SGR History and Background

The Sustainable Growth Rate (SGR) formula was created in 1997 as a target rate of growth in Medicare Part B spending for physician and non-physician practitioner services. The SGR is used to establish payment updates – one of several factors that set Medicare physician payment rates each year. The SGR formula was designed to bring actual spending in-line with allowable spending over time. It ties increases in the volume of services per Medicare beneficiary to growth in the GDP. Although adjustments are made for changes in law and regulation, these adjustments have not adequately reflected increased services resulting from technological innovation and Medicare benefit expansions (such as cancer screenings, diabetes management, etc.). This has prompted annual payment cuts that were then exacerbated by Congressional actions that stopped the cuts but failed to adjust the target, thereby leading to ever larger projected payment cuts.

The payment update for a year is determined by comparing cumulative actual expenditures to cumulative target expenditures in the prior year. For example, the 2009 payment update was set by comparing actual expenditures from 1996-2008 to targeted expenditures from 1996-2008. If spending exceeds the SGR targets, then the physician payment update is less than the increase in the inflationary cost of providing a service. However, spending includes drugs administered in a physician’s office and laboratory tests (actual products), and physician services (set by the fee schedule). Adjusting the payment update ONLY applies to physician services (fee schedule) and not to drugs or lab tests.

It has taken nearly a decade for the Medicare physician payment system to recover from the 5.4% cut imposed due to the SGR in January, 2002. During that time, payment rates fell further and further behind inflation in medical practice costs.

### HISTORY OF MPFS 2002-2012

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<td>2012</td>
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Dear Derm Coding Consult Reader

Spring 2012 is bringing a shower of new regulatory requirements, increased CMS RAC Audit activities, and American Recovery and Reinvestment Act (ARRA) incentive program reporting requirements. The coding and practice management staff is here to assist you in understanding and implementing these new regulations and requirements.

The House and Senate reached an agreement to delay the scheduled cuts to Medicare Physician reimbursement rates. The Medicare physician reimbursement rates will be maintained at the current rates for the next 10 months to avert the 27.4% cut that would have taken effect on March 1. Unfortunately, they failed to reach an agreement on finding a permanent fix for the Sustainable Gross Rate (SGR) formula which means they will have to meet again at the end of 2012 for another attempt. AAD staff will be monitoring this situation closely to update you with any changes as they occur.

Did you know?

• Every issue of Derm Coding Consult (back to the first issue in 1996) is available online and can be downloaded anytime at: http://www.aad.org/member-tools-and-benefits/publications/derm-coding-consult/derm-coding-consult.

• You can submit coding questions directly to AAD coding staff for an extremely quick turn around by e-mailing ppm1@aad.org.

• The AAD hosts live webinars to provide in-service training to physicians and practice management staff. Make a date with coding and practice management staff the third Thursday of the month for 1 hour webinars on key dermatology issues. Check out the schedule and register at: http://www.aad.org/member-tools-and-benefits/practice-management-resources/live-webinars.

Best,

Cynthia A. Bracy

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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American Academy of Dermatology Association
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Treatment of Psoriasis using laser (96920 – 96922)

There are also non-laser, excimer lamps which have an excimer light bulb that makes monochromatic 308-nm UVB, but these do not meet the FDA definition of a powered laser surgical instrument. Just like UVB from standard NB UVB bulbs, excimer lamp light is non-collimated and divergent.

The energy delivery to tissue with an excimer laser is far greater than that obtained with non-coherent excimer, narrow or broadband hand held UVB light source devices. The use of these lamp devices, is appropriately reported with CPT codes 96910 – 96912. Use of these excimer lamps is not appropriately billed with the 96920 – 96922 codes and may be considered fraudulent.

Summary of the 2012 ICD-9 Updates

Dermatology has seen significant changes in the malignant neoplasm ICD-9-CM code section. As of October 1, 2011, malignant neoplasm diagnosis codes have been expanded to include codes for basal cell carcinoma (BCC) and squamous cell carcinoma (SCC) based on anatomic location.

<table>
<thead>
<tr>
<th>OLD CODE</th>
<th>DESCRIPTION</th>
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<tbody>
<tr>
<td>173.1</td>
<td>Other malignant neoplasm of eyelid, including canthus</td>
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</table>

Effective 10/01/2011, based on anatomic location, dermatologists must now report:

<table>
<thead>
<tr>
<th>NEW CODE</th>
<th>DESCRIPTION</th>
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<tbody>
<tr>
<td>173.10</td>
<td>Unspecified malignant neoplasm of eyelid, including canthus</td>
</tr>
<tr>
<td>173.11</td>
<td>Basal cell carcinoma of eyelid, including canthus</td>
</tr>
<tr>
<td>173.12</td>
<td>Squamous cell carcinoma of eyelid, including canthus</td>
</tr>
<tr>
<td>173.19</td>
<td>Other specified malignant neoplasm of eyelid, including canthus</td>
</tr>
</tbody>
</table>

• Basal cell carcinoma (BCC) is now identified with the fifth digit of 1
• Squamous cell carcinoma (SCC) is now identified with the fifth digit of 2

WHAT DOES ‘OTHER UNSPECIFIED AND NEC’ CODES MEAN FOR DERMATOLOGY CODING

• Index entries with Not Elsewhere Classifiable (NEC) in the line designate ‘other specified’ codes in the index or tabular sections of the ICD-9-CM coding manual. When a specific code is not available for a condition, the index section directs the coder to the ‘other specified’ code in the tabular section; whereas the tabular section will include an NEC entry under a code to identify the code as the ‘other specified’ code.

• ‘Unspecified’ codes (usually a code with a fifth digit of ‘9’ or ‘0’ for diagnosis codes) titled “unspecified” are for use when the information in the medical record is insufficient to assign a more specific code.


CMS ISSUES UPDATED AND REVISED ABN EFFECTIVE JANUARY 1, 2012!

It is important that your dermatology practice uses the current updated and revised Advance Beneficiary Notice of Non-Coverage (ABN) which went into effect January 1, 2012.

The ABN is developed by The Centers for Medicare & Medicaid Services (CMS). The revised ABN is the new CMS-approved written notice that is issued by providers, practitioners, suppliers, and laboratories for items and services provided under Medicare Part B and given to beneficiaries enrolled in the Medicare Fee-For-Service (FFS) program. The revised ABN may not be used for items or services provided under the Medicare Advantage (MA) Program or for prescription drugs provided under the Medicare Prescription Drug Program (Part D). The revised ABN can now be used to fulfill both mandatory and voluntary notice functions.

A healthcare provider who fails to comply with the ABN instructions risks financial liability and/or sanctions. Medicare contractors will hold any provider who either failed to provide notification when required or gave defective notification financially liable, hence the importance of using the current updated version of the ABN.

CMS further states that when a healthcare provider can demonstrate that he/she did not know and could not reasonably have been expected to know that Medicare would not make payment will not be held financially liable for failing to provide ABN notification. However, a healthcare provider who gave a defective notice may not claim that he/she did not know or could not reasonably have been expected to know that Medicare would not make payment as the issuance of defective notice is clear evidence of knowledge.

NOTE: The Medicare beneficiary is not protected from liability if there is clear evidence that he/she knew that Medicare would not make payment for service(s) received.
Coding Q&A

Q: What is Appropriate When Coding for Neoplasms of Uncertain Behavior?

A: Skin lesions are generally considered benign or malignant, but certain lesions are designated as exhibiting “uncertain behavior.” The term “neoplasm of uncertain behavior” refers to a lesion whose behavior cannot be predicted. Even though it may currently be classified as benign, there’s a chance it could undergo malignant transformation over time. According to the ICD-9-CM guidelines, neoplasms of uncertain behavior are described as “certain histo-morphologically well-defined neoplasms, the subsequent behavior of which cannot be predicted from the present appearance.”

Selection for the appropriate excision code(s) is determined by three parameters: location, maximum excised diameter (which includes the margin) and lesion type, i.e., benign or malignant. Most of these lesions are excised with margins.

If the lesion is clearly benign (e.g. cyst, lipoma, prior biopsy of benign neoplasm), the excision can be coded as benign at the time of surgery (CPT codes 114xx). When there is a prior biopsy showing malignancy, the excision can be coded as malignant at the time of surgery (CPT codes 116xx).

Coding a lesion of uncertain behavior as malignant before pathology is available could result in incorrect coding if the lesion is found to be benign on histopathologic examination. Therefore, if the lesion is not clearly benign or malignant, coding and billing should be delayed until the pathology has been confirmed then the appropriate CPT code can be reported based on the histopathologic findings.

Q: How does Medicare know if you sent a claim to another carrier?

A: When Medicare beneficiaries register for Medicare coverage, they disclose all information about ‘other’ insurance the patient subscribes to. When you submit your claim to Medicare, you also provide information - when available - of other insurance plan the patient is subscribed to. At the time of claim adjudication, Medicare will perform a ‘coordination of benefits’ search and if there is another payer who may be either partially or wholly responsible for the claim, the provider of service will be advised accordingly in the ERA.

Q: Please discuss injected medicines during a global period. Can we bill the IL/IM administration code and/or the J-code for the medication?

A: Yes. It is absolutely important to bill the J-Code the drug at the same time as the administration CPT code. You may also be asked for the NDC # so it is important to keep that handy (NDC# can be found on either box of the container of the drug).
The CPT descriptor for an intermediate repair states: “Intermediate repair includes the repair of wounds that, in addition to the above (referring to simple closure), require layered closure of one or more of the deeper layers of subcutaneous tissue and superficial (non-muscle) fascia, in addition to the skin (epidermal and dermal) closure.” It is important to stress that this closure is used in instances when one or more than one layer of deep sutures are required to approximate dermis and/or obliterate space remaining within the subcutaneous tissue, in addition to a separate outer layer for fine epidermal/dermal approximation.

The “deeper layers of subcutaneous tissue and superficial (non-muscle) fascia” referred to in the CPT definition of intermediate repair refers to subcutaneous tissue that is deeper than the dermis rather than to the deep subcutaneous tissue. The superficial (non-muscle) fascia includes the layer commonly referred to as subcutaneous fat and envelopes the cutaneous nerves, vessels and adnexal structures. At the same time, it specifically excludes repair of deep fascia, i.e. muscle- enveloping fascia.

In summary, wounds that require closure of subcutaneous tissue or more than one layer of tissue beneath the dermis should be coded as intermediate repairs, unless the criteria for a complex closure are met.

Dog ears/Burrow’s triangles are typically included as a part of the intermediate or complex repair.”

Procedure codes outside of the integumentary (Skin) CPT code section include all repairs unless otherwise noted such as the lipoma/cyst excision codes found in the Musculoskeletal section which includes an intermediate repair and when medically necessary, a complex repair can be performed.

Intermediate repairs, are coded based on these three anatomic areas: neck, hands, feet and external genitalia; scalp axillae, trunk and/or extremities excluding hands and feet; and the face. Again, the codes are defined by the size of the wound repair:

12031 - 12037 Repair, intermediate wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet)

12041 – 12047 Repair, intermediate wounds of neck, hands, feet and/or external genitalia

12051 – 12057 Repair, intermediate wounds of face, ears, eyelids, nose, lips and/or mucous membranes;

Complex Repairs

Last category is the complex repair codes. These CPT codes are used when performing a repair on more complicated wounds such as scar revisions, debridements, extensive undermining, stents or retention sutures, all of which require more than a layered closure.

| MAC Jurisdictions consolidation from 15 to 10…… |

According to CMS, the efficiency and effectiveness of its contracted Medicare claims operations can be further increased by consolidating some of the smaller A/B MAC workloads to form larger A/B MAC jurisdictions, further reducing the size range among the A/B MACs. CMS further believes that reducing the number of A/B MAC contracts to ten will improve the efficiency and effectiveness of CMS’s internal MAC procurement and contract administration processes.

And then to 5

In order to achieve its ultimate goal of 10 A/B MAC contracts, over the next several years, CMS will consolidate the following 10 A/B MAC workloads, comprising 5 pairings, to form 5 consolidated A/B MAC contracts.

Medicare Administrative Contractor (MAC) Update
— continued from page 5

- A/B MAC Jurisdictions 4 and 7 (Louisiana, Arkansas, Mississippi, Texas, Oklahoma, Colorado, and New Mexico)
- A/B MAC Jurisdictions 5 and 6 (Minnesota, Wisconsin, Illinois, Kansas, Nebraska, Iowa, and Missouri)
- A/B MAC Jurisdictions 8 and 15 (Kentucky, Ohio, Michigan, and Indiana)
- A/B MAC Jurisdictions 13 and 14 (New York, Connecticut, Massachusetts, Rhode Island, Vermont, Maine, and New Hampshire)

Below is a map that shows how the consolidated A/B MAC jurisdictions will look like.

CPT explains the complex repair may include the creation of the defect and necessary preparation for repairs or the debridement and repair of complicated lacerations and avulsions.

Complex repairs are defined using anatomical sites: of trunk; scalp, arms or legs; forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and feet; and eyelids, nose, ears and lips. Complex repair codes follow the same anatomical pattern as simple and intermediate of as well as the size of the wound or laceration being repaired.

Cpt Assistant states: "Complex repair codes are used to delineate complicated repairs. These repairs include the layered repair of lacerations that also require debridement of wound edges before closure. Wounds following excision of some lesions may require extensive undermining to release and redistribute tension vectors to allow proper closure. Wide undermining is necessary to avoid uncertain distortion such as of eyelid or lip. The time and work in closing a wound is related to undermining, and consequently obtaining hemostasis in the undermined area, as well as placement of sutures."

13100 Repair, complex, trunk; 1.1 cm to 2.5 cm
13101 2.6 cm to 7.5 cm
+13102 each additional 5 cm or less (list separately in addition to code for primary procedure)

13120 Repair, complex, scalp, arms, and/or legs; 1.1 to 2.5 cm
13121 2.6 cm to 7.5 cm
+13122 each additional 5 cm or less (list separately in addition to code for primary procedure)

13130 Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm
13132 2.6 cm to 7.5 cm
+13133 each additional 5 cm or less (list separately in addition to code for primary procedure)

13150 Repair, complex, eyelids, nose, ears and/or lips; 1.0 cm or less
13151 1.1 cm to 2.5 cm
13152 2.6 cm to 7.5 cm
+13153 each additional 5 cm or less (list separately in addition to code for primary procedure)

Complex repairs have been simplified by the use of add-on codes for larger wound repairs. The add-on codes are not a stand alone code but must always be reported with a primary code in the respective sequence.

To report the repair codes accurately, Dermatologists are reminded to add the lengths of the repairs from the same classification and anatomic site grouping and report the total length as one code. It would not be appropriate to add together intermediate and complex closures, and/or repairs of the face and the extremities. Wound repair differ from excision of lesions, because the total size of multiple excised lesions in the same category of anatomic site is never combined or added.

**DOCUMENTATION OF COMPLEX VERSUS INTERMEDIATE REPAIRS**

The documentation in the operative report must reflect the location, size, type, medical necessity and complexity of the procedure performed. This portion of the documentation is a source of confusion and claim denials by the payers. The medical record needs to document the depth of the repair in simple terms with the size of the laceration for each closure. If this documentation is overlooked only the lowest level of service can be reported.

According to CPT Assistant®, August 2006 article which also appeared in Derm Coding Consult, Fall 2006 issue, “the use of layered closures and other advanced surgical techniques in cutaneous surgery has long been established as an effective way to reduce tension across the closure line, eliminate dead space and provide tensile strength to the wound during the post-operative period.”

If deep absorbable sutures (even just one) were placed and clearly documented the dual-layer closure, this work should be recognized as an intermediate repair. Failure to document a deep dual layer closure reduces the procedure to simple repair which is included or bundled into an excision.

Complex repair of wounds require more than layered closure. The documentation must include extensive undermining, stents or retention sutures. Complex repair also includes scar revision. The documentation must be able to differentiate and support the medical necessity from the other types of repairs that can be performed. The documenting of “complex” is not sufficient. There must be a clinical description of the procedure and appropriately classify the type of repair performed.

For more information, the Derm Coding Consult Fall, 2006 Intermediate and Complex Closure article can be found on www.aad.org.
Medicare Administrative Contractor (MAC) Update

— continued from page 6

AMA/CPT Code Book under Repairs

Consolidated A/B MAC Jurisdictions

CMS further states that it does not intend to re-compete the five A/B MAC contracts/jurisdictions based on their present area boundaries, as the current A/B MAC contracts run their course. These five contracts/jurisdictions will not be increased or reduced in size by CMS’s consolidation strategy. The five A/B MAC contracts/jurisdictions that will not be further consolidated are:

- **A/B MAC Jurisdiction 1** (California, Hawaii, Nevada, Pacific Islands)
- **A/B MAC Jurisdiction 9** (Florida, Puerto Rico, US Virgin Islands)
- **A/B MAC Jurisdiction 10** (Alabama, Georgia, Tennessee)
- **A/B MAC Jurisdiction 11** (North Carolina, South Carolina, Virginia, West Virginia)
- **A/B MAC Jurisdiction 12** (Delaware, Maryland, Pennsylvania, New Jersey, Washington DC)

MAC AWARD CONTESTS

On August 22, 2011, CMS announced that Noridian Administrative Services (NAS) was awarded the Round 2 contract for A/B MAC Jurisdiction F (AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY). However, on August 31, 2011, a protest was filed regarding the contract award with the Government Accountability Office (GAO). In accordance with the Competition in Contracting Act (CICA), the filing of the protests triggered an automatic stay on performance of the NAS contract pending GAO’s review of the protest allegations.

GAO normally issues its findings on bid protests within 100 days after the filing date. In this case, the deadline for the GAO decision on the protest is December 9, 2011. By the time this issue went to print, there are no updates as to the outcome of the investigation. In the meantime, during the GAO review period, the beneficiaries and providers in this jurisdiction will continue to receive Medicare claims processing and payment services by the MAC, carrier currently operating in the jurisdiction.

On June 23, 2011, CMS issued a solicitation for the A/B MAC Jurisdiction 5. Jurisdiction 5 includes the states of Iowa, Kansas, Missouri, and Nebraska. In addition, this jurisdiction includes certain Part A providers that are being reassigned from a legacy fiscal intermediary contract. Wisconsin Physician Services is currently serving as the A/B MAC for the states in Jurisdiction 5. CMS anticipates awarding this contract in March 2012.

For more information on MAC Awards and updates, please visit [https://www.cms.gov/MedicareContractingReform/01_Overview.asp#TopOfPage](https://www.cms.gov/MedicareContractingReform/01_Overview.asp#TopOfPage)

### Appropriate Use of ABNs

ABNs are not to be used in place of the regular patient financial consent and are not required for care that is either statutorily excluded from coverage under Medicare (i.e., care that is never covered) or fails to meet a technical benefit requirement (i.e., lacks required certification). However, the ABN can be issued voluntarily in place of the Notice of Exclusion from Medicare Benefits (NEMB) for care that is never covered e.g.:

- Care that fails to meet the definition of a Medicare benefit as defined in §1861 of the Social Security Act;
- Care that is explicitly excluded from coverage under §1862 of the Social Security Act which among others include:
  - Services for which there is no legal obligation to pay;
  - Services paid for by a government entity other than Medicare (this exclusion does not include services paid for by Medicaid on behalf of dual-eligibles);
  - Personal comfort items;
  - Routine physicals and most screening tests

The healthcare provider must document, at least one reason they believe the service may not be covered which may include:

- “Medicare does not pay for this test for your condition.”
- “Medicare does not pay for this test as often as this (denied as too frequent).”
- “Medicare does not pay for experimental or research use tests.”

and ensure that the beneficiary appends their signature that they understand the explanation about the document. Should the patient refuse to sign the ABN, services may still be furnished but, the healthcare provider must note that the patient refused to sign and have a second person witness in the medical record. This way even if Medicare denies payment, the beneficiary may still be held liable for the charge as they were notified via ABN.
Appropriate Use of ABNs
— continued from page 7

which they refused to sign.

To download a customizable version and view further instructions on use and completion of the ABN, please visit: https://www.cms.gov/BNI/02_ABN.asp

How do you know whether you are using the current revised ABN? Look for ’Approved OMB No. 0938-0566’ at the bottom of the ABN document - see example below....

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850. Form CMS-R-131 (03/11)

Form Approved OMB No. 0938-0566

Medicare recoupment changes

According to a recent Center of Medicare and Medicaid Services (CMS) Change Request (CR) 7688, the policy standard of “immediate recoupment” process that allows providers the option to avoid interest from accruing on claims overpayments when the debt is recouped in full prior to or by the 30th day from the initial demand letter date.

The current standard is the Medicare contractors begin recoupment of an overpayment on Day 41 from the date of the initial demand letter but the interest accrues and assesses on an overpayment if not paid in full by day 30. Whereas the “immediate recoupment” process implemented in CR7688 allows providers to request that recoupment begin prior to day 41. Providers who elect this option may avoid paying interest if the overpayment is recouped in full prior to day 31.

This is a voluntary repayment program.

- The providers who choose immediate recoupment must make this request in writing to their contractor.
- It must be submitted by mail, facsimile or e-mail and included Provider’s name, contact phone number, Medicare number and/or National Provider Identifier (NPI), Provider or Chief Financial Officer’s signature, demand letter number and what option the provider is requesting.
- This request can be a one-time request for a specific demanded overpayment (the total amount of the demanded overpayment); or a permanent request for the specific demanded overpayment and all future overpayments.
- Providers must understand by choosing immediate recoupment, they are waiving their rights to interest under Section 935 of the Medicare Modernization Act (MMA) should the overpayment be reversed at the Administration Law Judge level (ALJ) or subsequent higher levels.

--- see MEDICARE on page 9

2012 E-Prescribing Penalty

Dermatology practices are beginning to receive 2012 claims adjusted for unsuccessful 2011 reporting under the Medicare e-prescribing program. Eligible professionals who met the eRx payment adjustment inclusion criteria, but who failed to meet the reporting requirements in 2011, may have begun receiving the 2012 eRx payment adjustment starting January 1, 2012.

The 2012 eRx payment adjustment for not being a successful electronic prescriber will result in an eligible professional or group practice participating receiving 99% (1% less) of their Medicare Part B Physician Fee Schedule (PFS). Physicians subject to the e-prescribing penalty will see an indicator “LE” on the remittance advice to denote the penalty. The remittance advice should also contain the following Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC):

- CARC 237 – Legislated/Regulatory Penalty. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).
- RARC N545 – Payment reduced based on status as an unsuccessful e-prescriber per the Electronic Prescribing Incentive Program.

Additional assistance is also available from the CMS QualityNet Help Desk at 1-866-288-8912 (TTY 1-877-715-6222) or qnetsupport@sdps.org Monday-Friday from 7:00 a.m. to 7:00 p.m. CST.
Medicare recoupment changes

— continued from page 8

• Note the immediate recoupment process can be terminated at any time in writing.

• No recoupment will be considered after Qualified Independent Contractor (QIC) proceedings (30 days after a QIC decision) as voluntary payments. Medicare contractors will follow the rules proscribed by Section 935 of the MMA for all recoupment activity after a QIC decision.


Reporting for both the EHR and eRx Incentive Programs

Participation in both the EHR and the eRx incentive programs will only yield one incentive payment per eligible provider. Dermatologists participating in the EHR incentive program in 2012 will still need to report 10 qualifying eRx claims by June 30, 2012 to avoid the 2013 payment adjustment. Completing the CMS EHR attestation process and participation in the EHR incentive program does not eliminate the need to report for both programs without incurring a penalty for non-participation in the eRx incentive program.

The eRx incentive program does not require registration and is not registry-based. All eRx reporting is submitted through your Medicare claims. Medicare will monitor and audit your data in July of 2012 to determine if you have satisfied the minimum requirements to avoid the penalty in 2013.

Note: The complete list of codes that validate a qualifying eRx claim are:

*ENCOUNTER CODE (CPT)
90809, 90862, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99346, 99347, 99348, 99349, 99350

OR

*ENCOUNTER CODE (HCPCS)
G0101, G0108, G0109

Overview of CMS Penalties

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<th>YEAR</th>
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<td>1%</td>
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<td>1%</td>
</tr>
<tr>
<td>2013</td>
<td>0%</td>
<td>1.5%</td>
<td>0%</td>
<td>1.5%</td>
</tr>
<tr>
<td>2014</td>
<td>0%</td>
<td>2%</td>
<td>0%</td>
<td>2%</td>
</tr>
<tr>
<td>2015</td>
<td>1%</td>
<td>2%</td>
<td>1.5%</td>
<td>4.5%</td>
</tr>
<tr>
<td>2016</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
<td>6%</td>
</tr>
<tr>
<td>2017 and beyond</td>
<td>3%</td>
<td>2%</td>
<td>2%</td>
<td>7%</td>
</tr>
</tbody>
</table>

Note: Percentages based on Medicare Part B allowed charges.

CMS 5010 Reprieve is ending April 1st!

Version 5010 enforcement begins April 1, having been postponed from Jan. 1 to allow providers, payers, and vendors extra time to prepare. Below are some tips if you or your payer isn’t ready for the deadline.

What if you or your payer isn’t ready?

1. Go to a local billing service or clearinghouse. If your PMS vendor isn’t ready for 5010 or you haven’t made the necessary upgrades, your best bet is to enlist a clearinghouse or billing service to prevent lost revenue.

NOTE: Consider switching PMS vendors if your current one is not 5010-ready.
CMS 5010 Reprieve is ending April 1st!

— continued from page 9

2. **Fall back to paper if you are a low volume provider.**
   Going back to paper claims should be a last resort. Paper claims are burdensome for the practice and carry many error risks during processing.
   
   **NOTE:** Paper claims are not subject to 5010 regulation.

3. **See if your PMS vendor will compensate you.**
   If your PMS vendor isn’t ready, check if your contract permits financial compensation of lost claims for not supporting 5010.

   **NOTE:** Consult your practice’s attorney to review your vendor’s contractual options to help compensate you during the transition.

4. **Consider suspending billing.**
   You may be forced to suspend billing until you can send 5010 claims if you or your payer is not ready.

   **NOTE:** If you decide to suspend billing, you must rely on alternative resources.

Visit the CMS ICD-10 website for additional information and resources about the Version 5010 upgrade. Check with your clearinghouse and Medicare Administrative Contractor (MAC) for answers and tips.

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Did you know there is a time limit regulation on timely submission of Medicare claims to no more than 12 months (one calendar year) after date-of-service?

Medicare Has Now Announced Exemptions to Timely Filing Limits

As a result of the Affordable Care Act, Section 6404 passed in 2010, the maximum period for submission of all Medicare claims was reduced to no more than 12 months (one calendar year) after the date-of-service. Medicare has now announced that they will allow for the following exceptions to the one calendar year time limit for filing claims:

i. Administrative Error caused by Medicare through their Representative: If the failure to meet the filing deadline was caused by an error or misrepresentation of an employee, Medicare Contractor or agent of the Department of Health & Human Services (DHHS) that was performing Medicare functions and acting within the scope of its authority. In such cases, an extension of up to 6 months following the month in which the beneficiary, provider received notice that an error or misrepresentation was corrected will be provided.

ii. Retroactive Medicare Beneficiary Entitlement: When a beneficiary receives notification of Medicare entitlement retrospective to or before the date the service was furnished e.g. service(s) provided prior to Medicare benefits entitlement of a beneficiary. However, after the timely filing period has expired, the beneficiary receives notification of Medicare entitlement effective retrospective to or before the date-of-service, an extension of up to 6 months following the month in which the beneficiary or provider received notification of Medicare entitlement retroactive to or before the date of the furnished service.

iii. Retroactive Medicare Entitlement Involving State Medicaid Agencies: When a State Medicaid Agency recoups payment from a provider six months or more after the date-of-service to a dually eligible beneficiary (beneficiary covered by both Medicare & Medicaid) e.g., at the time the service was furnished, the beneficiary was only entitled to Medicaid and not to Medicare benefits. Subsequently, the beneficiary receives notification of Medicare entitlement effective retrospective to or before the date of the furnished service. The State Medicaid Agency recoups its money from the provider and the provider cannot submit the claim to Medicare because the timely filing limit has expired. In these cases, Medicare will extend the timely filing limit for 6 months following the month in which a State Medicaid Agency recovered Medicaid payment from the provider.

iv. Retroactive Disenrollment from a Medicare Advantage (MA) Plan or Program of All-inclusive Care of the Elderly (PACE) Provider Organization: This is where a beneficiary was enrolled in an MA plan or PACE provider organization, but later was disenrolled from the MA plan or PACE provider organization, retroactive to or before the date the service was furnished, and the MA plan or PACE provider organization recoups its payment from a provider 6 months or more after the date the service was furnished. In these cases, Medicare will extend the timely filing limit through the last day of the sixth month following the month in which the MA plan or PACE provider organization recovered its payment from a provider.

Waiving of timely claim submission limit shall only be applied to the above exceptions. For more information on the extension of timely filing limit rule, visit www.cms.gov/transmittals/downloads/R2140CP.pdf

Now you are in the know!