DERM CODING CONSULT

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NewsBriefs

New Drug Administration Codes Impact/Psoriasis Biologics

Effective January 1, 2005, the Centers for Medicare and Medicaid Services (CMS) began using a temporary set of government, or G codes for drug administration via infusion or injection. The new codes, required under the Medicare Modernization Act provisions, will permit drug administration billing to Medicare while current CPT codes for injections and infusions are being updated. In 2006, these temporary G codes will be replaced with a new set of CPT codes for these procedures. The new G codes are accompanied by new rules for how they can be used, including what other codes can be billed on the same day. These rules will also apply to the new set of CPT injection and infusion codes when they are released for 2006.

One of the most significant changes is the expanded category of drug administrations which are: hydration, therapeutic/diagnostic infusions and injections, and chemotherapy administration. Hydration codes are to be used for infusions of fluid & electrolytes and not for drug infusions. Therapeutic/diagnostic infusion and injection codes are to be used for non-chemotherapy procedures other than hydration. The chemotherapy admin-istration codes are to be used to report admin-istration of non-radionuclide anti-neoplastic drugs, and anti-neoplastic agents provided for treatment of non-cancer diagnoses, or substances such as monoclonal antibody agents and other biologic response modifiers.

In the past, chemotherapy codes could only be applied to treatments for cancer. The new definition encompasses biologic response modifiers, meaning that the in-office administration of any psoriasis biologic by infusion or injection is payable under Medicare. Chemotherapy administration codes can be used on the same day as codes for both the substance being administered and an E/M service. In the past, the administration of biologics could not be billed on the same day as an office visit.

New codes also apply to non-chemotherapy infusions and injections; these codes will be used by dermatologists who administer methotrexate and other drugs in their offices. These G codes will replace familiar CPT codes 90782 and 90784. The code for a subcutaneous or intramuscular therapeutic or diagnostic injection, 90782, is replaced by G0351.

— continued on page 6

AAD Comments on Ambulatory Surgical Center Proposed Rule

AAD, ASDS and ACMMSCO have submitted a joint comment letter on the Ambulatory Surgical Center (ASC) Proposed Rule, providing argument to CMS on the inappropriateness of deleting key dermatologic procedures from payment in an ASC. AAD shared the above letter with both American Society for Plastic Surgery (ASPS) and the American College of Surgeons (ACS), who also planned to submit comment to CMS and agreed with the arguments developed by AAD. In addition, the AAD signed onto the joint letter prepared by AMA on this issue.

Clinical Background on Key Procedures on the ASC Code Deletion List

For the sake of categorization, excisions are grouped by AMA CPT into measurement ranges determined by "measuring the greatest clinical diameter of the apparent lesion plus that margin required for complete excision." However, the clinical excision of a benign or malignant lesion is a three dimensional alteration to the skin and its underlying structures.

— continued on page 5

Contents

NewsBriefs 1, 6

AAD Comments on ASC Proposed Rule 1, 5

Letter From the Editor 2

Update on Patch Test Coding 2, 6

Coding Q & A 4

CMS Drug Administration Codes in 2005 4

Medicare Adds Psoriasis Meds 5

Billing Medicare for Purchased Tests/Interpretations 6

DermCAC Update 6

DermCAC Phone Listings 7

Medicare Returns Unprocessable Claims 8

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Letter From the Editor

Dear *Derm Coding Consult* Reader:

This issue provides you with more information on the new Medicare G Codes for injection and infusion administrative services, addition of psoriasis medications to the Medicare replacement drug demonstration project as well as information on Medicare's new "unprocessable" claim returns and updated telephone appeal information.

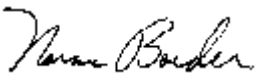
Please note that Biogen Idec's psoriasis biological **Amevive** has been assigned **J0215** as a billable HCPCS code.

The Coding Q&A section reflects the questions we've been receiving on the new G Codes as well as correct use of the photodynamic therapy code 96567. There is also an update on patch test billing as well as a quick review of current carrier LMRP's on patch testing requirements and limitations.

Medicare has also issued a clarification that it will continue to pay physicians at the local rate for purchased diagnostic and interpreted tests until further notice, for services purchased outside of the carrier's jurisdiction when submitted by a physician enrolled in the carrier's jurisdiction.

Finally, this issue of Derm Coding Consult also includes the updated DermCAC member list. Remember, the DermCAC member for your state participates regularly in meetings with your Medicare Carrier Medical Director. When issues or problems occur on Medicare claims, you can contact your DermCAC representative for assistance in identifying and correcting Carrier claims processing errors.

Best regards,



Norma L. Border, Editor

Biogen Idec's psoriasis biological **Amevive** has been assigned **J0215** as a billable HCPCS code.

Update on Patch Test Coding

The descriptor of CPT code 95044 is patch or application test(s) (specify number of tests). The directives regarding the use of this code state to report the actual number of tests done. The Medicare Carrier Manual, Pt. 3, Ch. XV, states that the reimbursement for allergy testing codes (95004-95078) is per test. It also states that the number of tests performed is recorded in the units box of the claim. The fee, which is per individual test, is multiplied by the number of tests.

24.A	B	C	D	E	F	G
DOS	POS	TOS	Procedure	Diagnosis	Charges	Days/Units
030105	11		95044	1	——	24

Example: 24 tests applied

There is a standard series of 24 or more patch tests applied and left in place for 48 hours. Test results are read at 48 hours, and sometimes again after 96 hours. Skin reactions are noted from grade 0 (no response) to grade 4 (blistering reaction). Additional test agents may be prepared and applied based on information and/or substances supplied by the patient.

Numerous Medicare carriers have medical policies on allergy testing. These policies list the valid ICD-9-CM codes that indicate coverage for patch testing. Some of the policies allow only a specific number of tests that may be done per year on a beneficiary.

Third party payers may have their own policy on patch testing. Check the payers web sites for their policies. Knowing what the payer's requirements are for billing patch testing is key for proper reimbursement.

A separately identifiable evaluation and management visit performed during the same encounter as the patch testing may be reported with modifier 25. The level of service reported would of course be dependent on the documentation in the medical record. Likewise, the level of service reported for the follow-up visits for the reading of the

— continued on page 6

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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.

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Coding Q& A

New Medicare G Codes

Q. Aren't the drug administration codes limited to chemotherapy treatment for patients with cancer diagnoses?

A. No, the new definition encompasses biologic response modifiers, meaning that the in-office administration of any psoriasis biologic by infusion or injection is payable under Medicare. New codes also apply to non-chemotherapy infusions and injections; these codes will be used by dermatologists who administer methotrexate and other drugs in their offices.

Q. Why should we use the new G codes? Aren't injections included and bundled with an E/M visit?

A. The new injection codes differ from those they replace in that they are payable along with other services on the same day. Codes 90782-90784 were only payable by Medicare if the same provider billed for no other services on the same day. If an injection was provided to a Medicare patient on the same day as an office visit, the injection was bundled by Medicare into the E/M visit. The new G codes will now allow dermatologists to bill for an office visit and an injection or infusion on the same day.

Q. If we aren't providing psoriasis biologicals to our patients at this point, can we still use the CPT codes?

A. The new G codes are required under the Medicare Modernization Act provisions and will permit drug administration billing to Medicare while current CPT codes for injections and infusions are being updated. However, you may still submit the CPT codes to your commercial insurance carriers.

Photodynamic Therapy

Q. Our office is using aminolevulenic acid in conjunction with a PDT light to treat acne. Can we use CPT 96567 to bill this service to an insurer?

A. CPT 96567 is used for photodynamic therapy which is the external application of light to destroy lesions after the application of photosensitive drug(s). The AMA CPT descriptor of this code states that the procedure is for destruction of premalignant and/or malignant lesions. Submitting this code for any procedure other than the destruction of a premalignant or malignant lesion would be inaccurate. The claim would be considered a false claim. ■

CMS Drug Administration Codes in 2005

OLD CPT CODE	2005 G CODE	DESCRIPTION
90780	G0347	Intravenous infusion, for therapy/diagnosis (specify substance or drug); initial, up to one hour
90781	G0348	Intravenous infusion, for therapy/diagnosis (specify substance or drug); each additional hour, up to eight hours (list separately in addition to code for procedure)
90781	G0349	Intravenous infusion, for therapy/diagnosis (specify substance or drug); additional sequential infusion, up to one hour (list separately in addition to code for procedure)
90782	G0351	Therapeutic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular
90784	G0353	Therapeutic or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug
	G0354	Therapeutic or diagnostic injection, additional substance or drug
96408	G0357	Chemotherapy administration, intravenous; push technique, single or initial substance/drug
96408	G0358	Chemotherapy administration, intravenous; push technique, each additional substance/drug (list separately in addition to code for primary procedure)
96410	G0359	Chemotherapy administration, intravenous infusion technique, up to one hour, single or initial substance/drug
96412	G0360	Chemotherapy administration, intravenous infusion technique, each additional hour, one to eight hours (list separately in addition to code for primary procedure)

Table adapted from "CMS Manual System Pub. 100-20 One-Time Notification"

Medicare Adds Psoriasis Meds

Medicare realizes the important role drugs play in treating serious diseases. However, only drugs administered in a physician's office have been covered under Medicare Part B. In recent years, many new medications have been developed that allow patients with serious and life-threatening illnesses to take these drugs in their own home. The Medicare Modernization Act of 2003 includes a two year demonstration project that will cover self-administered medications prior to the implementation of the Medicare Drug Benefit in 2006.

The Centers for Medicare & Medicaid Services (CMS) has contracted with TrailBlazer Health Enterprises, to assist in implementing the demonstration. TrailBlazer will manage the eligibility determination and enrollment process as well as coordinate outreach efforts to beneficiary advocacy groups, physicians, and others interested in this demonstration.

For a beneficiary to be eligible for this demonstration, he or she must meet the following criteria:

- Beneficiary must have Medicare Part A and Part B.
- Medicare must be the beneficiary's primary health insurance.
- Beneficiary must reside in one of the 50 states or the District of Columbia.
- Beneficiary must have a signed certification form from his/her doctor stating that he/she has prescribed or intends to prescribe for one of the covered medications for the specified condition.
- The beneficiary may not have any other insurance that has comprehensive drug coverage (such as Medicaid, an employer or union group health plan, or TRICARE) that would cover this medication.

As of January 10, 2005, CMS has added the following psoriasis medications to the drugs and conditions that will be covered under this demonstration.

• Psoriatic Arthritis	Etanercept (Enbrel)
• Psoriasis	Efalizumab (Raptiva) Etanercept (Enbrel) ■

AAD Comments on ASCPR

— continued from page 1

AAD questioned the clinical logic of deleting excision codes 11404 and 11424 from the ASC Procedure list and retaining only those codes where the excision measurement exceeds 4.0 cm. It implies that the physician will be forced to use a single criterion (anticipated excision diameter) in determining if a given patient should be treated in the ASC setting and ignores the possibility of other medical conditions or indicators that would argue for the expanded patient monitoring capabilities of an ASC setting, eg diabetic, cardiac, respiratory or circulatory conditions.

We took issue with the clinical logic in deleting both 11444 and 11446 excision codes for critical and delicate anatomical areas of the face, ears, eyelids, nose, lips, and mucous membranes, arguing that a linear calculation of the excision diameter should not be the sole criterion in determining the appropriateness of where these procedures are performed. The same arguments apply to the excision of a malignant lesion. We questioned the clinical rational in deleting excision codes 11604, 11624 and 11644 and retaining only those codes where the excision measurement exceeds 4.0 cm.

In addition, many excision procedures for benign and malignant skin lesions (especially of the size ranges indicted above) result in surgically created defects that require a layered or complex repair to meet the clinical standard of care. The American Academy of Dermatology Statement on Layered Closure states:

> Routine layered repair is not a cosmetic procedure to improve a patient's appearance, but rather the standard procedure needed to help the skin heal as near to normal as possible, recognizing that some scar is inevitable. For other defects, layered closure is not adequate, and complex repair procedures are necessary to maintain function and anatomic integrity.

We challenged the deletion of key repair codes that are the frequent immediate surgical consequence to excision of a benign or malignant lesion. Most health care payers now recognize the medical necessity and separate nature of layered repairs. AMA/CPT is very specific in its descriptors that excisions only include simple (non-layered) closure. Necessary intermediate or complex repairs are not included in the excision codes and are coded in addition to the excision.

The deletions proposed by CMS suggest that the physician will be forced to choose an alternate surgical setting (either in-facility or office-based) for any excision requiring more than a simple or intermediate closure. AAD is pressing for a meeting with key CMS staff to continue to educate them on the significant problems with this proposed rule. ■

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

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

NewsBriefs

— continued from page 1

The code for an IV push of non chemotherapy drugs, 90784 is replaced by G0353. (Additional IV pushes in sequence which is a new code without a CPT relation, should be coded G0354.)

The new injection codes differ from those they replace in that they are payable along with other services on the same day. Codes 90782-90784 were only payable by Medicare if the same provider billed for no other services on the same day. If an injection was provided to a Medicare patient on the same day as an office visit, the injection was bundled by Medicare into the E/M visit.

The new G codes will now allow dermatologists to bill for an office visit and an injection or infusion on the same day. Modifier 25 should be appended to the code for an E/M service that accompanies these new G codes for drug administration. No separate diagnosis is required. Note that the main reason for the patient's visit should be reflected in the claim logic regardless of order of the visit. Check with your local carrier, since these are new codes, as to their correct use. It was hinted that only one initial procedure would be allowed per visit.

More information on the new codes can be found at the CMS Web site, www.cms.hhs.gov. CMS will also publish a Medlearn Matters article at www.cms.hhs.gov/medlearn/matters regarding the new codes and how they should be used.

Billing Medicare for Purchased Tests/Interpretations

Medicare will continue to pay physicians at the local rate, until further notice, for services purchased outside of the carrier's jurisdiction when submitted by a physician enrolled in the carrier's jurisdiction. Physicians should continue to report their name and service facility location on claims for the purchased test/interpretation performed outside of the local carrier's jurisdiction. Physicians use their own PIN to bill for both the purchased portion of the test and the portion of the test that they performed. Per Change Request 3630 (Transmittal 415 issued on December 23, 2004),

Suppliers (Laboratories and IDTFs) are to bill local carriers regardless of where the tests are performed and carriers are to pay suppliers based on Zip codes of the location where the service was rendered. This request is effective April 1, 2005 Further information can be found on CMS Med Learn web site: http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3481.pdf ■

Update on Patch Test Coding

— continued from page 3

patch tests would be dependent upon medical necessity and the supporting documentation. The global service concept does not apply to patch test code 95044.

The Medicare Carrier's LMRP for AR, NM, OK, MO, LA allows a maximum of 30 patch tests per beneficiary per year. Medical necessity of patch testing must be documented.

The WV Medicare Carrier's LMRP states that not all patients would be expected to receive the same tests or the same number of sensitivity tests. Tests done would be based upon the patient history, physical examination findings, and the physician's clinical judgment.

WPS – Medicare Carrier for IL, MI, MN, WI has an LMRP that allows a maximum of 50 patch tests per beneficiary per year. Greater than 50 require documentation to support medical necessity.

Humana covers patch testing up to 30 tests one time per year. Claims must indicate type of test and number of tests performed.

Cigna covers patch testing to diagnose suspected contact allergic dermatitis.

Aetna recognizes that Patch testing is an accepted method of differentiating allergic contact dermatitis and irritant contact dermatitis. ■

DERMCAC Update

DERMCACs (Dermatology representatives to the Medicare Carrier Advisory Committee) are appointed by the individual state dermatologic societies. They meet with the Carrier Medical Director (CMD) on issues of importance that may affect coding and reimbursement for services provided by dermatologists. When there is a reimbursement issue with a specific Medicare Carrier, the DERMCAC in the particular state works with the CMD in resolving the issue.

DERMCACs play an important role in the Local Medical Review Policies (LMRP) process. The DERMCAC attends the Carrier Advisory Committee (CAC) meeting on a quarterly basis and monitors LMRPs that would be pertinent to dermatology and provides appropriate comments.

We are sincerely appreciative of the time the DERMCACs take from their practice to attend the quarterly CAC meetings. Their participation is most important to all dermatologists. We say THANK YOU to those of you who currently are DERMCACs and to those who have served as DERMCACs in the past. ■

Derm Coding Consult can be found on-line at **www.aad.org**

To contact your DermCAC for assistance, please fax pertinent documentation on the issue.
The DermCAC can then review the issue and contact you. An asterisk (*) indicates the alternate DermCAC.

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Medicare Returns Unprocessable Claims

The Centers for Medicare & Medicaid Services (CMS) announced that both unassigned CMS 1500 claims and assigned claims, or the electronic equivalent, that have incomplete or invalid data, including data governed by HIPAA* requirements, will be returned as unprocessable. CMS previously denied these claims with appeal rights.

Beginning July 1, 2005 CMS will return these claims without appeal rights. Once the claims are corrected and then processed, CMS will forward electronic crossover claims to COB trading partners that are HIPAA-compliant to be processed.

Read Your EOB Remittances – an M16 or an M31 error code indicates the claim is "unprocessable". If the claim was returned as unprocessable, please make the necessary corrections and submit a new claim.

CMS' Telephone Review (Appeal) Criteria

There are certain criteria that must be met in order for Medicare to perform a telephone review of a claim. Telephone reviews are limited to resolving minor issues and correcting errors. Telephone reviews are only applicable in situations where an initial determination has been made. Claims that cannot be processed are not initial determinations and therefore are not appealable."

Some examples of issues that may be handled by a telephone review include:

- Number of services/units
- Add, change or delete certain modifiers
- ICD-9 Diagnosis codes
- Erroneous denials (as duplicates)
- Procedure codes
- Place of service
- Dates of service

If the issues are more complex, it may be in your best interest to submit a written request form to your carrier for a review with any supporting documentation.

Return as Unprocessable – "return as unprocessable" refers to:

- Incomplete or invalid information is detected at the front-end of the claims processing system. The claim is returned either electronically or in a hardcopy/checklist form explaining the error(s) and how to correct it
- Incomplete or invalid information is detected at the front-end of the claims processing system and is suspended and developed. If corrections are submitted within a 45 day period, the claim is processed. Otherwise, the suspended portion is rejected and the provider is notified by means of the remittance notice.
- Incomplete or invalid information is detected within the claims processing system and is rejected through the remittance process. Providers are notified of any error(s) through the remittance notice and how to correct it.

If the claim is unprocessable, the claim can be corrected and refiled as a new claim with a year to 18 months filling rights. If the claim was denied there are 120 days to file an appeal. ■

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