AAD 1938 American Academy of Dermatology

Derm Coding Consult

Published by the American Academy of Dermatology Association

[Volume 14 | Number 1 | Spring 2010]

ICD-9-CM Coding

For office based services and procedures, reporting of ICD-9-CM codes differ from facility based services. Rule out or suspected diagnoses are not used to report services provided in an office. The guidance for choosing the appropriate diagnosis codes appear in the Medicare Claims Processing Manual, Pub 100 -4, Chapter 23, Section 10. The rules are applicable for reporting diagnoses codes on the CMS 1500 claim form.

The rules as listed in the Manual are:

1) "Use the ICD-9-CM code that describes the patient's diagnosis, symptom, complaint, condition or problem. Do not code suspected diagnosis.
2) Use the ICD-9-CM code that is chiefly responsible for the item or service provided.
3) Assign codes to the highest level of specificity. Use the fourth and fifth digits where applicable.
4) Code a chronic condition as often as applicable to the patient's treatment.
5) Code all documented conditions that coexist at the time of the visit that require or affect patient care or treatment. (Do not code conditions that no longer exist.)"

Using the above as guidance, in reporting the diagnosis of a neoplasm or lesion that is suspicious, the diagnosis options are:

238.2 - neoplasm of uncertain behavior,
239.2 - neoplasm of unknown behavior,
782.x – sign or symptom that brought the patient to the office, or
*Hold billing until the pathology report is received and use the appropriate ICD-9- CM code.

Check the carrier's guidelines regarding the use of 238.2 or 239.2. Not all carriers have the same rules for reporting the uncertain/unknown diagnosis.

One should never report any type of malignant diagnosis unless that diagnosis has been pathologically proven. Once a malignant diagnosis is given to a patient, it is very difficult to get that diagnosis eradicated from the patient's medical history. An invalid malignant diagnosis will impact the patient's insurance coverage.

What about use of the V codes for history of malignancies? When the primary malignancy has been excised and treatment to that site has been completed, the patient then has a history of the malignancy. Use V10.82 for history of malignant

— see **ICD-9_CM** *on page 2*

CMS Eliminates Payment for Consultation Codes

Effective Jan.1, 2010, The Centers for Medicare and Medicaid Services (CMS) eliminated payment for consultation codes (99241-99245 and 99251-99255). CMS now requires physicians to report either a new or established patient encounter code (99201-99205 and 99211–99215) depending on the complexity of the visit, where the visit occurred and whether the patient is a new or established patient to that physician.

CMS justifies this regulatory action by saying "the resources involved in doing an inpatient or office consultation are not sufficiently different than the resources required for an inpatient or office visit to justify the existing differences in payment levels." The policy change has resulted in a modest increase in CMS payments for the office visit codes that are billed by most physicians and those most commonly billed by primary care physicians.

OUTPATIENT/OFFICE SETTING BILLING GUIDELINES

In the office or other outpatient setting, dermatologists and non-physician practitioners (NPPs) will use the new or estab-

— see **CMS** *on page 5*

Contents

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

Letter from the Editor

Dear *Derm Coding Consult* Reader:

As we prepare this Spring 2010 issue of DermCodingConsult, my crystal ball looks more like a spinning top as to what can be expected from Congress on Medicare reimbursement for 2010 or Health System Reform. I do predict that the news will be "hot off the presses at the AAD 68th Annual Meeting in Miami.

Dermatologists participating in the 2010 Medicare Physician Quality Reporting Initiative (PQRI) will report on the three melanoma measures via a patient registry mechanism. Dermatologists will have until January 31, 2011 to submit their PQRI data through a CMS approved registry. As you plan on participating in PQRI in 2010, your practice should begin setting up a log or tickler system to track all of your melanoma patients in anticipation of the Academy sponsored registry. Please stay tuned to the Academy website at *www.aad.org* for more information.

The Academy has launched into it's third year of bringing coding & reimbursement as well as practice management topics to AAD members and their dermatology practice staff. Mark your calendars so that you don't miss out on the following programs:

Thursday, 03/18/10	**Billing MOHS procedures? Know the rules and guidelines**
Thursday, 04/01/10	**Ace Your Electronic Health Record (EHR) Implementation, Part One**
Thursday, 05/20/10	**Reducing Denied Claims (LCDs, NCCI edits EOB/Claim Denial codes)**

If you missed the 2010 Coding Update Webinar on January 21, this session is now available as a webcast.

Just go to the web site for more information on ordering the above webinars and the webcast at

http://www.aad.org/pm/education/webinar/index.html

The Practice, Policy & Management/Coding & Reimbursement staff look forward to seeing you in the AAD Resource Center, Booth 1057 in Miami.

Best regards,

Norma L. Border, Editor

2010 New AMA/CPT Definitions for a Transfer of Care

The AMA has finally defined when an encounter should be coded as a **transfer of care** versus a **consultation**. This definition is of interest for payors who still accept consultation services.

For transfer of care, the new AMA/CPT guidance states:

"Transfer of care is the process whereby a physician who is providing management for some or all of a patient's problems relinquishes this responsibility to another physician who explicitly agrees to accept this responsibility and who from the initial encounter is not providing consultative services. The physician transferring care is then no longer providing care for these problems though he or she may continue providing care for other conditions when appropriate."

"Consultation codes should not be reported by the physician who has agreed to accept transfer of care before an initial evaluation but are appropriate to report if the decision to accept transfer of care cannot be made until after the initial consultation evaluation, regardless of site of service."

Note: This transfer of care definition came from AMA CPT. However, it's something that societies have requested from CMS since 2006, *2010 AMA/CPT manual, page 4.*

ICD-9-CM Coding

— continued from page 1

One would never use the malignant code as a secondary diagnosis code unless the patient is currently being treated for a new malignant lesion. Medicare recognizes the V10.82 and V10.83 as primary diagnoses codes and substantiate the medical necessary for an evaluation and management service.

The Official Guidelines for the Use of ICD-9-CM codes may be found at: *http://www.cdc.gov/nchs/data/icd9/icdguide09.pdf#1*

These guidelines are also printed in the Professional Edition of the ICD-9-CM book, however if a more current version exists, that version will be on the above web link.

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:
Scott Dinehart, MD, FACP Editorial Board *Derm Coding Consult*
American Academy of Dermatology Association
P.O. Box 4014 Schaumburg, IL 60168-4014

Coding Update

SOFT TISSUE CODING CLARIFICATION

The Winter 2009 issue of *Derm Coding Consult* contained information for new soft tissue codes appearing in CPT 2010. Since that article appeared, the coding staff have received many inquiries on the appropriate use of the soft tissue codes.

The new musculoskeletal directives published in CPT 2010 gives guidance as to when the codes in the musculoskeletal system should be used. Note that the directives refer to these excisions as resections. However, the code descriptions of the individual codes state excision. The appropriate code should be selected based on where the tumor is located, skin, soft tissue, fascial or subfascial. The terms excision and resection mean the same in selecting the appropriate code. The directives explain that the size of the excision is based on the tumor size plus the most narrow margins to excise the lesion. The codes are less than 2cm or greater than 2 cm in some sites. In other sites the size used is 3cm or in some sites, 5cm. This measurement is taken at the time of the procedure. The sizing directives are consistent with the sizing directives of lesion excision in the integumentary system (CPT 11400-11446, 11600-11646). An excision of a skin lesion that extends into the soft tissue, even fascial or subfascial, is reported with the appropriate skin lesion excision code (11400-11446 or 11600-11646).

Soft tissue tumors are described as those tumors that originate under the skin, in the soft tissue. Excision of lesions such as lipomas or cysts that develop in the soft tissue would be reported with the appropriate soft tissue excision code. The soft tissue tumor excision includes simple and intermediate repair. However, a medically necessary complex repair may be separately reported.

The CPT Changes Book for 2010 gives examples of vignettes and procedure descriptions for the new soft tissue codes. The procedure description includes dissecting the tumor free of the surrounding structures and fascial attachments. This is a way of differentiating a soft tissue excision from a skin lesion excision.

Fascial or subfascial tumors are those tumors that originate within or below the deep fascial but do not involve bone. The directives for use of these codes are the same as those for the soft tissue tumor excisions, simple or intermediate repair are included in the procedure. A complex repair, if medically necessary, may be separately reported. The correct CPT code for the fascial or subfascial tumor excisions would be selected by the tumor size plus the most narrow margins which would be measured at the time of the procedure.

The directives for all the soft tissue, fascial and subfascial tumors include a simple repair or an intermediate repair if performed. A complex repair that is medically necessary would be separately reportable according to the CPT directives. However, do note that the National Correct Coding Initiative Column 1/Column 2 edits list the complex closures in Column 2 with the indicator are "1". That edit would prohibit reporting a complex closure at the same site of the soft tissue, fascial or subfascial tumor excision when the procedure was performed on a Medicare patient.

The excision of soft tissue, fascial and subfascial tumors all have 90 global days according to the Medicare database. Thus, follow-up visits related to the procedure are built into the reimbursement for that excision procedure and are not separately reportable. Likewise, if multiple procedures are performed, the multiple surgery rule would be applied for Medicare. Other carriers may have global days and multiple surgery rules that differ from Medicare rules.

See Derm Coding Consult, Winter 2009 for a listing of the new and revised site specific soft tissue, fascial or subfascial codes appearing in CPT 2010. Also, be sure to monitor your carriers' web sites for specific directives regarding the use of the soft tissue, fascial or subfascial codes. Medicare and other carriers will want to know the medical necessity that required the procedure performed.

What is the RAC Audit Process?

WHO IS ELIGIBLE TO BE AUDITED?

Recovery Audit contractors (RACs) are authorized by CMS to investigate claims submitted by all physicians, providers, facilities, and suppliers—essentially everyone who provides Medicare beneficiaries in the fee for service program with procedures, services, and treatments and submits claims to Medicare (and/or their fiscal intermediaries (FI), regional home health intermediaries (RHHI), Part A and Part B Medicare administrative contractors (A/B/MACs), durable medical equipment Medicare administrative contractors (DME MACs), and/or carriers.

BASIS FOR THE AUDIT

Now that the RACs have been assigned for a specific region of the country, they will receive a claim's file from CMS. The file contains the past claim's data from the National Claims History (NCH), compiling the claims that have been processed and paid after 10/01/07 in that assigned region. Monthly updates, including the current fiscal year, will be sent thereafter. RACs employ their own custom-designed computer programs and processes, utilizing their uniquely developed criteria based on Medicare rules and regulations, accepted clinical standards of medical practice, and coding and billing policies, to determine which specific sectors to review. They may also reference specific services included in the current year Office of the Inspector General's (OIG) work plan as well as Government Accountability Office (GAO) and Comprehensive Error Rate Testing (CERT) findings. From this information, the RAC will identify those situations in which claims have a high probability to be overpaid (and underpaid) in their region. These qualifiers are then entered into the RAC database for each claim to identify providers and begin the analysis and recoupment process.

TYPES OF AUDITS

There are two types of audits: automated reviews and complex reviews. An automated review occurs when a RAC makes a claim determination at the system level without a human review of the medical record, such as data mining. Errors found must be clearly non-covered services or incorrect

— see **RAC** *on page 4*

What is the RAC Audit Process?

— continued from page 3

application of coding rules and must be supported by Medicare policy, approved article, or coding guidance. A complex review occurs when a RAC makes a claim determination utilizing human review of the medical record. Records requiring a complex review are those with high probability of noncovered service or when there is no definitive Medicare policy, Medicare article, or Medicare-sanctioned coding guideline.

RAC audits can review all aspects of the supporting medical records including, but not limited to, evaluation and management (E/M) services as related to those that should be reimbursed as a component of a global surgery package, as well as those on duplicate claims. At this point in time, RAC audits may not question the level of some E/M codes.

CMS Regional Offices – Region I - X

The Regional Office should be your initial point of contact on any Medicare, Medicaid, or State Children's Health Insurance Program (SCHIP) issues:

CMS – Region I
(CT, ME, MA, NH, RI, VT)

Carol Maloof -
Acting & Deputy
Regional Administrator
Office of the Regional Administrator
JFK Federal Building
Room 2325
Boston, MA 02203-0003

Phone: (617) 565-1188
Fax: (617) 565-1339
Email: robosora@cms.hhs.gov

CMS – Region II
(NJ, NY, PR, Virgin Is.)

Carol Maloof -
Acting & Deputy
Regional Administrator
Office of the Regional Administrator
Jacob K. Javits Building
26 Federal Plaza
Room 3811
New York, NY 10278-0063

Phone: (617) 565-1188 / 212-264-3841
Fax: (212)264-2790
Email: robosora@cms.hhs.gov

CMS – Region III
(DE, DC, MD, PA, VA, WV)

Nancy B. O'Connor -
Regional Administrator
Office of the Regional Administrator
The Public Ledger Building
Suite 216
150 S Independence Mall West
Philadelphia, PA 19106

Phone: (215) 861-4140
Fax: (215) 861-4140
Email: rophiora@cms.hhs.gov

CMS – Region IV
(AL, NC, SC, FL, GA, KY, MS, TN)

Renard Murray -
Regional Administrator
Office of the Regional Administrator
Atlanta Federal Center
61 Forsyth Street, S.W.
Suite 4T20
Atlanta, GA 30303-8909

Phone: (404) 562-7150
Fax: (404) 562-7162
Email: roatlora@cms.hhs.gov

CMS – Region V
(IL, IN, MI, MN, OH, WI)

John Hammarlund -
Regional Administrator
Office of the Regional Administrator
233 North Michigan Avenue
Suite 600
Chicago, IL 60601

Phone: (206) 615-2306
(312) 353-3653
Fax: (312) 353-0252
Email: rosea_ora2@cms.hhs.gov

CMS – Region VI
(AR, LA, NM, OK, TX)

Renard Murray -
Regional Administrator
Office of the Regional Administrator
1301 Young Street
Suite 714
Dallas, TX 75202

Phone: (404) 562-7150
(214) 767-6427
Fax: (214) 767-6400
Email: roatlora@cms.hhs.gov

CMS – Region VII
(IA, KS, MO, NE)

Diane Livesay – Acting
Regional Administrator
Office of the Regional Administrator
601 East 12th Street
Room 235
Kansas City, MO 64106

Phone: (303) 844-2111
(816) 426-5233
Fax: (816) 426-3548
Email: roreaora@cms.hhs.gov

CMS – Region VIII
(CO, MT, ND, SD, UT, WY)

Diane Livesay – Acting
Regional Administrator
Office of the Regional Administrator
1600 Broadway
Suite 700
Denver, CO 80202

Phone: (303) 844-2111
Fax: (303) 844-6374
Email: roreaora@cms.hhs.gov

CMS – Region IX
(AZ, CA, HI, NV, Territories of American Samoa, Guam & the Commonwealth of the Northern Mariana Islands)

David Sayer - Regional Administrator
Office of the Regional Administrator
90 – 7th Street
Suite 5-300
San Francisco, CA 94103-6706

Phone: (415) 744-3501
Fax: (415) 744-3517
Email: rosfoora@cms.hhs.gov

CMS – Region X
(AK, ID, OR, WA)

John Hammarlund -
Regional Administrator
Office of the Regional Administrator
2201 6th Avenue
Suite 801
Seattle, WA 98121

Phone: (206) 615-2306
Fax: (206) 615-2027
Email: rosea_ora2@cms.hhs.gov

CMS Eliminates Payment for Consultation Codes

— continued from page 1

lished patient encounter CPT codes (99201-99215) depending on the complexity of the visit. All providers should follow the evaluation and management (E/M) documentation guidelines for all E/M services. These rules apply to circumstances where Medicare is the primary or secondary payor.

Note: There is no direct cross-walk between consultation codes and new or established E/M codes.

CMS encourages providers to select the E/M codes based on the content of the service. The duration of the visit is an ancillary factor and does not dictate the level of the service to be billed unless more than 50 percent of the face-to-face time (for office and outpatient encounters) or more than 50 percent of the floor time (for inpatient encounters) is spent providing counseling or coordination of care.

According to CMS, "Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported. The service should be documented during, or as soon as practicable after it is provided in order to maintain an accurate medical record."

INPATIENT SETTING BILLING GUIDELINES

In the inpatient (hospital) and the nursing facility settings, all providers who perform an **initial evaluation may bill** an initial hospital care codes (99221–99223) or nursing facility care codes (99304–99306). **The admitting physician of record** is distinguished in Medicare billing system from other physicians who may be furnishing specialty care by appending **modifier "-AI" - Principal Physician of Record**, appended to the E/M code reported by the admitting physician.

Follow-up visits in the facility setting shall be billed as subsequent hospital care visits (99231-99233) and subsequent nursing facility care visits (99307–99310).

The previous low level consultation codes (**99251-99252**) do not match the documentation components of the inpatient hospital care codes (**99221-99222**). There is no comparison for these two lowest-level inpatient consult codes, **99251** and **99252**. CMS manual directs providers the option to report the unspecified evaluation and management (E/M) code, 99499. This code will be denied without documentation. Unless advised by your carrier, once the claim is denied, refile it with supporting documentation.

Since this will cause a delay in reimbursement, some local carriers: Trailblazer, National Government Services, and

COMPARING E/M LEVELS – OFFICE/OUTPATIENT

Consult Code	New Patient Code	Established Patient Code	History	Exam	MDM
99241 15 min	99201 10 mins	99212 10 mins	Problem Focus	Problem Focus	Straight-fwd
99242 30 mins	99202 20 mins	99212/ 99213 10/15 mins	Exp Problem Focus	Exp Problem Focus	Straight-fwd
99243 40 min	99203 30 mins	99213/ 99214 15/25 mins	Detailed	Detailed	Low
99244 60 mins	99204 45 mins	99214/ 99215 25/40	Compre-hensive	Compre-hensive	Moder-ate
99245 80 mins	99205 60 mins	99215 40 mins	Compre-hensive	Compre-hensive	High

COMPARING E/M LEVELS – HOSPITAL

Old Consult Code	New Patient Code	History	Exam	MDM
99251 20 mins	99499 99231 15 mins	Problem Focus	Problem Focus	99231: Straight-fwd or low
99252 30 mins	99499 99232 25 mins	Exp Prob-lem Focus	Exp Prob-lem Focus	99232: Straight-fwd
99253 55 mins	99221 30 mins	Detailed	Detailed	Low
99254 80 mins	99222 50 mins	Compre-hensive	Compre-hensive	Moderate
99255 110 mins	99223 70 mins	Compre-hensive	Compre-hensive	High

Noridian have suggested reporting the subsequent hospital codes **99231-99232** when the work, documentation and medical necessity don't support the services of 99221. Refer to your local carrier for more information.

BILLING FOR NON-MEDICARE PAYORS

Dermatologists should check directly with commercial carriers that their practice is contracted with to verify the carriers' current consultation code billing policy.

Among the commercial carriers, United Healthcare has stated that it "will continue to reimburse consultation codes (99241–99245 and 99251–99255) according to the United Healthcare payment policies" when submitted for services provided to members covered under commercial plans.

— see **CMS** on page 6

CMS Eliminates Payment for Consultation Codes

— continued from page 5

However, UHC will "**not reimburse** for all United Healthcare Medicare Solutions e.g SecureHorizons®, AARP®, MedicareComplete®, Evercare®, and AmeriChoice® Medicare Advantage benefit plans, as these plans will follow CMS regulations and implement the change. "The change includes the revalued relative-value units (RVUs) for E&M CPT codes and a new coding edit, consistent with CMS, to deny the CPT consult code as a non-payable service (for Medicare programs).

BILLING CONSULTATION CODES WHEN MEDICARE IS THE SECONDARY PAYOR

Dermatologists must understand that the consultation **codes have not been deleted from the 2010 AMA/CPT manual** but that CMS has **discontinued reimbursement** for these codes. Therefore, these codes can still be reported to a primary payor other than Medicare when a service meets the consultation code guidelines and criteria has been performed. In this instance, when a consultation service (99241-99245 & 99251-99255) is provided and paid by a primary payor other than Medicare, the secondary reimbursement can be submitted to Medicare (secondary payor) using either method:

- Submit the claim to Medicare with the consultation code as it was originally submitted to the primary payor in which case, Medicare will deny the claim as a non-covered service; or
- Change the consultation code to reflect the new or established code that reflects the appropriate level of service provided before sending it on to Medicare for adjudication.

Note: Medicare states that provider **cannot** bill the patient for the balance when the service is denied as a non-covered service and/or the use of Advance Beneficiary Notice (ABN) is not appropriate in this case. Medicare also encourages providers to go ahead and change the codes, when possible (probably dropping the claim down to paper instead of submitting it electronically) as the co-insurance amount will end up being applied to patient deductible, especially at the beginning of the calendar year.

More information on CMS changes on consultation codes can be found at: Pub 100-04 Medicare Claims Processing or this link below: *http://www.cms.hhs.gov/transmittals/downloads/R1875CP.pdf* To view the instructions go to page 14.

TELEHEALTH CONSULTATION CODES

CMS will still recognize and reimburse for telehealth Medicare consultation G-codes (G0425 – G0427 and G0406-G0408). These G-codes **are intended for use when serving Medicare beneficiaries located at qualifying originating sites that require consultative input from a dermatologist who is not available for an in-person (face-to–face) encounter.** Billing guidelines state that the existing telehealth codes require these services be billed with either the "GT" (for interactive telecommunications) or "GQ" (for the store and forward communication) modifier to identify the telehealth technology used to provide the service. No office visit is to be billed if this is the only service received by the Medicare beneficiary.

Except for the federal telemedicine demonstration in Alaska and Hawaii, eligibility of originating sites is limited to rural health professional shortage areas (HPSAs) and counties not classified as a metropolitan statistical area (MSAs).

For more information on Telehealth consultation codes, please see *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6493.pdf*

Carrier Updates

TRICARE RESOLUTION FOR PAYMENT REDUCTION FOR ADD-ON CODES

In September 2009, the Academy was informed that Tricare Humana (South) was reimbursing add-on codes with a 50% reduction. Tricare representatives stated that the multiple surgical reduction rule was applied to CPT codes 11101 and 17003 when used with codes 11100 and 17000. With the assistance of the AAD Coding and Reimbursement Task force, the Academy was able to contact Tricare Humana (South) and reverse the rule in question. Our contact at Tricare informed us that they "are on schedule to complete reprocessing by November 30, 2009. This involves over 40,000 claims. System updates to correct the error in payment of add-on code have already been completed and in production as of October 26, 2009."

In December of 2009, this same error was reported for Tricare North and Tricare West. The Academy has been informed by Tricare North that they will follow Tricare Humana's lead and resolve this issue and reprocess claims. A system correction by Tricare West has not been confirmed. The AAD is working diligently on behalf of our membership to rectify this reimbursement error. Please keep us informed of any continued reimbursement errors due to the multiple surgery reduction rule for Tricare patients.

CAHABA – MODIFIER -76 REQUIREMENT RESOLUTION

Cahaba GBA had published an article regarding the proper use of **modifier -76** in November of 2009. In this article Cahaba stated that, "when reporting repeat procedures (the same procedure code), on the same day, for the same patient, modifier 76 should be used, not modifier 59." The Academy contacted Cahaba to notify them that this mandate was in direct conflict with CPT guidelines. **This mandate has since been reversed.**

CIGNA REQUIRES DOCUMENTATION FOR CPT 11100

In April 2009, CIGNA changed its policy to require providers to submit supporting documentation for any claims with procedures and services that are appended with a CPT modi-

— see **CARRIER UPDATES** *on page7*

Carrier Updates

— continued from page 6

fier 25 or 59. This policy change led to an error in the claims processing for CPT code 11100. CPT code 11100 was being denied as needing supporting documentation. Cigna concluded that, "the system was not processing these claims correctly between April 20 and June 8th. This was related to our previously communicated decision to reduce the number of code pair edits from roughly 17,000 to only 200 that require documentation." Since this processing error was brought to the attention of Cigna's medical director by the Academy, Cigna has corrected the edit in their claims processing system. The Academy has not received any additional complaints regarding CPT 11100 since fall of 2009.

CIGNA BUNDLING DENIALS - 17110 WITH 17000-59

The Academy has had a new complaint regarding bundling denials. This issue involves the use of CPT 17000-59 when billed with CPT 17110. Even after submission of medical records, the decision to deny payment was upheld. Complaints from California, Tennessee, and Arkansa have been received. This issue has been brought to the attention of the medical director and Cigna is working to resolve this issue.

Please bring claim denials to our attention were processed inappropriately. Our email is *ppm1@aad.org*.

HIGHMARK ANNOUNCES FASTER WAY TO SEND MEDICAL DOCUMENTATION

As of November 2, 2009, Highmark began accepting fax medical documentation for Medicare Part B Electronic Claims! When medical documentation is needed to process your Part B electronic claim, fax this information to Highmark Medicare Services any time prior to claim submission, including the same day. Look for the new "Fax Cover Sheet for Submitting Medical Documentation for Electronic Claims" on Highmark's home page of the EDI Center on their Web site, under the Reference Materials section or in the Electronic Billing Guide.

http://www.highmarkmedicareservices.com/edi/index.html
http://www.highmarkmedicareservices.com/edi/guide/chapter11.html

NATIONAL GOVERNMENT SERVICES: NY & CT

A service specific prepay audit was recently conducted by the Part B J13 National Government Services (NGS) for New York and Connecticut for claims billed with CPT code 99310, subsequent nursing facility care. The results of this audit found that only 13 percent (13%) of the total claims reviewed were billed correctly. Because of these results, NGS will be implementing a prepay edit for CPT code 99310.

CPT code 99310 requires at least 2 of these 3 key components: a comprehensive interval history, a comprehensive examination and medical decision making of high complexity.

5010 Transition Plan

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

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

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

QUESTIONS TO ASK YOUR PRACTICE-MANAGEMENT SOFTWARE VENDOR AND/OR BILLING VENDOR

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

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

In addition, once you obtain clarification about these questions, make sure you follow up with your clearinghouse vendor to see what its crosswalk strategy and conversation plan is, and how it can work with your practice-management

— see **5010** on page 8

5010 Transition Plan

— continued from page 7

software vendor to ensure a smooth transition to the new electronic transaction standard. Finally, if you are considering implementing an electronic health record (EHR) system, make sure the EHR vendor you choose is able to meet your needs with this new HIPAA electronic transaction standard. Note that CMS provides free claims-processing software for small practices. More information about this option is available at: *www.cms.hhs.gov/MLNProducts/downloads/MedicareRemit_0408.pdf.*

For more information please visit: *www.cms.hhs.gov/ICD10/*

Melanoma PQRI Measures — Mandated Registry Reporting for 2010

The 2010 Center for Medicare & Medicaid Services (CMS) final regulations governing Medicare physician payments significantly changes the PQRI program beginning January 1, 2010. Dermatologists will no longer be able to report the three melanoma measures for the PQRI program on their claims. The melanoma measures must be reported through an electronic registry. Participants will have until January 31, 2011 to submit this information through a CMS approved registry. Dermatologists may participate through two reporting periods: January 1 – December 31, 2010 or July 1 – December 31, 2010. Additionally, dermatologists must report a minimum of three measures to be eligible for the 2% bonus payment. The bonus payment is dependent on which reporting period you choose to participate in. Thus, if you choose to report during the January 1 – December 31, 2010 period, you will be eligible for a 2% bonus payment on your total Medicare Part B allowed charges during that time period. With the second reporting option (July 1 - December 31, 2010) the bonus would be based on a shorter time period. The Academy is currently working on identifying a vendor to offer a PQRI registry to Academy members in 2010. The registry will be available online by the end of March 2010. If you plan on participating in PQRI in 2010, your practice should begin setting up a system to track all of your melanoma patients in anticipation of the Academy's PQRI registry. Please stay tuned to the Academy website at *http://www.aad.org/pm/billing/PQRI/index.html* for more information.

Reminder for Group Practices Using the Evaluation & Management (E/M) code

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 face-to-face evaluation and management 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 can be reported unless the evaluation and management services are for unrelated problems. Instead of billing separately, select a level of service representative of the combined visits and submit the appropriate code for that level.

- If the reason for the second visit is an unrelated problem that could not have been addressed in the first encounter, the reason for the second visit must be clearly documented in the documentation field of the electronic claim or as an attachment to the CMS 1500 Claim Form
    - For example: Identify when a provider is practicing in an unrecognized subspecialty, such as Mohs surgeon, and list the diagnosis code that is unrelated to the other E/M service for the same date
- If denied, you can request a redetermination including documentation so that carrier can reconsider payment for the second visit
- Physicians in the same group practice but who are in different specialties can bill and be paid without regard to their membership in the same group

30.6.5 - Physicians in Group Practice *http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf*

Coding Q&A's

Q) A nail avulsion (11730) was performed to access the nail matrix for a nail biopsy (11755). Can both the nail avulsion and the biopsy of the nail matrix be reported?

A) It is the intent of the dermatologist as to which one was the more definitive procedure - biopsy (11755) or avulsion (11730). According to *CPT Assistant* clarification, "if the avulsed area of the nail plate is removed and reported with 11730 and the specimen is sent to pathology, then it is not appropriate to report 11755 for the biopsy of that avulsed specimen. Use the appropriate pathology code to report the pathological examination of that specimen. If a biopsy is performed on any portion of the unit, except for the avulsed portion of the nail plate, you may report both codes."

Q) Can we use the new botulinum drug, Dysport for hyperhidrosis procedures?

Botulinum toxin "abobotulinumtoxinA (Dysport™)" was approved by the FDA on April 29, 2009, for the treatment of adults with cervical dystonia to reduce the severity of abnormal head position and neck pain in both toxin-naïve and previously treated patients. The new HCPCS code for this drug is J0586, injection of abobotulinumtoxinA, 5 units. The FDA indication for Dysport™"supports the following diagnoses if applicable ICD-9-CM codes 333.83 (Spasmodic torticollis) and 723.5 (Torticollis, unspecified). According to Medicare, onabotulinumtoxia (J0585) is still the Medicare approved drug for Hyperhidrosis. First Coast L29088 *http://medicare.fcso.com/Publications_B/162823.pdf#search="dysport"*

— see **Q & A's** on page 9

Coding Q&A's

— continued from page 8

Q) How do we report an application of Unna boot but not to the lower extremities?

A) The Unna boot procedure CPT code (29580) descriptor refers to a special treatment of the lower leg extremities. There is no other CPT code for an application of a zinc bandage to another body area. Use the unlisted CPT 29799, unlisted procedure, casting or strapping, to code the application of a medicated dressing for ulcers to locations other than the lower extremity. (Remember to append the appropriate documentation when billing an unlisted code.)

The dressing may be reported to Medicare but usually it's the local DMERC carrier who pays for durable medical supplies. Medicare's reimbursement for A6222, 16 sq inches impregnated gauze without adhesive, each dressing, approximate pricing of $2.24. This may not be worth sending in a separate claim to the DMERC. For other payors, report either the E/M or 29799 with the supply code 99070.

Q) I received notice that the CPT definitions for 88312-88314 have changed in 2010. It appears the only true change is the phrase "including interpretation and report, each" has been added to each of the codes. Can you explain this meaning? Currently, our lab bills technical and we bill professional, using the appropriate modifiers. Is this no longer going to be possible in 2010?

A) 88312-88314 have been revised to remove the add on code status and add that an interpretation and report is required for each time the code is used. They can be reported separately from surgical pathology (88300-88309) or non surgical examination codes. According to Medicare's Relative Value Unit schedule, it is appropriate to report these codes as global, technical. or professional services.

Q) How do we code for CANDIDA Antigen injection for warts? Is it intralesional medication 11900 or destruction 17110? There is no code drug code for Candida.

A) 19000, intralesional injection would be the appropriate CPT code to report. Since there is no code for this off label drug use, report the unspecified drug code, J3490. In box 19 on the CMS 1500 claim name the drug, strength and dosage. If possible add the NDC# usually found on the bottle or box.

Q) Is cryotherapy considered "LOW" or "Moderate" risk in medical-decision making?

A) It's the medical necessity of removing a lesion so "minor surgery with no identified risk" is low on the table of risk and two out of three elements must be exceeded to determine the level of decision making.

Q) Does skin biopsy have a global period?

A) Per Medicare, biopsy of skin, CPT code 11100, has a zero day period.

Q) How many # diagnosis and/ or treatment options are needed in "moderate" complexity of medical decision making?

A) One or more chronic illnesses with mild exacerbation, progression, or side effect of treatment; or two or more stable chronic illnesses, or undiagnosed new problem with uncertain prognosis, or acute illness with systemic systems.

Q) Is it fraud to code "skin biopsy code 11100" when an entire lesion is actually removed by shave technique?

A) A biopsy may be a portion of the lesion or the entire lesion. Which is taken to identify the lesion The documentation must clearly indicate that a skin biopsy was performed. If the entire lesion is removed without full thickness, and is documented as such, then the appropriate code would be selected from the shave removal series of code (113xx). Medicare carrier's local coverage determination (LCD) addresses the documentation requirement for medical necessity when treating benign lesions. Be aware of the carrier's policy regarding shave removals for both benign and malignant lesions.

Q) Using the 1997 E/M Documentation Guidelines for level 3 Expanded problem focused examination requiring 6 elements identified by a bullet can one use affect mood, general appearance, orientation and vital signs as four bullets and 2 bullets from the skin exam areas?

A) If it is pertinent to the visit and the nature of the presenting illness/problem, the affect/mood/oriented x 3 and general appearance can be added to the skin exam. Dermatologists don't normally monitor the three of the seven viaSls required for the '97 E/M Guidelines constitutional bullet. This may be over documenting for a skin exam of two bullets if the medical necessity of the constitutional exam doesn't have any bearing on the presenting problem.

Q) Do Fever, Chill, Nausea and vomiting count as 1 or 2 bullets in ROS?

A) Usually one - Constitution

Q) Our dermatologist read a slide for another provider but never saw the patient. Is this patient new or established?

A) Interpret the phrase "new patient" to mean a patient who has not received any professional services, i.e., E/M service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous 3 years. For example, if a professional component of a previous procedure is billed in a 3 year time period, e.g., a lab/path interpretation is billed with no E/M service or other face-to-face service with the patient is performed, then this patient remains a "new patient" for the initial visit. An interpretation of a diagnostic test, reading an x-ray or EKG etc., in the absence of an E/M service or other face-to-face service with the patient does not affect the designation of a new patient. CMS manual 12,30.6

CMS Updates MUE claim adjudication process

The Centers for Medicare and Medicaid Services (CMS) has released revisions and updates to Medically Unlikely Edit (MUE) claims processing and adjudication, effective April 2010.

An MUE is a unit of service (UOS) edit on a CPT code for services that a single provider renders to a single beneficiary on the same date of service (DOS). The ideal MUE is the maximum UOS that would be reported for a CPT code on the vast majority of appropriately reported claims.

CMS developed the Medically Unlikely Edit (MUE) program to reduce the paid claims error rate for Part B claims due to clerica entries and incorrect coding based on anatomic considerations, CPT code descriptors, CPT coding instructions, established CMS policies, the nature of a service/procedure and unlikely clinical diagnostic or therapeutic services.

After the onset of the MUE program in 2008, CMS published MUE codes with values of 1-3. CMS has stated that all MUE values that are 4 or higher will not be published and will continue to be confidential information for use by CMS and CMS contractors, due to CMS concerns about fraud and abuse by providers who may incorrectly interpret MUE values as utilization guidelines.

In January 2010, CMS released the following revisions and updates to the claims processing and adjudication to reflect the following:

- Claim adjudication to MUEs will be as a line item of each claim rather than the entire claim;
- When a CPT code is changed on more than one claim line by using CPT modifiers, the claims processing system will separately adjudicate each line against the MUE;
- Medicare Administrative Contractors (MACs) processing the claims shall deny the entire claim line if the UOS on the claim line exceed the MUE for the CPT code reported,
- Since each line of a claim is adjudicated separately against the MUE, only that claim line is denied and the denial may be appealed to the MAC.
- CMS is setting MUEs to auto-deny the claim line item with units of service in excess of the MUE value; and
- CMS will set the units of service for each MUE high enough to allow for medically likely daily frequencies of services provided in most settings.

CMS has further clarified that each line of a claim is adjudicated separately against the MUE of the code on that line, the appropriate use of CPT modifiers to report the same code on separate line of a claim will enable a provider to report medically reasonable and necessary UOS in excess of an MUE. CPT modifiers such as 59 (distinct procedural service), will accomplish this purpose.

More information on the majority of active MUEs can be found on the MUE Webpage at *http://www.cms.hhs.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage* then click on "Medically Unlikely Edits"

AMGEN AD

IN THE KNOW...

Did you know that you can access the AAD website with just a click of a button? The Academy website contains up to date information on RAC audits, PQRI reporting, coding and documentation, and practice management. The website is a must have resource for your office. Not only can you find up to date information on current hot topics, you can sign up for upcoming webinars, research coding questions, and look up past articles in Derm Coding Consult. This information is available to you as a part of your membership and most of the links are accessible without the use of passwords or sign-on features.

To add The American Academy of Dermatology Website to your desktop, just go to Internet Explorer, type www.aad.org in the search engine, right click on any part of the AAD web page and click on create a short-cut. A link will be placed on your desktop!

Now you are in the know!

American Academy of Dermatology
PO Box 4014
Schaumburg, Illinois 60168-4014

Derm Coding Consult

Published by the American Academy of Dermatology Association

Distribution of *Derm Coding Consult* is made possible through support provided by Amgen Pfizer.