RUC 5 Year Review Impact on Dermatology

In the Spring of 2005, the Centers for Medicare and Medicaid Services (CMS) placed a large number of key dermatology codes on the American Medical Association’s Relative Value Scale Update (RUC) Committee’s Five Year Review (RUC 5YR) list. The results of that review by the AMA RUC and whether or not CMS has accepted those results will be included in the separate CMS regulation scheduled for release in June 2006.

There were a total of 47 dermatology codes on the RUC 5YR list. All but one was placed there by CMS. Almost every basic procedure code dermatology uses, from skin biopsy, to AK/wart destruction, to excision, repairs, as well as Mohs was included.

The Five Year Review is mandated by the Omnibus Budget Reconciliation Act of 1990. CMS is required to comprehensively review the relative values for physician work (PW/RVUs) assigned for each CPT code at least once every five years. A major factor in CMS code selection for this latest review was high Medicare utilization. However, for a large number of the dermatology codes, the time element of the physician work relative value unit (RVU) was still being based on the original estimates from the Hsiao Harvard Study developed 18 years ago.

To ensure that all dermatology codes would be valued fairly and accurately, last summer the American Academy of Dermatology, as well as the other medical specialty societies surveyed members regarding the time, effort, and cost associated with performing each procedure. The survey data was used to prove that the work and intensity of these codes justifies their current payment levels. CMS concurs that survey data is the best way to defend physician work times.

Dermatology had full or shared responsibility for surveying the following codes:

11100 Biopsy, skin lesion
12052 Layered closure of wound(s)
13121 Repair of wound or lesion
14040 Skin tissue rearrangement
14060 Skin tissue rearrangement
15240 Skin full graft
17262 Destruction of skin lesions
17281 Destruction of skin lesions

CMS had submitted all of these codes for review, because physician work times had never been reviewed by the RUC. AAD surveyed and successfully presented the data on these codes, convincing the RUC Workgroup that the survey data validated the current physician time required and the current RVU values of these services.

Destruction of Benign and Pre-Malignant Lesions
CMS placed CPT code 17003 on the RUC Five Year Review list because CMS believes that advances in technology and the migration to treating the majority of actinic keratoses via cryosurgery has resulted in a significant reduction to the physician work required for the procedure. CMS staff noted that the National Coverage Decision published in July, 2001 on actinic keratoses (AK) has sharply increased the billing of this service to Medicare. The RUC Workgroup reviewed previous and current survey data and made a determination that the application of cryosurgery to each additional lesion requires no more than two minutes of physician time and recommended that the current physician work value (PW/RVU) for CPT 17003 be decreased by 50% because of the Harvard Study overestimate of the time required for this low intensity service.

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Dear Derm Coding Consult Reader:

This issue of Derm Coding Consult includes a summary of the results of the AMA Specialty Society RVS Update Committee (AMA-RUC) Five Year Review on key dermatology procedure codes. All but one of the CPT codes were placed on the review list by the Centers for Medicare and Medicaid Services (CMS) either because the codes had never been presented to the RUC or because CMS is concerned at the increased volume of procedures being billed to Medicare. Although there is clinical data to support the increased incidence of skin cancers nationally, unfortunately, CMS will continue to press for better control over the volume of services being billed.

In this issue we are providing further clarification on appropriate coding for intralesional and intramuscular injections, requirements for billing these with an office visit as well as key J codes for the drugs being administered. CMS, in response to complaints from the Academy as well as other office based specialty societies has begun to issue clarifications to its recent extremely confusing instructions regarding consultations. In addition, CMS has temporarily stopped it’s phase out of surrogate UPIN numbers.

We have provided full information on CMS assignment of surgery code indicators to help dermatology practices better understand the application of the Multiple Surgery Reduction Rules (MSRR) and helpful CMS “rules of thumb” regarding services provided during a global period. As claim review audits are a cause of ongoing concern for dermatology practices, we also offer four keys to passing E/M audits.

I hope you are planning to attend the 2006 Summer Academy Meeting in San Diego, CA, July 26th – 30th. Do stop by the AAD Resource Center (Booth 120) in the Technical Exhibit Hall and say “Hello!”

Best regards!

Norma L. Border, Editor

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Editor’s Notes:

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

Mission Statement:

Derm Coding Consult is published quarterly (March, June, September and December) to provide up-to-date information on coding and reimbursement issues pertinent to dermatology practice.

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CMS PRIT Clarifies Consultation Documentation Requirement

CMS, in response to complaints from the Academy as well as other office based specialty societies has begun to issue clarifications to its recent confusing instructions regarding documentation requirements for consultations (CPT 99241-99245). In December of 2005 CMS issued Medicare Claims Processing Manual (MCPM) Transmittal 788 that imposed the additional requirement that a consulting physician verify that a written request for a consultation had been made in the patient chart before billing for the consultation.

The issue was submitted to the CMS Physician Regulatory Issues Team (PRIT) for discussion with CMS staff. PRIT is a group of CMS subject matter experts who work with William Rogers, MD to reduce the regulatory burden on physicians who participate in the Medicare Program. On April 12, 2006 posted a clarification on the CMS PRIT web site that Medicare does not expect the consulting physician to verify that the requesting physician has documented the consultation request in his/her patient's medical record. Issues may be submitted directly to CMS PRIT for review at the PRIT web site: www.cms.hhs.gov/PRIT.


A brief hold will be placed on Medicare payments for ALL Medicare claims for the last 9 days of the Federal fiscal year 2006 (September 22, 2006 - September 30, 2006) to all Medicare providers including physicians who bill Medicare contractors for their services. These payment delays are mandated by section 5203 of the Deficit Reduction Act (DRA) of 2006. All Medicare claims held as a result of this one-time policy that would have otherwise been paid on one of these 9 days will be paid on October 2, 2006.

If a provider anticipates an extreme hardship created by this payment hold, Medicare carriers may consider providing accelerated payments using normal procedures and with the usual billing documentation requirements. During this Medicare payment hold, no interest will be accrued or paid, and no late penalty will be paid to an entity or individual for any delay in a payment by reason of this one-time hold on payments.

Medicare contractors will continue to apply the fourteen day electronic claim payment floor and the 29-day paper claim payment floor. On a case-by-case basis, Medicare carriers may make adjustments, after October 1, 2006, for extenuating circumstances raised by a provider. For example, adjustments may be made to not charge a provider interest on an overpayment for those days for which offsets could not be made due to the hold of payments required by this DRA provision.

Please note that:
- Payments will not be staggered; and
- No advance payments during the 9-day hold will be allowed.

CR5047 is the official instruction issued to your carrier regarding changes mentioned in this article. CR5047 may be found by going on the CMS web site:

www.cms.hhs.gov/Transmittals/downloads/R944CP.pdf

Please contact your local Medicare carrier if you have questions about this issue. To find their toll free phone number, go on the CMS web site:


CMS Continues Surrogate UPINs

Medicare will continue to accept UPIN OTH000 for reporting the referring/ordering physician on a Medicare claim submitted by Medicare providers other than Independent Diagnostic Testing Facilities (IDTFs). CMS has rescinded Change Request (CR) 4177, that would have banned the use of surrogate UPIN OTH000 on Medicare claims.

CMS remains concerned that providers are using UPIN OTH000 when there is a valid UPIN assigned to the referring/ordering physician and will probably plan to limit or disallow use of this “catch-all” UPIN number over the next 18 to 24 months. If dermatology practices are routinely using UPIN OTH000, they should plan to start capturing any referring physician UPINs on a regular basis. More information is available on this issue at: www.cms.hhs.gov/MLNMattersArticles/downloads/MM4177.pdf

ALERT

Dermatology Taxonomy Code Needed When Applying for NPI

When applying for the new National Provider Identifier, dermatologists will be asked to provide the ten-digit Dermatology Taxonomy Code

207N00000X
Excision of Benign and Malignant Lesions

The excision codes have been under close scrutiny by CMS for some time, especially after the 2003 AMA CPT change to the methodology for measuring and coding the removal of a lesion. CMS submitted all thirty-six of the excision of lesion codes (benign: 11400-11446, malignant: 11600-11646) for the RUC Five Year review, noting that these services have never been fully surveyed and reviewed by the RUC.

However, in April 2002, to adjust for the revised “excised diameter” language in CPT, the AMA RUC allowed dermatology, with the family medicine, general surgery, and plastic surgery specialties to determine new physician work relative values (PW/RVU) for these services by using a mathematical model to estimate that 30% of benign lesions and 50% of malignant lesions would be reported with the next higher CPT code. The recommendation maintained the relative RVU ratio between codes within each excision site family; and also maintained budget neutrality within each excision site family. CMS accepted these recommendations and the new codes and PW/RVU were implemented in January, 2003.

However, in the 2004 Medicare Fee Schedule (MFS) Proposed Rule, CMS stated its opinion that the PW/RVUs for the excision of benign and malignant lesions of the same size should be equivalent. The AMA RUC as well as the above specialties vehemently opposed the CMS proposal. The specialty societies, coordinated by AAD, surveyed selected excision codes and presented data to the RUC and CMS that demonstrated that there is a measurable difference in physician work required in the excision of benign versus malignant lesions.

For the RUC Five Year Review, dermatology, plastic surgery, general surgery, otolaryngology, and podiatry once again conducted surveys to review each of the excision codes. The RUC Workgroup used the survey data and agreed that the primary difference in the work between the excision of a benign versus a malignant lesion is in:

- the pre-evaluation time (additional planning, discussions with a patient with a potential malignant lesion),
- the intensity of the physician intra-service time, and
- the level of post-operative visits.

Physician Work values (PW/RVUs) for twelve of the thirty-six excision codes were modified from their current values. Five of the RVU values were decreased slightly and seven were increased by roughly .50 PW/RVUs. These changes to the PW/RVU levels are pending in the separate CMS regulation scheduled for release in June, 2006 and will be reiterated in the 2007 Medicare Fee Schedule Proposed Rule.

Mohs Surgery

CMS referred the Mohs surgery codes 17304 and 17305 to the Five-Year Review as this complete family of services had never been surveyed and reviewed by the RUC. The American College of Mohs Micrographic Surgery and Cutaneous Oncology (ACCMMSCO), and the American Society for Mohs Surgery (ASMS) conducted surveys to collect data in support of these codes. The RUC Workgroup had extensive discussions regarding the performance of this procedure and the physician involvement and time for each of the steps/activities. However, the Workgroup reviewed prior RUC comments that the code descriptors for the Mohs services were confusing and open to various interpretations by Medicare and private payors.

In addition, CMS staff commented that the descriptors for the Mohs codes are not consistent with other integumentary coding conventions in CPT, which are based on the size of the lesion and anatomical site, rather than the number of specimens. As a result AAD was directed to work with the AMA CPT Editorial Panel to re-define the Mohs Micrographic Surgery section in CPT. After this revision was completed at the February 06 AMA CPT meeting, these codes were re-evaluated by AMA RUC at the April 06 meeting. The values determined for these codes will be published in the 2007 Medicare Fee Schedule Proposed Rule.

Photodynamic Therapy (PDT)

The AAD as well as DUSA submitted separate comments to CMS requesting that CPT code 96567 Photodynamic treatment, skin be placed on the RUC Five Year Review. Both argued that the original vignette failed to recognize the degree of pain associated with this treatment and the consequent requirement for physician involvement. After extensive and acrimonious discussion with the RUC Workgroup which suggested the potential need for further CPT revisions, AAD withdrew the code from the Five-Year Review, rather than risk a further decrease in its overall RVU valuation. AAD has this issue under review.

The September Issue of Derm Coding Consult will provide finalized information on how each of these codes will be valued in the 2007 Medicare Fee Schedule.
Four Keys to Passing E/M Audits

When Medicare carriers or private payers audit office visit records, keep in mind that they are looking for several key pieces of information that will either support or negatively impact the audit score for that evaluation and management visit. Following are four key identifiers that will flag not just the E/M visit they are auditing, but will also cause claim auditors to review all of the claims from a physician with a more critical eye.

Medical or Preventive Care Visit
Occasionally, a physician may indicate that the nature of an E/M visit is medical, when in fact the visit was for preventive care. Preventive services are often not covered per se by private insurers or Medicare and the cost is borne by the patient. Medicare only covers preventive medicine for patients who qualify for the new “Welcome to Medicare” – initial preventive-medicine exam. Patients often request specific preventive and screening services. However, unless the physician is thorough in documenting both a medical as well as preventive service, the evaluation and management service billed for the visit will be denied by the payer and/or the claim will trigger more in-depth review of billed office visits.

Using Correct Physician Identification Number
Many practices have dealt with the frustration of getting physician identification numbers for new physicians. If the physician has not received their own identification number, the temptation is to use someone else’s number in the practice. However, if Medicare or a private payer chooses to look at the number of services per day billed under a given provider number, it will send up red flags. The next logical step is for the payer to request medical records. A quick review will indicate that two different physicians are seeing patients and submitting claims under a single identification number.

Each Medicare claim form includes the following certification linked to the physician’s signature: “I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me…” Medicare permits physicians to hold claims for up to six months until their UPIN is assigned and then submit them for payment. However, dermatology practices should check with their contracted payers to determine if this is permissible and/or to ask that assignment of identification, be expedited.

With the advent of the National Provider Identification (NPI) and use of one NPI by all payers, the problems of delays in issuing provider numbers by various payers will be eliminated. However, in the mean time, it is better to hold claims for services until the provider identification number is received than to risk additional scrutiny for using identification numbers inappropriately.

Single Level Office Visits
Single Level Office Visits or “clustering” occurs when a physician bills only mid-level service visits for all patient encounters. It may be on the simple assumption that some visits will be a little higher and some will be a little lower. Claims auditors will review an office visit to determine if the medical necessity substantiates the level of service billed.

A physician who is “clustering” presumes “everything is going to average out and be just fine,” but that’s not the case statistically. In the average course of practice, patient visits demonstrate a consistent bell curve across both new and established patients. In reality, a physician who is “clustering” is upcoding some services and downcoding other services. This becomes quickly evident during an E/M audit and usually results in the payer requesting even more claims to review.

Reasonable and Medically Necessary
Medicare and private payers agree that physicians should be able to order any tests (e.g., screening tests) that they believe are appropriate for the diagnosis and treatment of their patients. However, Medicare and private payers are moving quickly to use scientific and clinical data to support or reject the appropriateness of specific diagnostic and/or therapeutic procedures in relation to determining or treating specific conditions. If a diagnostic test or procedure seems appropriate to address a unique set of clinical circumstances with a patient, the key to payment is inclusion of primary, secondary and even tertiary diagnoses and sufficient comment in the medical record to justify “reasonable and medically necessary.”

CPT Coding Update
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J-Codes
The appropriate drug code or J-code, would be reported with both the intramuscular and intralesional injection codes. The J-codes are listed in the Healthcare Common Procedure Coding System (HCPCS) book as well as in the 2006 AAD Coding & Documentation Manual, Chapter 5. These codes are Medicare’s National Level II Codes. The J-codes are used for drugs administered other than by oral method and should be billed in units as appropriate. Following are a number of key dermatology specific J-codes and descriptors:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J0133</td>
<td>Injection, acyclovir, 5mg (use for Zovirax)</td>
</tr>
<tr>
<td>J0215</td>
<td>Injection, alefacept, 0.5mg (use for Amevive)</td>
</tr>
<tr>
<td>J0585</td>
<td>Botulinum toxin type A, per unit (use for Botox)</td>
</tr>
<tr>
<td>J1438</td>
<td>Injection, etanercept, 25 mg (use for Enbrel) (use only when drug is administered with direct physician supervision, not when self administered)</td>
</tr>
<tr>
<td>J1745</td>
<td>Injection, infliximab, 10mg (use for Remicade)</td>
</tr>
<tr>
<td>J3301</td>
<td>Injection, triamcinolone acetonide, per 10 mg (use for Kenalog-10, Kenalog-40, (e.g. J3301 x 4 units)</td>
</tr>
<tr>
<td>J3490</td>
<td>Unclassified drugs</td>
</tr>
<tr>
<td>J9040</td>
<td>Bleomycin sulfate, 15 units (use for Blenoxane)</td>
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<td>J0215</td>
<td>Injection, alefacept, 0.5mg (use for Amevive)</td>
</tr>
<tr>
<td>J0585</td>
<td>Botulinum toxin type A, per unit (use for Botox)</td>
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<td>J1438</td>
<td>Injection, etanercept, 25 mg (use for Enbrel) (use only when drug is administered with direct physician supervision, not when self administered)</td>
</tr>
<tr>
<td>J1745</td>
<td>Injection, infliximab, 10mg (use for Remicade)</td>
</tr>
<tr>
<td>J3301</td>
<td>Injection, triamcinolone acetonide, per 10 mg (use for Kenalog-10, Kenalog-40, (e.g. J3301 x 4 units)</td>
</tr>
<tr>
<td>J3490</td>
<td>Unclassified drugs</td>
</tr>
<tr>
<td>J9040</td>
<td>Bleomycin sulfate, 15 units (use for Blenoxane)</td>
</tr>
</tbody>
</table>

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CMS Introduces New 1500 Claim Form

CMS has been busy revising the 1500 Claim form to accommodate the new National Provider Identifier (NPI). If you file electronically, check with your software vendor or clearinghouse to be sure your computer software can accept these new changes. Some large practices receive such software system upgrades automatically, but smaller practices may have to contact their vendors to see if their systems are ready or need to be upgraded.

Starting Oct 1, 2006, this revised CMS-1500 paper claim form can be used. There will be four new locations on this revised form to list the new National Provider Identifier (NPI). CMS requires the NPI on the new 1500 form starting May 23, 2007. But between Oct. 1, 2006 and May 22, 2007, practices may continue using the PIN or UPIN with or without the NPI.

The new CMS 1500 form splits four boxes into shaded and unshaded portions. The unshaded portions are used to list the NPI of the referring physician. Report the NPI in Boxes 17b (name of referring doctor), 32a (service facility location), 33a (billing provider), and in the unshaded lower half of Box 24j (rendering provider). The shaded portions can be used to continue to list the current PIN or UPIN in Boxes 17a, 32b, 33b, and the shaded upper half of Box 24j.

But starting May 23, 2007, only the NPI number should be listed in these shaded boxes.

Also on the new CMS 1500 form, there are additional changes to Box 24, which captures billing and diagnosis codes, modifiers and charges for as many as six services. Now for each service line used, leave the shaded line above it, blank. Either the current or the new version of the CMS-1500 may be used between Oct. 1, 2006 and Jan. 31, 2007. After February 1, 2007, the new CMS 1500 form must be used to resubmit a claim, even if the claim was originally filed on the old CMS-1500.

If filing paper claims with both the NPI and PIN/UPIN during the transition, first check with any non-Medicare secondary payers to see if they have the capacity to handle both UPIN and NPI numbers and the new CMS-1500. If the CMS 1500 is printed in house, the print program will have to be revised to accept the new fields. If using a clearinghouse, verify that its data system is updated. All the field definition and print program details on the new CMS 1500 form are published in Transmittal 899 to the Medicare Claims Processing Manual (MCPM) which can be printed or downloaded from, www.cms.hhs.gov/transmittals/downloads/R899CP.pdf

Understanding the Multiple Surgery Reduction Rule (MSRR)

CMS assigns a multiple surgery indicator for each of the surgery procedure codes. These indicators are:

0 Indicates multiple surgery rules do not apply
1 Indicates multiple surgery rules in effect before Jan. 1, 1995 apply
2 Standard multiple surgery rules apply
3 Indicates that the special rule for multiple endoscopic procedures applies if billed with another endoscopy in the same family

Each year, Medicare publishes the surgery procedure codes with the multiple surgery indicators in the Medicare Fee Schedule Database (MFSDB).

Medicare payment amounts are calculated using Multiple Surgery Reduction Rules when more than one surgical procedure is performed by the same physician on the same day. The Multiple Surgery Reduction Rules are not used unless at least two services have indicators other than “0.”

For example, when multiple surgeries are performed on the same day that have a multiple surgical indicator of “2,” the procedure with the highest fee schedule amount is paid at 100 percent, the second through fifth procedures at 50 percent, and additional procedures will be paid based on individual consideration. The limiting charge for non-par physicians is 115 percent of the reduced payment amount for each procedure.

Example: A dermatologist performed the following procedures with the respective fee schedule amounts:

- $300 fee schedule amount – primary procedure because it has the highest fee schedule amount;
- $200 fee schedule amount – secondary procedure because it has the second-highest fee schedule amount;
- $100 fee schedule amount – third procedure because it has the lowest fee schedule amount

These procedures would be paid as follows:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Fee Schedule Amount</th>
<th>Multiple Surgery Percentage</th>
<th>Allowable Amount</th>
<th>Limiting Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary</td>
<td>$300.00</td>
<td>100%</td>
<td>$300.00</td>
<td>$345.00</td>
</tr>
<tr>
<td>Secondary</td>
<td>$200.00</td>
<td>50%</td>
<td>$100.00</td>
<td>$115.00</td>
</tr>
<tr>
<td>Third</td>
<td>$100.00</td>
<td>50%</td>
<td>$ 50.00</td>
<td>$ 57.50</td>
</tr>
</tbody>
</table>

The amount of the reduction, and whether or not a reduction occurs is determined by two factors: the Multiple Surgery Indicator and the ranking of the procedure within the operative session. Multiple surgeries are distinguished from procedures that are components of or incidental to a primary procedure. Intra-operative services, incidental surgeries, or components of major surgeries are not separately billable. Co-surgeons, surgical... — continued on page 31
CMS' Global Surgery Rules of Thumb

The Center for Medicare and Medicaid Services (CMS) assigns a global period to every CPT procedure code. The global days/periods on procedure codes are listed and updated annually in the Medicare Physicians Fee Schedule Data Base (MPFSDB). The MPFSDB is located on the Centers for Medicare & Medicaid Services (CMS) web site at: new.cms.hhs.gov/apps/pfslookup/

Here are a few global surgery “rules of thumb” that may help you bill global surgery correctly:

- If additional procedures are performed during the same operative session as the original surgery to treat a complication(s), CMS considers the additional procedures under the multiple surgery reduction rule guidelines.

- Only surgeries that require a return to the operating room are paid by CMS, using Modifier -78. According to CMS, operating rooms are usually located in hospitals or Ambulatory Surgical Centers (Place of service codes 21, 22 or 24). An office which may include a surgical procedure room does not qualify as an operating room (Place of service code, 11).

- If the patient is returned to the operating room during the post-operative period on a different day of the original surgery for multiple procedures that are required as a result of complications from the original surgery, the complications rules would apply. The global surgery rules would not apply.

- If unrelated surgeries are performed during the post-operative period of another surgery by the same surgeon modifier -79 should be billed. When using the -79 modifier, a new global period begins for the second surgery.

- Modifier -24 should be applied to unrelated E/M services during the post-operative period beginning the day after a procedure such as an unrelated rash after a lesion excision. Treatment of a rash from the bandage of the excised lesion would be considered by CMS as part of the global surgery package.

- It is the responsibility of the physician to determine and document whether a surgical procedure performed during the post-op period was planned/staged at the time of the original procedure or whether it was due to complications that required a return trip to the operating room. A staged procedure is appended with a modifier -58.

- If a procedure has 000 global days, Medicare pays for E/M service performed the day before the surgery and then the surgical procedure the day after but usually not the day of surgery unless a separate, identifiable service is medically necessary.

Coding Q&A

Q. May I write off a Medicare patient’s co-payment?

A. Any dermatologist wishing to help an indigent Medicare patient by reducing or waiving co-payments must use consistent guidelines or this good deed could get them into trouble. The dermatology practice should have an indigent care policy in writing, such a policy should be available to all patients, and the application of the policy needs to be determined consistently for fairness by staff.

Whether your practice receives patient requests for co-payment waivers, once a week or only once or twice a year, a written indigent care policy will stand up to OIG scrutiny if it includes the following steps:

- Patients may ask for a waiver;
- Any patient who requests a waiver completes a printed application form;
- The patient should provide information that supports his or her need for a waiver;
- Limit the number of administrative and professional staff authorized to grant the waivers;
- Maintain documentation of the applications and waivers granted in each calendar year.

Q. Our office routinely bills an injection CPT code (90772) along with the specific drug HCPCS code. However, when the HCPCS code has the word "injection" in its title, is it appropriate to also charge the injection (e.g., J3301, Injection, triamcinolone acetonide, per 10 mg)?

A. When a drug J-code includes the term "injection," it is a merely a naming convention to indicate an injectable drug. It does not mean that the drug administration service is included in the drug J-code. Therefore, always code and bill the appropriate drug administration service in addition to the J-code for the drug.

Q. I’ve diagnosed a dermatological complaint. Rather than explaining the problem at length, I have the patient watch a 30 minute video that I have developed. The video addresses the problems and the treatment choices the patient has. After they have reviewed the video, I return to continue the office visit with the patient. Since the visit is over 40 minutes, and 30 minutes of it is counseling, can I bill a 99214 for an established patient?

A. No, 99214 would not be appropriate because the video time is not considered physician-patient face to face time. Evaluation and management service requirements are that the physician may bill only for the face to face service time and level of medical necessity.

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Understanding the Multiple Surgery Reduction Rule (MSRR)

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If criteria #3 is met, the highest ranked procedure with a multiple surgery indicator of ‘2’ or ‘3’ will be allowed at 100% (even if it is not the primary procedure in the operative session). The rest of the procedures with an indicator of ‘2’ or ‘3’ will be paid according to the indicator (each ‘2 at 50% and each ‘3 by endoscopy rules.)

Modifier -51

Modifier -51 is automatically generated by Medicare carrier payment systems when the multiple surgery reduction rules apply and related edits prompt the computer system to apply the multiple surgery reduction rules. Therefore, it is not necessary for providers to submit modifier -51 on claims for multiple surgery procedures.
Q. Is a certain form required to request a written redetermination from Medicare?

A. Physicians and beneficiaries may use a Form CMS-20027, Medicare Redetermination Request Form, however, it is not required. If the claimant chooses not to use the CMS form, the request will be handled by Medicare without delay providing the following information is included in a letter:

- Beneficiary name
- Medicare Health Insurance Claim Number (HICN)
- Name and address of provider/supplier of item/service
- Date of initial determination
- Date(s) of service for which the initial determination was issued
- Which item(s), if any, and/or service(s) are at issue in the appeal
- A signature on the review request

Note: There are Model Claims Appeal letters to address specific denial situations as well as a Claim Correction form that is approved and accepted by most health insurance carriers, located on the AAD website, at: www.aad.org/professionals/pracmanage/practicemgmtinfo/ModelClaimsLetters.htm

Send YOUR Coding Question to AAD
Do you have a coding question? The Derm Coding Consult editorial staff as well as the dermatologists who serve on its editorial board are happy to provide you with the answer to your question. We are happy to research and respond to your individual coding question. Your questions are our best indicator and source for identifying problem areas for dermatology practice coding and billing staff.

If you have a coding question, just fax it to (847) 330-1120, Attention: Derm Coding Consult.

You may also e-mail questions to the Derm Coding Consult editorial staff:

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