2013 Medicare Fee Schedule — Impact on Dermatology

The Centers for Medicare and Medicaid Services (CMS) released the 2013 Medicare Physician Fee Schedule Final Rule—including the much anticipated 2013 conversion factor (CF)—on November 1. The CF is the multiplier used with the relative value units (RVUs) assigned by CMS to each CPT procedure code to determine the dollar amount that will be paid for each service by Medicare.

For 2013, the Medicare conversion factor is set at $25.0008

This is a reduction of -26.5% from the 2012 CF of $34.0376, or

A drop of $9.0368 per RVU

The negative update is due to the Sustainable Growth Rate (SGR), a statutory formula that requires reductions to physician updates if physician spending in aggregate exceeds national targets. Since 2002, however, Congress consistently has prevented the negative updates from being implemented, and it is likely that a short-term fix will be enacted. Accordingly, it is recommended that physician practices wait for the new year before altering their superbills.

The American Academy of Dermatology Association (AADA) is proactively advocating on behalf of members on this issue. In addition, the AADA is asking physicians to write their members of Congress, through the AADA Dermatology Action Network (DAN) website, www.aad.org/dan, and ask for Congress to avert the cuts and end the SGR.

CMS Review of “Potentially Misvalued Services”

CMS is required to identify and review “potentially misvalued codes” and make appropriate adjustments to Medicare payment. To assist CMS in this process, the American Medical Association (AMA) established the AMA/Specialty Society Relative Value Scale Update Committee (AMA RUC). The AMA RUC ensures that specialty physicians are represented in these reviews. The AMA RUC makes annual recommendations regarding valuation of new and revised physician services to CMS and performs periodic broad reviews of the Resource-Based Relative Value Scale (RBRVS). CMS determines the appropriate adjustments to RVUs, taking into consideration AMA RUC recommendations, as well as other data sources.

Complex Repair Codes
13100-13153

A number of complex repair codes, including 13132 (27.36 percent reduction) and 13152 (23.08 percent reduction) received sizeable reductions. These codes and others in the complex repair family were identified by CMS as potentially misvalued codes that have not been reviewed since RBRVS implementation. The AMA RUC reviewed these codes in April 2012. CMS accepted most of the AMA RUC recommendations in this code family.

Shave Skin Lesion Codes
11300-11313

CMS presented interim values for Shave Skin Lesion Codes, 11300-11313, which were reviewed by the AMA RUC in April 2012. Because these values are interim, CMS may modify them after review of comments to the final 2013 Physician Fee Schedule. CMS did not accept AMA RUC recommendations on a number of shave skin lesion codes, as noted in CMS’ listing of interim work RVUs for 2013, but only one—a shave code, 11306—was reduced below its 2012 value.

--- see MEDICARE FEE SCHEDULE on page 2

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IMPORTANT Please Route to:
___ Dermatologist ___ Office Mgr ___ Coding Staff ___ Billing Staff

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Derm Coding Consult: Winter 2012
Letter from the Editor

Dear Derm Coding Consult Reader,

Every edition of Derm Coding Consult (DCC) takes on a unique flavor or theme. Content is largely dependent on key industry variables: current legislative/regulatory climate, ICD-9/CPT-4 coding revisions/updates, and commercial carrier issues. In determining the content for each issue, the focus is always on the most up-to-date information to lend guidance and support to dermatology practices. Every issue contains a blend of hot topics and coding and reimbursement scenarios to increase awareness and promote coding education for your staff.

This winter edition of DCC is no exception. External forces affecting coding and reimbursement are the recurrent theme for this issue. Included in this edition is the update to the CMS final rule, guidance on 2013 PQRS measure reporting, and expert advice on practical approaches to coding and reimbursement.

We encourage members to send topic suggestions and coding and reimbursement questions for future inclusion in the newsletter. Let us know what you would like to see in the spring issue of Derm Coding Consult!

ppm1@aad.org

Best,

Cynthia A. Bracy

Cynthia A. Bracy, RHIA, CCS-P

2013 Medicare Fee Schedule

— Impact on Dermatology

— continued from page 1

Surgical Pathology Codes 88305

The final 2013 fee schedule included a significant reduction in reimbursement for the technical component (TC) of surgical pathology code 88305. That code’s TC was cut by 52 percent, although CMS raised the professional component (PC) by 2 percent.

In addition, CMS advises that it will review surgical pathology codes 88300, 88302, 88304, 88305, 88307, 88309 in 2013 to determine the appropriate number of blocks to be included in practice expense (PE). Any changes to the values and the effective dates of those changes will be announced in the final 2014 Physician Fee Schedule.

Laser Codes 96920, 96921, 96922

CMS will address inclusion of a disposable laser tip in PE inputs. The AMA RUC recommendation provided new direct PE inputs for these laser codes, which included the disposable laser tip ($290). The tip had not been included in direct PE before. CMS excluded the supply item from direct PE for these services because the AMA RUC recommendation did not provide a rationale why the tip should be included now inasmuch as the codes have not included this item or a similar one before.

Physician practices do not currently bill for the laser tip, and it is not likely that a new code will be created.

In the final 2013 Physician Fee Schedule, CMS requested public comments on the rationale for including the laser tip prior to finalizing direct PE inputs for 2014. The AADA submitted comments to CMS on this issue.

Medicare Physician Fee Schedule Code-Specific Detail


The appendices for the Medicare Physician Fee Schedule are downloadable from the CMS web site at www.cms.gov/PhysicianFeeSchedule/
A Practical Approach to Evaluation and Management (E/M) Coding from a Dermatologist’s Perspective: Part II

In 2011, the AAD conducted the Electronic Health Records Survey to determine the implementation rate for the electronic health record (EHR) among AAD membership. The survey results demonstrated that nearly 40% of the respondents were using a fully implemented EHR. It is important to note that, to be fully implemented, an office would need to no longer use paper records in the treatment of patients. Additionally, all third party documentation (lab results, old medical records, etc…) would need to be scanned into the electronic record.

The increased implementation and experience working within the EHR environment has created new feedback to guide dermatologists on their quest for implementation. Below are some of the most commonly discussed advantages and cautions of using an electronic health record in a dermatology office. Keep in mind that the EHR is a tool that must be used appropriately in order to reap the rewards of the functionality. Working with vendors throughout the implementation process can help to avoid the common coding and documentation errors. The utilization of an EHR implementation process can help to avoid the common mistakes asked by dermatologists. The information is provided with the assumption that each E&M service must be reviewed on its own merits, and must be “reasonable and necessary” for the patient’s condition. It is important to note that state law and scope of practice may vary. In certain cases, specific answers may not be available for a question and may require that the physician contact the insurer’s Medical Director for clarification in writing.

Advantages to Using and EHR

1. Reduces the incidence of medical error by improving the accuracy and clarity of medical records.
2. Health information becomes readily available, reducing duplication of tests, reducing delays in treatment, and patients well informed to take better decisions.
3. Leads to quality improvement and improved patient outcomes.
4. Coding and billing can become more accurate due to legible and complete documentation.

Cautions When Using an EHR

1. EHRs have built in templates, this can include pre-populated templates/ default documentation. This type of information “cloning” can cause compliance concerns.
2. Exploding notes or documentation sets can rapidly expand the E/M documentation from a lower level code to the highest level of E/M services in that category of E/M codes. Medical necessity may not be documented and there may be no individualization of the medical record.
3. Documentation by exception could lead to incorrect documentation. Being able to select “all systems negative”, “reviewed lab and radiology and have no abnormal findings”, “comprehensive exam”, or “complete past, family, social history (PFISH)” puts the user at risk for over coding, medical malpractice, misinformed treatment and inappropriate patient care.
4. Using a system that automatically assigns an E/M code to the physician’s documentation is a compliance risk and may cause a physician’s records to be audited, either internally or by external government agencies/ non-Medicare insurers because of the higher than average use of level 4 and level 5 E/M codes.

Frequently Asked Questions Related to Evaluation and Management Services

AAD staff compiled the most frequently asked E/M questions asked by dermatologists. The information is provided with the assumption that each E&M service must be reviewed on its own merits, and must be “reasonable and necessary” for the patient’s condition. It is important to note that state law and scope of practice may vary. In certain cases, specific answers may not be available for a question and may require that the physician contact the insurer’s Medical Director for clarification in writing.

Q. We had a patient that had an angina episode during MOHs surgery. Our MOHs surgeon monitored the patient throughout the episode and was able to complete the surgery. The patient took sublingual nitroglycerin and stabilized. Documentation was well recorded. Following the procedure, the patient was sent to the E.R. for further evaluation per the instructions of his own doctor whom our MOHs surgeon notified. Our question is: Is it appropriate to charge an E&M during this visit?

A. Whether this E/M service is paid will be determined individually based on the code reported and if the documentation supported the code. This may be an instance when the Insurer’s Medical Director should be contacted prior to submission of the claim and be asked to review the documentation to determine if the E/M portion is billable. If the claim was already submitted and you received a rejection based on the insurer’s system edits, the claim can be appealed and the documentation to support the E/M service should be sent with the appeal.

Q. Can a physician “double dip” and use the same information as part of the history of present illness (HPI) and Review of systems (ROS)?

A. The review of systems (ROS) inquiries are questions concerning the system(s) directly related to the problem(s) identified in the HPI. Therefore, it is not considered “double dipping” to use the system(s) addressed in the HPI for ROS credit.

Novitas and Highmark (both Medicare contractors) have posted the following Q and A (#15) on their web sites below. Please check to make sure this same information is posted on your contractor’s web site. Use whatever information is posted on your contractor’s web site. If there is no specific answer provided to this question on your Medicare contractor’s web site, please write to your Medicare Contractor Medical Director to obtain the answer.

https://www.novitas-solutions.com/faq/partb/pet/lpet-
evaluation_management_services.html#15
Q. We would like to group all Isotretinoin patients that have labs as an E/M level 99214. If we have a high history and high ROS, then would the MDM would also be high due to data? If the Isotretinoin patient did not do labs, then would they be a 99213? I am having a hard time with this and would like some feedback on why or why not to do this.

A. The most important rule to remember when assigning codes to report any service is: there must be documentation to support the code selected. CPT coding is not based on the diagnosis of the patient. It is based on the service performed and documented and whether that service is medically necessary. As indicated in an earlier answer in this newsletter, Appendix C has clinical examples of a “typical” type of service for each level of service. The following has been excerpted from the guidelines related to the Clinical Examples found in Appendix C of the 2013 CPT code book: “Simply because the patient’s complaints, symptoms, or diagnoses match those of a particular clinical example, does not automatically assign that patient encounter to that particular level of service. The three components (history, examination, and medical decision making) must be met and documented in the medical record to report a particular level of service…”

Code each service based on what was performed and documented at each encounter not based on a template.

ICD-9 Code Freeze
Extended 1 year

The ICD-10 implementation deadline isn’t the only extension proposed by the Centers for Medicare & Medicaid Services (CMS). October 1, 2011 was the last major update of ICD-9-CM. Any further revisions to ICD-9-CM will only be for a new disease and/or a procedure representing new technology. October 1, 2011 was the last major update of ICD-10-CM/PCS until October 1, 2015.

Between October 1, 2011 and October 1, 2015 revisions to ICD-10-CM/PCS will be for new diseases/new technology procedures, and any minor revisions to correct reported errors in these classifications. The next ICD-10 code update is scheduled for October 1, 2015.

NCD vs. LCD: Treatment of Actinic Keratosis

Centers of Medicare and Medicaid Services (CMS) develops the National Coverage Determinations (NCD) after a request from a physicians’ group or specialty society. The American Academy of Dermatology (AAD), with the assistance of our member volunteers, worked with CMS to develop a NCD for Actinic Keratosis. NCD 250.4 is a basic coverage policy stating that if the physician determines a lesion to be an Actinic Keratosis the appropriate treatment selection is based on the patient’s medical history, the lesion’s characteristics, and the patient’s preference for a specific treatment.

Medicare NCD 250.4: “Treatment of Actinic Keratosis

“Actinic keratoses (AKs), also known as solar keratoses, are common, sun-induced skin lesions that are confined to the epidermis and have the potential to become a skin cancer. “Various options exist for treating AKs. Clinicians should select an appropriate treatment based on the patient’s medical history, the lesion’s characteristics, and on the patient’s preference for a specific treatment. Commonly performed treatments for AKs include cryosurgery with liquid nitrogen, topical drug therapy, and curettage. Less commonly performed treatments for AK include dermabrasion, excision, chemical peels, laser therapy, and photodynamic therapy (PDT). An alternative approach to treating AKs is to observe the lesions over time and remove them only if they exhibit specific clinical features suggesting possible transformation to invasive squamous cell carcinoma (SCC).

Effective for services performed on and after November 26, 2001. Medicare covers the destruction of actinic keratoses without restrictions based on lesion or patient characteristics.”

Medicare contractors develop LCDs when there is no National Coverage Determination (NCD) or when there is a need to further define an NCD. This allows Medicare Administrative Contractors (MACs) to clarify and set definitions to the types of lesions, preferred surgical methods used, and frequency of treatment in their Local Coverage Determinations (LCD). Not all MACs have Actinic Keratosis LCD policies. It is important to check the MAC in your state to determine whether you have an active LCD for the treatment of actinic keratosis. Please note that many MACs incorporate this information into their Benign Lesion LCD policies so these LCDs must be reviewed as well.

Example: PalmettoGBA J1 LCD for Actinic Keratosis

L28232 Actinic Keratoses PalmettoGBA J1 (California, Nevada, and Hawaii. U.S. territories of American Samoa, Guam and the Northern Mariana Islands) lists various treatments for actinic keratosis, and proposes a watch and wait approach.

“… Commonly performed treatments for AKs include cryosurgery with liquid nitrogen, topical drug therapy,
NCD vs. LCD: Treatment of Actinic Keratosis

—and curettage. Less commonly performed treatments for AK include dermabrasion, excision, chemical peels, laser therapy, and photodynamic therapy (PDT). An alternative approach to treating AKs is to observe the lesions over time and remove them only if they exhibit specific clinical features suggesting possible transformation to invasive squamous cell carcinoma (SCC).”

“All LCDs are Not Created Equal!

Local Coverage Determinations (LCDs) have an effective date and a distinct coverage area. LCDs typically include a description of each covered service, documentation requirements and information regarding the ICD-9 codes that do or do not support the medical necessity of the services provided. Below are some excerpts from various MAC LCDs outlining the medical policies for the removal of benign skin lesions. Please make sure to join your local MAC listserv to ensure that you are receiving the latest LCD updates.

L32668 Benign Skin Lesion, Novitas Solution, Inc. JH (Mississippi, Louisiana, Arkansas, Texas, New Mexico, Colorado, and Oklahoma) comments on the type of documentation expected for all lesion removals in their Benign Lesion LCD.

“Since you cannot accurately code the conditions listed under “Indications and Limitations,” their presence must be thoroughly documented in medical records to demonstrate compliance with this policy. The records must clearly and unequivocally document the medical necessity for lesion removal(s) when billing Medicare for the service. Documentation requirements should include location, description, associated symptoms, and completely document the medical necessity for lesion removal. Location, description, associated symptoms, and reason for clinical concern leading to decision for removal are all part of complete documentation.”

MAC Updates:

Novitas Solutions Inc, the new JH MAC contractor will be making the transition from Cahaba GBA coverage of Mississippi and soon Trailblazer contractors’ states: Colorado, Texas, New Mexico and Oklahoma.

Palmetto GBA J1 has lost their MAC contract to Noridian Administrative Services. Noridian Administrative Services (NAS) has been named the new Medicare Administrative Contractor JE (MAC) for Medicare Parts A and B in California, Nevada, and Hawaii, U.S. territories of American Samoa, Guam and the Northern Mariana Islands. It is not yet clear whether Palmetto GBA has appealed the decision. A final determination has not been issued.

New! NCCI Version 18.3

CMS developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and eliminate improper coding. They are based on coding conventions defined in the American Medical Association’s CPT book, current standards of medical and surgical coding practice, input from specialty societies, and analysis of current coding practice.

Effective October 1, 2012, CMS’NCCI Version 18.3 became effective. Version 18.3 has an abundance of edits effecting dermatology codes. However, this version of the NCCI edits does not include new or revised edits for dermatology, but instead reinforces preexisting coding guidelines. Coders will be able to use the newest NCCI file to search all possible code pairs to easily make a decision on whether modifier -59 can or cannot be used appropriately.
New! NCCI Version 18.3
— continued from page 5

The significant change in Version 18.3 is the addition of a complete listing of code pairs previously understood to be bundled together or not allowed for same anatomical site of service. For example, the bundling of an incision and drainage code (10040) with a simple repair code (12002) is now listed in the NCCI edit file as a column 1 and column 2 edit. It has always been understood that these codes pairs were not billable together, even with a modifier -59 appended, unless they were billed for separate anatomical sites of service. In Version 18.3, you are able to find this code pair and the appropriate modifier indicator to show the appropriate use of the code pairing. For this example, the modifier indicator is “1.” Modifier indicator “1” indicates that modifier -59 is allowed on the code in column 2 but only if the second code is performed on a separate anatomical site on the same date of service.

EX 1:

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Column 2</th>
<th>Modifier Indicator</th>
<th>Active Effective Date</th>
<th>Policy Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>10040</td>
<td>12001</td>
<td>1</td>
<td>10/1/2012</td>
<td>Misuse of Column 2 code with Column 1 code</td>
</tr>
<tr>
<td>10040</td>
<td>12002</td>
<td>1</td>
<td>10/1/2012</td>
<td>Misuse of Column 2 code with Column 1 code</td>
</tr>
<tr>
<td>10040</td>
<td>12004</td>
<td>1</td>
<td>10/1/2012</td>
<td>Misuse of Column 2 code with Column 1 code</td>
</tr>
</tbody>
</table>

In another example, if a lesion destruction were done at the same time as an excision and repair, both the codes would need a modifier -59 because of the destruction code not the excision code. In both code pairs (17000/11422 and 17000/12032), the destruction code (17000) is in Column 1 and considered the primary code to both the Column 2 codes: repair and excision.

EX 2:

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Column 2</th>
<th>Modifier Indicator</th>
<th>Active Effective Date</th>
<th>Policy Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>17000</td>
<td>12032</td>
<td>1</td>
<td>10/1/2012</td>
<td>Misuse of Column 2 code with Column 1 code</td>
</tr>
</tbody>
</table>

Additionally, CMS regulations are now reflected in the NCCI Version 18.3. For example, the NCCI version 18.3 states that all repairs will be denied with benign excisions of 0.5 cm or less unless performed on a separate anatomical site.

EX 3:

Mohs Micrographic Surgery (or a malignant or benign lesion excision) is performed with an intermediate repair; there is no new edit for this code pair (17311 & 12032). However, if you do a separate malignant destruction (17273), then the intermediate repair will require a modifier -59 due to the new Version 18.3 edit.

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Column 2</th>
<th>Modifier Indicator</th>
<th>Active Effective Date</th>
<th>Policy Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>17273</td>
<td>12032</td>
<td>1</td>
<td>10/1/2012</td>
<td>Misuse of Column 2 code with Column 1 code</td>
</tr>
</tbody>
</table>

Review the common code pairs used in your practice to understand which set will now require a modifier. The edits can be found on CMS website:

CMS NCCI Edits Overview Web Page:
http://www.cms.gov/NationalCorrectCodInitEd/01_overview.asp

CMS NCCI Edits Web Page:
http://www.cms.gov/NationalCorrectCodInitEd/NCCIEP/list.asp

Medicare Overpayment Interest Rates Increase

The Centers for Medicare & Medicaid Services (CMS) recently raised the interest rate to 11.0 percent for overpayment recoupment and underpayments for the 4th quarter of Fiscal Year 2011.

The interest rate is set each quarter by the Secretary of the Treasury, and was announced in July 2012 by CMS. The new interest rate took effect on July 18, 2012. The new interest rate is up eighth of a percentage point from the previous quarter.

— see MEDICARE on page 7
Medicare Overpayment Interest Rates Increase

— continued from page 6

According to CMS publication 100-06, Chapter 4, Section 30 - Medicare Financial Management Manual,

“Interest shall be assessed on overpayments, and shall be paid on underpayments, to providers and suppliers of services (including physicians and other practitioners), if the overpayment or the underpayment is not liquidated within 30 days from the date of the final determination.”

However, interest charges will be waived if the overpayment is completely liquidated within 30 days from the date of final determination, or if the contractor or the Regional Office (RO) determines that the administrative cost of collection would exceed the amount of interest, according to the CMS manual of financial management.

To avoid these costly fees, dermatology practices are encouraged to respond to Medicare audits and requests for refunds in a timely manner. Once an overpayment has been identified, complete the Overpayment Refund Form from your Medicare Carrier website and submit with the claim information and attach the check promptly.


2011 PQRS Feedback and Appeals

As of the first two weeks of November, CMS has completed issuing the 2011 PQRS incentives to those who successfully participated. The incentive payments will have been issued by the Carrier/MAC with the remittance advice and identified as a separate payment under the PQRS. Successful participants can identify the payment by the indicator “LE,” followed by the code “PQ11.”

All participants can request a feedback report of their performance through the Quality Reporting Communication Support Page (CSP) at http://www.qualitynet.org/pqrs. Those wishing to appeal their incentive eligibility can do so also through this portal within 90 days of the release of the 2011 PQRS final feedback reports. The latest date for submitting an informal review request is February 28, 2013.

There is still time to report PQRS for the 2012 reporting period. There are four dermatology-appropriate measures in 2012: measures 137, 138, 224, and 265. A dermatologist wishing to participate in PQRS must report at least three measures. Therefore, he or she only needs to report three of the four dermatology-appropriate measures to qualify. All of the quality measures must have at least one eligible instance for a dermatologist to qualify for the incentive. Additionally, a greater than zero percent performance rate for all three measures is necessary to qualify for the incentive payment. This means that you must perform the measure on at least one patient per measure to qualify for the incentive payment. Each of the four dermatology measures can only be reported via electronic registry, for a full year reporting period (January 1-December 31).

CPT® guidelines describe Adjacent Tissue Transfer (ATT) or rearrangement procedures as a tissue flap created by surgically freeing the skin and underlying subcutaneous tissue and/or fascia. The base of the tissue flap remains connected to one or more borders of the donor site, thus maintaining the blood supply to the surgically created flap.

Like other codes in the Integumentary System section of CPT® manual, ATT’s are reported from codes 14000 through 14302. These codes are based on the anatomic area and defect size. To select accurate code, bear in mind that the term ‘defect’ includes the primary and secondary defects. The primary defect, which results from the excision, and the secondary defect, which results from flap design to perform the reconstruction, are measured together to determine the square centimeter area (in sq. cm) in order to choose the correct code.

CPT further states that when an ATT or rearrangement is performed after the excision of a lesion, the excision of the lesion (CPT® codes 114xx or 116xx) is included with codes 14000-14302 and cannot be reported separately.

1. Patient presents with one undiagnosed lesion for which the physician performs a biopsy by shave technique. Several other benign lesions are treated with liquid nitrogen and two pre-malignant lesions are also treated with cryosurgery. How should these services be coded?

According to the CPT® code descriptor, the destruction of a benign or premalignant lesion can be achieved by any method, e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical currettement. The difference is in the code selection, and since there are two types of lesions treated (benign and premalignant) at the same time as the undiagnosed lesion that warrants a biopsy, these services will require the use of modifier to bypass the code bundle edits so the dermatologist can be reimbursed for all services performed. In the question posed above, services would be coded as:

17110, 11100 - 59, 17000 - 59, 17003

2. Can I bill for the excision of a benign or malignant lesion with an adjacent tissue transfer?

Coding Q&A’s

17003

CODING Q&A’S — see on page 8
Coding Q&A’s

— continued from page 7

3. A patient presents with nondystrophic nail(s). The physician performs nail bed scraping and obtains some nail clippings for use in performing a fungal culture. Is it appropriate to report CPT code 11755?

The CPT code descriptor for code 11755 is *Biopsy of nail unit (eg, plate, bed, matrix, hyponychium, proximal and lateral nail folds) (separate procedure).* This code entails significantly more work than simply scraping and nail clipping. Therefore, CPT code 11755 is not appropriate to be reported when obtaining nail clippings or nail bed scrapings for purposes of performing a fungal culture, KOH preparation, stain or test, or PAS stain. It is more appropriate to report nail bed scraping and clipping as part of the evaluation and management (E/M) code.

4. Tricare denied an E/M due to the diagnosis of ICD-9, V10.83, personal history of neoplasm. Medicare pays for this condition what can we do?

The Academy has received members’ complaints of this Tricare denial. We are in contact with Tricare to fix the problem. A suggestion was made to refile the claim with another diagnosis if supported in the medical record. Don’t remove the V10.83 code from the claim but relink the new diagnosis to the denied claim line.

5. A new dermatologist to our practice removes skin tags and sends them for pathology. The question came up if code 11200 should be reported since the lesions are being sent for pathology. Should we code these differently?

According to the AMA CPT® Codebook, the appropriate code for the procedure being done must be reported, if there isn’t a specific code then an unspecified code can be reported. For this scenario, report 11200, skin tag removal with 88304, pathology if performed. A patient financial responsibility waiver maybe in order since most skin tag removals are considered cosmetic.

6. I’m wondering why the professional component 88305 with a 26 modifier is billed with a later date of service than the procedure itself? By doing this, BCBS is charging copay for both the procedure and the pathology, causing the patient to have to pay their copay twice for what seems like only one date of service.

Both components (26 and TC) of a laboratory or pathology specimen are to be reported on the Date of Service (DOS) the specimen was taken. This was clarified by Medicare MedLearn #6018 on January 1, 2009. Since this is a common coding convention, BlueCross and Blue Shield should follow the same Date of Service logic.
Credentialing and Billing for Non-Physician Practitioners

— continued from page 8

In many states, some NPPs are permitted to practice independently or in collaboration with a physician and receive direct reimbursement for their services while Physician Assistants (PAs) are required by law to work under the supervision of a physician. However, all NPPs must be credentialed with Medicare in order to receive reimbursement as a participating provider.

Tips to Facilitate Seamless Medicare Enrollment Process

Provider enrollment can be exasperating and time-consuming. As we transition to a paperless healthcare industry, credentialing is still largely a paper-intensive process. Not only are the applications and contracts long and tedious, but the Center for Medicare and Medicaid Services (CMS) also requires many forms of authenticating paperwork to be submitted with the application.

The most efficient method for submitting your enrollment application is to use the Internet-Based Provider Enrollment, Chain and Ownership System (PECOS). PECOS guides you through the enrollment application so you only supply information relevant to your application.

To begin, visit the CMS website at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html and using the log-in information created when you originally applied for your National Provider Identification (NPI) number.

Completing the forms this way before printing, signing and mailing means more easily-readable information – which means fewer mistakes, questions, and delays when your application is processed. Signatures are still required to be handwritten. Don’t forget to complete this important step prior to mailing your typed form(s). Make a copy of the signed form for your records before mailing the original to your Medicare contractor!

Mail your completed signed application and all supporting documentation to the Medicare Administrative Contractor (MAC) serving your State or geographic location.

Completing the Application Form

Do not leave any blank or unanswered fields on the application. For sections that are not applicable to your practice, enter ‘N/A’ in that field.

If you intend to bill Medicare directly for your services, your practice name must match exactly with how it is listed on the IRS verification of the Tax Identification Number (TIN) or Employer Identification Number (EIN) form. This includes abbreviations and punctuation.

The NPI registration for the practice information must also match that of the IRS verification for your TIN/EIN form.

If you are not already enrolled for Electronic Funds Transfer (EFT) payments, you will be required to complete an EFT agreement. A voided check must accompany all EFT agreement forms. If your practice currently has any type of loan or credit line with the bank on the check, Medicare will require a letter from the bank stating that it will not seize any Medicare payments made for default payments due.

Plan accordingly and allow up to 90 days for Medicare credentialing.

Once you are credentialed and you have started providing services to Medicare beneficiaries, Medicare will pay for NPP services in one of three ways:

1. NPPs may bill directly for their services under the physician fee schedule and be paid at 85 percent of the physician fee schedule;

2. Services are billed as ‘incident to’ physician services, in which case physicians bill for the services at 100 percent of the fee schedule payment as though they personally performed the service.

3. Services of NPPs may be included in the payment bundle for services provided in hospitals and skilled nursing facilities.

Medicare enrollment application forms can be completed online by visiting PECOS at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html and using the log-in information created when you originally applied for your National Provider Identification (NPI) number.

<table>
<thead>
<tr>
<th>Type of Provider</th>
<th>855I - Medicare Enrollment Application for Physicians and Non-Physician Practitioners (NPPs)</th>
<th>855R - Medicare Enrollment Application for Reassignment of Medicare Benefits (PAs and those NPPs who are working for other institutions/physicians)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NPPs enrolling in the Medicare program for the first time</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>NPPs providing services in a private setting</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>NPPs providing services in a group setting</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>NPPs who have formed a professional corporation, professional association, limited liability company, etc., of which they are the sole owner</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>
E-Prescribing Reporting: 2012-2014

All Medicare providers (e.g. physicians, NPs, PAs, etc.) are eligible to earn a 0.5 percent incentive on their total Medicare Part B allowed charges by electronically prescribing a total of 25 times from January 1 to December 31, 2013 in conjunction with an E/M visit*. Additionally, providers who want to avoid a 2.0 percent penalty in 2014 must report an e-prescribing measure through their claims at least 10 times between Jan. 1 and June 30, 2013. Please note, you are not required to generate the electronic prescription in conjunction with an E/M code* for purposes of reporting for the penalty. You can simply report that you e-prescribed at least 10 times before June 30, 2013 to CMS to be exempt from the penalty in 2014. Furthermore, providers who successfully reported the e-prescribing measure for purposes of the incentive in 2012 will also be exempt from the 2.0 percent penalty in 2014. Exemptions are also available for the 2013 penalty, which are outlined below.

CMS Electronic Prescribing Program Exemptions for Avoiding 1.5% Penalty in 2013:

<table>
<thead>
<tr>
<th>If you:</th>
<th>Report:</th>
<th>Frequency:</th>
<th>Before:</th>
</tr>
</thead>
<tbody>
<tr>
<td>You successfully attested for meaningful use</td>
<td>Nothing; CMS will automatically exempt you from the penalty in 2013</td>
<td>N/A</td>
<td>Between Jan. 1, 2011 and June 30, 2012</td>
</tr>
<tr>
<td>You registered for the EHR Incentive Program on the CMS website and adopted a certified EHR system</td>
<td>Nothing; CMS will automatically exempt you from the penalty in 2013</td>
<td>N/A</td>
<td>Between Jan. 2, 2012 and Jan. 31, 2013</td>
</tr>
<tr>
<td>Practice in a rural area without sufficient high speed internet access</td>
<td>Attest on an online portal at <a href="https://www.qualitynet.org/portal/server.pt/community/communications_support_system/234">https://www.qualitynet.org/portal/server.pt/community/communications_support_system/234</a></td>
<td>1 time</td>
<td>January 31, 2013</td>
</tr>
<tr>
<td>Practice in an area without sufficient access to pharmacies that accept electronic prescriptions</td>
<td>Are unable to e-prescribe due to local, state or federal laws (e.g. prescribe mainly narcotics)</td>
<td>1 time</td>
<td>June 30, 2013</td>
</tr>
<tr>
<td>Are unable to e-prescribe due to local, state or federal laws (e.g. prescribe mainly narcotics)</td>
<td>Prescribe fewer than 100 total prescriptions between Jan. 1 - June 30, 2012</td>
<td>N/A</td>
<td>Between Jan. 1, 2013 and June 30, 2013</td>
</tr>
</tbody>
</table>

CMS Electronic Prescribing Program Reporting Options for Avoiding 2.0% Penalty in 2014:

<table>
<thead>
<tr>
<th>If you:</th>
<th>Report:</th>
<th>Frequency:</th>
<th>Before:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Successfully created an electronic prescription</td>
<td>G8553</td>
<td>10 times</td>
<td>June 30, 2013</td>
</tr>
<tr>
<td>Do not have at least 100 claims containing an E/M code between Jan. 1 - June 30, 2013</td>
<td>Nothing; CMS will calculate this and exempt you from the penalty in 2014</td>
<td>N/A</td>
<td>June 30, 2013</td>
</tr>
<tr>
<td>Do not have prescribing authority</td>
<td>G8644</td>
<td>1 time</td>
<td>June 30, 2013</td>
</tr>
<tr>
<td>Have less than 10 percent of your total allowed charges comprised of E/M codes between Jan. 1 - June 30, 2013</td>
<td>Nothing; CMS will calculate this and exempt you from the penalty in 2014</td>
<td>N/A</td>
<td>June 30, 2013</td>
</tr>
<tr>
<td>You successfully attested for meaningful use</td>
<td>Nothing; CMS will automatically exempt you from the penalty in 2014</td>
<td>N/A</td>
<td>Between Jan. 1, 2012 and June 30, 2013</td>
</tr>
<tr>
<td>You registered for the EHR Incentive Program on the CMS website and adopted a certified EHR system</td>
<td>Nothing; CMS will automatically exempt you from the penalty in 2014</td>
<td>N/A</td>
<td>Between Jan. 1, 2013 and June 30, 2013</td>
</tr>
</tbody>
</table>

2013 Coding and Documentation Manual for Dermatology – COMING SOON!

The 2013 Coding Manual Includes:

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In The Know…

Did you know you have more time to get ready for the transition to ICD-10-CM?


This means that all ‘covered entities’ – as defined by the Health Information Portable Accountability Act (HIPAA) – are required to adopt ICD-10-CM for use in all HIPAA transactions with dates of service on or after Oct. 1, 2014. The transition to ICD-10-CM does not affect physician use of the Current Procedural Terminology® (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes.

In order to be ready and compliant by Oct. 1, 2014, dermatology practices are encouraged to take advantage of the extended compliance deadline to revise individual ICD-10-CM implementation timelines.

For more information on ICD-10-CM implementation, visit the AAD ICD-10 Webpage at http://www.aad.org/member-tools-and-benefits/practice-management-resources/coding-and-reimbursement/icd-10

Now You Are In The Know!