AAD 1938 American Academy of Dermatology

Derm Coding Consult

Published by the American Academy of Dermatology Association

[Volume 20 | Number 3 | Fall 2016]

MACRA: A Very Brief Summary

The Medicare Access and CHIP Reauthorization Act (MACRA) was signed into law in April 2015. This law impacted Medicare payments in several ways. MACRA repeals the Sustainable Growth Rate (SGR) formula, which would have resulted in a 21% cut in 2015. Instead, there will be a positive annual update of 0.5% until 2019. MACRA also stopped the threatened elimination of 10 and 90 day global periods, which would have resulted in reductions in payments for most procedures.

MACRA eliminated three separate performance programs – Physician Quality Reporting System (PQRS), Value-Based Payment Modifier (VBM) and Electronic Health Record Incentive Program (EHR Meaningful Use). The last year that VBM, PQRS, and EHR MU programs exist and impact payment is 2016. These three programs will result in non-compliance penalties upwards of 10% in in 2018, with no opportunity for bonuses.

MACRA combined these three programs and added another category called clinical practice improvement activities, into one program called the Merit-Based Incentive Payment System (MIPS).

MIPS has the potential for payment adjustments of plus or minus 4% for the 2019 payment year. MACRA also incentivizes clinicians to take risk for higher payment in Advanced Alternative Payment Models (APMs). Physicians who are qualified providers in Advanced APMs do not participate in MIPS.

What has caught the attention of most dermatologists is the rule that CMS proposed in May 2016 to implement the MIPS and APM requirements. The American Academy of Dermatology (AAD) and most other specialty societies submitted comments which The Centers for Medicare and Medicaid services (CMS) is reviewing and using as they prepare the final rule.

The chart below illustrates the payment structure in CMS' proposed rule:

Performance Year	Payment Year	MIPS	Advanced APMs
2017	2019	+/- 4%	+ 5%
2018	2020	+/- 5%	+ 5%
2019	2021	+/- 7%	+ 5%
2020	2022	+/- 9% onward	+ 5% (through 2024)

While there are many problems with the MIPS/APM proposed rule, there has been little recognition that the potential penalties are less than what CMS already has in place, and there will be an opportunity for bonuses which are currently unavailable.

What is the Merit-Based Incentive Payment System (MIPS)?

The MIPS is a budget-neutral incentive payment program focused on quality and value. Under the proposed rule, physician payment will be based on a weighted composite score derived from four performance categories – including Quality (replaces PQRS), Resource Use (replaces VBM), Advancing Care Information (replaces EHR Meaningful Use), and Clinical Practice Improvement Activities (CPIA). Clinicians will be able to choose quality measures that will be published annually. CMS plans to compare resources used to treat similar care episodes and clinical condition groups across practices that can be risk-adjusted. The weighting of the EHR performance category may decrease as more users adopt EHRs. Examples of CPIA include care coordination, shared decision-making, safety checklists, and expanding practice access.

— see **MACRA** on page 2

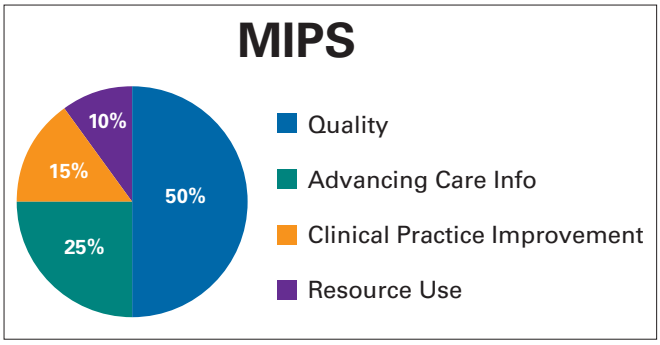
Contents

IMPORTANT Please Route to:

___ Dermatologist ___ Office Mgr ___ Coding Staff ___ Billing Staff

MACRA: A Very Brief Summary

— continued from page 1



Those who do not have to participate in MIPS include first year Medicare Part B participants, those who meet a low volume threshold (less than $10,000 in Medicare Part B billing charges and caring for 100 or fewer Part B patients per year), and those who qualify for certain Advanced APMs.

CMS estimates, that approximately 2,223 dermatologists will be excluded based on the above criteria. Because MIPS is a budget neutral program, there will be winners and losers. CMS anticipates approximately 45.5% of physicians will receive a negative adjustment and 54.1% to receive a positive adjustment.

What are Advanced Alternative Payment Models (Advanced APMs)?

An Alternative Payment Model (APM) is a payment model run by the Centers for Medicare and Medicaid Services, (CMS). However, not all APMS are Advanced Alternative Payment Models.

Advanced APMS must meet certain criteria which include the use of certified EHR technology, basing payment on quality measures comparable to those in the MIPS quality performance category, and either bearing more than nominal financial risk for monetary losses, or the APM is a Medical Home Model expanded by the CMS Innovation Center. In addition, an Advanced APM must also receive at least 25% of Part B revenue through the APM and at least 20% of patients must be Part B participants.

CMS has proposed the following CMS programs as Advanced APMS for 2017:

- Medicare Shared Savings Program ACO (Tracks 2 and 3)
- Next Generation ACO Model
- Comprehensive ESRD Care (large dialysis organization arrangement)
- Comprehensive Primary Care Plus (CPC+)
- Oncology Care Model (OCM) two-sided risk arrangement

The AAD estimates that a very small number of dermatologists will be Qualified Providers in Advanced APMs in 2017.

Please keep in mind that the MIPS and APM requirements are proposed and have not been finalized. They will be revised in the MIPS/APM Final Rule that will be released in November 2016. ❖

U.S. Preventive Services Task Update (USPSTF) for Preventive Skin Screenings

In July, the U.S. Preventive Services Task Force (USPSTF) updated its recommendations for preventive skin screenings of asymptomatic adults performed by primary care practitioners (PCPs). The focus of this task force is to rate the potential risk of death or substantial morbidity against the benefit of preventive services to determine the overall value of these services. Services given the rating of Level

— see **USPSTF** on page 3

Editor's Notes:
The material presented herein is, to the best of our knowledge accurate and factual to date. The information and suggestions are provided as guidelines for coding and reimbursement and should not be construed as organizational policy. The American Academy of Dermatology/Association disclaims any responsibility for the consequences of actions taken, based on the information presented in this newsletter.

Mission Statement:
Derm Coding Consult is published quarterly (March, June, September and December) to provide up–to–date information on coding and reimbursement issues pertinent to dermatology practice.

Address Correspondence to:
Mollie MacCormack, MD, FAAD Editorial Board Derm Coding Consult
American Academy of Dermatology Association
P.O. Box 4014 Schaumburg, IL 60168–4014

U.S. Preventive Services Task Update (USPSTF) for Preventive Skin Screenings

— continued from page 2

A or B are considered a part of the "essential benefits package" of the Patient Protection and Affordable Care Act (PPACA) and therefore, a covered service under this act.

For 2016, the USPSTF upheld its previous 2009 recommendation to not include preventive skin screenings in their Level A or Level B preventive services listing. A recent article of the Journal of the American Medical Association (JAMA), stated that while the screening of patients with high incident rates of melanoma, as well as focusing on high-risk anatomical sites, such as the back and scalp is needed, insufficient evidence was found to recommend melanoma and other skin cancer screenings for asymptomatic persons. However, it has been determined that public education campaigns, clinician counseling and education influenced patient discovery of concerning skin lesions and promoted earlier melanoma diagnosis by a dermatologist and other health care providers. This is a reversal of the USPSTF's previous determination of insufficient evidence of the benefits of patient education and awareness in reducing skin cancer risk. The USPSTF report does note that additional data is needed.

What does this mean for American Academy of Dermatology members? It basically means that preventive skin exams will remain a non-covered service under the PPACA.

As for reporting of skin screenings, it is important to remember not to use Preventive Medicine codes (9938X-9939X). Preventive Medicine codes, require a comprehensive examination and review of multiple body systems and age/gender appropriate screening test beyond that completed during a skin screening encounter.

How should these services be reported then? In first instance, review the patient's insurance to determine whether the insurer has chosen to define a dermatological skin screen as a preventive service. Second, In lieu of the Preventive Medicine codes report either the appropriate level of Evaluation and Management (E/M) service code (99201-99215) or the unspecified E/M code, 99499. If reporting this screening service using the 99499 code, complete remark box 18 of the CMS 1500 claim form with the remark "preventive skin screening" and include an evaluation and management CPT code (i.e. 99385 or 99214) so that the payer may value the 99499 service appropriately. Report skin screening services of asymptomatic patients with ICD-10 code Z12.83 - Encounter for screening for malignant neoplasm of the skin.

Example:

> *An established 48-year-old female patient with no complaints or concerns presents for annual skin screening examination. No abnormalities or concerns are noted during the skin examination. Patient's history is negative for history of melanoma, basal cell and squamous cell carcinoma. Education regarding self-skin examination is provided during the encounter and patient is advised to return in one year.*

Codes reported for this encounter;

CPT - 99499 or 992XX (Level selected dependent upon documentation)

ICD-10 Z12.83 Encounter for screening for malignant neoplasm of the skin

If, during the encounter, a condition, sign or symptom is found or a preexisting problem is addressed that is significant enough to require additional work, in terms of assessing the condition and determining the plan of treatment or monitoring beyond that which is provided during a skin screening examination, then the appropriate ICD-10 code for that condition should be reported first, followed by the screening encounter code, Z12.83 to identify the condition found during the screening.

For example:

> *An established 52-year-old male patient with no complaints or concerns presents for annual skin screening exam. During the exam you note a suspicions appearing mole on the patient's left flank. Patient's history is positive for a family history of melanoma and current use of anticoagulants. Treatment options including biopsy and monitoring the lesion are discussed with the patient. Patient request biopsy and will return in two weeks to have biopsy completed.*

In this example the codes and sequencing of reporting would be;

CPT – 9921X Level of service would be dependent upon documentation

ICD-10 - D48.5 Neoplasm of uncertain behavior of skin

Z12.83 Encounter for screening for malignant neoplasm of the skin

Z80.8 Family history of malignant neoplasm of other organs or systems

Z79.01 Long term (current) use of anticoagulants

While preventive skin screening examinations are a non-covered service for Medicare patients and therefore do not require an Advanced Beneficiary Notice of Non Coverage (ABN), private payers may or may not provide coverage for skin screenings. Make sure your patients are aware of their potential financial obligations should the carrier deny coverage of the service and request the patient sign a waiver outlining the service provided that you suspect may not be covered by their insurance. ❖

Nothing Lasts Forever: ICD-10-CM Code Freeze and Specificity Safe Harbor Ends October 1, 2016

Changes, revisions and addition of new codes to the ICD-10-CM code set have been frozen since the 2011 update, while the industry transitioned to the ICD-10 coding system.

This code freeze comes to an end on October 1 and the 2017 ICD-10-CM coding manual will have 1,943 new ICD-10-CM codes as well as several updates and revisions that were approved for implementation on October 1, 2016. None of the new codes specifically relate to dermatology. However, the updates to the coding guidelines and instructions, inclusion and exclusion notes, revisions and deletions will have some impact on dermatology-related codes.

The code-specificity safe harbor will also come to an end.

The 2017 AAD Coding and Documentation Manual has been updated with 2016-2017 revisions, deletions and coding instruction updates that will affect dermatology specific coding.

Background

In the 2015 Fall Edition of *Derm Coding Consult* (Fall 2015 DCC; page 3), it was reported that the Centers for Medicare and Medicaid Services (CMS) had issued a 12-month ICD-10-CM coding safe harbor. At the time, CMS announced that in an effort to allow Medicare Part B participating providers to adapt to the new coding system and to minimize effects on cash flow due to denied claims, traditional Medicare Part B Fee-for-Service claims would be granted a one-year grace period (safe harbor), during which ICD-10-CM specificity requirements would be waived.

During this grace period, CMS agreed not to deny claims as long as a valid ICD-10-CM code from the correct code family was used. The grace period allowed claims to be paid even if the diagnosis code listed was not as specific as it could have been.

While the correct level of ICD-10-CM code specificity has always been required for National and Local Coverage Determinations (NCD/LCD), other claim edits, prepayment reviews and prior authorization requests, physicians were granted amnesty from post-payment reviews due to the use of unspecified codes. Now, the specificity safe harbor for Medicare Part B Fee-for-Service claims ends on October 1, 2016. On this date, physicians and other Part B providers must be prepared to report claims with accurate ICD-10-CM codes and to the highest specificity.

Mitigating the risk of reporting unspecified ICD-10-CM codes

In order to be prepared, it is important that dermatology practices obtain and own a copy of the 2017 ICD-10-CM codebook. The American Academy of Dermatology (AAD) Coding and Documentation Manual has a list of dermatology-specific ICD-10-CM codes, as well as any updates that go into effect on October1, 2016.

A current coding manual is the only way to ensure that a current and accurate code is reported at the highest level of specificity.

Below are a few steps that will be helpful in mitigating the risk of reporting unspecified ICD-10-CM codes through coding documentation improvement:

- Review all healthcare provider medical record documentation and develop a list of the top ICD-10-CM codes routinely reported. Pay particular attention and identify the unspecified codes;
- Conduct detailed analysis of the diagnosis code list to identify physician and/or non-physician practitioner (NPPs) patterns or trends with a frequency of reporting unspecified ICD-10-CM codes;
- Develop a graph or excel spreadsheet listing individual provider ICD-10-CM code patterns and utilization.
- Schedule a one-on-one or group coding education session to educate the healthcare provider(s) on ways to improve code selection accuracy.
- If more specific diagnosis codes cannot be assigned due to provider style of medical record documentation, provide coding documentation improvement education to improve possibility of specific ICD-10-CM code selection
- Educate the appropriate coding staff on focused medical record documentation review to allow for accurate and specific ICD-10-CM code assignment.

Use of specific, targeted coding documentation elements to describe patient condition yields coding accuracy [See Summer 2016 DCC; page 4-5]

1. **Conduct frequent, targeted audits**
   Dermatology practices are encouraged to be proactive in conducting internal audits to identify trends in clinical documentation that could lead to unspecified diagnosis code assignment.

2. **Conduct frequent medical documentation reviews**
   There may be times where documentation may not be thorough or complete enough to report the desired level of specificity. If so, provide clinical documentation improvement education to mitigate the lack of use for ICD-10-CM clinical concepts, the framework on which ICD-10-CM codes are structured.

Having a certified professional coder on staff helps provide expert internal review of the medical record documentation and coding trends resulting in prompt and efficient error detection with appropriate corrective action.

3. **Unspecified codes are acceptable, sometimes**
   While there are a few instances in which the use of unspecified ICD-10-CM codes may be appropri-

— see **ICD-10-CM** on page 5

Nothing Lasts Forever: ICD-10-CM Code Freeze and Specificity Safe Harbor Ends October 1, 2016

— continued from page 4

ate, widespread use of numerous unspecified codes should be the exception, not the rule. Practices submitting unspecified ICD-10-CM codes after October 1, 2016, may potentially experience an increase in post-payment audits and quality-reporting errors. As audits increase, so will payer requests for medical records and clinical documentation.

Failure to submit requested clinical documentation upon payer request can lead to delayed or non- claim reimbursement. It can also be a trigger for payer audits.

Be proactive; don't be left holding the bag; don't be open to audits; use external resources when necessary.

Dermatology practices are encouraged to conduct routine internal medical record and coding reviews. Furthermore, consider setting up an additional review by an external certified coding professional/consultant to conduct a pre- and post-payment audit to ensure the medical record documentation supports the code selection submitted on the claim. Trained coding professionals evaluate electronic medical record (EMR) code assignments, identify software errors, and conduct advanced ICD-10-CM review and training for non-specific documentation and coding problem areas.

Some glitches in EMR software coding assistance have been reported. These errors, if left uncorrected, can lead to claim rejections and reimbursement delays. ❖

An Insight to Documentation Timeliness

Have you wondered what the guidelines for timeliness of medical record documentation in connection with appending of provider signature, submitting claims to Medicare, and the timely filing rule include?

You can find comfort in knowing that there is no single factor that will affect documentation timeliness. However, indicated below are several provisions that may affect 'timeliness' when talking about documentation and claim submission in a physician office setting.

(i) Medical Record Accuracy

The Centers for Medicare & Medicare Services (CMS) Internet-Only Manual (IOM) Publication 100-04, Chapter 12, Section 30.6.1.(*https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf*) state that healthcare providers are expected to complete the documentation of services *"during or as soon as possible after it is provided in order to maintain an accurate medical record."*

> *Medicare: A provider may not submit a claim until the documentation is completed. If a service is not documented, then it was not performed.*

Even though CMS does not provide any specific acceptable period/timeframe for medical record completion, it recommends that a reasonable expectation would be no more than a couple of days after the service has been rendered.

The IOM further states that if a service is not documented, then it was not performed. Medicare claim submission guidelines state that a dermatologist and/or qualified healthcare provider may not submit a claim to Medicare until the medical documentation is completed. Completion of documentation entails the appending of a legible signature to the medical record to indicate its completion.

(ii) Provider Signature

The CMS IOM Publication 100-08, Chapter 3, Section 3.3.2.4 (*https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c03.pdf*), states that services provided/ordered to Medicare beneficiaries must be authenticated by the author (requestor of the service). Methods of acceptable authentication include handwritten or electronic signatures.

The signature must be legible. If the signature is illegible, a signature log, attestation statement, or other documentation submitted to determine the identity of the author of a medical record entry is appropriate.

Stamped signatures are not acceptable except for a few exceptions, one of which is in the case of an author with a physical disability that can provide proof to a CMS contractor of his/her inability to sign their signature due to their disability in accordance with the Rehabilitation Act of 1973 (*https://www.disability.gov/rehabilitation-act-1973/*) .

In addition, CMS has a statement in the IOM stating "providers should not add late signatures to the medical record, (beyond the short delay that occurs during the transcription process). If a practitioner does not affix a signature at the time of the service after allowing limited delay due to transcription, then the provider may complete an attestation statement".

(iii) Timely Filing Limit

Timely filing does not apply to the medical record documentation but instead indicates that a claim for service(s) rendered must be submitted for adjudication to Medicare no later than 1 year from the date-of-service (DOS). If Medicare does not receive the claim within the 1-year time-frame, Medicare does not make payment and the patient is not liable.

Other third party payers may have different timely filing limits that are different from Medicare. It is

— see **DOCUMENTATION TIMELINESS** on page 6

An Insight to Documentation Timeliness

— continued from page 5

important that dermatology practices check with third party payers to determine the timely filing period and avoid potential claim denials due to untimely filing.

Correction(s) to the Medical Record

The Medicare Program Integrity Manual IOM, Chapter 3 states that all services provided to Medicare beneficiaries are expected to be documented in the medical record at the time they are rendered. Occasionally, certain entries related to services provided are not properly documented and may need correction. In such events, the documentation will need to be amended, corrected, or entered after rendering the service.

Regardless of whether a documentation submission to Medicare or its other entities originates from a paper record or an electronic health record (EHR), documents submitted must:

- Clearly and permanently identify any amendment, correction or delayed entry as such;
- Clearly indicate the date and author of any amendment, correction or delayed entry; and
- Clearly identify all original content, without deletion.

Recordkeeping Principles

Documentation submission to Medicare Administrative Contractors (MACs), Comprehensive Error Rate Testing (CERT), Recovery Audit Contractors (RACs), and Zone Integrity Program Contractors (ZPICs) containing amendments, corrections or addenda must abide by the following widely accepted recordkeeping principles:

a) Paper Medical Records:
Amendments or delayed entries to paper records must be clearly signed and dated upon entry into the record. Amendments or delayed entries to paper records may be initialed and dated if the medical record contains evidence associating the provider's initials with their name.

When correcting a paper medical record, use a single line strike through (example: strike through) so the original content is still readable and then sign and date the alteration or revision.

b) Electronic Health Records (EHR):
Medical record keeping within an EHR deserve special considerations; however, the principles specified above remain fundamental and necessary for document submission. Records sourced from electronic systems containing amendments, corrections or delayed entries must distinctly identify any amendment, correction or delayed entry and provide a reliable means to clearly identify the original content, the modified content, and the date and authorship of each modification of the record.

For more information on amendments, corrections and delayed entries in medical documentation, please visit *https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R615PI.pdf* ❖

FAQs

Q) Our Physician Assistant (PA) is following an out of town doctor's treatment plan, who do we report these services under: the out of town doctor or in office supervising doctor? Is this only for Medicare or all insurances?

A) *Incident to* is a Medicare billing guideline. The provider who is in the suite at the time of the PA's service is the supervising provider and not the "out of town" provider. For Medicare patients, the PA's services would be reported under this supervising provider. The ordering (or "out of town") provider's name and NPI is reported on the CMS1500 claim form in Item (box) 17 and 17a.

For commercial payers, state law regulations usually allow the "out of town" provider to report the PA's services so long as the "out of town" provider can be reached by common telecommunication. Check your state laws or the American Academy of Physician Assistants website (*www.aapa.org*) for further calrification.

Q) For the past couple of weeks our nurse has been providing wound checks on a patient whose wound now looks better but was referred to a wound clinic to monitor the healing. Would the diagnosis be considered an initial or subsequent visit?

A) Since this was a recheck, without any new therapy, this would be a subsequent "D" visit. Now, if this wound required a debridement or some other active treatment, then it would be an initial or "A" active treatment.

Q) A hospital consultation was requested of our provider. The patient was considered to be in a "hospital observation status." Doctor's level of service selected was 99223, Initial Hospital care, but that can't be reported for an observation patient. What would correlate to a 99223?

A) Hospital Observation status is a "patient status" level rather than a place. Observation services may take place in a regular bed in the Emergency Department (ED), in a special observation area of the ED, a formal observation unit, or even in an inpatient bed. For a Medicare patient, it's usually only reported by the admitting or supervising provider. Since Medicare no longer pays for consultations, other specialists can report an outpatient office visit (99201-99215) or the subsequent observation code services (99224-33226) in the outpatient facility: POS 22. If it's a non-Medicare patient and a consultation meets the criteria, report the 99241-99245 outpatient/office consultation services, again in POS 22. Both will require the facility's address in item 32 of the CMS 1500 claim form.

Q) Can we see a scheduled patient for patch testing by a medical assistant (MA) when the doctor is out of the office?

A) For a Medicare patient, the application of patch tests or other procedures performed by your MA can only be reported if a licensed healthcare provider (physician, NPP etc.) delegates and supervises the MA's procedural work. In this case, the patient needs to

— see **FAQ** on page 7

FAQs

— continued from page 6

be rescheduled for this appointment. For other payers, follow your state laws or payer guidelines .

The American Medical Association defines these terms as follows:

- "Delegate" means to transfer authority for the performance of a medical task to an unlicensed person.
- "On-site supervision" means that the physical presence of the physician is required in the same location (e.g.the physician's office suite) as the unlicensed person to whom the medical task has been delegated while the medical task is being performed. "On-site supervision" does not require the physician's presence in the same room. *http://aama-ntl.org/employers/state-scope-of-practice-laws*

Q) We have some confusion as to what happens when a provider leaves one practice and moves to another. We have a new Physician Assistant (PA) who will be bringing patients with her to our practice. How do we report services for these patients since they are new patients to the practice and the physician but not to the PA?

A) The patients the PA brings to the practice, if seen by the PA within the last 3 years would be considered established patients. If these patients are seen by another provider in the practice, they would be considered new patients since there has been no face to face service. This may cause a lot of confusion with the office staff. It may be better to report all these patients as established. Note that the 99203 and 99214 Evaluation and Management service elements are similar in that both require a detailed history and exam. It's the Medical Decision Making that differs. 99203 is low complexity whereas 99214 is moderate.

Q) With drug pricing being the way it is, is it okay for Medicare patients to purchase their own drugs or biologicals for the office to administer?

A) According to the Internet Only Manual (IOM) 100-02, Medicare program provides limited benefits for outpatient drugs. The program covers drugs that are furnished "incident to" a physician's service provided that the drugs are not usually self-administered by the patients who take them.

Generally, drugs and biologicals are covered only if all of the following requirements are met:

- They meet the definition of drugs or biologicals (see §50.1);
- They are of the type that is not usually self-administered. (see §50.2);
- They meet all the general requirements for coverage of items as incident to a physician's services (see §§50.1 and 50.3);
- They are reasonable and necessary for the diagnosis or treatment of the illness or injury for which they are administered according to accepted standards of medical practice (see §50.4);
- They are not excluded as non-covered immunizations (see §50.4.4.2); and
- They have not been determined by the FDA to be less than effective. (See §§50.4.4).

Medicare Part B does not generally cover drugs that can be self-administered, such as those in pill form, or that are used for self-injection. However, the statute provides for the coverage of some self-administered drugs. Examples of self-administered drugs that are covered include blood-clotting factors, drugs used in immunosuppressive therapy, erythropoietin for dialysis patients, osteoporosis drugs for certain homebound patients, and certain oral cancer drugs.

There are limited Medicare benefits for outpatient drugs. Drugs and/or biologicals purchased by the patient under their Part D program and taken to their physician's office for administration are not covered and only the administration can be reported with a notation of the drug purchase through the Part D program in item 19 on the CMS1500 claim.

For more information see: Centers for Medicare & Medicaid Services (CMS) Benefit Policy Manual, Publication 100-02, Chapter 15, §§50 & 60.1A ❖

In The Know.....

Do you know how to identify whether your patient's Medicare coverage is primary or secondary?

As a dermatology healthcare provider, it is your responsibility to determine whether Medicare is the primary or secondary payer for the items or services you provide to its beneficiaries.

Medicare Secondary Payer (MSP) is the term generally used when the Medicare program does not have primary payment responsibility. Medicare is the secondary payer when another entity - usually a commercial health plan - has the responsibility of paying for the healthcare service before Medicare. This is identified through payer coordination of benefits (COB).

The MSP provisions apply to situations where Medicare is not the beneficiary's primary health insurance plan.

Dermatologists who are non-compliant with the MSP rule could be deemed in violation of the Mandatory Claim Submission Law. Compliance with MSP rule, under regulations, is considered part of the agreement to participate in the Medicare program. This violation can result in:

- loss of contract to provide services to Medicare beneficiaries;
- subjection to provider audits

Though Medicare may be the primary payer for beneficiaries who are not covered by other types of health insurance, it may also be the primary payer in certain instances, provided several conditions are met.

The following identifies some common circumstances when Medicare and other health coverage are present, and which entity will be considered the primary or secondary payer.

— see **IN THE KNOW** on page 8

In The Know…..

— continued from page 7

Circumstance	Qualifier	Medicare Payment Status
Working Aged *Medicare beneficiaries aged 65 or older and Employer Group Health Plan (EGHP)*	• Individual aged 65 or older; • Covered by EGHP through current employment or spouse's current employment; or • Employer has 20 or more employees; • Must be enrolled in Medicare Part A	• Medicare pays Primary • GHP pays secondary
	• Individual aged 65 or older; • Covered by GHP through current employment or spouse's current employment; • Employer has 20 or more employees (or covered by multi-employer plan employing 20 or more PTE/FTE)	• GHP pays Primary • Medicare pays secondary
Disability and Employer GHP	• Individual is under 65, disabled and in active employment; • Covered by EGHP through his or her own current employment (or through a family member's current employment); • Employer has 100 or more employees (or at least one employer is a multi-employer group that employs 100 or more individuals)	• GHP pays Primary • Medicare pays secondary
End-Stage Renal Disease (ESRD):	• Individual has ESRD; • Covered by EGHP through his or her own current employment (or through a family member's current employment); • Is in the first 30 months of eligibility or entitlement to Medicare	• GHP pays Primary, • Medicare pays secondary during 30-month coordination period for ESRD
	• Individual has ESRD; • Covered by a Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA plan)****; • Is in the first 30 months of eligibility or entitlement to Medicare	• COBRA pays Primary • Medicare pays secondary during 30-month coordination period for ESRD
	• Individual is age 65 or older; • Covered by Medicare & COBRA	• Medicare pays Primary; • COBRA pays secondary
	• Individual is disabled and covered by Medicare & COBRA	• Medicare pays Primary • COBRA pays secondary
Retiree Health Plans	• Individual is age 65 or older; • Has an employer retirement plan	• Medicare pays Primary • Retiree coverage pays secondary
No-fault Insurance and Liability Insurance	• Individual is entitled to Medicare; • Was in an accident or other situation where no-fault or liability insurance is involved	• No-fault or Liability Insurance pays Primary for accident or other situation related health care services claimed or released • Medicare pays secondary *(When there is evidence that the no-fault insurer, liability insurer, or Workers' Compensation plan will not pay promptly, Medicare may make a conditional payment. A conditional payment is a payment Medicare makes for services another payer may be responsible for. Medicare makes this conditional payment so that the beneficiary won't have to use his/her own money to pay the bill. The payment is "conditional" because it must be repaid to Medicare when a settlement, judgment, award or other payment is made)*
Workers' Compensation (WC) Insurance	• Individual entitled to Medicare; • Covered under WC due to a job-related illness or injury	• W/C pays primary for health care items or services related to job-related illness or injury claims. (Medicare generally will not pay for an injury or illness/disease covered by W/C) • If all or part of a claim is denied by W/C on the grounds that it is not covered by W/C, a claim may be filed with Medicare. • Medicare may pay a claim that relates to a medical service or product covered by Medicare if the claim is not covered by W/C. • Prior to settling a W/C case, parties to the settlement should consider Medicare's interest related to future medical services and whether the settlement is to include a Workers' Compensation Medicare Set-aside Arrangement (WCMSA).

*****Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) – the law that provides continuing coverage of group health benefits to employees and their families upon the occurrence of certain qualifying events where such coverage would otherwise be terminated.*

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

Dermatology Practice Responsibility Under MSP

- Part B provider (i.e., physicians and suppliers):Request updated insurance profiles from beneficiary frequently;
- Inquire with beneficiary at each visit about insurance coverage or any changes thereof;
- Follow rules to obtain MSP information regarding beneficiary
- Group health coverage through employment
- Non-group health coverage from injury or illness; and
- Submit correct MSP coding on your claims including MSP type, explanation of benefits (EOB) form with all appropriate MSP information to the designated carrier. If submitting an electronic claim, provide the fields, loops, and segments needed to process an MSP claim.

Part A institutional provider (i.e., hospitals):

- Obtain billing information prior to providing hospital services. It is recommended that you use the CMS questionnaire, or a questionnaire that asks similar types of questions; and
- Submit any MSP information to the intermediary using condition and occurrence codes on the claim.

Federal law takes precedence over state laws and private contracts. Even if an entity believes that it is the secondary payer to Medicare due to state law or the contents of its insurance policy, the MSP provisions would apply when billing for such services.

The information above provides only a very high-level overview of the MSP provisions. See 42 U.S.C. 1395y(b) [section 1862(b) of the Social Security Act] and 42 C.F.R. Part 411, for the applicable statutory and regulatory provisions at *https://www.ssa.gov/OP_Home/ssact/title18/1862.htm*.

For more information on who pays first, see decision tree at: *https://med.noridianmedicare.com/documents/10521/2055738/MSP+Who+Pays/86269829-6eff-41e0-9639-dde7b3c6277a*

Now You Are In The Know!