inclusive billing of all services that are part of the global surgical package. When carriers process claims they are going to be watching for fragmented billing. Any additional service not directly related to the original procedure will need to be billed with an appropriate modifier (“-24”, “-25”, “-57”, “-58”, “-78” or “-79”) in order to bypass global period related claim edits. Intra-operative services and any other service furnished on the same day as the surgery are considered to be components of the surgical procedure and therefore, included in the global surgical fee. Carriers use these pre-payment edits to detect separate billing of services included in the global package.

CODING Q & A

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- A. According to the CCI, modifier -59 could actually be appended to either column code. However, local carriers may have requirements regarding the placement of the modifier on the column 2 code. See your Medicare carrier publications regarding the use of modifier -59 for directives.

Simply appending modifier -59 haphazardly causes claims to be denied. The prior issues of *Derm Coding Consult* containing articles regarding CCI and modifier -59 are: September 2001, June 2001, and June 1997. The cumulative index to all articles appears in the December 2002 issue on page 7. All issues of *Derm Coding Consult* may be accessed on the Web at www.aadassociation.org/coding.html.

Q. If I see a patient and do a procedure, may I also bill for an E/M visit?

- A. As long as the E/M visit is medically necessary and is significant and separately identifiable, it is appropriate to bill for the E/M service. The documentation in the medical record must support the level of E/M service reported. A -25 modifier would be appended to the E/M code.

Q. A claim was submitted for 11100 and 11101 -59. Why was 11101 -59 denied?

- A. Code 11101 is an add-on code. Add-on codes are those codes that may not be reported alone, they add-on to the main code. In this instance, 11101 is used for the second, or subsequent biopsy(s). It is not appropriate to append a modifier to add-on codes.

Add-on codes are listed in Appendix D of AMA/CPT.

Q. What code do we use to report a service when no code is listed in CPT?

- A. Code 17999 is for unlisted procedure, skin, mucous membrane and subcutaneous tissue. One should not select a code that approximates a procedure. If there is no code for the service provided, the unlisted procedure code should be reported. A report would need to accompany the claim giving pertinent information regarding the procedure.

Q. What is a LMRP?

- A. Local medical review policies (LMRP) are Medicare carrier policies. Such policies may be found on your Carrier's Web site, or all Carrier LMRPs are found on the Web at www.lmrp.net. The LMRP gives specific details regarding CPT and ICD-9-CM codes for various services, such as Removal of Benign Skin Lesions. Reviewing LMRPs will assist you in avoiding any denied claims from Medicare.

III. These ICD-9-CM codes identify the complicating pathology that justifies Medicare payment (reasonable and necessary):

238.2	Neoplasm of uncertain behavior, skin
369.8	Unqualified visual loss, one eye
372.13	Viral conjunctivitis
459.0	Hemorrhage, unspecified
682.0-682.9	Cellulitis and abscess
686.8	Other specified local infections of skin and subcutaneous tissue
695.89	Other specified erythematous conditions
695.9	Unspecified erythematous conditions
698.9	Unspecified pruritus disorder
782.0	Pain, paresthesia, burning of skin
959.8	Injury [trauma] of other specified site, skin

Note: Diagnoses from List II above must be accompanied by one of the diagnoses from List III for payment to be allowed. This second diagnosis gives justification (reasonable and necessary) for allowing payment.

This LMRP differs from what we have normally seen as more than one diagnosis is necessary to justify medical necessity.

The LMRP also defines lesions removed that do not pose a threat to the health or function of the patient, or removed at the request of the patient for improvement of appearance are considered cosmetic services. Cosmetic services are not a covered benefit by the Medicare program.

Documentation in the patient’s medical record must clearly state why it was medically necessary to remove the benign lesion. Conditions that are present and justify necessity are specifically listed in the LMRP.

Access the complete LMRP at www.NoridianMedicare.com.

Actinic Keratoses

The destruction CPT codes 17000, 17003 and 17004 are addressed in both of the above LMRPs. This has led to some confusion regarding payable diagnoses for these procedure codes that are specific to each LMRP. Noridian is allowing payment for claims for CPT codes 17000, 17003 and 17004, listing diagnoses from *either list on either LMRP*. Further, ICD-9-CM 702.0, Actinic Keratosis does not require a second complicating pathology code (List III in the Non-Malignant Skin Lesion Removal Medical Policy), and will allow payment as the only diagnosis.

Also note that HCPCS code J7308, Aminolevulinic acid HCl for topical administration is no longer billable effective for dates of service on/after January 1, 2003. Reimbursement for this drug has been incorporated into the practice expense RVUs for the CPT code 96567.

See the complete LMRP on www.noridianmedicare.com.



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