



Derm Coding Consult

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2015 Medicare Physician Fee Schedule final rule summary

Dermatology to see overall 2 percent cut in payments in 2015

The Centers for Medicare and Medicaid Services (CMS) released the 2015 Medicare Physician Fee Schedule, signaling additional challenges ahead for physicians in practice. The final rule, released October 31st, 2014, details a 2 percent reduction to dermatology services overall. In accordance with budget neutrality regulations, the decrease offsets minor increases for chronic care management services, malpractice adjustment, for internal medicine and primary care physicians. As with any change to reimbursement, the impact of the 2015 fee schedule varies according to individual practice patterns and mix of services. To view a list of the impact the 2015 Medicare Fee Schedule will have on select dermatology codes, visit AADA's fee schedule Web page. AADA plans to submit comment to CMS regarding many of changes and the overall impact to dermatology practices. Expanded summaries for the most notable changes to the 2015 fee schedule are detailed below.

Likely reductions to dermatology payments resulting from changes to global periods

Because of concerns about the accuracy of the valuation of global payments, CMS will eliminate global periods and value ALL surgical codes based only on the surgical day of service, and then pay separately for those follow-up services which are provided. AADA is concerned about the policy, as it may require additional patient co-pays for follow-up visits.

Global packages include the procedure and the services typically furnished in the periods immediately before and after the procedure. Beginning in 2017, CMS plans to implement this change for surgical codes with a 10-day global services period, and in 2018 implement the same change for surgical codes that have a 90-day global services period. However, CMS is unclear on a methodology of how to revalue the codes as 0 day global codes, and is seeking input.

It is estimated that these changes could result in a reduction in reimbursement for dermatology because of the loss of the automatic payments included in the global period. Currently, many dermatologists do not submit a claim, nor are they required to, when they see patients for follow up visits during the global period. When CMS unbundles the follow up visit from the surgical visit, dermatologists will

be allowed to bill and get reimbursed for the surgical day of service and each E/M visit needed for appropriate follow-up.

CMS postpones misvalued code proposal

CMS did not finalize the high expenditure codes (charges of \$10 million or more) that it identified in the proposed rule as potentially misvalued. Among these codes, there were six dermatology codes including two skin biopsy codes, two nail codes, an adjacent tissue transfer code and a destruction of benign lesion codes (CPT 11100, 11101, 11730, 11750, 14060 and 17110). CMS stated that it will reexamine the list in the future for review. As a result, there will be no changes in the values of the codes in 2015.

CMS corrected the wrong amount of the anesthetic cream that was used when valuing the practice expense for destruction of premalignant codes (17000 & 17003). The result is an approximately 11 percent reduction in payment for 17000 and almost 43 percent reduction in payment for 17003 for 2015.

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IMPORTANT Please Route to:

Dermatologist Office Mgr Coding Staff Billing Staff

2015 Medicare Physician Fee Schedule final rule summary

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Frequently Used Derm Codes CY 2015 MPFS Impact Table

| CPT/ HCPCS | Mod | Global | Description | 2015 Payment Amount ² \$ | 2014 Payment Amount ² \$ | % Payment Difference |
|---------------|-----|--------|-------------------------------|--|--|----------------------------|
| 11100 | | 000 | Biopsy skin lesion | \$103.82 | \$102.45 | 1.34% |
| 11101 | | ZZZ | Biopsy skin add-on | \$32.94 | \$32.60 | 1.04% |
| 11300 | | 000 | Shave skin lesion 0.5 cm/< | \$98.10 | \$96.01 | 2.18% |
| 11301 | | 000 | Shave skin lesion 0.6-1.0 cm | \$120.29 | \$118.22 | 1.76% |
| 12055 | | 010 | Intmd rpr face/mm 12.6-20 cm | \$481.17 | \$478.59 | 0.54% |
| 12056 | | 010 | Intmd rpr face/mm 20.1-30.0 | \$504.44 | \$551.31 | -8.50% |
| 14060 | | 090 | Tis trnfr e/n/e/l 10 sq cm/< | \$786.91 | \$784.52 | 0.31% |
| 14061 | | 090 | Tis trnfr e/n/e/l 10.1-30sqcm | \$1,027.14 | \$1,018.44 | 0.85% |
| 17000 | | 010 | Destruct premalg lesion | \$66.95 | \$75.23 | -11.01% |
| 17003 | | ZZZ | Destruct premalg les 2-14 | \$5.73 | \$10.03 | -42.89% |
| 17004 | | 010 | Destroy premal lesions 15/> | \$151.80 | \$149.38 | 1.62% |
| 17110 | | 010 | Destruct b9 lesion 1-14 | \$111.34 | \$109.26 | 1.91% |
| 17111 | | 010 | Destruct lesion 15 or more | \$132.46 | \$129.68 | 2.15% |
| 17311 | | 000 | Mohs 1 stage h/n/hf/g | \$666.62 | \$656.27 | 1.58% |

| CPT/ HCPCS | Mod | Global | Description | 2015 Payment Amount ² \$ | 2014 Payment Amount ² \$ | % Payment Difference |
|---------------|-----|--------|------------------------------|--|--|----------------------------|
| 17312 | | ZZZ | Mohs addl stage | \$392.02 | \$384.74 | 1.89% |
| 17313 | | 000 | Mohs 1 stage t/a/l | \$623.66 | \$613.64 | 1.63% |
| 17314 | | ZZZ | Mohs addl stage t/a/l | \$376.27 | \$368.97 | 1.98% |
| 17315 | | ZZZ | Mohs surg addl block | \$80.55 | \$79.17 | 1.75% |
| 77401 | | XXX | Radiation treatment delivery | \$20.76 | \$20.06 | 3.51% |
| 88305 | | XXX | Tissue exam by pathologist | \$73.03 | \$70.57 | 3.49% |
| 88305 | TC | XXX | Tissue exam by pathologist | \$34.01 | \$32.24 | 5.49% |
| 88305 | 26 | XXX | Tissue exam by pathologist | \$39.02 | \$38.33 | 1.81% |
| 88341 | | XXX | Immunohisto antibody slide | \$67.31 | NA | NA |
| 88341 | TC | XXX | Immunohisto antibody slide | \$45.47 | NA | NA |
| 88341 | 26 | XXX | Immunohisto antibody slide | \$21.84 | NA | NA |
| 99212 | | XXX | Office/outpatient visit est | \$43.68 | \$43.70 | -0.06% |
| 99213 | | XXX | Office/outpatient visit est | \$73.03 | \$73.08 | -0.06% |

¹ CPT codes and descriptors only are copyright 2014 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

² These calculations were made using a Conversion Factor of 35.8013, which is effective for January 1, 2015 - March 31, 2015. The Conversion Factor effective April 1, 2015 would be 28.2239. This might change contingent on Congressional action to allow continued payments without the Sustainable Growth Rate reduction.

To view the full text of the 2015 Physician Fee Schedule Final Rule please visit http://www.ofr.gov/OFRUpload/OFRData/2014-26183_PI.pdf ❖

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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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2015 PQRS Update

There will be several changes to the Medicare Physician Quality Reporting System (PQRS) in 2015. A bonus incentive payment for participating in PQRS will no longer be available; participation in 2015 will solely allow eligible professionals (EPs) to avoid a 2 percent payment reduction in 2017.

In 2015, EPs must report at least nine quality measures that cover at least three of the National Quality Strategy Domains. CMS also detailed a new requirement stating that at least one of the reported measures must be from a set of cross-cutting measures. Each measure must be reported for at least 50 percent of the EP's Medicare Part B fee-for-service patients seen Jan. 1 through Dec. 31, 2015 for which the measure applies. The five dermatology-specific measures, #137, #138, #224, #265, and #337, from the 2014 program will continue. Additionally, there will be a new pathology measure that applies to melanoma: measure #397. This measure looks at whether the EP has documented pathology reports for primary malignant cutaneous melanoma that include the pT category and a statement on thickness and ulceration and for pT1, mitotic rate.

If less than nine measures apply, EPs must go through the Measure Applicability Validation (MAV) process. CMS uses this process to evaluate whether or not EPs could have reported on additional measures, and determine whether or not they satisfied reporting requirements. The AAD will support dermatology-specific and identified dermatology-applicable measures that dermatologists and their affiliated non-physician clinicians will be able to report through the Academy's 2015 Quality Reporting System (QRS) registry. These measures and the most up-to-date information 2015 PQRS can be found at www.aad.org/QRS. ❖

2015 Coding Updates You need to know

The 2015 CPT coding manual has some new and/or revised text that require your attention for accurate coding.

i. Radiation Treatment Delivery – CPT code 77401

Instructions preceding the radiation treatment delivery section have been revised to state in part that *“All treatment delivery codes are reported once per treatment session. The treatment delivery codes recognize technical-only services and contain no physician work (the professional component).”*

Energies below the megavoltage range may be used in the treatment of skin lesions. Superficial radiation energies (up to 200 kV) may be generated by a variety of technologies and should not be reported with megavoltage (77402, 77407, 77412) for surface application.

Do not report clinical treatment planning (77261, 77262, 77263), treatment devices (77332, 77333, 77334), isodose planning (77306, 77307, 77316, 77317, 77318), physics consultation (77336), or radiation treatment management (77427, 77431, 77432, 77435, 77469, 77470, 77499) with 77401. When reporting 77401 alone, physician evaluation and management, when performed, may be reported with the appropriate E/M codes.”

It is important to note that treatment of skin lesions using superficial radiation therapy (energies of up to 200kv) are appropriately reported with CPT code 77401 - *Radiation treatment delivery, superficial and/or ortho voltage, per day*. The revised instructions further state that a physician evaluation and management (E/M) service, when performed during the same encounter can be reported with the appropriate E/M CPT code (9920x through 9921x).

ii. Immunohistochemistry (IHC) CPT codes 88341 – 88344

The biggest change in this section is that CMS has deleted the G codes (G0461 and G0462) as well as CPT code 88343. As a result, CPT code 88342 has been revised and two new IHC codes (88341 and 88344) have been introduced. To report each additional single stain, use CPT code 88341 while each multiplex antibody stain procedure will be reported with CPT code 88344. The code descriptor for CPT code 88342 has been revised to reflect that the service is per specimen for the initial single antibody stain procedure.

The instructions that apply to reporting immunohistochemistry have changed a little as shown below:

| CPT Code | 2015 Code Descriptor | 2014 Code descriptor |
|---|--|--|
| ▲ 88342 <i>(contains revised text)</i> | Immunohistochemistry or immunocytochemistry, per specimen; initial single antibody stain procedure | Immunohistochemistry or immunocytochemistry, each separately identifiable antibody per block, cytologic smear; first separately identifiable antibody per slide |
| #+● 88341 | (New code; out of numerical sequence; add on code) Report in conjunction with 88342 | NA |
| | <i>each additional single antibody stain procedure (List separately in addition to code for primary procedure)</i> | |

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2015 Coding Updates

You need to know

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| CPT Code | 2015 Code Descriptor | 2014 Code descriptor |
|---|--|----------------------|
| 88344 (New code, new instructions) | <i>each multiplex antibody stain procedure</i> | NA |
| <ul style="list-style-type: none"> ▶ Do not use more than one unit of 88341, 88342, 88344 for each separately identifiable antibody per specimen) ◀ ▶ (Do not report 88341, 88342, 88344 in conjunction with 88360, 88361 unless each procedure is for a different antibody) ◀ ▶ (When multiple separately identifiable antibodies are applied to the same specimen [ie, multiplex antibody stain procedure], use one unit of 88344) ◀ ▶ (When multiple antibodies are applied to the same slide that are not separately identifiable, [eg, antibody cocktails], use 88342, unless an additional separately identifiable antibody is also used, then use 88344) ◀ | | |
| G0461 | Deleted | |
| G0462 | Deleted | |

For more information on pathology fee schedule, please visit <http://www.cms.gov/physicianfeesched/downloads/> ❖

CMS turns up the heat on fraud and abuse

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 established the Medicare Integrity Program (MIP), in part, to strengthen the Centers for Medicare and Medicaid Services' (CMS) ability to detect and deter potential Medicare fraud, waste, and abuse. The MIP allows CMS to carry out program safeguard functions effectively and efficiently. In addition to processing claims, Medicare uses private contractors for program-integrity activities, including auditing providers and suppliers to review claims for medical necessity as well as reducing fraud and abuse.

As part of the MIP, CMS created new entities called Program Safeguard Contractors (PSCs), to perform program integrity functions. In 2003, when the Medicare Modernization Act (MMA) was signed into law, Section 911 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA), the Medicare Fee-For-Service (MFFS) Contracting Reform (MCR), was established. As a result of this, seven program-integrity zones were created based on the newly established Medicare Administrative Contractors (MAC) jurisdictions.

The Program Safeguard Contractors have evolved to become the new Zone Program Integrity Contractors (ZPICs) which were created to perform program integrity functions for Medicare Parts A, B, Durable Medical Equipment Prosthetics, Orthotics, and Supplies, Home Health and Hospice and Medicare-Medicaid data-matching. ZPICs work under the direction of CMS' Center for Program Integrity (CPI).

Who is affected?

All physicians, providers, and/or suppliers who submit claims to Part A/B Medicare administrative contractors (MACs), for services and supplies provided to Medicare beneficiaries.

This table and link lists all ZPICs and their zones: <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/#pa>

| ZPIC | Zone | Includes |
|--|------|--|
| Safeguard Services (SGS) http://www.safeguard-servicesllc.com | 1 | California, Hawaii, Nevada, American Samoa, Guam, and the Mariana Islands |
| AdvanceMed Corporation http://www.nciinc.com | 2 | Washington, Oregon, Idaho, Utah, Arizona, Wyoming, Montana, North Dakota, South Dakota, Nebraska, Kansas, Iowa, Missouri, Alaska |
| Cahaba Safeguard Administrators, LLC http://www.CahabaSafeguard.com | 3 | Minnesota, Wisconsin, Illinois, Indiana, Michigan, Ohio, Kentucky |
| Health Integrity http://www.healthintegrity.org/contracts/zpic-4 | 4 | Colorado, New Mexico, Texas, and Oklahoma |
| NCI AdvanceMed http://www.nciinc.com | 5 | Arkansas, Louisiana, Mississippi, Tennessee, Alabama, Georgia, North Carolina, South Carolina, Virginia, West Virginia |

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CMS turns up the heat on fraud and abuse

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| ZPIC | Zone | Includes |
|--|------|---|
| Under Protest - Currently serviced by Safeguard Services (SGS) | 6 | Pennsylvania, New York, Delaware, Maryland, D.C., New Jersey, Massachusetts, New Hampshire, Vermont, Maine, Rhode Island, Connecticut |
| Safeguard Services (SGS) http://www.safeguard-servicesllc.com | 7 | Florida, Puerto Rico, Virgin Islands |

The ZPIC Goal

The primary goal of ZPICs, formerly known as the Program Safeguard Contractors (PSCs), is to investigate instances of suspected fraud, waste, and abuse. ZPICs develop investigations early, and in a timely manner, take immediate action to ensure that Medicare Trust Fund monies are not inappropriately paid. They also identify any improper payments that are to be recouped by the MAC.

Differences between the RAC, CERT, and ZPIC audits

The Medicare Recovery Audit Contractors (RACs) focus the majority of their efforts toward adoption of CMS evidence-based coverage policies and site-of-service issues, e.g. identifying overpayments. Comprehensive Error Rate Testing (CERT) audits aim at measuring improper payments. ZPIC audits target potential fraud in the Medicare program and can audit the integrity of all Medicare claims for a particular provider with both pre- and post-payment audits. While ZPIC audits are similar in many ways to other CMS audits currently being performed nationwide, they do differ in one very important aspect – they carry the potential for Medicare fraud implications.

Because ZPICs can refer cases to the Department of Justice, Office of Inspector General, or other law enforcement agencies, a ZPIC review may only be the first step in a long legal battle.

A ZPIC audit may be performed as the result of other audits that based on findings and outcome will recommend a ZPIC audit. A ZPIC audit will hone the investigation on specific findings of the initial audit.

There are three primary reasons for conducting a ZPIC audit:

- ✓ analysis of rates (high rates of utilization of ultra-high resource utilization groups (RUGs);
- ✓ whistleblower complaints; and/or
- ✓ results of other audits.

Another major difference is that when ZPIC auditors contact and visit your facility, they usually come armed with specific information that they need to investigate. Unlike RAC and CERT audits who perform random audits, ZPICs will know exactly what they want to zero in on. Essentially, if you are targeted for a ZPIC audit, it is because a ZPIC **may** already have evidence that there is a problem with your billing practices.

MACs may use statistical sampling to calculate and project (i.e., extrapolate) the amount of overpayment(s) made on claims. In accordance with the 2003 MMA

Consequences of a failed ZPIC review can include payment delays and/or denials, recoupment of overpayments, and referral to other law enforcement agencies.

Overall, CMS considers an individual ZPIC as being responsible for detecting, deterring and even preventing Medicare fraud and abuse. In this capacity, the ZPIC is directly responsible for operating areas such as investigation, case development, administrative solutions and referral to law enforcement.

What happens with the ZPICs' audit findings?

Once the audit has concluded, the ZPICs will usually refer all identified overpayments to the affiliated MAC, who subsequently sends the supplier or provider a demand letter for recoupment of the perceived overpayment. In any case involving an overpayment, even where there is a strong likelihood of fraud, the MAC will typically request recovery of the overpayment. However, if there is a strong likelihood of fraud, the ZPIC will refer the matter to the Office of Inspector General (OIG) and not necessarily ask for recoupment. The more it looks like actual fraud, the higher chance of referral to the OIG rather than back to the MAC.

ZPICs can take one or more of the following actions to detect and deter fraud, waste, and abuse in the Medicare Program:

| Core Functions | While performing the core function on the left, ZPICs may, as appropriate: |
|---|--|
| <ul style="list-style-type: none"> ✓ Investigating potential fraud and abuse for CMS administrative action or referral to law enforcement; ✓ Conducting investigations in accordance with the priorities established by CPI's Fraud Prevention System; ✓ Performing medical review, as appropriate; ✓ Performing data analysis in coordination with CPI's Fraud Prevention System; ✓ Identifying the need for administrative actions such as payment suspensions and prepayment or auto-denial edits; and ✓ Referring cases to law enforcement for consideration and initiation of civil or criminal prosecution. | <ul style="list-style-type: none"> ✓ Request medical records and documentation; ✓ Conduct an interview; ✓ Conduct an onsite visit; ✓ Identify the need for a prepayment or auto-denial edit and refer these edits to the MAC; ✓ Withhold payments; and ✓ Refer cases to law enforcement. |

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CMS turns up the heat on fraud and abuse

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ZPICs also support victims of Medicare identity theft. A provider or supplier who believes that his/her provider information may have been stolen and used to submit Medicare claims for which payment was made can request that the local ZPIC investigate the case. The ZPIC will then work with CMS to determine the appropriate remedial action to assist the provider.

Guidance on how to avoid and report Medicare identity theft and information on current scams can be found at <http://www.cms.gov/MedicareProviderSupEnroll/downloads/ProviderVictimPOCs.pdf>

Prepare for a ZPIC audit before it happens

| What to do before a ZPIC audit | What to do when ZPIC requests medical record documentation | What to do when ZPIC has identified an overpayment as a result of the audit. |
|---|---|--|
| <ul style="list-style-type: none"> ✓ Conduct routine internal review of the services you provide in your practice to ensure your documentation is in order. ✓ Review the LCD documentation requirements section for services you provide to ensure you meet those criteria. ZPIC audits always want to ensure the LCD documentation requirements outlined are met. Develop documentation checklists for your files to assure you always have all the necessary documentation. ✓ Make sure your files are orderly and consistent. ✓ Whenever possible, get as much clinical documentation upfront for the services you provide. It is much easier to get the documentation you need at the time the service is rendered rather than having to go back if faced with one of these audits. | <ul style="list-style-type: none"> ✓ Begin compiling the documentation immediately. ✓ ZPICs expect you to provide clinical documentation to support the need for the items being audited. ✓ If you do not provide any clinical records that define medical necessity, the claim will be denied as not medically necessary. Therefore, you must contact the ordering physicians and request specific documentation related to why they prescribed the item in question. ✓ Conduct a comprehensive review of the documentation for completeness prior to submitting them to ZPIC. ✓ If you identify issues in your review, notify ZPIC immediately and prepare a corrective action plan to address those issues internally. ✓ Retain exact duplicate copies of the documentation you submit to ZPIC. ✓ If you are unable to meet ZPIC's deadline imposed (usually 30 days); immediately contact the ZPIC contractor and request an extension. Regulations provide that the ZPIC can not render a decision on a claim for failure to respond until after the 45th day. Therefore, you will always be able to request an extension to 45 days in the minimum. They have the discretion to extend further if necessary. | <ul style="list-style-type: none"> ✓ 30 days after receipt of the recoupment letter from ZPIC, you will receive an actual overpayment demand letter from your local MAC. ✓ Review the specific denial reasons in the audit results letter from ZPIC and begin attempting to get supporting documentation to counter the denials. ✓ Appeal the denial (where necessary) within 120 days; <ul style="list-style-type: none"> • the contractor will begin collection proceedings on the 41st day. So, you should either: <ol style="list-style-type: none"> a. Refund the overpayment within 30 days and then begin preparing your appeal; b. Request a repayment plan within 30 days; or c. Submit a valid request for Redetermination prior to the 41st day. ✓ Once a valid request is received prior to the 41st day, the limitation on recoupment provisions applies and the MAC cannot collect the overpayment while the appeal is pending. The same process applies for the second level of appeal (QIC) as well. (Reconsideration request must be received before the 61st day in order to stop collection of overpayment. Keep in mind that interest will begin accruing on the 30th day from the identification of the overpayment.) |

| What to do before a ZPIC audit | What to do when ZPIC requests medical record documentation | What to do when ZPIC has identified an overpayment as a result of the audit. |
|--|--|--|
| <ul style="list-style-type: none"> ✓ Do not rely on generated forms (templates) to document medical necessity. ✓ Make sure all documentation and ALL signatures are legible. (If not legible signatures have the name printed/typed below the signature) | <ul style="list-style-type: none"> ✓ If the number of claim records requested is too large to allow your response in a timely manner, you may ask them to accept a smaller number of claims (especially if it is a pre-pay audit and they are going to pull additional claims as you bill.) | <ul style="list-style-type: none"> ✓ If unsuccessful at Redetermination and Reconsideration, then request an ALJ Hearing and if you have not satisfied the overpayment by this time, then refund the money or request a repayment plan. |

Additional Resources:

The Role of the Zone Program Integrity Contractors (ZPICs), formerly known as the Program Safeguard Contractors (PSCs), MLN Matters (Feb. 29, 2012), is available at <http://www.cms.gov/MLNMattersArticles/Downloads/SE1204.pdf>

The Medicare Appeals Process: Five Levels to Protect Providers, Physicians and Other Suppliers - designed to provide education on the Medicare Part A and B administrative appeals process is available at <http://www.cms.gov/MLNProducts/downloads/MedicareAppealsprocess.pdf>

Medicare Fraud & Abuse: Prevention, Detection, and Reporting Fact Sheet - designed to provide education on preventing, detecting and reporting Medicare fraud and abuse, is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Fraud_and_Abuse.pdf ❖

Enhanced medical record document will save the day in ICD-10-CM coding!

Coding in a physician office can be very challenging. For those faced with coding challenges, you will agree that there are many times that you end up coding an encounter based on the signs and symptoms or just the clinical findings as documented in the patient medical record. Sometimes we just do not have enough information to make a definitive code selection. Either way, it is important to ensure that those coding patient encounters in the physician practice carefully review the medical documentation for coding accuracy.

The focus of this article is on the appropriate documentation requirements and coding of an encounter form. This article explores a couple of examples using the final diagnosis based on the clinical findings and histopathologic documentation and then based on the documentation, coding them both using ICD-9-CM and ICD-10-CM.

We will use the example of when a patient's chief complaint is a 'rash'.

The physician or other qualified healthcare provider will obtain the history of present illness (HPI), to include loca-

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Enhanced medical record document will save the day in ICD-10-CM coding!

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tion, context and quality as well as the duration and severity with any associated symptoms and modifying factors. Next the healthcare provider reviews the system(s) (ROS) affected, which, may focus predominantly on the integumentary system and other systems as necessary. The medical decision making may lead to more work-up, e.g., obtaining a biopsy for histological examination.

The physician or healthcare provider will further focus on the patient's personal, family medical and social history. Questions that are pertinent to the condition being managed may help further elucidate potential causes for the rash.

All of the above are very important, but in order to determine the most appropriate plan of care, the healthcare provider will make a decision as to what the best medical care/treatment is appropriate after having met with the patient and having discussed the evolution of the condition, in this case, the 'rash'.

Let's take a moment and review the following examples obtained from a real medical record and code them in ICD-9-CM as well ICD-10-CM.

Credit is given to Alexander Miller, MD, CA for his review, comment and contribution to the accuracy of the medical record documentation used in these examples.

Clinical Findings - Coding Examples

1. Examination of the lower legs of a corpulent middle aged female reveals tender redness along with hyperpigmentation and some areas of nodular induration in otherwise tight, bound down-looking skin above the ankle to the mid lower leg level.

A biopsy reveals 'a septal and lobular mixed inflammatory infiltrate in the subcutis composed of lymphocytes and occasional histiocytes, with fat necrosis. PAS highlights the so-called "arabesque" pattern of hyaline adipocyte membrane necrosis. No interface change is seen at the basal layer, and no changes suggestive of vasculitis are seen. Gram stain is negative for bacteria, and colloidal iron does not reveal increased dermal mucin. Lobular panniculitis is a reaction pattern secondary to numerous disease processes. While advanced stasis dermatitis (lipodermatosclerosis) is favored histologically in this biopsy, the exact etiology is best determined clinically'. Final diagnosis based on physician clinical observation is documented as panniculitis.

Final Diagnosis: Panniculitis
ICD-9-CM Code: 729.39 Panniculitis, other site
ICD-10-CM Code: M79.3 Panniculitis, unspecified

2. Patient presents with an intensely pruritic, papulovesicular, bilaterally symmetrical eruption localized to the face, neck, and exposed arms and forearms. The patient reports that recently he had started using a new sunscreen product on his exposed skin.

The biopsy specimen reveals an excoriated, acanthotic, mildly spongiotic epidermis with focal parakeratosis and lymphocyte exocytosis. Acantholysis is absent. A superficial perivascular lymphocytic infiltrate without eosinophils is seen in the dermis. The basal layer is intact. Neither fungal microorganisms nor basement membrane changes are seen with interpretation of a PAS histochemical stain. A colloidal iron stain does not reveal increased dermal mucin. The changes are most compatible with those of an eczematous process, including contact, nummular and atopic dermatitis.

Final Diagnosis: Allergic Contact Dermatitis due to Sunscreen use

ICD-9-CM Code: 692.3 Contact dermatitis and other eczema, due to drugs and medicines in contact with skin

E946.3 Adverse effect of emollients, demulcants and protectants

ICD-10-CM Code: L23.3 Allergic contact dermatitis due to drugs in contact with skin

T49.3x5A Adverse effect of emollients, demulcants and protectants, initial encounter

3. A patient presents with a new onset of a moderately pruritic eruption with onset two weeks following the initiation of a new lipid lowering drug regimen. A complete skin examination reveals a bilaterally symmetrical eruption of pink, variably sized macules and plaques on the chest, abdomen and proximal extremities.

[The note above does not indicate the specific drug type. Assuming this patient was prescribed with Niacin, a lipid lowering therapy drug, this same encounter would appropriately be reported with(*)]

Final Diagnosis: Drug eruption

ICD-9-CM Code: 693.0 Dermatitis due to drugs and medicines taken internally

E942.2 Antilipemic and antiarteriosclerotic drug

ICD-10-CM Code: L27.0 Generalized skin eruption due to drugs and medicaments taken internally

T46.905A Adverse effect of unspecified agents primarily affecting the cardiovascular system

***T46.6X5A** Adverse effect of antihyperlipidemic and antiarteriosclerotic drugs, initial encounter
(Instead of T46.905A)

When using ICD-10-CM codes, it is important to follow the coding instructions that prompt one to include additional coding information and sequencing rules.

The ICD-10 implementation deadline is scheduled for 10/1/15. Take advantage of the delay to improve and perfect your medical record documentation so there is enough information to allow for specific ICD-10-CM code selection. Do not underestimate the rigorous coding documentation requirements that will be expected of your medical records to enable accurate dermatologic ICD-10-CM code selection. ❖

Successful Tips to help you avoid unnecessary audits

Now, more than ever, it is of extreme importance for you to focus on compliance. An active, robust compliance program is absolutely necessary. Review the AAD Maintaining Compliance in *Dermatology: Safeguarding Against Legal and Financial Risk* from <https://www.aad.org/store/product/default.aspx?id=7357>

Q: How do I avoid unnecessary audits?

A: Beware of audit triggers. ZPICs and other audit contractors will quickly discover so-called “low-hanging fruit.” These are the easy-to-spot mistakes such as repeated use of incorrect codes and modifiers, abnormal increase in utilization over a given time and/or duplicate claims

Q: What do I need to know about the auditors and what are they looking for?

A: Know who the ZPIC contractor is for your state and jurisdiction. Learn as much as you can about ZPIC, review its web site and take note of target audit areas. See list of ZPIC contractors on page 4-5 and/or review the interactive map at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/#pa>

Pay close attention to the Office of the Inspector General (OIG) Work Plan, which is published annually in October to get an understanding of ‘hot topics.’ To view the OIG Work Plan, visit <http://oig.hhs.gov/publications/workplan.asp>

Q: What if I find a mistake myself? How should I proceed?

A: Even with adequate training, mistakes may still occur. Perform regular billing audits with review of medical records. Ensure that the medical record documentation supports the service codes reported. Such discrepancies are likely to stand out during data analysis.

If you discover an error, it’s important to correct it promptly and repay any overpayments your internal audit may reveal. By correcting billing errors, you demonstrate compliance with the coding guidelines as well as the law and show that you have a strong internal compliance program in place.

Q: I received a letter with an inquiry from ZPIC. What should I do next?

A: Respond to inquiries quickly. Set up a system to immediately flag requests for documentation or additional information from RAC and/or ZPIC contractors. Note that sometimes the request for medical records may not be on a CMS letterhead, so train staff to identify any correspondence requesting medical records to bring it to the responsible staff attention for immediate action. Delayed response can result in your practice receiving a demand letter before medical record documentation can be collected and submitted to build your appeal case.

Q: How much lead time is provided before an onsite audit is conducted?

A: Sometimes, though rarely, ZPICs can provide an audit notification a mere hour before the onsite visit. It is within your practice rights to supplement any

requested records with supporting documentation even after the visit is complete. In short, taking the time to carefully review your medical record and billing practices together with a strong compliance program will protect you from unnecessary audits.

Q: Can I appeal a ZPIC Audit? If so how does the Appeal Process work?

A: It is within your rights to appeal the outcome of the ZPIC audit if you feel that the results are unfavorable after ZPIC forwards its findings of the case to the MAC so the contractor can handle the appeal.

ZPICs are required to have a medical specialist involved in denials that are not based on the application of clearly articulated policy with clearly articulated rationale. A review or reconsideration involving the use of medical judgment should involve consultation with a medical specialist.

On the other hand, using the “appeal everything” strategy and not making internal operational changes that adhere to CMS payment criteria is a guaranteed approach to facilitating potential Medicare fraud investigations.

So it’s important to consider whether you have a case that’s appealable before deciding to move forward with an appeal in your case.

Here’s how the process works:

| | |
|---|--|
| First Level – Redetermination (Medicare Administrative Contractor) | Request for redetermination is initially reviewed by the appropriate MAC and must be received within 120 days of ZPIC’s initial decision. MACs are required to respond to a provider’s request for redetermination within 60 days of receipt. |
| Second Level – Reconsideration (Qualified Independent Contractor) | If a provider is dissatisfied with the outcome of the Level 1 appeal or redetermination process, a request for “reconsideration” may be filed to the appropriate Qualified Independent Contractor (QIC) within 180 days of the redetermination. Requests for reconsideration are required to be processed within 60 days by the QIC. |
| Third Level – Administrative Law Judge Hearing (ALJ) | If a provider is not satisfied with Level 2 result of reconsideration, a hearing before an Administrative Law Judge (ALJ) can be requested. The amount in controversy must be a minimum of \$120 and requests for a hearing from an ALJ must be received within 60 days of the provider’s notice of the reconsideration outcome. |
| Fourth Level – Medicare Appeals Council (MAC) | If the Level 3 appeal and decision by the ALJ is considered unfavorable by the provider, a fourth-level appeal request can be filed with the Departmental Appeals Board (DAB) / Medicare Appeals Council (MAC). Requests for a MAC review must be filed within 60 days of receipt of the ALJ’s decision. The MAC must subsequently issue a determination within 90 days of the review. |
| Fifth Level – U.S. District Court Review | If the Level 4 decision of the MAC is deemed unfavorable to the provider, the final step in the appeals process is to file suit in U.S. District Court. Requests must be filed within 60 days of the MACs decision and the amount in controversy must be at least \$1,180. |

It is important for all healthcare providers to remember that ZPIC audit appeals are usually won or lost with medical record documentation that clearly and concisely incorporates required CMS LCD payment criteria.

— see **AUDITS** on page 9

Successful Tips to help you avoid unnecessary audits

— continued from page 8

A successful ZPIC audit is one that ties CMS payment criteria to medical record documentation and present an evidence-based argument for payment. Some U.S. courts have determined that a provider's adherence to CMS payment criteria is sufficient evidence in the evaluation of claim denials.

Always focus on winning the appeal. Because the Medicare Appeals Council is the last administrative step in the ZPIC appeals process. The Appeals Council relies heavily on CMS payment criteria when making their decisions.

Also, It is very important that all required documentation be submitted during the first two stages – the Redetermination and Reconsideration stages of the ZPIC appeals process. If supporting documentation is not submitted by the end of stage 2, it is extremely difficult to add supporting documentation to a case under appeal.

The Medicare Appeals Process: Five Levels to Protect Providers, Physicians and Other Suppliers - designed to provide education on the Medicare Part A and B administrative appeals process is available at <http://www.cms.gov/MLNProducts/downloads/MedicareAppealsprocess.pdf> ❖

Extending Locum Tenens

A Locum Tenens physician is a doctor who is an independent contractor for hire on a temporary basis, to fill a position usually in cases in which the “regular physician” is out due to illness, vacation or pregnancy for a period of not more than 60 concurrent calendar days. It is usual for these physicians not to have a regular practice but provide temporary services to hospitals or practices.

A common question that is frequently asked when working with Locum Tenens, is what if the “regular physician” requires the services of a locum tenens physician for a period longer than 60 days? Can the locum tenens provider take a day off to restart the Locum Tenens period? The taking of a day off is not a consideration in the guidelines for locum tenens for establishing the 60-day period. It is only after the regular physician has returned to work that a new period of covered visit services can begin. If this is not possible, then it is recommended that the substitute physician enroll with the group.

CMS guidelines state that a regular physician may bill for the services of a locum tenens physician provided the following guidelines are met:

- The regular physician is unable to provide visit services
- The Medicare beneficiary has arranged for or seeks to receive services from the regular physician
- The regular physician pays the locum tenens for services on a per diem or similar fee-for-time basis
- The substitute physician does not provide services over a continuous period longer than 60 days
- The Q6 modifier should be submitted on the claim

- The practice must keep a listing of all patients seen by the locum tenens provider
- These guidelines do not apply to non-physician providers

For additional information, please visits : <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf> ❖

Coding Q&A

Q: Can CPT code 11755 be used for clipping the nail plate for PAS stain and for obtaining nail plate specimens for fungal cultures?

A. CPT code 11755, Biopsy of nail unit (eg plate, bed, matrix, hyponchium, proximal and lateral nail folds) is not meant to describe the act of clipping a nail. Nail biopsy should include components of the nail unit other than just the nail plate. Taking nail clippings for PAS or Fungal culture is just part of the E/M service, just like taking a swab for a throat culture, and is not a “Nail biopsy”. Nail biopsies normally require a digital block or local anesthetic, and represent more physician work than a nail clipping, or curetting under a nail for culture material.

Q: Our physician performed Mohs Surgery (MMS) on a patient yesterday. After 13 secondary stages, the patient was exhausted and a decision was made to finish MMS the next day where another stage was performed with clear margins. How should this be reported since 17312 is not a stand-alone CPT code?

A: According to Medicare’s MedLearn SE1318, it is appropriate to report a first stage MMS on the subsequent day. This MedLearn also has important documentation expectations for Mohs surgeons. The medical record must be clear that the provider acted as the surgeon as well as a pathologist. The record must support the medical necessity of the procedure including the location, number, and size of the lesion(s) with a detailed report of the number of stages and locations of the specimens taken and specimen per stage.

The specimen for histology taken in the first stage must describe depth of invasion, pathological pattern, cell morphology, and, if present, perineural invasion or presence of scar tissue. For subsequent stages, the pattern and morphology of the tumor (if still seen) is as described for the first stage; or, if differences are found, note the changes, there is no need to repeat the detailed description documented for the first stage, presuming that the description would fit the tumor found on subsequent stages.

The reporting of the 13 MMS second stages will be denied as excessive by Medicare if all are reported on one claim line. They have a claim editing system known as the Medically Unlikely Edit (MUE) to protect against typographical errors. Most CPT codes are published and found on Medicare website (www.cms.gov/ncci), codes 17312, 17314

— see CODING Q&A on page 10

Coding Q&A

— continued from page 9

and 17315 are not presently published. These codes need to be reported in units of 3 to 4 on the primary claim line followed by the same on subsequent claim lines with a 76 modifier, repeat procedure to avoid a duplicate claim denial. The 59 modifier may be required, check with your local Medicare contractor.

Q: Could you explain how to code a Full Thickness Graft/Excision of the Ear (malignant melanoma) with the donor site being the neck?

A: A full thickness graft to the ear would be reported with a 15260, Full thickness graft, free including direct closure of donor site; nose, ears, eyelids, and/or lips, 20 sq cm or less. Should the graft be greater than 20 sq cm, it would be appropriate to report the add on code, 15261 for each additional or part thereof 20 cm

As an example, a wound requiring 22 sq cm would be reported as 15260 plus the 15261 for the part thereof of additional 2 cm.

According to AMA CPT, an excision code may be reported with a Full Thickness graft. If a separate flap or graft is needed to repair the graft donor site, that may be reported as well. Of note, excisions are included in Adjacent Tissue Advancement codes (14000 – 14302), and are not separately reported.

Q: How do I know when the patient can be charged for services that Medicare denied?

A: This information is included on the Provider Remittance Notice (PRN) received from your Medicare Carrier or Medicare Administrative Contractor (MAC). It is an ANSI (American National Standards Institute) message that may start with PR (Patient Responsibility) or CO (Contractor Obligation). It's only when the PR is listed that a patient may be charged for anything that is denied.

Q: Is it appropriate to "balance bill" patients the difference between the billed and the covered amount?

A: This is a common question from dermatological practices who often question whether it is appropriate to balance bill their patients for the difference between the billed amount and the insurance covered amount. In most cases, the answer is NO.

Payer contracts often include a provision prohibiting physicians from billing their plan members for covered services in excess of applicable co-pays and co-insurances by including the phrase "the provider agrees to accept the payer's network rate as payment in full for covered services and shall not balance bill the payers subscriber" in the contract.

Dermatologists providing services to patients in an "out-of-network" situation should not assume that balance billing is permitted as state laws differ. Some state regulations may imply a contract between physicians and payers that prohibit physicians from balance billing, which may also apply to out-of-network physicians.

Before the patient is balance billed, it may be appropriate to consult legal counsel, the state medical board or state insurance commission for clarification. However, "in-network" providers need to take a further step and

review their payer contracts to determine whether balance billing is prohibited contractually before proceeding.

Providers who accept reimbursement from government-administered health care programs (Medicare and Medicaid) should check the terms of these programs to determine if there are any restrictions against balance billing.

Finally, providers are cautioned not to knowingly inflate their bills for services in order to circumvent the contractual and statutory restrictions against balance billing, as this can be viewed as insurance fraud, and may be punishable through civil monetary penalties as illustrated in The Social Security Act (SSA), Sec. 1128A. (42 U.S.C. 1320a-7a).

For a detailed description of the Act, please visit: <http://www.socialsecurity.gov/OPHome/ssact/title11/1128A.htm> ❖

Clarification by MAC Contractor

In 2009, the Office of Inspector General (OIG) Work Plan included reviewing 'incident to' services for appropriateness of physicians' billing for services. There still seems to be some confusion on these guidelines. Novitas Solutions' Medical Review Department (JL & JH Medicare Contractor) recently issued a comment on the inappropriate use of 'Incident to' stemming from providers' documentation. The audit found non-physician practitioners (NPP) performing and reporting the initial visits with only the supervising physician documenting a note in the medical record similar to the following:

- "Reviewed, examined and agree with..."
- "NPP and I performed history, exam and treatment plan as follows....."

Under Medicare's guidelines, this does not meet the criteria of "incident to." An initial patient history and physical exam performed by a NPP with the physician being present in the exam room and/or in the office suite and immediately available, is not covered under the "incident to" guidelines. Nor is the service of the NPP performing the initial history and exam with the physician later coming into the exam room to confirm the NPP's assessment and plan without performing all aspects of the initial new patient service.

Following the "incident to" guidelines, it is expected that the physician will perform the initial visit on each new patient and for an established patient, to see each new condition that that patient may present with.

Medicare defines "incident to" services as "services or supplies furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness."

In order to be covered as "incident to" the physician's service, the following criteria must be met:

- *services must be an integral, although incidental, part of the physician's professional service,*
- *commonly rendered without charge or included in the physician's bill,*

— see **MAC CONTRACTOR** on page 11

Clarification by MAC Contractor

— continued from page 10

- of a type that are commonly furnished in physician's offices or clinics, and
- furnished by the physician or by auxiliary personnel under the physician's direct supervision.

Without the physician's presence in the same office suite while the professional services are being provided by the NPP, does not qualify to be billed as "incident to" to a Medicare contractor.

"Incident to" services must be performed under the direct supervision of the physician. Medicare instructs that *"Direct supervision in the office setting does not mean that the physician must be present in the same room with his or her personnel. However, the physician must be present in the office suite and immediately available to provide assistance and direction throughout the time the service is performed."*

The guideline further indicates under Direct Supervision that, *"This does not mean, however, that to be considered "incident to," each occasion of service by auxiliary personnel (or the furnishing of a supply) need also always be the occasion of the actual rendition of a personal professional service by the physician. Such a service or supply could be considered to be "incident to" when furnished during a course of treatment where the physician performs an initial service and subsequent services of a frequency which reflects his/her active participation in and management of the course of treatment."*

Another area of the guideline causing confusion is the reporting hospital and skilled nursing home services performed by a non-physician provider (NPP). **The 'incident to' guidelines do not apply at any time within facilities.** If the patient is seen by the NPP independently, this service must be reported under the NPP's NPI number and not the physician's NPI. It is only when the physician provides and personally documents the substantial part of the patient's face-to-face service in the medical record that service can be reported under the physician's NPI.

Levels of Supervision:

- **General Supervision** means the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure.
- **Direct Supervision** in the office setting means the physician must be present in the office suite and immediately available to furnish assistance.
- **Personal Supervision** means a physician must be in attendance in the room during the performance of the procedure.

As to the reporting of "incident to" the physician is required to be in the suite (direct supervision) during the procedure and available to assist for a Medicare patient. For commercial payers, it is usually state law that defines the type of supervision which usually some reasonable method of telecommunications.

Who gets to report the incident to service?

- The ordering physician's name is always listed in the Ordering and Referring item on the CMS 1500.

- The physician, who is supervising that day's procedures, is considered the billing physician. This could be different than the ordering physician.
- If only the NPP is supervising because the physicians are not in the office then the NPP would report the service.
- If there is no clinical staff (MD, DO, NP/PA) in the suite, then the service can't be reported to Medicare.
- It's up to state law if a service is performed by an ancillary staff (RN, LPN, Tech etc) without general supervision, can be reported to a commercial payer.

It is always advisable to review your Medicare carrier website for information on "Incident to" billing, and in the Medicare Claims Processing Manual, Chapter 12 - Section 30.6.4 at <http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf>.

It is also important to check with the State regulations for rules and guidelines you must be aware of regarding non-physician providers. ❖

Medicare's Expanded Medically Unlikely Edits

On July 1, 2014, Medicare updated and expanded the Medically Unlikely Edits (MUE) system which will affect Dermatologists submitting claims with multiple units of services. MUEs limit the number of units of service for which a CPT code may be billed by a provider for the same patient during one calendar day. The edits include an "MUE adjudication indicator (MAI)" and an "MUE rationale." MUEs with an adjudication indicator of "2" or "3" are meant to address a vulnerability identified by the Department of Health and Human Services (HHS) Office of Inspector General (OIG) in which providers could bypass MUEs by listing multiples of the same code on different claim lines.

- The MAI of 2 shows the MUE is based on Medicare policy, AMA CPT code descriptor or anatomy.
- The MAI of 3 is based on clinical information such as billing patterns or prescribing instructions, CMS explains in MLN Matters article SE1422.
- Both MAI 2 and MAI 3 edits are "date of service" edits. The "1 Line Edits" are MUEs of the claim line only.

Exceptions to MUEs with a MAI of 3 could occur, but would be so rare that the abnormally high units of service value should be considered to be a billing error. As for edits with a MAI of 2, CMS has not identified any instances in which a higher value would be correct and the denials would be overturned.

Bilateral procedures such as an Unna boot, 29580, should be reported on one line, with modifier 50, Bilateral service modifier and a single unit of service. The unit price is increased to 150%.

For more information, MedLearn SE1422 can be found here: <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2014-Transmittals-Items/SE1422.html>

And for the MUE listing: <http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html>

— see **MEDICARE EXPANDED** on page 12

In The Know.....

Did you know that CMS has introduced four new modifiers?

The Centers for Medicare and Medicaid Services (CMS) recently announced that they established four new Healthcare Common Procedure Coding System (HCPCS) modifiers to define subsets of modifier 59. CMS states that modifier 59 is the most broadly used and applied modifier. By definition, modifier 59 has been used to indicate a “distinct procedural service.” According to American Medical Association Current Procedural Terminology (AMA CPT), modifier 59 is used to indicate that a “procedure or service was distinct or independent from other non-E/M services performed on the same day.

Services reported with modifier 59 indicate that multiple procedures that are not normally reported together, but are appropriate under the circumstances were performed.

Documentation must support that the service rendered was either a different session, different procedure or surgery, different site or organ system, separate incision/excision, or separate lesion, not ordinarily encountered or performed on the same day by the same individual.

It is important that the use of modifier 59 is limited to circumstances when no other modifier can best explain the circumstances of the encounter.

It is appropriate that if a more descriptive modifier is available to explain the circumstances of the encounter, that you report that instead of modifier 59. However, the use of modifier 59 is limited only to those circumstances that its use will best explain the circumstances of the encounter.

According to CMS, there is a need for more precise coding options, along with increased education and selective editing to reduce the errors associated with overpayments related to the use of modifier 59. To achieve this, CMS created the following HCPCS modifiers to selectively identify the subsets of modifier 59:

- **XE - Separate Encounter:** A service that is distinct because it occurred during a separate encounter
- **XS - Separate Structure:** A service that is distinct because it was performed on a separate organ/structure
- **XP - Separate Practitioner:** A service that is distinct because it was performed by a different practitioner
- **XU - Unusual Non-Overlapping Service:** The use of a service that is distinct because it does not overlap usual components of the main service

Collectively, these four codes are known as -X{EPSU}. CMS states it will continue to recognize modifier 59, but reminds healthcare providers that CPT instructions state that modifier 59 *should not be used when a more descriptive modifier is available*. This means that it may selectively require one of the more specific -X{EPSU} modifiers. For example:

11400: Excision, benign lesion...t/a/l;
0.5 or less when reported with
11100-**XS**: Skin Biopsy

OR
17311: Mohs first stage when reported with
17260-**XS**: Malignant lesion destruction....

The effective date for this new CMS directive is Jan. 1, 2015. However, CMS has stated that MACs are not prohibited from requiring the immediate use of the selective modifiers in lieu of modifier 59, when necessitated by local program integrity and compliance needs. Please check with your local MACs and determine what their new requirements will be.

For more information on this topic, please visit <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8863.pdf>

Now you are In The Know!

American Academy of Dermatology
PO Box 4014
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Medicare’s Expanded Medically Unlikely Edits

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| Code | MUE | Adjudication Indicator | MUE Rationale |
|-------|-----|----------------------------------|-----------------------------------|
| 10060 | 1 | 2 Date of Service Edit: Policy | Code Descriptor / CPT Instruction |
| 10061 | 1 | 2 Date of Service Edit: Policy | Code Descriptor / CPT Instruction |
| 11042 | 1 | 2 Date of Service Edit: Policy | Code Descriptor / CPT Instruction |
| 11043 | 1 | 2 Date of Service Edit: Policy | Code Descriptor / CPT Instruction |
| 11100 | 1 | 2 Date of Service Edit: Policy | Code Descriptor / CPT Instruction |
| 11200 | 1 | 2 Date of Service Edit: Policy | Code Descriptor / CPT Instruction |
| 11201 | 0 | 3 Date of Service Edit: Clinical | Clinical: CMS Workgroup |
| 11446 | 3 | 1 Line Edit | Clinical: Data |
| 11450 | 1 | 2 Date of Service Edit: Policy | CMS Policy |
| 11900 | 1 | 2 Date of Service Edit: Policy | Code Descriptor / CPT Instruction |
| 11901 | 1 | 2 Date of Service Edit: Policy | Code Descriptor / CPT Instruction |
| 12001 | 1 | 2 Date of Service Edit: Policy | Anatomic Consideration |
| 12002 | 1 | 2 Date of Service Edit: Policy | Anatomic Consideration |
| 13100 | 1 | 2 Date of Service Edit: Policy | Anatomic Consideration |
| 13101 | 1 | 2 Date of Service Edit: Policy | Anatomic Consideration |
| 13120 | 1 | 2 Date of Service Edit: Policy | Anatomic Consideration |
| 13121 | 1 | 2 Date of Service Edit: Policy | Anatomic Consideration |
| 14301 | 2 | 1 Line Edit | Code Descriptor / CPT Instruction |
| 15260 | 1 | 2 Date of Service Edit: Policy | Code Descriptor / CPT Instruction |
| 15271 | 1 | 2 Date of Service Edit: Policy | Code Descriptor / CPT Instruction |
| 15272 | 3 | 1 Line Edit | Code Descriptor / CPT Instruction |
| 15273 | 1 | 2 Date of Service Edit: Policy | Code Descriptor / CPT Instruction |
| 17264 | 3 | 1 Line Edit | Clinical: Data |
| 17266 | 2 | 1 Line Edit | Clinical: Data |
| 17276 | 3 | 1 Line Edit | Clinical: Data |