Derm Coding Consult

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Preparing for the increase in drug prior authorizations

As drug companies work to justify the value of their drugs, dermatologists and their patients become increasingly familiar with the requirements of prior authorization in order to get patients the therapies they need. The Academy has recognized that insurers are not only increasing prior authorization and step therapy requirements, they are now also increasingly looking to narrow formularies to restrict access, even when the therapy ordered is the right treatment for the patient's condition.

In late 2016, the Academy received a number of questions from physicians regarding a change to the CVS Caremark Advanced Control Formulary which resulted in loss of access to several topical medications. The patients affected were notified they had to switch from Enbrel, Cosentyx, and Otezla to Humira, Taltz, or Stelara respectively. While CVS refused to grandfather in all stable patients, physicians were allowed to request a grandfathering in exception for patients.

When requesting exceptions, documentation to support the medical necessity of not changing the patient's current treatment medication is key. The medical record should reflect the severity of the patient's condition, noted improvements to current treatment regimen, or failure to improve and any exacerbation of the condition while using one of the topical medications included in the payer's formulary.

The Academy recognizes requirements to justify access is a growing trend and has developed a new letter generator to help physicians craft drug-specific letters to insurers. This letter generator is part of the new Practice Management Center where dermatologists can simplify administrative burdens through dermatologist-specific tools and guidance in an array of practice management areas. ❖

ICD-10-CM Code Updates Impact 4th Quarter Quality Reporting for Some Eligible Professionals

Following the October 1, 2016, ICD-10-CM/PCS code set updates, the Centers for Medicare and Medicaid (CMS) became aware of a glitch that would impact the Physician Quality Reporting System (PQRS) due to the recent code updates.

CMS News announced on December 15, 2016 that - due to the consolidated coding updates - a large number of new codes were added or removed from the ICD-10-CM/PCS code sets, noting that these updates will impact CMS's ability to process data reported on certain quality measures for the fourth quarter of calendar year 2016.

The ICD-10-CM/PCS updates play a great role in quality reporting. Under the PQRS, calendar year (CY) 2016 is the performance period for the 2018 PQRS and Value Modi-

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fier (VM) payment adjustments. It is also the calendar year for eligible professionals (EPs) who were part of a Shared Savings Program Accountable Care Organization (ACO) participant Taxpayer Identification Number (TIN) in 2015 and are reporting outside their ACO for the special secondary reporting period, because their ACO failed to report on their behalf for the 2015 PQRS performance period.

CMS has since examined the impact this all will have on quality measures and determined that the updates will impact its ability to process data reported on certain quality measures for the fourth quarter of CY 2016.

Therefore, CMS has announced it will not apply the 2017 or 2018 PQRS payment adjustments to any EP or group practice that fails to satisfactorily report for CY 2016 solely as a result of the impact from the ICD-10-CM/PCS code updates on quality data reported for the fourth quarter of CY 2016. The Value Modifier program will consider solo practitioners and groups, as identified by their TIN, who meet reporting requirements in order to avoid the PQRS payment adjustment (either as a group or by having at least 50% of the individual eligible professionals in the TIN avoid the PQRS adjustment) to be "Category 1," meaning they will not incur the automatic downward adjustment under the Value Modifier program.

Are Dermatology Measures Impacted?

The following are the measures impacted by the ICD-10-CM/PCS code set updates:

- Diabetes Measures Group
- Cataracts Measures Group
- Oncology Measures Group
- Cardiovascular Prevention Measures Group
- Diabetic Retinopathy Measures Group

Based on the list above, dermatology is not affected nor impacted and is expected to be able to report and meet quality measure reporting successfully.

Failure to report measures satisfactorily

CMS indicated that if an individual EP or group practice fails to satisfactorily report PQRS due to other reasons than those listed above, the EP or group practice would be subject to the 2018 payment adjustment. Under the PQRS program, 2016 penalties to be calculated in 2018 are scheduled at 2% of the Medicare fee schedule.

For more information, please see *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/ICD-10_Update_Listserv.pdf* ❖

CMS Initiates Data Collection on Resources Used in Furnishing Global Services

Under the Medicare Physician Fee Schedule (MPFS), certain services, such as surgery, are valued and paid for as part of global packages. These packages include the procedure and the services typically provided in the time periods immediately before and after the procedure. For each of these global packages, Medicare establishes a single physician fee schedule (PFS) payment that includes payment for particular services that are assumed to be typically provided during the established global period.

Recently, the Centers for Medicare and Medicaid Services (CMS) finalized a policy, as required by the Medi-

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

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

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care Access and CHIP Reauthorization Act (MACRA), in which certain physicians who provide 10- and 90-day global services would be required to report information on the number of postoperative visits they provide.

Claims-Based Data Collection

Beginning on July 1, 2017, physicians who are part of practices with 10 or more practitioners and practice in one of the nine specified states listed below, will be required to report one post-operative follow-up CPT code 99024, normally included in the surgical package. This code indicates that an evaluation and management (E/M) service was performed during a post-operative period for a reason(s) related to the original procedure. This code must be reported for each postoperative no charge E/M visit they provide within the global period.

The nine states listed below are where physicians will be required to report the global postoperative visit code and were selected to represent those with a variety of "sizes" (measured by the number of Medicare beneficiaries per state) in all nine Census Bureau regions. Those states are:

- Florida
- Kentucky
- Louisiana
- Nevada
- New Jersey
- North Dakota
- Ohio
- Oregon
- Rhode Island

Dermatologists in these states are not required to report on all 10- and 90-day global codes. Rather, CMS has published a list of 293 10- and 90-day global codes, of which about 25% are dermatology codes. Codes affected must have been

- reported by more than 100 practitioners annually;
- reported more than 10,000 times; or
- allowed charges in excess of $10 million annually

Practices with fewer than 10 providers are exempt from reporting, but are encouraged to report if feasible. Although reporting is required for global procedures provided on or after July 1, 2017, the American Academy of Dermatology encourages all dermatologists to begin reporting as soon as possible.

CMS estimates that these codes will describe approximately 87 percent of all 10- and 90-day global services provided and about 77 percent of all Medicare expenditures for 10- and 90-day global services under the PFS.

This is a mandatory reporting requirement intended to allow CMS to gather sufficient data on postoperative visits for the purpose of improving the accuracy of valuation of surgical services under the physician fee schedule starting in 2019.

It is important for every dermatologist practicing in a group of 10 or more practitioners in one of the nine states listed above to participate in the mandatory reporting for Medicare patients beginning July 1, 2017.

Additional Data Collection via Survey

In addition to the claims-based data collection, CMS also finalized a policy to conduct a survey (through the RAND Corporation) of practitioners to collect additional data on post-operative activities to supplement the claims-based data collection described above.

CMS has not finalized the design of the survey instrument, but intends to begin surveying in mid-2017. This survey could impact healthcare providers in all states, not just the nine states selected for claims-based data reporting. CMS has also indicated that the agency plans to collect global code data from accountable care organizations (ACOs), but has not described how it plans to collect that data or when the ACO data collection will start.

CMS is required to collect data to use in valuing global surgical services by Section 1848(c)(8)(B) of the Social Security Act.

For more information on the survey, please visit CY 2017 PFS Final rule at *https://www.gpo.gov/fdsys/pkg/FR-2016-11-15/pdf/2016-26668.pdf - pages 80209 - 80224*.

Dermatology related CMS Global Surgery Data Collection Code List

CPT Code	Code Description
10040	Acne surgery
10060	Drainage of skin abscess
10061	Drainage of skin abscess
10120	Remove foreign body
10140	Drainage of hematoma/fluid
10160	Puncture drainage of lesion
10180	Complex drainage wound
11200	Removal of skin tags <w/15
11400	Exc tr-ext b9+marg 0.5 cm<
11401	Exc tr-ext b9+marg 0.6-1 cm
11402	Exc tr-ext b9+marg 1.1-2 cm
11403	Exc tr-ext b9+marg 2.1-3cm/<
11404	Exc tr-ext b9+marg 3.1-4 cm
11406	Exc tr-ext b9+marg >4.0 cm
11420	Exc h-f-nk-sp b9+marg 0.5/<
11421	Exc h-f-nk-sp b9+marg 0.6-1
11422	Exc h-f-nk-sp b9+marg 1.1-2
CPT Code	Code Description

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11423	Exc h-f-nk-sp b9+marg 2.1-3
11440	Exc face-mm b9+marg 0.5 cm/<
11441	Exc face-mm b9+marg 0.6-1 cm
11442	Exc face-mm b9+marg 1.1-2 cm
11443	Exc face-mm b9+marg 2.1-3 cm
11601	Exc tr-ext mal+marg 0.6-1 cm
11602	Exc tr-ext mal+marg 1.1-2 cm
11603	Exc tr-ext mal+marg 2.1-3 cm
11604	Exc tr-ext mal+marg 3.1-4 cm
11606	Exc tr-ext mal+marg >4 cm
11621	Exc s/n/h/f/g mal+mrg 0.6-1
11622	Exc s/n/h/f/g mal+mrg 1.1-2
11623	Exc s/n/h/f/g mal+mrg 2.1-3
11640	Exc f/e/e/n/l mal+mrg 0.5cm<
11641	Exc f/e/e/n/l mal+mrg 0.6-1
11642	Exc f/e/e/n/l mal+mrg 1.1-2
11643	Exc f/e/e/n/l mal+mrg 2.1-3
11644	Exc f/e/e/n/l mal+mrg 3.1-4
11646	Exc f/e/e/n/l mal+mrg >4 cm
11750	Removal of nail bed
11765	Excision of nail fold toe
12031	Intmd rpr s/a/t/ext 2.5 cm/<
12032	Intmd rpr s/a/t/ext 2.6-7.5
12034	Intmd rpr s/tr/ext 7.6-12.5
12041	Intmd rpr n-hf/genit 2.5cm/<
12042	Intmd rpr n-hf/genit2.6-7.5
12051	Intmd rpr face/mm 2.5 cm/<
12052	Intmd rpr face/mm 2.6-5.0 cm
13101	Cmplx rpr trunk 2.6-7.5 cm
13121	Cmplx rpr s/a/l 2.6-7.5 cm
13131	Cmplx rpr f/c/c/m/n/ax/g/h/f
13132	Cmplx rpr f/c/c/m/n/ax/g/h/f
13151	Cmplx rpr e/n/e/l 1.1-2.5 cm
13152	Cmplx rpr e/n/e/l 2.6-7.5 cm
13160	Late closure of wound
14020	Tis trnfr s/a/l 10 sq cm/<
14021	Tis trnfr s/a/l 10.1-30 sqcm
14040	Tis trnfr f/c/c/m/n/a/g/h/f
14041	Tis trnfr f/c/c/m/n/a/g/h/f
14060	Tis trnfr e/n/e/l 10 sq cm/<
CPT Code	**Code Description**
14061	Tis trnfr e/n/e/l10.1-30sqcm
14301	Tis trnfr any 30.1-60 sq cm
15100	Skin splt grft trnk/arm/leg
15120	Skn splt a-grft fac/nck/hf/g
15240	Skin full grft face/genit/hf
15260	Skin full graft een & lips
15732	Muscle-skin graft head/neck
15734	Muscle-skin graft trunk
15823	Revision of upper eyelid
17000	Destruct premalg lesion
17004	Destroy premal lesions 15/>
17110	Destruct b9 lesion 1-14
17111	Destruct lesion 15 or more
17260	Destruction of skin lesions
17261	Destruction of skin lesions
17262	Destruction of skin lesions
17263	Destruction of skin lesions
17270	Destruction of skin lesions
17271	Destruction of skin lesions
17272	Destruction of skin lesions
17273	Destruction of skin lesions
17280	Destruction of skin lesions
17281	Destruction of skin lesions
17282	Destruction of skin lesions
17283	Destruction of skin lesions
40808	BX of mouth
64615	Chemodenervation Migraine ❖

Home Visits

Recently, MAC's JK and J6 NGS issued an education reminder about reporting Home Visits. Home Visits are not common in Dermatology, but there are American Medical Association (AMA) CPT Home Visit Evaluation and Management (E/M) service codes, those reportable codes are 99341-99345 and 99347-99350. To qualify, the patient must be home but doesn't necessarily need to be home bound. The medical record must show the medical necessity of this place of service in lieu of an office or outpatient clinic.

CPT codes 99341 through 99350 are used to report E/M services provided to a patient residing in his or her own private residence (e.g., private home, apartment, town home) and not residing in any type of congregate/shared facility living arrangement including assisted living facilities and group homes.

The Home Visit codes apply only to the specific 2-digit Place of Service (POS) 12 (Home). Home Visit codes may not be used for billing E/M services provided in settings other than in the private residence of an individual. Home Visit codes 99341-99350 are paid when they are billed to report E/M services provided in a private residence. These,

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Home Visits

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like other E/M services, are face-to-face encounters between the patient and the physician in the beneficiary's home.

Along with Home Visit services, there are other (AMA) E/M CPT codes for other residential place of services: new patient codes 99324 - 99328 and established patient codes 99334 - 99337 for Domiciliary, Rest Home (e.g., Boarding Home), or Custodial Care Services, are used to report E/M services to residents residing in a facility which provides room, board, and other personal assistance services, generally on a long-term basis.

These CPT codes are used to report E/M services in facilities assigned places of service (POS) codes 13 (Assisted Living Facility), 14 (Group Home), 33 (Custodial Care Facility) and 55 (Residential Substance Abuse Facility). Assisted living facilities may also be known as adult living facilities.

Physicians and qualified non-physician practitioners (NPPs) furnishing E/M services to residents in a living arrangement described by one of the POS listed above must use the level of service code in the CPT code range 99324 - 99337 to report the service they provide.

More information can be found on CMS' website: Centers for Medicare & Medicaid Services Internet Only Manual, Publication 100-02, Chapter 12, Section 30.6.14.1 ❖

2017 Brings Medicare Changes

The Centers for Medicare and Medicaid Services (CMS) has announced a number of changes and updates for 2017 that will impact dermatologists. These updates were discussed in January's American Academy of Dermatology's - AAD Live Webinar. Those changes are:

- The 2017 Physician Fee Schedule conversion factor (CF) is $35.8887, a slight increase over the previous year's CF of $35.8043.

- Part B Deductible Increases – The deductible for 2017 is $183.00, a slight increase from $166 in 2016. Co-insurance remains 20 percent of the Medicare Physician Fee schedule amount. If your patient has Medicaid as secondary coverage, the Social Security Act requires that you file the claim to Medicaid even when not a contracted provider with Medicaid. Doing so, will determine what you may bill the patient in terms of remaining spend down amounts. Often these claims will cross over from Medicare to Medicaid for processing, however monitor Medicaid claims for timely processing.

- Medicare Beneficiary Identifier (MBI) Revision – Following the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), CMS is required to remove Social Security Numbers (SSNs) from all Medicare beneficiaries' cards by April 2019. A new randomly generated Medicare Beneficiary Identifier (MBI) will replace the SSN-based Health Insurance Claim Number (HICN) on the new cards for transactions like billing, eligibility status, and claim status.

  No earlier than April 2018, CMS will start mailing new Medicare cards with Medicare Beneficiary Identifiers (MBIs). At this time CMS is asking for assistance from providers to check beneficiaries addresses to help ensure that all Medicare patients receive their MBI cards. If the address on file is different from the address shown in electronic eligibility transaction responses, ask your patients or their guardians to update it. It needs to be correct to receive CMS' mailing of the MBI cards.

  The patient or beneficiary can change their address at the local office where they enrolled to get their Social Security or Medicare benefits or through their Social Security online account. For more information go tohttps://faq.ssa.gov/ics/support/KBAnswer.asp?questionID=3704

- Federal Claim Appeal Increase - Administrative Law Judge (ALJ) hearings and the Federal District Court review appeals require a certain dollar amount to review or hear appealed claim(s) also referred to as a controversy per the Social Security Act. This amount changes periodically.

  The 2017 ALJ minimum for appeals is $160 and the Federal District Court appeals increased from $1500 in 2016 to $1560. For both levels of appeals, the totals may come from a single claim or an accumulation of claims.

- Medicare Drug Waste Modifier – According to Change Request (CR) 9603, Medicare Part B claims reporting drug wastage of unused portions of drugs, except Competitive Acquisition Program (CAP) drugs and biologicals, must be reported with modifier JW – Drug amount discarded/not administered to any patient to identify after January 1, 2017.

  Documentation will be need to be available if requested by the contractor. The medical records sent must include the date and time the drug was discarded, the amount discarded, the reason for wastage and who wasted the drug. Check with your local Medicare contractor for requirements for provider reporting of drug wastage.

  For more information see: CR 9603: *www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9603.pdf*. ❖

Medicare Establishes Payment for Non-Face-to-Face Prolonged Service

This year, Medicare will allow separate payment for non-face-to-face prolonged evaluation and management (E/M) services. Prior to 2017 these services were considered to be bundled into or a part of the related E/M service provided.

CPT codes 99358 and 99359 are used to report extended non-face-to-face time spent by the physician or other practitioner that is directly related to an E/M at any level or other face-to-face service. Although this service is only reportable once per day, the total time spent in providing prolonged services should be reported even if the time is not continuous. Additionally, the prolonged service may be performed and reported on a different date than the primary service to which it is related.

CPT Code	Description	Work RVU
99358	Prolonged evaluation and management service; first hour	2.10
99359	Prolonged evaluation and management service; each additional 30 minutes	1.00

The time reported must be for services provided by the physician or other practitioner that are not within the scope of clinical staff and for which there is no other CPT code that can be used to report the work provided during the prolonged service time. For example, the time spent in medical team conferences, on-line medical evaluations, or other non-face-to-face services codes that have no time limit.

An example of non-face-to-face prolonged services would be extensive record review related to a previous or upcoming evaluation and management service. To report prolonged services in this example, the record review must relate to an encounter where patient care (face-to-face) has or will occur and be associated with ongoing patient management.

As the codes for reporting prolonged services are time based, the medical record should reflect the total time spent providing these services. Further, a summary of the work provided for these services should also be available within the medical record.

Use CPT code 99358 to report the first hour of prolonged E/M service. CPT code 99358 is reported only once (unit of 1) per day. CPT code 99359 is reported for each additional 30 minutes after the first hour. 99359 is also used to report the final 15 minutes after the first hour. Prolonged services less than 30 minutes in duration is not reported separately. Also, prolonged services less than 15 minutes after the first hour or beyond the final 30 minutes is not reported in addition to either 99358 or 99359. See the table below when determining how to report time spent in prolonged services.

Code/Units Reported	Total Time Spent in Prolonged Services
Not reported	1 to 29 minutes
99358	30 minutes to 1 hour and 14 minutes
99358 and 99359 x1	1 hour and 15 minutes to 1 hour and 44 minutes
99358 and 99359 x 2	1 hour and 45 minutes to 2 hours and 14 minutes ❖

FAQs

Q) There is a code we struggle with, it's the code used for the treatment of Mycosis Fungoides (MF) (C84.00) with excimer laser (i.e.: XTRAC or PHAROS). There are many journal articles justifying this treatment.

The usual code for excimer laser is 96920/21/22, but not only does the LCD restrict the use of these codes to psoriasis (L40.0-L40.9) even the CPT description states "laser treatment for inflammatory skin disease (psoriasis)." Since MF is a malignant, not inflammatory disease, it seems that even the CPT description excludes use of the 96920/21/22 codes for this.

We have struggled to find another code. The closest we can find is malignant destruction (172xx), but this seems to be for destruction of individual lesions, so it doesn't seem exactly right. It is the closest I can find? What would you suggest?

A) The conditions that Laser technology can be used for are ahead of new CPT codes or any revisions to old codes. There isn't a Medicare Contractor Local Coverage Determination (LCD) for any of the 969xx series codes; photochemotherapy or the laser codes for psoriasis. We can only suggest to report this treatment as unspecified CPT code 17999 or 96999. Make sure to add a narrative in CMS 1500 Item 19 on the claim noting the service work is similar to a specific 969xx series code and the diagnoses. Remember to include the articles which will prove your point.

Q) We are in the process of converting to an EMR system. Our trainer suggested we charge a surgical tray Code A4550. Is this OK? and if so what should I charge?

A) The Relative Value Unit's (RVUs) practice expense per CPT code includes all of these expenses, from the surgical table and light, to the Q-tip and sponges normally used. There are smaller payers who don't understand RVUs or process their claim editing system correctly and pay for these trays. Once they do an internal audit, expect to receive a refund notice.

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FAQs

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Q) We have a question regarding Simple Repairs (CPT Code Set, 12001-12018). Our understanding was that Simple Repairs were included in an Excision (CPT Code set 11400-11471 and 11600 - 11646). With this understanding I assumed that Simple Repairs would be included in a Mohs Micrographic Surgery (CPT Code Set 17311 - 17315). We had found information on Encoder pro that leads me to believe now that a Simple Repair can be billed with a Mohs Micrographic Surgery (CPT Code Set 17311-17315), but still cannot be billed with an Excision (CPT Code Set 11400-11471 and 11600-11646). I was hoping that you could shed some light on this and provide me with a clearer understanding as to when a Simple Repair (CPT Code Set 12001-12018) can and cannot be billed.

A) As odd as it seems, there is no repair included in Mohs Surgery, a simple and the other lineal repairs can be reported. AMA CPT guidelines still include a simple repair in most every other integumentary code.

Q) What is the general ruling for pathology reading, should it be billed on the collection date of the data or should it be billed on the actual date it was read?

A) This is a confusing question because diagnostic testing has different guidelines from anatomical pathology. According to Medicare MedLearn 6018, the Date of Service (DOS) is the date the specimen is taken and is used for billing purposes. The date path was read needs to be added separately to the path report, but reported the same date the speciman was taken.

Q) We are a new practice and employ 2 Physician Assistants (PAs). One of our major insurance companies will not upload our PAs into their system. They have instructed us to bill for the services rendered by the PA under the supervising physician. We are NOT trying to bill "incident to".

We are wondering what is the correct way to fill out the Health Insurance Claim Form. We have had several conflicting answers. In box 17 should this be the name of the PA or the Supervising physician? In 17b., which NPI should be included?? In box 24j, should this be the NPI of the PA or that of the Supervising Physician? In box 33, should this be the Group or Physician?

A) "Incident to" is a Medicare Guideline, many private payers follow Medicare's lead. Hopefully you have their policy in writing. Medicare has never officially stated how to identify a service on a claim that an NPP has provided. The coders have discussed the possibility of reporting the NPP's NPI in box 24 K on the CMS 1500 claim form. We aren't sure this will help, but check with your payer. Since commercial payers don't follow the usual "Incident to" criteria, we suggest you follow your state laws on physician supervision. This supervision normally is provided through reasonable telecommunications. ❖

Dermatology ICD-10-CM Quick Coder - Dermatitis

Contact Dermatitis

Causal Agent	Allergic	Irritant	Unspecified*	Documentation Requirements
Animal Dander	L23.81	L24.89	L25.8	Documentation for reporting contact dermatitis should include at minimum: Type as- Allergic Irritant *(Unspecified type is reported when the type of contact dermatitis is not documented)* Causal agent- *(Unspecified agent is reported when the agent is unknown or undocumented)* With the exception of the eyelids, these codes are not site specific. For some locations, documentation should include the anatomic site of the condition.
Adhesives	L23.1	L24.89	L25.8	
Cosmetics	L23.2	L24.3	L25.0	
Chemicals (other)	L23.5	L24.5	L25.3	
Detergents	L23.89	L24.0	L25.8	
Drugs(in Contact with Skin)	L23.3	L24.4	L25.1	
Dyes	L23.4	L24.89	L25.8	
Food (in contact with skin)	L23.6	L24.6	L24.5	
Metals	L23.0	L24.81	L25.8	
Plants (except food)	L23.7	L24.7	L25.5	
Oils and Greases	L23.89	L24.1	L25.8	
Other Agents	L23.89	L24.89	L28.8	
Solvents	L23.89	L24.2	L25.8	
Unspecified (unknown cause)	L23.9	L24.9	L25.9*	

Allergic dermatitis of Eyelid – includes contact dermatitis of eyelid

Eyelid	Upper	Lower	Unspecified	Documentation Requirements
RT	H01.111	H01.112	H01.113	Documentation should include the laterality and the lid affected (e.g. right or left and upper or lower). Document the causal agent, if known.
LT	H01.114	H01.115	H01.116	
Report an external cause code to identify the causal agent.				

Dermatitis due to Substance Taken Internally

			Documentation Requirements
Due to drugs taken internally	Generalized	L27.0	Documentation should include the drug or medication, food or other agent causing the adverse effect if known. *(Dermatitis due to contact with food, see L23.6, L24.6, or L25.4 above).*
	Localized	L27.1	
Report an external cause code to identify the causal agent (T36 – T50)			
Due to ingested food	L27.2		
Due to other substance taken internally	L27.8		
Due to unspecified substance taken internally	L27.9		

***Unknown Type or Cause**

If dermatitis type is unknown or documentation reflects uncertainty of the condition, consider reporting a sign or symptom instead	
Rash and other nonspecific skin eruption	R21
Other skin changes	R23.8

Other Types

Other specified dermatitis (i.e. Hand)	L30.8
Exfoliative dermatitis	L26
Infective dermatitis	L30.3
Nummular dermatitis	L30.0

In The Know.....

TRICARE Announces New Contracts & Regional Alignment

TRICARE recently announced that stateside beneficiaries will see a change to TRICARE regions and contractor affiliation that administer TRICARE benefits outside of military hospitals and clinics starting in late 2017. While the TRICARE benefits won't change, beneficiaries should expect changes in how they access care and how their providers submit claims.

Improved Integration between Military Hospitals & Clinics and Civilian Care

These new contracts awarded by the Department of Defense (DoD) will improve how Tricare manages quality of care, provider networks, referrals, enrollment, claims processing and customer service for beneficiaries who receive care in the civilian sector.

Reduction of Three TRICARE Regions to Two

Under the new contracts scheduled to take effect at the end of 2017, the North and South regions will combine into a single "East" region, while the West region will remain the same. The consolidation from three to two regional contracts is an effort to improve continuity of care, reduce administrative burdens on beneficiaries, and reduce unnecessary variation among contractors.

What does this mean for your practice?

Right now, there are no changes to beneficiary provider networks. Beneficiaries can continue seeing their primary care doctors and specialists.

Healthcare providers and beneficiaries alike will continue to use the same contact numbers, billing addresses and websites. Once the new contracts take effect at the end of 2017, a new contractor will administer health plans based on the region in which the beneficiary resides as follows:

- If beneficiary lives in or moves to the West Region: **Health Net Federal Services, LLC** will administer the health plan and provide TRICARE coverage.
- If beneficiary lives in or moves to the North or South region: the new East Region, and **Humana Government Business, Inc.** will administer the health plan.

Tricare Next Steps:

In the coming months, Tricare will pass on valuable information about changes to regions and contractor affiliation including:

- ✓ Contact information, addresses and websites of new contractors
- ✓ Information about changes in network providers
- ✓ What beneficiaries can expect under the new regional alignment

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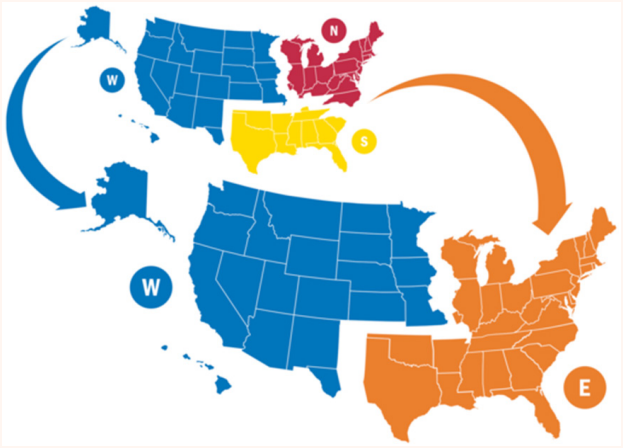

For more information on Tricare Contractor changes, visit: *http://www.tricare.mil/About/Partners/Changes*

Now You Are In The Know!