Navigating PQRS Incentives and Penalties in 2013

Dermatologists who report at least three quality measures to Medicare’s Physician Quality Reporting System (PQRS) in 2013 will not only make themselves eligible for a bonus payment of 0.5 percent of their total Medicare Part B allowed charges, but can also possibly avoid a 1.5 percent payment reduction to be assessed in 2015. If a dermatologist wishes to only avoid the 2015 reduction, but not earn a 0.5 percent incentive, then he or she only needs to report one measure during the 2013 reporting year.

A dermatologist wishing to earn the additional PQRS incentive must report at least three measures. Therefore, he or she only needs to report three of the four dermatology-appropriate measures (measures 137, 138, 224, and 265) and meet each of the chosen measures at least once to qualify for the incentive payment. This means that one must successfully perform the measure on at least one patient per measure to qualify for the incentive payment. Each of the four dermatology measures can only be reported via electronic registry, for a full year reporting period (January 1-December 31, 2012).

To solely avoid the 2015 payment reduction, a dermatologist can report one measure. This can be done either via registry, or by adding a special quality measure code to a Medicare claim during the 2013 reporting year. Note that one cannot report the dermatology-appropriate measures via claims. If choosing to report via claims, one will need to research the other available measures on the CMS website.

CMS is also allowing practices of at least two providers to participate in PQRS as a group, under one tax identification number, for purposes of earning a 2013 incentive payment and/or avoiding the 2015 payment reduction. In order to participate in this program, known as PQRS Group Practice Reporting Option (GPRO), the practice must self-nominate via a dedicated CMS website that will become available before July 15. One can find more information at the CMS website at www.cms.gov/pqrs or by calling the QualityNet Help Desk at 1-866-288-8912. Note that the AAD PQRS registry is not able to support GPRO reporting at this time.

HIPAA Omnibus Rule Compliance Deadline – September 23, 2013

The HIPAA Omnibus Rule went into effect on March 26, 2013. Physicians have been given 180 days to become compliant with the new rule. The compliance deadline is September 23, 2013.

To be considered compliant with the new rule dermatology practices must:

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IMPORTANT Please Route to:
___ Dermatologist ___ Office Mgr ___ Coding Staff ___ Billing Staff

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Letter from the Editor

Dear Derm Coding Consult Reader

Dermatologists and dermatology practices have been pushed and pulled in different directions over the last several years. 2013 is no exception. The year began with the threat of a 26.5% Medicare fee reduction, sequestration, and now physicians are faced with the incentive versus penalty conundrum. To minimize the complexity of navigating these mandates, CMS has offered a compromise for physicians opting out of reporting PQRS measures in 2013 to avoid the 2015 penalty.

Regulations may be changing and adding a new dynamic to your practice but some aspects remain a constant. In this issue of Derm Coding Consult, coding staff revisit general biopsy and excision guidelines and delve a little deeper to include the anatomical biopsy codes.

Have you ever wondered if you should bill for a split/shared visit rather than an “incident to” visit? Guidance on billing for physician extenders is also addressed in this issue. Staff has provided definitions and scenarios to help you determine which path is most appropriate.

As a reminder, practice management, quality, and coding staff will be on hand at the AAD Summer Meeting in the member resource center. We will be showcasing new product lines and will be available to answer member questions. It is always a pleasure to meet our members in person and discuss current practice issues. We look forward to seeing you in New York!

Best,

Cynthia A. Bracy, RHIA, CCS-P, Editor
Lesion Removal: Shave Removal, Destruction, and Excision Techniques versus Skin Biopsy – How Do They Differ?

This article is written in consultation with James A. Zalla, MD

Depending on morphology, healthcare providers use different methods and techniques to treat/remove or destroy suspicious skin lesions. Appropriate code selection depends upon the lesion morphology and the technique used, e.g. removal by shave, destruction or excision technique.

Removal by Shave Technique

According to the American Medical Association Current Procedural Terminology® (AMA CPT), shaving "is the sharp removal by transverse incision or horizontal slicing to remove epidermal and dermal lesions without a full thickness dermal excision. This includes local anesthesia, chemical or electrocauterization of the wound, and does not require suture closure."

Removal of lesions by shave technique is not considered an "excision," requires a more superficial "removal" and does not involve the full thickness of the dermis, which could result in portions of the lesion remaining in the deeper layers of the dermis. This is a therapeutic procedure, intended to remove a lesion or the problematic portion of the lesion. Removed tissue is typically submitted for pathologic examination. The obtaining of this tissue sample is not a separate biopsy procedure and cannot be reported as such.

Such service is appropriately reported using CPT Codes 11300 - 11313 Shaving of epidermal or dermal lesions. Each shaved lesion treated is reported separately and code selection is based on lesion size and anatomic location.

Removal by Destruction Technique

Destruction is defined as "the ablation of benign, premalignant or malignant tissues by any method (electrosurgery, cryosurgery, laser and chemical treatment), with or without curettement, including local anesthesia and not usually requiring closure."

These services are appropriately reported using CPT code groups 1700x, 1711x, and 1726x.

Removal by Excision Technique

An excision, whether for benign or malignant lesions, is defined as "full-thickness (through the dermis) removal of a lesion, including margins and includes simple (non-layered) closure when performed:"

The difference between excision and other techniques is that this technique requires removal of the entire thickness of the dermis through to the subcutaneous tissue.

Each excised lesion is reported separately, and code selection is determined by measuring the greatest clinical diameter of the apparent lesion plus that margin required for complete excision (lesion diameter plus the most narrow margin required equals the excised diameter).

It is always recommended that the measurement of lesion plus margins is done prior to excision.

These services are appropriately reported using CPT codes 1140x Excision – benign lesions or 1160x Excision – malignant lesions.

The following examples illustrate different methods used in the shave removal, biopsy, destruction, and excision of dermal and epidermal lesions and their corresponding proper coding.

EXAMPLE 1

A man has a 0.7 cm raised benign dermal nevus on his cheek that he constantly cuts while shaving. Such lesions arise deeper in the dermis but are not problematic unless they rise above the level of the adjacent skin. Appropriate treatment is to remove the raised component of such a lesion using the shave technique.

A "shave removal," recognizes that the remainder of this benign lesion persists down in the dermis after the procedure and a complete removal is neither intended nor desirable.

The fact that the removed tissue may then be sent for pathologic examination and confirmation does not make this procedure a biopsy procedure. The intent of the procedure is therapeutic rather than diagnostic, and the histopathology is done for confirmatory reasons.

This procedure will then be reported with CPT 11311 – Shaving of epidermal or dermal lesion, single lesion, face, ears, eyelids …; lesion diameter 0.6 cm to 1.0 cm for shaving this 0.7 cm facial lesion.

EXAMPLE 2

A patient presents with a pearly nodule on the left nasal ala. The dermatologist recognizes that this appears to be a deeper lesion that could be a basal cell carcinoma, and the prudent approach would be to biopsy the lesion for confirmation. A commonly used technique would be to biopsy the raised component of the lesion using the shave technique to remove the elevated portion specifically for histopathology exam, with the intent that upon confirmation that it is a basal cell carcinoma, subsequent definitive treatment will then be undertaken.

A shave technique may be selected in this instance because if the lesion, on histopathology exam, is shown to be a benign dermal nevus, a deeper scar from the biopsy would have been avoided. In this example, it does not matter — for coding purposes — whether the physician selected a razor, a curette, a punch, or a scalpel as the instrument for the biopsy; they would all be coded the same. The primary purpose of the procedure is diagnostic, to obtain tissue for histopathology examination and will be appropriately reported with CPT code 11100 – biopsy of skin, subcutaneous tissue and/or
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mucus membrane (including simple closure), unless otherwise listed; single lesion.

The fact that a pathology report may state “specimen consists of a shave specimen of skin” does not mean anything in deciding whether the procedure represents a skin biopsy by shave technique versus a shave removal of a lesion that happened to be submitted for pathologic confirmation.

Depending on the intent of the physician/healthcare provider, an instrument such as a razor blade is one of a number of instruments that may be used for either a shave removal or a skin biopsy. CPT codes 113xx – Shaving of epidermal or dermal lesion, single lesion…… which define that the shave technique was used to remove the lesion, may be reported for either benign or malignant lesions. The appropriate code is selected based on the anatomic site and the largest diameter size of the lesion itself, not including any additional margin.

Documentation in the medical record would include some indication for the procedure. In the case of a skin biopsy procedure, documentation such as “suspicious lesion,” “changing mole,” “history of bleeding lesion,” “variable pigmentation,” or “atypical appearing nevus,” or other similar descriptor can be extremely helpful in establishing the reason and medical necessity for the procedure. Similarly, documentation for a shave removal procedure might include “symptomatic lesion,” “rubs on waistband or bra,” “hits lesion shaving,” or other reasons why an elevated lesion is symptomatic lesion, “rubs on waistband or bra,” “hits lesion shaving,” or other reasons why an elevated lesion is best removed with the shave technique. The symptomatic nature of the lesion is also supported by using the secondary ICD-9 diagnosis code, 782.0.

However, if the defect following an excision goes “through the entire thickness of the dermis,” it is considered an excision even though the defect may not be closed. Sometimes dermatologists use a deeper tangential removal known as “saucerization” that may go through the dermis into fat. This may be done in the case of suspected melanomas to assure that the complete depth of the lesion is available for pathology. Such lesions are intentionally left open pending histopathology examination, anticipating that a more definitive excision procedure will be required. Such saucerization procedures are appropriately coded as excisions with the 11400 or 11600 series, depending on whether the lesion was pathologically determined to be benign or malignant. Because such procedures go “through the dermis,” they exceed the definition of shave removal procedures that would be coded in the 11300 series.

If fat is present on a clinically excised specimen, or demonstrated on the corresponding pathology slide, it is clear that the excision was extended through the dermis. There may, however, be instances in some body areas that lack subcutaneous tissue in which a specimen may include the full thickness of the dermis at that site but not have underlying fat.

It is also possible that a specimen may extend the full thickness through the dermis into fat, but the fat may pull away from the dermal specimen as it is harvested or in tissue processing for pathology. In such instances, the tissue slides would normally demonstrate that the full thickness of dermis was included on the specimen.

A shave removal procedure may vary in depth and width, and in some instances it may completely remove a lesion that occupies the upper or mid dermis. The fact that a lesion is removed in its entirety is irrelevant when deciding whether to code as a shave removal or an excision. According to CPT, a lesion may be completely removed, but if the level of removal does not go through the full thickness of dermis, it is not an “excision.”

CPT code descriptors are provided for use by physicians/healthcare providers and billers as well as carriers. Recognition of the same as uniform criteria allows for consistency of coding and fairness of payment.

While as a general surgical concept, the notion of excision may connote complete removal, the shave removal procedure codes in the integumentary section of CPT specifically do not use the term “excision” to avoid confusion, and no reference is made to whether the lesion is partially or completely removed.

EXAMPLE 3
A 17 y/o girl has a 1.1 cm raised brown nevus on her mid back that rubs on her bra. Her dermatologist removes it using a shave technique. Pathology report shows a benign compound nevus, and the lateral and underlying dermal margins are clear, confirming complete removal of the nevus.

The fact that the lesion was “completely” removed does not make this an excision. This procedure is appropriately reported with CPT code 11302 - shave removal benign lesion trunk, 1.1-2.0 cm.

EXAMPLE 4
A 50 y/o boater has a discreet but irregular 8 mm shiny red flat lesion on his back. The clinical diagnosis is probable superficial basal cell carcinoma, and the dermatologist elects to shave the lesion at the level of the mid dermis. If the intent of this procedure was therapeutic, it is appropriately reported as a shave removal, code 11301 – Shaving of epidermal or dermal lesion, single lesion, trunk, arms, legs ……; lesion diameter 0.6 cm to 1.0 cm.

However, if the intent of this procedure was diagnostic, it would be coded as a skin biopsy, code 11100 – biopsy of skin, subcutaneous tissue and/or mucus membrane (including simple closure), unless otherwise listed; single lesion.
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Some dermatologists would immediately follow obtaining the specimen for pathology with curettage as a definitive procedure with the therapeutic intent to cure. Assuming the pathology confirmed the diagnosis of basal cell carcinoma, the latter procedure is appropriately reported as 17261 - malignant destruction trunk, 0.6-1.0 cm.

If pathology confirmed a benign diagnosis, the procedure code 17110 – Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettment), or benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions would be reported. If pathology, however, confirmed an actinic keratosis, the destruction procedure code 17000 – Destruction (eg laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettment), premalignant lesions (eg. actinic keratoses), and first lesion would be reported.

In either case, only the definitive procedure is reported. Since obtaining tissue for histopathology examination is a component of the definitive procedure, a skin biopsy is not separately reported for the same lesion.

EXAMPLE 5
A 1.2 cm flesh-colored polypoid nodule on the upper thigh of a 45 y/o man is irritated by his clothing. It is removed at the base with scissors, exposing underlying fat, and hemostasis is achieved with electrocautery. Pathology confirms a benign fibrofatty polyp. This procedure is appropriately reported with CPT code 11402 - excision benign lesion leg, 1.1-2.0 cm.

EXAMPLE 6
A 0.6 cm flat red to black lesion on the arm of a 32 y/o tanning bed user is diagnosed as probable pigmented basal cell carcinoma, with melanoma a less likely consideration. The lesion is shaved off with a blade including a 0.2 cm margin. The wound base is then lightly electrodesiccated and curetted, leaving a 1.0 cm wound. Pathology confirms a pigmented basal cell carcinoma, and the deep and lateral margins are uninvolved.

This procedure is appropriately reported as 17261 - destruction malignant lesion arm, 0.6-1.0 cm diameter. It is not reported as an excision, since the level of removal did not extend through the dermis, nor would it be reported as a shave removal, because the lesion was destroyed after the specimen was obtained for pathology.

EXAMPLE 7
A variably pigmented 7 mm dark brown irregular flat lesion on the lower leg of a 24 y/o female tanning bed user is suspicious for a superficial malignant melanoma. The lesion is removed for pathology with a deep dermal shave procedure, including a 2 mm margin, and hemostasis is achieved with topical aluminum chloride solution. Pathology confirms a Level I melanoma in situ with deep and lateral margins uninvolved. This diagnostic procedure is appropriately coded as 11100, biopsy of skin.

EXAMPLE 8
A 55 y/o man has a 0.9 cm dark-brown shiny nodule on the upper back, diagnosed as probable nodular melanoma. The lesion is excised as an ellipse, including a 0.3 cm margin, and a 4.2 cm layered repair is performed. Pathology confirms a level III nodule melanoma, Breslow thickness 2.80 mm, margins uninvolved, and definitive wide excision is scheduled.

The initial procedures are appropriately reported as 11602 - Excision malignant lesion trunk 1.1-2.0 cm for the excised diameter of 1.5 cm, and intermediate repair 12032 - Layered closure trunk 2.6-7.5 cm. The documentation in the medical record must describe and support the use of the intermediate repair code.

For more information on reporting lesion removal, please check previous issues of Derm Coding Consult https://www.aad.org/store/search/default.aspx?catid=3.

Coding Anatomical Biopsies

Most dermatologists use the Integumentary section (10000 – 19999) in the AMA CPT® Code book for their procedural code selection. It instructs the reader “not to select a CPT code that merely approximates the service provided. If no such specific code exists, then report the service using the most appropriate unlisted procedure or service code.” It continues to explain that “any procedure or service in any section of this book may be used to designate the service rendered by any qualified physician...”

This allows for the reporting of codes selected for their anatomical areas as well as surgical procedures, in particular, specific biopsies and destruction codes which are found within their anatomical sections of AMA CPT®. This article reviews the anatomical biopsy codes and their appropriate use.

A biopsy is a surgical procedure to remove a piece of tissue or a sample of cells to be analyzed in a laboratory. A biopsy is not considered part of another procedure if performed on a different lesion or site as the same date of another surgical procedure.

40490: Biopsy of the lip. The lip biopsy is similar to a skin biopsy procedure except it is taken from the lip area. The lip area is understood to be only the vermilion/mucosal area or lip stick area. Anything outside of this area, CPT refers “for procedures on the skin of lips see 10040 et seq” or the integumentary section or in this case, the skin biopsy codes, 11100.
Coding Anatomical Biopsies

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67810: Eyelid Incisional biopsy including lid margin. The eyelid biopsy description was updated in the 2013 AMA CPT® Code book. It now is considered an incisional biopsy involving the top or bottom layers of the eyelid margin. Note that the code is out of sequence and listed under the Eyelid Incision section. To code for removal of a lesion involving mainly skin of the eyelid, CPT refers to integumentary codes.

69100: Biopsy of external ear. This biopsy area is limited to the external area of the ear, called the auricle or pinna. When there is a need to perform multiple ear biopsies, some coders will choose to report the skin biopsy codes instead. This is done in instances when the need to code for multiple ear biopsies is limited by CMS’ MUE (Medically Unlikely Edit) limits the number of procedural codes that can be billed to three. 41108: Biopsy of the floor of the mouth. This biopsy procedure is limited to the soft tissue are of the floor of the mouth. This code is rarely reported by dermatologists.

11755: Biopsy of nail plate, (e.g., plate, bed, matrix, hyponychium, proximal and lateral nail folds). According to CPT® Assistant, this code “is not intended to be reported when obtaining nail clippings or nail bed scrapings for purposes of performing a fungal culture, KOH preparation…” A nail clipping would be included in an evaluation and management service. CPT® Assistant further clarifies “When a biopsy of the nail bed is performed after avulsion of the nail plate, it is inclusive of the avulsion procedure and is not coded separately.”

54100: Biopsy of penis. The penile biopsy code refers directly to that part of the penile part of the genitalia. AMA CPT® instructs the coder to refer to the integumentary section for the skin biopsy.

56605: Biopsy of vulva or perineum, one lesion; 56606: ..., each separate additional lesion.

56605 and 56606 describes vulvar biopsy, which is referencing external female genitalia. This code also includes the “perineum.” The latter code descriptor should apply equally to females and males, as both sexes have a perineum. The code is in the AMA CPT® female genital system section, but its description of a perineal biopsy should be allowed and reported for both sexes. For more information: review AAD’s coding and documentation manual.

Medicare Beneficiary Codes

With more Medicare beneficiaries seeking coverage for services beyond their Part B entitlement, it is helpful to remember what the alpha or alphanumeric suffix means on a Medicare beneficiary’s identification number. Each alpha suffix (A, B, B1, C or D etc.) indicates the type of benefits the beneficiary is entitled to and together with the social security number, is referred to as the Health Insurance Claim Number (HICN).

These letters do not indicate that the beneficiary only has Part A or Part B coverage. The alpha suffix is only appended to the social security number after a beneficiary applies and is approved for Medicare benefits. The complete alpha numeric suffix may appear on all correspondence that is received from Social Security and on the Medicare card. The alpha suffix will not appear on the beneficiary’s social security card.

The “Is Entitled To” section on the front of the Medicare card shows the Medicare coverage information. You can find more information on what the letter means on the Social Security website: http://ssa-custhelp.ssa.gov/app/answers/detail/a_id/1366/~/meaning-of-the-letters-after-a-social-security-or-medicare-number

Advanced Beneficiary Notice

An Advanced Beneficiary Notice (ABN) is presented to the beneficiary by the provider to inform the beneficiary before the service is performed that Medicare most likely will not pay for a particular service. Thus, the beneficiary will be financially liable for that service should Medicare not pay for the service provided.

The ABN must be specific to the provided service. It is inappropriate to give every patient a generic waiver form to sign before a procedure. CMS states the provider must know and understand the CMS guidelines of coverage. The ABN form must be specific to the service in question and why Medicare may deny the service. The form’s language must be simple enough for the patient to understand. This notice must be presented prior to the service being rendered to allow the patient time to make a rational, informed consumer decision.

What happens if the patient refuses to sign the ABN?

The patient’s signature is the only proof the patient was advised, understands and agrees to the financial liability if the service is denied. If medically necessary, the provider can still proceed with the service without the patient’s signature by properly documenting the unsigned ABN.

The provider must note the following on the ABN presented to the beneficiary:

• Date of refusal to sign
• Who refused to sign (beneficiary, their representative, etc.)
• Who witnessed the refusal and the signature of the witness (not required, but recommended)
• The services and date of service involved (as they appear on the ABN)

If the claim is an assigned claim, the provider can bill the claim with the GA modifier. If Medicare denies the claim, the patient will be held financially responsible. However, if the claim is non-assigned, the patient is not liable and the provider must write-off the service. Providers may not
Advanced Beneficiary Notice
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bill a non-assigned claim with the GA modifier unless the beneficiary signs a valid ABN.

The issue of ABNs arises when billing cosmetic procedures. In that situation, report the diagnosis as V50.9—cosmetic non-covered and also report the CPT procedure code performed. Append the GY modifier, which indicates that it is a non-covered service, to the procedure code. The benefit of this modifier is the patient will receive a remittance advice stating their financial responsibility. If the patient requests a non-covered claim to be filed to Medicare, the provider must comply.

It’s not suggested to report A9270, Non-covered service, to Medicare especially with a GA modifier because the Medicare remittance advice will state the claim needs to be forwarded to the Durable Medical Equipment carrier (DMERC) since the code submitted is a HCPCS code.

For more information about the ABN, see CMS website: http://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html?redirect=/BNI/  

Coding Q&A
Q: How are unassigned claims affected by the 2 percent reduction under sequestration?
A: Unassigned claims are affected by the sequestration cuts. Beneficiary payments toward deductibles and coinsurance are not subject to the 2 percent payment reduction but Medicare’s payment to beneficiaries for unassigned claims is subject to the 2 percent reduction. The non-participating physician who bills on an unassigned basis collects the full payment from the beneficiary, and Medicare reimburses the beneficiary the Medicare portion (e.g., 80 percent of the reduced fee schedule amount.)

Note: The “reduced fee schedule” refers to the fact that Medicare’s approved amount for claims from non-participating physicians/practitioners is 95 percent of the full fee schedule amount. This reimbursed amount to the beneficiary would be subject to the 2 percent sequester reduction just like payments to physicians on assigned claims. Both are claims payments, but to different parties. If the limiting charge applies to the service rendered, providers cannot collect more than the limiting charge amount from the beneficiary.

Example: A non-participating provider bills an unassigned claim for a service with a limiting charge of $109.25. The beneficiary remains responsible to the provider for this full amount. However, sequestration affects how much Medicare reimburses the beneficiary. The non-participating fee schedule approved amount is $95.00, and $50.00 is applied to the deductible. A balance of $45.00 remains. Medicare normally would reimburse the beneficiary for 80 percent of the approved amount after the deductible is met, which is $36.00 ($45.00 x 80 percent = $36.00). However, due to the sequestration reduction, 2 percent of the $36.00 calculated payment amount is not paid to the beneficiary, resulting in a payment of $35.28 instead of $36.00 ($36.00 x 2 percent = $0.72).

Non-participating Providers are encouraged to discuss with their Medicare patients the impact of the sequestration reductions to Medicare payments.

Documentation Requirements for Surgical Debridement Services
J1 Palmetto GBA recently audited claims for surgical debridement services (updated CPT codes 11042 through 11047). These services require the documentation of both the measurement of the wound surface (devitalized tissue) area after debridement and the depth of tissue that is removed. The debridement documentation needs to reflect wound area and depth measurement in the medical record. It’s important to establish this process to avoid claim submission errors, denials for insufficient documentation and potential overpayments.

A common error found was the reporting of CPT Code 11043 when muscle and tendon are visible, but not actually surgically debrided. Another error is when the bone is visible, but is not documented as being part of the surgical debridement procedure. It would not be appropriate to report CPT Codes 11043 and 11044, respectively, in these instances when they involve the same wound site. The deepest level of tissue removed from the same wound determines the correct code.

The surgical debridement ‘add-on’ codes 11045 through 11047 state that an additional >20 square centimeters (cm²) or part thereof (at least additional sq. cm) of tissue was surgically debrided. This ‘add on’ code must to be reported with its primary code and should reflect the actual area of devitalized tissue removed. Many times these codes don’t reflect the true measurement of wounds in question. This latter point is particularly impor-
Q) A Dermatologist/Healthcare provider performs a cyst excision from the clitoris with excised diameter (including margins) of 1.2 cm. What are the appropriate codes to report for this procedure?

A) Excision of cyst on the clitoris in the above question is appropriately reported with CPT code 11422 – Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp neck, hands, feet, genitalia; excised diameter 1.1cm to 2.0cm. The appropriate ICD-9-CM code would be 624.8: Other specified non-inflammatory disorders of vulva and perineum.

Q) What modifier do I use to report an evaluation and management service (E/M) encounter within the surgical global period?

A) Global periods, also known as post-operative periods for surgical procedures vary from ‘0-day’, ‘10-day’ to ‘90-day’ period. Depending on the post-operative period of the surgical procedure, any E/M service performed within that period will be denied as included in the global surgical package payment unless you:

✔ Append Modifier 24 – Unrelated E/M service by the same physician or other qualified healthcare professional during a post-operative period to the E/M service code when the encounter is on a different day than the original surgery that initiated the post-operative global days. The E/M service is usually not related nor initiated by the original surgical problem triggering the global period.

✔ Append Modifier 25 – significant, separately identified E/M service by the same physician or other qualified healthcare professional on the same day of the procedure or other service to the E/M service code when the encounter is on the same day as the surgery. The E/M service diagnoses can be related to the surgical problem triggering the global period.

✔ Append Modifier 57 – Decision for surgery – to the E/M service code if the decision to perform a major surgery (090 days) is made on the same day as the surgery.

Q) Can I use CPT codes 96405 – 96406: Chemotherapy administration; intralesional, up to and including 7 lesions when injecting candida antigen for treatment of warts?

A) No. According to AMA CPT, codes 96405 – 96406: Chemotherapy administration; intralesional... are used for “parenteral administration of non-radioactive, antineoplastic drugs; antineoplastic agents provided for treatment of noncancerous diagnoses (e.g., cyclophosphamide for autoimmune conditions); and substances such as certain monoclonal antibody agents and other biologic response modifiers.”
To answer this scenario, the NPP’s scheduled patient presents with new issues. If the dermatologist takes over the total visit then, yes, it would be reported under the dermatologist. If the NPP addresses some of the old conditions and is presented with new issues that the dermatologist takes a ‘peek’ and documents a treatment plan, then this visit really doesn’t follow the guidelines of ‘incident to’ and should be reported under the NPP.

**Definitions:**

*Incident to billing* is when a medical service is provided in an office setting by someone other than the physician. If the situation meets certain guidelines, the physician may bill Medicare for the service. Incident to is a Medicare policy allowing a NPP provider to report services as if the physician provided the service for only established patients with established conditions. You need to check your other payers for their guidelines as well as your state laws. Office of Inspector General 2013 Work Plan is reviewing CMS’ ‘incident to’ guidelines for the third year looking for abuse.

*Shared/split billing* is when both the physician and a non-physician practitioner (NPP) have a face-to-face encounter with the physician, and the services of each are documented, signed and separately billed to Medicare. Split billing can be performed for the services a Nurse Practitioner, Physician Assistant or a Clinical Nurse Specialist (CNS) provides, so long as they and the physician document and sign the work they each performed. What is the difference between the two types of services? Payment is the difference. Medicare allows 100% of the Medicare fee schedule amount for coverable services submitted by a physician under the ‘incident to’ even though the patient didn’t see the physician. If claims for incident to services do not meet the guidelines, then claim is filed under the NPP.

**Physician extender scenarios:**

1. A PA-C sees a patient in follow-up with an established diagnosis and prescribes new medication. The physician is present in the office and verbally reviews the case and reads the note. Is this reported under the physician or PA-C?
   - CMS does not have a national policy that addresses this type of scenario. Local Medicare contactors such as J9 First Coast MAC have advised that a change of medication dosages that is present in the medical record is within the scope of practice for the NPP provided and should be allowed as an incident to visit. According to J9 First Coast, the ‘incident to’ visits need to be integral to the physician having seen the patient, availability and a prior treatment plan documented for the NPP to follow.

2. The physician sees the patient but leaves an order for NPP to perform the biopsies, LN2 or ED&C. This is reported under the physician, correct?
   - Again, there needs to be an order in the chart, the dermatologist must be in the suite and available.

3. A NPP sees a patient for an established diagnosis but makes a new diagnosis and starts a new treatment. The physician is in the office. The physician did not see the patient but discussed and reviewed the NPP’s note. Is this reported under the physician or NPP?
   - This scenario can only be reported under the NPP.

4. If the service is reported under the NPP, for a private insurance carrier, with our group number, what provider number is used to identify the NPP’s service since the NPP is part of our group contracts and NPPs do not require separate credentialing with the exception of Medicare and a few commercial carriers?
   - Presently there is no way to identify a NPP’s work on a claim form unless specified by the private payer to use in 24K item box. Contact your payers for this information.

5. If the service performed in the office meets the shared/split billing guidelines but does not meet the ‘incident to’ requirements in the office, can we still bill under the MD/DO?
   - No. Shared/split visits in the office must meet the ‘incident to’ requirements. The NPP must bill for the services under his/her own Medicare number.

6. Are nurses (RN & LPN) able to perform services ‘incident to’ an NPP when the NPP is present in the office?
   - The ‘incident to’ requirements apply to services ‘incident to’ both the physician and the NPP. A nurse is able to provide a service ‘incident to’ the NPP when the situation meets all requirements. If the nurse or auxiliary person performs E/M services, use code 99211. ❖
Medicare Claim Exceptions to the Timely Filing Period Requirement

Effective March 23, 2010, the Patient Protection and Affordable Care Act (PPACA), was amended to reflect updated time periods for filing Medicare fee-for-service (FFS) claims as part of the provisions aimed at curbing fraud, waste, and abuse in the Medicare program. Under this new law, all claims for services furnished on or after January 1, 2010, must be filed within one calendar year (12 months) from the date-of-service (DOS).

The Centers for Medicare & Medicaid Services (CMS) further announced four (4) exceptions to the 12-month timely claim-filing period. These exceptions provided extensions to the timely filing period when the failure to meet the filing time limit falls under the following criteria:

<table>
<thead>
<tr>
<th>Type of Error</th>
<th>Cause</th>
<th>Qualification Requirements for Exception (submitted to claims processing contractor)</th>
<th>Extension</th>
</tr>
</thead>
</table>
| **Administrative Error** | An employee, Medicare contractor, or agent of the Department who was performing Medicare functions and acting within the scope of its authority | ✓ Statement(s) from the beneficiary, beneficiary representative or healthcare provider outlining the error, how it was identified and how it was corrected; or
✓ Written report by Medicare or the Medicare contractor describing how its error caused failure to file the claim within the time limit; or
✓ Copies of a CMS or Medicare contractor letter or other written notice reflecting the error; or
✓ A written statement from an agency employee having personal knowledge of the error | Medicare timely filing limit will be extended by up to six (6) months following the month in which the error is rectified via notification either to the healthcare provider or beneficiary

**NOTE:** Four years from the DOS is the absolute deadline after which Medicare contractors are not permitted to accept requests for extension due to administrative errors. |

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**Retroactive Medicare Entitlement**

When CMS or one of its contractors determines that both the following conditions are met:

- On the DOS, the beneficiary was not entitled to Medicare benefits; and
- The beneficiary subsequently received notification of Medicare entitlement to be effective retroactive to or before the DOS.

Dermatologists, healthcare provider(s) and/or the beneficiary need to provide evidence of official notification for the retroactive Medicare entitlement to the claims processing contractor, the effective date of the entitlement and any documentation containing the services provided to the beneficiary and the corresponding dates of those services.

Medicare timely filing limit will be extended up to six (6) months following the month in which either the beneficiary or the healthcare provider received official notification of Medicare entitlement effective retroactive to the DOS.

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**Retroactive Medicare Entitlement Involving State Medicaid Agencies**

- Beneficiary was not entitled to Medicare benefits at time-of-service, then the beneficiary subsequently received notification of Medicare entitlement effective retroactive to or before the DOS;
- A State Medicaid Agency recovered the Medicaid payment for the furnished service from the healthcare provider six (6) months or more after the DOS.

Dermatologists, healthcare provider(s) will need to provide the claims processing contractor with information that verifies:

- The date that the State Medicaid Agency recouped the funds;
- Documentation confirming that the beneficiary was retroactively entitled to Medicare benefits to or before the DOS (i.e., the official letter to the beneficiary); and
- Documentation substantiating the services furnished to the beneficiary and the DOS.

Medicare timely filing limit will be extended up to six (6) months following the month in which the State Medicaid Agency recovered Medicaid payment from the healthcare provider.

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**Retroactive Disenrollment from a Medicare Advantage (MA) Plan or Program of All-inclusive Care of the Elderly (PACE) Provider Organization**

- Beneficiary was enrolled in an MA plan or in a PACE provider organization on the DOS;
- Beneficiary was later disenrolled from the MA plan or PACE provider organization effective retroactively to or before the DOS; and
- The MA plan or PACE provider organization recovered its payment for the furnished service from a healthcare provider six (6) months or more after the service was furnished.

Dermatologists, healthcare provider(s) will need to provide evidence that confirms each of the following:

- The beneficiary was previously enrolled in a MA plan or PACE provider organization and later disenrolled; and
- The effective date of disenrollment; and
- Proof of the recoupment of funds by the MA plan or PACE provider organization from the healthcare provider for services furnished to the disenrolled beneficiary.

Medicare timely filing limit will be extended up to six (6) months following the month in which the MA plan or PACE provider organization recovered its payment from a healthcare provider.

NGS Awarded J6 A/B Medicare Administrative Contract

The Centers for Medicare & Medicaid Services (CMS) has awarded National Government Services, Inc. (NGS) the administration contract of Part A and B Medicare fee-for-service claims for Jurisdiction 6 (J6).

J6 Part B Medicare fee-for-service claims are currently serviced by Wisconsin Physicians Services (WPS) and include the states of Illinois, Minnesota, and Wisconsin. This change will go into effect on September 7, 2013, and will impact only those dermatologists who provide services to Medicare beneficiaries in these states and are currently submitting claims to WPS.

Important updates and information on the J6 transition can be found at J6 NGS website as it becomes available.


Spring 2013 DCC Clarification

Suture Removal Q&A

The spring 2013 Derm Coding Consult issue raised questions on the appropriate reporting and billing for suture removal. According to AMA CPT and the Centers for Medicare and Medicaid, suture removal is included in the surgical package. It doesn’t matter if the surgical procedure has a 0, 10 or 90 global period, the suture removal is included in the procedure. Only when sutures are placed by another practice or facility or physician that has no association (Tax ID) with your practice then it is appropriate to report the suture removal. The question is how this is reported since there really is no CPT code.

The Coding Q&A shared a HCPCS code, S0630, Removal of suture: by a physician other than the physician who originally closed the wound. Although this S code could be reported, few carriers honor it especially Medicare. According CPT® Assistant, “Removal of sutures by other than the operating surgeon may be coded as a level of E/M service if suture removal is the only postoperative service performed.” When the sutures are placed by the same physician removing them there is no appropriate CPT code to report.

Preventive Services

Further clarification on the article ‘Preventive service’ was requested. Presently, most dermatologists are aware and understand that, by the nature of the work intensity, preventive service codes are appropriately reported by primary care providers. These codes are only reportable once per calendar year, and require extensive and specific patient care based on age requirements. According to the DHHS, regular skin exam/screening does not qualify as a preventive service. In these circumstances, it may be appropriate for the dermatologist to report an appropriate E/M service in lieu of the preventive service code.
In The Know.....

Do you know the surgical post-operative periods?

Based on the number of post-operative days, there are mainly three types of post-operative periods:

“000” days – Some Minor procedures
E.g. Mohs, biopsy, shave removal, nail procedures, (CPT codes 1731x, 1110x, 113xx and 117xx)
✓ No pre-operative period
✓ No post-operative days
✓ Visit on day of procedure (generally not payable as a separate service)

“010” days – Other Minor procedures
E.g. acne surgery, I&D, skin tags, excisions, destructions, repairs (CPT Codes 10040, 1006x, 1120x, 114xx, 116xx, 17xxx, 120xx, and 131xx)
✓ No pre-operative period
✓ Visit on day of the procedure (generally not payable as a separate service)

“090” days – Major procedures
E.g. flaps and grafts (CPT codes 140xx and 15xxx)
✓ One day pre-operative included
✓ Day of the procedure (generally not payable as a separate service)

Medicare allows for contractors to determine the reimbursement rate and global periods for some services e.g. 17999, 96999. A code whose price and global period is determined by the Medicare contractor has an indication of “YYY”. The post-period for these codes will either be 0, 10, or 90 days.

Note: Not all carrier-priced codes have an “YYY” global period indicator. Sometimes the codes have post-period specified as ‘000’, ‘010’, or ‘090’.

Add-on codes are assigned with “ZZZ” as post-operative period indicator because these codes are usually billed with another (primary) service. This means that there is no post-operative work included in the Medicare Physician Fee Schedule (MPFS) payment for the codes with “ZZZ” indicator. Payment is always made for both the primary and the add-on code, hence the post-operative period assigned is applied to the primary code.


Now you are In The Know!