

DERM CODING CONSULT

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NewsBriefs

Medicare Fee Schedule 2006

The Center for Medicare and Medicaid Services (CMS) is already dragging its feet on the 2006 Medicare Physician Fee Schedule (06 MFS). The proposed rule is scheduled for publication each year by mid to late June to ensure a 60 day comment period. At the recent CMS Open Door Forum staff announced the proposed rule would not be released until mid-July. But, for a change, this is not necessarily a bad thing. If published now, it would reflect the first in the series of legislatively required reductions to the MFS payment formula, and impose a 4.3% reduction in reimbursement next year.

Congress is being made aware of what the impact such a series of drops in Medicare reimbursement will have on Medicare beneficiary access to care as well as physician participation. Dermatologists actively lobbied their Congressional representatives on the need for correcting the Medicare fee schedule formula at the Washington Conference, May 20. Both the House and the Senate have introduced one or more bills that propose a 2.7% increase in Medicare payment as well as to adjust the reimbursement formula. The measures, one that would replace the current system permanently and the other that offers a more temporary solution, have doctors optimistic that lawmakers will act soon to ensure that reimbursement remains at levels that allow them to sustain current participation in the program.

In addition, last fall the Academy conducted a Practice Expense Supplemental Survey following rigid CMS guidelines for data submission. The purpose was to capture updated information on the administrative and clinical costs of operating a dermatology practice. This data has been submitted to CMS. We anticipate that CMS will accept the survey data and use it in place of the aging AMA Socioeconomic Measuring System data that CMS has used since the inception of the Medicare resource based/relative value system (RB/RVS). The result will be a better reflection of dermatology practice expense. ■

CMS Retains Key ASC Procedures

The Academy provided detailed comment as well as strong opposition to the CMS proposed rule that would have deleted over one hundred key dermatology codes from the Ambulatory Surgery Center (ASC) Fee Schedule in 2006. At the time, CMS' reasoning was that most of the deleted procedures were done primarily in the office setting, which is thought as the least expensive venue. Due to the arguments presented by the Academy as well as opposition by the AMA, the Federated Ambulatory Surgery Association and thirty other medical societies, CMS in its Final Rule rescinded the deletions of all but five procedures and added 65 more surgical procedures.

The CMS proposed ASC coverage update, released in November 2004, added 25 procedures including a skin graft add-on code. Of greater concern, the ASC Proposed Rule also called for the deletion of such procedures as lesion excisions, repairs and adjacent tissue transfers.

Comment by AAD stressed that ASCs are a least-expensive alternative for patients who need a sterile setting or anesthesia. If ASCs weren't available, these patients would need to go to hospital outpatient facilities which are usually more costly and not easily accessible in some rural areas. ■

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Letter From the Editor

Dear *Derm Coding Consult* Reader:

Dermatology faces two major challenges this year. The first is obtaining a realistic fix of the flawed Medicare Fee Schedule formula and the second is the AMA RUC Five Year Review.

AAD has primary or shared responsibility for surveying a significant number of key dermatology codes to validate or defend the current level of physician work RVUs. Dermatology is primary presenter/defender on the following codes:

11100	Biopsy, skin lesion
12052	Layer closure of wound(s)
13121	Repair of wound or lesion
14040	Skin tissue rearrangement
14060	Skin tissue rearrangement
15240	Skin full graft
17003	Destroy lesions, 2-14
17262	Destruction of skin lesions
17281	Destruction of skin lesions
17304	1st stage Mohs,
96567	Photodynamic tx, skin

In addition, CMS has placed all of the excision codes on the RUC 5 Year Review list. This requires AAD along with ACS, ASGS, ASPS, AAO-HNS and APMA to survey these codes to defend current physician work RVUs.

If you receive an AMA RUC Physician Work RVS Update survey packet, please complete and return the surveys as quickly as possible. The survey data will provide the basis for supporting current physician work RVUs. Changes in RVU levels will be incorporated into the 2007 Medicare Fee Schedule.

The minutes you spend completing these surveys may be the most important thing you do for the specialty of dermatology this year.

Best regards!



Norma L. Border, Editor

Coding Update

ICD-9-CM Coding

Updated coding guidelines for the International Classification of Diagnoses Version 9 Clinical Manual (ICD-9-CM) were published during the first quarter of 2005 in the *AHA Coding Clinic*, the official publication for ICD-9-CM codes. ICD-9-CM coding advice and guidelines are overseen by the following organizations: American Hospital Association (AHA); American Health Information Management Association (AHIMA); Centers for Medicare & Medicaid Services (CMS); and, National Center for Health Statistics (NCHS).

With the implementation of HIPAA Electronic Standards, ICD-9-CM is mandated for use by all health care payers. The following updated ICD-9-CM coding guidelines are of particular importance to providers of dermatological services.

A Review of Specifics

Abbreviations:

- NEC – not elsewhere classified
- NOS – not otherwise classified

Directives:

- Excludes – notes those terms that are excluded from the particular code
- Includes – notes those terms/conditions that are included in that particular code
- “Other” specified code – detail provided in medical record for which no code exists
- “Unspecified code” – insufficient information in the medical record for a specific code

Other Self Explanatory Terms:

- “code first” – means that this is the primary diagnosis
- “use additional code” – other diagnoses codes are required
- “in diseases classified elsewhere” – code to be selected from another section

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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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IS YOUR PRACTICE MISSING... *A piece of the puzzle?*



AAD's 2005 Coding and Documentation Manual: A Guide for Dermatology Practices

This comprehensive, easy-to-use resource illustrates coding and clinical information to help minimize coding errors, reduce claim denials, and assist dermatologists and their billing staff in submitting accurate claims to improve the reimbursement process. This manual comes with **AAD's Express Coder**, an 8.5" x 11" laminated card that puts frequently used codes at your fingertips and **AAD's E/M Pocket Pro** to help you select your E/M level code even faster.



Clinical Laboratory Improvement Amendments (CLIA) Manual: A Guide for Dermatology Practices

In 2003, the federal government made the first significant changes since 1988 to the Clinical Laboratory Improvement Amendments (CLIA). This manual emphasizes those changes and prepares dermatology offices for inspection. It also provides tailored information on quality control for the following tests: histopathology, histopathology-Mohs Surgery, potassium hydroxide (KOH) examination, fungal culture, ectoparasites, vaginal preps KOH/wet prep, cytodagnosis of molluscum contagiosum, microscopic hair shaft evaluation, staining procedures, and tzanck (cytodiagnostic) smear.

Don't forget about these other helpful PME publications:

- ✦ **Starting and Marketing a Dermatology Practice**
- ✦ **Valuing a Dermatology Practice**
- ✦ **OSHA Hazard Communication:
A Guide for Dermatology Practices**
- ✦ **Bloodborne Pathogens:
A Guide for Dermatology Practices**
- ✦ **OIG Compliance Manual:
A Guide for Dermatology Practices**
- ✦ **Office Policy and Procedure Manual:
A Guide for Dermatology Practices – COMING SOON!**
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A Guide for Dermatology Practices and**
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A Guide for Dermatology Practices**



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Evaluation and Management (E/M) Guidelines Reviewed

The only CMS approved Evaluation and Management (E/M) documentation guidelines are the 1995 or the 1997. The 1995 and 1997 guidelines may be downloaded from the CMS Web site <https://www.cms.hhs.gov/medlearn/emdoc.asp>. Physicians are permitted to use either set of E/M documentation guidelines *whichever is most advantageous to the physician*.

The key difference between the 1995 and 1997 documentation guidelines is the physical examination portion. The 1995 documentation guidelines use organs and body areas whereas the 1997 use a summary of examination bullets. Body areas for the 1997 guidelines are associated with the organ systems and these elements are identified by bullets.

History of Present Illness (HPI)

Location, Quality, Severity, Duration, Timing, Context, Modifying Factors, Associated Signs & Symptoms or status of 3 chronic illnesses

Review of Systems (ROS)

Constitutional, Eyes, ENT, CVS, Respiratory, Allergies, GI, GU, Skin, Neuro, Psych, Endocrine, Hematologic, Musculoskeletal, All Others (Negative)

Past Medical Family Social History (PFSH)

Personal HX: Surgeries, Illness, Disease, Medications

Family HX: Hereditary Illness,

Social HX: Marital, Work, Tobacco, ETOH, Drugs

Level of Exam	Perform and Document
Problem focused	One to five elements identified by a bullet
Expanded problem focused	At least six elements identified by a bullet
Detailed	At least twelve elements identified by a bullet
Comprehensive	Perform all elements identified by a bullet; document every element in each box with shaded border and at least one element in each box with an unshaded border ■

Physical Examination – Skin

Body Areas: Elements

Constitutional: (document 3)

- BP – pulse – respiration – temperature – HT – WT – appearance

Eyes:

- inspect conjunctivae & lids

Ears, Nose, Mouth, Throat:

- inspect lips, teeth & gums
- examine oropharynx

Neck:

- examine thyroid

Cardiovascular:

- observation of peripheral vascular system

Gastrointestinal:

- examine liver & spleen
- examine anus for condyloma, etc

Lymphatic:

- palpate lymph nodes (neck, axillae, groin, etc.)

Extremities:

- inspect & palpate digits & nails

Skin:

- inspect & palpate hair, scalp, eyebrows, face, chest, pubic area (when indicated) and extremities
- inspect & palpate skin & subcutaneous tissue in 8 of 10 areas:
 1. head & face
 2. neck
 3. chest, breasts & axilla,
 4. abdomen
 5. genitalia, groin & buttocks
 6. back
 7. right upper extremity
 8. left upper extremity
 9. right lower extremity
 10. left lower extremity
- inspect eccrine & apocrine glands of skin & subcutaneous tissue

Neurological/Psychiatric:

- orientation to time, place & person
- mood & affect ■

Medical Decision Making

Medical Decision Making:

# Diagnoses/Options	Complexity of Data	Risk	Complexity
Minimal	Minimal	Minimal	Straightfwd
Limited	Limited	Low	Low
Multiple	Moderate	Moderate	Moderate
Extensive	Extensive	High	High

Key Components required for assignment of E/M Service Levels:

New Patient: 3 out of 3 key components must meet or exceeded

Established Patient: 2 out of 3 key components must meet or exceeded.

(History, Exam and Medical Decision Making are the three components.) ■

Aetna Update

Aetna, Inc. has advised the Academy that it will honor the modifier -24 (Unrelated Evaluation & Management service by the same physician during a postoperative period) generally without documentation. According to an Aetna physician provider representative, the automated approval of new claims submitted with modifier -24 was implemented on May 13, 2005. Claims submitted after that date will be automatically processed and paid when the -24 is attached. Claims submitted prior to this automation change will have to be handled on appeal which is a manual process. Aetna still reserves the right to request documentation if the modifier is excessively used but it will no longer be a requirement for reimbursement. ■

National Provider Identifier

Starting May 23, 2005, all health care providers may apply for their National Provider Identifier (NPI). The NPI will replace health care provider identifiers in use today in standard health care transactions. All Health Insurance Portability and Accountability Act (HIPAA) covered entities except small health plans must begin using the NPI on May 23, 2007. Small health plans will have until May 23, 2008 to become compliant. For additional information, and to complete an application, visit <https://nppes.cms.hhs.gov/>

The Medicare program is not accepting the NPI in standard transactions yet. Explicit instructions on time frames and implementation of the NPI for Medicare billing will be issued later in 2006. Other health plans with whom you do business will instruct you as to when you may begin using the NPI in standard electronic claims transactions. ■

The 1995 and 1997 guidelines state:

1. Specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s) should be documented. A notation of “abnormal” without elaboration is insufficient.
2. Abnormal or unexpected findings of the examination of the unaffected or asymptomatic body area(s) or organ system(s) should be described.
3. A brief statement or notation indicating “negative” or “normal” is sufficient to document normal findings related to unaffected area(s) or asymptomatic organ system(s).

NOTE: There is some confusion generated from a Derm Coding Consult June 1999 article, regarding the CMS proposed 2000 E/M documentation guideline. This draft E/M guideline was expected to be approved for use in 2002. However, this proposed draft guideline was never published by CMS, leaving the 1995 and 1997 E/M documentation guidelines in place.

An instructional web tool, called the **NPI Viewlet**, is now available for viewing at <http://www.cms.hhs.gov/medlearn/np/npiviewlet.asp> and under “HIPAA Latest News” at www.cms.hhs.gov/hipaa/hipaa2. on the Centers for Medicare & Medicaid Services’ (CMS) web site. This tool provides an overview of the NPI, a walkthrough of the application, as well as live links to the National Plan and Provider Enumeration System’s (NPPES) web site where the learner can apply for an NPI. This tool is designed for all health care providers. ■

Correct Coding Initiative

The 2005 quarterly update of the National Correct Coding Initiative (NCCI) edits, Version 11.2 will be available on July 1, 2005 on CMS’ Web site. Version 11.2 also includes all the previous versions and updates since January 1, 1996. It consists of two tables:

- Column 1/Column 2 Correct Coding Edits, and
- Mutually Exclusive Code edits.

Column 2 codes with an indicator “1” are allowed to be billed with a modifier. This is usually modifier -59. Indicator “0” does not allow a modifier and indicator “9” is not applicable because the edit has been deleted.

CMS developed this edit system to promote national correct coding methodologies. It identifies improper coding that leads to inappropriate payment of Part B claims. The coding policies developed are based on coding conventions defined in the AMA CPT manual as well as CMS national and local policies and edits; coding guidelines developed by national societies; analysis of standard medical and surgical practices and review of current coding practice. CMS’ NCCI edits Web site is <https://www.cms.hhs.gov/physicians/cciedits/> ■

Coding Update

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“see also” – additional information available in another section

General Guidelines

- Locate code in alphabetical index
- See other applicable directives in tabular index
- Code to the highest level of digits (three, four, or five)

Neoplasm Coding

When the histological term is documented the term should be referenced in lieu of the Neoplasm Table. The Neoplasm Table is used to identify the lesion as consistent with benign, malignant, or uncertain behavior. Treatment for a malignancy would be reported with the appropriate malignant code.

When the primary malignancy has been previously excised or destroyed and there is no further treatment directed to that site AND there is no evidence of the existing primary malignancy, the appropriate personal history code, **V10**, should be reported. (See V codes below,)

Other Diagnosis Coding Directives

The reason for the encounter would be the primary diagnosis code listed.

This reason could either be a diagnosis, condition, or problem.

If a diagnosis cannot be confirmed, or a specific diagnosis code is unavailable, a symptom code would be the appropriate diagnosis code to report.

In an office setting, diagnoses such as “probable”, “rule-out”, “suspected” are not to be reported.

A symptom code would be reported in the absence of a definitive diagnosis.

Conditions that were previously treated but no longer exist should not be reported.

Only those conditions that are present at the time of the patient encounter should be reported.

Of course, underlying conditions that may affect the patient’s health at the time of the encounter would be reported as secondary conditions.

When the interpretation of a diagnostic test is available at the time of coding, the definitive diagnosis should be reported. Signs or symptoms would not be reported as additional diagnoses when the definitive diagnosis is available, unless directives from a carrier require symptom codes.

V Codes

There are many V codes that are pertinent as they fully describe the patient encounter. Payers may have specific rules regarding V codes that you need to know prior to use of these codes. Pertinent V-codes for dermatologic services are listed below.

History of:

- V10.82** Personal history of malignant melanoma of skin
- V10.83** Personal history of other malignant neoplasm of skin
- V16.8** Family history of other specified malignant neoplasm

(condition classifiable to codes **140-199**)

- V19.4** Family history of skin conditions

Aftercare codes following surgery are:

- V58.41** Encounter for planned postoperative wound closure
 - V58.42** Aftercare following surgery for neoplasm
- (conditions classifiable to codes **140-239**)

Long-term (current) drug use:

- V58.62** Long-term (current) use of antibiotics
- V58.66** Long-term (current) use of aspirin
- V58.69** Long-term (current) use of other medications {high risk medications}

Follow-up examination

- V67.00** Following surgery, unspecified

New ICD-9-CM Codes

New ICD-9-CM codes become effective on October 1, 2005. However, there are no new codes of any particular importance to dermatology. The complete list of new codes may be found in the May 4, 2005 Federal Register, Proposed Rule: Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates. ■

Save the Date!

Dermatology Coding & Practice Management Midwest Regional Seminar

Thursday, September 29, 2005



Register online at:
www.aad-m.org

Coding Questions & Answers

Q. May I bill for suture removal?

- A. No. Suture removal is a part of the routine follow-up care for a patient. Even if the suture removal is done outside the global period, it stands to reason that if one placed the sutures, one should be expected to remove the sutures.

Q. May I charge for an office visit when I remove the sutures?

- A. The answer to this question would be dependent upon the medical necessity of such a visit. Why is it necessary to perform such a visit?

If it is necessary to counsel the patient based upon the diagnosis, such a visit could be billed with time being the determining factor. Counseling would comprise 50% or more of the time spent with the patient during this encounter to qualify for choosing the level of service based on time. Documentation of the total encounter and the time spent in counseling the patient would need to be clearly documented in the patient's medical record.

Q. I am so confused by the lack of hyperhidrosis codes. My doctor administers Botox injections for axillae hyperhidrosis. I can't find a code for this procedure in AMA/CPT or AAD's Coding & Documentation Manual other than an unspecified code. However, the insurance carrier suggested that I use a chemodenervation destruction code. What is correct?

- A. On page one, the AMA CPT Instructions for Use of the CPT Book, states "Do not select a CPT code that merely approximates the service provided. If no such procedure or service exists, then report the service using the appropriate unlisted procedure or service code."

As no code exists for the injections of Botox for the treatment of hyperhidrosis at this point in time, either the unlisted code **17999** or **64999** should be reported for this procedure.

The only deviation to these CPT instructions would be if an insurance company has a written policy on coding guidelines. These insurance reimbursement guidelines would supersede CPT coding policy because they are internal system issues.

Generally before reimbursement of unspecified codes, the insurance carrier will send a request for an operation report. Carriers may accept a procedural description in Box 19 of the CMS 1500 claim form.

The ICD-9 diagnosis codes for hyperhidrosis are:

- 705.21** Primary Focal Hyperhidrosis: axillae, face, palms, soles
- 705.22** Secondary focal Hyperhidrosis: Frey's Syndrome

The HCPCS code **J0585** is used to bill for Botulinum toxin type A (Botox), per unit. Verify with the Carrier regarding billing for the amount of drug injected as well as the wasted amount. Both amounts should clearly be documented in the medical record. Billing Note: The unit field on a CMS-1500 claim form only has room for two digits. If billing for used and wasted drugs over 99 units report on two lines.

Q. My doctor performed a shave removal with the intent of removing a patient's 0.5cm suspicious pigmented lesion on the arm. The biopsy report yielded a malignant melanoma with a recommended re-excision of the margins. The patient returned in seven days for the re-excision. Is it correct coding to bill 11300 for the shave and the appropriate excision code (1160x) for the malignant destruction with a 58 modifier as a staged procedure?

- A. Since each of these procedures were performed on separate days, the coding of the shave for the first procedure and subsequent excision is correct. The use of modifier 58 in this case would not be needed because there is a zero (0) global period for shave removal codes.

Had the initial procedure been an excision, followed by the re-excision seven days later, modifier 58 would be needed. An excision of a benign or malignant lesion has a ten (10) day global period. Thus, the use of the 58 modifier would be appropriate in this example. ■

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www.dermexchange.org



Using E Codes to Differentiate Between Injury and Poisoning

The use of ICD-9-CM "E" codes are optional. Most coders don't bother to use them for lack of understanding of their statistical importance. There are good reasons to include an E code in your diagnosis coding. They specify, for example, the difference between poisonings and adverse effects.

An E code is for therapeutic use (adverse effect) and a poisoning code is a main code (not an E code). An adverse effect is a reaction to the correct drug taken as prescribed. A poisoning, on the other hand, is a reaction to:

- taking the wrong drug;
- a non-prescribed drug in conjunction with a correctly prescribed drug;
- or the wrong dosage of a correct drug,
- or an overdose.

To code an adverse effect, you must first code the manifestation(s) of the poisoning column, followed by a secondary E code from the External Cause (E-Code) adverse effects column in the ICD-9-CM Table of Drugs and Chemicals. This identifies the drug causing the reaction.

(Check the Tabular List before assigning your E code. Don't code directly from the Table of Drugs and Chemicals.)

Example:

A patient given ampicillin for an infection develops generalized itching (code 698.9) shortly after starting the course of antibiotics. She returns to the doctor, who discontinues the ampicillin use because of the adverse effect. The correct diagnosis coding for this case would be 698.9 unspecified pruritic disorder, E930.0. Drug causing adverse effect: penicillin. ■



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Mandatory Electronic Submission of Medicare Claims

All physicians, providers and suppliers who bill Medicare are required under the Administrative Simplification Compliance Act (ASCA) to submit all claims for items and services **electronically** as of October 16, 2003. All paper claims will be denied.

The exceptions in place for this electronic claim submission requirement include the following:

- A physician, practitioner, or supplier with fewer than 10 FTEs (full time equivalent employees.)
- A provider that submits claims when more than one other payer is responsible for payment prior to Medicare payment.
- A provider that only furnishes services outside the United States.
- A provider experiencing a disruption of electrical services beyond its control
- A provider can establish an unusual circumstance exists that precludes submission of electronic claims.

Additional Information

The official instruction issued to your carrier regarding this change may be found at: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

For additional information relating to this issue, please refer to your local Carrier.

Their toll free phone numbers may be found at: <http://www.cms.hhs.gov/medlearn/tollnums.asp> ■

