2010 Medicare Fee Schedule-Initial Analysis

Although Congressional focus is on the larger health care reform issues, it still needs to act to avoid a cut of -21% in payments under the Medicare physician fee schedule that will occur on January 1, 2010. In July, 2008, Congress voted to override President Bush’s veto in order to pass HR 6331 - the Medicare Improvements for Patients and Providers Act. (MIPPA) HR 6331 which included legislation to avoid the 10.6% cut in payments under the Medicare physician fee schedule (MFS), became law immediately on July 15, 2008. Key to avoiding this potentially disastrous cut for 2010 is the legislative elimination of the Sustainable Growth Rate (SGR) as part of the Medicare Fee Schedule formula.

SUSTAINABLE GROWTH RATE

Section 1848(f) of the Act, as amended by section 4503 of the Balanced Budget Act of 1997 (BBA) (Pub. L. 105-33), enacted on August 5, 1997, replaced the Medicare Volume Performance Standard (MVPS) with a Sustainable Growth Rate (SGR) provision. It specifies the formula for establishing yearly SGR targets for physicians' services under Medicare. The use of SGR targets is intended to control the growth in aggregate Medicare expenditures for physicians’ services.

The SGR targets are not direct limits on expenditures. Payments for services are not withheld if the SGR target is exceeded by actual expenditures. Rather, the fee schedule update is adjusted to reflect the comparison of actual expenditures to target expenditures.

• If expenditures exceed the target, the update is reduced.
• If expenditures are less than the target, the update is increased.

The SGR update for a year is determined by comparing cumulative actual expenditures to cumulative target expenditures (referred to as “allowed expenditures” in the statute. The 2010 update will reflect a comparison of cumulative actual to cumulative target expenditures from April 1, 1996 through December 31, 2009. Target expenditures for each year are equal to target expenditures from the previous year increased by the SGR (which is a percentage figure computed by combining four factors specified below).

The statute specifies a formula to calculate the SGR based on the CMS Actuary estimates of the change in each of four factors. The four factors for calculating the SGR are as follows:

1. The estimated percentage change in fees for physicians’ services;
2. The estimated percentage change in the number of Medicare fee-for-service beneficiaries;
3. The estimated 10-year average annual percentage change in GDP per capita; and
4. The estimated percentage change in expenditures due to changes in law or regulations.

IMPACT OF SGR FOR 2010 MFS

Section 1848(d)(1)(E) of the Social Security Act (the Act) requires the Secretary to develop an estimate of the Sustainable Growth Rate (SGR) and conversion factor applicable to Medicare payments for physicians’ services for the following year. CMS has developed estimates and information applicable to physician fee schedule payments in calendar year 2010. The SGR and proposed 2010 MFS conversion factor shown below are estimates, only. The actual SGR and adjustment — see MEDICARE 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:

It’s Summer 2009 and AAD Members should know that everything you need to implement the new FTC Red Flag Identity Theft Prevention regulations by the August 1, 2009 deadline is available FREE on the AAD web site at http://www.aad.org/pm/compliance/redflagsrule/. 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

Our thanks to all of the Academy members who participated last summer in the American Medical Association Physician Practice Information Survey (AMA PPIIS). Dermatology achieved its participation goal of 100%. The AMA has submitted the results to the Centers for Medicare and Medicaid Services (CMS) and we anticipate that the data will be incorporated into the 2010 Medicare Fee Schedule proposed rule. The new survey shows that dermatology data demonstrated an average indirect practice expense cost of $264.88/total PE/Hr. This supports the previous AAD Practice Expense Supplemental Survey results submitted to CMS in 2005 of an average indirect practice expense cost of $234.20/total PE/Hr. As a result, there should be no erosion of the significant gains in Practice Expense RVUs that have benefited dermatology over the last three years.

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.

AAD 2009 Webinar Schedule

Managed Care Contracting 07/16/09
Making the Most ofModifiers 09/17/09
Mastering CCI Edits 10/22/09
2010 Coding Updates 11/19/09

All webinars are presented at 12 noon CDT.

Best regards,

Norma L. Border, Editor

Coding Update

NEW ICD-9-CM CODES FOR 2010

There are a number of new ICD-9-CM codes that become effective October 1, 2009, that are pertinent for dermatologists. The new diagnosis codes must be used on October 1, 2009, and after, but not before that date.

The new codes that may be pertinent to dermatology practices are listed below.

209.31 Merkel cell carcinoma of the face
209.32 Merkel cell carcinoma of the scalp and neck
209.33 Merkel cell carcinoma of the upper limb
209.34 Merkel cell carcinoma of the lower limb
209.35 Merkel cell carcinoma of the trunk
209.36 Merkel cell carcinoma of other sites
209.75 Secondary Merkel cell carcinoma
274.02 Chronic gouty arthropathy without mention of tophus (tophi)
453.51 Chronic venous embolism and thrombosis of deep vessels of proximal lower extremity
453.52 Chronic venous embolism and thrombosis of deep vessels of distal lower extremity
V10.90 Personal history of unspecified malignant neoplasm
V10.91 Personal history of malignant neuroendocrine tumor
V15.06 Allergy to insects and arachnids
V72.60 Laboratory examination, unspecified
V72.61 Antibody response examination
V72.63 Laboratory examination ordered as part of a routine general medical examination
V72.63 Pre-procedural laboratory examination
V72.69 Other laboratory examination
V87.44 Personal history of inhaled steroid therapy
V87.45 Personal history of systemic steroid therapy
V87.46 Personal history of immunosuppressive therapy

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

Mission Statement:
Derm Coding Consult is published quarterly (March, June, September and December) to provide up-to-date information on coding and reimbursement issues pertinent to dermatology practice.

Address Correspondence to:
Brett Coldiron, MD, FAAP, Derm Coding Consult
American Academy of Dermatology Association
P.O. Box 4014 Schaumburg, IL 60168-4014
Coding Update

There are numerous new or revised external cause codes (E codes). E codes are used to report external causes. An E code would always be used along with the main diagnosis code indicating the nature of the condition that prompted the patient visit.

Just because there may be a specific code for a diagnosis, that does not mean the carrier will pay for a service related to the diagnosis. One must review carriers’ websites for information regarding specific diagnosis codes.

For the complete listing of new, revised, or invalid codes effective October 1, 2009, see the following link: http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#TopOfPage.

Medicare Update

USE OF MODIFIER -25 PER CMS

There is an increase in the Centers for Medicare and Medicaid Services (CMS) sub-contractor auditor focus on evaluation and management services in general and those billed with the -25 Modifier in particular. Dermatology practices should be familiar not only with the AMA CPT Modifier -25 instructions but also with the CMS instructions for the use of modifier -25 contained in several sections of the Medicare Claims Processing Manual, Publication 100-4, Chapter 12.

To assist you, those CMS manual sections are provided below with emphasis added to indicate those parts that are being cited as deficient in the medical record or being used as the basis for denials of reviewed claims.

First, in section 30.6.6 Payment for Evaluation and Management Services Provided During Global Period of Surgery, the following directives are given:

“B. CPT Modifier “-25” - Significant Evaluation and Management Service by Same Physician on Date of Global Procedure

Medicare requires that Current Procedural Terminology (CPT) modifier -25 should only be used on claims for evaluation and management (E/M) services, and only when these services are provided by the same physician (or same qualified non-physician practitioner) to the same patient on the same day as another procedure or other service.

Carriers pay for an E/M service provided on the day of a procedure with a global fee period if the physician indicates that the service is for a significant, separately identifiable E/M service that is above and beyond the usual pre- and post-operative work of the procedure. Different diagnoses are not required for reporting the E/M service on the same date as the procedure or other service. Modifier -25 is added to the E/M code on the claim.

Both the medically necessary E/M service and the procedure must be appropriately and sufficiently documented by the physician or qualified non-physician practitioner in the patient’s medical record to support the claim for these services, even though the documentation is not required to be submitted with the claim. If the physician bills the service with the CPT modifier “-25,” carriers will pay for the service in addition to the global fee without any other requirement for documentation unless one of the following conditions is met:

When inpatient dialysis services are billed (CPT codes 90935, 90945, 90947, and 93937), the physician must document that the service was unrelated to the dialysis and could not be performed during the dialysis procedure;

When preoperative critical care codes are being billed on the date of the procedure, the diagnosis must support that the service is unrelated to the performance of the procedure; or

When a carrier has conducted a specific medical review process and determined, after reviewing the data, that an individual or a group has high use of modifier “-25” compared to other physicians, has done a case-by-case review of the records to verify that the use of modifier was inappropriate, and has educated the individual or group, the carrier may impose prepayment screens or documentation requirements for that provider or group.

Carriers may not permit the use of CPT modifier “-25” to generate payment for multiple evaluation and management services on the same day by the same physician, notwithstanding the CPT definition of the modifier.”

Further directives in Chapter 12 regarding the use of modifier -25, are found under Section 40.1 Definition of a Global Surgical Package.

C. “Minor Surgeries and Endoscopies

Visits by the same physician on the same day as a minor surgery or endoscopy are included in the payment for the procedure, unless a significant, separately identifiable service is also performed. For example, a visit on the same day could be properly billed in addition to suturing a scalp wound if a full neurological examination is made for a patient with head trauma. Billing for a visit would not be appropriate if the physician only identified the need for sutures and confirmed allergy and immunization status.”

Section 40.2 Billing Requirement for Global Surgeries includes the following under A, 8:

“Significant Evaluation and Management on the Day of a Procedure”

Modifier “-25” is used to facilitate billing of evaluation and management services on the day of a procedure for which separate payment may be made. It is used to report a significant, separately identifiable evaluation and management

— see Medicare Update on page 4
service by same physician on the day of a procedure. The physician may need to indicate that on the day a procedure or service that is identified with a CPT code was performed, the patient’s condition required a significant, separately identifiable evaluation and management service above and beyond the usual preoperative and postoperative care associated with the procedure or service that was performed. This circumstance may be reported by adding the modifier “-25” to the appropriate level of evaluation and management service.

Claims containing evaluation and management codes with modifier “-25” are not subject to prepayment review except in the following situations:

“When carriers have conducted a specific medical review process and determined, after reviewing the data, that an individual or group have high statistics in terms of the use of modifier “-25,” have done a case-by-case review of the records to verify that the use of modifier “-25” was inappropriate, and have educated the individual or group as to the proper use of this modifier.”

The above CMS instructions clearly state that separate diagnoses are not necessary, but the key issue is a “significant and separately identifiable service”. Thus the medical necessity of performing a separate evaluation and management service must be evident.

Sufficient documentation is imperative. The documentation in the medical record must be complete and capture what exactly was done during the encounter. Key documentation elements of every evaluation and management service include: history, physical exam, medical decision making and time. Simply drawing a line through a list won’t describe to a CMS auditor whether those questions were asked of the patient or not.

includes an entire chapter on documenting Evaluation and Management services to ensure the completeness of coding and clinical information to help minimize coding errors and reduce claim denials, as well as assist dermatologists and their billing staff in submitting accurate claims to improve the reimbursement process. Also included are the E/M PocketPro, exam templates and the AAD E/M Documentation Audit Tool.

For more information or to place an order contact the Member Resource Center at 866-503-SKIN (7546).

CMS Expands Current Scope of Part B Claim Editing for Ordering/Referring Providers

To comply with requirements of the Social Security Act (the Act), the Centers for Medicare & Medicaid Services (CMS) announced it will expand its claim editing to verify that ordering and/or referring providers on a claim are enrolled in Medicare and eligible to order or refer Medicare services. These changes take effect October 5, 2009.

The Act states that only physicians and Non-Physician Providers (NPPs) (who meet the definitions at section 1861(r) and 1842(b)(18)(C) of the Act) may order or refer services for Medicare beneficiaries. In addition, Section 1833(q) of the Act requires that all physicians and NPPs who meet these definitions must be uniquely identified on all claims for services they order or refer. Since 1992, a physician or supplier who bills Medicare for a service or item that was the result of an order or referral must show the name and unique identifier of the ordering/referring provider on the claim. As of May 23, 2008, this unique identifier must be the National Physician Identifier (NPI).

IMPLEMENTATION PROCESS
Implementation of these changes will be in two phases. During Phase 1, which begins Oct. 5, 2009, received claims are edited through the Multi-Carrier System (MCS) to determine if the billed services’ require an ordering/referring provider. If required but missing on the claim, CMS will continue to process the claim with Remark Code M68 – missing/incomplete/invalid attending, ordering, rendering, supervising, or referring physician identification on the remittance advice.

If the ordering/referring provider is on the claim, MCS will verify this information against the national Provider Enrollment Chain and Ownership System (PECOS) file and the Medicare Administrative Contractor’s (MAC) master provider file. Even if the Provider is on the master file but not listed on the specialty eligible to order or refer, the claim will process. However, a message will be included on the remittance advice (RA) notifying the billing provider that in future, the claims may not be paid if the ordering/referring provider is not enrolled in Medicare or if the ordering/referring provider is not of the specialty eligible to order or refer.

In Phase 2, if the billed service requires an ordering/referring provider but none is present, the claim will not be paid. If the ordering/referring provider’s NPI and name is reported on the claim, Medicare will verify this against their records to ensure the ordering/referring provider is enrolled and in a specialty eligible to order or refer. Phase 2’s start date has not yet been publicized.

Note: If multiple Provider Transaction Access Numbers (PTANs)-are associated to the NPI in MCS, Medicare contractors will use the first active PTAN with an eligible specialty to order and refer. In Phase 2 claims that fail the edits described above will be deemed unpayable.
Blue Cross Blue Shield Settlements: Be Sure you are Paid Correctly

The class action lawsuits brought by several state and county medical societies and physicians against the for-profit health insurers has resulted in settlements which require the health insurers to significantly change the way they conduct business. The Physicians Advocacy Institute (PAI) is charged with enforcing the settlements on behalf of physicians. As of April 21, 2009, all the provisions in the Blue Cross Blue Shield Settlement Agreement have taken effect.

This means that settling Blue Cross Blue Shield plans:
- May not seek overpayment recovery beyond 18 months
- Must use a clinically based definition of medical necessity
- Must adhere to most CPT© coding rules including payment for E&M codes appended with a-25 modifier and payment for add-on codes
- Must provide 90 days advance notice of material adverse change
- May not require physicians to participate in all products
- Must disclose their methodology for determining UCR amounts

If you believe a Blue Cross Blue Shield company (or any of the other settling insurers) has violated a provision of the settlement agreement, you may file a compliance dispute by completing the simple two page form available on www.hmosettlements.com. There is absolutely no cost to physicians to file disputes.

Practices have saved hundreds of thousands of dollars. Many payments and savings have not reached this magnitude but have still been important to the individual practices involved. For example, one Oklahoma practice received payment of over $9000 for previously denied modifier 59 claims. A New Jersey practice saved over $13,000 when the insurer agreed to cease all overpayment recovery efforts.

Physicians have also successfully used this compliance process to enforce other rights in the settlement agreements, including their right to have accurate EOB’s sent to patients insured by plans in which they don’t participate and their right not to participate in HMO products. In addition to the Blue Cross Blue Shield Settlement Agreement, settlements with Anthem/WellPoint, HealthNet and Humana remain in effect.

For more information, please go to www.hmosettlements.com, www.ama-assn.org/go/settlements or contact the compliance dispute facilitators,

Deborah Winegard at dwinegard@npmlaw.com for Blue Cross Blue Shield and Humana disputes; or Cameron Staples at cstaples@npmlaw.com for Anthem/WellPoint and HealthNet disputes.

Reminder for Submission of Modifier -22

In an effort to reduce the number of development letters sent to providers by Medicare carriers, here is a reminder of the requirements for use of Modifier -22. The CMS Internet Only Manual (IOM 100-4) Claims Processing Manual lists the following requirements in Chapter 12, Section 40.2, part A, item 10.

**UNUSUAL CIRCUMSTANCES**

Surgeries for which the services performed are significantly greater than usually required, may be billed with the -22 modifier added to the CPT code for the procedure. In addition, the claim must include:
- A concise statement about how the service differs from the usual; and
- An operative report with the claim.

This can be done by entering a concise description to justify the modifier -22 on the electronic notepad or Item 19 for providers eligible to file paper claims. Providers eligible for paper claims submission may also attach the report. If additional information is required beyond what is listed in Item 19 or the electronic notepad, a development letter will be sent to request the operative note.

If you do not attempt to supply this information initially for procedures billed with modifier -22, the service will be paid at the Medicare Fee Schedule rate with no additional allowance. If you get a remittance notice and realize this information was omitted, you may not resubmit the claim. You are required to follow the claim reopening process.

CMS Medicare contractors are working to reduce the number of development letters sent to physicians and providers. Compliance with these instructions when there are unusual circumstances that warrant Modifier -22 use will help improve timeliness of claim processing and decrease the unnecessary practice costs associated with development letters such as postage and photocopies.

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CMS Expands

— continued from page 4

Dermatology practices should note that if the ordering and/or referring physician and NPP is not enrolled in the Medicare program or is ineligible to order/refer the services, claims may not be paid after phase 2 implements. They should verify their Medicare enrollment by going to www.cms.hhs.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp#To pOfPage.

The official CMS instruction, CR6417, can be viewed by visiting www.cms.hhs.gov/Transmittals/downloads/R510OTN.pdf
Where Can I Find Published MUE’s?

The Centers for Medicare and Medicaid Services (CMS) developed the Medically Unlikely Edit (MUE) program to reduce the paid claims error rate for Part B claims. An MUE for a HCPCS/CPT code consists of the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service. All HCPCS/CPT codes do not have an MUE.

Many of the MUE code edits have been made public and are posted on the CMS website. These edits are updated on a quarterly basis and will contain some code edits of a value of 4 or more. However, many MUE’s are still unpublished, such as those for the Mohs procedure codes. Some of the MUE edits remain unpublished because CMS considers them proprietary and is concerned that their publication would result in gaming of the system. As a result, there really is no way to research the “allowable units” for an unpublished MUE.

The MUEs are not meant to replace utilization guidelines—MUE values do not represent units of service that may be reported without concern about medical review. Providers should report only services that are medically reasonable and necessary.

For a list of published MUE’s please visit the CMS website: http://www.cms.hhs.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage

ICD-10 Preparation Checklist

The Centers for Medicare & Medicaid Services has released a final rule for replacing the 30-year-old ICD-9-CM code set with ICD-10-CM and ICD-10-PCS. The final rule outlines the effective date as 60 days after publication in the Federal Register, and the compliance date for the two classification sets is established as October 1, 2013. A second rule related to the HIPAA transaction standards – X12 version 5010 and NCPDP version D.0 establish earlier effective dates, with the latest being January 1, 2013. The HIPAA transactions software must be updated to accommodate the use of the ICD-10-CM and ICD-10-PCS code sets.

Dermatology practices are encouraged to start thinking about the effect 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 electronic health record (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 coming out with educational materials, training Webinars and other resources as the date for implementation draws closer.

New FTC Red Flags Rule Must be Implemented by August 1, 2009

The Federal Trade Commission (FTC) released a new rule in November 2007 to protect consumers from identity theft by requiring financial institutions and creditors with covered accounts to implement a written identity theft prevention program. Under the FTC’s guidelines, physicians who regularly bill their patients for services rendered (including copayments and coinsurance) are considered creditors and must comply with the red flags rule. This rule will be enforced by the FTC beginning August 1, 2009.
### FTC Reg Flags Rule

— continued from page 6

#### BRIEF HISTORY

Congress passed the Fair and Accurate Credit Transactions Act (FACTA) in 2003 which required the FTC to develop rules and guidelines regarding the detection, prevention, and mitigation of identity theft for financial institutions and creditors as defined by FACTA. The FTC, in turn, created the Red Flags Rule. A “Red Flag” is defined as a pattern, practice, or specific activity that could indicate identity theft[1]. In this context, identity theft typically means a patient’s use of someone else’s information to obtain medical care. This kind of identity theft can cause a variety of harms including false billing, the exhaustion of benefits for the innocent victim, or the potentially life-threatening corruption of a patient’s medical records. Thus, the FTC is requiring all creditors who have covered accounts to comply with the Red Flags Rule and develop identity theft prevention programs.

| A creditor is someone who... | a. Extends, renews, or continues credit.  
|                            | b. Arranges for someone else to extend, renew, or continue credit.  
|                            | c. Is the assignee of a creditor who is involved in the decision to extend, renew, or continue credit.  |
| A covered account is...     | d. an account used mostly for personal, family, or household purposes, and that involves multiple payments or transactions  
|                            | e. an account for which there is a foreseeable risk of identity theft.  |

### ASSESSING THE RED FLAGS RULE AND ITS IMPACT ON DERMATOLOGY

To meet the requirements of the Red Flags Rule, dermatology practices that defer payments must write and implement an identity theft protection plan. The plan must include the following aspects[2]:

<table>
<thead>
<tr>
<th>Policy</th>
<th>Example Procedures[2]</th>
</tr>
</thead>
</table>
| Identify relevant patterns, practices, and specific forms of activity that are “red flags” signaling possible identity theft and incorporate those red flags into the Program. | a. alerts, notifications, or warnings from a consumer reporting agency;  
| | b. suspicious documents;  
| | c. suspicious personal identifying information;  
| | d. suspicious activity relating to a covered account; or  
| | e. notices from customers, victims of identity theft, law enforcement authorities, or other entities about possible identity theft in connection with covered accounts.  |
| Detect red flags that have been incorporated into the Program. | a. Obtaining identifying information about, and verifying the identity of, a person opening a covered account.  
| | b. Authenticating customers, monitoring transactions, and verifying the validity of change of address requests, in the case of existing covered accounts.  |
| Respond appropriately to any red flags that are detected to prevent and mitigate identity theft. | a. Monitoring a covered account for evidence of identity theft.  
| | b. Contacting the customer.  
| | c. Changing any passwords, security codes, or other security devices that permit access to a covered account.  
| | d. Reopening a covered account with a new account number.  
| | e. Not opening a new covered account.  
| | f. Closing an existing covered account.  
| | g. Not attempting to collect on a covered account or not selling a covered account to a debt collector.  
| | h. Notifying law enforcement.  
| | i. Determining that no response is warranted under the particular circumstances.  |
| Ensure the Program is updated periodically to reflect changes in risks from identity theft. | a. The program requires changes in methods of identity theft.  
| | b. The program requires changes in methods to detect, prevent, and mitigate identity theft.  |

— see FTC Red Flags Rule on page B
HOW A DERMATOLOGY PRACTICE WOULD COMPLY WITH THE RULING

To meet the requirements of the Red Flags Rule, dermatology practices must first develop a written protocol explaining how you will protect your patients from identity theft. The following table gives you guidelines on developing this protocol:

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td>Appoint someone within your practice to develop the compliance plan. Insure this “compliance officer” is able to set aside a significant amount of time to develop the plan and enact it in the future.</td>
</tr>
<tr>
<td>Step 2</td>
<td>The compliance officer should determine if the practice meets the criteria of the rule. They should first determine if the practice meets the definition of a creditor and if so whether they deal with covered accounts.</td>
</tr>
<tr>
<td>Step 3</td>
<td>If the practice is found to be a creditor and deal with covered accounts, the compliance officer should perform an analysis and risk assessment of the practice’s current policies and procedures for fraud transactions. Once the compliance officer has determined what transactions involve the risk of identity theft, he/she should develop policies and procedures for each of those transactions. Each transaction should include a policy explaining how the practice will identify a red flag, the means of detecting the red flag, and a procedure detailing how staff will respond to that red flag. For example, is the identification of new patients being confirmed by checking a photo ID? Does the name on the patient’s insurance information match their ID? If you receive notice that a patient or consumer has been the victim of identity theft, what would you do? Has the practice dealt with identity theft before and if so how was it handled? It would be a good idea to consult your internal HIPAA policies and procedures manual as there could be potential overlap with your identity theft compliance plan. Because the rule allows for flexibility in tailoring your program, if your compliance officer reasonably determines that your practice has a low risk of identity theft, developing a program should be simple and straightforward, with only a few red flags needed. For example, where the risk of identity theft is low, your program might focus on how to respond if you are notified by a patient or consumer that the person’s identity was misused at your practice.</td>
</tr>
<tr>
<td>Step 4</td>
<td>As applicable, consult your board of directors, practice medical director, owner or appropriate committee within your practice to approve the compliance plan.</td>
</tr>
<tr>
<td>Step 5</td>
<td>Train staff that come into contact with patients and would be in a position to check their identity or see other signs that indicate the patient doesn’t seem to be who she/he claims to be such as having a different blood type from what is indicated in the medical records. Have an in-service session about it or hand out training materials at a staff meeting. The key step to enforcing this plan is adequate training. Ensure that service providers you use for activities that would be covered by your program, such as debt collectors, have an appropriate program or comply with your program.</td>
</tr>
<tr>
<td>Step 6</td>
<td>The compliance officer should re-evaluate the plan every year to determine if changes need to be made. If changes are required, staff should be re-trained on those specific changes.</td>
</tr>
</tbody>
</table>

The American Academy of Dermatology, along with the American Medical Association (AMA), and other medical organizations continue to push the FTC to reconsider applying this “red flags” rule to medical practices. The Academy has questioned this rule and has called for it to be reversed so that dermatology practices are exempt. The Academy will continue to address this issue with the AMA so that compliance becomes more manageable and practical and does not represent an additional administrative burden.

ADDITIONAL RESOURCES

For additional information regarding the FTC’s Red Flags Rule, please visit the following websites:


Red Flag and Address Discrepancy Requirements: Suggestions for Health Care Providers ➤
Coding Q & A's

Q. What is the correct procedural code for destruction of an inflamed seborrheic keratosis (SK)? Is it 17110?
A. Correct. The full descriptor for 17110 is: Destruction (eg, laser surgery, electro surgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions. Seborrheic keratoses are defined as benign lesions.

Q. What is the procedural code for destruction of warts?
A. CPT 17110 is the correct code for the destruction of a new patient presented with concerns of multiple lesions. After examining and evaluating the patient, a lesion is clinically noted as a suspected basal cell carcinoma. The dermatologist’s medical decision is to biopsy that particular lesion during the encounter. The other lesions posed no medical concern as they were diagnosed as benign, non-symptomatic lesions. Can both the biopsy and E/M (adding modifier -25) be reported?

Q. If a punch biopsy proves to be melanoma and a re-excision with margins is required, can both be reported?
A. Yes, but only if the procedure has a 000 or a 010 day global period attached to it. For example, biopsy code 11100 has a 000 global day. If you bill a 99212 and 11100 together, the 99212 would require a modifier -25 for proper billing and reimbursement. Be sure to verify with carriers as to their particular directives on the use of modifier -25.

Q. If a biopsy report comes back as atypical by the dermatopathologist who “recommends an excision with 5 mm margins,” is that considered a benign or malignant excision? How would the original biopsy be reported?
A. Unless the pathology confirms a malignancy, atypical is still considered benign. This would be reported as a benign removal. Report the diagnosis code 238.2.
B. Report 238.2 “neoplasm of uncertain behavior” for the original biopsy diagnosis code. Do note that some carriers require 239.2 to be used for the biopsy.

Q. If a patient returns for a biopsy of a suspicious lesion and there are no other issues...is an additional E/M visit usually included?
A. If the patient is scheduled to return for a second procedure/service following a recent E/M visit that identified the need for that service, an additional E/M would not be appropriate. However, if the patient presents with a new complication/condition that is significant or separately identifiable to the scheduled service an E/M service would be appropriate.

Q. The intent of a biopsy is to remove a portion of skin, suspect lesion, or entire lesion so that it can be examined pathologically. Whereas, the intent of the shave removal and other integumentary system procedures that involve removal of tissue is to remove the lesion... See article “Shave Removal Versus Biopsy with Shave Technique”, Derm Coding Consult, Summer 2008, pages 7-8. ✤
2010 Medicare Fee Schedule
— continued from page 1

factors used to compute physician payments for 2010 will be based on later data and published by November 1, 2009 in the Federal Register as part of the physician fee schedule final rule for 2010.

At this point in time and barring the key legislation needed to avert these cuts, the CY 2010 physician fee schedule update is required by law to be determined as if the scheduled conversion factors for CY 2007, CY 2008, and CY 2009 had not been overridden by specific legislative changes.

• Section 101 of the Tax Relief and Health Care Act of 2006 (MIEA-TRHCA) provided a 1-year update of 0 percent for the conversion factor for CY 2007 and specified that the conversion factor for CY 2008 must be computed as if the 1-year update had never applied.

• Section 101 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) provided a 6-month increase of 0.5 percent in the CY 2008 conversion factor, from January 1, 2008, through June 30, 2008, and specified that the conversion factor for the remaining portion of 2008 and the conversion factors for CY 2009 and subsequent years must be computed as if the 6-month increase had never applied.

• Section 131 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) extended the increase in the CY 2008 conversion factor that was applicable for the first half of the year to the entire year, provided for a 1.1 percent increase to the CY 2009 conversion factor, and specified that the conversion factors for CY 2010 and subsequent years must be computed as if the increases had never applied.

IMPACT OF UPDATE ADJUSTMENT FACTOR FOR 2010

The CY 2010 physician fee schedule update is determined according to a statutory formula by multiplying:

(i) one plus the Medicare Economic Index (MEI), and

(ii) one plus the update adjustment factor (UAF).

The MEI measures the weighted average price change for various inputs involved with producing physicians’ services. The UAF compares actual and target expenditures, and, for a given year, is determined by a formula. The estimates as well as CMS current projections of actual expenditures for CY 2009 produces the current estimate of the UAF for 2010 at -29.6%. However, Since section 1848(d)(3)(D) of the Act does not allow the update adjustment factor for a given year to be greater than 3.0 percentage points nor less than -7.0 percentage points, the UAF for 2010 is estimated to be -7.0 percentage points.

As a result, the methodology and estimated CY 2010 conversion factor published this month in the 2010 Medicare Fee Schedule: Proposed Rule is determined by applying the 2010 MEI and the 2010 UAF to the CY 2009 conversion factor that would have applied for CY 2009 but for section 131 of MIPPA (the CY 2009 pre-legislation conversion factor). The estimated CY 2010 MFS conversion factor update of -21.5 percent is calculated by dividing the estimated CY 2010 conversion factor by the CY 2009 conversion factor and subtracting 1.

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Amgen and Wyeth are proud sponsors of the American Academy of Dermatology Coding Consult Newsletter.
IN THE KNOW...
Link individual Provider NPI/PTAN number to each group practice in order to receive Medicare payments

Did you know that Medicare requires all individual provider National Provider Identification Number (NPI) and Provider Transaction Access Number (PTAN) to be linked to each group for which they are performing services to receive reimbursement?

To receive Medicare payment, individual (NPI/PTAN) providers must be linked to each group they belong to. Providers must complete the CMS 855R reassigning benefits to the group.

DON’T LET YOUR PAYMENTS BE INTERRUPTED!
Payments will be interrupted if individual rendering providers are not linked to the group that bills Medicare on their behalf.

If you are an individual provider reassigning partial benefits to a group, remember to submit CMS Form 588 - (EFT) application and a voided check or deposit slip (or a letter from the bank on bank letterhead) along with your 855R application.

Now you are in the know!