AAD 1938 American Academy of Dermatology

# Derm Coding Consult

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## CMS Releases Third Quarterly Correct Coding Initiative Edit Updates, Effective July 1, 2016

The Centers for Medicare & Medicaid Services (CMS) developed the National Correct Coding Initiatives (NCCI) edits in 1996 to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment in Part B claims.

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

NCCI includes three types of edits:

### NCCI Procedure-to-Procedure (PTP) Edits

These edits were developed to prevent improper payment when incorrect code combinations are reported.

The NCCI PTP edits prevent inappropriate payment of services that should not be reported together. Each edit has a column one and column two Healthcare Common Procedure Coding System -HCPCS/CPT code. If a provider reports the two codes of an edit pair for the same beneficiary on the same date of service (DOS), the column one code is eligible for payment but the column two code is denied unless a clinically appropriate NCCI-associated modifier is also reported.

For example, an excision of a benign lesion (including margins) on the trunk with a total excised diameter of 1.6cm, when reported at the same time as a skin biopsy performed on a different lesion from the one that was excised is reported as follows:

11402
11100 - 59

| Column 1 | Column 2 | Modifier 0=not allowed 1=allowed 9=not applicable |
|---|---|---|
| 11402 | 11100 | 1 |

### Medically Unlikely Edits (MUE)

This type of edit was developed to reduce the paid claims error rate for Part B claims. An MUE for a HCPCS/CPT code is the maximum units of service that a provider can report under most circumstances for a single beneficiary on a single date of service.

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 analyte;
- Nature of equipment; and
- Clinical judgment

— see **CMS THIRD QUARTERLY CORRECT CODING** on page 2

## Contents



**IMPORTANT Please Route to:**

___ Dermatologist ___ Office Mgr ___ Coding Staff ___ Billing Staff

# CMS Releases Third Quarterly Correct Coding Initiative Edit Updates, Effective July 1, 2016

— continued from page 1

For example, complex repair code, 13121 - scalp, arms, and/or legs; 2.6cm to 7.5cm has an MUE of 1 due to anatomical consideration:

| HCPCS/ CPT Code | Practitioner Services MUE Values | MUE Adjudication Indicator | MUE Rationale |
|---|---|---|---|
| **13121** | 1 | 2 Date of Service Edit: Policy | Anatomic Consideration |

**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 also eligible for payment.

For example, additional destruction of premalignant lesion(s) (actinic keratosis), second to fourteen lesions, cannot be reported without the primary destruction code 17000 on the same DOS as follows:

17000
+17003

### Policy Manual Background

The NCCI Policy Manual for Medicare Services and NCCI edits have been developed for application to Medicare services 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 correct coding, the reduction of inappropriate payment and 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/she has been coding incorrectly, the provider should contact his/her Medicare Administrative Contractor (MAC) about potential payment adjustments.

*The edits previously contained in the Mutually Exclusive edit file were **NOT** deleted but were moved to the Column One/Column Two Correct Coding edit file*

Previously, there were two files developed and maintained by CMS:

- Column One/Column Two Correct Edits
- Mutually Exclusive edits

In 2012, CMS consolidated the two files and now only publishes the PTP Coding edit. This file can be found at *https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html*

The consolidation into PTP Edits edit file has helped simplify the use of the edit files.

### NCCI Policy Today

CMS reserves the right to publish all MUE values that are 4 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 facility claims for inpatient services. As such, healthcare providers are discouraged from incorrectly interpreting MUE values as utilization guidelines. MUE values do **NOT** represent units of service that may be reported without concern about medical review. Providers **MUST** continue to only report services that are medically reasonable and necessary.

— see **CMS THIRD QUARTERLY CORRECT CODING** on page 3




**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.



**Address Correspondence to:**
Mollie MacCormack, MD, FAAD Editorial Board Derm Coding Consult
American Academy of Dermatology Association
P.O. Box 4014 Schaumburg, IL 60168–4014

# CMS Releases Third Quarterly Correct Coding Initiative Edit Updates, Effective July 1, 2016

— continued from page 2

CPT codes representing services denied based on NCCI edits cannot be billed to Medicare beneficiaries. Since 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, since 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.

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

CMS posts PTP and MUE quarterly version updates to its NCCI PTP and MUE at *https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Version_Update_Changes.html*

Sometimes, other payers may utilize the NCCI edits as they deem necessary. It is important for dermatology practices to check other payer contracts to determine if they use the NCCI policies to allow for correct coding and claim processing.

The latest package of PTP CCI edits, Version 22.2, effective July 1, 2016, is now available via the CMS Data Center (CDC) at *https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html*. Choose the Version 22.2 - Practitioner PTP Edits to view.

For more information, please see: *https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html* ❖

# An Inside view: Zone Program Integrity Contractors Update

In the past, Academy staff has assisted members in understanding and dealing with Recovery Audit Contractor (RAC) audits. RAC audits have always been a source of concern for physicians, but now, we are hearing of Zone Program Integrity Contractors (ZPIC) audits. ZPIC audits and their potential negative impact on physician practices should not be taken lightly. They are in full force and are more ominous because they are targeting solo and small dermatology practices. Unlike the RACs, who focus on finding billing errors, ZPICs are focused specifically on uncovering fraud.

ZPIC audits are foreboding because they function with a very different set of rules and they do not require Medicare's approval to audit any specific area within a physician practice. They report directly to the Department of Justice (DOJ) and/or the Office of Inspector General (OIG). Typically, auditors will appear unannounced for a site visit creating immediate disruption in physician services. They are not required to inform providers on basic things such as what they will be auditing, what errors have been found or even the dollar amounts that have come into question. Knowing the error prior to the investigation makes ZPICs more of a menace to providers because it potentially opens every audit to be a fraud referral to law enforcement agencies.

Interestingly, ZPICs are self-incentivized. There is no recoupment bonus and no contract to consider as occurs with the RACs. Their only function is to investigate and uncover fraud.

It is important to know what may trigger a ZPIC audit and the answer can be as simple as random billing errors, a specific issue found in the claim data or a complaint from a MAC contractor or a whistle blower. The majority of ZPIC audits come from data analysis.

The actual ZPIC audit process can start with a letter requesting a specific amount of medical documentation that will need to be received within a predetermined amount of time, usually 30 days. Some ZPIC auditors arrive onsite for an unannounced visit, firmly requesting immediate attention. Should this occur, check and copy all auditors' photo identifications and ask for a business card from each auditor and allow the auditors a private room for their visit. Practice Managers may want to consider cancelling patient visits for that day and perhaps consider sending staff home as it will allow less opportunity for the auditors to interview clinical staff members.

Once the records are reviewed and the documentation is assessed, if overpayments are found, the local Medicare Administrative Contractor (MAC) is notified and will issue a specific overpayment demand letter. As with any audit, ZPIC audits allow the usual five-levels of appeals process: Redetermination, Reconsideration, Administrative Law Judge hearing, Department appeals board review and Federal court review. If an overpayment is determined after all steps have been exhausted, it can be paid upon receipt or the provider can allow recoupment to be taken from future claims remittance. If there is no provider payment or request for payment plan within 30 days, the overpayment amount is considered delinquent and interest starts accruing.

The most difficult and perhaps enduring part of a ZPIC audit is the prepayment review. The error that was initially identified by the ZPIC auditors, will continue for an indefinite period of time. Each claim will require a prepayment review by the MAC before final payment is made. There is no definitive time limit for the prepayment review to end, which can be very damaging to the financial health of small practices. The only true way to stop a prepayment audit is to correct the coding and billing errors that have been noted.

There are many websites that offer good suggestions on how to prepare and handle any medical audit. One very simple suggestion is to make sure you thoroughly read and understand the audit request document. Who

— see **ZONE PROGRAM INTEGRITY CONTRACTORS UPDATE** on page 4

# An Inside view: Zone Program Integrity Contractors Update

— continued from page 3

is requesting the review? Also, if needed, make sure to contact legal counsel. Another good suggestion is to take some time and prepare your practice as if you were going to be visited. Make sure all the licenses and credentials on display are current, ensure that your medical refrigerator only contains appropriate items, and ensure that all medical files are HIPPA compliant. An audit defense needs to involve your legal and accounting experts as well as your clinical risk management team before a ZPIC team is at your door.

As with any audit, the best strategy is to try and prevent them. The Office of Inspector General (OIG) has strongly suggested that physicians and healthcare providers have at least 10 medical records or more reviewed internally or externally each year. It is of extreme importance to regularly inspect, review and remain diligent in compliance programs.

For more information on ZPIC Audits, please visit: *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Fraud_and_Abuse.pdf* ❖

# Clear documentation results in "Bigger and Better Data"

Data drives Quality Measures, this mantra has been a part of healthcare for many years and with new payment methodologies looming for 2018, the quality of the data that Dermatologists report has never been more important.

A large portion of this data is generated by the documentation recorded within electronic health records (EHRs) or the CPT and ICD-10 codes entered in practice management systems and reported on the healthcare claim form. Poor quality documentation is bad for payers, providers and patients. Your documentation affects billing accuracy, quality measures, risk management, healthcare data analytics and audit outcomes.

In terms of patient care, accurate, complete and comprehensive documentation allows you or another physician to provide seamless continuity of care for your patients.

As the codes captured and reported are derived from documentation of the encounter or service, it's crucial to get it right. Reporting unspecified codes for certain ICD-10 categories may result in denials as these codes may not be included in CMS' LCSs and NCDs. After October 1, 2016, when CMS' ICD-10 grace period ends, we expect to see an increase in the number of claim denials due to the continued use of unspecified ICD-10 codes that may no longer support CMS' medical necessity requirements.

While use of ICD-10 codes with high levels of specificity may be required to obtain coverage, it's essential to ensure that use of such codes is supported by documentation in the medical record as the potential of post payment audits for reporting unsupported ICD-10 codes may become an even greater concern.

**"CMS requires that the CPT and ICD-10-CM codes reported on the claim form must be supported by the documentation in the medical record."**

**Beyond The Clinical Concepts of ICD-10**

In the last edition of Derm Coding Consult, we discussed ICD-10 Clinical Concepts, the frame work on which ICD-10 codes are built and how to incorporate these concepts into your clinical documentation to support accurate coding of conditions.

In this edition of Derm Coding Consult, you will learn about other common practices of clinical documentation that may lead to inaccurate reporting of diagnosis codes. There may be additional elements of your clinical documentation that may lead to inaccurate reporting of diagnosis codes.

Ambiguous language and unclear terms often times result in documentation which may seem specific and detailed but from a coding aspect, lends itself to unspecified or unsupported codes. ICD-10 guidelines continue to instruct us to not report a diagnosis documented as probable, suspected, rule out, working diagnosis or other similar terms indicating uncertainty. Additional terms, indicating uncertainty, were identified and include:

| Unclear Documentation Terms | |
|---|---|
| Consistent with | Compatible with |
| Indicative of | Suggestive of |
| Suspect | Probable |
| Versus | History of (i.e. diabetes, hypertension) |

Using these terms in your documentation, adds uncertainty to the patient visit that you are reporting and there may be a need to clarify the condition or only the signs and symptoms documented during the encounter should be reported.

Example 1:

> *The lesion in the patient's left flank area has now developed some central blistering, and there are some satellite lesions in a dermatome distribution that are consistent with herpes zoster.*

The above vignette indicates an uncertain diagnosis as the term, "consistent with" is not considered a definitive statement of condition. As is, this encounter would most accurately be reported with ICD-10 code L98.9 Disorder of the skin ad subcutaneous tissue, unspecified.

Another potential for unclear documentation involves how conditions or manifestations with an underlying etiology or causal factors are documented. It is important to note that the information relayed in cases of this nature may be used to determine the quality of care provided in terms of managing each condition treated.

— see **BIGGER AND BETTER DATA** on page 5

# Clear documentation results in "Bigger and Better Data"

— continued from page 4

Example 2:

> *Patient presents for follow-up of non-pressure chronic ulcer of the right ankle. Skin breakdown does not extend beyond the dermis.*
>
> *History is positive for type 1 Diabetes Mellitus (DM)*
> *Assessment: Ulcer, right ankle, DM1*

In the vignette above the documentation does not state or imply the relationship between the ulcer and the diabetes. As it cannot be assumed that these two conditions are inter-related, each condition would be interpreted as unrelated and reported as two distinct conditions.

Improved documentation for this case:

> *Type 1 DM patient with non-pressure chronic ulcer of the right ankle presents for follow-up. Skin breakdown does not extend beyond the dermis.*
>
> *History is positive for type 1 DM*
> *Assessment: Ulcer, right ankle due to DM1*

The improved documentation both implies the ulcer's relationship to the underlying condition, "Type 1 DM patient with non-pressure chronic ulcer" and states the relationship in the assessment.

We do not advocate diagnosis code bloat to make for "Bigger and Better Data", we do support documentation and reporting of diagnosis codes that fully reflect the acuity of a patient's condition and the complexity of care you provide for your patients. ❖

# Have coding questions? We have coding answers.

In early September 2015, in preparation for ICD-10 implementation, the Academy created an ICD-10 Member Community page dedicated exclusively to all things ICD-10. The page was created to serve as a direct communication portal between physicians and Academy staff and it also served as an ongoing educational repository of ICD-10 materials and updates. Through the page, coding staff reviewed and answered several hundred questions related to ICD-10.

The Academy is now happy to announce that the community page has been expanded to become an all-inclusive Coding page! Members now have a place to directly send in their coding questions regarding any CPT or ICD-10 topic and a member of our coding staff will respond to it in a timely manner. Once questions are answered they are posted and visible to all. The Coding Community has a searchable feature which allows members to search for specific topics and key words within the questions we have received. It is quite possible that the question you have has already been answered!

The coding community can be accessed by clicking on this link: *http://community.aad.org/communities/community-home?CommunityKey=b88f7ea1-5810-4b40-9bf4-bdf4e67d3d7c*

Some of the questions and answers that have been posted on the community page are included below

**Q. Can you tell me the proper code for billing a procedure where we would shave then use electrodesiccation and curettage on an unknown lesion? Would we bill for a shave excision and ED&C?**

A. No, only the destruction would be reported. According to Alexander Miller, MD, FAAD author of *DermWorld, Cracking the Code, January 2014*: The CPT specifies that the destruction may be done by any of a variety of methods, including electrosurgery (electrodessication or electrofulguration), cryosurgery (liquid nitrogen freeze), or laser or chemical techniques, with or without a curetting. Thus, any of the aforementioned destructive modalities used on its own or in any combination for treating a lesion will constitute a single destruction.

**Q. I was recently at a coding meeting during the AAD meeting in DC. I wanted to gather options on a few items I heard. Is the measurement of an ED&C lesion taken pre-treatment or after the first curetting pass? The other issue was size of lesion at the time of excision. Should it be the measurement documented in the previous note or measuring the biopsy site on the day of excision?**

A. A review of publications and discussions on how to best determine lesion diameter made it clear that there is no consensus on how this should be done. It seems best to concentrate, from the coding standpoint, on what is desired: a true measurement of the lesion's diameter. Although the preoperative visible lesion size may be used for this determination, it does not always represent the true diameter. A curetting may reveal a broader and deeper subclinical spread. Occasionally, a second curetting, done after electrodessication, will further extirpate a focus of friable tumor, thereby expanding the lesion diameter. The goal is to truthfully provide what you, the treating medical professional, perceive as the actual maximum diameter of the lesion. This may be an initial measurement prior to treatment, it may be the size after one curetting, or it may be the diameter after more than one curetting.

To accurately report the work provided during the excision of a lesion, the lesion should be measured including margins prior to the excision on the same day and documented in the record of the excision. The size of the lesion documented in a previous encounter's record is not to be used during the procedural service, as the documentation for services in an office setting must "stand alone". This means the documentation

— see **CODING QUESTIONS AND ANSWERS** on page 6

# Have coding questions? We have coding answers.

— continued from page 5

of an encounter must contain all elements needed to support the services reported for that encounter. ❖

## FAQs

**Q. We understand Medicare has to be our lowest payer. Would this affect our giving non-insured patients a discount on services rendered?**

A. This is tricky, especially since CMS is rather vague on the subject. You may not charge self-pay patients less than Medicare allowables but you can offer self-pay patients a discount. It must be the same discount across the board for all self-pay patients. Charity care is a little different.

All practices have set fee schedules but none should be lower than Medicare allowables. Private insurer schedules must be as high (or higher depending on the contract) than Medicare's. Private payers may reimburse certain procedures lower than Medicare rates but you still must charge them at least the Medicare allowable rate and then adjust the bill.

As with most Medicare guidelines, you can't discriminate with patients charges. The key to all of this, is that the policy must be in writing in your Office and Policy Manual under Financial Policies.

For further information, I am including an explanation on this from the Winter 2005 edition of *Derm Coding Consult below:*

Per section 1128(b) (6) of the Social Security Act, a provider may not bill a non-Medicare patient a lesser fee than a Medicare patient. Providers may have a fee schedule for their privately insured patients and another for their Medicare patients. The Medicare fee schedule could be lower than the privately insured fee schedule, but not higher. In the case of a nonparticipating provider not accepting assignment, the addition of the limiting charge is the fee that should be compared and should not exceed the privately insured fees. It is also appropriate for a provider to have another fee schedule for the uninsured that is lower than both the private and Medicare fee schedules because it applies to a specific type of patient, the uninsured. A provider should have a clear definition as well as practice policy and procedure as to how and when each fee schedule is applied.

**Q. My understanding is the office assessments should only be for "present" and "History of" diagnoses for that encounter. One provider reported actinic keratosis under assessments which were treated at the last appointment. When questioned, the comment was if the patient had a follow up for dermatitis which was gone what should be reported?**

A. There is a guideline in ICD-10 (Chapter 2, section d – Primary Malignancy previously excised) like ICD-9 that once a lesion is removed and the margins are clear, that lesion's diagnosis can only be reported as a "history of." If the patient is being treated with Efudex for actinic keratosis then the L57.0 can be reported as the treatment is active.

Once a lesion is removed, it can only be reported as a history of. A follow up to dermatitis doesn't have a diagnostic guideline. When the patient comes back for a follow up for this type of condition, it can be reported to close the medical record on this condition. Most times the patient doesn't come back but the physician may note in the patient's words that it cleared up with use of meds or by itself

**Q. When a mid-level provider is seeing a patient as an 'incident to' service and needs to change the dosage of a medication that was previously prescribed by the MD, does this qualify as 'incident to' or does the mid-level now have to bill under their own NPI number?**

A. Because the medication was previously ordered by the prescribing MD, it would be 'incident to' as long as all the other qualifiers for 'incident to' are met.

**Q. If the mid-level provider orders labs or X-rays does this disqualify the service as 'incident to'?**

A. The answer to this question will depend on several things including the documentation for the individual encounter, what the physician initially established as the plan of care and any changes to that plan of care. If the mid-level is evaluating a new problem not initially addressed in the plan of care then the mid-level would need to bill the services under their own NPI number rather than 'incident to'. If the MD's plan of care included monitoring lab test results or rechecking something by X-ray, then it would be considered 'incident to'. Again, it will depend on the documentation and the given circumstances. ❖

# Dermatology ICD-10-CM Quick Coder Insect Bites and Stings

**Instructions: It is very important to read these instructions before using this coding sheet in order to understand its layout.** Diagnoses which are anatomic site specific have different codes based upon location and are listed on the grid below. Diagnoses which are not anatomic site specific, (i.e. venomous bites) can also be found on the grid.

Reporting of codes from the venomous bite category require an additional code to report the resulting condition of the venom (rash, pruritus, infection).

| Site | | Non Venomous (specified by site) | Venomous (Not Site Specific)* | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | Stings | | | Spider Bites | | | Ant | Centipede |
| | | | Bee | Hornet | Wasp | Unknown Spider | Brown Recluse | Black Widow | | |
| | | | T63.441- | T63.451- | T63.461- | T63.301- | T63.331- | T63.311- | T63.421- | T63.411- |
| Scalp | | S00.06X- | Parasites | | | | | | | |
| Eyelid | Rt | S00.261- | Bed Bug | Flea | Tick | Chigger | Lice | | Mites | |
| | Lt | S00.262- | Code to nonvenomous category, by site | | | Any site | Head | B85.0 | Hair follicle | B88.0 |
| Lip | | S00.561- | | | | B88.0 | Body | B85.1 | | |
| Head, other | | S00.86X- | | | | | Pubic | B85.3 | Sandflea | |
| Ear | Rt | S00.461- | | | | | Mixed | B85.4 | Any site | B88.1 |
| | Lt | S00.462- | | | | | Infestation | B85.2 | | |
| Neck | | S10.86X- | All codes included on the table require a 7th character to define the episode of care for the bite or sting. Episode of care 7th characters are:<br>A - use for encounters where the patient is receiving active treatment for the condition.<br>D - use for encounters after the patient has received active treatment of the condition and is receiving routine care for the condition during the healing or recovery phase.<br>S – use when complications or conditions arise as a direct result of the sting or bite after the injury has healed. A code for the complication or resulting condition must be sequenced first followed by the bite or sting code.<br><br>*For venomous bites or stings, an additional code is needed to report the resulting condition (rash, pruritus, etc.) | | | | | | | |
| Breast | Rt | S20.161- | | | | | | | | |
| | Lt | S20.162- | | | | | | | | |
| Thorax, front wall | Rt | S20.361- | | | | | | | | |
| | Lt | S20.362- | | | | | | | | |
| Thorax, back wall | Rt | S20.461- | | | | | | | | |
| | Lt | S20.462- | | | | | | | | |
| Low back & pelvis/ buttock | | S30.860- | | | | | | | | |
| Abdominal wall | | S30.861- | | | | | | | | |
| Penis | | S30.862- | | | | | | | | |
| Scrotum | | S30.863- | | | | | | | | |
| Vagina/vulva | | S30.864 | | | | | | | | |

| Upper Extremities | | | | | | Lower Extremities | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Shoulder | Rt | S40.261- | Right Digits | Thumb | S60.361- | Hip | Rt | S70.261- | Right Digits | Great Toe | S90.461- |
| | Lt | S40.262- | | Index | S60.460- | | Lt | S70.262- | | | |
| Upper arm | Rt | S40.861- | | Middle | S60.462- | Thigh | Rt | S70.361- | | Lesser Toes | S90.464- |
| | Lt | S40.862- | | Ring | S60.464- | | Lt | S70.362- | | | |
| Elbow | Rt | S50.361- | | Little | S60.466- | Knee | Rt | S80.261- | | | |
| | Lt | S50.362- | Left Digits | Thumb | S60.362- | | Lt | S80.262- | Left Digits | Great Toe | S90.462- |
| Forearm | Rt | S50.861- | | Index | S60.461- | Lower Leg | Rt | S80.861- | | | |
| | Lt | S50.862- | | Middle | S60.463- | | Lt | S80.862- | | Lesser Toes | S90.465- |
| Wrist | Rt | S60.861- | | Ring | S60.465- | Ankle | Rt | S90.561- | | | |
| | Lt | S60.862- | | Little | S60.467- | | Lt | S90.562- | | | |
| Hand | Rt | S60.561- | | | | Foot | Rt | S90.861- | | | |
| | Lt | S60.562- | | | | | Lt | S90.862- | | | |

# In The Know…..

### Medicare Updates Claims Processing Manual Publication 100-04

Did you know that on April 29, 2016, the Centers for Medicare and Medicaid Services (CMS) released MLN Matters® Number: MM9578?

MM9578 provides updates to Chapter 1 and Chapter 16 of the Medicare Claims Processing Manual correct remittance advice messages. The updates include the standard format and corrections to non-compliant remittance advice code combinations.

### Background

The Social Security Act, Section 1171, requires a standard set of operating rules to regulate the health insurance industry's use of Electronic Data Interchange (EDI) transactions.

Uniform use of Claims Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) regulates the way in which group codes, CARCs and RARCs can be used. The rule requires specific codes which can be used in combination with one another when one of the approved scenarios apply. This rule is authored by the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE).

As a result, Medicare and all other payers must comply with the CAQH CORE-developed code combinations. The business scenario for each payment adjustment must be defined, if applicable, and a valid code combination should be selected for all remittance advice messages.

The following code revisions were made:

| | | |
|---|---|---|
| **When a MAC rejects an out of jurisdiction professional claim as unprocessable** | • Group Code of CO<br>• CARC 109<br>• RARC N104 | Previously, RARC MA130 was used on the explanation of benefits (EOB) when one of these 3 situations occurred.<br><br>Effective October 1, 2016, when any of the situation listed occurs, MA130 will be replaced with the updated CARC codes in the middle column to the left. |
| **When a MAC rejects misdirected Railroad Retirement Board claims as unprocessable** | • Group Code of CO<br>• CARC 109, and<br>• RARC N105 | |
| **When a MAC rejects misdirected United Mine Workers Association claims as unprocessable** | • Group Code CO<br>• CARC 109, and<br>• RARC N127 | |

To view the official instruction #CR9578 issued to your Medicare Administrative Contractor (MAC) regarding this change, please visit *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3510CP.pdf*.

**Now you are In The Know!**

American Academy of Dermatology
PO Box 4014
Schaumburg, Illinois 60168-4014