CMS Steadfast on ICD-10-CM Implementation Deadline

The Centers for Medicare and Medicaid Services (CMS) will hold fast to October 1, 2014, as the ICD-10-CM implementation deadline. In an update on June 27, 2013, CMS Administrator Marilyn Tavenner affirmed the ICD-10-CM deadline and encouraged providers, payers, and vendors across the health-care industry to prepare to use the new codes for services provided on or after October 1, 2014.

With the October 1, 2014, ICD-10-CM deadline approaching, dermatology practices may be wondering how to code a claim that is submitted on or after October 1, 2014, for a service that was provided prior to October 1, 2014. CMS has clarified that:

- If the date of service (DOS) is before October 1, 2014, you should use the ICD-9-CM codes.
- If the DOS is on or after October 1, 2014, you should use the ICD-10-CM codes.

Depending on your payers’ instructions, if you have overlapping DOS, you may not be able to use ICD-9-CM and ICD-10-CM codes on the same claim. You may be required to split the services that would typically be captured on one claim into two claims: one claim with ICD-9-CM codes for services provided prior to October 1, 2014, and another claim with ICD-10-CM codes for services provided on or after October 1, 2014.

The AAD recommends that you check with your payers to clarify their preference when the time comes to submit such claims. Make sure that your system, third-party vendors, billing services and clearinghouses are able to handle claims with both ICD-9-CM and ICD-10-CM codes in the months following October 1, 2014.

Example:

A patient has an appointment on September 29, 2014, and presents with a lesion of uncertain behavior. A biopsy is performed. Two days later, the histopathology comes back with a confirmation of malignancy and the patient is called to return for an excision of the lesion. The patient returns on October 2, 2014 for the procedure. In this case, your practice will submit a claim with an ICD-9-CM code for the first visit and another claim with an ICD-10-CM code for the second visit (when the procedure is performed).

CMS posted a Frequently Asked Questions (FAQs) document online which provides guidance on claim submission, how to split claims for services that span the October 1, 2014, and transition date questions. For more information please visit: https://questions.cms.gov/.

The Academy is encouraging all dermatology practices to be proactive and continue the ICD-10-CM transition and implementation process to avoid claim reimbursement interruption. In order to assist its members with resources, an ICD-9-CM to ICD-10-CM Code Crosswalk is available for purchase at http://www.aad.org/store-home.
Letter from the Editor

Dear Derm Coding Consult Reader

Staff has just returned from another successful summer academy meeting in New York City. I had the pleasure of meeting and talking to many who attended. The resource center was buzzing with activity. Staff was on hand to answer questions on coding, PQRS, practice management, and the upcoming HIPAA compliance deadline.

AAD meetings offer us the perfect opportunity to discover new ways to address member needs. We gain valuable insight on how to improve website resources and add value to our current products. This meeting was no exception. Coding staff was able to sit with dermatologists and discuss ways to enhance the coding and documentation manual and hear recommendations on webinar topics for 2014. The feedback we receive helps us to ensure we are developing resources that suit your practice needs.

In this edition of Derm Coding Consult we are building upon suggestions for material that we receive throughout the year. You will find up-to-date information on the 2014 Medicare Fee Schedule and the upcoming ICD-10-CM compliance deadline, as well as, practical coding tips and guidance for real-life dermatology practice scenarios. Please continue to send feedback and suggestions to: dcc@aad.org.

Best,

Cynthia A. Bracy, RHIA, CCS-P

Cynthia A. Bracy

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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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CMS Releases CY 2014 Physician Fee Schedule Proposed Rule

The CY 2014 Medicare Physician Fee Schedule (MPFS) proposed rule was published in the Federal Register on July 19, 2013. The rule advances Centers for Medicare and Medicaid Services (CMS) efforts to reduce physician reimbursements and includes some changes that will impact dermatology practices. The estimated conversion factor (CF) with a Sustainable Growth Rate (SGR) fix is 35.6653, representing a 4.8% increase. CMS estimates that dermatology as a specialty will see a 2 percent drop in payments. Most dermatology codes would see a payment change of between +3% and -3%. As in previous years, code values will appear in the final fee schedule rule in November.

The proposed rule includes a list of codes identified by Medicare contractor medical directors (CMDs) as potentially misvalued, including the CPT codes for the first stage of Mohs surgery on the head and neck and on the trunk and extremities, 17311 and 17313. CMS will likely drop these codes from the list of those that are potentially misvalued/in need of review because they were reviewed at the April 2013 American Medical Association RVS Update Committee (RUC) meeting—too late for the results to be considered in this proposed rule.

In addition, the proposed rule includes nearly 200 “potentially misvalued” codes identified with higher total Medicare payments in the physician office (non-facility) setting than in the hospital outpatient department (OPD) or ambulatory surgery center (ASC) (facility) settings. CMS is proposing to limit the non-facility practice expense (PE) RVUs for individual codes so that the total non-facility PFS payment amount would not exceed the total combined amount Medicare would pay for the same code in the facility setting. While, the overall impact of
CMS Releases CY 2014 Physician Fee Schedule Proposed Rule

— continued from page 2

these changes for all of dermatology would be 0%, several dermatology codes would be reduced as follows:

- 17311, Mohs micrographic technique, first stage, -76.4%
- 96910, Photochemotherapy with UV-B, -48.52%
- 96912, Photochemotherapy with UV-A, -50.92%

CMS also proposes to revise the Medicare Economic Index (MEI) based on 10 of 13 recommendations of the MEI Technical Advisory Panel. The MEI is used to reflect average annual price changes for various inputs involved in furnishing physicians’ services. It consists of two broad categories of physicians’ time and physicians’ PE. This revision would result in the physician work cost weight is increasing by 2.6% compared to current MEI and the PE cost weight would decline by 2.6%. Accordingly values for Dermatology codes are more heavily reliant on PE than most specialties— the proposed MEI revision would reduce dermatology payments by 4%. When this reduction is combined with the positive 2% impact on dermatology physician work RVUs, the net result would be a 2% reduction in 2014. It is important to note that this is only a proposed fee schedule, and we will know more about specific changes to the fee schedule when the final rule is released in November. In particular, we expect to see the extent to which CMS accepts the RUC recommended values for the Mohs and destruction of malignant lesion codes that were presented to the RUC in April. We also expect to see whether CMS grants the AADAs request to accept the RUC recommended values and practice expense for the complex repair, shave, laser, and pathology codes.

Among the recommendations, Telehealth “originating sites” regulations would be modified to define rural Health Professional Shortage Areas (HPSAs) as those located in rural census tracts as determined by Department of Health and Human Services (HHS) Office for Human Research Protections (ORHP) CMS hopes that defining “rural” to include geographic areas located in rural census tracts within Metropolitan Statistical Area (MSAs) would allow for the appropriate inclusion of additional HPSAs as areas for telehealth originating sites and expand access to health care services for Medicare beneficiaries located in rural areas. In addition, the proposed rule would add transitional care management services (CPT codes 99495 and 99496) to the list of telehealth services for CY 2014 on a category 1 basis (services that are similar to professional consultations, office visits, and office psychiatry services that are currently on the list of telehealth services).

The rule also recommends a number of policy changes, including proposed updates to the Physician Quality Reporting System, a process for technological review of Clinical Laboratory Fee Schedule (CLFS) codes, and continued phase-in of the Physician Compare Website.

The AADA expects to file comments to CMS on the proposed rule by the September 6 submission deadline.

AAD President: Defend the future of dermatology

Over the summer, AAD President Dirk Elston, MD, FAAD, issued an alert to the full membership to address the impending challenges that the dermatology specialty is facing from key policymakers including CMS, Congress and private payers. With this changing environment in mind, Dr. Elston called on AAD members to adapt and take action. Additionally, he cautioned “The wellbeing of the patient is our primary concern and no service or procedure should be performed solely to enhance the revenue of the provider. The majority of our members are at risk of losing both fair reimbursement and fundamental scope of practice because of the abuses of a few. Our specialty can prevail if we stand united and hold ourselves to the highest ethical standards within the practice of medicine.”

The AAD is advocating to protect and ensure the continued viability of dermatology, and to prevent the erosion of appropriate, evidence-based practice patterns. Additionally, the AAD has and continues to develop resources and educational programs to benchmark best practices and assist members who may question whether they overuse services. Several articles in the Member to Member e-newsletter have highlighted issues related to dermatopathology, procedures and visits, 10-day global visits, destruction codes, phototherapy, and Mohs micrographic surgery. AAD members are encouraged to review Member to Member and Derm Coding Consult for the latest information about accurate diagnostic and procedural coding, as well as Medicare reimbursement issues in dermatology. For more information, contact the AADA Government Affairs Department at govtaffairs@aad.org.

NCCI Surgical Package Clarified

In the past few years, payers have increased their scrutiny on medical record documentation to ensure that the reimbursement for services rendered matches what is documented in the patient record. Most dermatology practices have either had a claim denied or have received a request for medical records when a claim is submitted with an evaluation and management (E/M) service done on the same day as a procedure.

— see NCCI on page 4
As if this is not enough, the National Correct Coding Policy Manual for Part B Medicare Carriers (NCCI) - revised every quarter – recently released Version 19.2, which went into effect July 1, 2013. In this version, the Centers for Medicare and Medicaid Services (CMS) added enhanced narrative under the integumentary section code edits that reiterate and affect the reporting of an E/M service on the same date of service (DOS) as a procedure.

Since NCCI edits are applied to same day services performed by the same provider to the same patient, certain global rules are applicable. An E/M service performed on the same date of service as a procedure with a global period of either ‘0’, ‘10’ or ‘90’ days can be separately reported under limited circumstances.

The new NCCI narrative states: “If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. E/M services on the same date of service as the minor surgical procedure are included in the payment for the procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E/M service.

However, a significant and separately identifiable E/M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25. The E/M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E/M services apply.”

Though the NCCI edits are considered to be exhaustive and all-inclusive, they still do not contain all carrier or payer edits, as some Medicare carriers may have separate edits not included in the NCCI. For example, policies governing the use of modifier 25 vary among CMS carriers; some prefer providers to include modifier 25 when reporting a new patient E/M service with a procedure, while others don’t. Therefore, dermatologists are encouraged to clarify with their regional Medicare carriers to establish their preference on whether to report modifier 25 on a new patient code or not.

The new NCCI narrative further states: “For major and minor surgical procedures, postoperative E/M services related to recovery from the surgical procedure during the postoperative period are included in the global surgical package as are E/M services related to complications of the surgery that do not require additional trips to the operating room. Postoperative visits unrelated to the diagnosis for which the surgical procedure was performed unless related to a complication of surgery may be reported separately on the same day as a surgical procedure with modifier 24 (‘Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period’).”

Though the statements above indicate that the E/M service is included in the minor procedure, it does not preclude one from reporting a separate E/M service – when performed and accurately documented. The safest, practical thing Dermatologists should remember is that if an E/M service is reported on the same day as a surgical procedure, their E/M documentation must indicate that the E/M service was above and beyond the procedure and, upon review, must stand on its own merit to support the level of service reported.

According to NCCI, modifier 25 can be appended to an E/M service code when reported with minor surgical procedures or procedures not covered by global surgery rules to indicate that the E/M service is separate and significantly identifiable from other services reported on the same date of service. Since all procedures include pre-, intra- and post-procedural work that is inherent in the procedure, providers must not report an E/M service code for this work.

For example, the work descriptor for CPT Code 11100 – Biopsy of Skin lesion includes:

**Pre-operative Work:** Prior to biopsy of lesion, obtain pertinent history from patient to include: previous skin cancer, prior treatment history, sun protection history, etc. Discussion with patient will include: indication for biopsy procedure, risks, and benefits; description of biopsy procedure method, and expected result and/or scarring. In addition, patient agreement/informed consent is obtained and staff is advised for preparation of patient and necessary anesthetic, supplies, and instrument tray preparation.

**Intra-Service Work:** inspection and palpation of the lesion to assess depth and to select most representative site for specimen. Cleanse biopsy site with suitable antiseptic; inject appropriate local anesthetic; apply sterile drapes; obtain skin specimen with scalpel, skin punch, or suitable instrument depending on depth and amount of tissue needed. Collect specimen in labeled formalin container. Undermine wound edges as needed to facilitate repair. Suture to approximate wound edges, or achieve hemostasis with pressure, chemical, or electrocautery, or application of topical hemostatic agents. Apply antibiotic ointment and sterile dressing.

**Post-operative Work:** instruction of patient and/or family on postoperative wound care, dressing changes, and follow-up. Patient advised how to recognize significant complications, e.g., bleeding, or allergic reaction to antibiotic ointment or adhesive dressings. Patient advised when results will be available and how they will be communicated; completion of medical record; and communication of results to referring physician as appropriate.
NCCI Surgical Package Clarified
— continued from page 4

Example: NCCI Edits When Minor Procedure Code is reported with E/M service Code.

<table>
<thead>
<tr>
<th>Proc Code</th>
<th>E/M</th>
<th>E/M</th>
<th>E/M</th>
<th>E/M</th>
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<td>99215&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

<sup>1</sup> = append modifier 25
<sup>4</sup>The same rules above apply to consultation codes 9924x when reported with a procedure

On the other hand, a procedure with a global period of ‘90’ days is defined as a major surgical procedure. If an E/M is performed on the same day as a major surgical procedure for the purpose of deciding whether to perform this surgical procedure, the E/M service is separately reportable with modifier 57. Other preoperative E/M services on the same date of service as a major surgical procedure are included in the global payment for the procedure and are not separately reportable. NCCI does not contain edits based on this rule because Medicare Contractors have separate edits, so check with your local carrier for clarification.

The Global Surgical Package

The CMS Internet Only Manual (IOM) (Claims Processing Manual, Publication 100-04, Chapter 12 (Physicians/ Nonphysician Practitioners), Section 40.1 (Definition of a Global Surgical Package), (C) (Minor Surgeries and Endoscopies) defines all procedures with a global surgery indicator of ‘0’ or ‘10’ as minor surgical procedures. This IOM section further states that E/M services on the same day as the surgery are included in the payment for the procedure unless a significant and separately identifiable E/M service is performed. The significant and separately identifiable E/M service may be reported separately with modifier 25 - “Significant Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service”.

The IOM, under Definition of a Global Surgical Package, (A) (Components of a Global Surgical Package) and (B) (Services Not Included in the Global Surgical Package) further defines all procedures with a global surgery indicator of ‘90’ as major surgical procedures. Preoperative E/M services on the day of surgery are included in the global surgical fee except an E/M service for the purpose of deciding whether to perform the major surgical procedure. The latter may be reported with modifier 57 - “Decision for Surgery”.

For major and minor surgical procedures, postoperative E/M services related to recovery from the surgical procedure during the postoperative period are included in the global surgical package, as are E/M services related to complications of the surgery that do not require additional trips to the operating room.

Postoperative visits unrelated to the diagnosis for which the surgical procedure was performed unless related to a complication of surgery may be reported separately on the same day as a surgical procedure with modifier 24 - “Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional during a Postoperative Period”.

For examples of appropriate and inappropriate use of modifier 25, please review the Q&A section in this issue.

Coding Q&A

Below are a few examples of circumstances that may or may not be appropriate for separate E/M service code reporting as referenced in the article on NCCI clarification:

Q: The patient presents for the first time with a lesion on the back that won’t heal. A problem focused history and exam with a straight forward medical decision making to perform a biopsy is performed. How do you code this service?

A: According to CPT Code 11100 – Biopsy of Skin work descriptor obtained from the AMA RBRVS Data Manager, efforts to obtain pertinent history, performing a limited/straight forward exam are all included in the procedure work requirement as shown below:

Pre-service work includes: Prior to biopsy of lesion, obtain pertinent history from patient to include: previous skin cancer, prior treatment history, skin protection history, etc. Discussion with patient will include: indication for biopsy procedure, risks, and benefits; description of biopsy procedure method, and expected result and/or scarring. In addition, patient agreement/informed consent is obtained. ….

Intra-service work includes: inspection and palpation of the lesion to assess depth and to select most representative site to obtain specimen. Cleanse biopsy site with suitable antiseptic; inject appropriate local anesthetic; apply sterile drapes; obtain skin specimen with scalpel, skin punch, or suitable instrument depending on depth and amount of tissue needed. Collect specimen in labeled formalin container. Undermine wound edges as needed to facilitate repair. ….

NCCI version 19.2 further states that “The fact the patient is “new” to the provider is not sufficient

— see CODING Q&A on page 6
alone to justify reporting an E/M service on the same DOS as a minor surgical procedure, nor is the decision to perform surgery – unless this was a major procedure (90 day global period)

So in this case, an E/M service cannot be justified to be distinct, above and beyond, significant and separately identifiable from the procedure. You would only report CPT code 11100

Q: A patient presents for follow-up of clinically premalignant lesion or nodule of the face which was previously treated with Efudex with exacerbation. The decision is made to treat the lesion with LN2. The patient also requires a refill of a topical steroid to treat lichen planus. How do you code this service?

A. It would be appropriate to report an E/M service at the same time as the procedure if the following process occurs:

The premalignant lesion was previously addressed with no improvement, the provider obtains a problem focused history from patient regarding prior treatment and a problem focused exam of the lesion site(s) and then decide to treat the lesion with LN2. The provider then reviews the medical history form completed by the patient and vital signs obtained by clinical staff and obtains an expanded problem focused history and examination. The physician formulates and develops a treatment plan for the lesion. Diagnosis and treatment options are discussed with the patient. The physician reconciles medication(s) and writes prescription(s). The medical record documentation is completed. Any treatment failures or adverse reactions to medications that may occur after the visit are handled (with the help of clinical staff). Care coordination, telephonic or electronic communication assistance, and other necessary management tasks related to this office visit are provided as needed.

Q. The patient presents for the first time with a clinically benign lesion or nodule of the lower leg which has been present for many years. A biopsy is performed. How should I code this encounter?

A. It would not be appropriate to report an E/M service in the following case:

The provider reviews the medical history form completed by the patient and vital signs obtained by clinical staff. A problem focused history examination is conducted. The physician formulates a diagnosis and develops a treatment plan (diagnostic skin biopsy) and completes the medical record documentation. Care coordination, telephonic or electronic communication assistance, and other necessary management tasks related to this office visit, as well as responding to any interval testing results or correspondence are performed as needed.

Q. Why is Medicare denying 96910 when reported during a global surgery with a Modifier 79, unrelated procedure?

A. According to CMS Claims Processing Manual 104, Chapter 12, 40.4.A:

‘Carriers do not allow separate payment for an additional procedure(s) with a global surgery fee period if furnished during the postoperative period of a prior procedure and if billed without modifier “-58,” “-78,” or “-79.” These services should be denied. Codes with the global surgery indicator of “XXX” in the MFSDB can be paid separately without a modifier.’

The Medicare Surgical data base lists the 96900-96912 series as XXX and explains that the Global concept does not apply to these codes. Thus a modifier should not be necessary.

Q. I just received a Medicare denial as duplicate procedure when billing for two excisions, 11401 listed on two separate claim lines, one with Modifier 59. What’s wrong?

A. Effective July 1, 2013, Modifier 59 can only be used, when medically necessary, to unbundle a procedure code that has been bundled related to the National Correct Coding Initiative (NCCI). Claims billed with the same procedure code two or more times for the same date of service, should be submitted with an appropriate repeat procedure modifier. Rather than Modifier 59, Modifier 76 should be used to report a service or procedure that was repeated by the same practitioner subsequent to the original service or procedure. If multiple same lab or pathology services are reported, Modifier 91 is used to report repeat laboratory tests or studies performed on the same day on the same patient.

Remember Modifiers 76 and 91 do not replace anatomical modifiers such as RT, LT, 50, E1-E4, FA, F1-F9, TA, and T1-T9.

If billing a procedure code two or more times for the same date of service, the claim should be submitted with the procedure code listed on one line without modifier 76 or 91 and each subsequent procedure listed on a separate line using the Modifier 76 or 91.

This is now reflected in the CMS IOM Manual 100-04, chapter 1, section 120: Transmittal 2678, CR 8121

“The claims processing systems contain edits which identify exact duplicate claims and suspect duplicate claims. All exact duplicate claims or claim lines are auto-denied or rejected (absent appropriate modifiers). Suspect duplicate claims and claim lines are auto-denied or rejected (absent appropriate modifiers). Suspect duplicate claims and claim lines are auto-denied or rejected (absent appropriate modifiers).
lines are suspended and reviewed by the claims administration contractors to make a determination to pay or deny the claim or claim line.”

If the CPT code has a maximum Medically Unlikely Edit (MUE) such as 88305, it is still questionable whether that maximum unit can be reported on the first and the remaining subsequent units reported on second claim line with Modifier 91.

Please check your local Medicare contractor for more information.

Q. A biopsy was done in the hospital but the reimbursement was less than half of what is paid in the office. Why is the reimbursement different for each place of service?

A. In the Medicare Learning Network article MedLearn SE 1313, Place of Service Coding for Physicians in an Outpatient Setting, CMS advised that the payment for hospital and outpatient facilities involves Medicare Part A for the facility setting and Part B for the physicians’ services. There is no practice expense (overhead) for the physician performing a procedure in a hospital, thus CMS limits their reimbursement to usually 40% of the allowable. According to this guidance, there are improper claim submissions which the RACs are monitoring. If a mistake is found, CMS requires that it must be refunded within 60 days from the date the mistake was discovered. http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1313.pdf

Q. A patient was seen in the office. The claim has been denied because the patient is in a hospice program. How do we report this service and reprocess the claim?

A. For a patient enrolled in hospice, Medicare contractors should deny any Part B services furnished on or after January 1, 2002, by dermatologists that are submitted without GW modifier (Service not related to the hospice patient's terminal condition - http://www.cms.gov/Regulations-and-Guidance/Guidance/manuals/downloads/clm104c11.pdf). The service will be denied if submitted with the GW modifier and found during a review that the service is related to the terminal diagnosis. Services related to a terminal diagnosis provided during a Hospice period are included in the Hospice payment and are not paid separately. This hospice care is reimbursed by the Medicare Part A per diem program. If the dermatological service is related to the terminal diagnosis, the claim should be billed to the hospice program for payment.


**CMS Clarifies Mohs Documentation Requirements**

In a recent undated article, Medicare Learning Network (MLN) Matters® Number: SE1318, the Centers for Medicare and Medicaid Services (CMS) reiterated its documentation requirements for submitting claims to Medicare contractors for Mohs Micrographic Surgery (MMS) reimbursement. Medicare states that they will only reimburse for MMS services when the Mohs surgeon acts as both surgeon and pathologist. Otherwise you may not bill Medicare for MMS if preparation or interpretation of pathology slides is performed by a physician other than the Mohs surgeon.

**CMS’ Findings on Coding Problems**

The article also provides examples of coding for Mohs that CMS found problematic during an audit of the CPT codes associated with MMS across several states in a region. In this audit, Medicare Recovery Auditors found instances in which the preparation and/or interpretation of the slides of tissue removed during the procedures was performed by someone other than the surgeon (or his/her employee).

1. A physician billed CPT Code 17311 (Mohs Micrographic Surgery), while on the same date of service also separately billed CPT Code 88305 (Surgical Pathology, gross and microscopic examination) for the preparation and interpretation of the slides taken during the procedure for a specimen examination by a different practitioner without a modifier. The auditors determined that CPT Code 17311 was, therefore, an overpaid claim. In this instance, CMS would send an overpayment refund request.

2. A physician billed CPT Code 17313 (Mohs Micrographic Surgery) while on the same date of service also separately billed CPT Code 88305 (Surgical Pathology, gross and microscopic examination). 88305 was billed for the preparation and interpretation of the slides during the procedure for a specimen examination by a different practitioner without a modifier. The auditors determined that CPT Code 17313 was an overpaid claim and would instruct CMS to send an overpayment refund request.

**Tips to Help Prevent Reimbursement Problems**

The MLM article also states that “MMS is a precise, tissue-sparing, microscopically controlled surgical technique used to treat selected skin cancers. It is an approach that aims to achieve the highest possible cure rates, and minimize wound size and consequent distortions at critical sites such as the eyes, ears, nose, and lips, the majority of skin cancers can be managed by simple excision or destruction techniques.” The article further advises:  

--- see MOHS on page 8
CMS Clarifies Mohs Documentation Requirements

— continued from page 7

- The medical record of a patient undergoing MMS should clearly show that this procedure (Mohs) was chosen because of the complexity (e.g. poorly defined clinical borders, possible deep invasion, prior irradiation), size or location (e.g. maximum conservation of tumor-free tissue is important).
- Medicare will consider reimbursement for MMS for accepted diagnoses and indications, which you must document in the patient’s medical record as being appropriate for MMS and that MMS is the most appropriate choice for the treatment of a particular lesion.

See MLN Matters Number SE1318 page 3.

Furthermore, the article restates the following coverage limitations:

- Only physicians (MD/DO) may perform MMS
- The physician performing MMS must be specifically trained and highly skilled in MMS techniques and pathologic identification
- If the surgeon performing the excision using MMS does not personally provide the histologic evaluation of the specimen(s), the CPT codes for MMS cannot be used, rather the codes (11600-11646) for the standard excision of malignant lesions should be chosen

The article provides the following additional guidance:

- If MMS on a single site cannot be completed on the same day because the patient could not tolerate further surgery and the additional stages were completed the following day, you must start with the primary code (CPT codes 17311 or 17313) on day two. Computer edits will reject claims where a secondary code (e.g., CPT code 17312) is billed without the primary code (e.g., CPT code 17311) also appearing on same date of service, and the same claim
- Your documentation in the patient’s medical record should support the medical necessity, the number and locations of the specimens taken of this procedure. The operative notes and pathology documentation should clearly show that the procedure was performed using accepted MMS technique, in which the physician acted in two integrated, but distinct, capacities as surgeon and pathologist.
- The notes should also contain the location, number, and size of the lesion(s), the number of stages performed, and the number of specimens per stage.
- The physician must describe the histology of the specimens taken in the first stage. That description should include:
  - depth of invasion;
  - pathological pattern;
  - cell morphology; and
  - if present, perineural invasion or presence of scar tissue.

- For subsequent stages, the physician may note that the pattern and morphology of the tumor (if still seen) is as described for the first stage or, if differences are found, note the changes. There is no need to repeat the detailed description documented for the first stage, presuming that the description would fit the tumor found on subsequent stages.

To view all Local Coverage Determinations (LCDs), please visit:

http://www.cms.gov/medicare-coverage-database/search/search-results.aspx?SearchType=Advanced&CoverageSelection=Both&PolicyType=Both&ProviderType=All&CntrctrType=9&KeyWordSearchType=Exact&kq=true&bc=IAAAAAAIAAAAAAAAAAAAA3%3d%3d&

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CMS Launches Physician Compare Website

The Centers for Medicare and Medicaid Services (CMS) recently launched the redesign of its Physician Compare website, as required by the Affordable Care Act (ACA) of 2010. CMS created Physician Compare to provide consumers with a central hub to view more information on the Medicare providers who treat them. It functions as a search engine of physicians and other healthcare professionals who provide Medicare services. All providers who treat Medicare patients are included in Physician Compare. New physicians and group practices are added three to six months after enrolling in Medicare.

The redesigned website allows a consumer to search for a provider by location (including a nearby landmark), specialty, medical condition, and even the specific body part for which the consumer may require care. Every Medicare provider also has his or her own page that lists gender, languages spoken, education, residency information, group and hospital affiliations, Medicare assignment, board certifications, and the various quality programs in which the provider is currently participating.

As of now, a provider’s page includes indicators denoting participation in the Physician Quality Reporting System (PQRS), PQRS Group Practice Reporting Option (GPRO), Electronic Prescribing (eRx) Incentive Program, and Electronic Health Records (EHR) Incentive Program. The provider’s page only lists whether the provider has participated in one or more of these programs; CMS plans to add the specific quality measure data of those participating in PQRS GPRO and Accountable Care Organizations.

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CMS Launches Physician Compare Website

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(ACOs) in 2014, reflecting data collected in the 2012 program year. Quality ratings for individual providers participating in these programs will be included on Physician Compare in the future. For more information on Physician Compare, visit www.medicare.gov/physiciancompare, or email questions to PhysicianCompare@Westat.com.

Notice of New CMS Interest Rate for Overpayments and Underpayments

Medicare Regulation 42 CFR 405.378 provides for the assessment of interest at the higher of the current value of funds rate (one percent for calendar year 2013) or the private consumer rate as fixed by the Department of the Treasury.

The Department of the Treasury has notified the Department of Health and Human Services that the private consumer rate has been changed to 10.375 percent effective July 17, 2013, for Medicare overpayments and underpayments. Please share with appropriate staff. More information can be found at:


Effective April 1, 2014: Revised CMS 1500 Paper Claim Form

ICD-10-CM implementation requires the revision of the CMS 1500 claim form to allow for the addition of the referring physician requirement. The National Uniform Claim Committee (NUCC), which maintains the CMS 1500 claim form for CMS, recently changed the form to accommodate the October 1, 2014 ICD-10-CM implementation and other required changes. CMS 1500 claim form version 02/12 has been approved as the required format for submitting claims to Medicare and all other payers on paper.

Features of the Revised Form

The 02/12 revised form adds the following functionality:

- Indicators for differentiating between ICD-9-CM and ICD-10-CM diagnosis codes.
- Expansion of the number of possible diagnosis codes from 4 to 12.
- Qualifiers to identify the following provider roles (on item 17):
  - Ordering
  - Referring
  - Supervising

Instructions for Completing the Revised Form (02/12)

The Medicare Claims Processing Internet Only Manual (IOM, Pub. 100-04) Chapter 26 will instruct contractors and providers on how to complete the revised claim form. Once the manual update is available, it will be posted on the CMS website. CMS plans to begin accepting and processing paper claims submitted using the revised form beginning January 6, 2014. Between January and March 31, 2014, CMS will accept and process both paper forms: 02/12 and the older form 08/05.

Beginning April 1, 2014, CMS plans to only accept and process paper claims submitted on the revised CMS 1500 claim form (version 02/12). These dates are tentative and subject to change. CMS will provide more information as it is available.

Note - The Administrative Simplification Compliance Act (ASCA) requires that Medicare claims be sent electronically unless certain exceptions are met. Some Medicare providers qualify for these exceptions and send their claims to Medicare on paper. For more information about ASCA exceptions, please see the related article in Fall 2010, "Derm Coding Consult," or contact the Medicare contractor who processes your claims.

Medicare Administrative Contractor Transitions

This fall there will be three Medicare Part B jurisdictions that will transition to new Medicare Administrative Contractors (MAC). National Government Services (NGS) was awarded MAC contracts for jurisdictions 6 (Illinois, Minnesota & Wisconsin) and K (Maine, Massachusetts, New Hampshire, Rhode Island & Vermont). NGS will take over from J6 Wisconsin Physician Services (WPS) and J14 National Health Insurance Company (NHIC), respectively.

Noridian Administrative Services (NAS) will be taking over jurisdiction E (California, Hawaii, Nevada, American Samoa, Guam and Northern Mariana Islands), replacing J1- Palmetto GBA as the MAC. See box below for transition dates and affected states.

Due to past transition issues, the AAD suggest that you monitor and track all claims and remittance advices (RA) during the pre- and post-transition period. Check the outgoing contractor’s cutoff date. Claims sent to an incorrect contractor will delay claims processing. The incoming MAC may have new mailing addresses and telephone numbers. Prepare for dark days where no claims will be processed or paid and no Interactive Voice Response (IVR) is available to check patient eligibility or claim status.

How can your dermatology practice be proactive?

- Sign up for both the new MAC’s listserv and the outgoing MAC listserv. Subscribing to both will ensure up to date information. Resource tools are available concern-
Medicare Administrative Contractor Transitions
— continued from page 9

...ing the implementation on most MAC websites.

• Access and bookmark the MAC’s website, particularly the part on the MAC transition/implementation and visit it regularly.

• Remember the contractor number is going to be changing; your Electronic Data Interchange (EDI submissions need to reflect the new MAC number at date of the cutover. Keep the clearing house or vendor up-to-date. Attend the MAC’s outreach and education events to learn and understand new or updated local coverage determinations (LCD) which may be different from those outgoing.

• Realize that there will be new addresses for appeals and other important information. Although CMS will monitor the MAC’s operations and performance closely to ensure the timely and correct processing of the workload, review remittance advises (RA) as the incoming MAC may edit claims differently.

With some organizations, this transition shouldn’t be too difficult. Medicare has a MedLearn with a timeline to follow the transition process at:


Upcoming Medicare Part B MAC transitions:

<table>
<thead>
<tr>
<th>States (Jurisdiction)</th>
<th>Outgoing MAC</th>
<th>Incoming MAC</th>
<th>Transition date</th>
</tr>
</thead>
<tbody>
<tr>
<td>California, Hawaii, Nevada, American Samoa, Guam and Northern Mariana Islands (J-E)</td>
<td>Palmetto GBA</td>
<td>Noridian Administrative Services</td>
<td>Sept. 13, 2013</td>
</tr>
</tbody>
</table>

Provider Enrollment: Medicare Voluntary Termination of Enrollment

The Centers for Medicare and Medicaid Services (CMS) require Medicare contractors to process voluntary terminations with an applicable CMS 855 form. Company letterhead is not acceptable.

This mandate is in the CMS Internet Only Manual, Publication 100-08 Program Integrity Manual, Chapter 15 Section 10.1, which states, “... if an enrolled provider is adding, deleting, or changing information under its existing tax identification number, it must report the change using the applicable Form CMS-855. Letterhead is not permitted.”

Part B providers and suppliers are instructed to complete the appropriate paper application sections listed in the chart below or go to the Internet-based Provider Enrollment Chain and Ownership System (PECOS) to submit the electronic application. PECOS supports the Medicare Provider and Supplier enrollment process by allowing registered users to securely and electronically submit and manage Medicare enrollment information. CMS has established PECOS as an alternative to the paper (CMS-855) enrollment process. Internet-based PECOS will allow physicians, non-physician practitioners and provider and supplier organizations to enroll, make changes in their Medicare enrollment, view their Medicare enrollment information on file with Medicare, or check on status of a Medicare enrollment application via the Internet.

The following may serve as a guide for your credentialing analyst:

855I (Physician or Non-Physician Practitioner)
• Individual physician or non-physician practitioner-Sections 1A, 13 and 15
• Physician Assistant (PA)- Sections 1A, 2F, 13 and 15
• Employer terminating PA- Sections 1A, 2G, 13 and 15

CMS-855R (Group Members excluding PA)
• Individual practitioner terminating a reassignment- Sections 1, 2, 3A4 and 7
• Organization terminating a reassignment- Sections 1, 2, 3, 4B (must be the authorized or delegated official) and 7

CMS-855B (Clinics/Group Practices and Certain Other Suppliers)
• Terminating an Employment Arrangement with a Physician Assistant - Sections 1, 2B1, 13 and either 15 or 16- or Sections 1A, 2G, 13 and either 15 or 16

Last year, CMS introduced six new internet PECOS tutorials for the individual, and organization/supplier. These tutorials provide a step-by-step demonstration of initial enrollment, change of information, revalidation and other provider actions. The six tutorials cover:

• Initial Enrollment: Step-by-step demonstration of an initial enrollment application in PECOS.
• Change of Information: Step-by-step demonstration of how to update or change information for an existing enrollment already on file with CMS.

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Provider Enrollment: Medicare Voluntary Termination of Enrollment

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- Revalidation: Step-by-step demonstration on how to submit your revalidation application using PECOS.
- Voluntary Withdraw: Example of how to deactivate an existing enrollment record.
- Reactivation: Step-by-step demonstration of how to re-enroll based on enrollment information that already exists in PECOS.

We suggest you bookmark Pecos website for easy reference: https://pecos.cms.hhs.gov/pecos/login.do

Another new item on PECOS website is a Reassignment Report where individuals who reassign their benefits to you can be verified. CMS upgraded the online enrollment system to allow access to a reassignment report. It is available for all organizations and individuals that are accepting reassignments. The option to view this report is only available if the enrollment has current reassignments. The reassignment report is accessible via the Application Questionnaire page and displays the following columns:

- Provider Name,
- National Provider identifier (NPI),
- Current Enrollment Status,
- Enrollment State,
- Revalidation Notice Sent Date, and
- Revalidation Status.

The report displays up to 50 records on the screen. For reassignment reports containing more than 50 records, the authorized user will be prompted to download the report into an excel spreadsheet by clicking the Generate Report button at the bottom of the screen.

More detailed information can be found on your local Medicare website or the PECOS’ website: https://pecos.cms.hhs.gov/pecos/login.do. Additional instruction on how to complete a PECOS form can be found in the fall 2010 issue of Derm Coding Consult. 

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In The Know.....

CMS says “No Plans for ICD-10 End-to-End Testing”

Did you know that The Centers for Medicare and Medicaid Services (CMS) no longer plans to offer nationwide End-to-End testing for ICD-10 directly with providers – at this time?

CMS states it feels confident that the current level of testing done each quarter for any changes to the Medicare claims processing systems will effectively ensure that claims are processed properly — and that ICD-10 diagnosis codes will be accepted and claims will be processed correctly — once ICD-10 is implemented.

Several Medicare Administrative Contractors (MACs) posted notices on their websites notifying all their trading partners of this plan. Trading partners include claims clearinghouses that work with smaller, less technologically sophisticated providers, larger medical groups, as well as the more tech-savvy hospitals and other providers that directly submit claims to the MACs for reimbursement.

To see a sample of the announcement, visit Palmetto GBA’s webpage at http://www.palmettogba.com/palmetto/providers.nsf/ls/1B~987KA52644?opendocument&utm_source=J1BL&utm_campaign=J1BLs&utm_medium=email

However, Dermatologists need to know this does not mean that it is unnecessary to perform end-to-end testing for your practice. In fact, CMS awarded National Government Services (NGS) with a one-year contract to develop a process and methodology for End-to-End testing of the Administrative Simplification Requirements based on industry feedback and participation. CMS is encouraging all HIPPA covered entities to participate by becoming industry collaboration partners, providing feedback in industry webinar sessions, or volunteering to pilot the ICD-10 End-to-End testing process. This process will be an industry-wide “Best Practice” for End-to-End testing that lays the groundwork for a more efficient, less time-consuming method for health care provider testing of future standards, leading to more rapid adoption of the future standards.


CMS further anticipates that most ICD-10 system changes are expected to be complete by Oct. 1, 2013, a full year ahead of schedule.

Now you are In The Know!