



# Derm Coding Consult

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## AAD Comments on 2010 Medicare Proposed Rule

### RESOURCE-BASED PRACTICE EXPENSE (PE) RELATIVE VALUE UNITS (RVUS)

CMS proposes to replace an outdated data source (the AMA Socioeconomic Monitoring Survey) for determining practice (PE) costs with the Physician Practice Information Survey (PPIS). The survey, administered by the AMA in 2007 and 2008, was multispecialty, nationally representative, and included both physicians and non-physician practitioners. Before the PPIS, the data source for calculating PE costs was over a decade old, with many specialties' rates being based on data from 1995-1999, which clearly does not reflect current practice costs. Since 2004, both MedPAC and the Government Accountability Office have been calling for CMS to update its practice expense data, a request which was fulfilled through the PPIS.

Seventy organizations contributed to the cost of this undertaking including AAD. While some specialty groups are vehemently calling for blending of existing data with new data, such an approach would only serve to preserve the previous distortions and continue to utilize data that is now more than ten years old. The Academy strongly supports the proposal as written to fully implement the use of the PPIS to determine practice expense costs. The PPIS PE survey data will improve payment accuracy and correct significant inequities, which are goals shared by Congress, CMS, MedPAC, and the Administration.

### CONSULTATION SERVICES

CMS most surprising proposal is to eliminate the use of all inpatient and office consultation codes in a budget neutral manner for 2010, with the resulting savings in RVUs and payment re-distributed to the new and established office visits and initial hospital visits. The Academy understands some aspects of CMS' reasoning behind its proposal to eliminate consultation codes in the inpatient and office settings. However, we believe that eliminating these codes altogether, particularly without making some concurrent revisions to the documentation requirements and claims submission instructions for the remaining evaluation and management codes, could have unintended consequences that will negatively impact patient care.

The Academy is concerned that the proposed change will require significant physician education which cannot easily be accomplished before the proposed January 2010 effective

date. This proposal will also have a disproportionate impact on the small subset of physicians within each specialty who primarily see difficult tertiary and quaternary referrals and should not be adversely affected by the payment system for doing so. AAD also challenged the assertion that as CMS has relaxed documentation requirements for consultations there is truly a reduction in physician work. In light of efforts underway attempting to improve coordination of care among primary care physicians and specialists, this seems like an important opportunity to incentivize thorough communication.

Finally, we believe there will be coding inequities with the elimination of the consultation codes, particularly for those specialists who practice within multispecialty groups as current CMS policy requires that if a physician in a multi-specialty group sees a new patient (formerly as a consultation) who has already been seen by another primary care or specialist physician within that same group practice within the last three years, that the patient visit be billed as an established patient visit, rather than as a new patient visit, even though the physician work required would be the same as a new patient visit.

— see **KEY AAD COMMENT** on page 11

## Contents

<i>AAD Comments on 2010 Medicare Proposed Rule</i> . . . .	<b>1, 11</b>
<i>Letter from the Editor</i> . . . . .	<b>2</b>
<i>Coding Update</i> . . . . .	<b>2</b>
<i>Medicare Update</i> . . . . .	<b>3</b>
<i>OIG Focus on 'Incident to'</i> . . . . .	<b>3-4</b>
<i>FAQs from AAD "Incident to" Webinar</i> . . . . .	<b>4-5</b>
<i>Mandatory Use of New ABN</i> . . . . .	<b>5-6</b>
<i>Coding Q&amp;A's</i> . . . . .	<b>7</b>
<i>AAD Coding Staff Can Help!</i> . . . . .	<b>8</b>
<i>Using Modifiers -51 and -59 Correctly</i> . . . . .	<b>8-9</b>
<i>MAC Carrier Tips and Updates</i> . . . . .	<b>9-10</b>
<i>Do You Have a 5010 Transition Plan?</i> . . . . .	<b>10</b>
<i>PQRI reporting for 2010 - AAD Offers Online Registry</i> . . . . .	<b>11</b>
<i>In the Know...</i> . . . . .	<b>12</b>

### IMPORTANT Please Route to:

Dermatologist    Office Mgr    Coding Staff    Billing Staff

## Letter from the Editor

Dear *Derm Coding Consult* Reader:

The topics in this *Derm Coding Consult* reflect the broad range of issues that Academy members have been faced with over the last few months. Many of you are transitioning from a Medicare Carrier to a Medicare Administrative Contractor. We hope that the MAC Carrier Tips and Updates will help you deal with changes in billing and medical review policies. There is also additional guidance on use of Modifiers 51 and 59, to answer the question, "When should I use each of these modifiers?"

We've also included further clarification on what CMS considers Medically Necessary vs. Cosmetic Services and when an Advance Beneficiary Notice of Noncoverage (ABN) is required.

Please be aware that the Centers for Medicare and Medicaid Services (CMS) as well as the Office of the Inspector General are carefully scrutinizing current requirements for billing "incident to" services as well as proposing additional information requirements to ensure that these services are performed by appropriately trained and licensed health care providers.

Finally, the Academy is happy to announce the next in our series of Coding Webinars with CEU credits available for dermatology practice staff at convenient times for in-service training.

**October 22     Mastering CCI Edits**  
**November 16     2010 CPT/ICD Coding Update**

Each of these LIVE web based learning sessions is designed to make learning and in-service training convenient. Each session will begin at: 1 pm EDT – 12 pm CDT – 11 am MST – 10 am PST. If you have missed any of our webinars, these are also available as webcasts which can be purchased and downloaded to view at your convenience.

Best regards,



Norma L. Border, Editor

## Coding Update

### H1N1 - CMS VACCINE UPDATE

Prior to the expected mid October delivery of approximately 50 million doses of influenza A (H1N1) vaccine, CMS has added two new Level II HCPCS codes to the 2009 Medicare Physician Fee Schedule Database (MPFSDB). Effective Sept. 1, the appropriate codes to report the H1N1 (swine flu) administration are:

- **G9142 Influenza A (H1N1) vaccine, any route of administration** to describe the H1N1 vaccine itself. At this publication, the H1N1 vaccine is scheduled to be free to providers to administer. Thus CMS will not reimburse this code.
- **G9141 Influenza A (H1N1) immunization administration (includes the physician counseling the patient/family)** to describe the administration of the H1N1 vaccine. This administration is reimbursed such as the regular flu administration, G0008 or 90471. Deductibles and copays don't apply.
  - Report as one unit for each H1N1 vaccine administration.
  - No Medicare payment will be made for H1N1 test or supplies such as nasal swabs, masks etc.

How to Bill for non Medicare Administration of 2009-2010 H1N1 Influenza Vaccination

The codes are as follows:

- 90470-H1N1 immunization administration (intramuscular, intranasal), including counseling when performed
- 90663-Influenza virus vaccine, pandemic formulation, H1N1 \*

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### 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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## Medicare Update

### TRANSITIONING TO ICD-10 – START PLANNING NOW

ICD-10 will have a significant effect on dermatology practices. There will be changes involving claims software programs, fee schedules and contracts, coding documentation, claim forms, and superbills. Staff, including physicians, will need to be trained on all of the new coding guidelines, as well as documentation standards. Productivity will be affected when the ICD-10 code set goes into effect on Oct. 1, 2013, so it is to the practice's benefit to be as prepared as possible.

### THE VALUE OF ICD-10

ICD-10 provides better data needed to meet the demands of an increasingly global and electronic health care environment. It provides a significant opportunity to improve the capture of information about the increasingly complex delivery of health care. ICD-10 will provide better data to support:

- Quality measurement and patient safety improvement activities.
- Pay-for-performance initiatives.
- Improved public health and bioterrorism monitoring.
- More accurate reimbursement rates.

### ICD-10 PREPARATION CHECKLIST

Dermatology practices are encouraged to start thinking about the effects this new coding standard will have and how to map out a business compliance plan that accounts for:

- Compliance dates your practice will have to meet.
- The intersection of ICD-10, the latest version of the 5010 electronic transactions standards, and potentially your practice's adoption of an EHR system.
- How physician practices can address the many challenges ICD-10 will bring to payer contracting.
- Patient encounter documentation.
- Staff training.
- Research and benchmarking data.
- Software modifications.
- How to work with your vendors and payers to comply with this complex mandate.

The Academy will be distributing educational materials, offering training Webinars and other resources as the date for implementation of ICD-10 draws closer. ✨

## OIG Focus on 'Incident to'

The 2009 Office of Inspector General (OIG) work plan included reviewing 'incident to' services for appropriateness of physicians' billing for services provided by unqualified help. The OIG findings from the 2007 first quarter have prompted the Centers for Medicare & Medicaid Services (CMS) to rethink its 'incident to' policies. The following are the OIG discoveries:

- CMS approved and paid more than 24 hours of physicians' services in a day, half of which were performed by non-physicians. Approximately \$85 million or 990,000 allowed services were performed by non-physicians compared to the 934,000 services (\$105 million) that the physicians personally performed.
- Two-thirds of the invasive services allowed by Medicare were performed by non-physicians.
- Unqualified non-physicians performed 21 percent or \$12.6 million for approximately 210,000 services not performed personally by physicians. It was found that 7 percent of this group lacked appropriate licenses or certifications, no verifiable credentials, and/or medical/surgical training.

### OIG RECOMMENDATIONS TO CMS:

1. Revamp the 'incident to' rule requiring that physicians who do not personally perform the billed Medicare service to allow the following individuals: licensed physicians or non-physicians who have the necessary training, certification, and/or licensure, pursuant to state laws, state regulations, and Medicare regulations to personally perform the services under the direct supervision of a licensed physician.
2. Require physicians to report a special CPT modifier to identify these services allowing CMS to monitor services performed by non-physicians for appropriate qualifications.
3. Require CMS to monitor and review these service claims.

### CURRENT 'INCIDENT TO' REQUIREMENTS CMS Requirements for billing services and procedures as "incident to" are:

- The services are commonly furnished in a physician's office.
- The physician must have **initially** seen the patient and formulated a treatment plan.
- The direct provider supervision of auxiliary personnel, regardless of whether the individual is an employee, leased employee or independent contractor of the physician must represent a direct financial expense to the practice (such as a "W-2" or leased employee, or an independent contractor).
- The physician has an active part in the ongoing care of the patient.

— see **OIG** on page 4

## OIG Work Plan Focuses on ‘Incident to’

— continued from page 3

- If auxiliary personnel perform services outside the office, (e.g., patient’s home or institution other than hospital or Skilled Nursing Facility (SNF)), the services are covered ‘incident to’ only **if there is direct physician supervision**.
- The documentation needs to reflect who performed the service with initials and credentials.
- The provider who is supervising is the billing provider (24K) and the ordering but not supervising is the referring provider (17a).

### Additional billing and documentation requirements for ‘incident to’ service

- Auxiliary medical staff who are qualified under state law governing medical practice to perform the specified medical service may be reimbursed by Medicare for services provided “incident to” a physician’s service.
- The services are reimbursed under the physician’s fee schedule as if the physician actually performed them. Report these services with the employing/supervising physician’s NPI in Item 33 of the CMS-1500 claim form.
- The only Non-Physician Providers who may bill E/M services (above the level of 99211) under the “incident to” criteria are NPs, CNSs, and PAs.
- To ensure proper reimbursement according to the fee schedule, Medicare requires that documentation submitted to support billing “incident to” services must clearly link the services of the NPP to the services of the supervising physician.
- Co-signature or legible identity and credentials (i.e., MD, DO, NP, PA, etc.) are required of both the practitioner who provided the service and the supervising physician on documentation entries. (Check with your local carrier)
- Some indication of the supervising physician’s involvement with the patient’s care. This indication could be satisfied by:
  - Notation of supervising physician’s involvement within the medical record text entry or,
  - Documentation from other dates of service (e.g., initial visit, etc.) other than those requested, establishing the link between the two providers. Failure to provide such information may result in denial of the claim for lack of documentation from the billing provider.

Refer to the IOM, Pub. 100-04, Chapter 12, for more information regarding “incident to” guidelines at:

<http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf>

<http://www.cms.hhs.gov/MLN MattersArticles/downloads/SE0441.pdf> \*

## FAQs from AAD “Incident to” Webinar

### Q1) Is it correct that a NPP’s cannot see ANY new patients or problems/conditions as ‘incident to’?

A1) Correct. A NPP who is reporting a physician service as “incident to” can only see an established patient with an established treatment plan.

### Q2) Does a NPP need to have their own NPI number to treat and report a service for a new patient visit or an established patient’s new problem?

A2) If a NPP performs a new service and/or treatment of condition it can only be reported under the NPP’s own NPI and reimbursed at 85% of physicians’ fee schedule.

### Q3) If the dermatologist has not seen the patient initially, but is brought in to consult the patient under the NPP, we cannot bill incident to?

A3) A NPP is only allowed to report ‘incident to’ a physician’s documented treatment plan. This physician’s “quick peek” doesn’t qualify the NPP to report an ‘incident to’ new patient or an established patient’s new condition service. The NPP’s service would need to be carved out, forgoing the new condition. In this case, the NPP should report the service under their personal NPI.

### Q4) How much time can lapse for a treatment plan to allow the NPP to report under ‘incident to’?

A4) This would be under the provider’s clinical judgment as Medicare manual does not address a time period. Both AMA/CPT and CMS consider a new patient iss one who has not been seen in three years.

### Q5) If the patient encounter does not include a modifier, is it a problem just to report one for reimbursement?

A5) There are no modifiers noting a NPP’s service for ‘incident to’. How and who applies any modifiers to a patient’s claim should be an office policy and reflect the documentation.

### Q6) Our NPP sees patients in our satellite office with no MD on site. Our commercial payers do not recognize our NPP separately but we were told to report the service as ‘incident to’ for reimbursement. Is this compliant?

A6) ‘Incident to’ is a Medicare term. Payers know services are performed by NPP and medical staff as ‘incident to’ with the assumption a provider is in the office. If a payer makes such a recommendation, get it in writing.

— see FAQ’s on page 5

## FAQs from AAD “Incident to” Webinar

— continued from page 4

### Q7) Must there be direct supervision when flu shots, laboratory tests, or x-rays are performed in an office setting in order to be billed as “incident to” services?

A7) Diagnostic/laboratory services have their own regulations. “Incident to” doesn’t apply.

### Q8) Can the tech report 99211 with a procedure? Can our MA inject Amevive into a patient? If so what do we charge for it? If we are unable to charge 11900, injection code, can we charge a 99211, nurse visit?

A8) If medical staff have a scope of practice in your state to perform a service under direct provider supervision in the office, 11900 may be appropriate. All surgical procedures do include a pre, intra and post op service. The 99211 reported with a procedure needs to be significant, separate and identifiable service that is over and above a procedure. Check CMS’ NCCI edit as 99211 is bundled into many surgical procedures, \*

## Mandatory Use of New ABN

Mandatory use of the revised ABN (form CMS-R-131) became effective on March 1, 2009. The original date was September 1, 2008, but extended to the March date. For your convenience, the full ABN form is provided on page 6. The directives for using this ABN clarify that:

- Provider is not required to issue an ABN for statutorily excluded services
- Provider is required to issue an ABN for care that is not reasonable and necessary.

In order to know whether an ABN is necessary, the dermatologist must decide whether the service is being performed for a cosmetic reason or whether the service is not reasonable and medically necessary.

Following are some examples of when an ABN must be presented to the patient based on the service not being reasonable and necessary:

A patient exhibits a non-symptomatic skin lesion. For this example, assume there is no medical reason for removing this lesion, but the lesion is excised. An ABN would need to be presented and signed by the patient prior to the surgical procedure.

If the lesion is excised for cosmetic reasons, no ABN would be necessary. It needs to be clear in the medical record documentation as to whether the service is not medically necessary or being done for cosmetic reasons.

If a claim is submitted to Medicare for a service that is not reasonable and medically necessary, modifier **GA** must be appended to the procedure code to indicate that the patient has signed an ABN and the original copy is in the medical record.

A **GY** modifier must also be appended to the procedure code to indicate that the service provided is non-covered by Medicare. The appropriate ICD-9-CM code would be reported.

Submitting a claim to Medicare for a cosmetic service is voluntary. If submitting a claim, be sure to use the **V50.x** ICD-9-CM code directed by the Medicare carrier. This diagnosis code informs the Carrier that the service is an elective service. Also, append the **GY** modifier to the procedure code to indicate the service was a non-covered service.

The original signed ABN becomes a part of the patient’s medical record. A copy of the signed ABN must be given to the patient, per Medicare’s instruction.

Medicare Claims Processing Manual, Chapter 30, Financial Liability Protections gives directions for correctly using an ABN. For the ABN to be validly administered, these directions must be followed carefully and completely. The transmittal may be viewed at: <http://www.cms.hhs.gov/Transmittals/downloads/R1587CP.pdf>

Be sure to look for specific guidance from your Medicare carrier or Medicare Administrative Contractor (MAC) on their web sites regarding the use of ABN forms as well as cosmetic services. If you are not using the ABN Form CMS-R-131 (03/08) on page 6 for Medicare patients, then you are not using a valid ABN. \*

## AAD Coding Staff Can Help!

The AAD Practice, Policy & Management Department has four certified coders on staff to assist you with coding and documentation questions. This is a free service provided to members of the Academy. Feel free to call or email us with any questions that may arise related to coding, documentation and reimbursement.

The general coding staff email address is: [ppm1@aad.org](mailto:ppm1@aad.org)

Or you may contact the coding staff directly:

Peggy Eiden, CPC, CCS-P, CPCD 1-847-240-1799  
[peiden@aad.org](mailto:peiden@aad.org)

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Cindy Bracy, RHIA, CCS-P 1-847-240-1840  
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(A) Notifier(s):

(B) Patient Name:

(C) Identification Number:

### ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

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

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

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

#### WHAT YOU NEED TO DO NOW:

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

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

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

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

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

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

#### (H) Additional Information:

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

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

(I) Signature:

(J) Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

## Coding Q & A's

**Q: We have a doctor leaving the practice. Is it our responsibility to notify Medicare and the Commercial insurances that we are providers with that she is leaving our practice? How does that typically work?**

A: The practice can initiate the information update by completing form 855R updating Medicare info about the practice and its departing provider. If this is not done, any issues that arise with the PTAN associated with the practice will be the practice responsibility to deal with.

If the provider decides to participate in the Medicare program at a different location she/he will also have to complete form 855R updating/changing Medicare enrollment info.

**Q: If a provider repays or Medicare recoups an alleged overpayment identified by the Recovery Audit Contractors (RAC) and the provider later wins an appeal, will CMS reimburse the provider with interest?**

A: At certain times, CMS is required to pay interest when an appeal decision is favorable to the provider. The payment of interest in response to a favorable provider appeal decision is determined by CMS' interpretations of the appeal regulations. Regulations determine the process for all overpayments, not just RAC identified overpayments.

The source of the following Q&A's is the material presented at the Coding & Documentation Workshop during the 2009 Summer Academy Meeting.

**Q: A dermatologist excised a 4.5 subfascial lipoma and then did the pathology, which included gross, microscopic, and preparing a report, would 88304 or 88305 be reported?**

A: Code **88304** is the pathology code for skin cyst/tag/debridement, soft tissue debridement and soft tissue lipoma. Thus code **88304** would be reported for lipomas. Code **88305** would be used for other specimens commonly examined by dermatologists.

**Q: Can code 96405-96406 be used for injecting bleomycin into warts?**

A: No. Codes **96405** and **96406** are used for injecting such drugs as alpha interferon for the treatment of cutaneous malignant lesions.

**Q: When using a chemical peel for the destruction of numerous actinic keratoses of the face, what code should be used?**

A: This is one of those procedures that could be reported in two ways. The directives for destruction for pre-malignant lesions state that any method of destruction can be used including chemical destruction. Codes **17000-17004** are for destruction by any method, code **15788** is used for an epidermal peel or code **15789** is used for a dermal peel. The documentation in the medical record would be the key to selecting the appropriate CPT code.

**Q: Can an E/M always be reported with a procedure?**

A: An E/M service may be reported if the E/M service provided is a separate and **significantly identifiable service** above and beyond the procedure performed. There must be medical necessity for this E/M service which must be clearly documented in the medical record. The E/M Service would be reported with modifier **-25**.

**Q: If a lesion is removed by shave removal and the pathology report indicates the margins are not clear, should this procedure be reported as a biopsy?**

A: No. The pathology report has no bearing on the procedure performed. The procedure performed and documented was a shave removal, thus the appropriate code to report would be **113XX**. One always reports the procedure code that matches the documentation in the medical record.

**Q: When a 4.5cm symptomatic subfascial lipoma is excised from the chest, is it appropriate to report a repair code along with the soft tissue excision code 21556?**

A: The excision codes in the musculoskeletal section of CPT include all repairs unless stated differently. Therefore, a repair would not be separately reported with CPT code **21556**.

**Q: Our physician saw a patient in the hospital and billed a consultation level service. The patient is now coming into the office for a follow up, can the mid-level practitioner bill "incident to" the physician?**

A: The non-physician provider may bill "incident to" the supervising physician 1st visit as long as the physician has established patient care as long as there is a supervising physician in the office. \*

## Using Modifiers -51 and -59

### Correctly

The AMA CPT descriptor for modifier **-51** is, “**Multiple Procedures:** When multiple procedures, other than E/M services, physical medicine and rehabilitation services, or provision of supplies (eg, vaccines), are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier **-51** to the additional procedure or service code(s). **Note:** This modifier should not be appended to designated add-on codes (see [Appendix D](#)).”

The AMA CPT descriptor for modifier **-59** is, “**Distinct Procedural Service:** Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier **-59** is used to identify procedures or services, other than E/M services, that are not normally reported together but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision or excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier **-59**. Only if no more descriptive modifier is available and the use of modifier **-59** best explains the circumstances should modifier **-59** be used. **Note:** Modifier **-59** should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier **25**.”

There is overlap in the descriptors of these two modifiers. Thus, the question is, “When should I use each of these modifiers?”

In reviewing the Medicare Carriers’ web sites, most of the Carriers advise providers that modifier **-51** is not needed nor its use recommended. These Carriers’ claims processing systems will append modifier **-51** when it is necessary. Thus, do not use modifier **-51** unless directed to do so by the payer.

In a recent webinar, Highmark, the carrier for Delaware, New Jersey, Pennsylvania, Maryland and District of Columbia specifically advised providers to use modifier **-51**. To use modifier **-51**, append it to the secondary procedure(s) that is the procedure with the lesser value. The primary procedure would be the highest valued code.

For Medicare carriers, it is important to use modifier **-59** according to the directives of the National Correct Coding Initiative (NCCI) edits. The NCCI Policy Manual for Medicare Services contains the necessary information on when and how to use modifier **-59** for Medicare claims. Access the Manual and the specific CCI edits at: <http://www.cms.hhs.gov/NationalCorrectCodInitEd/>.

These edits were established by Medicare to assure that individual services are provided and that unbundling has not

occurred. The edits indicate that codes may not be reported together except under special circumstances. For example, by the descriptor of the adjacent tissue transfer codes, **14000-14060**, the excision of the lesion is included in the code descriptor and may not be separately reportable. If an excision of a lesion was performed on one site and an excision of a lesion was followed by an adjacent tissue transfer at a different site, then the Modifier **-59** would be appended to the excision of the first lesion to indicate this excision was unrelated, (i.e., at a different site), to the adjacent tissue transfer.

The Mutually Exclusive Edits and the Column 1 and Column 2 edits list those code combinations that when reported together require modifier **-59**. In all cases, the code that is listed in the second column is appended with modifier **-59** when that code is reported with the code listed in the first column. The only way to be sure of the exact placement of modifier **-59** is to access the NCCI edit tables. Misuse of modifier **-59** may cause a claim denial.

The following are examples of services reported together and the correct placement of modifier **-59**:

**17004**  
**17110 -59**

**17110**  
**17000 -59**

**17000 -59**  
**+17003**  
**17110**

**11300**  
**11100 -59**

#### Q. If two lesions of the same size from the same anatomical site were excised, how is this reported?

- A. The NCCI Policy Manual for Integumentary services states, “If multiple lesions are removed separately, it may be appropriate depending upon the code descriptors for the procedures to report multiple HCPCS/CPT codes utilizing anatomic modifiers or modifier **-59** to indicate different sites or lesions.” The only way to be absolutely sure of correct modifier **-59** placement is to check the NCCI edits.

Based on that information, the following examples would be:

**11600 – RT** (if on right side)  
**11600 – LT** (if on left side)  
or  
**11600**  
**11600-59**

Non-Medicare carriers may have different requirements for the use of modifier **-51** and **-59**. Be sure to follow each carrier’s guidelines regarding the use of any modifiers. ✦

## MAC Carrier Tips and Updates

With the new Medicare Administration Contractors (MAC) settling in, there have been some updates to Local Coverage Determinations (LCD). These changes are important to how dermatologists appeal claims to Medicare. According to CMS, it's the provider's responsibility to know and use CMS's rules correctly. Following are updated MAC coverage areas and website information:

**NHIC** (ME, MA, NH, RI, & VT)

**J14 MAC NHIC billing information and support is available at:**

[http://www.medicarenhic.com/ne\\_prov/billing\\_info.shtml](http://www.medicarenhic.com/ne_prov/billing_info.shtml)

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**First Coast** (FL, PR, US Virgin Islands) **J9 MAC - Debridement services -- revision to the LCD**

**LCD ID number: L29128 (Florida)**

**LCD ID number: L29146 (Puerto Rico/U.S. Virgin Islands)**

The local coverage determination (LCD) for debridement services was effective for services rendered on or after February 2, 2009, for Florida and on or after March 2, 2009, for Puerto Rico and the U.S. Virgin Islands. Since that time, a revision was made based on recommendations from internal and external sources.

The following sections of the LCD were updated/ revised:

- Under the "LCD Title" section of the LCD, the title was changed to "wound debridement services."
- Under the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD, verbiage was added/deleted under the following sub headings:
  - "Skin Debridement (CPT codes 11000-11001)"
  - "Surgical Debridement (CPT Codes 11040-11044)"
  - "Active Wound Care Management"
- Added "Limitations" section to the LCD.
- Updated the "Documentation Requirements" section of the LCD.
- Updated the "Utilization Guidelines" section of the LCD, including clarification that all codes and all wounds are included on any given date or over time, for ulcers requiring more than eight total services.
- Updated the "Sources of Information and Basis for Decision" section of the LCD.
- Updated the LCD "Coding Guidelines" attachment.

## EFFECTIVE DATE

The revisions to this LCD are effective for services rendered on or after September 30, 2009. First Coast Service Options Inc. LCDs are available through the CMS Medicare Coverage Database. Coding Guidelines for an LCD (when present) may be found by selecting "LCD Attachments" in the "Jump to Section..." drop-down menu at the top of the LCD page. For LCDs with a future effective date, select the "Display Future Effective Documents" link at the top of the list of LCDs page.

**NGS** (IN, MI, CT, NY)

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**National Government Services** (NY&CT) **J13 - 99245 Review**

National Government Services (NGS) will resume prepayment reviews of claims billed with CPT code 99245. This review will include individual Part B claims submitted by all providers in the Health Now and GHI regions of Jurisdiction 13. Further review of the remainder of Jurisdiction 13 will be reviewed at a later date.

Following receipt of a claim with CPT 99245 billed, a letter will be sent to the provider requesting documentation from the beneficiary's medical record supporting the level of service. Requested documentation should be returned within 30 days of request. If documentation is not received within 45 days the claim will automatically be denied as not medically necessary. Providers will receive results via the standard provider remittance notice.

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**Noridian** (AK, OR & WA as well as AZ, NM, ND, SD, MT & WY) **J2 & J3 MAC - Skin Lesion Removals LCD L10106.**

Noridian's updated LCD on Skin Lesion Removals contains a couple of important changes that need to be read such as:

- In depth reporting explanation of Actinic Keratosis and melanoma biopsy versus a shave procedure;
- Photodynamic therapy for malignant lesions is not a covered benefit.
- Instructions to report a V code, V49.89, Other specified conditions influencing health status with the benign lesion diagnosis code. V49.89 is a secondary diagnosis which is required on the claim but not linked to the claim line. (Per CMS, only one diagnosis per claim line.) By using this code, providers will be asserting the medical record documentation includes verification of the complicating sign, symptom or diagnosis that supports payment for the lesion removal.
- Another major change for dermatology is the reporting of 239.2, Neoplasm of unspecified nature, Bone, soft tissue and skin, rather than the usual 238.2, Neoplasm of uncertain behavior of other and unspecified sites and tissues, Skin. Per Noridian, 238.2 can only be reported for keratoacanthoma.

— see **MAC Carrier Tips** on page 10

## MAC Carrier Tips and Updates

— continued from page 9

- Diagnosis, 706.2, Sebaceous cyst, is included in both Diagnoses List I and List II. Noted with an asterisk. If the cyst is greater than 2.0 cm in diameter, no secondary diagnosis is required. If a cyst is 2.0 cm or less, a secondary diagnosis is required.

Noridian's LCD L10106 can be found at <https://www.noridianmedicare.com/p-medb/coverage/index.html>

**Palmetto GBA** (CA, UT, HA, NV, NC, SC, VA & WV)

### J1 MAC –

#### Mohs Micrographic (MMS) Surgery LCD L28278

Revision History Explanation made:

- Removed statement regarding:
  - o frozen section not adequately identifying melanoma cells at the margin
  - o excision of melanoma is the essential element in the removal of a primary lesion and data continues to accumulate supporting the efficacy of narrow surgical margins.
  - o modifier 59 should not be appended to pathology codes unless a separate biopsy/excision does not involve Mohs surgery.
- Added diagnosis codes that Support Medical Necessity: 171.0-171.8, 172.0-172.8, 173.5, 173.6, 173.7, 184.1-184.8, 187.1-187.4, 187.7, 187.8, 232.0-232.8 and 233.5.

#### Removal of Skin lesions L28300

#### General Information; Documentation Requirements

Office visits will be covered when the diagnosis of a benign skin lesion(s) is made even if the removal of a particular lesion or lesion(s) is not medically indicated and is therefore not done.

- **Actinic Keratosis L28232**  
**Utilization Guidelines**

Accordingly, this Palmetto A/B MAC will deny claims for CPT codes 17000-17004 when the diagnoses submitted are:

- 1) Malignant melanoma of skin 172.0-172.9
- 2) Other malignant neoplasms of skin 173.0-173.9
- 3) Neoplasms of uncertain behavior, skin 238.2

AMA/CPT code 96567 does list malignant lesions as part of its description. Palmetto is not aware of any PDT that is used for malignant skin lesions or benign skin lesions other than actinic keratoses, and will, accordingly, restrict the coverage of 96567 to the treatment of actinic keratoses. \*

## Do You Have a 5010 Transition Plan?

Dermatology practices are encouraged to start considering a 5010 transition plan that will require staff to:

- Update or replace practice-management-system software.
- Train clinical and administrative staff.
- Review and modify organizational work flow.
- Evaluate vendor, clearinghouse, and health plan contracts, and data requirements.
- Develop appropriate processes and budgets to implement these new requirements.

The updated HIPAA transactions also play a critical role with the future of ICD-10 because ICD-10 cannot be implemented without the successful implementation of 5010.

To meet the requirements of the new HIPAA 5010 electronic transaction standards by Jan. 1, 2012, you need to begin preparing your practice now. Make sure you call your billing and/or practice-management vendors and ask them the following questions:

1. Does my vendor contract include an update to the 5010 standards or will I be required to pay for this upgrade? If so, how much will it cost?
2. When will my system be upgraded with the 5010 standards?
3. Will I need to purchase any new hardware?
4. Will you be increasing your yearly fees to cover the cost of 5010 implementation?
5. Will there be testing and validation phases where I can see if any problems occur when submitting claims?
6. Whom should I call if we have problems submitting claims?
7. Will the 5010 upgrade include a 277 Claims Acknowledgment electronic transaction to show me if there was an error in the claim?
8. Will the 5010 upgrade include a Functional Transaction 999 to show me that the claim was accepted by the carrier?
9. If there is an error with the claim, will I receive a "readable" error report and will my system be able to accept this?
10. Will this require any additional training by my staff? If so, where can I obtain this training?

In addition, once you obtain clarification about these questions, make sure you follow up with your clearinghouse vendor to see what its crosswalk strategy and conversation plan is, and how it can work with your practice-management software vendor to ensure a smooth transition to the new electronic transaction standard. Finally, if you are considering implementing an electronic health record (EHR) system, make sure the EHR vendor you choose is able to meet your needs with this new HIPAA electronic transaction standard.

Note that CMS provides free claims-processing software for small practices. More information about this option is available at: [www.cms.hhs.gov/MLNProducts/downloads/MedicareRemit\\_0408.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/MedicareRemit_0408.pdf).

For more information please visit: [www.cms.hhs.gov/ICD10/](http://www.cms.hhs.gov/ICD10/) \*

# Key AAD Comments on 2010 Medicare Proposed Rule

— continued from page 1

## OVERSIGHT FOR AMA RB/RVS UPDATE COMMITTEE

CMS also requested comments on the concept proposed by MedPAC to establish an expert panel separate from the AMA RUC to improve the review of relative values of physician services within the RBRVS. The AAD has been a part of AMA Specialty Society Resource-Based/Relative Value Update Committee (RUC) since its inception. We support the concept of practicing physician direct input in determining physician work RVUs and relative practice expense inputs.

The Academy commented that a superimposed panel or system composed of individuals without accountability who may or may not be actively involved in the day to day practice of medicine and who might lack the insight and understanding that presently is represented at the RUC, would ultimately undermine the carefully established relativity that exists for the majority of procedures that have been RUC-refined.

## PHYSICIAN QUALITY REPORTING INITIATIVE

CMS proposes changing the Physician Quality Reporting Initiative (PQRI) significantly for 2010. For dermatology this means that CMS will only allow registry-based PQRI reporting for the three melanoma measures (# 136, 137, and 138) beginning January 1, 2010. However, CMS is also proposing a transition to all registry based reporting as the standard for all PQRI reporting in 2011. The Academy supports this proposal, as registry based reporting reduces common coding errors and allows physicians to determine whether their data was accurately reported to CMS.

However, CMS is also proposing to change the registry based reporting criteria requiring that a physician must report a minimum of three measures and report on 15 patients for at least one of these measures. These criteria will adversely affect dermatologists' ability to successfully report PQRI measures. Dermatology currently has few NQF-endorsed performance measures, and in 2010 dermatologists will only be able to report on three measures, all of which are related to melanoma (referenced above). Therefore, the Academy strongly disagreed with these two proposed requirements.

## ELECTRONIC PRESCRIBING

CMS proposes significant changes to the e-prescribing incentive program, including a reduction in the reporting requirement from 50 percent of applicable e-prescribing cases to 25 cases per year. The Academy strongly supports this proposal to reduce the reporting burden. The Academy also agrees with CMS' proposal to revise the reporting option to one G code stating that the provider successfully completed an electronic prescription for the specified patient,

as well as allowing both registry and EHR reporting. The Academy is also pleased that CMS will list all of the e-prescribing vendors who meet the qualifications for the incentive program on their website.

However, AAD does have concerns regarding CMS' plan to publicly report the names of successful e-prescribers on the website. First, it is critical that in exercising this authority, CMS takes all necessary measures to ensure the accuracy of the information before publicly releasing it on the website. Second, since ambulatory care must make up 10% of a provider's charges to qualify for this program, many dermatologic surgeons will not qualify for this program and will be left off the website. Since the e-prescribing incentive program is new in 2009, the Academy is concerned that the public may not understand the purpose of the list of names, and furthermore will not fully understand the inclusion criteria for the program. AAD urged CMS to consider delaying the posting of physicians' names until physicians and the public alike have a better understanding of the details of the incentive program. \*

## PQRI reporting for 2010 - AAD Offers Online Registry

Medicare's Physician Quality Reporting Initiative (PQRI) will continue to allow dermatologists to earn a bonus payment of up to 2 percent of their total claims in 2010. In order to receive the bonus, though, dermatologists will likely have to report their PQRI participation through an online registry. The Centers for Medicare and Medicaid Services (CMS) stated in the proposed fee schedule rule that beginning Jan. 1, 2010, PQRI will no longer allow claims-based reporting for the three melanoma measures.

To help dermatologists meet this potential new requirement, the American Academy of Dermatology will begin offering a PQRI registry for 2010 reporting. Based on the proposed rule for 2010 (which does not become final until November), dermatologists are slated to be able to report on three quality measures related to melanoma; As noted on p. 1, two other new rules are also possible, though the Academy is opposing their immediate implementation. First, all PQRI participants must report at least three measures in order to be eligible for a bonus payment. In addition, participants would be required to report on a minimum of 15 patients for at least one measure to qualify for the bonus payment. Dermatologists will have until February 2011 to report on all of their patients who meet the measure guidelines for 2010.

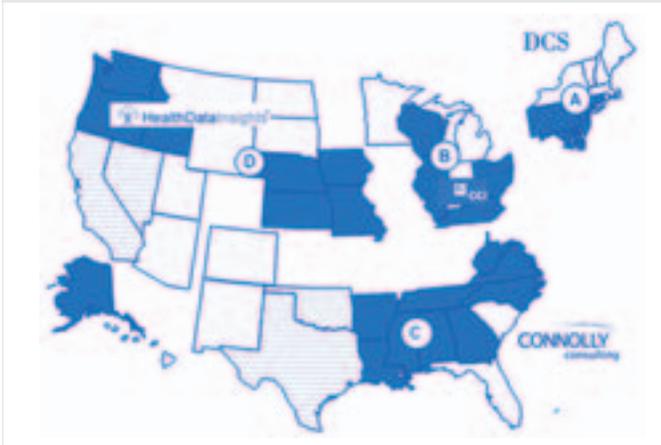
Data from the registry will be directly sent to CMS in February 2011 and CMS will evaluate the data to determine if the reporting guidelines have been met. If they have, CMS will issue a 2 percent bonus payment directly to the practice.

The online 2010 registry will be available to dermatologists at minimal cost. Details will be available in November on the Academy Web site and in Dermatology World. \*

## IN THE KNOW...

**RAC Contractors, regions assigned and contact email addresses:**

- Region A Diversified Collection Services  
<http://www.dcsrac.com>
- Region B CGI  
<http://racb.cgi.com>
- Region C Connolly Consulting [www.connollyhealth-care.com](http://www.connollyhealth-care.com)
- Region D HealthDataInsights [www.healthdatainsights.com](http://www.healthdatainsights.com)



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## Upcoming Webinars in 2009 – Mark Your Calendars!

*Practice Management Essentials Webinars refresh knowledge of coding, practice management, payer regulations, and updates through the use dermatology specific examples and definitions. Perfect for in-service training for physicians and staff. Visit [www.aad.org/webinars](http://www.aad.org/webinars) to register today!*

**Mastering CCI Edits – Oct. 22**

**2010 Coding updates – Nov. 19**