MIPPA + 09 Medicare Fee Schedule = 1% Gain for Dermatology

The Centers for Medicare and Medicaid Services (CMS) published the 2009 Medicare Physician Fee Schedule Final Rule (09 MFS FR) in the Federal Register on 11/19/08 as a Final rule with comment period and can be downloaded from the Federal Register web site at: http://www.gpoaccess.gov/fr/browse.html

MEDITCARE IMPROVEMENTS FOR PATIENTS AND PROVIDERS ACT OF 2008 (MIPPA)
On July 1, 2008, payments for physicians' services were scheduled to be cut by 10.6 percent under the Sustainable Growth Rate (SGR) formula that determines doctors’ fees for Medicare outpatient services. Lobbying efforts by the Academy as well as the American Medical Association and other physician groups warned that doctors would likely respond by refusing to accept new Medicare patients. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) averts this cut through the end of 2008, and it increases physician fees by 1.1 percent in 2009. The 09 MFS FR Final Rule also announced that the preliminary estimate for the sustainable growth rate (SGR) for CY 2009 is 7.4 percent.

MEDITCARE CONVERSION FACTOR FOR 2009
The conversion factor (CF) for CY 2009 is $36.0666.

This is a drop of - $2.02/RVU from the 2008 Conversion Factor (CF) of $38.0870.

The big question is, if the Medicare Update is + 1.1%, why is the 09 Conversion Factor lower? The answer is that the American Medical Association and the majority of medical specialty societies, including AAD, successfully lobbied Congress to move the Budget Neutrality Adjustment (BNA) from the physician work RVUs to the Conversion Factor. For 2009 and future, Congress mandated that the BNA now be applied to the Conversion Factor in the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA).

CMS must apply a BNA if increases to RVU values for new or revised procedure codes exceed $20 million in any year. Prior legislation required that CMS apply a “budget neutrality adjustment” to “adjust” Medicare payment downward, but did not mandate where the adjustment should occur. Last year CMS applied the BNA of 0.8893 to the physician work RVU which resulted in a – 11.94 drop in RVU value per CPT code. This year MIPPA requires CMS to apply the reduction to the CF percent (0.9359). The difference is roughly a - $4 per RVU drop in payment (2008) Vs. a - $2.564 per RVU drop in payment (2009).

RESOURCE-BASED PRACTICE EXPENSE RELATIVE VALUE UNITS (PE/RVUs)
CMS continues to incorporate the AAD practice expense supplemental survey data completed in 2004 via the multi-year transition to PE/RVU values. Transitioning this data for the third year into the 2009 fee schedule for dermatology specific procedure codes increases the precision in determining the PE/RVUs for the services dermatologists provide, as well as improves the overall accuracy of the practice expense component of the fee schedule. The impact of the PE/RVU transition equates to a +2% in 2009 and a projected +5% in 2010.

Why should dermatologists care if the BNA is on the PW/RVU vs. Conversion Factor? Every payer that uses an RBRVS based payment system sets their own conversion factor each year, but most rely on the RVUs set by Medicare. Non-Medicare payers were using the reduced total RVUs and as a result, the Medicare reductions to RVUs were “creeping into” Private payer payments.

Contents

MIPPA + 09 Medicare Fee Schedule ............................................. 1, 3
Letter from the Editor .............................................................. 2
Coding Update ................................................................. 2, 3
Physician Self Referral and Anti-Markup Regulations ................. 4
Physician Self Referral and Anti-Markup Issues ......................... 4
CMS 2009 HCPCS Update ....................................................... 4
CMS Announces Medicare Premiums, Deductibles for 2009 .......... 5
Provider Enrollment Rule Changes ....................................... 6
3 Tips to Successfully Reach your MAC .................................. 6
RAC Contract Award Dispute .................................................. 6
NPPES- Keeping it Safe and Updated ..................................... 7
What is PQRI? ................................................................. 7
Appealing a Medicare Overpayment Request .......................... 8
Coding Q&A ........................................................................ 9, 10
Every Dermatology Practice Office Needs Internet ................... 9, 10
2009 PQRI Melanoma Measures ......................................... 11
CMS Awards J14 MAC Contract to NHIC ................................. 9, 10
In the Know........................................................................ 12

IMPORTANT Please Route to:
____ Dermatologist  ____ Office Mgr  ____ Coding Staff  ____ Billing Staff
Letter from the Editor

Dear Derm Coding Consult Reader:

What a difference a year makes and the passage of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) makes in physician reimbursement. The 2009 Medicare Fee Schedule: Final Rule incorporates the MIPPA provisions and provides a modest increase for dermatology procedures, mostly realized through the phasing in of increases in practice expense RVUs per code. While, initially disconcerting, the legislative impact of requiring CMS to put any budget neutrality adjustment on the Medicare Conversion Factor rather than the Physician Work RVUs will ensure, moving forward, that Medicare payment reductions are not “invisibly” picked up by private insurers.

MIPPA is still only a temporary fix. The Sustainable Growth Rate (SGR) formula has not been fixed or eliminated and can significantly impact Medicare payment in 2010. Fortunately, there is new focus in Congress on Health Care legislation in general and Medicare in particular. I view it as a hopeful sign for the New Year.

CMS has finalized the Anti-Mark-up provisions and dermatologists will have to pay close attention to the new requirements. Please check the AAD website for additional information on how the new CMS changes to the Self-Referral Rules may impact your pathology or lab test billing to Medicare.

Dermatologists have three melanoma measures that are part of Medicare’s Physician Quality Reporting Initiative (PQRI) for 2009. The Centers for Medicare and Medicaid Services (CMS) has indicated that for physicians who submitted claims for PQRI, a series of utilization reports will be issued along with a reimbursement check in mid-2010.

Best regards,

Norma L. Border, Editor

Coding Update

On January 1 of each year, new CPT codes become effective. The new or revised codes are a result of the AMA CPT Editorial Panel process. The Panel meets three times a year and reviews code proposals submitted by specialties or other interested parties. To get an overview of changes in CPT, one should refer to Appendix B in the AMA CPT manual which summarizes additions, deletions or revisions of CPT codes. New codes are identified by the symbol •, and revised codes are identified by symbol ▲.

A major change in CPT 2009 occurs in the hydration, therapeutic, prophylactic, diagnostic injections and infusions section. The codes 90760 – 90779 have been deleted and are replaced by codes 96360 – 96379. There also are some changes to the directives preceding the code sets from the directives that were in CPT 2008. The new code to report for a subcutaneous or intramuscular injection is:

• 96372 Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular

Note: the directives in the parenthetical under this code regarding the reporting of 96372, that without physician supervision, only 99211 may be reported.

A key revision in the integumentary section addresses add-on services. The additional text clarifies the coding when the number of additional lesions treated are less than 10. A clarification has been made by adding the phrase “or part thereof”, after the term “each additional.”

For example:

11200  Removal of skin tags, multiple fibrocutaneous, any area; up to and including 15 lesions

▲ 11201 each additional 10 lesions, or part thereof  (List separately in addition to code for primary procedure)

Other dermatology related codes clarified with or part thereof are in the skin replacement surgery and skin substitutes section. This clarification of add-on codes gives direction to the provider that any amount up to the additional amount is reported with the add-on code.

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.

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ICD-9-CM 2009 FOR DERMATOLOGY CODING
The changes in 2009 ICD-9-CM are summarized in the Introduction section of the book. New codes are identified by the symbol • and revised codes are identified by the symbol ▲. Be aware that in the alphabetical listing of diagnoses, code changes are identified with these same symbols as well as a ✓ to identify those codes that need an additional digit.

Some of the new codes for 2009 of particular interest to dermatology practices are the following:

078.12  Plantar wart  Verruca plantaris
172.X  Malignant melanoma of skin  Includes: melanoma in situ of skin (4th digit, site specified, required)
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
707.0X  pressure ulcer site  (5th digit, site specified, required)
707.2X  pressure ulcer stages  (5th digit, stage, required)
759.89  Birt-Hogg-Dube syndrome


MIPPA + 09 Medicare Fee
The clearest examples are the PE/RVU changes to the Benign Lesion Destruction codes:

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
<th>PE 08</th>
<th>PE 09</th>
<th>Total 08</th>
<th>Total 09</th>
<th>Pmt 08</th>
<th>Pmt 09</th>
<th>Diff 09</th>
</tr>
</thead>
<tbody>
<tr>
<td>17110</td>
<td>Destruet lesion, 1-14 (4th digit, stage, required)</td>
<td>2.37</td>
<td>1.90</td>
<td>4.27</td>
<td>3.80</td>
<td>1.57</td>
<td>1.10</td>
<td>0.47</td>
</tr>
<tr>
<td>17111</td>
<td>Destruet lesion, 15 or more (4th digit, stage specified, required)</td>
<td>2.21</td>
<td>1.96</td>
<td>4.17</td>
<td>3.82</td>
<td>1.15</td>
<td>1.01</td>
<td>0.14</td>
</tr>
</tbody>
</table>

The AMA is sponsoring a multi-specialty supplemental study of practice expense costs. The Academy is participating in and contributing to this additional practice expense survey and is encouraging members to participate to help maintain these PE/RVU gains.

GEOGRAPHIC PRACTICE COST INDICES (GPCI);
Geographic Practice Cost Indices are applied separately to the Work, PE and malpractice insurance RVUS for each procedure code. They have the potential to increase or decrease reimbursement above or below the National Medicare Fee Schedule amount. MIPPA reinstates the 1.0 floor on the work GPCI for rural areas (1.5 for Alaska)

Following is the current formula for calculating the Medicare payment amount for every office visit and procedure:

RVU work x (GPCI work) + RVU PE x (GPCI PE) + RVU malpractice x (GPCI malpractice)

x Conversion Factor = $ Medicare Payment$

APPLICATION OF THE HPSA BONUS PAYMENT
CMS has adopted a proposal to require use of the AQ modifier from physicians who practice in areas that are designated as Health Provider Scarcity Areas (HPSAs) as of December 31 of the prior year but not included on the list of zip codes for automated HPSA bonus payments in the current year. However many physicians are unaware of the need to use AQ modifier to insure HPSA payments.

PHYSICIAN AND NON-PHYSICIAN PRACTITIONER (NPP) ENROLLMENT ISSUES
CMS has responded to ongoing complaints regarding the enrollment system problems and has clarified that the effective date of billing for physicians/NPPs would be the later of:

(1) the date of filing of Medicare enrollment application or
(2) the date that the physicians or NPP first started furnishing services at its new practice location.

PETENTIALLY MIS-VALUED SERVICES UNDER THE PHYSICIAN FEE SCHEDULE
CMS has identified physician services in the Medicare Fee schedule that are still based on Harvard Study values or because of high Medicare utilization and requested that the AMA Specialty Society RB/RVS Update Committee (AMA RUC) re-evaluate these codes. Dermatology procedures in these categories include: simple and intermediate repairs, complex Repairs, destruction of malignant lesions, site specific biopsies, and key pathology codes.
Physician Self Referal and Anti-Markup Regulations

1. Alternative 1: substantially all professional services option
Under the first option, where the performing physician (that is, the physician who supervises the technical component (TC) or performs the professional component (PC), or both) performs substantially all (at least 75 percent) of his or her professional services for the billing physician or other supplier, the services furnished by the physician on behalf of the billing physician or other supplier will not be subject to the anti-markup payment limitation. If the performing physician does not meet the “substantially all” services requirement of Alternative 1, an analysis under the Alternative 2 requirements may be applied on a test-by-test basis to determine whether the anti-markup payment limitation applies.

According to CMS, both the “substantially all professional services” and “site-of-service” tests are measures of whether a performing/supervising pathologist “shares a practice” with the billing physician.

Analysis of the Billing Alternatives

1. Alternative 1
Under the first option, a dermatology practice may contract with a pathologist, who isn’t part of the practice. The pathologist must then perform “substantially all” (i.e., at least 75 percent) of his/her professional services for the same dermatology practice billing Medicare. None of those services would then be subject to the anti-markup payment limitation.

Under Alternative 1, the performing physician (i.e., the pathologist who supervises the TC and/or performs the PC) would be considered to share a practice with the dermatology practice if the pathologist furnishes “substantially all” (at least 75 percent) of his or her professional services through that dermatology practice billing Medicare. This means that the pathologist may then be able to furnish up to 25 percent of his or her professional services to other medical practices acting as a locum tenens physician, or in other circumstances without disqualifying himself or herself from sharing a practice with the dermatology practice for which s/he provides the bulk (that is, at least 75 percent) of his or her professional services. For example, suppose pathologist A furnishes at least 75 percent of her services through dermatology practice B, and furnishes 25 percent of her professional services through urology practice C and laboratory supplier D. Under this example, pathologist A would be considered to be sharing a practice with dermatology practice B.

According to CMS, “substantially all” requirement is satisfied if the billing dermatology practice has a reasonable belief, when submitting a claim, that:

• the performing pathologist has furnished substantially all of his or her professional services through the billing dermatology practice for the period of 12 months prior to and including the month in which the service was performed; or

• the performing pathologist will furnish substantially all of his or professional services through the billing dermatology practice during the following 12 months (including the month the service is performed).

2. Alternative 2
If the first option cannot be met, then a dermatology practice should apply a second alternative standard on a test-by-test basis. Under this “site-of-service” standard, only technical components performed and supervised and professional components performed in the billing dermatologist’s practice will avoid the anti-markup rules.

In applying these two new anti-markup billing standards, CMS is trying to assess whether the performing or supervising pathologist actually shares space with the billing dermatology practice. All other arrangements that do not meet either of these two requirements are subject to Medicare’s anti-markup payment limitation and the Medicare reimbursement may not exceed the lowest of: 1) the outside lab’s charge to the dermatologist; or 2) the Medicare fee schedule amount.

Go to (Insert AAD web site) for full detail on application of the new anti-mark-up provisions. Additional information and examples will be included in the Spring issue.

Physician Self-Referral and Anti-Markup Issues

CMS has issued changes to its anti-markup pathology billing rule. The new anti-markup revisions are part of CMS’ continued efforts to curb risks of abuse of the physician self-referral laws by preventing medical groups from marking up pathology lab services.

CMS has established a flexible approach—based on two alternatives driven by who performs the tests and where the tests are performed—to determine if the anti-markup provisions apply to particular pathology lab tests. These two alternatives offer a simpler approach to preventing potentially abusive arrangements and reducing potential for overutilization while providing some flexibility with preserving non-abusive diagnostic testing arrangements. For purposes of billing Medicare for pathology lab services, compliance should be analyzed first under Alternative 1 criteria, and failing that, under Alternative 2 to determine whether or not the anti-markup payment limitations apply:

— see MIPPA on page 5
2009 PQRI Initiative

-- continued from page 4

Physician Quality Reporting Initiative (PQRI)

The Medicare Physician Quality Reporting Initiative is extended by MIPPA. Physicians reporting on approved quality measures are provided a 2 percent incentive payment for the services they deliver in 2009 and 2010.

There are three dermatology-specific PQRI measures for 2009. CMS has confirmed that in circumstances where no NQF-endorsed measure is available, a quality measure that has been adopted by the AQA would also meet the requirements of section 1848(k)(2)(B)(i) of the Act.

These measures are identified in Table 17 of the Final Rule. The dermatology measures are:

- Melanoma: Follow-Up Aspects of Care
- Melanoma: Continuity of Care – Recall System
- Melanoma: Coordination of Care

ELECTRONIC PRESCRIBING (E-PRESCRIBING) INCENTIVE PROGRAM

MIPPA creates new financial incentives to encourage Medicare physicians to adopt technology that will allow them to order prescriptions electronically. Use of this technology will reduce medical errors and help physicians consider cost issues as they make prescribing decisions. Beginning in 2009, physicians will receive a 2 percent increase in payments, phasing down to 0.5 percent in 2013. However, in 2014 and afterward, physicians that have not implemented the technology will lose 2 percent of their Medicare payments.

2009 PQRI Initiative CMS 2009 HCPCS Update

The Center of Medicare and Medicaid (CMS) has announced the scheduled release of modifications to the HCPCS code set. These changes have been posted to the HCPCS Web site at http://www.cms.hhs.gov/HCPCSReleaseCodeSets/ANHCPCS/.

All changes are effective January 1, 2009, unless otherwise indicated in the effective date column. ♤

SKIN SUBSTITUTE PRODUCTS

The 2009 HCPCS Annual Update includes a new code series, Q4100-Q4115, effective January 1, 2009, to identify skin substitute products. Codes J7340, J7341, J7342, J7343, J7344, J7346, J7347, J7348, J7349 and C9357 are discontinued effective December 31, 2008.


The HCPCS coding facilitates accurate coding of these products. Medicare Part B is not changing the way the payment amounts are determined for the products in the new codes. To the extent that single-source drugs or biologicals were within the same billing and payment code as of October 1, 2003, Medicare Part B will continue to treat them as multiple-source drugs for payment purposes as required by Section 1847A(c)(6)(C)(ii). ♤

CMS Announces Medicare Premiums, Deductibles for 2009

The standard Medicare Part B monthly premium will be $96.40 in 2009, the same as the Part B premium for 2008. This is the first year since 2000 that there was no increase in the standard premium over the prior year. This monthly premium paid by beneficiaries enrolled in Medicare Part B covers a portion of the cost of physicians’ services, outpatient hospital services, certain home health services, durable medical equipment, and other items.

By law, the standard premium is set to cover approximately one-fourth of the average cost of Part B services incurred by beneficiaries aged 65 and over. The remaining Part B costs are financed by Federal general revenues. The income to the program from premiums and general revenues are paid into the Part B account of the Supplementary Medical Insurance trust fund, and Part B expenditures are drawn from this account. For more information, go to: http://www.cms.hhs.gov/apps/media/fact_sheets.asp ♤
Provider Enrollment Rule Changes

On November 18, 2008, the Federal Register published the provider enrollment provision of the Physician Fee Schedule final rule. The determinations are as follows:

- Establish an effective date of billing date as the later of the filing of a Medicare enrollment application or the date an enrolled provider first started rendering services at a new practice location.
- Physicians and non-physician practitioners may retrospectively bill for services rendered up to 30 days prior to the effective date if all requirements are met.
- Providers are permitted to retrospectively bill for services up to 90 days prior when there is a Presidentially declared disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act.
- Physicians and non-physician practitioners are required to notify their Medicare contractor of a change of ownership, adverse legal action, or change of location within 30 days. Failure to notify contractor may result in an overpayment for the date of the reportable change.
- Providers are prohibited from obtaining additional billing privileges if their current billing privileges are suspended or an overpayment is pending.
- Providers and suppliers are required to maintain ordering and referring documentation for 7 years from the date of service.
- Providers must establish the effective revocation date as the date of Federal exclusion or debarment, conviction, license suspension or revocation, or the date a practice location is determined to be not operational by CMS or its contractor.
- Physicians and non-physician practitioners would not be allowed to bill for services after the date of a reportable event. For all other revocation actions, individual practitioners will be required to submit all outstanding claims within 60 days of the effective date of revocation.

Two considerations have been left for further discussion in 2009. These include revoking billing privileges of individuals and/or organizational entities that had a tax delinquency unsuccessfully levied in the past.

3 Tips to Successfully Reach your MAC

Every dermatology practice has or will be transitioning to a new Medicare Administrative Contractor within the next 12 to 24 months. As dermatologists in California and New Jersey can tell you, this is not a simple process and can result in significant delays to Medicare payments to your practice.

TIP #1: When you have problems, contact your medical, physician specialty or state society. Societies will have contacts within MACs unavailable to the general public and may already have been troubleshooting similar problems from other providers. If that doesn’t work, contact your regional CMS office.

TIP #2: Register with the new MAC contractor for an electronic account several weeks, if not months, before the actual MAC transition date. You can also sign up early to be on an email list or listserv sponsored by the new MAC to receive updates on items such as changes to Local Coverage Determination policies.

TIP #3: It may not be possible to resolve delays caused by an enrollment backlog at the new MAC, but if your denials are NPI-related, make sure the information (name, address, etc.) linked to your identifier is correct. Check CMS’s NPI lookup and make sure it matches completely to the information listed with your new MAC contractor.

RAC Contract Award Dispute Leads to New Audits

Audits of medical providers’ claim records by the Recovery Audit Contractor (RAC) program have been postponed because of a dispute over who gets to conduct them. The Centers for Medicare and Medicaid Services (CMS) awarded regional RAC contracts Oct. 6 to four new contractors, but two other companies who were not awarded contracts have filed formal complaints. Upon receiving the complaints, CMS suspended the phase-in of new contracts, which were to begin in 2009.

Two companies not selected to be RAC contractors complained to the U.S. Government Accountability Office (GAO) that the award process was unfair. By law, the RAC contracts must be suspended while the GAO investigates the complaints. The GAO has 100 days to issue a decision under the Competition and Contracting Act (CICA) of 1984, meaning a decision is unlikely until early February 2009.

A September Medicare RAC report indicated that the government recovered nearly $1 billion in improper Medicare payments to medical providers through its pilot RAC program in five states from 2005 until earlier this year. The report data supports that suspended contracts will have a substantial impact on continued payment recovery efforts.

In addition, RAC training sessions in November and December to educate providers on the audit process are likely to be postponed by CMS until after GAO announces its decision.

More information on can be found at http://www.cms.hhs.gov/RAC/03_RecentUpdates.asp#TopOfPage

Use the following link to review the September Medicare RAC report: http://www.cms.hhs.gov/RAC/Downloads/Appealupdate63008ofRACEvalRept.pdf
NPPES—Keeping It Safe and Updated

The Centers for Medicare & Medicaid Services (CMS) recommends that each dermatologist:

- Know and maintain their NPPES User IDs and passwords;
- Reset their NPPES passwords at least once a year. See the NPPES application help page regarding the ‘Reset Password’ rules. Those rules indicate the length, format, content, and requirements of NPPES passwords; and
- Review their NPPES records in order to ensure that the information reflects current and correct information.

MAINTAINING NPPES ACCOUNT INFORMATION FOR SAFETY AND ACCESSIBILITY

Dermatologists should maintain their own NPPES account information (i.e., user ID, password, and secret question/answer) for safety and accessibility purposes. Health care providers can view their NPPES information in one of two ways:

1. By accessing the NPPES record (https://nppes.cms.hhs.gov/NPPESWelcome.do) and following the NPI hyperlink and selecting Login. The user will be prompted to enter the user ID and password that he/she previously created.*

   * If the health care provider has forgotten the password, enter the user ID and click the “Reset Forgotten Password” button to navigate to the Reset Password page. If the health care provider enters an incorrect user ID and password combination three times, the user ID will be disabled. Please contact the NPI Enumerator at (800) 465-3203 if the account is disabled or if the health care provider has forgotten the user ID.

2. By accessing the NPI Registry (https://nppes.cms.hhs.gov/NPIRegistryHome.do)

   The NPI Registry gives the health care provider an online view of the Freedom of Information Act (FOIA)-disclosable NPPES data. The health care provider can search for its information using the name or NPI as the criterion.

UPDATING NPPES INFORMATION

Physicians can correct, add, or delete information in their NPPES records by accessing their NPPES records and following the NPI hyperlink and selecting Login. The user will be prompted to enter the user ID and password that he/she previously created.

Note: Required information cannot be deleted from an NPPES record; however required information can be changed/updated to ensure that NPPES captures the correct information. Certain information is inaccessible via the Web, thus requiring the change/update to be made via paper application. The paper NPI application/update form can be downloaded and printed at the CMS Web site. (http://www.cms.hhs.gov/cmsforms/downloads/CMS10114.pdf)

Or providers can apply for an NPI online or can call the NPI enumerator to request a paper application at (800) 465-3203.

Note: All current and past CMS NPI communications are available on the CMS Web page. (http://www.cms.hhs.gov/NationalProvIdentStand/)

What is PQRI?

The Physician Quality Reporting Initiative (PQRI) is a program developed by the Centers for Medicare and Medicaid Services (CMS) to provide a financial incentive bonus to physicians who volunteer to report on best practice quality measures.

HOW ARE MEASURES DEVELOPED?

The measures are developed from evidence-based guidelines of care. The melanoma measures were developed in conjunction with a variety of national stakeholders. The AAD worked with the AMA’s Physician Consortium for Performance Improvement (PCPI), the National Quality Forum (NQF), the Ambulatory Care Alliance (AQA), and the National Committee on Quality Assurance (NCQA).

ELIGIBILITY

Eligible participants include Doctor of Medicine, Doctor of Osteopathy, Physician Assistant, Nurse Practitioner, Clinical Nurse Specialist, and Certified Registered Nurse Anesthetist (and Anesthesiologist Assistant).

REPORTING

There is no cost to join the PQRI program, and there is no registration or enrollment required. Dermatologists simply begin reporting applicable measures on their CMS claim form with the appropriate ICD-9 and CPT.

Category II codes from January 1, 2009 to December 31, 2009. Dermatologists must report on at least 80% of eligible patients on at least three or more measures. If you are reporting on less than three measures, you must report on at least 80% of Part B eligible patients for each measure. Presently, Medicare Advantage (Part C) programs do not apply.

BONUS PAYMENT

If participants successfully meet the criteria of the PQRI program and report all applicable measures, they will receive a bonus of 2% of total Part B charges to CMS for that year. A participant in the PQRI program can check on their reporting status by visiting https://applications.cms.hhs.gov/category.html?name=acctmngmt. Registration is required on this webpage to view your feedback report. After you have registered, you will be able to access the PQRI portal available at www.qualitynet.org/pqri and view your report. This report will provide information on your bonus payment and eligibility requirements.
Appealing a Medicare Overpayment Request

Has your dermatology practice ever had CMS dispute a Medicare claim for overpayment? If you have had this occur, you need to be aware of their rules in disputing overpayments. You must first send a rebuttal letter within 15 days of the overpayment notice, and then send an appeal letter after that to a Qualified Independent Contractor (QIC). The appeal letter must go out within 30 days of the first notice. This appeal letter is labeled a “redetermination” and is considered a first level appeal. If you choose to not write a rebuttal and appeal letter, CMS reserves the right to directly collect the overpayment after 41 days.

After you have submitted your rebuttal letter and first level appeal letter, QIC will send a revised notice of overpayment to your office. If you still wish to appeal this second letter, you will need to file a second level appeal called “reconsideration”. Once you submit this second level appeal letter, CMS cannot collect overpayment from you until 76 days after the first notice. However, it is important to note that CMS reserves the right to collect 12.5% interest on any overpayment after the 41st day of initial notice. Thus, if you believe you will not win from a second level appeal, it is not in your best interest to file this letter as you will be charged interest on the overpayment.

If you still believe that the QIC should not have charged for overpayment after your second level appeal has failed, your last option is to file a third level appeal. This appeal goes to an administrative law judge (ALJ). The ALJ has the right to reverse a decision made by the QIC and it has the ability to refund not only the overpayment but also any interest paid.

Tips for Filing an Appeal Letter

- Make sure you submit all of your documentation ON TIME.
- Make a packet of materials including medical records, referral letters, patient history, clinical decision making, etc.
- Date and page stamp all of your materials.
- Include a title page in this packet of materials which contains an organized breakdown of what is contained in the packet – state exactly what page the specific condition is listed on in the medical record.
- Include journal articles and clinical standards supporting your medical decision making.
- Don’t assume the QIC panel reviewing your case is made up of clinical experts. Many of them may not have a thorough clinical background.
- Have someone with no knowledge of the case review the file before it is sent out for obvious errors or missing materials.
- Research other Local Coverage Determinations (LCDs) to document if they support your case
- Note that you can send additional materials to the QIC after you have submitted your appeals letter as long as it is sent BEFORE QIC begins reviewing your case.

**Flowchart:**
- Physician receives overpayment notice from CMS
- Physician files rebuttal letter within 15 days
- Notice of QIC responds with revised overpayment to physician within 41 days of first notice
- Interest begins accruing
- Physician files second level appeal to QIC within 76 days of first notice
- QIC issues decision
- Physician can file a third level appeal to ALJ if s/he does not agree with QIC’s decision
- QIC begins reviewing your case
Q: I purchased the technical component (TC) of a diagnostic service. How do I indicate this information when I complete the claim?
A: Dermatologists purchasing the TC or interpretation (PC) of certain diagnostic tests from a separate entity would submit a separate claim for the purchased service. First, complete the outside lab information (Item 20 or the electronic equivalent) for all purchased diagnostic services, indicating the amount that was paid for the service.

Next, enter the address of the location where the service was actually rendered in the service facility location information area (paper claim form Item 32 or electronic equivalent) and indicate the NPI of the provider who actually rendered the service in the service facility location ID area (Item 32a or electronic equivalent). For Medicare’s purposes, Item 32a is used only when reporting purchased diagnostic tests (PDT) or interpretations.

Points to remember for all purchased diagnostic tests (PDT) service claims:
- An NPI is required for all PDT claims.
- If an NPI is missing, invalid, or submitted in the wrong area (e.g., valid NPI submitted in Item 32b or electronic equivalent), claims will be returned as unprocessable.

Note: The NPI should not be reported for providers outside the local jurisdiction. Instead, the purchasing provider would report their own NPI. The NPI is still reported for providers rendering purchased diagnostic tests (PDT) services within the state.

Example: If you purchase services performed in a facility in another city, you would report the provider’s address and NPI. If you purchase a diagnostic service from a mobile provider from out of state, report the physical location where services were performed and your NPI, since the mobile provider is out of state.

- Do not complete Item 32b. If any information is entered, the claim will be rejected or returned as unprocessable.

Note: Since only one address can be billed per claim, do not include the PC on a claim with a purchased TC or vice versa. Failure to submit a separate claim for each component will result in the claim being returned as unprocessable.

Q: Can minor claims errors or omissions be corrected outside of the appeals process?
A: Yes, a clerical error reopening can be initiated via the telephone or in writing; or, in many cases, the denied service(s) can simply be resubmitted. Resubmitting claims to correct minor clerical errors or omissions is the most efficient method for addressing certain denied services.*

NOTE: Resubmit the denied service(s) ONLY; resubmitting an entire claim will create a duplicate denial.

If these errors are received via written and telephone requests, it may take up to 60 days to process and finalize an adjustment, versus 14-30 days for a resubmitted claim. Ensure that you review the type of clerical error or omission you are attempting to correct and select the most efficient option available.

Determine if the error can be corrected and resubmitted prior to writing in or calling to request a clerical error reopening.

Minor clerical errors or omissions that can be corrected and resubmitted:
- Change of diagnosis codes
- Add, change, or delete modifiers (e.g., 24, 25, 50, 59, 78, 79, RT, LT)
- Incorrect place of service

Written or telephone clerical error reopenings are appropriate only for services that were processed and received an approved amount, and could include the following types of situations:
- Number of services (NB) billed
- Submitted charge amount
- Date of service (DOS)
- Add, change or delete certain modifiers
- Procedure code, excluding codes requiring documentation on the initial submission or codes being upcoded

Q: Why did I receive a duplicate denial on my remittance advice (ANSI code 18) when I have never received payment or denial on the claim?
A: Duplicate denials occur when a provider submits more than one claim for the same patient and the claim includes identical information such as date of service, type of service, procedure code, place of service, and billed amount. A claim may be denied as a duplicate when an Automated Development System (ADS) letter regarding a National Provider Identifier (NPI) mismatch has been sent to the provider and the provider resubmits the claim instead of responding promptly to the letter.

Prior to resubmitting any claim, a provider should check the status of the original claim by using the Provider Contact Center’s Interactive Voice Recognition (IVR) system. Always allow at least two weeks (10 business
**Coding Q & A's**

— continued from page 7

As of March 1, 2009, CMS indicates that this will be a required field. CMS believes that it is in the best interest of the provider and the beneficiary to know the approximate costs. This enables the beneficiary to make an informed decision and should assist the provider when billing the patient if Medicare denies the charges.

Source: CMS Internet Only Manual (IOM) Publication 100-04 Chapter 30 Section 50.5.7 www.cms.gov/manuals /iom/list.asp

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**Q:** In reviewing a patient’s record before a follow-up appointment, I remembered a detail that I forgot to jot down during the last visit. How can that information be added without risking suspicion if those records are scrutinized?

**A:** You should add the note where it will be obvious and legible. Do not just cram it in wherever it may fit. Be sure to always use the current date for the entry, never backdate chart entries. Include in the note that the information is being added late. If possible, provide a short explanation as to why it was not originally included. Make the addition as soon as possible, and never alter any record that has already been requested.

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**Every Dermatology Practice Office Needs Internet**

In today’s increasingly electronic environment, it is beneficial for offices to provide internet access to their staff. There is a plethora of reliable information available at your fingertips. Whether you need to research a coding and billing issue on the Medicare website, AAD’s website, or another trusted website, the information is almost always available with just a click of the mouse.

This capability affords you the means to check the current physician fee schedule, look up NCCI edits, research LCD documentation, and so much more.

It is also beneficial for dermatology practice staff to have the ability to download resource documents onto their desktop. Storing valuable data allows them the ability to troubleshoot and refer to data when similar topics arise. Often, Academy staff are called on for guidance and have documentation that is too large in volume to reasonably fax or mail to a dermatology office. However; this information is in file format that can be easily e-mailed and used.

**KEEPING UP ON MEDICARE CHANGES AND UPDATES?**

Internet access is also vital to the dermatology practice staying abreast of the sudden changes in Medicare instructions and regulations. Each of the Medicare carriers and MAC’s have a listserv that the dermatology practice should join to receive automatic email updates on a regular basis. Having this information in a timely manner is essential to practice coders and billers. They will be informed of LCD revisions and claim submission requirement changes as they occur. This will reduce rejected and denied claims saving countless hours of staff time and lost revenue.

Listserv sign-up is available on your Medicare carrier or MAC’s website. A complete list of Medicare contractor websites and listserv links are included in the 2009 edition of the Coding and Documentation Manual available through the AAD. To pre-order your copy, please contact the Member Resource Center at 866-503-SKIN (7546).

— see PQRI on page 8
### 2009 PQRI Melanoma Measures

<table>
<thead>
<tr>
<th>Measures</th>
<th>Description</th>
<th>Numerator</th>
<th>Denominator</th>
</tr>
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</table>
| **#136** 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 within 12 months: 1. Patient was asked specifically if he/she had any new or changing moles 2. A complete physical skin examination was performed and the morphology, size and location of new or changing pigmented lesions were noted 3. Patient was counseled to perform a monthly self skin examination | If follow-up performed: CPT II 0015F  
If follow-up not performed for system reasons: CPT II 0015F with modifier 3P (system reason)  
If follow-up not performed and reason is not specified: CPT II 0015F with modifier 8P (reason not specified) | Must include one ICD-9 (172.x or V10.82) diagnosis code AND one CPT E/M service code (99201- 99245) |
| **#137** Melanoma: Continuity of care-recall system | Percentage of patients, regardless of age, with a current diagnosis of melanoma or a 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 | If recall system utilized: CPT II 7010F  
If recall system not utilized for system reasons: CPT II 7010F with modifier 3P (eg monitored by another provider)  
If recall system not utilized and reason is not specified: CPT II 7010F with modifier 8P (not utilized) | Must include one ICD-9 (172.x or V10.82) diagnosis code AND one CPT E/M service code (99201- 99245) |
| **#138** Melanoma: Coordination of care | Percentage of patient visits, regardless of patient age, with a new occurrence of melanoma who have a treatment plan documented in the chart that was communicated to the physician(s) providing continuing care within one month of diagnosis | If treatment plan is communicated: CPT II 5050F AND CPT II 1127F  
If treatment plan is not communicated for system reasons: CPT II 5050F with modifier 2P (patient reason) or 3P (system reason) AND CPT II 1127F  
If treatment plan is not communicated and reason is not specified: CPT II 5050F with modifier 8P (reason not specified) AND CPT II 1127F | Must include one ICD-9 (172.x or V10.82) diagnosis code AND one CPT E/M service code (99201- 99245) |

| CPT only © 2007 American Medical Association. All Rights Reserved. | Derm Coding Consult, Winter 2008 | page 11 |
CMS AWARDS J14 MAC CONTRACT TO NATIONAL HERITAGE INSURANCE CORPORATION (NHIC)

The Centers for Medicare & Medicaid Services (CMS) announced on November 19th, 2008 that National Heritage Insurance Corporation (NHIC) has been awarded a contract for the combined administration of Part A and Part B Medicare claims payment in Maine, Massachusetts, New Hampshire, Rhode Island and Vermont,

As the A/B MAC contractor, NHIC will immediately begin implementation activities and will assume full responsibility for the claims processing work in its five-state jurisdiction no later than May 2009. NHIC will be reaching out to providers and state medical associations to provide education and information about the implementation. For more details, visit NHIC’s website at www.medicarenhic.com.

The list of new contractors and the states they cover, along with other information, can be found at http://www.cms.hhs.gov/MedicareContractingReform

IN THE KNOW...
Plantar Wart Update
Effective October 1, 2008, a new ICD9 Diagnostic code, 078.12, Plantar Wart, has been created to specifically identify plantar warts or Verruca plantaris. They are often contracted when the human papilloma virus (HPV) invades the epidermis of the foot though a cut. Plantar warts may resolve spontaneously but have a tendency to recur. When there is pain associated with weight-bearing on the area of the foot, removal is recommended. There are many ways to remove warts such as with keratolytic agents, cryotherapy, laser cautery or surgical curettage.

This is the 2009 revisions for Warts:

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<tr>
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<td>Viral Warts, unspecified</td>
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<td>Condyloma NOS</td>
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<td>Verruca NOS</td>
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<td>Condyloma NOS (added)</td>
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<td>Genital warts NOS (added)</td>
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<td>Plantar Wart (NEW Code )</td>
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<td>Verruca plantaris</td>
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<td>Verruca</td>
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You are in the Know!

This newsletter is supported by an educational grant from Amgen Wyeth.