Derm Coding Consult

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Congress Passes 12-Month Physician Payment Extension

On Thurs, December 9th, the U.S. House passed a 12-month extension of the Medicare physician payment rates, averting the 23 percent cut set to take effect December 1. The legislation provides a freeze at the current payment level through 2011. President Obama is expected to sign it into law immediately.

This Congressional "fix" freezes the Medicare Conversion Factor at the 2010 level of $36.8729.

The speed of the legislation was spurred by warnings from organized medicine that a massive reduction in Medicare reimbursement would cause a large number of physicians to stop seeing Medicare patients. Military families also would have found their access to physicians jeopardized because their TRICARE coverage is based on the Medicare fee schedule. The measure also enacts the first substantive changes to the Obama administration's sweeping health care overhaul passed earlier in the year. It strengthens requirements for individuals to repay the federal government subsidies received for health insurance if their income rises.

The Medicare payment cuts would have taken effect Jan. 1. These cuts were put in place by 1997 budget legislation in an attempt to restrain Medicare cost via the sustainable growth rate (SGR) calculation, but Congress has routinely delayed the scheduled cuts under strong lobbying from physicians. Congress has delayed the Medicare pay cut on 5 separate occasions this year alone. The formula pegs Medicare reimbursement to growth in the gross domestic product. Organized medicine has contended that the formula is flawed because physician practice costs exceed gross domestic product inflation. The SGR formula has mandated Medicare rate reductions every year going back to 2003.

The hope is that the 1-year freeze will give Congress enough time to hammer out a permanent solution to the Medicare reimbursement crisis that physicians will find more equitable and Congress will find more affordable. Under consideration are the recent recommendations of a bipartisan commission created by President Obama to reduce the federal budget deficit. It is proposing a Medicare freeze through 2013, reducing them by 1% in 2014, and then instituting a new Medicare payment formula in 2015 that rewards providers for the quality, not the quantity of the services provided

The legislation doesn't address complaints of doctors' groups in states like California, who claim the Medicare payment formula now favors doctors in rural states. The legislation extends expiring Medicare payment policies and funds minor changes to Medicare, Medicaid, and the Children's Health Insurance Program.

The cost of postponing the Medicare fee schedule payment cuts for one year is $15 billion. The bill includes a further $4 billion to extend other expiring health-care provisions. To cover the $19 billion total cost of extensions, the bill tightens requirements that shrink health insurance subsidies for individuals if their income rises. Under the health care law, the subsidies for people earning up to 400% of the federal poverty level are calculated based on a person's expected earnings. The law passed by the Senate Wednesday removes those caps and replaces them with a sliding repayment scale.

The AADA, along with the majority of the medical community, supported efforts to enact a 12-month fix through the end of 2011 to give us adequate time to work with the new Congress on a long-term solution to permanently replace the broken sustainable growth rate (SGR) formula.

AAD MEMBERS CONTACTED REPRESENTATIVES AND SENATORS

Our thanks to AAD members who contacted their Members of Congress via the ...

AADA's Dermatology Advocacy Network (DAN) website at *www.aad.org/DAN*

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IMPORTANT Please Route to:

___ Dermatologist ___ Office Mgr ___ Coding Staff ___ Billing Staff

Letter from the Editor

Dear *Derm Coding Consult* Reader

Another year has passed and dermatologists and physicians have dodged the major drop (23%) in Medicare reimbursement for 2011. Despite congressional promises and legislative initiatives, the Sustainable Growth Rate formula has not been fixed or eliminated.

Bottomline: Do not make any premature changes to your billing master files using the published Medicare conversion factors for January 1st. Your Medicare Administrative Contractor will notify you in late December regarding the conversion Factor Freeze.

May I suggest that one of your dermatology practice's New Year's resolutions should include starting to plan for and implementing ICD-10-CM. CMS has mandated a single ICD-10 implementation date for all users, e.g. ambulatory and physician reporting. ICD-9-CM claims for services prior to implementation date will continue to flow through systems for a limited period of time. **Services provided on or after October 1, 2013 must be coded in ICD-10-CM.** These compliance dates are firm and not subject to change.

The 2011 AAD Coding & Documentation Manual has added a whole new section on not only ICD-10-CM implementation requirements but also the new HIPAA Administrative Simplification transactions and code sets 5010 version (for eligibility, claims, claims status, payment and remittance advice, and referral certification). If you process claims or other transactions electronically, you must upgrade your practice management information systems or ensure that your billing service and/or clearinghouse is updating to the 5010 version of the standard by January 1, 2012 or your claims will be rejected and you will encounter subsequent payment delays.

Please welcome Lisa Miller, our new Assistant Director of Payment Policy. She joins our writers and article contributors Peggy Eiden, Faith McNicholas, Cindy Bracy, Rachna Chaudhari,William Brady and me in wishing all the peace and joy of this Holiday Season to you and to your families!

Best regards,

Norma L. Border, Editor

Congress Passes 12-Month Physician Payment Extension

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This legislative success demonstrates their effectiveness in delivering the message to:

- Quickly pass an additional 12-month Medicare physician payment fix.
- Protect patient access to care.
- Protect jobs in physician offices during these difficult economic times.

Review your Medicare Options

The AADA urges physicians to review their 2011 Medicare participation options before December 31. For updated information to support your decision about 2011 Medicare participation, read the revised Medicare participation options summary (www.aad.org/pm/billing/medicare/_doc/medicare_participation_options_2011.pdf).

E-mail AADA Government Affairs staff with any comments or questions regarding the SGR fix at govtaffairs@aad.org.

Medicare Fee Schedule for 2011

The Centers for Medicare & Medicaid Services (CMS) has released the Medicare Fee Schedule: Final Rule (MFS:FR) for calendar year (CY) 2011. This Final Rule provides the update for the Medicare Conversion Factor, changes to the Relative Value Units (RVUs) for specific procedure codes, as well as a number of significant changes in the Physician Quality Reporting System (PQRS, previously PQRI)). Also included in the MFS: FR are certain provisions of both the Patient Protection and Affordable Care Act of 2010 (ACA) and the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). The payment policies and rates adopted in the final rule are effective for services on or after January 1, 2011.

Congress has acted to avert the cut under the Sustain-

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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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able Growth Rate (SGR) formula, an across-the-board 24.9 percent reduction in physician payment rates. The preliminary estimate of the CY 2011 Medicare Sustainable Growth Rate (SGR): SGR is -13.4%.

For CY 2011, the current CF of $36.8729 will remain in place.

Practice Expense and Medical Liability Changes: CY 2010 marks the conclusion of the 4-year transition of the Practice Expense (PE) bottom-up methodology. In 2007, the methodology for calculating direct PE RVUs was changed from top-down to bottom-up and phased in over a 4 year period. For CY 2011, direct PE RVUs will be calculated using this methodology only. Dermatology continues to benefit from the AAD decision to survey and submit supplemental practice expense data to CMS in 2005 that increased the indirect practice expense hourly rate for dermatology from $118/hr to $152/hr.

CY 2011 is also the second year of the 4-year phase in of the PE RVUs from the AMA Physician Practice Information Survey (PPIS), which uses a 50/50 blend of the PPIS data and previous PE RVUs from the SMS and supplemental survey data. (75/25 for CY 2010, 50/50 for CY 2011, 25/75 for CY 2012, and 0/100 for CY 2013). Dermatology also aggressively participated in this survey effort in 2008. As a result, the indirect practice expense hourly rate for dermatology has been increased again from $152/hr to $182/hr. These survey result increases are reflected in increases to the Practice Expense RVUs for dermatology procedures.

For example, 11100 Biopsy, skin lesion, in 2011 the PE/RVUs have increased from 1.74 pe/rvu to 2.10 pe/rvu and the medical liability or MLI/rvu has increased from 0.08 to 0.11. The result of these two rvu changes results in the total non/facility RVUs for 11100 increasing from 2.63/RVU to 3.02/RVU, an overall increase of 0.39/RVU and at the 2010 CF, would mean a dollar increase of $14.38 for 11100.

This type of incremental RVU change is being made to all key dermatology procedures. If we were facing a positive Conversion Factor environment, dermatology would see a combined impact for 2011 of +4%.

2011 New and Updated Codes cont.

The 2011 CPT procedure codes are updated for use starting January 1, 2011. To clarify the service the word "Excision" was removed from the Debridement subheading. CPT added guidelines related to wound debridement (11042-11047) that are reported by depth of the tissue removed and the surface area of the wound. These services may be reported for injuries, infections, wounds and chronic ulcers. When performing debridement of a single wound, report depth using the deepest level of tissue removed. In multiple wounds, sum the surface area of those wounds that are at the same depth, but do not combine sums from different depths.

Be prepared for the sequencing coding changes again in this year's manual similar to last year. This is caused by the lack of numbers in some sections without rearranging the whole CPT manual. AMA/CPT identifies these codes with the # symbol.

The debridement codes (11040 & 11041) for partial and full thickness skin have been deleted while other debridement codes have been revised to clarify the depth of tissue debrided beyond skin, including all superficial layers above.

The debridement codes (11042, 11043 & 11044) were revised by surface and depth. Prior the update these codes just stated the depth of subcutaneous, muscle and bone which remain the same. What has changed is the addition description of a surface area which was set to 20 sq cm with an add-on code with additional 20 sq cm or part thereof of at least a sq cm to use the add on code. 11042 & its add on code, #11045 (which is out of sequence) are intended to describe debridement of subcutaneous tissue and includes the epidermis & dermis. These codes have a zero global period and anesthesia is included if used.

CPT Key to symbols:
● new code ▲ revised code # re-sequenced

▲11042 Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less

#✚● 11045 each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure) (Use 11045 in conjunction with 11042)

● 11043 Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq cm or less

#✚● 11046 each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure) (Use 11046 in conjunction with 11043)

● 11044 Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less

#✚● 11047 each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure) (Use 11047 in conjunction with 11044)

CPT explains if the procedure is a debridement of skin alone, the active wound care management codes in the medicine chapter are to be reported. There is a cross reference to use the Active wound codes 97597 or 97598 for debridement of skin: epidermis and/or dermis.

11010, 11011 & 11012 code revisions still are used for the debridement treatment of open fractures. Since there are no changes to the burn debridement, continue to use the 16000 Burn codes series.

For example: When bone is debrided from a 4 sq cm heel ulcer and from a 10 sq cm ischial ulcer, report the work with a single code, 11044. When subcutaneous tissue is debrided from a 16 sq cm dehisced abdominal wound and a 10 sq cm thigh wound, report the work with 11042 for the first 20 sq cm and 11045 for the second 6 sq cm.

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2011 New and Updated Codes cont.

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If all four wounds were debrided on the same day, use modifier 59 with 11042 and 11044.

CPT modifiers convey information that a specific service or procedure has been altered without a change to the code's intent. This year CPT updated modifiers 50, 76, and 78.

The word "Operative" was edited from Modifier -50 Bilateral Procedure description. It now refers to a bilateral procedure performed during the "same session" only for listed codes such as Unna boots (29580). "Other Qualified Health Care Professional" was added to clarify the use of Modifier 76, Repeat procedure and 78, Return to the operating room for an unplanned procedure. A directive note was added that these modifiers are not to be used on E/M codes.

- 50 Bilateral Procedure: Unless otherwise identified in the listings, bilateral procedures that are performed at the same session, should be identified by adding modifier 50 to the appropriate 5 digit code.

-76 Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional: It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure or service. Note: This modifier should not be appended to an E/M service.

-78 Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period: It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure). When this procedure is related to the first, and requires the use of an operating/procedure room, it may be reported by adding modifier 78 to the related procedure. (For repeat procedures, see modifier 76.)

Medicare Fee Schedule for 2011 cont.

Rebasing the Medicare Economic Index (MEI): CMS finalized its proposal with minor modification to rebase and revise the MEI for CY 2011. The MEI is an inflation index for physician practice costs that is used as part of the statutory formula to calculate annual updates to the PFS rates. Rebasing involves moving the base year for the structure of costs of an input price index, and revising relates to other types of changes such as changing data sources, cost categories or price proxies used in the price index. CMS is rebasing and revising the MEI to use a 2006 base year in place of a 2000 base year, which means that the cost weights in the index will reflect physicians' expenses in 2006. The impact of MEI rebasing on dermatology services is a 3 percent increase.

CMS also intends to convene a technical advisory panel to review all aspects of the MEI, including inputs, input weights, price-measurement proxies and productivity adjustments. The panel's analysis and recommendations will be taken under consideration by CMS in future rulemaking.

Direct PE Supply Price Changes: CMS finalized its proposal to correct minor errors in the total price inputs for a number of supply items due to mathematical mistakes in multiplying the unit price and the quantity. The direct PE database has been modified to reflect the correct supply costs for Mohs codes 17311, 17312, 17313 and 17314, and allergy test codes 95044 and 95052 when performed in the nonfacility setting. However, these changes are not significant enough to affect the PE/RVUs for any of these codes.

Potentially Misvalued Services Under the Physician Fee Schedule: CMS acknowledged the significant progress in working with the AMA RUC to address the potential misvaluation within the resource-based relative value scale (RB/RVS). The ACA identified seven categories of potentially misvalued services. CMS will continue working with the RUC to identify and review codes that:

- experience rapid growth,
- services performed by the same physician on the same date of service 95%,
- ongoing assessment of Harvard-valued codes, and
- codes with utilization of over 100,000 services.

SURGICAL PATHOLOGY CODE REVIEW BY AMA RUC

The surgical pathology codes (CPT 88300, 88302, 88304, 88305 and 88307) were identified as part of the AMA RUC review of Harvard valued codes with Medicare utilization greater than 1 million. The College of American Pathologists and the AAD conducted standard RUC surveys for each of these codes. The survey data demonstrated that the current work values assigned to these codes is accurate. CMS has accepted the RUC recommendation to retain current work values for all of these codes.

CY 2011 Identification and Review of Potentially Misvalued Dermatology Services: CMS finalized its proposal to review the codes on the MPC list, which includes codes 17000 and 11100.

These codes will be added to the RUC agenda with the intent of providing a current and comprehensive recommendation on the appropriate physician work value (PW/RU). At minimum, AAD will have to provide significant survey data to support the current values of these codes.

Codes with Low Work RVUs Commonly Billed in Multiple Units Per Single Encounter: CMS has also finalized its plan to have the RUC review codes with low work RVUs commonly billed in multiple units. The list of codes to be reviewed includes 17003 and 11101. At minimum, AAD will have to provide significant survey data to support the current values of these codes.

Geographic Practice Cost Indices (GPCIs): For CY 2011, CMS has finalized new GPCIs for each Medicare locality, while keeping the GPCI cost share weights the same pending the results of further CMS and Institute of Medicine IOM) studies. CMS will address the cost share weights again in the CY 2012 PFS proposed rule. However, The Affordable Care Act (ACA) has also established a permanent 1.0 floor for the PE GPCI for frontier states (Montana, Wyoming, Nevada, North Dakota, and South Dakota). The ACA temporarily extended the 1.0 work GPCI floor for all GPCI's, but only through December 31, 2010. Therefore, the CY 2011 physician work GPCIs and summarized GAFs

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do not reflect the 1.0 work floor.

Refinement Panel Process: The Refinement Panel provide stakeholders with an opportunity to review and discuss interim work RVUs with a clinically diverse group of experts which then provides informed recommendations to CMS. However, CMS retains its authority to set the RVUs and make adjustments to the work RVUs resulting from refinement if policy concerns warrant their modification.

Adjacent Tissue Transfer or Rearrangement (CPT codes 14301 and 14302): CMS found that the instrument pack for CPT code 14301 should be EQ138 (instrument pack, medium ($1500 and up)) instead of EQ137 (instrument pack, basic ($500-$1499)). CPT code 14301 should have one SA054 (pack, post-op incision care (suture)) as a supply input in both the non-facility and facility settings. This is included in the PE/RVU increase from 14.34 PE/RVU to **17.55 PE/RVU**.

Excision and Debridement codes: Dermatology utilization of these codes is less than 2%. CPT codes 11043 and 11044 were identified by the RUC's Five-Year Review Identification Workgroup through the "Site-of-Service Anomalies" potentially misvalued code screen in September 2007. CPT codes 11010, 11011, 11012, and 11042-11047 were reviewed by the RUC. The RUC and the specialty society agreed that the revisions made to 11010, 11011 and 11012 were editorial and the current work RVUs for these services correctly related to the typical patient and should be maintained, recommendations which CMS has accepted on an interim final basis for CY 2011. Although the RUC recommended specific work RVUs for these codes, CMS has disagreed with this and is maintaining or reducing the current work RVUs to interim values for 2011. However, CMS has agreed to change the global period to zero for these codes. For CY 2011, services previously reported by CPT codes 11040 and 11041 will now be reported with revised CPT codes 97597 and 97598.

PROVISIONS OF THE AFFORDABLE CARE ACT

Maximum Period for Submission Of Medicare Claims: The ACA reduced the maximum time period for submission of Medicare fee-for-service claims to one calendar year after the date of service. This change, which applies to services furnished after Jan. 1, 2010, reflects a reduction to the prior maximum timely filing deadline of 15 to 27 months. The ACA also mandated that providers and suppliers file claims for services furnished prior to Jan. 1, 2010 no later than December 31, 2010. The final rule revises the timely filing regulations to reflect these new requirements. It also establishes three new exceptions to the timely filing requirements for retroactive entitlement situations, dual-eligible beneficiary situations, and retroactive disenrollment from Medicare Advantage plans or PACE provider organizations.

PHYSICIAN FEEDBACK PROGRAM

The ACA contains two provisions relevant to the Physician Feedback Program. Section 3003 continues the confidential feedback program and requires the Secretary, beginning in 2012, to provide reports that compare patterns of resource use of individual physicians to other physicians. In addition, Section 3007 requires the Secretary to apply a separate, budget-neutral payment modifier to the Fee-For-Service PFS payment formula. The value-based payment modifier, which will be phased in beginning January 1, 2015 through January 1, 2017, will provide for differential payment under the fee schedule to a physician or groups of physicians, and later, possibly to other eligible professionals, based upon the relative quality and cost of care of their Medicare beneficiaries. CMS' goal is to have Medicare physicians receive a confidential feedback report prior to implementation of the value-based payment modifier.

2011 Office of Inspector General Work Plan

Dermatology practices have a vested interest in the yearly Office of Inspector General (OIG) work plan. The OIG has set the compliance standard that should be incorporated into every dermatology practices' Compliance Plan to protect against any form of fraudulent or abusive claims filing practices and to quickly identify these should they occur.

The Centers for Medicare & Medicaid Services (CMS) and its contractors are directed to review, educate and monitor compliance on problems identified by OIG. In 2006 the OIG reviewed consultation services and found that frequently services billed as consultations did not meet current definition or documentation requirements. Many were found to be "transfer of care" services. As a result, CMS directed local Medicare carriers to educate providers on the appropriate use of consultations. After three years of education further OIG investigations found no resolution to the problems identified and as a result, consultations services were eliminated from Medicare fee schedule.

Your practice's Compliance Plan needs to be updated regularly, in conjunction with the OIG's Work Plan which is released each October. To assist physician practices, the OIG does have a small business compliance plan on their website. Basically, it suggests regular review of 5-10 charts a year for seasoned providers and twice as many for new providers to the practice to ensure that Medicare documentation and claims filing requirements are being met by all providers in the practice. It's important to review the OIG plan and identify areas that may apply to your practice. Your compliance plan needs to be fluid to allow it to be modified in a timely way to reflect the OIG's current areas of interest.

- **OIG 2011 Work Plan impact on Dermatology:** Evaluation and Management (E/M) claims coding. In 2009, these services represented 19 percent of all Medicare Part B payments. Per CMS's Medicare Claims Processing Manual, providers are responsible for submitting accurate claims for the services they render. Due to the type, setting, and complexity of E/M services provided as well as the patient status of new or established, the OIG will be review claims to determine whether coding patterns vary by provider billing patterns.
- **Cloned Medical Records.** Medicare contractors have noted an increased frequency of medical records with identical documentation across services. Multiple E/M services for the same providers and beneficiaries to identify electronic health records (EHR) documentation practices associated with potentially improper payments.
- **Global Period Monitoring.** OIG will review industry practices related to the number of E/M services provided by

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2011 Office of Inspector General Work Plan

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physicians and reimbursed as part of the global surgery fee. CMS's Medicare Claims Processing Manual directs providers to "select the code for the service based upon the content of the service" and this "documentation should support the level of service reported." The OIG will continue to review the global surgery fee concept from last year. Physicians receive a single fee for all their services associated with a surgical procedure and any related E/M services provided during the global surgery period. The review is related to the number of global E/M services provided and if there has been a change since the global fee concept was developed in 1992.

- **Beneficiary Assignment.** Another area of concern is assignment. According to the Social Security Act, § 1842(h)(1), Medicare participating physicians agree to accept payment on an "assignment" for all services furnished to Medicare beneficiaries. The OIG will determine to what extent is inappropriately billed in excess of Medicare allowable. CMS defines "Assignment" as a written agreement between beneficiaries, their physicians or other suppliers, and Medicare. The beneficiary agrees to allow the physician to request direct payment from Medicare for covered Part B services by assigning the claim to the physician. In return, the physician agrees to accept the Medicare's allowed amount published by the carrier. OIG is well aware beneficiaries may not understand their rights and responsibilities regarding Medicare billing and coverage guidelines.
- **Correct Use of GA and GZ Modifiers.** Providers may note services as not reasonable and necessary on claim submissions using GA or GZ modifiers on claims expecting Medicare to deny the claim. A recent OIG study found that Medicare paid for 72 percent of these claims, amounting to $4 million in potentially inappropriate payments. There will be a determination to the extent of paid claims with these modifiers, and the types of providers and services. The Medicare contractors' policies and practices used will be reviewed.
- **Correct use of modifier GY.** The GY modifier is used on those claims where a service does not meet the definition of a covered service but the patient has requested the claim be sent to Medicare for a denial. The modifier GY is to be used for coding services that are statutorily excluded or do not meet the definition of a covered service. Beneficiaries are liable, either personally or through other insurance, for all charges associated with the provision of these services. Per CMS' Medicare Claims Processing Manual, no beneficiaries advance notice of charges for services is required for excluded services by Medicare statute. As a result, beneficiaries may unknowingly acquire large medical bills for which they are responsible. In FY 2008, Medicare received over 75.1 million claims with a modifier GY totaling approximately $820 million. Patterns and trends will be reviewed for physicians and suppliers' use of modifier GY.

More information on the 2011 OIG Work Plan can be found at: http://oig.hhs.gov/publications/workplan/2011/

Office Visits with Patch Testing

Q. Is it appropriate to report an Evaluation and Management (E/M - 99201-99215) service for the second and third visits for the interpretation and report following a Patch test (95044)?

A. The current confusion on reporting an E/M comes from the AMA/CPT Manual where under the Allergy and Clinical Immunology definition which states, "Do not report E/M services for test interpretation and report, " and continues with "If a significant separately identifiable E/M service is performed, the appropriate E/M service code should be reported using modifier 25."

Effective January 1, 2008, the AMA/CPT descriptors for the allergy diagnostic test codes (CPT codes 95004, 95024, and 95027) were updated to included "test interpretation and report by a physician." The Centers for Medicare & Medicaid Services (CMS) added physician work to codes: 95004, 95024 and 95027 but Patch test code 95044, was not included in this update.

The Patch Test codes (95044, 95052, 95056) have no physician work and depending on patient care, it may be appropriate to report an E/M service that occurs on the same day as patch testing evaluation and the follow up services involved in the process of monitoring the results of these tests. If this is the case, an E/M may be reported using modifier 25 to separate the E/M from procedure. The modifier is recognized by most payers. The E/M level needs to be based on the current history, exam and decision-making criteria, as the time spent testing the patient doesn't contribute to the E/M components. Again, depending on patient care provided, the E/M may be appropriate but must be supported with clear documentation in the medical record.

The other issue with Medicare and third party payers is the different patch testing policies, including very different unit allowable tests per patient per year. Carefully review any limitations in payer policies that may influence office procedures and patient care. The standard pharmaceutical patch test kit application is usually 24 to 30 patch tests which are applied and left on for 48 hours. The results are interpreted after this period. However, some tests may be left up to 96 hours for a reaction.

Most medical policies cover basic testing of 20-50 units. Any more must be medically necessary and reported on separate claims lines in smaller unit amount using a 59 modifier. There is no global concept that applies to patch test codes.

As of this writing four Medicare Carriers have local coverage determination on Allergy Testing - IL, WI, MN, MI, NE, MO, IA & KS: WPS L30471; CO, NM, OK & TX: Trailblazer L26791; CA, NV, HA: Palmetto L28234; and FL, PR & VI: First Coast L31267. WPS allows 50 units a year and documentation to support more. Trailblazer's limit is 30 tests and the others do not mention an amount.

From limited research it was found that most third party payers follow the usual manufacture guidelines of 24-30 units. Again, if more are done, documentation is required to support medical necessity.

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Office Visits with Patch Testing

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DEFINITION OF A 'NEW PATIENT' FOR E/M SERVICES

Q. How do I determine if I should bill a patient as a new patient or as an established patient? What are the guidelines I should follow?"

A. CMS defines this in the Internet Only Manual (IOM) as follows:
" a 'new patient' is a patient who has not received any professional services, such as evaluation and management (E/M) service or other face-to-face service (e.g., surgical procedure) from the physician or physician within a group practice (same physician specialty) within the previous three years."

For example, if a professional component of a previous procedure is billed in a three-year time period (e.g., a lab interpretation is billed and no E/M service or other face-to-face service with the patient is performed) then this patient remains a new patient for the initial visit. An interpretation of a diagnostic test, reading of an x-ray or electrocardiography (EKG), etc., in the absence of an E/M service or other face-to-face service with the patient does not affect the designation of a new patient.

If a patient has been seen in the hospital (e.g., CPT code 99231 (subsequent hospital care) by a specialty (07), the face-to-face service requirement has been met for that specialty in that same group practice. When that patient is seen in follow-up for the first time in the office by a new member of the same group, he/she is considered to be an established patient, not a new patient.

Reference:
CMS Internet Only Manual, Publication 100-04 (PDF, 1.31 MB), Chapter 12, Section 30.6.7.

Medicare EHR Incentive Payment Eligibility

Eligible dermatologists must have an enrollment record in the Provider Enrollment, Chain and Ownership System (PECOS) in order to receive a Medicare EHR incentive payment.

DID YOU KNOW?

Billing and receiving payments from Medicare does not necessarily mean that an eligible professional has an enrollment record in PECOS.

DON'T WAIT!

1. Act now to verify that you have an enrollment record in PECOS.
2. If you do not have an enrollment record in PECOS, establish your enrollment record now.

If you have submitted a Medicare enrollment application within the last 90 days, and your enrollment application has been accepted for processing by the carrier or A/B MAC, you need not take any additional actions. (You will be contacted by your carrier or A/B MAC if additional information is needed.)

How can I find out if I have an enrollment record in PECOS?
Choose one of the following:

1. Use Internet-based PECOS to look for your PECOS enrollment record. (You will need to first set up your access to Internet-based PECOS.) Go to ***Verify PECOS Record*** for more information. If no record is displayed, you do not have an enrollment record in PECOS.
2. Check the Ordering Referring Report on the CMS website. If you are of a specialty permitted to order and refer and you are on that report, you have a current enrollment record in PECOS. Go to ***Ordering and Referring Report***.
3. Contact your designated Medicare enrollment contractor and ask if you have an enrollment record in PECOS. Go to ***Contractor List*** for contact information.

I don't have an enrollment record. What should I do?

Internet-based PECOS is the fastest and most efficient way to submit your enrollment application. For instructions, see ***Basics of Internet-based PECOS for Physicians and Non-Physician Practitioners*** . If you encounter problems or have questions as you navigate the system, there is ***help available.***

Electronic Health Record Incentives – Get the Facts from CMS and the Academy:
www.cms.gov/EHRincentiveprograms
www.aad.org/hitkit

Coding Q&A's

Q: Can I bill Medicare for unused drugs I have to throw away for safety reasons? We will sometimes inject a patient with a drug, but the patient doesn't need the entire amount in the vial and it is unsafe to store and reuse once opened.

A: You can bill for unused drugs, but you have to list the unused amount separately on your CMS-1500 form. Use the modifier JW (drug amount discarded/ not administered to any patient) on the claim line with the leftover or unused drugs and biological that were discarded.

Q: We received a couple of denials from Medicaid for J3301, Kenalog stating that we need to include the NDC code for the drug that is being administered, the strength, and the dosage. Are you aware of what the NDC code is and where it can be found?

A: The Nation Drug Code (NDC) number can be found either on the drug's box or vial. If not there, the number can be found on the FDA's website.

www.accessdata.fda.gov/scripts/cder/ndc/default.cfm

NEW PATIENT, SHARED/SPLIT SERVICE

Q) When a new patient is seen in the office, our non-physician practitioner (NPP) sees the patient and performs the history and exam. The NPP then discusses the case with the dermatologist who in turns sees the patient and performs the medical decision-making. Can this service be reported under the dermatologist's NPI number as an "incident to" service?

— see **CODING Q&A'S** on page 8

A) No, in your scenario this service must be reported under the NPP NPI number. A new patient service does not meet the "incident to" guidelines as described in Medicare's (CMS) Internet Only Manual (IOM) Publication 100-02, Chapter 15, Section 60.1-2. One of the requirements is the services are part of the physician's professional service in the course of diagnosis or treatment of an injury or illness. The manual states: "There must have been a direct, personal professional service furnished by the physician to initiate the course of treatment of which the service being performed by the NPP is an incidental part."

This scenario is a Shared/Split visit which Medicare would allow if performed on a patient in the hospital. The NPP sees the patient in the morning documents a visit and the dermatologist follows up later in the day and documents a visit which are then reported as one service.

"INCIDENT TO" FAQ'S

Q: May a physician assistant (PA) see a new Medicare patient and bill the service "incident to?"

A: No. By incident to definition, a practice cannot bill a new patient visit with a PA under the NPI number of the PA's supervising physician.

Q: Can a PA see a new Medicare patient? What about a Medicare patient who comes to the office when no physician is on-site?

A: Yes. A PA may see and treat any Medicare patient and provide a service within his or her state law guidelines and scope of practice as long as the state's supervision requirements are met. Since the "incident to" criteria have not been met, the claim should be submitted with the PA's NPI.

Q: If a patient was initially diagnosed by one physician in a group practice and a PA sees the patient for a follow-up visit for the same condition while a different physician in the group is within the suite of offices, may the service be billed "incident to?"

A: Yes. In Medicare's eyes, all physicians within a group are interchangeable. In this situation the claim should be submitted with the NPI number of the physician who was within the suite of offices while the "incident to" visit took place.

Q: What should be done if a PA is seeing an established Medicare patient with an established problem for an "incident to" visit and the patient begins to describe a new condition that is unrelated to the physician's previous diagnosis?

A: The PA has the following options: 1) see and treat the patient for the new condition and bill for this and subsequent visits for the new problem with his or her NPI or 2) have the physician see and treat the patient for the new problem in order to establish a diagnosis so that future visits with the PA for this new problem can be billed "incident to" as long as other "incident to" criteria are met.

Q: After an initial visit, what role should the physician have in a Medicare patient's ongoing care while the PA see the patient "incident to?"

A: The medical record should reflect that the physician has an "ongoing involvement in the patient's care."

2011 E-Prescribing Changes

E-prescribing incentive reporting changes for 2011 have included two reporting options. You may report either by individual physician, NP or PA or you may utilize a group reporting option. The group reporting option is split into two options: Option I (GPRO I) which is for group practices with more than 200 providers or Option II (GPRO II) for group practices with 2 - 200 providers. In order to report through the GPRO option, you must also participate in the GPRO PQRI option and report measure groups with contain non-dermatology measures. Below is an important reporting requirement that is new for 2011.

You must report the e-prescribing measure 68553 *through your claims* between Jan 1 and June 30, 2011 at least 10 times per provider to avoid the 1% penalty in 2012.

Can claim *exemption* if:

- Eligible professional does not have at least 100 cases containing an E/M code between Jan. 1 and June 30, 2011
- Eligible professional is not a physician, NP or PA as of June 30, 2011
- Eligible professional does not have prescribing authority
- Eligible professional has less than 10% of their total allowed charges comprised of E/M codes between Jan. 1 and June 30, 2011
- Eligible professional is in a rural area without internet access or access to pharmacies that accept electronic prescriptions

*CMS will announce the G codes to report these criteria by mid-December on the CMS website.

The reporting period for e-prescribing in 2011 is January 1, 2011 to December 31, 2011. To report through claims, you would need to report the G code G8553 along with a denominator code at least 25 times. The list of denominator codes are 90801, 90802, 90804-90809, 90862, 92002, 92004, 92012, 92014, 96150-96152, 99201-99205, 99211-99215, 99304-99310, 99315-99316, 99324-99328, 99334-99337, 99341-99345, 99347-99350, G0101, G0108, and G0109.

If this measure is reported successfully 25 times in 2011, you will be exempt from a penalty in 2013.

*As a reminder, a group practice must be defined as a single Taxpayer Identification Number (TIN) with two or more eligible providers, as identified by their individual NPI, who have reassigned their Medicare billing rights to the group or TIN.

Medicare Participation Options for Physicians – 2011

For the 10th time in 10 years, physicians are facing a double-digit Medicare payment cut. Absent quick Congressional intervention, Medicare's physician conversion factor will drop by 30.8% to $25.5217 on January 1, 2011.

The American Academy of Dermatology will continue to campaign for a permanent replacement for the current dysfunctional system. Virtually all members of the Administration and Congress say they support this goal in principle. However, debate over the cost of permanent reform and how to finance it has stymied efforts to enact a longer-term solution.

The Centers for Medicare and Medicaid Services requires that physicians who wish to change their Medicare participation or non-participation status in 2011 to do so by December 31, 2010. CMS may or may not open another new par/non-par enrollment period should there be any delay in the scheduled cuts. Those dermatologists who wish to change their status from participating to non-participating or from non-participating to participating may not be able to do so after December 31, 2010. Private contracting, a third option in which neither the physician nor the patient receives reimbursement from Medicare, is available on a year round basis.

To help ensure that dermatologists are making informed decisions about their contractual relationships with the Medicare program, the AAD has developed the following overview of the situation with respect to the Medicare payment updates for 2011 and the various participation options that are available to physicians.

The Academy is not advising or recommending any one of the three options described in this document. The purpose of the document is to ensure that dermatologist decisions about Medicare participation are made with complete information about the available options.

Special considerations in the 2011 participation decision

Today Medicare payments are about 1% higher than in 2001 whereas even by Medicare's conservative measure, dermatologist's costs for providing services to Medicare patients have risen by 22%. Without action, payments will fall by 30.8% in 2011 and this gap will increase significantly. Unless Congress acts quickly, adequate payments for physicians and long-term stability of the Medicare payment system are not assured and dermatologists will need to take this into account as they consider their options.

Any additional actions by Congress and/or CMS will be provided at the AAD Web site at http://www.aad.org/gov/congressional/ and this document will be modified as appropriate to reflect those actions.

Physicians who want to continue their current par or non-par status do not need to do anything to maintain their status. Those who want to switch their status need to notify their contractor in a written document that is received or post-marked on or before December 31, 2010.

Medicare Contractual Options for Physicians

There are three Medicare contractual options for physicians:

1. Physicians may sign a PAR agreement and accept Medicare's allowed charge as payment in full for all of their Medicare patients.
2. Physicians may elect to be a non-PAR physician, which permits them to make assignment decisions on a case-by-case basis and to bill patients for more than the Medicare allowance for unassigned claims.
3. Physicians may become a private contracting physician, agreeing to bill patients directly and forego any payments from Medicare to their patients or themselves.

Physicians who wish to change their status from PAR to non-PAR or vice versa are required to do so before December 31, 2010. Unless CMS reopens the enrollment period, once made, the decision is binding throughout the calendar year except where the physician's practice situation has changed significantly, such as relocation to a different geographic area or a different group practice. To become a private contractor, physicians must give 30 days notice before the first day of the quarter the contract takes effect.

Those considering a change in status should first determine that they are not bound by any contractual arrangements with hospitals, health plans or other entities that require them to be PAR physicians. In addition, some states have enacted laws that prohibit physicians from balance billing their patients.

1) Participation

PAR physicians agree to take assignment on all Medicare claims, which means that they must accept Medicare's approved amount (which is the 80 percent that Medicare pays plus the 20 percent patient copayment) as payment in full for all covered services for the duration of the calendar year. The patient or the patient's secondary insurer is still responsible for the 20% copayment but the physician cannot bill the patient for amounts in excess of the Medicare allowance. While PAR physicians must accept assignment on all Medicare claims, Medicare participation agreements do not require physician practices to accept every Medicare patient who seeks treatment from them.

Medicare provides several incentives for physicians to participate:

- The Medicare approved amount for PAR physicians is 5 percent higher than the Medicare approved amount for non-PAR physicians
- Directories of PAR physicians are provided to senior citizen groups and individuals who request them.
- Carriers provide toll-free claims processing lines to PAR physicians and process their claims more quickly.

2) Non-participation

Medicare approved amounts for services provided by non-PAR physicians (including the 80 percent from Medicare plus the 20 percent copayment) are set at 95 percent of Medicare approved amounts for PAR physicians, but non-PAR physicians can charge more than the Medicare approved amount.

Limiting charges for non-PAR physicians are set at 115 percent of the Medicare approved amount for non-PAR physicians. However, because Medicare approved amounts for non-PAR physicians are 95 percent of the rates for PAR physicians, the 15 percent limiting charge is effectively only 9.25 percent above the PAR-approved amounts for the services.

With the anticipated cut on January 1, many non-PAR physicians may consider balance billing an extra 9 percent as one means of helping close the gap between 2010 and the new 2011 payment amounts. When considering whether to be non-PAR, however, physicians should consider whether their total revenues from Medicare, including amounts the program

— see **MEDICARE PARTICIPATION** on page 10

Medicare Participation Options for Physicians – 2011

— continued from page 9

pays, patient co-pays and balance billing, would exceed their total revenues as PAR physicians, particularly in light of collection costs, bad debts, and claims for which they do accept assignment.

The 95 percent payment rate is not based on whether physicians accept assignment on the claim, but whether they are PAR physicians. When non-PAR physicians accept assignment for their low-income or other patients, their Medicare approved amounts are still 95 percent of the approved amounts paid to PAR physicians for the same service. Non-PAR physicians would need to collect the full limiting charge amount roughly 35 percent of the time they provide a given service in order for the revenues from the service to equal those of PAR physicians for the same service. If they collect the full limiting charge for more than 35 percent of the services they provide, their Medicare revenues will exceed those of PAR physicians.

Assignment acceptance, for either PAR or non-PAR physicians, also means that the Medicare carrier pays the physician the 80 percent Medicare payment. For unassigned claims, even though the physician is required to submit the claim to Medicare, the program pays the patient, and the physician must then collect the entire amount for the service from the patient.

3) Private Contracting

Provisions in the Balanced Budget Act of 1997 give physicians and their Medicare patients the freedom to privately contract to provide health care services outside the Medicare system. However, private contracting decisions may not be made on a case-by-case or patient-by-patient basis. Once physicians have opted out of Medicare, they cannot submit claims to Medicare for any of their patients for a two-year period.

A physician who has not been excluded under sections 1128, 1156 or 1892 of the Social Security Act may, however, order, certify the need for, or refer a beneficiary for Medicare-covered items and services, provided the physician is not paid, directly or indirectly, for such services (except for emergency and urgent care services).

For example, if a physician who has opted out of Medicare refers a beneficiary for medically necessary services, such as laboratory, DMEPOS or inpatient hospitalization, those services would be covered by Medicare.

To privately contract with a Medicare beneficiary, a physician must enter into a private contract that meets specific requirements, as set forth in the sample private contract below. In addition to the private contract, the physician must also file an affidavit that meets certain requirements, as contained in the sample affidavit below. There is a 90-day period after the effective date of the first opt-out affidavit during which physicians may revoke the opt-out and return to Medicare as if they had never opted out.

Emergency and Urgent Care Services Furnished During the "Opt-Out" Period

Physicians who have opted-out of Medicare under the Medicare private contract provisions may furnish emergency care services or urgent care services to a Medicare beneficiary with whom the physician has previously entered into a private contract so long as the physician and beneficiary entered into the private contract before the onset of the emergency medical condition or urgent medical condition. These services would be furnished under the terms of the private contract.

Physicians who have opted-out of Medicare under the Medicare private contract provisions may continue to furnish emergency or urgent care services to a Medicare beneficiary with whom the physician has not previously entered into a private contract, provided the physician:

- Submits a claim to Medicare in accordance with both 42 C.F.R. part 424 (relating to conditions for Medicare payment) and Medicare instructions (including but not limited to complying with proper coding of emergency or urgent care services furnished by physicians and practitioners who have opted-out of Medicare).
- Collects no more than the Medicare limiting charge, in the case of a physician (or the deductible and coinsurance, in the case of a practitioner).

Note that a physician who has been excluded from Medicare must comply with Medicare regulations relating to scope and effect of the exclusion (42 C.F.R. § 1001.1901) when the physician furnishes emergency services to beneficiaries, and the physician may not bill and be paid for urgent care services.

ADDITIONAL INFORMATION SOURCES:

The American Medical Association (AMA) also has a number of useful tools to determine how the payment cuts may impact individual practice revenue (e.g., Medicare Payment Calculator):

http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/medicare/medicare-participation-guide.shtml

2011 – New PQRI appeals process

Physicians will soon have a new forum to appeal CMS decisions to deny payment of a Physician Quality Reporting Initiative (PQRI) bonus. In the 2011 Medicare Physician Fee Schedule CMS proposes in the to establish an informal appeals process through the program's Quality Net Help Desk starting in 2011.

The proposed process for initiating a PQRI Bonus appeal would be as follows:

1. Email the Quality Net help desk (qnetsupport@sdps.org) to request a Bonus Payment Denial review. The request to Quality Net must be sent within 90 days of the release of the feedback report to the physician. Reports typically come out in the fall.
2. The email must summarize the reasons for the appeal and any concerns regarding the PQRI reporting process. Requestors may include any evidence to support their claim, but it's not required.
3. There are no formal hearings. Quality Net help desk will respond in writing within 60 days of the receipt of the Appeal request.

All Quality Net decisions are final. There are no further reviews or appeals after the Quality Net help desk reviews the case. Physicians will receive an incentive PQRI bonus when it's determined that reporting requirements have been satisfactorily met.

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In the Know...

Have you ever wondered what the symbols preceding the CPT codes meant? Every year, the AMA/CPT manual is updated and with that comes revised code descriptors, changes to coding guidelines, new CPT codes and add-on codes etc. Below is a list of all the symbols and what they mean when they precede a CPT code

●	Indicates that code is new for the calendar year
▲	Indicates that code has been revised which has resulted in a substantial alteration of the procedure description
+	Indicates that CPT code is an add-on code
Ø	Indicates that the code is exempt from the use of modifier 51, but is not designated as a CPT add-on procedure or service
►◄	Indicates that guidelines, cross-reference and/or explanatory text have been revised
Θ	indicates that a code includes moderate sedation
⚡	Indicates that a code for a vaccine is pending FDA approval
#	Indicates that the code is out of sequence or resequenced
O	Indicates that the code has either been recycled or reinstated

Now you are in the know!

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Not Too Late for PQRI 2010!

It's not too late to participate in the Medicare's Physician Quality Reporting Initiative (PQRI) for 2010. Dermatologists have three melanoma measures and reporting on these measures will be via a patient registry mechanism. Dermatologists will have until January 31, 2011 to submit this information through a CMS approved registry. For more information, check out the Academy website at *http://www.aad.org/education/QRSinfo.html* for more information.

2011 Coding Update Webinar - Jan 20th

If you missed the 2011 Coding Update Webinar on November 18, 2010, please plan to join us on January 20, 2011 for a recap of all the CPT, ICD and Medicare changes as well as how recent legislation will impact physician reimbursement.

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