

# DERM CODING CONSULT

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## 2008 Medicare Physician Fee Schedule: Final Rule

CMS published the 2008 Medicare Physician Fee Schedule (MFS) on Nov. 27, 2007. This is the sixth year that dermatologists along with other specialties will be negatively impacted by the -12% Budget Neutrality Adjustment as well as continued use of -11% Five-Year Review Physician Work Adjuster. CMS chose to ignore AAD as well as AMA comment that applying a budget neutrality adjustment to the physician work RVUs to offset the RVU increases for the E/M codes and other services is a step backward. As a result of the above adjustments, the Medicare Conversion Factor (CF) for 2008 is set at \$34.0682, a drop of \$3.83/RVU from the 2007 Conversion Factor of \$37.8975. The main factor in the reduction is the flawed Sustainable Growth Rate (SGR) formula, causing a -10.1 % reduction to the conversion factor.

In addition to the flawed SGR formula-caused reduction, last year's Tax Relief and Health Care Act (that staved off the 2007 MFS cut) used what amounts to a Congressional accounting gimmick (not fully funded) that potentially doubles the MFS cut for 2008. The Academy and the physician community are vigorously advocating for a repeal of the SGR and at least a 2 year fully-funded positive update for the Medicare Fee Schedule. But, time is running out on the 2007 Congressional calendar.

There is consensus on Capitol Hill that physicians cannot receive a -10.1 reduction in payment. Some Members of Congress agree that a two-year positive update is needed. However, others are looking at another one-year freeze. Both legislative options are considered "pricey" and any legislation would be under the current federal budget "PAY as you GO" rules.

The Medicare Modernization Act set the floor for all Geographic Practice Cost Indicators (GPCI) in 2005 at 1.00, providing more fee schedule parity in rural areas. However, this provision will expire on Jan. 1, 2008. Dermatologists practicing in rural areas will see additional reductions to the total Medicare fee schedule amount for each service they provide.

The total impact on dermatology is somewhat mitigated by the continued CMS transition to a new practice expense methodology that incorporates the AAD Practice Expense Supplemental Survey (PESS) data submitted to CMS in

— continued on page 8

## Changes to Self-Referral Rules Relating to Diagnostic Tests

Effective January 1, 2008, the Centers for Medicare and Medicaid Services (CMS) has imposed new provisions on how Medicare will pay for diagnostic test services. These anti-markup restrictions would prohibit the markup of a technical component (TC) and professional component (PC) [modifier 26] and would apply when the diagnostic service is purchased from an outside supplier, or performed at a site other than "the office of the billing physician or supplier."

Medicare regulations currently prohibit the markup of the TC of certain diagnostic tests that are performed by outside suppliers and billed to Medicare by a different individual or entity. In addition, Medicare program instructions restrict who may bill for the PC (the interpretation) of diagnostic test. With this revision, CMS has expanded the anti-markup rule to cover both the PC and the TC of diagnostic test services provided by the physician or group when they are performed outside the billing physician's office.

The provisions apply to the TC and PC when diagnostic test services are purchased or performed outside the billing physician's office the practice could bill only for the lesser of:

- 1) the [performing] supplier's net charge to the billing physician or group practice;
- 2) the physician or group practice's actual charge; or

— continued on page 7

### 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 publication of the 2008 Medicare Fee Schedule: Final Rule. It provides the regulatory and legislative 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 again reduce the Medicare Conversion Factor by -10.1% for services on or after Jan. 1, 2008, unless for the sixth time in a row there is a last minute Congressional fix.

MedPAC estimates that Medicare 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!

The Academy with the AMA and all other specialty societies are working vigorously to avert implementation of the 2008 fee schedule. Please help by going to the Dermatology Advocacy Network web site at: <http://www.capitolconnect.org/aad/> and informing your Congressional representative(s) of the impact this reduction in Medicare payment will have on your dermatology practice!

Please check the AAD web site for additional information on how the new CMS changes to the Self-Referral Rules may impact your pathology or lab test billing to Medicare.

The Health Policy & Practice/Coding & Reimbursement staff: Vernell St. John, Peggy Eiden and Faith McNicholas, join me in wishing all the peace and joy of this Holiday Season to you and to your families!

Best regards,



Norma L. Border, Editor



## Coding Update

### Integumentary Codes

The changes in CPT 2008 in the Integumentary system are minimal. There are no new codes within the integumentary system this year.

Clarifying introductory language for the excision codes, both benign and malignant, has been added. This new language clarifies that adjacent tissue transfer codes (14000-14350) includes the excision of lesions. Thus, excision of a lesion is not billable when that excision site is closed with an adjacent tissue transfer. This is not a change in reporting, but just a clarification for all providers and coders. Likewise, the introductory language in the adjacent tissue transfer codes has been revised to indicate the same clarification.

A revised code symbol (▲ precedes code 17110. There has been only an editorial change to that code with the addition of the word "proliferative". When the destruction codes were changed in 2007, the word proliferative was inadvertently omitted from the 17110 descriptor. The addition makes the full descriptor read:

- ▲ **17110** Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettment), of benign lesions other than skin tags or cutaneous vascular proliferative lesions.

### Evaluation and Management Services

The revised code symbol (▲ is noted in codes for initial and subsequently nursing facility care (99304-99310). The code descriptors have not been revised, however typical times are now listed as established through the RUC process. Previously there has been no typical time indicated for any of these codes.

### CPT Modifiers

Although there are indicators that there are changes to modifiers **-22, -25, -32, -51, -58, -59, -76, and -78**, on examination one will discover that the intent of each of these modifiers has not changed. In the AMA CPT effort to acknowledge all providers, the language for these modifiers has been revised to eliminate the word "physician" in the explanatory text and replace it with the phrase "It may be

— 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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## Inappropriate Billing of Dermatology Services

Which procedures are covered and which are not is a frequent source of consternation for physicians, frustration for patients and aggravation for billing and reception staff. The Coding and Reimbursement Task Force of the AADA as well as the AAD are committed to providing guidelines that are consistent with the highest ethical standards. The following information is provided in an effort to clarify some potential coverage issues. Information regarding coverage is provided as an effort to assist with patients who may present to the office saying, "My other dermatologist bills Medicare for this" or "If you do not do this, I will go to someone that will bill my insurance". A discussion of the implications of billing for non-covered procedures is also provided.

Coverage and non coverage vary with each insurance carrier and with Medicare and Medicaid. While each has their own guidelines, there are some themes that are consistent throughout. For instance, it would not be reasonable to bill any carrier for a cosmetic procedure such as injections of botulinum toxin or hyaluronic acid when their indication is aesthetic enhancement. Other cosmetic issues are treated in a similar manner by most carriers - if the patient is getting a procedure performed to look better, the carrier should not be billed for the service. This does not mean that you cannot get the carrier to pay by using codes that are covered but if you do this, you may be engaging in fraud and/or inducement.

### Cosmetic vs. Covered

In many instances, coverage or non coverage depends on a few simple rules. When a patient is asked why he or she wants something done and the answer is "it is ugly" the definition of the procedure is cosmetic. When the chief complaint is as presented in the vignettes of the CPT book, the patient presents with a complaint that a seborrheic keratosis is painful because the strap from a bra is rubbing it, the procedure is medically indicated. For most situations, common sense will provide the answers to whether or not a procedure is covered.

For example, the shave removal of a benign raised mole on the tip of the nose or forehead to improve appearance should be considered a non-covered service, compared to the shave removal of a similar mole on a man's cheek that is being cut shaving, an accepted medical necessity.

Dermatologists are encouraged to become comfortable candidly explaining to patients that certain services are just not covered. "You should not expect your health insurance to cover removal of your innocent asymptomatic moles, any more than your automobile collision insurance should pay for a tune-up on your car."

As alluded to above, the treatment of some seborrheic keratoses has been and remains a continuing source of problems for patients, physicians, CMS and carriers. If the claims are submitted inappropriately, patients come to expect that they will not have to pay for the procedure.

Of course, waiver forms should be used to document the patient's acceptance of financial responsibility for such non-covered or "cosmetic" services. CMS has such a form called Notice of Exclusion of Medicare Benefits (NEMB). This form may be accessed at the following Web site:

<http://www.cms.hhs.gov/BNI/Downloads/CMS20007English.pdf>

Skin tag removal is another area of confusion. However, CMS policy in this instance follows its logic for seborrheic keratoses- if they are infarcted, painful or bleeding, they should be covered. If they simply don't look good, they are not covered. A claim for the removal procedure may be submitted to Medicare and Medicare may pay for their removal but this does not mean that Medicare medical necessity policy was followed. Commercial carriers will vary with their coverage policies and physicians should be informed as to the particular coverage for the appropriate codes with each patient. If there is any question, it may be wise to obtain a waiver. However, submitting a claim for not medically necessary services as if they were medically necessary is fraudulent.

### Laser Destructions

The use of the laser destruction codes (17106-17108) was discussed in the Derm Coding Consult - Winter 2004 issue. This excellent article discusses when Medicare may cover the use of lasers as medically necessary. The most frequent question raised by physicians is whether Medicare will cover the use of lasers for the treatment of rosacea. Some practitioners have mistakenly billed their Medicare carrier for treatments with pulse dye or other lasers using the 17106 code and the diagnosis of rosacea as well as telangiectasis and cherry angiomas. According to CPT and the Derm Coding Consult article, this is not consistent with CPT guidelines and its utilization for this purpose may be considered to be fraud. CPT codes 17106-17108 are to be used only for the destruction of vascular cutaneous proliferative lesions.

### Skin Screening/Routine Examinations

What about coverage for skin cancer screenings? All dermatologists agree that this service is vital to patients and there is a lot of data to suggest that it is cost effective for carriers. However, Medicare explicitly states that routine preventive screening examinations are not covered. As with seborrheic keratoses, there are specific conditions that specify the coverage of medically necessity lesions. In addition, although CMS guidelines are clear on this issue of preventive screenings, policies of individual carriers are varied and diverse.

Screening patients should be submitted to Medicare or private carriers with the appropriate screening codes and waivers should be obtained while patients that want specific lesions or conditions evaluated should have claims submitted using the appropriate codes for the office visit and likely diagnosis. Attempts to get routine screening examinations paid for by using another code will get the visit paid and avoid any confrontations with patients but in many instances is fraudulent billing. However, a skin screening for a patient with a history of a malignant lesion, such as a basal cell carcinoma, squamous cell carcinoma, or malignant melanoma would be justified and not simply a preventive screening. The use of the appropriate V10.8x code as a diagnosis would identify the skin screening as a medically necessary service.

— continued on page 7

## 2008 New PQRI Quality Measures

CMS has introduced two structural measurement codes that can be used by all physicians:

- 1) Adoption/use of Health Information Technology (Electronic Health Records-HER); and
- 2) Adoption/Use of e-Prescribing.

These PQRI measures will be available Jan. 1, 2008 for all physicians that have an EHR and are e-prescribing. These measures can be reviewed in their entirety on the Academy's Website.

### Adoption/Use of Health Information Technology (Electronic Health Record)

This measure documents whether provider has adopted and is using health information technology. To qualify, the provider must have adopted a qualified electronic medical record (EMR). For the purpose of this measure, a qualified EMR can either be a Certified Commission for Healthcare Information Technology (CCHIT) certified EMR or, if not CCHIT certified, the system must be capable of all of the following: generating a medication list, generating a problem list, and entering laboratory tests as discrete searchable data elements.

This measure is to be reported at each visit occurring during the reporting period for patients seen during the reporting period. There are no diagnoses codes associated with this measure.

Numerator: G8447: Patient encounter was documented using a CCHIT certified EMR OR G8448 patient encounter was documented using a non-CCHIT certified EMR.

Denominator: All patients aged 18 years and older.

A CPT E/M code is required to identify patients for inclusion: 99201-99205, 99211-99215, 99241-99245.

### HIT-Adoption/Use of e-Prescribing

Documents whether provider has adopted a qualified e-Prescribing system and the extent of use in the ambulatory setting. To qualify this system must be capable of ALL of the following: generating a complete active medication list incorporating electronic data received from applicable pharmacy drug plan(s) if available, selecting medications, printing prescriptions, electronically transmitting prescriptions, and conducting all safety checks, providing informa-

tion related to the availability of lower cost, therapeutically appropriate alternatives (if any), providing information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient's drug plan.

This measure is to be reported at each visit occurring during the reporting period for patients seen during the reporting period. There are no diagnoses codes associated with this measure. The measure is reported using G, CPT E/M and HCPCS codes.

Numerator: G8443 all prescriptions created during the encounter were generated using a qualified e-Prescribing system OR qualified e-Prescribing system available, prescription(s) not generated or not generated via qualified e-Prescribing system for system/patient reasons, G8445 no prescriptions were generated during the encounter. Provider does have access to a qualified e-Prescribing system OR G8446 some or all prescriptions generated during the encounter were handwritten or phoned in due to one of the following: required by state law, patient request, or qualified e-Prescribing system being temporarily inoperable.

Denominator: All patients aged 18 years and older; 99201-99205, 99211-99215, 99241-99245, G0101, G0108, G0109.

The Academy's Web site will continue to offer information on PQRI quality measures. Additional articles about the 2008 measures will be featured in upcoming issues of *Dermatology World*. ■

## Coding Update

— continued from page 2

necessary to". This change however did not take into consideration that the descriptors of many of these modifiers still include the word "physician". It appears that the CPT Editorial Panel will need to revisit the modifier language in the future.

Even though there are few changes in the integumentary system section of CPT, there are a few additional changes to the skin replacement and wound care codes as well as to the immunization and vaccine codes. New code books should be purchased annually. There may be revisions to other codes in other sections of the CPT book that you use on occasion. Without current coding books, you and your dermatology practice run the risk of submitting claims with improper codes. ■

### 2007 PQRI Claims Filing Deadline

The 2007 Physicians Quality Reporting Initiative (PQRI) for the three dermatology specific melanoma measures will end on December 31, 2007. Dermatologists will have until February 29, 2008 to submit 2007 claims with 2007 dates of service for reporting against these measures in order to qualify for the 2007 PQRI Bonus payment.

Additional Information: To learn more about PQRI visit the Academy's Web site <http://www.aad.org/professionals/pracmanage> and CMS Web site <http://www.cms.hhs.gov/PQRI>.

### 2008 AAD Coding & Documentation Manual

The 2008 AADA Coding & Documentation Manual is the comprehensive, easy to use resource dermatologists and their billing staff should have to meet all AMA CPT, HCPCS and ICD-9-CM coding and E/M documentation requirements. Order yours now online at <http://www.aad.org/professionals/Marketplace/>, or order it through the AAD Member Resource Center at 1 866 503 7546.

## Inappropriate Billing of Dermatology Services

— continued from page 5

frontations with patients but in many instances is fraudulent billing. However, a skin screening for a patient with a history of a malignant lesion, such as a basal cell carcinoma, squamous cell carcinoma, or malignant melanoma would be justified and not simply a preventive screening. The use of the appropriate V10.8x code as a diagnosis would identify the skin screening as a medically necessary service.

CMS Manual 100-04, Chapter 12, 30.6.2 covers the directives for billing of a medically necessary visit occurring during the same encounter as a preventive medicine service. How to bill for each component of the encounter is clearly described in this directive. The CMS Manuals may be accessed at: <http://www.cms.hhs.gov/Manuals/>.

### Mohs Micrographic Surgery

Mohs surgery deserves special comment. There are clear published guidelines regarding what lesions and body sites are candidates for Mohs surgery. A valid indication for Mohs should exist and should be clearly noted in the medical record. The abusive use of Mohs surgery for lesions that are small, well-defined, not frankly invasive, and not on body areas where the preservation of normal tissue is of a high priority, is a concern for all dermatologic surgeons and should be avoided. See *Derm Coding Consult - Winter 2006* for more information on Mohs surgery as well as your own Medicare Carrier's policy and guidelines.

## Changes to Self-Referral Rules Relating to Diagnostic Tests

— continued from page 1

3) the fee schedule amount for the test that would have been paid if the supplier had billed Medicare directly.

Physicians are permitted to determine where the TC and PC are performed, provided that the arrangement is in compliance with the purchased test rules and physician self-referral rules. CMS also notes that the anti-markup rules do not apply to independent labs that have not ordered the TC. According to CMS, these revised requirements are designed to address potential program abuse where physicians and other suppliers, order tests and bill CMS for the same tests that they did not perform at a markup.

The final rule prohibits the markup of the TC and PC of diagnostic tests in order to prevent physicians, physician group practices, and medical groups from profiting through such practices. CMS has expressed concerns that allowing physicians, group practices, or other suppliers to purchase or otherwise contract for the provision of diagnostic testing services and to then realize a profit by applying markups when billing Medicare may lead to program and patient abuse in the form of overutilization of services, resulting in higher costs to the Medicare program.

The final provisions were designed by CMS to reduce overutilization of diagnostic tests, so that tests are ordered because they are medically necessary and not because a profit can be made on the test. Practices can maintain relationships with other professionals on a part-time or contrac-

### Consequences of Inappropriate Billing

When a person knowingly submits a claim that he/she should know is not a covered service, civil sanctions may be imposed per claim submitted. An assessment of up to three times the amount of the improper claim will be in addition to the civil sanction which may be as much as \$10,000 per claim.

If a person is determined to have knowingly and willingly defrauded Medicare, Medicaid or any other federal health care benefits program, a criminal penalty may be imposed. The penalty may include imprisonment plus a fine of up to \$250,000 per claim as well as exclusion from the Medicare/Medicaid program for five or more years.

Having a Compliance Plan in place can be beneficial in a sanction situation. Without such a plan, damages may be as much as tripled. It is important to keep the Compliance Plan up to date. The AAD *OIG Compliance Manual: A Guide for Dermatology Practices* can help design and maintain such a plan within the practice.

It is hoped that by providing this information to the membership, the AADA can educate physicians and patients alike to these potential problems in coverage and the misuse of reporting not medically necessary services to a payer. ■

tual basis. If the services are furnished in the office of the billing supplier, the anti-markup rules will not apply, unless the services of an independent contractor are billed as a purchased test.

The anti-markup provisions do not apply to non-purchased TCs and PCs performed in the office of the billing physician or other supplier. However, the anti-markup provisions apply irrespective of whether:

- 1) the billing entity outright purchases the TC or the PC; or
- 2) the physician or other supplier performing the TC or PC reassigns his or her right to bill the Medicare program to the billing entity (unless the performing supplier is a full-time employee of the billing entity).

See the examples of when the Anti-Markup Provisions provisions do or do not apply on the AAD website:

### When does the new CMS rules apply ...

- **Example 1:** A dermatology group practice contracts with a leasing company that supplies a technician and a pathologist to perform testing on samples. The technician performs the tissue sampling and the pathologist reads the slides. All work that is done outside the office of the billing group practice, is instead performed in a space that is rented exclusively "24/7" by the group practice (thus meeting the definition of a "centralized build-

## Medicare Access 2008

If you don't have access to the internet in your office, you are at risk of not knowing your Medicare Carrier's current rules and regulations. Carriers publish information that is pertinent to providers on their Web sites. The latest fee schedule information for 2008 will be placed on the Carrier Web site as soon as it is released by CMS. Carriers also publish newsletters regularly which contain valuable information for providers. Without internet access you do not have the most up to date information regarding Medicare claims and are at risk for submitting false or even fraudulent claims.

## Enrollment Changes

Remember to check Medicare beneficiaries' enrollment cards to determine if they have traditional Medicare card or are now enrolled in a Medicare Advantage (MA) plan. A Medicare Advantage Plan member will not have a standard Medicare card. Instead, the card will have an insurer ID card, such as Blue Cross/Blue Shield, Aetna, Humana, or Cigna logos will be visible on the ID card. The address on the back of the card is where the claim should be mailed. Every carrier (Aetna, Humana, Cigna) has their own type of MA plan ID Card. Look for the MA notation as well as where to send the claim to identify the beneficiary's MA plan. ■

## Changes to Self-Referral Rules Relating to Diagnostic Tests

— continued from page 7

**Because the centralized building does not qualify as “the office of the billing physician or other supplier,” the anti-markup provisions apply to both the TC and the PC, and the group may bill Medicare the lowest of the either: (1) the leasing company's net charge to the group; (2) the group's actual charge; or (3) the fee schedule amounts for the TC and interpretation that would be allowed if the leasing company were enrolled in and billed Medicare directly.**

### Key point

- o *Leasing space away from the billing practice is not an exemption from the anti-markup provisions.*
- **Example 2:** Same as Example 1, except that the TC and PC are performed by a technician who is employed by the billing practice and an independent contracting pathologist of the billing practice, respectively. Here, the anti-markup provisions will apply to both the TC and the PC because the work was not done in the “office of the billing physician or other supplier” (the office of the group practice). It does not matter that the technician is an employee and the pathologist is an independent contractor because the work was not performed in the office of the billing group practice.

### Key point

- o *Though part work was performed by a technician who is an employee of the billing practice, and the PC by a contracted pathologist at an off-site location does not qualify as an exemption to the anti-markup requirements.*
- **Example 3:** Same as Example 5, except that the independent contractor physician performs the PC in his or her home and reassigns his or her reimbursement of benefits to the group. The group's billing of the TC is not subject to the anti-markup provision, but the group's billing of the PC is subject to the anti-markup provision because the work was not performed in the office of the billing supplier.

### Key point

- o *Outsourcing the PC to an independent contracting physician who perform the work off-site is subject to anti-markup requirement.*
- **Example 4:** A group practice purchases both a diagnostic test and its interpretation from a laboratory and bills the TC and

PC to Medicare. The anti-markup provisions apply to both the TC and the PC. Because the TC and the PC were purchased, the location(s) at which the TC and the PC were performed does not matter.

### Key point

- o *Purchase of both the TC and PC from a laboratory by a billing practice when the test is performed offsite, is subject to the anti-markup requirement.*

## When the new CMS rules do not apply...

- **Example 5:** A physician in a group practice orders a diagnostic test and a technician who is a part-time employee of the group performs the test in the group's office. A physician who is an independent contractor of the group performs the PC in the group's office and reassigns his or her right to payment to the group. The anti-markup provisions do not apply to the group's billing of the TC or the PC.

### Key point

- o *An independent contracting physician performing the PC on-site can reassign his or her right to payment to the billing practice and still be exempt from the anti-markup requirement.*
- **Example 6:** A group practice orders a diagnostic test from an independent laboratory. The laboratory performs the test and contracts with a physician to perform the PC. The laboratory bills Medicare for both the TC and the PC. The laboratory is not subject to the anti-markup provision for the PC, because the laboratory did not order the test.

### Key point

- o *If the off-site laboratory contracts with the billing practice ordering the PC, the laboratory is exempt from the anti-markup provision.*
- **Example 7:** Same as Example 6, except that a physician orders a diagnostic test from an independent diagnostic testing facility (IDTF). The IDTF bills Medicare for both the TC and the PC of the test. The anti-markup provisions do not apply because the IDTF did not order the test.

### Key point

- o *The lab that performed the test off-site on orders from the billing practice, then bills Medicare for both TC and PC is exempt from the anti-markup provision.*

## CODING Q & A

### Q. Which Mohs code is appropriate when done on the dorsal surface of wrist?

A. One has to clarify what "wrist" means in order to answer the question. If the lesion was proximal to the tips of the radius and ulna bones of the forearm, then it is an "arm", and it should be coded as 17313. If the lesion was distal to the tips of the above bones, then it is the "hand", and it's coded as 17311.

### Q. Do we bill blood work at 99211 for a nurse visit if we then send it out to be processed? Are there any restrictions or guidelines for this such as global period?

A. If the patient was only scheduled to have blood drawn then only the draw 36415, collection of venous blood by venipuncture can be reported. Every procedure has a certain amount of ancillary staff pre work.

### Q. When following the 1997 CMS guidelines for skin examination, one of the constitution bullet points includes vital, signs, blood pressure, pulse rate. How does dermatology fit in this category as these are not normally things that we evaluate a patient for. We think this is more for internal medicine not dermatology.

A. Dermatologists' offices don't usually perform vitals on a regular basis; may be one but not three out of the seven. Perhaps including a phrase regarding the patient's constitutional general appearance (In/no apparent distress) will count toward that bullet. It is only when a comprehensive exam is done that all the items within a bullet need to be documented to meet this level of service.

### Q. On the Advance Beneficiary Notice (ABN) form, is the completion of the estimated cost field required?

A. Although CMS doesn't mandate completion of the estimated cost field, it is in the best interest of the provider and the beneficiary to know the approximate costs. This enables the beneficiary to make an informed decision on whether or not to receive the service at their own expense if Medicare denies the charges.

## Billing for Beneficiaries with Dual MEDICARE/MEDICAID Coverage

### Q. Our office provides services to patients with dual Medicare and Medicaid coverage. We are only signed up to accept assignments from Medicare and do not intend to bill Medicaid? Can we bill Medicare only and bill the balance to the patient?

A. It is inappropriate to bill the patient for the services until both Medicare and Medicaid have processed the claim. Once Medicare has processed the claim, the balance if not automatically submitted or crossed over to Medicaid by Medicare, must be submitted by the provider to Medicaid with the Medicare payment information.

When Medicaid has processed the claim, the balance that is patient responsibility per Medicaid may be billed to the patient. If Medicaid indicates that Medicare has paid more than Medicaid allows, the balance is provider obligation and not patient responsibility. In this case the account would be adjusted to indicate a zero balance and the patient would not be billed.

For additional information visit the CMS websites at: [www.cms.hhs.gov/medicaideligibility/](http://www.cms.hhs.gov/medicaideligibility/) or <http://www.cms.hhs.gov/manuals/downloads/ge101c01.pdf>

## Extending Locum Tenens

### Q. After the 60-day period, can the locum tenens physician take a day off and the 60-day period begin again?

A: If the regular physician requires the services of a locum tenens physician for a period longer than 60 days, then the substitute physician needs to enroll with the group. Otherwise the substitute physician taking a day off is not a consideration in the guidelines for locum tenens for establishing the 60-day period.

CMS guidelines state that a regular physician may bill for the services of a locum tenens physician provided the following guidelines are met:

1. The regular physician is unable to provide visit services
2. The Medicare beneficiary has arranged for or seeks to receive services from the regular physician
3. The regular physician pays the locum tenens for services on a per diem or similar fee-for-time basis
4. The substitute physician does not provide services over a continuous period longer than 60 days
5. The Q6 modifier should be submitted on the claim ■

## Medicare Access 2008

If you don't have access to the internet in your office, you are at risk of not knowing your Medicare Carrier's current rules and regulations. Carriers publish information that is pertinent to providers on their Web sites. The latest fee schedule information for 2008 will be placed on the Carrier Web site as soon as it is released by CMS. Carriers also publish newsletters regularly which contain valuable information for providers. Without internet access you do not have the most up to date information regarding Medicare claims and are at risk for submitting false or even fraudulent claims.

### 2008 Part B Deductible

The beneficiary's deductible for calendar year 2008 is \$135.00. As you begin seeing patients in 2008, your office staff will need to be reminded to collect the appropriate co-

pay as well as any applicable deductible. Collections done at the time of the patient visit will certainly alleviate any unnecessary billing.

### Enrollment Changes

Remember to check Medicare beneficiaries' enrollment cards to determine if they have traditional Medicare card or are now enrolled in a Medicare Advantage (MA) plan. A Medicare Advantage Plan member will not have a standard Medicare card. Instead, the card will have an insurer ID card, such as Blue Cross/Blue Shield, Aetna, Humana, or Cigna logos will be visible on the ID card. The address on the back of the card is where the claim should be mailed. Every carrier (Aetna, Humana, Cigna) has their own type of MA plan ID Card. Look for the MA notation as well as where to send the claim to identify the beneficiary's MA plan. ■

## National Provider Identifier (NPI) Required on all Part B Claims

Effective March 1, 2008, all Medicare fee-for-service claims must include an NPI in the primary provider fields on the claim (i.e., the billing, pay-to provider and rendering provider fields). You may continue to submit NPI/legacy pairs in these fields or submit only your NPI. The secondary provider fields (i.e., referring, ordering and supervising) may continue to include only your legacy number, if you choose. Failure to submit an NPI in the primary provider fields will result in your claim being rejected, beginning March 1, 2008.

### Test NPI Only Use

If you already bill using the NPI/legacy pair in the primary provider fields and your claims are processing correctly, now is a good time to submit a small number of claims containing only the NPI in the primary provider fields to your Medicare carrier or Medicare Administrative Contractor (MAC). This test will serve to assure your claims will successfully process when only the NPI is mandated on all claims.

### Q: How is the National Provider Identifier (NPI) number reported on the claim differently when billing as an individual versus billing as part of a group?

A. Billing with individual and group NPIs is very similar to billing with Provider Identification Numbers (PINs) and group numbers. However, there are distinct differences depending on how you submit claims to Medicare, whether electronic or paper. Please refer to the chart below for instructions on submitting NPIs as either an individual or as part of a group on your claims to Medicare:

Type of Claim	Submission Method	NPI Billing Instructions
Individual/ Solo Practice	Paper	Individual NPI is placed in Item 33a of the CMS-1500 (08/05).
Individual/ Solo Practice	Electronic	The individual NPI number should be submitted in the billing provider loop (2010AA, NM109 with an XX qualifier in the NM108 element).
Group	Paper	Individual NPI is placed in the lower portion of Item 24J and group NPI is placed in Item 33a of the CMS-1500 (08/05).
Group	Electronic	The group NPI number should be submitted in the billing provider loop (2010AA, NM109 with an XX qualifier in the NM108 element) and the individual NPI number should be submitted in the rendering provider loop (2310B, NM109 with an XX qualifier in the NM108 element).

## Aetna Revises Repair Payment policy

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Aetna recently informed the Academy that it will update its payment policy governing reimbursement of repairs on benign lesions. This policy update is expected to provide for fairer and more appropriate reimbursement of repairs. According to Aetna this repair coverage policy change takes effect after November 10, 2007 and will be automated in Aetna claims processing systems allowing claims to be paid automatically without review. Any claim initially denied by the automated claim system, may be appealed.

Aetna's directive instructs its appeals reviewers to allow payment of appropriate repair codes when billed with excisions of benign lesions for claims processed after 05/16/2007, with automated payment for these codes to be effective after their 11/10/07 system upgrade. Aetna is advising that there will be a 180 days retrospective review period. This look-back period will be for claims processed after 5/16/07. This also means that there will be no clinical documentation criteria that will be required for approval on appeal and that claims processed as early as 12/16/06 will be eligible for payment as part of the retro application of this policy. However, Aetna will continue their policy of not reimbursing for lesion repairs for benign excisions of 1 cm or less.

This change in policy is the result of intensive efforts by the Academy to educate key Aetna Medical Directors regarding the level of effort required for an intermediate or complex repair and that it frequently requires more work than the

excision to remove the benign or malignant lesion. This difference in the physician work for repairs is reflected in the work RVUs assigned by the AMA RUC and used to calculate Medicare payment.

As a major health care payer, the Aetna Medical Directors' chief concerns can be summarized as follows:

- **LACK OF CLEAR AMA CPT DEFINITIONS**—while the 2006 CPT Assistant article on repairs was meant to define and clarify intermediate and complex repairs, Aetna is concerned that clearer guidance is still needed to help claims review and adjudication.
- **POOR RECORD KEEPING**—Aetna reported that they receive poor documentation on repairs in operative reports from dermatologists, plastic surgeons, and other surgical specialists when reviewing documentation supporting claims for intermediate repairs. According to Aetna, claims involving small benign lesions seem to involve unnecessary repair levels. For malignant lesions, they require that documentation of the closure methodology must appear in the operative report.

The Academy representatives expressed their commitment to continue to educate dermatologists on coding and documentation conventions via the AAD quarterly *Derm Coding Consult* newsletter as well as in the AAD courses and workshops on Coding & Documentation. ■

## CMS Beneficiary Notices Initiative

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Both Medicare beneficiaries and providers have certain rights and protections related to financial liability under the Fee-for-Service (FFS) Medicare and the Medicare Advantage (MA) Programs. These financial liability and appeal rights and protections are communicated to beneficiaries through notices given by providers.

The Advance Beneficiary Notice - General Use (ABN-G) should be used by providers, physicians, practitioners, and suppliers for any situation where Medicare payment is expected to be denied including laboratory tests. The Advance Beneficiary Notice - Laboratory Use (ABN-L) is specifically for use when only laboratory services are being delivered.

### ABN Modifiers

Claims submitted to Medicare should include appropriate ABN modifiers when there is a reasonable probability that Medicare will not pay for the specific service.

- Modifier GZ is used to indicate that Medicare is expected to deny the item or service as not reasonable and necessary and the provider does not have an advance beneficiary notification (ABN) signed by the beneficiary.
- Modifier GA is used to indicate that Medicare is expected to deny the service as not reasonable and necessary and the provider does have an ABN signed by the beneficiary.
- Modifier GY is used to indicate that an Item or service is statutorily excluded or does not meet the definition of any Medicare benefit

For any claim that does not meet the medical necessity requirement of a local coverage determination (LCD), append modifier GA or GZ to the billed service. More information on appropriate ABN and related modifier use is available at: [http://www.cms.hhs.gov/BNI/01\\_overview.asp](http://www.cms.hhs.gov/BNI/01_overview.asp) ■

## **Dermatology Lowest in Medicare Denials**

The latest data from the Medicare Part B Extract Summary System (BESS) Carrier Data File (2005) reflects that Dermatology ranked number one with the lowest overall Medicare Part B Claims denial rate at 4.36% of total submitted claims volume. This speaks well for the care and accuracy of claims data submitted by dermatology practices to Medicare.

Ranked 2nd thru 5th lowest denial rates were Rheumatology at 5.36%, Cardiology at 6.08%, Geriatric Medicine at 6.40% and Gastroenterology at 6.48%. The medical specialties with top five highest denial rates were: General Practice at 50.82%, Obstetrics/Gynecology at 46.89%, Multi-Specialty Practices at 45.15%, Emergency Medicine at 30.86% and General Surgery at 30.4%. ■

### **AAD OIG Compliance Manual: A Guide for Dermatology Practices**

The manual provides dermatologists with full instructions for implementing the voluntary Department of Health and Human Services (DHHS) Office Of Inspector General (OIG) "Compliance Program for the Individual and Small Group Practice". This is a "how to do it" product is designed to ensure that the dermatology practice is in compliance with Medicare and Medicaid claims filing requirements. Order it on-line at <http://www.aad.org/professionals/Marketplace/>

Or Order it thru the AAD Member Resource Center at 1 866 503 7546

## **Reprieve on Tamper Resistant Prescription Pads**

On September 29, 2007, President Bush signed the "Transitional Medical Assistance, Abstinence Education, and QI Programs Extension Act of 2007," delaying the implementation date from October 1, 2007 to April 1, 2008 for all non-electronic Medicaid prescriptions to be written on tamper-resistant paper.

CMS will implement the tamper-resistant prescription law in two phases. For the first phase, by April 1, 2008 a paper prescription form for a Medicaid patient must contain at least one of three tamper-resistant characteristics in order to be considered "tamper resistant." For the second, by October 1, 2008, these prescription forms must contain all three tamper resistant characteristics. CMS will issue additional guidance on this implementation delay as it becomes available.

Initial guidance that CMS has issued on this requirement was issued in a letter to the State Medicaid Directors located at the following web site: <http://www.cms.hhs.gov/SMDL/downloads/SMD081707.pdf>

Additional information will be posted at: <http://www.cms.hhs.gov/> ■

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## **DERM CODING CONSULT**

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