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Derm Coding Consult

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CIGNA Modifier Policy Update

CIGNA'S NEW POLICY ON MODIFIER 25/59: CLAIMS CODE EDITING AND DOCUMENTATION REQUIREMENTS

CIGNA recently released details of its new claims edit policy that took effect on April 27, 2009. The new policy involves reviewing supporting documentation for claims billed with certain code combinations that carry modifiers 25 and 59 respectively. The CIGNA policy is based on applying the Center of Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and requires supporting documentation for some claims submitted with modifiers 25 and 59. Previously, CIGNA indicated that it was going to implement a policy that would require documentation on all 17,000 NCCI code sets. However the Academy with the assistance of the American Medical Association (AMA) communicated that this policy change would cause an administrative burden for physicians and their office staff. CIGNA agreed to revise their policy and only require supporting documentation on 200 specific code sets for modifiers 25 and 59.

CIGNA has published the code combinations that require additional documentation with modifiers 25 or 59 on their secure website for Health Care Professionals, www.cignaforhcp.com. Click on the "Resource" page and then click on "Claim Editing Procedures" to access the information. **As of April 27, 2009, CIGNA will require additional documentation for some dermatology codes using modifier 25 or 59. Please see the table on page 10 for specific code sets.**

If your practice performs procedures from one of the code pairs listed, for claims submitted electronically, then you must check Box 19/Loop 2300 on the claim submission to indicate that you submitted supporting documentation. This documentation should be faxed to CIGNA at (570) 496-2945 or sent via mail to the CIGNA address on the back of the patient's ID card. CIGNA has stated that payment will not be delayed to the physician, and as long as the practice indicates in Box 19/Loop 2300 on the claim submission, payment will be sent to the physician even if the additional documentation has not yet been reviewed by the time the claim is processed.

For paper claims submitted via regular mail, CIGNA requests that a copy of the appropriate documentation be included with the paper claim. Processing of the claim will not be delayed to review the documentation.

The Academy will continue to work with the AMA and other physician groups to convince CIGNA of these burdensome requirements that drive up the cost of care and compromise timely access to quality, dermatologic services. The Academy welcomes the opportunity to hear about specific dermatology practices affected by this policy and would encourage physicians to contact Rachna Chaudhari at rchaudhari@aad.org for further information.

— see CIGNA on page 10

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IMPORTANT Please Route to:

Dermatologist Office Mgr Coding Staff Billing Staff

Letter from the Editor

Dear *Derm Coding Consult* Reader:

Spring 2009 seems to be bringing a shower of new regulatory requirements, increased CMS RAC Audit activities as well as increased documentation requirements. Which all seem just a bit contrary to the new Obama Administration's interest in expediting and expanding electronic health information interfaces.

Did you know that every issue of *Derm Coding Consult* (back to the first issue in 1996) is available on line and can be downloaded anytime at: <http://www.aad.org/members/publications/consult.html>. To be frank, it would be quicker and less expensive for the Academy, if each issue of *Derm Coding Consult* came to you via the internet.

Did you know that you can submit coding questions directly to AAD Practice Policy and Management staff? E-mail questions to us at: dcc@aad.org or ppm1@aad.org.

AAD Members should know that everything they need to implement the new FTC Red Flag Identity Theft Prevention regulations is available FREE on the AAD web site at <http://www.aad.org/pm/compliance/redflagrule/>

AAD has also provided clarification on the correct implementation of PQRI Measure #138 reporting for your practice. Visit the AAD PQRI web page at: <http://www.aad.org/pm/billing/PQRI/index.html>

The Academy has a new webinar schedule for 2009. Make a date with the Practice Policy and Management staff and key dermatologists for the third Thursday of the month for one hour webinars on key dermatology issues. Check out the schedule and register at: <http://www.aad.org/pm/education/webinar/index.html>.

"Incident To" Requirements	06/18/09
Managed Care Contracting	07/16/09
Making the Most of Modifiers	09/17/09
Mastering CCI Edits	10/22/09
2010 Coding Updates	11/19/09

Best regards,



Norma L. Border, Editor

Coding Update

CODING & DOCUMENTATION GUIDELINES REVIEW

With the increased CMS audit scrutiny of physician billing, the most frequently asked coding questions from dermatology practices are focusing on the documentation necessary to support specific levels of E/M services for both new and established patients. The following review and dermatology specific scenarios should help clarify these requirements

1997 E/M Documentation Guidelines - Scenarios

The documentation guidelines require physicians to document a certain number of elements, depending on the level of exam. Lesser exams require fewer elements as follows:

Level of 1997 Exam

Problem Focused	One to five elements identified by a bullet
Expanded Problem Focused	At least six elements identified by a bullet
Detailed	At least twelve elements identified by a bullet.

The majority of exams performed by dermatologists are level II or level III exams. For such exams, vital sign measurement may not be required for the average new or established patient, but a comment about the general appearance of the patient may be appropriate. The following is offered as examples of documentation required for level I, level II or level III exams. For space considerations, only the exam documentation has been listed.

The content of the examination should be based on clinical judgment, the patient's history, and the nature of the presenting problem(s). Individual elements are listed in line item format for clarity and identified by bullets (•) in the left column, however, they need not be charted and a narrative or other

— see **Coding Update** on page 3

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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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Coding Update

— continued from page 2

format is acceptable as well. Chart reviewers are required to “give credit” for each element documented regardless of how the record is organized.

Level I New Patient visit (99201) - requires a problem focused exam, physicians must perform and document one to five elements identified by a bullet.

Example: Initial visit 65 year old male with a symptomatic seborrheic keratosis on the upper back.

- Back 12mm Keratotic acanthotic brown lesion with follicular dilatation and inflamed base right upper back.

The above is sufficient exam documentation for a 99201 initial visit. The patient’s age may suggest that the dermatologist also look over the sun exposed face, arms and chest as well as the back, but if only these four more elements are documented, it would not be enough to qualify as an expanded problem focused exam, which would require six elements. The addition of another element, such as a comment on exam of the scalp or neck or general appearance would add the required number of elements for the next level exam.

Level II New Patient visit (99202) - requires an expanded problem focused exam, and requires at least six elements (bullet • items)

Example: 16 year old male with severe cystic acne.

EXAM

Constitutional

- Gen’l appearance well developed muscular male

Neuro/Psych

- Orientation Oriented x3, mature, cooperative

Skin

- Head incl. Face open and closed comedones, forehead, paranasal, with papules and pustules cheeks with few inflamed acne cysts left jaw
- Neck several cysts left lateral neck with ingrowing hairs occipital hairline
- Chest comedo and papular acne upper mid chest
- Back acne cysts on posterior shoulders

TOTAL 6 ELEMENTS

For an established patient, a level III visit, CPT (99213) also may include an expanded problem focused exam. Therefore, documentation of six elements in the above example of acne would meet the exam requirement for a level III follow up visit. Also, since established patients only require documentation of at least two of the three key components for a given level visit, if the history and medical decision making for a level III follow up exam meet the documentation requirements for that visit, the exam documentation may be less than the six elements otherwise required.

Level III New Patient Office Visit (99203) requires a detailed examination that must document at least twelve elements, identified by a bullet (•).

Example: 53 year old female with multiple concerns, including rash on face and scalp, moles on face and body, and fungus toenails.

EXAM

Constitutional

- Gen’l appearance slightly obese, tanned female

Neuro/Psych

- Orientation Oriented x3
- Mood worried about possible skin cancers

Skin

- Scalp/hair moderate seborrheic scaling frontal temporal hairline, occiput, and medial eyebrows
- Face Seborrheic dermatitis on forehead
- Neck six 2-4 mm Skin tags lateral base neck
- Chest multiple, typical, tan-to-brown seborrheic keratoses lateral chest, 6-8 mm and SKs mid and upper back, 6-10 mm.
- Back 6 mm Hairy, tan nevus right mid dorsal forearm
- Right upper extrem light brown lentiginosa both hands
- Left upper extrem firm, 6 mm., tan dermal nodule with adherent epidermis right lateral calf
- Right lower extrem opaque thickening distal two-thirds left 2nd and 3rd toenails consistent with onychomycosis
- Left lower extrem

TOTAL 12 ELEMENTS

The exam documented above would meet the criteria for a detailed exam. The level of history and medical decision making would also have to be documented appropriately to support a 99203 initial visit. For an established patient, a level IV visit, CPT (99214) also may include a detailed exam. Therefore, documentation of twelve elements in the above example of acne would meet the exam requirement for a level IV follow up visit. Also, since established patients only require documentation of at least two of the three key components for a given level visit, if the history and medical decision making for a level IV follow up exam meet the documentation requirements for that visit, the exam documentation may be less than the twelve elements otherwise required. *

Correction — Winter 2008 “In the Know”

- 078.19 Other specified viral warts
Common Wart
Flat Wart_- Veruca
~~Genital Wart *~~

New Red Flags Regulation

WHAT ARE RED FLAG REGULATIONS?

Red Flag Regulations or RFR's are a part of the implementation of the Fair and Accurate Credit Transactions Act of 2003 which has provisions to deter and prevent identity theft. There are three parts to the Red Flag Rules:

1. Entities that use consumer reports find an address discrepancy between the info provided and the report.
2. Issuers of smartcards or smartcards.
3. Identity-theft prevention.

Identity thieves use an individual's identifying information to open new accounts and/or misuse existing accounts. The increased incidence of identity theft nationally is creating havoc for consumers and businesses. All medical practices are required to implement a program to detect, prevent, and mitigate instances of identity theft.

HOW DOES THIS APPLY TO MY PRACTICE?

Medical practices are most affected by the third rule of the RFR. Practices that do not demand payment in full and agree to bill insurance for the balance are considered creditors. A creditor is defined in the Red Flag Regulations as any entity that regularly extends, renews, or continues credit; any entity that regularly arranges for the extension, renewal, or continuation of credit; or any assignee of an original creditor who is involved in the decision to extend, renew, or continue credit. Patient billing and medical records are considered covered accounts due to the nature of the relationship. There is opportunity for multiple payment or installment payment plans and/or multiple visits.

HOW TO BECOME COMPLIANT?

An identity theft prevention program must contain policies and procedures to perform an internal risk assessment and detection. Practices must develop a written program that identifies and detects the relevant warning signs – or “red flags” – of identity theft. Compliance with HIPAA or the False Claims Act does not replace compliance with RFR's.

WHEN IS THE RFR EFFECTIVE?

The effective compliance date for rule three has been extended to 08/01/09 (originally was set for 11/01/08). For more information visit www.worldprivacyforum.org/pdf/WPF_RedFlagReort_09242008fs.pdf

Or the AAD web site at: <http://www.aad.org/pm/compliance/redflagrule/> *

Insurers Review Billing for Photochemotherapy (CPT 96910)

Recent private insurer and Medicare audit findings on claims for CPT code 96910 Photochemotherapy tar and ultraviolet B (Goeckerman treatment) or petrolatum and ultraviolet B indicate that the procedure was not being documented or billed appropriately. As currently defined in AMA CPT, this procedure specifically includes the use of Tar or petrolatum with the light therapy.

The American Medical Association's (AMA) Current Procedure Terminology (CPT) coder's Desk Reference defines CPT 96910 as “the physician uses photosensitive chemicals and light rays to treat skin ailments”. The photosensitive chemicals are further defined as either tar or petrolatum. A review of the Practice Expense Data used by the Center for Medicare and Medicaid Services (CMS) to set the Practice Expense RVUs includes clinical staff time and includes the cost of medical supplies needed to provide this service.

AAD Coding & Reimbursement staff are receiving a growing number of reports from dermatology practices that private insurers as well as Medicare are reviewing photochemotherapy treatment documentation. Carriers are reducing the procedure to 96900 if the documentation in the medical record or flow sheet does not include the documentation of application of tar, petrolatum or other emollient. They are especially noting if the application of an emollient had been documented and if not, what was the medical necessity of non-application.

For more information published by one Medicare carrier about photochemotherapy codes go to: http://www.medicarenhic.com/ne_prov/articles/photochemotherapy_0807.pdf *

CMS Lifts Physician Signature Requirements

A physician's signature is not required on orders for clinical diagnostic tests that are paid on the basis of the clinical laboratory fee schedule, the Medicare physician fee schedule, or for physician pathology services. While a physician order is not required to be signed, the physician must clearly document in the medical record his or her intent that the test be performed. Make sure that your office, billing, and/or laboratory staffs are aware of this updated guidance regarding the signature requirement for diagnostic tests.

For more information on **Trans. 94, CR #6100, Pub. 100-02, MLN: MM6100**, go to: <http://www.cms.hhs.gov/Transmittals/downloads/R94BP.pdf> *

Dermatology Specialty Name Changes

The CMS National Uniform Claims Committee (NUCC) updated several Specialty names in late 2008. The CAQH Universal Provider Datasource (UPD) service is the industry standard for collecting provider data used in credentialing, claims processing, quality assurance, emergency response, member services, such as directories and referrals, and more. By streamlining data collection electronically, CAQH uses the NUCC Specialty names in the CAQH Standard Provider Credentialing Application.

Effective January 30, 2009, your Specialty name in the CAQH application may have been changed. If so, you will receive a reminder message when you first login to the system on or after January 30, 2009 with the new name.

CAQH UPD is reducing duplicative paperwork and millions of dollars of annual administrative costs for more than 700,000 physicians and other health professionals, as well as over 450 participating health plans, hospitals and healthcare organizations.

A single, standard online form permits providers in all 50 states and the District of Columbia to enter their information free of charge through an interview-style process. All data is stored in a secure, centralized database housed in the United States. The UPD form meets the data-collection requirements of URAC, the National Committee for Quality Assurance (NCQA) and the Joint Commission (JCAHO) standards. Indiana, Kansas, Kentucky, Louisiana, Maryland, New Jersey, Ohio, Rhode Island, Tennessee, Vermont and the District of Columbia have adopted the CAQH standard form as their mandated or designated provider credentialing application.

UPD makes it easy for providers to access, manage and revise their information at their convenience. Providers keep total control of the data, authorizing only the UPD-participating organizations of their choice. Revisions are made available instantly to authorized healthcare organizations – there’s no need to contact each organization individually.

To update your Dermatology Specialty name, follow the UPD system re-attestation instructions and trigger the system audit function. The audit will identify the Specialty name as a required fix, so select the new Specialty name from the drop-down menu and complete the re-attestation process.

Listed below for your reference are the changes being made to Dermatology Specialty names:

Provider Type:	Old Specialty Name:	New Specialty Name:
Osteopathic Doctor (DO)	Dermatology, Dermatological Surgery	Dermatology, Procedural Dermatology
Medical Doctor (MD)	Dermatology, Dermatological Surgery	Dermatology, Procedural Dermatology

If you need additional information or assistance in completing your application, please contact the Provider Help Desk at caqh.updhelp@acsgrs.com or (888) 599-1771. Help Desk hours are 7:00 a.m. – 9:00 p.m. EST, Monday – Thursday, and 7:00 a.m. – 7:00 p.m. on Fridays. Please include your CAQH Provider ID in any email messages or have it available when you use the toll-free support number. *

New Medicare Advantage Dispute Resolution Process:

Dermatologists have frequently expressed concern that Medicare Advantage PFFS plans pay less than the standard Medicare physician payment schedule amounts or otherwise do not correctly implement Medicare payment policies. Through a contract with First Coast Service Options (FCSO), CMS has set up a new dispute resolution process for these types of problems. After a MA PFFS plan informs a physician in writing that a payment dispute has been denied through the MA organization’s own payment dispute process, a physician who disagrees with the pricing decision has the right to request that First Coast Service Options review that decision. The request must be in writing and should be made on a standard form that will be available at the contractor’s PFFS website at http://www.fcso.com/whatwedo/QIC/139297.asp#P-5_0 *

New RACs rollout in 23 states

CMS has expanded the Recovery Audit Contractors (RAC) program and awarded contracts in the following four jurisdictions:

Region	Recovery and Audit Contractor (RAC)	Assigned States (so far)
A	Diversified Collection Services Inc.	Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, New York
B	CGI Technologies and Solutions Inc.	Michigan, Indiana, Minnesota
C	Connolly Consulting Associates Inc.	South Carolina, Florida, Colorado, New Mexico
D	Health Data-Insights Inc.	Montana, Wyoming, North Dakota, South Dakota, Utah, Arizona

PRG-Schultz will perform subcontracting work in regions A, B and D, and Viant will subcontract in Region C. RACs will begin operating in the 23 states, denoted above, March 1. After Aug. 1, RACs will be introduced to the remaining 27 states, but a more exact schedule for those states has yet to be defined. CMS will move forward with implementing the full RAC contract program by 2010.

— see RACs on page 6

New RACs rollout in 23 states

— continued from page 5

Physicians will begin receiving demands from Recovery Audit Contractors (RACs) to submit medical record documentation for claims submitted to Medicare. However, there are specific limits to the number of medical records the RAC may request. Make sure your practice manager or administrator knows these limits.

RAC record request limitations are:

- solo practitioner, 10 medical records per 45 days;
- partnership of 2-5 individuals, 20 records per 45 days;
- group of 6-15 individuals, 30 records per 45 days;
- and, large group of 16 or more individuals, 50 records per 45 days *

Meeting Paper Claims Filing Qualifications

The Administrative Simplification Compliance Act (ASCA) requires that all claims be submitted to Medicare electronically, with few exceptions. The exceptions to the electronic claim submission requirements are the following:

- **Small provider** - a provider with fewer than 9 FTEs that bills a Medicare carrier
- **Dental claims**
- **Demonstration project participant** in which paper claim filing is required due to the inability of the Applicable Implementation Guide, adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to report data essential for the demonstration
- **Mass immunizations**, such as flu injections, may be permitted to submit paper roster bills
- **Medicare tertiary claims** when more than one other payer is responsible for payment prior to Medicare payment (Note: claims in which Medicare is the secondary payer (MSP) are required to be billed electronically unless you meet another circumstance)
- **Medical Services** furnished outside of the United States
- **Disruption in electricity and communication** connections that are beyond its control; and "Unusual circumstance" exists that precludes submission of claims electronically

1.) How do I file for a waiver so I can send paper claims?

You don't need to file a waiver to submit paper claims unless you have received an ASCA development letter requesting information from you regarding paper claim submission. Only providers that submit 31 or more paper claims in a quarter or have had a previous two-year waiver receive the ASCA development letters.

2.) I have less than 9 employees. How can I obtain a waiver?

If a provider files 31 or more paper claims in a quarter, they will be reviewed by their local carrier's ASCA Monitoring Department. If you have less than 10 full time equivalent employees, then you will need to respond to the ASCA department letter with the correct documentation to receive a waiver which may allow you to continue to submit paper claims. You cannot file a waiver to submit paper claims unless you have received an ASCA development letter requesting information from you regarding paper claim submission.

3.) I am getting my Medicare Secondary Claims (MSP) denied because I am sending them on paper. My software does not allow me to bill MSP claims electronically. How do I get a waiver for my MSP claims?

MSP claims are not an exception to the ASCA requirements. All Medicare claims (see exceptions above) must be billed electronically. You should contact your claims software vendor regarding their software's ability to send MSP claims electronically. If your vendor software is not capable of filling out MSP claims, you can use other software or most Medicare Carrier EDI departments offer FREE software which is capable of sending MSP claims. Their staff is more than willing to assist you in obtaining and supporting this free software.

4.) Where do I get a waiver request form to send paper claims?

There is no waiver request form. Your Medicare Carrier or MAC Contractor's ASCA monitoring Department will request documentation such as the practice's payroll hours for a quarter, a Federal 941 tax form showing the number of employees, a flu roster schedule or a dental license. This documentation is only requested from a provider that submits 31 or more paper claims in a quarter or has had a previous two-year waiver to submit paper claims and has received the ASCA development letter.

5.) How do I contact my Medicare Carrier's ASCA Monitoring Department?

If you have any questions, please contact your Medicare carrier or A/B MAC, at their toll-free number, which may be found on the CMS website at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

Please be aware that CMS requires that each provider filing paper claims will be reviewed every two years once they have been issued a waiver. If you receive a letter from the ASCA requesting documentation to continue to submit paper claims, you will have 90 days to provide the requested documentation. If you do not qualify or do not respond to the letter within the 90 days, on the 91st day after the letter is sent, your paper claims will be denied. *

CMS Changes Provider Enrollment, Billing Rules

The Centers for Medicare & Medicaid Services (CMS) has curtailed retrospective billing privileges for physicians and non-physician providers (NPPs) with pending Medicare enrollment applications effective Jan. 1, 2009. The shorter retrospective-billing period while the application is being processed, is among the changes and improvements to enrollment and billing rules now in effect for services furnished by physicians and NPPs effective Jan. 1, 2009 published in the Federal Register issued Oct. 30, 2008 by CMS.

Establishment of an Effective Billing Date

The final rule establishes the effective date of billing for physicians and NPPs as the later of:

- (i) the date of filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor; or
- (ii) the date an enrolled physician or NPP first started furnishing services at a new practice location.

Prior to Jan. 1st, 2009, Dermatologists and NPPs had 23 months to retroactively bill for services furnished to Medicare beneficiaries while their Medicare Enrollment Application is being processed. Not anymore.

CMS final rule changes state that physicians and NPPs who meet all program requirements may only bill retrospectively:

- a) For services furnished up to 30 days prior to the effective date, rather than the 23 months allowed under regulations prior to Jan., 2009; and
- b) For services furnished up to 90 days prior to the effective date if the President has declared an emergency under the Robert T. Stafford Disaster Relief and Emergency Assistance Act.

To avoid complications and unnecessary claim denials, Dermatologists should be proactive and submit the enrollment packages into Medicare sooner than later to allow ample time for the application to be processed. Dermatology practices are encouraged to check with the local Medicare carrier to establish the average time it takes for the application to be processed and plan accordingly.

INTERNET-BASED MEDICARE ENROLLMENT IS AVAILABLE

Now dermatologists can enroll or make a change in their Medicare enrollment information online. The Internet-based Provider Enrollment, Chain and Ownership System (PECOS) allows physicians and non-physician practitioners to enroll, make a change in their Medicare enrollment, view their Medicare enrollment information on file with Medicare, or check on the status of a Medicare enrollment application via the Internet.

The Centers for Medicare & Medicaid Services (CMS) announced that Internet-based PECOS is available to physicians and non-physician practitioners in District of Columbia and all 50 States. Physicians and non-physician practitioners in who wish to access Internet-based PECOS may go to <https://pecos.cms.hhs.gov>.

FASTER

By submitting the initial Medicare enrollment application through Internet-based PECOS, an enrollment application can be processed as much as 50 percent faster than by paper. This means that it will take less time to enroll.

Physicians and non-physician practitioners are required by regulation to report certain changes in their enrollment information within specified timeframes. Internet-based PECOS will allow them to update, make corrections, and check on the status of their Medicare enrollment applications. Changes include a change in practice location, ownership, or final adverse action (e.g., medical license suspension or revocation.) For additional information about the types of changes that must be reported, go to the download section of www.cms.hhs.gov/MedicareProviderSupEnroll.

SECURE

Internet-based PECOS meets all required Government security standards in terms of data entry, data transmission, and the electronic storage of Medicare enrollment information. Only authorized individual physicians and non-physician practitioners can enter enrollment information into PECOS or view PECOS data from the Internet. User IDs and passwords protect the access to their enrollment information.

After physicians or non-physician practitioners create User IDs and passwords or change their passwords, they should keep this information secure and not share it with anyone. By safeguarding their User IDs and passwords, they are taking an important step in protecting their enrollment information. CMS does not disclose Medicare enrollment information to anyone except when we are authorized or required to do so by law.

EASY

Internet-based PECOS is a scenario-driven application process with front-end editing capabilities and built-in help screens. The scenario-driven application process will ensure that physicians and non-physician practitioners complete and submit only the information necessary to enroll or make a change in their Medicare enrollment record. In contrast to the information collected on the CMS-855I, physicians and non-physician practitioners will no longer see questions that are not applicable to their enrollment scenarios when using Internet-based PECOS.

Note: Physicians and non-physician practitioners are still required to sign and date the Certification Statement and mail the Certification Statement and all supporting paper documentation to the Medicare contractor.

A Medicare contractor will not process an Internet enrollment application without the signed and dated Certification Statement and the required supporting documentation. The effective date of filing an enrollment application is the date the Medicare contractor receives the signed Certification Statement that is associated with the Internet submission.

ADDITIONAL INFORMATION

For information about Internet-based PECOS, including important information that physicians and non-physician practitioners should know before submitting a Medicare enrollment application via Internet-based PECOS, go to www.cms.hhs.gov/MedicareProviderSupEnroll. *

2007 PQRI Report Issues

CMS announced the release of a new report entitled *Physician Quality Reporting Initiative (PQRI): 2007 Reporting Experience*. The report provides a detailed analysis of the 2007 PQRI reporting experience and outlines some of the challenges and successes of the 2007 program, as well as some of the business reasons that may explain why these challenges occurred.

This report describes several issues identified for 2007 and CMS' plans for modifications to the analytics for the 2008 PQRI. In addition, CMS will apply these modifications to the 2007 PQRI data and rerun the data. CMS expects that additional eligible professionals will qualify for an incentive payment for both 2007 and 2008 based on these efforts. It is anticipated that these activities will be completed by fall 2009.

The report is available on the CMS Web site at:

<http://www.cms.hhs.gov/PQRI/Downloads/PQRI2007ReportExperience.pdf> *

Blue Cross Blue Shield of Illinois Pass-through Billing Update

Blue Cross Blue Shield of Illinois has announced it will suspend the April 1, 2009 implementation of "pass-through" billing policy changes related to laboratory services. The changes BCBSIL planned to implement would have prohibited pass-through billing.

Citing current economic conditions, BCBSIL expressed concern that the change would have negative unintended financial consequences for some medical practices. For now BCBSIL will continue to reimburse treating physicians who bill for lab services. Click this link to view the full BCBSIL statement: <http://www.bcbsil.com/provider/ptb.html> *

CODING Q&A's

Q. I participated in a recent AAD webinar on (date) and would like a little more information on when it's ok to bill a level 4 office visit for a new or established patient?

A. For an established patient, a level 4 or 5 service (99214, 99215) requires two out of the three key components of: a detailed history, a detailed exam, a moderate complexity medical decision making (MDM). Of course, one could document a detailed history and a detailed exam on probably most patients, but the medical necessity of doing such would be driven by the chief complaint. Thus, the nature of the presenting chief complaint must support two out of the three components which must meet or exceed a detailed history, a detailed exam, and/or moderate complexity MDM, is medically necessary.

The same applies to a new patient level 4 or 5 service (99204, 99205, 99244, 99245), however, all three components must meet or exceed a comprehensive history, comprehensive exam, and high complexity MDM for level 5 and moderate complexity of a level 4. Dermatologists rarely see new patients that require that type of service.

Q. What are the key points that need to be included in the progress note in order to justify an E/M level 4 or 5 billing?

A. Medicare has directed that the amount of documentation doesn't matter, what matters is the medical necessity for the E/M based on the chief complaint or nature of presenting problem. In an audit, Medicare will disallow documentation that isn't pertinent to the patient's symptoms.

The September 2000 issue of *Derm Coding Consult*, pages 4-6, gives information on selecting the appropriate level of E/M service. You may view that article at: http://www.aad.org/members/publications/_doc/DDC_00_Sept.pdf

Q. When and how is Modifier -52 used?

A. Modifier 52 should be billed with a service or procedure that is partially reduced or eliminated at the physician's discretion.

Medicare requires an operative report for surgical procedures and a concise statement as to how the reduced service is different from the standard procedure. Both of these documents are needed to determine the correct payment allowance based on the procedure performed.

Claims for non-surgical services reported with modifier 52 must contain a statement as to how the reduced service is different from the standard service. You may include other documentation (submitted with claim or faxed) but it is not necessary if the statement can convey the scope of the reduced service. If a statement explaining the reduction of the service or procedure is not submitted, the code billed with the 52 modifier will be denied.

Q. Is 2009 PQRI bonus based on:

- the total % of patients in Medicare's database from our practice? or
- the new Melanoma patients that are seen starting January 1 through December 31, 2009?

A. The PQRI bonus is calculated from total amount of your 2009 Medicare allowables received. The bonus payment for PQRI is a flat 2% bonus on covered Medicare Part B PFS and Medicare Railroad services between 1/1/09-12/31/09.

At this time, Part C Advantage or Part D Drug are not

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Coding Q & A's

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included in this program. So if your allowable are \$100,000 and assuming the claims are reported and captured correctly, the bonus would be \$2,000.

Q. For PQRI can the Evaluation and Management service (E/M) code have a different diagnosis code?

A. Yes the Evaluation and Management (E/M) office visit (99201-99245) may have another diagnosis for that day's service. Note, the office visit code must be reported along with the PQRI measures. If your billing system only allows 6 lines and surgeries were performed on the same day, split the surgeries to another claim/invoice.

Q. I didn't get a 2007 Bonus check but there is a 2007 feedback report. Can I appeal my claims?

A. No appeals are available but due to the many claim errors, CMS has advised they will review the 2007 bonus program for only those physicians who participated but didn't receive a 2007 bonus check. CMS's analysis won't be available until late fall.

Q. According to the March 30, 2009 AAD Member Alert clarification on Measure 138, CMS stated this measure cannot be used for a history of melanoma (V10.82) how will the bonus be calculated?

A. The bonus will be calculated on the reporting of the three melanoma measures for a new or reoccurrence. Take care to report those claims correctly. Review the explanation of benefits (EOB) remittance remark (RA) for N365. This RA will confirm the codes were accepted and transferred by the carrier to the National Claims History Analysis contractor's file. *

Internet Access Requirement for Practice Success

What is the claim status of Jane Doe's last visit?

Where do I find a copy of the new ABN form?

How can I verify insurance more efficiently?

What are the most current HIPAA rules and regulations?

If you have ever asked yourself these questions, then it is time for your dermatology office to get connected. Internet access is invaluable to a dermatology practice. Staff will spend less time on the phone researching insurance information and more time on direct patient contact. Staff will have instant access to valuable information from a variety of reliable web-based resources. This information will aid your staff in various areas of productivity from the front desk to the billing and coding staff.

Front Desk Opportunities

Dermatology office staff has a constant need for current information. Many insurance carriers now have web sites with 24 hour access. This allows the front desk staff to verify insurance coverage in real time. This is a very effective tool when trying to reduce the number of claims rejected due to lapsed or invalid insurance coverage. The advent of HIPAA (Health Insurance Portability Accountability Act) has created many guidelines designed to protect the patient's health information and dictates how it should be stored. Fortunately, insurance carriers have previously addressed many of the security issues and have safeguards in place for Protected Health Information (PHI), and access to their sites has not been affected.

Billing Staff Opportunities

One of the greatest areas of opportunity to gain efficiencies is with the billing staff. There is a wealth of information available on the carrier web sites. Previously, in order to check the status of a claim there were two choices. The staff could call the carrier directly to check claim status or they could request a status check in writing delivered via fax or mail. In either case, it would take a very long time to check a large number of claims and it can be a very frustrating process.

By utilizing the carrier web site an unlimited number of claims can be checked at any time of the day that is convenient. Once the requested information has been obtained, some web sites will allow online reviews, corrections and/or resubmissions that can decrease the turnaround time for a resubmitted claim.

The Internet may be used as a source for information on referring physicians. Online lookups (mini dictionaries/lists relating to a particular set of data) for a physician UPIN (Unique

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CIGNA Modifier Policy Update

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TABLE 1
CPT® Code Combinations with Modifier 25 That Require Documentation Submitted with the Claim
Effective April 27, 2009

Initial Code	Secondary Code		
95044	99214	<p>EXAMPLE: If a dermatologist sees a patient and codes a 95044 for allergy patch testing along with a code of 99214 for an outpatient office established visit on the same day of service, the biller would have to attach a modifier 25 and submit supporting documentation to CIGNA.</p>	<p>EXAMPLE: If a dermatologist sees a patient and codes a 17000 for destruction of a premalignant lesion and an 11200 for removal of skin tags on the same day of service, the biller must attach a modifier 59 to 11200 and submit additional documentation to CIGNA.</p>
95044	99215		
95044	99245		
96401	99215		
96402	99215		
96409	99215		
96413	99215		

TABLE 2
CPT® Code Combinations with Modifier 59 That Require Documentation Submitted with the Claim
Effective April 27, 2009

Initial Code	Secondary Code	Initial Code	Secondary Code	Initial Code	Secondary Code
11055	11721	17000	11402	17110	11305
11055	17000	17000	11403	17110	11306
11055	17110	17000	11404	17110	11308
11200	11301	17000	11420	17110	11310
11200	11302	17000	11421	17110	11311
11200	11306	17000	11422	17110	11400
11200	11310	17000	11423	17110	11401
11200	11400	17000	11440	17110	11402
11200	11401	17000	11441	17110	11403
11200	11402	17000	11442	17110	11420
11200	17004	17000	11600	17110	11421
11200	17111	17000	11601	17110	11423
11300	11200	17000	11602	17110	11440
11305	11200	17000	11603	17110	11441
12031	12041	17000	11604	17110	11641
12031	12051	17000	11621	17110	17000
12032	12052	17000	11622	17110	17261
17000	11056	17000	11623	17110	17262
17000	11200	17000	11641	17110	17280
17000	11300	17000	11642	17110	17281
17000	11301	17000	11643	17110	17282
17000	11302	17000	40490	17111	11302
17000	11303	17000	69100	17111	17000
17000	11305	17004	11301	17311	17262
17000	11306	17004	11310	20550	20551
17000	11307	17004	11311	20550	20552
17000	11310	17004	17110	20550	20553
17000	11311	17004	17111	20551	20552
17000	11312	17110	11301	20551	20553
17000	11400	17110	11302		
17000	11401	17110	11303		

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CIGNA Modifier Policy Update

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How the new CIGNA modifier policy affects dermatologists:

- Dermatologists will only have to submit documentation with any claim using modifier 25 when the claim relates to patch testing (95044) used in conjunction with a level 4 or 5 visit (99204, 99205, 99214, 99215; please see Table 1).
- Dermatologists will have to submit documentation with their claims using modifier 59 to CIGNA depending on the specific code pair being used (please see Table 2).
- Box 19/Loop 2300 on the claim form must be checked to indicate that the claim contains supporting documentation, which can then be faxed or mailed subsequently.
- Claims processing and payment will not be delayed pending review of supporting documentation. CIGNA, however, does reserve the right to recoup payment if it is determined that the claim was paid in error due to inappropriate or lack of supporting documentation.
- The list of code pairs subject to this policy will be reviewed periodically and may change following CIGNA's periodic review. Please check the CIGNA website at www.cignaforhcp.com for future updates. *

Internet Access Requirement for Practice Success

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The Internet may be used as a source for information on referring physicians. Online lookups (mini dictionaries/lists relating to a particular set of data) for a physician UPIN (Unique Provider Identification Number), for example, can save a tremendous amount of time for a specialty practice. As opposed to looking up each individual physician through a separate search, the lookup lists all physicians in one place. Most carriers will provide manuals listing provider numbers, office location and other demographic information, but they are published yearly, whereas the web is usually more current. Other lookups available include license numbers, specialty specific information and physician office information.

Accurate claims coding is important to every practice and keeping current with all the changes can be daunting. Carriers send out updated bulletins quarterly or annually, but storing and cataloging all the paper can present problems for a practice. Accessing the Medicare web site, as one example, allows anyone to search and quickly find the exact policy needed and the necessary information about the codes involved. Looking for a National Coverage Determination or Local Medical Review Policy can be easily and quickly found via the Internet thus saving the time it would have taken to look through all of the paper bulletins. *

Revised Coding Information for Removal of Benign Skin Lesions

Effect June 1, 2009, there is a Local Coverage Determination revision for National Government Services' (NGS) Benign Lesion L27364/A47397 for: NY, CT, IN, & OH. AAD staff found the only other LCD with similar language in First Coast Options' Benign Lesion LCD, L29424 for: FL, PR, & VI.

The LCD erroneously restates CPT language that has been out of date since the Excision of benign and malignant CPT codes descriptors were revised by AMA/CPT seven years ago. The Academy is working diligently to address this LCD language change with the assistance of James A Zalla, MD FAAD who served on the AMA CPT Editorial Panel at that time and co-chaired the multispecialty CPT Task Force that recommended the revised language change. This is contrary to AMA CPT guidance in the October 2004, *cpt Assistant* article on Biopsies clarifies if the excision service claim is held for the results of pathology the appropriate code from either 11400-11446 (benign) or 11600-11646 (malignant) may be reported.

We are working vigorously to educate these Medicare contractors on this error. However, dermatologists in these states must be aware of the potential impact of these LCDs on their claim submissions.

Per NGS, recent medical review of documentation indicated an educational need with regard to the reporting of removal of lesions. The local coverage determination (LCD) and coding article (SIA) for Removal of Benign Skin Lesions (L27362/A47397) will be revised on June 1, 2009 and include the following guidelines.

If a benign skin lesion excision was performed, report the applicable CPT code, even if final pathology demonstrates a malignant or carcinoma in situ diagnosis for the lesion removed. The final pathology does not change the CPT code of the procedure performed. An ambiguous but low suspicion lesion would be reported as a benign lesion (codes 11400-11446) reflecting the procedure that was performed. A moderate-to-high suspicion lesion may be reported as a malignancy (codes 11600-11646), if the appropriate excision was performed.

To report removal of lesions of uncertain morphology, prior to identification of the specimen, report ICD-9-CM code 239.2 (neoplasms of unspecified nature, bone, soft tissue, and skin), or ICD-9-CM code 709.9 (unspecified disorder of skin and subcutaneous tissue) since proper coding requires the highest level of diagnosis known at the time the procedure was performed." (ICD-9-CM code 709.9 will be added to the list of payable diagnoses in the LCD.)

Dermatologists who submit Medicare claims to NGS and First Coast Options' for excision of lesions should be aware of the revised LCDs and other future revisions due to the transitions of the Medicare Administrative Contractors. *

IN THE KNOW...

New Billing Rules for CLIA Waived tests

The Clinical Laboratory Improvement Amendments of 1988 (CLIA) regulations require a facility to be appropriately certified for each test performed. To ensure that Medicare and Medicaid pay only for laboratory tests categorized as waived complexity under CLIA in facilities with a CLIA Certificate of Waiver (COW), laboratory claims are currently edited at the CLIA certificate level. So, if a dermatology practice only has a COW, the regulations require such facilities to perform only CLIA-waived tests.

In 2008, the Food & Drug Administration (FDA) approved additional CPT codes as waived tests under CLIA. Below are some common dermatology CPT laboratory codes that **DO NOT** require modifier QW to be recognized as waived tests.

CPT code	Description
81002	Urinalysis, by dipstick or tablet reagent....
81025	Urine pregnancy test, by visual color comparison methods

More information on CLIA Waived Tests modifiers can be found at MLN Provider Assistance Inquiry **New Waived Tests – JA6287** issue at the following link:
<http://www.cms.hhs.gov/ContractorLearningResources/downloads/JA6287.pdf>

You are in the Know!

Derm Coding Consult

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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 of dermatology specific examples and definitions. Perfect for in-service training for physicians and staff.

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|---|-------------------------------|
| "Incident to" Requirements – June 18 | Mastering CCI Edits – Oct. 22 |
| Managed Care Contracting – July 16 | 2010 Coding updates – Nov. 19 |
| Making the Most of Modifiers – Sept. 17 | |

Practice Management Essentials Webinars refresh knowledge of coding, practice management, payer regulations and updates through the use of dermatology specific examples and definitions. Perfect for in-service training for physicians and staff.

Visit www.aad.org/webinars to register today!