ICD-10-CM: Are you ready?

On October 1, 2014, dermatology practices will be required to start using the ICD-10-CM code set. As of this date, all claims submitted must have the ICD-10-CM code sets in place. Claims submitted with the ICD-9-CM code sets will be rejected and will be deemed unprocessable which will create a potentially significant financial disruption to your practice.

Are you ready for the transition to ICD-10-CM?
There are several notable milestones that you need to pass prior to your transition to ICD-10-CM. This means that the necessary documentation and programming upgrades must be installed and ready for use in the various systems throughout your practice. Having these check points in place will allow you to send and receive the ICD-10-CM codes in the necessary transactions and reporting processes.

To assist you in achieving a smooth and effective transition, the American Academy of Dermatology (AAD) has many resources available for you at http://www.aad.org/ICD10.

Below are some quick pointers to ensure your readiness for ICD-10-CM compliance and implementation on October 1, 2014:

Will your clinical documentation meet the rigorous ICD-10-CM requirements?
Dermatologists will need to provide clear and precise medical record documentation to define the patient condition being managed. Precise, clear documentation allows for accurate allocation of ICD-10-CM codes to their highest specificity.

To achieve improved, clear and precise documentation, try one of the following litmus tests:

✅ Take a moment, review your clinical documentation. Try coding your encounter using the ICD-10-CM code sets. When doing so, ask yourself: are you are able to append an ICD-10-CM code to its highest specificity for the patient’s condition.

Yes, then

No, then

- You are in good shape. Continue your clear, precise and detailed documentation technique.
- Your documentation style contains unclear, imprecise language that leads to the selection of unspecified codes.
- Initiate and implement immediate education on practice documentation guidelines and policies for clinicians in your practice. Plan on improving the documentation style to include clear and precise language that define patient condition to include condition granularity*, location*, lateral-ity* as presented upon examination and medical decision-making. Doing this now will reduce future deficiencies. Make this an ongoing project until everyone is comfortable with the new policies.
- ICD-10-CM coding conventions and guidelines require that diagnoses codes are reported to their highest specificity.

Example:
Patient presents with 5 mm diameter ill-defined, suspicious mole with irregular margins on arm. Mole has varying shades of color, though mostly pink with flat and papular components.

Diagnosis: Dysplastic Nevi

ICD-10-CM Code: D23.6 Other benign neoplasm of skin of unspecified upper limb, including shoulder.

— see ICD-10 on page 2

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IMPORTANT Please Route to:
___ Dermatologist ___ Office Mgr ___ Coding Staff ___ Billing Staff
Letter from the Editor

Dear Derm Coding Consult Reader

It is that time of year where most of us are anxious for the warmth of spring and yearning for the change of seasons. Healthcare is much like the changing of seasons. This year brings new and improved healthcare guidelines, an evolving marketplace of healthcare coverage opportunities, and the rebirth of our ICD coding classification.

Change brings excitement and oftentimes mixed emotions. The feeling of apprehension is heightened this year due to the implementation of ICD-10-CM on October 1, 2014. The Academy has provided resources for you on the website by creating an ICD-10 dedicated webpage, recording a three part ICD-10 webinar series, hosting live webinars, and including ICD-10 specific articles in Derm Coding Consult (DCC). AAD staff writers will continue to add valuable articles in each edition of DCC this year to assist practices with a smooth transition. If you have misplaced an edition from the past year or need an additional copy, you may download the file from our website.

I would like to take a moment to introduce and welcome Ana Maria Bustos to the Government Affairs staff. Ana Maria is the new Senior Manager, Coding & Reimbursement. She comes to the AAD from the American Academy of Physical Medicine and Rehabilitation. You may contact her at: abustos@aad.org or through our general coding and reimbursement staff email, ppm1@aad.org.

Looking forward to seeing you at the AAD Summer Academy Meeting in Chicago!

Best,

Cynthia A. Bracy, RHIA, CCS-P

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Editor, Derm Coding Consult

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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American Academy of Dermatology Association
P.O. Box 4014 Schaumburg, IL 60168–4014

ICD-10-CM: Are you ready?

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Versus:
Patient presents with 5 mm diameter ill-defined, suspicious mole with irregular margins on right upper arm. Mole has varying shades of color, though mostly pink with flat and bumpy components.

Diagnosis: Dysplastic Nevi
ICD-10-CM Code: D23.61 Other benign neoplasm of skin of right upper limb, including shoulder

✓ Understand when and why current claims are down-coded or denied. Are claim denials due to insufficient documentation or are the denials based on lack of medical necessity justifying the reason for the services rendered?

If your answer is Yes, then If your answer is No, then
Your documentation contains unclear, imprecise language that leads to the selection of unspecified codes. Or, you may have omitted a secondary diagnosis as required by the Local Coverage Determination (LCD) guidelines.
You are in good shape. Continue your clear, precise and detailed documentation technique.

You need to:
Initiate and implement immediate education on practice documentation guidelines and policies for clinicians in your practice. Plan on improving the documentation style to include clear and precise language to define patient condition that includes condition granularity*, location*, laterality* as presented upon examination and medical decision-making. Doing this now will reduce future deficiencies. Make this an ongoing project until everyone is comfortable with the new policies.
This should be an ongoing exercise until everyone is comfortable with the new documentation requirements.
This will improve your adherence to ICD-10-CM coding conventions and guidelines that require diagnoses code to be reported to the highest specificity possible.

*— see ICD-10 on page 3
ICD-10-CM: Are you ready?

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Is your system capable of sending and receiving ICD-10 diagnoses code sets?

Your next step to achieving a smooth and efficient ICD-10-CM transition is to test the systems in your practice [e.g. Practice management software (PMS)] that are used to send and receive diagnosis codes. Perform a comprehensive test on your transactions and systems, focusing on ensuring that the ICD-10-CM codes can be sent from your system, received by the receiving system, and processed appropriately. You are responsible for ensuring that your systems are compliant with ICD-10-CM code set requirements. It is a critical step in ensuring that you are ready for implementation on October 1, 2014.

To ensure your PMS is ready to comply with CMS requirements, use the following step by step roadmap to navigate ICD-10-CM system compliance:

<table>
<thead>
<tr>
<th>For your Practice</th>
<th>For Your Clearinghouse</th>
<th>For your Payer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initiate immediate discussions with your vendors (clearinghouse, payers, billing company, etc.) to assess their ICD-10-CM readiness and compliance.</td>
<td>Ask them to provide status updates on their ICD-10-CM readiness</td>
<td>Ask them to provide status updates on their ICD-10-CM readiness</td>
</tr>
<tr>
<td>Test all transactions and work flow processes that require the use of ICD-10-CM diagnoses code sets that have the biggest impact on your practice, e.g. claim submission, eligibility verification, quality reporting, etc.</td>
<td>Confirm that they can receive ICD-10-CM codes on transactions and provide reports and acknowledgement back to your system.</td>
<td>Confirm that they can receive ICD-10-CM codes on transactions and provide reports and acknowledgement back to your system.</td>
</tr>
<tr>
<td>Submit transactions to the appropriate entities, either directly or through a billing office, clearinghouse, etc.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Successful PMS testing ensures that payments and cash flow will not be interrupted after October 1, 2014.

Note: Each HIPAA covered entity (i.e., provider, payer, and clearinghouse) is responsible for its own compliance with the ICD-10-CM code set requirements.

Dermatology practices must plan on performing two types of testing: internal and external. During both phases of testing, it is imperative that you work closely with your vendor to address any system issues identified during the testing period that may be a problem when systems go live on October 1, 2014.

You are ready to ‘Go LIVE!’

You have improved your clinical documentation, you have performed both internal and external testing of your system and work processes with your trading partners. You now feel comfortable that the transactions and workflow processes that include ICD-10-CM diagnoses codes will function properly after the compliance deadline.

With the use of these tips and litmus tests, you will be equipped to ensure a smooth transition and minimal or no
ICD-10-CM: Are you ready?
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Delays in transaction processing and claims payment after October 1, 2014.

Glossary:
The biggest change faced by clinicians in ICD-10-CM clinical documentation will affect the need to document:

* Granularity – be specific with the description of condition being treated. Improved granularity allows for more specific diagnoses code choice. If unsure, it is recommended that you hold claim submission for final histopathologic report, where applicable.
* Location – ensure that the clinical documentation specifies the location for the condition being managed to allow for accuracy in ICD-10-CM diagnosis code selection.
* Laterality – ICD-10-CM coding conventions and guidelines require that dermatology conditions when diagnosed list the anatomic side affected (left or right). All neoplasm and injury & poisoning conditions require distinction of the anatomic side affected.
* This would be a good time to test any manual and workflow processes used in your practice, e.g. those used to collect and report diagnosis codes for various reasons, such as “superbills,” encounter forms, and data reporting forms.

Coming to “Terms” with ICD-10-CM

Now is the time to become familiar with ICD-10-CM terminology. Terminology in ICD-10-CM will seem similar to ICD-9-CM, but the descriptors may have significant changes. As of October 1, 2014, documentation needs to incorporate the specific ICD-10-CM information in order to report the most specific dermatologic ICD-10-CM codes available.

Below are some of the unique characteristics of the new ICD-10 CM code sets. For example: ICD-10-CM captures specific information such as:

* Laterality (Right, Left, Bilateral, Unilateral)
  Dermatologists’ documentation in ICD-10-CM requires that dermatologists determine and document which side of the body the condition being treated is located. Documenting right side, left side, bilateral or unilateral locations will be important. If this indication is omitted from the medical record, the condition would be considered unspecified. There is speculation that payers may not cover unspecified laterality diagnoses.

This chart has some examples of laterality:

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>173.20 Unspecified malignant neoplasm of skin &amp; external auricular canal.</td>
<td>C44.201 Malignant neoplasm of skin &amp; external auricular canal, unspecified</td>
</tr>
<tr>
<td>N/A unless the CPT procedure code is modified with a RT for right</td>
<td>C44.202 Malignant neoplasm of skin of right ear &amp; external auricular canal,</td>
</tr>
<tr>
<td>N/A unless the CPT procedure code is modified with LT for left</td>
<td>C44.203 Malignant neoplasm of skin of left ear &amp; external auricular canal,</td>
</tr>
</tbody>
</table>

* Anatomic Locations
  Coding the anatomical site of a condition should not be a hardship as this is common to dermatological documentation. For the most part, the location numbers are remaining the same: location of a lip is ‘0’; eyelid – ‘1’; ear – ‘2’; etc...

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>172.0 Malignant melanoma of skin of lip</td>
<td>C43.0x Malignant melanoma of lip</td>
</tr>
<tr>
<td>172.1 Malignant melanoma of skin: eyelid including canthus</td>
<td>C43.1x Malignant melanoma of eyelid includes canthus</td>
</tr>
<tr>
<td>172.2 Malignant melanoma of skin: ear &amp; external auricular canal</td>
<td>C43.2x Malignant melanoma of ear &amp; external auricular canal</td>
</tr>
</tbody>
</table>

* Code First
  The principal diagnosis or the first code sequenced in the medical record that defines the primary reason for the visit as determined by the end of the encounter. There is no change to this guideline from ICD-9 CM to ICD-10-CM. If there is no instruction then sequencing is based on the condition that brought the patient into the office, especially if this was the focus of treatment. Signs and symptoms should not be used as a principal diagnosis if a definitive diagnosis has been established.

* Combination Codes
  The term represents a single code used to classify two diagnoses, either a diagnosis with an associated sign and symptom or one with an associated condition. This code should be reported alone if it clearly identifies all the elements of the documented diagnosis.

Example:
ICD-10-CM pressure ulcer codes are combination codes that include:

* the site (lower back) of the pressure ulcer;
* the location (right/left) of the pressure ulcer;
* the stage of the pressure ulcer.

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>707.03 Pressure ulcer, lower back</td>
<td>L89.132 Pressure ulcer of right lower back, stage II</td>
</tr>
<tr>
<td>707.22 Pressure ulcer stage II</td>
<td>L89.152 Pressure ulcer of sacral region, stage II</td>
</tr>
</tbody>
</table>

* Excludes1 and Excludes2, and Borderline Diagnosis Codes
  Similar to ICD-9-CM, there are coding conventions, general guidelines, and chapter-specific guidelines in
Coming to “Terms” with ICD-10-CM

— continued from page 4

ICD-10-CM. These conventions and guidelines are rules and instructions that must be followed to classify and assign the most appropriate code. As with ICD-9-CM, adherence to these guidelines is required under the Health Insurance Portability and Accountability Act (HIPAA). Many of the conventions and guidelines in ICD-9-CM are the same in ICD-10-CM. This will focus on a new Coding Convention: Excludes1 and Excludes2.

Excludes1 and Excludes2

As in ICD-9-CM, a variety of informational notes appear in both the Alphabetic Index and Tabular List of ICD-10-CM. These types of notes consist of includes notes, excludes notes, code first notes, use additional code notes, and cross reference notes. ICD-10-CM incorporates two types of excludes notes: Excludes1 and Excludes2. Each type of note has a different definition for use but is similar in that they indicate codes excluded from each other are independent of each other.

Excludes1

An Excludes1 note is a pure excludes note. It means “NOT CODED HERE!” It corresponds with what the current ICD-9-CM Excludes note indicates. An Excludes1 note indicates that the code excluded should never be used at the same time as the code above the Excludes1 note. An Excludes1 note is used when two conditions cannot occur at the same time, such as a congenital form versus an acquired form of the same condition.

Excludes2

An Excludes2 note represents “Not included here.” An Excludes2 note indicates that the condition excluded is not part of the condition represented by the code, but a patient may have both conditions at the same time. When an Excludes2 note appears under a code, it is acceptable to use both the code and the excluded code together when appropriate.

ICD-10-CM

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>692.89 Contact dermatitis: Unspecified cause</td>
<td>L25.X</td>
</tr>
</tbody>
</table>

Excludes1: allergic contact dermatitis (L23.-)
allergy NOS (T78.40)
dermatitis NOS (L30.9)
irritant contact dermatitis (L24.-)

Excludes2: dermatitis due to ingest substance (L27.1)
dermatitis of eyelid (H01.1-)
eczema of external ear (H60.5-)
perianal dermatitis (L71.0-)
radiation-related disorders skin & subcutaneous tissue (L55-L59)

• Granularity

This is a term used in ICD-10-CM which refers to the hierarchy and the amount of information in the diagnostic description. In the previous example, ICD-10-CM, Chapter 12, Disease of the Skin and Subcutaneous Tissue expands the condition of ‘contact dermatitis’ from the unspecified ICD-9-CM diagnostic code of 692.X to more specific ICD-10-CM classifications of L23, L24, L25 and L30.

• Encounter Type (Initial, Subsequent, Sequela)

The Initial encounter is the first time the patient is seen for a condition requiring active treatment. The appropriate 7th character of ‘A’ for initial encounter should also be assigned for a patient who delayed seeking treatment.

The Subsequent care encounter is after the patient has completed active treatment and is receiving routine care for the healing or recovery phase. Examples of aftercare are: medication adjustment, and follow-up visits following treatment. Character ‘D’ is reported as the 7th character for a subsequent visit.

A Sequela is the residual effect (condition produced) after the acute phase of an illness or injury has terminated. Its 7th character is ‘S.’ There is no time limit for when a sequela code can be used. The residual may be apparent early, such as an acute condition, or it may occur months or years later, such as that due to a chronic condition. Coding of sequela generally requires two codes sequenced in the following order: The condition or nature of the sequela is sequenced first. The sequela code is sequenced second. Note the ICD-10 Code book as there are exceptions to this rule.

The ICD-10-CM Manual guidelines require reporting a 7th character on an ICD-10-CM code when required. It is usually for a condition stemming from an injury or poisoning accident such as a drug overdose causing a reaction.

As this is a small example of the ICD-10-CM Guidelines, please refer to the ICD-10-CM Coding Manual for complete instructions. It is important to read the introduction section under each Chapter heading to understand the use of these codes. ICD-10-CM like ICD-9-CM is divided into the Alphabetic Index and Tabular Index. The Alphabetic Index will locate the diagnosis but the Tabular Index is the structure of the code that needs to be understood to report the appropriate diagnosis code. This is where the fourth through seventh characters can be found. It’s important to use the Tabular Index when applying diagnosis codes.

These guidelines can be found at these sites:


Why is the OIG work plan important for my practice?

The mission of the Office of Inspector General (OIG) is to protect the integrity of the Department of Health & Human Services (HHS) programs. The OIG fights fraud, abuse and waste and promotes efficiency, economy and effectiveness in all HHS programs and operations.

Each year, typically during the month of October, the OIG releases its Work Plan for the upcoming fiscal year. The Work Plan is a brief explanation of the new and ongoing reviews and activities the OIG plans in respect to the HHS programs with Congress’ direction. This year’s Work Plan was delayed until the end of January, causing much apprehension because of the perception of a tougher plan. The main focus is on the Centers of Medicare and Medicaid Services (CMS) Part A and B beneficiaries.

The OIG’s Work Plan is meant to be viewed as a valuable tool by dermatology practices. Practice compliance efforts would benefit by reviewing this year’s OIG target list of items to review to ensure CMS guidelines are being followed. Some items the OIG will focus on for 2014 are listed below:

- E/M services and inappropriate payments - The OIG considers “cloning,” or copying and pasting, old documentation into new chart notes within the EHR as not reflective of the work performed during a current patient visit. This “cloned” documentation may inappropriately equal a higher level of service.

- Medicare Administrative Contractors (MACs) – Use of evaluation of local edits: The OIG evaluates local MAC claim processing edits to identify improper payments before Medicare payments are distributed to ensure claims are paid correctly.

- Medicare Secondary Payer and Improper Medicare payments for beneficiaries with other insurance coverage – Medicare must ensure the beneficiary payment status is established correctly. If Medicare is the secondary payer, they are to be billed as such. It’s the primary payer and the patient’s responsibility to advise the provider of Medicare’s hierarchy status. CMS has set up a special recovery portal for this coverage. For more information please visit: http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/MSRP/Medicare-Secondary-Payer-Recovery-Portal.htm

- Data Accuracy of Physician Compare Website – CMS is required by law to develop the Physician Compare Website for beneficiaries to make informed choices about their health care. PECOS is the data source that is used but the OIG has found it to be inaccurate or incomplete. The OIG will review CMS’s efforts to ensure that the Physician Compare website contains accurate information on health care providers.

- Manufacturer reporting of Average Sales Prices (ASP) for Part B Drugs (New) - Previous OIG work found that many drug manufacturers did not provide CMS with their ASP Part B drug data. CMS relies on this data to set drug payment amounts. It’s recommended that CMS seek a legislative change to directly require all manufacturers of Part B-covered drugs to submit the ASP with a Medicaid rebate program.

- Comparison of ASP to Average Manufacturer Prices (AMP) - Reimbursement for certain ASP drugs is lower than the AMP. When the OIG finds that the ASP for a drug exceeds the AMP by a certain percentage (5%), the OIG notifies the HHS, who may disregard the ASP for the drug when setting reimbursement amounts (e.g., apply a price substitution policy). This will help with price revision to reflect current price trends.

- Physicians – Place of Service (POS) coding errors: This is an ongoing OIG review for correct/appropriate use of POS codes for physicians. Part B claims for services performed in facility but reported and paid in error as non-facility will be reviewed for different levels of payments. The OIG will review whether providers are complying with assignment rules and determine to what extent beneficiaries were appropriately billed in excess of amounts allowed by Medicare during 2012. OIG will assess the effects of their participation and claim assignments. Payment for compounded drugs under Medicare Part B – Guidelines state the compound drug has to meet FDA standards and the Cosmetic Act to be appropriately used and a coverage benefit.

- Enhanced enrollment screening process for Medicare Providers - In keeping with the OIG’s effort to prevent fraud, waste and abuse, CMS will perform impromptu site visits, fingerprinting and background checks as needed when performing provider revalidation/enrollment.

- Idle Medicare provider records (New) – Enforcement of the law that requires providers to bill at least one claim within a 12 month period or risk deactivation. Payments to Provider subject to debt collection – Providers with outstanding overpayment requests will have to settle the debt to change any billing information. All debt will follow provider wherever they go until it is liquidated. Electronic Health Record (EHRs) security and provider accountability. Under the work plan, the OIG will examine for the first time the security of medical devices that network with EHRs and audit how well providers participating in the meaningful use program protect their EHRs. The OIG noted that establishing these audits is a “core Meaningful Use objective.” The OIG will also continue to focus on other EHR-related issues such as examining EHR documentation vulnerabilities, oversight of HIPAA’s privacy and breach notification regulations, providers who have received meaningful use payments and security of protected medical information stored on portable devices.

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Why is the OIG work plan important for my practice?

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The OIG Work Plan details the areas of compliance concerns that will be monitored, reviewed and audited. These efforts take two years to finish. Are there some areas of concern in their plan that may be worth investigating in your practice? If so, they should be proactively reflected in your compliance program updates as needed. To help your practice in its compliance efforts, please consider: AAD Compliance Manual https://www.aad.org/store/product/default.aspx?id=7357

For additional information the 2014 OIG Work Plan is available at www.oig.hhs.gov

PQRS Incentive Guidelines for 2014

There will be several changes to the Physician Quality Reporting System (PQRS) in 2014. The 2014 PQRS reporting period is the last year to earn the 0.5 percent bonus payment of total Medicare Part B allowed charges. Participation in 2014 PQRS will also allow eligible professionals to avoid a 2 percent payment reduction in 2016.

CMS raised the number of PQRS measures that providers must report to earn an incentive from 3 measures to 9 measures, but lowered the reporting threshold for the measures from 80 percent to 50 percent. This means that to earn the additional 0.5 percent incentive, providers must report on at least 50 percent of patients for which the chosen measures apply. Four of the dermatology-related measures, 137, 138, 224, and 265, will continue as measures from the 2013 program. Additionally, there is a new dermatology-related measure, measure #337, included in the 2014 program, as well.

Eligible providers must report at least 9 measures to be eligible for the incentive. However, to solely avoid the 2 percent payment reduction in 2016, providers can report at least 3 measures. CMS lowered the reporting threshold to 50 percent for this option, as well. To report on 9 measures for PQRS, dermatologists may apply other measures — not specific to dermatology — that are still applicable to their practices. The 9 measures must also cover at least three National Quality Strategy domains. The AAD has developed recommendations of other measures that dermatologists may be able to report:

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
<th>National Quality Strategy Domain</th>
</tr>
</thead>
<tbody>
<tr>
<td>#137 — Melanoma: Continuity of Care</td>
<td>Percentage of patients, regardless of age, with a current diagnosis of melanoma whose information was entered, at least once within a 12 month period, into a recall system that includes: • A target date for the next complete physical skin exam, AND • A process to follow up with patients who either did not make an appointment within the specified timeframe or who missed a scheduled appointment.</td>
<td>Effective Clinical Care</td>
</tr>
<tr>
<td>#138 — Melanoma: Coordination of Care</td>
<td>Percentage of patient visits, regardless of age, with a new occurrence of melanoma who have a treatment plan documented in the chart that was communicated to the physician(s) providing continuing care within one month of diagnosis.</td>
<td>Communication and Care Coordination</td>
</tr>
<tr>
<td>#224 — Overutilization of Imaging Studies</td>
<td>Percentage of patients, regardless of age, with a current diagnosis of stage 0 through IIIC melanoma or a history of melanoma of any stage, without signs or symptoms suggesting systemic spread, seen for an office visit during the one-year measurement period, for whom no diagnostic imaging studies were ordered.</td>
<td>Efficiency and Cost Reduction</td>
</tr>
<tr>
<td>#265 — Biopsy Follow-Up</td>
<td>Percentage of new patients whose biopsy results have been reviewed and communicated to the primary care/referring physician and patient by the performing physician.</td>
<td>Communication and Care Coordination</td>
</tr>
<tr>
<td>#337 — Tuberculosis Prevention for Psoriasis and Psoriatic Arthritis</td>
<td>Patients who have a documented negative annual TB screening or have documentation of the management of a positive TB screening test with no evidence of active tuberculosis, confirmed through use of radiographic imaging (i.e., chest x-ray, CT).</td>
<td>Effective Clinical Care</td>
</tr>
<tr>
<td>#130 — Documentation of Current Medications in the Medical Record</td>
<td>Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counter, herbsals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications’ name, dosage, frequency and route of administration.</td>
<td>Patient Safety</td>
</tr>
</tbody>
</table>

— see PQRS on page 8
PQRS Incentive Guidelines for 2014
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<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
<th>National Quality Strategy Domain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure #131 — Pain Assessment and Follow-Up</td>
<td>Percentage of visits for patients aged 18 years and older with documentation of a pain assessment using a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present.</td>
<td>Community/Population Health</td>
</tr>
<tr>
<td>Measure #173 — Preventive Care and Screening: Unhealthy Alcohol Use — Screening</td>
<td>Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use at least once within 24 months using a systematic screening method.</td>
<td>Community/Population Health</td>
</tr>
<tr>
<td>Measure #194 — Oncology: Cancer Stage Documented</td>
<td>Percentage of patients, regardless of age, with a diagnosis of cancer who are seen in the ambulatory setting who have a baseline American Joint Committee on Cancer (AJCC) cancer stage or documentation that the cancer is metastatic in the medical record at least once during the 12 month reporting period.</td>
<td>Effective Clinical Care</td>
</tr>
<tr>
<td>Measure #205 — HIV/AIDS: Sexually Transmitted Disease Screening for Chlamydia and Gonorrhea</td>
<td>Percentage of patients aged 13 years and older with a diagnosis of HIV/AIDS for whom chlamydia, gonorrhea, and syphilis screenings were performed at least once since the diagnosis of HIV infection.</td>
<td>Effective Clinical Care</td>
</tr>
<tr>
<td>Measure #226 — Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention</td>
<td>Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.</td>
<td>Community/Population Health</td>
</tr>
<tr>
<td>Measure #245 — Chronic Wound Care: Use of Wound Culture Technique in Patients with Chronic Skin Ulcers (Overuse Measure)</td>
<td>Percentage of patient visits for those patients aged 18 years and older with a diagnosis of chronic skin ulcer without the use of a wound surface culture technique.</td>
<td>Effective Clinical Care</td>
</tr>
<tr>
<td>Measure #246 — Chronic Wound Care: Use of Wet to Dry Dressings in Patients with Chronic Skin Ulcers (Overuse Measure)</td>
<td>Percentage of patient visits for those patients aged 18 years and older with a diagnosis of chronic skin ulcer without a prescription or recommendation to use wet to dry dressings.</td>
<td>Effective Clinical Care</td>
</tr>
</tbody>
</table>

These measures will be available to report through the Academy’s forthcoming 2014 QRS registry at www.aad.org/qr, where one can also find the full measure specifications, as well as the most up-to-date information about the changes to the 2014 PQRS.

Coding FAQ’s

Q) When the Dr. has seen a patient in consultation in the hospital as a new patient, what code should be used when that same patient then comes to the office for the first time? Should 99203 or 99214 be used?

A) If the physician and the patient have had a face to face encounter within three years, the patient is considered an established patient. In the case detailed in the question the appropriate service would be established, therefore 99214

Q) We are seeing denials for our physician’s new patient visits. The denial message is saying that this patient was seen by our group in the last three years. Why is this occurring? What can we do about it?

A) In a multi-specialty group, if the patient was seen by a non-physician practitioner (NPP), this may cause your new patient visit to be denied as a new physician visit. If you can provide documentation that shows that the non-physician practitioner and the physician are trained in different specialties, request a redetermination of the claim with the documentation.

A new patient is defined as a patient who has not received any professional services, i.e., evaluation and management (E/M) service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous 3 years.

Currently, under the CMS enrollment process, NPPs are not afforded the opportunity to designate a subspecialty. A NPP can only designate their primary licensure, e.g. Nurse Practitioner, Physician Assistant, Certified Nurse Midwife, etc.

Reference:
• Centers for Medicare and Medicaid Services (CMS) Publication 100-4, Chapter 12, Section 30.6.7A *

Q) Do the body areas of the examination section of the 1995 score sheet work exactly as the organ systems?

A) You may count up to 7 body areas or 7 organ systems for an expanded problem focused or detailed examination and you may count 8 body areas or 8 organ systems for a comprehensive examination. However, you may not add body areas and organ systems together to determine the level of the examination.

Novitas Date Posted: 10/16/2009, Date Revised: 11/15/2013

Q) How does Novitas Solutions review Evaluation and Management Services (E/M) billed with the -25 modifier?

— see CODING FAQ’S on page 9
A) Modifier -25 is defined as a significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service. In the review of E/M services billed with the -25 modifier, Novitas Solutions will first identify within the medical records the documentation specific to the procedure or service performed on that date of service. Next, we will consider the additional documentation separate from the documentation specific to the procedure or service to determine:

- If there is a significant, separately identifiable E/M service that was rendered and documented, and
- If the required components of the E/M service are supported as “reasonable and necessary” per Social Security Act, Section 1862(a)(1)(A), and What level of care is supported by the documentation?

Date Posted: 07/29/2008, Date Revised: 11/15/2013

Q) Is CPT code 96910 the recommended code for UVB therapy for vitiligo?

A) The UVB treatment CPT® code for vitiligo is the unspecified code, 17999. It is suggested that you check with the patient’s carrier’s medical policy because they may require a different code to be used if vitiligo is a covered benefit.

If code 17999 is reported on the claim, make a note in the CMS1500 #19 remark box or loop 2300 to 2400 indicating that the work was similar to a 96910 or 96900 (if no emollient was applied) and the code’s pricing.

Q) When a biopsy (or other procedure) is done on the “cutaneous lip” (i.e.: the area above or under the lip, but not the skin of the actual lip), is this coded as lip biopsy?

Similarly, when a biopsy (or other procedure) is done on an area called “eyelid” but is actually on the area surrounding the eye (i.e.: under the eye), is this still coded as eyelid?

A) Last year the American Medical Association (AMA) clarified both codes. The 40490 code is only reported when the biopsy is performed in the lipstick area or the mucus area of the vermilion. The 67810 code, eyelid biopsy’s description is an incisional biopsy of eyelid skin including lid margin. If the biopsy is done anywhere else, the AMA CPT directs one to the integumentary section the biopsies and shaves codes.

Clarification:
FAQ Winter 2013

Q) Sixty days ago, patient had Mohs procedure with advancement flap done. Today, patient presents with a new lesion on the trunk. Patient is otherwise in good health and recovering from the surgery well. Exam shows a black, stuck-on, flat-topped papule with no identifiable features. Dermatologist suspects a seborrheic keratosis. Biopsy is performed and cryotherapy to freeze two irritated seborrheic keratosis noted during the upper body exam is performed.

What is the appropriate code for this visit?

A) In this context, it is appropriate to only report 17110-79 because the procedure is being performed during the advancement flap global period. Based on the documentation above, a separate biopsy (11100) cannot be reported as it is inherent to the destruction. According to CPT coding guidelines, tissue sampling (biopsy) – when performed at the same time as a destruction – is considered inherent to the destruction procedure and cannot be separately reported. There isn’t much information documented to justify reporting a separate E/M service.

According to the National Correct Coding Initiative (NCCI) Manual Chapter 1:

If the biopsy is performed on the same lesion on which a more extensive procedure is performed, it is separately reportable only if the biopsy is utilized for immediate pathologic diagnosis prior to the more extensive procedure, and the decision to proceed with the more extensive procedure is based on the diagnosis established by the pathologic examination.

If a biopsy submitted for pathologic evaluation that will be completed after the more extensive procedure is performed, the biopsy is not separately reportable with the more extensive procedure.

This information is found in the National Correct Coding Initiative (NCCI) Manual Chapter 1 on CMS website: http://www.cms.gov/Medicare/Coding/NationalCorrectCoding/index.html
Did you know that the new CMS 1500 Form, version 02/12, is available for use with your claim submission?

The Centers for Medicare and Medicaid Services (CMS) announced that beginning January 6, 2014, all Medicare Administrative Contractors (MACs) will accept claim submissions on the revised CMS 1500 form, version 02/12. CMS further states that MACs will continue accepting claims on the old CMS form, 08/05 through March 31, 2014.

As of April 1, 2014, the only acceptable format for paper claim submission will be on the revised CMS 1500 Form, version 02/12. Paper claim submissions using any previous format will be returned to providers as unprocessable.

Dermatology practices can use both the old and/or revised CMS 1500 forms until March 31, 2014 – a period Medicare is referring to as the ‘dual-use period’. Photocopies of the CMS-1500 claim forms are NOT acceptable.

NOTE: Regardless of the paper claim form version used to submit your claims, you cannot submit ICD-10 codes for claims with dates of service prior to October 1, 2014.

**Review of significant changes to CMS-1500 Form, 02/12**

There are some notable changes to the CMS 1500 form, 02/12 that dermatology practices need to be aware of. These include:

i. qualifiers to identify whether providers are being identified as having performed an ordering, referring, or supervising role in the furnishing of the service. Enter one of the following qualifiers as appropriate to identify the role that this physician (or non-physician practitioner) is performing:

<table>
<thead>
<tr>
<th>Qualifier</th>
<th>Provider Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>DN</td>
<td>Referring Provider</td>
</tr>
<tr>
<td>DK</td>
<td>Ordering Provider</td>
</tr>
<tr>
<td>DQ</td>
<td>Supervising Provider</td>
</tr>
</tbody>
</table>

Enter the qualifier to the left of the dotted vertical line on item 17

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**Item 17 (Electronic Loop 2310A OR 2420F OR 2420E)** - Enter the name of the referring or ordering physician if the service or item was ordered or referred by a physician. All physicians who order services or refer Medicare beneficiaries must report this data. Similarly, if Medicare policy requires you to report a supervising physician, enter this information here. When a claim involves multiple referring, ordering, or supervising physicians, use a separate CMS-1500 claim form for each ordering, referring, or supervising physician.

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Are you ready for ICD-10 implementation?
Prepare for the October 1 deadline with AAD Resources!

ICD-10-CM: What you Need to Know
Prepare for the impact ICD-10 will have on practices with the AAD’s new on-demand webinar series. This 3-part series provides dermatology-specific coding guidelines and offers examples on how to report current ICD-9-CM codes with ICD-10-CM codes after the implementation deadline.

2014 Coding and Documentation Manual for Dermatology
Updated annually, there isn’t a more complete coding guide for dermatology available! The 2014 Coding Manual includes an ICD-10-CM implementation overview with dermatology-specific examples and the Dermatology ICD-9-CM and ICD-10-CM Express Coders.

ICD-9-CM to ICD-10-CM Crosswalk for Dermatology
Link over 300 of the most frequently used ICD-9-CM codes to corresponding ICD-10-CM codes with this laminated quick reference card.

Check out our newly updated ICD-10-CM webpages!
The Academy’s ICD-10-CM webpages have recently been updated with free resources and tools such as an implementation calendar, ICD-10 code converter, FAQs, and much more. Help your practice prepare for a smooth transition to ICD-10-CM!

Visit www.aad.org/ICD10

Visit www.aad.org/store
and use promo code ICD2014 to receive pricing listed above.
In The Know.....
— continued from page 11

Most of the services rendered in a dermatology practice are rarely referred, ordered or supervised, in which case enter qualifier DK – Ordering provider (electronic loop 2420E) as the identity for the role of the dermatologist or non-physician practitioner rendering the service.

i. The new form uses letters, instead of numbers as diagnosis code pointers. Report to their highest level of specificity;

ii. Expansion to the number of possible diagnosis codes on a claim from 4 to 12. Do not insert a ‘period’ in the ICD-9-CM or ICD-10-CM code;

iii. New ‘ICD indicators’ to differentiate between ICD-9 and ICD-10 codes reported on a claim. Enter the applicable ICD indicator as follows:
   ‘9’ for ICD-9-CM diagnosis
   ‘0’ for ICD-10-CM diagnosis
   Enter the indicator as a single digit between the vertical, dotted lines

Note: Do not report both ICD-9-CM and ICD-10-CM codes on the same claim form. If there are services you wish to report that occurred on dates prior to Oct.1, 2014, and those that occur after ICD-10-CM codes go into effect, send separate claims so that you report ICD-9-CM on a single claim form and ICD-10-CM codes on another claim form.

Now you are In The Know!