New CPT Coding Updates for 2016

The 2016 American Medical Association’s (AMA), Coding Procedural Terminology (CPT) manual has some new and/or revised coding information that requires your attention to accurately select appropriate CPT codes.

Radiation Treatment Delivery

I. High dose rate electronic brachytherapy, skin surface application

0394T is a new Category III CPT code that was introduced in the 2016 CPT manual to be reported for High dose rate electronic brachytherapy, skin surface application, per fraction, includes basic dosimetry, when performed. This code is scheduled to sunset in January 2021.

Coding instruction indicates:

(Do not report 0394T in conjunction with 77261, 77262, 77263, 77300, 77306, 77307, 77316, 77317, 77318, 77332, 77333, 77334, 77336, 77427, 77431, 77432, 77435, 77469, 77470, 77499, 77761, 77762, 77763, 77767, 77768, 77770, 77771, 77772, 77778, 77789)

(For high dose rate radionuclide surface brachytherapy, see 77767, 77768)

(For non-brachytherapy superficial [e.g., ≤200 kV] radiation treatment delivery, use 77401)

Revised coding instructions

Instructions that precede the radiation treatment delivery section, have once again been revised to include Category III codes 0394T – high dose rate electronic brachytherapy, skin surface application, per fraction, includes basic dosimetry, when performed and 0395T – High dose rate electronic brachytherapy, interstitial or intracavitary treatment, per fraction, incudes basic dosimetry, when performed, to the list of excluded codes that cannot be reported with megavoltage codes 77402, 77407 and 77412 for surface application.

The revised instructions in part state “Energies below the megavoltage range may be used in the treatment of skin lesions. Superficial radiation energies (up to 200 kV) may be generated by a variety of technologies and should not be reported with megavoltage (77402, 77407, 77412) for surface application. Do not report clinical treatment planning (77261, 77262, 77263), treatment devices (77332, 77333, 77334), isodose planning (77306, 77307, 77316, 77317, 77318), physics consultation (77336), or radiation treatment management (77427, 77431, 77432, 77435, 77469, 77470, 77499) with 77401, 0394T, or 0395T. When reporting 77401 alone, evaluation and management, when performed, may be reported with the appropriate E/M codes.

II. Reflectance Confocal Microscopy (RCM)

Reflectance confocal microscopy is a set of new codes in 2016. Note that this set of codes has status indicator C – which means the codes are carrier-priced or that individual carriers will determine reimbursement.

Below is a complete list of codes and their descriptors:

- 96931 Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; image acquisition and interpretation and report, first lesion
- 96932 Image acquisition only, first lesion

Contents

- New CPT Coding updates for 2016 .......................... 1-2
- OIG released Fiscal Year (FY) 2016 Work Plan ........ 2-3
- Excision of Subcutaneous Soft Tissue Tumors ........ 3-5
- Clarifying “Other” and “Unspecified” in ICD-10-CM... 5-6
- CMS Reveals Important Dermatology MUEs ........ 6-7
- Amending the Medical Record ........................... 7
- Tales from the ICD-10 Member Community ............ 7-9
- In the Know ........................................ 12

IMPORTANT Please Route to:

___ Dermatologist ___ Office Mgr ___ Coding Staff ___ Billing Staff
New CPT Coding Updates for 2016

--- continued from page 1

• 96933
  image acquisition and report only, first lesion
++ 96934
  image acquisition and interpretation and report, each additional lesion
    (List separately in addition to code for primary procedure)
    (Use 96934 in conjunction with 96931)
++ 96935
  image acquisition only, each additional lesion
    (List separately in addition to code for primary procedure)
    (Use 96935 in conjunction with 96932)
++ 96936
  interpretation and report only, each additional lesion
    (List separately in addition to code for primary procedure)
    (Use 96936 in conjunction with 96933)

III. Multi-spectral Digital Skin Lesion Analysis

Another set of codes that have been introduced for 2016 are category III codes for Multi-spectral digital skin lesion analysis. Like the codes for High dose rate electronic brachytherapy, skin surface application, the Multi-spectral digital skin lesion codes will sunset in January 2021.

• 0400T
  Multi-spectral digital skin lesion analysis of clinically atypical cutaneous pigmented lesions for detection of melanomas and high-risk melanocytic atypia; one to five lesions
• 0401T
  six or more lesions

For more information on new codes and revised coding instructions, please consult the 2016 AAD Dermatology Coding and Documentation Manual. To order a copy, visit https://www.aad.org/store/product/default.aspx?id=9961

OIG releases Fiscal Year (FY) 2016 Work Plan

The Office of Inspector General’s (OIG) Work Plan for fiscal year (FY) 2016 has been released. It summarizes new and ongoing OIG reviews with respect to the U.S. Department of Health and Human Services (HHS) programs.

The OIG reported expected recoveries of more than $3 billion in FY 2015, including nearly $1.13 billion in audit receivables and nearly $2.22 billion in investigative receivables.

The American Academy of Dermatology (AAD) coding staff has reviewed the OIG Work Plan and identified the following areas as having a potential impact on dermatology practices:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Primary Objective</th>
<th>Criteria</th>
<th>Expected Issue Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Providers—Billing and Payments</td>
<td>NEW Physicians—referring/ordering Medicare services and supplies</td>
<td>We will review select Medicare services, supplies and durable medical equipment (DME) referred/ordered by physicians and non-physician practitioners to determine whether the payments were made in accordance with Medicare requirements. Pursuant to ACA Sec. 6405, CMS requires that physicians and non-physician practitioners who order certain services, supplies and/or DME are required to be Medicare-enrolled physicians or non-physician practitioners and legally eligible to refer/order services, supplies and DME. If the referring/ordering physician or non-physician practitioner is not eligible to order or refer, then Medicare claims should not be paid.</td>
<td>FY 2016, ACA</td>
</tr>
</tbody>
</table>

--- see OIG 2016 WORK PLAN on page 3

Editorial Advisory Board

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Designation</th>
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<tbody>
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<td>Theresa Oloier, Senior Graphic Designer</td>
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Coding & Reimbursement Task Force 2015-2016

<table>
<thead>
<tr>
<th>Name</th>
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<tbody>
<tr>
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<td>Editor</td>
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<td>Contributing Writer</td>
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<tr>
<td>CPC, CPCD, PCC, ESC</td>
<td>Contributing Writer</td>
</tr>
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<td>Contributing Writer</td>
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<tr>
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<td>Contributing Writer</td>
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<td>Resident Member</td>
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<td>Chair</td>
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<td>Member</td>
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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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### OIG releases Fiscal Year (FY) 2016 Work Plan

— continued from page 2

<table>
<thead>
<tr>
<th>Subject</th>
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<th>Expected Issue Date</th>
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<tbody>
<tr>
<td>Other Providers—Billing and Payments</td>
<td>NEW Prolonged services—reasonableness of services</td>
<td>We will determine whether Medicare payments to physicians for prolonged evaluation and management (E/M) services were reasonable and made in accordance with Medicare requirements. Prolonged services are for additional care provided to a beneficiary after an evaluation and management service has been performed. Physicians submit claims for prolonged services when they spend additional time beyond the time spent with a beneficiary for a usual companion evaluation and management service. The necessity of prolonged services are considered to be rare and unusual. The Medicare Claims Process (MCP) manual includes requirements that must be met in order to bill a prolonged E/M service code. (MCP manual, Pub. 100-04, Ch. 12, Sec. 30.6.15.)</td>
<td>FY 2016</td>
</tr>
</tbody>
</table>

| Prescription Drugs—Quality of Care and Safety | REVISED Covered uses for Medicare Part B drugs | We will review the oversight actions that CMS and its claims processing contractors take to ensure that payments for Part B drugs meet the appropriate coverage criteria. We will also identify challenges contractors face when making coverage decisions for drugs. If Part B MACs do not have effective oversight mechanisms, Medicare and its beneficiaries may pay for drug uses that are not medically accepted. Medicare Part B generally covers drugs when they are used to treat conditions approved by FDA, referred to as “on-label” uses. Part B may also cover drugs when an “off-label” use of the drug is supported in major drug compendia or when an off-label use is supported by clinical evidence in authoritative medical literature. (Medicare Benefit Policy Manual, Pub. No. 100-02, Ch. 15, § 50.4.2.) | FY 2016 |

| Billing and Payments | NEW CMS management of the ICD-10 implementation | We will review aspects of CMS’s early management of the implementation of the 10th version of the International Classification of Diseases (ICD-10) codes in Medicare Parts A and B. This may include reviewing CMS’s and its contractors’ (e.g., MACs) assistance and guidance to hospitals and physicians and assessing how the transition to ICD-10 is affecting claims processing, including claims resubmissions, appeals, and medical reviews. We may also determine how ICD-10 diagnosis codes are being applied to selected CMS payment rules and safeguards (e.g., national or local coverage decisions related to coverable conditions). Starting on October 1, 2015, Medicare claims with a date of service on or after October 1, 2015, are required to contain a valid ICD-10 code. The ICD-10 system includes about 70,000 diagnosis codes and replaces the use of ICD-9 in Medicare, which included only about 15,000 codes. CMS has advised providers that it will allow for some flexibility during the first 12 months of implementation; e.g., Medicare review contractors will not deny claims billed under the Part B physician fee schedule based solely on the specificity of the ICD-10 diagnosis code as long as the physician/practitioner used a code from the correct “family” of codes. | FY 2017 |

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<tr>
<th>Subject</th>
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</tr>
</thead>
<tbody>
<tr>
<td>MA Organizations’ Compliance With Part C Requirements</td>
<td>Risk-adjustment data—sufficiency of documentation supporting diagnoses</td>
<td>We will review the medical record documentation to ensure that it supports the diagnoses that MA organizations submitted to CMS for use in CMS’s risk-score calculations and determine whether the diagnoses submitted complied with Federal requirements. Prior OIG reviews have shown that medical record documentation does not always support the diagnoses submitted to CMS by MA organizations. MA organizations are required to submit risk-adjustment data to CMS in accordance with CMS instructions. (42 CFR § 422.310(b).) Payments to MA organizations are adjusted on the basis of the health status of each beneficiary, so inaccurate diagnoses may cause CMS to pay MA organizations improper amounts. (Social Security Act, §§ 1853(a)(1) (Q) and (a)(3).)</td>
<td>FY 2016</td>
</tr>
</tbody>
</table>

For excision of benign lesions of cutaneous origin (eg, sebaceous cyst), see CPT codes 11400-11446.

### Excision of Subcutaneous Soft Connective Tissue Tumors

The 2016 American Medical Association Current Procedural Terminology (AMA CPT) manual includes specific coding instructions that must be adhered to when reporting excision of soft connective tissue tumors.

According to AMA CPT coding guidelines, excision of subcutaneous soft connective tissue tumors include simple or intermediate repair and involves the simple or marginal resection of tumors that are confined to subcutaneous tissue below the skin but above the deep fascia. These tumors are usually benign and are resected without removing a significant amount of surrounding normal tissue.

For excision of benign lesions of cutaneous origin (eg, sebaceous cyst), see CPT codes 11400-11446.

AMA CPT further states that musculoskeletal lesion excision codes pertain to subcutaneous, superficial or deep soft tissues these codes are appropriate to report for lesions (or tumors) that occur in the subfascial or fascial tissue, muscles and joints, as listed in the musculoskeletal section.

A sebaceous cyst is a skin lesion and may be very large, distending the skin and pushing into the subcutaneous fatty tissue, but it is a skin lesion, and therefore, should be coded using the integumentary lesion excision codes (11400 – 11446), depending on the size of the cyst.

— see EXCISION OF SUBCUTANEOUS TISSUE on page 4
Excision of Subcutaneous Soft Connective Tissue Tumors

— continued from page 3

Excision of fascial or subfascial soft tissue tumors involves the resection of tumors confined to the tissue within or below the deep fascia, without involving the bone. These tumors are usually benign, are often intramuscular, and are resected without removing a significant amount of surrounding normal tissue. These excisions include simple or intermediate repair.

NOTE: Digital (fingers and toes) subfascial tumors are defined as those tumors that involve the tendons, tendon sheaths, or joints of the digit. Tumors that simply abut but do not breach the tendon, tendon sheath, or joint capsule are considered subcutaneous soft tissue tumors.

For radical resection of tumor(s) of cutaneous origin (eg, melanoma), see CPT codes 11600-11646.

Radical resection of soft connective tissue tumors involves the resection of the tumor with wide margins of normal tissue. Although these tumors may be confined to a specific layer (eg, subcutaneous, subfascial), radical resection may involve removal of tissue from one or more layers.

Radical resection of soft tissue tumors is most commonly used for malignant connective tissue tumors or very aggressive benign connective tissue tumors.

Code Selection

Code selection for excision of subcutaneous, fascial or subfascial and radical resection of soft connective tissue tumors is based on the location and size of the tumor. For optimal code selection, determine the lesion size by measuring the greatest diameter of the tumor plus the margin required for complete excision of the tumor. The margins refer to the narrowest margin required to adequately excise the tumor, based on the physician’s judgment. The measurement of the tumor plus margin should be made at the time of the excision.

Vessel exploration and/or neuroplasty should be reported separately. Extensive undermining or other techniques to close a defect created by skin excision, may require a complex repair which should be reported separately. Dissection or elevation of tissue planes to permit resection of the tumor is included in the excision.

When coding musculoskeletal procedures, it is important to note that the excision performed meets the criteria listed in the code descriptor. The physician must determine and document the depth of the excision to determine whether the integumentary system or musculoskeletal system CPT codes are appropriate.

The list below illustrates CPT codes for excision of soft connective tissue tumors:

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Code Descriptor</th>
<th>CPT Code</th>
<th>Code Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>21011</td>
<td>Excision, tumor, soft tissue of face or scalp, subcutaneous; less than 2 cm</td>
<td>21012</td>
<td>2 cm or greater</td>
</tr>
<tr>
<td>21013</td>
<td>Excision, tumor, soft tissue of face and scalp, subfascial (eg, subgaleal, intramuscular); less than 2 cm</td>
<td>21014</td>
<td>2 cm or greater</td>
</tr>
<tr>
<td>21550</td>
<td>Bopsy, soft tissue of neck or thorax</td>
<td>21552</td>
<td>3 cm or greater</td>
</tr>
<tr>
<td>21555</td>
<td>Excision, tumor, soft tissue of neck or anterior thorax, subcutaneous; less than 3 cm</td>
<td>21554</td>
<td>5 cm or greater</td>
</tr>
<tr>
<td>21556</td>
<td>Excision, tumor, soft tissue of neck or anterior thorax, subfascial (eg, intramuscular); less than 5 cm</td>
<td>21558</td>
<td>5 cm or greater</td>
</tr>
<tr>
<td>21920</td>
<td>Bopsy, soft tissue of back or flank; superficial</td>
<td>21925</td>
<td>deep</td>
</tr>
<tr>
<td>21930</td>
<td>Excision, tumor, soft tissue of back or flank, subcutaneous; less than 3 cm</td>
<td>21931</td>
<td>3 cm or greater</td>
</tr>
<tr>
<td>21932</td>
<td>Excision, tumor, soft tissue of back or flank, subfascial (eg, intramuscular); less than 5 cm</td>
<td>21933</td>
<td>5 cm or greater</td>
</tr>
<tr>
<td>21935</td>
<td>Radical resection of tumor (eg, sarcoma), soft tissue of back or anterior thorax; less than 5 cm</td>
<td>21936</td>
<td>5 cm or greater</td>
</tr>
<tr>
<td>23065</td>
<td>Bopsy, soft tissue of shoulder area; superficial</td>
<td>23066</td>
<td>deep</td>
</tr>
<tr>
<td>23075</td>
<td>Excision, tumor, soft tissue of shoulder area, subcutaneous; less than 3 cm</td>
<td>23076</td>
<td>3 cm or greater</td>
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<tr>
<td>23076</td>
<td>Excision, tumor, soft tissue of shoulder area, subfascial (eg, intramuscular); less than 5 cm</td>
<td>23077</td>
<td>5 cm or greater</td>
</tr>
<tr>
<td>23077</td>
<td>Radical resection of tumor (eg, sarcoma), soft tissue of shoulder area; less than 5 cm</td>
<td>23078</td>
<td>5 cm or greater</td>
</tr>
<tr>
<td>24065</td>
<td>Bopsy, soft tissue of upper arm or elbow area; superficial</td>
<td>24066</td>
<td>deep (subfascial or intramuscular)</td>
</tr>
<tr>
<td>24075</td>
<td>Excision, tumor, soft tissue of upper arm or elbow area, subcutaneous; less than 3 cm</td>
<td>24076</td>
<td>3 cm or greater</td>
</tr>
<tr>
<td>24076</td>
<td>Excision, tumor, soft tissue of upper arm or elbow area, subfascial (eg, intramuscular); less than 5 cm</td>
<td>24077</td>
<td>5 cm or greater</td>
</tr>
<tr>
<td>24077</td>
<td>Radical resection of tumor (eg, sarcoma), soft tissue of upper arm or elbow area; less than 5 cm</td>
<td>24079</td>
<td>5 cm or greater</td>
</tr>
<tr>
<td>25065</td>
<td>Bopsy, soft tissue of forearm and/or wrist; superficial</td>
<td>25066</td>
<td>deep (subfascial or intramuscular)</td>
</tr>
<tr>
<td>25075</td>
<td>Excision, tumor, soft tissue of forearm and/or wrist area, subcutaneous; less than 3 cm</td>
<td>25076</td>
<td>3 cm or greater</td>
</tr>
<tr>
<td>25076</td>
<td>Excision, tumor, soft tissue of forearm and/or wrist area, subfascial (eg, intramuscular); less than 3 cm</td>
<td>25077</td>
<td>3 cm or greater</td>
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</table>
Excision of Subcutaneous Soft Connective Tissue Tumors

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<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Code Descriptor</th>
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<tbody>
<tr>
<td>26115</td>
<td>Excision, tumor or vascular malformation, soft tissue of hand or finger, subcutaneous; less than 1.5 cm</td>
<td>#26111</td>
<td>1.5 cm or greater</td>
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<tr>
<td>26116</td>
<td>Excision, tumor, soft tissue, or vascular malformation, of hand or finger, subfascial (eg, intramuscular); less than 1.5 cm</td>
<td>#26113</td>
<td>1.5 cm or greater</td>
</tr>
<tr>
<td>26117</td>
<td>Radical resection of tumor (eg, sarcoma), soft tissue of hand or finger; less than 3 cm</td>
<td>26118</td>
<td>3 cm or greater</td>
</tr>
<tr>
<td>27047</td>
<td>Excision, tumor, soft tissue of pelvis and hip area, subcutaneous; less than 3 cm</td>
<td>#27043</td>
<td>3 cm or greater</td>
</tr>
<tr>
<td>27048</td>
<td>Excision, tumor, soft tissue of pelvis and hip area, subfascial (eg, intramuscular); less than 5 cm</td>
<td>#27045</td>
<td>5 cm or greater</td>
</tr>
<tr>
<td>27049</td>
<td>Radical resection of tumor (eg, sarcoma), soft tissue of pelvis and hip area; less than 5 cm</td>
<td>#27059</td>
<td>5 cm or greater</td>
</tr>
<tr>
<td>27323</td>
<td>Biopsy, soft tissue of thigh or knee area; superficial</td>
<td>27324</td>
<td>deep (subfascial or intramuscular)</td>
</tr>
<tr>
<td>27327</td>
<td>Excision, tumor, soft tissue of thigh or knee area, subcutaneous; less than 3 cm</td>
<td>#27337</td>
<td>3 cm or greater</td>
</tr>
<tr>
<td>27328</td>
<td>Excision, tumor, soft tissue of thigh or knee area, subfascial (eg, intramuscular); less than 6 cm</td>
<td>#27339</td>
<td>5 cm or greater</td>
</tr>
<tr>
<td>27613</td>
<td>Biopsy, soft tissue of leg or ankle area; superficial</td>
<td>27614</td>
<td>deep (subfascial or intramuscular)</td>
</tr>
<tr>
<td>27615</td>
<td>Radical resection of tumor (eg, sarcoma), soft tissue of leg or ankle area; less than 5 cm</td>
<td>27616</td>
<td>5 cm or greater</td>
</tr>
<tr>
<td>27618</td>
<td>Excision, tumor, soft tissue of leg or ankle area, subcutaneous; less than 3 cm</td>
<td>#27632</td>
<td>3 cm or greater</td>
</tr>
<tr>
<td>27619</td>
<td>Excision, tumor, soft tissue of leg or ankle area, subfascial (eg, intramuscular); less than 5 cm</td>
<td>#27634</td>
<td>5 cm or greater</td>
</tr>
<tr>
<td>28043</td>
<td>Excision, tumor, soft tissue of foot or toe, subcutaneous; less than 1.5 cm</td>
<td>#28039</td>
<td>1.5 cm or greater</td>
</tr>
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<td>28045</td>
<td>Excision, tumor, soft tissue of foot or toe, subfascial (eg, intramuscular); less than 1.5 cm</td>
<td>#28041</td>
<td>1.5 cm or greater</td>
</tr>
<tr>
<td>28046</td>
<td>Radical resection of tumor (eg, sarcoma), soft tissue of foot or toe; less than 3 cm</td>
<td>28047</td>
<td>3 cm or greater</td>
</tr>
</tbody>
</table>

Codes with ‘#' are out of numerical sequence

For more coding instructions and guidelines, review the 2016 AMA CPT Coding manual.

Clarifying “Other” and “Unspecified” in ICD-10-CM

The ICD-10 Member Community and AAD Coders have received a number of questions seeking clarification on the appropriate use and reporting of an “Other code” versus an “Unspecified code”.

While members understand that from a claim processing standpoint, an “Other” specified code is preferable to reporting an “unspecified” code, appropriately reporting these codes based on the documentation of the disease, injury, or disorder in the medical record is the key.

In general, an “other specified” code is reported when ICD-10 does not include a distinct code for the condition documented. An “unspecified code” is reported when the documentation of the disease, injury or disorder lacks a specific element as listed in the family or category of the condition - for example a specific type, location, or laterality. The specific elements needed to differentiate codes within a category vary depending upon the category.

ICD-10 employs clinical concepts to create these distinct elements within each family or category of codes. Although there are 21 distinct clinical concepts, each category will include only one or two of these concepts. In reporting conditions for Dermatology, the most commonly reported concepts are: type of condition, anatomic site, laterality, severity of the condition, etiology/manifestation, temporal factors such as acute or chronic, episode of care, caused by or underlying cause of the condition, and agent (chemical, infectious, substance). Recognizing these concepts as the difference in codes within a category is essential to understanding and appropriately reporting “other” versus “unspecified” code choices.

For example, the clinical concept of type is used to distinguish the code choices for category L70 – Acne.

L70 Acne
L70.0 Acne vulgaris
L70.1 Acne conglobata
L70.2 Acne varioliformis
L70.3 Acne tropica
L70.4 Infantile acne
L70.5 Acne excoriée des jeunes filles
L70.8 Other acne
L70.9 Acne, unspecified

As the category is broken down by the concept of type, if the type of acne is not specified in the documentation, the code reported would be L70.9 Acne, unspecified. Documentation of the condition’s particular anatomic location or site without specificity of the type should also be reported as acne unspecified. To report L70.8 Other acne, the condition would be documented as a specific type not listed within the category.

Another example of the distinction between “other” and “unspecified” can be seen in the family of codes used to report Allergic contact dermatitis (L23).
Clarifying “Other” and “Unspecified” in ICD-10-CM

— continued from page 5

For example:

L23 Allergic contact dermatitis
  L23.0 Allergic contact dermatitis due to metals
  L23.1 Allergic contact dermatitis due to adhesives
  L23.2 Allergic contact dermatitis due to cosmetics
  L23.3 Allergic contact dermatitis due to drugs in contact with the skin
  L23.4 Allergic contact dermatitis due to dyes
  L23.5 Allergic contact dermatitis due to other chemical products
  L23.6 Allergic contact dermatitis due to food in contact with the skin
  L23.7 Allergic contact dermatitis due to plants, except food
  L23.8 Allergic contact dermatitis due to other agents
  L23.81 Allergic contact dermatitis due to animal (cat) (dog) dander
  L23.89 Allergic contact dermatitis due to other agents
  L23.9 Allergic contact dermatitis, unspecified cause

The code choices within this category identify the agent causing the condition. Should a specific agent not included in the code choices be documented as the cause of the dermatitis, for example allergic contact dermatitis due to leather, then the “other” code should be reported (L23.89 Allergic contact dermatitis due to other agents). If the agent causing the condition is not documented or not yet known, the “unspecified” code (L23.9 Allergic contact dermatitis, unspecified cause) should be reported.

At times, more than one of the clinical concepts will be incorporated into the category. When this occurs, missing any of these elements in the documentation will also lead to reporting of an unspecified code.

An example of a category which includes multiple clinical concept elements is L89 – Pressure ulcer. In this category the type of condition is not further specified. The code choices within the L89 category are first broken into distinct groupings based upon the anatomic site and laterality of the ulcer. Each grouping is subdivided by the severity of the ulcer.

For example:

L89.01 Pressure ulcer of right elbow
  L89.010 Pressure ulcer of right elbow, unstageable
  L89.011 Pressure ulcer of right elbow, stage 1
  L89.012 Pressure ulcer of right elbow, stage 2
  L89.013 Pressure ulcer of right elbow, stage 3
  L89.014 Pressure ulcer of right elbow, stage 4
  L89.019 Pressure ulcer of right elbow, unspecified stage

ICD-10 category L89 provides additional subcategories should the site, laterality, or stage of the condition not be included in the documentation of the condition.

CMS Reveals Important Dermatology MUEs

The Centers for Medicare and Medicaid Services (CMS) has expanded its presentation of Medically Unlikely Edits (MUE). These claim edits limit the number of units of service (UOS) of a code which may be billed by a provider for the same patient on the same calendar day. MUE’s were originally developed to stop typographical errors. Prior to CMS’ expansion of the MUE edits in 2013, all edits were based on a single claim line. If two procedures, each with an allowance of one unit were billed, the second procedure would be dropped to the next line with an appropriate modifier and CMS would pay both claim lines.

CMS recognized this overriding billing method’s potential for abuse and in 2013, CMS expanded the edits to include an “MUE adjudication indicator” (MAI) and an “MUE rationale.” MUEs with an adjudication indicator of “2” or “3” are meant to address a vulnerability first identified by the U.S. Department of Health and Human Services (HHS) Office of Inspector General. This vulnerability allowed providers to bypass MUEs by listing multiples of the same code on different claim lines with appropriate modifiers.

An MAI of “2” shows the MUE is based on Medicare policy, CPT code descriptor, or anatomy. An MAI of “3” is based on clinical information such as billing patterns or prescribing instructions. CMS explains in MLN Matters article SE1422 that both MAI 2 and MAI 3 edits are “date of service” (DOS) edits. The “1 Line Edits” are MUEs of the claim line only.

Exceptions to MUEs with an MAI of “3” may occur, but they are rare, and abnormally high units of service values should be considered a billing error.

For edits with a MAI 2, CMS has not identified any instances in which a higher value would be correct and payable. These will be difficult to overturn, but the Qualified Independent Committee and the Administrative Law Judge are not required to abide by these edits. If the medical record supports the high units of service, an appeal may be in order.

Medically Unlikely Edits (MUE) that took effect October 1, 2015 which affect dermatology are listed in the table below. This year, CMS published the MUE edits for add-on biopsy code 11101 – Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; each separate/additional lesion and Mohs Micrographic Surgery series (17311-17315.)
CMS Reveals Important Dermatology MUEs

— continued from page 6

<table>
<thead>
<tr>
<th>HCPCS/ CPT Code</th>
<th>Practitioner Services MUE Values</th>
<th>MUE Adjudication Indicator</th>
<th>MUE Rationale</th>
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<td>Code Descriptor / CPT Instruction</td>
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Amending the Medical Record

According to the Centers for Medicare and Medicaid Services (CMS) transmittal 615 of Medicare’s Program Integrity Manual, Medicare Administrative Contractors (MACs) may accept the provider’s initials along with amendments, additions, or changes to the patient’s medical record, as long as the initials can be used to identify the provider from information elsewhere in the record.

This policy revision, which was effective October 1, is in response to reports that MACs were rejecting initials as insufficient documentation for amendments to the record. Transmittal 615 does not require a MAC to accept initials in lieu of a signature, it now explicitly states they may allow this form of validation of the amended record.

The language regarding the use of initials goes beyond that of the December 2012 Program Integrity Manual transmittal 442. The previous transmittal stated amended, delayed or additional information entered into the medical record needed to be signed and dated when added to a paper record and amendments of an electronic record must provide a means to clearly identify the identity of the provider and the date of each modification to the record.

When initials are used to identify the author of revisions to the medical record, the area changed must be dated by the provider. In addition, the medical record must contain “evidence associating the provider’s initials with their name.”

What remains unclear is what would be considered sufficient proof. For example initials that are clearly identifiable as “JS” placed next to addenda or revised information in a medical record. Will this be considered enough “evidence” to identify that the revision was made by Dr. John Smith, who signed elsewhere in the record?

We recommend maintaining a signature log for paper records that includes the initials of each provider next to his or her signature for each provider who enters information into the medical record. For electronic medical records, develop a tracking method that works for those who enter information. Both formats will also require the date of each revision made to the record.

Never delete original content from the medical record. CMS makes it clear in the transmittal, to use a single line strike through so that any content being “removed” from the record is still clearly visible after the revision.

Take care when adding amendments. Changes made to medical records to support billing for higher level of a service should never be allowed. Amendments to the medical record should be rare, and usually occur as the result of discovery by the provider after the encounter, such as a test result or medication change.

Resources:

Tales from the ICD-10 Member Community

In early September 2015 the Academy’s Coding and Reimbursement Team opened the ICD-10 Member Community, providing members with a web based environment where ICD-10 coding questions could be posted and answers provided by the Academy’s coders and ICD-10 task force members. Many of our members have and continue to take advantage of this resource as we continue moving forward post ICD-10 implementation. The ICD-10 Member Community can be found here: [http://community.aad.org/communities/community-home?CommunityKey=b88f7ea1-5810-4b40-9bf4-bdf4e67d3d7c](http://community.aad.org/communities/community-home?CommunityKey=b88f7ea1-5810-4b40-9bf4-bdf4e67d3d7c)

— see ICD MEMBER COMMUNITY TALES on page 8
Below are the top five ICD-10 related questions from the Community:

1. **Question:** What is the best way to code for multiple Nevi (at multiple sites) on a full skin exam?

   **Answer:** We understand the frustration that ICD-10’s level of specificity for this condition has created by taking a very straightforward code, 216.9, and expanding it to eleven possible choices. It is also unfortunate that ICD-10 has not included one code to report nevi of multiple sites.

   The two examples below may help provide some clarity of how these codes are reported -

   **Example 1:** Patient presents for an evaluation of multiple benign nevi on the scalp, nose, eyelids, ears, neck, cheeks, lips, back, shoulders, arms, forearms, dorsal hands, chest, breast, abdomen, genitalia, buttocks, thighs, calves, shins, and feet...bilaterally are evaluated, a code for all sites evaluated should be reported:

   In this example the codes would be:

   - ICD-10 Code | Site of Melanocytic nevi
   - D22.0 | Lip
   - D22.11 | Right eyelid, including canthus
   - D22.12 | Left eyelid, including canthus
   - D22.21 | Right ear and external auricular canal
   - D22.22 | Left ear and external auricular canal
   - D22.39 | Other parts of face
   - D22.4 | Scalp and neck
   - D22.5 | Trunk
   - D22.61 | Right upper limb, including shoulder
   - D22.62 | Left upper limb, including shoulder
   - D22.71 | Right lower limb, including hip
   - D22.72 | Left lower limb, including hip

   As CMS will require that laterality be reported with this category or family of codes, reporting multiple sites with ICD-10 code D22.9 – Melanocytic nevi, unspecified, may result in denial or pending of the claim.


   **Example 2:** Patient with a history of melanoma is seen. The provider documents that benign looking nevi were found on the chest, right shoulder, right and left forearm and left calf, right ankle, scalp, right eyelid, right and left ear, and forehead. Three nevi, two on the cheek and one on the neck are clinically suspicious for melanoma and excised. Numerous non-inflamed seborrheic keratoses were also identified and removed during the encounter.

   In the second example the codes reported would be:

   - D48.5 – Neoplasm of uncertain behavior of skin
   - Z85.820 – Person history of malignant melanoma of skin
   - L82.1 – Other seborrheic keratosis
   - D22.5 – Melanocytic nevi, chest
   - D22.61 – Melanocytic nevi, right upper limb, including shoulder
   - D22.62 – Melanocytic nevi, left upper limb, including shoulder
   - D22.71 – Melanocytic nevi, right lower limb, including hip
   - D22.72 – Melanocytic nevi, left lower limb, including hip
   - D22.4 – Melanocytic nevi, scalp and neck
   - D22.11 – Melanocytic nevi, right eyelid
   - D22.39 – Melanocytic nevi, other parts of face
   - D22.21 – Melanocytic nevi, right ear and external auricular canal
   - D22.22 – Melanocytic nevi, left ear and external auricular canal

2. **Question:** Can anyone confirm whether the actinic keratosis code L57.0 requires a secondary code?

   **Answer:** ICD-10 category L57 allows the physician to select and report a secondary code to identify the underlying cause if the condition is determined to be caused by a source other than solar radiation. It is up to the provider to determine and document within the medical record if the underlying cause of the condition is due to a source other than solar radiation.

   However, if the condition is due to solar radiation or the underlying cause is not documented, it would be appropriate to report a single code for Actinic Keratosis (L57.0).

   This guidance is strictly based upon ICD-10 rules. Reporting criteria for medical necessity are determined by individual and governmental payers as established within their payment policies. We encourage you to contact your payers to review their medical necessity payment policies to determine reporting criteria for this condition.

3. **Question:** I am trying to find the ICD-10 codes for Atypical Fibroxanthoma and Spindle Cell Carcinoma. In an online search for atypical fibroxanthoma it is coming up as malignant neoplasm.

   As only a limited number of ICD-10 codes can be reported, the diagnosis codes that support the procedural services performed and the reason for the encounter should be listed first. These ICD-10 codes will determine if the services provided meet the payer’s medical necessity policies and allow for processing of the claim. Other conditions which co-exist during the encounter and require or affect patient care, treatment, or management should also be coded and reported, up to the number of codes allowed on the claim.

   In the second example the codes reported would be:

   - D48.5 – Neoplasm of uncertain behavior of skin
   - Z85.820 – Person history of malignant melanoma of skin
   - L82.1 – Other seborrheic keratosis
   - D22.5 – Melanocytic nevi, chest
   - D22.61 – Melanocytic nevi, right upper limb, including shoulder
   - D22.62 – Melanocytic nevi, left upper limb, including shoulder
   - D22.71 – Melanocytic nevi, right lower limb, including hip
   - D22.72 – Melanocytic nevi, left lower limb, including hip
   - D22.4 – Melanocytic nevi, scalp and neck
   - D22.11 – Melanocytic nevi, right eyelid
   - D22.39 – Melanocytic nevi, other parts of face
   - D22.21 – Melanocytic nevi, right ear and external auricular canal
   - D22.22 – Melanocytic nevi, left ear and external auricular canal

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**For Spindle Cell Carcinoma it is coming up as malignant neoplasm or sarcoma on my searches online.**

**In my search in the ICD-10 book and in the coding section of our EMR crosswalk I am not finding anything for either.**

**Answer:** Using the ICD-10 Index code search, Atypical Fibroxanthoma directs you to see Neoplasm, connective tissue, uncertain behavior. On crossing over the neoplasm table, the code, uncertain neoplasm of the connective tissue of the skin directs you to D48.5 - Neoplasm of uncertain behavior of skin.

To find spindle cell carcinoma (AKA sarcomatoid carcinoma) search for sarcoma in the ICD-10 Index, and once there, spindle cell carcinoma directs you to Neoplasm, connective tissue, malignant. Once in the neoplasm table, you would then search for the code based on anatomic location.

**4. Question: Is there an ICD-10 code for Basosquamous Cell Carcinoma?**

**Answer:** Basosquamous cell carcinoma, although considered a mixed type carcinoma, is still a specified type and should be reported from the **C44 category as an Other specified malignant neoplasm of the skin.**

As with both the basal cell and squamous cell carcinoma codes, ICD-10 provides both site and laterality specific codes for other specified malignant neoplasm of the skin.

**5. Question: I’m under the impression that in order to code for history of MM, BCC, SCC etc (Z85.820 & Z85.828), both need to be paired with (preceded by) a Z08 encounter code, indicating that the malignancy no longer exists. Is this correct?**

**Answer:** There are no coding instructions that indicate that these two codes have to be reported together. The use of Z85.828 is appropriate to use as first listed diagnosis. Please check your payer(s) policy as we have noticed some payers will not accept an encounter claim with the Z85.xxx code without a problem code on the claim form.

The coding instructions indicate that if your primary code is Z08 – **Encounter for follow-up examination after completed treatment for malignant neoplasm,** one should then also report an additional code from Z90.x to identify any acquired absence of organs and/or Z85.x to identify the personal history of malignant neoplasm.

ICD-10 code Z08 replaced ICD-9 codes V67.1 Follow-up examination following radiotherapy and V67.2 Follow-up examination following chemotherapy. This indicates Z08 is most likely reported for patients undergoing extensive treatment targeted at malignant neoplasms e.g. chemotherapy, radiation therapy etc. and this code would be reported once the radiotherapy or chemotherapy treatment is complete.

However, if your primary code is Z85.820 - **Personal history of malignant melanoma of skin** (conditions classifiable to C43 [melanoma and other malignant neoplasms of skin]), ICD-10 does not provide an instruction stating an additional code is required.

ICD-10 Official guidelines Chapter 21, #4 History (of) states: personal history codes explain a patient’s past medical condition that no longer exists and is not receiving any treatment, but that has the potential for recurrence and therefore may require continued monitoring e.g. Z85.

#8 Follow-up under the coding guidelines state in part: **Follow-up codes are used to explain continuing surveillance following completed treatment of a disease, condition or injury. They imply that the condition has been fully treated and no longer exists. Follow-up codes may be used in conjunction with history codes to provide the full picture of the healed condition and its treatment. The follow-up code is sequenced first, followed by the history code. The use of ‘may’ in the instructions is interpreted as an indication that this is not mandatory, but optional in a dermatology patient with history of malignant neoplasm circumstance.**

Additional topics and questions as well as links to AAD ICD-10 Resources are available on the ICD-10 Member to Member Community.
**In The Know…**

**CDC Clarifies Use of Excludes1 Note Instruction**

Did you know that the Centers for Disease Control and Prevention (CDC) have issued a comment providing clarification on the appropriate application of Excludes1 Note? The clarification states in part “**If the two conditions are not related to one another, it is permissible to report both codes despite the presence of an Excludes1 note**”.

For example, a patient who presents with a Nevus on one cheek (D22.30) and hemangioma on the other cheek (D18.01) can now have that encounter reported with both ICD-10-CM codes D22.30 as well as D18.01 to identify both conditions regardless of the Excludes1 note located at D18.

**Example of Excludes1 coding instruction**

<table>
<thead>
<tr>
<th>ICD-10-CM Code Category</th>
<th>Code Description</th>
<th>Coding Instruction</th>
<th>ICD-10-CM Code Category</th>
<th>Code Description</th>
<th>Coding Instruction</th>
</tr>
</thead>
<tbody>
<tr>
<td>D18</td>
<td>Hemangioma and lymphangioma, any site</td>
<td>Excludes1: benign neoplasm of glomus jugulare (D35.6) blue or pigmented nevus (D22.-) Nevus NOS (D22.-) Vascular nevus (Q82.5)</td>
<td>D22</td>
<td>Melanocytic nevi</td>
<td>Includes: atypical nevus blue hairy pigmented nevus nevus NOS</td>
</tr>
<tr>
<td>D23</td>
<td>Other benign neoplasms of skin</td>
<td>Includes: benign neoplasm of hair follicles benign neoplasm of sebaceous glands benign neoplasm of sweat glands</td>
<td>D17</td>
<td>Benign lipomatous neoplasm</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Excludes1: benign lipomatous neoplasms</td>
<td>D22</td>
<td>Melanocytic nevi</td>
<td>Includes: atypical nevus blue hairy pigmented nevus nevus NOS</td>
</tr>
</tbody>
</table>

To view the CDC clarification, visit [http://www.cdc.gov/nchs/data/icd/Interim_Coding_advice_on_Excludes_1_note.pdf](http://www.cdc.gov/nchs/data/icd/Interim_Coding_advice_on_Excludes_1_note.pdf).

**Now you are In The Know!**