2006 Medicare Fee Schedule:
Late Fix by Congress

In December, Congress considered the Deficit Reduction Act of 2005. Versions of this bill and of a subsequent conference report were passed by both chambers. However, because of technical “points of order” against three specific minor provisions in the act, the final version passed by the two chambers differed slightly. The Deficit Reduction Act of 2005 was taken up again soon after the full Congress reconvened on January 31, 2006, passed and was signed into law by President Bush on February 8, 2006.

New (Old) Conversion Factor
This legislation eliminates the -4.4% cut by freezing Medicare physician payments for one year at 2005 levels and retains the 2005 Medicare Fee Schedule (MFS) Conversion Factor of $37.8975 per RVU. In addition, the Senate pay-for-performance proposal has been deleted. However, CMS is moving forward with implementation of its Physician Voluntary Reporting Program.

Automatic Reprocessing of Claims
Medicare Carriers are expected to begin processing claims at the higher 2005 MFS level within two business days of the legislation being signed. CMS also announced that it will automatically reprocess any claims submitted between January 1, 2006 and February 8, 2006. However, since Medicare Carriers process 20 million claims per week, this reprocessing will be phased in and completed by July 1, 2006. Physicians will receive a lump sum payment of the differential between the -4.4% reduced payment and the higher freeze amount.

Incorrect Beneficiary Copay and Deductibles
CMS understands that beneficiaries may have paid less under the lower 06 MFS in place from January 1st thru February 8th. While sensitive to Office of Inspector General concerns regarding improper waiver of beneficiary payment, CMS believes that where a beneficiary has already been charged for the appropriate cost-sharing amount under an existing fee schedule, it would not be cost effective to attempt to collect the difference for the revised cost-sharing amount. CMS believes that waiving the additional retroactive co-pay or deductible amount would not be inappropriate.

CMS Phase Out of Surrogate
UPIN Numbers

CMS has announced that as of April 1, 2006 claims submitted with the surrogate Unique Physician Identification Number (UPIN) OTH000 will no longer be recognized as valid. The use of UPIN OTH000 will result in the claim being denied as unprocessable. Currently physicians and other providers are allowed to bill for services using the surrogate UPIN numbers when an individual UPIN has been requested but not assigned. However, the Medicare Program Safeguard contractor has found that in many cases OTH000 is being used when a UPIN has been assigned.

As of April 1, 2006, physicians and other providers must submit the assigned UPIN for the ordering or referring physician. CMS requests that those responsible for Medicare claims submission search for the provider’s UPIN number before using a surrogate UPIN number.

A UPIN Registry listing can be found at: www.upinregistry.com/provider_form.asp.

Although OTH000 UPIN is being eliminated, the following surrogate UPINs will still be accepted, when applicable: RES000 Used by those meeting the description of “intern,” “resident” or “fellow.” (If a resident has been assigned a UPIN, the assigned UPIN should be used.)

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Letter from the Editor

Dear Derm Coding Consult Reader:

This issue of Derm Coding Consult includes a summary of the late legislative fix to the 2006 Medicare Fee Schedule as well as further clarification on consultation documentation requirements, corrections to the drug administration codes, as well as cautions from the Office of Inspector General regarding correct use of CPT Modifiers -25 and -59. In addition, there is information on phase out of surrogate UPIN numbers and completion of revisions to the HCFA or CMS 1500 billing form.

The Academy is still very concerned with CMS decision to accept but delay the incorporation of the adjustment of dermatology practice expense indirect costs based on survey data provided by the Academy. The Practice Expense Supplemental Survey (PESS) provided valid dermatology specific practice expense information based primarily on tax data and responses to specific financial questions regarding individual physician share of practice operating costs. The results of the PESS survey should positively impact Practice Expense RVUs for all key dermatology procedure codes. However, CMS has announced its intent to completely review the Practice Expense/RVU methodology.

I hope you are planning to attend the 64th Annual Meeting in San Francisco, March 3rd – 7th. Do stop by the AAD Resource Center (Booth 2025) in the Exhibit Hall and say hello.

Best regards!

Norma L. Border, Editor

Please stop by booth 1801 and thank Amgen Wyeth for their sponsorship of Derm Coding Consult!

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CPT Coding – More on Consultations

The directives for the consultation codes state that a consultation may be requested by a physician or other appropriate source. What is an “other appropriate source?” That question was posed to AMA/CPT and was addressed in the January 2006 issue of the AMA publication cpt Assistant. The examples given of other appropriate sources include: attorney, chiropractors, insurance company, nurse practitioner, occupational therapist, physical therapist, physician assistant, psychologist, social worker or speech-language therapist. Medicare does allow a non physician provider (NPP) to perform a consultation service as long as that service is within the scope of practice and licensure requirements for the NPP within that particular state. However, do be aware that a second opinion visit to satisfy a third party payer requirement is a non covered service by Medicare.

The Medicare Manual regarding the documentation for consultation services has been updated as of January 1, 2006. The additional text in the Medicare Manual addresses the consultation request as well as the consultation report. See CMS Transmittal 788, dated December 20, 2005 (http://www.cms.hhs.gov/transmittals/downloads/R788CP.pdf). The Medlearn Matters article number MM4215 is an educational article detailing the transmittal regarding consultations. Access all Medlearn articles on the CMS Web site (http://www.cms.hhs.gov/MedlearnMattersArticles/).

Consultation Request:

• Written request and need for consultation must be documented in patient’s medical record;
• Initial request may be verbal between requesting physician and consulting physician and the conversation must be documented in the patient’s medical record indicating the request for the consultation was from a physician or qualified NPP.
• The reason for the consultation must be documented by the consulting physician or qualified NPP in the patient’s medical record and must be included in the requesting physician or qualified NPP’s plan of care.

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 DERMCODINGCONSULT AT: www.aad.org/professionals/publications

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Consultations in a facility setting:
• Only one initial consultation code may be reported by a consultant per patient admission in the facility.
• A second opinion requested by the patient and/or family must be arranged by the attending physician. The consultation requirements must be met by the consultant in order to report an initial in-patient consultation code.
• When the patient and/or family request a second opinion consultation, Medicare does not require a written report be sent to the attending provider.

Initiating Treatment
During a consultation, the consultant may order tests, perform a biopsy, prescribe medication, etc. Such services do not negate reporting the encounter as a consultation.

Transfer of Care
Total care of a patient is rarely, if ever, transferred to a dermatologist. The dermatologist may take over the care of a certain condition, such as psoriasis, but not the total care of the patient. Therefore, transfer of care is not usually an issue for dermatologists when reporting consultation codes.

The number of consultation codes reported to Medicare over the past several years has increased as well as has the level of consultation visits. Since the consultation codes are valued greater than the evaluation and management codes, Medicare is scrutinizing the utilization of the consultation codes. Make sure that all the necessary reporting and documentation requirements are met when reporting the appropriate consultation code.

More on New E/M Codes
Evaluation and Management E/M services performed in a Nursing Facility (formally called Skilled, Intermediate or Long term care facilities) have generated a number of questions from Academy members. Can dermatologists use the new codes 99304 – 99306 for initial patient evaluations and codes 99307 – 99310 for the subsequent visits?

According to the CPT manual, there are very specific guidelines and instructions for the Initial Nursing Facility care codes - 99304 – 99306. The admitting or readmitting physician is required to provide major input into the development of the patient’s multi-disciplinary plan of care. As long as the requirements specified in the particular code are met and documented, these codes may be used by any physician. Note, that these particular codes are used for new or established patients.

If a dermatologist is not the admitting physician, but is asked to render a medical opinion, an inpatient consultation, 99251 – 99255 in Nursing Facility is appropriate when all the consultation requirements are met. A subsequent Nursing Facility service code 99307 – 99310 is appropriate for an additional or follow-up service. For Medicare patients, check with your Medicare local carrier for any additional requirements.
New Drug Administration Codes – Corrections

A perceptive reader of Derm Coding Consult identified some errors in the Fall/Winter 2005 issue. We apologize for the errors. The following table is the corrected table of the 2006 drug administration codes. You may want to consider making a copy of this table and inserting it in the last issue so that you won’t inadvertently use the wrong information.

NEW Drug Administration Codes – 2006: Corrections

<table>
<thead>
<tr>
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<th></th>
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<tbody>
<tr>
<td>90782</td>
<td>G0351</td>
<td>90772</td>
<td>Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular</td>
</tr>
<tr>
<td>90783</td>
<td></td>
<td>90773</td>
<td>intra-arterial</td>
</tr>
<tr>
<td>90784</td>
<td>G0353</td>
<td>90774</td>
<td>intravenous push, single or initial substance/drug</td>
</tr>
<tr>
<td>G0354</td>
<td></td>
<td>90775</td>
<td>each additional sequential intravenous push of a new substance/drug (list separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>90779</td>
<td></td>
<td>90779</td>
<td>Unlisted therapeutic, prophylactic or diagnostic intravenous or intra-arterial injection or infusion</td>
</tr>
<tr>
<td>G0355</td>
<td></td>
<td>96401</td>
<td>Chemotherapy administration, subcutaneous or intramuscular; non hormonal anti-neoplastic</td>
</tr>
<tr>
<td>G0356</td>
<td></td>
<td>96402</td>
<td>hormonal anti-neoplastic</td>
</tr>
<tr>
<td>96405</td>
<td></td>
<td>96405</td>
<td>Chemotherapy administration; intralional, up to and including 7 lesions</td>
</tr>
<tr>
<td>96406</td>
<td></td>
<td>96406</td>
<td>intralional, more than 7 lesions</td>
</tr>
<tr>
<td>96408</td>
<td>G0357</td>
<td>96409</td>
<td>Intravenous, push technique, single or initial substance/drug</td>
</tr>
<tr>
<td>G0358</td>
<td></td>
<td>96411</td>
<td>Intravenous, push technique, each additional substance/drug (list separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>96410</td>
<td>G0359</td>
<td>96413</td>
<td>Chemotherapy administration, intravenous infusion technique; up to 1 hours, single or initial substance/drug</td>
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<tr>
<td>96412</td>
<td>G0360</td>
<td>96415</td>
<td>each additional hour, 1 to 8 hours (list separately in addition to code for primary procedure)</td>
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<tr>
<td>96414</td>
<td>G0361</td>
<td>96416</td>
<td>Initiation of prolonged chemotherapy infusion (more than 8 hours), require use of a portable or implantable pump</td>
</tr>
<tr>
<td>G0362</td>
<td></td>
<td>96417</td>
<td>each additional sequential infusion (different substance/drug), up to 1 hour (list separately in addition to code for primary procedure)</td>
</tr>
</tbody>
</table>

2006 Medicare Fee Schedule:
Late Fix by Congress
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Extended Physician Enrollment Period
CMS appreciates that some physicians faced with the -4.4% reduction may have elected to not participate in Medicare for 2006. The legislative fix permits CMS to re-open the Physician enrollment period for 45 days from the date of enactment, Feb. 8, 2006 to March 25, 2006. Should a physician decide to revise their participation election, that choice will be retroactive. If a dermatologist had elected not to participate because of the anticipated reimbursement cuts, he or she may now choose to participate in Medicare and that new election will be effective January 1, 2006.

CMS Phase Out of Surrogate UPIN Numbers
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VAD000 Used by physicians serving on active duty in the United States Military and those employed by the Department of Veterans Affairs.

PHS000 Used by physicians serving in the Public Health Service, including Indian Health Service.

RET000 Used by retired physicians who have not been issued a UPIN. (Retired physicians who have been assigned a UPIN must use the assigned UPIN.)

For more information, see Medlearn Matters Article #4177 http://www.cms.hhs.gov/MedlearnMattersArticles/.
Correct Use of Modifiers -25 and -59

A recent study done by the Office of Inspector General (OIG) showed that in calendar year 2002, thirty-five percent of Medicare claims for services reported with modifier -25 did not meet the specified documentation requirements. These errors have led to improper Medicare payments of $538 million dollars.

Modifier -25

The CPT descriptor and explanatory text for Modifier -25: “Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service: The physician may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient’s condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed.

A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see Evaluation and Management Documentation Guidelines for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M service.

Note: This modifier is not used to report an E/M service that resulted in a decision to perform surgery (see modifier 57).

Some points to remember when using Modifier -25:

- The patient’s condition required a significant, separately identifiable E/M service beyond the usual preoperative and post-operative care of the procedure performed.
- Documentation must support the level of E/M service reported.
- Two separate diagnoses codes are not required.
- Two separate diagnoses codes do not alone justify the use of this modifier.
- Medicare requires modifier -25 rather than -57 when a minor procedure (one with 0 or 10 day global period) is performed during the same encounter as an E/M service.

The OIG study data also showed that Modifier -25 was appended erroneously to evaluation and management services when no procedure was done during the same encounter. Remember to use modifier -25 appropriately and not on every E/M visit when a procedure is not performed during that encounter.

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Local Coverage Determinations

Section 522 of the Benefits Improvement and Protection Act established Local Coverage Determinations (LCD). A LCD is based on the reasonableness and necessity of a procedure in accordance with Section 1862(a)(1)(A) of the Social Security Act. The LCD is the decision of the fiscal intermediary or carrier regarding coverage of a procedure or service.

The LCD was mandated by the Centers for Medicare & Medicaid Services (CMS) in the November 11, 2003 final rule. All Local Medical Review Policies (LMRP) were to be converted to LCD by December 31, 2005.

Note that the new LCD contains only the language pertaining to the reasonableness and necessity of the procedure or service provided. A companion article accompanies the LCD with specifics regarding that particular service or procedure. Coding guidelines are also included in the companion article.

In order to know the circumstances of allowable coverage by Medicare, one must be familiar with the LCDs that the individual Medicare Carrier has developed. All Medicare carriers have Web sites. On the web site the LCDs may be found under medical policy. It is important to read not only the LCD but the accompanying articles as well. Denial of claims can be avoided by knowing exactly what the LCDs of your Medicare Carrier require for documenting and submitting claims for specific services and procedures. Some examples of LCDs are those for Mohs Micrographic Surgery, Benign or Non-malignant Skin Lesions, Photochemotherapy, and Routine Foot Care.

For a link to a listing of all the Medicare Carrier Web sites, go to http://www.cms.hhs.gov/mcd/index_contractorsites.asp

Now Available...


This comprehensive, easy-to-use resource illustrates coding and clinical information to help minimize coding errors and reduce claim denials, as well as assist dermatologists and their billing staff in submitting accurate claims to improve the process of reimbursement.

Need to find a code quickly?

Included in your purchase of the manual is AAD’s 2006 CPT Express Coder that makes frequently used codes easy-to-find. Available on a double-sided laminated card, this handy reference is the perfect resource to save you time in locating common dermatologic codes.

To order, call toll-free 1-866-503-SKIN (7546)
Q. Medicare has denied an incision and drainage, 10060, of an inflamed sebaceous (keratinous) cyst, 706.2. They have always paid for it before. What is wrong?

A. The sebaceous cyst is firm, globular, movable, and tender. These cysts seldom cause discomfort and usually don’t require medical attention unless the cyst ruptures or becomes infected. CMS will consider removal of seborrheic keratoses, sebaceous cysts, nevi (moles) or skin tags as medically necessary if any of the following criteria is met:

- Skin lesions are causing symptoms, such as burning, itching, irritation, or bleeding; or
- The lesion has evidence of inflammation, e.g., purulence, edema, erythema; or
- Due to its anatomic location, the lesion has been subject to recurrent trauma; or
- The lesion restricts vision or obstructs a body orifice; or
- Lesion appears to be dysplastic or malignant (due to coloration, change in appearance or size, etc., especially in a person with dysplastic nevus syndrome, history of melanoma, or family history of melanoma); or
- Biopsy suggests or is indicative of dysplasia (pre-malignancy) or malignancy.

In the absence of any of the above indications, removal of seborrheic keratoses, sebaceous cysts, nevi (moles) or skin tags is considered cosmetic. In response to the question above, a documented symptom of infection, inflammation, etc. should be used as the primary diagnosis, the sebaceous cyst, 706.2 is secondary and billed with the procedure of Incision and Drainage, 10060, and the denied claim should be appealed.

Correct Coding of Re-Excision

Q. I have a patient who came in for a wide excision of a previously excised melanoma of the posterior trunk. The margins were clear after the initial excision but the margins were very close so the surgeon decided to operate again. Should this be coded as excision of benign lesion or malignant lesion? I should mention that the diameter is noted as 3 cm.

A. This is a question that comes up quite often — the appropriateness of assigning an excision of malignant lesion CPT code or excision of benign lesion CPT code when a patient undergoes a re-excision procedure subsequent to a procedure in which the patient underwent an excision of a malignant lesion. The CPT Changes 2003 reference book published by the AMA as well as the instructions appearing immediately before the “Excision Malignant Lesion” section of the AMA CPT manual provide guidance on this very issue:

“To report a re-excision procedure performed to widen margins at a subsequent operative session, see codes 11600 – 11646, as appropriate. Append the modifier -58 if the re-excision procedure is performed during the postoperative period of the primary excision procedure.”

The appropriate code to assign for a re-excision of a malignant lesion at a subsequent operative session is a malignant lesion excision code. In the specific example, the proper code is 11603, assuming that the 3 cm diameter includes the margin required for complete excision.

Whether you are coding from the AMA CPT Manual or the AAD Coding and Documentation manual, always remember to refer to the instruction section that precedes the code section when you are deciding which code to select. Those additional instructions help provide clear guidance as to the appropriateness of your code selection.
Correct Use of Modifiers -25 and -59
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Modifier -59
In a similar OIG study in 2003, it was found that forty percent of code pairs with modifier -59 did not meet the Medicare documentation requirements. Specifically, in fifteen percent of the errors, the services reported were not distinct from each other and inadequate documentation was noted in twenty five percent of the cases. The misuse of modifier -59 resulted in an estimated improper payment rate at $59 million.

Modifier -59 is a Distinct Procedural Service. CPT states, “Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier -59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician. However, when another already established modifier is appropriate it should be used rather than modifier -59. Only if no more descriptive modifier is available, and the use of modifier -59 best explains the circumstances, should modifier -59 be used.”

Other modifiers that are available in lieu of modifier -59 are the location modifiers.

LT and RT are used for left and right side on the body, respectively. There are eyelid modifiers (E1-E4) as well as modifiers for the digits (FA-F9, TA-T9). These Level II modifiers may be found in the AAD 2006 Coding & Documentation Manual as well as AMA CPT, the HCPCS books and the Correct Coding Initiative (CCI) edits.

When using modifier -59 for Medicare claims, it is important to use it properly according to the CCI edits. Randomly appending modifier -59 to services may cause a claim to be rejected. Likewise, overuse of modifier -59 may lead to an audit. Be sure to review your carriers’ guidelines on the use of modifiers. ■

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