CMS Reflects on Successful ICD-10 Implementation

On October 1, 2015, the U.S. health care system transitioned the way patient encounters are coded from ICD-9 to ICD-10, a transition that has set the stage for meaningful improvements in public health. This transition and implementation have affected nearly every healthcare provider in the country. "and, anxiety levels were high," wrote Acting Administrator Andy Slavitt in his February 24th 2016 Centers for Medicare and Medicaid services (CMS) blog.

Implementation Success: 4 Lessons Learned

The smooth implementation of the transition to ICD-10 was an enormous task for CMS. To achieve successful implementation, CMS had four major elements, Mr. Slavitt wrote:

1. **Be Customer Focused:** CMS listened to the real-world needs of the people who would have to live with the results of the implementation of the transition to ICD-10. As such, it developed and launched primers such as "The Road to 10" aimed specifically at smaller physician practices, providing guidance on how to prepare proper documentation and be better prepared for the transition to ICD-10.

   CMS released a series of training videos to help providers with the transition , and also provided an unprecedented level of external testing of the new coding system, with three periods of voluntary end-to-end testing for physicians and other healthcare providers.

   > *"Because we listened to and collaborated with our partners, we were able to address concerns and multiply our ability to get resources to physicians," CMS' Slavitt wrote in his blog.*

2. **Be Highly Collaborative:** CMS realized that without the cooperation of the healthcare industry, successful implementation could not be managed. Utilizing its close partnerships with the American Medical Association (AMA), the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), state medical societies, physicians and other clinicians, billing agencies, equipment suppliers, and a variety of other stakeholders enabled the ICD-10 implementation to go as smoothly as it did.

3. **Be Responsive and Accountable:** CMS recognized that challenges occur and need to be anticipated and need to be made known as they occur and resolved as soon as possible. "In the case of ICD-10, the potential for challenges weren't only in our own systems, but in the systems of any physician office, hospital, or state Medicaid plan. At the suggestion of physician groups, we named an ICD-10 Ombudsman," CMS said.

4. **Be Driven by Metrics.** The CMS team created a scorecard and heat map to locate and track issues as they occurred. It launched an ICD-10 Coordination Center to handle any issues as they arose.

CMS' Slavitt concluded "For thousands of physicians and other clinicians around the country, the change to ICD-10 was a big undertaking, requiring time, planning, and a period of adjustment.

But on October 1, proper execution and good implementation made all the difference. On the big day, the ICD-10 Coordination Center was packed, and the CMS teams and our partners were geared up and ready to make sure that any burden on physicians could be minimized and concerns quickly addressed."

Contents

IMPORTANT Please Route to:

___ Dermatologist   ___ Office Mgr   ___ Coding Staff   ___ Billing Staff

CMS Reflects on Successful ICD-10 Implementation

As the chart below indicates, CMS has continued to receive and process the same amount of claims, with little to no interruption in service. The amount of claims rejected has decreased slightly with the use of ICD-10 code set, according to CMS figures.

Final 2015 ICD-10 Claims Dashboard Medicare Fee-for-Service Metrics

Metrics	Historical Baseline	Q4 CY 2015
Total Claims Submitted	4.6 Million per day	4.6 Million per day
Total Claims Rejected	2% of total claims submitted	1.9%
Total ICD-10 Claims Rejected	0.17% of total claims submitted	0.07%
Total ICD-9 Claims Rejected	0.17% of total claims submitted	0.07%
Total Claims Denied	10% of total claims processed	9.9%

*NOTE: *Metrics for total ICD-9 and ICD-10 claims rejections were estimated based on end-to-end testing conducted in 2015 since CMS has not historically collected this data. Other metrics are based on historical claims submissions.*

Just as CMS made plans for a smooth the transition, the American Academy of Dermatology (AAD) provided tips for successful ICD-10 implementation and will continue to provide coding documentation improvement information and coding education to its members, as well as other practice management assistance.

"The outcome of all the AAD efforts helped ensure a seamless and successful ICD-10 transition for its members", said Mark Kaufmann, MD, Co-Chair of the ICD-10 Workgroup. ❖

Medicare: ICD-10 Grace period to end October 1, 2016 – Will your documentation support codes during an audit?

On July 6, 2015, the Centers for Medicare and Medicaid Services (CMS), in conjunction with the American Medical Association (AMA), released a joint announcement regarding ICD-10 flexibility. In that announcement, CMS and the AMA stated that traditional Part B fee-for-service claims would not be denied beginning October 1, 2015 through September 30, 2016 due to the use of non-specific codes. The announcement further indicated that all claims processed during the grace period will not be subjected to post-payment claim reviews.

What this means is, that during the grace period, CMS will not deny claims solely for the lack of specificity as long as the provider reported the correct ICD-10 three character category including all the characters required for that specific code.

Additionally, the announcement also indicated that if a National Coverage Determination (NCD) or Local Coverage Determination (LCD) limits coverage to specified diagnosis codes, the claim **MUST** include one of those codes or risk not getting paid. The consistent use of unspecified codes could be viewed as a sign of insufficient documentation by some payers.

For example, a claim would not be denied nor be subjected to post-payment review when submitted as *L24.9 – Irritant contact dermatitis, unspecified cause –* as long as this diagnosis is included in the NCD or LCD. Even though the record may have documentation indicating the specific cause was due to a detergent.

As October 1, 2016 quickly approaches, dermatologists and their staff are reminded to take advantage of this

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Medicare: ICD-10 Grace period to end October 1, 2016 – Will your documentation support codes during an audit?

grace period and practice the use of specific codes for accuracy before the grace period comes to an end.

Do not rely on your Electronic Health Record (EHR) to automatically select choices based on your documentation. Depending on the software system that you have purchased, the codes selected automatically may come from a mapping list of unspecified ICD-10 codes. Healthcare providers are urged to rely and depend on their acquired ICD-10 knowledge and the use of experienced medical coders to select the appropriate ICD-10 --codes for the conditions reported based on the medical record documentation.

After October 1, 2016, reporting unspecified codes increases the risk of reimbursement delays while the payer requests to review medical records for more information that may yeild a more specific code. Using the previous dermatitis example above, irritant contact dermatitis due to detergents should be reported with specified code L24.0 and not its unspecified counterpart L24.9 after October 1, 2016.

CMS has indicated that after October 1, 2016, unspecified codes will no longer be paid without review of medical record documentation. If the documentation allows for a more specific diagnosis code, such claims will be denied. Further, the use of unspecified codes will allow healthcare payers the opportunity to conduct claim audits and queries.

Understanding the ICD-10 Code Structure:

For ease and accuracy in code choice selection, healthcare providers must understand the ICD-10 diagnosis code structure and the clinical concepts associated with the codes. The inclusion of these concepts within your documentation can help with the reporting of accurate and specific ICD-10 codes.

The number and type of concepts required for ICD-10 is not foreign to clinicians, however the concepts as applied to an ICD-10 code are new and in some cases quite unexpected. Although there are 21 different clinical concepts contained in ICD-10, those most often presented in dermatology do not include all 21 concepts.

Many ICD-10 categories and codes capture more than one of these concepts within a single code. Knowing which concept a particular category is built upon helps in determining whether the condition is reported with an "other specified" or "unspecified" code choice.

The chart to the right lists examples of ICD-10-CM clinical concepts, terms used to describe or identify the concept, and examples of code descriptions.

Clinical Concept	ICD-10 Descriptors	Example	Comment
Site	Identifies a specific anatomic site or location such as the chest wall and	Cutaneous abscess of chest wall	These two concepts are often present together, for example left upper eyelid
Laterality	Specifies whether skin lesions are located on the left or right side of the anatomy	Cellulitis of right axilla	
Type	Varies depending upon the ICD-10 category	Non-bullous impetigo	Classifies additional information regarding the specific form or nature of the condition within the category e.g. non-bullous impetigo or acne vulgaris
Severity	Identifies the degree, stage, percentage of body effected, deep, or superficial nature of the condition	Non-pressure chronic ulcer of left thigh limited to breakdown of skin	Captured in the documentation in statements such as the degree, stage, percentage of, or the terms deep or superficial
Etiology	Describes interrelated conditions or disease process such as skin ulcers due to diabetes	Type II DM with other skin ulcer	Document conditions or disorders associated with a primary disease diagnosis, as these will likely have their own ICD-10 diagnostic code.
Manifestations		Papulo-squamous disorders in diseases classified elsewhere	Descriptors to include in your documentation to relate these conditions and support reporting of etiology manifestation code pairs are primary or secondary, with and due to.
Causal Factors	The infectious agent, physical agent, or drug leading to the condition or disorder	Contact Dermatitis	Details of an eruption or abscess may need to be specified e.g. an eruption is caused by a drug the causal factor or name of the drug should be included in the documentation
Temporal Factors	Defines chronological or progressive course of a disease or condition	Chronic bullous disease of childhood Transient acantholytic dermatosis	Described by the terms transient, recurring, acute, or chronic, as seen in chronic bullous disease.
Complications	Conditions may be classified with or without complications with inclusion of the type of complication	Varicose veins of right lower extremity with ulcer of calf	Documentation should include terms which describe the presences of the complication such as with abscess, foreign body or ulcer
Signs and Symptoms	Disturbances of skin, swelling, mass, lump, induration, scaling	Hypoesthesia of skin	Include complaints that do not result in a definitive diagnosis at the conclusion of the encounter.
Adverse Effects	The result of or reaction to an agent or drug that is taken and administered as describe by the physician or manufacture	Lichenoid drug reaction	Documentation should indicate or state the relationship between the adverse effect and the drug or biological agent.
Episode of care	Initial encounter, subsequent encounter, sequela (late effect)	Laceration with foreign body of right index finger with damage to nail, initial encounter	Include in your documentation the type of care provided during the encounter as initial (active care or diagnosis), subsequent (follow-up during the healing phase) or sequela care.
External causes	Injury, work related, intentional self harm	Bitten by dog Civilian activity done for income or pay	Describes how and where the injury occurred, what the patient was doing at the time of the injury and if the injury is related to employment.❖

Mohs Micrographic Surgery (MMS) LCDs reveal strict documentation requirements

In recent months, many of the Medicare Administrative Contractors (MACs) have updated their Mohs Micrographic Surgery (MMS) Local Coverage Determinations (LCDs) due to the transition to ICD-10 diagnosis codes and the American Academy of Dermatology's (AAD) Appropriate Use Criteria for Mohs Surgery. These changes have also increased the associated documentation requirements that Mohs surgeons **MUST** comply with in order to avoid unnecessary pre and post payment audits.

Academy staff members have received information from some Mohs surgeons currently undergoing post payment audits on MMS with denials to their appeals due to the lack of proper documentation. It is highly recommended that physicians and billing staff review their respective LCDs for appropriate requirements.

The following are some specific elements of documentation identified as required in updated LCDs for MMS and which, if lacking, may lead to denials of appeals;

- *The diagnosis is appropriate for MMS and that MMS is an appropriate choice as the treatment of the particular lesion. The options for care (both the primary procedure options and repair options) must be discussed with the patient and clearly noted in the pre-procedure (or post procedure as appropriate) documentation. In summary, the minimal medical record documentation entails that the beneficiary was informed of their treatment options and explained the risks/benefits of the MMS technique and associated repair.*

- *Operative documentation should note: complexity, location, number, and size of the lesion(s); number of stages performed; number of specimens per stage.*

- *Documentation supporting the medical necessity of this procedure should be legible, maintained in the patient's medical record, and made available to Medicare upon request.*

- *Operative notes and pathology documentation in the patient's medical record should clearly show that MMS was performed using accepted MMS technique, in which the physician acts in two integrated and distinct capacities: surgeon and pathologist (therefore confirming that the procedure meets the definition of the CPT code(s)).*

Additionally, there are LCDs that are more specific to Histology documentation. This can be found in CMS' MedLearn on Mohs surgery, MM1318 which requires the following:

- *First stage: if tumor present, depth of invasion; pathological pattern of the tumor; cell morphology; if present, note perineural invasion of scar tissue. Any subsequent stages: if the tumor characteristics are the same as in the first stage, note this fact only. If the tumor characteristics are different from the first stage, describe the differences.*

Some LCDs have an unusual MMS documentation requirement. In addition to the measurement of the lesion and repair, a photograph may be requested detailing:

- *Measurement of the primary lesion necessitating MMS and measurements in support of repair or related procedures (such as but not limited to adjacent tissue transfer/rearrangements, grafts/flaps) completing the MMS procedure and confirming the primary defect measurement or other relevant measurements should be verifiable.*

- *Documentation of the clinical tumor border definition may be accomplished by: Preoperative photography with the skin stretched to delineate the visible clinical borders with or without debulking curettage (using a centimeter ruler or relation of size by another anatomic structure)….When the surgical defect created by MMS requires reconstruction, it should be clear in the documentation that the reconstructive technique performed was an appropriate choice to preserve functional capabilities and to restore physical appearance.*

You are encouraged to review your local Mohs LCD to ensure all proper documentation guidelines are being followed. Please visit *https://www.cms.gov/medicare-coverage-database/search/search-results.aspx?CoverageSelection=Local&ArticleType=All&PolicyType=Final&s=All&CptHcpcsCode=17311&from2=lastupdated_criteria.asp&bc=gAAAAAAAAAAAA%3d%3d=&*

L34195	Mohs Micrographic Surgery CGS Administrators, LLC
L35701	Mohs Micrographic Surgery Noridian Healthcare Solutions, LLC
L35702	Mohs Micrographic Surgery Noridian Healthcare Solutions, LLC
L35703	Mohs Micrographic Surgery Noridian Healthcare Solutions, LLC
L35704	Mohs Micrographic Surgery Noridian Healthcare Solutions, LLC
L35494	Mohs Micrographic Surgery Wisconsin Physicians Service Insurance Corporation
L33689	Mohs Micrographic Surgery (MMS) First Coast Service Options, Inc.
L34961	Mohs Micrographic Surgery (MMS) Novitas Solutions, Inc.
L33436	Mohs Micrographic Surgery (MMS) Palmetto GBA ❖

Academy Resources at your Finger tips

Each year, the Academy creates and updates a series of educational coding resources for our members. These resources are available to help facilitate the day to day business operations of your practices. These last few years, a great deal of focus and emphasis was placed on ICD-10 education and all the steps needed to accomplish a smooth transition from ICD-9 to ICD-10.

In addition to several ICD-10 resources, the Academy has many resources available for other coding needs and solutions that physicians and their staff members will find very helpful. Some of those resources are highlighted and detailed below.

- **Updated Quick Coder**- Newly improved coding tool that contains a sampling of the most frequently used codes in Dermatology in a grid format. The uniqueness of this free resource is that it has specific anatomical locations on the Y axis and specific diagnostic conditions on the X axis. When selecting a specific anatomical location and pairing it with a specific condition a quick correct ICD-10 code is available to the user. This resource can be found here: *https://www.aad.org/practice-tools/coding/icd-10/icd-10-quick-coder*.
- **AAD Coding and Documentation Manual (CDM)** - This is an Academy educational staple. This resource is reviewed and updated annually for accuracy. It contains valuable information on basic tools for coding, procedural coding (CPT coding), Modifiers, HCPCS and ICD-10.
- **AAD Coding Today** – A subscription based online coding resource that allows subscribers to easily search for codes in an electronic format and provides a bundling matrix to identify potential National Correct Coding Initiative (NCCI) edits before reporting services, thus reducing denials for these issues. The Academy introduced this resource in mid-2015 and it has been reviewed and updated to include all coding changes for 2016. It also extensively details ICD-10, CPT coding, Medicare Physician Fee Schedule Database (MPFSD), and Local Coverage Determinations (LCDs).
- **Coding Webinars** – Each year the Academy builds a portfolio of webinars on diverse coding topics to provide members with quick and up to date coding information. Some of the topics included are ICD-10 clinical documentation as part of correct coding, late breaking hot topics, and transitioning into ICD-10 etc.
- **ICD-10 Resources** - The Academy has a detailed library of ICD-10 resources that cover every aspect of ICD-10 from implementation through the final step, claim submissions. For these purposes, the Academy has created an ICD-10 e-book, ICD-10 crosswalk, ICD-10 Member to Member articles, DCC special spring 2015 edition on all things ICD-10, ICD-10 Quick Coder and a dedicated ICD-10 member community where members can post their ICD-10 specific coding questions to be answered by one of our on staff coding experts.

For more information on all of our coding resources, please be sure to visit the Coding Corner on the Academy's webpage at *https://www.aad.org/practice-tools/coding* ❖

ICD-10 Laterality and Use of Modifiers

One of the features available in ICD-10 is the ability to choose a code that identifies specific anatomic sites and/or laterality (i.e. left, right, bilateral). The use of site and laterality specific ICD-10 diagnosis codes does not negate the use of CPT modifiers to identify the body site and/or laterality on which the procedure was performed. This is a relatively new concept for dermatology as, prior to ICD-10, the skin was considered one continuous organ system without laterality.

For Medicare claim processing purposes, it is imperative to report an appropriate site or laterality modifier when submitting such services to Wisconsin Physician Services Government Health Administration (WPS) GHA. For additional information about new features in ICD-10, please refer to the CMS Medicare Learning Network ICD-10-Classification Enhancements at *https://www.cms.gov/Medicare/Coding/ICD10/downloads/icd-10quickrefer.pdf.*

CPT modifiers should be added to the claim line to identify the site of the procedure. The modifier reported should be consistent with the site and laterality of the condition reported by the ICD-10 code.

CPT anatomic modifiers include;

Modifier	Anatomic Site
LT	Left side
RT	Right side
E1	Upper left, eyelid
E2	Lower left, eyelid
E3	Upper right, eyelid
E4	Lower right, eyelid
FA	Left hand, thumb
F1	Left hand, second digit
F2	Left hand, third digit
F3	Left hand, fourth digit
F4	Left hand, fifth digit
F5	Right hand, thumb
F6	Right hand, second digit
F7	Right hand, third digit
F8	Right hand, fourth digit
F9	Right hand, fifth digit
TA	Left foot, great toe
T1	Left foot, second digit
T2	Left foot, third digit
T3	Left foot, fourth digit
T4	Left foot, fifth digit
T5	Right foot, great toe
T6	Right foot, second digit
T7	Right foot, third digit
T8	Right foot, fourth digit
T9	Right foot, fifth digit ❖

"Incident to" Billing Guidelines – Are You Meeting All the Requirements?

There are proven benefits to providing "incident to billing" services within a physician practice. Two significant benefits, include increased productivity without significantly increasing costs, and a reduction in wait times for return visits.

In addition to enabling your practice to care for more patients each day, the benefit of billing "incident to" services for non-physician practitioner (NPP) services is that even though the midlevel provider has performed the work during that visit, the encounter is reimbursed at 100 percent of the Medicare fee schedule, as opposed to 85 percent when the service is billed under the midlevel's own National Provider Identification Number (NPI).

Unfortunately, "incident to" billing is often misunderstood and leading to encounter errors that fail to meet all of the Centers for Medicare and Medicaid Services (CMS) "incident to" requirements. These types of errors may expose your practice to preventable financial and compliance risks.

For an encounter or service to be reported as "incident to" the encounter or service must meet the following criteria:

- The encounter must be provided in a non-institutional setting and documentation of the encounter should reflect that the required criteria for "incident to" services were met.

- A physician must perform the initial evaluation and management (E/M) service, establish the patient's diagnosis, initiate care of that diagnosis, and establish the plan of care for the problem to be managed subsequently by the NPP. Consequently, "incident to" services cannot be rendered on a new patient's first visit or an established patient's visit for a new problem.

- Additionally, the physician must remain actively involved in the course of treatment. This does not mean the physician must provide a personal professional service each time the patient is seen by the NPP. What is required is that the physician provides subsequent services at a frequency that reflects the physician's continuing active participation in the management of the course of treatment.

Per CMS, the services provided during the "incident to" encounter by an NPP must be part of the patient's normal course of treatment as established previously in the physician's plan of care. If, in the course of an "incident to" encounter, a new problem is addressed or a necessary change in the course of treatment or plan of care occurs, the encounter no longer meets "incident to" criteria. In either of these two occurrences, a physician briefly meeting with the patient, performing a portion of the visit with the NPP, or co-signing the NPPs note will not supersede the required criteria regarding the physicians initiating care of the problem.

Determine in advance how encounters intended as "incident to" which no longer meet the required criteria will be handled. Asking the following questions will help you: Will the NPP complete the encounter or will the physician take over, evaluating the patient and establishing a plan of care for the new condition? Will the patient be asked to return for the new problem?

If the NPP provides the service for the new problem or alters the plan of care, the encounter must be billed under his or her own NPI.

Determining how these encounters will be handled prior to the completion of the encounter and the claim hitting the billing department for submission will go a long way towards accurately billing for these services.

There are additional requirements an NPP must meet in order to provide "incident to" services. The NPP must practice within the state law's scope of practice and must be licensed in the state where the service is provided. The NPP must be a "direct expense" to the physician or group. Physicians which have been excluded from the CMS program may not provide "incident to" services for another physician or group practice.

The final and often most misinterpreted criteria requirement is physician supervision. "Incident to" services must be furnished under a physician's direct supervision. Direct supervision means that the supervising physician must be present in the office suite and immediately available to provide assistance and direction at the time of service.

CMS has clarified that the supervising physician need not be the physician who performed the initial service. Therefore, in a group practice, any physician member of the group may be present in the office to supervise. However, only the supervising physician may bill Medicare for "incident to" services. For example; physician A provides the initial service and establishes the plan of care. On a subsequent visit the NPP is providing the "incident to" service, but physician A is out of the office on the day of the subsequent encounter and physician B is supervising the encounter. In this example the "incident to" encounter must be billed under physician B's NPI number.

Source Medicare Benefit Policy Manual, Chapter 15, 60.1 – 60.3 Medicare Learning Network, MLN Matters #SE0441 ❖

Provider Enrollment Revalidation – Cycle 2

The Center of Medicare and Medicaid Services (CMS) has released Medicare Learning Network (MLN) Matters® Special Edition Article SE1605. It is advising all providers who are enrolled in Medicare, to expect another revalidation that is to be done through their Medicare Administrative Contractors (MACs). In an effort to streamline the revalidation process and reduce provider burden, CMS has implemented several revalidation processing improvements that are captured within this article.

Provider Enrollment Revalidation – Cycle 2

This Cycle 2 enrollment revalidation effort does not change other aspects of the enrollment process such as changes of ownership, practice location or reassignments, final adverse action, changes in authorized or delegated officials or, any other changes. Any direct request for revalidation from the MAC is totally separate from this Cycle 2 revalidation and should be handled on its own.

- CMS has made it easier to check when a provider's need to revalidate for Cycle 2. The information is found on http://go.cms.gov/MedicareRevalidation

- Providers are encouraged to submit their revalidation within six months of the due date or when the notification is received from the MAC. The due date will generally be on the last day of a month and will remain with the provider throughout subsequent revalidation cycles.

- Submit a revalidation application through Internet-based PECOS located at https://pecos.cms.hhs.gov/pecos/login.do, the fastest and most efficient way to submit your revalidation information. Electronically sign the revalidation application and upload your supporting documentation or sign the paper certification statement and mail it along with your supporting documentation to your MAC; or

- Complete the appropriate CMS-855 application available at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProvider-SupEnroll/EnrollmentApplications.html ;

- If applicable, pay your fee by going to https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do ; and

- Respond to all development requests from your MAC timely to avoid a hold on your Medicare payments and possible deactivation of your Medicare billing privileges.

For more specific details, see MedLearn SE1605 or CMS website: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Revalidations.html ❖

Frequently Asked Questions

Q. Can CPT code11755 be used for clipping the nail plate for KOH and for obtaining nail plate scrapings for Periodic Acid Schiffs (PAS)?

A. Per AMA CPT *Assistant*, CPT code, 11755 is not meant to describe the act of clipping a nail. Nail biopsy should include components of the nail unit other than just the nail plate. Taking nail clippings for PAS or Fungal culture is just part of the E/M service, just like taking a swab for a throat culture, and is not a "Nail biopsy". Nail biopsies normally require a digital block or local anesthetic, and represent more physician work than a nail clipping, or curetting under a nail for culture material.

Q. If a claim is denied for a routine exam or screening procedure, do I need an Advance Beneficiary Notice (ABN) on file in order to bill the patient?

A. An ABN is not required for services that are statutorily excluded from Medicare coverage. An ABN is not required on file in order to bill the patient for non-covered services such as routine skin screenings, cosmetic procedures, removal of non-medical medically unnecessary lesions, skin tags etc. If the patient requests the service to be filed to Medicare to allow the consideration of secondary insurance, use the GY modifier advising Medicare this is a non-covered service.

If there is a question regarding the coverage of the service, explain the cost and have the patient sign the ABN. This service will need the GA modifier appended indicate that an ABN is on file and that this may not be a covered service. The ABN must have a full description for this denial. Here is an example: "These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam."

For more information on the ABN, see https://www.cms.gov/MEDICARE/medicare-general-information/bni/abn.html

Q. Is it appropriate to balance bill patients the difference between the billed insurance amount and the payer's covered amount?

A. Dermatologists often wonder whether it is appropriate to balance bill their patients for the difference between the billed amount and the insurance covered amount. In most cases, the answer is no. There are often provisions in the payer's contract prohibiting physicians from billing their plan members for covered services in excess of applicable co-pays and co-insurances. Their typical terminology is: "the provider agrees to accept the payer's network rate as payment in full for covered services and shall not balance bill the payers subscriber" in the contract.

Dermatologists providing services to patients in an "out-of-network" situation cannot assume that balance billing is allowed. Some state regulations differ and may imply a contract between physicians and payers that prohibit physicians from balance billing, which may also apply to out-of-network physicians. Before dermatologists balance bill a patient, it may be time to research the state medical board or state insurance commission for clarification. "In-network" dermatologists need to review their payer contracts to determine whether balance billing is allowed. Also, those who accept reimbursement from government-administered health care programs need to determine if there are any restrictions against balance billing.

Be aware that knowingly inflating the amount for services in order to circumvent the contractual and statutory restrictions against balance billing may be viewed as insurance fraud, and may be punishable through civil monetary penalties as illustrated in The Social Security Act (SSA), Sec. 1128A.(42 U.S.C. 1320a–7a). For a detailed description of the Act, please visit: http://www.socialsecurity.gov/OPHome/ssact/title11/1128A.htm ❖

In The Know.....

National Uniform Claim Committee (NUCC) Updates Healthcare Provider Taxonomy Codes (HPTC)

Do you know what the claim adjudication remark codes (CARC) mean?

On February 19, 2016, the Centers for Medicare and Medicaid Services (CMS) released MLN Matters® Number: MM9461 that went into effect on April 1, 2016. In this MLN instruction, CMS Change Request (CR)# 9461 instructs all Medicare Administrative Contractors (MACs) to obtain the most recent Healthcare Provider Taxonomy Code (HPTC) set and update their internal HPTC tables and/or reference files.

The instruction (CR 9461) requires the MACs to use standards adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to electronically transmit certain health care transactions and claims.

As such, Dermatology practices, especially billing and coding staff, are encouraged to review the list(s) of HPTC codes as they relate to claim adjudication and reporting of provider types. Understanding what these codes mean will help the coding and billing staff to know how the claim(s) was processed and what the remark codes mean.

The HPTC code set is maintained by the National Uniform Claim Committee (NUCC) to allow standardized classification of health care providers, and is updated twice a year.

Below is a short list of updated codes and links to where you can view them:

Type	Link
Claim Adjustment Reason Codes (CARC):	http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/
Remittance Advice Remark Codes (RARC):	http://www.wpc-edi.com/reference/codelists/healthcare/remittance-advice-remark-codes/
Healthcare Provider Taxonomy Code Set:	http://www.wpc-edi.com/reference/

❖ The complete code set can be found at http://www.wpc-edi.com/reference/

When reviewing the Health Care Provider Taxonomy code set online, you can identify revisions made since the last release by the color code:

✓ New items are green;
✓ Modified items are orange; and
✓ Inactive items are red.

For more information, please review MLN Matters® Number: MM9461 at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9461.pdf

Now you are In The Know!

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