DERM CODING CONSULT

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NewsBriefs

CMS Will Delay Paying Non-HIPAA Compliant Claims

The Centers for Medicare and Medicaid Services (CMS) announced its *Modification of Medicare Contingency Plan for HIPAA Implementation* on February 27, 2004. Effective July 1, 2004, the modification continues to allow submission of non-HIPAA compliant electronic claims. However, the payment of electronic claims that are not HIPAA compliant will take thirteen additional days.

In its announcement, CMS states: "only those claims submitted electronically in a HIPAA compliant format will now be considered eligible for payment as early as the 14th day after the date of receipt. All other claims, including those submitted electronically in a pre-HIPAA format under a Medicare contingency plan, will not be paid earlier than the 27th day after the date of receipt."

If your office is still filing electronic claims in pre-HIPAA formats, please be aware that on July 1st, the minimum period between claim receipt by the Medicare Carrier and claim payment to you will increase.

If you are already submitting HIPAA compliant claims or will do so on or before July 1, 2004, then this change does not apply to you.

Currently, Medicare pays electronic media claims (EMC) no earlier than the 14th day after the date of receipt (13-day waiting period). Non-electronic claims cannot be paid earlier than the 27th day after the date of receipt (26-day waiting period). HIPAA requires that claims submitted electronically, effective October 16, 2003, be in a format that complies with the appropriate standard adopted for national use. The Administrative Simplification and Compliance Act (ASCA) requires claims to be submitted to Medicare electronically, with some exceptions, effective October 16, 2003. If you need additional information concerning this Medicare contingency plan modification, please visit the CMS website at www.cms.hhs.gov/manuals/pmtrans/R114cp.pdf. ■

National Provider Identification Number (NPI)

The Centers for Medicare and Medicaid Services has begun the initial steps toward assigning a National Provider Identification number (NPI) to all physicians and providers. The NPI will be a unique identification number that will be used by **all** health care providers and by **all** health plans. Currently, health plans assign identification numbers to their contracted health care providers. Consequently, providers who do business with multiple health plans have multiple identification numbers, one for each plan. In the near future, physicians, health care providers, health plans and health care clearing houses will use the NPI as specified by HIPAA standards.

The HIPAA final rule (45 CFR 162.103) establishes a unique health identifier for health care providers for use in the health care system and the adoption of the **National Provider Identifier** (NPI). It also establishes the implementation specifications for obtaining and using the NPI for health care providers.

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***Derm Coding Consult* is funded by an unrestricted educational grant from Biogen Idec**

Letter From the Editor

Dear *Derm Coding Consult* Reader:

I am happy to announce that starting with this March 2004 issue, *Derm Coding Consult* is being underwritten by an educational grant from BIOGEN. Please be sure to thank your BIOGEN representative for this sponsorship!

With its revision of the HIPAA Contingency Plan for electronic claims filing and the new regulation for the phased-in implementation of a single, national provider identification number, the Centers for Medicare and Medicaid Services continues to press for full electronic claims filing for Medicare Part B claims. With the next HIPAA compliance deadline for the Security Standards set for April 21, 2005, dermatologists who have or who are planning to move to electronic claims filing, will reap the benefits of this new "one claim form for all payers" environment!

In addition to access to all the back issues of *Derm Coding Consult*, here are two more good reasons for making internet access in your dermatology practice routine. Internet access ensures quick and regular communications from your Medicare carrier on new or revised medical review policies and billing instructions. The Medicare Carriers now have searchable Medicare Fee Schedule data bases on-line.

We've also provided updated information for accessing your CMS Regional Office too (see page 6). In those situations where you have been unable to get consistent and timely information from your Medicare Carrier, your best recourse may be to the Regional office that supervises your Medicare Carrier. Internet access also assures you of timely information from CMS on implementation of the new Medicare Prescription Drug program provisions.

We continue to get a lot of questions on pathology service coding and billing. We've recapped this topic for you. As always, we look forward to your calls, comments and questions!

Best regards,

Norma L. Border, Editor

Coding Update

No More Grace Periods

The Health Insurance Portability and Accountability Act (HIPAA) continues to affect physician billing practices. The HIPAA rule requires date of service compliance for medical code sets. Since HCPCS and ICD-9-CM codes qualify as code sets, that provision in the rule translates to "no more Grace Periods" for using these codes. In other words, any code used to report a service must be a valid code on the date the service was provided.

HCPCS Coding

HCPCS codes are classified as Level I Current Procedural Terminology (CPT) codes, and Healthcare Common Procedure Coding System (HCPCS) Level II codes. CPT codes are the five position numerical codes and HCPCS are the five position alpha numeric codes.

Prior to HIPAA, the Centers for Medicare and Medicaid Services (CMS) allowed a 90 day grace period, which was January 1 through March 31, for discontinued HCPCS codes. In other words, discontinued codes could still be reported to CMS from January 1 through March 31 of the year and were allowed for reimbursement. New codes for that particular calendar year, regardless of the date of the encounter, did not absolutely have to be reported until April 1st. At the end of the grace period, April 1st, claims would have been denied without the use of the proper codes.

This HIPAA requirement also affects any new HCPCS codes mid-year. Those codes that will be affected are the CPT Category II and Category III codes. These codes are published on the American Medical Association (AMA) Web site (www.ama-assn.org) either on January 1 and July 1. Those published on January 1 become effective on July 1 and must be used for services provided on or after that date. Those published on July 1 become effective on January 1 of the next year and must be used for services provided on or after that date. Category II codes are used for performance measurement. These codes are not reported for reimbursement purposes. Category II codes are not used in place of Category I codes. Category III codes are tracking codes used for emerging technologies. If a Category III codes exists, it must be reported rather than an unlisted Category I code.

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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 (Spring, Summer, Fall and Winter) 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

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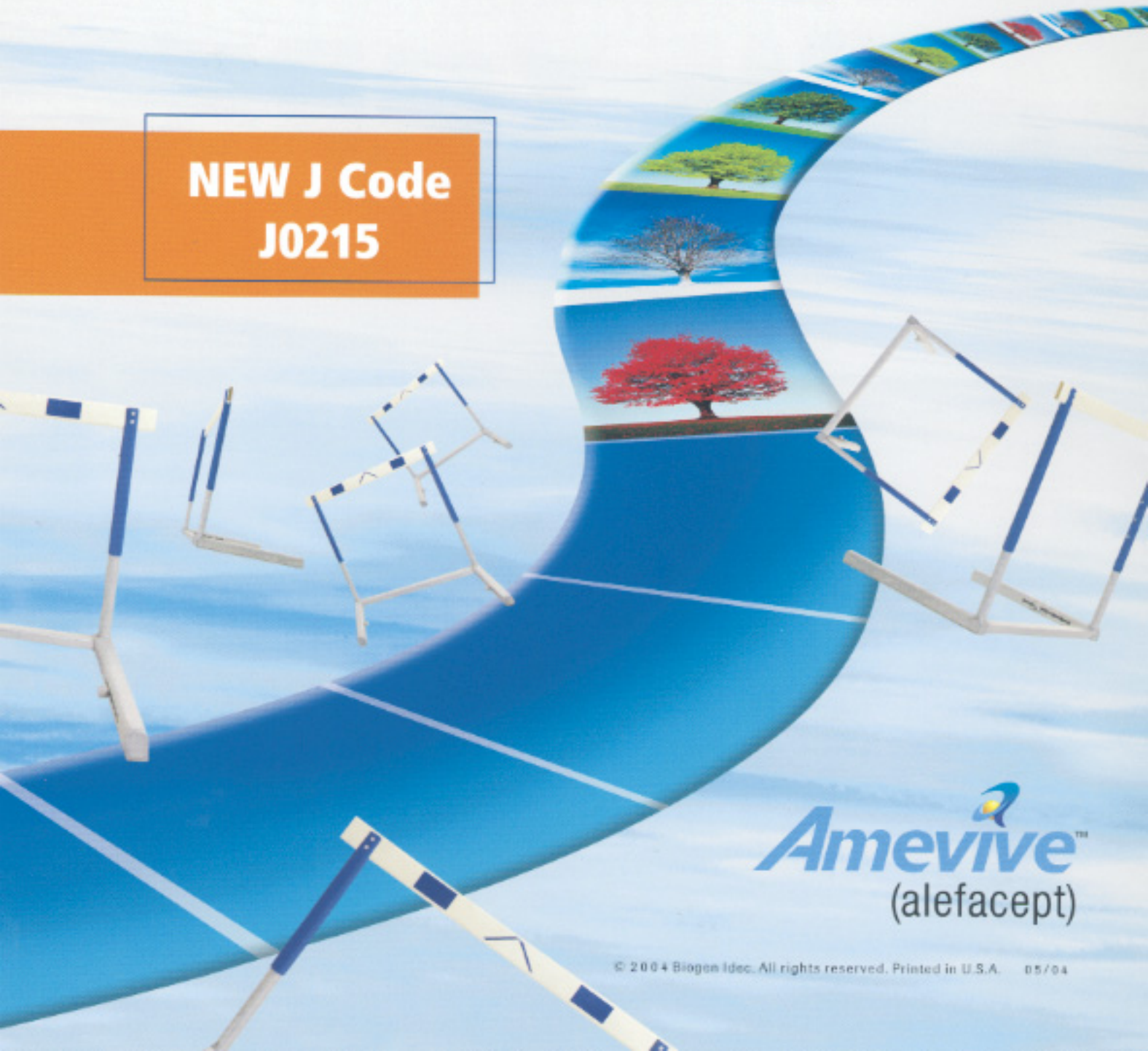

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New Service Location Instructions

Effective April 1, 2004, the Centers for Medicare and Medicaid Services (CMS) will require that the name, address and zip code of the facility where services were rendered are entered in Block 32 of the CMS-1500 form. In addition, only one name, address and zip code may be entered in Block 32. This will be problematic for those providers who have multiple locations and who have billed services for more than one location on a given claim and are still submitting paper claims to Medicare.

This change also affects professional and technical components of service. For instance, if the technical component is purchased, the name, address and zip code of where that component was done would necessitate a separate claim. Block 20 would be marked as YES, with the exact amount the physician was charged for this purchased component. A separate claim for the professional component of the service with the provider location information would also have to be filed.

However, multiple tests may be billed as one claim when claims are submitted in the electronic format, ASC X12 837. Multiple purchased technical components may be submitted as long as the appropriate line level information is submitted indicating the different service locations.

Revised instructions for CMS 1500 Item 20 state:

> "Complete this item when billing for diagnostic tests subject to purchase price limitations. Enter the purchase price under charges if the "yes" block is checked. A "yes" check indicates that an entity other than the entity billing for the service performed the diagnostic test. A "no" check indicates that "no purchased tests are included on the claim." When "yes" is annotated, item 32 must be completed. When billing for purchased diagnostic tests on the Form CMS-1500, each test must be submitted on a separate claim form."

Revised instructions for Item 32 now require that:

> "Providers of service (namely physicians) must identify the supplier's name, address, zip code and PIN when billing for purchased diagnostic tests. When more than one supplier is used, a separate Form CMS-1500 should be used to bill for each supplier.
>
> This item is completed whether the supplier personnel performs the work at the physician's office or at another location…(this) Item is completed for all laboratory work performed outside a physician's office. If an independent laboratory is billing, the place where the test was performed, and the UPIN must be indicated."

Your Medicare Carrier has been directed to provide you with educational information regarding this change. These changes were first publicized in Transmittal R28B4, CR# 2631 and you may access this change at http://www.cms.hhs.gov/manuals/pm_trans/R28B4.pdf.

All CMS Medicare program transmittals can be accessed at: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp. ■

National Provider Identification Number (NPI)

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The NPI will not replace your Tax Identification Number (TIN), nor is it designed to correspond to the TIN. The NPI will eventually replace the Unique Physician Identification Number (UPIN) in Medicare. NPIs and UPINs will also be cross walked. The use of the NPI will improve the effectiveness and efficiency of the health care industry in general, by simplifying the administration of the health care system and enabling the efficient electronic transmission of health information.

The NPI must be used in connection with electronic transactions identified in HIPAA. NPIs will be issued to health care providers that submit claims or conduct other transactions specified by HIPAA. The NPI will be a 10 position numeric identifier with a check digit in the last position to help detect data entry errors. It does not contain embedded intelligence. In other words it contains no information about the health care provider (such as where they are located).

This final rule also implements some of the requirements of the Administrative Simplification subtitle F of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). **Physicians and other health care providers may apply for NPIs beginning on, but no earlier than, May 23, 2005**. Derm Coding Consult will provide more information on this process as it becomes available. ■

Medicare Issues Final Rule on EMTALA

CMS issued its final rule clarifying hospital obligations to patients who request treatment for emergency medical conditions under the Emergency Medical Treatment and Labor Act (EMTALA). According to outgoing CMS Administrator Tom Scully, "The regulation carries out EMTALA in a common sense and effective way to ensure that people who come to hospitals seeking emergency care are promptly screened and stabilized. This rule will improve people's access to emergency care by encouraging physicians to be on call, and by permitting hospitals to take the most effective steps for getting emergency treatment for patients who need it."

EMTALA *does not impose* any requirement on physicians that they serve on a call schedule. Physicians are often told by hospitals that they are required to, but the truth is that the hospital must impose an obligation on physicians, in order to meet the requirement imposed upon *them* by the Medicare Statute. This obligation is based on state law governing contracts, derived from agreements attendant to medical staff membership, rather than an obligation placed on the physician by Federal Law. New regulations:

- *do not* require a 24 hour coverage for under represented specialties when that is not feasible;
- do permit physicians to serve on call at more than one hospital simultaneously and,
- even permit the ER to direct the patient to the specialist (be it his office or another hospital where he is working) to examine the patient.

It is the hospital's responsibility to develop protocols for handling specialty needs when its specialists are not available on call.

EMTALA (Section 1395dd (d) (1) (C)) does impose penalties on physicians who fail to respond to an emergency situation when he or she is assigned as the on-call physician. This does not apply to any particular physician or particular specialty to provide coverage on an on-call basis. The courts and CMS's expectations in upholding EMTALA are directed at hospitals, which are left to their own devices on how to ensure compliance of their medical staff.

Hospitals are expected to structure this coverage requirement by using the Interpretive Guidelines Document that includes a *general statement* to the effect that *any* specialty service that a hospital offers should be available or an on-call physician covering that service. This is a very broad statement *and does not* distinguish between specialists. It also does not address the needs of small rural hospitals or other facilities where the number and types of specialty services available are limited.

CMS uses an informal 3-physician "rule of thumb" requiring a hospital to ensure that it has 24 hour on-call coverage for any specialty for which it has three or more physicians. It has not been clarified whether this means they are active staff in that particular specialty. Therefore, a hospital with only one or two specialists would have less than full coverage for that specialty without being considered in violation of EMTALA regulations. The final rule was published in the September 9th, 2003 Federal Register and became effective November 10, 2003. ■

Medicare Update

CMS Regional Offices Provide Information for Physicians

The Centers for Medicare and Medicaid Services has Regional Offices in ten major cities throughout the U.S., in addition to CMS Central Office in Baltimore:

I. Boston	II. New York	III. Philadelphia
IV. Atlanta	V. Chicago	VI. Dallas
VII. Kansas City	VIII. Denver	IX. San Francisco
X. Seattle		

CMS Regional Offices serve as the first point-of-contact for beneficiaries, health care providers, physicians, state and local governments, and the general public. The CMS Regional Offices are responsible for monitoring the performance of the Medicare Intermediaries and Carriers in their service area. Regional Office Provider Service representatives can be an effective next step if complaints to a Carrier for resolution of an enrollment or billing problem have not brought results or relief.

About 35 percent of CMS employees work in a Regional Office, performing essential day-to-day functions for Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP), including:

- Customer Service
- Program Operations, Management and Evaluation
- Communication, Education and Outreach
- Partnership with State and Local Health and Social Service Programs

Dermatologists can access local Regional Office web pages by going to http://www.cms.hhs.gov/about/regions/professionals.asp and clicking on the Regional Office link for your area, or on your state in the map or state list provided. ■

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

OIG Work Plan 2004

Each year, the Office of the Inspector General (OIG) publishes a Work Plan for the Department of Health and Human Services (DHHS) for the upcoming year. The Work Plan encompasses all entities that receive federal money. The overall objective is to identify the vulnerabilities in the various programs and to promote the economy, efficiency and effectiveness of the programs. Funding CMS programs accounts for more than 82% of the total DHHS budget. With this large outlay of funds, the OIG wants to make sure that the money is allocated and paid accurately and prudently.

In Fiscal Year 2002, OIG estimated that $13.3 billion was improperly paid for Medicare services. Compared to the $23.2 billion that was first estimated as improper payment in the 1996 Fiscal Year, there have been significant strides in educating providers in reporting services properly. The following studies are scheduled under the 2004 Work Plan to address pertinent issues for physicians.

Consultations

OIG will be looking at the consultations billed by physicians or other health care providers to determine whether these consultations were appropriate. They will be seeking to uncover the primary reasons consultations were inappropriately billed. This same issue was in the 2003 Work Plan, however there was no expected issue date for results, whereas the 2004 Plan indicates study results are expected in the 2004 Fiscal Year.

Dermatologists' use of consultation codes has increased over the past few years. This increase may be due to the fact that Medicare issued new guidelines clarifying the instructions for use of consultation codes in 1999. The following table from Medicare BESS data shows dermatology use of consultation codes for years 2000 – 2002.

The criteria that must be met in order to bill a consultation as opposed to an E/M visit are:

1. Service provided by a physician when opinion or advice regarding a specific problem is requested by another physician or other appropriate source;
2. The request and the need for the consultation must be documented in the patient's medical record;
3. The consulting physician prepares a written report of the findings that is provided to the physician who requested the consultation.

See June 2002 *Derm Coding Consult* for additional information regarding consultations at http://www.aadassociation.org/coding.html. Also check your Medicare Carrier Web site for guidelines on reporting consultation services. The Medicare Claims Payment Manual, Chapter 12, Section 30.6.10 contains full instructions on information requirements for documenting and billing consultations.

E/M Services

With over $23 billion of Medicare reimbursement in 2001 paid for evaluation and management (E/M) services, the OIG will be examining high volume usage, especially of the higher levels of E/M coding. This same initiative was in the 2003 Work Plan, with published results expected in Fiscal Year 2004.

Remember: The level of E/M service reported must be substantiated by the documentation in the medical record. The key is proper documentation to support the level of service billed. In an audit situation, the key components necessary for the level of service reported must be documented. Documentation in the medical record supporting the proper code(s) billed, using the appropriate modifiers, is always of utmost importance. Use of current codes, CPT and ICD-9-CM, are vital.

Modifier -25

Of the $23 billion spent for E/M services, $1.7B were related to E/M services with modifier -25 appended. OIG plans to verify that these E/M services were appropriate; in other words, a medically necessary, separately identifiable E/M service was provided with a procedure at the same encounter. According to the Medicare Carriers Manual, carriers may do pre-payment audits of those providers who have high usage of modifier -25.

Medicare Consult Data

Code	# Billed by Derms	Derm % of Total Billed	Year
99241	63,818	12.83%	2002
	63,672	12.21%	2001
	57,973	11.36%	2000
99242	209,651	12.34%	2002
	187,435	11.51%	2001
	155,046	10.51%	2000
99243	129,255	3.10%	2002
	106,346	2.82%	2001
	84,377	2.60%	2000
99244	12,972	0.29%	2002
	12,050	0.30%	2001
	10,138	0.29%	2000

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OIG Work Plan 2004

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CCI Edits

The use of Modifier –59 in accordance with the Correct Coding Initiative will continue to be reviewed to determine that the modifier is used appropriately. In 2001, $565 million was paid to providers who billed code pairs with modifier -59 according to the CCI tables. However, an OIG report published in September 2003 on CCI yielded a positive conclusion. OIG reported that the CCI is effective in preventing inaccurate payments based on the edits. Appending modifier -59 inappropriately just to get paid for a service may be considered fraud. Be sure you follow CCI guidelines for the use of this modifier. These can be accessed at http://cms.hhs.gov/physicians/cciedits.

Incident To

Another area of concern to OIG is the billing of services that are "incident to" services. According to Medicare rules, an "incident to" service may only be billed when the service is provided under the physician direct supervision. Because the "incident to" services are billed at 100% of the fee schedule allowance, the OIG is questioning whether these services are being correctly reported as truly "incident to" services.

The complete text of the OIG 2004 Work Plan may be downloaded from the OIG site: http://www.oig.hhs. gov/publications/docs/workplan/2004/2-CMS%20FY04.pdf. ■

Coding for Pathology Services

Coding for pathology services can be confusing. Errors on claim forms may cause denials because it appears that the physician office lab is out of compliance with CLIA. Local modifiers have been eliminated with the new HIPAA standards and submitting claims with deleted codes will cause denials. Common coding errors include using the incorrect CPT code or not using the modifier QW for waived tests. If you bill for a service that is not covered under your CLIA certificate and it is denied, you can't bill the patient. CPT codes 88304, 88305 and histopathology tests require a different CLIA certificate than the Physician Provided Microscopy Procedures (PPMP). A missing CLIA certificate number on the claim form will cause a denial.

The AADA's **CLIA Quick Facts**, highlighting the new Final Rules Lab Requirements Quality and Personnel Requirements, can be found on the AADA's Web site at http://www.aadassociation.org/CLIAQuickFacts1.html.

Many claims for services with professional and technical components are denied because they were submitted without information indicating whether or not they are purchased. Services without appropriate claim fields completed reject with a remark code such as "diagnostic tests performed by a physician must indicate whether purchased services (modifier 90) or "our records indicate that you billed a diagnostic test subject to price limitations; however you did not indicate whether the tests were performed by an outside entity or no purchased tests are included on the claim (item 20 and 32 not completed).

If you purchase slide preparation from a histology lab, is your office properly reflecting payments made to that lab for the preparation of multiple pathology slides for review by the referring physician? You need to use the appropriate CPT code and modifiers TC and 90, as well as putting a "yes" in item 20 to indicate the amount of the laboratory's charge to the physician as well as the Medicare PIN number, address, and zip code of the laboratory that actually performed the test in Box 32 of the CMS 1500 claim form.

Histology labs may directly bill Medicare if they have a provider number. If either the lab or the physician bills Medicare for slide preparation the other entity may not bill for the same service.

Procedure codes 88304 and 88305 are commonly billed more than once per claim. This is another area where confusion arises. Modifier 59 should be used only with codes that can be affected by CCI edits.

Non-Medicare billing factors to consider are whether your state has a law prohibiting billing for services that were not provided in your office. Check with your State Medical Society or the State Pathology Association. It is necessary to know carrier's requirements regarding billing services that were not provided in your office. In both instances, you need to know what you are permitted to bill.

Read your carrier's newsletter on a regular basis. Visit their Web site. Internet access is the way to keep abreast of changes. Sign up for your Medicare carrier's list serve to receive updates and provider bulletins by email.

Check for further articles on Pathology Coding in *Derm Coding Consult* at http://www.aadassociation.org/DermCodingConsults/Sept00.pdf. The Winter 2003 issue contains the cumulative index that will direct you to all articles on pathology coding. ■

Coding Update

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ICD-9-CM Coding

International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) contains the codes one uses to report patient diagnoses. These codes are three position codes which may require additional one or two digits. When fourth or fifth digits are required and are omitted, the claim will be rejected as the ICD-9-CM code reported will not be a valid code.

ICD-9-CM codes become effective on October 1 of each year. The updated listing of ICD-9-CM codes is published in the Federal Register in April or May as part of the Proposed Changes to the Hospital Inpatient Prospective Payment Systems. The *Federal Register* index for 2004 may be accessed at http://www.access.gpo.gov/su_docs/fedreg/frcont04.html.

Due to the HIPAA date of service requirements, the diagnoses codes (ICD-9-CM) reported must be based on the date the service was rendered to the beneficiary. Thus, on October 1 of the year, any new ICD-9-CM or revised codes must be reported as of that date.

The elimination of grace periods was addressed in CMS Transmittals 89 and 95. These transmittals also direct Carriers to provide education to providers regarding the date of service requirement. Carriers are to place articles in their newsletters/bulletins and on their Web sites for educating the providers regarding the change. The CMS Web site should also have a provider education article regarding the grace period elimination (http://www.cms.hhs.gov/medlearn/matters).

It will be necessary for the coding changes to be made to not only the office software but also to the patient encounter forms for the October 1 date for ICD-9-CM codes and the January 1 date for the HCPCS level I and level II codes. Also, remember the July 1 date for any pertinent Category III codes that may become effective. ■

Derm Coding Consult is underwritten by an educational grant from Biogen Idec.

Please be sure to thank your Biogen Idec representative for this sponsorship!

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