2014 Medicare Fee Schedule — Impact on Dermatology

The Centers for Medicare and Medicaid Services (CMS) released the 2014 Medicare Physician Fee Schedule Final Rule—including the 2014 conversion factor (CF)—on November 27. The CF is the multiplier used with the relative value units (RVUs) assigned by CMS to each CPT procedure code to determine the dollar amount that will be paid for each service by Medicare.

For 2014, the final Medicare conversion factor is set at $35.8228, which is 5.2% higher than in 2013. Congress agreed on a 0.5% increase in the physician fee schedule for three months, averting the 24% reduction that the Sustainable Growth Rate (SGR) correction would have caused. The SGR is a statutory formula that requires reductions to physician updates if physician spending in aggregate exceeds national targets.

Since 2002, Congress consistently has prevented the negative updates from being implemented by legislating short-term fixes. This year, Congress is exploring permanent alternatives to the SGR, and the American Academy of Dermatology Association (AADa) is proactively advocating on behalf of members for a pragmatic, viable resolution of the SGR issue.

CMS Review of “Potentially Misvalued Services”

CMS is required to identify and review “potentially misvalued codes” and make appropriate adjustments to Medicare payment. To assist CMS in this process, the American Medical Association (AMA) established the AMA/Specialty Society Relative Value Scale Update Committee (AMA RUC). The AMA RUC ensures that specialty physicians are represented in these reviews. The AMA RUC makes annual recommendations regarding valuation of new and revised physician services to CMS and performs periodic broad reviews of the Resource-Based Relative Value Scale (RBRVS). CMS determines the appropriate adjustments to RVUs, taking into consideration AMA RUC recommendations, as well as other data sources. For 2014, CMS accepted many of the AMA RUC’s recommendations.

This year, CMS took a novel approach to identifying potentially misvalued codes by relying upon contractor medical directors (CMDs) to assist in developing a list of potentially misvalued codes. The AADA and others questioned the methodology CMS used to solicit input from CMDs as well as the criteria that CMDs used to identify codes. In the final rule, however, CMS defended its use of CMDs. CMS stated it believed stakeholders’ opportunity to provide comments and the input of the AMA RUC assured a viable process for determining whether the codes are in fact misvalued and for making changes to the values.

The codes identified by Medicare as potentially misvalued included CPT codes for first stage of Mohs surgery on head and neck and on trunk and extremities (17311 and...
Letter from the Editor

Dear Derm Coding Consult Reader

Every edition of Derm Coding Consult (DCC) seems to take on a flavor of its own. The content is largely dependent on key industry variables: current legislative or regulatory climate, ICD-9/CPT-4 coding revisions/updates, and commercial carrier concerns. In determining the content for each issue, the focus is always on the most up-to-date information to lend guidance and support to dermatology practices. Every issue contains a blend of hot topics and coding and reimbursement scenarios to increase regulatory awareness and promote coding education.

This winter edition of DCC is no exception! Forces affecting coding and reimbursement seem to be the recurrent theme for this issue. Included is an update on the CMS final rule, guidance on 2014 PQRS measure reporting, and expert advice on how to prepare for the upcoming switch from ICD-9-CM to ICD-10CM on October 1, 2014.

We encourage members to send article topic suggestions and coding and reimbursement questions for future inclusion in the newsletter. Let us know what you would like to see in the spring issue of Derm Coding Consult!

You may email suggestions and questions to the coding staff at ppm1@aad.org or to the editor at dcc@aad.org.

Best,

Cynthia A. Bracy, RHIA, CCS-P

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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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17313). In the final rule, CMS acknowledged that these codes had been reviewed at the April 2013 meeting of the AMA RUC. Because CMS received recommendations from the AMA RUC for these codes subsequent to the publication of the proposed rule, CMS opted to propose interim final values for these codes rather than finalizing them as potentially misvalued codes.

Dermatology Codes Impacted By Final Rule

The final rule will impact reimbursements on a number of dermatology codes.

Overall, services provided by the dermatology specialty face a 1.5% reduction in Medicare payments. Although the impact of the Medicare Economic Index (MEI) changes described below is -2%, the overall increase of 0.5% should also be included, for a -1.5% net change. The impact of that 1.5% reduction for individual practices will vary depending on the practice’s mix of services.

The most significant impacts are in the destruction of premalignant lesion code family and the photochemotherapy code family, as follows:

**Destruction of premalignant lesions (actinic keratosis)**
- 17000 Destruction premalignant lesion (-9.8%)
- 17003 Destruction premalignant lesion 2-14 (+47%)\(^1\)
- 17004 destruction premalignant lesions 15 or greater (-13.4%)

**Photochemotherapy**
- 96910, Photochemotherapy with uv-b (-8.8%)
- 96912, Photochemotherapy with uv-a (-8.3%)

\(^1\) This value is based on an error in Practice Expense, and will be reduced in future CMS rulemaking.

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Mohs micrographic surgery codes
- 17311 Mohs stage 1/h/n/h/f/g (-1.1%)  
- 17312 Mohs add surgery (-3.2%)  
- 17313 Mohs stage t/a/l (+ 1.3%)  
- 17314 Mohs add surgery t/a/l (+0.1%)  
- 17315 Mohs surg add block (+0.3%)  

Codes with Higher Total Medicare Payments in Office than in Hospital or ASC

In the proposed rule, CMS identified over 200 codes that, according to the proposed rule, “may have misvalued resource inputs.” The proposed rule defined these codes as those for which the total physician fee schedule payment when furnished in an office or other nonfacility setting would exceed the total Medicare payment when the service is furnished in a facility, either a hospital outpatient department or an ambulatory surgery center (ASC).

The following dermatology codes (with proposed reductions) were identified in the proposed rule:
- 17311, Mohs, first stage (-764%)  
- 96900, UV light therapy (-6.46%)  
- 96910, Photochemotherapy with uv-b (-48.52%)  
- 96912, Photochemotherapy with uv-a (-58.82%)

In the final rule, however, CMS reacted to comments it received criticizing its proposed methodology. Accordingly, CMS will not adopt the proposed methodology or payment reductions at this time. While CMS is not reducing values for these codes now, CMS maintains that the identified codes are potentially misvalued. Accordingly, the codes will face further scrutiny going forward.

Medicare Economics Index (MEI)

Under the final rule, CMS is reclassifying some expenses from practice expense (PE) to physician compensation, based on recommendations of the Medicare Economics Index (MEI) Technical Advisory Panel (TAP). This change will increase physician compensation cost share by 2.6% and reduce PE weight by the same amount. The increase in physician compensation weight will be accomplished through a higher Conversion Factor (CF). The lower PE weight is accomplished by lower PE values. Accordingly, the PE must be lowered by approximately 10% to offset the 4.8%, increase in the CF.

This reclassification will negatively impact dermatology payments because dermatology procedures are valued based on practice expense more than most other specialties. It is important to note that codes with 2013 interim values, including complex repair codes (13100-13153) and shave skin lesion codes (11300-11313), are among those codes that will sustain reductions because of the MEI modification.

Many dermatology procedures have high PE relative to physician work, so the MEI change had a negative impact on dermatology payments of 2%. Dermatology benefitted from the last MEI change in 2011, which resulted in a 3% increase in payments for dermatology.

Medicare Physician Fee Schedule Code-Specific Detail


The appendices for the Medicare Physician Fee Schedule are downloadable from the CMS web site at www.cms.gov/PhysicianFeeSchedule/  

Superficial Radiation Therapy Use in Dermatology

New generation of radiation therapy devices presents challenges

A new generation of devices has renewed dermatologists’ interest in using superficial radiation therapy to treat non-melanoma skin cancers (NMSCs). While surgical treatment is considered the optimal “primary” intervention for NMSCs, superficial radiation therapy appears to provide an alternative for patients where surgical intervention is contraindicated.

Superficial radiation therapy (SRT) is different from the external electron beam radiation therapy used by radiation oncologists based on its energy value. SRT is referred to as low energy radiation therapy utilizing x-rays. Electron beam radiation is delivered via external devices called linear accelerators that deliver photon beams (either x-rays or gamma rays)

Dermatologists interested in providing superficial radiation therapy are faced with a number of challenges, including coding, regulatory and policy issues.

The American Academy of Dermatology Association (AADA) recently approved a Position Statement on Superficial Radiation Therapy (SRT) & Electronic Surface Brachytherapy (eBx) for Cutaneous Basal Cell (BCC) and Squamous Cell Carcinomas (SCC). To view the Position Statement please click here: http://www.aad.org/Forms/Policies/Uploads/Elektronic%20Surface%20Brachytherapy.docx

The Position Statement is intended to offer dermatologists guiding principles on the provision of SRT and electronic brachytherapy services in order to provide high quality care for patients. Individually, each physician must determine the most appropriate the most appropriate treatment for their patients based on the facts and circumstances of each individual patient.

Radiation Therapy Workgroup

Given the development of these new devices and the revived interest in SRT, the Academy’s Health Care Finance
Superficial Radiation Therapy Use in Dermatology

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Committee formed the Radiation Therapy Workgroup to proactively gather as much information as possible about the new superficial radiation therapy devices and how they are being used. Workgroup members reached out to industry as well as other professional organizations. They worked with AADA staff to review available information and supporting literature related to superficial radiation therapies and to craft a position statement to guide dermatologists who would choose to use this method of treatment.

Coding Challenges

New devices and new procedures are unique in that they provide challenges in the area of coding and therefore potentially in the area of reimbursement as well. Coding protocol for superficial radiation therapy currently appears to be in a state of flux. There are four recognized procedural terminology (CPT) codes available to report radiation treatment delivery:

- 77401 - radiation treatment delivery, superficial and/or orthovoltage
- 77402 - … single treatment area, single port or parallel opposed ports, simple blocks or no blocks, up to 5 MeV;
- 77407 - … 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; up to 5 MeV; and
- 77412 - … 3 or more separate treatment areas, custom blocking, tangential ports, wedge, rotational beam, compensators, electron beam; up to 5 MeV.

These codes are usually reported on the day the radiation treatment is delivered to the patient.

In the past year, however, CPT Codes 77401 – 77407 have come under scrutiny by the Centers for Medicare and Medicaid Services (CMS) and the American Medical Association (AMA) because of high utilization.

Accordingly, CMS has requested a review of this family of codes , and the American Society for Radiation Therapy (ASTRO) has taken the position with AMA/CMS that codes 77402 – 77412 are not appropriate to be reported for treating skin conditions—even though these codes are now routinely reported by dermatologists.

In light of these developments, P C T Code 77401 is the most appropriate code to report when providing radiation treatment for skin conditions. According to CPT guidelines code 77401 can only be reported once per session, regardless of number of the lesions treated.

The AADA CPT Advisors are monitoring all discussions pertaining to this family of codes to ensure that dermatologists are not limited in providing these services and we will provide further guidance on appropriate coding as it evolves at AMA/CPT.

2014 PQRS Measure Reporting Update

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 three measures to nine, 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-specific measures, 137, 138, 224, and 265, will continue as measures from the 2013 program. Additionally, there will be a new dermatology-specific measure included in the 2014 program, as well. This measure, entitled “tuberculosis prevention for psoriasis and psoriatic arthritis patients on a biological immune response modifier,” will measure the percentage of patients whose providers are ensuring active tuberculosis prevention, either through yearly negative standard tuberculosis screening tests, or are reviewing the patient’s history to determine if they have had appropriate management for a recent or prior positive test.

To solely avoid the 2 percent payment reduction in 2016, providers can report on at least three measures. However, CMS lowered the reporting threshold to 50 percent for this option as well. To report on nine measures for PQRS, dermatologists may apply other measures — not specific to dermatology — that are still applicable to their practices. The AAD has developed a list of other measures that dermatologists will be able to report through the Academy’s forthcoming 2014 QRS registry at www.aad.org/qr s, where one can also find the most up-to-date information about the changes to the 2014 PQRS.

Regulatory Issues

State radiation safety regulations govern the provision of electronically produced radiation therapies. The AADA is working to ensure that state rulemaking activity does not impede dermatologists’ ability to provide superficial radiation therapy. The state regulatory environment remains dynamic and could adversely impact dermatologists. State radiation safety agencies are focusing on radiation-related education and training, and there is concern that more states may implement regulations that limit the use of these devices to providers who meet specific education and training requirements. The Radiation Therapy Workgroup is addressing the issues of safely providing superficial radiation therapy to patients and dermatologists’ radiation-related education and training.

Policy Issues

The Stark Law In-Office Ancillary Services Exception (IOASE) currently allows certain medical services, including radiation therapy, to be provided under a self-referral
2014 PQRS Measure Reporting Update
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business model. Some dermatologists, who are providing superficial radiation therapy services, are purchasing these devices and providing services under a self-referable business model. The IOASE, however, is at risk of being eliminated because of growing opposition to it in Congress. The AADA is actively monitoring threats to the IOASE and advocating in support of maintaining the exception. Dermatologists who are contemplating providing superficial radiation therapy services are cautioned to also consider the potential impact a change to the IOASE may have on their current business model.

Preparing for ICD-10-CM: Meet Coding Expectations Now, Rather than Later!

The ICD-10-CM implementation deadline will be here before we know it! On Oct. 1, 2014, all “covered entities,” as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) – must be prepared to begin using ICD-10-CM codes on all HIPAA transactions. There are no exceptions to this mandate and therefore all physicians, all specialty practices and the healthcare world must be ready for the challenge of reporting diagnostic codes in a completely new way. The transition to ICD-10-CM will not affect the use of the American Medical Association Current Procedural Terminology® (AMA CPT®) codes or the Healthcare Common Procedure Coding System (HCPCS) codes.

Successful transition from ICD-9-CM and implementation of ICD-10-CM codes will require significant planning, communication, assessment of training needs, implementation and testing. All of these stages involve milestones that are achieved in incremental phases.

Every aspect of the dermatology practice will be affected in some way, but certain functions are critical and must be addressed from the beginning. Your practice size will dictate the pace of transition. The fewer people involved in the implementation process, the less complicated it is to get things done. Among the important issues to be addressed from the beginning is the medical record documentation and claim submission system. Whether you use an Electronic Health Record (EHR) or superbill, there should be a clear plan in place on how your practice will convert those to ICD-10-CM, this can be achieved by identifying a staff member who will compile a list of most frequently used ICD-9-CM codes and transition those into the new ICD-10-CM codes.

Payers will have updated rules for authorization in coverage decisions to facilitate ICD-10-CM claim adjudication. Correct coding speeds correct claim.

Different staff members will need different types or different levels of training. For example, coders will need training in the new codes, medical terminology, anatomy and physiology training, administrative and clerical staff members as well as clinicians will need to understand the importance of adequate documentation to ensure that there are no disruptions to cash flows.

If billing is handled within the practice it is important to review the current superbill and determine what needs to be updated before October 1, 2014. If billing is outsourced, it would be appropriate to ask the billing company if it is ready to handle the transition. As a good rule of thumb, review all the processes currently affected by ICD-9-CM coding and ensure that they are ready to accurately transition to ICD-10-CM.

From the coding perspective, ensure that staff has the tools they need to perform their duties effectively, such as the 2014 Dermatology Coding Manual. They can begin practicing by checking out what the current ICD-9-CM codes translate to in ICD-10-CM.

Transition

Transitioning to ICD-10-CM will create some growing pains to your practice’s business and data-related processes. Identify where and how you currently use ICD-9-CM. Take a moment to review the current coding, billing and reporting templates because these may require updating with new refined algorithms. It would also be good practice to contact your practice management software provider and confirm that the software is appropriately updated and ready for the transition.

Take a close look at the areas that will be impacted by the transition. For example an area likely to be impacted is the financial area. It is anticipated that there will be system changes to processes, software updates, resource material update for such things as superbills, templates and others that are used for capturing information. All of these items will need to be accounted and budgeted for ahead of time.

Along with those expenses, staff training will need to be budgeted for as well. Dermatology practice staff members will require special training and practice to be able to be prepared for ICD-10-CM coding. Providers, coders, and other staff members should be encouraged to spend time reviewing the new ICD-10-CM code book, paying particular attention to chapters that pertain to dermatology, e.g., Chapters 2 (Neoplasms), 12 (Diseases of the skin & Subcutaneous Tissue), 18 (Symptoms, Signs and Abnormal Clinical and Laboratory Findings), 19 (Injury, Poisoning & Certain Other...), 20 External Causes of Morbidity and 21 (Factors Influencing Health Status....). Coding entities such as American Academy of Professional Coders (AAPC), American Health Information Management Association (AHIMA) and American Academy of Dermatology (AAD) have courses online or on-site that can be helpful.

Most dermatology practices are currently using electronic health record (EHR) systems. Practices should determine now if an ICD-10-CM function or update is already built into the EHR system that is being used. A good place to start is by contacting your EHR vendor, Remember, it is not just whether your system will capture ICD-10-CM that matters,
Preparation for ICD-10-CM: Meet Coding Expectations Now, Rather than Later!

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but also whether your system helps you define and capture the key coding concepts necessary to allow for detailed documentation to support proper ICD-10-CM coding. It is never too early to start looking at the internal processes of your practice. Spend some time reviewing your medical records to ensure there is adequate documentation to assign the right ICD-10-CM codes.

Implementation

For successful implementation, understand your current practice systems and processes and how they may be affected by the implementation of ICD-10-CM. Define the tasks and create a checklist that will determine readiness, assessment of your current clinical documentation practices, and familiarization with the coding transition standards.

Time is of the essence and must be used wisely going forward. Start by prioritizing the most important items. There are different types of resources available from CMS and AAD to help with training and understanding of what this ICD-10-CM transition will mean for your practice. Create and maintain a reasonable timeframe and provide constant updates to the rest of the staff involved in the implementation project.

Testing

Testing your system is the final phase and the one that will determine your readiness and preparedness. Testing should be done with both internal and external components. The most effective way to tell is by testing the system with some ‘practice’ claims and takes it through the process currently used in your practice. Make sure the ‘practice’ claim goes through the workflow of your process - from the moment the patient arrives to the moment the claim is submitted. Track it and identify any new areas that might be affected. Walk it through your practice’s daily work cycle; it can be helpful to show you which areas you may need to improve on.

If you are stuck and are not sure how to run a test, create a patient encounter for a lesion removal, run the scenario through your office to see how your systems, your business, and all the different parts of the practice handle that in the ICD-10-CM environment. Running a test will allow you to make an assessment of your technical components, your software, and all your business components such as the EHR system and the practice management system.

Review your coding to ensure that once you crosswalk your diagnosis codes to ICD-10-CM, you arrive at an accurate code. ICD-10-CM coding is driven by the medical record documentation available. Based on the processes you have put in place, can you confidently assign and save an ICD-10-CM code? Does your system have a way to keep track of assigned codes? There will be a great need to perform constant audits and testing to ensure there is enough documentation to assign appropriate ICD-10-CM codes.

Speak to your vendor and ask if you can test some claims to make sure your codes and claims are accepted by the system. If so, then you know your implementation worked. Working with clearinghouses is a great example of working with an external partner. Regardless of how much you prepare for a big project, there are always bottlenecks, setbacks, and barriers. The keys to achieving success with the transition are:

- Get started now; and
- Keep moving.

Oct. 1, 2014, is closer than you think!

For additional information please visit: http://www.aad.org/members/practice-management-resources/coding-and-reimbursement/icd-10 to learn more on ICD-10 transition.

Resources:

AAD ICD-10 FAQs www.aad.org/icd-10-faqs
AAPC ICD-10 Information http://aapc.com/icd-10/index.aspx
AHIMA ICD-10 Information http://www.ahima.org/education/onlineed/Programs/ICD10

Update on ZPIC

For the last couple of years, the healthcare industry focus has been on Recovery Audit Contractors (RA) audits but another group is also of particular interest and is also from the Centers for Medicare and Medicaid Services (CMS) that is of more concern, this group is called the Zone Program Integrity Contractors (ZPIC). These groups are hired by CMS to perform different medical reviews, data analysis and Medicare audits. This contractor program is different from other Medicare audit contractors because their primary goal is to identify Medicare fraudulent payments. CMS has noted that “The ZPIC program will focus on quick response to fraud and administrative actions, furthermore, ZPICs may take immediate action to ensure that Medicare Trust Fund monies are not inappropriately paid out and that any mistaken payments are recouped. The fundamental activities of the ZPIC will help ensure payments are appropriate and consistent with Medicare and Medicaid coverage, coding, audit policy and will also identify, prevent or correct potential fraud, waste, and/or abuse.”

ZPIC auditors focus their effort on reviewing physicians, hospices, and skilled nursing facilities. Their auditors are in full force across the nation, pursuing providers with surprise on-site visits, targeted data analysis, random audits, 100% pre-payment holds, extrapolations and follow-up to whistle-blower actions.

As with any audit, the main purpose is to determine whether there is potential fraud or billing errors. If the
### Update on ZPIC

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Investigation does not result in a case, the ZPIC will act to prevent further payment of inappropriate claims and recover any overpayments. If the investigation becomes a case, the investigation will be closed and the case will be referred to the Office of Inspector General (OIG) and/or Department of Justice (DOJ). Regardless of whether the investigation becomes a case, the ZPIC will seek recoupment whenever it determines that there is an overpayment. All audit requests should be taken seriously, but special emphasis should be placed on those from the ZPIC. These audits are concerning and must be addressed in a timely manner and must be handled appropriately in order to avoid further investigations. Therefore, when responding to a ZPIC audit, it is important that the provider’s documentation is clear and complete. Providers facing ZPIC audits must act immediately and effectively to address targeted audit issues. Like all CMS audits, the multilevel appeal process is still available.

CMS recently announced plans for a new program integrity mechanism, called the Unified Program Integrity Contractor (UPIC). The main objective of these UPICs according to information published by CMS is to “integrate the program integrity functions for audits and investigations across Medicare and Medicaid, and to ensure that the Center for Program Integrity’s national priorities for both Medicare and Medicaid are executed and supported locally.” Additionally, CMS has made it clear that UPICs will take on some of the functions currently carried out by the ZPICs. At this time, CMS has yet to publish an official statement with regard to the UPIC, so there are few details on the timeframe for this transition.

The Medicare Administrative Contractors (MACs) will continue to process Medicare claims but their integrity responsibilities will now be transferred to the UPICs. Additionally, Medicaid Integrity Contractors (MIC) will likely be phased out but it is expected that Recovery Auditors will continue to function in the same manner in which they have been doing so to date.

### 2014 CPT Changes

#### Revised Codes

- **88342** Immunohistochemistry or immunocytochemistry, each separately identifiable antibody per block, cytologic preparation, or hematologic smear; first separately identifiable antibody per slide
- **15777** Implantation of biologic implant (e.g., acellular dermal matrix) for soft tissue reinforcement (i.e., breast, trunk) (List separately in addition to code for primary procedure)

#### New Code

- **88343** Immunohistochemistry or immunocytochemistry, each separately identifiable antibody per block, cytologic preparation, or hematologic smear; each additional separately identifiable antibody per slide (List separately in addition to code for primary procedure.) Visit www.aad.org/coding for detailed guidelines on how to report these codes.

#### Deleted Code

- **13150** Repair, complex, eyelids, nose, ears and/or lips; 1.0 cm or less

### Coding Q&A

**Q:** In reading the article—NCCI Surgical Package Clarified—published in Fall Derm Coding Consult—is my interpretation correct that no E/M service can be billed for any minor surgical procedure (0, 10 day global period) unless I perform a major surgical procedure (90 day global period)?

**A:** No, the intent of the article was to highlight the fact that an E/M may be appropriately reported as long as it is performed, and documented that it was significant, separately identifiable and above and beyond the work already included in the procedure.

One example is a patient with psoriasis who returns to the office for acne follow-up. The patient states they feel well on topicals but has had increasing plaques on trunk and extremities. Physician injects intralesional Kenalog to several plaques as well as a change in topical prescription due to worsening of condition. Further discussion of biologics and pre-testing is performed. Patient is scheduled to start a biologic pending blood results.

Though patient presents with one diagnosis, it is appropriate to report a separate E/M service due to patient worsening condition which ultimately results in an expanded problem focused HPI and Exam with low complexity medical decision making. The injection for Kenalog is reported separately.

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**Coding Q&A**

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**Q:** Patient presents for acne follow-up visit. Currently on oral antibiotics and topical retinoid, patient states acne has flared up in the past few days, denies any bowel disease or depression. After a detailed HPI and exam with a low-complexity medical decision-making, acne surgery is performed along with a discussion on possible treatment with Accutane prescription once the lab results are received.

**A:** This example also allows for reporting of separate E/M service due to patient worsening condition, ultimately resulting in both a procedure and prescription management.

**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 keratoses 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.

**Q:** A new patient (one who has not received any professional services from this dermatologist, this practice and this specialty/subspecialty within the practice in the past three years) is referred by their primary care physician for a malignant lesion. The dermatologist examines the patient, discusses Mohs technique and schedules the procedure for the following week. Can you bill an E/M service for the initial visit?

**A:** Yes, having met all criteria for appropriate reporting of an E/M encounter, it is appropriate to report this service as a new-patient encounter (9920x). See more examples at Cigna Government Services (CGS) a Medicare contractor, at http://www.cgsmedicare.com/kyb/pubs/news/2012/0512/cope18891.html

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**Common Errors Negatively Affect Practice Bottom-line**

Claim denials can quickly become one of the factors negatively impacting a dermatology practice’s bottom line. Most practices will write off the denied claims without any effort of appeal or correction, generally assuming that denied claims equal lost revenue. Delayed payments and costly claim appeals can further compound an already difficult situation. All of these factors can be mitigated by having a check list of safeguards in place before submitting claims.

In this article, we will address the most common errors that can cause claims to be denied – thus negatively affecting your practice’s bottom-line. Additionally the goal is for you and your staff members to learn a few techniques that may help remedy the situation and bring the funds flowing back into your practice!

**1. Failure to correctly capture updated demographics and verify insurance coverage**

This is the number one reason most medical billing claims are denied by the payer. It all starts with the front desk- the frontline of defense in all practices. Once erroneous information is captured and entered into the system during registration, these errors will follow the claim all the way to the payer.

The most common denial notes seen on a claim are:

- ✓ Members’ coverage terminated or not eligible for services on the date of service
- ✓ Services not authorized
- ✓ Services not covered by plan benefits
- ✓ Maximum benefits met

Remember, life is a cycle and we are all in constant motion. People change jobs, move to new residences, and change insurance providers and coverage. Just because someone has been your patient since the ’80s doesn’t mean that their data has not changed.

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**Coding Myth**

‘Correct coding equals reimbursement and reimbursement equals correct coding’

**NOT TRUE!**

To avoid these denial notes, ensure staff verifies and obtains the following during each visit:

- ✓ Correct insurance information - member eligibility and coverage

--- see ERRORS on page 9
Common Errors Negatively Affect Practice Bottom-line

— continued from page 8

- Is the correct insurance payer entered?
- Is the policy number valid?
- Does the claim require a group number to be entered?
- Is the patient relationship status to the insured accurate?
- For patients with multiple insurance policies, have you noted which is the primary insurance for coordination of benefits?

✓ Correct Patient Demographics
- Is the patient’s name spelled correctly?
- Is the patient’s date of birth and sex correct?
- Is the patient mailing address updated?

2. Insufficient documentation to support accurate and appropriate code assignment

Patient encounter must capture and accurately document all the “dones”:

✓ What was done
✓ Why was it done
✓ Where was it done
✓ Who did (“done”) it
✓ When was it done
✓ How was it done

A brief description of what, why, where and when the service was done as well as who performed the service needs to be noted in the patient record. If it is not documented, you cannot bill for it. Your documentation should match/reflect the selected CPT code reported to allow for accurate reimbursement.

3. Using Wrong Diagnosis or Procedure Codes

Accurate claim coding allows the payer to know the symptoms, condition/illness for which the patient sought the care in the first place. It also should allow the payer to understand the treatment or service rendered by the provider. Simple mistakes can be avoided by ensuring that claims have the appropriate diagnosis or procedure codes. These additional steps can prevent a claim denial with notes stating ‘service not medically necessary’ or ‘procedure does not match authorization,’ etc.

There are several reasons the wrong diagnosis or procedure code could end up on the claim. Before claim submission, ask yourself:

✓ Does the diagnosis code correspond with the procedure performed?
✓ Does the procedure code performed match the authorization obtained?
✓ Does the procedure meet the coverage determination guidelines for medical necessity?

Reimbursement, in many ways, is tied to understanding and timely response to payer reimbursement policies and requests. For example, a general skin exam or cosmetic service may have CPT codes associated with it but that does not mean those CPT codes are going to be recognized or accepted by the payer as covered services under their reimbursement policies—this is certainly the case for most carriers including Medicare. Additionally, to avoid claim denials based on medical necessity, appropriate medical necessity parameters need to be clearly documented and outlined before claim submission.

4. Duplicate Billing

Duplicate billing is defined as billing for the same procedure or service more than once on the same date of service for the same patient. To avoid these errors, educate yourself and understand how each payer processes claims and reimburses for covered services. It is highly likely that each contract you sign assigns this responsibility to you. Understand the EOB remark codes to establish reason for denial. Gone are the days when payers would hold a provider’s hand to figure out the error – Now they expect us to know the rules of the game. What you don’t know will likely hurt you financially.

For example, Medicare carriers recently, announced that they will deny claims with duplicate code billing on the same date of service (DOS) e.g. 11401, 11401-59. To avoid the second procedure from denying as a duplicate code, Medicare requires you to report the second code with modifier 59 & 76 (to show that the procedure was repeated) e.g. 11401-59, 76.

5. Upcoding or Unbundling

Upcoding and unbundling are common and frequent mistakes as well. To avoid them, you need to know what they are. Upcoding is defined as inappropriately selecting a level of service or procedure performed in order to receive a higher reimbursement rate or reporting a non-covered service by using a covered service procedure code.

Unbundling, on the other hand is the “un-wrapping” of all the components of one designated code and billing for all of its components separately and individually. It is of importance to understand that some services are considered all inclusive. Understand what is integral to the service provided, for example, local days, supplies, management etc.

Denials can be due to any of these simple mistakes listed above can be refilled or appealed. Normal claim adjudication takes up to 14 days on a payment turnaround. Claims that are refilled or appealed can have a reimbursement time of 30-45 days. These delays can have a significant impact on a practice’s cash flow.
To minimize the impact of delayed payer reimbursements it is important to determine the area that is most frequently triggering claim denials:

- **Is it the Front Desk?**
  - Data entry errors;
  - Financial Consent Form when applicable;

- **Or the Provider?**
  - Missing Documentation;
  - Inaccurate Code Selection;

- **Or the Billing department?**
  - Inaccurate Codes Used;
  - NCD/LCD Requirements Not Met;
  - Missing, Misplaced, or Incorrect Modifier Use;
  - Timely Filing;

Once a claim denial “focal point” has been identified, it becomes easier to provide education to those in that area and establish checks and balances to avoid future errors. It is also important to know how each payer processes claims, the reimbursements for covered services and understanding the contractual appeal rights and appealing claim denials with updated information.

Other helpful tips for practices include preparing and ensuring that your charge tickets are accurate and ready for data entry once patient visits are complete. Additionally, review charge tickets and know what necessary information will be required on the CMS-1500 form, ensure all services are accurately captured on the claim form and, finally, understand the EOB remark codes. You can review the Key provided by Washington Publishing Company at [http://www.wpc-edi.com/reference/codelists/healthcare/remittance-advice-remark-codes/](http://www.wpc-edi.com/reference/codelists/healthcare/remittance-advice-remark-codes/)

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**Medicare Secondary Payer Billing**

As we are getting ready to start a new year, it is good practice for physician offices to refresh their patients’ registration information. Each new year for the first few months of the year, practices should ask their patients whether there are any changes to their insurance coverage. This is especially important for Medicare eligible patients whose insurance may have changed since their last visit. They could have joined a Medicare Advantage plan or obtained additional insurance which would result in Medicare no longer being the primary insurance payer for that patient.

**Coordination of Benefits**

Medicare Secondary Payer (MSP) is the term used when Medicare is not considered as the primary insurance payer. The term used to assign the responsibilities of more than one private insurance carrier is called “Coordination of Benefits.”

Often MSP is confused with Medicare supplemental insurance which is usually referred to as a Medigap policy. This is a private health insurance policy designed specifically to supplement Medicare deductibles, coinsurance and other expenses not covered under the program.

It is the provider’s responsibility to determine whether the patient has other insurance that is primary to Medicare and to include this information when submitting claims to Medicare for secondary payment. Often, Medicare Secondary Payer (MSP) cases are identified after processing and the Medicare payment must be recovered from the provider. This is a costly and time-consuming process for both the provider and Medicare.

A provider must determine who the primary or secondary payer is for each patient encounter prior to submitting a claim to Medicare. This can be accomplished by questioning the beneficiaries about other coverage. The questions asked will verify that the information is correct and up-to-date. Some questions to ask beneficiaries include, but are not limited to:

- Does the patient or spouse have coverage with another group health policy through your current or former employer? If so, does the company provide coverage and have more than 20 or 100 working employees?
- Is the patient currently on COBRA?
- Is the patient receiving workmen compensation benefits?
- Has the patient filed a claim with a no-fault insurance or liability insurance?
- Is the patient being treated for an injury or illness where a third party is liable?


After gathering any information and updates the patient may have provided for completion of the questionnaire with both the patient’s negative and positive responses, CMS requires the document to be on file for ten years. The method of filing that record (paper or electronic) is left to the provider.
Medicare Secondary Payer Billing
— continued from page 10

If a questionnaire can’t be furnished by the provider, it will be up to the beneficiary, employer, insurer, or attorney to complete a Secondary Claim Development (SCD) Questionnaire. For more information, see the “Medicare Secondary Claim Development Questionnaire” at http://www.cms.gov/Medicare/Coordination-of-Benefits/InsurerServices/medicare-sec-claimdevquest.html on the CMS website.

There is a penalty for an incorrect claim filed to Medicare. Federal law allows Medicare to recover the payment with a fine up to $2,000 for knowingly, willfully, and repeatedly providing inaccurate information related to the existence of other health insurance or coverage.

Reporting Correct MSP Type

Another consideration is reporting the correct MSP type (insurance type code) on the electronic or paper claims. An incorrect MSP type will result in claim denials. The two-digit numeric value assigned to each MSP type, as well as a description of the MSP type is provided below in an effort to help providers identify the correct value to report on electronic claims (the MSP type is not indicated on paper claims, other than checking the appropriate box in Item 10).

Medicare considers a Secondary Payer if a beneficiary is covered under any of the following insurance plans:

- Group Health Insurance is provided by an employer to a policyholder who is actively working.
- Automobile or Liability Insurance is applicable in cases where an accident has occurred, whether it is a car accident, a fall or medical malpractice.
- Workmen’s Compensation covers injuries on the job. The employer’s Workmen’s Compensation Carrier is responsible for the claim first.
- United Mine Workers is a Medicare plan a beneficiary could elect, if they are qualified.

Other coverage plans can be considered a Secondary Payer to Medicare, including supplemental insurance, which is an insurance policy purchased to pay benefits after Medicare has paid the claim as the primary insurer. These plans are referred to as Medigap.

Health Maintenance Organizations (HMOs), which offer several different types of coverage, can be primary to Medicare. Senior HMO plans, called Medicare Advantage plans are not considered primary to Medicare as they are a different way for seniors to receive Medicare benefits.

Medicare will not cover the following: Black Lung and Veterans Administration claims. Black Lung is covered under the Federal Black Lung Program. Medicare cannot pay claims submitted with a Black Lung Diagnosis code unless a copy of the Explanation of Benefits from the Black Lung Program is submitted showing that no payment was made.

Veterans Administration claims will not be covered under Medicare. However, if a claim isn’t filed with the VA, then Medicare may reimburse based on medical necessity.

Under MSP policy, the beneficiary must understand and be responsible for monitoring correct payment of their Medicare claims; notify Medicare of any changes to the primary carrier or any other coverage for any motor vehicle accident, workmen compensation case or other third party claims, They must contact their local Coordination of Benefits Agreement (COBA) Contractor especially if there is any legal action taken.

Identification of Beneficiaries

Employers are also responsible to identify beneficiaries where the MSP requirement applies to proper primary payments where by law Medicare is the secondary payer. There is no discrimination against employees and employees’ spouses age 65 or over, people who suffer from permanent kidney failure and disabled Medicare beneficiaries for whom Medicare is secondary payer. They must complete and submit CMS’ Data Match reports timely on identified employees.

The COB Contractor is primarily an information gathering entity. A variety of methods and programs are used to identify situations in which Medicare beneficiaries have other health insurance that is primary to Medicare:

- When a claim is submitted with an explanation of benefits (EOB) attached from an insurer other than Medicare, a questionnaire is sent to the beneficiary to collect information on the existence of other insurance that may be primary to Medicare.
- When a diagnosis appears on a claim that information is received through correspondence or on a claim that indicates a traumatic accident, injury, or illness, which might form the basis of MSP an attorney is sent to collect information on the existence of other insurance that may be primary to Medicare. This questionnaire may be sent to the beneficiary, provider, attorney, or insurer.

This process confirms MSP information received from a third party payer.

The goal of these MSP information-gathering activities is to identify MSP situations rapidly and to ensure the correct responsible party.

In The Know.....

Did you know that coverage guidelines exist for most of the services provided by dermatologists?

Both commercial payers and Medicare provide elaborate guidance on criteria that meets medical necessity to allow for coverage of services. With all the Medicare Administrative Contractor consolidation, you will find that the coverage policies are being merged in relation to the consolidation. Services that were routinely paid previously are now suddenly being denied and you may be wondering “What is causing the denial?”

Visit your new Medicare Contractor website often, familiarize yourself with the coverage policies and review any changes. This is good practice, as it will reduce the rate of denied claims and reduce claim appeals that tend to hold reimbursement at bay.

To view your Local Medicare coverage as well as national coverage policies, visit the single access portal at [http://cms.gov/medicare-coverage-database/overview-and-quick-search.aspx](http://cms.gov/medicare-coverage-database/overview-and-quick-search.aspx)

Below is a list of current Medicare Local Coverage Determinations (LCD) pertaining to dermatology that you can refer to:

- Botulinum Toxins
- Debridement Services
- Incision and Drainage (I & D) of Abscess of Skin, Subcutaneous and Accessory Structures
- Removal of Benign Skin Lesions
- Excision of Malignant Skin Lesions
- Mohs Micrographic Surgery
- Routine Foot Care and Debridement of Nails
- Debridement Services

**Note:** Each LCD has a distinct reference number originated by the contractor.

The following are national Medicare coverage determinations (NCDs):

- 250.1 Treatment of Psoriasis
- 250.4 Treatment of Actinic Keratosis

To review your commercial carriers’ policies, visit their website directly or contact your Provider representative for guidance.

**Now you are In The Know!**