DERM CODING CONSULT

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2007 Medicare Fee Schedule Proposed Rule Grim

The proposed 2007 Medicare Fee Schedule has been published in two parts. The first part of the proposed rule was published in the June 29th Federal Register and included CMS proposed changes to the practice expense RVU calculation methodology and changes to physician work RVUs as a result of the AMA RUC Five year review. The second part of the 2007 Medicare Fee Schedule was published in the August 22nd Federal Register and announced a -5.1 percent reduction in payments for all physician services in 2007. The proposed rule could result in an up to a 7 percent reduction for dermatology because of specific reductions to physician work RVUs for several key dermatology codes.

The Centers for Medicare and Medicaid Services (CMS) has proposed applying a mandated budget neutrality adjustment of -5.1% to the fee schedule to bring Medicare payments to physicians in line with the allowable spending level based on the federally mandated but flawed Sustainable Growth Rate (SGR) formula. As proposed, the adjustment would reduce physician work RVUs, undermining values established by physicians through the RUC process. The AADA and many other specialty societies are calling for the budget neutrality adjustment to be applied to the conversion factor (CF) as it has been in the past. As it has for the last five years, avoiding major reductions to Medicare physician reimbursement will require some kind of Congressional action.

Highest Impact on Destruction Codes

The benign and pre-malignant destruction codes (CPT 17000, 17003, 17004) have long been a CMS concern because of the high volume of over 18 million procedures ($356 million per year) billed to Medicare by dermatologists. Dermatology performs 92% of all the benign and pre-malignant destruction procedures billed to Medicare. CMS also believes that advances in technology and the migration to treating the majority of actinic keratoses via cryosurgery have resulted in a significant reduction in the time and work required to perform these procedures. CMS placed CPT 17003 on the RUC Five Year Review list because it represents the physician time, skill and intensity for destruction of a single lesion. The shift to cryosurgery as the dominant destruction technique was also reflected in the dermatologist responses to the AMA RUC Five Year Review surveys conducted by AAD in August 2005.

Proposed RVU Changes for CPT 1700X Codes

CVU	06 Total RVU	07 Total RVU	Change to Total RVU	60 CF 37.8975	07 Est CF 37.8975	Chg in $$
17000	1.60	1.70	+0.10	60.62	64.41	+3.79
17003	0.27	0.19	-0.08	10.23	7.20	-3.03
17004	5.21	3.97	-1.24	197.41	150.42	-46.98

AADA comments on fee schedule provisions

AADA submitted comment on the June 29th proposed rule and took issue with CMS rejection of the physician work value established through the RUC Five Year Review process for CPT code 17004, destruction of 15 of more benign, pre-malignant lesions. CMS has proposed reducing the physician work relative value units (RVUs) for this code from 2.80 to 1.58, a steeper reduction than the 1.80 value for the code established by the RUC process which was based on AADA survey data. The physician work RVU of 1.58 significantly undervalues the level of physician time and work intensity for this procedure.

— continued on page 11

Contents

Letter From the Editor

Dear *Derm Coding Consult* Reader

We may be enjoying the warm sunny days of Fall, but it's another gloomy forecast for the 2007 Medicare Fee Schedule! For the fifth year in a row, Congress has failed to fix what everyone admits is a flawed formula for calculating physician reimbursement. Once more, it is extremely important that dermatologists take the time to inform their Congressional representative and Senator how devastating a five percent reduction in Medicare payment will be for themselves as small business owners and for their Medicare patients.

The Academy will take every regulatory step open to it to press the Centers for Medicare and Medicaid Services (CMS) for equitable reimbursement for dermatology. The drop in work values to the benign and pre-malignant destruction codes while costly to every dermatologist, does reflect the change in treatment methodology from curettement and electro-desiccation to cryosurgery as identified by our own survey results.

Of greater and more long term impact will be CMS adoption and use of Practice Expense Supplemental Survey data in the 2007 Medicare Fee Schedule. The AADA survey data has resulted in CMS increasing the dermatology hourly indirect costs from $119.40/hr to 159.40/hr. CMS incorporation of this updated indirect practice expense data over the next four years will result in a series of positive updates to dermatology's practice expense RVUs.

While dermatology may not be happy with the impact of the 2007 Medicare Fee Schedule, it should not feel particularly targeted by CMS. Fourteen other specialties are faced with overall reductions of 8% to 16% in 2007.

Best regards,

Norma L. Border, Editor

Coding Update

Clarifying Use of Modifier -25

The following examples are offered to help clarify those instances when a Modifier **-25** may be used in order to bill for an evaluation and management service and a therapeutic injection at the same visit.

Example 1: E/M service is separately identifiable from a therapeutic injection.

A dermatologist sees an acne patient for an initial evaluation and management visit or a follow-up visit. In the process of evaluation an acne nodulocyst is identified and after a discussion of treatment alternatives, is injected with triamcinolone. The visit would be billed as: **992XX-25, 11900, J330X**

Example 2: E/M service is not separately reimbursed when the value of the E/M performed is included in the therapeutic and diagnostic injection service.

A dermatologist sees a patient for a **scheduled intralesional wart injection**, asks about patient's health and prior allergic reactions, instructs on post-injection care of the injection site and administers the injection. The E/M service is integral to the injection and is not separately reimbursable. ■

No Grace Period on ICD-9-CM Code Changes

Effective for dates of service on and after October 1, 2004, CMS no longer provides a 90-day grace period for physicians, practitioners and suppliers to use in billing discontinued ICD-9-CM diagnosis codes on Medicare claims. The Health Insurance Portability and Accountability Act (HIPAA) requires that medical code sets be date-of-service compliant, and ICD-9-CM diagnosis codes are a medical code set. This is a reminder that Medicare carriers use the annual *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)* coding update effective for dates of service on or after October 1, 2006.

The Centers for Medicare & Medicaid Services (CMS) places listings of the new, revised, and discontinued codes at www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#TopOfPage on the CMS web site and ICD updates are available at this site in June each year. Updated ICD codes can also be viewed at the National Center for Health Statistics (NCHS) web site at: www.cdc.gov/nchs/icd9.htm. on an annual basis. ■

Address Correspondence to:
Brett Coldiron, M.D., FACP
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.

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Medical Decision Making

The Medical Decision Making component of evaluation and management visit coding is confusing to many dermatologists. Medical Decision Making (MDM) as it pertains to evaluation and management (E/M) coding is utilized by the dermatologist when establishing the diagnosis and the management or course of treatment for the patient. The complexity of the diagnosis and management is determined by:

- Number of diagnoses and management options;
- Amount and/or complexity of data to be reviewed; and
- Risk of significant complications, morbidity and/or mortality.

As with the other components of selecting the appropriate level of E/M service, each of these areas has certain criteria. The levels of Medical Decision Making (MDM) are:

- Straightforward
- Low complexity
- Moderate complexity
- High complexity

Number of diagnoses and management options

In choosing the level of diagnoses and management options, the following should be considered:

- Types of problems and number or problems discussed during the encounter;
- Complexity of determining the diagnoses;
- Management options determined by the dermatologist.

The dermatologist should clearly document in the medical record appropriately to identify those issues that relate to the bullets listed above. Each problem addressed during an encounter should be clearly documented. Documentation should include information about the problem. If the problem is an existing problem that has been previously diagnosed, the current condition of that problem should be stated in the medical record. For example, rash improved or rash worsened, with explanatory text would be documented.

Problems	Points
Self limited or minor	1
Est, stable or improved	1
Est, worsening	2
New, no addtl workup	3
New, addtl workup	4

For a new problem without an established diagnosis, the dermatologist should document the clinical impression. If a diagnosis is not established during the encounter, one would report the symptoms that necessitated the encounter. However, if the encounter took place in a hospital facility one could report a diagnosis of "rule out" or "probable".

The management/treatment options should be documented. The management option includes the treatment selected by the dermatologist to address the presenting problems. **This is separate from the procedure note if a procedure was done during the same encounter**. The documentation should include initiation or changes in treatment and/or therapy. If a consultation is requested, the record should indicate from whom the consultation was requested. Likewise, a referral and to whom the referral was made should be documented.

Amount and/or Complexity of Data to be Reviewed

This portion of the Medical Decision Making is based upon:

- Obtaining and reviewing past medical records and/or obtaining history from another source(s) rather than the patient;
- Discussion with the dermatologist or other physician who performed or interpreted test results that yielded unexpected results;
- Review of specimen, or image by the dermatologist who ordered the test as supplemental to the dermatologist who performed the test and provided the interpretation.

Documentation would of course be key in supporting this portion of the Medical Decision Making.

Amount/Complexity of Data to be Reviewed	Points
Review/order clinical lab tests	1
Review/order tests in radiology section of CPT	1
Review/order tests in medicine section of CPT	1
Discuss test results with performing physician	1
Decision or obtain old records and/or obtain history from other than patient	1
Review and summarization of old records and/or obtaining history from other than patient and/or discuss case with another health care provider	2
Independent visualization of image, or specimen itself, not simply review of report	2

When reviewing past medical records, documentation should be made in the medical record of pertinent facts noted in those records. Simply stating that previous medical records were reviewed is not sufficient documentation. The dermatologist must elaborate any pertinent findings within the previous medical records or state that no relevant information was found pertaining to that particular patient encounter.

Any discussions with other dermatologists or other specialists pertaining to the patient should be documented in the patient's medical record. Likewise, any reviewing of specimens or images with findings should also be documented.

— continued on page 6

Medical Decision Making

— continued from page 5

Risk of Significant Complications, Morbidity, and/or Mortality

The three components making up the table of risk include:

- Presenting problem(s)
- Diagnostic procedure(s) ordered
- Management options

The **presenting problem(s)** centers around the number of diagnoses options and the management options for each diagnosis. The complexity of establishing a diagnosis is a factor in this portion of Medical Decision Making.

The **diagnostic procedure(s)** ordered are categorized by the level of risk. For example, a KOH is considered a minimal risk as there is minimal risk to the patient when performing a KOH. The level of risk of the diagnostic procedure correlated to the level of risk to the patient.

Management options are associated with risk levels. A low level of risk includes the advice given for over the counter medications. A moderate level of risk includes prescription drug management.

The table below may be used to assist in determining whether the level of risk of significant complications, morbidity, and/or mortality is minimal, low, moderate, or high. Because determination of risk is complex and not readily quantifiable, the table includes common clinical examples rather than absolute measures of risk.

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
Minimal	One self-limited or minor problem, e.g., insect bite, tinea corporis	Blood tests requiring venipuncture; KOH; UA	Rest, superficial dressings
Low	Two or more self-limited or minor problem. One stable chronic illness. Acute uncomplicated illness.	Skin biopsy	OTC drugs. Minor surgery with no identified risk factors.
Moderate	One or more chronic illnesses with mild exacerbation, progression, or side effects o treatment. Two or more stable chronic illnesses. Undiagnosed new problem with uncertain prognosis. Acute illness with systemic symptoms.	Deep needle or incisional biopsy.	Minor surgery with identified risk factors. Prescription drug management.
High	One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment. Acute or chronic illnesses or injuries that pose a threat to life or bodily function.	(No dermatologic procedures listed.)	Elective major surgery with identified risk factors. Drug therapy requiring intensive monitoring for toxicity.

Medical Decision Making				
Number Dx or Mgmt Options	Minimal = 1	Limited = 2	Multiple = 3	Extensive = 4
Amount/Complexity	Minimal = 1	Limited = 2	Multiple = 3	Extensive = 4
Risk Level	Minimal	Low	Moderate	High
Level of MDM	**Straight Forward**	**Low**	**Moderate**	**High**

Additional notes regarding Medical Decision Making:

1. Simply listing the diagnoses in the medical record is not sufficient.
2. Treatment or plan of care must be documented.
3. A chief complaint must be documented. Without such, the visit would be considered by Medicare as a preventive care visit with no risk present.
4. Complexity of risk is based on patient's condition.

This article is based on information from the Center for Medicare & Medicaid Services MedLearn Products **Evaluation and Management Services Guide** and **Medicare Resident & New Physician Guide**. These publications may be viewed and downloaded from the CMS MedLearn site (www.cms.hhs.gov/MLNProducts/). ■

Use of Intermediate and Complex Repairs

The use of layered closures and other advanced surgical techniques in cutaneous surgery has long been established as an effective way to reduce tension across the closure line, eliminate dead space and provide tensile strength to the wound during the post-operative period. The following is intended to clarify appropriate coding for intermediate and complex repairs:

1. The CPT descriptor for an intermediate repair states: *"Intermediate repair includes the repair of wounds that, in addition to the above (referring to simple closure), require layered closure of one or more of the deeper layers of subcutaneous tissue and superficial (non-muscle) fascia, in addition to the skin (epidermal and dermal) closure."* It is important to stress this closure is used in instances when one or more than one layer of deep sutures are required to approximate dermis and/or obliterate space remaining within the subcutaneous tissue, in addition to a separate outer layer for fine epidermal/dermal approximation. The *"deeper layers of subcutaneous tissue and superficial (non-muscle) fascia"* referred to in the CPT definition of intermediate repair refers to subcutaneous tissue that is deeper than the dermis rather than to the deep subcutaneous tissue. The superficial (non-muscle) fascia includes the layer commonly referred to as subcutaneous fat and envelopes the cutaneous nerves, vessels and adnexal structures. At the same time, it specifically excludes repair of deep fascia, i.e. muscle-enveloping fascia. In summary, wounds that require closure of subcutaneous tissue or more than one layer of tissue beneath the dermis should be coded as intermediate repairs, unless the criteria for a complex closure are met.

Note: Dog ears/Burow's triangles are typically included as a part of the intermediate repair.

The following examples represent a typical intermediate closure:

A. A 2 cm. epidermoid cyst on the back is excised. The resulting defect is confined to the epidermis, dermis and subcutaneous tissue. To close the defect, the skin edge is undermined sufficiently to allow for wound edge eversion. Buried absorbable sutures are placed within the subcutaneous tissue and deep dermis. In order to close the defect and approximate the wound edges, non-absorbable epidermal sutures are then placed in interrupted or running fashion.

B. A 1.5 cm. nevus located on the lateral thigh is excised. The resulting defect extends through the epidermis and dermis and into the subcutaneous tissue, but does not involve the fascia of the underlying muscle. The wound edge is undermined and buried absorbable sutures are used to close the subcutaneous and dermal components of the defect. Subcuticular running sutures are used to approximate the epidermal skin edge.

The CPT descriptor describes a complex layered closure as "*the repair of wounds requiring more than layered closure, viz., scar revision, debridement (eg, traumatic lacerations or avulsions), extensive undermining, stents or retention sutures.*" Complex repair codes are used to delineate complicated repairs. These repairs include the layered repair of lacerations that also require debridement of wound edges before closure. Wounds following excision of some lesions may require extensive undermining to release and redistribute tension vectors to allow proper closure. Wide undermining is necessary to avoid uncertain distortion such as of eyelid or lip. The time and work in closing a wound is related to undermining, and consequently obtaining hemostasis in the undermined area, as well as placement of sutures.

Note: Dog ears/Burow's triangles are typically included as a part of the complex repair.

The following examples represent a complex layered closure:

A. Following removal of a1.8 cm. basal cell carcinoma on the mid cheek, a curvilinear closure is designed to fall within the relaxed skin tension lines. The lesion is initially excised and the feasibility of a linear repair is confirmed by wide undermining. The defect is then converted to a curvilinear ellipse. The wound edges are extensively undermined to reduce tension and distortion of adjacent structures. Hemostasis is obtained with electrocoagulation. Buried absorbable suture is also used to close the subcutaneous and dermal component of the defect. Simple interrupted sutures are used to approximate the epidermal edges.

B. A 1 cm. basal cell carcinoma is excised adjacent to the left alar crease. A primary closure is designed to fall within the alar crease. The resulting curvilinear defect measures 4x1.5 cm. The cheek is extensively undermined to prevent distortion and periostal sutures are placed to advance cheek medially to fix position of the alar rim upon closure. Buried absorbable sutures are used to close the subcutaneous and dermal components of the defect. Interrupted sutures are then used to close the epidermis.

C. A 1.6 cm. congenital nevus is excised on the forehead just above the right eyebrow. A vertical closure is designed to prevent distortion of the eyebrow. The skin edges are undermined and buried absorbable sutures are used to close the frontalis muscle, subcutaneous tissue and dermis. Running surface sutures are then used to close the epidermis.

D. A Nevus Sebaceous measuring 5cm x 1cm on the vertex of the scalp is excised. The wound is undermined in the sub-galeal plane and the galea is reapproximated using interrupted absorbable sutures. Staples are used to close the epidermis

E. A previously biopsied basal cell carcinoma is excised from the anterior tibial surface of an 80 year old man. The resulting defect measures 1.8 cm in diameter and extends through subcutaneous tissue to muscle fascia and periosteum. In order to accomplish a primary linear closure the wound edges are undermined extensively in all directions. Due to the atrophic nature of the patient's

— continued on page 8

Use of Intermediate and Complex Repairs

— continued from page 7

skin subcutaneous buried sutures cannot be utilized. The wound edges are approximated with interrupted vertical nylon sutures and the repair completed with multiple interrupted nylon sutures. The wound is dressed with antibiotic ointment and a dry sterile dressing.

Note: There are instances in which the location of the defect or the patient's age or health may not permit the use of buried sutures. In these instances the surgical record should record the extent of the physician work to justify the level of coding.

The above article was developed by the members of the AAD Coding & Reimbursement Task Force with the guidance of its Chair, Allan S. Wirtzer, MD. The Coding & Reimbursement Task Force Members are: Brian Baker MD, Kenneth Beer, MD, Joseph S. Eastern MD, Christopher B. Harmon MD, Cyndi Jill Yag-Howard MD, J. Mark Jackson MD, Alexander Miller MD, Margaret E. Parsons MD, Pamela Kim Phillips MD, Robert A. Skidmore Jr. MD, Ben M. Treen MD, James A. Zalla, MD. ■

Medicare Updates

Medicare Appeals - Telephone and Written Reopenings

Effective January 1, 2006 clerical errors or omissions can be corrected via the telephone or in writing as a **reopening request**. Clerical errors or omissions have been defined by the Centers for Medicare & Medicaid Services (CMS) as human or mechanical errors on the part of the provider/supplier of the services or the contractor, such as:

- Mathematical or computational mistakes
- Transposed procedure or diagnostic codes
- Inaccurate data entry
- Misapplication of a fee schedule
- Computer errors
- Denial of claims as duplicates, which the party believes were incorrectly identified as a duplicate

Examples of reopenings include (this is not an all inclusive listing):

- Diagnosis changes/additions
- Certain modifier changes/additions
- Date of service changes
- Procedure code changes

If the above changes will result in a reduction of payment, these changes cannot be initiated as a phone reopening and should be sent in writing to the carrier's Recoupment team. (Check the carrier web site for the address)

If any of the above changes, upon research, are determined to be too complex, the carrier phone representative will inform the practice that these need to be sent in writing with appropriate documentation. A request to correct a clerical error or omission that does not require medical documentation to be reviewed by a medical professional or anyone other than the contractor employee handling the call, can be initiated via the telephone or in writing.

When initiating a telephone reopening the following information needs to be available:

- Beneficiary Medicare health insurance claim (HIC) number (with alpha/numeric suffix)
- Beneficiary given name: first initial and last name
- Beneficiary exact birth date
- Date of services being reviewed
- Name of provider/supplier
- Medicare provider number
- Course of action being requested (e.g., diagnosis change, modifier addition, etc.)

The timeframe to initiate a reopening is:

- Within 12 months after the date of the initial determination.
- After the 12-month period, but within four years after the date of the initial determination, for good cause.

Note: All requests for good cause must be submitted in writing and cannot be initiated via the telephone.

Submitting a reopening request in writing

When submitting a written reopening request, the following items are required. If these items are not included, a letter will be sent out dismissing the appeal indicating that the information is necessary in order to have a valid request. The dermatology practice will need to include the following information on either one of these forms or submit a letter requesting a written reopening:

- **CMS 20027 form**
- **Medicare Part B Inquiries/Review** form or
- Redetermination request letter, includes
  - Clear statement that this is a request for re-opening
  - Beneficiary name
  - Medicare health insurance claim number
  - Name and address of provider/supplier of item/service
  - The specific date(s) of the service
  - Which items and/or services requested for review

Include a copy of the Medicare remittance advice and any supporting documentation with the request.

— continued on page 12

"INCIDENT TO " SERVICES

Q. If a patient comes in solely for a nares culture (hx of staph infection being screened for nasal carriage), what are the billable codes when the nurse/MA is the only clinical staff seeing the patient?

A. In order for a medical assistant to take the culture, an order from the provider would need to be documented in the patient's medical record from a previous visit, such as the "if the wound doesn't heal, come back for a nares culture" and the **nurse/MA** must have their state's scope of practice to be able to perform such a test.

If the culture is being done in the office, the office must have the appropriate CLIA certificate. If one simply takes the scraping for the culture and puts it in the container, then 99211 would be billed if the supervising provider is in the office suite. No service may be billed to Medicare as "incident to" if a supervising provider is not in the office suite.

Q. Could the culture be taken and billed by an MA as well as an RN?

A. Yes, as long as a supervising provider is in the suite and available. However, verify with your malpractice carrier and state scope of practice for ancillary staff. Again, documentation should be in the medical record stating the instance when the test should be done.

Q. If a culture is taken in addition to a routine E/M (patient seen for an infected wound and a culture is obtained) is there any additional billable code or is this part of the E/M?

A. Obtaining the culture is part of the E/M service and not separately billable.

Q. A patient on Methotrexate presents only for venipuncture, can 36415 and 99211 be reported when the RN is the only personnel seeing the patient?

A. The service being performed is venipuncture, therefore code 36415 would be the appropriate code to report. Unless there is a medical necessity and documentation in the medical record to support an E/M service, reporting 99211 would not be appropriate. For either code 36415 or 99211 to be reported as "incident to", the supervising provider must be available in the office suite.

Q. May venipuncture be performed by a MA as well as an RN?

A. State laws and scope of practice of medical personnel determine the services that can be performed as "incident to" by ancillary staff. One should also verify with the malpractice carrier regarding coverage.

Q. The dermatologist performs a medically necessary E/M visit and then venipuncture is performed "incident to." What codes are reported?

A. The appropriate level of E/M service supported by documentation in the medical record and the venipuncture code, CPT 36415, are both reported.

Q. An Unna boot is applied. Can supplies be billed or are they included in the reimbursement?

A. Supplies are already included in the reimbursement of the code for Unna boot thus supplies are not separately billable.

Q. Similarly, if a Profore dressing is applied, which is a proprietary type of Unna boot that generates greater compression, can it be billed separately?

A. No. However, one may consider appending modifier -22, unusual procedure, to the Unna boot code 29580. A report would need to accompany the claim to describe the unusual procedure.

Q. If an MA applies an Unna boot based on the dermatologist's order is the service billable?

A. Yes, as long as **the dermatologist** is in the office suite, the application of the Unna boot, code 29580, would be reported as "incident to". If **the dermatologist** is not in the office suite, then service cannot be billed as "incident to". If the service is provided by a licensed provider (eg, PA, NP) the service would be reported under that provider's number.

Q. An excision or biopsy on the leg is done and because of venous insufficiency an Unna boot is applied to aid wound healing. Is the Unna boot separately billable from the surgical/ biopsy codes or is it included in the procedure code?

A. One would need to check the Medicare Carrier's policies on Unna boots and/or venous insufficiency. The medical necessity of the Unna boot application should be clearly documented in the medical record.

— continued on page 10

— continued from page 9

Q. If an Iodoflex dressing is applied to an infected wound can this supply be billed separately?

A. Dressings are not separately billable for dermatologic procedures.

Q. I want to do a biopsy on the leg but the patient has no palpable dorsalis pedis or posterior tibual pulse. To assess the arterial status an arterial Doppler blood pressure measurement is used to obtain an ankle-brachial index (ABI). Can I code 93922 with the diagnosis code 443.9?

A. NO. Per CPT such hand held devices do not produce a hard copy record and is considered part of vascular physical exam. See CPT directive text on Non-Invasive Vascular Diagnostic Studies.

Note: The use of a simple hand held or other Doppler device that does not produce hard copy output, or that produces a record that does not permit analysis of bidirectional vascular flow, is considered to be part of the physical examination of the vascular system and is not separately reported. (AMA CPT 2006, page 388)

Q. An Advanced Registered Nurse Practitioner (ARNP) sees a patient with me and we share the history and physical examination components of the evaluation and management, how is this service billed?

A. Only one E/M service may be billed for this encounter. The level of E/M service reported would be dependent upon the documentation in the medical record.

Q. If I do an excision and perform the subcutaneous closure and the ARNP does the epidermal closure do I bill the 116xx code at 100%?

A. The layered closure includes the subcutaneous and epidermal closure and that closure would be reported along with the appropriate excision code. As long as the ARNP scope of practice allows the performance of the epidermal closure and that service is performed "incident to", that service is a part of the repair code reported. Certainly both the excision and repair may be billed at 100%. The highest valued service would be reimbursed at 100% and the other service would be reimbursed at 50%.

Q. A patient returns for a suture removal from a biopsy. The nurse or medical assistant removes the sutures. Can this be billed with 99211?

A. When you have placed sutures, you should not charge to remove them.

Q. A patient returns for wound care of a biopsy site. The nurse or medical assistant sees the patient. Can this service be billed with 99211?

A. Since the skin biopsy code 11100 has 0 global days, one could bill an "incident to" service. Medicare global surgery rules state that anything related to the surgical procedure is included during the global period. As this wound care is for a service that has 0 global days, the global surgery rule is not applicable.

Q. A patient returns after a surgical procedure and is seen by the MA who reviews the pathology report with the patient. Can this be billed as a 99211?

A. In this scenario, only if a supervising provider is in the office may 99211 be billed as "incident to" and **if there is medical necessity**. If this visit occurs during the global period, the service is not billable according to Medicare's global surgery rule as this service is related to the surgical procedure. Note: that an MAs scope of practice may vary from state to state. For example, in California, an MA may report results but may not interpret them. Consequently, any discussion of the significance of the results is to be done by the physician, and not the MA.

Q. When are the charges billed by an NP or PA reduced?

A. The NP and PA services are reimbursed at 85% of the Medicare fee schedule when the NP or PA bills under his or her own provider number. Services that are billed "incident to" are reimbursed at 100% of the Medicare fee schedule.

Q. Can we use patient information to demonstrate operational processes during staff meetings?

A. Yes. This is an appropriate use of PHI for healthcare operations, as long as the demonstration is pertinent to the discussion and the minimum amount of information necessary is used. de-identified information whenever possible, but it's probably not feasible in this instance.

Q. How do you code for candida antigen intralesional injections?

A. The correct codes for the intralesional injections would be 11900 (one through seven) and 11901 (more than seven lesions). The choice of the code is by number of lesions treated, not the number of injections. At present, there is no J code for candida antigen. Therefore, there is no set reimbursement rate. It is advisable to contact the

— continued on page 11

Coding Q & A

— continued from page 10

insurance company prior to purchasing the antigen to make certain that it is reimbursable or to determine if they have any specific method to bill it. Use the unlisted J code J3490 for the candida antigen. When unlisted codes are used, there is an area on the (CMS 1500) claim form where additional information can be entered (box 19). This is where the name of the medication, the strength used and the amount used (amount dispensed plus waste, if any) is listed since the unlisted code is nonspecific.

Q. A patient has made an appointment with a dermatologist. The patient's attending physician suggested that the patient make the appointment with "a" dermatologist. The attending physician and the dermatologist have not had any contact, either verbal or written, concerning this patient's care. The dermatologist will send a written report to the attending physician. Is this a consultation?

A. No. The attending physician is not requesting the advice, or opinion, from "a" dermatologist. The dermatologist does not have any documentation indicating a request for an opinion or advice from the attending physician. While it is good medical practice for the dermatologist to share his/her findings with the attending physician, this does not make the service a consultation. The dermatologist would bill for an initial or subsequent care visit as appropriate.

Q. Is an Advance Beneficiary Notice (ABN) required for each service rendered when there is an extended course of treatment?

A. No, an ABN covering an extended course of treatment is acceptable provided the notice identifies all the dates of services and procedures for which the physician believes Medicare will not pay. If, as the course of treatment progresses, additional services are furnished which the physician believes Medicare will not pay, the beneficiary must be separately notified of the likelihood of Medicare nonpayment and the beneficiary must agree to pay.

Q. Our office had a communication error over scheduling which impacted and upset a longtime patient. As a 'good will' gesture, is it appropriate to waive the patient's co-pay or the whole visit?

A. Waiving the co-pay or the fee for the whole visit could be offered as a good will gesture as long as this is an exception and is not a part of the practice's written policy. Incorporating this as a standard method to address "errors" may jeopardize your insurance contract and/or liability insurance. A monetary gesture should not routinely be the answer to this type of problem. Mistakes happen. A personal phone call and/or card of apology would also be a valid response with the assurance that this mistake is being corrected. ■

2007 Medicare Fee Schedule Proposed Rule Grim

— continued from page 1

AADA has also joined other medical specialty societies in praising CMS adoption and use of Practice Expense Supplemental Survey data in the 2007 Medicare Fee Schedule. The AADA surveyed members in 2005 and submitted the data to CMS to demonstrate that the administrative costs of operating a dermatology practice have been significantly undervalued by CMS. AADA survey data has resulted in CMS increasing the dermatology hourly indirect costs from $119.40/hr to 159.40/hr. CMS incorporation of the updated indirect practice expense data over the next four years will result in a series of positive updates to dermatology's practice expense RVUs.

CMS has also proposed another physician practice information survey, covering all specialties. AADA has called for this new survey to be subjected to the same rigorous methodological and statistical standards as the recently completed specialty specific surveys.

AADA will also submit comment on the second part of the 2007 Medicare Fee Schedule Proposed Rule based on input from Academy members to the proposed changes to contracting, location and equipment requirements for independent diagnostic testing facilities (IDTFs). The proposed rule changes are designed to target what CMS considers inappropriate "condo" or "pod" laboratories that bill as IDTFs but are not bona-fide, independent laboratories. AADA will also comment on new proposed requirements that any health care entity that accepts reassigned claims must allow the physicians and any other health care professional who provided the services full access to the billing information for those services. CMS is expected to publish the 2007 Medicare Fee Schedule Final Rule in November. ■

Protect Practice from Potential Penalties

The latest advice from CMS is to "Get it in writing." If you have received billing instructions from your local Medicare carrier that prove to be incorrect, the Medicare carrier must waive any penalties against you for incorrect billing if you can document that your errors were the result of following incorrect written guidance from the carrier or CMS. The new policy is retroactive to July 24, 2003, according to CMS Pub.100-4 Transmittal 739 (www.cms.hhs.gov/transmittals/downloads/R739CP.pdf)

"Written guidance" includes e-mails, hard copies, faxes or even floppy disks with communication that are given to the practice. Information you have obtained from a carrier website posting also counts, but there must be some way to prove the communication came from CMS or a carrier.

A prudent practice is to retain hardcopy of the various instructions you receive from your local carrier in a monthly or quarterly folder marked: Carrier instructions — From date — to date. If you download the carrier's provider newsletter with billing or medical policy changes on a regular basis or if you research a medical coverage or billing instruction from the web site, make a print-out of the website info that contains the website address. However, information received over the phone might not qualify. If you have asked a key billing question in a phone conversation with Medicare carrier provider representatives or claims handling staff, ask for a written response. To insure that you will have a written response to a key Medicare billing question from your carrier, make sure you ask the question in writing AND request a written response. ■

Medicare Updates

— continued from page 8

All redetermination requests must be submitted in writing. A redetermination, previously titled appeal, is for services where an initial claim determination grants appeal rights and medical documentation is required for a complex review. (A clerical error or omission should be handled as a reopening, not as a redetermination.)

The following information needs to be included when requesting a redetermination:

- CMS 20027 form
- Medicare Part B **Inquiries/Review** form or
- Redetermination request letter:
  - Clearly state in the inquiry that this is a request for a redetermination
  - Beneficiary name
  - Medicare health insurance claim (HIC) number
  - Name and address of provider/supplier of item/service
  - Date of services for which the initial determination is being reviewed
  - Which items and/or services requested for review ■

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

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