CMS Releases Dermatology Specific Comparative Billing Report (CBR) on the Use of Modifier 59

In January 2015, the Centers for Medicare and Medicaid Services (CMS), released a Dermatology specific Comparative Billing Report on the use of modifier 59. To accomplish this, CMS enlisted the help of eGlobalTech (eGT) and Palmetto GBA to develop and disseminate the report. CMS announced this was done based on a 2005 Office of Inspector General (OIG) report, and indicated that 40% of dermatology claims audited, did not conform to CPT guidelines for the use of modifier 59. 

CBRs are designed as an educational tool for providers on their billing or referral patterns for pre-determined topics, in this case, the use of modifier 59. Each CBR contains data-driven tables and graphs with an explanation of findings that compare providers' billing patterns to those of their peers in their state and across the nation for claims filed with modifier 59. These reports are only made available to the providers who receive them, and not shared with anyone else.

The January 2015 report, CBR201501, contained analysis for Dermatology's use of Modifier 59 which included review of codes 11101 and 17003 as well as the following:

- modifier 59 applied to E/M service codes;
- multiple administration of same injectable drug code;
- appending modifier 59 to wrong code combination that does not appear in the NCCI edit list;
- use of other possible modifier appropriate to report circumstances than modifier 59 (e.g. 76 for repeat procedures).

According to eGT, CBR201501 -

- Was sent to approximately 5,100 dermatologists.
- CBRs are strictly educational;
- CBRs are only sent to those considered to be outliers;
- The reports are not shared with MACs, RACs, or anyone else; and
- No punitive action will be taken as a result of the information that is gathered.

Comparison and Methodology

The American Academy of Dermatology (AAD) reached out to eGT seeking clarification on the comparison and methodology that was used for this CBR. They informed us that the data reviewed indicated that the claims used for the study, were correctly coded with both the primary procedure code, as well as the add-on code, e.g. 17000, 17003 or 11100, 11101. However, there were circumstances when both the primary and the add-on code were appended with modifier 59.

Though most of these claims will be paid, they will be identified as part of incorrect coding upon post payment review, for example in the Comprehensive Error Rate Testing (CERT) program. The CERT program, evaluates a statistically valid random sample of claims to determine if they were paid properly under Medicare coverage, coding and billing rules or an Office of Inspector General (OIG) review of Medicare reimbursement patterns such as the one conducted in 2005.

It was further indicated, that the 'peer comparison' was based on ‘Dermatology’ as a specialty and did not take into consideration any dermatology sub-specialties. For example, general dermatologists were compared to surgical dermatologists etc. The AAD has requested that eGT consider refining the comparison process to ensure that surgical dermatolo-
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gists are compared to other surgical dermatologists with similar practice profiles and similarly, general dermatologists to be compared with their peers etc.

Examples of Appropriate Use of Modifier 59

It is important that dermatology practices know the appropriate use of modifier 59 to avoid claim audits. Appending modifier 59, or any modifier, on an add-on code is inappropriate, unless your payer specifically requests you to do so.

For example:

17000 -59 OR 11301 OR 11603 -59
+17003
11100 -59
11100 - 59
17110
+11101
11101
17110

Modifier 59 – Distinct Procedural Service – is used to identify procedures/services, other than evaluation and management services (E/M), that are normally reported together, but are appropriate under the circumstances.

Documentation must support 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 provider to the same patient.

It is not appropriate to use modifier 59 where another established modifier more descriptive of the circumstances is available to be used. Modifier 59 should only be used as modifier of last resort.

The table to the right indicates examples of CPT code combinations with modifiers.

<table>
<thead>
<tr>
<th>Column1/Column 2 Edits</th>
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<tbody>
<tr>
<td>Column 1</td>
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More information on appropriate use of modifier 59 can be found in the National Correct Coding Initiative (NCCI) edits at http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html

The Troubles with Modifier 59 and the X modifiers

In August of 2014, the Centers for Medicare and Medicaid Services (CMS) issued MedLearn MM8863 which introduced a new set of X (EPSU) modifiers effective on January 5, 2015. The X-modifiers are a sub-set of modifier 59, but do not replace modifier 59 itself. They will never be reported with modifier 59 and should never be required if one of the “more specific” modifiers is appropriate. If a National Correct Coding Initiatives (NCCI) Procedure to Procedure (PTP) edit does not exist, CMS carriers have stated that modifier 59 should not be appended nor will any of the subset modifiers be required.

— see MODIFIER 59 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.

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The table to the right indicates examples of CPT code combinations with modifiers.
The Troubles with Modifier 59 and the X modifiers

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The X (EPSU) modifiers are:

**XE**—Separate encounter, a service that is distinct because it occurred during a separate encounter. This modifier should only be used to describe separate services performed during different encounters on the same date of service when a PTP edit exists between the CPT codes being reported.

**XS**—Separate structure, a service that is distinct because it was performed on a separate organ/structure. This modifier should only be used to report services performed on the same date by the same physician on different organs/structures when a PTP edit exists between the CPT codes being reported.

**XP**—Separate practitioner, a service that is distinct because it was performed by a different practitioner. This modifier should only be used to report services performed on the same date by the same physician (or a physician of the same specialty or group) performed at the same encounter when a PTP edit exists between the CPT codes being reported.

**XU**—Unusual non-overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service.

CMS assumes correct CPT coding rules are followed when codes are submitted and the edits will be bypassed only when the rules are met (ie, separate organ system, separate encounter).

There has been a great deal of confusion around the appropriate use of these X modifiers and CMS has not provided enough clarification on their appropriate use. Because of the uncertainty, CMS has issued new instructions (SE1503) to continue using Modifier 59 until there are more specific details issued from your local Medicare carrier.

**Why were the X modifiers created?**

The Office of inspector General (OIG) believes modifier 59 is widely overused and sometimes abused with “a projected Comprehensive Error Rate Testing (CERT) error rate in 2013 of $2.4 billion in Medicare Physician Fee Schedule (MPFS) payments that were made on lines with modifier -59, with a $320 million projected error rate”.

Modifier 59 defines a surgical service that is separate and distinct from one procedure which may be considered bundled or mutually exclusive to another procedural service. These edits are found in the National Correct Coding Initiatives (NCCI) located on CMS’ website. They allow code sets an option to be allowed, not allowed or not applicable.

The biggest problem with modifier 59 is that its use is so varied. It identifies separate encounters, anatomical sites and/or distinct services. Many times modifier 59 edits make a payment allowance never intended by CMS. It is frequently abused because its use allows payment whether the bundled service(s) is appropriate or not. CMS is well aware of its easy “fix.” Appending a 59 without reasonable coding convention and it still gets paid especially for a denied claim. The hope is for a better coding option with added education which will reduce the overpayment errors.

CMS, as we understand, will selectively require a more specific X(EPSU) modifier for billing certain codes at high risk for incorrect billing. For example, a particular National Correct Coding Initiative (NCCI) code pair may be identified as payable only with the XS, separate structure modifier but not the 59 or other X (EPSU) modifiers. The X (EPSU) modifiers are more selective versions of modifier 59; it would be incorrect to include both modifiers on the same line.

Modifier 59 should be the modifier “of last resort” to unbundle a distinct surgical service. A clear understanding of the National Correct Coding Initiative is needed to be able to append modifiers correctly. CMS has a simple information manual that explains their Excel spreadsheet use on their website [www.cms.gov/ncci](http://www.cms.gov/ncci).

Presently, Academy coding staff suggests, not to use the X (EPSU) until your local Medicare carrier or commercial payer advise how to report them. Check with their website.

**What to do while waiting for CMS’ update to the X modifiers?**

Correct coding of modifiers can be found in many places. The CMS NCCI edit website lists an educational manual, *How to use the National Correct Coding Initiative Tool* in which the edits are explained on a spread sheet. A second resource is surgical bundling information, in the *Policy Manual for Medicare Services*. The *AMA CPT Coding Book* and the *AAD’s Coding and Documentation Manual* are other sources for modifier information. An overlooked resource is Medicare’s instruction of modifier use from the *National Physician Fee Schedule Relative Value File*. This is specific to surgical procedures as to what CMS considers bilateral, assistant at surgery, etc.

**National Correct Coding Initiative (NCCI) edits**

NCCI edits, also referred to as NCCI Procedure to Procedure (PTP) edits; identify code combinations, reported as Column 1 and Column 2. CMS considers the Column 2 code to be a “subset” (or bundled or mutually exclusive) of the Column 1 code, and the two codes are not reportable together unless specific requirements are met. To use a modifier to bypass an edit for reimbursement of both procedures is inappropriate.

For example, as Table 1 shows, CPT code 11900 (intralesional injection) is inclusive to CPT code 17000 (premalignant destruction), if they are performed at the same lesion site. This does not reflect an accurate coding example because the injection should not be used for an anesthetic agent which is not separately reportable. However, CMS identified an abuse pattern and created the edit to ensure proper claim payment.

If a dermatologist performs an excision (11400) with benign lesion destruction (17110), both codes are reportable and a modifier will be necessary to “bypass” the edit. 11400 is mutually exclusive to the 17110 which...
The Troubles with Modifier 59 and the X modifiers

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requires 11400 to be modified. The medical necessity documentation of both procedures will support reporting both codes with the appropriate modifier. According to CMS, there must be a NCCI procedure to procedure (PTP) edit, which in this case there is, to require a modifier. Otherwise it is not needed.

<table>
<thead>
<tr>
<th>Col 1</th>
<th>Col 2</th>
<th>Effect Date</th>
<th>Allowance</th>
</tr>
</thead>
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</tr>
<tr>
<td>17110</td>
<td>11400</td>
<td>19990101</td>
<td>1</td>
</tr>
</tbody>
</table>

The American Medical Association’s Current Procedural Terminology (CPT) manual, instructs that “when another, already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive a modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used?” November 2012, CMS issued the same coding instruction in Transmittal 1136.

What are these modifiers that should be reported before the X (EPSU) and 59 modifier? There are CMS guidelines for more specific information; check with your local carriers who may have different policies.

**Modifier 50 - Bilateral procedure**

There are only a few CPT procedure codes Dermatology reports for a bilateral procedure. The most common is the Unna Boot (29450) and the newer CPT codes for the applications of multi-layer compression systems (29581 to 29584.)

According to the American Medical Association, “Modifier 50 is used to report bilateral procedures that are performed at the same operative session” (by the same physician). “Bilateral procedures are procedures typically performed on both sides of the body. The intent of this modifier is for it to be appended to the appropriate unilateral code as a one-line entry on the claim form indicating that the procedure was performed bilaterally.”

Modifier 50 is used to identify bilateral procedures, which are typically performed on both sides of the body (mirror image) during the same operative session. To determine if Modifier 50 would apply to a procedure code(s), it would be best to review the AMA CPT code description itself or Medicare’s National Physician Fee Schedule Relative Value File under the bilateral column. If this column lists the number one (1) - a bilateral modifier 50 is allowed for that specific code. Bilateral procedures (2 units) are reported with one procedure code (one unit), appended with modifier 50. This information should appear on the claim as one line item, with a unit number of 1 to indicate the procedure was performed bilaterally. A bilateral code, allowable fee needs to be increased by 150%.

If the service is performed on either side of the body, it may be appropriate use of HCPCS Level II RT (right) and LT (left) modifiers, but not used when modifier 50 applies.

**Modifiers LT (Left) and RT (Right)**

Modifiers LT (Left Side) and RT (Right Side) apply to codes identifying procedures that usually can be performed on paired organs, such as ears, eyes, nostrils, and extremities.Modifiers RT and LT should be used together whenever a procedure is performed on both sides. CMS requires these modifiers whenever they are appropriate. According to the X (EPSU) modifier preview, RT and LT modifiers are more specific when performing a right arm procedure (biopsy) with lesion destruction of left shoulder during the same operative session. It’s reported as 11100 RT and 17110 LT. Payers and claim editing systems still vary on the acceptance of these informational modifiers and may still require modifier 59 in addition to the anatomic modifiers (RT and LT).

**Modifier 76 Repeat Procedure**

CMS carriers are requiring Modifier 76 (repeat procedure by the same physician or other qualified healthcare provider) be appended to a second duplicate CPT code instead of modifier 59. Not all CMS contractors or private payers follow these same guidelines. If the exact same CPT code is reported twice without a modifier 76, CMS will deny it as a duplicate service. Instead of using modifier 59 (which indicates same procedure, separate location or structure), some carriers encourage the use modifier 76, while others say to use units. CMS does not want modifier 59 used in this scenario.

**Anatomical Modifiers**

The most specific modifiers are the eyelid (E1-E4), finger (FA-F9) and the toe (TA-T9) modifiers, but CMS may require both these specific modifiers and modifier 59 be reported if the same CPT code is used twice in the same session such as when repairing an eyelid. The modifiers alone should suffice without the 59 modifier.

**Fingers & Eyelids**

| FA – Left hand, thumb |
| F1 – Left hand, second digit |
| F2 – Left hand, third digit |
| F3 – Left hand, fourth digit |
| F4 – Left hand, fifth digit |
| F5 – Right hand, thumb |
| F6 – Right hand, second digit |
| F7 – Right hand, third digit |
| F8 – Right hand, fourth digit |
| F9 – Right hand, fifth digit |
| E1 – Left upper eyelid |
| E2 – Left lower eyelid |
| E3 – Right upper eyelid |
| E4 – Right lower eyelid |

**Toes & Right and Left**

| TA – Left foot, thumb |
| T1 – Left foot, second digit |
| T2 – Left foot, third digit |
| T3 – Left foot, fourth digit |
| T4 – Left foot, fifth digit |
| T5 – Right foot, thumb |
| T6 – Right foot, second digit |
| T7 – Right foot, third digit |
| T8 – Right foot, fourth digit |
| T9 – Right foot, fifth digit |
| LT – Left side |
| RT – Right side |

We will update our members once more specific X (EPSU) information is available. Also check for more information on AAD’s Website. [www.aad.org/practicemanagement](http://www.aad.org/practicemanagement)
Billing for Drugs and Biologicals in your practice – Dose versus Units

Recently, the Centers for Medicare and Medicaid Services (CMS) indicated that they have noticed an increase in erroneous billing for injectable drugs and biologicals by healthcare providers: MLN # SE1316 http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1316.pdf.

Did you know that there are guidelines in place that help to accurately report and bill for unused drugs or biologicals from single use vials or single use packages that are appropriately discarded? For example, these guidelines may be applicable in cases when a dermatologist or other qualified healthcare provider discards the remainder of a single use vial or other single use package after administering a dose or quantity of the drug or biological to a patient. The guidelines allow payment for the amount of drug or biological discarded as well as the dose administered, up to the amount of the drug or biological as indicated on the vial or package label.

Coding guidelines require healthcare providers to bill the total dose of injectable drugs, used or discarded, using the same drug Healthcare Common Procedure Coding System (HCPCS) J-code.

Use of JW Modifier

In order to accurately report the discarded portion of the drug, your local Medicare Administrative Contractor(s) (MACs) may require the use of the modifier JW - Drug amount discarded/Not administered to any patient to identify the unused drug or biologicals from single use vials or single use packages that are appropriately discarded.

This modifier, when billed on a separate line of the claim, will allow payment for the amount of discarded drug or biological.

For example, a single use 100 unit vial, has 95 units administered to a patient with the remaining 5 units discarded. In this case, the 95 unit dose is billed on one line, while the discarded 5 units may be billed on another line with modifier JW - Drug amount discarded/Not administered to any patient. Both line items would be processed for payment. The JW modifier is only applied to the amount of drug or biological that is discarded.

The JW modifier is not permitted when the actual dose of the drug or biological administered is less than the billing unit. For example, one billing unit for a drug is equal to 10 mg of the drug in a single use vial. A 7 mg dose is administered to a patient while 3 mg of the remaining drug is discarded. The 7 mg dose is billed using one billing unit that represents 10 mg on a single line item.

Example1:

A dermatologist administers 7 units of Bleomycin to a patient from a 15 unit dose vial. The Bleomycin HCPCS code, J9040, represents 15 units as a single dose. Since the patient did not receive the remaining 8 units, you cannot bill the unused drug with a JW modifier because the HCPCS code represents a single dose vial of 15 units, therefore, the code cannot be split into two lines.

Correct coding requires you to bill this as one unit to represent the 15 unit code J9040. Payment for the entire 15 unit dose will be made for a single dose vial on a single claim line even where you only administered 7 units to the patient and the remaining 8 units were appropriately discarded.

Example2:

A Dermatologist administers 70 units of onabotulinumtoxin A (e.g., Botox) to a patient from a 100 unit single-use vial. The HCPCS code J0585 defines its measure as 1 unit. This encounter will be billed with HCPCS J0585 x 70 units. Because the patient or another unrelated patient did not receive the remaining 30 discarded units, one can bill the unused drug with a JW modifier because the single dose vial represents 100 units.

Correct coding requires you to bill HCPCS J0585 per each unit administered and the discarded on a separate claim line to equal the 100 unit single-use vial.

Example3:

20 mg of Triamcinolone Acetonide is drawn up into a syringe. 15 mg of the material is injected intralesionally and the rest is discarded. HCPCS code, J3301, is based on up to 10 mg as the unit dose for Triamcinolone Acetonide. For billing purposes, you would bill J3301 X 2 for the 15 mg injected and discard the unused 5 mg. The unused, discarded portion of the drug cannot be billed.

This claim would not be split into two lines because the administered drug and that discarded (5 mg) equal the maximum unit dose that the payer will approve for payment.

Example4:

A Dermatologist administers 70 units of Botox to a patient from a 100 unit single-use vial. The HCPCS code, J0585, defines measure of unit as 1 unit. This encounter will be billed with HCPCS J0585 X 70 units. Because the patient did not receive the remaining 30 units, you cannot bill the unused drug with a JW modifier because the HCPCS code represents a single dose vial of 100 units.

Correct coding requires you to bill this as one unit to represent the 100 units code J0585. Payment for the entire 100 unit dose will be made for a single dose vial on a single claim line even where you only administered 70 units to the patient and the remaining 30 units were appropriately discarded.

In order to appropriately bill for drugs and biologicals, you need to understand the HCPCS code definition for the injection that you are billing and whether it is a single- or multiple-dose vial.

The dosage in the HCPCS definition is used to determine the correct number of units billed for each individual drug. A second line may be added to indicate any discarded amount from a single-dose vial.

— see BILLING FOR DRUGS AND BIOLOGICALS on page 6
Billing for Drugs and Biologicals in your practice—Dose versus Units

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CMS and your local Medicare Carrier encourage providers to use drugs and biologicals in a clinically appropriate and efficient manner to minimize waste. The documentation in the patient’s medical record must clearly reflect the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain. This kind of detailed documentation helps benefit your practice by justifying your billing in the event a medical review should occur.


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CMS Advance Beneficiary Notices (ABN)

An Advance Beneficiary Notice is a vehicle to protect both the patient and the provider under the Fee-for-Service (FFS) Medicare and the Medicare Advantage (MA) Programs. The benefit of an ABN is that it serves as a warning to the patient that Medicare may not pay for the services the provider recommends, therefore giving notice to that patient that they will have to pay for the service should Medicare reject the claim. Should the claim be denied once it has been submitted, the patient still has the right to file an appeal.

The Advance Beneficiary Notice (ABN-G) is used by providers, physicians, practitioners, and suppliers for situations where Medicare coverage for reimbursement is questionable. There are special modifiers used to request Medicare's determination of the financial liability of the service.

The ABN modifiers are reported on the claim line of the CPT code(s) that are questionable and may not be reasonable or medically necessary for reimbursement.

These are the different modifiers with case scenarios:

- **Modifier GA** appended to procedural/service code on claim line, it states an ABN is signed by the patient who was advised Medicare may deny a questionable service which may transfer the financial liability with the estimated cost to the patient. Usually the services are covered under a Local Coverage Determination (LCD) but there may be doubt to it being reasonable or medically necessary. The use of this modifier doesn’t impact Medicare unless the service is not medically necessary. The routine use of an ABN with the GA waiver for all services performed would not be appropriate to Medicare guidelines. If Medicare denies the claim, the claim denial will be medical necessity and noted in the patient’s explanation of benefits (EOB).

- **Modifier GY** is appended to the claim line of a non-covered (usually a cosmetic) procedure. It advises Medicare that this service is statutorily excluded or does not meet the definition of any Medicare benefit. This modifier helps in cases where the patient asks for the claim to be filed for secondary carrier coverage. Per the Social Security Act, a physician must file a claim if asked by a beneficiary.

- **Modifier GX** is an informational notice of liability. It is similar to Modifier GY in that the service is statutorily excluded but in this case, an advance beneficiary notification (ABN) was signed by the patient. This is a good modifier for dermatology practices to use for their cosmetic patients to protect themselves from an accidental filing of a statutorily excluded claim.

- **Modifier GZ** is used to indicate that Medicare is expected to deny the item or service as not reasonable and necessary and the provider does not have an advance beneficiary notification (ABN) signed by the beneficiary. According to CMS, these claims will be denied with no appeal rights.

More information on appropriate ABN and related modifier use is available at: [http://www.cms.hhs.gov/BNI/01_overview.asp](http://www.cms.hhs.gov/BNI/01_overview.asp)

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New Illinois Pathology Billing Law

At the start of each new year, dermatology practices face the challenge of staying on top of important changes related to patients, payments and compliance requirements. For Illinois dermatology practices, the new year—2015—brought an important change related to their pathology billing. Effective January 1, 2015, a new pathology billing law came into force making Illinois the 16 state to adopt new anti-mark and disclosure requirements governing how pathology lab services are billed. This new law bans markup for pathology tests purchased from an outside lab or dermatopathologists, and requires that charges be detailed and disclosed to patients and payers. It applies to how a practice bills their non-Medicare private payers for these services.

Practices billing for dermatology pathology lab services should pay close attention to the anti-markup and disclosure requirements. For example, dermatologists supervising the slide preparation and reading their own slides in their offices will continue to be able to do so, and bill their payers. On the other hand, if the dermatologist does not supervise or perform any part of the pathology services, they can no longer mark-up the cost of the purchased test they bought from either a lab or dermatopathologist when billing a patient or insurer.

While the practice purchasing the test may charge a specimen acquisition or processing fee, this is limited to the actual costs incurred for specimen collection and transportation; this charge should be itemized and indicated as a distinct service. It’s important to note here that most private payers do not typically pay for such processing fee. If the dermatologist sends their specimen out to be prepared by a lab, but then interprets their
New Illinois Pathology Billing Law

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own slides, it would be best to have the lab bill the payer for their portion of their work (the technical component), while the dermatologist reading their own slide can bill for the interpretation portion.

In addition, the billing practice must disclose the name of the pathologist or lab that provided the pathology service and the actual amount paid for each pathology service. Finally, a patient has the right to pursue a refund request if they receive a bill that violates this law, which basically means that if the practice marks the cost and/or does not disclose who performed the test and how much it was purchased for, then it puts itself at risk and will be required to refund either the patient or their insurer.

In situations where the dermatopathology service is split so that dermatologist purchases the slide processing portion from an outside lab and then interprets their own slide, it is advisable to bill for only the portion performed while having the outside lab bill for their respective portion. A good rule of thumb would be to bill only for whatever portion the dermatology practice actually performed. Alternatively, some practices may choose to purchase slides from an outside lab, then perform their own reading in-house before billing a payer or patient. This approach, while feasible, must comply with both the anti-markup and disclosure requirements.


Compliance Guide for Dermatopathology eBook

This AAD resource will help you assess the complex compliance requirements for a number of current pathology arrangements (Anti-kickback statute, The Stark Law, regulations concerning state account billing and markups), and will provide concrete examples of pathology billing arrangements to avoid potential pitfalls. This eBook is available at https://www.aad.org/store/product/default.aspx?id=8193.

Coding Q&A

Q. An ambiguous, but low-suspicion lesion is excised with minimal surrounding, grossly normal skin/soft tissue margins, as for a benign lesion. Would this be reported using the excision of benign lesion codes 11400-11446 or the excision of malignant lesion codes 11600-11646?

A. According to AMA CPT clarification, selection of the appropriate excision code is determined by three parameters: location, maximum excised diameter (which includes the margin), and lesion type (ie, benign or malignant). If the lesion is clearly benign (eg, cyst, lipoma, prior biopsy of benign neoplasm), the excision would be coded as benign at the time of surgery (11400-11471). However, if you have a prior biopsy showing malignancy, the excision can be coded as malignant at the time of surgery (11600-11646).

Note: Coding the excision of a cutaneous lesion pending pathology (eg, lesion of unspecified behavior) as malignant before a pathology report is available could result in incorrect coding if the lesion is found to be benign on histopathologic examination. Therefore, if the lesion is not clearly benign or malignant, it is recommended that coding and billing be delayed until the pathology has been confirmed.

Q. Patient presents with irritated skin tags which are treated and reported as follows to Noridian Administrative Services (NAS):

701.9;
782.0;
11200

NAS denied claim stating relevant diagnosis code was not reported. How can one appeal this claim?

A. According to NAS LCD#24361 - Skin Lesion Removal (Excludes Actinic Keratosis and MOHS), diagnosis code 701.9 – Unspecified hypertrophic and atrophic conditions of skin is listed under List II with the following comment “These ICD-9-CM codes identify those conditions for which payment is allowed only if the conditions have complications, consistent with the provisions noted above in Indications and Limitations of Coverage, items A through G. Providers are instructed that the addition of a second diagnosis code, V49.89 Other specified conditions influencing health status, is required and by using that code, providers will be asserting that their medical record documentation includes verification of the complicating sign, symptom or diagnosis that supports payment for the lesion removal.”

In order to have this claim appropriately adjudicated, one has to include ICD-9-CM code V49.89 as a secondary diagnosis but only for Noridian.

Q. My patient is asking for an ACA preventive skin screening, is that covered and how is that reported?

A. According to the Affordable Care Act (ACA) Implementation, FAQs - Set 18, coverage of Preventive Services are evidenced-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (USPSTF) with respect to the individual involved, except for the recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention issued on or around November 2009, which are not considered current. If a recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of that service, the plan or issuer can use reasonable medical management techniques to determine any coverage limitations. These requirements do not apply to grandfathered health plans.

The United States Preventive Services Task Force (USPSTF) allows for a consultation of appropriate sun protection clothing for a child. Presently, skin screening prevention service is listed on the “C” recommendations until there is enough evidence-based literature. The Academy is working to change this.

--- see Q&A’s on page 8 ---
In The Know.....

Medicare Announces January ICD-10 End-to-End Testing Results

During the week of January 26 through February 3, 2015 Medicare Fee-For-Services (MFFS) healthcare providers, clearing houses and billing agencies participated in the first successful ICD-10 end-to-end testing week for 2015 with Medicare Administrative Contractors (MACs).

The Centers for Medicare and Medicaid Services (CMS) announced that all providers that volunteered to participate were included in this end-to-end testing week.

Below is a breakdown report from CMS:

<table>
<thead>
<tr>
<th>Total Number of Participants</th>
<th>661</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Number of Provider NPIs</td>
<td>1,400 registered to do the testing (equally split between direct claim submitters and clearing houses/billing agencies)</td>
</tr>
<tr>
<td>Total Number of Test Claims Received</td>
<td>14,292</td>
</tr>
<tr>
<td>Types of Claims Received</td>
<td>56% - Professional, 38% - Institutional, 6% - Supplier</td>
</tr>
<tr>
<td>Total Number of Claims Accepted</td>
<td>12,149</td>
</tr>
<tr>
<td>Percentage of Claims Accepted</td>
<td>81%</td>
</tr>
<tr>
<td>Breakdown of Claims Rejected</td>
<td>3% - Invalid submission of ICD-9-CM or ICD-9-PCS codes, 3% - Invalid submission of ICD-10-CM or ICD-9-PCS codes, 13% - Non-ICD-10 related errors e.g. incorrect NPI #, health insurance claim number, submitter ID, DOS outside the range valid for testing, invalid HCPCS code, invalid POS</td>
</tr>
</tbody>
</table>

CMS has indicated overall satisfaction with the outcome for ICD-10 testing and also reported that they did not identify any issues with any professional claims submitted during the testing week. This indicates that there were no CMS front-end system rejections.

Based on these outcomes, CMS states that they are ready to accept and adjudicate ICD-10 claims.

CMS has announced that they will provide educational sessions to healthcare providers in preparation for the upcoming testing weeks to avoid future non-ICD-10 related errors identified during the testing week.

The American Academy of Dermatology encourages dermatology practices to participate in payer or clearing house testing events as part of the ICD-10 implementation readiness. If your dermatology practice participated in the January testing week, you are automatically eligible to test again in July 2015.

For more information on participating in testing opportunities, visit https://www.aad.org/members/practice-and-advocacy-resource-center/payment-and-reimbursement/coding-resource-center/icd-10 or contact your carrier for a volunteer form.

Now you are In The Know!

Coding Q&A

— continued from page 7

The AMA CPT preventive medicine codes (9938x-9939x) should be reported by primary, pediatrics and internal medicine and not specialists. Since there are no specific CPT codes for skin screening, there are two potential suggestions. Practices can report the appropriate level of Evaluation and Management office service code (99201-99215) with a V70.0, wellness diagnosis or V76.43, melanoma skin screening. If the patient has a history of neoplasm (V10.83) or melanoma (V10.82), these diagnoses are considered primary for Medicare and should be considered. Alternatively, practices can report the unspecified E/M code, 99499 making a comment in the CMS-1500 remark box 18 that the service is a “skin screening.” The diagnosis would be the same as above.

Additional information may be found here: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs18.html

Q) If I’m removing a sebaceous cyst and it is 2 cm and I use a 8mm punch tool to core the center and dig out the cyst— what size do I use in billing? Is it the lesion diameter (2 cm) or the excision diameter (8 mm)?

A) The 2015 AMA CPT Manual clarified the use of the Musculoskeletal excisions of soft connective tissue tumors to excluded sebaceous cysts. The parenthetical instructions now point to the Integumentary section: 11400-11446 which would be reported by the diameter of lesion with the narrowest of margins.

Now you are In The Know!