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Dermatology Issues in 2010 MFS Final Rule

The primary focus for most dermatologists in the 2010 Medicare Fee Schedule: Final Rule is the frightening spectre of the **-21.2%** drop in the Medicare Conversion Factor, from the 2009 CF rate of $36.0666 **to a new low of $28.3895/RVU for 2010.** There are a number of provisions in several of the current Health System Reform legislative proposals that would address the ongoing problem of the flawed Sustainable Growth Rate (SGR) formula that creates this annual issue. In the event of either a single year or "final fix" to the SGR with a estimated 0.5% Medicare payment update, the revised Medicare conversion factor for 2010 would be $36.2469.

In the absence of the impact of the Sustainable Growth Rate (SGR) formula on the Medicare Conversion Factor, dermatology would have seen a modest 3% increase in overall Medicare payments as a result of the updates to practice expense and liability risk factors detailed in the next two sections of this article.

CMS ADOPTION OF AMA - PHYSICIAN PRACTICE INFORMATION SURVEY (PPIS) DATA

CMS announced in the 2010 MFS Final Rule that the AMA - Physician Practice Information Survey (PPIS) data will be incorporated into the 2010 Medicare Fee Schedule (MFS) and that the resulting value changes to specialty specific practice expense indirect costs will be phased in over four years.

Dermatology successfully maintained comparability between the new 2008 AMA PPIS Survey and the 2004 AAD PESS survey. For PPIS Survey, Dermatology was able to demonstrate a total PE/hour = $264.88. In our 2004 Practice Expense Supplemental Survey, dermatology had a total PE/hour = $234.20. As a result, Dermatology now has the 2nd highest Indirect PE/hour in the CMS data base. However, there will be no additional PE/RVU increases for dermatology as the major impact from the AAD PESS survey has been phased in from 2007-2010. As a result of the AMA PPIS data CMS has increased the Dermatology Indirect PE/Hr from $158.49 (based on AAD 2004 PESS data) to $184.62 based on AMA PPIS data.

MEDICAL LIABILITY INSURANCE

CMS has updated the MLI/RVUs based on risk factors calculated from aggregate specialty insurance premium data. These risk factors are an index calculated by dividing the national average premium for each specialty by the national average premium for the specialty with the lowest average premium, allergy/immunology = 1.00 for all three categories.

Dermatology has substantial insurance premium data available for all three categories:

Dermatology Non-surgical risk factor = 1.14
Highest – Cardiac Surgery = 6.89

Dermatology Minor surgery risk factor = 2.06
Highest - Cardiac Surgery = 6.89

Dermatology Major surgery risk factor = 3.96
Highest – Neurology = 10.28

As a result, there are small but consistent increases to the MLI/RVUs for most dermatology procedures.

NEW ADJACENT TISSUE TRANSFER CODES (14301-14302)

There was an attempt to block inclusion of non-facility practice expense data for both codes, which would have restricted the use of the second code to inpatient and ASC settings only. However, CMS commented that regardless of the infrequency that this could be performed in an office setting. CMS wanted the PE in-office values for 14302. AAD submitted the values as instructed directly to CMS and the 2010 MFS Final Rule includes N/F Practice Expense RVUs for both new codes.

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IMPORTANT ***Please Route to*:**
___ Dermatologist ___ Office Mgr ___ Coding Staff ___ Billing Staff

Letter from the Editor

Dear *Derm Coding Consult* Reader:

Another year has passed and dermatologists and physicians everywhere are again facing a major drop (21.2%) in Medicare reimbursement for 2010. Despite a summer full of promises and legislative initiatives, the Sustainable Growth Rate formula has not been fixed or eliminated. I anticipate the usual "last minute" rescue, so don't make any premature changes to your billing master files using the published Medicare conversion factor of $28.3895.

Dermatologists will again have three melanoma measures as part of Medicare's Physician Quality Reporting Initiative (PQRI) for 2010. Reporting on these measures will be via a patient registry mechanism and participating dermatologists will have until January 31, 2011 to submit this information through a CMS approved registry. Please stay tuned to the Academy website at *www.aad.org* for more information.

The 2010 CMS Final Rule also has changes in the E-Prescribing incentive program. Providers will still be required to meet a threshold to participate in the program, however they will only need to report that they successfully e-prescribed a total of 25 times for the entire year and will only need to report one G code indicating that they successfully prescribed electronically for a Medicare Part B patient.

If you missed the 2010 Coding Update Webinar on November 19, 2009, plan to join us on January 21, 2010 for a recap of all the CPT, ICD and Medicare changes as well as how recent legislation will impact physician reimbursement.

The Practice, Policy & Management/Coding & Reimbursement staff: Vernell St. John, Peggy Eiden, Faith McNicholas, and Cindy Bracy, join me in wishing all the peace and joy of this Holiday Season to you and to your families

Best regards,

Norma L. Border, Editor

CMS Discontinues Payment for IP/OP Consultation Codes

As the Centers for Medicare and Medicaid Services (CMS) proposed in August, it has discontinued or eliminated payment for consultation codes effective January 1, 2010. CMS will continue to recognized Telehealth consultations.

Citing DHHS-Office of the Inspector General (OIG) studies, CMS commented that 75% of consultations do not meet current requirements. 47% are billed as wrong type or wrong level, 19% did not meet the definition of a consultation and 9% lacked required documentation. In its response to commentors, CMS also argued that they have tried to work with AMA CPT and physician specialty societies to revise definitions and clarify documentation requirements in order to fix the consultation issue.

CMS believes the rationale for different (Evaluation and Management (E&M) vs. Consultation) codes are no longer supported as documentation requirements for consults are similar to initial patient visits. Current documentation requirements provide no justification for different payments of a consultation and regular evaluate and management (E/M) visits.

CMS will distribute the resulting savings from the elimination of payment for consults as a 6 percent increase to the physician work RVUs for the new and established outpatient visit codes. CMS has not yet issued any related instructions on billing under this new policy. The Academy will alert AAD Members as soon as additional and more specific instructions are released by CMS. However, the assumption is that patient visits that were formerly billed as consultations would now be billed at the appropriate level of new or (under some group practice situations) established patient evaluation and management codes.

The most current CMS utilization data (2007) places the percentage of dermatology usage of the consultation codes at the following levels nationally:

CPT Code	Total 2007Util	% Derm Util	09Medicare Fee$
99241	344,796	15.63	$ 48.69
99242	1,538,957	16.77	$ 90.89
99243	5,035,428	3.85	$ 124.79
99244	6,108,732	0.27	$ 184.30
99245	2,280,379	0.05	$ 226.50 *

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

CPT 2010

Be prepared to see some sequencing changes in CPT 2010. With new soft tissue codes added to the Musculoskeletal Section there were not available codes to keep the new codes in numerical sequence. There are other sections of CPT which also experienced this sequencing issue. AMA/CPT identifies the codes that are out of sequence with the # symbol. The sequence anomalies will most definitely be a change that providers and coders will need to recognize.

A workgroup of various specialties, including dermatology, worked on the CPT Proposal for the soft tissue codes. The new soft tissue codes were added to allow for lesion size difference. If there was an existing code, it was revised to specify the lesion size. There were some sites that soft tissue codes had not been available such as the face and scalp. The workgroup added those codes so there would be soft tissue excision codes available for all pertinent sites.

The revised and new soft tissue codes in CPT 2010 are listed below along with biopsy codes that were unchanged.

Key to symbols: ● new code ▲ revised code # resequence

- ● **21011** Excision, tumor, soft tissue of face or scalp, subcutaneous; less than 2 cm
- ● **21012** 2 cm or greater
- ● **21013** Excision, tumor, soft tissue of face and scalp, subfascial (eg, subgaleal, intramuscular); less than 2 cm
- ● **21014** 2 cm or greater

21550 Biopsy, soft tissue of neck or thorax

- ▲ **21555** Excision, tumor, soft tissue of neck or anterior thorax, subcutaneous; less than 3 cm
- # ● **21552** 3 cm or greater
- ▲ **21556** Excision, tumor, soft tissue of neck or anterior thorax, subfascial (eg, intramuscular); less than 5 cm
- # ● **21554** 5 cm or greater

21920 Biopsy, soft tissue of back or flank; superficial

21925 deep

- ▲ **21930** Excision, tumor, soft tissue of back or flank, subcutaneous; less than 3 cm
- ● **21931** 3 cm or greater
- ● **21932** Excision, tumor, soft tissue of back or flank, subfascial; less than 5 cm
- ● **21933** 5 cm or greater

23065 Biopsy, soft tissue of shoulder area; superficial

23066 deep

- ▲ **23075** Excision, tumor, soft tissue of shoulder area, subcutaneous; less than 3 cm
- # ● **23071** 3 cm or greater
- ▲ **23076** Excision, tumor, soft tissue of shoulder area, subfascial (eg, intramuscular); less than 5 cm
- # ● **23073** 5 cm or greater

24065 Biopsy, soft tissue of upper arm or elbow area; superficial

24066 deep

- ▲ **24075** Excision, soft tumor of upper arm or elbow area, subcutaneous; less than 3 cm
- # ● **24071** 3 cm or greater
- ▲ **24076** Excision, soft tumor of upper arm or elbow area, subfascial, less than 5 cm
- ● **24073** 5 cm or greater

25065 Biopsy, soft tissue of forearm and/or wrist, superficial

25066 deep

- ▲ **25075** Excision, soft tissue tumor of forearm and/or wrist, subcutaneous, less than 3 cm
- # ● **25071** 3 cm or greater
- ▲ **25076** Excision, soft tissue tumor of forearm and/or wrist, subfascial, less than 3 cm
- # ● **25073** 3 cm or greater
- ▲ **26115** Excision, tumor or vascular malformation, soft tissue of hand or finger, subcutaneous, less than 1.5 cm
- # ● **26111** 1.5 cm or greater
- ▲ **26116** Excision, tumor or vascular malformation, soft tissue of hand or finger, subfascial (eg, intramuscular); less than 1.5 cm
- # ● **26113** 1.5 cm or greater

27040 Biopsy, soft tissue of pelvis and hip area; superficial

27041 deep, subfascial or intramuscular

- ▲ **27047** Excision, soft tissue tumor of pelvis and hip area, subcutaneous; less than 3 cm
- # ● **27043** 3 cm or greater
- ▲ **27048** Excision, soft tissue tumor of pelvis and hip area, subfascial; less than 5 cm
- # ● **27045** 5 cm or greater

27323 Biopsy, soft tissue tumor of thigh and/or knee area; superficial

27324 deep, subfascial or intramuscular

- ▲ **27327** Excision, soft tissue tumor of thigh and/or knee area, subcutaneous; less than 3 cm
- ● **27337** 3 cm or greater
- ▲ **27328** Excision, soft tissue tumor of thigh and/or knee area, subfascial; less than 5 cm
- ● **27339** 5 cm or greater

27613 Biopsy, soft tissue of leg or ankle area, superficial

27614 deep

- ▲ **27618** Excision, soft tissue tumor of leg or ankle area, subcutaneous; less than 3 cm
- # ● **27632** 3 cm or greater
- ▲ **27619** Excision, soft tissue tumor of leg or ankle area, subfascial; less than 5 cm
- # ● **27634** 5 cm or greater
- ▲ **28043** Excision, soft tissue tumor of foot or toe, subcutaneous; less than 1.5 cm
- # ● **28039** 1.5 cm or greater
- ▲ **28045** Excision, soft tissue tumor of foot or toe, subfascial; less than 1.5 cm
- # ● **28041** 1.5 cm or greater

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Coding Update

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It is important to note that simple and intermediate repairs are included in the above codes. However, a medically necessary complex repair is separately billable. Those instructions are and other repair directives may be found in the directive section of the Musculoskeletal System preceding the numerical listing of codes.

New directives have been added in CPT 2010 for the adjacent tissue transfer codes, 14000. The directives clarify that an adjacent tissue transfer requires an additional incision. Undermining alone of the adjacent tissues to achieve closure would not be coded with the 14000 codes, but rather the appropriate complex repair code.

Code 14300 was deleted and two new codes were added to account for larger adjacent tissue transfers. An adjacent tissue transfer or rearrangement in any area with a defect size of 30.1 sq cm to 60.0 sq cm would be reported with code 14301. Code 14302 is an add-on for each additional 30.0 sq cm, or part thereof, of any area. This code would be reported along with code 14301.

Directives were added preceding CPT code 15740. These directives explain the use of the island pedicle flap and the neurovascular pedicle flap. The island pedicle flap is described as a cutaneous flap which is transposed into a nearby defect using an axial vessel in its design. This type flap is generally tunneled under the skin and held in its new place with sutures. The direct closure of the donor site is included in the code.

Be sure to update your encounter forms, computers and any coding tools that you use with these new codes. Eliminate denials by using the appropriate codes in 2010.

New MOC-D Tool Includes Registry for PQRI Reporting

Dermatologists can now meet the requirements of component 4 of Maintenance of Certification for Dermatology (MOC-D) and satisfy reporting requirements for Medicare's Physician Quality Reporting Initiative (PQRI) program for 2009 using the Clinical Performance Assessment Tool (CPAT). The American Academy of Dermatology created CPAT to help dermatologists meet the component 4 requirements of MOC-D, and now is adding a segment to the current online melanoma module that includes a registry. Dermatologists who use the melanoma module can use the built-in registry to report on melanoma-specific measures in PQRI and receive a 2 percent bonus on their estimated total allowed charges for covered Medicare Part B services. NetHealth, the registry vendor, will send the PQRI data to the Centers for Medicare and Medicaid Services (CMS) at the end of the reporting period.

Dermatologists who have not yet participated in PQRI or feel their claims-based reporting was inaccurate can report the melanoma measures through this registry option and be eligible for the 2 percent incentive. The registry will be available to members beginning Nov. 3, 2009 and members will have until Jan. 31, 2010 to submit their measure information. For more information on PQRI and MOC-D, visit the Academy's Web site at *www.aad.org*.

OIG Identifies Inappropriate Derm "Incident-to" Billing

The Department of Health and Human Services/Office of the Inspector General (OIG) released a report in August that indicates it is taking a much closer look at "incident-to" billing. Titled "Prevalence and Qualifications of Nonphysicians Who Performed Medicare Physician Services," the report looked at physicians who billed more than 24 hours of Medicare services in a single day. The study examined the practice of "incident-to" billing to assess the qualifications of non-physicians caring for Medicare patients. The full OIG report is available at *http://oig.hhs.gov/oei/reports/oei-09-06-00430.pdf.*

The OIG study findings revealed that when physicians billed for more than 24 hours of Medicare services in a single day, fifty percent of those services were not performed by the physician, and 21 percent of those services were performed by non-physicians who lacked necessary licensing, certification or specific formal training to perform those services.

The OIG study also identified dermatology as the specialty third most likely to have billed for more than 24 hours of Medicare services in a single day. It identified five problem areas, three of which were related to dermatology: micrographic surgical removal of tumors, skin surgery, and complex wound repair. The study also found that medical assistants were reported by the surveyed physicians to have performed all of the micrographic surgical removal of tumors that were not performed by physicians.

OIG conducted the survey by identifying a random sample of 250 "physician-day" combinations. Thirteen percent of the physicians identified in the study are dermatologists. Since a single physician can account for more than one physician-day, the sample yielded 221 physicians who billed for more than 24 hours of Medicare services in a single day. The OIG auditors required that these physicians to identify the individual who performed each billed service and to provide their credentialing information. The OIG concluded from the data provided that there is clearly inappropriate use of medical assistants by dermatologists and reported to CMS that there is clear need for closer oversight of "incident to" billing and issuance of aggressive policy and instruction to specifically prohibit such practices as it is perceived that these may endanger Medicare beneficiaries.

To ensure that your dermatology practice is appropriately addressing "incident to," begin by reviewing the Academy's

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OIG Identifies Inappropriate Derm "Incident-to" Billing

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Position Statement on the Use of Non-Physician Office Personnel available on line at *www.aad.org/forms/policies/Uploads/PS/PS-Use%20of%20Non-Physician%20Office%20Personnel%206-15-07.pdf*

Dermatologists must also be knowledgeable regarding their state's licensing, certification and training requirements for all of their clinical support staff. In addition, dermatology practices must also be knowledgeable regarding Medicare rules and instructions on "incident to" as well as Medicare contractor or carrier policies on the use of non-physician clinical staff and billing for their services.

The Academy's upcoming 68th Annual Meeting in Miami will have two forums providing clarification on incident-to billing:

- Ethical Economics in Dermatology and Dermatologic Surgery forum (F030), and
- Use of Physician Extenders forum (F017).

For additional resources for members on "incident-to" billing, visit the Practice Management section of the Academy's Web site. AAD and the Society of Dermatology Physician Assistants recently presented a joint webinar on "Incident To" Requirements on 06/18/09 and the webcast is available for purchase. Dermatologists with any question about "incident-to" coding or billing may also contact any member of the Academy's Coding and Reimbursement staff at *ppm1@aad.org*.

HCPCS Gives Modifier PC New Meaning

The Healthcare Common Procedure Coding System (HCPCS) modifier PC (Wrong Surgery on Patient) was recently established to be appended, where appropriate, to all claim lines related to a surgical error.

Some dermatologists, or their billing services, may be incorrectly using the HCPCS modifier PC to indicate the Professional Component for certain services not related to surgical error when the modifier 26 should have been used. You need to be aware that the use of the PC modifier on Medicare claims will result in the claim being denied.

Please be sure that you and your billing personnel/services prepare claims submitted to Medicare with the correct codes in order for the claims to process correctly.

- Modifier PC is used to identify Wrong Surgery on Patient. The modifier PC is to be appended, where appropriate, to all claim lines related to a surgical error.
- Modifier 26 is used to identify the professional component of a service or a procedure.

If you have questions, please contact your Medicare contractor at their toll-free number. The numbers are available at the following website:
http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip

United Amends Medicare Advantage Participation Agreement to Comply with MIPPA

Effective January 1, 2010, the Medicare improvements for Patients and Providers Act of 2008 (MIPPA) places limits on the amount of cost-sharing imposed on dual eligible beneficiaries. Due to MIPPA regulatory changes, United Healthcare issued amendments to network participation agreements. The Medicare Advantage Regulatory Requirements Appendix contains a new cost-sharing provision specifying that healthcare providers are prohibited from collecting cost-sharing amounts directly from patients who are, under the state Medicaid program. These patients are not responsible for paying Medicare cost-share amounts. The Balanced Budget Act of 1997 stated that physicians and facilities must either accept the payment received from UnitedHealthcare as payment in full for these patients or seek reimbursement from the appropriate state source (e.g., state Medicaid agency, a Medicaid managed care organization, or another third party identified by the state). For more information please read the United Healthcare September Network Bulletin at: *https://www.unitedhealthcareonline.com/ccmcontent/ProviderII/UHC/en-US/Assets/ProviderStaticFiles/ProviderStaticFilesPdf/Tools%20and%20Resources/Network%20Bulletin/NetworkBulletin_Sept_2009.pdf*

Red Flags Rule enforcement delayed to June 1

The Federal Trade Commission is delaying enforcement of its identity theft Red Flags Rule for a fourth time, pushing back the November 1 deadline to June 1, 2010.

The latest delay comes at the request from Congress, which is considering exempting entities with fewer than 20 employees from the identity theft rule.

The House of Representatives passed the bill late last month. The Senate is now considering the bill.

The previous delay announcement came in July. The House Appropriations Committee requested the additional three months to educate small businesses about Red Flags Rule compliance. The delay also allowed financial institutions and creditors more time to implement written identity theft prevention programs, according to the FTC.

Red Flags was initially supposed to go into effect November 1, 2008, but was pushed back to May 1, 2009, then to August 1, 2009, then to November 1, 2009, and now to June 1, 2010.

Medicare Contractor One-Time Mailing to Individual Practitioners

The Centers for Medicare and Medicaid Services (CMS) have directed Medicare Contractors to notify all active sole proprietor physicians and non-physician practitioners (NPPs) of their reporting responsibilities with a one-time mailing. Medicare Contractors must complete this mailing to physicians who are sole proprietors by November 30, 2009 and to sole proprietor NPPs by December 31, 2009.

Dermatologists are advised that Medicare Contractors will deactivate a physician's or NPPs billing privileges should this mailing be returned as undeliverable if the Medicare Contractor does not already have a change of address enrollment application pending. If you have recently changed practice location, be sure to submit this information to CMS on the appropriate form(s) – (Form 855R).

The mailing explains the physician/NPP's responsibilities for maintaining and reporting changes to CMS such as practice location, adverse provider status, business structure, business name or TIN and/or practice status changes. Dermatologists and NPPs should review this mailing to ensure that they are in compliance with the reporting responsibilities and make sure that administrative staff are also aware of these responsibilities.

If Medicare billing privileges are deactivated, they will remain so until an updated Provider Enrollment Form (CMS855) is received and processed. Any claims for Medicare services rendered from the date of provider deactivation until the date of reactivation may not be payable. Medicare contractors will follow the procedures in the CMS Program Integrity Manual, Chapter 20 section 13, regarding reactivation of Medicare billing privileges.

If you have questions, please direct them to your local Medicare Carrier. The MLN matter # MM6278 (Effective November 2, 2009) and additional information can be downloaded from the following CMS website: *http://www.cms.hhs.gov/ContractorLearningResources/downloads/JA6278.pdf*.

You may also submit questions the Academy Practice Policy & Management staff at *www.ppm1@aad.org*

CMS Expands Claim Editing on Ordering/Referring Provider NPIs

Medicare Administrative Contractors (MACs) and Medicare Carriers are installing new claims edits to ensure that providers and suppliers bill for ordered or referred items or services only when those items or services are ordered or referred by eligible physicians and non-physician practitioners. Any physician or non-physician practitioner who orders or refers must be enrolled in the Medicare Provider Enrollment, Chain and Ownership System (PECOS) and must be of the type/specialty that is eligible to order/refer services for Medicare beneficiaries.

CMS is expanding claim editing to meet Section 1833(q) of the Social Security Act requirements. **Claims that are the result of an order or a referral must now contain the National Provider Identifier (NPI) and the name of the ordering/referring provider.**

Phase 2 of this Claims Editing for Ordering/Referring Providers will be implemented Jan. 4, 2010, and could result in more claims not being paid. During Phase 1, all Part B received claims were edited through the Multi-Carrier System (MCS) to determine if the billed services' required an ordering/referring provider. If required but missing on the claim, Medicare Administrative Contractors (MACs) and Medicare Carriers continued to process the claim but added Remark Code M68 to the remittance advice – *missing/incomplete/invalid attending, ordering, rendering, supervising, or referring physician identification on the remittance advice.*

In **Phase 2**, (starting 1/4/2010) 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, the MAC or Carrier will verify this against CMS' records in Provider Enrollment Chain and Ownership System (PECOS) to ensure the ordering/referring provider is enrolled and in a specialty eligible to order or refer.

If the ordering/referring provider is not in PECOS, the carrier will search its claims system for the ordering/referring provider information. If the search does not turn up any information on the ordering/referring provider, the claim will **be rejected**. If the ordering/referring provider is in PECOS or the claims system but is not of the specialty to order or refer, the claim will also be rejected.

Dermatologists submitting paper claims are advised not to use periods or commas within the name of the ordering/referring provider. Hyphenated names are permissible.

Physicians and non-physician practitioner Medicare enrollment can be verified by going to *www.cms.hhs.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp#TopOfPage.*

The official CMS instruction, CR6417, can be viewed at: *http://www.cms.hhs.gov/ContractorLearningResources/downloads/JA6417.pdf*

Providers who want to verify their enrollment in PECOS may do so by accessing PECOS at *https://pecos.cms.hhs.gov/pecos/login.do* on the CMS website. Instructions on how to use PECOS can be accessed at *http://www.cms.hhs.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp* on the CMS website.

The first part of this article appeared in Derm Coding Consult, Summer 2009, and can be found at: *http://www.aad.org/members/publications/_doc/DermCodingConsult_Summer09.pdf*

Dermatology Issues in 2010 MFS Final Rule cont.

CMS FOCUS ON HARVARD-VALUED AND HIGH UTILIZATION CODES

In the 2010 MFS Final Rule CMS indicated in that it will request the AMA RUC to review CPT procedural codes that have RVU values based on the original RB/RVS (Hsiao) study. CMS also stated that the focus of the review should give priority to high volume procedures as well as low intensity services. Dermatology has a significant number of codes that fall into this category. The Academy will be obligated to survey these codes in order to defend their current Physician Work/RVU values. AAD has developed an on-line survey capability to help speed this process. However, the RUC has not determined the timing as to when these codes should be surveyed and presented.

Dermatology codes that fall into the Harvard-Valued category are:

- Simple and intermediate repairs:
  - o 12001, 12002, 12004, 12011, 12013, 12031, 12032, 12034, 12041, 12042, 12051
- Complex Repairs:
  - o 13101, 13131, 13151, 13152, 13160
- Destruction of Malignant Lesions:
  - o 17260, 17261, 17263, 17270, 17271, 17272, 17273, 17280, 17282, 17283
- Site Specific Biopsies:
  - o 40490 – Biopsy of Lip, 67810 - Biopsy of eyelid

CMS DECISION ON RVU VALUES FOR 17106-17107-17108

In October 08 AMA RUC continued its review of potentially misvalued codes using various screening mechanisms, including codes with site of service and high Intensity of Work/Per Unit of Time (IWPUT) anomalies, high volume procedures and new technology designations. Dermatology codes 17106, 17107, and 17108 (destruction of cutaneous vascular proliferative lesions) were identified by the use of an IWPUT screen.

In preparation for the defense of these codes and in comment to CMS, AAD has voiced its deep concern that a ranking system (IWPUT) not formally recognized by CMS was used to identify and value these three services, each of which is performed less than six thousand times per year on Medicare patients. AAD offered to provide clinical guidance to CMS regarding appropriate edits for valid ICD-9-CM diagnostic codes that would virtually eliminate the use of these services for treatment of all but a very limited number of Medicare patients with valid diagnoses.

This AAD Action Plan was rejected in favor of simply reducing payment for continued inappropriate use of these procedures under Medicare. CMS in its own comment in the Rule admits that it had "some concerns with certain aspects of the review of these codes. AAD requested that a CMS Refinement Panel review the valuation of these codes. The Multi-Specialty Refinement Panel met on August 11, 2009 to discuss the physician work values (PW/RVU) for Codes 17106-17107-17108. Although there was some acknowledgement regarding work intensity, this was countered by reiteration of the key arguments against the current code values. The results of the Multi-Specialty Refinement Panel balloting in the 2010 Medicare Fee Schedule: Final Rule reflect minor increases to the Physician Work RVUs for these codes.

CMS Clarifies POS/DOS for the PC/TC of Diagnostic Tests

The Centers for Medicare and Medicaid Services (CMS) has clarified its transmittal **"Physician or other supplier billing for diagnostic tests performed or interpreted by a physician who does not share a practice with the billing physician or other supplier"** in regard to Place Of Service (POS) and Date Of Service (DOS), Interpretation (PC) and Technical Component (TC) of Diagnostic Tests. The changes will take effect Jan. 4, 2010.

The regulation required an anti-markup payment limitation to the TC of the physician bill for a diagnostic test when performed by another physician who did not share a practice with the billing physician. As of Jan. 1, 2009, the anti-markup payment limitation, besides applying to the TC of a diagnostic test in certain situations, may also apply to the professional component (PC), or test interpretation, of a diagnostic test in certain situations.

The POS codes designate where the service was actually provided. Therefore, dermatologists should take care to bill the correct POS code on the CMS1500 claim form. CMS states that Carriers will pay close attention to the validity of the POS coding, as illustrated below:

i. Only one POS (other than services provided in the patient's home – 12) may be submitted on Form CMS-1500 for services paid under the MPFS.

ii. If the POS is not valid (e.g., the number designation has not been assigned or defined by CMS), the claim will be returned as unprocessable.

iii. If a claim lacks a valid, contains an invalid POS in item 24b, the claim will be returned as unprocessable with remark code M77 (Missing/incomplete/invalid place of service).

iv. If the POS is missing and the carrier cannot infer the POS from the procedure code billed (e.g., a procedure code for which the definition is not site-specific or which can be performed in more than one setting), the claim will be returned as unprocessable.

v. If the POS is valid but inconsistent or incompatible with the procedure billed (e.g., the place of service is inpatient hospital and the procedure code billed is office visit), claim will be returned as unprocessable since the carrier typically will not know whether the procedure code or the place of service is incorrect in such instances.

*– see **CMS** on page 8*

CMS Clarifies POS/DOS for the PC/TC of Diagnostic Tests

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Example	Place of Service (POS)	POS
If the dermatologist bills for lab services performed in his/her office	Office	11
If the dermatologist bills for a lab test furnished by another physician, who maintains a lab in his/her office	Other	99
If the dermatologist bills for a lab service furnished by an independent lab	Independent Laboratory	81
If an independent lab bills for the lab service	Place where the sample was taken	
An independent laboratory taking a sample in its laboratory	Independent Laboratory	81
If an independent laboratory bills for a test on a sample drawn on a hospital inpatient	Hospital Inpatient	22
perform services in an ambulatory surgical center (ASC)	Ambulatory Surgical Center (ASC)	24

Note: Items 21 and 22 on the Form CMS-1500 must be completed for all laboratory work performed outside a physician's office.

For services paid under the MPFS, only one POS maybe submitted on CMS1500 Form.

INTERPRETATION OF DIAGNOSTIC TESTS

Interpretation of a service performed in the physician's home, would be either POS "office" (11) as long as it meets the definition of office, or "other" (POS 99). The practice locations reflected in the physician's enrollment information may be instrumental in making the POS determination in this situation. Dermatologists must note that Medicare has both facility and non-facility designations for services paid under the MPFS. The jurisdiction for processing a payment for services is governed by the payment locality where the interpreting physician's service is furnished and will be based on the ZIP code.

Interpretation of service done in a hotel room would be reported with POS "office" (11) ("only if the hotel room is considered as the physician's office in the physician's enrollment information"). If both the physician and the patient are located in the hotel room at the time that the interpretation is performed, the POS code would "temporary lodging" (16). If the hotel room is neither the "office" nor the patient's temporary lodging, the appropriate POS is "other" (99).

Interpretation provided outside of the United States will generally not be paid for by Medicare. The term "outside the U.S." means outside the 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

In cases where it is unclear which POS code applies, your Medicare contractor can provide guidance.

If a diagnostic test which has a separate TC and PC is provided under arrangement to a hospital, the physician who reads the test can bill and be paid for the professional component. Both the technical and professional components of the test are also subject to the physician self-referral prohibition.

When a physician performs a diagnostic test under arrangement to a hospital and the test and the interpretation are not separately billable, the interpretation cannot be billed by the physician. The hospital is the only entity that can bill for the diagnostic test which encompasses the interpretation. The POS code for the test including the interpretation is hospital outpatient (22).

One of the service categories CMS says the law excludes from the SNF Consolidated Billing provision is "physician services," which are separately billable to the Medicare Part B contractor. The physician service for the interpretation is billed directly to the Medicare Part B contractor. Since many diagnostic tests include both a TC and a PC, suppliers need to generate two bills.

The appropriate POS code should be identified along with the ZIP code. In order to avoid application of the anti-markup payment limitation, the physician performing the test must share a practice with the billing physician or other supplier. There are two ways a performing physician may share a practice with the billing physician or other supplier:

i. If the performing physician furnishes substantially all (for purposes of this section, at least 75 percent) of his or her professional services through the billing physician or other supplier; or

ii. If the technical component (TC) or professional component (PC) of the diagnostic test is performed in the office of the billing physician or other supplier. The office of the billing physician or other supplier is any medical office space (regardless of the number of locations) in which the ordering physician or other supplier regularly furnishes patient care, and includes space where diagnostic testing is furnished, if the space is located in the same building (as defined in 42 C.F.R. §411.351, of the physician self-referral rules).

The use of "office" or POS code "11" has been problematic for dermatologists who perform services in an ambulatory surgical center (ASC), CMS states that these services shall be reported with POS code 24. It is inappropriate for physicians

— see **CMS** on page 9

CMS Clarifies POS/DOS for the PC/TC of Diagnostic Tests

— continued from page 8

to use office (POS code 11) for ASC based services unless the physician has an office at the ASC, the physician service was actually performed in the office suite portion of the facility, and no concurrent or overlapping hours exist between the ASC and the physician's office.

For services in a hospital outpatient department, report POS code 22, unless dermatologist maintains a separate office space in the hospital or on hospital property and that dermatologist office space is not considered a provider-based department of the hospital. In such instance, report POS "office" (11), as long as the service was actually performed in the office suite portion of the department. It is important to note that use of POS code 11 or office in the hospital outpatient department or on hospital property is subject to the physician self-referral provisions set forth in 42 C.F.R 411.353 through 411.357.

The appropriate DOS for the professional component is the actual date the interpretation was performed. If the test or TC was performed on April 30 and the interpretation was read on May 2, use April 30 as the DOS for the performance and May 2 as the DOS for the interpretation.

NOTE: Special rules applicable for the DOS of the technical component of clinical laboratory and pathology specimens are contained in 42 CFR 414.510.

For more information and clarification, please visit *http://www.cms.hhs.gov/transmittals/downloads/R1823CP.pdf* or contact your local Medicare Contractor.

CMS Announces 2010 Annual Participation Enrollment Program Extension

Due to revisions in to the 2010 Medicare Physician Fee Schedule (MPFS), the Centers for Medicare & Medicaid Services (CMS) has extended the 2010 Annual Participation Enrollment Program end date from December 31, 2009, to January 31, 2010. The announcement means that contractors will accept and process any Participation elections or withdrawals that are received or postmarked on or before January 31, 2010. Note the effective date for any Participation status change during the extension remains January 1, 2010.

To view the CMS press release, please visit:

http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=3539&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=1%2C+2%2C+3%2C+4%2C+5&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date

Coding Q & A

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

A: No. Codes 96405-96406 are used for injecting such drugs as alpha interferon for the treatment of cutaneous malignant lesions. To report the injection of bleomycin into warts, use code 11900 for up to and including 7 lesions or code 11901 for more than 7 lesions. The HCPCS code for bleomycin is J9040 for 15 units. Thus if you inject more than that amount, bill the code with the appropriate number of units. Only bill the drug code if your practice has purchased the drug.

Q. Does Medicare require modifier -79 on procedures other than surgical? We have been using modifier -79 on biopsies and destructions.

A. Modifier -79 is used when an unrelated procedure or service is done by the same physician during the postoperative period. Any procedure or service performed during the global period would require modifier -79 to designate that the procedure or service was unrelated to the original procedure or service.

This would also apply to a procedure done by a physician of the same specialty within a group practice during a global period.

Q: How would I code with a destruction 17110/078.10 or 11900/078.10 and injected w/ Candida?

A: Per AMA/CPT guidelines, the destruction and the Candida injection cannot be performed on the same lesion on the same day in the same session. The most effective method to achieve the required result must be reported. In the above question, provider can either report the 17110 or 11900, J3490. Based on CMS guidelines, you may require a secondary diagnosis to show the medical necessity for 17110 as stated earlier in today's webinar. However, if this case applies to commercial payors, it would be advisable to verify coverage with patient plan if this problem persists.

— see ***Coding Q&A*** *on page 10*

Coding Q&A's

— continued from page 9

Q. How do we explain to patients that dermatology visits are not appropriate to be coded as preventative visits?

A. Refer your Medicare patients to the Medicare publication, "Medicare & You 2009", which every Medicare patients receives. The list of covered preventive services begins on page 38. Skin exam is not included in the list, thus is not a covered service by Medicare. Check non-Medicare carrier web sites for instructions on their interpretation and use of preventive comprehensive medicine codes.

According to the preventive code descriptors in CPT, the preventive comprehensive medicine codes include "age/gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures."

Note: If a patient has a history of skin cancer or malignant melanoma, the skin examination would be a covered service, reported with the diagnosis code V10.82 or V10.83.

Q. For patients who are enrolled in a Medicare Advantage plan, what fee schedule should we use and how much can we collect from the patient?

A. Use the Medicare fee schedule. Prior to seeing the Medicare Advantage (MA) patient, be sure to contact that MA plan to determine the amount that will be the patient's responsibility. Note that non-contracted providers must accept the amount that original Medicare would pay and they may not charge the MA patient any more than their co-pay.

Q. What code would be reported for dermoscopy?

A. There is no code to report as the use of the dermoscopy is just a part of the evaluation and management of the patient.

Q. What ICD-9-CM code would be used to report Angiolymphoid Hyperplasia with Eosinophilia?

A. According to information we received from the National Center for Health Statistics, two codes would be reported; 228.01 for Hemangioma of skin and subcutaneous tissue and code 288.3 for Eosinophilia.

Q. Where can we find information regarding physician assistants (PA) and nurse practitioners (NP)?

A. Both PA and NP organizations have extensive information on their respective web sites. It is of utmost importance to review the rules of your state for non-physician providers. The NP web site (www.aanp.org) gives the contact information for state boards of nursing and other pertinent information. The PA web site (www.aapa.org) gives links to state licensing authorities plus other pertinent information. Also be sure to review the Academy's Position Statement on the Use of Non-Physician Office Personnel as mentioned in this issue in the OIG "Incident to" article.

Q. When reporting destruction of an actinic keratosis (17000) and destruction of 15 or more seborrheic keratoses (17111) on the same claim, which code gets modifier -59?

A. According to the National Correct Coding Initiative (NCCI) edits, code 17000 is reported with modifier -59. However, when reporting 17004 (destruction of 15 or more actinic keratoses) with 17110 or 17111, modifier -59 is appended to 17110 or 17111.

Note: Be sure to review your Medicare carrier's benign lesion policy regarding medical necessity of treating seborrheic keratoses. There are specific conditions that must be present and documented in order for the treatment of these lesions to be covered by Medicare.

NCCI Edits Effective 07/01/07 (DCC Fall 07)

Mutually Exclusive Edits

Column 1	Column 2	* = In existence prior to 1996	Effective Date	Deletion Date *=no data	Modifier 0=not allowed 1=allowed 9=not applicable
17004	17110		20070701	*	1
17004	17111		20070701	*	1
17110	17000		20070701	*	1
17111	17000		20070701	*	1

Column1/Column 2 Edits

No changes

Q. As a certified coder, I was trained to bill 11101 on separate lines when additional biopsies are performed, i.e., 11100, 11101, 11101, 11101, etc., and I am being reimbursed correctly by our Medicare carrier.

A. This is not the usual way of reporting add-on codes. Typically Medicare requires that add-on codes be reported with the appropriate number of units. Follow the directives from your carrier when reporting any service.

Q. "If a provider has performed a self-audit prior to RAC review and want to extrapolate these findings, will all these claims included in a self-audit be excluded from RAC review?

A. If a provider self-discloses a payment error and the Claims Processing Contractor confirms that a payment error exists and the sampling/extrapolation methodology used was correct, then these claims will not be reviewed by the RAC. The claims processing contractor will exclude the self-disclosed claims in the RAC data warehouse."

Amgen Pfizer

(final page content to be determined per Amgen Pfizer)

Correction

The last paragraph on page one of our Fall 2009 issue says that current CMS policy requires billing as an established patient visit when the patient has been seen by a primary care provider in the same group. That statement is incorrect based on the information found in the Medicare Claims Processing Manual, Publication 100-04. In a group practice, the physicians must be in the same specialty when determining whether the patient is new or established.

Chapter 12 states the following:

"30.6.5 - Physicians in Group Practice (Rev. 1, 10-01-03) Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician. If more than one evaluation and management (face-to-face) service is provided on the same day to the same patient by the same physician or more than one physician in the same specialty in the same group, only one evaluation and management service may be reported unless the evaluation and management services are for unrelated problems. Instead of billing separately, the physicians should select a level of service representative of the combined visits and submit the appropriate code for that level.

Physicians in the same group practice but who are in different specialties may bill and be paid without regard to their membership in the same group."

IN THE KNOW...

Did you know that HIPAA requires covered entities to retain HIPAA-related documents (e.g. security incident or breach logs, policies and procedures, written communications) for six (6) years? On the other hand, the period of time that covered entities are required by Federal law to retain patient medical records varies.

State Laws govern the period for medical retention. The Federal Register 42 CFR 485.721(d) states that In the absence of a state statute, the retention period should be for five years after the date of discharge; or in the case of a minor, three years after the patient becomes of age under state law or five years after the date of discharge, whichever is longer.

For Federal regulations and guidelines, see AHIMA at *http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_012546.pdf*

For State regulations and guidelines, see AHIMA at *http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_012547.pdf*

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