



Derm Coding Consult

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Preventive Coding for Dermatology

The recent Healthcare Reform Law requires more preventive coverage by insurance companies. The Departments of Labor, Health and Human Services and Treasury released final interim rules implementing the preventive health services provisions under the Affordable Care Act New Rules on Preventive Care of July 14, 2010. The rules are designed to make preventive health services accessible and affordable by requiring coverage of recommended preventive health services that have strong scientific evidence of their health benefits and not charging plan participants' co-payments, co-insurances or deductibles for these services when they are delivered by an in-network provider. These will likely lead to a much greater demand for preventive services from patients, creating challenges, along with opportunities, for dermatologists.

The Preventive Medicine Service codes (99381-99397) were revised in 2002. They provide a means to report a routine or periodic history and physical examination in **asymptomatic** individuals. They represent comprehensive (age and gender appropriate) history; examination; counseling, anticipatory guidance, or risk factor reduction interventions; and ordering of appropriate immunization(s) and laboratory or diagnostic procedures for recommended physician intervention standards, which are set and published by preventive medicine agencies.

The main factor in using the Preventive Medicine codes is the absence of complaints by the patient. Comparing AMA/CPT codebook descriptions between the Evaluation and Management (E/M) - **Office or Other Outpatient Services** codes (99201-99215) to Preventive Medicine services, the Office or Outpatient Services all include the phrase - "nature of presenting problem." The presenting problem is generally the reason or chief complaint for the encounter and based on that problem, the physician performs a history, examination and medical decision making.

Can dermatologists report preventive medicine care service codes (ex: 99381-99397) with diagnosis of V76.43, screening for melanoma? There is conflicting information regarding insurance companies covering skin screenings. Many of your patients are requesting this service especially since there is no co-pay, co-insurance or deductible associated with preventive visits codes.

If a patient is asymptomatic, without complaint, no chief complaint or presenting illness and the reason for the visit is specifically to provide preventive services, rather than any postoperative cancer follow-up care, the Preventive Medicine codes (99391 to 99387) may be appropriate. There are no coding guidelines. It is the dermatologist's judgment how

long follow up care is needed for successful cancer treatment. If the service is recommended for cancer reoccurrence then report the Evaluation and Management service (E/M) at the appropriate level with the diagnosis of the specific personal cancer history.

The Preventive Medicine services definition is similar to other E/M services except the variation in the application of the comprehensive history and comprehensive examination definitions. The Preventive Medicine comprehensive history obtained is not problem-oriented, and does not involve a chief complaint or presenting illness but includes a comprehensive system review (ROS) and a comprehensive or interval past, family, and social history (PFSH), as well as a comprehensive assessment/history of pertinent risk factors.

Preventive medicine codes include counseling/anticipatory guidance/risk factor reduction interventions such as sun screen protection, self education on changing moles and self exams etc. which are provided at the time of the initial or periodic comprehensive preventive medicine examination.

If there is an insignificant or trivial problem/abnormality that is encountered in the process of performing the preventive medicine service which does not require additional work, the performance of the key components of a problem-oriented E/M service should not be reported.

Usually an insurance carrier will only pay one preventive medicine service per year. If the patient requests these preventive visit codes to be used, have the patient sign a financial liability waiver.

— see **PREVENTIVE CODING** on page 3

Contents

Preventive Coding for Dermatology	1, 3, 4
Letter from the Editor	2
New and Improved AAD Website Launch!	2
ICD-10-CM: Part 2 of 3	3, 4
5010 Testing: Time is running out!	4, 5
Making Cents of Incentives	5, 6, 8
In the Know	8

IMPORTANT Please Route to:

Dermatologist Office Mgr Coding Staff Billing Staff

Letter from the Editor

Dear *Derm Coding Consult* Reader

Let me take this opportunity to introduce myself as your new editor of *Derm Coding Consult*. I have been with the Academy since 2008. During my tenure I have served as assistant editor to *Derm Coding Consult* and an editor for the annual publication of the AAD Coding & Documentation Manual.

It is a privilege and an honor to assume the role of editor for *Derm Coding Consult* from the capable hands of Norma Border. I know you find your practice environment constantly buffeted by payer issues and national payment policy delays. I look forward to the challenge of providing you with timely and consistent information on coding, reimbursement, and practice management issues.

In this issue, we address the CMS incentive programs for EHR, E-Prescribing, and PQRS. We have included tables to assist you in determining how your practice can avoid penalties and reap the maximum incentive benefit allowed. The tables contain detailed information on the various incentive programs, their years of effectiveness, and the applicable percentage of incentive or penalty that will be imposed.

On March 31, 2011, CMS proposed a rule that would implement the Medicare Shared Savings Program created by the Affordable Care Act. This program provides incentives for physicians to create “accountable care organizations” (ACOs) that would enter into an agreement with Medicare to take responsibility for improving quality and coordination of care for beneficiaries, while lowering their costs, in return for a share of the resulting savings. The Academy is currently reviewing the impact this rule will have for dermatology. If you would like to review the proposed rule in its entirety, it is published in the Federal Register and can be found under Special Filings at: <http://www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1>.

Best,



Cynthia A. Bracy, RHIA, CCS-P
Specialist, Practice Management Resources

CIGNA Policy Update!

Good news for dermatology! As of 02/21/11, CIGNA has removed dermatology-specific CPT codes from their Modifier -59 policy. This policy required documentation to be submitted with claims and became effective May of 2010.

If you have rejected claims with dates of service prior to 02/21/11, these will still need to be appealed. Remember to include documentation with your appeal in order to receive appropriate reimbursement. *

Dermal Injections for HIV Related Lipodystrophy

Dermatologists treating HIV patients for facial lipodystrophy syndrome (LDS), need to be aware that CMS finds Dermal injections only “reasonable and necessary” using FDA approved dermal fillers. Documentation should reflect a diagnosis of depression associated with LDS caused by anti-retroviral HIV treatment.

Because dermal fillers are carrier priced, CMS Contractors are requesting the invoice price of the fillers to be included in the claims remark area, CMS-1500 Item 19 or the electronic claim equivalent. The procedure codes for reporting Lipodystrophy are as follows:

- Radiesse: Use Healthcare Common Procedure Coding System (HCPCS) code Q2026, reported for 1 unit/0.1 ml injection
- Sculptra: Use HCPCS code Q2027, reported for 1 unit/0.1 ml injection
- Injection(s) of Dermal filler: G0429
- Diagnoses codes: 272.6 (Lipodystrophy with 042 (HIV)

CMS Medlearn: MM6809 revised *

New and Improved AAD Website Launch!

We hope you are enjoying the new and improved AAD Website! The look is fresh and updated. You will notice that many of the links that were previously available to non-members are now exclusively available only to valued AAD members. *

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Editor's Notes:

The material presented herein is, to the best of our knowledge accurate and factual to date. The information and suggestions are provided as guidelines for coding and reimbursement and should not be construed as organizational policy. The American Academy of Dermatology/Association disclaims any responsibility for the consequences of actions taken, based on the information presented in this newsletter.

Mission Statement:

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

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Preventive Coding for Dermatology cont.

— continued from page 1

MEDICARE COVERAGE

Medicare does not cover these codes. There is a special 'Welcome to Medicare' and an Annual Wellness service. Both services are reported with G codes. These services have specific documentation elements which are not typically performed by dermatologists.

Preventive Medicine codes are selected by the absence of patient complaints; new or established patient; and by the patient's age. Note that the new patient three year rule applies to Preventive Medicine codes. The initial Preventive Medicine visit code can only be reported if the patient has not been seen by a physician or another physician of the same specialty from the same group practice within the past three years.

How should a 'skin screening' for an asymptomatic Medicare patient be reported? If a patient has:

- No signs or symptoms (is asymptomatic)
 - o Report an Office E/M service (99201-99215) with the V76.43 screening for melanoma. Advise the patient of their financial liability prior the exam and have them sign an Advance Beneficiary Notice (ABN). Append a GA modifier to the CPT code on the CMS 1500 claim form thus telling CMS an ABN has been signed by the patient who is aware they may be financial liability for this service.
- No signs or symptoms but a personal history of neoplasms (V10.83) or melanoma (V10.82) again report an Office E/M service using the appropriate V code diagnosis. Medicare should cover these diagnoses but follow the ABN guidelines above so the patient is aware of a potential liability.

This article reflects the reporting method from the intent of AMA/CPT coding guidelines on Preventive Medicine codes. Third-party payers may request that these services be reported with these codes. Third-party payers should be contacted for their specific reporting guidelines. An alternate method is the unspecified E/M code 99499 with a narrative in CMS1500 item 19. *

ICD-10-CM: Part 2 of 3

The ICD-CM has been revised periodically to incorporate changes in the medical field. The Tenth Revision (ICD-10) differs from the Ninth Revision (ICD-9) in its organization and structure, code composition and level of detail, although the overall content is similar. There are 14,025 ICD-9-CM codes and 68,069 ICD-10-CM codes.

HOW IS ICD-10-CM STRUCTURED?

ICD-10-CM has an index and tabular list that is very similar to the current ICD-9-CM, however, the alphabetic index is more in-depth compared to the ICD-9-CM alphabetic index. ICD-10-CM also uses an indented format for both the index and tabular lists, just like the ICD-9-CM. The tabular list contains categories, subcategories, codes and descriptors arranged numerically within the 21 separate chapters.

There are two parts of ICD-10-CM coding guidelines and coding conventions:

- Index to diseases and injury; and
- Index to external causes of injury.

Chapter 2 of the ICD-10-CM contains codes for most benign and all malignant neoplasms (C00-D49), however, this does not restrict the dermatology practice coder to search only in this section of the book for appropriate diagnosis. The appropriate diagnosis may be found in another section of the ICD-10-CM code book hence the importance of beginning one's code assignment by search in from the Index section before choosing the appropriate code in the tabular section.

The Table of Drugs and Chemicals and the Neoplasm Table will now be located in the Index to Diseases and Injury. An index to External Causes has also been included (V01-Y95).

The former 'V' and 'E' code classifications that were supplemental to ICD-9-CM are now incorporated into the Tabular Section in ICD-10-CM as individual chapters (V01-Z99).

This new ICD-10-CM structure will allow for further expansion that was previously not possible with ICD-9-CM as more positions in more chapters are left open and available for future modifications.

SIMILARITIES AND DIFFERENCES BETWEEN THE TWO CODING SYSTEMS

ICD-10-CM uses 3-7 alpha and numeric digits and full code titles, even though the format is very much the same as ICD-9-CM (e.g., ICD-10-CM has the same hierarchical structure as ICD-9-CM).

The 7th character in ICD-10-CM is used in several chapters (e.g., the Obstetrics, Injury, Musculoskeletal, and External Cause chapters). It has a different meaning depending on the section where it is being used (e.g., in the Injury and External Cause sections, the 7th character classifies an initial encounter, subsequent encounter, or sequelae (late effect)). Primarily, the changes in ICD-10-CM are in its organization and structure, code composition, and level of detail.

The Tabular List is a chronological list of codes divided into chapters based on body system or condition. The list is presented in code number hierarchical structure, just as it was in ICD-9-CM. Codes are considered invalid if they are missing an applicable character. To look codes up, the same method used in ICD-9-CM is applied: look up diagnostic terms in the Alphabetic Index, then verify the code number in the Tabular List.

Many conventions have the same meaning as in ICD-9-CM, e.g. abbreviations, punctuation, symbols, notes such as "code first" and "use additional code" will still mean the same as in ICD-9-CM.

TABULAR CODE LISTING

The Tabular List consists of categories, subcategories and valid codes. The valid ICD-10-CM codes contain letters (alpha) and numbers (numeric) and can be from 3 - 7 characters long. The following is a content description of each specific character:

- Character 1** alpha (All letters used except 'U' which has been reserved for newly discovered diseases or unknown etiology).
- Character 2** numeric
- Character 3 to 7** numeric or alpha, not case sensitive

— see ICD-10-CM on page 4

ICD-10-CM: Part 2 of 3

— continued from page 3

Note: Some ICD-10-CM codes may have an 'x' used as a 4th- to 6th character place holder. The place holders have been included in the Tabular List to enable users to code more accurately, although they may appear to be out-of-order.

Codes longer than 3 characters always have a decimal point after the 3rd character.

ICD-9-CM FORMAT



Category



Etiology, anatomical site, manifestation

ICD-10-CM FORMAT



Category



Etiology,
anatomical site,
manifestation



Extension & Severity

It is imperative that detailed and specific documentation is provided to allow for accurate ICD-10-CM code selection.

Example:

Contact dermatitis can be coded as follows:

From the alpha index, search for “dermatitis, contact” choose ICD-10-CM code to its highest specificity based on the documentation provided as to the cause of the disease as follows:

- L23 Allergic contact dermatitis; or**
- L23.3 Allergic contact dermatitis due to drugs in contact with skin; or**
- L23.81 Contact dermatitis due to animal (cat) (dog) dander**

BENEFITS OF REPORTING YOUR CLAIMS USING ICD-10-CM

This classification system will provide much better data for:

- Measuring the quality, safety, and efficacy of care;
- Reducing the need for attachments to explain the patient's condition;
- Designing payment systems and processing claims for reimbursement
- Conducting research, epidemiological studies, and clinical trials
- Setting health policy
- Operational and strategic planning and designing healthcare delivery systems
- Monitoring resource utilization
- Improving clinical, financial, and administrative performance
- Preventing and detecting healthcare fraud and abuse
- Tracking public health and risks

Laterality (side of the body affected) has been added to relevant codes, which allows the coding personnel to specify the location of disease. ICD-10-CM codes will reflect modern medicine and updated medical terminology.

Dermatology practices must note the need for coding personnel to have knowledge in physiology and anatomy to provide them with a basis of understanding the ICD-10-CM coding system.

Example:

- T36.7x1 – Poisoning by antifungal antibiotics, systematically used, accidental (unintentional)

There are two types of Excludes notes in ICD-10-CM:

Excludes 1 – Indicates that the code excluded should never be used with the code where the note is located (do not report both codes).

Example:

L10 – Pemphigus

Excludes 1: pemphigus neonatorum (L01.03)

Excludes 2 – Indicates that the condition excluded is not part of the condition represented by the code but a patient may have both conditions at the same time, in which case both codes may be assigned together (both codes can be reported to capture both conditions).

Example:

L27.2 – Dermatitis due to ingested food.

Excludes 2: Dermatitis due to food in contact with skin (L23.6, L24.6, L25.4)

Look out for Part 3 of **“Planning and Implementing ICD-10”** in the Winter issue of Derm Coding Consult.

For more information, contact AAD coding staff at ppm1@aad.org or visit www.aad.org/member-tools-and-benefits/practice-management-resources/coding-and-reimbursement/icd-10.

ADDITIONAL RESOURCES

The following organizations offer providers and other ICD-10 resources:

CMS ICD-10 General Information http://www.cms.gov/ICD10/12_2010_ICD_10_CM.asp#TopOfPage

WEDI (Workgroup for Electronic Data Interchange) - <http://www.wedi.org>

HIMSS (Health Information and Management Systems Society) - <http://www.himss.org/icd1053> *

5010 Testing: Time is running out!

Below are key points as indicated in a recent jointly sponsored webinar given by HIMSS and CMS:

- Wait to test when your vendor/clearinghouse is ready with a 5010 update and clarify whether new updates will be made before the December 31, 2011 deadline so that you can plan to retest appropriately.
- If your vendor makes an update to the software after you have concluded testing you will need to re-test for 5010. This will ensure the update is working properly. Vendors can make additional updates anytime between now and December 31, 2011.
- Practices need to be aware of a potential need to retest. Some vendors are doing things in steps where as others are delaying the publishing of updates for a final version of the 5010 errata.
- Make sure you test all potential scenarios you encounter in your practice. When you become aware of a new scenario later in the year (post initial 5010 testing) you will need to retest scenario.
- Run the 5010 test parallel to 4010 submission to compare results/validate submission is successful.

— see 5010 TESTING on page 6

5010 Testing: Time is running out!

— continued from page 3

- You may have to integrate HIS systems if you use multiple programs/systems.
- Some payers have set up test links on their websites, request a minimal number of claims to be tested, and have specific scenario protocol requirements. Please check with your individual carriers for specific requirements.
- Monitor reports, claims, & remittance notices during testing process!

Provider testing needs to include:

1. Testing – Clearinghouse to Payer
2. Testing – Provider to Payer
3. Testing – Billing Agent to Clearinghouse to Payer
4. Testing – Billing Agent to Payer

Take Away....Test, Test, & Retest!

- ICD-10-CM is accommodated in all applicable transactions, but not valid for use until October 1, 2013. *

Making Cents of Incentives

The past few years have brought significant changes to medical practices as CMS began instituting new programs aimed at encouraging providers to adopt health information technology and begin participating in clinical quality reporting. Confusion reigns as these programs become more frequent and increasingly complex. This article will provide the basics of each reporting program and advise practices on how to participate in them.

There are four separate and distinct incentive programs within CMS. These programs include the Electronic Health Record (EHR) Incentive Program, the Electronic Prescribing (eRx) Incentive Program, the Maintenance of Certification (MOC) Incentive Program and the Physician Quality Reporting System (PQRS), formerly known as the Physician Quality Reporting Initiative (PQRI). CMS has structured these programs so they operate completely independently of each other. Thus, as a practice, you must participate in each program if you wish to receive the incentive and avoid the penalty in the future.

Each program is also structured in a different manner and the associated incentives and penalties all occur during different time periods:

OVERALL CMS INCENTIVES AVAILABLE TO PROVIDERS

Year	EHR Incentive*	eRx Incentive*	PQRS Incentive	MOC Incentive	Total Incentives Available
2011	\$44,000 (dispersed over a 5 year period)	1%	1%	0.5%	2.5% OR \$44,000 + 1.5%
2012	\$44,000 (dispersed over a 5 year period)	1%	0.5%	0.5%	2% OR \$44,000 + 1%

Year	EHR Incentive*	eRx Incentive*	PQRS Incentive	MOC Incentive	Total Incentives Available
2013	\$39,000 (dispersed over a 4 year period)	0.5%	0.5%	0.5%	1.5% OR \$39,000 + 1%
2014	\$24,000 (dispersed over a 3 year period)	0%	0.5%	0.5%	1% + \$24,000

Note: Percentages based on Medicare Part B allowed charges.

*EHR and e-prescribing incentive cannot be combined. Providers must select one program to participate in.

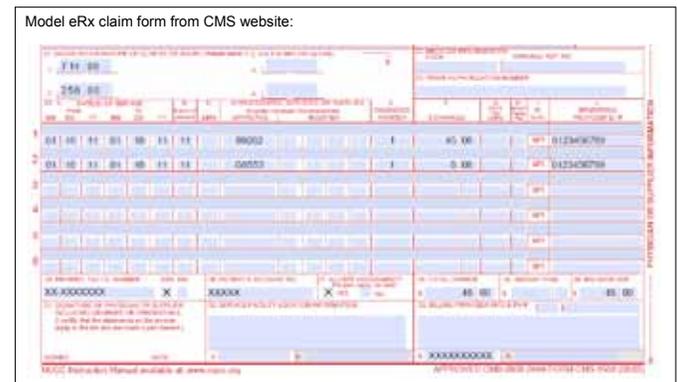
OVERALL CMS PENALTIES APPLICABLE TO PROVIDERS

YEAR	EHR PENALTY	E-PRESCRIBING PENALTY	PQRS PENALTY	TOTAL PENALTIES
2012	0%	1%	0%	1%
2013	0%	1.5%	0%	1.5%
2014	0%	2%	0%	2%
2015	1%	2%	1.5%	4.5%
2016	2%	2%	2%	6%
2017 and beyond	3%	2%	2%	7%

Note: Percentages based on Medicare Part B allowed charges.

ELECTRONIC PRESCRIBING INCENTIVE PROGRAM

The eRx Incentive Program is the most timely as the penalty for not participating begins January 1, 2012. All dermatology practices should be aware of this and begin e-prescribing immediately if they do not meet any of the exclusion criteria for the program. To begin e-prescribing, providers can either purchase a stand-alone e-prescribing software system or use an EHR with an e-prescribing component integrated within it. If you do not currently have an EHR in your practice, you can visit www.getrxconnected.org/aad to search for stand-alone e-prescribing products or use a free e-prescribing system at www.nationaleRx.com. Please note the free system does not provide technical support.



Once providers begin e-prescribing, the practice will have to notify CMS by reporting G8553 on their Medicare claim form in box 24D at least 10 times before June 30, 2011 and 15 additional times before December 31, 2011. If reporting is successful, the providers in the practice are eligible to earn a 1 percent incentive on their total Medicare Part B allowed charges for the year and can avoid a 1 percent penalty in 2012 and a 1.5 percent penalty in 2013.

— see **MAKING CENTS** on page 6

Making Cents of Incentives

— continued from page 5

Exemption from this requirement is available under the following circumstances and must be noted on your claims before June 30, 2011:

If You:	Report:	Frequency:	Before:
Successfully created an electronic prescription	G8553 along with the applicable denominator code*	25 times	June 30, 2011 (10 times) Dec. 31, 2011 (15 times)
Do not have at least 100 cases containing an encounter code in the measure denominator* between Jan. 1 – June 30, 2011	Nothing; CMS will calculate this and exempt you from the penalty in 2012	N/A	June 30, 2011
Are not a physician, NP or PA as of June 30, 2011	Nothing; CMS will automatically exempt you from the penalty in 2012	N/A	June 30, 2011
Do not have prescribing authority	G8644	1 time	June 30, 2011
Have less than 10 percent of your total allowed charges comprised of codes in the denominator* between Jan. 1 and June 30, 2011	Nothing; CMS will calculate this and exempt you from the penalty in 2012	N/A	June 30, 2011
If you practice in a rural area without sufficient high speed internet access	G8642	1 time	June 30, 2011
If you practice in an area without sufficient access to pharmacies that accept electronic prescriptions	G8643	1 time	June 30, 2011

*Denominator codes include: 90801, 90802, 90804-90809, 90862, 92002, 92004, 92012, 92014, 96150-96152, 99201-99205, 99211-99215, 99304-99310, 99315, 99316, 99324-99328, 99334-99337, 99341-99345, 99347-99350, G0101, G0108, and G0109

EHR INCENTIVE PROGRAM

The EHR Incentive Program is significantly more complex than the e-prescribing incentive program. Only physicians are eligible for the Medicare EHR Incentive Program, and they must meet several requirements to obtain the \$44,000 in incentive funds including (1) using a certified system (list of certified systems is available at <http://onc-chpl.force.com/ehrcert>), (2) using their system in a meaningful way which will be determined through the reporting of various measures, and (3) reporting clinical quality measures. Dermatologists can register on the CMS website for the EHR Incentive program at http://www.cms.gov/EHRIncentivePrograms/20_RegistrationandAttestation.asp, and will only need to perform the required measures for 90 days in the first year of reporting. Thus, a provider would need to begin using their certified EHR technology in a meaningful way by October 1, 2011 if they wish to receive the incentive funds this year. For a full list of the measures you will be required to report and more information, please visit <http://www.aad.org/member-tools-and-benefits/practice-management-resources/hit-kit/ehr-incentives/ehr-incentives>.

For further assistance with EHRs or eRx, please email hit@aad.org.

MOC INCENTIVE PROGRAM

The MOC Incentive Program requires physicians to meet certain guidelines through the American Board of Dermatology to obtain the 0.5% incentive available from now until 2014. For more information on this program, please contact the American Board of Dermatology at <http://www.abderm.org/>.

For further assistance with MOC, please email abderm@hfhs.org, or call (313) 874-1088.

PQRS PROGRAM

The Physician Quality Reporting System (PQRS) allows physicians to be eligible for a bonus payment of 1 percent of their total Medicare Part B allowed charges if they report on at least three quality measures. These quality measures represent clinical best practices approved CMS. For 2011, dermatologists can report on melanoma measures 137, 138, and 224.

These measures can be reported only through a qualified electronic registry. If dermatologists choose to report on the three melanoma measures, they must report on at least 80 percent of their eligible patients for measures 137 and 224, and on at least 80 percent of eligible visits for measure 138 in order to be eligible for this incentive.

Each of the quality measures must have at least one eligible instance for a dermatologist to qualify for the incentive. Since the only applicable diagnosis for measure 138 is a new diagnosis of melanoma, dermatologists must see at least one patient with a new diagnosis of melanoma (that is also a Medicare patient) in order to report measure 138 successfully. Additionally, you must successfully meet the measure for at least one patient per measure.

Measure #137 - Melanoma: Continuity of Care – Recall System

Percentage of patients, regardless of age, with a current diagnosis of melanoma or a history of melanoma whose information was entered, at least once within a 12 month period, into a recall system that includes:

- A target date for the next complete physical skin exam
- A process to follow up with patients who either did not make an appointment within the specified timeframe or who missed a scheduled appointment

Measure #138 - Melanoma: Coordination of Care

Percentage of patient visits, regardless of patient age, with a new occurrence of melanoma that has a treatment plan documented in the chart that was communicated to the physician(s) providing continuing care within one month of diagnosis.

Measure #224 - Melanoma: Overutilization of Imaging Studies in Stage 0-IA Melanoma

Percentage of patients, regardless of age, with Stage 0 or IA melanoma, without signs or symptoms, for whom no diagnostic imaging studies have been ordered related to the melanoma diagnosis.

The Academy continues to provide practice support by offering an online reporting registry — the Quality Reporting System (QRS) — for members to report their Physician Quality Reporting System data to CMS.

— see **MAKING CENTS** on page 8



AMGEN[®]



Amgen and Pfizer are proud sponsors of the American Academy of Dermatology Coding Consult Newsletter.

In The Know!

Did you know how much information you will need to accurately assign an ICD-10-CM code?

ICD-10-CM uses 3–7 alpha and numeric digits and full code titles, even though the format is very much the same as ICD-9-CM (e.g., ICD-10-CM has the same hierarchical structure as ICD-9-CM). The changes in ICD-10-CM are in its organization and structure, code composition, and level of detail. This new ICD-10-CM structure will allow for further expansion that was previously not possible with ICD-9-CM as more positions in more chapters are left open and available for future modifications.

Let's look at Acne, frequently reported in a dermatology practice. In ICD-9-CM we code Acne as 706.1 whereas in ICD-10-CM, we will need to have enough information provided in the chart as what type of Acne the patient is presenting.

Example:

ICD-10-CM has eight (8) codes for acne as follows:

L70	Acne
	<i>Excludes 2: acne keloid (L73.0)</i>
L70.0	Acne Vulgaris
L70.1	Acne conglobata
L70.2	Acne varioliformis
	<i>Acne necrotica miliaris</i>
L70.3	Acne Tropica
L70.4	Infantile Acne
L70.5	Acn' excorl'e des jeunes filles
	<i>Picker's Acne</i>
L70.8	Other Acne
L70.9	Acne, Unspecified

Now you are in the know! ✨

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Making Cents of Incentives

— continued from page 6

MEASURE	APPLICABLE CPT CODE	APPLICABLE ICD-9 CODE
137	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, or 99215	172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9, or V10.82
138	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 11600-11604, 11606, 11620-11624, 11626, 11640-11644, 11646, 14000-14001, 14020-14021, 14040-14041, 14060-14061, 14301-14302, 17311, or 17313	172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, or 172.9
224	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, or 99215	172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9, or V10.82

Participants will be able to choose either a one-year reporting period, from January 1-December 31, 2011, or a six-month reporting period from July 1-December 31, 2011. The incentive will be based only on claims filed during the chosen reporting period. The final day to enter and submit all data into the Academy's registry is January 31, 2012 and all associated claims must be processed by the end of February 2012.

Visit www.aad.org/QRS to read more about the quality measures, as well as purchase the 2011 Physician Quality Reporting System Melanoma Reporting module.

For further assistance with PQRS, please email swainberg@aad.org. ✨



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