NewsBriefs

First Glimpse at 05 Medicare Fee Schedule
The Centers for Medicare and Medicaid Services (CMS) has at last published the 2005 Medicare Physician Fee Schedule – Proposed Rule. Publication was delayed for eight weeks as CMS staff wrestled to incorporate required modifications to the calculation methodology contained in the Medicare Modernization Act.

CMS 05 MFS Proposed Rule Impact on Dermatology Services
Even with the positive 1.5% increase in the Medicare conversion factor, there are still procedure codes where dermatologists may see changes in relative value units (RVUs). However, the Medicare Prescription Drug Improvement & Modernization Act of 2003 (MMA 03) also included a number of legislative provisions that CMS has been struggling to incorporate.

05 MFS Conversion Factor (CF)
The Medicare Modernization Act also mandated a positive 1.5% increase in the conversion factors for 2004 and 2005. This is an estimated modest increase of $0.56 per RVU from last year’s conversion factor of 37.3374. We believe the 05 MFS Conversion Factor amount will be approximately 37.90. Therefore, every physician will see a slight increase in reimbursement if there have been no other changes to the total non-facility RVU for a particular code. Note, this increased amount to the conversion factor has yet to be published by CMS, but is based on the action taken by Congress.

Medical Economic Index Rebasing of RVUs
For the 2004 rule, CMS reduced the work RVUs by 0.57 percent (0.9943), the practice expense by 0.77 (0.9923) percent and increased the malpractice RVUs by 19.86 percent (1.1986). There is some concern that an additional reduction to the physician work RVUs may be proposed for all procedural codes with only a slight increase in the malpractice RVUs for dermat codes.

Other Reimbursement Anomalies
We expect CMS to finally correct the erroneous increase to the practice expense RVUs for the laser treatment for psoriasis codes (96920, 96921, 96922) that inflates reimbursement by over 50%. AADA identified the error in our comments on the proposed rule in 2003. In addition, there was a similar anomaly for CPT 11012 Debridement code. We will closely review all the integumentary system CPT codes to determine the status on these and to determine if there may be other anomalies.

Bush Calls for National Health Information Infrastructure
President George W. Bush has made a national health information "infrastructure" a new focus for his administration and has called for the health care industry to expand its use of information technology. How will this new federal initiative affect your dermatology practice? First, President Bush proposed the expansion of the electronic medical record (EMR) calling for its widespread use within 10 years. Bush is promoting a proposal to establish a national EMR system and issued an executive order to create a national health information technology office within HHS.

Tommy Thompson, Secretary of the Department of Health and Human Services (HHS) hosted a health information summit meeting in Washington, D.C., on May 6th and stressed the need for incentives for physician practices to

— continued on page 8
Letter From the Editor

Dear Derm Coding Consult Reader:

The Centers for Medicare and Medicaid Services (CMS) is again coming down to the wire on their release of the 2005 Medicare Physician Fee Schedule Proposed Rule. The law requires CMS to publish the rule in a timely manner to ensure that all interested parties have sixty days to provide comment. CMS must publish the final rule by November 1, 2004 in order to be able to implement it on January 1, 2005. Unfortunately, key sections have been impacted by various provisions of the Medicare Modernization Act. The regulation must explain how CMS intends to implement the changes to administrative procedures and expanded Medicare Benefits. We will provide a detailed update on the impact of the proposed rule in the Fall issue of Derm Coding Consult.

We’ve taken the opportunity in this issue to share with you quite a few of the Coding Q&A’s that have come into us from members over the last few months via phone and e-mail. Please fell free to contact HPP/Coding & Reimbursement staff anytime with your questions. That’s why we are here.

The Academy is proud to announce the publication of our new CLIA Manual for Dermatology Practices. The new CLIA manual discusses the changes in federal regulations released in 2003 from the Centers for Medicare and Medicaid Services (CMS) that will streamline and simplify the quality control and personnel rules under the Clinical Laboratory Amendments of 1988 (CLIA).

Your Fall issue of Derm Coding Consult will provide full details on the 2005 Medicare Fee Schedule – Proposed Rule as well as a detailed update on the phased-in implementation of key sections of the Medicare Modernization Act. However, there is growing dissatisfaction from Congress and Medicare beneficiaries with rapid drug price inflation that may create a legislative backlash, even before the prescription drug program is implemented! It is shaping up to be a campaign debate issue.

Best regards,

Norma L. Border, Editor

Coding Update

New ICD Codes for Hyperhidrosis

Effective October 1, 2004, two new ICD-9-CM codes are available for types of hyperhidrosis. Currently the ICD-9-CM code for the diagnosis of hyperhidrosis is 780.8. The two new codes should not be used prior to October 1, 2004.

These new codes and their descriptors are:

705.21 primary focal hyperhidrosis
705.22 secondary focal hyperhidrosis

There is no specific CPT code for the injections of Botox for hyperhidrosis, however, a proposal has recently been submitted to the AMA CPT for new codes for this treatment. CPT directives state that when a code is not available in CPT, one should report the procedure with an unlisted code and not a code that approximates the service. Thus the injection should either be reported with:

17999 – unlisted procedure, skin, mucous membrane and subcutaneous tissue;

or

64999 – unlisted procedure, nervous system.

In mild cases in which hyperhidrosis treatment is not considered medically necessary, the cosmetic procedure code A9270 can be used for non-Medicare patients, if the patient accepts the responsibility for payment for a cosmetic service.

The Botox would be reported with the HCPCS code J0585 and the number of units.

Note: Using CPT 64614 would not be appropriate. When Botox is being injected for hyperhidrosis, it is not injected into muscle. The descriptor for 64614 is chemodenervation of muscle(s), extremity(s) and/or trunk muscle(s), leg for dystonia, cerebral palsy, multiple sclerosis.

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Editor’s Notes:
Coding and reimbursement issues are an evolving process. It is important to keep issues of Derm Coding Consult and most important to share them with your staff involved with coding and reimbursement issues. Please note that the information provided in each issue is accurate to our best ability and knowledge at the time of publication.

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.

VISIT DERM CODING CONSULT AT:
www.aadassociation.org/coding.html

Order your 2005 AAD Coding & Documentation Manual by calling the MRC Toll-free at 866-503-SKIN (7546).
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CODING Q & A’s

Q. How do you code for candida antigen intralesional injections?

A. The correct codes for the intralesional injections would be 11900 (one through seven) and 11901 (more than seven lesions). The choice of the code is by number of lesions treated, not the number of injections.

At present, there is no J code for candida antigen. Therefore, there is no set reimbursement rate. It is advisable to contact the insurance company prior to purchasing the antigen to make certain that it is reimbursable or to determine if they have any specific method to bill it.

Use the unlisted J code J3490 for the candida antigen. When unlisted codes are used, there is an area on the (CMS 1500) claim form where additional information can be entered (box 19). This is where the name of the medication and the dosage given is listed since the unlisted code is nonspecific.

Q. When we resubmit denied claims; we write “corrected claim” on the CMS 1500. But it consistently gets denied a second time as “duplicate”. How can we avoid these “duplicate” claims (because this forces us to call the insurance company, sit on hold and when they find the claim it’s resubmitted again).

A. If you have received a denial from the carrier, you have to correct whatever caused it to be denied the first time. Use the denial code from the insurer to identify the specific problem. If you examine the denial and find out where the error lies, you can avoid this problem in the future.

Resubmitting a claim without indicating any changes is “duplicating” the claim. If you resubmit it without making any changes, it will deny again as a duplicate. Duplicate claims annoy the carriers because they feel it is a waste of their time and money (as well as your staff’s time).

To correct simple errors or omissions on a non-Medicare claim, you can use the AHIP Claim Correction Form. The AHIP Claim Correction Form can be found on the AADA web site at http://www.aadassociation.org/pandp_intro.html. It was designed by a coalition of medical specialty societies, including AADA to develop a consistent means of identifying and correcting claim submission errors in order to improve handling by the insurance carriers and speed claims payment to physicians.

The Claim Correction Form can be downloaded and stored as a word document for easy use in your office. Dermatology practice information specific to your office can be pre-loaded and with the use of this form, can be used with many of the private insurance carriers to correct or appeal a previously incorrectly processed claim.

The Claim Correction Form is designed so that your billing staff can easily tab from each section to the next to fill in the appropriate information. This form can be submitted electronically in lieu of submitting the claim a second time which would cause another denial because the carrier considers it a duplicate claim.

To appeal a denial, you will need to correct whatever error it was that caused the claim to deny in the first place (eg. medical necessity, missing claim information, missing modifier, etc). You may be able to appeal the claim by calling your carrier’s appeal line, and requesting a review by phone. This can be faster than resubmitting the claim. All you need to do is have them amend the claim they have on file.

Remember to run an aged trial balance report from your Accounts/Receivable so that you don’t lose track of corrected or appealed claims.

Q. Do most insurance companies and Medicare pay for 96902 Microscopic examination of hair or trichogram? How much does Medicare pay? It is not listed in the published fee schedule we received.

A. Regarding CPT 96902, you can not pull up a price for it on your carrier’s Medicare Fee Schedule data base, because CMS has classified it as “B” for bundled, and they will not pay for this. Payment for “B” status code services is always bundled into payment for other services. Although there may be Relative Value Units (RVUs) and a payment amount could be established for these codes, no separate payment is made. CPT 15850, Removal of sutures, is another B status code.

Q. Can we bill 90780 and 99211 for the nurse to set medication out and mix, place in a bag and hook up to the patient? The patient is monitored and it takes 30 minutes to receive the medication.

A. No. unless there are additional services unrelated to the administration of the IV, 99211 cannot be billed in addition to 90780. However, Code 90780 was given work-related RVUs for 2004 to improve it’s reimbursement level.
Q. Is the CPT code 99211, for established patient, only used for brief services provided by a nurse?

A. According to AMA/CPT, the descriptor of CPT code 99211 states that the service may or may not require the presence of a physician. This code would be appropriate to use if the physician or nurse provided a brief service.

Q. What code should be reported for laser treatment of acne?

A. There is no CPT code for this service. According to AMA/CPT directives, when a code is not available for the service rendered, the appropriate unlisted code would be reported. Thus, for the laser treatment of acne, report code 17999.

Q. How do you report an intralesional Kenalog injection?

A. The injection is reported with CPT 11900 for up to and including seven lesions or 11901 for more than seven lesions. Note, the descriptor says lesions, not needle sticks. A lesion may involve more than one needle stick.

To report the Kenalog, use the HCPCS code J3301. This J code is for triamcinolone acetonide per 10mg. The instructions for this code state to use for Kenalog-10, Kenalog-40, Triam-A. This code may be billed in multiple units. Thus, if 20mg were used, report J3301 with 2 in the units box (box 24G on the CMS-1500 form).

Q. A new patient presents with no chief complaint. The patient lives alone and feels the need to have a complete skin check by a dermatologist. The dermatologist performs the complete skin check, but is unsure of how to code this encounter.

A. According to the E/M guidelines, to report 99201-99205 requires taking history, physical exam and medical decision making. In addition, the history must include a chief complaint. However, the dermatologist should explore the “felt a need” point further with the patient. Is there a Family History issue? Was a friend diagnosed with melanoma or other skin condition. What were the findings of the skin exam? ■

*Derm Coding Consult is also available online at www.aadassociation.org/coding.html*
**Medicare Drug Program Resources**

Any Physician routinely prescribing medications for his or her Medicare patients is probably starting to get a lot of questions from them regarding the new Medicare Prescription Drug Program. To help you help your elderly patients, the Centers for Medicare and Medicaid Services have set up the following Information Resources for Physicians:

1. Download a free patient-education brochure at www.medicare.gov
   (or call 1-800-MEDICARE to order a limited number of free copies).
3. Attend a CMS Open Door Forum in person or by telephone (toll-free). These forums address concerns and issues of physicians, nurses, and allied health professionals. Visit www.cms.hhs.gov/opendoor for further details.
4. Visit www.cms.hhs.gov/medicareform for the latest information on MMA.
5. Contact your carrier for information by using the toll-free provider lines. Visit www.cms.hhs.gov/medlearn/tollnums.asp for your carrier’s toll-free number.

**New AADA CLIA Manual Reflects Updated Regulations**

The AADA CLIA Manual will be ready for the Summer Academy Meeting in July, 2004. The new CLIA manual discusses the changes in federal regulations released in 2003 from the Centers for Medicare and Medicaid Services (CMS) that will streamline and simplify the quality control and personnel rules under the Clinical Laboratory Amendments of 1988 (CLIA).

CMS regulates all laboratory testing (except research) performed on humans in the U.S. through the Clinical Laboratory Improvement Amendments (CLIA). In total CLIA covers approximately 175,000 laboratory entities. The Division of Laboratory Services, within the Survey and Certification Group, under the Center for Medicaid and State Operations has the responsibility for implementing the CLIA Program.

The objective of the CLIA program is to ensure quality laboratory testing. Although all clinical laboratories must be properly certified to receive Medicare or Medicaid payments, CLIA has no direct Medicare or Medicaid program responsibilities.

“For the first time, CLIA requirements have been reorganized in a more logical fashion to parallel the flow of patient specimens through the laboratory,” said CMS Administrator Tom Scully in a recent press release announcing the CLIA regulatory changes. “This reorganization should help laboratories and medical practices understand and apply the requirements more easily as well as reduce laboratory errors.”

The updated Clinical Laboratory Amendments of 1988 (CLIA) manual includes new forms, logs and a training manual for staff that can be customized for use in your practice with the included CD-ROM. Changes include the following categories:

- **Quality Control.**
- **Lab Director Requirements**
- **Proficiency Testing.**
- **Educational Resources.**

Pre-orders may be place by calling the Member Resource Center at (866)-503-7546. Questions on CLIA in the interim, may be directed to Carol Sieck, R.N., MSN Senior Manager/ Guidelines Development and Research, via e-mail at csieck@aad.org or phone (847) 240-1796.

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*Derm Coding Consult* is underwritten by an educational grant from BIOGEN. Please be sure to thank your BIOGEN representative for this sponsorship!
MMA Regulatory Relief

Physicians have worked for a long time to secure the regulatory relief provisions in the Medicare Modernization Act (MMA). Chief among these are those provisions that will help bring more fairness and due process to Medicare audits and reduce unnecessary paperwork.

Reducing Overpayment Demands

Under the MMA provisions, if physicians are audited by Medicare carriers and told that they must repay so-called "overpayments," they will be able to wait until their appeal has been heard before the carrier can demand repayment. In addition, repayments can now be requested to be made in installments instead of having to be made all at once in 30-60 days. The law also places limits on carriers' use of "extrapolation," which is the process by which they multiply errors made on a small number of claims to calculate the total number of potential errors and which have resulted in enormous overpayment demands.

E&M Pilot Studies

Medicare officials have also been working to address longstanding concerns about excessive documentation requirements for evaluation and management services. The Medicare Modernization Act (MMA) builds upon this effort by preventing the Medicare program from imposing any new evaluation and management documentation guidelines for physicians as a national standard until several pilot tests have been completed. The pilot tests would have to demonstrate that any proposed new guidelines succeed in identifying clinically relevant documentation while decreasing non-clinically pertinent and burdensome documentation time and content.

New National Coverage Determinations Manual

The Medicare National Coverage Determinations Manual (NCDM) is a new manual that replaces the Medicare Coverage Issues Manual. The manual is structured in the same sequence as CPT categories to provide a more logical organization than the previous manual. Where there is no national coverage determination that affects a particular CPT category, the category is listed as reserved in the chapter table of contents.

The NCDM will be organized as two chapters: Chapter 1 will include a description of all national coverage determinations made by CMS. Chapter 2, when available, will be a listing of CPT and HCPCS codes that are related to each determination.

New Medicare Coverage policy instructions will be published in this manual instead of the Coverage Issues Manual (CIM) that will be phased out. A crosswalk from the new manual to the source manual instruction will be provided. A crosswalk from the CIM to the NCDM will also be provided. Manual transmittals through Revision Transmittal Number 5, dated December 19, 2003, are included in this update. As new transmittals are issued, they will be included and identified on this website: www.cms.hhs.gov/manuals/103_cov.determ.

Key Derm Codes in CMS Top 200

Do you wonder where dermatology codes rank on the Center for Medicare and Medicaid Services Top 200 billed to Medicare? The following table is derived from Medicare Fee for Service statistics for 2002. This table shows where the Evaluation & Management (992XX), as well as Integumentary (100XX-17999), Pathology (883XX), and Allergy/Immunology (95XXX) procedure codes are ranked by the total number of services by all physicians to Medicare and the total allowed charges per code. It should be no surprise that established patient E&M visits rank highest in number billed.

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Medicare Part B Physician/Supplier Nat'l Data: CY2002
Bush Calls for National Health Information Infrastructure

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adopt this new technology. Thompson announced that as part of the Consolidated Health Informatics Initiative (CHI), HHS and other federal departments related to health care are trying to identify appropriate, existing data standards and endorse them for use in the federal health care sector. Several legislative proposals include payment incentives for physician practices to acquire and incorporate use of a standardized electronic medical record (EMR).

The use of electronic health technology in the ambulatory setting is expected to improve patient safety, produce superior clinical outcomes and enhance administrative efficiencies. The President proposed a national health information "infrastructure" that would allow quick, reliable and secure access to information about patient care, while also protecting patient privacy. Such a system would allow physicians and other health providers to obtain up-to-date records of patients who have agreed to be part of the system, regardless of when and where patients receive care. ■

A Little Bit About ADA/M

The Association of Dermatology Administrators/Managers (ADA/M) is comprised of about 500 managers, administrators, attorneys, accountants and physicians in private, group and academic dermatology practices. ADA/M Members are provided strong business guidance and support through links to information and leaders who have expertise in dermatology practice issues. ADA/M’s network includes specialists in the fields of continuing education, managed care and financial issues, credit and collection, jurisprudence and ethics, and coding. ADA/M also sponsors its own job bank while enabling members easy access to others as well. ADA/M can be the first stop to enhancing your professional practice management career in dermatology.

ADA/M is a not-for-profit organization which is committed to providing education, professional recognition, growth and networking to its members, while advocating responsible and progressive business practices for dermatology in a quality health care environment. For more information, visit the ADA/M web site at www.ada-m.org or E-mail: adam@amsinc.org ■