Derm Coding Consult

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Tips for Managing the Advance Beneficiary Notice Process

What is an ABN?
An advanced beneficiary notice (ABN) is a written notice that every qualified healthcare provider (QHP) participating in Medicare programs must provide patients before furnishing items or services that are usually covered by Medicare, but under certain circumstances, are expected not to be covered.

How does an ABN work?
The ABN allows the patient to make an informed decision about whether to receive the item or service that may potentially not be covered and accept financial responsibility for the service or items, if Medicare does not pay for them.

What happens if a practice doesn't give a patient an ABN?
If the patient does not get a written notice when required, he/she may not be held financially liable if Medicare denies payment. This may cause the QHP to be financially liable for the unpaid service. When an ABN is required and the QHP fails to issue one, or if Medicare finds that the ABN is invalid and the provider knew or should have known that Medicare would not pay for a usually covered item or service, the QHP may be financially liable for the unpaid service and cannot ask the patient to pay for the service.

Refunds are considered timely when they are made within 30 days after you received the Remittance Advice from Medicare or within 15 days after a determination on an appeal, if you or the beneficiary files an appeal CMS source.

What if the patient paid beforehand?
If payment was previously collected from the patient, the QHP must refund the patient the proper amount in a timely manner. The ABN is used for Medicare Part B (outpatient) and Part A (limited to hospice, home health agencies, and religious nonmedical healthcare institutions only) items and services.

What happens if the practice complied with the ABN protocols, but Medicare pays for the service?
When an ABN is required and the patient is notified that the item or service provided is not covered, but the patient has signed the ABN form, the practice can seek payment from the patient directly at the time of service. If by chance, Medicare pays all or part of the claim for items or services previously paid by the patient, the practice is required to refund the patient any and all amounts in a timely manner.

When to issue an ABN?
Most practices struggle with the appropriate use of the ABN and its modifiers. An ABN must be completed and issued to the patient at the time of service when,

- The QHP believes that Medicare may not pay for an item or service;
- Medicare usually covers the item or service; and
- Medicare is expected to deny payment for the item or service because it is not medically reasonable and necessary for the patient at this time eg. not considered reasonable and necessary under Medicare program standards or service or

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IMPORTANT Please Route to:
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therapy is in excess of Medicare capped amounts and does not qualify for a cap exception.

What are medical necessity criteria?

Medicare will routinely deny an item or service as not medically reasonable and necessary when it is considered:

- ✓ Experimental and investigational or considered "research only";
- ✓ Not indicated for diagnosis and/or treatment in the case;
- ✓ Not considered safe and effective; or
- ✓ More than the number of services Medicare allows in a specific period for the corresponding diagnosis.

CMS: *To be considered medically necessary, services must meet specific medical necessity requirements contained in the statute, regulations, and manuals and specific medical necessity criteria defined by the National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) (if any exist for the services being reported).*

Issuing an ABN voluntarily?

A practice is not required to notify the patient before furnishing a statutorily excluded service for services and items that are known and documented under Medicare policy that it is not a Medicare benefit. However, the practice can choose to issue a voluntary ABN or other financial consent as a courtesy to inform the patient about his/her forthcoming financial liability. When an ABN is issued voluntarily, it has no effect on financial liability and the beneficiary is not required to check an option-box or sign and date the notice.

For more information and a complete list of Medicare non-covered services, see the MLN publication, "Items and Services That Are Not Covered Under the Medicare Program" at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Items-and-Services-Not-Covered-Under-Medicare-Booklet-ICN906765.pdf*.

Completing the ABN

The ABN should be:	
• Issued (preferably in person) to and understood by the Medicare patient or his/her representative, for the purpose of giving notice under applicable state or other law.	• Explained in its entirety with all questions related to the ABN answered
• Completed on the approved, standardized notice format, with all required blanks completed. You may include attachments that list additional items and services. Medicare permits limited customization, such as preprinting information in certain blank fields of the ABN form.	• Signed and dated by the patient or his/her representative after he/she selects one option box. If you issue the ABN on an electronic screen, you must ask the beneficiary if he/she prefers a paper version and issue a paper ABN if he/she prefers such. You should retain a copy and give the beneficiary a paper copy (whether the ABN is signed on paper or electronically). If you maintain electronic medical records, you may scan the signed hard copy for retention.
• Issued far enough in advance of potentially non-covered items or services to allow sufficient time for the patient to consider available options.	• Kept for 5 years from the date-of-care delivery when no other requirements under state law apply. Medicare requires you to keep a record of the ABN in all cases, including when the patient declined the care, refused to choose an option, or refused to sign the ABN.

Claim Reporting and Use of ABN Modifiers

Report the procedure or Current Procedural Terminology® (CPT®) code as usual to Medicare and append the appropriate ABN modifier. The chart below provides the claim-reporting modifiers associated with ABN use.

— see **ADVANCE BENEFICIARY** 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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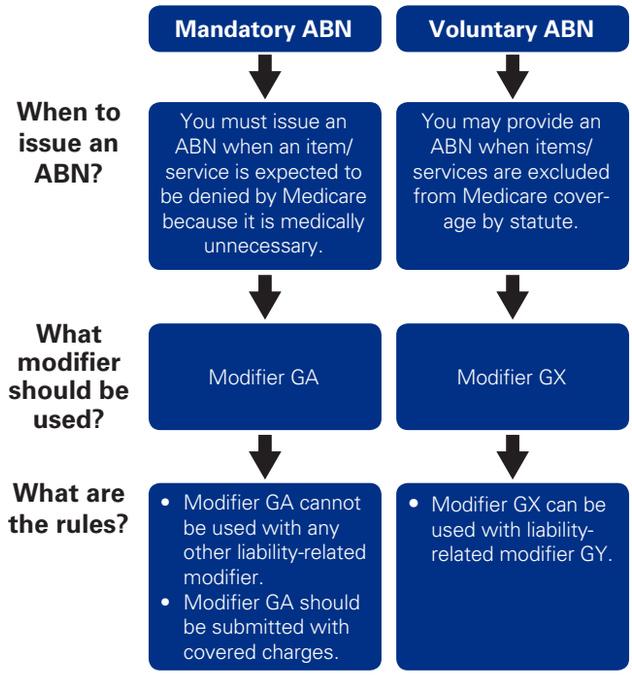
	Modifier	When to Use the Modifier
GA	**Waiver of Liability Statement Issued as Required by Payer Policy, Individual Case**	Report when you issue a mandatory ABN for a service as required and it is on file. You do not need to submit a copy of the ABN, but you must have it available upon request.
GX	**Notice of Liability Issued, Voluntary Under Payer Policy**	Report when you issue a voluntary ABN for a service Medicare never covers because it is statutorily excluded or is not a Medicare benefit. You may use this modifier in combination with modifier GY.
GY	**Item or Service Statutorily Excluded, Does Not Meet the Definition of Any Medicare Benefit**	Report that Medicare statutorily excludes the item or service or the item or service does not meet the definition of any Medicare benefit. You may use this modifier in combination with modifier GX.
GZ	**Item or Service Expected to Be Denied as Not Reasonable and Necessary**	Report when you expect Medicare to deny payment of the item or service due to a lack of medical necessity and no ABN was issued.

For more information on the appropriate use of ABN, see MLN publication, "Medicare Advance Beneficiary Notices" at *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/abn_booklet_icn006266.textonly.pdf*.

ABN Flowchart



Source: Flowchart is reproduced from High-Risk Areas in Medicare Billing Current Developments Newsletter © 2010 by Strategic Management Systems, Inc. and Atlantic Information Services, Inc.

Modifier 25 Audits

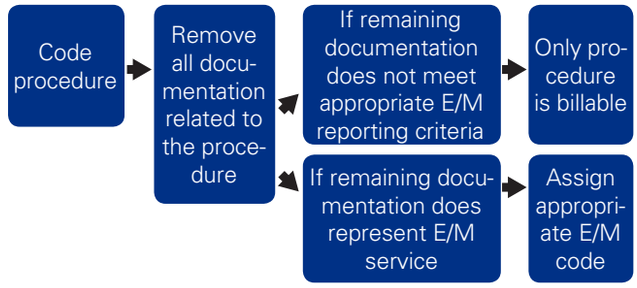
Anthem announced that beginning in the fourth quarter of 2017 it would begin performing audits related to modifier 25 usage. Anthem may contact in-network physicians, particularly outliers of modifier 25, to request additional documentation related to the services billed. Anthem has indicated that if it finds discrepancies or if documentation does not justify modifier 25 usage, it could initiate recoupments as appropriate.

When is it appropriate to use modifier 25?

- Modifier 25 indicates that on the day a procedure was performed, the patient's condition required a **significant separately identifiable** E/M service **above** and **beyond** the other service or procedure provided **during the encounter**.
- **"Separately identifiable"** is work that exceeds that which is normally required to perform a procedure or included in the payment for the procedure itself.

To identify, highlight all the documentation related to performing the procedure including:		
Evaluating, examining, diagnosing the patient	Decision to perform the procedure and all portions of patient consent	Performing the procedure and providing post-operative instructions/medications

- When utilizing modifier 25, it is essential that documentation clearly reflect distinct E/M and procedure services. How can you tell if the documentation clearly reflects the distinct E/M?



Additional Reasons Payers Request Records

Dermatology practices are often inundated with medical-record requests from multiple payers looking to gather data for a plethora of reasons. Sometimes, the information within the record is needed to substantiate the level of the E/M or procedural service reported, to accomplish target-probe education reviews, (TPE) or to perform recovery audits (recovery audit contractor [RAC] audits) or zone integrity audits (ZPIC

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Additional Reasons Payers Request Records

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audits). These types of requests will usually have a negative impact on a practice's revenue cycle and, in some cases, there is potential for other types of consequences. There are, however, some additional reasons medical records are requested.

If you participate in a Medicare Advantage (MA) plan, the Affordable Care Act marketplace health plan, or a Medicaid-managed care plan, you may receive record requests that do not fall into any of the previously defined review practices. Rather, the payer is requesting the record to determine the patient's overall health risk based on all of the patient's existing medical conditions at the time of the visit. If the conditions are included within the requested documentation of the specific encounter, the payer will use this information to justify a higher rate of federal funding. This means that these plans are part of a risk adjustment (RA) payment model. Basically, these health plans will receive funding to provide coverage for their beneficiaries through an RA assessment.

The RA payment model was developed as a way to try to fairly distribute cost/funding by transferring federal dollars from plans that provide coverage for lower-risk enrollees to plans that have a larger population of high-risk enrollees.

This payment model uses an actuarial tool to evaluate the health of its members using risk scores based on patient demographic information (e.g., age, gender) and the diagnosis data reported from claims and medical record documentation. These risk scores are assigned to each beneficiary enrolled in the plan and used to predict future healthcare expenditures per member. The number of acute or chronic conditions and what illnesses the patient presents determines the level of risk assigned to each patient.

Most RA plans validate their patient population's health status by means of an RA model using hierarchical condition categories (HCCs) to rank each patient's severity of illness and to produce an RA factor (RAF) score. The RAF score is cumulative, i.e., the sicker the patient, the higher the score. The total RAF is multiplied by a conversion factor to determine the federal funding the plan receives for each patient per month.

Using diagnostic information taken from claims data, the plan will determine which enrollees have reported conditions that are included in the HCC listings. Federally funded plans such as MA plans may be subject to annual RA data validation (RADV) audits by the department of Health and Human Services (HHS). The plan must be able to validate the member's HCCs through record review.

In the validation process, the plan will seek the five best claims documentation to confirm the patient's HCC-related condition as reported in the plan's determination of the RAF. The records selected for validation are then passed on to the funding source (i.e., the Centers of Medicare & Medicaid Services [CMS]) to confirm the HCC and RAF score. Any records determined to be insufficient to support the HCC reported are discarded by the funding source and the plan is denied the RAF score for that condition.

How does this relate to your practice? Consider the following scenario.

A. A 76-year-old-female is seen by her primary care physician (PCP) with complaints of itchy varicose veins in her legs, type 2 diabetes mellitus (DM2), and congestive heart failure (CHF). She is referred to dermatology to evaluate and treat her legs. The PCP reports diagnosis codes for the varicose veins in her legs, DM2, and CHF.

   Per claims data, the raw RAF score is 1.333

PCP Claim Data RAF	
Patient/Diagnosis	**HCC**
76-year-old female	0.437
Varicose veins of lower extremity (I83)	0.410
DM without complications (E08-E13)	0.118
CHF (I09 – I51)	0.368
Raw RAF Score	**1.333**

B. The patient is then seen by the dermatologist who confirms the diagnosis of varicose veins and initiates treatment. The comorbidities of DM and CHF are noted within the documentation, however only the ICD-10-CM code for the condition treated, which, in this case, is varicose veins is reported.

Per claims data, the raw RAF score is 0.847

Dermatology Claim Data RAF	
Patient/Diagnosis	**HCC**
76-year-old female	0.437
Varicose veins of lower extremity (I83)	0.410
DM (not coded/reported)	0.0
CHF (not coded/reported)	0.0
Raw RAF Score	**0.847**

In this scenario, only two of the four possible RAFs are reported in the claims data. However, in its quest for best

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Additional Reasons Payers Request Records

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supporting documentation substantiating the reported HCCs, the plan can use encounter data that are included within the documentation but not captured in the claim to authenticate the HCC conditions reported.

The plan may request medical records from any healthcare entity that has provided medical services for the enrollee and generated a claim, including the dermatology practice in this example.

While including the additional conditions that affect or modify the assessment and plan of care may not impact the practice's bottom line at the claim level, it does impact the payer's, which may trickle-down to your practice in terms of fee schedule and plan participation. HCCs do not just appear in RA payment models. An HCC-approach is making an appearance in many emerging payment methodologies, including the cost performance components of Medicare Access and CHIP Reauthorization Act's (MACRA's) Merit-based Incentive Payment Systems (MIPS). MIPS uses a value-based payment adjustment calculated by comparing your cost for each enrollee to the per capita cost determined by the risk of your patients, and the HCCs are the bases for determining that risk. Omitting the codes for those chronic conditions that, although not managed by dermatology, impact the decision process, treatment provided, risk of complications, or healing time fails to reflect the level of risk assumed and the quality of care provided by dermatologist.

Accurate HCC assignment relies on complete medical record documentation and diagnosis coding at the highest degree of specificity. The documentation of the encounter should indicate that the diagnosis reported is being monitored, evaluated, assessed or addressed, or treated (MEAT).

For RADV, only two of the four MEAT criteria need to be documented. A simple but detailed statement is sufficient to meet this requirement. For example, in our case scenario above, a simple statement for our patient could be, "Diabetes mellitus type 2 appears controlled on Metformin and congestive heart failure is stable on Lasix. She is encouraged to continue her medications and follow-up with primary care as needed."

It is clear that HCCs are a precursor in the shift away from relative value unit (RVU)/ Current Procedural Terminology® (CPT®)-driven module of reimbursement. While not every physician will treat all of the patient's conditions, the documentation and acknowledgement of all existing comorbidities that affect or modify the care provided is becoming more and more a necessity. ❖

Appropriate Use of "Not Otherwise Classified" HCPCS/CPT® Codes

According to the American Medical Association's (AMA') Current Procedural Terminology® (CPT®) code set, correct coding requires that services be reported with the most specific code available and that appropriately describes the service performed. "Not Otherwise Classified" (NOC) codes are only to be used when a more specific CPT code or Healthcare Common Procedure Code (HCPCS) is not available.

After January 15, 2018, all claims reported with an unspecified code, even with a description in the CMS1500 Item 19 narrative box, will be rejected if there is an appropriate specific CPT or HCPCS code available.

Claims for all drugs and biologicals reported require a HCPCS/CPT code that most accurately describes the drug and/or biological. It is also important to ensure that the reported units of service for the HCPCS/CPT code are consistent with the drug quantity utilized and its description.

If the medication utilized does not have a HCPCS/CPT assigned to it, it is then appropriate to use an NOC code based on the unspecified descriptor. A description of the strength and dosage of the drug and/or biological is required in the narrative field of the claim.

Unlisted Codes for Drugs and Biologicals
J3490 -Unclassified drugs
J3590 - Unclassified biologics
J9999 - Not otherwise classified, antineoplastic drugs

These HCPCS codes are commonly used when:

- Drug/biological does not have a specific HCPCS code
- Drug/biological is administered by a route other than stated in the code descriptor

When submitting a claim, the appropriate HCPCS (specific) and national drug code (NDC) are required.

Note: The units of service for an NDC dose may not match the available dosage forms. In these cases, adjust the number of units of service billed to cover the actual amount provided as close as possible to avoid reporting fractions.

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Appropriate Use of "Not Otherwise Classified" HCPCS/CPT® Codes

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Billing NOC Drug and Biological Codes
In order for a payer to process a claim correctly using NOC codes (e.g., J3490, J3590, and J9999), report the following information in block 19 of the CMS 1500 claim form or electronic equivalent:

- Name of drug with its NDC number
- Dosage (mg, mL, etc.)
- Route of administration (IV, IM, SC, PO, etc.)

HCPCS Photodynamic Therapy Drug Codes
The advent of the new 2018 Photodynamic Therapy (PDT) codes (96573 and 96574) coincides with newly available aminolevulinic products on the market. Some have J codes, which are FDA approved with NDC numbers and a fee schedule listed on Medicare's website, but others do not. Ensure that specific drugs are reported along with their dosage, strength, and administrative route.

If you are not using these specific drugs and strength listed below, do not report them. If there is no specific drug code to report, report the NOS codes (J3490).

The 2018 HCPCS drug codes reported with PDT:

- **J7308** is a valid 2018 HCPCS code for *Aminolevulinic acid hcl for topical administration, 20%, single unit dosage form (354 mg)* or just *Aminolevulinic acid hcl top* for short, used in *medical care* as of 01/01/2004
- **J7309** is a valid 2018 HCPCS code for *Methyl aminolevulinate (mal)* for topical administration, 16.8%, 1 gram or just *Methyl aminolevulinate, top* for short, used in *Other medical items or services* as of 01/01/2018
- **J7345** is a valid 2018 HCPCS code for *Aminolevulinic acid hcl for topical administration*, 10% gel, 10 mg or just *Aminolevulinic acid, 10% gel* for short, used in *medical care* as of 01/01/2018

References

1. *Centers for Medicare & Medicaid Services. Internet Only Manual. Pub. 100-04. In: Claims Processing Manual. Chapter 17: Drugs and Biologicals. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html*. Accessed Feb 18, 2018.
2. *Centers for Medicare & Medicaid Services. Local Coverage Article: Approved Drugs and Biologicals; Includes Cancer Chemotherapeutic Agents (A53049). https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=53049&ver=51&Date=02%2f18%2f2018&SearchType=Advanced&ContrId=&DocID=A53049&bc=JAAAABgAAAAA&. Accessed Feb 18, 2018.* ❖

Pathology Billing: Successfully Navigating a "Minefield"

Billing for dermatopathology can often seem like a confusing maze, leading to frustration. One of the reasons is because there is a wide variety of arrangements and options that can be used to appropriately bill for dermatopathology services.

Failing to understand those options that work best for your dermatology practice can risk compliance headaches, leading to potential legal pitfalls and costly fines. For the past 10 years, pathology billing has been under a heightened level of scrutiny due to changing state and federal rules and regulations to curb mark-up arrangements and targeting fraud and abuse schemes.

To help dermatologists and their practice staff better understand which dermatopathology billing approach is appropriate for their practice, the Academy has developed a number of resources. These resources, which range from basic overview to more extensive and technical guidance, should be studied and used by members and their staff to keep the practice away from any legal risk and financial consequences.

The basics include articles published in *Dermatology World*:

- **Dermpath Billing: Do's and Don'ts** *https://www.aad.org/dw/monthly/2016/october/dermpath-billing-dos-and-donts*
- **Dermpath Fraud and Abuse: Six Scenarios to Consider** *https://www.aad.org/dw/monthly/2016/january/dermpath-fraud-and-abuse-six-scenarios-to-consider*

The more extensive guidance, which includes a practice management resource and Academy policy statements, can also be found online at:

- **Compliance Guide for Dermatopathology eBook** *https://www.aad.org/store/product/default.aspx?id=8193*.
- **Academy Policies on Pathology Billing** *https://www.aad.org/Forms/Policies/Uploads/PS/PS%20Pathology%20Billing.pdf*. *https://www.aad.org/Forms/Policies/Uploads/PS/PS%20Physician%20Choice%20of%20Consultant%20for%20Interpretation%20of%20Skin%20Biopsy%20Specimens.pdf* ❖

Frequently Asked Questions

Q. Is it acceptable to use the chief complaint for an HPI element (if it is repeated by the provider in the HPI)?

A. Yes, the chief complaint may be repeated within the HPI if elicited by the performing provider. *Updated 6/9/2017*

Q. Can someone other than the healthcare provider collect and document the HPI (e.g., MA)?

A. The HPI must be elicited and documented by the performing provider, because eliciting the correct scope of HPI information requires the provider's clinical skill. When the provider is utilizing the services of a scribe, the scribe may enter the information, as elicited specifically by the provider, in the medical record. *Updated 6/9/2017*

Q. Can a nurse document the chief complaint?

A. The nurse may document the chief complaint but the record must demonstrate the provider's review and acknowledgement of the complaint. *Updated 6/9/2017*

Q. In the scenario in which modifier 25 is not appropriate, do we have the choice of billing for either the E/M service or the procedure (i.e., cryotherapy for single AK, which is the patient's CC), if one reimburses higher than the other?

A. The AMA CPT instructions state that the service that was rendered must be reported. In this case, it would be the AK destruction procedure, which should be reported with code 17000. The E/M information is considered a component of the minor procedure and should not be unbundled for payment purposes.❖

In the Know...

CMS eliminates the use of modifier GT for telehealth services

Did you know that CMS has eliminated the use of modifier GT (via interactive audio and video telecommunications systems) for all professional claims for telehealth services effective January 1, 2018?

In its place, the use of the telehealth place of service (POS) code 02 was implemented in January 2017 to certify that the service meets the telehealth requirements.

CMS MLN Matters® (MM10152), which was released on November 29, 2017, announced that Change Request (CR) 10152 has revised previous guidance that instructed healthcare practitioners to submit claims for telehealth services using the appropriate CPT or HCPCS code for the professional service along with modifier GT (via interactive audio and video telecommunications systems).

Little reprieve

Even with this reprieve, some rules and requirements will stay the same. For example, Medicare Administrative Contractors (MACs) will continue to apply the following rules and requirements:

- *"One every three days"* frequency edit logic for telehealth services when subsequent hospital care codes (99231, 99232, and 99233) are billed with POS 02 for claims with dates of service on January 1, 2018, and after.
- *"One every 30 days"* frequency edit logic for telehealth services when subsequent nursing facility care codes (99307, 99308, 99309, and 99310) are billed with POS 02 for claims with dates of service on January 1, 2018, and after.

This frequency editing will apply even when the services are span-dated on the claim (e.g., the "from" date and the "to" date of service are not equal, and the "units" field is greater than one).

According to MLN telehealth services, asynchronous "store and forward" technology is only permitted in federal telemedicine-demonstration programs based in Alaska or Hawaii. As such, the rules and requirements for using modifier GQ are still required, where applicable. For example, to demonstrate federal telemedicine programs in Alaska or Hawaii, telehealth services performed "via an asynchronous telecommunications system" are still required to be billed with modifier GQ along with the appropriate CPT or HCPCS code for the professional service (e.g., 99201-GQ).

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By billing and appending modifier GQ with the appropriate level of service, you are certifying that the asynchronous medical file was collected and transmitted to you at a distant site from a federal telemedicine-demonstration project conducted in Alaska or Hawaii.

Practitioners at the distant site who may furnish and receive payment for covered telehealth services (subject to state law) are:

- ✓ Physicians
- ✓ Nurse practitioners (NPs)
- ✓ Physician assistants (PAs)
- ✓ Nurse-midwives
- ✓ Clinical nurse specialists (CNS)
- ✓ Certified registered nurse anesthetists

For more information on billing for telehealth services for Medicare beneficiaries, see:

- ➢ **Medicare Learning Network—Telehealth Services** *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf*
- ➢ **Elimination of modifier GT for telehealth services** *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10152.pdf*

Now You Are In The Know! ❖