

# DERM CODING CONSULT



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## NEWSBRIEFS

### Bush Signs Medicare Reform Into Law

President Bush signed the Medicare legislation (HR 1) passed by Congress last month in a ceremony near the White House on December 8th. The bill, considered a "domestic policy victory" for Bush, enacts the most far-reaching changes in the Medicare program since its creation in 1965. It adds a long-awaited prescription drug benefit to the program, gives seniors more coverage choices, makes Medicare more cost-efficient and preserves the "fiscally strained program" by including a 1.5% increase for physician reimbursement under Medicare Part B in 2004 and 2005. AADA strongly supported this proposal for short-term relief and looks forward to working with Congress to enact additional legislation that will resolve the long-term, systemic flaws in the payment formula itself.

AADA efforts also ensured that non-oncologists as well as oncologists benefit from increased practice expense payments for the administration of infusions and other Part B-covered drugs. In addition, new funds are provided for these payments and budget neutrality limits are waived to ensure that Medicare is not "robbing Peter to pay Paul" for the administration of Part B-covered drugs. In addition, the bill includes provisions instituting coverage "for all immunizing drugs and biologicals used when treating multiple sclerosis", and Medicare also will begin covering some treatments for rheumatoid arthritis under the legislation. Medicare currently covers only Johnson & Johnson's rheumatoid arthritis medication Remicade. Under the legislation, the program in 2004 will begin covering Amgen's Enbrel and Abbot Laboratories' Humira on a limited basis.

Congress allocated \$400 billion over 10 years that includes new "demonstration projects or pilot programs" for: a two-

year program to cover chiropractic services under Medicare without prior approval by a physician; a three-year project to allow Medicare to contract with private firms for "identifying underpayments and overpayments and recouping payments"; and a \$500 million two-year, six-state project to cover a limited category of self-administered prescription drugs for at least 50,000 Medicare beneficiaries.

A proposal to establish a mandatory electronic prescribing system for Medicare patients was transformed into a less burdensome voluntary e-prescribing system, thanks to lobbying by the AADA and the Alliance of Specialty Medicine. Effective lobbying by the AADA and the Alliance kept a complex new procedural coding system (ICD-10-PCS) out of the drug bill. AADA efforts also led to the deletion of lab services copayments and competitive bidding for laboratory services from the Medicare drug bill.

Massive legislation such as the Medicare drug bill includes many provisions whose impact will become clearer after enactment. Not only did the legislation include the increase to the Medicare Conversion Factor, it also increased the assigned values for all non-urban geographic practice cost indices (GPCI) to create better parity of Medicare payments to rural physicians.

The AADA is very pleased that it has achieved success on virtually every key issue that was lobbied on behalf of its membership and for this reason the AADA endorsed passage of the Medicare Prescription Drug Improvement and Modernization Act of 2003.

*Derm Coding Consult* is also available online at  
[www.aadassociation.org/coding.html](http://www.aadassociation.org/coding.html)

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Dear *Derm Coding Consult* Reader:

For the second year in a row, it's been necessary for Congress to legislate a "fix" in order to provide a modest but positive increase of 1.5% in the 2004 Medicare Conversion Factor. As we go to press, we are still waiting for full details on how the above change to the 2004 Medicare Fee Schedule will be communicated by the Medicare Carriers. However, the Centers for Medicare and Medicaid Services have been consistent in their reassurances that physicians will be able to submit claims as of January 1, 2004 that will be reimbursed at the 1.5% increase level.

I am happy to announce that starting with the March 2004 issue, *Derm Coding Consult* is being underwritten by an educational grant from BIOGEN.

In response to member requests, the Academy is pleased to announce the publication of the 2004 AAD *Coding and Documentation Manual: A Guide for Dermatology Practices*. The new manual, which will be an annual coding publication, 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 reimbursement process. It includes the 2004 CPT Codes with full official descriptions for procedures; updated E/M Codes with the documentation guidelines as well as skin-examination templates; updated ICD-9-CM Diagnosis Codes in alphabetic order with codes for each major clinical category pertinent to dermatology; the HCPCS Level II Codes for drugs and lab tests used in a surgical and/or dermatopathological office setting. Price for the new AAD Coding & Documentation Manual is \$115.00 (plus S&H). To order, go to AAD web site at: [www.aad.org/Marketplace/Catalog/codingdoc.html](http://www.aad.org/Marketplace/Catalog/codingdoc.html) or call 866 503 7546 x 4000

Best regards,



Norma L. Border, Editor

By now you should have the new 2004 CPT book in hand and have noted the changes affecting the integumentary system.

### Starred Procedures

The most notable change in 2004 is the elimination of the starred procedures. Starred procedures were identified in CPT with an asterisk \* following the code. These codes were minor surgical procedures that did not have pre or post operative work identifiable due to variable pre or post services.

The elimination of the starred designation in CPT allows more consistent use of modifier -25. A separately, identifiable medically necessary evaluation and management service provided beyond the usual preoperative or postoperative care should be reported with modifier -25. According to the text in the *AMA CPT Changes 2004 – An Insider's View*, "The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M service on the same date."

The starred designation is removed from the following codes in the integumentary system:

10040, 10060, 10080, 10120, 10140, 10160, 11000, 11200, 11300, 11305, 11310, 11730, 11900, 11901, 11100, 12001, 12002, 12004, 12011, 12013, 12031, 12032, 12041, 12051, 15786, 16020, 16025, 17000, 17110, 17250, 17260, 17270, 17280, 17340, 17360, 17380

Code 99025, Initial (new patient) visit when starred surgical procedure constitutes major service at that visit, has therefore been deleted.

### Skin Biopsy

Language has been added in *CPT 2004* to clarify the use of skin biopsy. There previously had been no introductory text to the skin biopsy codes, 11100 and 11101. The added text clarifies that when tissue is obtained and sent for pathology

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Address correspondence to either:  
James A. Zalla, M.D., or Ronald L. Moy, M.D.  
Editorial Board, *Derm Coding Consult*  
American Academy of Dermatology Association  
P.O. Box 4014  
Schaumburg, IL 60168-4014

### 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](http://www.aadassociation.org/coding.html)

## MICRO DERMABRASION CLARIFICATION

A question regarding coding for micro dermabrasion was addressed in the April issue of the AMA publication *CPT Assistant*. The question was whether CPT code 15780, dermabrasion, total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis) would be appropriate to use for reporting micro dermabrasion. The response given in *CPT Assistant* was that code 15783, dermabrasion, superficial, any site, would be the appropriate code to use.

The AADA disagrees with the interpretation that code 15783 would be used to report micro dermabrasion. In a letter to *CPT Assistant* from Dr. James Zalla, with concurrence from the CPT Advisors, Dr. Allan Wirtzer, Dr. Stephen Stone, Dr. P. Kim Phillips, it was recommended that code 17999, unlisted skin procedure, or code A9270, non covered service (for cosmetic services) be reported. Micro dermabrasion is more similar to a superficial chemical peel and certainly does not involve the physician work that is valued in code 15783.

According to explanations in the AMA publication *Principles of CPT Coding*, Third Edition, regarding the use of unlisted codes, one is directed not to select a code that is "close" to the procedure performed. Correct coding principles would require that the appropriate unlisted code be reported.

## REFINEMENT PANEL VOTE ON MOHS CODE (CPT 17310)

As noted in the text of the Final Rule, Dr. Daniel Siegel testified on behalf of the AADA before a multi-specialty refinement panel convened by CMS on September 17. He defended the AADA request for 0.95 physician work RVUs to be assigned to CPT 17310. The ACMMSCO and ASDS also testified. The interim PW-RVU for this procedure in 2003 is 0.62. The AADA and other affected groups protested this value and advocated for 0.95. The CMS final decision is to assign 0.95 work RVUs to CPT code 17310. This change to the physician work RVUs was not included in Appendix B of the 04 MFS Final Rule published on November 7, 2003. However, CMS staff assures us that this change will appear in the Rule implementing the Medicare Prescription Drug Improvement and Modernization Act of 2003.

CMS now includes all local carrier LMRPs and draft LMRPs on their database Web site,  
[www.cms.hhs.gov/mcd](http://www.cms.hhs.gov/mcd)

## HIPAA – PLEASE LIMIT YOUR SHARING OF PHI INFO WITH AADA!!

Every health organization and practice was expected to be in compliance with the HIPAA Privacy Standard compliance deadline of April 14, 2003. At minimum, all covered entities as well as business associates of each dermatology practice have examined the type of individual patient **protected health information (PHI)** being used or disclosed.

HIPAA Privacy Standards compliance requires that dermatology practices **exercise vigilance in any situation where protected health information may be shared with an outside entity**. This requirement applies when you request assistance from the AADA/Health Policy and Practice department in resolving claims filing problems with any health insurance payer, carrier or plan.

The AADA/Health Policy and Practice (HPP) department does not qualify as a business associate under HIPAA. HPP will implement HIPAA compliant procedures in regard to dermatology practice requests for review and comment on patient medical records, claims forms, remittance information and correspondence. These are considered non-routine disclosures. Therefore, every dermatology practice as a covered entity must:

- develop reasonable criteria for determining, and limiting disclosure,
- provide 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 a particular purpose, given the characteristics of their business and workforce, and to implement policies and procedures accordingly.

The **minimum necessary standard** is intended to make dermatologists evaluate their everyday information procedures and enhance protections as needed to prevent unnecessary or inappropriate access to PHI. It is intended to reflect and be consistent with, not override, professional judgment and standards.

The Privacy Rule applies to individually identifiable health information (IIHI) in all forms: electronic, written, oral, and any other.

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

### HPP STAFF DOES NEED:

- Patient sex (if pertinent)
- Date(s) of Service
- ICD-9-CM diagnostic code(s) for the service;
- CPT procedure code(s) for the services
- CPT modifiers used
- Charge amount
- Fee schedule amount

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CMS's has undertaken a project to insure that the Medicare Fee-for Service program is paying its claims correctly. With the state the economy is in, and the fact that CMS must maintain budget neutrality, it is critical that Medicare contractors "pay the correct amount for covered and correctly coded services rendered to eligible beneficiaries by legitimate providers". The Improper Medicare FFS Payments Report describes the performance measurement program for the FFS Medicare Program.

2003 is the first time CMS has produced the Improper Medicare Fee-For-Service (FFS) Payments Report. Actually, two programs have been established to monitor the accuracy of Medicare FFS. The Comprehensive Error Rate Testing Program (CERT) and the Hospital Payment Monitoring Program (HPMP). The CERT Contractor calculates error rates for Carriers, Durable Medical Equipment Carriers (DMERCs) and Fiscal Intermediaries (FIs). HPMP calculates the error rate for the Quality Improvement Organizations (QIOs).

The OIG has been measuring error rates since 1996. BNA's Medicare Report stated that in the year 2000 Medicare paid an estimated \$61 million in excessive payments to hospitals because of incorrect coding on claims for discharges. The Inspector General (IG) determined that coding errors occurred because CMS doesn't have controls or edits to detect excessive payments. The results of the 2000 audit were similar to the 1999 claims audit that found \$52 million in excessive payments.

CMS uses a methodology to calculate the Medicare Fee-for-Service error rate using an OIG approved methodology. In 2002, they randomly selected a sample of 128,000 submitted claims; requesting medical records from the providers who submitted the claims and reviewing them to see if the claims complied with Medicare's coverage, coding and billing rules. If providers failed to submit the requested documentation, the claims were treated as errors and those providers were sent overpayment letters.

For the first time CMS will be able to view the error rate at a contractor and/or provider specific level, thus have sufficiently detailed information so problems can be better assessed and corrected using the CERT methodology. This will enhance CMS's ability to manage Medicare payments.

The findings revealed that a significant amount of money was paid out to claims that were not compliant with Medicare rules. For example, a 14.4% claims error rate for Carriers; 13.6% for DMERCs; 14.4% for FIs; and for QIOs it was 3.5%.

The error rate lists incorrectly paid claims by service type for Carriers, FIs and DMERCs. For Carriers, subsequent hospital visits had a 35.8% error rate (\$1.8 billion). Surgical dressings (DMERCs) had a 40% (\$23.3 million) error rate and for FIs, non-PPS hospital in-patient claims error rate was 53% (\$901.7 million).

As far as providers go, those with the highest compliance error rate were chiropractors (30.6%) and physical therapists (29.4%).

In 2003 there was a high provider non-response (probably due to misunderstandings about new HIPAA regulations, and therefore the figures were adjusted). To alleviate this non-response problem in future years CMS has developed a new strategy. Letters requesting medical records will clarify the role of the CERT contractor and the fact that it is not a violation of HIPAA to submit records to the contractor.

Carriers, DMERCs and FIs will continue to educate providers about the CERT contractors in order to lower the non-response rate for medical record submission. CMS will require CERT contractors to intensify their attempts at collecting the necessary data. Carriers/ DMERCs and FIS will assist CERT contractors in contacting non-responders. CMS is also requesting funding to support an Electronic Medical Record Submission Pilot Program to facilitate the submission of medical records.

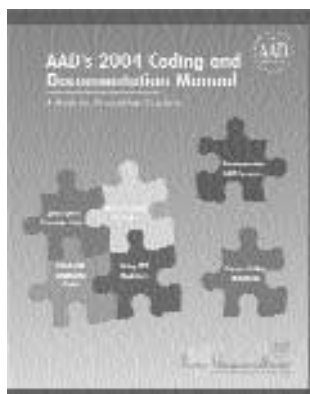
CMS has also said that in addition to the corrective actions to lower non-response rates, other corrective actions that are underway will be to refine one-on-one educational contacts with providers who have high billing errors. The goal is to monitor the error rate to develop appropriate corrective action plans, implement these corrective action plans and reduce the error rate in future years.

## Now Available...



### **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.**



### **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.

**To Order, call toll-free 1-866-503-7546**

Even with the positive 1.5% increase in the Medicare conversion factor, there are still procedure codes where dermatologists will see an overall reduction in relative value units (RVUs). However, the Medicare Prescription Drug Improvement & Modernization Act of 2003 (MPDIMA) also included a legislative adjustments and increase to the Medical Economic Index (MEI) as well as the non-urban geographic practice cost indices (GPCI) to create better parity of Medicare payments to rural physicians. CMS has advised that it will recalculate the entire Appendix B of the 04 MFS Final Rule published in early November.

**04 MFS Conversion Factor (CF) Reset by Congress at 37.3374**

This is a modest increase of \$0.5518 per RVU from last year's conversion factor of 36.7856. Therefore, every physician will see a slight increase in reimbursement if there have been no other changes to the total non-facility RVU for a particular code.

**Medical Economic Index Rebased of RVUs**

For the final rule, CMS reduced the work RVUs by 0.15 percent (0.9985), the practice expense by 1.320 (0.9868) percent and increased the malpractice RVUs by 20.61 percent (1.2061). This has resulted in an additional reduction of .001 to the physician work RVUs for all procedural codes with only a slight increase in the malpractice RVUs for derm codes.

Reduction to photochemotherapy codes is a result of CMS repricing of topical drugs included in the practice expense direct inputs for these codes. AADA is working with key dermatologists and the National Psoriasis Foundation to submit updated drug pricing information to CMS.

Reduction to photodynamic therapy codes reflects the impact of CMS use of the dermatology scaling factor. However, CMS will revise related instructions to permit billing of the topical light activating agent under a J code as of January 1, 2004.

**Other Reimbursement Anomalies**

To date, CMS has not corrected the erroneous increase to the practice expense RVUs for the laser treatment for psoriasis codes (96920, 96921, 96922) that inflates reimbursement by over 50%. AADA identified the error in our comments on the proposed rule. In addition, there is a similar anomaly for CPT 11012 Debridement code and there may be others. In discussing this with CMS staff in late September, CMS had not identified the cause of these changes but appreciated AADA honesty in pointing out the disparity.

The following table shows the effect of the new \$37.3374 Conversion Factor as well as the MFS 2004 relative value unit changes to codes frequently billed by dermatologists.

MFS COMPARISON CY '03 WITH '04 MPDI&M Fix			PW RVU		N/F PE		Malpractice		N/F total		CF '04	CF'03
			FR '04	FR '03	FR '04	FR '03	FR '04	FR '03	FR '04	FR '03	37.3374	36.7856
11100	A	Biopsy of skin lesion	0.81	0.81	<b>1.26</b>	1.24	<b>0.05</b>	0.04	<b>2.12</b>	2.09	<b>79.16</b>	76.88
11101	A	Biopsy, skin add-on	0.41	0.41	<b>0.34</b>	0.38	0.02	0.02	<b>0.77</b>	0.81	28.75	29.80
11402	A	Benign exc+marg	1.51	1.51	<b>2.25</b>	2.28	<b>0.14</b>	0.12	<b>3.90</b>	3.91	<b>145.62</b>	143.83
11441	A	Benign exc+marg	1.48	1.48	2.40	2.40	<b>0.13</b>	0.11	<b>4.01</b>	3.99	<b>149.72</b>	146.77
11602	A	Malig exc+marg	1.95	1.95	<b>2.86</b>	2.73	<b>0.16</b>	0.13	<b>4.97</b>	4.81	<b>185.57</b>	176.94
11641	A	Malig exc+marg	2.16	2.16	<b>3.06</b>	2.92	<b>0.18</b>	0.15	<b>5.40</b>	5.23	<b>201.62</b>	192.39
17000	A	Destroy benign/premal lesion	0.60	0.60	<b>0.98</b>	1.04	<b>0.04</b>	0.03	<b>1.62</b>	1.67	60.49	61.43
17003	A	Destroy lesions, 2-14	0.15	0.15	<b>0.11</b>	0.12	0.01	0.01	<b>0.27</b>	0.28	10.08	10.30
17004	A	Destroy lesions, 15 or more	2.79	2.79	<b>2.32</b>	2.45	<b>0.14</b>	0.12	<b>5.25</b>	5.36	196.02	197.17
17304	A	Chemosurgery of skin lesion	<b>7.59</b>	7.60	8.09	8.09	<b>0.37</b>	0.31	<b>16.05</b>	16.00	<b>599.27</b>	588.57
17305	A	2nd stage chemosurgery	2.85	2.85	3.81	3.81	<b>0.14</b>	0.12	<b>6.80</b>	6.78	<b>253.89</b>	249.41
17306	A	3rd stage chemosurgery	2.85	2.85	<b>3.83</b>	3.81	<b>0.14</b>	0.12	<b>6.82</b>	6.78	<b>254.64</b>	249.41
17307	A	Followup skin lesion therapy	2.85	2.85	<b>3.78</b>	3.82	<b>0.14</b>	0.12	<b>6.77</b>	6.79	<b>252.77</b>	249.77
17310	A	Extensive skin chemosurgery	<b>0.95</b>	0.62	<b>1.65</b>	1.48	<b>0.06</b>	0.05	<b>2.66</b>	2.15	<b>99.32</b>	79.09
96567	A	Photodynamic tx, skin	0.00	0.00	<b>0.98</b>	5.10	<b>0.04</b>	0.03	<b>1.02</b>	5.13	38.08	188.71
96900	A	Ultraviolet light therapy	0.00	0.00	<b>0.48</b>	0.49	0.02	0.02	<b>0.50</b>	0.51	18.67	18.76
96910	A	Photochemoterpy/ UV-B	0.00	0.00	<b>1.07</b>	1.57	<b>0.04</b>	0.03	<b>1.11</b>	1.60	41.44	58.86
96912	A	Photochemoterpy/ UV-A	0.00	0.00	<b>1.34</b>	1.80	<b>0.05</b>	0.04	<b>1.39</b>	1.84	51.90	67.69
96913	A	Photochemoterpy/ UVA/ B	0.00	0.00	<b>1.78</b>	2.71	<b>0.10</b>	0.08	<b>1.88</b>	2.79	70.19	102.63
99202	A	Office/outpatient visit, new	0.88	0.88	<b>0.79</b>	0.77	<b>0.06</b>	0.05	<b>1.73</b>	1.70	<b>64.59</b>	62.54
99203	A	Office/outpatient visit, new	1.34	1.34	<b>1.13</b>	1.10	<b>0.10</b>	0.08	<b>2.57</b>	2.52	<b>95.96</b>	92.70
99213	A	Office/outpatient visit, est	0.67	0.67	<b>0.70</b>	0.69	<b>0.04</b>	0.03	<b>1.41</b>	1.39	<b>52.65</b>	51.13
88304	A	Tissue exm by pathologist	0.22	0.22	<b>0.87</b>	0.90	0.03	0.03	<b>1.12</b>	1.15	41.82	42.30
88304-26	A	Tissue exm by pathologist	0.22	0.22	0.10	0.10	0.01	0.01	0.33	0.33	<b>12.32</b>	12.14
88304-TC	A	Tissue exm by pathologist	0.00	0.00	<b>0.77</b>	0.80	0.02	0.02	<b>0.79</b>	0.82	29.50	30.16
88305	A	Tissue exm by pathologist	0.75	0.75	<b>1.74</b>	1.77	<b>0.06</b>	0.05	<b>2.55</b>	2.57	<b>95.21</b>	94.54
88305-26	A	Tissue exm by pathologist	0.75	0.75	0.34	0.34	0.02	0.02	1.11	1.11	<b>41.44</b>	40.83
88305-TC	A	Tissue exm by pathologist	0.00	0.00	<b>1.40</b>	1.43	<b>0.04</b>	0.03	<b>1.44</b>	1.46	<b>53.77</b>	53.71

**BOLD = Increases**

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HIPAA – PLEASE LIMIT YOUR SHARING OF PHI INFO WITH AADA!!

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(HPP STAFF DOES NEED: cont'd)

- 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
- Patient Age or Birthdate

When requesting AADA/HPP review of a billing problem by e-mail, fax or mail,

Please review the documents being sent and apply the **minimum necessary** standard.

1. Copies should be made of the pertinent documentation required for review: medical record, billing form, remittance advice, correspondence.
2. The copy should be reviewed and 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 the PHI for **all** the patients listed has been blocked.

4. When faxing documentation with PHI for review: e.g. medical record, billing form, remittance advice, correspondence, use a confidentiality disclaimer on the cover of the fax, such as:

*This fax is intended only for the use of the person or office to whom it is addressed and may contain information that is privileged, confidential, or protected by law. All others are hereby notified that receipt of this fax does not waive any applicable privilege or exemption for disclosure and that dissemination, distribution, or copying of this communication is prohibited. If you have received this fax in error, please notify this office immediately at the telephone number listed above.*

examination during another procedure, such as an excision, a destruction, or a shave removal, a separate biopsy code is not appropriate.

For example, it would not be appropriate to report 11100 and 11400 for the same lesion when a full thickness excision was performed and sent to the pathologist for examination.

The biopsy code is used only when tissue is obtained for pathology examination and is unrelated to other procedures performed at the same encounter.

### Adjacent Tissue Transfer or Rearrangement

Additional text has been added to clarify the defect size when selecting the proper Adjacent Tissue Transfer or Rearrangement code. The defect size includes the primary and secondary sites according to the added text. Further text states, "The primary defect resulting from the excision and the secondary defect resulting from the flap design to perform the reconstruction are measured together to determine the code." This additional text should prove to be extremely helpful in not only selecting the proper code, but in the proper adjudication of claims.

### Category III codes

Category III codes are those temporary codes for emerging technologies, services and procedures. Category III codes

are released/updated every six months on the AMA Web site. The new codes appear in January and June, with a six month window for Carriers to implement the code in their systems. There currently are no established payment policies for Category III codes. Payers will establish their own policies for payment of the services represented by these codes.

A Category III code of interest to dermatology first appeared in CPT 2003, with the new indented code appearing in the 2004 edition.

0044T Whole body integumentary photography, at request of a physician, for monitoring of high-risk patients; with dysplastic nevus syndrome or familial melanoma

- 0045T with history of dysplastic nevi or personal history of melanoma

Category III codes are to be archived after five years unless the need for such code(s) can be demonstrated. We will want to collect data to monitor the use and reimbursement of these Category III codes to determine future need.

To assist you in correct coding, order the new *AAD's Coding & Documentation Manual: A Guide for Dermatology Practices*. See the AADA Web site for ordering instructions. [www.aad.org/Marketplace/Catalog/derm\\_products.html#Practice](http://www.aad.org/Marketplace/Catalog/derm_products.html#Practice)



**American Academy of Dermatology**  
**P.O. Box 4014**  
**Schaumburg IL 60168-4014**