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Derm Coding Consult

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CMS Contract Changes Impact Local Coverage Determinations (LCDs)

The Centers for Medicare and Medicaid Services (CMS) is in process of shifting from state-based Medicare Part B Carriers to Medicare Administrative Contractors (MAC) that will be in charge of processing both Medicare Part A and Medicare Part B claims. Between 2005 and 2009, CMS will replace the Medicare Carriers that currently perform claims processing functions with new A/B MACs that will perform many of the same tasks, but will do so more efficiently. Central to the implementation of the contracting reform is the creation of new jurisdictions to be administered by the MACs. Detailed information on these contracting changes is available on the following CMS web site: *http://www.cms.hhs.gov/MedicareContractingReform/*

During the initial implementation phase (2005-2009), CMS plans to complete and award contracts for 15 A/B MACs servicing the majority of all types of providers (both Part A and Part B). CMS designed the new MAC jurisdictions to balance the allocation of workloads, promote competition, account for integration of claims processing activities, and mitigate the risk to the Medicare program during the transition to the new contractors. The new jurisdictions reasonably balance the number of fee-for-service beneficiaries and providers. These jurisdictions will be substantially more alike in size than the existing fiscal intermediary and carrier jurisdictions, and they will promote much greater efficiency in processing Medicare's billion claims a year.

With this change in contracting, the new **A/B MACs will be required to develop an integrated and consistent approach to medical coverage across its service area**, which will benefit both beneficiaries and providers. The outgoing contractor will provide the MAC with any Local Coverage Determinations (LCDs), formerly known as Local Medical Review Policies (LMRPs). The MAC is required to consolidate the existing LCDs of the outgoing carriers/intermediaries within its jurisdiction so that they are the same throughout the jurisdiction.

In consolidating the LCDs, **the incoming contractor must select the least restrictive LCD from the existing LCDs on a single topic**. It must also consolidate the active edits in the system related to the consolidated LCDs. In addition, the MAC must provide a minimum comment period of 45 days on any proposed revision that restricts an existing LCD and it must ensure that the effective date for the LCD change (i.e., cutover) allows for a minimum notice period of 30 days. This allows time for educating affected providers through bulletins and/or meetings/training seminars.

Only a third of the MAC contracts have been awarded so far, Jurisdictions 1, 3, 4, 5, and 12 (see MAC Jurisdiction Table, page 6). In those states which are currently transitioning from one or more Medicare Carriers to a MAC contractor, there have already been problems with changes and differences between the Medicare Carrier LCDs and those being implemented by the MACs. While this type of problem should not occur, there is evidence of claims errors as a result of changes to the LCDs in place and the related claims processing edits.

Wisconsin Physician Service (WPSIC) J5 MAC WPSIC (Kansas, Iowa, Nebraska, Missouri) removed Actinic Keratosis diagnosis 702.0 from the updated MAC Benign and premalignant Lesion LCD resulting in claims denials and/or additional The

— see **CMS Contract Changes** *on page 6*

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IMPORTANT ***Please Route to*:**

___ Dermatologist ___ Office Mgr ___ Coding Staff ___ Billing Staff

Letter from the Editor

Dear *Derm Coding Consult* Reader:

As the Centers for Medicare and Medicaid Services (CMS) shifts from Carriers to MACs, it will require careful vigilance and reporting by Academy members of any discrepancies or differences in claims payment or claims denials that result from changes to medical coverage policies usually contained in the Local Coverage Determinations (LCDs). The process for selecting and consolidating multiple LCDs into a regional MAC LCD is already proving problematic in those states where the new contracts are being implemented. AAD Members and their Practice Management staff should keep a close eye on initial claims processed by a new Medicare Administrative Contractor to determine if there are any key changes to medical coverage policies.

Time is running out if your dermatology practice has been submitting claims with both an NPI and a legacy number. Although those claims have been paid, you need to test your ability to get paid using only your NPI by submitting one or two claims today with just the NPI (i.e., no Medicare legacy number). If the NPI Crosswalk cannot match your NPI to your legacy number, the claim with an NPI-only will reject. You can and should do this test now!

The AAD Coding & Reimbursement Task Force which serves on the *Derm Coding Consult* Advisory Board has developed the article on "Surgical Procedure Documentation" to remind Academy members of the importance of this documentation. We are aware that Insurance companies are increasing their review of surgical notes to determine if the documentation justifies the level of service that is being billed. An insurer audit that results in a request for repayment is an expensive way to learn this lesson. The AAD 2008 Coding & Documentation Manual provides code-specific reminders of what should be included. There is also new stringency with regard to the documentation requirements for History of Present Illness, and we have provided additional comment.

Best regards,

Norma L. Border, Editor

Coding Update

ICD-9 CODE CHANGES TO 624 FOR 2008

The International Classification of Diseases, Clinical Modification (ICD-9-CM) revised the coding and reporting structure for Non-inflammatory disorders of vulva and perineum, effective as of October 1, 2007.

624 Non-inflammatory disorders of vulva and perineum (REQUIRES 4th DIGIT)

Excludes ▸ *abnormality or vulva and perineum complicating pregnancy, labor, or delivery (654.8)*

condyloma acuminatum (078.1)

fistulas involving:

Perineum – see alphabetic index

Vulva (619.0-619.8)

vulval varices (456.6)

vulvar involvement in skin conditions (690-709.9)

624.0 Dystrophy of vulva (REQUIRES 5th DIGIT)

Excludes ▸ *carcinoma in situ of vulva (233.32)*

Severe dyslasia of vulva (233.32)

Vulvar intraepithelial neoplasia III [VIN III] (233.32)

624.01 Vulvar intraepithelial neoplasia I [VIN I]

Mild dysplasia of vulva

624.02 Vulvar intraepithelial neoplasia II [VIN II]

Moderate dysplasia of vulva

624.09 Other dystrophy of vulva

Kraurosis of vulva

Leukoplakia of vulva

Note: In the AAD 2008 Coding and Documentation Manual, Chapter 6, Alphabetic Listing of All Major Dermatologic ICD Diagnostic Codes and in the Numeric Listing of All Major Dermatologic ICD Diagnostic Codes, the above changes were not listed. Dermatology Practices should insert this information at page 234 & 265.

Editorial Advisory Board

Editor's Notes:
The material presented herein is, to the best of our knowledge accurate and factual to date. The information and suggestions are provided as guidelines for coding and reimbursement and should not be construed as organizational policy. The American Academy of Dermatology/Association disclaims any responsibility for the consequences of actions taken, based on the information presented in this newsletter.

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.

Address Correspondence to:
Brett Coldiron, M.D., F.A.C.P. Editorial Board *Derm Coding Consult*
American Academy of Dermatology Association
P.O. Box 4014 Schaumburg, IL 60168-4014

Surgical Procedure Documentation

Edited and Approved by AAD Coding & Reimbursement Task Force, Allan S. Wirtzer, MD, Chair

Documentation of surgical procedures is an important task that must not be overlooked or glossed over. Insurance companies will frequently review surgical notes to justify the level of service that is being billed. There are a number of facts that may be included in your records for each of your surgical cases.

For all excisional procedures, the record would include the preoperative diagnosis and planned operative procedure. The size and site of the lesion would be included as it directly impacts the choice of CPT code. If a procedure more complicated than just an excision and repair (such as a flap or graft) is to be performed, it would be noted why this choice is being made. All of the details of the surgical procedure would be detailed, not only for coding purposes, but for medico-legal reasons as well. These would include such things as:

- Skin preparation, anesthesia, and patient positioning.
- In the case of excisions, the "excised diameter" (measured prior to incision) would be noted.
- Type of incision, i.e., linear, curvilinear, elliptical, with size or length
- The depth of the defect would be included – is the defect through the dermis? does it extend into the superficial, mid, or deep subcutaneous tissue? does the defect include muscular fascia? does it include cartilage?
- In the instance in which a defect is to be closed/covered with a graft or a flap, the appropriate size of the surgical defect would be noted. For grafts this would be the size of the defect following removal of the lesion whereas for a tissue rearrangement procedure, it would be the combined size of the primary and secondary defects. For grafts, the location, size, and repair of the donor defect would be described.
- Indications for intermediate or complex closure and plane of undermining.
- Details of the closure, including the amount of undermining, type and number of buried sutures and skin sutures. If buried sutures are placed, the reason for their placement would explicitly be indicated, (i.e., minimize dead space, optimize functional outcome).
- Wound dressing and patient instructions

DOCUMENTATION EXAMPLE:
PREOPERATIVE DIAGNOSIS: BASAL CELL CARCINOMA
PROCEDURE: EXCISION WITH COMPLEX REPAIR

The procedure, risks, benefits, alternatives and expected outcomes were discussed with the patient and consent was obtained. Patient identified, procedure verified, site identified and verified.

With the patient in a sitting position, the previously biopsied lesion on the right medial cheek was outlined and measured. The lesion plus the necessary margin (the "excised diameter") was noted to be 2.4cm. An ellipse was designed around the lesion to conform to relaxed skin tension lines in an effort to minimize scarring and deformity of surrounding structures. The patient was then placed in a supine position. The lesion and surrounding skin were prepped with cleansing solution, draped and anesthetized with xylocaine 1% with Epinephrine. Using a #15 blade the skin was excised along premarked lines. The resulting defect measured 6.0 X 2.6cm and extended through deep subcutaneous tissue. Wound margins were extensively undermined at the level of the deep subcutaneous fascial plane in an effort to limit functional deformity of the adjacent ala nasi and corner of the mouth and to reduce tension on wound margins. Bleeding vessels were controlled with bipolar cautery. The resulting dead space was closed and wound edges opposed with multiple buried 4 0 Vicryl sutures. Wound margins were meticulously closed with running 5-0 nylon suture, resulting in a linear closure with little to no wound tension. Blood loss was estimated to be less than 5 cc. A surgical dressing was placed over the wound. Post operative instructions were reviewed. The patient left the OR alert and fully oriented.

In the case of less complex procedures, such as cryodestruction or electrodessication, it is desirable to include the location and size of the lesions treated, along with any relevant symptoms. Diagrams are particularly helpful in decreasing the effort to detail the location of the treated sites.

Insurance companies have denied surgical services on the basis of inadequate documentation. If you expect to get reimbursed for a particular service it is imperative that you be aware what that service requires and that you've properly documented your work.

CMS Issues New Advance Beneficiary Notice of Non-Coverage

On Monday, March 3, 2008, CMS implemented use of a revised Advance Beneficiary Notice of Non-coverage (ABN) (CMS-R-131). The ABN is a notice given to beneficiaries to convey that Medicare is not likely to provide coverage in a specific case, in those instances where coverage by Medicare is not deemed medically necessary or when a service is specifically excluded from Medicare coverage, such as cosmetic procedures, or routine skin screenings. Physicians, other providers (including institutional providers like outpatient hospitals), licensed practitioners and suppliers paid under Part B, must complete the ABN to the extent specified in the instructions and deliver the notice to affected beneficiaries or their representative before providing the items or services that are the subject of the notice.

This revised ABN form replaces the General Use ABN (CMS-R-131-G), and the Lab ABN (CMS-R-131-L) for physician ordered laboratory tests. The new ABN form and instructions are posted on the Beneficiary Notice Initiative web page (*www.cms.hhs.gov\bni*). Updated manual instructions and a Spanish version of the form will be available on this web page in the near future.

Key features of the new ABN form are:

- New official title, the "Advance Beneficiary Notice of Non-coverage (ABN)", in order to more clearly convey the purpose of the notice;
- New form replaces both the existing ABN-G and ABN-L;
- New form also replaces the Notice of Exclusion from Medicare Benefits (NEMB),
- New mandatory field for providing cost estimates of the items/services at issue; and
- New beneficiary option, under which an individual may choose to receive an item/service, and pay for it out-of-pocket, rather than have a claim submitted to Medicare.

CMS is allowing a 6-month transition period from the March 3, 2008 date of implementation for use of the revised form and instructions. Dermatology practices may begin using the new ABN (CMS-R-131) now, but no later than September 1, 2008.

NEW ABN REPLACES NEMB

Previously the ABN was only required for denial reasons recognized under section 1879 of the Social Security Act. The revised version of the ABN may also be used to provide voluntary notification of financial liability. This new version of the ABN eliminates the need for the Notice of Exclusion from Medicare Benefits (NEMB) in voluntary notification situations, such as cosmetic procedures.

The ABN is an OMB-approved form and the wording cannot be altered except as permitted by the instructions for the form. ABNs must be reproduced on a single page. The page may be either letter or legal-size, with additional space allowed for each blank needing completion when a legal-size page is used. However, some allowance for customization of format is allowed as mentioned for those choosing to integrate the ABN into other automated business processes.

Dermatology practices may elect to place their logo at the top of the notice by typing, handwriting, pre-printing, use of a label or other means. At a minimum, the name, address, and telephone number (including TTY when appropriate) of the dermatologist must appear, whether incorporated into the logo or not, to ensure the beneficiary's ability to follow-up with additional questions.

The ABN must be verbally reviewed with the beneficiary or his/her representative and any questions raised during that review must be answered before it is signed. The ABN must be delivered far enough in advance that the beneficiary or representative has time to consider the options and make an informed choice. Employees or subcontractors of the physician may deliver the ABN. ABNs are never required in emergency or urgent care situations. Once all blanks are completed and the form is signed, a copy is given to the beneficiary or representative. In all cases, the dermatology practice must retain the original notice on file.

COMPLETING THE NEW ABN

There are 10 blanks for completion in this notice, labeled from (A) through (J), with accompanying instructions for each blank below. We recommend that the labels for the blanks be removed before use. Blanks (A)-(F) and blank (H) may be completed prior to delivering the notice, as appropriate. Entries in the blanks may be typed or hand-written, but should be large enough (i.e., approximately 12-point font) to allow ease in reading. (Note that 10 point font can be used in blanks when detailed information must be given and is otherwise difficult to fit in the allowed space.) The Option Box, Blank (G), must be completed by the beneficiary or his/her representative. Blank (I) should be a cursive signature, with printed annotation if needed in order to be understood.

The dermatology practice must enter a cost estimate under the heading for Blank (F) for any items or services listed and/or described in Blank (D) of the form. There is flexibility in listing individual or total cost of items. The revised ABN will not be considered valid absent a good faith attempt to estimate cost. CMS will be flexible in defining what a good faith estimate is, particularly in consideration of cases where the ordering and rendering providers may be different.

The option box and the three checkboxes represent the beneficiary's possible choices regarding the potentially non-covered care described in the body of the ABN. The beneficiary or representative must select only 1 of the 3 checkboxes. Under no circumstances can the dermatology practice staff decide for the beneficiary or representative which of the 3 checkboxes to select. If the beneficiary cannot or will not make a choice, the notice should be annotated.

If a beneficiary chooses to receive some, but not all of the items or services that are subject of the notice, the items and services listed under Blank (D) that they do not wish to receive may be crossed out, if this can be done in a way that also clearly strikes the reason(s) and cost information in Blanks (E) and (F) that correspond solely to that care. If this cannot be done clearly, a new ABN must be prepared.

***(A)* Notifier(s):**

***(B)* Patient Name:** ***(C)* Identification Number:**

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for ***(D)***_____ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the ***(D)***_____ below.

(D) _____	***(E)* Reason Medicare May Not Pay:**	***(F)* Estimated Cost:**

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the ***(D)***_____listed above.

  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

***(G)* OPTIONS:** **Check only one box. We cannot choose a box for you.**

❑ **OPTION 1.** I want the ***(D)***_____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

❑ **OPTION 2.** I want the ***(D)***_____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

❑ **OPTION 3.** I don't want the ***(D)***_____listed above. I understand with this choice I am **not** responsible for payment**,** and **I cannot appeal to see if Medicare would pay.**

***(H)* Additional Information:**

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY**: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

***(I)* Signature:**	***(J)* Date:**

CMS Contract Changes

— continued from page 1

"each" for Premalignant destruction code 17003 and Mohs LCD is still under discussion for inconsistencies in the language. Physicians' documentation and reimbursement will be held to these LCD.

As each state shifts from a local Medicare Carrier to a regional A/B MAC contractor, there is the potential for similar errors to occur. If such errors or omissions are found, contact AAD Practice, Policy and Management department immediately at . With the help of the DermCAC members in these areas, we have been successful in correcting these errors.

Medicare Contracting Reform (or section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003) is the legislative impetus requiring these changes. Section 911 mandates that the Secretary for Health & Human Services replace the current contracting authority to administer the Medicare Part A and Part B Fee-for-Service programs, contained under Sections 1816 and 1842 of the Social Security Act, with the new Medicare Administrative Contactor authority.

As CMS consolidates administration of Part A and Part B into integrated MACs, the following improvements to services for beneficiaries and providers can be expected:

Improved Beneficiary Services

- Most beneficiaries will have their claims processed by only one contractor, reducing the number of separate explanation of benefits statements a beneficiary will receive and need to organize.
- A/B MACs will be required to develop an integrated and consistent approach to medical coverage across its service area, which benefits both beneficiaries and providers.
- Beneficiaries will be able to have their questions on claims answered by calling 1-800-MEDICARE, as their single point of contact.

Improved Provider Services

- 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.
- Requiring MACs to focus on financial management will result in more accurate claims payments and greater consistency in payment decisions.

National Provider Identifier Deadline Is May 23, 2008

The National Provider Identifier (NPI) will be required for all HIPAA Standard Claims Transactions on May 23, 2008. For all primary and secondary provider fields, only the NPI will be accepted and sent on all HIPAA electronic transactions (837I, 837P, NCPDP, DDE, 276/277, 270/271 and 835), paper claims (UB-04 and CMS-1500) and SPR remittance advice.

Time is running out, if your dermatology practice has been submitting claims with both an NPI and a Medicare legacy number. Although those claims have been paid, you need to test your ability to get paid using only your NPI by submitting several claims with just the NPI (i.e., no Medicare legacy number). If the Medicare NPI Crosswalk cannot match your NPI to your Medicare legacy number, the claim with an NPI-only will reject. CMS is encouraging physicians and providers to do this test now!

Only claims with valid NPI numbers will be accepted. Using Medicare legacy identifiers in any primary or secondary provider fields will result in the rejection of the transaction or claim.

— see **NPI Deadline** *on page 7*

A/B MAC Jurisdictions

Jurisdiction#	MAC Contractor	Award Date	Jurisdiction Areas
1	Palmetto	10/25/07	Amer. Samoa, California, Guam, Hawaii, Nevada, and N. Mariana Islands
2		9/2007	Alaska, Idaho, Oregon, and Washington
3	Noridian	7/31/07	Arizona, Montana, North Dakota, South Dakota, Utah, and Wyoming
4	Trailblazer	8/3/07	Colorado, New Mexico, Oklahoma, and Texas
5	WPS	9/4/07	Iowa, Kansas, Missouri, and Nebraska
6		7/2008	Illinois, Minnesota, and Wisconsin
7		9/2007	Arkansas, Louisiana, and Mississippi
8		9/2008	Indiana and Michigan
9		9/2008	Florida, Puerto Rico, and U.S. Virgin Islands
10		9/2008	Alabama, Georgia, and Tennessee
11		7/2008	North Carolina, South Carolina, Virginia and West Virginia
12	Highmark	10/24/07	Delaware, District of Columbia, Maryland, New Jersey, Pennsylvania
13	NGS	3/18/08	Connecticut and New York
14		7/2008	Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont
15		7/2008	Kentucky and Ohio

NPI Deadline

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If the NPI-only test claims are processed and paid, continue to increase the volume of claims sent with only the NPI. If the NPI-only test claim rejects, go into your **National Plan and Provider Enumeration System (NPPES)** record and validate that the information you are sending on the claim is the same information in NPPES. If it is different, make the updates in NPPES and resend a small batch of claims 3-4 days later. If your claims are still rejecting, you may need to update your Medicare enrollment information to correct this problem. Call your Medicare carrier, FI, or A/B MAC enrollment staff or the National Supplier Clearinghouse for advice right away. Have a copy of your NPPES record available. The enrollment telephone numbers are likely to be quite busy, so don't wait.

NEED MORE INFORMATION?

Still not sure what an NPI is and how you can get it, share it and use it? More information and education on the NPI can be found at the CMS NPI page *www.cms.hhs.gov/NationalProvIdentStand* on the CMS web site. You can apply for an NPI online at *https://nppes.cms.hhs.gov* or can call the NPI enumerator to request a paper application at 1-800-465-3203. The American Academy of Dermatology's web site also provides guidance for dermatology practices on acquiring and using the NPI at *http://www.aad.org/pm/resources/npi.html*

NOT JUST FOR MEDICARE

Dermatologists and their practice staff should also be keeping track of the various deadlines contracted payers have established for transitioning to the National Provider Identifier (NPI). Creating a sample chart that includes payers and transition stages can be a helpful tool in doing so. Similarly, dermatologists and their practice staff should maintain a chart that keeps track of the various provider identification numbers they currently use. Legacy provider identifiers include provider identification numbers (PINs), unique physician identifier numbers (UPIN's) used by CMS, and other provider identification numbers. Taxpayer identification numbers are not legacy provider identifiers.

Caution! Some Clearinghouses Continue to Strip NPI from Medicare Claims

It has come to CMS' attention that some clearinghouses continue to strip NPIs, as well as other information, from Medicare claims. If your clearinghouse continues to strip your NPI from your claims for any reason, notify your Medicare Contractor immediately so that CMS can work with your clearinghouse to resolve the issue.

WHAT TO DO IF CLAIMS REJECT

1) Check your record in the National Plan and Provider Enumeration System (NPPES)

a) Validate that the legacy identifier you sent on the claim is also reported in your NPPES record. If the legacy identifier is not there, it needs to be added.

b) Validate that the Legal Business Name (for a provider/supplier who is an organization) or the Legal Name (for a provider/supplier who is an individual or a sole proprietorship) is correct.

c) Validate that the correct Entity type was selected at the time of NPI application. Individuals obtain an NPI as Entity Type 1. Organizations obtain an NPI as Entity Type 2 NPI.

If you requested an NPI number through the EFI alternative or submitted a paper NPI application, you should use the NPI Registry to check the content of your NPPES record. Make sure to have the Customer Service Representative at your Medicare contractor verify your Employer Identification Number (EIN) because the NPI Registry does not display EINs.)

2) If the above validation is successful and your claims continue to reject, call the Customer Service Representative at your Medicare contractor.

a) Have a copy of your NPPES record or your NPI Registry record in hand. A copy of your NPPES record can be printed from NPPES by going online at *https://nppes.cms.hhs.gov* and using the User ID and password selected when you applied for your NPI. If you obtained your NPI through the EFI alternative or submitted a paper NPI application, you should print your record from the NPI Registry at *https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do*. EINs and Social Security Numbers (SSNs) are not displayed in the NPI Registry.

b) Have the claim reject number and message

c) Be prepared to give the following information:

i) Legal Business Name of the organization or Legal Name of the individual

ii) Contractor Tracking Number (if known

iii) Approximate date (month/year) when the CMS-855 enrollment application was submitted or last updated

iv) Provider/Supplier Tax Identification Number (EIN or SSN)

v) National Provider Identifier (NPI)

vi) Medicare legacy Identifier

vii) Practice location on claim (i.e., where is the practice located (e.g., 100 Main St., New Orleans, LA)

viii) Contact Information where you can be reached if further discussion is needed

Documentation of HPI Elements

The 1995 Evaluation and Management (E/M) guidelines for documentation are often to the physician's advantage, but have some drawbacks. One is that the History of Present Illness (HPI) did not adequately address the patient with controlled chronic problems. These guidelines specify eight elements of the HPI (location, quality, severity, duration, timing, context, modifying factors and associated signs and symptoms), which pertain to acute problems. They define an extended HPI as having four or more of these elements and a brief HPI as having one to three of them.

This definition may undervalue the HPI for follow-up visits with patients who have multiple chronic conditions. If these are well-controlled enough to be asymptomatic, even the most careful and thorough HPI might not be able to turn up four or more of the specified elements for carriers who do not allow negative as the HPI. (This is less of a problem with carriers who do allow negatives in the HPI) Thus, the HPI tended to put a ceiling on the level of the visit being problem focused or expanded problem focused limiting the level of a follow-up visit to 99213 unless both the Exam and the Medical Decision Making were involved enough to justify a higher level without reference to the history.

1997 Evaluation and Management (E/M) Guidelines may be to the physician's advantage in such cases, as they define an extended HPI as four or more elements of the HPI ***or the status of three or more chronic conditions***, leaving the brief HPI to consist of one to three elements ***or the status of one or two chronic conditions*** (although this is not explicitly stated as such).

For example, when a patient presents periodically for monitoring of well-controlled eczema, acne, and urticaria, the HPI may document the status of these conditions rather than location, quality, duration of the present illness etc. The number of conditions will determine whether the HPI is brief or extended.

To see this in practice, consider the following portion of a visit note:

S: Patient X returns today for a routine four-month F/U for evaluation and management for seborrheic dermatitis, rosacea, and allergic contact dermatitis to nickel. Recent flare of seborrheic dermatitis controlled with short course of desonide; other two problems doing well. Reviewed medication list; compliance appeared acceptable.

In this case, 97 guidelines may be to the physician's advantage, as CMS auditors would classify this as an extended HPI. Auditors are to use either 95 or 97 guidelines, and to choose the one that is to the physician's advantage. Most require that either 95 or 97 be used for the entire encounter (i.e. you cannot choose 97 guidelines for the history, and 95 for the physical exam).

Both 95 & 97 CMS E/M Documentation guidelines state that the Review of System (ROS) and/or Past Family Social History (PFSH) may be recorded by ancillary staff or on a form completed by the patient. (The physician must review and make a notation to confirm the information recorded by others.)

Both E/M guidelines do not specifically state that the HPI may be recorded by ancillary staff or on a form completed by the patient. The guidelines are instructions for physicians and providers on correct documentation. Presently, it has become more apparent that some carriers expect physicians to document the History of Present Illness. According to a Cahaba Medical Director, HPI establishes the nature of presenting illness thus formulating the medical decision making. Carriers who have issued policy clarifications that only the physician may record HPI elements include: Noridian Administrative Services, Inc., Wisconsin Physician Services, and Palmetto Government Services. Dermatologists are advised to review their local carrier E/M documentation policies and to notify us or their DermCACs if unusual or onerous policies are adopted.

Coding Q & A's

Q. Can CPT 11755 be used for clipping the nail plate for PAS stain and for obtaining nail plate specimens for fungal cultures?

A. No, CPT 11755 is not meant to describe the act of clipping a nail. Nail biopsy should include components of the nail unit other than just the nail plate. Taking nail clippings for PAS or Fungal culture is just part of the E/M service, just like taking a swab for a throat culture, and is not a "Nail biopsy". Nail biopsies normally require a digital block or local anesthetic, and represent more physician work than a nail clipping, or curetting under a nail for culture material.

Q. We have been told by our local carrier, Noridian Administrative Services, Inc. to bill Zostavax, the new shingles vaccine, under Part D Prescription Plan and we are confused on how to bill for this drug and need clarification.

A. CMS has determined that Zostavax is to be covered under Part D. You will need to contact the beneficiary's prescription drug plan to determine the procedure for payment.

Q. The term "extensive undermining" is mentioned in the AMA CPT Repair (Closure) guidelines for complex repair, but is not included for intermediate repair. Is there a distinction?

A. Undermining is done to release the skin and to decrease tnesion to facilitate a repair that will return the skin to its natural appearance or normal functionality. In some instances there may be minor undermining and at other times extensive undermining may be appropriate.

— see **Coding Q & A's** *on page 9*

Coding Q & A's

— continued from page 10

Q. The term "instrumentation" is used in reference to intermediate repair (or any repair)?. What would this include?

A. "Instrumentation" describes skin stretching devices that are used intra operatively. The device, such as a towel clamp, mobilizes the tissue to reduce the final defect size.

Q. What should we do if we are unable to obtain the NPI for a referring or ordering physician or provider? What information should we put in Item 17b? Will CMS provide a surrogate NPI?

A. CMS advises that every attempt should be made to obtain the NPI of the referring or ordering physician or provider. If after several attempts you are unable to obtain this information, the performing provider shall report his own name and NPI in the ordering/referring fields. CMS will not be issuing any surrogate NPIs. (See CMS Change Request (CR) 5890, dated January 18, 2008)

Q. Does Medicare allow for a scribe to provide dictation for a physician during a consultation?

A. Medicare does not regulate by whom a note is transcribed into the medical record or to whom it is dictated. The service of a scribe must truly be that of a scribe only. The person doing the scribing at the patient encounter must not be seeing the patient in a clinical capacity. The scribed record must make clear that the physician has performed all components of the service and where there may be ambiguity, that the scribe's function has been limited to the transcription.

Q. Can you define "office suite" as it applies to "incident to" services?

A. The Medicare Benefit Policy Manual, Chapter 15, Section 60.1 states, "Direct supervision in the office setting does not mean that the physician must be present in the same room with his or her aide. However, the physician must be present in the office suite and immediately available to provide assistance and direction throughout the time the aide is performing services."

There is no Medicare law or regulation that defines the term "office suite". The key factor in "incident to" billing is the physician's availability to the practitioner performing the service. Noridian uses a general rule that "immediately available" means the supervising physician is able to provide assistance and direction in five minutes or less. The supervising physician must be within the same entity to be considered immediately available. For example, if the patient is being seen in the clinic and the supervising physician is located in the adjoining hospital, the physician is not considered to be in the "office suite".

Q. Does Medicare pay for photodynamic therapy for malignant and non-malignant lesions when performed by an esthetician?

A. Medicare may make payment if the procedure is within the esthetician's scope of practice as defined by the State and if the "incident to" requirements are met.

Q. If a claim is denied for a routine exam or screening procedure, do I need an ABN on file in order to bill the patient?

A. An ABN is not required for services that are statutorily excluded from Medicare coverage. An ABN is not required on file in order to bill the patient for non-covered services such as routine skin screenings, cosmetic procedures, removal of non medical medically unnecessary lesions, skin tags etc. If the patient requests the service to be filed to CMS to allow the consideration of secondary insurance, use the GY modifier advising Medicare this is a non covered service. If there is a question to the coverage of the service, explain this, the cost and have the patient sign the ABN. This service will need the GA modifier appended to tell Medicare that an ABN is on file and may not be a covered service. The ABN must have a full description for this denial. Here is an example: "These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam."

On March 3rd, 2008, CMS announced the implementation of the revised Advance Beneficiary Notice of Non-coverage (ABN) which replaces the General ABN, the Lab ABN and the Notice of Exclusions from Medicare Benefits (NEMB). For more information on the revised ABN, see pages 4 & 5. **CMS Issues New Advance Beneficiary Notice of Non-Coverage**

Q. Is it appropriate to balance bill patients the difference between the billed and the covered amount?

A. Dermatologists often wonder whether it is appropriate to balance bill their patients for the difference between the billed amount and the insurance covered amount. In most cases, the answer is **NO**. Payer contracts often include a provision prohibiting physicians from billing their plan members for covered services in excess of applicable co-pays and co-insurances by including the phrase *"the provider agrees to accept the payer's network rate as payment in full for covered services and shall not balance bill the payers subscriber" in the contract.*

Dermatologists providing services to patients in an "out-of-network" situation should not assume that balance billing is permitted. The laws differ from state to state. Some state regulations may imply a contract between physicians and payers that **prohibit** physicians

— see **Coding Q & A's** *on page 10*

Coding Q & A's

— continued from page 9

from balance billing, which may also apply to out-of-network physicians.

Before dermatologists engage in balance billing, it may be appropriate to consult legal counsel, the state medical board or state insurance commission for clarification. However, "in-network" dermatologists need to take a further step and review their payer contracts to determine whether balance billing is prohibited contractually before proceeding.

Dermatologists who accept reimbursement from government-administered health care programs should check the terms of these programs to determine if there are any restrictions against balance billing.

Finally, dermatologists are cautioned not to knowingly inflate their bills for services in order to circumvent the contractual and statutory restrictions against balance billing, as this can be viewed as insurance fraud, and may be punishable through civil monetary penalties as illustrated in The Social Security Act (SSA), Sec. 1128A. (42 U.S.C. 1320a–7a). For a detailed description of the Act, please visit: *http://www.socialsecurity.gov/OPHome/ssact/title11/1128A.htm*

New Instructions Limit Beneficiary Identity Theft and Fraud

CMS says that current policy for routine mailing of Medicare Summary Notices (MSNs) to easily permits Medicare beneficiary identity theft and fraudulent claims. To better protect the personal health information (PHI) of Medicare beneficiaries and prevent Medicare fraud, CMS has now instructed contractors to no longer include the Health Insurance Claim Number (HICN) on MSNs.

When a beneficiary's name and HICN did not match on a claim submitted by a practice or provider, the contractor was instructed to deny the claim and send an MSN to the beneficiary. However, these MSNs may also include personally identifiable information (PII) that does not belong to the beneficiary — creating an opportunity for identity theft and fraud.

Effective Jan. 7, 2008 contractors now replace the first five numbers of the HICN with X's on all (pay, no-pay and duplicate copy) MSNs. When Medicare eligibility cannot be established, A/B MACs and carriers are to return the claim to the physician or provider as "unprocessable" using Reason Code 140. The contractor will not mail a Medicare Summary Notice (MSN). You can read transmittal 1399 in full on the CMS website at *http://www.cms.hhs.gov/transmittals/downloads/R1399CP.pdf*.

Know What the HICN Suffix Means

Did you know what the alpha or alphanumeric suffix means on a Medicare beneficiary's identification number? The alpha suffix (A, B, B1, C or D etc.) indicates the type of benefits the beneficiary is entitled to and together with the social security number, is referred to as the Health Insurance Claim Number (HICN).

These letters do not indicate that the beneficiary only has Part A or Part B coverage. The alpha suffix is only appended to the social security number after a beneficiary applies and is approved for Medicare benefits. The complete alpha numeric suffix may appear on all correspondence that is received from Social Security and on the Medicare card. The alpha suffix will never appear on the beneficiary's social security card.

The "Is Entitled To" section on the front of the Medicare card shows the Medicare coverage information. You can find more information on what the letter means on the Social Security Web site: *http://www.ssa.gov*. Search for "letters at end of Medicare number" in the frequently asked question section.

Code	Identification
A	Wage Earner (Retirement)
B	Wife
B1	Husband
B2	Young Wife
C1-C9	Child - Includes disabled or student child
D	Aged Widow
D1	Widower
D6	Surviving Divorced Wife
E	Widowed Mother
E1	Surviving Divorced Mother
E4	Widowed Father
E5	Surviving Divorced Father
F1	Father
F2	Mother
F3	Stepfather
F4	Stepmother
F5	Adopting Father
F6	Adopting Mother
G	Claimant of Lump-Sum Death Benefits
HA	Wage earner (disability)
HB	Wife of disabled wage earner
HB1	Husband of disabled wage earner
HC	Child of disabled wage earner
M	Uninsured — Premium Health Insurance Benefits (Part A)
M1	Uninsured — Qualified for but refused HIB (Part A)
T	Uninsured — Entitled to HIB (Part A) under deemed or renal provisions
W	Disabled Widow
W1	Disabled Widower
W6	Disabled Surviving Divorced Wife

New Medicare Provider Enrollment Applications Issued

The Centers for Medicare and Medicaid Services (CMS) requires that all individuals providing services to Medicare beneficiaries complete form CMS-855I (Medicare Enrollment Application — Physicians and Non-Physician Practitioners) in order to enroll with Medicare. If you are a physician/non-physician practitioner who is enrolled in Medicare but has not submitted or updated your CMS-855 form since 2003, you are required to complete and submit a new application.

In some cases, the Physician/Non-Physician Practitioner must also complete form CMS-855R (Medicare Enrollment Application — Reassignment of Medicare Benefits).

CMS advises that physicians/ non-physician practitioners must obtain an NPI number from The National Plan and Provider Enumeration System (NPPES) prior to completing the CMS-855I or CMS-855R enrollment applications and report it on the application forms. Failure to report the NPI number will render the application unprocessable by the Medicare carrier.

CMS has also made a few, but major, changes to the CMS-855I and the CMS-855B. The biggest change was the removal of the requirement that providers submit a copy of the original NPI notification e-mail or letter with their application. This requirement had been in place since the addition of the NPI to the CMS-855 forms.

CMS released new versions of some of the Medicare provider enrollment applications (CMS-855). Specific revisions were to:

- The CMS-855I (individual providers);
- The CMS-855B (Part B business entities)

CMS will continue to accept the old versions of the applications through June 30, 2008. However, providers who wish to begin using the new forms may do so immediately.

To download the revised forms, go to:
http://www.cms.hhs.gov/CMSForms/CMSForms/list.asp?filterType=none&filterByDID=0&sortByDID=3&sortOrder=descending&intNumPerPage=10.

For tips on how to complete the enrollment process, please refer to "Tips to facilitate the Medicare Enrollment process for the Physicians and Non-Physician Practitioners," at:
http://www.cms.hhs.gov/MedicareProviderSupEnroll/downloads/Enrollmenttips.pdf

For additional tips on the completion of CMS 855I section, please see:
http://www.aad.org/pm/resources/_doc/NPI101GuidanceManagement-Final-10.10.2007.pdf

For more information on the changes to the CMS-855 applications, read MLN Matters article at:
http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0810.pdf.

If a physician/non-physician practitioner wants to opt out of Medicare, they may contact their Medicare contractor for instructions on the opt-out process or visit the AAD web site at:
http://www.aad.org/pm/medicare/_doc/MedicareParticipationOptions2008.pdf

Medicaid Requires Tamper-resistant Rx Pads

As of April 1, 2008, all Medicaid outpatient prescriptions must be written on tamper-resistant pads. The pads must have one or more security or tamper-resistant features, and by Oct. 1, they must have at least three security features. Examples of security features include serial/sequential numbering, VOID pantograph paper, quantity check-off boxes and safety paper with uniform background color.

The provision applies to all written, non-electronic prescriptions provided in settings other than certain institutions and clinical facilities. It will not apply to prescriptions transmitted to pharmacies electronically, orally or via facsimile, nor will it apply to emergency fills of prescriptions when an oral, faxed, electronic or compliant written prescription is sent within 72 hours of the date on which the prescription was filled.

The Centers for Medicare & Medicaid Services (CMS) issued broad guidance on the requirement, but state Medicaid directors have to issue specific regulations that define rules for their particular state. Once your state's Medicaid agency issues guidance, order your compliant prescription pads as soon as possible. This requirement, and the uncertainty of each state's policies, will most likely cause order backlogs and confusion among pharmacists, physicians and the nation's 55 million Medicaid beneficiaries.

CMS Revises CMS-1500 Submission Requirements

The Centers for Medicare and Medicaid (CMS) has revised information required for claim submission using Form CMS-1500 (08/05), effective January 1, 2008. Dermatology practices should report their service facility NPI in Box 32a. Box 32b should include their identification qualifier of 1C, plus the PIN or legacy number (if required by Medicare claims processing policy). CMS is encouraging the dermatology practices to precede their PIN or legacy number in Box 32b with the ID qualifier of 1C, then a blank space between the qualifier and the PIN or legacy number. CMS mandates that all claims should be submitted electronically, unless otherwise exempted by current HIPAA regulations.

For more information please visit:
www.cms.hhs.gov/transmittals/downloads/R1393CP.pdf ,

http://www.aad.org/pm/resources/npi.html or

http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5749.pdf

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