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CMS announces new Quality Payment Program as part of MACRA

Begins January 1, 2017 with "ramp up" time for physicians who wish to participate

On October 14 the Centers for Medicare and Medicaid Services (CMS) released its final rule implementing the Merit-Based Incentive Payment System (MIPS) and the Advanced Alternative Payment Model (APM) incentive payment provisions included in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). This rule, called the Quality Payment Program (QPP), details some changes to the way dermatologists and all physicians will be reimbursed under Medicare.

QPP combines multiple quality reporting systems into MIPs, including value-based payment modifiers, PQRS, and Meaningful Use reporting for Electronic Health Records (EHRs). CMS intends to encourage participation in alternative payment models. In 2019 physician payments will be adjusted based on MIPS or APM participation in 2017. For physicians doing MIPS reporting, payments will be affected by + 0-4%, based on measures reported. Very few dermatologists will be qualified providers in APMs, a program that excludes providers from MIPS reporting and qualifies providers for different incentives.

The reporting period will be a minimum of 90 continuous days any time between January 1 and December 31, 2017. **Individuals and group practices can avoid the penalty in 2019 by reporting any one measure during 2017 in the quality performance category; one activity in the improvement activities performance category; or report the required measures of the advancing care information performance category**. The requirements for avoiding the penalty in 2017 are very low, but in future years reporting requirements will be significantly increased, so CMS is encouraging everyone to report as much as possible in 2017, to prepare for future years.

Resource use will not have any weight during 2017, but reports on costs assigned to providers will be available, since this category will have increasing weight in future years.

A few physicians will be excluded from new requirements in 2017 due to the low-volume threshold, which has been set at less than or equal to $30,000 in Medicare Part B allowed charges or less than or equal to 100 Medicare patients.

The American Academy of Dermatology Association (AADA) fought hard for small practices and the QPP's "pick your pace" provision reflects this request. CMS heard from many physician groups that a hard January 1, 2017 start for the new payment program was not enough time for physicians to begin the new payment system. There is a low threshold to avoid a penalty, and the minimum reporting period was reduced from one full year to 90 days.

What do I need to do to prepare?

AADA has a MACRA readiness plan for members wanting to learn how this new payment program affects future payments and plans to report measures.

- ***Visit and bookmark the AAD MACRA Resource Center*** at *https://www.aad.org/advocacy/physician-payment/macra-implementation*. This resource will

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IMPORTANT Please Route to:

___ Dermatologist ___ Office Mgr ___ Coding Staff ___ Billing Staff

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give you clear, plain language of the explanation of the rule and its impact on dermatology, a MIPS calculator that explains the financial impact of the rule, and an updated MACRA readiness checklist incorporating all final rule changes.

- ***See the resources that CMS has prepared*** at *https://qpp.cms.gov/* . This site will give you the official CMS interpretation of their complex rule, including information about APM participation.

Merit-based Incentive Payment System (MIPS) combines existing Medicare reporting requirements (i.e. PQRS, MU and value-based modifier) into a single entity that ties fee-for-service payment to performance on an overall physician quality score. Initially MIPs will be the pathway for most dermatologists in the Medicare program.

Advanced Alternative Payment Models (APMs) reward physicians who are participating in payment models that attempt to incentivize health care decision-making based on quality, outcomes, and cost savings. The vast majority of dermatologists will not report as an Advanced APM.

MACRA does outline several criteria for physicians to be excluded from the program entirely. If you meet one of the following criteria, you do not need to participate in the program:

- See less than 100 Medicare Part B patients per year
- Have less than $30,000 in Medicare Part B allowed charges
- 2017 is your first year as a Medicare participating provider

Since MIPS will be the pathway for most dermatologists in 2017, it is important to understand the different modes of participation and how to report. Even if your practice does not have an electronic health record (EHR), you can still participate in MIPS. However, be aware that CMS is creating a transition period in 2017 and participation will only become increasingly challenging in later years which may be unattainable if you do not have an EHR.

Simply Avoid The 4% Penalty in 2019

If all you want to do is avoid the 4% penalty in 2019, you simply have to choose to report ONE of the following options in 2017:

- Report one quality measure
- One practice improvement activity
- Five measures from the required set of measures in the advancing care information section (formerly meaningful use)

For a full list of dermatology-specific quality measures, please see *https://qpp.cms.gov/measures/quality*. You would simply have to report one of the measures from the dermatology specialty measure set, which you can do through the Academy's quality registry DataDerm - *www.aad.org/dataderm*. If you successfully report one quality measure through DataDerm in 2017, you would avoid the 4% penalty in 2019.

You can report one measure one time to avoid the penalty, however Academy staff strongly recommend you report for at least a 90-day period to insure the accuracy of your reporting and the fact that additional reporting will be required in future years. Additionally, most of the dermatology-specific measures are only reportable through a registry and may require 90 days of reporting for accuracy. If you choose to report non-dermatology-specific measures through claims, please be aware that claims-based reporting has been found to be less accurate than registry reporting by CMS.

— see **MACRA** 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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If you prefer not reporting quality measures, you can also review the list of applicable practice improvement activities at *https://qpp.cms.gov/measures/ia* and choose one to report in 2017 to avoid the 4% penalty in 2019.

If you have an EHR, you can instead choose to report five advancing care information measures through your EHR vendor, which include the following:

1. Security risk analysis
2. Electronic prescribing
3. Provide patient access to portal
4. Send a summary of care record
5. Request/accept a summary of care record

The security risk analysis must be performed annually in your practice while measures #2-5 must be performed on at least one patient.

Obtain a Neutral or Small Incentive in 2019

If you want to obtain a small incentive in 2019, you can choose to report one of the following options in 2017 for a 90-day calendar period:

- Report two quality measures
- Report two practice improvement activities
- Report five measures from the required set of measures plus one additional measure from the performance section in the advancing care information category

As noted above, there are dermatology-specific quality measures you can report through DataDerm as well as a full list of practice improvement activities on the CMS website. You must report quality measures on at least 50% of **ALL** your patients during a 90-day calendar period in 2017.

To report additional measures in the performance section of the advancing care information category, please select from the following list:

1. Provide patient access to portal
2. Provide patient-specific education
3. Patient views, downloads or transmits health information
4. Patient performs secure messaging
5. Incorporate patient-generated health data
6. Send a summary of care record
7. Request/accept a summary of care record
8. Clinical information reconciliation

Obtain a Modest Incentive (up to 4%) in 2019

If you prefer aiming to be a top performer in MIPS in 2017, you can choose to report ALL of the following over a 90-day calendar period:

- Report 6 quality measures
- Report one high-weighted or two medium-weighted practice improvement activities
- Report five measures from the required set of measures in the advancing care information category

You must report 6 quality measures on at least 50% of **ALL** your patients during a 90-day calendar period in 2017, and you can report through DataDerm.

CMS will also provide an attestation portal for reporting of practice improvement activities and advancing care information measures. You should also consult with your EHR vendor to determine if they will report the advancing care information category to CMS.

Additional Resources

The Academy has developed a MIPS financial assessment tool to help dermatologists determine which pathway is best for their practice and how it will affect their reimbursement. Visit *https://www.aad.org/advocacy/physician-payment/macra-implementation/financial-assessment-tool* to determine how MIPS will impact your practice in 2017. Furthermore, dermatologists can download a MACRA readiness checklist and learn about additional criteria for the program at *www.aad.org/macra*. For questions, please see the Academy's MACRA community at *https://www.aad.org/advocacy/physician-payment/macra-implementation/discussion-community*. ❖

No Dermatology Specific ICD-10-CM Code Changes for 2017

The annual ICD-10-CM update for 2017 has no significant changes or new codes that specifically pertain to dermatology, however, the 2017 update does include a few coding guidelines and instructions that may impact how you report your patients' conditions. While these updates are not included in the 2017 ICD-10-CM Manual, (guideline revisions are not released until after publication of the manual), they are in effect for 2017.

Excludes1 Notes

The update to the Excludes1 guideline was released earlier this year clarifying its use. Excludes1 notes are used to indicate that a code pairing should not be reported together. For example, congenital and acquired forms of the same condition.

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No Dermatology Specific ICD-10-CM Code Changes for 2017

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Exceptions occur when the two conditions are unrelated as is the case with nevi and other conditions of separate anatomic sites.

Bilateral Conditions

When a patient has a bilateral condition and each side is treated during separate encounters, assign the "bilateral" code as the condition exists on both sides even if the encounter is to treat the first or only one side (e.g., treatment of cellulitis of external ear). On subsequent encounters, if the condition is no longer present in the previously-treated site, assign the appropriate unilateral code for the side where the condition remains. If the treatment on the first side did not completely resolve the condition, then the bilateral code would still be appropriate to report during subsequent encounters.

Episode of Care – 7th Characters A and D

Additional clarification was provided in the description of initial and subsequent episode of care 7th characters. They are most often used with injury and adverse effect codes and represent the type of care provided during the encounter.

The 7th character **A** , is used for each encounter where the patient is receiving active care for the condition or injury. The revised guidance for subsequent encounters, reported with 7th character **D**, is defined as those visits occurring after the patient has completed active treatment for the condition or injury.

Documentation of the encounter should reflect the type of care as Active care, which would include diagnosis and treatment of the condition, or subsequent care such as that provided during a follow up encounter.

For complication codes, active treatment refers to treatment for the condition described by the code, even though it may be related to an earlier precipitating event or condition.

For example, code T81.31XA-Disruption of external operation (surgical) wound, not elsewhere classified, initial encounter, is used when active treatment is provided for the dehiscence of skin and subcutaneous tissue closure, even though the condition relates to the procedure of a previous encounter

Complications of Care

Not all conditions that occur during or following medical care or surgery are classified as complications. Code assignment is based on the provider's documentation of the relationship between the condition and care or procedure, unless otherwise instructed by the classification. There must be a cause-and-effect relationship between the care provided and the condition, and an indication in the documentation that it is a complication.

"With"

When the word "with" is used in a code title, the Alphabetic Index, or an instructional note in the Tabular List, it is interpreted to mean "associated with" or "due to". The classification presumes a causal relationship between the two conditions linked by the term "with".

Guidance instructs that the two conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated.

For conditions not specifically linked by these relational terms in the classification, provider documentation must link the conditions in order to code them as related.

Etiology / Manifestation

Certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology. For such conditions, ICD-10-CM coding convention requires the underlying condition be sequenced first, followed by the manifestation. whenever such a combination exists, a "use additional code" note at the etiology code, and a "code first" note at the manifestation code is provided within the ICD-10. These instructional notes indicate the proper sequencing order of the codes, etiology followed by manifestation.

L51 – Erythema multiforme
Use additional code to for adverse effect, if applicable, to identify drug

The language *"if applicable"* was added to the guidance for 2017, clarifying that when the condition is not a manifestation due to an underlying condition or cause, it is appropriate to report the condition alone.

Clinical Criteria and Code Assignment

There is a new guideline confirming that the assignment of a diagnosis code is based on the provider's diagnostic statement that the condition exists. The code assignment is not based on clinical criteria used by the provider to establish the diagnosis but rather by the provider's statement that the patient has a particular condition.

For more information and the complete 2017 ICD-10-CM Guidelines go to; *http://www.cdc.gov/nchs/icd/icd10cm.htm# FY 2017 release of ICD-10-CM*. ❖

New Medicare Advantage Provider Enrollment Requirements starting 2019

The 2017 Physician Fee Schedule Final Rule requires that starting in 2019, all providers services to a Medicare Advantage Organization (MA organization) must be screened, approved and enrolled in and approved status with Medicare as a prerequisite.

- An "approved status" is a status in which a provider or supplier is enrolled in, and is not revoked from, the Medicare program.
- The term "MA organization" refers to both MA plans and also MA plans that provide drug coverage, otherwise known as MA-PD plans.

"this final rule is necessary to help ensure that Medicare enrollees receive items or services from providers and suppliers that are fully compliant with the requirements for Medicare enrollment and that are in an approved enrollment status in Medicare. This final rule will assist our efforts to prevent fraud, waste, and abuse and to protect Medicare enrollees by carefully screening all providers and suppliers, especially those that potentially pose an elevated risk to Medicare, to ensure that they are qualified to furnish Medicare items and services." CMS says

The Centers for Medicare and Medicaid Services (CMS) states that it strives to further strengthen the provider and supplier enrollment process to prevent problematic providers and suppliers from entering the Medicare program. This includes, but is not limited to, enhancing the program integrity monitoring systems and revising provider and supplier enrollment regulations in 42 CFR 424, subpart P, and elsewhere, as needed. According to the final rule, "this action creates consistency with the provider and supplier enrollment requirements for all other Medicare (Part A, Part B, and Part D) programs. Out-of-network or non-contract providers and suppliers are not required to enroll in Medicare to meet the requirements. (CMS) states that requiring enrollment from those furnishing items or services to MA beneficiaries gives CMS improved oversight of the providers and suppliers treating beneficiaries and the Medicare Trust Funds dollars spent on their care."

With this development, CMS will be required to conduct rigorous screening and rescreening of providers and suppliers that include risk-based site visits and, in some cases, fingerprint-based background checks of providers requesting to participate in the MA organization plans. This, CMS says, will be achieved through the CMS enrollment processes, and will further ensure that only qualified providers and suppliers treat Medicare beneficiaries. Expect CMS to provide further information before implementing this screening and enrollment requirement in 2019.

For more information, please visit h*ttps://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1654-F.html* , page 971 – 973. ❖

New AAD Practice Management Tools and Advocacy Resources Regarding Prior Authorizations

Dermatology is unique in that it has experienced increasing prices for both generic and specialty medications. A recent GAO report titled, Generic Drugs Under Medicare, found that "Topical drugs, such as creams and ointments… represented 46 percent of all extraordinary price increases between 2011 and 2012."[1] Insurers have responded to rising prices by increasingly requiring prior authorizations for high cost drugs.

Prior authorizations are an administrative burdensome requirement on practices and delay patients from receiving their necessary medications. According to a 2010 survey, "more than two-thirds (69%) of physicians typically wait several days to receive prior authorization from an insurer for drugs."[2] To obtain a better understanding of the specific impact on dermatologists the AADA's Drug Pricing and Transparency Task Force surveyed a total of 208 AAD members and 500 Association of Dermatology Administrators & Managers (ADAM) members. Respondents were primarily those responsible for completing prior authorizations in their practices. Most respondents indicated they process six or more prior authorizations daily and cited not being listed on a formulary, or being listed on a higher tier are key reasons for prior authorizations with some also citing step therapy and cost as reasons. Most importantly, the majority agree that they have seen an increase in the number of drugs requiring prior authorizations and the subsequent delays in patient treatment this year.

In response to the growing burden, the American Academy of Dermatology Association (AADA's) Drug Pricing and Transparency Task Force developed a new online Prior Authorization/Drug Pricing Toolkit. It includes resources for dermatologists and their staff to help with processing prior authorizations and educational information for patients to help keep their drug costs manageable. The toolkit can be accessed at the following link: *https://www.aad.org/practice-tools/running-a-practice/prior-authorization-drug-pricing-toolkit*. Supplementary resources are under development and will be available to help with prior authorizations in the coming months as well.

In addition to these new resources, the AADA is active at the state level in helping to advocate for legislation to streamline prior authorizations. During the 2016 state legislative sessions the AADA wrote letters supporting legislation in New Jersey, New York, and Ohio. Specifically, the legislation would instigate necessary reforms that will ensure that the prior authorization process does not unduly burden physicians or patients in accessing optimal drug therapy, as undue delays can cause irreparable harm to patients in need of specific treatments. ❖

[1] *Government Accountability Office. Generic Drugs Under Medicare. August 2016*

[2] *American Medical Association. Federation Survey of Prior Authorization Experiences. May 2010.*

Office Visit E/M Billing, While Beneficiary Is Inpatient

The American Academy of Dermatology's (AAD) coding team often receives the question *'why do I have to bill an inpatient Evaluation and Management (E/M) service when the patient was brought to my office?'*

The answer is straightforward, for purposes of payment under the Medicare Physician Fee Schedule (MPFS), the Place of Service (POS) code is used to reflect the actual setting where the Medicare beneficiary receives the face-to-face service. For example, if the physician's face-to-face encounter with a patient occurs in the office, the POS code on the claim reflects the 2-digit POS code 11 for office. In these instances, the 2-digit POS code (Item 24B on the claim Form CMS-1500) will match the address and ZIP code entered in the service location (Item 32 on the 1500 Form) – the physical/geographical location of the physician.

However, there are two exceptions to this general rule. These are for service rendered to:

- a patient who is a registered inpatient; or
- is an outpatient of a hospital.

In these cases, the correct POS code -- regardless of where the face-to-face service occurs -- is that of the appropriate inpatient POS code (POS code 21) or that of the appropriate outpatient hospital POS code (POS code 19 or 22, for outpatient services performed off or oncampus).

In the example above if the patient seen in the physician's office is actually an inpatient of the hospital, the correct POS code is 21,. In this example, the POS code reflects a different setting than the address and ZIP code of the practice location (the physician's office).

The Centers for Medicare & Medicaid Services (CMS) Internet Only Manual (IOM) Publication 100-04, Chapter 26, Section 10.5 under Special Considerations for Services Furnished to Registered Inpatients states:

> *"When a physician/practitioner furnishes services to a registered inpatient, payment is made under the PFS at the facility rate. To that end, a physician/practitioner/supplier furnishing services to a patient who is a registered inpatient, shall, at a minimum, report the inpatient hospital place of service (POS) code 21 irrespective of the setting where the patient actually receives the face-to-face encounter. In other words, reporting the inpatient hospital POS code 21 is a minimum requirement for purposes of triggering the facility payment under the PFS when services are provided to a registered inpatient. If the physician/practitioner is aware of the exact setting the beneficiary is a registered inpatient, the appropriate inpatient POS code may be reported consistent with the code list annotated in this section (instead of POS 21). For example, a physician/practitioner may use POS 31, for a patient in a SNF receiving inpatient skilled nursing care, POS 51, for a patient registered in a Psychiatric Inpatient Facility, and POS 61 for patients registered in a Comprehensive Inpatient Rehabilitation Facility."*

For MPFS payment purposes, what determines payment is the locality where the physician or supplier furnished the service. Medicare has both facility and non-facility designations for services paid under the physician fee schedule. In accordance with Chapter 1, Section 10.1.1 (Payment Jurisdiction Among Local Medicare Administrative Contractors (MACs) for Services Paid Under the Physician Fee Schedule and Anesthesia Services) of the payment manual, the jurisdiction for processing a request for payment for services paid under the MPFS is governed by the payment locality where the physician or supplier furnished the service and will be based on the ZIP code. CMS requires that the address and ZIP code of the physician's practice location be placed on the claim form in order to determine the appropriate locality – item 32 on the paper claim Form CMS 1500 or in the corresponding loop on its electronic equivalent, except for patients registered as inpatient or outpatient during the encounter, as discussed above.

For more information on CMS Consolidated Billing, visit: *http://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html*. ❖

Medicare Overpayments

What does Medicare consider an "overpayment?" According to the Overpayments Rule, it means any funds that a "person" has received or retained under Medicare to which the "person," after applicable reconciliation, is not entitled.

In this context "person" equates to a provider or supplier who furnishes services under Medicare Part A and B. Beneficiaries are not included in this context.

Per this rule, providers have the duty to identify, report, and return overpayments in a timely and effective manner. Failing to follow this rule may result in sanctions under the False Claim Act and other Civil Monetary Penalties Laws.

To comply with the regulatory requirements, once an overpayment is identified and a proof of receipt is found, it must be determined if the total amount in question is an overpayment. If it is identified as an overpayment, it must be refunded to the government payer within 60 days from discovery or the date of any corresponding cost report. The 60-day time clock starts on the day the overpayment is identified (including quantification), or the day of confirmation of the potential overpayment.

In extraordinary circumstances, where there is credible information of a potential overpayment, the provider or supplier has up to eight months to report and return the

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Medicare Overpayments

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overpayment (six months for timely investigation and two months [60 days] for reporting and returning). One example is a Medicare contractor's determination of an overpayment awaiting a medical review.

This rule also provides that if a health care provider or supplier has reported a self-identified overpayment to either the Self-Referral Disclosure Protocol managed by CMS or the Self-Disclosure Protocol managed by the Office of the Inspector General (OIG), the provider or supplier is considered to be in compliance with the provisions of this rule as long as they are actively engaged in the respective protocol.

https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-02-11.html. ❖

FAQs

Q) Can you provide the ICD-10 code and CPT code for administering the flu vaccine?

A) Medicare's Outreach and Education Medicare Learning Network publishes on their website a Flu and Vaccine guide. There are many different kinds of flu vaccines listed, check CMS website below for the CPT code. The administration code is G0008 with the ICD-10 code of Z23, Encounter for immunization.

This Immunization chart can be found on CMS's website: *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/qr_Immun_bill.pdf*

Q) We are seeing patients with skin cancers that are crossing anatomic locations when preforming Mohs. The lesion starts out on the cheek and then after Mohs the final defect encompasses both the cheek and lower eyelid. How would one bill this complex repair if part of the repair is on the lower eyelid and the other part the cheek? Is there a percentage of involvement required to bill as eyelid repair vs cheek?

Guidance is not always available or published by AMA CPT or Medicare for some dermatological specific questions. When guidance is not provided by these sources, the AAD Coding staff rely on the coding and practice knowledge from AAD Member Dermatologists, many of whom serve on our coding committees.

Assistance from two Mohs surgeons from the Healthcare Finance Committee was sought to provide the following response:

"This is a very common issue in dermatologic surgery. I tend to just code for the site consistent with the site of the original biopsy so I don't have the issue of trying to use an eyelid closure procedure code with a cheek diagnosis code. In response to your question, I'd recommend coding for the site specific closure that involves the majority of the closure (51%)."

Q) My Mohs surgeon just asked me if when he closes a wedge incision on an ear, is the closure considered a linear closure?

A) When it's just an ear wedge, it is pretty much a complex closure and not a flap. If you take out a wedge to even cartilage or do a "star" like wedge, then it may be coded as a flap.

Q) Can you clarify if a simple repair can be reported for a Mohs case when the wound is healed by second intention? Does the AMA CPT 2016 code book definition include granulating wounds?

A) This is incorrect. There is no closure involved, so no validation for billing a closure.

See AMA CPT initial prefatory language: *"Use the codes in this section to designate wound closure utilizing sutures, staples, or tissue adhesives (eg, 2-cyanoacrylate), either singly or in combination with each other, or in combination with adhesive strips. Wound closure utilizing adhesive strips as the sole repair material should be coded using the appropriate E/M code."*

Pursuant to the above, when none of the above is done, there is no wound closure, and no closure billing is justified.

The AMA CPT Data Manager includes the following intra service work for Mohs:

"…After all required Mohs layers have been taken and a tumor-free plane is reached, remove the temporary dressing. Re-anesthetize wound, obtain hemostasis as needed, and evaluate defect for wound management. Apply a final dressing."

Simple Repair intra service work includes the following:

> *Injection of local anesthetic for anesthesia and hemostasis. Waiting for adequate anesthesia. The area is cleansed and sterile draping is applied. The wound is repaired. Closure of the defect may require; additional removal of wound debris, irrigation, and manual application of pressure for hemostasis, and dressing applied when appropriate. This process is repeated for each wound area when the code choice reflects the summation of multiple wounds in the same anatomic site.*

We also suggest if these services were reported in error to refund them as soon as possible. Medicare has a 60-day limit when overcharges are discovered.

Include in the remittance, the finding and what steps have been taken to correct the issue. Note these changes in your Policy and Procedure Manual now so if an audit does occur proof of the correction can be provided. Often self-reporting and informing the payer of changes implemented will help mitigate potential negative action from the payer.

— see **FAQ** on page 8

In The Know.....

HHS finalizes rule to improve health equity under the Affordable Care Act

Did you know that The Department of Health and Human Services (HHS) issued a final rule to advance health equity and reduce health care disparities?

Affordable Care Act: Non-discrimination rule
The Affordable Care Act's section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age, or disability when providing medical care. The rule applies to dermatology practices and requires that the practice take reasonable steps to provide timely and meaningful access to care for all patients without discrimination. Dermatology practices must adhere to nondiscriminatory standards and practices when treating patients with disabilities and/or with limited English proficiency by providing auxiliary aids, assistance, and/or qualified interpreters.

How does your practice comply?

1. Designate a compliance officer to assess the requirements and document all requirements. Review FAQs explaining Section 1557.
2. By Oct. 16, 2016, post a Notice of Nondiscrimination policy (download model policy) on both your practice's website and in a conspicuous office location so that it's visible to patients. You must also post taglines (view model taglines) in at least the top fifteen non-English languages spoken in the state.
3. You must also post the notice and taglines on any documents you provide patients addressing patient care. If it is an electronic document, include a link to the Notice of Nondiscrimination policy and taglines.
4. In the event patients need interpreters, you should investigate local language assistance resources, either through the current interpreting vendor used for complying with the ADA, a local affiliated hospital, your state medical association's list of language interpreting services, or a new language interpreting vendor you identify in your area. When contracting with a vendor, negotiate a per-use basis contract, which is not only useful but cost-effective.

Note: patients needing interpreting services cannot be charged for this service, neither under this nondiscrimination regulation nor the ADA.

5. Practices may want to combine the Nondiscrimination Notice with other compliance protocols when notifying patients of their rights (e.g., HIPAA Notice of Privacy Practice) as an efficient and cost-effective approach to compliance.
6. If you have 15 or more employees, you must develop a grievance procedure to manage complaints. Learn more about developing and managing a grievance procedure.

The Office for Civil Rights (OCR) will be updating their website periodically with additional information, technical guidance, and model forms. Be sure to check in routinely to minimize risks of complaints and investigations at *www.hhs.gov/civil-rights/for-providers/index.html*.

AAD compliance resources:

- View all compliance topics
- *DW* (June 2016): Setting up a compliance process
- *DW* (Feb. 2012): Complying with the law while treating patients with special needs

Now You Are In The Know!

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FAQ

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Q) If a patient has destruction of twenty lesions via cryosurgery for Disseminated Superficial Actinic Porokeratosis (L56.5), what is the appropriate CPT code?

A) The correct CPT code to report destruction of 20 DSAP lesions is 17111 – *Destruction of benign lesions other than skin tags or cutaneous vascular proliferative lesions; 15 or more lesions*. This code should be reported with 1 unit regardless of the number of lesions destroyed beyond 15 lesions.

Q) I think our LCD declines payment for this, even though these lesions are being destroyed because they have the same p53 mutations as actinic keratosis. (I believe that is correct). Is it unreasonable to use the DSAP diagnosis as part of EM code, but bill the destruction as a premalignant AK? This is a confusing coding issue and I'm glad someone asked about it.

A) DSAP is not actinic keratosis, regardless of mutations, it is considered a benign lesion. The destruction of these lesions should be reported as 17110-Destruction of benign lesions.

As this would be considered by Medicare a non-covered service, we recommend informing the patient of such and obtaining an Advance Beneficiary Notice (ABN) prior to completing the procedure. ❖