
The Centers for Medicare and Medicaid, (CMS) has announced that it has resumed ICD-10 Acknowledgement Testing. Testing will be done through September 30, 2015 as published in - MLN Matters® Number: SE1501. During the acknowledgement testing, healthcare providers and other submitters, such as clearing houses, can submit claims with ICD-10 codes and ICD-10 companion qualifiers. While claims are not reviewed for reimbursement purposes, submitters will receive an acknowledgement that their claim was accepted or rejected.

For successful acknowledgment, be sure to use ICD-10 qualifiers (0), which differ from ICD-9 (9) qualifiers to differentiate ICD-9 claims from ICD-10 claims. Check with your practice management software provider on how to set this up.

All Medicare fee-for-service (FFS) providers, who submit electronic claims, can try acknowledgement testing with their Medicare Administrative Contractor (MAC) at any time until September 30.

What Dermatologists can do to participate

- There is no need to register to participate;
- You may submit an unlimited number of claims;
- You can “acknowledgement test” claims directly, through a clearinghouse or through your billing agency.

To submit claims for testing, you must use:

- Current dates of service;
- The test indicator “T” in the Interchange Control Structure (ISA) 15 field;

Analysis of acknowledgement testing to date has not found any issues with Medicare systems for FFS claims. Rejected claims have been largely due to improperly prepared test claims—issues unrelated to ICD-10. Specific issues have been:

- An invalid National Provider Identifier (NPI), or an NPI that is not on the NPI crosswalk;
- Invalid Healthcare Common Procedure Coding System (HCPCS) codes on professional claims
- Invalid postal ZIP codes on professional claims

Beyond testing with Medicare as described above, you can check with your commercial health plans, clearing-houses, and billing services for more acknowledgement testing opportunities.

End-to-End Testing

While registration has closed for the Medicare FFS end-to-end testing described below, some health plans continue to offer opportunities. If you have not conducted end-to-end testing yet, check with your health plans, clearing-houses, and billing services about the opportunities available to do so.

Questions about Acknowledgment Testing

The EDI Help Desk is available Monday-Friday, 9:00 a.m. - 4:00 p.m. local MAC time. You can also contact the EDI via Email Inquiry forms or by telephone available on your local MAC website.


Contents

- CMS: Acknowledgement Testing Available until Sept. 30, 2015 ........................................1
- Medicare Announces Final April 2015 ICD-10 End-to-End Testing Results ..................... 2
- A good time to review your NPI Numbers ........ 3
- CMS provides clarification regarding ICD-10 Flexibility Policy .................................... 3
- What do “NEC” and “NOS” mean in ICD-10 coding? How do I choose between them in Dermatology? ........................................ 4
- CMS Proposed Physician Fee Schedule Rule for Calendar Year 2016 ............................ 4-5
- Consult Reporting Guideline Reminders .......... 5-6
- Frequently Asked Questions (FAQs) .......... 6-8
- In the Know ..................................... 8

IMPORTANT Please Route to:

___ Dermatologist ___ Office Mgr ___ Coding Staff ___ Billing Staff
Medicare Announces Final April 2015 ICD-10 End-to-End Testing Results

During the week of April 27 through May 1, 2015, Medicare Fee-For-Services (MFFS) healthcare providers, clearing houses and billing agencies participated in the second successful ICD-10 end-to-end testing week with Medicare Administrative Contractors (MACs).

The Centers for Medicare and Medicaid Services (CMS) announced that most providers that volunteered to participate were accommodated.

<table>
<thead>
<tr>
<th>Testing period:</th>
<th>January 26 thru February 3, 2015</th>
<th>April 27 thru May 1, 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Number of Participants</td>
<td>661</td>
<td>875</td>
</tr>
<tr>
<td>Total Number of Provider NPIs</td>
<td>1,400 (equally split between direct claim submitters and clearing houses/billing agencies)</td>
<td>1,600 (representing a broad cross-section of provider, claim, and submitter types)</td>
</tr>
<tr>
<td>Total Number of Test Claims Received</td>
<td>14,929</td>
<td>23,138</td>
</tr>
<tr>
<td>Types of Claims Received</td>
<td>56% - Professional 38% - Institutional 6% - Supplier</td>
<td>50% - Professional 43% - Institutional 7% - Supplier</td>
</tr>
<tr>
<td>Total Number of Claims Accepted</td>
<td>12,149</td>
<td>20,306</td>
</tr>
<tr>
<td>Percentage of Claims Accepted</td>
<td>81%</td>
<td>88%</td>
</tr>
<tr>
<td>Breakdown of Claims Rejected</td>
<td>3% - Invalid submission of ICD-9-CM or ICD-9-PCS codes 2% - Due to invalid submission of ICD-10 diagnosis or procedure code 3% - Invalid submission of ICD-10-CM or ICD-9-PCS codes 13% - Non-ICD-10 related errors e.g. incorrect NPI #, health insurance claim number, submitter ID, DOS outside the range valid for testing, invalid HCPCS code, invalid POS</td>
<td></td>
</tr>
</tbody>
</table>

CMS indicated a successful outcome for the April ICD-10 testing week. There was an increase in participants and claim acceptance rate in comparison to the January 2015 end-to-end testing period. Similar to the January end-to-end testing errors, in the April testing there were some rejections stemming from non-ICD-10 related errors. Examples of these non-related errors include: incorrect NPI number, Health Insurance Claim Number, Submitter ID, dates of service outside the range valid for testing, invalid HCPCS codes and invalid place of service.

Based on the outcome, the indications are there were no specific ICD-10 related issues which in turn resulted in zero rejections due to front-end CMS systems issues for professional and supplier claims. CMS states that these results indicate that they are ready to accept and adjudicate ICD-10 claims.

Remittance Advices (RAs) were sent to the April end-to-end testing participants per standard procedure. In addition, all testers received a report on the disposition of all of their test claims around May 29.

To avoid future non-ICD-10 related errors identified during the testing week, CMS announced they will provide educational sessions to healthcare providers in preparation for the upcoming testing weeks.

There is still time to get ready!

The American Academy of Dermatology encourages dermatology practices to participate in payer testing events as part of the ICD-10 implementation readiness. If your dermatology practice participated in the testing week, you are automatically eligible to test again in July 2015.

For more information on participating with your payer testing opportunities, visit https://www.aad.org/members/practice-and-advocacy-resource-center/payment-and-reimbursement/coding-resource-center/icd-10 or contact your carrier for a volunteer form.

Editor’s Note:

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.

Address Correspondence to:

David E. Geist, MD, FAAD
Editorial Board Derm Coding Consult
American Academy of Dermatology Association
P.O. Box 4014 Schaumburg, IL 60188–4014
A good time to review your NPI numbers

Dermatology practices are encouraged to perform periodical checkups on all their business operations and administrative tasks. This helps to identify flaws or glitches that may need to be updated or addressed. While practices are focused on getting ready to meet the ICD-10-CM compliance deadline on October 1, 2015, other areas should not be neglected.

Dermatology practices may not have thought about their NPI numbers for years, but they should periodically review their NPI profile to determine that all the data elements are complete, correct and accurate. Doing so will go a long way to maintain the smooth running of the practice.

It’s a good practice to verify the practice’s set of NPI numbers particularly if the practice has changed or expanded over the years. One area that may be lacking sufficient accuracy is the specialty taxonomy codes, which classifies a provider’s scope of medical specialty. For example, a dermatologist, who is also a Mohs surgeon, should be classified first as a dermatologist, then second as a Mohs surgeon. Under the NPI dermatology taxonomy, there are some five subspecialities which are rolled up into the specialty.

Taxonomy codes: Up to 15 taxonomy codes may be reported as part of each individual dermatologist’s NPI information. Make sure your primary taxonomy code (Dermatology — 207N00000X) is registered as it is required. In addition, while optional, it is recommended to include all appropriate secondary dermatology subspecialties that accurately reflect your current scope of dermatologic clinical services. The primary and secondary taxonomy codes for dermatology include:

Primary:
• Dermatology — 207N00000X

Secondary:
• Clinical & Laboratory Dermatological Immunology — 207N0002X
• Dermatological Surgery — 207NS0135X
• Dermatopathology — 207ND0900X
• Mohs — Micrographic Surgery - 207ND0101X
• Pediatric Dermatology — 207NP0225X

For more information, visit https://nppes.cms.hhs.gov/NPPES/Welcome.do or call 1-800-465-3203 to manage and update your NPI taxonomy classification.

CMS provides clarification regarding ICD-10 Flexibility Policy

On July 6, 2015, the Centers for Medicare and Medicaid Services (CMS), along with the American Medical Association (AMA) released a Joint Announcement regarding an ICD-10 flexibility policy. What seemed to be understood, was if a provider reported an ICD-10 code within a “family of codes” the claim would be valid.

Due to numerous inquiries, CMS released a clarification statement on July 27, 2015. Traditional Medicare Part B Fee-for-Service claims will not be denied during post-payment review solely on the basis of the code specificity, as long as the provider used a code from within the correct ICD-10-CM three-character category including all the characters required. For example, the provider would not be penalized on post-payment review for submitting code L25.9 (Unspecified contact dermatitis, unspecified cause) even though the record indicates the patient had allergic contact dermatitis due to other agent, (L23.8).

There are other important limitations listed in CMS’ FAQs that are noteworthy for providers:

• Claims will not be processed unless they include valid ICD-10-CM codes. In the example above, the claim will be rejected if the provider submits it with code L25 or L23, since this code is further subdivided into 4-character codes.

• The ICD-10 flexibility policy applies only to post-payment reviews, not to prepayment reviews, prior authorization, or initial claims adjudication.

• If a National Coverage Determination (NCD) or Local Coverage Determination (LCD) limits coverage to specific diagnosis codes, the claim must include one of those codes, or it will not be paid. For example, one contractor’s LCD for infective dermatitis includes several codes from ICD-10-CM category L30 (Other and unspecified dermatitis). However, it does not include code L30.3 (Infective dermatitis, infectious eczematoid dermatitis). If a provider submits code B30.3, the claim will not be paid even though this code is in the same three-character category as the covered codes.

• Also, CMS points out in the FAQs that LCDs and NCDs that contain codes for right side, left side, or bilateral do not allow the provider to report the code for unspecified side.

It is of extreme importance to review your local LCD for covered ICD-10-CM diagnosis codes. Many unfortunately continue to list the unspecified codes. Check with your other payers as this ICD-10 flexibility is a Medicare policy.

After October 1, 2015 it will still be crucial to assign codes that are not only valid but also specific. Use of unspecified codes may result in claim denials and loss of payment.


To view AAD’s Quick Coder online, please visit https://www.aad.org/members/practice-and-advocacy-resource-center/coding-resources/icd-10-center/icd-10-quick-coder
Derm Coding Consult: Fall 2015

What do “NEC” and “NOS” mean in ICD-10 coding? How do I choose between them in Dermatology?

As practices are developing their superbills for reporting ICD-10-CM codes on October 1, 2015, the Academy’s coding staff has addressed many questions on the difference between the abbreviations: Not Elsewhere classified “NEC” and Not Otherwise Specified”NOS.” These are common diagnostic abbreviations from ICD-9-CM which have carried over to ICD-10-CM.

Dermatology diagnostic coding has been limited to reporting “unspecified” diagnosis codes, the question of difference didn’t seem to matter. With increased code choices in ICD-10-CM, the choice between ‘NOS’ and ‘NEC’ could make a difference in claim adjudication.

Both code sets use the abbreviations “NEC” and “NOS” to denote diagnoses “not elsewhere classified” and “not otherwise specified.” NEC is the equivalent of using an “other”’ code selection and NOS is the equivalent of using an “unspecified” code selection.

What exactly are the differences between the two?

Not Otherwise Specified (NOS) is an abbreviation frequently used in both ICD-9-CM and ICD-10-CM. It is found in the Tabular listing and is equivalent to “unspecified.” The use of “NOS” diagnosis codes means that the medical record does not provide enough information to assign a more specific code in a particular category. In many, but not all code categories, the fourth digit “9” for ICD-9 signifies an unspecified code. In ICD-10-CM, unspecified codes may be represented with a “9” in the 4th or 6th character place or a “0” in the 5th character place.

Note: that ICD-9 refers to the code spaces as digits but since ICD-10 is an alphanumeric system, those spaces are referred to as characters.

Not Elsewhere Classified (NEC) is also present in both ICD-9-CM and ICD-10-CM. It may be referred to as “Other” or “other specified” in the Tabular list. This is used when the medical record documents a condition to a level of specificity not identified by a specific ICD-9 or ICD-10-CM code. In ICD-10-CM, the 4th or 6th character is 8 and in some cases the 5th character “9” represents an NEC code.

“NEC” codes are usually highlighted in gray in each coding book.

“NOS” codes are usually highlighted in yellow.

For example, if the physician documents “contact dermatitis” but does not specify the type, coders report ICD-9-CM code 692.9 (contact dermatitis and other eczema, unspecified cause). In ICD-10-CM, that code becomes L23.9 (allergic contact dermatitis, unspecified cause).

Coders still need to look in the Tabular List for the final code. The index does not always provide the complete code. As in ICD-9-CM, codes in ICD-10-CM may have additional characters not listed in the Alphabetic Index. In addition, codes may have instructional notes, such as “use additional code” or “sequence first” which may only be found in the tabular listing.

Even though ICD-10-CM codes include more detail than ICD-9-CM codes, coders will still have the option to use an unspecified code. What remains unclear is how payers will reimburse for the unspecified codes. This may be reason enough to delay claim adjudication until the medical record can be reviewed for specificity.

CMS Proposed Physician Fee Schedule Rule for Calendar Year 2016

The Centers for Medicare and Medicaid Services (CMS), released their Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2016 Proposed Rule on July 8, 2015. This Proposed Rule was published in the Federal Register on July 15th, 2015. It is important to keep in mind that this is a “proposed rule;” specific changes will be noted with the publication of the Final Rule which usually occurs in November. In the proposed rule, the specialty of Dermatology is set to see an increase of 1% overall this year, with the 0.5 % update factor provided within the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Additionally, with MACRA, the threats of reductions usually caused by the Sustainable Growth Rate (SGR) have also been eliminated. In 2015, the conversion factor was $35.9335 and in 2016 it has a slight increase at $36.1096.

For 2016, some Dermatology specific codes have some value increases due mainly to MACRA and the 0.5% increase. The attached chart below provides a closer look at the changes CMS has proposed for 2016

Estimated Payment Amounts for CY 2016 Medicare Physician Fee Schedule Proposed Rule – Select Dermatology Codes

<table>
<thead>
<tr>
<th>2015 CPT/HCPCS Description</th>
<th>2015 Payment Amount</th>
<th>2016 Payment Amount</th>
<th>% Payment Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>1100 Biopsy skin lesion</td>
<td>$104.21</td>
<td>$106.52</td>
<td>2.22%</td>
</tr>
<tr>
<td>1101 Biopsy skin add-on</td>
<td>$33.06</td>
<td>$33.58</td>
<td>1.58%</td>
</tr>
<tr>
<td>11300 Shave skin lesion 0.5 cm</td>
<td>$98.46</td>
<td>$99.66</td>
<td>1.22%</td>
</tr>
<tr>
<td>11301 Shave skin lesion 0.6-1.0 cm</td>
<td>$120.74</td>
<td>$123.13</td>
<td>1.99%</td>
</tr>
<tr>
<td>12051 Intmd rpr face/mm 2.5 cm</td>
<td>$261.24</td>
<td>$265.77</td>
<td>1.73%</td>
</tr>
<tr>
<td>12052 Intmd rpr face/mm 2.6-5.0 cm</td>
<td>$297.89</td>
<td>$302.60</td>
<td>1.58%</td>
</tr>
<tr>
<td>14060 Tis tmfr e/n/e/l 10 sq cm</td>
<td>$789.82</td>
<td>$800.91</td>
<td>1.40%</td>
</tr>
<tr>
<td>14061 Tis tmfr e/n/e/l 10.1-30 sq cm</td>
<td>$1,030.93</td>
<td>$1,046.82</td>
<td>1.54%</td>
</tr>
<tr>
<td>17000 Destroy premalg lesion</td>
<td>$67.20</td>
<td>$68.25</td>
<td>1.56%</td>
</tr>
<tr>
<td>17003 Destroy premalg les 2-14</td>
<td>$5.75</td>
<td>$5.78</td>
<td>0.49%</td>
</tr>
<tr>
<td>17004 Destroy remal lesions 15/&gt;</td>
<td>$152.36</td>
<td>$154.19</td>
<td>1.20%</td>
</tr>
<tr>
<td>17106 Destruction of skin lesions</td>
<td>$347.48</td>
<td>$351.35</td>
<td>1.11%</td>
</tr>
<tr>
<td>17110 Destroy b/9 lesion 1-14</td>
<td>$111.75</td>
<td>$113.75</td>
<td>1.78%</td>
</tr>
<tr>
<td>17111 Destroy lesion 15 or more</td>
<td>$132.95</td>
<td>$134.69</td>
<td>1.30%</td>
</tr>
<tr>
<td>17311 Mohs 1 stage h/n/hfg</td>
<td>$669.08</td>
<td>$679.22</td>
<td>1.52%</td>
</tr>
<tr>
<td>17312 Mohs addl stage</td>
<td>$393.47</td>
<td>$399.01</td>
<td>1.41%</td>
</tr>
</tbody>
</table>

— see PHYSICIAN FEE SCHEDULE on page 5
**CMS Proposed Physician Fee Schedule Rule for Calendar Year 2016**

— continued from page 4

<table>
<thead>
<tr>
<th>2016 CPT / HCPCS</th>
<th>Description</th>
<th>2015 Payment Amount $</th>
<th>2016 Payment Amount $</th>
<th>% Payment Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>17313</td>
<td>Mohs 1 stage t/a/l</td>
<td>$625.96</td>
<td>$635.53</td>
<td>1.53%</td>
</tr>
<tr>
<td>17314</td>
<td>Mohs addi stage t/a/l</td>
<td>$377.66</td>
<td>$383.12</td>
<td>1.45%</td>
</tr>
<tr>
<td>17315</td>
<td>Mohs surg addi block</td>
<td>$80.85</td>
<td>$81.97</td>
<td>1.38%</td>
</tr>
<tr>
<td>67810</td>
<td>Biopsy eyelid &amp; lid margin</td>
<td>$173.56</td>
<td>$176.21</td>
<td>1.53%</td>
</tr>
<tr>
<td>77401</td>
<td>Radiation treatment delivery</td>
<td>$20.84</td>
<td>$25.28</td>
<td>21.28%</td>
</tr>
<tr>
<td>88305</td>
<td>Tissue exam by pathologist</td>
<td>$73.30</td>
<td>$74.39</td>
<td>1.48%</td>
</tr>
<tr>
<td>88346</td>
<td>Immunofluorescent study</td>
<td>$94.51</td>
<td>$94.97</td>
<td>0.49%</td>
</tr>
<tr>
<td>96567</td>
<td>Photodynamic tx skin</td>
<td>$132.59</td>
<td>$138.66</td>
<td>4.58%</td>
</tr>
<tr>
<td>96910</td>
<td>Phototherapy with uv-b</td>
<td>$69.71</td>
<td>$73.30</td>
<td>5.15%</td>
</tr>
<tr>
<td>99212</td>
<td>Office/outpatient visit est</td>
<td>$43.84</td>
<td>$44.41</td>
<td>1.31%</td>
</tr>
<tr>
<td>99213</td>
<td>Office/outpatient visit est</td>
<td>$73.30</td>
<td>$74.02</td>
<td>0.98%</td>
</tr>
</tbody>
</table>

1 CPT codes and descriptors are copyright 2014 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
2 These payment rate calculations were made using conversion factor of $35.9335 for CY 2015 and $36.1096 for CY 2016.

**Potentially Misvalued Codes**

CMS has also identified “potentially misvalued codes” through the use of a “high expenditure by specialty screen.” The codes identified by CMS that are relevant to Dermatology include:

- **11100-** Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion
- **11101-** Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; each separate/additional lesion
- **96567-** Photodynamic therapy by external application of light to destroy premalignant and/or malignant lesions of the skin and adjacent mucosa (e.g. lip) by activation of photosensitive drug(s), each phototherapy exposure session
- **96910-** Photochemotherapy; tar and ultraviolet B (Goekerman treatment) or petroleum and ultraviolet B

When codes are identified in this way, they will need to be reviewed. In this case, review will more than likely occur in the 2016 cycle and new values if needed, will be in place for 2017. 2017 will also be the year in which the global surgery revaluation will occur which includes all the 10 and 90 day global codes. This year no 10 and 90 day global codes were identified because of this.

**Physician Quality Reporting System (PQRS) measures**

A new psoriasis measure was added, which brings the number of dermatology-specific measures in PQRS to six. The new measure, “Clinical Response to Oral Systemic or Biologic Medications,” reads:

This measure evaluates the proportion of psoriasis patients receiving systemic or biologic therapy who meet minimal physician or patient-reported disease activity levels. It is implied that establishment and maintenance of an established minimum level of disease control, as measured by physician and/or patient-reported outcomes, will increase patient satisfaction with and adherence to treatment.

The 2018 PQRS payment adjustment is the last adjustment that will be issued under the PQRS. Following the 2018 PQRS payment adjustment, adjustments to payment for quality reporting and other factors will be made under the new Merit-Based Incentive Payment System (MIPS), as required by the MACRA. MIPS will be replacing the current Value-Based measures (VBM) and Electronic Health Records Meaningful Use (MU) programs. New MIPS performance categories are quality, resource use, MU, and a new category named “clinical practice improvement.”

**Supervision of non-physician practitioners (NPPs)**

The 2016 Proposed Rule as written, explains that it will only be possible to attain the 100% incident-to billing of a non-physician provider if the supervising physician is the one who previously saw and initiated the care of a patient. If this is not met, the care should be listed at the 85% NPP rate. Currently, if any physician is present when a patient is seen by an NPP, 100% of the incident-to rate can be used.

The Academy will be providing a comment letter to CMS on various points of interest to the specialty of Dermatology. Again, as previously noted, these are all proposed changes. Final changes will be known once the Final Rule is released in November.

**Consult Reporting Guideline Reminders**

AAD Coding Staff have received numerous calls on Consultation reporting. Effective Jan. 1, 2010, The Centers for Medicare and Medicaid Services (CMS) eliminated payment for consultation codes (99241-99245 and 99251-99255). CMS now requires physicians to report either a new or established patient encounter code (99201-99205) depending on the complexity of the visit, where the visit occurred and whether the patient is a new or established patient to that physician.

CMS justifies this regulatory action by saying “the resources involved in doing an inpatient or office consultation are not sufficiently different than the resources required for an inpatient or office visit to justify the existing differences in payment levels.”

Each type of visit has appropriate guidelines to follow. In the office or other outpatient setting, dermatologists and non-physician practitioners (NPPs) will use the new or established patient encounter CPT codes (99201-99215) depending on the complexity of the visit rather than the
consultation codes. All providers should follow the evaluation and management (E/M) documentation guidelines for all E/M services. These rules apply to circumstances where Medicare is the primary or secondary payer. CMS encourages providers to select the E/M codes based on the content of the service.

According to CMS, “Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported. The service should be documented during, or as soon as practical after it is provided in order to maintain an accurate medical record.”

The guidelines relevant to inpatient (hospital) and to nursing facility settings, indicate that all providers who perform an initial evaluation may bill an initial hospital care codes (99221–99223) or nursing facility care codes (99304–99306). The admitting physician of record is distinguished in the Medicare billing system from other physicians who may be furnishing specialty care by appending modifier “-AI” - Principal Physician of Record, appended to the E/M code reported by the admitting physician.

Follow-up visits in the facility setting shall be billed as subsequent hospital care visits (99231-99233) and subsequent nursing facility care visits (99307–99310). The previous low level consultation codes (99251-99252) do not match the documentation components of the inpatient hospital care codes (99221-99222). There is no comparison for these two lowest-level inpatient consult codes, 99251 and 99252. The CMS manual gives providers the option to report the unspecified evaluation and management (E/M) code 99499. This code will be denied without documentation. Unless advised by your carrier, once the claim is denied, refile it with supporting documentation.

Since this will cause a delay in reimbursement, some local CMS contractors have suggested reporting the subsequent hospital codes 99231-99232 when the work, documentation and medical necessity don’t support the services of 99221. The use of code 99221 requires a detailed history and exam with straightforward or low medical decision making. Refer to your local carrier for more information.

For non CMS patients, Dermatologists should check directly with the commercial carriers that their practice has contracted with to verify the carriers’ current consultation code billing policy. For example. among the commercial carriers, United Healthcare has stated that it “will continue to reimburse consultation codes (99241–99245 and 99251–99255) according to the United Healthcare payment policies” when submitted for services provided to members covered under commercial plans.

---

Q) I am wondering what the AAD is recommending for ICD-10 coding of keratosis pilaris (KP) (benign dry skin condition – not Darier’s). Our providers have always used ICD-9 code 757.39

It’s been recommended to report L85.8 for acquired KP and Q82.8 for congenital KP. 757.39/ Q82.8 is for Darier’s and our providers said the benign dry skin KP is not the same as Darier’s as this is a much more problematic condition. Is the same code used for both conditions in ICD-10 as it is in ICD-9?

A) This is one of the debilitating factors in ICD-9-CM in that we do not have enough code specificity and granularity. As you have demonstrated here, in ICD-10-CM it is important to pay attention to the details. As you have been reporting this condition as a congenital anomaly (73759 - Other specified congenital anomaly) This condition would be reported with ICD-10-CM code Q82.8 Keratosis Follicularis.

If on the other hand, this was reported as an acquired condition with ICD-9 code 701.1 – keratosis pilaris would be coded as L85.8 – Other specified epidermal thickening.

It is important to note that code selection in ICD-10-CM will be dependent on the medical record documentation and information presented by the provider in order to select and report the accurate code.

Q) A Medicare patient was seen in our office and treated. We then found out that this patient also received services from an inpatient facility on the same date of service. Usually, our provider would perform a hospital visit consult in the inpatient facility but this patient was transported by the inpatient facility to our office for his appointment. How would we bill this?

A) The Internet Only Manual (IOM) Publication 100-04, Chapter 26 provides the following advice when providers render a service to a patient who is a registered inpatient or outpatient of a hospital:

**Section 10.5 -** When a physician/practitioner furnishes services to a registered inpatient, payment is made under the PFS at the facility rate. To that end, a physician/practitioner/supplier furnishing services to a patient who is a registered inpatient, shall, at a minimum, report the inpatient hospital POS code 21 irrespective of the setting where the patient actually receives the face-to-face encounter. In other words, reporting the inpatient hospital POS code 21 is a minimum requirement for purposes of triggering the facility payment under the PFS when services are provided to a registered inpatient. If the physician/practitioner is aware of the exact setting the beneficiary is a registered inpatient, the appropriate inpatient POS code may be reported consistent with the code...
list annotated in this section (instead of POS 21). For example, a physician/practitioner may use POS 31, for a patient in a SNF receiving inpatient skilled nursing facility care, POS 51, for a patient registered in a Psychiatric Inpatient Facility, and POS 61 for patients registered in a Comprehensive Inpatient Rehabilitation Facility.

**Section 10.6** - For purposes of payment under the Medicare Physician Fee Schedule (MPFS), the POS code is generally used to reflect the actual setting where the beneficiary receives the face-to-face service. For example, if the physician’s face-to-face encounter with a patient occurs in the office, the correct POS code on the claim, in general, reflects the 2-digit POS code 11 for office. In these instances, the 2-digit POS code (Item 24B on the claim Form CMS-1500) will match the address and ZIP entered in the service location (Item 32 on the 1500 Form) – the physical/geographical location of the physician. However, there are two exceptions to this general rule – these are for a service rendered to a patient who is a registered inpatient or an outpatient of a hospital. In these cases, the correct POS code – regardless of where the face-to-face service occurs – is that of the appropriate inpatient POS code (at a minimum POS code 21) or that of the appropriate outpatient hospital POS code (at a minimum POS code 22) as discussed in section 10.5 of this chapter. So, if in the above example, the patient seen in the physician’s office is actually an inpatient of the hospital, POS code 21, for inpatient hospital, is correct. In this example, the POS code reflects a different setting than the address and ZIP code of the practice location (the physician’s office).

In addition to the above guidelines, the Medical Learning Network (MLN) Matters article MM7631, advises the following regarding reporting place of service when the patient is registered as an inpatient or outpatient of a hospital.

The service location information is used by physicians/practitioners/suppliers to report the name, address and ZIP code of the service location where they furnished services (e.g., hospital, clinic, or office) and is used by contractors to determine the applicable “locality” and Geographic Practice Cost Index (GPCI)-adjusted payment for each service paid under the MPFS.

There are two (2) exceptions to this face-to-face provision/rule in which the physician always uses the POS code where the beneficiary is receiving care as a registered inpatient or an outpatient of a hospital, regardless of where the beneficiary encounters the face-to-face service. The correct POS code assignment will be for that setting in which the beneficiary is receiving inpatient care or outpatient care from a hospital, including the inpatient hospital (POS code 21) or the outpatient hospital (POS code 22). In other words, reporting the inpatient hospital POS code 21 or the outpatient hospital POS code 22, is a minimum requirement for purposes of triggering the facility payment under the PFS when services are provided to a registered inpatient or an outpatient of a hospital respectively. If the physician/practitioner is aware of the exact setting the beneficiary is a registered inpatient (or hospital outpatient), the appropriate inpatient POS code, 99211-99223, (or appropriate outpatient POS code, 99201-99215) may be reported consistent with the code list annotated in Pub. 100-04, Medicare Claims Processing Manual, Chapter 26, Section 10.5. However, it is more important that the physician/practitioner report the POS consistent with the patient’s general inpatient or outpatient hospital status than the precise inpatient/ outpatient POS code (in order to trigger the facility payment rate under the PFS).

“The Medicare Claims Processing Manual” (Chapter 26) already requires this for physician services (and for certain independent laboratory services) provided to beneficiaries in the inpatient hospital and CR7631 clarifies this exception and extends it to beneficiaries of the outpatient hospital, as well.

Therefore, based on guidance from Novitas Solutions Critical Inquiries representative, the above referenced guidelines, the physician should report the physical address of where the service was furnished in box 32, so that locality and Geographic Practice Cost Index (GPCI) adjusted payments for each service can be determined. The provider would report the appropriate inpatient (21) or outpatient (22) place of service, along with the corresponding inpatient or outpatient procedure code rather than an office procedure code.

Q) Some of my providers use Candin to treat warts. Some insurance companies will reimburse J3490 for the drug and others will not (even on appeal with Candin info).....when they inject this they use the 11900/11901 codes. Would it be appropriate to use 17110 and not bill the Candin at all? Any advice would be appreciated

A) Candin is considered an off label drug for wart destruction and not presently FDA approved. With that said, it can be reported and most time paid as an unspecified drug J3490 with the intradermal injection codes, 11900 or 11901. Remember, to receive payment for an unspecified drug, it must be described on the CMS 1500 claim in item 19, remark box. It will require the name of the drug, the National Drug Category (NDC) code number (which can be found on the drug’s box or vial) plus the strength and dosage. If 17110 is reported, it is unlikely the drug will be paid because it should be included in the practice expense.

Reprinted with permission from AMA CPT Pathology and Laboratory: Surgical Pathology

Q) May multiple units of code 88344, Immunohisto- chemistry or immunocytochemistry, per specimen; each multiplex antibody stain procedure, be reported? The paren- thetical note after code 88344 seems to indicate that multiple units may be reported, ie, one for each multiplex anti- body stain procedure.

— see FAQs on page 8
In The Know…

Did you know that one of the main reasons Medicare enrollment applications are denied is that the applicant forgets to include the required current Version of the Electronic Fund Transfer (EFT) - CMS-588 Form?

All healthcare providers/suppliers are required to submit a new EFT Authorization Agreement (CMS-588 version 09/2013) with their initial or revalidation application. A voided check or bank confirmation letter should also be sent as documentation showing that the legal business name on the EFT form and the bank account and routing number match Medicare records.

**Note:** The older version of the form will not be accepted.

An exception applies to those individual healthcare providers who reassign all their benefits to a group practice and to those ordering/certifying suppliers who do not have Medicare billing privileges.

For more tips on how to avoid application processing delays due to missing EFT information, please refer to [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se1126.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se1126.pdf)

Now you are In The Know!

Frequently Asked Questions (FAQs)

--- continued from page 7

A) Yes, code 88344 may be reported once for each multiplex antibody stain procedure per specimen. The unit of service for this family of services is the antibody stain procedure per specimen (ie, the single antibody stain procedure or the multiplex antibody stain procedure).

In addition, several parenthetical notes provide specific reporting instruction for this family of services, as listed:

(Do not use more than one unit of 88341, 88342, 88344 for each separately identifiable antibody per specimen)

(Do not report 88341, 88342, 88344 in conjunction with 88360, 88361 unless each procedure is for a different antibody)

(When multiple separately identifiable antibodies are applied to the same specimen [ie, multiplex antibody stain procedure], use one unit of 88344)

(When multiple antibodies are applied to the same slide that are not separately identifiable, [eg, antibody cocktails], use 88342, unless an additional separately identifiable antibody is also used, then use 88344)

To clarify, multiplex antibody stain procedure refers to a procedure in which multiple antibodies are separately identifiable (eg, 34betaE12/P504s). In this setting, one unit of code 88344 would be reported for the 34betaE12/P504s multiplex antibody stain procedure. On the other hand, antibody cocktails in which multiple antibodies are applied to a tissue section in the procedure, which are not separately identifiable (eg, AE1/AE3), are not considered to be a multiplex antibody stain procedure. In this setting, one unit of code 88342, instead of code 88344, would be reported for the antibody stain procedure.

If a separate multiplex antibody procedure is performed on the same patient specimen, then an additional unit of code 88344 may be appropriate to report. However, as noted in the parentheticals, each separately identifiable antibody may only be billed with one unit of service (eg, 88341, 88342, 88344), for each specimen. ❖