

# DERM CODING CONSULT

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## National Physician Identifier Database

The Centers for Medicare & Medicaid Services (CMS) has announced how it will disclose physician National Provider Identifier (NPI) data contained in the National Plan and Provider Enumeration System (NPPES). The notice spells out:

- who will have access to physician and health care provider NPI numbers,
- what information associated with each number will be available, and
- how the number and data can be accessed.

CMS will make the NPI database available August 1, 2007 and the information will be available in both a “query-only” online database and a downloadable file. For example, if a dermatology practice needs the NPI of a referring non-dermatologist, they will access the database to query for that information and report it on a claim.

### Action Needed

In preparation for the NPI database becoming public, dermatology practices are strongly encouraged to perform a final spot check to ensure that the data elements associated with their NPI profile are accurate, complete, correct, and up to date, no later than July 16, 2007.

Contrary to erroneous reports, **CMS will not disclose social security number, Internal Revenue Service individual taxpayer identification number, or date of birth.**

### Window of opportunity

Dermatology practices that would like to review and delete data elements supplied on their NPI application(s) that are considered **optional** can do so prior to the time CMS makes the online database available. It is important to verify two key data fields:

1. **Taxonomy codes:** Up to 15 taxonomy codes may be reported as part of each individual dermatologist’s NPI information. Therefore, make sure your primary taxonomy code (Dermatology — 207N00000X) is registered as it is required. In addition, while optional, it is recommended to include all appropriate secondary dermatology subcodes that accurately reflect your current scope of dermatologic clinical services. The primary and secondary taxonomy codes for dermatology include:
  - **Dermatology — 207N00000X**
    - **Clinical & Laboratory Dermatological Immunology — 207NI0002X**
    - **Dermatological Surgery — 207NS0135X**
    - **Dermatopathology — 207ND0900X**
    - **Mohs — Micrographic Surgery - 207ND0101X**
    - **Pediatric Dermatology — 207NP0225X**

### 2. “Other Names,” and/or “Other Provider Identifiers”:

Data contained in these fields are optional. It is recommended to include your legacy identifiers (PIN/UPIN and any other payer ID numbers) here. A Social Security Number, FEIN, or DEA number are not legacy ID numbers and should not appear in these sections of your NPI file.

### Subsequent updates

All healthcare providers are required by HIPAA regulation to update their NPPES data within 30 days of any change and are required to disclose their NPIs to any entity that needs them for use in a standard transaction such as claims submission.

Dermatology practices that want to remove information from their NPI profile must do so by submitting a change request to NPPES online at <https://nppes.cms.hhs.gov/NPPES/> Welcome by using their User IDs and passwords and submitting updates via the Web.

If you don’t have a User ID and password, you can request one via the NPPES site. If you are unable to submit an online request, please call the NPI Enumerator at 1-800-465-3203 to request an NPI Application/Update Form and submit the updates on that form.

Visit <http://www.cms.hhs.gov/NationalProvIdentStand/> for more information or to apply for or review your NPI information.

When ready for release, the NPI database will be accessible at: [www.cms.hhs.gov/NationalProvIdentStand/](http://www.cms.hhs.gov/NationalProvIdentStand/) ■

## Contents

National Physician Identifier Database .....	1
Letter From the Editor .....	2
Medicare Advantage PFFS “Deeming” Issues .....	2, 8
Physician Practice Information survey — Frequently Asked Questions .....	5
Coding Q & A.....	5, 6, 7
PQRI — Frequently Asked Questions .....	7

IMPORTANT Please Route to:

Dermatologist  Office Mgr  Coding Staff  Billing Staff

## Letter From the Editor

Dear *Derm Coding Consult* Reader

The Academy has been working closely with the Alliance of Specialty Medicine to prevent the Medicare Physicians Quality Reporting Initiative (PQRI) from becoming a mandatory program in 2008 and subsequent years. PQRI is currently slated to run on a temporary basis from July 1 to December 31, 2007. AAD is one step closer to achieving this goal with the introduction on May 24 of S. 1519, "Voluntary Medicare Quality Reporting Act of 2007" sponsored by US Senators Ben Cardin (D-MD) and Arlen Specter (R-PA).

S. 1519 was drafted by the Alliance, which is comprised of 11 national medical societies representing more than 200,000 specialty physicians, including dermatologists. If signed into law, the Cardin-Specter bill will provide much needed relief from the federal government's rushed effort to impose value-based purchasing on the Medicare physician reimbursement system.

The Academy remains actively engaged in the ongoing fight to repeal the flawed SGR formula and replace it with a fairer and more accurate formula for calculating Medicare physician payments.

S. 1519 would stop mandatory PQRI dead in its tracks, ensure that quality reporting and measurement remain voluntary and can be enacted right away because the legislation has no associated costs. The timing is good for this legislation since both chambers are interested in adding Medicare physician measures to legislation now moving through the process that would provide funds to erase a shortfall in monies for the SCHIP program.

Please contact Laura Saul Edwards, Director of Federal Affairs at ledwards@aad.org or 202-712-2602 if you have any questions about S. 1519.

Best regards,



Norma L. Border, Editor

## Medicare Advantage PFFS "Deeming" Issues:

The American Academy of Dermatology (AAD) with the Alliance for Specialty Medicine (ASM) met with senior CMS staff on March 14th to press for direct CMS intervention and resolution of the growing number of participation, claims filing and reimbursement problems physicians are experiencing with the Medicare Advantage — Private Fee For Service Plans (MA-PFFS) being aggressively marketed to beneficiaries around the country. Of primary concern is that when a dermatologist is presented with a MA-PFFS card by a patient and if he/she sees the patient as scheduled without fully researching the MA-PFFS billing and reimbursement, the MA-PFFS "deems" the dermatologist to be a participating provider.

During this meeting and a second follow-up meeting on May 31st, AAD and ASM brought forward examples of the growing administrative difficulties. Of primary concern are the following Medicare Advantage FFS Plan contracting provisions which need to be modified to:

- Enable the physician to determine on a prospective basis, with full terms, conditions and fee schedule information in hand (*not merely be determined to have knowledge of or access to*) whether or not he/she chooses to be either a deemed or non-contracting provider.
- Enable the provider to provide care to the patient without risk of a de facto contract and be able to bill for that encounter as a non-contracting provider.

This tenet of providing sufficient information for a physician to make an informed decision after full disclosure of contract provisions and payment terms has been the basis of the Medicare Participating Provider agreement process each year.

The primary concern is with the current "deeming" methodology for establishing physician participation by these Medicare Advantage — Private Fee For Service Plans. Complaints received from dermatologists focus on the following "deemed participation" issues.

In essence, one or more federally contracted Medicare Advantage Private FFS plan(s) is:

- disadvantaging the beneficiary by misleading them that the plan is **the same as** standard Part B Medicare coverage;
- paying providers at less than the Medicare Fee Schedule amounts;

— continued on page 8

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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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## American Academy of Dermatology and AMA Conducting Physician Practice Information Survey

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For the first time in nearly a decade, the American Academy of Dermatology (AAD), the American Medical Association (AMA), and more than 70 other medical specialty societies, have worked together to coordinate a comprehensive multi-specialty survey of America's physician practices during 2007. The purpose of the survey is to collect up-to-date information on physician practice characteristics in order to posi-

tively influence national decision makers while further developing and refining AMA and AAD policy. Thousands of practices will be surveyed from virtually all physician specialties to ensure accurate and fair representation for all physicians and their patients. The Gallup Organization has been retained to conduct the PPI survey among a representative sample of practices in each of the participating specialties. ■

### Physician Practice Information Survey — Frequently Asked Questions

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#### Why should I participate in this study?

You were randomly selected as part of a statistically-controlled sample to represent thousands of other providers in your specialty and region of the country.

This study represents your practice's opportunity to communicate accurate financial and operational information to policy makers including members of Congress and the Centers for Medicare and Medicaid Services. **Your participation in this study will ensure that the voice and priorities of dermatology are clearly heard.**

#### What type of information is being collected?

The PPI survey is focused on collecting information on:

- practice characteristics,
- provider hours worked,
- number of patient visits, and
- number of procedures performed.

The survey also seeks to quantify common professional expenses associated with medical practice (during 2006), participation in Medicare, and common characteristics of

managed care plans. Finally, current topics of national interest such as medical malpractice coverage and the use of electronic medical records are explored.

#### How long will this survey take?

There are two components associated with the PPI survey; one to be completed by the provider and the other by the practice's manager/administrator. Advance study materials include worksheets to help efficiently organize the information. Once these worksheets are filled in, each component of the survey takes approximately 15 minutes to complete by phone or web.

#### Are my responses confidential?

The Gallup Organization adheres to strict confidentiality guidelines. All information that would permit identification of any participant will be regarded as strictly confidential.

#### Where can I see results of the study?

Results of the final study may be published in *AMANews*, *JAMA*, the *Journal of Health Economics*, and a wide variety of other professional journals. In addition, practices participating in the 2007 PPI survey will receive a special data summary document containing highlights of study results. ■

### CODING Q & A

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**Q. I disagree with the statement in *Derm Coding Consult Spring 2007* that states, "The only thing that changes for the 17000, 17003 and 17005 codes is that these codes are reported for the treatment of actinic keratoses only." Other diagnoses that would be considered are endometrial hyperplasia or leukoplakia.**

A. The information we publish in *Derm Coding Consult* is for our dermatology members. We give them guidance in using the integumentary codes properly.

Destruction of endometrial hyperplasia lesions are most accurately coded with destruction codes found in the Female Genitalia System. It is inaccurate to use codes from other organ systems when a more precise code is available.

Leukoplakia lesion found in the mouth would be appropriately reported with CPT code 40820. However, if the lesion is on the lip, then 17000 could be reported. One would need to check their Carrier's policy on the destruction of premalignant lesions to determine whether codes 702.8 or 528.6 are covered. If not a covered diagnosis, one would need to have the patient sign an ABN.

**Q. When determining the number of diagnoses and/or management options for a patient who presents with multiple AKs located in various locations on the body, should each AK be considered a separate problem thus resulting in a higher level of medical decision making or should the multiple AKs be considered as one problem?**

A. In this scenario, if the patient presents with complaints of multiple AKs, the "Number of Diagnosis/ Management options" would be Extensive, if doctor documented each AK and the reason for removal. "Amount of Complexity" would be minimal to low unless many tests/biopsies or old records were ordered and reviewed. The "Table of Risk" would be Low for a minor surgery without risk and Moderate with risk. However, the intensity of diagnosing lesions should also be considered. Diagnosing multiple AKs would not be the same as diagnosing extensive erythrodermas or generalized bullous diseases.

In the table of Medical Decision Making (MDM), two out of three elements are needed to determine the level

— continued on page p 6

— continued from page 5

of MDM. Since Complexity really doesn't come into play and the amount of AKs removed and documented are somewhere between Multiple and Extensive, the MDM is based on the Table of Risk of low to moderate.

The assumption is that a new patient would require evaluation prior to performing any procedure. Thus an E/M service would be appropriate. However, if only destruction of AKs is performed, there must be a significant, separately identifiable E/M visit documented in order to report the E/M service.

### Medical Decision Making

<b>A Number Dx Management Options</b>	1 Minimal	2 Limited	3 Multiple	4 Extensive
<b>B Amount Complexity</b>	1 Minimal	2 Limited	3 Multiple	4 Extensive
<b>C Highest Risk See Table of Risk</b>	Minimal	Low	Moderate	High
<b>Level Of MDM</b>	Straight-forward	Low	Moderate	High

### Q. One of my payors is requesting Medical Records! What do I do now?

- A. Relax, take a deep breath and follow the guidance below:
- The request requires a response within a limited time frame. Take care of it immediately. Don't let it sit and be forgotten on your desk. If a CMS request is not honored timely, expect a refund request for all those services for which records were requested.
  - Gather all the pertinent documentation information for the date of service requested. This may include more than just the SOAP note.
  - Read the medical record. If there is reference to the patient's history form, medication list, etc., include this information.
  - This is not the time to change or make amendments to the documentation. This should have been done prior to a review. But this is a good time to see where your shortcomings may be and start making changes in your documentation going forward.
  - Make sure that the dermatologist or other clinical staff who provided the service reviews the documentation to confirm that the record is complete.
  - Keep copies of what is sent to the payor.
  - Confirm the insurance's audit results. Conduct your own audit and compare it with their results. Everyone makes mistakes, even insurance companies. If you don't agree, ask for another review with an explanation.
  - Use the results of the payor feedback as well as the internal audit results as an educational tool to improve documentation going forward.

**Note:** The AAD OIG Compliance Manual provides a step by step methodology for setting up an internal

audit/compliance program to identify and decrease billing errors ensuring that medical records are fully documented at the time of the patient visit. This information should not be viewed as legal advice which may also be necessary.

### Q. Does Medicare pay for telephone calls?

- A. Medicare does not reimburse for procedure codes 99371 — 99374, Telephone calls by a physician to a patient. These procedure codes have a "B" status in the Medicare Physician Fee Schedule Relative Value file. The file defines "B" status as follows: "Bundled code. Payments for covered services are always bundled into payment for other services not specified.

The physician cannot collect any amounts for these services from the patient. Providing the patient with an Advanced Beneficiary Notice (ABN) or Notice of Exclusion of Medicare Benefits (NEMB) does not bypass the rules stating the services are not payable or collectable separately. You can access the Medicare Physician Fee Schedule Relative Value File at the following Website: <http://www.cms.hhs.gov/PhysicianFeeSched/PFSRVF/list.asp#TopOfPage>

From this page, choose the appropriate year and quarter. The file requires software to unzip the file.

### Q. May a doctor submit a claim for payment when he or she knows the Medicare contractor will deny the claim? Must a claim be submitted for non-covered or not medically necessary services?

- A. If the doctor provides services that are not covered under Medicare, but the secondary or supplemental insurer requires a Medicare denial in order to cover the services, the original submission of the claim to Medicare is not fraudulent. Use the GY modifier. This tells CMS the service is for a non covered, statutorily excluded service.

**Note:** If the carrier mistakenly pays the claim, the physician must return the amount paid and indicate that the service is not covered.

### Q. Do I need to share my National Provider Identifier (NPI) with other providers?"

- A. The answer is, yes, you are required under the law to share your NPI with other providers who need the number for billing purposes.

### Q. May a dermatology practice as a HIPAA covered entity leave messages for patients at their homes, either on an answering machine or with a family member, to remind them of appointments or to inform them that a prescription is ready?

- A. The Privacy Rule does not prohibit covered entities from communicating with patients regarding their health care. This includes leaving messages for patients on their answering machines. However, covered

— continued on page p 7

## CODING Q & A

— continued from page 6

entities must implement policies to reasonably safeguard the individual's privacy, which would entail limiting the amount of information disclosed on an answering machine to only the necessary information.

### Q. How is CPT Modifier -58 used?

A. CPT Modifier **-58** — Use when the second procedure is related to the original service and is performed within the global period.

AMA CPT and Medicare agree that modifier **-58** — Staged or related procedure or service by the same physician during the postoperative period, should be used when, after a procedure, the patient's condition requires the physician to perform an additional procedure.

CPT 2007 instructs physicians to use modifier **-58** to indicate that the performance of a procedure or serv-

ice during the postoperative period was:

- planned prospectively at the time of the initial procedure;
- more extensive than the initial procedure;
- for therapy following a diagnostic surgical procedure.

To use the **-58** modifier, these pre-planned procedures or services must be documented in the original operative report. It is suggested not to document a specific number of times the procedure will be needed. If more follow-up procedures are needed than anticipated, the original documentation will substantiate the post op work with a **-58** modifier. Although this often applies when the initial procedure has a 90-day global period, modifier **-58** may also be used on procedures that follow initial services with 10 day or even 0-day global periods. The global period will refresh with each time the **-58** modifier is used. ■

## PQRI — Frequently Asked Questions

### Q. How will the PQRI bonus be calculated?

A. The bonus is based on the number of times the physician reports the measures and will not exceed 1.5% of Medicare total allowed charges under the Physician Fee Schedule for the reporting period July 1 — Dec. 31, 2007. The bonus calculation is the number of times a physician reports X 300% X the national average per measure payment amount (Medicare will provide this figure). For example, if a dermatologist reports on 5 Medicare new or past melanoma patients X 3 = 15. Assuming the Medicare determined national average per measure of \$100 for the 2007 6-month period the reimbursement would be \$1,500 (5 patients reported x 3 x \$100). Similarly, if the national average per measure amount is determined to be \$125 the payment for reporting on 6 Medicare patients would be \$2,250.

### Q. How and where should I place the CPT Category II codes on the 1500 claim form for the PQRI program?

A. On the 1500 claim for field 24D necessary data elements or fields include: date and place of service, PQRI data code and modifier P code if applicable, diagnosis, charge (\$0.00 should be entered for PQRI codes), and your NPI. Charge for the E & M service incurred.

### Q. Will there be a co-payment to beneficiaries for PQRI?

A. There is no separate beneficiary co-payment related to PQRI. Beneficiaries will receive the following notice on their Medicare Summary Notice (MSN) "This code is for informational/reporting purposes only. You should not be charged for this code. If there is a charge, you do not have to pay the amount." If patients ask why the participating doctor is performing the measures, the physician may respond that they have chosen to participate in Medicare's quality reporting program for improved patient care.

### Q. Will PQRI measure results be reported to beneficiaries or others?

A. No. Data reported in 2007 will not be publicly reported to Medicare beneficiaries or in any other public forum. CMS will provide confidential feedback reports to participating eligible doctors who choose to report near the time that the lump sum bonus payments will be made in mid-2008.

### Q. Can a Non Par physician participate in PQRI?

A. Both Par and Non Par providers can participate in PQRI and receive the bonus. The PQRI program is not applicable to physicians who "opt-out" of Medicare.

### Q. Are dysplastic nevi included in the PQRI dermatology measures?

A. No. The PQRI measures only apply for patients with melanoma or a history of melanoma, not to dysplastic nevi. The ICD-9 codes for the melanoma measures, including melanoma in situ, are 172.x and V10.82 for personal history of Melanoma.

### Q. Are patients in Medicare Advantage plans included in PQRI?

A. No. PQRI is only for Medicare Fee For Service (FFS) beneficiaries. Medicare Advantage plans and Rural Health Center/Federally Qualified Health Centers are not part of the PQRI program for 2007.

### Q. Will doctors receive feedback on their reporting during the July 1 — December 31 reporting period?

A. CMS will provide feedback reports at or near the time that the lump sum bonus payments are made in mid-2008. Because of the short lead time for PQRI implementation CMS will not be able to provide interim reports.

**Additional Information:** To learn more about PQRI visit the Academy's Web site <http://www.aad.org/professionals/prac-manage> and CMS Web site <http://www.cms.hhs.gov/PQRI> or contact Sandra Peters, AAD, [speters@aad.org](mailto:speters@aad.org). ■

## Medicare Advantage PFFS “Deeming” Issues:

— continued from page 2

- using the federal contract as the basis for deeming a physician to be participating in one or more participation contracts under state law (as a quasi- all products clause);
- placing the burden on the physician practice to research the potential impact of participation and level of payment while the patient is in the waiting room;
- placing the physician at risk of being charged with patient abandonment if he/she refuses to accept the plan and does not see the patient; in addition, to avoid a charge of abandonment the practice has to be prepared to refer the patient to another physician who can see the patient in a timely manner.

Marketing of these plans is such that patients have been told there is no change from their Medicare Part B coverage. The burden is on the dermatology practice to not only verify coverage but also determine fee schedule amounts by calling the 800 number on the card or accessing the MA-PFFS website. Attempts to obtain this information at the time of the scheduled appointment result in practice administrative staff tied up on the phone waiting to ask basic questions or being unable to access the web site information in a timely manner.

In the mean time, the dermatology practice must:

1. make the patient wait until they have confirmation of the coverage and fee schedule, or
2. reschedule the patient until they can confirm new coverage and fee schedule, or
3. treat patient — and become a deemed contractor, not only for the Medicare Advantage — Private FFS plan but also for other Plan products for that insurer, via an undisclosed all products clause.

Acceptance of the PFFS Plan occurs with the treatment of the first patient who presents the plan card. The physician is then deemed to accept not only this patient, but any other plan enrollee as well.

Neither the Medicare Advantage PFFS Plans nor CMS in its Frequently Asked Questions clearly state that reimbursement of deemed providers is made at the **2007 Medicare Physician Fee Schedule per procedure amounts**. All payment descriptors are linked to the undisclosed “terms and conditions” of the Medicare Advantage PFFS plan.

Complaints from AAD members indicate that dermatologists frequently find that the Medicare Advantage PFFS Plan’s fee

schedule is significantly lower than Medicare’s published fee schedule. Physician providers who feel they have not been paid the appropriate amount may appeal.

Most Medicare carriers are paying electronic provider claims within 7-10 days. However, Medicare Advantage PFFS plans frequently take 30 days or longer. Why are Medicare Advantage PFFS plans not being held to the same standards for timely processing and payment of claims as are Medicare Carriers?

For AAD members, the primary concern is that each dermatologist is forced to make a business decision as well as a necessity of medical care decision at the point where the card is presented. The physician must either:

- accept the card, the patient and the consequences; or
- reject or delay treatment of an already scheduled patient, as well as
- make provision for their interim care (via referral to PCP) AND
- have a long standing physician/patient relationship negatively impacted.

Contracting abuses by health insurers (similar to the above complaints regarding Medicare Advantage PFFS plans) are already a focus for both state and federal legislative committee hearings and corrective legislation. ■

### Important Information About Private Fee For Service (PFFS) Plans

CMS has posted on its Web site contact information for most of the major Medicare Advantage PFFS plans to allow physicians easier access to the plans’ terms and conditions. The AMA urged CMS to compile this information in response to physician complaints pertaining to difficulties accessing these plans’ terms and conditions. Visit the CMS Web site for contact information for all PFFS plans: <http://www.cms.hhs.gov/privatefeeforserviceplans/>



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