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CMS to Reprocess ACA and 2010 MPFS Changes

Dermatology practices that billed Medicare for claims between Jan. 1 and May 31, 2010, will likely not have to request a reopening or adjustments under the reprocessing procedure as long as the billed amount was at or above the revised 2010 Medicare Physician Fee Schedule.

CMS has announced that the Medicare Administrative Contractors (MAC) have begun reprocessing claims affected by the implementation of various parts of the Affordable Care Act (ACA) and corrections to the 2010 Medicare Physician Fee Schedule (MPFS) retroactive to January 2010.

Please do not automatically resubmit your affected 2010 claims without a reopening/adjustment form because they will be denied as duplicate claims, thereby slowing/delaying the retroactive adjustment process.

In the majority of cases, dermatologists will not have to request reopening/adjustments because your MAC will automatically reprocess your claims if your charges were above the retroactive 2010 MPFS.

Claims that contain submitted charges lower than the revised 2010 fee schedule amount will not be automatically reprocessed at the higher rates. In such cases, the practice will need to request a manual reopening/adjustment from your MAC. Reopening forms and mailing addresses can be obtained from your respective MAC website. To ensure that claims qualify for reopening/adjustment by your MAC, you will need to confirm that the billed amounts for all claims in question were billed **below** the retroactive allowed MPFS.

Given the large workload involved, CMS has indicated that it is taking steps to ensure that new claims coming into the Medicare program are processed timely and accurately, even as the retroactive adjustments are being made. CMS **will begin** to reprocess these claims over the next several weeks and expects that this effort will take some time. The reprocessing time-frame will vary depending upon the type of claim, volume, and the individual MAC. **MACs will follow the normal process for handling any applicable underpayments or overpayments that occur while reprocessing your claims.** Any underpayments will be included in your next regularly scheduled remittance.

How do I know if I need to request a re-opening/adjustment? If your practice submitted claims with charges **lower than the** retroactively revised MFPS amounts in 2010, you will need to request a re-opening/adjustment. Do not re-submit claims, as these resubmissions will be denied as duplicate claims. CMS is extending the one-year time limit normally in place for re-opening/adjustment to allow for adjustment of these claims as necessary.

If your practice submitted claims with charges **above** the revised MPFS, you will not need to request a reopening/adjustment from your MAC. In this case, your claims will be automatically reprocessed, and you neither need to resubmit claims nor request a re-opening/adjustment.

If you are eligible for a retroactive CMS increase in reimbursement rates, please refer to the Office of Inspector General policy regarding the "Waiver of Beneficiary Obligations" related to the retroactive application of increased payment rates in certain limited circumstances (*oig.hhs.gov/fraud/docs/alertsandbulletins/Retroactive_Beneficiary_Cost-Sharing_Liability.pdf*).

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IMPORTANT Please Route to:

___ Dermatologist ___ Office Mgr ___ Coding Staff ___ Billing Staff

Letter from the Editor

Dear *Derm Coding Consult* Reader

The Academy issued an Alert on February 15th that some dermatology practices may need to request claim re-openings from their Medicare Administrative Contractors for underpaid 2010 Medicare claims. Per CMS, there were timing issues related to implementation of the Affordable Care Act (ACA) and corrections to the 2010 Medicare Physician Fee Schedule (MPFS) which delayed the re-processing of claims submitted last year between January 1, 2010 and March 31st. CMS will begin to reprocess these claims over the next several months.

The good news is that the majority of dermatologists' Medicare fee-for-service claims will be automatically reprocessed and will receive additional Medicare payment due to the retroactive effective dates of the ACA provisions and MPFS corrections. *If your services were billed at or above the retroactively revised Medicare allowed amount, then your claims will be automatically reprocessed without any action required by the practice.*

The bad news is that claims that contain charges which were lower than the revised 2010 fee schedule amount will not be automatically reprocessed at the higher rates. In such cases, the practice will need to request a manual reopening / adjustment from the Medicare Administrative Contractor (MAC). Reopening forms and mailing addresses can be obtained from your MAC's website.

Bottom line and moving forward: we encourage dermatology practices to not make any premature year end changes to billing master files using the published Medicare conversion factor. These have been subject to change every year for the last five years. If the dermatology practice reduces its fees to match Medicare's, it is voluntarily giving Medicare a reduced rate and Medicare has no obligation to reimburse the difference to the higher conversion factor when a legislative fix is put in place.

Has your dermatology practice started to plan for and implement ICD-10-CM? CMS has mandated that there will be a single ICD-10 implementation date for all users, e.g. ambulatory and physician reporting. **All Services provided on or after October 1, 2013 must be coded in ICD-10-CM.** These compliance dates are firm and not subject to change. The 2011 AAD Coding & Documentation Manual has added a whole new section on not only ICD-10-CM implementation requirements, but also on preparing your practice for the new HIPAA 5010 electronic transaction standard set for January 1, 2012.

Don't miss the Getting Ready for ICD-10 Webinar on April 21, 2011 for key information on how to prepare for this major ICD change that will impact every dermatology practice and physician reimbursement.

My thanks to all of our Derm Coding Consult readers who have consistently indicated that it is one of the Academy's most valued publications in their practice. It has been a pleasure and honor to serve as its Editor since September, 1999. I know you will join me in welcoming Cynthia Bracy as its new Editor!

Best regards,

Norma L. Border, Editor

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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Office Visits with Patch Testing

A question was raised if it is appropriate to report an Evaluation and Management (E/M - 99201-99215) service for the second and third visits for the interpretation and report following a Patch test (95044). The confusion comes from the AMA/CPT book, under Allergy and Clinical Immunology definition that explains the use of this section, which states, "Do not report E/M services for test interpretation and report." It continues with "If a significant separately identifiable E/M service is performed, the appropriate E/M service code should be reported using modifier 25."

Effective January 1, 2008, the AMA/CPT descriptors for the allergy diagnostic test codes (CPT codes 95004, 95024, and 95027) were updated to included "test interpretation and report by a physician" including the E/M explanation. The Centers for Medicare & Medicaid Services (CMS) added physician work to codes: 95004, 95024 and 95027 but Patch test code 95044, was not included in this update.

Patch Test codes have no physician work and depending on patient care, an E/M may be appropriate to report an E/M service that occurs on the same day as patch testing evaluation and the follow up services involved in the process of monitoring the results of these tests. If this is the case, an E/M may be reported using modifier 25 to separate the E/M from procedure. The modifier is recognized by most payers. The E/M level needs to be based on the current history, exam and decision-making criteria, as the time spent testing the patient doesn't contribute to the E/M components. Again, depending on patient care provided, the E/M may be appropriate but must be supported with clear documentation in the medical record.

The other issue with Medicare and third party payers is the different patch testing policies, including very different unit allowable tests per patient per year. Carefully review any limitations in payer policies that may influence office procedures and patient care. The standard pharmaceutical patch test kit application is usually 24 to 30 patch tests which are applied and left on for 48 hours. The results are interpreted after this period although some tests may be left up to 96 hours for a reaction. Most medical policies cover basic testing of 20-50 units. Any more must be medically necessary and reported on separate claims lines in smaller unit amount using a 59 modifier. There is no global concept that applies to patch test codes.

As of this writing four Medicare Carriers have local coverage determination on Allergy Testing - IL, WI, MN, MI, NE, MO, IA & KS: WPS L30471; CO, NM, OK & TX: Trailblazer L26791; CA, NV, HA: Palmetto L28234; and FL, PR & VI: First Coast L31267. WPS allows 50 units a year and documentation to support more. Trailblazer's limit is 30 tests and the others do not mention an amount. There is a limit to patch testing set by CMS' Medically Unlikely Edits (MUE). This number has not been published. MUEs were put in place by CMS to eliminate data entry errors.

From limited research, it was found most third party payers follow the usual manufacture guidelines of 24-30 units. Again, if more are done, documentation is required to support medical necessity.

CMS Auto Denial of Claims Submitted With a GZ Modifier

All provider claim lines submitted with a GZ modifier will automatically be denied, effective July 1st, 2011, the Centers for Medicare & Medicaid Services (CMS) announced, adding that such items will not be subject to complex medical review.

The GZ modifier indicates that an ABN was not issued to the Medicare beneficiary at time of service. It further signifies that based on an informed knowledge of the Medicare policy, the provider expects denial of reimbursement for a particular service due to lack of medical necessity.

In addition, any claim line item(s) submitted with the GZ modifier will be denied with denial code - Claim Adjustment Reason Code (CARC) 50 (These services are non-covered services because this is not deemed a 'medical necessity' by the payer) reflected. Dermatology practices will also see denial Group Code CO (Provider/Supplier liable) to show that this line item is provider liability.

DON'T BE LEFT HOLDING THE BAG

A few tips to enhance revenue collection among Medicare patients in your dermatology practice:

- ✔ Ensure that your patients are well-informed and educated on the service(s) being provided
- ✔ Educate patients on the difference between medically and medically unnecessary service(s)
- ✔ Briefly educate and explain the Medicare policy on the non-medically necessary service being provided
- ✔ Inform the patient should they opt to proceed with the service, they consent to be responsible for the total charged amount at TOS
- ✔ Collect payment for all non-covered services before the patient leaves the office

For more information on the official instruction, please visit *http://www.cms.gov/Transmittals/downloads/R2148CP.pdf* and/or *http://www.cms.gov/Transmittals/downloads/R366PI.pdf on the CMS website or contact AAD coding and reimbursement staff at ppm1@aad.org.*

CMS to Reprocess ACA and 2010 MPFS Changes (Cont.)

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Any claims submitted for charges lower than the revised 2010 fee schedule amount will not be automatically reprocessed at the retroactive rates. Dermatologists in this circumstance will need to take action to receive the difference in reimbursement on claims that were adjudicated using the lower MPFS.

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CMS to Reprocess ACA and 2010 MPFS Changes

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How long do I have to request a re-opening/adjustment?
Currently, there is a one-year time limit for dermatologists to request the reopening of claims, CMS has acknowledged that these circumstances fall under the "good cause" criteria described in the Claims Processing Manual, and therefore, extending the time period to request adjustment of these claims, is necessary.

When will I receive reimbursement for underpaid claims?
MAC's will follow the normal process for handling any underpayments or overpayments while reprocessing your claims. Underpayments will be included in your next regularly scheduled remittance after the adjustment.

What if the automatic claim adjustment shows that I was overpaid?
Your MAC will send a request for repayment when a claim adjustment for a non-institutional provider (e.g., physician, other practitioner, supplier, etc.) results in an overpayment. If this overpayment is less than $10, your contractor will not request repayment until the total amount owed accrues to at least $10. See the Financial Management Manual, Publication 100-06, Chapter 4, Section 70.16 or Section 90.2 (*www.cms.gov/manuals/downloads/fin106c04.pdf*) for more information.

Where can I find more information?
If you have specific questions about reprocessing of claims affected by ACA or changes to the 2010 MPFS, please contact your MAC directly or visit *http://www.cms.gov/PhysicianFeeSched/*.

What can I do to prepare for a similar situation?
Dermatology practices can choose the type of fee schedule to use for claim submission to participating payers. Below are a few examples:

Scenario	# of Fee Schedules	Advantages	Disadvantages	Observation
Use a Standard Fee schedule for all participating payers (e.g. Medicare, BCBS, Aetna etc)	One (1)	• Fee schedule is usually marked up by a certain percentage • Claims always billed above the allowed amount allowing to capture the higher reimbursing plans one may not be are not aware of	• Contractual write-off usually significant -especially for the least paying plan • Less time spent managing and monitoring fee schedule changes	• Unanticipated changes to fee schedule will barely affect your submitted claims
Use and bill only for allowed amounts to each individual payer	Multiple – based on # of provider participating plans	• Easy detection when claim has been paid inaccurately	• Unanticipated fee schedule changes will affect your bottom line • Close monitoring, managing and updates of fee schedule constantly required	• Claims submitted at lower fee schedule will be reimbursed as billed. Payer will not adjust your claim on your behalf to reimburse at the revised higher fee schedule • Claim re-opening/ adjustment will be required • Process may take time
Bill Medicare only for the allowed amount and bill all commercial payers with one standard fee schedule	Two (2)	• Easy detection when Medicare claim has been paid inaccurately • Commercial fee schedule will always be billed above the allowed amount, thus capturing those higher reimbursing plans you are not aware of	• Unanticipated fee schedule changes will affect your bottom line • Close monitoring, managing and updates of fee schedule constantly required • Contractual write-off is usually significant especially for the least commercial paying plan • Requires time managing the fee schedule	• Claims submitted at lower fee schedule will be reimbursed as billed. Payer will not adjust your claim on your behalf to reimburse at the revised higher fee schedule • Claim re-opening/ adjustment will be required and may take time. • Changes to your commercial fee schedule will barely affect your submitted claims

Graph is found at *www.aad.org/pm/billing/medicare*. For questions or issues you cannot resolve through your carrier, please contact AAD/A staff at *ppm1@aad.org* or call the AAD Member Resource Center at (866) 503-7546.

Shave Removal Vs Biopsy

This article is prepared by James A. Zalla, MD and reviewed by the members of the AAD Coding & Reimbursement Task Force- February 2008.

According to AMA CPT, shaving is the sharp removal by transverse incision or horizontal slicing to remove epidermal and dermal lesions without a full thickness dermal excision. This includes local anesthesia, chemical or electrocauterization of the wound, and does not require suture closure.

A shave removal is a distinct procedure, intended to remove a lesion or the problematic portion of the lesion. Removed tissue is also typically submitted for pathologic examination, however, the obtaining of that tissue is not a separate biopsy procedure and may not be coded as such. Only the shave removal code would be reported.

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Shaving of epidermal or dermal lesions (11300-11313) is not considered an "excision" and excision codes (11400-11646) would not be used to report these services. The "removal" of a lesion by the shave technique requires a more superficial "removal" than an excision procedure in the integumentary system, but does not require complete removal of the lesion. Shave removal does not involve the full thickness of the dermis, whereas excision codes require removal of the entire thickness of the dermis through to the subcutaneous tissue.

The following examples illustrate different methods used in the shave removal, biopsy, destruction, and excision of dermal and epidermal lesions and their corresponding proper coding.

Example 1

A man has a 0.7 cm raised benign dermal nevus on his cheek which is being cut while shaving. Such lesions arise deeper in the dermis but are not problematic unless they raise above the level of the adjacent skin. Appropriate treatment is to remove the raised component of such a lesion with the shave technique, a "shave removal," recognizing that the remainder of this benign lesion persists down in the dermis after the procedure and a complete removal is neither intended nor desirable. The fact that the removed tissue may then be sent for pathologic examination and confirmation, primarily for medical legal reasons, does not make this procedure a biopsy procedure. The intent of the procedure is therapeutic rather than diagnostic, and the histopathology is done for confirmatory reasons. Example 1 is reported with CPT 11311 for shaving this 0.7 cm facial lesion.

Example 2

A patient presents with a pearly nodule on the left nasal ala. The dermatologist recognizes that this appears to be a deeper lesion that could be a basal cell cancer, and a prudent approach would be to biopsy it for confirmation. A commonly used technique would be to biopsy the raised component of that lesion using a shave technique to remove the elevated portion specifically for pathologic exam, with the intent that if it is a basal cell cancer, subsequent definitive treatment will then be undertaken. A shave technique may be selected in this instance because if the lesion on pathology exam is shown to be a benign dermal nevus, a deeper scar from the biopsy would have been avoided. In this example, it does not matter for coding purposes whether the physician selected a razor, a curette, a punch, or a scalpel as the instrument for the biopsy; they would all be coded the same. The primary purpose of the procedure is to obtain tissue for pathologic examination. This second example is appropriately coded as a skin biopsy procedure, CPT 11100.

The fact that a pathology report may state "specimen consists of a shave specimen of skin" does not mean anything in deciding whether the procedure represents a skin biopsy by the shave technique versus a shave removal of a lesion that happened to be submitted for pathologic confirmation.

An instrument such as a razor blade is one of a number of instruments that may be used for either a shave removal or a skin biopsy, depending on the intent of the physician. CPT codes 11300- 11313, which are defined by the shaving technique used to remove the lesion, may be reported for either benign or malignant lesions. The appropriate code is selected based on the anatomic site and the largest diameter size of the lesion itself, not including any additional margin.

Documentation in the medical record would include some indication for the procedure. In the case of a skin biopsy procedure, documentation such as "suspicious lesion," "changing mole," "history of bleeding lesion," "variable pigmentation," or "atypical appearing nevus," or other similar descriptor can be extremely helpful in establishing the reason for the procedure. Similarly, documentation for a shave removal procedure might include "symptomatic lesion," "rubs on waistband or bra," "hits lesion shaving," or other reasons why an elevated lesion is best removed with the shave technique.

An excision procedure, whether for benign or malignant lesions, is defined as full thickness (through the dermis) removal of a lesion including margins, and if a simple (non-layered) closure is performed, it is included in the excision procedure. Each excised lesion is coded separately, and code selection is determined by measuring the greatest clinical diameter of the apparent lesion plus that margin required for complete excision (lesion diameter plus the most narrow margin required equals the excised diameter). The measurement of lesion plus margin is made prior to excision.

If the defect following an excision goes "through the entire thickness of the dermis," it is considered an excision even though the defect may not be closed. Sometimes dermatologists use a deeper tangential removal known as "saucerization" that may go through the dermis into fat. This is may be done in the case of suspected melanomas to assure that the complete depth of the lesion is available for pathology. Such lesions are intentionally left open pending pathology exam, anticipating a more definitive excision procedure will be needed. Such saucerization procedures are appropriately coded as excisions with the 11400 or 11600 series depending on whether the lesion was pathologically determined to be benign or malignant. Because such procedures go "through the dermis," they exceed the definition of shave removal procedures that would be coded in the 11300 series.

If fat is present on a clinically excised specimen, or demonstrated on the corresponding pathology slide, it is clear that the excision had to extend through the dermis. There may, however, be instances in some body areas that lack subcutaneous tissue in which a specimen may include the full thickness of the dermis at that site but not have underlying fat.

It is also possible that a specimen may extend the full thickness through the dermis into fat, but the fat may pull away from the dermal specimen as it is harvested or in tissue processing for pathology. In such instances, the tissue slides would normally demonstrate that the full thickness of dermis was included on the specimen.

A shave removal procedure may vary in depth and width, and in some instances it may completely remove a lesion that

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occupies the upper or mid dermis. The fact that a lesion is removed in its entirety is irrelevant when deciding whether to code as a shave removal or an excision. A lesion may be completely removed, but if the level of removal does not go through the full thickness of dermis, it is not an "excision" according to CPT. Such descriptors in CPT are to be used by physicians and billers as well as carriers, and recognition of the same criteria by all allows for consistency of coding and fairness of payment.

While as a general surgical concept, the notion of excision may connote complete removal, in the integumentary section of CPT, the shave removal procedure codes specifically do not use the term "excision" to avoid confusion, and no reference is made to whether the lesion is partially or completely removed.

Example 3

A 17 y/o girl has a 1.1 cm raised brown nevus on her mid back that rubs on her bra. Her dermatologist removes it using a shave technique. Pathology report shows a benign compound nevus, and the lateral and underlying dermal margins are clear, confirming complete removal of the nevus. This procedure is properly coded 11302, shave removal benign lesion trunk, 1.1-2.0 cm. It is not coded as an excision, despite the fact that it was "completely" removed.

Example 4

A 50 y/o boater has a discreet but irregular 8mm shiny red flat lesion on his back. The clinical diagnosis is probable superficial basal cell skin cancer, and the dermatologist elects to shave the lesion at the level of the mid dermis. If the intent of this procedure was therapeutic, it is appropriately coded as a shave removal, code 11301. If the intent of this procedure was diagnostic, it would be coded as a skin biopsy, code 11100. However, some dermatologists would immediately follow obtaining the specimen for pathology with curettage as a definitive procedure with the therapeutic intent to cure. Assuming the pathology confirmed the diagnosis of basal cell cancer, the latter procedure is properly coded as a malignant destruction trunk, 0.6-1.0 cm, 17261. If pathology confirmed a benign diagnosis, the procedure code 17110, destruction of a benign lesion would be reported. If pathology, however, confirmed an actinic keratosis, the destruction procedure code 17000 would be reported. In either case, only the definitive procedure is reported. Since obtaining tissue for pathology is a component of the definitive procedure, a skin biopsy is not separately reported for the same lesion.

Getting Ready for ICD-10-CM – Part 1

STATUTE AND REGULATION

HIPAA Transactions and Code Sets: 5010 Transactions, ICD-10-CM

On January 16, 2009, the U.S. Department of Health and Human Services (DHHS) released the final rule mandating that everyone covered by the Health Insurance Portability and Accountability Act (HIPAA) must implement ICD-10 for medical coding on **October 1, 2013**.

In a related final rule released the same day, DHHS mandated that transaction standards for all electronic health care claims must switch to Version 5010 from Version 4010/4010A by **January 1, 2012**.

Two regulations impacting your claims processing need your attention *now*. The first regulation, if you process claims or other transactions electronically, requires you to upgrade your practice management information systems or ensure that your billing service and/or clearinghouse is updated to the 5010 version by January 1, 2012 ***or your claims will be rejected and you will encounter subsequent payment delays***. The second regulation updates the medical code sets from ICD-9-CM to ICD-10-CM for diagnoses. ICD-10-CM must be adopted by October 1, 2013. ***(There will be no change in use of CPT for professional service reporting.)***

The following timeline identifies when each of these changes will go into effect.

Begin preparing now for the ICD-10 transition to ensure your readiness by the **October 11, 2013**, compliance deadline. Preparing now can help you avoid potential reimbursement issues.

Date	Compliance Step
January 1, 2010	• Payers and providers should begin internal testing of Version 5010 standards for electronic claims
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 and inpatient procedures • CPT codes will continue to be used for outpatient services

For more information on the implementation timeline, please visit *http://www.cms.gov/ICD10/03_ICD-10andVersion5010ComplianceTimelines.asp#TopOfPage*

In addition, a number of other regulations impacting dermatology practices are coming from the Affordable Care Act (ACA) passed by Congress on March 23, 2010. One of these includes adopting standardized operating rules for the various HIPAA transactions that would provide the necessary business rules and guidelines for the electronic exchange of information that are not defined by the standards or their implementation specifications. This would ideally eliminate or at least reduce the complexity of "companion guides" to

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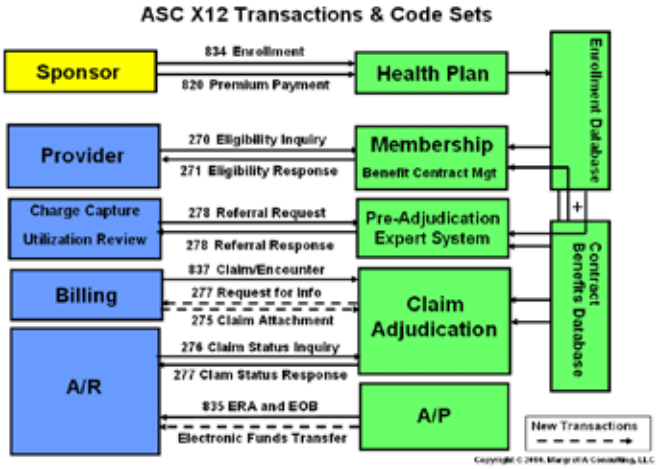
which individual payers now require adherence. Electronic funds transfer (EFT) and health claims attachment standards (such as clinical documentation supporting claims) will also be adopted so that all elements of processing claims can be automated. ACA also requires health plans to certify that their data and information systems are in compliance with HIPAA standards, or be subject to compliance penalties. Finally, a national health plan identifier (HPIN) must be adopted – that will give dermatology practices better information about who to contact for information about their claims processing.

What transactions and code sets are available and what do they do?

The following is a schematic of the current and proposed HIPAA Administrative Simplification transactions and code sets. Transactions are standards developed by the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12. The standards are identified by a number and a name (e.g., 837 Claim or Equivalent Encounter Information and Coordination of Benefits: Professional). Names have been shortened in the schematic. The standards provide electronic transmission protocols for exchanging specified data between two parties.



As illustrated, there are transactions that enable a health plan sponsor, such as an employer, to electronically enroll a beneficiary into a health plan and pay premiums. When a beneficiary seeks services from a provider, the provider may use the eligibility inquiry and response set of standards to validate the patient's insurance status and determine the amount the patient is responsible to pay. In some cases, a health plan may require authorization for certain procedures, drugs, or referrals, and the referral request and response may be used to support such exchange of information electronically. Many providers send electronic claims to health plans. With the new claims attachment set of standards, the health plan may electronically request additional information (for example, clinical documentation) and the provider may return an attachment electronically – especially if the provider has an electronic health record (EHR). Providers may also electronically seek information about the status of a claim, and receive an electronic remittance advice as an explanation of benefits is sent to the patient. By January 2014, the electronic funds transfer (EFT) will become effective.

For each change, you will want to prepare well in advance. This primer helps you understand the terminology and how to plan for each change.

Q1: What is "5010" and why is it important to me?
A1: "5010" is the new version of the HIPAA transactions standards being adopted by January 1, 2012. If you use the electronic transactions (i.e., submit claims and receive payments electronically), you may notice some differences in data you need to input or information you receive in a transaction response.
Q2: Can I still use a health plan's Web portal to file claims?
A2: Yes, provided the inquiries and claims submissions adhere to the new version 5010.
Q3: Can I still file paper claims?
Q3: Yes, if you use the 1500 claim form updated in 2007 you do not need to adopt electronic transactions, although you will achieve efficiencies using electronic transactions such as speedier payment.
Q4: What is a transaction?
A4: A transaction is a specification of what data, in what format, and in what sequence must be used to construct a message that is able to be transmitted from one computer system to another.
Q5: Will I be required to use all of the standard transactions?
A5: No, some providers choose not to use some of the transactions because they are not as applicable to their practice's business needs. However, many providers under utilize the transactions where they could be beneficial to them.

What is the 5010 Version of the Transactions and What Changes Do They Include?

The 5010 version of the HIPAA transactions correct technical issues, accommodate new business needs, and remove inconsistencies in reporting requirements that were present in the 4010 version such as:

- Implementation guides (TR3s) are reformatted to present clearer and more instructional information consistently across all transactions.
- Instructions for reporting "situational data" identify the specific situations in which the data are required. Health plans cannot require situational data if the situation does not require it. Situational loop and segment repeats have been eliminated. Multi-functional fields have been separated into unique fields.
- Data used for the same purpose in different transactions is represented consistently across all transactions to avoid confusion.
- The 5010 transactions require providers to use their NPI as the primary identifier. **Transactions without the NPI will be rejected.**
- ICD-10-CM is accommodated in all applicable transactions, but not valid for use until October 1, 2013.

For more information, contact AAD coding staff at *ppm1@aad.org*.

Look out for Part 2 of **"Getting Ready for ICD-10-CM"** in the Summer Issue of Derm Coding Consult.

Coding I&D

Q: Our office performed an Incision and Drainage (I&D) today in the office. The service is within the post-operative period of the original surgery our surgeon performed. Can we bill the I&D performed in the office using a modifier 58?

A: No. The I&D is not a separately payable service and cannot be billed to the patient. According to the Centers for Medicare & Medicaid Services (CMS) Internet Only Manual (IOM) Publication 100-04, Chapter 12, Section 40.A, complications from surgery which do not require a return trip to the operating room are considered part of the global surgery package from the original surgery and are not separately payable. Modifier 58 is not appropriate in this situation. **WPS Medicare Part B MAC eNews for Monday, December 20, 2010**

DOCUMENTATION QUESTION

Q: What is the definition of "extensive undermining" as it relates to a complex repair (13100-13160) of a wound?

A: This is one of the most difficult questions on which to give advice. As you know, CPT gives no directives as to what "extensive undermining" is. Complex repair codes are used to delineate complicated repairs. These repairs include the layered repair of lacerations that also require debridement of wound edges before closure. Wounds following excision of some lesions may require extensive undermining to release and redistribute tension vectors to allow proper closure. Wide undermining is necessary to avoid uncertain distortion such as of eyelid or lip. The time and work in closing a wound is related to undermining, and consequently obtaining hemostasis in the undermined area, as well as placement of sutures. Be sure the documentation in the medical record is thorough to support the use of the complex repair code.

CODING FOR SUTURE REMOVAL

Q: May I bill for suture removal?

A: No. Suture removal is a part of the routine follow-up care for a patient. Even if the suture removal is done outside the global period, it stands to reason that if one placed the sutures, one should be expected to remove the sutures.

Q: Can I bill for suture removal if I was not the physician that placed the sutures?

A: You can charge the appropriate E/M visit for this encounter as appropriate to the level of documentation.

MEDICARE BILLING FOR PA/NPP

Q: If a patient was initially diagnosed by one physician in a group practice and a PA or NP sees the patient for a follow-up visit for the same condition while a different physician in the group is within the suite of offices, may the service be billed "incident to?"

A: Yes. In Medicare's eyes, all physicians within a group are interchangeable. In this situation the claim should be submitted with the NPI number of the physician who was within the suite of offices while the "incident to" visit took place. The ordering physician's name and NPI would be listed on the CMS 1500 in Box 17.

General Coding Tip!

Whether you are coding from the AMA CPT Manual or the AAD Coding and Documentation manual, always remember to refer to the instruction section that precedes the code section when you are deciding which code to select. Those additional instructions help provide clear guidance as to the appropriateness of your code selection.

Three Medicare Quality Reporting Measures for 2011: Registry Reporting Required to Earn Bonus

Update on Reporting Three Medicare Quality Measures for Melanoma During 2011

Dermatologists who report on three quality measures to the Centers for Medicare & Medicaid Services (CMS) in 2011 will be eligible for a bonus payment of 1 percent of their total Medicare Part B allowed charges. As part of the Physician Quality Reporting System (PQRS, formerly known as PQRI), dermatologists are eligible for the incentive if they report on at least 80 percent of their eligible patients for measures 137 (recall system) **and** 224 (over utilization of imaging), **and** on at least 80 percent of eligible visits for measure 138 (coordination of care).

Registry Reporting Required to Earn Bonus

To qualify for the incentive payment, dermatologists must report on all three melanoma measures using a qualified registry. These measures cannot be reported via claims. The Academy will continue to offer an online reporting registry – the Quality Reporting System (QRS) – for members to report their PQRS data to CMS. Through a partnership with a vendor, NetHealth, the Academy will open its 2011 registry module for purchase in March (NetHealth was CMS-qualified last year and is in the process of recertification for 2011). Dermatologists choosing to report with the Academy's registry will need to purchase the registry and have until **Jan. 31, 2012** to submit all data, and all associated claims must be processed by the end of February 2012.

Practice Management Tips for Quality Reporting

In general, practices should have a mechanism in place to identify their patients with a history of melanoma and their new melanoma patients, so that they can enter those patients into a registry when it becomes available (e.g., using your practice management system to query your patient list for "history of melanoma" and "new melanoma" patients). Measure 224 (Over Utilization of Imaging Studied in Stage 0-1A Melanoma) measures the percentage of patients with stage 0 or IA melanoma, without signs or symptoms, for whom **no** diagnostic imaging studies were ordered, and ***replaces*** measure 136 (patient asked about new/changing moles, physical exam and counseling performed), which is no longer in the program for 2011. ***For measure 224, dermatologists should be sure to document the stage of the melanoma, and whether or not they ordered diagnostic imaging studies, in the patient's chart. While recording this information may not be typical for many practices, it is especially vital in the unlikely event of a CMS audit.***

Melanoma measures 137 and 138 continue as measures from the 2010 program.

Participants Can Choose One-Year or Six-Month Reporting Periods

Participants will be able to choose either a one-year reporting period, from Jan. 1 – Dec. 31, 2011, or a six-month reporting period from July 1-Dec. 31, 2011. The incentive will be based only on claims filed during the chosen reporting period.

One Eligible Instance for Each Measure Required to Earn Bonus; EHR Integration Coming Soon

All of the quality measures must have at least one eligible instance for a dermatologist to qualify for the incentive. For example, "new melanoma" is the only applicable diagnosis for measure 138, so to successfully report measure 138, the dermatologist must have at least one Medicare patient with a new diagnosis of melanoma. If not, then the dermatologist does not qualify for the incentive, even if he or she is reporting on the other two measures. Additionally, a greater than zero percent performance rate for all three measures is necessary to qualify for the incentive payment. This means that you must perform the measure on at least one patient per measure to qualify for the incentive payment. For dermatologists using an electronic health record (EHR) system in their office, the Academy is developing an integration between EHRs and the QRS registry and expects it to be available later this spring. NexTech and Encite EHRs will be included in the EHR integration interface, so offices that use these EHRs will be able to populate the registry directly, without manual entry, when this functionality is available. Dermatologists would still need to register and purchase the registry through the Academy's website. The Academy continues to reach out to other EHR vendors to encourage integration of their products with the QRS registry.

CODING DETAILS

Measure #137 - Melanoma: Continuity of Care – Recall System

Percentage of patients, regardless of age, with a current diagnosis of melanoma or a history of melanoma whose information was entered, at least once within a 12 month period, into a recall system that includes:

- A target date for the next complete physical skin exam

  AND

- A process to follow up with patients who either did not make an appointment within the specified timeframe or who missed a scheduled appointment

Applicable CPT Codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, or 99215

Applicable ICD-9 Codes: 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9, or V10.82

Measure #138 - Melanoma: Coordination of Care

Percentage of patient visits, regardless of patient age, with a new occurrence of melanoma who have a treatment plan documented in the chart that was communicated to the physician(s) providing continuing care within one month of diagnosis.

Applicable CPT Codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 11600-11604, 11606, 11620-11624, 11626, 11640-11644, 11646, 14000-14001, 14020-14021, 14040-14041, 14060-14061, 14301-14302, 17311, or 17313

Applicable ICD-9 Codes: 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, or 172.9

– see **PQRS** on page 10

Three Medicare Quality Reporting Measures for 2011: Registry Reporting Required to Earn Bonus

— continued from page 9

Measure #224 - Melanoma: Overutilization of Imaging Studies in Stage 0-IA Melanoma
Percentage of patients, regardless of age, with Stage 0 or IA melanoma, without signs or symptoms, for whom no diagnostic imaging studies have been ordered related to the melanoma diagnosis

Applicable CPT Codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, or 99215

Applicable ICD-9 Codes: 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9, or V10.82

Important update regarding holding for pathology results
Many dermatology practices use the code 238.2 (unknown neoplasm) when performing a biopsy that is consistent for melanoma and refer the patient to another provider for definitive care. In this scenario, the physician would not be billing a 172.x and would not be eligible to report on measure 138.

The simplest way to address this issue is to report the 172.x code at the follow-up for suture removal or if the patient returns to clinic to discuss the biopsy results. Billing a 172.x with a phone consultation (99441-99443) is not included in the PQRS measure specifications and will not count towards measure 138.

Another option is to hold the initial claim when performing a biopsy on a lesion suspicious for melanoma. If the patient indeed has a melanoma, then the physician is able to code a 172.x for that patient. The physician's reimbursement should not be affected if the office chooses to hold the claim.

For More Information
Visit *www.aad.org/QRS* to read more about reporting the dermatology-specific quality measures, to download the most frequently asked questions (PDF available) and to purchase the 2011 Melanoma Physician Quality Reporting Module when it becomes available in March, or contact Scott Weinberg at (202) 712-2616 or *sweinberg@aad.org*.

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5010 Deadline Reminder!

Physician offices need to ensure compliance with the HIPAA 5010 compliance requirement effective 01/01/2012. Most insurance contractors began external testing in January of 2011 in preparation for the mandate. It is important to consult your vendor and/or clearinghouse regarding plans and time frames for 5010 implementation. Medicare is stressing the importance of preparing, testing, and going into production early. Waiting to implement 5010 will negatively affect your reimbursement.

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