Photo-documentation, Meaningful Use, and the Derm EMR

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DISCLOSURE OF RELATIONSHIPS WITH INDUSTRY

Daniel M Siegel, MD, MS, FAAD
FO88 Photodocumentation in Dermatology

DISCLOSURES
Modernizing Medicine – Advisory Board
Caliber ID – Board of Directors
Photodocumentation Definition

  - Vaccination to prevent frivolous lawsuits.
  - A way to increase provider and patient happiness.
- Press Ganey and other rating systems.

A picture is worth a thousand words

- The note may say left, the patient says right, the red mark is near the midline.
- What do you believe?
  - Your eyes!
- Plaintiff's attorney's love wrong site surgery. It is a $lam Dunk.
Common Sense

- An old concept.
- “...an extensive and compelling treatment of the Aristotelian conception of the common sense, which has become part and parcel of Western psychological theories from antiquity through to the Middle Ages, and well into the early modern period.”

Common Sense

- Removed from med school curricula and residency training and replaced with political correctness.
- An unfortunate occurrence we will try to correct today.
Common Sense

- A photograph should document a finding in such a way that you can find the same site a later visit.
  - Someone else can find the site.

- After a long day, when you finish your notes, you can look at one or more images and jog your memory.

Common Sense

- A photograph should allow easy assessment of change:
  - Has the pigmented lesion changed?
  - Has the extent of psoriasis changed?
  - Has the cellulitis /lymphangitis extended or regressed?
  - Everyday questions answerable with good pictures.
Common Sense

- A picture should be well composed and its message should be clear.
- The viewer ideally should be able to hold the image in their mind or side by side with the patient and be able to find the sites of concern.

5.5 cm from somewhere to somewhere else and 4 cm from another spot.

What are the landmarks?

😊

Solo pic.
3.5 cm to lateral canthus is a good landmark. But why not take the image head on?

2.5 cm to somewhere near the nose.

But why is the lesion covered up?

Is the exposure washed out?

😢
The bx site itself.
Telangiectasias.
A seb ker.
Most critically the bx site is not covered!

Of course, too much marking can be a problem too!
You can over mark on the picture so much you can't see the landmarks anymore.
Common Sense Rule #1

- Electrons are cheap.
- Take as many pictures as you have to to be sure you can see what you want and need to see.

Common Sense Rule #2

- Use a fine marker to mark and a ruler to measure.
Photo Measuring Labels

Pressure sensitive labels measure 6 cm x 11 mm with a place for name, location index.
Use to color code photos, for example one color for Pre-op and another color for Post-op.
Available in black, blue, green and red. 500 labels per roll. (specify color)

To see prices or order, click on the Log In button.

- Photo Measuring Labels, back, roll of 500
  LP/BLK
- Photo Measuring Labels, blue, roll of 500
  LP/BLU
- Photo Measuring Labels, green, roll of 500
  LP/Gr
- Photo Measuring Labels, red, roll of 500
  LP/RL
Something Your Institution Will Not Like

- The best marker is a Sharpie®.
- It is safe and doesn’t smear with routine, non-alcohol preps.
- Removes easily with alcohol.

Something Your Institution Will Not Like

- If you don’t want to spend $30 on a reprint, see the NY Times blog at http://wellblogs.nytimes.com/2008/10/22/planning-surgery-bring-a-sharpie/?_r=0
Common Sense Rule #3

- Take a “square” picture.
- Avoid bizarre angles you can’t reproduce or orient on.
  - Face on, ears centered vertically, full face horizontally.
  - Side view, nasal tip level with tragus.
  - Posterior view.
  - Top view.

Some nice free reference material for refining your technique:

- [http://trebol.sirexmedica.com/download/Photographic_Standards.pdf](http://trebol.sirexmedica.com/download/Photographic_Standards.pdf)
Common Sense Rule #4

- For everyday general images almost any current generation iPhone or Android phone or point and shoot digital camera will work for you.
  - Regardless of device, remember HIPAA.
  - Secure the images and secure the permission to use them.
  - There are many apps..... Search with Google.
- Use the “flash” to beat the blur.
Common Sense Rule #5

- Skin cancer work is for most of us “everyday”.
- Location and size are critical.
  - You need not be Richard Avedon.

Common Sense Rule #6

- If you are doing lots of cosmetic procedures, consider spending the $$$ for a high quality system to capture reproducible results every time.
  - Prove you conquered that tear trough deformity or really rejuvenated that vulva.
  - Before and afters are critical.
Common Sense Rule #7

- If you don’t photograph everything (we do) and a bx comes back “positive” call the patient and have them take a selfie.
  - Not a bad idea to have patients take a selfie when they make an appt

- Avoid the “you should know where it is. You’re the doctor” conversation.

Common Sense Rule #8 EMR KISS

- Lots of options.
- I am biased toward EMA by Modernizing.
  - I serve as an advisor.

- Why?

- Compose your image in the native iPad interface, capture, annotate, done.

- No memory card downloads and other time wasting intermediate steps.
Meaningful Use

- Nothing specific for imaging and the program may or may not die, but images will let you communicate more clearly with your referring docs and may get you some ACO action if desired… or not.
- MU is going away soon...think MIPS or not.

The Centers for Medicare & Medicaid Services (CMS) has extended the attestation deadline for providers participating in the Medicare EHR Incentive Program to Monday, March 13, 2017, at 11:59 p.m. ET.

Provider groups seek indefinite halt to Meaningful Use, parts of MIPS

Sixteen healthcare provider associations have joined to send a letter to Health and Human Services Secretary Tom Price asking for indefinite delays in implementing Stage 3 of the electronic health records meaningful use program as well the Stage-3 like measures in the Merit-based Incentive Payment System.
Additionally, the groups say providers should not be required to move to the 2015 Edition of certified electronic health records systems.


“Our members are very concerned with the unrealistic timeframe and the difficult-to-meet requirements laid out in Stage 3 of the Meaningful Use program, as well as with the related requirements under MIPS,” member associations contend in the letter to Price.

Furthermore, the current schedule for providers to implement the 2015 Edition by January 2018 does not take into account provisions in the 21st Century Cures Act that include improving the usability of EHRs and reducing regulatory burdens.
The letter likely will receive a warm reception because Price, a physician, has criticized the overall usability of EHRs. During his time in Congress, he introduced the Meaningful Use Hardship Release Act of 2015 (H.R. 3940) and was an early co-sponsor of the FLEX-IT Act (H.R. 5001). Both bills sought to reduce regulatory burdens so physicians could focus more on patient care.

During his confirmation hearing, Price said it was imperative to ensure that meaningful use metrics “actually correlate with the quality of care that’s being provided, as opposed to so many things that are required right now of the physician or the provider that make it so they are wasting their time documenting these things so that it fits into some matrix somewhere, but it doesn’t result in higher quality of care or outcomes for patients.”

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**The Derm EMR**

- Lots of options.
- I am biased toward EMA by Modernizing.
  - I serve as an advisor.
- Why?
- Compose you image in the native iPad interface, capture, annotate, done.
- No memory card downloads and other time wasting intermediate steps.
Are you getting paid for your efforts?

Whole Body Photography

96904

Whole body integumentary photography, for monitoring of high risk patients with dysplastic nevus syndrome or a history of dysplastic nevi, or patients with a personal or familial history of melanoma

CPT Changes: An Insider’s View 2007
What Is the RUC?

- The relative value scale update committee established in 1992.
- The super bowl of AMA committees.
- Stage for violent, desperate, pitched battles over reimbursement.
- The RUC helps decide what you get paid.
- The government is also at the table helping.

New Skin Biopsy CPT Codes!

- The AAD is conducting a RUC survey to establish relative values for new codes for tangential, punch, and incisional skin biopsies.
- These new codes will REPLACE current skin biopsy codes 11100 and 11101 in 2019.
- If you receive a survey, answer thoughtfully!
- Questions? Contact Helen Olkaba at holkaba@aad.org or (202)712-2612
Wake up now!!!! - RUC Process

• Small impact on the public and specialty psyche until 2010.
The RUC; 29 sharks in a tank with nothing to eat but each other.

RUC – Who gives a %$&#!

- RUC recommendations to CMS are the source of most payments for the CPT codes that the lifeline of our practices.
- When a code is new or revised or increases in use at 10% or more a year for three years or CMS simply sets its sights on a code for a variety of reasons, the specialty that is the main user of the code must survey those codes to refine work values.
**RUC – You give a @#$%!**

- Some lucky random or targeted subset of the membership gets to respond to the surveys. For Mohs codes, it will be a random mix of AAD members who also belong to ASMS/ACMS/ASDS.
- For treatment with a specific device such as an excimer laser, it might be all docs in all manufacturers database.
- When it comes to common things like destructions or biopises it is **YOU**.

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**RUC – You give a @#$%?**

- The email may not catch your eye and may get stuck in your spam folder.
- May have a header like: “**Your expertise requested - valuation of Surgical Pathology, prostate needle biopsy – Physician Work Survey**”
- Or “**AAD Request - Skin Biopsy Value Survey-Critical**”
- Please move it to your inbox and follow the instructions.
RUC – You give a @#$%?

You get a survey via email and you can print our a reference service list (RSL).

A list of codes of same global period with values above and below where the code under review is likely to land.

Print it out!

RUC – You give a @#$%?

This RSL may seem dumb when you look at but for procedural and technical reasons that you really don’t want to hear about, it is the best list your RUC team including docs and staff, can put together from allowable codes.
RUC – You give a *&%#?

Survey data is our currency at the RUC table.
Good data gives us a good chance to get a fair value for the work we do.
Bad data gets us bad values.
If you get a survey and don’t fill it out and we get &%$ed, it is your fault.

RUC – You give a *&%#?

Most of you ignore the survey and bitch when values go down.
Others of you open the survey, whip through in 45 seconds and bitch when values go down.
  – “One minutes wonders,” those who think everything takes a minute are the bane of our existence.
Don’t blame me. It is YOUR fault if we get screwed.
RUC – You give a *&%#?

Others thoughtfully fill out the surveys and if enough do his, there is nothing to bitch about.

With that good data we can get fair valuation.

RUC – %$&# hits the fan!

Demographics are easy.
– You have no conflicts of you do the procedure unless you own the manufacturer of the device under discussion.
RUC – $#%& hits the fan!

The rest of the Qs ask about times and comparison of work to the RSL.

– We and staff cannot tell you the “correct” times and RVUs.

RUC – $#%& hits the fan!

Work (your doctor work!) has three parts:

– Pre-service: talking to and examining patient, reviewing charts, obtaining consent, infiltrating local anesthesia.

– All stuff you do before the procedure.
RUC – $#%& hits the fan!

Intraservice work:

- Skin to skin time: scalpel to skin starts it, last suture or staple ends it.
- Step on laser pedal starts it, last burst ends it.
- First touch of curette to skin, last cautery zap….

RUC – $#%& hits the fan!

Post service work:

- Dressings, wound care instructions, charting, phone calls, path slips.
  - Anything that you the doc do counts.
RUC – $#%& hits the fan!

No preservice or post service work would imply you simply walked, carved a chunk of flesh and walked out – no discussion, no anesthesia.

Most don’t work that way.

RUC – Common sense.

If this sounds bizarre you can learn more by visiting http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/medicare/the-resource-based-relative-value-scale/the-rvs-update-committee.page?
Coming up next week:

- Biopsies are on the menu.
  - New codes to be more granular on bx techniques.

Why?

- Utilization and expenditure.

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New Skin Biopsy CPT Codes!

- The AAD is conducting a RUC survey to establish relative values for **new** codes for **tangential**, **punch**, and **incisional** skin biopsies.
- These **new** codes will **REPLACE** current skin biopsy codes 11100 and 11101 in 2019.
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RUC – Common sense.

- Dialogs in Dermatology FREE special issue.
- [Link](http://olc.aad.org/diweb/catalog/item/id/1212136/sid/23967614/q/f2=1&c=171&q=cms)
- Listen on the plane going home.
Of course, if you have common sense and simply Google the words 2017 final rule physician time and choose the top match you get to
Details for title: CMS-1654-F

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<tr>
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<th>CMS-1654-F</th>
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The final rule went on display at the Office of the Federal Register's Public Inspection Desk on November 02, 2016, and will be available until the regulation is published on November 15, 2016. See CMS-1654-F in the "Related Links" section below.

Downloads

- CY 2017 PFS Final Rule Addenda [ZIP, 1MB]
- CY 2017 PFS Final Rule Sample PE Worksheet [ZIP, 74KB]
- CY 2017 PFS Final Rule Direct PE Inputs [ZIP, 89KB]
- CY 2017 PFS Final Rule Indirect Practice Cost Indicators [ZIP, 10KB]
- CY 2017 PFS Final Rule Physician Time [ZIP, 92KB]
- CY 2017 PFS Final Rule PE Add-on [ZIP, 17KB]
- CY 2016 Utilization Data Crosswalk to CY 2017 [ZIP, 10MB]
- CY 2016 Analytic Crosswalk to CY 2017 [ZIP, 11KB]
- CY 2017 PFS Final Rule CPT Codes Subject to 90 Percent Usage Rate [ZIP, 97KB]
- CY 2017 PFS Final Rule HCPCS Codes Defined as Misvalued for Target [ZIP, 33KB]
- CY 2017 PFS Final Rule Outpatient Add-on List [ZIP, 27KB]
- CY 2017 PFS Final Rule List of Codes Subject to Phase-In [ZIP, 12KB]
- CY 2017 PFS Final Rule GPCI Public Use Files [ZIP, 1MB]
- CY 2017 PFS Final Rule List of Medicare Telehealth Services [ZIP, 10KB]
- CY 2017 PFS Final Rule List of Designated Cares Management Services [ZIP, 19KB]
- CY 2017 PFS Final Rule Calculation of FE RVUs under Methodology for Selected Codes [ZIP, 14KB]
- CY 2017 PFS Final Rule Medicare Add-on [ZIP, 13KB]
- CY 2017 PFS Final Rule Malpractice Crosswalk Table [ZIP, 5KB]
- CY 2017 PFS Final Rule Malpractice Risk Factors and Premium Amounts by Specialty [ZIP, 17KB]
- CY 2017 PFS Final Rule Malpractice Override List [ZIP, 9KB]
- CY 2017 PFS Final Rule Moderate Sedation Work Values Table [ZIP, 25KB]
- CY 2017 PFS Final Rule RVUs Invasive Cardiology Outside of Surgical Range [ZIP, 10KB]
- CY 2017 PFS Final Rule Multiple Procedure Payment Reduction Files [ZIP, 42KB]
- CY 2017 PFS Final Rule RVUs for MPPR Codes under Alternative Discount Factors [ZIP, 13KB]
- CY 2017 PFS Final Rule Crosswalk from 5 Character Placeholders to Final CPT Codes [ZIP, 8KB]
- CY 2017 PFS Final Rule PHE Town Hall on Data Collection on Resources Used in Furnishing Global Services [PDF, 319KB]

Related Links

- CMS-1654-F (PDF)
- CMS-1654-F (Text)
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<tr>
<td>Acne surgery</td>
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<td>Drainage of pilonidal cyst</td>
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<td>Remove foreign body</td>
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<td>Remove foreign body</td>
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<td>Drainage of hematoma/ fluid</td>
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<td>Debride infected skin</td>
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<td>Deb subq tissue 20 sq cm</td>
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A new WWW I came across does this well

RVU.GURU
**Rvu Data**

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<td>0005F</td>
<td>Osteoarthritis composite</td>
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<tr>
<td>00100</td>
<td>Anesth salivary gland</td>
</tr>
<tr>
<td>00102</td>
<td>Anesth repair of cleric lip</td>
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<td>00103</td>
<td>Anesth blepharoplasty</td>
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<td>Anesth electroshock</td>
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<td>0012F</td>
<td>Cap bacterial assess</td>
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<td>00120</td>
<td>Anesth ear surgery</td>
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<td>00124</td>
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<td>PW GPCI</td>
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### MANHATTAN, NY Payments

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<td>Conversion Factor</td>
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Coming up next week:

- We did not go looking for this.
- But we have no choice.
- We need good data.

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These new codes will REPLACE current skin biopsy codes 11100 and 11101 in 2019.

If you receive a survey, answer thoughtfully!

Questions? Contact Helen Olkaba at holkaba@aad.org or (202)712-2612.
Coming up next week:

- If we have good data we can be paid fairly.
- Bad data means pain.
  – “One minute wonders” are the bane of the RUC teams existence.

CMS usually accepts many recommendations of the RUC.

CMS can make their own decisions if they are not adequately guided.
"The nine most terrifying words in the English language are: 'I'm from the government and I'm here to help.'"

-Ronald Reagan

SUMMARY

We are all part of the team.
New Skin Biopsy CPT Codes!

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