

DERM CODING CONSULT

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2006 Medicare Fee Schedule: Unexpected Dermatology Impact

With no advance notice, the Centers for Medicare and Medicaid Services (CMS) in its Medicare Fee Schedule Final Rule (MFS FR) has withdrawn the entire Practice Expense/Relative Value Unit (PE/RVU) recalculation proposal for 2006. As a result, all PE RVUs are frozen at 2005 MFS FR levels. Therefore the anticipated dermatology PE/RVU gains probably will not be realized for 2006.

Medicare Conversion Factor for 2006

06 MFS Conversion Factor (CF) is	36.1770
This is \$1.721 drop in value per RVU from 05 CF	<u>37.8975</u>
	-\$1.721/RVU

This represents a negative **-4.4%** update in Medicare physician payments in 2006.

In the 2006 Medicare Fee Schedule, CMS recapped all the legislation and regulations that impact transitioning to a Resource Based Practice Expense RVU "bottom up" methodology. The Practice Expense Supplemental Survey (PESS) submitted in 2005 by the Academy as well as five other specialty societies has been accepted by CMS. However, CMS argues that it does not have sufficient data from other specialties. As a result:

1. There will be no increase in PE RVUs for those societies that submitted PESS;
2. The PESS data could, at earliest, possibly be included in 2007 MFS PR; and
3. CMS still plans to use a transition period for implementing any resultant changes to PE/RVUs.

CMS Admits Major Data & Calculation Errors

CMS admits that almost all of the practice expense data published in the 06 MFS proposed rule in August was incorrect due to an error in the agency's programming

calculations. CMS plans to work with the medical community to clarify the PE Methodology proposal; answer any questions related to the proposal; and provide additional data and corrected information. CMS intends to resolve the "confusion" with the PE/RVU methodology before publication of Calendar Year 2007 MFS proposed rule (on or about July 1, 2007).

Academy Efforts

The Academy has joined other affected Medical Specialty Societies to determine if there is any legal recourse that might be pursued against CMS for failure to incorporate data that meets CMS pre-set criteria. In addition, AAD representatives and staff will be meeting with CMS to press for inclusion of the practice expense indirect cost data as quickly as possible.

Finally, the Academy's Washington Office is making every effort to keep the Physician Reimbursement issues before Congressional staff and to press for either a freeze of Medicare reimbursement at the 2005 Fee Schedule level or for a 1% positive update to the Medicare conversion factor for 2006. ■

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Reminder: Medicare Part B deductible for 2006
will be \$124.

Letter From the Editor

Dear *Derm Coding Consult* Reader:

This issue of *Derm Coding Consult* includes a summary of the disappointing contents of the 2006 Medicare Fee Schedule: Final Rule (06 MFS). The fee schedule reflects the anticipated drop in the Conversion Factor. However, the greater disappointment for dermatology is CMS decision to accept but delay the incorporation of the adjustment of dermatology practice expense indirect costs based on survey data provided by the Academy.

The Academy contracted with Doane Marketing Research to administer an effective practice expense survey to members. The Practice Expense Supplemental Survey (PESS) provided valid dermatology specific practice expense information based primarily on tax data and responses to specific financial questions regarding individual physician share of practice operating costs. The PESS survey data as incorporated in the 2006 MFS Proposed Rule would have positively impacted Practice Expense RVUs for all key dermatology procedure codes. The result would have almost offset the -4.4% reduction to the conversion factor!

The Academy's Washington Office is making every effort to press Congress for either a freeze of Medicare reimbursement at the 2005 Fee Schedule level or for a modest 1.0% positive update to the Medicare conversion factor for 2006. When asked, please add your voice to those dermatologists who are contacting their Congressional representatives and telling them that this situation can not be allowed to continue!!

Please join me in welcoming Amgen Wyeth as the new sponsor for *Derm Coding Consult*! An unrestricted educational grant from Amgen Wyeth will assist us in continuing to bring AAD members the latest updates on coding and reimbursement issues.

Best regards!



Norma L. Border, Editor

CPT Coding Changes for 2006

There are a significant number of changes in AMA CPT 2006 that will affect dermatologists. To code correctly, it is imperative to use the most current coding materials. Following are the key coding changes:

Clarification on Consultations

Consultations may be requested by a physician or other appropriate source. However, AMA CPT clarifies that the consultation codes may not be used if the consultation is requested by the patient and/or family. The appropriate evaluation and management code would be reported when the patient and/or family request a consultation. Modifier 32 should be appended to the consultation code when the consultation was mandated by a third party payer or other source.

For consultations done in the office or other setting, i.e., nursing facility, domiciliary care facility, the consultation codes **99241 – 99245** would be reported. These codes are appropriate for either a new or established patient. Any follow-up visits would be reported with the appropriate established patient evaluation and management codes, **99211 – 99215**, with the proper site of service location reported.

Deleted Consultation Codes

Inpatient follow-up consultation codes **99261 – 99263** have been deleted. The coding directives are to use the appropriate subsequent inpatient hospital codes **99231 – 99233**. The confirmatory consultation codes **99271 – 99275** have also been deleted. The appropriate CPT code based on the type of service and the location of the service should be reported. If a consultation is mandated by a third party, modifier -32 is still appropriate. The rationale for the code deletions is that the other subsequent consultation codes are more specific and the deleted codes were redundant.

Clarification of E/M Services for Nursing Facility Care

The following new Evaluation and Management codes are used for patients' residing in a Nursing Facility. These facilities were formerly referred to as Skilled Nursing Facility (SNF), Intermediate Care Facility (ICF), or Long Term Care Facility (LTCF). The difference between Nursing Facility and Domiciliary care, rest home, custodial care

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Editor's Notes:

Coding and reimbursement issues are an evolving process. It is important to keep issues of *Derm Coding Consult* and most important to share them with your staff involved with coding and reimbursement issues. Please note that the information provided in each issue is accurate to our best ability and knowledge at the time of publication.

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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CPT Coding Changes for 2006

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facility or assisted living facility is the Nursing Facility has a medical component.

The new Initial Nursing Facility Care codes are used by a physician who provides the admission or re-admission care of new or established patient in a Nursing facility having a medical component. Codes **99301 – 99303** have been deleted and replaced with new codes **99304 – 99306**. These new codes are used by the admitting physician to describe the patient's level of medical plan of care.

The new Nursing Facility Subsequent Care codes **99307 – 99310** are used by the physician managing the patient's follow-up medical plan of care in the nursing facility having a medical component.

E/M Codes for Non-Medical Facility

The new codes for patients in a domiciliary care, rest home, custodial care facility or assisted living facility are **99324 – 99328** for new patients and **99334 – 99337** for established patients. These codes are used by the physician who is providing an evaluation and management service much like an office/outpatient visit but in a non-medical facility.

MODIFIER CLARIFICATION

Modifier -25

Additional text was added to the descriptor of modifier -25 for clarity. In essence, the documentation must clearly support the level of E/M service provided. The italicized/underlined text below is the additional text.

“Modifier -25 Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service: The physician may need to indicate on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. *A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see E/M guidelines for instructions on determining level of E/M).* The E/M may be prompted by a symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M service.

Note: This modifier is not used to report an E/M service that resulted in a decision to perform surgery (see modifier 57).”

Integumentary System Coding Changes

The codes for salabrasion (**15810 – 15811**) have been deleted. This procedure is outdated and rarely performed. The deletion of these codes is consistent with the CPT process of deleting obsolete or inappropriate codes.

Graft Code Changes

There are major additions of codes pertaining to graft procedures. The forty-four new and revised graft codes and their descriptors are listed below. Directive text has been added in this area to assist in proper code selection. New codes include those to report the harvesting of skin tissue.

Reminder of symbols associated with changes in CPT codes:

- identifies a new code
- ▲ identifies a revised descriptor
- + identifies an add-on code

Skin Replacement Surgery and Skin Substitutes

The bilaminar skin substitute/neodermis codes, i.e., Apligraf, **15342 – 15343** have been deleted. In place of these codes, report the appropriate code **15170 – 15171**, **15175 – 15176**, **15340 – 15341**, **15360 – 15361**, or **15365 – 15366**.

The xenograft codes are used for applying non-human skin grafts after debridement of burn wounds, traumatic injury areas, soft tissue infections or necrosis, and surgery.

- **15040** Harvest of skin for tissue cultured skin autograft, 100 sq cm or less
- ▲ **15100** Split-thickness autograft, trunk, arms, legs; first 100 sq cm or lesion, or one percent of body area of infants and children (except 15050)
- **15110** Epidermal autograft, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children
- +● **15111** each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof
(List separately in addition to code for primary procedure)
- **15115** Epidermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children
- +● **15116** each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof
(List separately in addition to code for primary procedure)
- ▲ **15120** Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children (except 15050)
- **15130** Dermal autograft, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children
- +● **15131** each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof
(List separately in addition to code for primary procedure)

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CPT Coding Changes for 2006

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- **15135** Dermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less or one percent of body area of infants and children
- +● **15136** each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof
(List separately in addition to code for primary procedure)
- **15150** Tissue cultured epidermal autograft, trunk, arms, legs; first 25 sq cm or less
- +● **15151** additional 1 sq cm to 75 sq cm
(List separately in addition to code for primary procedure)
- +● **15152** each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof
(List separately in addition to code for primary procedure)
- **15155** Tissue cultured epidermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 25 sq cm or less
- +● **15156** additional 1 sq cm to 75 sq cm
(List separately in addition to code for primary procedure)
- +● **15157** each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof
(List separately in addition to code for primary procedure)
- **15170** Acellular dermal replacement, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children
- +● **15171** each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof
(List separately in addition to code for primary procedure)
- **15175** Acellular dermal replacement, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children
- +● **15176** each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof
(List separately in addition to code for primary procedure)
- **15300** Allograft skin for temporary wound closure, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children
- +● **15301** each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof
(List separately in addition to code for primary procedure)
- **15320** Allograft skin for temporary wound closure, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children
- +● **15321** each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof
(List separately in addition to code for primary procedure)
- **15330** Acellular dermal allograft, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children
- +● **15331** each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof
(List separately in addition to code for primary procedure)
- **15335** Acellular dermal allograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children
- +● **15336** each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof
(List separately in addition to code for primary procedure)
- **15340** Tissue cultured allogeneic skin substitute; first 25 sq cm or less
- +● **15341** each additional 25 sq cm
- **15360** Tissue cultured allogeneic dermal substitute; trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children
- +● **15361** each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof
(List separately in addition to code for primary procedure)
- **15365** Tissue cultured allogeneic dermal substitute, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children
- +● **15366** each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof
(List separately in addition to code for primary procedure)
- ▲ **15400** Xenograft, skin (dermal), for temporary wound closure; trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children
- +▲ **15401** each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof
(List separately in addition to code for primary procedure)
- **15420** Xenograft skin (dermal), for temporary wound closure, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children

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New Drug Administration Codes

As last year's CMS assigned G-codes for drug administration moved through the AMA CPT code change process, the structure and usage of these codes was further refined. With the change in code definitions (see table below) the cross-

walk from the 2005 HCPCS G codes to the new 2006 CPT codes also became more complicated. The following table includes the original CPT codes, the CMS assigned HCPCS G-codes and finally the new CPT code(s). ■

NEW Drug Administration Codes - 2006

Old CPT Code	2005 TEMP G-Code	2006 NEW CPT Code	2006 Drug Administration Code Descriptions
90780	G0347	90765	Intravenous infusion, for therapy, prophylaxis or diagnosis (specify substance or drug); initial, up to one hour
90781	G0348	90766	Intravenous infusion, for therapy, prophylaxis or diagnosis (specify substance or drug); each additional hour, up to eight hours (list separately in addition to code for procedure)
90781	G0349	90767	Intravenous infusion, for therapy, prophylaxis or diagnosis (specify substance or drug); additional sequential infusion, up to one hour (list separately in addition to code for procedure)
		90768	Intravenous infusion, for therapy, prophylaxis or diagnosis (specify substance or drug); concurrent infusion, (list separately in addition to code for procedure)
90782	G0351	90772	Therapeutic prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular For administration of vaccines/toxoids, see 90465-90466, 90471-90472) (Report 90772 for non-antineoplastic hormonal therapy injections) (Report 96401 for antineoplastic non-hormonal injection therapy) (Report 96402 antineoplastic hormonal therapy injections) (Do not report 90772 for injections given without direct physician supervision, To report, use 99211)
		90773	Therapeutic prophylactic or diagnostic injection (specify substance or drug); intra-arterial
90784	G0353		Therapeutic prophylactic or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug
	G0354		Therapeutic or diagnostic injection, additional substance or drug
96408	G0357	90774	Therapeutic prophylactic or diagnostic injection (specify substance or drug); Chemotherapy administration, intravenous; push technique, single or initial substance/drug
96408	G0358	90775	Therapeutic prophylactic or diagnostic injection (specify substance or drug); Chemotherapy administration, each additional sequential intravenous push of a new technique, each additional substance/drug (list separately in addition to code for primary procedure)
96410	G0359		Chemotherapy administration, intravenous infusion technique, up to one hour, single or initial substance/drug
96412	G0360		Chemotherapy administration, intravenous infusion technique, each additional hour, one to eight hours (list separately in addition to code for primary procedure)
		90779	Unlisted therapeutic, prophylactic or diagnostic intravenous or intra-arterial injection or infusion

Update on National Provider Identification (NPI)

CMS has announced that between May 23, 2005 and January 2, 2006, its Medicare claims processing systems will accept an existing Medicare Legacy (UPIN) number and reject, as unprocessable, any claim that includes only the new National Provider Identification (NPI). CMS is busy accepting applications for the new NPI number from physicians and other health providers. From January 3, 2006, and through October 1, 2006, CMS systems will accept either a Medicare UPIN number or an NPI as long as it is accompanied by the current UPIN Medicare number.

However, as of October 2, 2006, and through May 22, 2007, the CMS claims systems will accept either an existing legacy Medicare number **and/or** an NPI. This will allow for up to 6-7 months of provider testing before only an NPI will be accepted by the Medicare Program on May 23, 2007 which is the transition date for using NPI only on claims submitted to Medicare. To apply for an NPI, visit: <https://nppes.cms.hhs.gov> on the CMS Web site. To request a paper application, call 1-800-465-3203. ■

Coding Questions & Answers

Q. What are the correct diagnoses codes for keratoacanthoma?

- A. According to ICD-9-CM, the diagnosis of keratoacanthoma is to be reported with **238.2**. Code 238.2 in the neoplasm table is associated with lesions of uncertain behavior.

When a biopsy is done and the pathology report yields “keratoacanthoma”, the procedure code would be 11100 and the diagnosis code could be **238.2**.

However, the pathology report for the keratoacanthoma may state, “squamous cell carcinoma, KA type”. In that particular instance, the diagnosis code would be 173.x.

When an excision or destruction is performed of a suspected keratoacanthoma, the appropriate excision or destruction procedure code, benign or malignant would be selected based upon the diagnosis in the pathology report. The diagnosis code chosen would also be based upon the pathology report, using the appropriate code 173.x for a squamous cell cancer, KA type.

Q. Is it legal to offer discounts to self-pay patients without an indigent policy when the discounted billed amount is still higher than Medicare’s allowance?

- A. Per section 1128(b)(6) of the Social Security Act, *a provider may not bill a non-Medicare patient a lesser fee than a Medicare patient*. Providers may have a fee schedule for their privately insured patients and another for their Medicare patients. The Medicare fee schedule could be lower than the privately insured fee schedule, but not higher. In the case of a non-participating provider not accepting assignment, the addition of the limiting charge is the fee that should be compared and should not exceed the privately insured fees.

It is also appropriate for a provider to have another fee schedule for the uninsured that is lower than both the private and Medicare fee schedules because it applies to a specific type of patient, the uninsured. A provider should have a clear definition as well as practice policy and procedure as to how and when each fee schedule is applied.

Q. When is it appropriate to use the -58 Modifier “Staged Procedure”?

- A. Modifier **-58** is described as a “staged or related procedure or service by the same physician during the postoperative period.” It indicates that a procedure was followed by another procedure or service during the postoperative period. The **-58** is used to describe procedure that was:

1. previously planned at the time of the original procedure;
2. more extensive than the original or
3. for therapy following the original procedure.

The Modifier **-58** could be used on the subsequent margin excision or repair done days later after the original procedure, within the postoperative (global) period, to signify that a more comprehensive therapeutic procedure was a staged or planned procedure. From the National Correct Coding Initiative (CCI) perspective, this action would result in the allowance and reporting of both services as separate and distinct.

Q. Will our office receive a CD-ROM with the Medicare Fee Schedule for 2006?

- A. The “Dear Doctor” letter for the 2006 calendar year in a CD-ROM format was sent to providers in early November. CMS is requiring all carriers to use CDs for the 2006 letter, which notifies you of the time period in which you may change your Medicare participation status. The enrollment period will begin on Nov. 15 and end on Dec. 31.

If you continue to participate and have no changes to your Medicare participation, providers will not have to do anything. But if you participate and wish to switch to non-par status in 2006, you must send a written notice to each carrier you bill informing it that you’ll be non-par effective Jan. 1, 2006. If you are switching from non-par to par, fill out the CMS-460 and return it to your carrier by Dec. 31.

The Medicare Fee Schedule will not be found on the 2006 CD-ROM. Some predict Congress may step in at the last minute to eliminate the 2006 pay cuts. If Congress acts to reverse the pay cut, CMS’ or local carriers’ Web sites are better prepared to update the providers with the latest information. ■

CPT Coding Changes for 2006

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- ● **15421** each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof
(List separately in addition to code for primary procedure)
- **15430** Acellular xenograft implant; first 100 sq cm or less, or one percent of body area of infants and children
- ● **15431** each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof
(List separately in addition to code for primary procedure)

Codes **16010** and **16015** have been deleted. Such services are to be reported using codes **16020 – 16030**.

- ▲ **16020** Dressings and/or debridement of partial thickness burns, initial or subsequent; small (less than 5% total body surface area)
- ▲ **16025** medium (e.g., whole face or whole extremity, or 5% to 10% total body surface area)
- ▲ **16030** large (e.g., more than one extremity, or greater than 10% total body surface area)

Ligation

- **37718** Ligation, division, and stripping, short saphenous vein
- **37722** Ligation, division, and stripping, long (greater) saphenous veins from saphenofemoral junction to knee or below

Chemodenervation

- **64650** Chemodenervation of eccrine glands; both axillae
- **64653** Chemodenervation of eccrine glands; other areas (e.g., scalp, face, neck), per day

(For chemodenervation of extremities (e.g., hands or feet), use **64999**)

Botox Treatment for Hyperhidrosis

The above two new codes are for the treatment of focal hyperhidrosis of the axillae and focal hyperhidrosis **of other areas** using botulinum toxin. These new codes specifically describe the chemodenervation of neuro-eccrine glands rather than those of muscle. **In addition to the chemodenervation code, the injectible material should be reported with the appropriate HCPCS J code(s):**

J0585 Botulinum Toxin Type A, Per Unit

In 2005, ICD-9-CM expanded the hyperhidrosis codes:

- 705** Disorders of sweat glands
- 705.2** Focal hyperhidrosis
Excludes generalized (secondary) hyperhidrosis (**780.8**)
- 705.21** Primary focal hyperhidrosis
- 705.22** Secondary focal hyperhidrosis ■

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