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Last Minute Fix to 2007 Medicare Fee Schedule

The 109th Congress, in the last minutes of its session, passed the Tax Relief and Health Care Improvement Act of 2006 which includes a provision to freeze the Medicare Fee Schedule Conversion Factor (CF) at the 2006 level of $37.8975. This will effectively eliminate the anticipated negative 5.1 percent reduction in payments for physician services in 2007. However, the legislation also includes specific "pay for performance" quality measures and dermatology will still see specific reductions to physician work RVUs for several key dermatology codes.

The Center for Medicare and Medicaid Services (CMS) is moving forward with instructions to carriers to ensure that claims submitted on or after January 2, 2007 will be processed under the provisions of the Act, which legislated:

- 0% increase to the Medicare Conversion Factor, effectively freezing it at the 2006 level of $37.8975
- extension of the Medicare physician participation sign-up period which is from November 15, 2006 through February 14, 2007
- extension of the 1.00 floor for all rural Geographic Practice Cost Indices
- a new quality reporting initiative with a potential bonus payment to physicians reporting quality measures of up to 1.5% on allowed charges for claims submitted within the six month period, July 1, 2007 and December 31, 2007.

Passage of the Tax Relief /Health Care Relief Act 2006 only affects the Medicare Conversion Factor and does not negate the impact of 2007 Medicare Fee Schedule Final Rule. The legislation also waives the requirement for CMS to publish proposed and final rules for comment on these legislated changes. The legislation will be implemented via appropriate manual instructions.

The good news for dermatology is that rather than a negative overall impact of -8%, the legislative impact drops this to a negative -3% for dermatology. Dermatologists should be cautioned that while the conversion factor remains the same for 2007, the RVU values for dermatology codes have changed as a result of CMS incorporation of the following:

- +3% PE/RVU increase in 2007 based on updated indirect practice expense values for dermatology codes, when fully implemented in 2010 this will be a +13% increase to PE/RVUs for dermatology and +7% impact over total RVU values (See Table 34, 07 MFS FR, pg 69764
- -6% PW/RVU decrease based on RUC Five Year Review (5YR) changes to key dermatology codes. (See Table 34, 07 MFS FR, pg 69764
- -10% Budget Neutrality adjustment applied to the PW/RVUs for all CPT codes to offset overall increases in excess of $20 million resulting from the RUC 5YR revaluing of codes including evaluation and management visits.

NOTE: Application of the budget neutrality adjustment is not reflected in CMS Appendix B of the 07 MFS FR, so that the reduction in PW/RVUs and total RVUs would not be included in any non-Medicare use of the fee table.

The 2007 Medicare Fee Schedule Final Rule, published on December 1, 2007 incorporates CMS proposed changes to the practice expense RVU calculation methodology. CMS will phase in changes to the practice expense RVUs resulting from CMS adoption and use of AADA Practice Expense Supplemental Survey data that 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.

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Letter From the Editor

Dear *Derm Coding Consult* Reader

The 109th Congress has adjourned but not before leaving a "naughty or nice?" present behind! Congress has once more provided a legislated freeze which will keep the conversion factor at the 2006 level. While the legislative freeze spares us the anticipated -5.1% reduction, it does not affect those CMS changes to RVU values resulting from acceptance of AAD practice expense data which increases PE/RVUs for dermatology codes) and the RUC Five year review changes to physician work RVUs.

While dermatology may not be happy with the impact of the RUC Five Year Review on the 2007 Medicare Fee Schedule, it should recognize that the Academy's AMA RUC Team members have successfully steered dermatology codes thru the lengthy AMA Practice Expense Review Committee process with sustained or increased PE/RVU values for the last five years. In addition, the Academy's AMA RUC Team members have successfully defended against CMS' attempt to re-value all excisions at the same level regardless of difference in work between benign and malignant lesions. Finally, the Academy's AMA RUC Team contributed to the significant gain in value and reimbursement for evaluation and management services. These gains would be more readily apparent if CMS had not applied the required budget neutrality adjustment to the physician work RVUs.

The Academy is working with the American College of Mohs Micrographic Surgery and Cutaneous Oncology (ACMMSCO), and the American Society for Dermatologic Surgery (ASDS) to challenge the CMS withdrawal of the multiple surgery rule exemption for the Mohs stage 1 codes. We have obtained a legal opinion that CMS has failed to provide proper notice and opportunity to comment on a proposed payment change. We are awaiting a response from CMS on this issue.

The AAD Editorial Staff for Derm Coding Consult, Peggy Eiden, CCS-P, CPC, CDC, Vernell St. John, CPC, CDC look forward to seeing you at AAD's Annual Meeting In DC!

Best regards,

Norma L. Border, Editor

Last Minute Fix to 2007 Medicare Fee Schedule

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CMS selected over 700 codes for examination as part of the Congressionally-required Five Year Review, including almost fifty dermatology codes. Because of over-all revaluing of procedural and evaluation and management codes, CMS appled a mandated budget neutrality adjustment of -.1023% to the Physician Work RVUs.

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.

2007 Fee Schedule changes to CPT 1700x Codes

CPT	06 Total RVU	07 Total RVU	Change to Total RVU	06 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

Along with this revaluing of the **1700x** codes was the CMS request that use of these codes be limited to treatment of pre-malignant lesions. This necessitated a change to the AMA CPT code definitions for **17000**, **17003** and **17004** (limiting to premalignant actinic keratoses) as well as **17110** and **17111** to include destruction of all other benign lesions (except skin tags or those with site specific codes).

2007 Fee Schedule changes to CPT 1700x Codes ■

CPT	06 Total RVU	07 Total RVU	Change to Total RVU	06 CF 37.8975	07 Est CF 37.8975	Chg in $$
17110	2.32	2.31	-0.01	89.90	87.66	-0.25
17111	2.64	2.73	+0.09	100.03	103.31	+3.28

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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AMA CPT Approves New Site Specific Mohs Codes

The Mohs Micrographic Surgery codes have been revised by CPT and revalued by CMS for 2007. The Centers for Medicare and Medicaid Services (CMS) requested in 2005 that the AMA RUC review the work relative values for the Mohs Surgery family of CPT codes. However, the AMA RUC was unable to validate the current code work relative values without a fundamental coding change. It was felt by CMS that the code descriptors for Mohs services were confusing and open to interpretation by payers.

CMS also commented that the nomenclature for these services was not consistent with the other integumentary coding conventions in CPT, based on the size of the lesion and anatomical site. Although the Mohs community and payors had historically interpreted CPT code **17310** correctly as an add-on code to be reported for each additional specimen beyond the first five specimens, concern was expressed by CMS regarding the potential for over-utilization.

The Academy as well as the American College for Mohs Micro-graphic Surgery and Cutaneous Oncology and the American Society for Mohs Surgery worked with the CPT Editorial Panel to re-define the Mohs Micrographic Surgery section in CPT. The result is a revised set of five Mohs surgery codes that now incorporate site-specific elements in the descriptors.

17311 Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toludine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; first stage, up to 5 tissue blocks.

17312 Each additional stage after the first stage, up to 5 tissue blocks (List separately in addition to code for primary procedure).

(Use **17312** in conjunction with **17311**)

17313 Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; first stage, up to 5 tissue blocks.

17314 Each additional stage after the first stage, up to 5 tissue blocks (List separately in addition to code for primary procedure).

(Use **17314** in conjunction with **17313**)

17315 Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toludine blue), each additional block after the first 5 tissue blocks, any stage (List separately in additional to code for primary procedure).

(Use **17315** in conjunction with **17311 – 17314**)

(Codes **17304 – 17310** have been deleted.)

(If additional special pathology stains or immunostains are required, use **88311 – 88314**, **88342**)

(Do not report **88302 – 88309** on the same specimen as part of the Mohs surgery)

Any repair following Mohs surgery should be separately reported. ■

Coding Update

New Mohs Codes and Multiple Surgery Reduction Rule (MSRR)

The new AMA CPT structure of the Mohs codes for 2007 defines **17311** and **17313** as stage one codes that will be subject to MSRR. The stage two and incremental codes **17312**, **17314** and **17315** are defined in CPT as add-on codes and are automatically exempt from the MSRR.

The multiple surgery reduction rule (MSRR) is defined in CMS regulation as a payment adjustment mechanism. Therefore, CMS has the authority to exempt or to apply the MSRR at will. CMS (formally HCFA) specifically exempted the Mohs codes from MSRR in the 1992 Medicare Fee Schedule Final Rule, published 11/25/91. However, CMS is required to notify any affected health care provider of a change in payment calculation and provide an opportunity to comment before such a change is implemented.

In late October, the Academy contacted a prominent Washington DC legal firm to request an opinion as to whether or not CMS has complied with the regulatory requirements and provided an opportunity to comment on this payment change for Mohs procedures. Initial research by legal staff supports the argument that CMS has not provided an opportunity to comment as required under federal regulations.

The Academy, in a joint effort with ASDS and ACMMSCO, has submitted a letter with this opinion to Leslie Norwalk, Acting Administrator for CMS, and is awaiting CMS response and is also pursuing a meeting with CMS to discuss this issue. It is hoped that the result of this correspondence and/or meeting with Acting Administrator Norwalk will result in a delay in the implementation of this change in the MSRR exemption for 2007 which will allow time to continue to comment on the necessity of a permanent MSRR exemption for the Mohs codes. ■

Q. How is a preventive service defined as opposed to a medical service and under what circumstances would a dermatologist bill for it?

A. The meaning of 'preventive' as used in *Derm Coding Consult,* Summer 06, refers to a visit that is not medically necessary, not necessarily the preventive visit codes (**99381 – 99397**). A dermatologist would rarely perform a preventive visit (**99381 – 99397**) as described in CPT. Both the initial and periodic comprehensive preventive visit as stated in CPT are:

> "evaluation and management of an individual including age and gender appropriate history, examination, counseling/anticipatory guidance/ risk factor reduction interventions, and the ordering of appropriate immunization(s), labs/diagnostic procedures, new/established patient ages…"

A skin screening exam would not cover all that is expected to be performed with these codes. Rather than the **993xx** preventive codes, consider billing an Evaluation and Management code (**99201 – 99215**) for the visit and allowing the diagnosis code to explain the visit.

For a routine skin screening, **V76.43** is an appropriate diagnosis but most likely not payable. Following are other appropriate ICD-9-CM V-codes which may be used:

V10.82 Personal History of Malignant Neoplasm

V10.83 Unspecified, Personal history of malignant neoplasm

V13.3 Personal history of diseases; skin and subcutaneous tissue

V16.8 Family History; Other specified malignant neoplasm

V19.4 Family History of Skin Conditions

V50.1 Elective surgery for purposes other than remedying health states; other plastic surgery for unacceptable cosmetic appearance.

V50.9 Elective surgery…; Unspecified

V65.40 Counseling NOS

V65.49 Counseling; Other specified counseling

V65.9 Unspecified reason for consultation

V76.43 Special screening for malignant neoplasms; other sites; Skin

V82.0 Special screening for other conditions; Skin conditions

Q. Recently, we saw a regular patient who had plastic surgery out of town. Instead of traveling back to the plastic surgeon, she came to her dermatologist to have the sutures removed. The suture removal took 20 – 30 minutes to complete. What CPT code should be used in this case?

A. A simple suture removal without anesthesia by another physician is usually coded as an office visit. Usually, a **99211** is used with diagnosis code, **V58.32**. If the suture removal was done by the physician and documented as to the complexity of amount of sutures, difficult of removing, etc then bill the E&M service based on time. As an example, **99213** is a fifteen minute visit.

If the sutures were removed during the global postoperative care period 10 or 90 days, the physician removing the sutures or providing related post op care may bill the original surgical procedure code with a modifier **-55**, Post-operative management only. The reimbursement is usually 20 – 25% of the surgical allowable. However, this may be problematic because the CPT code submitted with the **-55** modifier must match to the original surgical procedure code.

Opting out of Medicare

Q. I'm contracted with other health plans as well as Medicare. However, I want to stop accepting new Medicare patients. Does this mean I have to stop accepting new patients on the other plans? If this is true, may I see new Medicare patients if they are willing to pay out of pocket? Can they then submit their own claims to Medicare for reimbursement?

A. Yes, you can stop accepting new Medicare patients while continuing to accept new patients on other health plans.

However, you may not see either new or established Medicare patients who want to pay you out of pocket unless you opt out of Medicare. When you "opt out," you privately contract with your Medicare patients for your services. The patient agrees to pay your charges, and both sides agree not to submit any claims or receive any payment from Medicare for your services. Unless you formally opt out of Medicare, you are expected to file claims on behalf of your Medicare patients and abide by the applicable Medicare payment limitations. This is true whether you are a "participating" or "nonparticipating" Medicare physician.

Q. We have a dermatologist using a laser treatment to destroy telangectasias. What is the most appropriate code, now that CPT 17000-17004 are limited to coding the treatment of pre-malignant lesions?

A. As of January 1, 2007, only pre-malignant lesions – actinic keratoses will be billable under **17000 – 17004**. Destruction of all other benign lesions, not otherwise identified under a site specific or other code (e.g. skin tags or proliferative lesions) should be billed using **17110 – 17111**.

Please also see the article on *Appropriate use of CPT Codes **17106 – 17108*** by Pamela Kim Phillips, MD, in the Dec 2004 issue of Derm Coding Consult. It provides additional clarification on why it is not appropriate to bill the destruction of telangectasias using the vascular proliferative lesion codes (17106-17108). ■

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Note: Indices for prior year issues are available at: http://www.aad.org/professionals/Publications/DermCoding Consult.htm

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Accessing Your Local medicare Fee Schedule

Dermatologists may download a copy of their local carrier's fee schedule directly from the following CMS web site, at: http://www.cms.hhs.gov/PhysicianFeeSched,

1) click on *PFS Carrier Specific Files* in left-hand column

2) scroll down and click on your State and the appropriate fee schedule year – *2007*.

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