



Derm Coding Consult

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Medicare Fee Schedule Announces -29% Cut for 2011

The Centers for Medicare & Medicaid Services (CMS) released the proposed rule detailing Medicare physician payment policies for 2011, in the Federal Register on July 13, 2010.

This rule includes not only the standard CMS annual update to the Medicare Fee Schedule but also information on how many of the provisions of the Affordable Care Act (ACA) will be implemented.

2011 CONVERSION FACTOR UPDATE

The legislation that replaced the 21 percent Medicare payment cut on June 1st with a 2.2 percent increase expires on November 30th. Physicians will face a 23 percent cut on December 1, 2010. In addition, the proposed rule estimates that the 2011 Medicare Economic Index (MEI) will be 0.3 and that will trigger an additional 6 percent payment reduction on January 1, 2011. In the absence of any legislation to address this, physicians will be facing a 29% cut to the Medicare Conversion Factor, which will drop from \$36.8948 to \$26.1953.

MEDICARE ECONOMIC INDEX (MEI)

The Medicare Economic Index (MEI) which measures practice cost increases tied to the composition of a 1973 medical practice, does not adequately reflect the costs of providing patient care in 2010. The proposed rule announces that CMS will convene a technical panel to review all aspects of the MEI. However, the proposed rule also includes elimination of some of the current MEI cost categories and addition of others. CMS also intends to "rebase" the MEI using 2006 data collected in the Physician Practice Information Survey. Dermatology is seeing the positive results of that survey in the four-year transition of updated practice expense values. The impact of the proposed changes will increase index weights for practice expense and professional liability insurance (PLI) and reduce them for physician work. This then triggers increases in practice expense and PLI relative value units. However, rather than reducing work relative values to offset the practice expense and PLI increases, CMS proposes making the offsets to the conversion factor. It could result in another 7.9 percent reduction to the conversion factor on top of the 29 percent cut. In commenting on this proposed rule, AAD intends to question the wisdom of adopting these changes in advance of the technical panel's more comprehensive review of the MEI.

SPECIALTY IMPACT OF THE 2011 MEDICARE FEE SCHEDULE

CMS has estimated the specialty impacts of the proposed rule. These estimates do not include the impact of the SGR-driven pay cuts scheduled for December 1, 2010 and January 1, 2011 under current law. For Dermatology, the impact of the practice expense changes and multiple procedure reductions at the completion of the practice expense transition would be a 1% increase for the PE/RVU and MPPR changes. The impact of the proposed rebasing of the MEI for physician specialties, ranges from a 4 percent increase for radiation oncology to a 3 percent cut for anesthesiology, emergency medicine and psychiatry. The impact of the MEI rebasing for Dermatology would be 2%. The combined impacts of all the 2011 changes would be cumulatively 3% for dermatology. The combined impact for other specialties range from an increase of 4 percent for allergy/immunology to a decrease of 6 percent for radiology.

PRACTICE EXPENSE AND PLI RELATIVE VALUES

Dermatology continues to benefit from the continued 2011 transition of the data from the Physician Practice Information (PPI) Survey. Practice expense relative values will be computed utilizing a 50/50 blend of the prior practice expense relative values based on the SMS and supplemental survey data and the new practice expense relative values utilizing the PPI Survey data. The Academy successfully submitted supplemental survey data to CMS in 2005 and also participated in the AMA PPI Survey in 2008.

— see **MEDICARE** on page 6

Contents

Medicare Fee Schedule Announces -29% Cut for 2011	1
Letter from the Editor	2
ICD-10 CM Readiness Timeline	2
Lypodystrophy Coding Update for HIV Patients	3
How to Handle MUE Denials	3
Medicare turns Up the HEAT on Fraud	4
Q&A	4
PECOS – How To.....	5
Provider Signature Attestation Statement	
– What do I need?	8

IMPORTANT Please Route to:

Dermatologist Office Mgr Coding Staff Billing Staff

Letter from the Editor

Dear *Derm Coding Consult* Reader

As we prepare this Fall 2010 issue of *DermCodingConsult*, and as my crystal ball predicted, Congress did come through with the usual “last minute” rescue effective June 1 2010 with an increase of 2.2% to bring the Medicare conversion factor up from **\$36.0846** to **\$36.8948**/RVU.

There is still no happy ending as the 2.2% increase runs out on November 30th as a lame duck Congress sits in Washington DC. As detailed in our lead article, Dermatologists will face a -23 percent cut on December 1, 2010. In addition, the proposed rule estimates that the 2011 Medicare Economic Index (MEI) will trigger an additional -6 percent payment reduction on January 1, 2011. Bottomline, we are facing a -29% cut to the Medicare Conversion Factor, which will drop from **\$36.8948** to **\$26.1953**.

The Academy will be playing an active role in Washington DC to ensure that Medicare Physician Reimbursement remains active on the Fall Congressional Agenda.

AAD Coding & Reimbursement staff are receiving an increased number of contacts from AAD members with questions regarding the various CMS/Medicare audits as well audits being conducted by private payers. You should know that on July 15th, the Academy presented our latest webinar:

Audit Survival Kit/Coping w Medicare Audits (including RAC, MAC, Payer-initiated audits)

It's now available for order as a webcast at <http://www.aad.org/pm/education/webinar/index.html>

The new online Audit Survival Kit is available free at: http://www.aad.org/pm/billing/coding/_doc/AADAuditSurvivalToolkit.pdf

If you need help with coding questions or an audit, don't hesitate to contact Coding & Reimbursement staff at ppm1@aad.org

The Practice, Policy & Management/Coding & Reimbursement staff, Peggy Eiden, Faith McNicholas, and Cindy Bracy look forward to seeing you at the AAD Summer Meeting in Chicago! Please drop by the AAD Resource Center, Booth 1905 in the Hyatt Regency Chicago Exhibit Hall.

Best regards,



Norma L. Border, Editor

ICD-10 CM Readiness Timeline

Now is the time for every dermatology practice to begin planning for the October 1, 2013 deadline for ICD-10 CM compliance. Below is a step-by-step timeline your practice will need to follow in order to be compliant with the transition. Contact your vendor to ensure your electronic billing system is up to date with the compliance plan. CMS has assured providers that there will be **NO** exception to the October 1, 2013 deadline which requires all diagnoses reported on claims to be submitted using ICD-10 CM. *

DATE	COMPLIANCE STEP
December 31, 2010	Internal testing of Version 5010 must be complete to achieve Level I Version 5010 compliance
January 1, 2011	• Payers and providers should begin external testing of Version 5010 for electronic claims
	• CMS begins accepting Version 5010 claims
	• Version 4010 claims continue to be accepted
December 31, 2011	External testing of Version 5010 for electronic claims must be complete to achieve Level II Version 5010 compliance
January 1, 2012	• All electronic claims must use Version 5010
	• Version 4010 claims are no longer accepted
October 1, 2013	• Claims for services provided on or after this date must use ICD-10 codes for medical diagnosis
	• CPT codes will continue to be used for outpatient services

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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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Lypodystrophy Coding Update for HIV Patients

CMS has provided additional information on the dermal fillers for lypodystrophy. CMS has published an update stating that these services will be covered effective 03/23/10 and thereafter in the 2010 MPFS. However, only G0429: Dermal Filler injection(s) for the treatment of facial lipodystrophy syndrome has been awarded an RVU of NF1.45 so based on this information and calculating reimbursement, using the current conversion factor and locality of the provider of service, one can establish the reimbursement rate or just checking the MPFS from ones local carrier.

The other 2 codes Q2026 and Q2027 have a '0' RVU which means they will be carrier priced. Please note that these two codes are classified as items and/or services that CMS chose to exclude from the fee schedule payment by regulation. No RVUs or payment amounts are shown and no payment may be made under the fee schedule for these codes. Payment for them, when covered, continues under reasonable charge procedures.

The following is an abstract from the transmittal CR 6974 released 06/25/10.

"In CR 6974, contractors are being instructed to manually adjust the effective date for HCPCS codes G0429, Q2026, and Q2027 on the procedure code file and the MPFSDB. HCPCS codes G0429 (Dermal Filler injection(s) for the treatment of facial lipodystrophy syndrome (LDS) (e.g., as a result of highly active antiretroviral therapy)), Q2026 (Injection, Radiesse, 0.1ml) and Q2027 (Injection, Sculptra, 0.1ml) are effective for dates of service on or after March 23, 2010."

Please note that these procedures must have type of service status 1- medical care or 9 – other medical service in order to be processed accurately. There is no site of service differential, which means the reimbursement rate is the same whether the procedure was provided in a facility or non-facility setting. For more information, please visit: <https://www.cms.gov/MLN MattersArticles/downloads/MM6974.pdf> to view Medlearn MM6974 and <http://www.cms.gov/Transmittals/downloads/R1992cp.pdf> to view CR 6974.

UNITEDHEALTH GROUP SETTLEMENT

UnitedHealth Group (UHG), the parent company of United Healthcare (UHC), finalized a settlement in 2009 for \$350 million. This settlement was the result of a lawsuit from the American Medical Association (AMA), the Medical Society of the State of New York, and the Missouri State Medical Association against UHG for using a flawed database to determine out-of-network rates to providers. UHG agreed to settle the lawsuit with New York Attorney General Andrew Cuomo and pay \$350 million toward the establishment of a settlement fund. This fund will be used to reimburse providers who may not have received adequate compensation due to the flawed database.

Formal Settlement Notices and claim forms have been mailed to physicians by UnitedHealth Group. If you received this mailing, the Notice Number located on the outer page under the return address will help you complete the claim form. AMA members can call the AMA Practice Manage-

ment Center at (800) 621-8335 with specific questions regarding the filing of claims after reviewing the guide, Settlement Notice, and claim form. If you have not received a formal Settlement Notice you can visit www.ama-assn.org/go/ucrsettlement to download a copy of the claim form and access additional information regarding the Settlement.

Settlement claim forms must be submitted by First-Class Mail no later than October 5, 2010. It is also advised to file your claim and supporting documentation via Certified Mail to retain proof of receipt. Claims received postmarked after this date will be deemed as not submitted and no longer qualify for consideration in the settlement.

Although you must submit your claim form by First-Class Mail, UnitedHealth is allowing supporting documentation to be submitted electronically. If you prefer to submit your supporting documentation in an electronic format, such as .bmp or PDF files, you can include a clearly labeled CD with your claims. Documentation will also be accepted through e-mail. Please send e-mailed documentation to: unitedhealthcare@berdonclaimsllc.com. The supporting documentation can be from your practice management system and/or accounting records. The Settlement Claims Administrator prefers that you submit electronic supporting documentation that is prepared tab-delimited text files, such as Microsoft® Excel®.

The American Medical Association (AMA) has prepared a guide to assist physicians maximize their recovery from the UnitedHealth Group Settlement Fund. A nine step process, developed to assist you in the process of determining eligibility for submitting the UnitedHealth Group Settlement claim, can be found on the American Academy of Dermatology website at: http://www.aad.org/pm/billing/managedcare/_doc/UHG_step-by-step.pdf *

How to Handle MUE Denials

Medically Unlikely Edits (MUE's) are a common reason for claim denials. MUE's test entire claims lines against a specified number of units. If a single claim line exceeds the MUE limit, one of two things will happen:

- Claim is returned when the claim lines have units of services exceeding the MUE limit. The claim line is not denied, so no appeal process exists.
- Instead, physicians should resubmit corrected claims.
- Claim is processed by a Part B Medicare Administrative Contractor on the Medicare Claims System (MCS), the MAC will deny the entire claim line if the units of service on the line exceed the MUE limit. Since claim lines are denied, the denial may be appealed.

An MUE denial, just like a CCI edit denial, is not a medical necessity denial. It is a coding denial. Even if you have an Advanced Beneficiary Notice (ABN) on file, claims denied based on the MUE edits cannot be billed to the patient. In April of 2009, CMS stated that physicians cannot utilize an ABN "under any circumstances" to bill a Medicare patients for a service denied due to an MUE "even if the denial is upheld due to lack of medical necessity on appeal." You are prohibited from billing the patient for services denied due to an MUE edit.*

— see **IN THE KNOW** on page 8

Medicare turns Up the HEAT on Fraud

A new push to eliminate waste, fraud and abuse in the Medicare program has resulted in greater scrutiny of reimbursements as the government calls in the HEAT to burn violators and save scarce tax dollars.

In May 2009, the Department of Health and Human Services (DHHS) pledged to fight waste, fraud, and abuse in the Medicare program, creating the Health Care Fraud Prevention and Enforcement Action Team (HEAT) as a more effective tool for the fight. HEAT's purpose, fighting Medicare fraud, has become a top priority for both Department of Justice (DOJ) and DHHS.

In order to help reduce the skyrocketing healthcare costs and improve the quality of health care, HEAT's main mission is to assemble and strengthen significant resources across government entities to prevent waste, fraud and abuse in the Medicare and Medicaid programs and to crack down on the fraudulent claims that abuse the system by harming short- and long-term solvency of these essential programs.

HEAT, Medicare Fraud Strike Forces, law enforcement agencies and Medicare contractors are marshalling resources and manpower, developing effective strategies and using technology to detecting health care fraud and improper reimbursements. HEAT's initiative is aimed at stopping fraud before it happens and eliminating fraudulent providers in the Medicare program.

KNOW YOUR CARRIER RULES AND REGULATIONS

According to the Medicare Claims Processing Manual, Chapter 30, Medicare participating providers must know and understand the rules and regulations that apply to all services billed by and on behalf of the provider to the Medicare program. Physicians may be held liable for any activity performed under their Medicare provider transaction access number (PTAN). Ignorance of the laws and regulations cannot be used as an excuse.

Claims submitted to the Medicare program with any deliberate omission, misrepresentation, or falsification of any information contained in the enrollment application or in any communication (by any means) to Medicare may be punishable by criminal, civil, or administrative penalties and/or imprisonment.

Dermatologists and Non-Physician Providers (NPPs) are required to sign a certification statement upon enrollment with the Medicare program. By signing the Certification Statement, the provider certifies acknowledgement and agreement to:

- adhere to the Medicare laws, regulations, and program instructions that apply;
- be punished by criminal, civil, or administrative penalties including, but not limited to, the denial or revocation of Medicare billing privileges, and/or the imposition of fines, civil damages, and/or imprisonment should they be found liable for any deliberate omission, misrepresentation, or falsification of any information contained in the application or contained in any communication (i.e., claim submission, verbal communication, electronic communication, written communication) supplying information to Medicare, or any deliberate alteration of any text on the application form;
- not to submit claims with deliberate ignorance or reckless disregard of their truth or falsity (e.g. grossly negligent without concern and/or ignoring any potential consequences of so doing).

A copy of the Medicare Claims processing Manual can be found at <http://www.cms.gov/manuals/downloads/clm104c30.pdf>.

Particularly effective in the fight against Medicare fraud, is the False Claims Act (FCA) which allows for penalties of between \$5,000 and \$10,000 for each false claim plus damages of up to 3 times the amount of damages the Government sustains as a result of that false claim. Claims that are "knowingly" submitted as false claims may be found liable under the act for penalties for each false claim submitted.

According to the law, "The terms "knowing" and "knowingly" mean that a person

- has actual knowledge of the information;
- acts in deliberate ignorance of the truth or falsity of the information; or
- acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

You can view the False Claims Act (FCA) by going to <http://www.cms.gov/smdl/downloads/smdl032207att2.pdf>.

For more information on HEAT program, please visit the Stop Medicare Fraud website at <http://www.stopmedicarefraud.gov/index.html>. *

Q&A

Q: Patient presents with history of skin cancer and a "knot" on the Labia Majora that she can't see but claims it is annoying her. Provider diagnoses it is a "milia" or small cyst. Patient is relieved but wants the milia removed because it is annoying. How should the provider proceed and ensure appropriate reimbursement for this service?

A: The payer may consider this procedure not medically necessary. Acne treatment is usually considered border-line by most payers and removal of milia may be considered as such. Dermatologists are required to report the most accurate and specific diagnosis and procedure codes in order to receive the appropriate reimbursement from the payer otherwise this claim may be characterized as a "false claim" submission in order to receive reimbursement for services that are not medically necessary.

To avoid the provider not getting paid, it is advisable to discuss and inform the patient - **before providing the services** - that the service they are requesting may not be covered by their insurance plan as it may be perceived as not medically necessary but a patient's choice to enhance appearance. The patient will be required to pay for the visit out-of-pocket, **at time of service**.

However, if the patient insists on proceeding with the service and insists on the claim being filed to the payer, the provider **must** ensure the patient signs a **financial consent** stating that should the service provided not get paid by the insurance, **the patient is ultimately responsible for the bill**. So when the claim is denied, provider can go ahead and bill the patient for the total billed amount. *

PECOS – How To....

The Centers for Medicare & Medicaid Services (CMS) has established an Internet-based Provider Enrollment, Chain and Ownership System (PECOS) as an alternative to the paper (CMS-855) enrollment process. PECOS allows physicians, non-physician practitioners (NPPs) and other Medicare providers and supplier organizations to enroll, make changes and view their enrollment information on file with Medicare. PECOS also allows providers to check on the status of a Medicare enrollment application electronically.

All Medicare fee-for-service providers and suppliers **are required** to enroll and maintain their Medicare enrollment with the Medicare program in order to receive Medicare payments for covered services provided to any Medicare beneficiary.

APPLICATION OPTIONS

Physicians and NPPs can apply for or make a change in their enrollment information contained in the Medicare program either by using PECOS or the paper enrollment application form CMS-855I or CMS-855R).

USING PECOS AS YOUR PREFERRED METHOD

Before initiating a Medicare enrollment action using PECOS, you will need:

- An active National Provider Identifier (NPI).
- National Plan and Provider Enumeration System (NPPES) User ID and password.

NOTE: PECOS can be accessed with the same User ID and password that a physician or NPP uses for NPPES.

- For assistance in establishing your NPPES User ID and password, contact the NPI Enumerator at 1-800-465-3203 or send an email to customerservice@npienumerator.com.
- Forgot your password? Visit <https://nppes.cms.hhs.gov/NPPES/Welcome.do> and select the "Reset Password Page" under the NPPES Application help page.

(For security reasons, CMS recommends that a physician/or NPP change their NPPES password at least once a year)

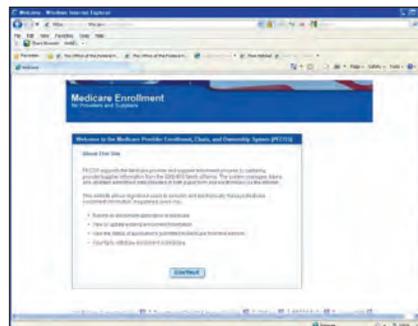
- Personal identifying information, e.g. physician's or NPPs legal name as it appears on file with the Social Security Administration (SSA), date of birth, and Social Security Number.
- Professional license and certification information, e.g. physician's or NPPs professional license, professional school degrees or certificates.
- Practice location information, e.g. physician's or NPPs medical practice location, the legal business name, Professional Corporation, or Limited Liability Company (LLC) as it appears on file with the Internal Revenue Service (IRS) and on the IRS CP575, as well as any Federal, State, and/or local (city/county) business licenses, certifications and/or registrations that are required to operate as a health-care facility.
- If applicable, information about any final adverse action. A final adverse action includes:
 - a Medicare-imposed revocation of any Medicare billing privileges;
 - suspension or revocation of a license to provide health care by any State licensing authority;
 - revocation or suspension by an accreditation organization;

- a conviction of a Federal or State felony offense (as defined in 42 CFR 424.535(a)(3)(A)(i)) within the last 10 years preceding enrollment, revalidation, or re-enrollment; or
- an exclusion or barring from participation in a Federal or State health care program

USING PECOS TO COMPLETE YOUR ENROLLMENT FORM

To complete your Enrollment or update your Medicare application using PECOS, follow these three basic steps:

- **Log-in:** Using your NPPES User ID and password, go to PECOS at <https://pecos.cms.hhs.gov/pecos/login.do> and complete, review, and submit the electronic enrollment application via PECOS.



- **Print, Sign and Date:** Print the 2-page Certification Statement (Section 15 or pages 25- 27), sign, and date the 2-page Certification Statement. The 2-page Certification Statement must be signed by the physician or NPP enrolling or making changes to enrollment information. CMS requires an original signature – preferably in blue ink. Copied or stamped signatures **are not** accepted.



NOTE: A Medicare contractor will **not** process a PECOS enrollment application **without** an original, signed and dated 2-page Certification Statement with all the required supporting documentation.

The effective date of filing an enrollment application **is the date the Medicare contractor receives the signed 2-page Certification Statement** that is associated with the Internet submission.

- **Mail:** Mail the 2-page Certification Statement and all supporting paper documentation to the Medicare contractor within 7 days of the electronic submission. It is recommended that you retain a copy of the complete application for your records as well.
 - Your local Medicare Enrollment Provider Contact Information can be found at <http://www.aad.org/pm/billing/medicare/>

PECOS LIMITATIONS

While PECOS supports most Medicare enrollment application actions, there are some limitations to the system. A few of the actions PECOS **cannot be** used for are to:

PECOS – How To....

— continued from page 5

- Change physician/NPPs name or Social Security Number;
- Change an existing business structure, e.g. a sole owner of an enrolled Professional Association, Professional Corporation, or LLC cannot change the business structure to a sole proprietorship or vice-versa
- Reassign benefits to another supplier if that supplier does not have a current Medicare enrollment record in PECOS

PROCESSING TIMEFRAMES

Since PECOS is believed to help reduce the necessary time frame for a Medicare contractor to review and process a Medicare enrollment application, CMS has established recommended processing periods for applications submitted via PECOS separately from those submitted on paper. Applications submitted through PECOS require Medicare contractors to process 90 percent of the applications (e.g., initial enrollments, changes of information, and reassignments) within 45 days of receipt of the signed and dated 2-page Certification Statement and the supporting documentation.

On the other hand, 80 percent of initial paper enrollment applications are processed within 60 days, and 80 percent of paper changes and reassignments are completed within 45 days.

For more information on Medicare enrollment please visit <http://www.cms.gov/medicareprovidersupenroll/> *

Medicare Fee Schedule Announces -29% Cut for 2011

— continued from page 1

CMS will implement recommendations from the AMA/Specialty Society RVS Update Committee (RUC) to correct direct practice expense inputs for several services. A new process for requesting supply and equipment price modifications is outlined. Dermatology procedures reflect small but positive increases to malpractice (MLI) RVUs.

POTENTIALLY MISVALUED SERVICES

As part of the ongoing effort to address potentially misvalued services, CMS is requesting the RUC to review services that fall into five categories: high volume/cost items on the RUC's Multi-Specialty Points of Comparison (e.g., cataract surgery, colonoscopy); codes with low work RVUs commonly reported with multiple units (e.g., allergy tests); codes with high volume and low work RVUs (e.g., X-ray exams); site-of-service anomalies (i.e., services initially performed inpatient that have migrated to outpatient); and 23+ hour stay services. Currently, one of these identification measures flags any procedure that exhibits a 10% increase in Medicare utilization over a three year period. Procedures meeting this criteria will be flagged for "high utilization" and brought forward for review by the AMA RUC.

EXPANSION OF MULTIPLE PROCEDURE PAYMENT REDUCTIONS

Effective January 1, 2011, CMS proposes to expand the multiple procedure payment reduction (MPPR) to CT and CTA, MRI and MRA and ultrasound procedures provided to a patient in the same session, regardless of the imaging modality, and not

limited to contiguous body parts. Although CMS acknowledges that it is highly unlikely that a physician would provide more than one advanced imaging service involving two different modalities (e.g., MRI and CT) to the same patient on the same date, it plans to implement a 50 percent reduction to account for the perceived efficiencies in the cost of performing the subsequent services.

GEOGRAPHIC PRACTICE COST INDEXES (GPCI) ADJUSTMENTS WC497

The current Medicare payment formula applies a separate geographic practice cost index (GPCI) to each of the separate RVU values for physician work, practice expense and malpractice insurance. Application of the GPCIs creates the primary differences in Medicare payment between geographic areas. The proposed rule makes a number of changes to the GPCIs. The ACA extends the floor of 1.00 on the work GPCI through 2010. However, the 2011 proposed GPCIs do not incorporate this floor and it's elimination with affect reimbursement for dermatologists practicing in rural areas.

The ACA also requires that the Practice Expense GPCIs only reflect 1/2 of the geographic differences in employee wages and rents for 2010 and 2011, except in localities where this would reduce payments, and it establishes a permanent, non-budget neutral floor of 1.00 on the PE GPCI for five frontier states. In addition, the ACA also requires CMS to evaluate certain aspects of the PE GPCIs and implement indicated revisions no later than January 1, 2012. CMS will analyze the office expense component of the PE GPCI, the weights that are assigned to the various components, and the feasibility of using actual data, such as office rental data to replace the current proxies like apartment rental data.

The original law establishing the Medicare payment schedule requires CMS to update the GPCIs every three years. However, in the proposed rule for 2011, CMS has combined the ACA-required review with the regular update of the GPCI data. CMS will now be using employee wage data from the Bureau of Labor Statistics instead of the 2000 Census, which has become dated, and using Physician Practice Information survey data to update the weights of the different elements. The later should also be beneficial for dermatology practices. As required by law, the GPCI updates are being phased in over two years, in 2011 and 2012. Because there are so many different changes to the GPCIs occurring at one time, it is not possible to differentiate their various effects on specialty or locality payments.

CONFIDENTIAL FEEDBACK REPORTS AND VALUE-BASED MODIFIER

Congress has directed CMS to refine and expand its current efforts to provide confidential feedback reports comparing the cost and quality of care across physicians and to use this data to create a value-based payment modifier by 2015. As required under a prior law, CMS has done limited testing with confidential feedback reports using existing commercial software to compare resource use for different types of care episodes. However, CMS found these groupers "do not work well" for beneficiaries with chronic conditions. Now CMS is charged with creating a Medicare-specific, transparent method of grouping episodes by January 1, 2012. Until that software exists, CMS intends to provide physicians with feedback reports showing how they compare to their peers on total costs per Medicare beneficiary and total costs of treatment with any of the following five conditions: diabetes, congestive heart failure, coronary artery disease, chronic obstructive pulmonary disease and prostate disease. *



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In the Know...

The Centers for Medicare & Medicaid Services (CMS) developed the Medically Unlikely Edits (MUE) program to reduce the paid claims error rate for Medicare claims that may be caused by clerical entries, incorrect coding based on anatomic considerations, HCPCS/CPT code descriptors, CPT coding instructions, established CMS policies, nature of a service/procedure, nature of an analyte, nature of equipment, prescribing information, and unlikely clinical diagnostic or therapeutic services.

An MUE is a unit of service (UOS) edit on a HCPCS/CPT code for services provided to a Medicare beneficiary by a single physician/NPP on the same date of service. An ideal MUE represents the maximum UOS that would be reported for a HCPCS/CPT code on the vast majority of appropriately reported claims. CMS has set the UOS for each MUE high enough to allow for medically likely daily frequencies of services provided in most settings.

The MUE program also allows providers the capability to report medically reasonable and necessary UOS in excess of an MUE because adjudication is made against each line of a claim and not the entire claim. Appropriate use of CPT modifiers to report the same code on separate line of a claim will enable providers to UOS in excess of an MUE.

Appropriate CPT modifiers that will accomplish this purpose include:

- **76** - repeat procedure by same physician
- **77** - repeat procedure by another physician
- **91** - repeat clinical diagnostic laboratory test
- **59** - distinct procedural service

Note: Modifier 59 must only be used if no other modifier can provide a better description of the reported service.

- Anatomic modifiers - e.g., **RT, LT, F1, F2**

Since MUEs are set to auto-deny based on an individual claim line item with UOS in excess of the recommended value, denials may be appealed and submitted to your local contractor.

A denial of services due to an MUE is a coding denial and not a medical necessity denial, hence providers cannot issue an Advance Beneficiary Notice of Noncoverage (ABN) in connection with services denied and cannot bill the beneficiary for UOS denied based on an MUE. The denied UOS shall be providers' liability.

Originally, MUEs were all confidential and only for use by CMS and its contractors. Since October 1, 2008, CMS has published some MUE values that can be viewed at http://www.cms.hhs.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage

MUE values that are still not published continue remain confidential information for use only by CMS and its contractors only.

For more information on MUEs, view the CMS Manual System Transmittal 652 at <http://www.cms.gov/MLN MattersArticles/2010MMAN/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=8&sortOrder=ascending&itemID=CMS1234257&intNumPerPage=10>

Now You are in The Know! *

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PROVIDER SIGNATURE ATTESTATION STATEMENT - WHAT DO I NEED?

WPS Medicare has received questions from providers regarding the information a provider signature attestation statement should contain. In response to these inquiries we have developed an example of a signature attestation statement to provide further guidance. While not a Medicare mandated form, for your convenience it can be completed and submitted as an attestation statement if required. Any similar statement is acceptable provided it is signed, dated, and contains sufficient information to identify the patient and date of service. To view this form, please visit our Website at http://www.wpsmedicare.com/part_b/business/2010_0518_attestation_example.pdf. *



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