



# Derm Coding Consult

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## 2018 ICD-10-CM Updates

The use of ICD-10-CM codes has expanded from classifying morbidity and mortality information for statistical purposes to diverse sets of applications in research, health care policy, and health care finance. Due to widespread industry changes and initiatives, coding and clinical processes continue to evolve.

With only a few short months left for dermatology practices to implement the 2018 ICD-10-CM coding updates, the AAD coding team members are here to help and provide timely coding updates that will impact your dermatology practice in 2018.

For a detailed list of updated and/or revised codes, please see <https://www.aad.org/aad-store>.

It is of importance to note that there are constant changes to code listings and changes can occur in many different ways. Some of these changes can occur in the shape of new code additions, code revisions, code descriptor revisions, grammatical changes and on occasion changes can be as subtle as an addition or deletion of a punctuation sign such as a comma or a semicolon within a code descriptor. Below is a summary of the diagnoses coding changes that are of importance in a dermatology setting.

### Chapter 4 – Endocrine, Nutritional and Metabolic Diseases

The endocrine, nutritional and metabolic diseases section was moderately updated to include conditions missing from previous versions of ICD-10-CM. Of note to dermatology, there is additional information to

**E78.00** - *Pure hypercholesterolemia, unspecified which now includes (Pure) hypercholesterolemia NOS.*

### Chapter 5 – Mental, Behavioral and Neurodevelopmental Disorders

#### Substance Use Disorders, In Remission

Distinguishing between a current substance use disorder and one that is in remission (i.e., full criteria have been met in the past but currently the patient is no longer experiencing symptoms) is important for both clinical treatment and statistical reporting purposes. Recent editorial updates in this chapter include such things as distinguishing between a patient who is in mild early remission from a patient who is in mild sustained remission; a patient who is in moderate early remission from one who is in moderate sustained remission; and a patient who is in severe early remission from one that is in severe sustained remission. Dermatologists may report these codes as an additional diagnosis to describe

associated mental or behavioral illness that impacts care or treatment of the skin condition. The following updates are included to address and further harmonize the ICD-10-CM code set with the DSM-5 clinical criteria for diagnosing substance use disorders:

- F10 Alcohol related disorders
- F11 Opioid related disorders
- F12 Cannabis related disorders Includes: marijuana
- F13 Sedative, hypnotic, or anxiolytic related disorders
- F14 Cocaine related disorders
- F15 Other stimulant related disorders
- F16 Hallucinogen related disorders
- F17 Nicotine dependence
- F18 Inhalant related disorders
- F19 Other psychoactive substance related disorders

### Chapter 9 – Diseases of the Circulatory System

There are multiple revisions to the diseases of the circulatory system section. For dermatologists, category *I83 – Varicose veins of lower extremities* has been revised to reflect a single extremity which includes revisions from the word 'extremities' to 'extremity' in the code descriptors.

### Chapter 12 - Diseases of the Skin and Subcutaneous Tissue

Dermatologists routinely refer to the diseases of the skin and subcutaneous tissue section of the diagnosis coding

— see **ICD-10-CM** on page 2

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#### IMPORTANT Please Route to:

Dermatologist    Office Mgr    Coding Staff    Billing Staff

# 2018 ICD-10-CM Updates

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manual. Most notably, a few additions and revisions have been included to improve the coding structure in the following categories:

- L57 Skin changes due to chronic exposure to nonionizing radiation
- L89 Pressure ulcer
- L92 Granulomatous disorders of skin and subcutaneous tissue
- L97 Non-pressure chronic ulcer of lower limb, not elsewhere classified
- L98 Other disorders of skin and subcutaneous tissue, not elsewhere classified

## Chapter 17 - Congenital Malformations, Deformations and Chromosomal Abnormalities

Among the revisions, deletions and additions to category Q82 - Other congenital malformations of skin, it is worth noting that within this chapter Q82.2 Mastocytosis and its inclusion note were revised. In 2018 Q82.2 has been revised to Congenital cutaneous mastocytosis. The updated inclusion note allows use of this code to report congenital urticaria pigmentosa. Non-congenital urticaria pigmentosa will be reported with D47.01

## Chapter 18 - Symptoms, Signs and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified

This section has several additions to it. For dermatology coding, the following categories include relevant updates:

- R53 Malaise and fatigue
- R60 Edema, not elsewhere classified

## Chapter 19 – Injury, Poisoning and Certain Other Consequences of External Causes

There are a few updates you will need to pay attention to under the Injury, poisoning and certain other consequences of external causes section. It is important to note that codes in this chapter pertain to traumatic wounds and are not used to report surgical wounds. A few of the updates are highlighted under the following categories:

- S00 Superficial injury to the head
- S01 Open wound of head
- T07 Unspecified multiple injuries
- T14 Injury of unspecified body region

## Chapter 20 - External Causes of Morbidity

Other than the relief that code X50 – overexertion and strenuous or repetitive movements and the external cause of morbidity has now been deleted, there are some other additions to the external causes or morbidity section you may be interested in knowing about. Check out the following external cause code categories:

- V86 Occupant of special all-terrain or other off-road motor vehicle, injured in transport accident
- W29 Contact with other powered hand tools and household machinery
- X19 Contact with other heat and hot substances
- X32 Exposure to sunlight ❖

# Understanding Phototherapy Services

## What is the difference between CPT 96900 and 96910 and when is each code appropriate?

Understanding how phototherapy services differ allows for accurate coding and clear documentation of this important treatment modality in dermatology practice. During the delivery of both the 96900 and 96910 services, ultraviolet phototherapy is performed. However, the critical distinction between the codes lies in what services are provided by the medical staff.

### CPT 96900 – Actinotherapy

Prior to actinotherapy, no application of tar, petrolatum, or other light effect enhancing agent occurs in the office.

### CPT 96910 – Photochemotherapy; tar and ultraviolet B (Goeckerman treatment) or petrolatum and ultraviolet B

Prior to photochemotherapy, application of tar, petrolatum, or other light effect enhancing topical product occurs within the office, by staff or patient.

— see **PHOTOTHERAPY** on page 3

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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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# Understanding Phototherapy Services

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The key delineation between these two phototherapy codes is dependent on whether application of the topical product occurs during the office encounter or prior to the arrival to the office.

To that end, it is important for a physician to indicate in their clinical notes if the application of topical product occurred in-office and if a patient was offered or required assistance in the application of product. When providing photochemotherapy, it is understood that staff is available to assist the patient with topical applications, positioning and appropriate shielding. However, for privacy or other reasons, patients may prefer to perform these activities themselves.

If your office routinely provides phototherapy services, it is recommended that you develop standard operating procedures which could include a form indicating:

- What topical agent was applied, if any
- To what areas the topical product was applied
- Who applied the topical product
- If the patient applied the topical, document that assistance was offered and refused

These descriptors were prepared by the Phototherapy Documentation Workgroup, a workgroup formed by the American Academy of Dermatology Association. ❖

## 2018 CPT Coding Updates

For 2018, there are a few changes and new codes included in the CPT book that will impact dermatology. For example, CPT code 96567 will include editorial changes and two new codes will be introduced. The first new PDT code will identify photodynamic therapy where the photosensitizing agent is applied by the physician or qualified healthcare provider and the second addresses photodynamic therapy in which the provider debrides hyperkeratotic lesions prior to treatment. The American Medical Association CPT Editorial Panel also approved 2 category III codes for fractional ablative laser fenestration of burn scars.

The new and revised codes are highlighted below (final code numbers will be available by CPT in November 2017).

### Category I Medicine Photodynamic Therapy

▲96567 Photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitive drug(s), per day

This code should be used when a physician or qualified healthcare provider is not directly involved in providing the PDT treatment.

●96X73 Photodynamic therapy by external application of light to destroy premalignant lesions of the

skin and adjacent mucosa with application and illumination/activation of photosensitizing drug(s) provided by a physician or other qualified health care professional, per day (Do not report 96567, 96X74 with 96X73 for the same anatomic area)

●96X74 Debridement of premalignant hyperkeratotic lesion(s) (ie, targeted curettage, abrasion) followed with photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitizing drug(s) provided by a physician or other qualified health care professional, per day (Do not report 96567, 96X73 with 96X74 for the same anatomic area).

### Fractional laser fenestration of burn and traumatic scars Category III

●01XXT Fractional ablative laser fenestration of burn and traumatic scars for functional improvement; first 100 cm<sup>2</sup> or part thereof, or 1% of body surface area of infants and children

+●02XXT each additional 100 cm<sup>2</sup>, or each additional 1% of body surface area of infants and children, or part thereof (List separately in addition to code for primary procedure)

(Use 02XXT in conjunction with 01XXT)

(Report 01XXT, 02XXT only once per day)

(For excision of cicatricial lesion(s) [eg, full thickness excision, through the dermis], see 11400-11446)

For more information, please see the 2018 AAD Coding and Billing Manual (Formerly AAD Coding and Documentation Manual). ❖

## Consultations Versus Referrals of Care

Determining when an encounter is truly a consultation or a referral is often confusing. This is in part due to the language used by the physician or non-physician practitioner when sending the patient to a dermatology practice. However, being able to differentiate between these two types of encounters is of extreme importance.

Consultation services (CPT Codes 99241 – 99245) have a higher RVU (Relative Value Unit) than Outpatient or Office encounter codes (CPT Codes 99201 – 99215). This means that the consultation codes are reimbursed at a higher value than comparable office encounter codes. Not having a clear understanding between a consultation and other Evaluation and Management (E/M) services may be costly to a practice.

There are three crucial points that help to identify and determine if a service provided is in actuality a consultation service. The first step is determining who initiated

— see **CONSULTATIONS** on page 4

## Consultations Versus Referrals of Care

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the encounter. Consultations must be requested by an appropriate source, such as a physician, physician's assistant, nurse practitioner or other eligible practitioner. Second opinions at the request of the patient or a family member do not constitute a consultation. If the patient states that a physician or other applicable source requested they see a dermatologist, additional information regarding the requesting provider's intent for the visit must be determined to meet the requirement of a consultation. Per CPT guidelines, the purpose of a consult service is to offer an opinion or advice regarding the patient's condition or to assist in determining a treatment plan for the condition.

A written request labeled "Consult and Treat" can be misleading and unclear as to the other provider's purpose for the patient's encounter with the dermatologist. Although initial treatment can occur during a consultation, continued or follow-up visits should be at the direction of the original provider. Continuing to follow-up with the patient after the initial treatment negates the intent of a consult service. If you're unsure of the intention of the encounter, seek clarification from the requesting provider prior to rendering the service.

The second requirement to determine a consultation service is rendering the service. The final requirement is reporting back to the requesting provider. Both of these requirements are fulfilled by writing and submitting a detailed letter of findings (in the office setting), or written report (in a large multi-specialty group), to the requesting provider. Typically, the letter or report will begin with a statement of appreciation for allowing you to see the patient in consultation. Exam findings, assessment, and recommendations for treatment should be included in the letter or written report.

In a multi-specialty group, one dermatologist may request a consultation from another provider in the same group practice. The consulting dermatologist must have expertise in a sub-specialty beyond the requesting physician's or appropriate source's knowledge.

Finally, it is important to note that Medicare does not allow or reimburse for Consultation services. When providing a consultation for a Medicare beneficiary, report the service with another appropriate E/M code such as New or Established Office or Other Outpatient Services (CPT codes 99201-99213). ❖

## Updated Advance Beneficiary Notices of Non coverage (ABNs) Forms

In March 2017, the Office of Management and Budget (OMB) approved the renewal of the Advance Beneficiary Notice of Non Coverage, Form CMS-R-131, and its instructions. These forms are reviewed every three years by law. In the current edition, there are no substantive changes to the form. However, the form expiration date has been advanced to March, 2020. The date (3/2020) can be found on the bottom left of the form. Additionally, as mandated by law, the following statement has been added to the form: *"CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: [AltFormatRequest@cms.hhs.gov](mailto:AltFormatRequest@cms.hhs.gov)."*

The use of the ABN is required by Medicare to give notice to patients that a service may not be paid by Medicare and allows the patient the option to have the service rendered as self pay, or refuse the service. Patients need to be made aware of their financial responsibility before they sign the ABN. The practice can then bill the patient based on the practice rate for the service rendered which may be higher than Medicare allows for that particular service. With a signed ABN, the practice has proof of the patient's informed consent to provide the service and their agreement to be financially responsible for the service. These forms are only to be used on Medicare Fee for Service or Traditional Medicare patients (Part A and B.)

As of June 21, 2017, Providers must use the correct CMS-R-131 (03/2020) form which can be copied on the practices letterhead. It must be given to the patient in advance before the service is rendered to allow them time to decide, and must cover all the potential non-covered services that are being provided. Repetitive notices are acceptable, if necessary. The ABN may be completed prior to the patient's arrival for the provider's convenience (Blanks A-F), with the beneficiary or representative responsible for filling out their section (Blanks G-I). Keep a copy of the ABN in the patient's file for documentation purposes. A copy must also be provided to the patient.

If an ABN is not given to the patient and Medicare denies the service, the practice will have to write off the service as the patient cannot be held responsible. The only exceptions allowable are the services that Medicare never pays for which are referred to as "statutorily excluded" services. Examples of "statutorily excluded" services common for dermatology would be cosmetic surgery or conditions that do not meet medical necessity like non inflamed SK or skin tags that the patient doesn't like. If the service is cosmetic, not reasonable or medically necessary, no ABN is needed. In these cases, having the patient sign a financial waiver of responsibility would be a better choice for a non-covered service.

Should the patient ask for their non-covered service claim to be filed, the practice must file it due to the regulations in the Social Security Act. It's important to report this non covered service correctly so it doesn't get paid or denied. The simplest way is to report the procedure with the diagnosis code Z41.8 - Encounter for other procedure for purposes other than remedying health state. Also add the GY modi-

— see **ABNS** on page 4

# Updated Advance Beneficiary Notices of Non coverage (ABNs) Forms

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fier- Non covered service with no Medicare responsibility to the procedure code. Modifier explanations are below.

ABNs are not to be used in place of the regular patient financial consent and are not required for care that is either statutorily excluded from coverage under Medicare (i.e. care that is never covered) or fails to meet a technical benefit requirement (i.e. lacks required certification). For example:

- Care that fails to meet the definition of a Medicare benefit as defined in §1861 of the Social Security Act;
- Care that is explicitly excluded from coverage under §1862 of the Social Security Act which among others includes:
  - o Services for which there is no legal obligation to pay;
  - o Services paid for by a government entity other than Medicare (this exclusion does not include services paid for by Medicaid on behalf of dual-eligibles);
  - o Personal comfort items;
  - o Routine physicals and most screening tests

The latest version of the ABN (with the release date of March 2017 (3/2020) printed in the lower left hand corner) is now available and its effective date for use is on June 21, 2017.

To download a customizable version and view further instructions on use and completion of the ABN, please visit: [https://www.cms.gov/BNI/02\\_ABN.asp](https://www.cms.gov/BNI/02_ABN.asp) ❖

## ABN Claim Reporting Modifiers

GA: Waiver of Liability Statement Issued as Required by Payer Policy, Individual Case

Report when you issue a mandatory ABN for a service as required and it is on file. Append this modifier to codes for services that may not be covered by Medicare. You do not need to submit a copy of the ABN, but you must have it available on request and give a copy to the patient.

GX: Notice of Liability Issued, Voluntary Under Payer Policy

Report when you issue a voluntary ABN for a service Medicare never covers because it is statutorily excluded or is not a Medicare benefit. You may use this modifier in combination with modifier GY.

GY: Item or Service Statutorily Excluded, Does Not Meet the Definition of Any Medicare Benefit

Report that Medicare statutorily excludes the item or service or the item or service does not meet the definition of any Medicare benefit. You may use this modifier in combination with modifier GX.

GZ: Item or Service Expected to Be Denied as Not Reasonable and Necessary

Report when you expect Medicare to deny payment of the item or service due to a lack of medical necessity and no ABN was issued. ❖

## FAQs

**Q) I just received a Medicare denial as duplicate procedure when billing for two excisions, 11401 listed on two separate claim lines, one with Modifier 59. What's wrong?**

A) Although the NCCI was initially developed for use by Medicare Carriers (A/B MACs processing practitioner service claims) to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment of Part B claims, the application of the NCCI guidelines may vary from payer to payer. In order to ensure one is reporting the correct modifier for the individual payer, please check payer policies for clarification.

In response to the inquiry above, there is a possibility that the payer may have been looking for the use of modifier 76 instead of modifier 59. Here is why:

Modifier 76 is reported to communicate that a service or procedure was repeated by the same practitioner to the same patient on the same date of service (DOS) subsequent to the original procedure or service. In practice, the modifier may be used when a procedure with exactly the same code descriptor was done more than once, but on separate, distinct lesions/locations. Without the modifier, subsequent reporting of the same procedure by the same provider could mistakenly be interpreted and denied as a duplicate service. See CMS announcement through MLN SE1314 at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1314.pdf>

On July 1, 2013, the use of Modifier 59 was modified to indicate that it can only be used, when medically necessary, to unbundle a procedure code that has been bundled related to the National Correct Coding Initiative (NCCI). Claims billed with the same procedure code e.g. 11401 as indicated in your inquiry above, two or more times for the same date of service, by the same provider, should be submitted with an appropriate repeat procedure modifier. According to Medicare, to avoid inappropriate duplicate claim denial, rather than using Modifier 59, Modifier 76 should be used to report a service or procedure that was repeated by the same practitioner subsequent to the original service or procedure e.g. 11401, 11401-76.

Similarly, if multiple same laboratory or pathology services are reported, Modifier 91 is used to report repeat laboratory tests or studies performed on the same day to the same patient by the same provider. Remember Modifiers 76 and 91 do not replace anatomical modifiers such as RT, LT, 50, E1-E4, FA, F1-F9, TA, and T1-T9.

If billing a procedure code two or more times for the same date of service, the claim should be submitted with the procedure code listed on one line without

— see **FAQ** on page 6

modifier 76 or 91 and each subsequent procedure listed on a separate line using the Modifier 76 or 91 accordingly. This is reflected in the CMS IOM Manual 100-04, chapter 1, section 120: Transmittal 2678, CR 8121 - The claims processing systems contain edits which identify exact duplicate claims and suspect duplicate claims. All exact duplicate claims or claim lines are auto-denied or rejected (absent appropriate modifiers). Suspect duplicate claims and claim lines are suspended and reviewed by the claims administration contractors to make a determination to pay or deny the claim or claim line. See complete instruction at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf>

It is still questionable whether the maximum unit can be reported on the first claim line and additional units beyond the Medically Unlikely Edit (MUE) allowable reported on the next claim line with modifier 91. For example, the MUE of a CPT code 88342 is 3 units per date of service. If four or more units are performed on the same date of service, the additional units beyond the first three units may be reported with the same CPT code and the appropriate modifier on a subsequent claim line. Some contractors may prefer this is reported on a single claim line in units with the use of the appropriate modifier. Please check your local Medicare contractor for more information.

Sometimes, your local Medicare carrier may prefer the use of one of the X{EPSU} modifiers in lieu of modifier 59 or 76 to report multiple procedures. When necessary, and if your payer allows the use of X{EPSU} modifiers, please review MedLearn MM8863 which states that the X-modifiers do not replace modifier 59, cannot be reported with modifier 59 and should never be required if one of the “more specific” modifiers is appropriate. Check your local contractor for specific instructions on the use of the X{EPSU}.

There has been a great deal of confusion around the appropriate use of the X modifiers with no clear guidance nor clarification on their appropriate use from CMS. Because of the uncertainty, CMS issued updated instructions (MLN SE1503 - <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1503.pdf>) to allow continued use of Modifier 59 until there are more specific details issued from your local Medicare carrier.

To avoid unwarranted duplicate claim denials and lack of proper use of modifiers, please check with your local Medicare carrier for specific instructions.

Other reference:  
See Spring 2015 *Derm Coding Consult*, page 2 at <https://www.aad.org/members/publications/derm-coding-consult>

**Q) A new physician has joined our practice and is waiting to be credentialed with our managed care plans. How should we bill for this physician’s services?**

A) Until the new physician is accepted or credentialed by the managed care plan(s) he or she may not bill that plan. Since this is a different employee hire, it would not be appropriate to bill for that physician’s services under another physician’s ID number.

A claim is submitted only by the physician who provided the service.

Usually commercial payers will allow you to hold claims and file them retroactively to the original credentialing application date. Medicare however, only allows for thirty days from the credentialing approval date.

**Q) What is the proper ICD-10-CM code for dysplastic nevus?**

A) The most appropriate answer is, it depends on information contained in the clinical documentation or the pathology report. In ICD-10-CM dysplastic nevi are coded as a benign neoplasm (D23.-). However, should the clinical exam as documented in the medical record or should the pathology report identify uncertainty regarding the malignant potential of the lesion, the more appropriate code to report is D48.5 – neoplasm of uncertain behavior. Documentation of the encounter may also identify lesions suspicious for malignancy based on lesion appearance or in consideration of patient past medical history of malignant neoplasms which increase the likelihood of malignant behavior in the new lesion. In the pathology report, uncertainty may be communicated in terms of differential diagnoses.

**Q) How do we report a re-excision to clear margins when pathology yields dysplastic nevus?**

A) Although the lesion may be considered suspicious, it is not confirmed as a malignant lesion. Therefore, the excision of benign lesion codes would be appropriate and not the excision of malignant lesion codes. However, a dysplastic nevus has uncertain malignant potential. Consequently, D48.5 is also appropriate.

**Q) If multiple lesions are being excised, is it appropriate to add the lesion sizes and margins and report one excision code?**

A) No. Each lesion plus the narrowest margin to fully excise the lesion is reported separately. The only time lesions may be combined is when through one excision, two lesions are excised. That, of course, would be when the two lesions are in extremely close proximity and only one excision is required to remove both lesions. In such an instance, the lesion sizes and margins would be added together and reported with one code.

**Q) Does the Academy have any information on Whole body photography?**

A) Since the Medicare fee schedule lists this service as a restricted “R” code, each Medicare Administrator Carrier is allowed to decide if there is coverage. This leaves little available information on 96904, Whole Body Phototherapy.

The AAD’s Coding and Documentation Manual describes this procedure as:

“Whole body photography, also known as full-body photography, full-body screening, photographic surveillance or dermal screening, involves the taking of photographs of specific lesions or of the whole body, in order to identify suspicious areas which might be malignant melanoma, the most virulent form of skin cancer (causing 75% of all skin cancer related deaths) at the earliest possible stage. Whole body photography

## FAQs

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is most often used for high-risk patients, while single-lesion pictures might be used for monitoring a particular mole or moles when biopsy does not seem warranted”

There may be commercial payers who do cover 96904, please check with them directly.

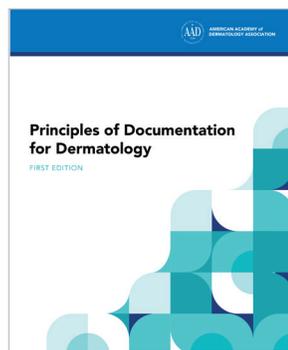
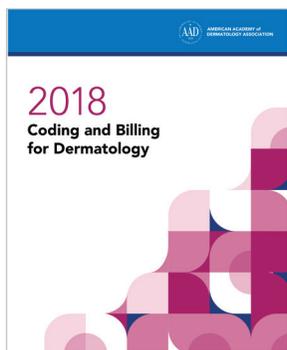
### Q) What is the best ICD-10 code for a suture removal for the following:

**Scenario 1: Pt had Mohs surgery for BCC of the nose (Dx: C44.311). Returns to office for suture removal. We are using CPT 99024 (Post Op F/U visit, no charge). Would the primary dx code be Z48.02 (Encounter for removal of sutures) and the second dx code be hx of BCC (Z85.828) or the BCC Dx (C44.311), since the condition is still receiving treatment with the suture removal?**

**Scenario 2: Pt had facial excision for BCC (Dx C44.319), returns to office for suture removal. Again, using 99024 (Post Op F/U, no charge), should we use Z48.02 (Encounter for removal of sutures)?**

- A) 99024 identifies that the encounter is part of the post op service and has no reimbursement value. This code is usually posted for tracking purposes to note that the patient returned for follow-up related to the surgical procedure. As a post-procedural follow-up visit(s) is still part of the treatment plan, continue to report the original diagnosis for the lesion. The reporting of the original diagnosis would also be appropriate for re-excisions, even if the final pathology came back as a scar. The reason for re-excision was that the findings of the first excision were not clear of the malignancy, supporting continued reporting of the lesion. As the minor and major surgical packages include payment for suture removal, this service should not be billed for even if performed after the global period has ended.” Mohs, Shaves and biopsies have zero global days and 99024 should not be used to report encounters after these procedures as there are no post op values included in these codes. ❖

## AADA Adds Two New Coding Titles for 2018



The medical coding landscape has changed dramatically in the past few years. In 2018, we will see even more

changes to codes and processes as they relate to accurate claims submissions. The AADA has addressed the upcoming changes by expanding its coding library with the debut of a new resource, 2018 Coding and Billing for Dermatology. This next generation manual, written by AADA's coding experts specifically for dermatology practices, contains the same great content you've come to expect from previous AADA coding resources. Inside you will find everything you need to accurately complete your claims in 2018, such as tips to minimize coding errors and reduce claim denials, modifier use, how to understand and use the CMS National Correct Coding (NCCI) and Medically Unlikely Edits (MUEs) tables. This exclusive resource also features AMA CPT® procedure codes and guidelines specific to dermatology, ICD-10-CM diagnoses, HCPCS codes, and modifier tips and examples.

Another great resource to add to your coding library in 2018 is Principles of Documentation for Dermatology, First Edition. This new resource, also written by AADA's coding experts, contains documentation specifications for CPT® and ICD-10-CM, vignettes and sample cases that demonstrate good, better, best required documentation, and dermatology-specific quality measures that you can easily apply to your practice.

The AADA has you fully covered when it comes to coding correctly in 2018 with these two, dynamic new resources designed with dermatology specialty good practices in mind. Make sure your practice is ready to implement the upcoming coding, billing and documentation mandates by reserving your copy now! Visit [store.aad.org](http://store.aad.org) today! ❖

## In the Know...

### Medicare Provider Enrollment Revalidation

Section 6401(a) of the Affordable Care Act established a requirement for all enrolled providers/suppliers to revalidate their Medicare enrollment information under new enrollment screening criteria. In an effort to streamline the revalidation process and reduce provider/supplier burden, the Centers for Medicare & Medicaid Services (CMS) has implemented several revalidation processing improvements.

1. Check <http://go.cms.gov/MedicareRevalidation> for the provider/suppliers to confirm whether physician or qualified healthcare professional (QHP) is due for revalidation;
2. If the QHPs due date is listed, it is highly recommended that you submit your revalidation within six months of your due date or when you receive notification from your Medicare Administrative Contractor (MAC) to revalidate.

Sometimes, the MAC will send a revalidation notice within 2-3 months prior to the revalidation due date via email. The email notification will:

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## In the Know...

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- identify organizations to which individual QHPs reassign benefits;
- be sent to email addresses reported on QHPs prior applications, or
- be sent via postal mail to at least two of your reported addresses on file

### How To Revalidate

Revalidate your entire enrollment record, including:

- ✓ All active practice locations
- ✓ Current reassignments

For more details, see the Revalidation checklist at <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/RevalidationChecklist.pdf>

### When To Revalidate?

Revalidations are due on the last day of the month (i.e.: June 30, July 31, August 30, etc). QHPs are expected to submit their revalidation application by this date. Generally, this due date will remain constant for each QHP throughout all subsequent revalidation cycles.

CMS offers several ways to view and group the revalidation dates of every provider. To find out your revalidation due date, visit <https://data.cms.gov/revalidation> - it lists all currently enrolled providers/suppliers and their revalidation due date

- Due Dates are updated every 60 days at the beginning of the month
- Due Dates are listed up to 6 months in advance
- Due Dates that are not yet assigned will be listed as – To Be Determined (TBD) (more than 6 months until the due date)
  - ❖ If you are within 2 months of the listed due date on [Data.CMS.gov/revalidation](https://data.cms.gov/revalidation) but have not received a notice from their MAC to revalidate, you are encouraged to submit your revalidation application.

### How to Submit the Revalidation Form

- Through Internet-based PECOS located at <https://pecos.cms.hhs.gov/pecos/login.do>, This is 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

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certification statement and mail it along with your supporting documentation to your MAC; or

- Complete the appropriate CMS-855 application, downloadable at <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html>;
- Where applicable, pay your fee by going to <https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do>; and
  - ❖ Respond to all development requests from your MAC in a timely manner to avoid a hold on your Medicare reimbursements and possible deactivation of your Medicare billing privileges.

Do not submit a revalidation if:

- You have not received an email/mailed letter from your MAC requesting you to revalidate
- Due date is not listed on [data.CMS.gov/revalidation](https://data.cms.gov/revalidation)
  - ❖ Unsolicited revalidations will be returned

If your intention is to submit changes to your provider enrollment record, submit a 'change of information' application using the Internet Based PECOS or the appropriate CMS-855 form.

### Now You Are In The Know!