New Skin Biopsy Codes: It’s All About the Technique!

For CPT® 2019, the American Medical Association (AMA) CPT® Editorial Panel will introduce six new codes for primary skin biopsy—three base codes and three add-on codes—all of which will be effective January 1, 2019. These three new codes will replace existing codes 11100 and 11101 (skin biopsy), which will be deleted. These new codes have been established for healthcare providers to report biopsy procedures based on the technique used to obtain tissue sample(s).

The AMA CPT Editorial Panel created the following new codes to differentiate between biopsy modalities, namely tangential, punch, and incisional biopsies:

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>11100</td>
<td>Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), single lesion</td>
<td>11101</td>
<td>each separate/additional lesion (List separately in addition to code for primary procedure)</td>
<td>Deleted as of 12/31/18</td>
</tr>
<tr>
<td>+11102</td>
<td>Tangential biopsy of skin, (eg, shave, scoop, saucerize, curette), single lesion</td>
<td>+11103</td>
<td>each separate/additional lesion (List separately in addition to code for primary procedure)</td>
<td>Effective as of 01/01/19</td>
</tr>
<tr>
<td>+11104</td>
<td>Punch biopsy of skin, (including simple closure when performed), single lesion</td>
<td>+11105</td>
<td>each separate/additional lesion (List separately in addition to code for primary procedure)</td>
<td>Effective as of 01/01/19</td>
</tr>
<tr>
<td>+11106</td>
<td>Incisional biopsy of skin (eg, wedge), (including simple closure when performed), single lesion</td>
<td>+11107</td>
<td>each separate/additional lesion (List separately in addition to code for primary procedure)</td>
<td>Effective as of 01/01/19</td>
</tr>
</tbody>
</table>

Skin biopsy codes can be reported to indicate that:

- the intent of the procedure was to obtain tissue for **diagnostic histopathologic examination**; and
- the procedure was performed independently, or was unrelated and distinct from other procedures/services provided during the same encounter.

Biopsies performed on a different lesion(s) or site(s) on the same date of service may be reported separately, as they are not considered components of the other procedures performed during the same encounter.

National Correct Coding Initiative (NCCI) edits apply; for information on proper use and application of modifiers, see [https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html](https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html).

Tissue samples obtained during excisions, destructions, or shave removals are routinely submitted for histopathologic evaluation and should **not be reported separately**.

Unlike existing biopsy codes (11100 and 11101) which do not classify the biopsy technique used for tissue sampling, these new codes (11102, 11104, and 11106)

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will define three distinct biopsy techniques to clearly describe the service and depth of the tissue sample obtained.

Reporting Multiple Biopsy Procedures during the Same Encounter

When multiple biopsies are performed during the same encounter, only one primary code and one or more additional add-on code(s) appropriate for the biopsy techniques used are reported.

**Note:** Only one primary code is reported, regardless if multiple biopsy techniques are used.

The following chart illustrates how to report multiple biopsy procedures performed during the same encounter.

<table>
<thead>
<tr>
<th>2 Tangential Biopsies</th>
<th>3 Punch Biopsies</th>
<th>2 Incisional Biopsies</th>
<th>1 Punch Biopsy, 2 Tangential Biopsies</th>
</tr>
</thead>
<tbody>
<tr>
<td>11102</td>
<td>11104</td>
<td>11106</td>
<td>11104</td>
</tr>
<tr>
<td>✦ 11103</td>
<td></td>
<td>✦ 11105</td>
<td>✦ 11107</td>
</tr>
</tbody>
</table>

The following examples show how to report multiple different biopsy procedures performed during the same encounter.

- An incisional biopsy (11106) should always be reported as the primary procedure code when used with other biopsy techniques.

- A punch biopsy (11104) should be reported as the primary procedure when a tangential biopsy is performed during the same encounter. The tangential biopsy should be reported with the add-on code (11103).

**Add-on code 11105 may be reported in conjunction with codes 11104 and 11106, when additional biopsies of the same or different techniques are performed to sample separate/additional lesions during the same encounter. Add-on code 11107 may only be reported in conjunction with code 11106 for incisional biopsy.**

**Focus On the Intent of the Procedure and Expectations for Proper Documentation**

Due to the complexity of the new skin biopsy codes, there is a need to pay close attention to procedural details and intent. Biopsy codes should only be used when the _intent is to obtain a tissue sample for histopathologic examination._

Re-education of healthcare provider(s) on medical record documentation is critical. Coding staff will need to adjust medical record review in order to identify procedural intent and technique(s) used during...
New Skin Biopsy Codes: It’s All About the Technique!

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the procedure, so that the appropriate biopsy code can be selected.

The following examples illustrate how the new codes can be applied starting on January 1, 2019.

Example 1
A 58-year-old male presents for evaluation of a suspicious lesion on the mid-forehead area.

Clinical evaluation reveals changes suspicious for basal cell carcinoma. A skin biopsy is considered necessary and appropriate to clarify the diagnosis. The procedure is explained to the patient, including the potential for bleeding, infection, and scarring. All of the patient’s questions are answered and the patient provided his informed verbal consent.

The area is injected with 1% lidocaine with epinephrine local anesthetic and a tangential (shave) biopsy of the mid-forehead is performed using a #15 scalpel blade to remove the superficial portion of the lesion. Aluminum chloride 35% is used for hemostasis. A dressing with triple antibiotic ointment is applied. The patient tolerated the procedure well. Written wound-care instructions are provided. The patient is advised that he will be notified of the pathology results and will be asked to return to the office for follow-up, according to the results.

Examination also revealed an actinic keratosis (x1) on the left forearm. The etiology is discussed, and the patient is made aware of the pre-cancerous nature of the lesion. Treatment with liquid nitrogen cryotherapy is recommended. The procedure, risks, and benefits are explained to the patient, including the potential for bleeding, infection, hypopigmentation, and scarring. All of the patient’s questions are answered and patient provided his verbal consent.

The lesion is treated with liquid nitrogen at the time of the visit. The patient tolerated the procedure well. The expected crusting and/or blistering response is discussed with patient. The proper care of the treatment area at home is discussed and information is printed and given to the patient.

Report:  17000 Destruction, Actinic Keratosis, single lesion;
• 11102 Tangential biopsy of skin
•• 11102-59 each separate/additional lesion

Example 2
A 79-year-old male presents for his annual skin examination. Examination of the right sideburn and right temple areas reveals two pearly papules. Biopsy of the two lesions is recommended. The procedure is explained, including the potential for bleeding, infection, and scarring. All of the patient’s questions are answered. Informed verbal consent is obtained from the patient. A biopsy is performed at the time of the visit by tangential technique using a scalpel blade. Aluminum chloride 35% is used for hemostasis. A dressing with bacitracin is applied. The patient tolerated the procedure well. Written wound-care instructions are provided to the patient and he is informed that he will receive a phone call in about a week regarding the biopsy results.

Examination of the mid-frontal scalp also reveals a keratotic lesion with an erythematous base. Biopsy of the lesion is recommended. The procedure is explained, including the potential for bleeding, infection, and scarring. The patient’s questions are answered. Informed verbal consent is obtained from the patient. A biopsy is performed at the time of the visit using the tangential technique with a scalpel blade. Aluminum chloride 35% is used for hemostasis. A dressing with bacitracin is applied. The patient tolerated the procedure well. Written wound-care instructions are provided to the patient and he is informed that he will receive a call in about a week regarding the biopsy results.

Report:  • 11102 Tangential biopsy of skin
•• 11103 each separate/additional lesion

Example 3
A 64-year-old male with a history of renal transplant and chronic lymphocytic leukemia presents for evaluation of multiple problems that have developed. His renal function has been worsening and he has needed intermittent hemodialysis. He is on multiple medications, including immunosuppressive agents. He has developed a widespread purpuric eruption within the last two days after being prescribed an antibiotic for an ulcerative plaque on his thigh by his primary care physician. The ulcer is painful and enlarging. He also has a purpuric nodule on the right ankle and three keratotic nodules on the right forearm. He feels ill and will be seeing his nephrologist later in the afternoon.

Examination reveals a 10 x 14 cm purpuric plaque on the left thigh with central ulceration. He has multi-
Impression:

1. Drug eruption vs vasculitis: A punch biopsy is recommended to help clarify the diagnosis. The risks and benefits are discussed and reviewed. The patient agrees. **A 4-mm punch biopsy is performed** on a representative early lesion on the right lower leg after the area is prepared and draped and anesthetized with 1% lidocaine. Two 4-0 monofilament polybutester sutures are used to close the defect.

2. Pyoderma gangrenosum vs infection vs calciphylaxis: An **incisional biopsy** is recommended to clarify the diagnosis. The patient is agreeable to the procedure. The area is prepared and draped in the usual fashion. A 1% lidocaine is used for anesthesia and a **2-cm long elliptical incisional biopsy is obtained** to include the central ulcer and purpuric border. The specimen included fat that showed evidence of necrosis. A gritty sensation is noted when excising the tissue, furthering the suspicion of underlying calciphylaxis and is noted on the pathology requisition.

3. Possible Kaposi’s sarcoma on the right ankle vs hemosiderotic dermatofibroma or acroangiodermatitis: **A tangential biopsy is recommended and performed** to obtain tissue sample for histopathologic examination using a #15 blade.

4. Keratotic papules on the right forearm: These lesions are suspicious for squamous cell carcinoma arising in the setting of immunosuppression. Sporothricosis is in the differential diagnosis but appears less likely as the lesions are not clearly situated along lymphatic channels. **Tangential biopsy of all three lesions is recommended and performed using shave technique with a scalpel blade.**

**Example 4**

A 49-year-old female presents for evaluation of two new suspicious lesions located on the upper and lower left lateral neck. Biopsy of the two lesions is recommended to confirm diagnosis. The procedure is explained and the potential for bleeding, infection, and scarring is discussed with the patient. All of the patient’s questions are answered. Patient provided her informed verbal consent.

Both suspicious lesions are anesthetized with 1% lidocaine with 1:100,000 epinephrine after sterile preparation and drape. Tissue samples are obtained via **shave technique** using a #15 blade. Hemostasis is achieved by light electrosiccation. The tissue is transported to the laboratory for sectioning and histopathologic study.

**Report:**

- **11102** Tangential biopsy of skin
- **+11103** each separate/additional lesion (List separately in addition to code for primary procedure)
Reduce Drug Code Denials Related to Incomplete Claims Data
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format, as required for most claims editing systems. The NDC is found on the manufacturer’s vial, bottle, or tube label containing the drug. If the NDC provided by the manufacturer does not include 11 digits, it will be necessary to add a leading zero to the appropriate section to create the 5-4-2 arrangement.

In this arrangement, “5” indicates the pharmaceutical company; “4” is the drug identifier; and “2” conveys the drug’s strength. When converted, the NDC submitted will consist of five digits in the first segment; four digits in the second segment; and two digits in the third segment. The placeholder zeroes must be entered on the claim, whenever digits are needed to complete a segment. For more information on NDC format conversion, see the article, “Converting and Reporting NDC Codes” in the “In the Know” section of the fall 2012 issue of the Derm Coding Consult. The NDC code (in the converted format with its preceding N4 product ID qualifier to indicate the NDC code follows) is placed at the claim line in field 24A of the CMS 1500 claim form.

Additional information related to the drug provided is required in the claim line of the CMS 1500 form or its electronic counterpart. This line must include a description of the drug, the NDC unit of measure (UOM) and the number of units of the drug given, which is also indicated in the Healthcare Common Procedural Coding System (HCPCS) J-code reported. NDC units are based on the numeric quantities administered to the patient. The UOM information is included in the product label. Be sure to check with your payers for any specific policy regarding the type of units reported.

The units of measure most commonly used in dermatology are:

- **UN** (Unit): Powder for injection that needs to be reconstituted (bill per vial), pellet, kit, patch, tablet, or device
- **ML** (Milliliter): Liquid, solution, or suspension
- **GR** (Gram): Ointments, creams or bulk powder in a jar

Relaying this information on the CMS 1500 claim form or an electronic claim format in the appropriate fields is crucial. Beginning in the shaded area of box 24 on the drug-supply-charge claim line, enter the qualifier “N4” followed by the NDC code, without any space between them. Please check with your software vendor to determine if the N4-qualifier is automatically populated in this field. If so, omit adding it to the claim line and enter the NDC. Add a space and enter the drug description as provided by the product label. Finally, enter a space followed by the UOM-qualifier and the quantity. Note that the quantity entered here may not match the units of service indicated in field 24G of the claim form, as one is based on NDC UOM quantity and the other on HCPCS code description units. The NDC units of service relate to drug rebate and cost comparison and the HCPCS units of service are used to calculate payment (see the following example).

Entry of this information in the appropriate form-fields in your billing software should result in electronic claims in the correct format. If issues occur with how the NDC information is conveyed in your electronic claims, consult your billing software vendor or claims clearinghouse for assistance in correcting these issues.

**Patients Supplying Their Own Drugs**

Medicare provides limited benefits to its members for outpatient drugs. “The program covers drugs that are furnished under the ‘incident to’ benefit (section 1861(s)(2)(A) or (B) of the Social Security Act). A Food and Drug Administration (FDA) approved drug or biological can be covered and which is furnished by a physician’s practice or hospital (respectively), provided that the drug is not usually self-administered by the patient, and is reasonable and necessary for the diagnosis or treatment of the illness or injury according to accepted standards of medical practice.”

There must be an incurred cost for the drug or biological by the physician practice, and it must be administered by the physician or auxiliary personnel under the physician’s personal supervision.

Per the “incident-to” guidelines in the Medicare Benefit Policy Manual (CMS Internet-Only Manual [IOM] Publication 100-02, Chapter 15, Sections 50 and 50.3), providers are not allowed to instruct patients to purchase a drug themselves and bring it to the provider’s office for administration.

Information needed to report NDC codes:

- Drug administered
- Drug quantity and strength (i.e., mg/mL)
- NDC from drug label (in 5-4-2 format)
- NDC unit of measure (based on NDC unit of measure)
Reduce Drug Code Denials Related to Incomplete Claims Data
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But for those rare circumstances when the provider has not incurred a drug expense, it is appropriate to report only the administration of a drug with a narrative in Item 19 of the CMS-1500 claim form to indicate how/where it was obtained (e.g., patient purchased through Part D, starter sample from pharmaceutical company, etc.).

For other regulations related to the billing of chemotherapy administration, refer to the IOM Medicare Claims Processing Manual Publication 100-04, Chapter 12, Section 30.5 at MCPM.

Claim Reopenings or Level 1 Appeals for Denied Services

Not every Medicare denial requires a formal appeal. Most Medicare Administrative Contractors (MAC) have developed automated claim “reopenings” to handle these simple corrections. This method significantly reduces the amount of time required to reprocess a denial. It is important that reopenings be submitted on the correct form, which can be identified by consulting your local MAC website. The reopening-request form requires correct information (please do not confuse this form with a Level 1 Appeal Redetermination request). Not all MACs have separate forms, and it is important that one follows outlined policies. A reopening request is appropriate when processed claims are denied for minor errors or omissions. Examples presented by the MACs include:

- Date of service correction (within the same year) that does not result in an overpayment
- Place of service corrections/changes
- Correcting a transposed CPT/HCPCS code
- Correcting the number of services (units)
- Changes or additions to diagnosis codes
- Adding, changing, or removing some modifiers
- Correcting the billed amount
- Correcting a zip code

Do not confuse the re-opening for a Level 1 Redetermination Appeal when a claim is denied or partially denied. Confusing the two will only delay payment on the claim. Some common causes of denials include proof of medical necessity; frequency limitations; corrections that require the review of medical records; services submitted with the incorrect year of service; or any other change that is not a simple correction.

For additional information to help you determine whether to submit a reopening or a redetermination, please contact your local MAC contractor.

FAQs

Incident-to Services

These questions and answers are listed on JK and J6 NGS (National Government Services Medicare Contractor’s website at https://www.ngsmedicare.com/ngs/portal/ngsmedicare/newngs/home-lob/pages/policy-education.

“Incident-to” Office Guidelines

The Centers for Medicare & Medicaid Services (CMS) rules for billing office service as “incident to” a physician’s services are summarized within these questions. Of note, the concept does not apply to services performed in a hospital environment, which includes inpatient, outpatient, and emergency room in hospital locations.

1. There are two ways in which office services may qualify for incident-to billing:

   Component services be performed by a clinical office employee of the physician or NPP who is the billing provider.

Clinical employees may perform component functions as part of the billing provider’s service (e.g., administration of non-self-administrable drugs). The service must represent an integral part of the patient’s care and of a type commonly rendered in an office setting. Or Full services may be performed and billed incident-to by Medicare-enrolled NPPs within a group practice that employs both Medicare-enrolled physicians and NPPs, when incident-to requirements are met.

In a group practice of physicians and NPPs who participate with Medicare, an NPP may perform a service under direct physician supervision and
the service may be billed under the physician’s national provider identifier (NPI) if all incident requirements are met. This rule applies to care for stable, established patients, for whom the NPP is following a plan of care originally developed by the physician, and during which the physician is readily available in the office suite for any necessary supervision. When these requirements are not met, the NPP’s service must be billed with the NPP’s NPI.

2. Services must be medically reasonable and necessary and within the scope of Medicare coverage and the billing provider’s scope of practice:
   a. Services not covered by Medicare (e.g., massage therapy or spiritual counseling) may not be included as part of a physician’s service.
   b. Physicians may not bill services performed by non-Medicare enrolled physicians or Non-Physician Practitioners (NPPs).

3. Incident-to concepts apply only in the office setting (POS 11)
   b. The term “Clinic” only applies as defined, i.e., as a physician owned and operated clinic, where providers work together in a large office. The concept does not apply to hospital or other facility-based clinics.

4. The incident-to service must be integral although incidental
   a. When services are performed by employees of the provider, they must be an integral part of the provider’s overall plan of care and essential to the patient’s course of treatment (e.g., obtaining vital signs or administering an injection on the provider’s behalf).
   b. When a service is performed by a clinical employee without physician participation (e.g., a nurse sees the patient for a blood pressure check or review of medication), the service may be billed by the physician using CPT 99211, as long as the physician is present in the office suite during the service and all incident-to requirements are met.

5. Incident-to billing does not apply to new patients or established patients who present with new problems.
   a. As with all E&M services, the rendering provider must elicit the history of the present illness (HPI) from the patient because this requires clinical skill. When the HPI reveals a new problem(s), the visit cannot be billed as incident-to by the NPP because it may require changes to the physician’s original plan of care. This visit can be performed and billed by either the physician or the NPP but it cannot be billed by the NPP using the physician’s NPI.
   b. Services to new patients or established patients who present with new problems must be billed using the NPI of the provider who sees the patient that day. This means that such patients may be seen by either a physician or NPP within a practice, but that service can only be billed under the physician’s NPI when the physician actually sees the patient. NPPs that see patients in these circumstances must bill the service as performed by an NPP.

6. Services to established patients with no new problems may be provided by NPPs and billed under the NPI of the supervising physician, as long as the physician is immediately available in the office suite and the NPP is following the plan of care set forth by the physician on the initial visit.
   a. The record must reflect an initial physician visit, and periodic review and oversight by the physician of his/her initial plan of care as administered by the NPP.
   b. Visits with established patients, who are experiencing new problems, require active physician participation, and it cannot be billed on an incident-to basis.
   c. For all patients, it is expected that the physician performs and documents intermittent, subsequent services of a frequency that reflects active participation of the course of treatment for the specific problem.

7. Incident-to billing for visits including medication adjustment(s)
   a. A physician’s initial plan of care may include prescription medication that may require

— see FAQ on page 8
adjustment on subsequent visits; the need for medication adjustment does not represent a “new problem.” These visits may be billed by an NPP as incident-to the original plan of care when the physician includes that instruction in the original plan.

For example, “…have started patient on losartan 100 mg. po qd for BP 160/90; patient to RTO in 2 weeks for f/u. Dosage may be adjusted by NP on f/u visits.”

8. Direct supervision by a physician is required

a. Incident-to billing requires direct supervision by the supervising physician, who must be present in the office suite and be immediately available and able to provide assistance and direction throughout the time the service is performed.

b. The supervising physician does not have to be in the same room but must be in the office or clinic suite.

c. For group practices, any physician member of the group may provide supervision to NPPs under this guideline.

9. Documentation

a. Documentation must support evidence that a supervising physician was present and available. The documentation submitted to support billing incident-to services must clearly link the services of the NPP staff to the services of the supervising physician(s). Evidence of the link may include:

i. While co-signature of the supervising physician is not required, it is suggested as a means of verifying the physician’s availability for oversight.

ii. The NPP performing the service may include entry in the note of the identity and credentials of the supervising physician who was available during the visit.

iii. Documentation from other dates of service, both initial and subsequent, should clearly establish a link between the two.

— see IN THE KNOW on page 10

In the Know...

CMS Releases Fourth Quarter CCI Edit Updates, Effective October 1, 2018

In the continued effort to promote national correct coding methodologies and to control improper coding that can lead to inappropriate payment in Part B claims, the CMS develops, maintains, and updates the National Correct Coding Initiative (NCCI) Edits every quarter.

These edits are based on CMS coding policies and use coding conventions defined in the American Medical Association’s CPT code set (AMA CPT), national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and review of current coding practices.

There are three types of NCCI edits:

NCCI Procedure-to-Procedure (PTP) Edits

Developed to prevent improper payment when incorrect code combinations are reported, the NCCI PTP edits allows for non-payment of healthcare insurance claims of services that should not be reported together. Each edit has a column one and column two HCPCS/CPT code. If a healthcare provider reports a combination of the two codes in an edit pair for the same beneficiary on the same date of service (DOS), the code in column one is eligible for payment but the code in column two will be denied unless a clinically appropriate NCCI-associated modifier is also reported.

Modifier 59 Effects on New CPT Biopsy Codes

As we continue to learn more about how the new CPT codes for biopsy will be affected by the NCCI edits when reported in conjunction with other procedures, it is important for dermatology practices to remain up to date on the appropriate use of modifier 59 in order to avoid unwarranted claim denials and audits.

Appending modifier 59—or any modifier—on an add-on code is inappropriate, unless your payer specifically requests you to do so.

Modifier 59 Distinct Procedural Service, is used to identify procedures/services, other than evaluation and management services (E/M), which are normally reported together, but are appropriate under the circumstances.

— see IN THE KNOW on page 10
New CPT® Skin Biopsy Codes and ICD-10-CM Code Changes for 2019 Announced

The proposed fee schedule includes 6 new skin biopsy codes and changes to ICD-10-CM that will directly impact your dermatology practice starting this fall.

Get $10 OFF AADA individual coding titles or receive FREE SHIPPING on select packs.

Use Promo Code CODEDC19 at aad.org/2019Coding
In the Know...

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Documentation must support a different session, different procedure or surgery, different site or organ system, or separate lesion not ordinarily encountered or performed on the same day by the same provider to the same patient.

The following example from the CMS NCCI Edits Column 1 and Column 2, indicates the appropriate use of modifier 59 when biopsy codes are reported with other procedures.

<table>
<thead>
<tr>
<th>Column1/Column 2 Edits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Column 1</td>
</tr>
<tr>
<td></td>
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<tr>
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<tr>
<td></td>
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<tr>
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<td>17110</td>
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<tr>
<td>17110</td>
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<tr>
<td>17262</td>
</tr>
</tbody>
</table>

**Medically Unlikely Edits (MUE)**

Developed to reduce paid-claims error-rate for Part B claims, an MUE for a HCPCS/CPT code is the maximum units of service that a healthcare provider can report under most circumstances for a single beneficiary on a single DOS.

MUEs prevent payment for an inappropriate number/quantity of the same service on a single day. These edits are based on:

- Anatomic considerations;
- HCPCS/CPT code descriptors;
- CPT instructions, CMS policies;
- Nature of service/procedure
- Nature of analytes;
- Nature of equipment; and
- Clinical judgment

For example, the primary skin biopsy (tangential, punch, and incisional) codes 11102, 11104, and 11106 will have an MUE of “1” due to date of service limitations.(see following table).

<table>
<thead>
<tr>
<th>HCPCS/CPT Code</th>
<th>Practitioner Services MUE Values</th>
<th>MUE Adjudication Indicator</th>
<th>MUE Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>•11102</td>
<td>1</td>
<td>2 Date of Service Edit</td>
<td>Date of Service Edit</td>
</tr>
<tr>
<td>•11103</td>
<td>6</td>
<td>3 Date of Service Edit</td>
<td>Date of Service Edit</td>
</tr>
<tr>
<td>•11104</td>
<td>1</td>
<td>2 Date of Service Edit</td>
<td>Date of Service Edit</td>
</tr>
<tr>
<td>+11105</td>
<td>3</td>
<td>3 Date of Service Edit</td>
<td>Date of Service Edit</td>
</tr>
<tr>
<td>•11X06</td>
<td>1</td>
<td>2 Date of Service Edit</td>
<td>Date of Service Edit</td>
</tr>
<tr>
<td>+11107</td>
<td>2</td>
<td>3 Date of Service Edit</td>
<td>Date of Service Edit</td>
</tr>
</tbody>
</table>

**Note:** Not all HCPCS/CPT codes have an MUE.

**Add-on Code Edits**

Add-on code edits consist of a listing of HCPCS and CPT add-on codes with their respective primary codes. An add-on code is eligible for payment if, and only if, one of its primary codes is eligible for payment.

For example, additional biopsy codes (+11103, +11105, +11107) cannot be reported without a primary biopsy code (11102, 11104, 11106) on the
same DOS. The combination of reporting add-on code(s) with primary destruction code(s) are as follows:

<table>
<thead>
<tr>
<th>Add-on CPT Code</th>
<th>Approved For Reimbursement When Reported With</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>+11103</strong></td>
<td>11102, 11104, and 11106</td>
</tr>
<tr>
<td><strong>+11105</strong></td>
<td>11104, and 11106</td>
</tr>
<tr>
<td><strong>+11107</strong></td>
<td>11106</td>
</tr>
</tbody>
</table>

**Policy Manual Background**

The NCCI Policy Manual for Medicare Services and NCCI edits were developed to apply to Medicare services that are billed by a single provider for a single patient on the same date of service. The edits were developed for the purpose of encouraging consistent and correct coding and reducing inappropriate payment, which do not include all possible combinations of correct coding edits or types of unbundling that exist.

Healthcare providers are obligated to code correctly, even if edits do not exist to prevent the use of an inappropriate code combination. If a provider determines that he or she has been coding incorrectly, the provider should contact his or her MAC about potential payment adjustments.

The Column One/Column Two Correct Coding edit file helps to simplify the use of the procedure-to-procedure (PTP) edit files. With this, edits appear in the single Column One/Column Two Correct Coding edit file.


CMS reserves the right to publish all MUE values that are four or higher because of concerns about fraud and abuse. National healthcare organizations and contractors with information about MUE values that are not published on the CMS website should continue to maintain confidentiality of those values. In addition, a minimal number of MUEs with lower values that are believed by CMS to be particularly vulnerable to fraud and abuse may not be published.

NCCI edits are utilized by Medicare claims-processing contractors to adjudicate provider claims for physician services, outpatient hospital services, and outpatient therapy services. They are not applied to...
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facility claims for inpatient services.

Healthcare providers should not interpret MUE values as indicating utilization guidelines. MUE values do not represent units of service that may be reported without concern about medical review. Providers must continue to report only services that are medically reasonable and necessary.

CPT codes that represent services that are denied based on the NCCI edits cannot be billed for Medicare beneficiaries. Because these denials are based on incorrect coding rather than medical necessity, the provider cannot utilize an “Advanced Beneficiary Notice” (ABN) form to seek payment from a Medicare beneficiary. Furthermore, because the denials are based on incorrect coding rather than a legislated Medicare benefit exclusion, the provider cannot seek payment from the beneficiary with or without a “Notice of Exclusions from Medicare Benefits” (NEMB) form.

Because the NCCI is a CMS program, its policies and edits represent CMS national policy. However, the NCCI policies and edits do not supersede any other CMS national coding, coverage, or payment policies.

Sometimes, other non-CMS payers may utilize the NCCI edits, as they deem necessary. It is important for dermatology practices to check with their non-CMS payers to determine if they use the NCCI policies to guide correct coding and claim processing.

The latest package of PTP CCI edits, Version 25.0, effective January 1, 2017, is now available via the CMS Data Center (CDC) at https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html.

For more information, please see:

- Overview and Background at https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html.

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