

# MAD NEWS

The Newsletter of the Massachusetts Academy of Dermatology  
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## President's Message

by Kathryn Bowers M. D.

The past few months have been a very busy time period for the Massachusetts Academy of Dermatology. We have participated in a public service project, lobbied legislation, held an educational meeting and generated some publicity in the news media.

More than 60 of our members attended the spring Business Meeting last month hearing presentations on a variety of practice management topics and discussing issues affecting our practices. In March, along with the Massachusetts Melanoma Foundation, we conducted our Third Annual Skin Cancer Screening at the State House. Also, on Beacon Hill, we participated in a press conference to promote Sen. Bill 1329 calling for further regulations on tanning facilities and testified at a public hearing regarding this same bill.

***We are pleased that a number of dermatologists have been involved in personally advocating on these issues including Dr. Karen Rothman and Dr. Marie France Demierre who testified at the hearing. Drs. Alice Gottlieb and Barbara Gilcrest have written letters to legislative committees on tiering and sun tan parlor bills. As these issues come up for floor debate we will be calling on everyone to contact their legislators.***

Taken together, these and some of our other activities cover the entire spectrum of our mission to provide continuing education for our members and promote public education and safety regarding skin care for our patients. Details on some of these activities are contained in this newsletter.

As always there are new issues facing us. As we previously alerted you one of the most important issues is the spread of physician tiering programs by the insurance plans and government agencies. We had a very intense discussion with the Tufts representatives at the Spring meeting. Initially introduced to help us compare our performance with our peers, the ratings are now being used to penalize doctors on prescribing

or procedures. We anticipate it will be a part of the new Commonwealth Health Care program and as CMS expands its Pay4Performance program they will add some form of tiering to the Medicare system.

A variety of organizations are pushing back on these initiatives on both the Federal and state level. The

Massachusetts Medical Society has introduced a bill in the legislature to require plans to explain their rating criteria, provide details to physicians on how their rating was determined and provide an independent panel to mediate complaints. Meanwhile, each physician is strongly advised to check their rating and contact the plan if you believe it is incorrect. The Mass Medical Society website has a list of contacts at each of the plans. **(Massmed.org)**

Our plans for the Annual Meeting scheduled for October 12<sup>th</sup> thru Oct. 14<sup>th</sup> at Wentworth by the Sea in New Hampshire are nearly complete. As always it will be an excellent educational opportunity coupled with an opportunity to socialize with colleagues in a beautiful setting. So please save the date and respond promptly when the meeting notice is mailed in a few weeks.

I look forward to seeing you in the Fall.

## Tufts Notice on Changes on Claims Policy

Tufts Health Plan recently sent a notice of the following changes in their payment for claims under their Global Surgical Policies.

Effective July 1<sup>st</sup> they will deny claims for evaluation and management rendered on the day prior to a major surgical procedure, the same day or within 90 days after a procedure;

They will also deny E&M codes rendered on the same day as a minor surgical procedure.

**What they did not include in the notice is that these claims for e & m services will be paid if filed with Modifier 25 explanations.**

## **Physician Tiering Programs Are Expanding Doctors Need to Check Their Profiles**

As expected the use of physician profiles by the insurance plans has been expanding rapidly and the use of different co-payments is now covering more and more of their products. A few years ago when the profiling movement began doctors were advised it was to assist them in improving their practice in accordance with their peers. The Massachusetts Government Insurance Commission introduced a different copay policy based on physician ratings and it is expected to be included in the Connector insurance products.

The Massachusetts Medical Society is taking aggressive steps to address many of the issues in these programs that are extremely unfair to physicians. The MMS has filed a bill (H. 104/Sen.653) to address inaccuracies in the collection, analysis and use of data to profile doctors. It also calls for greater public disclosure by the plans on the process by which physicians are rated, more input from independent medical sources, a requirement that physician ratings be risk adjusted and use a case mix component.

Physicians are advised it is extremely important that they challenge their profile if they believe there is any question about its accuracy. The MMS website (massmed.org) includes a great deal of information in its "Advocacy" section.

## **Spring Meeting Hears About Practice Management, Malpractice Issues and Commonwealth Health Plan**

The annual Spring Meeting of the Massachusetts Academy of Dermatology attracted 65 physicians along with some physician assistants/nurse practitioners and other interested parties last month at the Massachusetts Medical Society Conference Center. Topics covered included malpractice issues, one plan's tiering program, and the new Commonwealth Health Insurance Connector Program. A luncheon discussion period provided an opportunity for members to raise other specific issues.

Dr. Dan Rome, Tufts Vice President for Medical Affairs, presented a detailed review of the history of the plan's physician profiling program and the methodology used in the process. He noted that initially physicians were tiered based upon their hospital affiliation but beginning in July, 2007

specialists will be rated according to resource use and quality measures.

During the question period Dr. Rome was challenged to explain what some dermatologists believe are flaws in the process including ratings for doctors who see more patients with advanced problems than their peers. He replied to several questioners that the process is ongoing and they are working on identifying extreme conditions and developing a rating system for them. More information may be found at: [tuftshealthplan.com/providers](http://tuftshealthplan.com/providers).

Eric Dahlberg, an associate manager for the Connector, provided details on the program's implementation which began last November and faces a July 1 deadline when everyone eligible should be enrolled in one of the plans. His presentation focused on the various levels of eligibility for the differing plans, the variety of insurance products available and the responsibilities for employers. More information may be found at: [mass.gov/connector](http://mass.gov/connector) or telephone: 617-933-3140.

During the lunchtime Business Meeting questions were raised about a variety of billing and claims issues with different plans including identifying the difference between a referral and a consultation, use of Modifier 59 and policy of Harvard Pilgrim Healthcare to reduce code for closures by 50 percent. The need for clear guidelines on the accepted scope of practice for nurse practitioners/physician assistants was also discussed. These issues are being researched and the membership will be advised of the results.

Several of the presentations are available on the MAD website.

## **Ensuring Timely and Appropriate Reimbursement**

by Lisa Spoden, PhD, MHA Executive Director, ADA/M

There are certainly ways to maximize and speed up the reimbursement you deserve from all payers – government and private –and do so legally. As a former Medicare Fair Hearing Officer for Medicare, then group practice administrator and hospital administrator, we worked continually on this very issue. Over the years I have gathered many tools to do so and recently published the "*Managed Care Survival Guide for Health Care Providers*". It was published last July by HCPPro and is available for \$199 on their web site at <http://www.hcmarketplace.com/prod-4440-EXCROSS.html>.

The following article provides six steps to ensure speedy reimbursement.

Certain common coding and billing mistakes occur again and again for health care providers. The result? Payers deny otherwise legitimate claims and offices experience delays in getting their reimbursement. But if you know what to watch for, you can avoid many of these mistakes.

1. Don't Use Outdated Manuals: Don't use old manuals to code claims. The AMA publishes new manuals with new CPT and ICD-9 codes every year. But some facilities try to save money by using the same manual for several years, particularly if the codes the facility uses most often haven't changed. This is penny-wise and pound-foolish, as you'll realize if you consider much it will cost you in time and aggravation if even a few claims are rejected because of old or invalid codes. Instead, be sure to use the most recent CPT and ICD-9 manuals when coding your claims.

2. Don't Use Truncated Diagnosis Codes: Don't use a three-digit diagnosis code when a four- or five-digit code would be more descriptive. Sometimes a three-digit code is the right choice. But payers require you to use the longer, more specific codes when they're appropriate. For example, there's a three-digit code for diabetes. But there are two additional digits you can add to show the type of diabetes and how long the patient has been in that condition. If you don't use all five digits, a payer might reject your claim. So learn which diagnoses require the longer codes, and make sure to use them.

3. Identify Patients Correctly: Check to be sure you've entered your patient's identifying information correctly. Often, when several members of the same family are insured under one policy, each family member has a separate identifying Health Insurance Claim Number or subscriber number. If you misidentify the patient, your claim may be rejected. For example, the final digit or letter in a health insurance claim number may be the only thing that distinguishes between a husband and wife covered under the same policy. If you remove a skin lesion on the husband and then mistakenly bill it under the wife's health insurance claim number, you can run into trouble or at least have your payment delayed.

4. Use Modifiers Properly: Use modifiers when appropriate, and pay attention to your carrier's instructions on using them. Modifiers provide crucial information to the payer—for example, whether a procedure was done on the same day as another unrelated procedure, or whether there were post surgical complications that required further surgery.

If you omit modifiers or use them incorrectly, you won't be reimbursed appropriately, or your claim may be denied outright. So be sure to keep up with the information in your carrier's bulletins so you know when and how to use modifiers.

5. Use the Right Site-of-Service Code: Make sure you use a site-of-service code that's appropriate for the type of service provided. For example, don't bill under an ASC code if the service was provided in a physician's office. Most surgical procedures that can be performed in a physician's office have a different fee if billed as if performed in a licensed ASC. So you could be losing out on reimbursement you're entitled to if you're not careful about using the correct site of service.

6. Don't Omit Referring Physician's Name and NPI #: Don't forget to include the referring physician's name and physician's NPI # (was UPIN) when submitting claims for diagnostic tests or consultations. Even if the treating physician at your facility personally ordered the diagnostic test, the claim must indicate that. Forgetting to include the referring physician's name and NPI will cause the payer to reject your claim. So be sure your facility makes the referring or requesting physician's information available to whoever prepares and submits the claims. Please note: The original effective date for the new NPI numbers was May 23, 2007. The date has now been moved to May 23, 2008.

I hope that these six guides to help you avoid the delays and aggravation that avoidable mistakes can cause and ensure you timely and appropriate reimbursement.

The Association of Dermatology Administrators / Managers (ADA/M) is the nation's premier resource for management and administrative professionals affiliated with dermatology offices. ADA/M provides tools, resources, and opportunities for professional growth, that empower its members to improve the efficiency and profitability of their dermatology practices.

### **Save the Dates!**

*Please mark your calendars  
and plan to attend.*

**2007 Annual Meeting: October 12-14;  
Wentworth-by-the-Sea, Newcastle, NH**

**2008 Business Meeting: May 14, 2008;  
Mass Medical Society, Waltham, MA**

**2008 Annual Meeting: September 19-21;  
Woodstock Inn, Woodstock, VT**

## **Legislative Matters** **By Martin Cohn, MAD Associate Director /** **Lobbyist**

We have had a lot of activity at the State House with regard to Senate Bill 1329, an act to further regulate tanning facilities.

In April, Massachusetts Academy of Dermatology President Dr. Kathryn Bowers participated in a news conference to announce the refiling of the bill with State Senators Resor and Timilty, as well as Deb Girard, Executive Director of the Melanoma Foundation of New England. The news conference received extensive coverage.

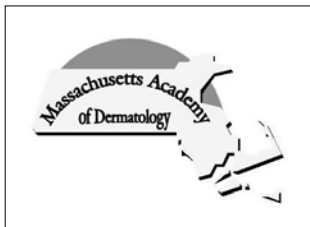
In June, the Joint Committee on Public Health held a hearing on the bill. We lined up three panels that included not only our members Dr. Karen Rothman and Dr. Marie France Demierre, but also melanoma survivors. Additionally, we submitted written testimony.

At the hearing, we learned that the Indoor Tanning Association hired a Boston-based lobbying firm to try to defeat the legislation.

We are anticipating that the Committee on Public Health will again report the bill out favorably. Then, the matter will go before the Senate and House.

Medi-spa Task Force Update — Drs. Jeffrey Dover and Karen McCoy continue to work on the Legislative Task Force established to study issues surrounding medi-spas. The deadline for the Task Force to report back to the Legislature has been extended to Fall, 2007.

State House Skin Screening Update — A total of 84 individuals were screened in 5-1/2 hours. Of that number, 34 were referred for follow up care. Of the 34 individuals referred for follow-up, the following presumptive diagnoses were listed: (5) Basal cell carcinoma, (2) Squamous cell carcinoma, and ONE MELANOMA! Many thanks to Dr. Karen Rothman for chairing the event. And, thanks to the following dermatologists who volunteered: Drs. Caroline Bevona, Kathryn Bowers, Dan Finn, Christine Hayes, Dennis Lee, Nikki Levin, Jennifer Lin, Bonnie Mackool, Pamela Norden, Thanks also to Catherine Pereira, NP and Ann-Marie Desorcy, CMA.



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