What Is the Qualified Medicare Beneficiary (QMB) Program?

The Qualified Medicare Beneficiary (QMB) program is one of four Medicare savings programs established by Medicare to help beneficiaries of modest means pay for all, or some of Medicare’s cost sharing amounts (i.e., premiums, deductibles, and copayments) through assistance from the state.

The QMB program is subject to the federal poverty level (FPL) guidelines, and benefactor eligibility to the program, each of which may change yearly. In order to qualify for QMB benefits, the beneficiary must meet federally established income requirements. It is important to note that under certain circumstances, federal law allows states to limit their liability to providers for Medicare deductibles, co-insurance, and copayments.

The program pays the coinsurance, deductible, and co-payment amount for covered services for Medicare Part A and B. Per CMS “Medicare providers and suppliers may not bill people in the QMB program for Medicare deductibles, coinsurance, or copays, but state Medicaid programs may pay for those costs.” Therefore providers, even those who are not contracted with their state Medicaid program, are not allowed to bill a QMB for either the provider’s customary charges for Medicare Part A or Part B services or the balance of the allowed Medicare rate. Therefore, Medicare and Medicaid payments made for services rendered to a QMB are considered as payment in full.

In 2016, 7.5 million individuals (more than one out of eight beneficiaries) were enrolled in the QMB program. These beneficiaries are protected from liability for Medicare Part A and Part B charges, even when the provider fee is less than the Medicare rate. Providers who balance bill a qualified QMB beneficiary above what is considered payment in full, are inviting sanctions under the Social Security Act, which defends the beneficiary's rights. For example, if the provider’s charge is $150 and Medicare’s approved amount is $100 and the allowed amount is $80, the provider can only bill the patient for $20, which is the balance of the approved amount of $100. The remaining balance of the provider’s charge of $50 cannot be billed to the patient, as it is considered an adjustment. However, with QMB Beneficiaries, the patient balance may be paid by Medicaid. If not, the remaining balance of $20 is also considered an adjustment, and cannot be billed to the patient.

Eligibility requirements for the QMB program vary by state. Generally, the applicant must be enrolled in Medicare Part A and satisfy the income and assets guidelines under the FPL. If the applicant is not enrolled in Part A but meets other eligibility guidelines, the applicant’s home state will institute a process for the applicant to enroll in Medicare

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IMPORTANT Please Route to:
___ Dermatologist  ___ Office Mgr  ___ Coding Staff  ___ Billing Staff
**What Is the Qualified Medicare Beneficiary (QMB) Program?**

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Part A and the QMB program. To determine eligibility, income and assets are calculated differently by individual states. General income limits for 2018 are $1032 per month for individuals and $1,392 per month for married couples. Resource limits for the QMB program are $7,560 for one person and $11,340 for married couples. Stocks, bonds, and money held in checking or savings accounts are included in this determination. An applicant’s home, car, furniture, household and personal items are not included as part of the resource limits.

Last October, the Centers for Medicare & Medicaid Services (CMS) alerted providers that the QMB remittance advice (RA) service was interrupted because a claim-processing error affecting secondary payers. A more recent notice (CR10433), effective July 2, 2018, notifies that CMS has reinstated the QMB information in the RA and modified notice CR9911 to avoid disrupting claims processing by secondary payers.

Under CR10494, Medicare administrative contractors (MACs) will initiate non-monetary mass adjustments for claims impacted by CR 9911 QMB RA updates prior to December 31, 2017, that have not been voided or replaced. These claims processed with the QMB information will be identified and automatically reprocessed. No provider action will be necessary. (Refer to MM10494 issued by CMS for additional details).

CR 9911 changed the Medicare summary notice (MSN) to include new messages for QMB that reflect $0 cost-sharing liability for the provider’s enrollment period. CMS modified the RA to include new remittance advice remark codes (RARC) to alert providers to refrain from collecting Medicare cost-sharing when the patient is a QMB participant.

- N781 is associated with deductible amounts and
- N782 is associated with coinsurance.


**2019 ICD-10-CM Updates**

Unlike 2018 ICD-10-CM code updates, 2019 includes large number of the new and/or updated diagnosis codes that pertain to dermatology. In this article we focus on introducing the new categories/subcategories that will impact your dermatology practice on October 1, 2018.

**Chapter 2 – Neoplasms**

Neoplasms often occur on eyelids. Although laterality may be sufficient in reporting some eye conditions, eyelid neoplasms must be reported by describing the actual eyelid involved as well as laterality.

Below are some examples of the proposed updates to the neoplasm code categories that help provide eyelid specificity for better data collection and documentation:

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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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## 2019 ICD-10-CM Updates

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<table>
<thead>
<tr>
<th>Category</th>
<th>Sub-category</th>
<th>Description</th>
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<th>Description</th>
<th>New Code</th>
<th>Description</th>
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<td>C43</td>
<td>C43.11</td>
<td>Malignant melanoma of right eyelid, including canthus</td>
<td>C43.111</td>
<td>Malignant melanoma of right upper eyelid, including canthus</td>
<td>C43.112</td>
<td>Malignant melanoma of right lower eyelid, including canthus</td>
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<tr>
<td></td>
<td>C43.12</td>
<td>Malignant melanoma of left eyelid, including canthus</td>
<td>C43.121</td>
<td>Malignant melanoma of left upper eyelid, including canthus</td>
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<td>Malignant melanoma of left lower eyelid, including canthus</td>
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<td>C4A</td>
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<td>Merkel cell carcinoma of right upper eyelid, including canthus</td>
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<td>C44.1021</td>
<td>Unspecified malignant neoplasm of skin of right upper eyelid, including canthus</td>
<td>C44.1022</td>
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<td>C44.1091</td>
<td>Unspecified malignant neoplasm of skin of left upper eyelid, including canthus</td>
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<td>Basal cell carcinoma of skin of left lower eyelid, including canthus</td>
</tr>
<tr>
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<td>C44.13</td>
<td>Sebaceous cell carcinoma of skin of eyelid, including canthus</td>
<td>C44.131</td>
<td>Sebaceous cell carcinoma of skin of unspecified eyelid, including canthus</td>
<td></td>
<td></td>
</tr>
<tr>
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<td>C44.132</td>
<td>Sebaceous cell carcinoma of skin of right eyelid, including canthus</td>
<td>C44.1321</td>
<td>Sebaceous cell carcinoma of skin of right upper eyelid, including canthus</td>
<td>C44.1322</td>
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<td>C44.1391</td>
<td>Sebaceous cell carcinoma of skin of left upper eyelid, including canthus</td>
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<td>Sebaceous cell carcinoma of skin of left lower eyelid, including canthus</td>
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<td>C44.1921</td>
<td>Other specified malignant neoplasm of skin of right upper eyelid, including canthus</td>
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<td>C44.199</td>
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<td>C44.1991</td>
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<td>Other specified malignant neoplasm of skin of left lower eyelid, including canthus</td>
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<tr>
<td>D03</td>
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<td>Melanoma in situ of right eyelid, including canthus</td>
<td>D03.111</td>
<td>Melanoma in situ of right upper eyelid, including canthus</td>
<td>D03.112</td>
<td>Melanoma in situ of right lower eyelid, including canthus</td>
</tr>
<tr>
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<td>D03.12</td>
<td>Melanoma in situ of left eyelid, including canthus</td>
<td>D03.121</td>
<td>Melanoma in situ of left upper eyelid, including canthus</td>
<td>D03.122</td>
<td>Melanoma in situ of left lower eyelid, including canthus</td>
</tr>
<tr>
<td>D04</td>
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<td>Carcinoma in situ of skin of left upper eyelid, including canthus</td>
<td>D04.122</td>
<td>Carcinoma in situ of skin of left lower eyelid, including canthus</td>
</tr>
<tr>
<td>D22</td>
<td>D22.11</td>
<td>Melanocytic nevi of right eyelid, including canthus</td>
<td>D22.111</td>
<td>Melanocytic nevi of right upper eyelid, including canthus</td>
<td>D22.112</td>
<td>Melanocytic nevi of right lower eyelid, including canthus</td>
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<tr>
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<td>Melanocytic nevi of left upper eyelid, including canthus</td>
<td>D22.122</td>
<td>Melanocytic nevi of left lower eyelid, including canthus</td>
</tr>
<tr>
<td>D23</td>
<td>D23.11</td>
<td>Other benign neoplasm of skin of right eyelid, including canthus</td>
<td>D23.111</td>
<td>Other benign neoplasm of skin of right upper eyelid, including canthus</td>
<td>D23.112</td>
<td>Other benign neoplasm of skin of right lower eyelid, including canthus</td>
</tr>
<tr>
<td></td>
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<td>D23.121</td>
<td>Other benign neoplasm of skin of left upper eyelid, including canthus</td>
<td>D23.122</td>
<td>Other benign neoplasm of skin of left lower eyelid, including canthus</td>
</tr>
</tbody>
</table>
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Chapter 6 – Diseases of the Nervous System
This section has been expanded to include the subcategory “Breakthrough pain.” Breakthrough pain is defined as transient severe exacerbation of pain that occurs in patients whose baseline pain is otherwise tolerable or stable chronic pain controlled by around-the-clock analgesics, usually including treatment with opioids. This definition differentiates breakthrough pain from recurrent acute pain and from chronic pain that is not yet sufficiently managed. Although initially identified in patients with chronic cancer pain, breakthrough pain is now also recognized in patients with chronic pain of non-cancer-related origin such as arthritis. By itself, breakthrough pain is associated with greater functional impairment and disability. Updates are included in category **G89** – Pain, not elsewhere classified to include the new **breakthrough pain** code **G89.13**.

Chapter 7 – Diseases of the Eye and Adnexa
The current ICD-10-CM individual eyelid specificity codes are challenging to apply to inflammatory dermatoses. Blepharitis most often involves both upper and lower eyelids of the same side. A single code indicating that both eyelids are affected, with laterality, reduces the number of codes needed on a claim to report the condition. As such, the following modifications are included under the following subcategory:

<table>
<thead>
<tr>
<th>Category</th>
<th>New Code</th>
<th>Description</th>
<th>New Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H01.00 Unspecified blepharitis</td>
<td>H01.00A</td>
<td>Unspecified blepharitis, right eye, both eyelids</td>
<td>H01.00B</td>
<td>Unspecified blepharitis, left eye, both eyelids</td>
</tr>
<tr>
<td>H01.01 Ulcerative blepharitis</td>
<td>H01.01A</td>
<td>Ulcerative blepharitis, right eye, both eyelids</td>
<td>H01.01B</td>
<td>Ulcerative blepharitis, left eye, both eyelids</td>
</tr>
<tr>
<td>H01.02 Squamous blepharitis</td>
<td>H01.02A</td>
<td>Squamous blepharitis, right eye, both eyelids</td>
<td>H01.02B</td>
<td>Squamous blepharitis, left eye, both eyelids</td>
</tr>
</tbody>
</table>

**Rosacea Conjunctivitis and Other disorders of eye and adnexa**

Rosacea is a common inflammatory dermatologic condition that affects the midface and eyes. The following new code category has been proposed to better track and identify patients with this dermatologic and ophthalmologic condition.

Chapter 19 – Injury, Poisoning and Certain Other Consequences of external Causes
There are a few notable updates to the section listed under the “Injury, poisoning and certain other consequences of external causes” section. Codes that may be of interest include:

**T65** Toxic effect of other and unspecified substances
**T79** Certain early complications of trauma, not elsewhere classified
**T81** Complications of procedures, not elsewhere classified

Chapter 21 – Factors Influencing Health Status and Contact With Health Services

**Immunization Not Carried Out**
In order to better track problems in manufacturing or shipping, inclusion terms have been added to existing codes to show that a vaccine could not be given due to problems in availability caused by either a delay in delivery or manufacturing.

**Z28** Immunization not carried out and under immunization status

Includes: vaccination not carried out

Other changes in Chapter 21 are found in the following categories:

**Z72** Problems related to lifestyle
**Z78** Other specified health status

For more changes and updates, please see the 2019 Dermatology Coding and Billing Manual at [insert link to AAD Store here].

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Derm Coding Consult: Summer 2018
CMS Modifies Fee-for-Service Recovery Audit Program for Institutional Providers

In 2015, the Centers for Medicare & Medicaid Services (CMS) announced a modified method to calculate additional documentation request (ADR) limits for Medicare fee-for-service (FFS) Recovery Audit Contractor (RAC) programs. These program modifications, affect institutional (i.e., facility) providers, and went into effect in January 2016. This change only affects dermatologists providing services to Medicare beneficiaries in an institutional (facility) setting.

Modified Adjusted ADR Limit

In the spirit of payment-error reduction, CMS has introduced the modified adjusted ADR, which allows RACs to request more documentation from providers with high denial rates. Under the modified method, a provider’s “adjusted ADR limit” would vary based on the provider’s denial rate. The sliding scale ADR policy is intended to reward providers with higher billing accuracy and fewer audits, while increasing the scrutiny of providers with high levels of billing errors.

Example of the ADR limit sliding scale used during a three 45-day cycle:

<table>
<thead>
<tr>
<th>Denial Rate (Range)</th>
<th>Adjusted ADR Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>(% of Total Paid Claims)</td>
<td></td>
</tr>
<tr>
<td>91 – 100%</td>
<td>5.0%</td>
</tr>
<tr>
<td>71 – 90%</td>
<td>4.0%</td>
</tr>
<tr>
<td>51 – 70%</td>
<td>3.0%</td>
</tr>
<tr>
<td>36 – 50%</td>
<td>1.5%</td>
</tr>
<tr>
<td>21 – 35%</td>
<td>1.0%</td>
</tr>
<tr>
<td>10 – 20%</td>
<td>0.5%</td>
</tr>
<tr>
<td>4 – 9%</td>
<td>0.25%</td>
</tr>
<tr>
<td>0 – 3%</td>
<td>No reviews for 3 (45-day) review cycles</td>
</tr>
</tbody>
</table>

Baseline ADR Limits

A baseline annual ADR limit is established for each provider based on the number of Medicare claims paid in the previous twelve-month period associated with the provider’s six-digit CMS certification number (CCN) and individual national provider identifier (NPI) number. Using the baseline annual ADR limit, an ADR cycle limit is also established to determine whether RACs conduct provider-claim reviews with either a shorter or longer look-back period.

Risk-Based, Adjusted ADR Limits

The adjusted ADR limit is recalculated every third 45-day cycle, and the denial rate for the previous three (3) cycles will determine the adjusted ADR limit for the subsequent three (3) cycles. Depending on the individual provider’s denial rate, the adjusted ADR limit can range from zero (0) reviews to five (5) percent of the total paid claims for the following three (3) 45-day billing cycles.

After three (3) 45-day billing cycles, CMS will review the provider’s billing-accuracy rates and adjust each provider’s ADR limit up or down, based on their individual compliance with Medicare billing rules. Providers who demonstrate accurate billing will have their ADR limit decreased, while providers who have high billing-error levels will have increased scrutiny of their claims.

Use of Extrapolation

CMS will consider allowing recovery auditors (RAs) to use extrapolation to estimate overpayment amounts for providers who:

- Maintain a high denial rate for an extended time period.
- Have excessively high denial rates for a shorter time period.
- Have a moderate denial rate, whose improper payments equal a significantly high overpayment dollar amount.

The Good News

The modified ADR policy has reduced the annual ADR limit to one-half (0.5) percent of a provider’s total number of paid Medicare claims from a previous twelve-month period. Previously, limits were set at ten (10) percent of all claims submitted for the previous full-calendar year, which was then divided into eight (8) periods (45 days).

Note: This instruction does not change the ADR limits for Physician/Non-Physician Practitioners and Suppliers.

Other modifications include the following:

- ADR letters are sent on a 45-day cycle
  - The baseline annual ADR limit is divided by eight (8) to establish the ADR cycle limit.
  - This is the maximum number of claims that can be included in a single 45-day period.
  - RACs may go more than 45 days between record requests.
  - Under no circumstances should RACs make requests more frequently than every 45 days.

- ADR limits must be diversified across all claim types of a facility
  - Diversification is based on the types of bill (TOB) that the provider was paid in the previous year.
According to the official CMS Blog (https://blog.cms.gov/2017/11/15/cmss-2017-medicare-fee-for-service-improper-payment-rate-is-below-10-percent/), in CMS’ continued commitment to reduce improper payments in all of its programs, it is re-examining existing corrective actions and exploring new and innovative approaches to reduce improper payments, while minimizing the burden to its partners.

Due to successful actions previously put in place to reduce improper payments, the Medicare FFS improper payment rate decreased from eleven (11) percent in 2016 to nine and a half (9.5) percent in 2017, representing an estimated $4.9 billion decrease in improper payments. The 2017 Medicare FFS estimated improper payment rate represents claims incorrectly paid between July 1, 2015 and June 30, 2016. (See Figure 1.)

For more information, visit the Medicare Fee-for-Service Recovery Audit Program modification for Institutional Providers at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/Institutional-Provider-Facilities-ADR-Limits-May-2016.pdf. Questions from institutional providers concerning this update can be directed to RAC@cms.hhs.gov.

### Routine Foot Care and Wart Paring

**Routine Foot Care and Wart Paring**

A common coding question in dermatology concerns Medicare coverage of routine foot care. Medicare Part B does not cover routine foot care, unless it is part of a medically necessary treatment for a disease or condition, such as metabolic, neurologic, or peripheral vascular disease. In addition, the need must be severe enough that if such services are not provided, the patient would be at risk for disability as outlined below.

Common non-covered procedures for routine foot care are:

- cutting or removal of corns and calluses (11055-11057);
- clipping, trimming, or debridement of nails (11720-11721); or
- any services with the absence of localized illness, injury, or symptoms involving the foot or other hygienic and preventive maintenance care in the...

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**Source:** CMS Official Blog.November 15, 2015
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realm of self-care, such as cleaning and soaking the feet and the use of skin creams to maintain skin tone of both ambulatory and bedridden patients.

Services normally considered routine may be covered if they are performed as a necessary and integral part of an otherwise covered service, such as treatment of mycotic nails, treatment of ulcers, wounds, or infections. The class findings (outlined below) or the presence of qualifying systemic illnesses that cause peripheral neuropathy must be present.

The following physical and clinical findings must be documented and maintained in the patient record in order for routine foot care services to be reimbursable. Presumption of coverage can be assumed only when the physician performing the routine foot care has identified one or more of the conditions listed below. The physician must identify the following to be appropriately reimbursed: (1) Class A finding (Q7); (2) two of the Class B findings (Q8); or (3) one Class B and two Class C findings, in addition to a primary condition (Q9).

Class A findings (Q7):
- Non-traumatic amputation of foot or integral skeletal portion thereof

Class B findings (Q8):
- Absent posterior tibial pulse
- Advanced trophic changes as evidenced by any three of the following:
  - hair growth (decrease or increase)
  - nail changes (thickening)
  - pigmented changes (discoloring)
  - skin texture (thin, shiny)
  - skin color (rubor or redness)
- Absent dorsalis pedis pulse

Class C findings (Q9):
- Claudication
- Temperature changes (e.g., cold feet)
- Edema
- Paresthesias (abnormal spontaneous sensations in the feet)
- Burning

Another common coding question is regarding the treatment of warts on the feet. Warts on the feet are covered to the same extent as warts located elsewhere in the body. A common coding error is reporting Current Procedural Terminology (CPT®) code 11055, Paring or cutting of benign hyperkeratotic lesion (e.g., corn or callus); single lesion, for the destruction of warts. Paring a wart without cryosurgery or another method of benign lesion destruction would be included in an evaluation and management (E/M) service; therefore, it would not be appropriate to report code 11055.

Medicare requires that the documentation for these service to include the location of each lesion treated, identification (by number or name) of, and description of all nails treated. Medicare has also requested a description of the procedure beyond the simple term of “nail debrided.” In addition, the record needs to reflect the necessity of each service. The CMS-1500 claim form requires that the appropriate finger (FA-F9) and toe (TA-F9) modifier to be appended for reimbursement. For additional information, review Chapter 15 of the Medicare Benefit Policy Manual Publication 100-2, which is available at [http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf](http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf).

FAQs

**Q. What specific information can ancillary staff (e.g., RN, LPN, CNA) document during an evaluation and management (E/M) encounter? Can ancillary staff act as a scribe for a provider?**

A. Ancillary staff may only document:
- Review of systems (ROS)
- Past, family and social history (PFSH)
- Vital signs

These three components must be reviewed by the physician or non-physician practitioner (NPP), who must write a statement indicating that they were reviewed and attest that they are correct and/or expand upon or add information to the findings.

Only the physician or NPP who is conducting the E/M service can perform the history of present illness (HPI). This is considered physician work and cannot be delegated to ancillary staff. The physical examination and the medical decision making (MDM) are also considered physician work and cannot be delegated to ancillary staff. In certain
instances, an office or emergency room triage nurse may document pertinent information regarding the chief complaint (CC)/HPI, but this information should be treated as preliminary information. The physician providing the E/M service must consider this information preliminary and needs to document that he or she explored the HPI in more detail.

Scribes:
A scribe is an non physician practitioner (NPP), nurse, or other appropriate staff member designated by the physician/NPP to document or dictate on their behalf. A scribe does not have to be an employee of the physician/NPP. The medical record must clearly reflect:

- who performed the service
- who recorded the service
- notation from the physician/NPP that he or she reviewed the documentation for accuracy; and
- signed and dated by the performing physician/NPP. For example:

**Handwritten Note:**
- Identification of scribe:
  - “______ scribing for Dr.______” or “______ is scribing for me today.”
- Notation from physician/NPP that he or she reviewed for accuracy:
  - “I agree with the above documentation.” or “I agree the documentation is accurate and complete.”

**EMR/Dictated Note:**
- Identification of scribe:
  - “Dictated by ______.”
- Notation from physician/NPP that he or she reviewed for accuracy:
  - “I agree with the above documentation.” or “I agree the documentation is accurate and complete.”

**Q. What should I do if I received two primary payments?**

**A.** There are times when a provider will receive a primary payment from another insurance company after Medicare has paid as the primary payer/insurance. When this happens, it should be assumed or deduced that Medicare is the secondary payer, instead of the primary payer. If you receive two primary payments, you should refund Medicare’s payment in full.

- Refund the Medicare payment to your local Medicare Contractor within 60 days of the date the overpayment error was identified, even if Medicare’s records show that Medicare is the primary payer/insurance.

  - Send a copy of the other insurer’s explanation of benefits (EOB) and the overpayment refund form (ORF) with your check. The ORF is available on all Medicare contractors’ website under Browse by Topic, Overpayments.

  - If you send a refund without the primary insurer’s EOB, your local Medicare contractor may apply the refund to other accounts receivable for that provider or provider group.

  - After the local Medicare contractor processes and applies your refund, you may resubmit the claim as a Medicare secondary payer claim

  - After 30 days, you may call the provider contact center (PCC) to verify the refunded status. Note: The interactive voice response (IVR) system will not specify that the claim was refunded. The status will only be reflected as processed and paid.

- Although your check will be deposited almost immediately, it may take as long as 30 days for the status of the claim to show a refund status. Please do not resubmit your claim before the refund is applied to the original claim, otherwise, the new claim will be denied as a duplicate.

- Remember that you can obtain claim-status information through the IVR at any time.

- If Medicare records show that Medicare is the primary payer/insurance for the patient, your local Medicare contractor will request that these records (common working file [CWF] records) be updated to reflect that Medicare is the secondary payer/insurances. The coordination of benefits (COB) contractor will update the records.

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- Note that updates to CWF records can take up to 100 days.
- To avoid additional overpayments while Medicare's records are being updated, file all subsequent claims for that patient with the EOB from the primary insurer.

- A good resource to help determine when Medicare is the primary or secondary payer is available on your local Medicare contractor website under the Medicare secondary payer (MSP) tool, i.e., the MSP Lookup Tool. For more information, refer to Chapter 3 (Section 10-4) of the CMS IOM Publication 100-05, which is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/msp105c03.pdf.

In the Know...

Use of External Causes of Morbidity and Factors Influencing Health Status Diagnosis Codes

Did you know that the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) contains codes that can be reported to provide supplemental information and help support the medical necessity for most conditions?

Chapter 20: External Causes of Morbidity (V00-Y99)

This chapter in ICD-10 CM contains codes used to report external causes of morbidity and should never be sequenced as the first or principal diagnosis on the claim; rather they are used to capture the cause of the diagnosis.

External-cause codes are intended to provide data for injury research and evaluation of injury prevention strategies. These codes are used to capture how the injury or health condition happened (cause), the intent (unintentional/accidental or intentional, such as suicide or assault), the place where the event occurred, the activity of the patient at the time of the event, and the person's status (e.g., civilian, military).

Chapter 21: Factors Influencing Health Status and Contact with Health Services (Z00-Z99)

Frequently referred to as “Z-codes,” these codes may be used in any healthcare setting either as a primary diagnosis code or secondary code, depending on the circumstances of the encounter.

Some Z-codes are used to indicate the reason for an encounter (e.g., Z12.83, Encounter for screening of malignant neoplasm of skin, can be reported in any healthcare setting). Others can be reported to support medical necessity (e.g., Z85.820, Personal history of malignant melanoma of skin [conditions classifiable to C43.X] or Z85.828, Personal history of other malignant neoplasm [conditions classifiable to C44.X]).

Persons encountering health services to seek advice or treatment for a feared condition that cannot be demonstrated or problem in normal state, (also known as “worried well”) can be coded with Z71.1.

Certain Z-codes may only be used as first-listed or principal diagnosis. To see a complete list of Z-codes that may be reported as first-listed or principal diagnosis, see ICD-10-CM coding guidelines in Chapter 21 (Section C, 16), which is available at https://www.cdc.gov/nchs/data/icd/10cmguidelines_fy2018_final.pdf.

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Unless a provider is subject to a state-based external-cause code reporting mandate or these codes are required by a particular payer, reporting of ICD-10-CM codes in Chapter 20, External Causes of Morbidity, is not required. There is no national requirement for mandatory ICD-10-CM external-cause code reporting. However, in the absence of any mandatory reporting requirement, dermatologists and qualified healthcare providers (QHPs) are encouraged to voluntarily report external-cause codes, as they provide valuable data for injury research and evaluation of injury prevention strategies.
Marketing Ad
(to come)
Below are some routine dermatology-related uses for Z-codes:

<table>
<thead>
<tr>
<th>Category</th>
<th>Reason for Use</th>
<th>Appropriate use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact/Exposure</td>
<td>Indicates contact with, and suspected exposure to diseases</td>
<td>First-listed or principal; secondary</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Indicates an encounter for testing, or, more commonly, as a secondary code to identify a potential risk.</td>
</tr>
<tr>
<td>Status</td>
<td>Indicates that a patient is either a carrier of a disease or has the sequelae or residual of a past disease or condition</td>
<td>First-listed or principal code</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Informative because the status may affect the course of treatment and its outcome. Should not be used with a diagnosis code from one of the body system chapters, if the diagnosis code includes the information provided by the status code.</td>
</tr>
<tr>
<td>History (of):</td>
<td>Personal history codes indicate a patient’s past medical condition that no longer exists and is not receiving any treatment, but condition has the potential for recurrence and, therefore, may require continued monitoring.</td>
<td>Secondary (medical necessity): The history of an illness, even if no longer present, is important information that may alter the type of treatment ordered.</td>
</tr>
<tr>
<td>two types of history Z-codes</td>
<td></td>
<td>Family history codes are for use when a patient has a family member(s) who has had a particular disease that causes the patient to be at higher risk of also contracting the disease</td>
</tr>
<tr>
<td>Screening</td>
<td>Indicates testing for disease or disease precursors in seemingly well individuals so that early detection and treatment can be provided for those who test positive for the disease.</td>
<td>First-listed or principal</td>
</tr>
<tr>
<td></td>
<td>Rule out or confirming a suspected diagnosis because the patient has some sign or symptom is a diagnostic examination, not a screening.</td>
<td>If the reason for the encounter is specifically the screening examination.</td>
</tr>
<tr>
<td>Counseling</td>
<td>Reported when a patient or family member receives assistance in the aftermath of an illness or injury, or when support is required in coping with family or social problems.</td>
<td>First-listed or principal</td>
</tr>
</tbody>
</table>

For more information on the appropriate use of external causes of morbidity and factors influencing health status diagnosis codes, see ICD-10-CM coding guidelines at [https://www.cdc.gov/nchs/data/icd/10cmguidelines_fy2018_final.pdf](https://www.cdc.gov/nchs/data/icd/10cmguidelines_fy2018_final.pdf).

Now You Are In The Know! ✦