

# DERM CODING CONSULT

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## AAD Takes Issue with Medicare Fee Schedule 2008

### Budget Neutrality Adjustment

The Academy is very disappointed in the Centers for Medicare and Medicaid Services (CMS) decision in the Medicare Fee Schedule Proposed Rule (08 MFS PR) to make the budget neutrality adjustment to the physician work values (RVUs) for 2008. From 1998 to 2006, CMS achieved budget neutrality requirements by adjusting the Medicare conversion factor. In the AAD comment on the 08 MFS PR, AAD strongly urged CMS to make any budget neutrality adjustment for 2008 to the conversion factor, rather than impose a nearly 12 percent reduction to the physician work RVUs.

### Five-Year Review Work Adjuster

CMS also announced that the Five-Year Review Work Adjuster will increase from -10.1% in 2007 to -11.8% in 2008. The AAD strongly urged CMS to eliminate using this type of work adjuster. In 2007, CMS created a new "work adjuster" to ensure budget neutrality following the implementation of the improved work RVUs for Evaluation and Management Services from the 2005 Five-Year Review of the RBRVS.

The Academy has always questioned the appropriateness of CMS using adjustments to the work relative values as a mechanism to preserve budget neutrality. The AAD firmly believes that applying budget neutrality to the work RVUs to offset the improvements in E/M and other services is a step backward and strongly urged CMS to apply any necessary adjustments to the conversion factor.

### Publishing RVU for Non-covered Services

AAD joins many other medical specialty societies in the repeated request that CMS publish RVU values for CPT codes that remain non-covered by Medicare. As all payers are required under HIPAA to use AMA CPT as part of the National Electronic Claims Standard, we strongly support CMS publishing relative values for all CPT services and procedures, regardless of Medicare's coverage policies.

### Physician Practice Information Survey Data

CMS currently utilizes practice expense data and physician hours from the 1995-1999 AMA Socioeconomic Monitoring System (SMS) survey to calculate a "practice expense per hour" estimation for each specialty. In 2004, the AAD successfully completed such a survey effort and our survey results were accepted by CMS in 2005 and incorporated into the 2007 Medicare Fee Schedule. AAD, in conjunction with over 70 specialty societies is participating in a new survey

effort, the Physician Practice Information (PPI) Survey. The data will be provided to CMS in the spring of 2008 for implementation in the 2009 Medicare Physician Fee Schedule. However, AAD remains concerned that this survey methodology and results may undermine or be inconsistent with the rigorous CMS criteria and the statistically valid results which AAD submitted to CMS in 2005 as a Practice Expense Supplemental Survey.

### Multiple Procedure Payment Reduction for Mohs

The proposed rule explicitly withdraws the Multiple Procedure Reduction Rule (MPRR) exemption for Mohs surgical procedures. This exemption for the Mohs Micrographic surgery codes was established in the 1992 Medicare Physician Fee Schedule and maintained by CMS within all subsequent fee schedules since 1992. We believe that this CMS action will unduly impact not only those Medicare beneficiaries who have or will be diagnosed with skin cancer but also those surgical dermatologists who provide these services.

On September 5th, dermatologists representing the Academy, the American College of Mohs Surgery (ACMS), the American Society for Dermatologic Surgery (ASDS) and the American Society for Mohs Surgery (ASMS) met with senior CMS management staff to discuss the impact of this proposed change and to present additional data to argue against it. ■

### Contents

Letter From the Editor .....	2
Coding Update .....	2, 6
Medicare Carriers Reject Claims with NPI Errors CMS Dissemination of NPPES Data Medicare Update .....	5
CMS Awards New MAC Contracts .....	6
Coding Q & A .....	7 & 8

#### IMPORTANT Please Route to:

Dermatologist  Office Mgr  Coding Staff  Billing Staff

## Letter from the Editor

Dear *Derm Coding Consult* Reader

There's no good news with the Centers for Medicare and Medicaid Services (CMS) publication of the 2008 Medicare Fee Schedule: Proposed Rule. As predicted, it lays out the impact of three significant reductions to physician reimbursement. A budget neutrality adjustment will shave away at the Physician Work RVUs for every CPT code. The continued incorporation of the Sustainable Growth Rate formula will further reduce the Medicare Conversion Factor 9.9 percent reduction to Medicare physician reimbursement levels for services on or after Jan. 1, 2008. MedPAC estimates that payment will be cut every year for the foreseeable future, a trend that will have grave consequences for the entire health care system. If Congress does not act, physicians will receive payment rates lower than those of 1999!

This is a reminder to each of you that the American Medical Association (AMA), in collaboration with the dozens of supporting medical specialty societies, will be conducting a cross-specialty survey of physician practices throughout 2007. The **Physician Practice Information Survey** will be presented to physicians in a broad array of specialties, including dermatology, throughout the year. The Gallup Organization will be collecting and processing the data of physicians from each of the AMA-recognized specialty groups.

The AAD strongly encourages every dermatologist who receives the survey to complete it. This will ensure the greatest amount of representation for Academy members and their patients. In her "Call to Action" letter, Diane R. Baker, MD, FAAD, Academy President, is urging AAD members to take the necessary time to fully complete the surveys. Information on practice expense will be collected, and participating will ensure that AAD members are fairly represented to top policy makers — including those within the Centers for Medicare and Medicaid Services. Members who receive the survey should contact the Gallup organization with any questions they have, using the 800 number provided in the survey.

On a happier note, please join me in welcoming to the Academy our new Coding & Reimbursement Specialist, Faith McNicholas, CPC, who will also be working as an Assistant Editor on *Derm Coding Consult*.

Best regards,



Norma L. Border, Editor

## Coding Update

### New NCCI Edits

CMS has updated the National Correct Coding Initiative (NCCI) edits as of July 1st to address problems related to the revised benign lesion codes. The NCCI Edit explanation of the following table: Column 1 is the primary code; Column 2 is the secondary code. The NCCI edit is on the Column 2 secondary code which is automatically bundled into Column 1 primary code. If the services were performed on two separate lesions and/or sites or at separate patient encounters, if appropriate, these edits may be bypassed with modifier -59 on the Column 2 code. Some of the Medicare carriers are very particular that modifier -59 be placed on the Column 2 code whereas some Medicare carriers allow modifier -59 to be placed on either code.

### New NCCI Edits—07/01/07

#### Mutually Exclusive Edits

Column 1	Column 2	Effective Date	Modifier 0 = not allowed 1 = allowed 9 = N/A
17004	17110	20070701	1
17004	17111	20070701	1
17110	17000	20070701	1
17111	17000	20070701	1

#### Column 1 and Column 2 Edits

#### No Changes

Modifier -59 is an important NCCI-associated modifier that is often used incorrectly. For NCCI, its primary purpose is to indicate that two or more procedures are performed at different anatomic sites or different patient encounters. It should only be used if no other modifier more appropriately describes the relationships of the two or more procedure codes. Documentation in the medical record must satisfy the criteria required by any NCCI-associated modifier used.

— 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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## Medicare Carriers to Reject Claims With NPI Errors

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Medicare has "turned on" new edits that must be able to match a physician's appropriate PIN to his or her correct National Provider Identifier (NPI) and may reject claims if a match cannot be made. Prior to September 4, 2007, most Medicare carriers permitted claims to process through their computer systems even if a match to the physician's NPI number and their old legacy billing number(s) could not be made.

AAD strongly encourages dermatologists to immediately check with their billing office to determine if any new error codes have been returned. These codes could indicate an NPI mismatch in the Medicare system. Dermatologists who use a clearinghouse should double check that their NPI or

these error codes are not being stripped off of their claims.

**NOTE:** Medicare must be able to match single, incorporated physicians—those who have an LLC or other incorporated business arrangement. These physicians must have two NPIs—one for themselves and one for their corporation. In some cases Medicare may have originally assigned these physicians one NPI rather than the two that are now needed to match a physician to his or her correct NPI number. In these cases, re-enrollment in Medicare is required. In addition, physicians in large group practices who may have multiple Medicare NPIs could also experience claims interruptions if there are matching problems. ■

## CMS Dissemination of NPPES Data

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The National Plan and Provider Enumeration System (NPPES) health care provider data that are disclosable under the Freedom of Information Act (FOIA) was disclosed to the public by the Centers for Medicare & Medicaid Services (CMS) beginning September 4, 2007. CMS is extending the period of time in which physicians with NPI numbers can view their FOIA-disclosable NPPES data and make any edits they feel are necessary.

CMS made the NPPES health care provider data available on Tuesday, September 4, 2007. CMS has stated that the downloadable file will be ready approximately one week later. Physicians and health care providers should go to <http://www.cms.hhs.gov/NationalProvIdentStand/> for assistance in accessing this data.

The delay in the dissemination of NPPES data does not alter the requirement that HIPAA covered entities must comply with the

requirements of the NPI Final Rule no later than May 23, 2008.

CMS reminds all health care providers who are covered entities under HIPAA that:

- they are required by the NPI final rule to update their NPPES data within 30 days of any changes; and
- health care providers who have been assigned NPIs should check the information in their NPPES records to ensure it is correct and current.

A dermatologist may wish to delete optional NPPES data that was furnished when applying for the NPIs since the information provided in these optional fields is not required. A primary "Healthcare Provider Taxonomy Code" is required when applying for an NPI; however, reporting of additional Taxonomy Codes (total of 15) is optional. ■

## Medicare Update

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### CMS Clarifies Policy on Documenting Patient HPI

In a clarification of policy that may change the way some dermatology offices operate, the Centers for Medicare and Medicaid Services (CMS) recently clarified its documentation requirements for the gathering of patient history of present illness (HPI) and chief complaint (CC) during an evaluation and management (E&M) visit. According to the clarification, only the billing physician or non-physician provider (NPP) may review and record the HPI and chief complaint. Simply counter-signing what a nurse or medical assistant has written is no longer acceptable, according to CMS.

The American Academy of Dermatology has contacted carriers that have provided the CMS clarification to physicians in their regions. Wisconsin Physician Services (WPS), Palmetto GBA, as well as Noridian (NAS), have each informed physicians that HPI must be gathered by a physician or NPP.

In Noridian's documentation policy clarification, the carrier states:

"Noridian reminds providers that E&M codes are valued as including all elements of work to be performed by the physician or non-physician provider when 'physician' criteria are met. Although ancillary staff may question the patient regarding the chief complaint, that does not meet the criteria for documentation of the HPI. The information gathered by ancillary staff (i.e. Registered Nurse, Licensed Practical Nurse, Medical Assistant) may be used as preliminary information but needs to be confirmed and completed by the physician."

"The ancillary staff may write down the HPI as the physician dictates and performs it. The physician shall review the information as documented, recorded, or scribed and write a notation that he/she reviewed it for accuracy, did perform it, adding to it if necessary, and signing his/her name. Reviewing information obtained by ancillary staff and writing a declarative sentence. ■

## CMS Awards New MAC Contract

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) enables the Centers for Medicare & Medicaid Services (CMS) to make significant changes to the Medicare fee-for-service program's administrative structure. Through implementation of Medicare Contracting Reform, CMS will integrate the administration of Medicare Parts A and B for the fee-for-service benefit to new entities called Medicare Administrative Contractors (MACs). This operational integration will centralize information once held separately, creating a platform for advances in the delivery of comprehensive care to Medicare beneficiaries. However, it also means that every dermatologist will experience a change in the Medicare entity that processes and pays Medicare Part B claims. Derm Coding Consult will report the MAC Contract awards as these are released by CMS.

**On September 5, 2007**, CMS announced it awarded the third A/B MAC contract for Jurisdiction 5 to Wisconsin Physicians Service Health Insurance Corporation (WPS). WPS will be responsible for the workload in the states of Iowa, Kansas, Missouri and Nebraska. As the new "J5 A/B MAC", WPS will immediately begin implementation activities and will assume full responsibility for all Part A and Part B Carrier workload no later than September 9, 2008.

**On August 2, 2007**, CMS announced that it had awarded the J4 A/B MAC contract to TrailBlazer Health Enterprises (TrailBlazer). As the "J4 A/B MAC", TrailBlazer immediately began implementation activities and will assume full responsibility for the work in Colorado, New Mexico, Oklahoma, and Texas no later than Spring 2008.

**On July 31, 2006**, CMS awarded the Jurisdiction 3 (J3) A/B MAC contract to Noridian Administrative Services (NAS). As the "J3 A/B MAC", NAS immediately began implementation activities and assumed full responsibility for the work in March 2007. J3 includes: Arizona, Montana, North Dakota, South Dakota, Utah, and Wyoming.

Between 2005 and 2009, the Centers for Medicare & Medicaid

Services (CMS) will continue to replace the carriers that currently perform claims processing and related functions for the Medicare program with new MACs that will perform many of the same tasks, but will do so more efficiently. CMS believes this will result in improved Provider Services, including:

- A simplified interface with a single MAC for Part A and Part B processing and other services will benefit providers;
- Competition will encourage MACs to deliver better service to providers; and
- Requiring MACs to focus on financial management will result in more accurate claims payments and greater consistency in payment decisions.

### Medicare's MAC Jurisdictions (Bold=Contracts awarded)

1. American Samoa, California, Guam, Hawaii, Nevada, and Northern Mariana Islands
2. Alaska, Idaho, Oregon, and Washington
3. **Arizona, Montana, North Dakota, South Dakota, Utah, and Wyoming**
4. **Colorado, New Mexico, Oklahoma, and Texas**
5. **Iowa, Kansas, Missouri, and Nebraska**
6. Illinois, Minnesota, and Wisconsin
7. Arkansas, Louisiana, and Mississippi
8. Indiana and Michigan
9. Florida, Puerto Rico, and U.S. Virgin Islands
10. Alabama, Georgia, and Tennessee
11. North Carolina, South Carolina, Virginia and West Virginia
12. Delaware, District of Columbia, Maryland, New Jersey, and Pennsylvania
13. Connecticut and New York
14. Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont
15. Kentucky and Ohio ■

## Coding Update

— continued from page 2

The HCPCS/CPT codes remain bundled unless the procedures/surgeries are performed at different anatomic sites or separate patient encounters. From an NCCI perspective, the definition of different anatomic sites includes different organs or different lesions in the same organ. However, it does not include treatment of contiguous structures of the same organ. For example, treatment of the nail, nail bed, and adjacent soft tissue constitutes a single anatomic site.

### HCPCS GY and KX Re-Defined July 1

The July 1, 2007 update to the HCPCS codes included two key modifier definition revisions. Modifier GY has been expanded to make it useful to non-Medicare payers with the

addition of "item or service..is not a contract benefit."

Modifier KX has also been expanded to be applicable for more than just "documentation on file." Effective July 1, use of Modifier KX implies a full awareness of what is required by the carrier or health care payer medical policy.

### New Modifier Definitions

- GY – item or service statutorily excluded, does not meet the definition of any Medicare benefit or for non-Medicare insurers, is not a contract benefit
- KX – requirements specified in the medical policy have been met ■

### ICD V-CODES FOR DERMATOLOGY

#### Q. Which ICD-9-CM V Code should we use in order to indicate a diagnosis for history of an atypical mole?

- A. There is no specific V code to indicate “history of an atypical mole.” The following is a listing of usual dermatology V codes. For a patient with a history of an atypical mole, V13.3 - Personal history of diseases; skin and subcutaneous tissue, may be an appropriate code. Please note that not all V codes are considered for payment especially as primary diagnosis; it depends on the carrier.

- 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

*\*\*NOTE: This v-code is appropriate to report for patients who are following up for an annual body check due to history of malignant neoplasms. In this case, V10.82 Personal History of Malignant Neoplasm can be reported as the secondary code. Patient has no other complaints.*

### CODING FOR DESTRUCTION OF WARTS

We have received a number of questions regarding Wart destruction. For example, a patient presents with 20+ warts. After reviewing treatment options, the warts are injected with Candida. The patient returns for follow-up 3 – 4 weeks later and the same warts are injected with Candida and also frozen using liquid nitrogen. The patient returns for another follow-up visit 4 weeks later with little or no improvement of the warts. At this visit, the same warts are injected with Bleomycin.

#### Q. Can physician bill for injection of Candida using 11900?

- A. Yes, the Candida is injected intralesionally into the wart(s). Thus, in this instance, code 11901 would be reported as 20 warts were injected. Code 11900 is for up to and including 7 lesions and 11901 is used for

injecting more than 7 lesions. Since there is no J-code available for Candida, the unclassified drug code J3490 would be reported listing the drug, strength and amount injected.

#### Q. How should the physician bill for the injection of Candida plus the use of liquid nitrogen?

- A. Destruction per CPT is by any method. It would be inappropriate to report both a destruction and an injection code on the same date of service for the same lesions. The most definitive service provided should be the reported procedure.

#### Q. Would it be appropriate to bill for 11900 plus the Bleomycin on the last visit?

- A. When Bleomycin is used as the method of destruction, the intralesional injection code, 11900 or 11901 would be reported along with J9040 Bleomycin sulfate. The code J9040 is for 15 units of Bleomycin sulfate.

### CODING SHAVE REMOVAL ON SCALP COMPLICATED BY EXCESSIVE BLEEDING

We saw a patient with a suspicious lesion on the scalp and our dermatologist removed it by shave technique. However, during the procedure, it got complicated as the patient began to bleed excessively. It took over 45 minutes to control the bleeding (achieve hemostasis) and do a simple closure of the wound.

#### Q. How should we code this to reflect the extra time it took with this patient?

- A. The appropriate CPT code will be 1130X – Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; (depending on the size of the lesion), and could be reported with Modifier -22 to reflect that the procedure was unusual and complicated. According to CPT, a wound from a shave removal does not require suture closure.

**“Modifier -22 - unusual procedural services** – When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding -22.”

You may also report ICD-9 code 998.11 - “Hemorrhage complicating a procedure” as secondary code to the lesion descriptor that is being excised.

If you have documented information on the cause for the excessive bleeding e.g. patient is on aspirin or coumadin therapy which, in many instances will cause excessive bleeding, the appropriate V58.6X - “Long term current drug use – specify type of drug” should be reported as tertiary code.

### USING MODIFIERS WITH E/M VISITS

#### Q. When do I use a modifier on an E&M visit when a patient is still within a surgical global period?

- A. Global periods for surgical procedures are: 0, 10-day and 90-day period for major surgeries. Depending

— continued on page 8

## Coding Q & A

— continued from page 6

on the global surgery period, any E&M codes rendered during that period will be denied as included in the global surgery payment unless one of the following situations apply:

- for an E&M on same day as surgery if the visit is for a separately identifiable, non-related service, use **Modifier -25 Significant, separately identifiable E/M;**
- for E&M on other days within the surgery period if the visit is for a separately identifiable, non-related service, use **Modifier -24 Unrelated E/M during post-op period;** or
- for E&M if the decision is made on that day for a major surgery (90-day global only), use **Modifier -57 Decision for Surgery.**

### MEDICARE PAYMENT POLICIES

#### Q. Where can I find the Medicare Physician Fee Schedule Data Base (MPFSDB) Indicator Key?

- A. The fee schedule information may be found in the CMS Internet Only Manuals (IOMs). The direct link to the CMS IOMs is <http://www.cms.hhs.gov/Manuals/IOM/list.asp>. Locate the Claims Processing Manual (Pub. 100-04), select Chapter 23 and scroll down to section 90 (page 121). The fee schedule information starts with 2001 and is current through 2006. You may view the 2007 Medicare Physician Fee Schedule and the Indicator File on the CMS web site at: **CMS** <http://www.cms.hhs.gov/apps/pfslookup/>

#### Q. Why is Medicare denying a claim for a Xenograft procedure?

- A. According to Medicare: Xenograft, Skin (CPT codes 15400-15431) is an application of a non-human skin graft or biologic wound dressing (e.g. porcine tissue or pigskin) to a part of the recipient's body following debridement of the burn wound or area of traumatic injury, soft tissue infection and/or tissue necrosis, or surgery. However, the Medicare Fee Schedule shows that this service is allowed only as an inpatient procedure.

#### Q. How do I know when the patient can be charged for services that Medicare denied?

- A. Included in the information listed for each processed claim on the Provider Remittance Notice (PRN) you receive from your Medicare Carrier or MAC is an ANSI

(American National Standards Institute) message that may start with PR (Patient Responsibility) or CO (Contractor Obligation). This indicates that the patient may be charged for anything that is denied as a PR (Patient Responsibility).

### PATIENT INFORMATION

#### Q. Sometimes our office has trouble contacting patients with positive test or biopsy results. How should this situation be handled?

- A. First, be sure to check your records to see if there is another authorized person to contact or an emergency number in the chart or computer registration.

If there are no emergency contacts listed, write a letter to the patient with instructions to call and schedule an appointment to discuss the test results. The test results and recommendations may be included if there is confidence that the patient will understand the results and pursue follow up care. If the initial letter to the patient fails to generate a timely response (7-10 days), send a letter via certified mail with a return receipt, which directly spells out the test results, treatment recommendations and the result possibilities if the patient fails to get treatment.

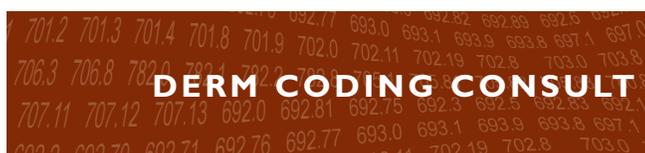
In addition, be sure to document all attempted phone call contacts as to date, time, name of caller and number called and keep copies of all correspondence and return receipts. If the medical situation is fatal or disabling, contact your medical malpractice carriers for additional recommendations.

#### Q: If a 19-year-old patient presents an insurance card listing him or her as a qualified dependent on a parent's health plan, and the parent calls for information about why the child was seen by the dermatologist, can we release any information other than verifying the patient's presence?

- A: Assuming the age of majority is 18 years of age in your state, this patient is legally an adult. Although his or her parent's plan provides the health care coverage, the parent does not have the right to access his or her child's Protected Health Information (PHI) without a written authorization from the patient.



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