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# Derm Coding Consult

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## CMS Asks Dermatology to Help Test New Quality Measures

The Centers for Medicare & Medicaid Services (CMS) will begin testing eleven new quality measures – **including three measures: 136, 137 & 138 for melanoma** – for possible adoption in the Physician Quality Reporting Initiative (PQRI) Program in 2009. These new midyear measures focus on kidney disease, skin disease, eye care, imaging, arthritis, and cancer, including melanoma. CMS wishes to gather test data for these measures to help in the planning and implementation of future PQRI measure sets.

The Academy is encouraging dermatologists to submit data for these test measures on Part B claims from July 1, 2008, through September 30, 2008. There are no financial incentives for reporting these test measures in 2008. However, a high level of reporting by dermatologists will make it more likely that the measures will be included in the 2009 program, making dermatologists eligible for bonus payments.

Dirk M. Elston, M.D., co-chair of the AMA Physician Consortium for Quality Improvement Dermatology Work Group, encourages American Academy of Dermatology members to participate. “Dermatologists in many states need a menu of quality measures they can report to ensure first tier patient co-pays for their patients,” Dr. Elston said. “Some may need them for licensure. Please support your peers by reporting these measures. This will encourage CMS to adopt them for 2009.”

### DERMATOLOGY MEASURES FOR PQRI TESTING PROGRAM:

#### Measure 136: CPT II 0015F - Melanoma Follow Up Aspects of Care

Percentage of patients, regardless of age, with a new diagnosis of melanoma or a history of melanoma who received all of the following aspects of care at least once within the 12-month reporting period:

- patient was asked specifically if he/she had any changing moles; and
- patient received a complete physical skin examination and the morphology, size, and location of new or changing pigmented lesions were noted; and
- patient was counseled to perform a monthly skin self-examination.

#### Measure 137: CPT II 7010F - Melanoma Continuity of Care – Recall System

Percentage of patients, regardless of age, with a current diagnosis of melanoma or history of melanoma who were entered into a recall system with the date for the next complete physical skin examination specified at least once within 12 months.

#### Measure 138: CPT II 5050F – Melanoma Coordination of Care

Percentage of patients, regardless of patient age, with a new occurrence of melanoma that have a treatment plan documented in the chart that was communicated to the physicians providing continuing care within one month of diagnosis.

- CPT II 1127F - New episode for condition
- CPT II 1128F – Subsequent episode for condition

— see **Dermatology Measures** on page 6

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#### IMPORTANT Please Route to:

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## Letter from the Editor

Dear *Derm Coding Consult* Reader:

Finally, There's good news! First, the Congressional override of the Bush veto has not only maintained the 2008 Medicare Fee Schedule: Proposed Rule at the ½% increase for the balance of 2008 but also ensures a 1.1% increase for 2009! In addition any budget neutrality adjustment will be factored into the Conversion Factor rather than adversely impacting the physician work RVUs.

The second piece of good news is the availability of three dermatology specific. PQRI Performance test measures for 2008 and the approval of these as incentive based measures for 2009. The important point is that dermatologists report the test measures for 2008 to indicate dermatology's commitment to participating in the PQRI programs.

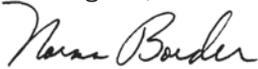
The third piece of good news is that dermatology participation in the American Medical Association Physician Practice Information Survey (AMA PPIS) is at 60%. The Academy's participation goal is 100%. This will ensure that as the Centers for Medicare and Medicaid incorporate the new survey data, there will be no erosion of the significant gains in Practice Expense RVUs that have benefited dermatology over the last three years.

Finally, the Academy is happy to announce the introduction of Coding Webinars with CME and CEU credits available for both the dermatologist and his staff at convenient times for in-service training.

**August 21**    **Essential Dermatology Coding – I**  
**September 18**    **Evaluation and Management Essentials**  
**October 23**    **Essential Dermatology Coding – II**

These have each been approved for AMA PRA Category 1 Credit™. Each of these LIVE web based learning sessions is designed to make learning and in-service training convenient for you and your practice staff. Each session will begin at: 1 pm EDT – 12 pm CDT – 11 am MST – 10 am PST. Save these dates and join us.

Best regards,



Norma L. Border, Editor

## Coding Update

### NEW ICD-9-CM CODES TO BE EFFECTIVE IN OCTOBER

The National Center for Health Statistics (NCHS) and the Centers for Medicare and Medicaid Services are the U.S. governmental agencies responsible for overseeing all changes and modifications to the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM). The ICD-9-CM is based on the World Health Organization's Ninth Revision, International Classification of Diseases (ICD-9) which is used to code and classify morbidity data from the inpatient and outpatient records, physician offices, and most National Center for Health Statistics (NCHS) surveys.

In April 2008, the NCHS and CMS released more than 300 new and revised ICD-9-CM to be effective October 1st, 2008. Dermatology practices claim submissions will be affected by the

- more than 80 new codes that have been introduced;
- more than 10 codes that have been revised codes;
- more than 10 codes that have been rendered invalid.

An important revision in the 2009 ICD-9-CM codes relates to melanoma in situ. Melanoma in situ is now included in code 172, malignant melanoma of skin. A fourth digit is needed with code 172 to relate to the specified site.

#### New ICD-9-CM Codes Effective October 1st, 2008

| Code   | Description   |
|--------|---|
| 078.12 | Plantar wart  |
| 199.2  | Malignant neoplasm associated with transplant organ |
| 569.44 | Dysplasia of anus                                   |

— see **New ICD-9-CM Codes** on page 4

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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

# CMS Issues 2009 Medicare Fee Schedule Proposed Changes

On July 7th, the Centers for Medicare & Medicaid Services (CMS) issued proposed changes to the Medicare Physician Fee Schedule (MPFS) for 2009. These annual updates for the MPFS set payment policies and the payment rates for services furnished by physicians and non-physician practitioners (NPPs) to people with Medicare. The proposed regulations are based on existing legislation only.

However, on July 15th, Congress overrode the Bush veto of the Medicare Improvement Act for Patients and Providers (H.R. 6331). This legislation reversed the 10.6 percent cut that took effect July 1 as well as the projected -5.4 percent cut scheduled for 2009. It will continue the 0.5 percent payment increase for 2008 and provide an additional 1.1 percent increase in 2009. The MPFS will be revised in the final rule to reflect this legislation.

The MPFS CY 2009 proposed rule continues an initiative of the Bush Administration to transform the Medicare fee-for-service program into a prudent purchaser of health care services, paying for quality of care, not just quantity.

Under the MPFS, a relative value is assigned to each of more than 7,000 types of services to capture the amount of work, the direct and indirect (overhead) practice expenses, and the malpractice premiums typically involved in furnishing the service. The higher the number of relative value units (RVUs) assigned to a service, the higher the payment. The RVUs for a particular service are multiplied by a fixed-dollar conversion factor to determine the payment amount for each service. CMS updates the conversion factor annually using a statutory formula adopted in the Balanced Budget Act of 1997 (BBA). Since 2002, that formula has yielded a negative update to the conversion factor, and every year since 2003, Congress has enacted legislation to prevent the negative update from taking effect for the year.

## EXPANDING PHYSICIAN QUALITY REPORTING INITIATIVE (PQRI).

CMS continues to expand incentive payments for those physicians who report certain quality data under the Physician Quality Reporting Initiative (PQRI). This program will also provide valuable information as Medicare moves toward paying for quality of care, not just quantity of services. There are three dermatology specific test measures for services furnished from July 1, 2008 thru Sept. 30th. The MPFS CY 2009 proposed rule includes proposals for additional improvements to the program for purposes of reporting data on quality measures in 2009.

## POTENTIALLY MISVALUED SERVICES UNDER THE MPFS

The proposed rule identifies the fastest growing higher cost procedures, including services with potentially unexplained high RVUs and procedures that have not been reviewed by the RUC since the fee schedule was created. CMS has requested that the RUC begin reviewing the identified codes immediately. The following dermatology procedures have been identified for this review: 13121 (11%), 14021 (15%), 14300 (16%), 15740 (17%), 69100 (13%), 96567 (57%),

96920 (36%), 96921 (30%). The Academy will be required to submit detailed explanations regarding these increases.

## QUALITY STANDARDS FOR PHYSICIANS AND NPPS PROVIDING DIAGNOSTIC TESTING SERVICES:

CMS is proposing to require that physicians and NPPs who furnish diagnostic testing services meet most of the quality and performance standards required for Independent Diagnostic Testing Facilities (IDTF). CMS is specifically soliciting comments on whether to limit this enrollment requirement to less than the full range of diagnostic testing services, and, if so, what criteria should be used to limit this provision. In addition, CMS is proposing to give physicians and NPPs who are currently enrolled in Medicare until September 30, 2009 to comply with these new standards, rather than the January 1, 2009 effective date for the 2009 final rule.

## PROPOSED CHANGES TO ANTI-MARKUP PROVISIONS

This proposed rule proposes two alternatives to revising the anti-markup rule in §414.50. The first alternative would not require application of the anti-markup rule to diagnostic testing services provided by a physician who shares a practice with a single physician or physician organization. In all other cases, the anti-markup rule would apply. The second alternative would clarify anti-markup provisions that were finalized in the MPFS CY 2008 final rule by providing guidance pertaining to various terms of the rule, including what would constitute the "office of the billing physician or other supplier" and other concepts such as "outside supplier."

In addition, CMS is soliciting comments on:

- defining "net charge;"
- whether, in addition to or in lieu of the anti-markup provision, CMS should prohibit reassignment in certain situations and require the physician supervising the technical component or performing the professional component to bill Medicare directly; and
- whether CMS should delay beyond January 1, 2009, the effective date of certain anti-markup provisions published in the MPFS CY 2008 final rule, or delay the effective date of any proposed revisions to that rule.

## E-PRESCRIBING

In the MPFS 2009 Proposed Rule, CMS is proposing to retain the provisions that would allow for use of computer-generated faxes in instances of temporary/transient transmission failure or communication problems that preclude the use of the adopted NCPDP SCRIPT standard, and add an exemption for computer-generated faxes used by dispensers to request refills from providers that are not capable of receiving and processing refill requests using the adopted NCPDP SCRIPT standard. ✱

## New ICD-9-CM Codes

— continued from page 2

|        |  |
|--------|--|
| 695.10 | Erythema multiforme, unspecified   |
| 695.11 | Erythema multiforme minor  |
| 695.12 | Erythema multiforme major  |
| 695.13 | Stevens-Johnson syndrome   |
| 695.14 | Stevens-Johnson syndrome-toxic epidermal necrolysis overlap syndrome                     |
| 695.15 | Toxic epidermal necrolysis   |
| 695.19 | Other erythema multiforme  |
| 695.50 | Exfoliation due to erythematous condition involving less than 10 percent of body surface |
| 695.51 | Exfoliation due to erythematous condition involving 10-19 percent of body surface        |
| 695.52 | Exfoliation due to erythematous condition involving 20-29 percent of body surface        |
| 695.53 | Exfoliation due to erythematous condition involving 30-39 percent of body surface        |
| 695.54 | Exfoliation due to erythematous condition involving 40-49 percent of body surface        |
| 695.55 | Exfoliation due to erythematous condition involving 50-59 percent of body surface        |
| 695.56 | Exfoliation due to erythematous condition involving 60-69 percent of body surface        |
| 695.57 | Exfoliation due to erythematous condition involving 70-79 percent of body surface        |
| 695.58 | Exfoliation due to erythematous condition involving 80-89 percent of body surface        |
| 695.59 | Exfoliation due to erythematous condition involving 90 percent or more of body surface   |

|        |  |
|--------|--|
| 707.20 | Pressure ulcer, unspecified stage  |
| 707.21 | Pressure ulcer, stage I  |
| 707.22 | Pressure ulcer, stage II   |
| 707.23 | Pressure ulcer, stage III  |
| 707.24 | Pressure ulcer, stage IV   |
| 729.90 | Disorders of soft tissue, unspecified V87.09                             |
| 729.92 | Nontraumatic hematoma of soft tissue                                     |
| 729.99 | Other disorders of soft tissue   |
| 760.61 | Newborn affected by amniocentesis  |
| 760.62 | Newborn affected by other in utero procedure                             |
| 760.63 | Newborn affected by other surgical operations on mother during pregnancy |
| 998.30 | Disruption of wound, unspecified   |
| 998.33 | Disruption of traumatic wound repair                                     |
| 999.81 | Extravasation of vesicant chemotherapy                                   |
| 999.82 | Extravasation of other vesicant agent                                    |
| 999.88 | Other infusion reaction  |
| 999.89 | Other transfusion reaction   |
| V51.8  | Other aftercare involving the use of plastic surgery                     |
| V87.01 | Contact with and (suspected) exposure to arsenic                         |
| V87.09 | Contact with and (suspected) exposure to other hazardous metals          |

— see Codes on page 5

## New ICD-9-CM Codes

— continued from page 4

### New ICD-9-CM Codes Effective October 1st, 2008

#### Code Description

|        |   |
|--------|---|
| V87.11 | Contact with and (suspected) exposure to aromatic amines                        |
| V87.19 | Contact with and (suspected) exposure to other hazardous aromatic compounds     |
| V87.2  | Contact with and (suspected) exposure to other potentially hazardous chemicals  |
| V87.39 | Contact with and (suspected) exposure to other potentially hazardous substances |
| V87.41 | Personal history of antineoplastic chemotherapy                                 |
| V87.42 | Personal history of monoclonal drug therapy                                     |
| V87.49 | Personal history of other drug therapy  |

### Revised ICD-9 Codes Effective October 1st, 2008

| Code   | Description                                       |
|--------|---|
| 172._  | Includes Malig Melanoma in SituSkin               |
| 707.00 | Pressure ulcer, unspecified site                  |
| 707.01 | Pressure ulcer, elbow                             |
| 707.02 | Pressure ulcer, upper back                        |
| 707.03 | Pressure ulcer, lower back                        |
| 707.04 | Pressure ulcer, hip                               |
| 707.05 | Pressure ulcer, buttock                           |
| 707.06 | Pressure ulcer, ankle                             |
| 707.07 | Pressure ulcer, heel                              |
| 707.09 | Pressure ulcer, other site                        |
| 998.31 | Disruption of internal operation (surgical) wound |

### Invalid ICD-9 Codes effective October 1st, 2008

| Code  | Description                                    |
|-------|--|
| 695.1 | Erythema multiforme                            |
| 729.9 | Other and unspecified disorders of soft tissue |
| V51   | Aftercare involving the use of plastic surgery |

**Note: This list is not considered final as there may be a handful of changes to the list prior to the effective date of October 1st. Dermatology practices should note that there is no longer a grace period for the transition of ICD-9 codes. For a complete list of new ICD-9 codes please visit [www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07\\_summarytables.asp#TopOfPage](http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#TopOfPage).**

**These new codes will also be incorporated in the 2009 AAD Coding & Documentation manual – ICD-9-CM section.**

## Price Increase on Triamcinolone Acetonide

Effective July 1, 2008, the Centers for Medicare and Medicaid Services has increased the average sales price (ASP) for triamcinolone acetonide (Kenalog) 10mg (J3301) for third quarter 2008. The ASP rate went to \$1.516 from \$1.375, which represents a 10.26% increase. This price became effective July 1.

## Physician Orders Required for Lab Services

Medicare carriers have identified a recent increase in the number of errors attributed to lack of physician orders for diagnostic laboratory services billed. CMS guidelines define an order as:

“... a communication from the treating physician/practitioner requesting that a diagnostic test be performed for a beneficiary. The order may conditionally request an additional diagnostic test for a particular beneficiary if the result of the initial diagnostic test ordered yields to a certain value determined by the treating physician/practitioner (e.g., if test X is negative, then perform test Y).”

— see **Physician Orders** on page 12

# Dermatology Measures

— continued from page 1

| Measure  | Numerator   | Denominator   |
|--|---|---|
| #136   | <p><b>Melanoma follow up aspects of care:</b><br/> <b>If melanoma follow-up performed: CPT II 0015F</b></p> <p>If follow-up not performed for system reasons: <b>CPT II 0015F with modifier 3P (system reason)</b></p> <p>If follow-up not performed and reason is not specified: <b>CPT II 0015F with modifier 8P (reason not specified)</b></p>   | Must include one ICD-9 diagnosis code and one CPT E/M service code* |
| #137   | <p><b>Melanoma Continuity of Care– Recall System</b><br/> <b>If recall system utilized: CPT II 7010F</b></p> <p>If recall system not utilized for system reasons: <b>CPT II 7010F with modifier 3P (eg monitored by another provider)</b></p> <p>If recall system not utilized and reason is not specified: <b>CPT II 7010F with modifier 8P (reason not specified)</b></p>   | Must include one ICD-9 diagnosis code and one CPT E/M service code* |
| #138   | <p><b>Melanoma Coordination of Care</b><br/> <b>If patient diagnosed with a subsequent episode of melanoma: CPT II 1128F</b></p> <p>If treatment plan is communicated: <b>CPT II 5050F AND CPT II 1127F</b></p> <p>If treatment plan is not communicated due to patient refusal: <b>CPT II 5050F with modifier 2P (patient reason) AND CPT II 1127F</b></p> <p>If treatment plan is not communicated for system reasons: <b>CPT II 5050F with modifier 3P (system reason) AND CPT II 1127F</b></p> <p>If treatment plan is not communicated and reason is not specified: <b>CPT II 5050F with modifier 8P (reason not specified) AND CPT II 1127F</b></p> | Must include one ICD-9 diagnosis code and one CPT E/M service code* |
| <p>* ICD-9 diagnosis codes include the following: 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9</p> <p>* ICD-9 diagnosis code V10.82 appropriate only for measures 136 and 137</p> <p>* CPT E/M service codes include the following: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, and 99245</p> |   |   |

## PQRI MODIFIERS:

- 2P:** Documentation of patient reason(s) (e.g., patient asks that treatment plan not be communicated to the physician(s) providing continuing care)
- 3P:** Documentation of system reason(s) (eg, another physician performed this service)
- 8P:** Melanoma follow-up not performed, reason not otherwise specified

To learn more about how you can help CMS test these measures, visit the Academy's Website at [www.aad.org/pm/medicare/index.html](http://www.aad.org/pm/medicare/index.html) and CMS's Website at <http://www.cms.hhs.gov/pqri> and select the "Measures/Codes" link on the left side of the page.

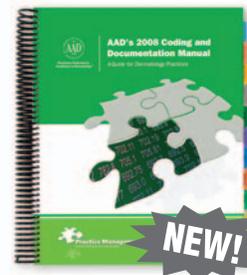
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# Shave Removal Versus Biopsy with Shave Technique Versus Excision – How Do They Differ?

*This article was prepared by James A. Zalla, MD and reviewed by the members of the AAD Coding & Reimbursement Task Force in February 2008.*

According to AMA CPT, shaving is the sharp removal by transverse incision or horizontal slicing to remove epidermal and dermal lesions without a full thickness dermal excision. This includes local anesthesia, chemical or electrocauterization of the wound, and does not require suture closure.

A shave removal is a distinct procedure, intended to remove a lesion or the problematic portion of the lesion. Removed tissue is also typically submitted for pathologic examination, however, the obtaining of that tissue is not a separate biopsy procedure and may not be coded as such. Only the shave removal code would be reported.

Shaving of epidermal or dermal lesions (11300-11313) is not considered an “excision” and excision codes (11400-11646) would not be used to report these services. The “removal” of a lesion by the shave technique requires a more superficial “removal” than an excision procedure in the integumentary system, but does not require complete removal of the lesion. Shave removal does not involve the full thickness of the dermis, whereas excision codes require removal of the entire thickness of the dermis through to the subcutaneous tissue.

The following examples illustrate different methods used in the shave removal, biopsy, destruction, and excision of dermal and epidermal lesions and their corresponding proper coding.

## EXAMPLE 1

A man has a 0.7 cm raised benign dermal nevus on his cheek which is being cut while shaving. Such lesions arise deeper in the dermis but are not problematic unless they raise above the level of the adjacent skin. Appropriate treatment is to remove the raised component of such a lesion with the shave technique, a “shave removal,” recognizing that the remainder of this benign lesion persists down in the dermis after the procedure and a complete removal is neither intended nor desirable. The fact that the removed tissue may then be sent for pathologic examination and confirmation, primarily for medical legal reasons, does not make this procedure a biopsy procedure. The intent of the procedure is therapeutic rather than diagnostic, and the histopathology is done for confirmatory reasons. Example 1 is reported with CPT 11311 for shaving this 0.7 cm facial lesion.

## EXAMPLE 2

A patient presents with a pearly nodule on the left nasal ala. The dermatologist recognizes that this appears to be a deeper lesion that could be a basal cell cancer, and a prudent approach would be to biopsy it for confirmation. A commonly used technique would be to biopsy the raised component of that lesion using a shave technique to remove the elevated portion specifically for pathologic exam, with

the intent that if it is a basal cell cancer, subsequent definitive treatment will then be undertaken. A shave technique may be selected in this instance because if the lesion on pathology exam is shown to be a benign dermal nevus, a deeper scar from the biopsy would have been avoided. In this example, it does not matter, for coding purposes, whether the physician selected a razor, a curette, a punch, or a scalpel as the instrument for the biopsy; they would all be coded the same. The primary purpose of the procedure is to obtain tissue for pathologic examination. This second example is appropriately coded as a skin biopsy procedure, CPT 11100.

The fact that a pathology report may state “specimen consists of a shave specimen of skin” does not mean anything in deciding whether the procedure represents a skin biopsy by the shave technique versus a shave removal of a lesion that happened to be submitted for pathologic confirmation.

An instrument such as a razor blade is one of a number of instruments that may be used for either a shave removal or a skin biopsy, depending on the intent of the physician. CPT codes 11300- 11313, which are defined by the shaving technique used to remove the lesion, may be reported for either benign or malignant lesions. The appropriate code is selected based on the anatomic site and the largest diameter size of the lesion itself, not including any additional margin.

Documentation in the medical record would include some indication for the procedure. In the case of a skin biopsy procedure, documentation such as “suspicious lesion,” “changing mole,” “history of bleeding lesion,” “variable pigmentation,” or “atypical appearing nevus,” or other similar descriptor can be extremely helpful in establishing the reason for the procedure. Similarly, documentation for a shave removal procedure might include “symptomatic lesion,” “rubs on waistband or bra,” “hits lesion shaving,” or other reasons why an elevated lesion is best removed with the shave technique.

An excision procedure, whether for benign or malignant lesions, is defined as full thickness (through the dermis) removal of a lesion including margins, and if a simple (non-layered) closure is performed, it is included in the excision procedure. Each excised lesion is coded separately, and code selection is determined by measuring the greatest clinical diameter of the apparent lesion plus that margin required for complete excision (lesion diameter plus the most narrow margin required equals the excised diameter). The measurement of lesion plus margin is made prior to excision.

If the defect following an excision goes “through the entire thickness of the dermis,” it is considered an excision even though the defect may not be closed. Sometimes dermatologists use a deeper tangential removal known as “saucerization” that may go through the dermis into fat. This may be done in the case of suspected melanomas to assure that the complete depth of the lesion is available for pathology. Such lesions are intentionally left open pending pathology

— see [Shave Removal](#) on page 8

# Shave Removal

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exam, anticipating a more definitive excision procedure will be needed. Such saucerization procedures are appropriately coded as excisions with the 11400 or 11600 series depending on whether the lesion was pathologically determined to be benign or malignant. Because such procedures go “through the dermis,” they exceed the definition of shave removal procedures that would be coded in the 11300 series.

If fat is present on a clinically excised specimen, or demonstrated on the corresponding pathology slide, it is clear that the excision had to extend through the dermis. There may, however, be instances in some body areas that lack subcutaneous tissue in which a specimen may include the full thickness of the dermis at that site but not have underlying fat.

It is also possible that a specimen may extend the full thickness through the dermis into fat, but the fat may pull away from the dermal specimen as it is harvested or in tissue processing for pathology. In such instances, the tissue slides would normally demonstrate that the full thickness of dermis was included on the specimen.

A shave removal procedure may vary in depth and width, and in some instances it may completely remove a lesion that occupies the upper or mid dermis. The fact that a lesion is removed in its entirety is irrelevant when deciding whether to code as a shave removal or an excision. A lesion may be completely removed, but if the level of removal does not go through the full thickness of dermis, it is not an “excision” according to CPT. Such descriptors in CPT are to be used by physicians and billers as well as carriers, and recognition of the same criteria by all allows for consistency of coding and fairness of payment.

While as a general surgical concept, the notion of excision may connote complete removal, in the integumentary section of CPT, the shave removal procedure codes specifically do not use the term “excision” to avoid confusion, and no reference is made to whether the lesion is partially or completely removed.

## EXAMPLE 3

A 17 y/o girl has a 1.1 cm raised brown nevus on her mid back that rubs on her bra. Her dermatologist removes it using a shave technique. Pathology report shows a benign compound nevus, and the lateral and underlying dermal margins are clear, confirming complete removal of the nevus. This procedure is properly coded 11302, shave removal benign lesion trunk, 1.1-2.0 cm. It is not coded as an excision, despite the fact that it was “completely” removed.

## EXAMPLE 4

A 50 y/o boater has a discreet but irregular 8mm shiny red flat lesion on his back. The clinical diagnosis is probable superficial basal cell skin cancer, and the dermatologist elects to shave the lesion at the level of the mid dermis. If

the intent of this procedure was therapeutic, it is appropriately coded as a shave removal, code 11301. If the intent of this procedure was diagnostic, it would be coded as a skin biopsy, code 11100. However, some dermatologists would immediately follow obtaining the specimen for pathology with curettage as a definitive procedure with the therapeutic intent to cure. Assuming the pathology confirmed the diagnosis of basal cell cancer, the latter procedure is properly coded as a malignant destruction trunk, 0.6-1.0 cm, 17261. If pathology confirmed a benign diagnosis, the procedure code 17110, destruction of a benign lesion would be reported. If pathology, however, confirmed an actinic keratosis, the destruction procedure code 17000 would be reported. In either case, only the definitive procedure is reported. Since obtaining tissue for pathology is a component of the definitive procedure, a skin biopsy is not separately reported for the same lesion.

## EXAMPLE 5

A 1.2 cm flesh colored polypoid nodule on the upper thigh of a 45 y/o man is irritated by his clothing. It is removed at the base with scissors, exposing underlying fat, and hemostasis is achieved with electrocautery. Pathology confirms a benign fibrofatty polyp.

This procedure is properly coded as 11402, excision benign lesion leg, 1.1-2.0 cm.

## EXAMPLE 6

A 0.6 cm flat red to black lesion on the arm of a 32 y/o tanning bed user is diagnosed as probable pigmented basal cell cancer, with melanoma a less likely consideration. The lesion is shaved off with a blade including a 0.2 cm margin. The wound base is then lightly electrodesiccated and curetted, leaving a 1.0 cm wound. Pathology confirms a pigmented basal cell carcinoma, and the deep and lateral margins are uninvolved.

This procedure is properly coded as 17261, destruction malignant lesion arm, 0.6-1.0 cm diameter. It is not coded as an excision, since the level of removal did not extend through the dermis. It is not coded as a shave removal, since the lesion was destroyed after the specimen was obtained for pathology.

## EXAMPLE 7

A 55 y/o man has a 0.9 cm dark brown shiny nodule on the upper back, diagnosed as probable nodular melanoma. The lesion is excised as an ellipse, including a 0.3 cm margin, and a 4.2 cm layered repair is performed. Pathology confirms a level III nodular melanoma, Breslow thickness 2.80 mm, margins uninvolved, and definitive wide excision is scheduled.

The initial procedures are properly coded 11602, Excision malignant lesion trunk 1.1-2.0 cm for the excised diameter of 1.5 cm, and intermediate repair 12032, Layered closure trunk 2.6-7.5 cm. The documentation in the medical record must describe and support the use of the intermediate repair code.✱

## Court Dismisses Medicare's Anti-Markup Rule - Anatomic Pathology Challenge

On May 5, 2008, a federal district court reversed course and dismissed a lawsuit challenging the Centers for Medicare and Medicaid Services (CMS) from enforcing its new anti-markup rules for pathology services. The court ruled that the urology plaintiffs had no standing to contest CMS's new pathology billing rules, which came into effect on January 1, 2008. The court further ruled that it had no jurisdiction over this matter and that the plaintiffs should pursue their grievances with CMS through Medicare's administrative process before pursuing civil action.

The court's dismissal unblocks its preliminary temporary injunction issued on March 31, 2008, which had prevented CMS from enforcing part of its new anti-markup rule pertaining to anatomic pathology services performed in a condo/pod laboratory. Dr. Thomas Olsen, Chair of the AAD Task Force on Dermatopathology, responded to the court's decision. "The court's decision simplifies a confusing and controversial loophole of Stark regulations yet still allows for subcontracting and billing of pathology services if performed on the site of the practice."

### IMPACT ON DERMATOLOGY PRACTICES

Dermatologists who have slides prepared by an outside lab and read their own dermatopathology slides continue to be subject to the long standing anti-markup rule related to "purchased diagnostic tests." If the dermatologist chooses to bill Medicare for both the slide preparation (TC) and interpretation (PC), the TC must be submitted on a separate claim form indicating where the service was performed. The dermatologist will be reimbursed for the TC claim the lesser of:

- the pathology lab's fee to the dermatologist; or
- the Medicare fee schedule amount.

The dermatologist may also choose to bill Medicare for the professional component (PC) and have the outside lab bill Medicare for the TC.

Dermatologists billing Medicare for the TC or PC of an ordered anatomic pathology service that is **not performed at the practice location** are now subject to the new anti-markup regulations and the Medicare reimbursement may not exceed the lowest of:

- the outside supplier's charge to the dermatologist; or
- the Medicare fee schedule amount.

The new anti-markup regulation excludes the provision of anatomic pathology service provided on-site — i.e., in the office of the dermatology practice. When either the TC or PC is performed on-site, the dermatologist is not subject to the anti-markup rules for anatomic pathology services, even if these services are subcontracted and not performed by the dermatologist.

By January 2009 CMS is expected to clarify the application of its new anti-markup rule, issue additional proposed rules, or both. Prior to the court's decisions, CMS indicated that it will review arrangements whereby the condo lab moves into a makeshift lab "on site" or puts a practice exam room off site in the condo or pod lab. CMS is also considering limiting the number of practices for which a pathologist could read slides.

"The Academy will continue to follow the convoluted path of CMS's anti-markup regulations as it relates to members to ensure that the new rules do not have unintended negative consequences for patient access to timely and reliable pathology tests." Dr. Olsen said. ✱

## Temporary Relief for Cash-Flow Disruption Due to NPI Problems

Dermatology practices experiencing financial hardship due to NPI-related claims-processing delays should contact their Medicare carrier to find out whether or not they qualify for these advance payments. The advance payments are not loans, CMS states, and are only appropriate when Medicare cannot process the claims on time. Advance payment is not based on the unpaid claim amounts Medicare may owe the practice. It is designed to keep the practice operating until Medicare regular payments resume. As such, practices will eventually have to repay this advance via offsets to remittances.

The dermatologist or the dermatology practice manager should call the Medicare carrier to explain the cash shortage and the practice's inability to meet business obligations for the next 30 days. Following the phone call, submit a letter to the carrier, recapping the conversation and acknowledging that your practice would be indebted to Medicare should the advance payment be approved. The statement must be signed by appropriate management staff who is authorized to commit the practice to indebtedness.

### DETERMINING IF THE PRACTICE QUALIFIES?

Upon receipt of the statement of indebtedness, the local carrier will submit a recommendation to the CMS regional office. The amount of the advance payment is entirely at CMS' discretion. (Note: If a practice is currently under investigation, delinquent on a Medicare payment or does not have an NPI #, the advance request will be denied.)

### REPAYMENT

When the time for repayment is due, dermatology practices will not have to repay the advance payment back to CMS via check. Rather, CMS will instruct the local carrier to deduct the amount owed from future Medicare reimbursements. The practice management staff should note that there will be no claims level detail on the affected remittance advices, which will simply show that a certain amount "is deducted to offset the advance payment."

To learn more, visit [http://www.cms.hhs.gov/NationalProvl-dentStand/02\\_WhatsNew.asp](http://www.cms.hhs.gov/NationalProvl-dentStand/02_WhatsNew.asp) ✱

## NPI Requirements for CMS-1500 (08/05)

In order to avoid rejection of claims submitted to Medicare, there are specific requirements for the use of National Provider Identification (NPI) numbers. If the NPI number isn't used where necessary or if the NPI number isn't valid, a claim will be returned as unprocessable. An unprocessed claim cannot be appealed. That claim must be corrected and resubmitted.

The name of the referring or ordering provider must be listed in Box 17. That provider's NPI number would be placed in Box 17b, within the unshaded portion. Box 17a should be left blank as UPIN numbers are now obsolete for Medicare claims. The NPI registry allows one to search the NPI database to locate the NPI number of an individual provider or an organizational provider. This registry may be accessed at the following link: <https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do>

### BOX 17B

|  |  |          |   |          |
|--|--|----------|---|----------|
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE |  | 17a.     | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES |          |
|  |  | 17b. NPI | FROM  | TO       |
|  |  |          | MM DD YY  | MM DD YY |

The NPI number of the provider in a group who has rendered the service must be placed in the NPI location within the unshaded portion of Box 24J. For both Box 17b and Box 24J, invalid NPI numbers will result in a claim that cannot be processed and thus the claim will be returned.

### BOX 24J

| 24. A. DATE(S) OF SERVICE |    |    | B.               | C.   | D. PROCEDURES, SERVICES, OR SUPPLIES |          | E.                | F.         | G.         | H.      | I.        | J.                      |
|---------------------------|----|----|------------------|------|--------------------------------------|----------|-------------------|------------|------------|---------|-----------|-------------------------|
| From To                   |    |    | PLACE OF SERVICE | ENCL | (Explain Unusual Circumstances)      |          | DIAGNOSIS POINTER | \$ CHARGES | DAYS UNITS | PCS PER | ED. QUAL. | REFERRING PROVIDER ID.# |
| MM                        | DD | YY | MM               | DD   | YY                                   | MODIFIER |                   |            |            |         |           |                         |
|                           |    |    |                  |      |                                      |          |                   |            |            |         |           | NPI                     |

The address of the provider is to be entered in Box 33. The NPI number would be entered in Box 33a. If an individual provider is part of a group practice or incorporated entity, the group or entity address as well as their identifier number would be used in these fields. If the provider is in solo practice, his or her address and NPI number would be appropriate. Note that in the instance of a solo provider, that provider's NPI number is not required in Box 24j.

### BOX 33, 33A

|   |  |   |  |                                      |        |
|---|--|---|--|--------------------------------------|--------|
| 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) |  | 32. SERVICE FACILITY LOCATION INFORMATION |  | 33. BILLING PROVIDER INFO & PH # ( ) |        |
| SIGNED  |  | DATE                                      |  | a. NPI                               | b. NPI |

### DIAGNOSIS CODES

In addition to having the NPI numbers placed appropriately on the CMS-1500 form, there are directives for the diagnosis codes. Medicare requires that only one diagnosis (1, 2, 3, or 4) pointer be entered in Box 24e. This certainly doesn't mean that you can't list additional diagnoses in Box 21. In fact, there are times when more than one diagnosis may be pertinent for one condition. Some Medicare carriers require a secondary diagnosis code along with a primary diagnosis code. Both codes would be listed in Box 21, but only one diagnosis pointer for the primary diagnosis would be entered in Box 24e.

| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Paste Items 1, 2, 3 or 4 to Item 24E by Line) |    |    |                  | 22. MEDICARE RESUBMISSION CODE ORIGINAL REF. NO. |                                      |          |                   |            |            |         |           |                         |
|---|----|----|------------------|--|--------------------------------------|----------|-------------------|------------|------------|---------|-----------|-------------------------|
| 1. _____  |    |    |                  | 2. _____   |                                      |          |                   |            |            |         |           |                         |
| 2. _____  |    |    |                  | 3. PRIOR AUTHORIZATION NUMBER                    |                                      |          |                   |            |            |         |           |                         |
| 3. _____  |    |    |                  | 4. _____   |                                      |          |                   |            |            |         |           |                         |
| 24. A. DATE(S) OF SERVICE   |    |    | B.               | C.   | D. PROCEDURES, SERVICES, OR SUPPLIES |          | E.                | F.         | G.         | H.      | I.        | J.                      |
| From To   |    |    | PLACE OF SERVICE | ENCL   | (Explain Unusual Circumstances)      |          | DIAGNOSIS POINTER | \$ CHARGES | DAYS UNITS | PCS PER | ED. QUAL. | REFERRING PROVIDER ID.# |
| MM  | DD | YY | MM               | DD   | YY                                   | MODIFIER |                   |            |            |         |           |                         |
|   |    |    |                  |  |                                      |          |                   |            |            |         |           | NPI                     |

The complete directions for completing the CMS-1500 form may be found in the CMS Claims Processing Manual, Chapter 26. <http://www.cms.hhs.gov/manuals/downloads/clm104c26.pdf>

Individual carriers may have specific directives as to what information should be entered in Box 19. That specific information should be available on the individual carrier's web site.

Note: CMS requires claims to be submitted electronically. However, a small dermatology practice may be exempt from this requirement if there are fewer than ten full time employees. A small provider has the option of submitting all, some or none of their claims electronically. Currently, providers can obtain the necessary software from individual Medicare carriers to submit claims electronically.

## Coding Q & A's

**Q: We have been told to enter information regarding the National Drug Codes (NDC) for our Medicare-Medicaid patients. Can you clarify this information? Where should the National Drug Codes be indicated on the paper claim?**

A: Physicians' offices, hospital outpatient departments and outpatient clinics that submit paper claims and serve patients dually eligible for Medicaid and Medicare must now include National Drug Codes (NDC) and corresponding quantity amounts on claims for all physician-administered drugs. This requirement was implemented with Change Request (CR) 5835.

Medicare providers billing paper claims for dually eligible patients are required to submit the NDCs for physician-administered drugs in the shaded area of item 24 of the CMS-1500 paper claim form in order for this data to be crossed over to Medicaid.

- NDCs shall be placed in the shaded portion of Item 24 as 13-position entries, beginning with the qualifier N4 and followed immediately by the 11-digit NDC code.
- Example: N499999999999
- The drug quantity must also be captured on all crossover claims for Medicaid billing. The drug quantity shall be placed in the shaded portion of Item 24 in positions 17 through 24 preceded by one of the following qualifiers: UN (units), F2 (international units), GR (gram) or ML (milliliter). (There are six bytes available for quantity. If the quantity is less than six bytes, then left justify and space-fill the remaining.)
- Examples: UN2 or F2999999
- Medicare will crossover NDC information to State Medicaid agencies in loop 2400 NTE.

### EXAMPLE

NDC Code:

| 10                | 01 | 05 | 10 | 01 | 05 | 11 | 11563 | 13 | 600.00 | 20 | N | 12345678901 | 0123456789 |
|-------------------|----|----|----|----|----|----|-------|----|--------|----|---|-------------|------------|
| N499999999999 UN2 |    |    |    |    |    |    |       |    |        |    |   |             |            |

**Note: Prior to these requirements, the shaded area of the CMS-1500 paper claim form has not been used by Medicare for any purpose.**

**Q: When we biopsy, curettage and electrosurgery a lesion on the same day & path confirms malignancy, can we code 17262?**

A: You may report the destruction of the malignant lesion as long as you wait until you receive the pathology report to confirm the fact that the lesion was malignant.

Documentation is the key issue. The medical record should indicate that the definitive procedure was the destruction with a portion of the tissue sent to pathology for examination. The biopsy code is not appropriate to report separately as the biopsy is considered an integral component of the definitive procedure, which in this case is the destruction.

**Q: What is the definition of "extensive undermining" as it relates to a complex repair (13100-13160) of a wound?**

A: This is one of the most difficult questions on which to give advice. As you know, CPT gives no directives as to what "extensive undermining" is.

The following text is from an article on Intermediate and Complex Repair that was published in Derm Coding Consult, Fall 2006.

"Complex repair codes are used to delineate complicated repairs. These repairs include the layered repair of lacerations that also require debridement of wound edges before closure. Wounds following excision of some lesions may require extensive undermining to release and redistribute tension vectors to allow proper closure. Wide undermining is necessary to avoid uncertain distortion such as of eyelid or lip. The time and work in closing a wound is related to undermining, and consequently obtaining hemostasis in the undermined area, as well as placement of sutures."

Be sure the documentation in the medical record is thorough to support the use of the complex repair code.

**Q: What is the code to use for the diagnosis of angiokeratoma?**

A: The ICD-9-CM code for this lesion is the benign skin lesion code 216.x. A 4th digit is needed to indicate the specific site of the lesion.

This may be a covered service if the lesion and documentation meets the criteria as set forth in the carrier's benign skin lesion removal policy. ✱

## Physician Orders

— continued from page 5

An order may be delivered via the following forms of communication:

- a written document signed by the treating physician/practitioner, which is hand-delivered, mailed, or faxed to the testing facility;
- a telephone call by the treating physician/practitioner or his/her office to the testing facility; and
- an electronic mail by the treating physician/practitioner or his/her office to the testing facility.

If the order is communicated via telephone, both the treating physician/practitioner or his/her office, and the testing facility must document the telephone call in their respective copies of the beneficiary's medical records.

If you receive a request for medical records from the CERT contractor or your local Medicare contractor, it is critical that the physician orders for all laboratory services be included. Without the orders, the services will be determined to be medically unnecessary and payment for these services will be rescinded.

For more information, go to: <http://www.cms.hhs.gov/Transmittals/Downloads/R80BP.pdf> \*

## IN THE KNOW...

Did you know that insurance companies require 'proof of timely filing' for inquiries on claims that are in excess of 90 days from date of service? Imagine this: after repeated telephone calls to follow up on unpaid claims, the payer requests that you resubmit the claim as it is "not on file." After receipt of your duplicate claim, they demand 'proof of timely filing' because they cannot track/find the original claim you submitted.

Each payer has its own requirements for what is considered 'proof of timely filing.' Taking the extra step to contact your payers or visiting their website to verify and understand these requirements can make a huge difference in expediting the reimbursement of the already-delayed claim. Some practice management software can generate a claim submission report for each batch of claims transmitted. This report will state whether the payer received and accepted the claim as a clean one in preparation for possible reimbursement or that there is an error which requires your attention and subsequent resubmission. Most payers will accept this electronic report document as 'proof of timely filing.'



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## Derm Coding Consult

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