



## Medicare Rural Health Clinic Version

### KEY CONCEPTS OUTLINE

#### **Module 5: Supplemental Review of Medicare Coverage Guidance and the Advance Beneficiary Notice**

##### I. Overview of Medicare Coverage

###### A. In order to be covered by Medicare, items and services must:

1. Fall into a Medicare benefit category;
2. Not be statutorily excluded;
3. Be reasonable and necessary; and
4. Meet other Medicare program requirements for payment. <Medicare Program Integrity Manual, Chapter 3 § 3.6.2.1>

###### B. Coverage guidance:

1. The Social Security Act defines Medicare benefit categories and exclusions, supplemented by regulatory guidance (e.g. 42 C.F.R. §§ 409, 410) and sub-regulatory guidance (e.g., the *Medicare Benefit Policy Manual*) published by CMS.
2. In some cases, CMS publishes National Coverage Determinations (NCDs), discussed later in this module, specifying the circumstances under which an item or service is reasonable and necessary. <Medicare Program Integrity Manual, Chapter 3 § 3.6.2.2>
3. If there is no NCD, MACs may publish Local Coverage Determinations (LCDs), discussed later in this module, specifying the circumstances under which an item or service is reasonable and necessary. <Medicare Program Integrity Manual, Chapter 3 § 3.6.2.2>
4. If there is no NCD or LCD applicable to an item or service, contractors determine if it is reasonable and necessary based on the following criteria:

- a. It is safe and effective;
- b. It is not experimental or investigational;
- c. It is appropriate, including duration and frequency;
- d. It is furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the beneficiary's condition or to improve the function of a malformed body member;
- e. It is furnished in a setting appropriate to the beneficiary's medical needs and condition;
- f. It is ordered and furnished by qualified personnel; and
- g. It meets, but does not exceed, the beneficiary's medical need. < *Medicare Program Integrity Manual*, Chapter 3 § 3.6.2.2 >

## II. National and Local Coverage Policies

### A. Medicare Coverage Database

1. CMS hosts a comprehensive coverage website entitled the Medicare Coverage Database where National and Local Coverage Determinations and related documents are published.

***Link: Coverage Database (NCDs, NCAs, LCDs) under Medicare-Related Sites – General***

- a. CMS has published a helpful guide that provides an overview of how to use the coverage database. The *MLN Booklet – How to Use the Medicare Coverage Database*, last updated June 2020, can be accessed from CMS' MLN Publications website.
2. Types of Documents on the Medicare Coverage Database <42 C.F.R. 405.1060; 405.1062; *Medicare Program Integrity Manual*, Chapter 13 §§ 13.1.1, 13.1.3, 13.5.1 >
  - a. National Coverage Determination (NCD)

*An NCD describes national Medicare coverage policies and generally provides the conditions under which an item or service is covered. NCDs are binding on all Medicare contractors and in most cases on ALJs in the appeals process.*

b. National Coverage Analysis and Decision Memoranda

*CMS publishes NCAs and Decision Memoranda describing CMS coverage decisions and providing the clinical basis and rationale of the decisions, including clinical evidence and studies.*

c. Local Coverage Determination (LCD)

*MACs publish LCDs to describe local coverage policy and as educational tools to assist and provide guidance to providers within their jurisdiction. LCDs are not binding on Medicare contractors or ALJs, but they must be given substantial deference. LCDs no longer contain pertinent diagnostic information.*

d. Local Coverage Articles

*MACs publish coverage articles addressing local coverage, coding, billing, medical review, and claims considerations, including pertinent diagnostic information. The articles may include newly developed educational materials, coding instructions, or clarification of existing billing or claims policy.*

### Case Study 1

**Facts:** A patient presents to the RHC for destruction of several benign lesions on his right upper and lower eyelids (ICD-10-CM diagnoses H02.821 and H02.822). The physician documents in the patient's record that the lesions are causing pain, obstructing the patient's vision, and occasionally bleed. The physician removes 4 lesions using electrocautery (HCPCS 17110). In addition, the physician removes a small asymptomatic hemangioma on his cheek (ICD-10-CM diagnosis D18.01) and no other complicating diagnoses were documented in relation to the hemangioma. The physician removes the lesion (HCPCS 17106) and tells the patient to return to the RHC in two weeks for a recheck.

**Turn to the LCD: *Benign Skin Lesion Removal (Excludes Actinic Keratosis and Mohs) (L33979)* in the materials behind the outline and review the requirements for the procedures.**

- Is the removal of the benign lesions on the eyelids a covered procedure (HCPCS 17110)?
- Is the removal of the hemangioma on the cheek a covered procedure (HCPCS 17106)?
- Should the RHC have asked the patient to sign an ABN prior to performing the procedure(s)?

### III. Coverage of Laboratory Services

A. CMS publishes laboratory NCDs, along with additional coding and coverage information in a “*Lab NCD Manual*” entitled *Medicare National Coverage Determination (NCD) Coding Policy Manual and Change Report, Clinical Diagnostic Laboratory Services*.

1. Portions of the *Lab NCD Manual* are included in the materials behind the outline for reference.

**Link: *Clinical Diagnostic Laboratory NCD Manual under Medicare -Related Sites - General***

2. The *Lab NCD Manual* contains a list of “Non-covered ICD-10-CM Codes for All Lab NCD Edits” that are never covered by Medicare for a diagnostic laboratory service. It is not clear whether the list applies to other NCDs or to laboratory tests not covered by an NCD. <*Lab NCD Manual*>
3. The *Lab NCD Manual* contains national policies and MACs may not issue or maintain local policies (i.e., LCDs) that are inconsistent with the *Lab NCD Manual*. <Program Memorandum AB-02-110>
4. There are three “lists” of diagnosis codes applicable to each NCD
  - a. Non-Covered ICD-10-CM Codes for All NCD Edits
    - i. This is a master list set forth at the beginning of the NCD manual.
    - ii. This list applies to all NCDs and represents diagnoses for which a laboratory test covered by an NCD will never be a covered Medicare benefit. <Program Memorandum AB-02-110>
      - a) It is not clear whether CMS takes the position that the list of “ICD-10-CM codes denied” also applies to laboratory tests that do not fall within the scope of one of the laboratory NCDs.
    - iii. Tests performed for one of these diagnoses may be billed to the patient without an ABN. <Medicare Claims Processing Manual, One-Time Notification Transmittal 11>
      - a) If a test performed for one of these diagnoses is billed to Medicare, the test should be billed with the -GY modifier (discussed in a later module). <Medicare Claims Processing Manual, One Time Notification Transmittal 11>

- b. ICD-10-CM Codes Covered by Medicare
  - i. This list is set forth in the body of each NCD.
  - ii. These codes are presumed to support medical necessity. <Program Memorandum AB-02-110>
- c. ICD-10-CM Codes That Do Not Support Medical Necessity
  - i. This list is set forth in the body of each NCD.
    - a) In many cases, this list includes all diagnosis codes not included in one of the two lists discussed above.
  - ii. These codes represent diagnoses that generally do not support medical necessity but for which there may be exceptions. <Program Memorandum AB-02-110>
  - iii. Tests performed for one of these diagnoses may be billed to the patient if the patient was given an effective ABN. <Program Memorandum AB-02-110>

### Case Study 2

**Facts:** Patient presents to a provider-based RHC for an Initial Preventive Physical Exam (IPPE). After completion of the IPPE, the physician orders a CBC (complete blood count) with the diagnosis Z00.00 - Encounter for general adult medical examination without abnormal findings. The RHC nurse draws the blood and submits the order and diagnosis with the specimen to the hospital to perform the laboratory test.

**Turn to the excerpts from the Lab NCD Manual that follow the outline.**

- Will the laboratory test be covered by Medicare?
- To bill the patient for the venipuncture and lab test, would the RHC and/or the hospital need to issue an ABN to the patient prior to performing the venipuncture and lab test?

#### IV. Coverage of Outpatient Drugs

*Medicare covers outpatient drugs under three circumstances:*

- *Statutorily covered drugs*
- *Drugs incident to a physician's service and NOT usually self-administered*
- *Drugs integral to a procedure*

##### A. Statutorily Covered Drugs

1. The following drugs are covered by Medicare as specifically authorized by statute:
  - a. Blood clotting factors for hemophilia patients;
  - b. Drugs used in immunosuppressive therapy;
  - c. Erythropoietin for dialysis patients; and
  - d. Certain oral anti-cancer drugs and anti-emetics used in certain situations. *< Medicare Benefit Policy Manual, Chapter 15 § 50.5 >*

##### B. Drugs Provided Incident to a Physician's Service

1. Medicare covers drugs provided incident to a physician's or NPP's service that are not usually self-administered by the patient. *< Medicare Benefit Policy Manual, Chapter 15 § 50 >*
2. The local MAC makes the determination that a drug is usually self-administered by applying the following guidelines. *< Medicare Benefit Policy Manual, Chapter 15 § 50.2.A >*
  - a. The determination a drug is self-administered is not patient specific. The decision is based on the usual method of administration for all Medicare beneficiaries who use the drug. *< Medicare Benefit Policy Manual, Chapter 15 § 50.2.C >*
  - b. Drugs administered by any method other than injection and infusion are considered to be usually self-administered, with limited exceptions. *< Medicare Benefit Policy Manual, Chapter 15 § 50.2.B >*

*Self-administered drugs include oral drugs, suppositories, topically applied drugs, and inhalation drugs.*

- c. Drugs administered by subcutaneous injection are presumed to be usually self-administered. *< Medicare Benefit Policy Manual, Chapter 15 § 50.2.C.3 >*

- d. Drugs administered intravenously or by intramuscular injection are presumed to be not usually self-administered. < *Medicare Benefit Policy Manual*, Chapter 15 § 50.2.C.1 and 2 >
3. Each MAC publishes a Self-Administered Drug (SAD) Exclusion List with the injectable drugs the MAC has determined to be usually self-administered and not covered. Each MAC's SAD Exclusion List is posted on the Medicare Coverage Database.

***Link: Coverage Database (NCDs, NCAs, LCDs) under Medicare-Related Sites – General***

### C. Drugs Integral to a Procedure

1. Medicare covers certain self-administered drugs if they are an integral component of a procedure, or are directly related to it, or facilitate the performance of or recovery from the procedure. < *Medicare Benefit Policy Manual*, Chapter 15 § 50.2.M >

***Examples of drugs integral to a procedure***

- *Sedatives administered in a pre-procedure area*
- *Eye drops and certain other drugs related to eye procedures*
- *Antibiotic ointment such as bacitracin*

2. A CMS representative has indicated the “overwhelming majority” of self-administered drugs are non-covered. The representative recommended comparing other items to the above list to determine if they may be covered. <Hospital Open Door Forum, August 23, 2011 >
  - a. The representative used the example of insulin given to control a patient's blood sugar as a non-covered drug, stating it would not be integral to a procedure because its purpose was to control a patient's blood sugar and not to be used as part of a procedure. <Hospital Open Door Forum, August 23, 2011 >
3. A drug will not be considered covered if the drug itself is the treatment rather than being an integral component of or facilitating the performance of or recovery from a procedure. < *Medicare Benefit Policy Manual*, Chapter 15 § 50.2.M >

Examples of drugs considered a **treatment and not integral to a procedure**

- Drugs given to a patient for continued use at home
- Oral pain medication given to a patient who develops a headache while receiving a drug infusion
- Daily routine insulin or hypertension medication given before a procedure in the clinic
- A fentanyl patch or oral pain medication given to a patient presenting with pain

4. Handout 7 is an algorithm of the coverage of self-administered drugs that are integral to a procedure. Billing for drugs during or incident to a qualifying visit was discussed in a prior module.

## V. Medicare's Financial Liability Protections

- A. The Limitation on Liability ("LOL") statute is a Medicare law designed to protect beneficiaries from unexpected personal liability for a non-covered service if they are unaware the service is not covered by Medicare. < *Medicare Claims Processing Manual*, Chapter 30 § 10 >

*The beneficiary may not be charged for a non-covered service if:*

- The service is denied for a reason specified in the "LOL" statute; AND
- The beneficiary did not have advance notice Medicare would not pay for it.

- B. Circumstances When Limitation on Liability Applies (and Advance Notice is Mandatory to Charge the Patient)
  1. The item or service is not reasonable and necessary. < *Medicare Claims Processing Manual*, Chapter 30 §§ 20, 20.1 >
    - a. The item or service is not considered by Medicare to be medically necessary under the circumstances.
    - b. The service is a preventative service that is usually covered but will not be covered in this instance because frequency limitations have been exceeded.
  2. The service is custodial care. < *Medicare Claims Processing Manual*, Chapter 30 § 20.1 >

3. The item or service is experimental (e.g., research use only or experimental use only laboratory tests). *<Medicare Claims Processing Manual, Chapter 30 §§ 20.1 and 40.2.2>*
- C. Circumstances When Limitation on Liability Does Not Apply (and Advance Notice is Voluntary, Beneficiary May be Charged Without Notice)
1. The item or service fails to meet a technical benefit requirement. *<Medicare Claims Processing Manual, Chapter 30 § 20.2>*
    - a. "Technical denials" occur if coverage requirements for an item or service are not met or there is a failure to meet a condition of payment required by regulation. *<Medicare Claims Processing Manual, Chapter 30 § 20.2>*

*Example: Denial of a drug or biological because it is usually self-administered by the patient is considered a technical denial.*

2. The item or service does not fit into a Medicare benefit (i.e., is statutorily excluded). *<Medicare Claims Processing Manual, Chapter 30 § 20.2>*
  - a. "Categorical denials" occur when the denial is based on other statutory provisions not referenced in the LOL statute. *<Medicare Claims Processing Manual, Chapter 30 §§ 20.1 and 20.2>*

*Items or services excluded from Medicare coverage include:*

- *Routine physicals and most screening tests, except the Initial Preventative Physical Exam and Annual Wellness Visit*
- *Most vaccinations, except flu, pneumococcal and hepatitis B*
- *Routine eye care, examinations and most eyeglasses*
- *Hearing aids and hearing examinations*
- *Dental care and dentures*
- *Routine foot care and flat foot care*
- *Orthopedic shoes and orthotic foot supports*
- *Cosmetic surgery and surgery performed for cosmetic purposes*

## VI. Advance Beneficiary Notice of Non-coverage (ABN)

### A. General Rule

1. A properly prepared and delivered ABN form satisfies the Limitation on Liability notice requirement for outpatient services that are not considered reasonable and necessary or are custodial. < *Medicare Claims Processing Manual*, Chapter 30 §§ 20, 30, and 50 >

## B. The ABN Form

1. The Advance Beneficiary Notice (CMS-R-131 (Exp. 06/30/2023)), available in English, Spanish, and large print, is the required form for providing notice of non-coverage for outpatient services. Handout 8 is the ABN Form.
2. The ABN may not be modified except as specifically allowed in the completion instructions. < *Medicare Claims Processing Manual*, Chapter 30 § 50.5, C >

**Link: Beneficiary Notice Initiative under Medicare-Related Sites – General**  
Use the links on the left navigation to go to the FFS ABN page.

## C. Delivery of the ABN

1. The ABN should be delivered in person to the beneficiary or their representative and the provider must answer all inquiries of the beneficiary, including the basis for the determination that the service is not covered. < *Medicare Claims Processing Manual*, Chapter 30 § 50.8, 50.8.1 >
  - a. If delivery in person is not possible, delivery may be by telephone, mail, secure fax, or email. < *Medicare Claims Processing Manual*, Chapter 30 § 50.8.1 >
    - i. If notice is by telephone, a copy should be mailed, faxed or emailed to the beneficiary for them to sign and return to the provider. In order to be effective, the beneficiary must not dispute the contact. < *Medicare Claims Processing Manual*, Chapter 30 § 50.8.1 >
2. Beneficiary Comprehension
  - a. An ABN will not be considered effective unless the beneficiary, or their authorized representative, comprehends the notice. < *Medicare Claims Processing Manual*, Chapter 30 § 50.8 >
  - b. The only printed versions of the form allowed are the OMB approved English and Spanish versions, and insertions should be made in the language of the printed form. < *Medicare Claims Processing Manual*, Chapter 30 § 50.5, A >

- c. Oral assistance should be provided for languages other than English and Spanish and documented in the "Additional Information" section. < Medicare Claims Processing Manual, Chapter 30 § 50.5, A >
3. Beneficiary Representative
- a. If the patient is unable to comprehend the notice, notice must be provided to a known legal representative if the patient has one. < Medicare Claims Processing Manual, Chapter 30 § 50.3 >
    - i. If the beneficiary does not have a representative, one may be appointed following CMS guidelines and as permitted by State and Local laws. < Medicare Claims Processing Manual, Chapter 30 § 50.3 >
  - b. If a representative signs on behalf of the beneficiary, the name of the representative should be printed on the form and the signature should be annotated with "rep" or "representative". < Medicare Claims Processing Manual, Chapter 30 § 50.3 >
  - c. An authorized representative is an individual authorized under State or other applicable law to act on behalf of a beneficiary when the beneficiary is temporarily or permanently unable to act for themselves (e.g., a legally appointed representative or legal guardian). < Medicare Claims Processing Manual, Chapter 30 § 500 >
    - i. In states with health care consent statutes providing for health care decision making by surrogates for individuals who lack advance directives or guardians, it is permissible to rely on individuals designated under those statutes to act as authorized representatives. < Medicare Claims Processing Manual, Chapter 30 § 500 >
4. Timing of Delivery
- a. The ABN must be provided far enough in advance of delivery of potentially non-covered items or services to allow the beneficiary time to consider all available options and make an informed decision without undue pressure. < Medicare Claims Processing Manual, Chapter 30 §§ 40.2.1, 50.8 >
    - i. The ABN is not effective if it is provided during an emergency, the beneficiary is under great duress, or the beneficiary is coerced or misled by the notifier, the notice, or the manner of delivery. < Medicare Claims Processing Manual, Chapter 30 § 40.2 >
  - b. A valid ABN remains effective as long as there has been no change in:
    - i. The care described on the original ABN;

- ii. The beneficiary's health status which would require a change in the treatment for the condition; and/or
  - iii. The Medicare coverage guidelines for the non-covered item or service (i.e., updates or changes to the coverage policy of the item or service). *< Medicare Claims Processing Manual, Chapter 30 § 50.8, A >*
- c. For items or services that are repetitive or continuous, a new ABN may be issued after one year, however, it is not required unless a change has occurred making the ABN no longer effective. *< Medicare Claims Processing Manual, Chapter 30 § 50.8, A >*

*Caution: Medicare Claims Processing Manual, Chapter 30 § 40.2 continues to state that notice is not effective if delivered more than a year before the item or service is provided. This section was published in 2019 and is presumably superseded by the above guidance published in 2021.*

## 5. Completion of the Form

*Unless noted otherwise, information in this section is from the "Form Instructions, Advance Beneficiary Notice of Non-coverage (ABN), OMB Approval Number: 0938-0566" available on the FFS ABN webpage and included in the materials behind the outline.*

- a. "Notifier(s)"
  - i. If the notifier in the header is an entity other than the billing entity, the notifier should annotate the Additional Information section of the ABN with information for contacting the billing entity for questions. *< Medicare Claims Processing Manual, Chapter 30 § 50.3 >*
  - ii. If multiple entities are involved in rendering or billing for the care (e.g., one entity provides the technical component and another entity provides the professional component), separate ABNs are not necessary. *< Medicare Claims Processing Manual, Chapter 30 § 50.3 >*
- b. "Blank D"
  - i. The "Blank D" field is filled in with one of the following general categories as applicable: Item, Service, Laboratory Test, Test, Procedure, Care, Equipment. All "Blank D" fields must be filled in for the ABN to valid.

- ii. In the column under “Blank D”, describe the specific item or service that is non-covered, including the frequency or duration of repetitive or continuous services. Items can be grouped, e.g., “wound care supplies” or “observation services” rather than listed individually.
- c. “Reason Medicare May Not Pay:”
- i. Explain the reason the item may not be covered by Medicare.
  - ii. Simply stating “medically unnecessary” or the equivalent is not acceptable. < *Medicare Claims Processing Manual*, Chapter 30 § 40.2.1, C >

*Tip: Be specific about the reason for denial, for example:*

- “Medicare does not pay for custodial care, except for some hospice services”
- “Medicare does not pay for this test for your condition”.

d. “Estimated Cost”

- i. Provide a good faith estimate of the cost of the non-covered services to the patient. The cost to the patient is the provider’s usual and customary charge and is not limited by the Medicare allowable or payment amount.

**Caution:** *The final amount billed to the patient may be affected by state laws requiring providers to give uninsured patients a discount, including discounts based on financial need or equal to the discount given to their largest payer.*

- a) An estimate will be considered to be made in good faith if the estimate is within the greater of \$100 or 25% of the cost of the service to the patient (i.e., amount billed to the patient) and may be given as a range or may exceed the final amount billed.

*Examples of good faith cost estimates for a service with a \$1000 charge:*

- Any estimate greater than \$750
- Between \$750 - \$1100
- No more than \$1200

- ii. Multiple services may be grouped together into a single cost estimate.

- iii. An average daily cost estimate may be provided for complex projections (i.e., observation services).
- iv. Unknown costs
  - a) The hospital may not have a policy of routinely or frequently failing to provide a cost estimate, however, the patient may sign an ABN without a cost estimate in limited circumstances.
    - 1) If additional services may be required (i.e. reflexive testing), the cost of the initial services should be given, along with a notation that additional services may be provided.
    - 2) If the costs cannot be determined, make a notation in the cost estimate area that no cost estimate is available.

### Case Study 3

**Facts:** A Medicare patient presents to the RHC for a B12 injection that, under the applicable Medicare coverage policy, was not considered medically necessary for the patient's condition. The patient signed an ABN before the injection was performed. The ABN was properly prepared with an estimated cost of \$50-\$75 for the injection and medication.

The RHC provided the injection; however, due to the patient's body weight, the patient required a higher dose than normally used, resulting in a final total charge of \$100 for the procedure. The RHC billed Medicare and Medicare denied coverage as patient responsibility. After receiving the remittance advice, the RHC sent the patient a bill for \$100.

The patient claims the RHC is overcharging and he is only going to pay \$75 based on the estimated cost listed on the ABN.

- e. "Options"
  - i. The beneficiary or their representative must check one of the options or have the provider check the option if they are unable to do so.
    - a) The provider should make a note on the ABN if they checked the option at the request of the beneficiary.

- ii. If the beneficiary refuses to choose an option, the ABN should be annotated with the refusal and the annotation should be witnessed. < *Medicare Claims Processing Manual*, Chapter 30 § 40.2.2, B and 50.6, A.2.>
- iii. Special Instructions for Dually Eligible Beneficiary
  - a) Dually eligible beneficiaries have both Medicare and Medicaid, including patients enrolled in a Qualified Medicare Beneficiary (QMB) Program.
  - b) For dually eligible beneficiaries, Option 1 must be modified by lining through certain language as designated in the "Form Instructions", included in the materials behind the outline. This is an exception to the general prohibition on modifying the ABN form.
  - c) Dually eligible beneficiaries should be instructed to choose Option 1 in order for the claim to be submitted for Medicare adjudication and, if denied, submitted to Medicaid for a determination.
    - 1) If both Medicare and Medicaid deny coverage, refer to the "Form Instructions" or MLN Booklet *Dually Eligible Beneficiaries under Medicare and Medicaid*, included in the materials behind the outline, for more information on potential beneficiary liability.
- iv. If there are multiple items on the ABN and the beneficiary wants to select different options for each of the items, more than one ABN should be used to accommodate the beneficiary's choices.
- f. "Additional Information"
  - i. May be used for witness signatures or to make annotations, such as advising the beneficiary to notify their provider of tests or services that were ordered but not received. If items are added after the date of the ABN, they must be dated.
- g. "Signature"
  - i. The beneficiary or their representative should sign and date the notice.
  - ii. If the beneficiary refuses to sign but still desires to receive the item or service, the ABN should be annotated with the refusal and the annotation should be witnessed. < *Medicare Claims Processing Manual*, Chapter 30 § 40.2.2, B and 50.6, A.2.>

#### Case Study 4

**Facts:** A Medicare patient presented to the hospital for a minor non-cosmetic surgical procedure related to varicose veins. Under an applicable LCD, the procedure is not considered medically necessary for patients with a diagnosis of varicose veins. A properly prepared ABN was reviewed with the patient.

The patient refused to sign the ABN, but still wants to proceed with the procedure based on the recommendation of his physician. Two witnesses acknowledged in writing on the ABN form that the ABN had been reviewed with the patient, but that he refused to sign it. May the hospital bill the patient for the procedure, even though they did not sign the ABN?

#### 6. Copy of the ABN

- a. The hospital should retain the original ABN and give a copy to the beneficiary. <Medicare Claims Processing Manual, Chapter 30 §§ 40.2.1 B and 50.5 C>
  - i. The ABN should be retained for 5 years, or longer as required by state law. <Medicare Claims Processing Manual, Chapter 30 § 50.7>

**Caution:** The ABN should be retained even if the beneficiary refuses the service or refuses to sign or choose an option.

- b. Carbon copies, fax copies, electronically scanned copies, and photocopies are all acceptable. <Medicare Claims Processing Manual, Chapter 30 §§ 40.2.1 B and 50.5 C>

#### D. Other Considerations for an Effective ABN

- 1. Interplay between the ABN and EMTALA requirements
  - a. EMTALA Requirements Take Priority over ABN Requirements
    - i. Under the Emergency Medical Treatment and Active Labor Act (EMTALA) hospitals have an obligation to complete a medical screening examination (MSE) and stabilize a patient presenting to its emergency department, or in certain circumstance, presenting to other areas of the hospital. <Medicare Claims Processing Manual, Chapter 30 § 40.4>

- a) CMS and the OIG take the position that where EMTALA applies, it is improper to present an ABN to a patient before completing the MSE and stabilizing the patient. < *Medicare Claims Processing Manual*, Chapter 30 § 40.4>
- b. Contractor's Medical Necessity Determinations for EMTALA Required Care
  - i. The MAC is required to make medical necessity determinations of EMTALA screening/stabilization services based on the "information available to the treating physician or practitioner (including the patient's presenting symptoms or complaint) at the time the item or service was ordered or furnished". <Social Security Act § 1862 (d)>
  - ii. The Intermediary should not apply frequency edits to EMTALA screening/stabilization services. <Social Security Act § 1862 (d)>
- 2. Medicare Advantage Plan Beneficiaries
  - a. The ABN form may not be used for services provided under Medicare Advantage Plans. < *Medicare Claims Processes Manual*, Chapter 30 § 50.1>
- 3. Prohibition on Routine, Blanket and Generic ABNs
  - a. In general, "generic" ABNs (i.e. merely stating denial is possible"), "routine," ABNs (i.e. no specific reason Medicare will not pay), and "blanket" ABNs (i.e. given for all claims) will not be considered to be effective. < *Medicare Claims Processing Manual*, Chapter 30 § 40.2.2 C>

*Routine ABNs may be given for frequency limited service (e.g., screening mammography) if the ABN states the frequency limitation (e.g., "Medicare does not pay for this service more often than \_\_\_\_\_.")*

## VII. Billing Outpatient Non-Covered Items or Services

- A. Handout 9 is an overview of billing for outpatient non-covered services, as discussed in this section.

**Note:** *The following information applies to an RHC because the services are billed on the UB04 claim form to the Part A MAC.*

### B. An Effective ABN Was Issued

#### 1. Bill to the MAC with Occurrence Code 32

- a. When an ABN is provided, the claim for the items or services for which the ABN was given must be filed with an occurrence code 32. <Medicare Claims Processing Manual, Chapter 1 § 60.4.1>
  - b. The occurrence date should be the date that the ABN was given to the beneficiary. <Medicare Claims Processing Manual, Chapter 1 § 60.4.1>
2. Bill as covered charges
    - a. Items or services for which an ABN was given should be billed as “covered charges.” <Medicare Claims Processing Manual, Chapter 1 § 60.4.1>
  3. Other covered or non-covered services billed on the same claim
    - a. If other covered or non-covered items or services are billed on the same claim, modifier –GA should be used to identify those items or services for which an ABN was given. <Medicare Claims Processing Manual, Chapter 1 § 60.4.1>
  4. Collecting payment from the beneficiary after denial by the MAC
    - a. Where the MAC denies payment for services, for which an effective ABN was provided, payment for the services is collected from the beneficiary.
    - b. Medicare charge limits do not apply to services for which an effective ABN was given. <Medicare Claims Processing Manual, Chapter 30 § 50.12>
- C. An ABN Was Required but Not Issued
1. May bill on a “Fully Non-Covered Claim”
    - a. A “fully non-covered claim” is billed without indicators of liability or only provider liability indicators and is used to bill entirely non-covered services for which the RHC is liable. <Medicare Claims Processing Manual, Chapter 1 § 60.1.3.1>
    - b. Indicators of liability on a “Fully Non-Covered Claim”
      - i. No indicators of liability at the claim or line level (i.e., no condition code 21 which is a claim level indicator of beneficiary liability); or,
      - ii. All indicators of liability at the claim or line level must indicate that the RHC, and not the beneficiary, is liable (i.e., no modifier –GY which is a line level indicator of beneficiary liability). <Medicare Claims Processing Manual, Chapter 1 § 60.1.3.1>
  2. Bill as non-covered charges

- a. Charges should be billed as non-covered. < *Medicare Claims Processing Manual*, Chapter 1 § 60.1.3.1>
- 3. Other covered or non-covered services billed on the same claim
  - a. Modifier -GZ indicates a line item expected to be denied as not reasonable and necessary and no ABN was given. The -GZ triggers automatic denial and RHC liability. < *Medicare Claims Processing Manual*, Chapter 1 §§ 60.1.3.1 and 60.4.2, Table 8; *Medicare Program Integrity Manual*, Chapter 3 § 3.3.1.1 (G)>

#### D. At Request of the Beneficiary (Demand Bill)

- 1. Bill to the MAC with Condition Code 20
  - a. Where the RHC expects a service to be non-covered due to a categorical or technical denial, but the beneficiary requests that the claim be submitted to Medicare for a determination anyway, the claim should be submitted with condition code 20. This has traditionally been referred to as a "demand bill." < *Medicare Claims Processing Manual*, Chapter 1 § 60.3.1>
  - i. The beneficiary has the right to have any service provided to them billed to Medicare for an official payment decision that they may appeal. < *Medicare Claims Processing Manual*, Chapter 1 § 60.3.1>

*Caution: The UB04 Manual states that condition code is limited to home health and inpatient SNF claims. On February 19, 2010, CMS issued Medicare Claims Processing Manual Transmittal 1921 stating that condition code 20 may be used on any claim, when appropriate.*

- 2. Bill as non-covered charges
  - a. The charges for which coverage is "in dispute" must be submitted as non-covered charges. < *Medicare Claims Processing Manual*, Chapter 1 § 60.3.1>
- 3. Other covered services billed on same claim
  - a. Covered services may, but are not required, to appear on the same claim as non-covered services billed with condition code 20. < *Medicare Claims Processing Manual*, Chapter 1 § 60.3.2>
- 4. Other non-covered services billed on a separate claim

- a. Other non-covered services (i.e., billed with occurrence code 32 or condition code 21) must be submitted on a separate claim from demand bill services. Claims with condition code 20 are exempt from same day billing rules. <Medicare Claims Processing Manual, Chapter 1 § 60.3.2>
5. Voluntary ABN issued (Limitation on Liability does not apply)
    - a. Modifier –GX may be used to identify items subject to categorical or technical denial for which an ABN was given anyway (i.e., voluntary ABN). <Medicare Claims Processing Manual Transmittal 1921 B>
      - i. Modifier –GX may be reported with other liability modifiers, including modifier –GY. <Medicare Claims Processing Manual Transmittal 1921>
- E. Billing for Denial Notices for Secondary Payers (No-pay Bill)
1. Bill to the MAC with Condition Code 21
    - a. Where services are clearly non-covered (i.e., categorical or technical denials) but a claim is being submitted to Medicare for purposes of obtaining a denial notice that can be forwarded to secondary payers, the claim should be submitted with condition code 21. These types of claims are sometimes referred to as “no-pay bills.” <Medicare Claims Processing Manual, Chapter 1 § 60.1.3>
  2. Bill as non-covered charges
    - a. All charges on no-pay bills must be submitted as non-covered charges. <Medicare Claims Processing Manual, Chapter 1 § 60.1.3>
  3. Other covered and non-covered services billed on same claim
    - a. Non-covered services being billed for a denial must be submitted with modifier –GY, rather than condition code 21, when they appear on the same claim as covered and other non-covered services. <Medicare Claims Processing Manual, Chapter 1 § 60.1.2 (B)>
      - i. Modifier –GY indicates a line item that is statutorily excluded or does not meet the definition of any Medicare benefit (i.e., categorical and technical denial). Modifier –GY triggers beneficiary liability. <Medicare Claims Processing Manual, Chapter 1 § 60.4.2, Table 8>
  4. Voluntary ABN issued (Limitation on Liability does not apply)

- a. Modifier –GX may be used to identify items subject to a categorical or technical denial for which an ABN was given anyway (i.e., voluntary ABN). <Medicare Claims Processing Manual, Transmittal 1921 B>
- i. Modifier –GX may be reported with other liability modifiers, including modifier –GY. <Medicare Claims Processing Manual, Transmittal 1921>

Version 03/15/2023  
Check for Updates

## CASE STUDIES WITH ANALYSIS

### Case Study 1

**Facts:** A patient presents to the RHC for destruction of several benign lesions on his right upper and lower eyelids (ICD-10-CM diagnoses H02.821 and H02.822). The physician documents in the patient's record that the lesions are causing pain, obstructing the patient's vision, and occasionally bleed. The physician removes 4 lesions using electrocautery (HCPCS 17110). In addition, the physician removes a small asymptomatic hemangioma on his cheek (ICD-10-CM diagnosis D18.01) and no other complicating diagnoses were documented in relation to the hemangioma. The physician removes the lesion (HCPCS 17106) and tells the patient to return to the RHC in two weeks for a recheck.

Turn to the LCD: *Benign Skin Lesion Removal (Excludes Actinic Keratosis and Mohs) (L33979)* in the materials behind the outline and review the requirements for the procedures.

- Is the removal of the benign lesions on the eyelids a covered procedure (HCPCS 17110)?
- Is the removal of the hemangioma on the cheek a covered procedure (HCPCS 17106)?
- Should the RHC have asked the patient to sign an ABN prior to performing the procedure(s)?

**Analysis:** For HCPCS 17110, the LCD requires a covered diagnosis from List I/Group 1 codes. Both diagnoses codes for cysts of the eyelids and the other symptoms, including pain and vision obstruction, are considered to be medically necessary for the procedure. The RHC may bill Medicare for the covered services. For HCPCS 17106, the procedure is not medically necessary based on the documentation for the removal of an asymptomatic lesion (i.e., a diagnosis code from Group 2/List II *and* Group 3/List III must be reported for the service to be considered for payment). If the patient had signed an ABN prior to performing the procedure, the patient would have been financially liable for the service. In this case, the RHC is financially liable for the procedure and may not bill the patient for the procedure.

## Case Study 2

**Facts:** Patient presents to a provider-based RHC for an Initial Preventive Physical Exam (IPPE). After completion of the IPPE, the physician orders a CBC (complete blood count) with the diagnosis Z00.00 - Encounter for general adult medical examination without abnormal findings. The RHC nurse draws the blood and submits the order and diagnosis with the specimen to the hospital to perform the laboratory test.

**Turn to the excerpts from the Lab NCD Manual that follow the outline.**

- Will the laboratory test be covered by Medicare?
- To bill the patient for the venipuncture and lab test, would the RHC and/or the hospital need to issue an ABN to the patient prior to performing the venipuncture and lab test?

**Analysis:** The Lab NCD Manual provides a list of codes that are never covered by Medicare for a diagnostic lab service because the test is performed for screening purposes and is not covered by statute. If a code from this section is given as the reason for the test, the test may be billed to the patient without issuing an ABN. The patient has the right to have the claim submitted to Medicare, upon request. If a test performed for one of the non-covered diagnoses is billed to Medicare, the test should be reported with modifier -GY and charges reported in the non-covered column (discussed later in this module). In this scenario, both the venipuncture reported by the RHC and the lab test reported by the main provider should be reported in the non-covered column with modifier -GY to indicate patient liability.

Version 03/15/2023  
Check for Updates

### Case Study 3

**Facts:** A Medicare patient presents to the RHC for a B12 injection that, under the applicable Medicare coverage policy, was not considered medically necessary for the patient's condition. The patient signed an ABN before the injection was performed. The ABN was properly prepared with an estimated cost of \$50-\$75 for the injection and medication.

The RHC provided the injection; however, due to the patient's body weight, the patient required a higher dose than normally used, resulting in a final total charge of \$100 for the procedure. The RHC billed Medicare and Medicare denied coverage as patient responsibility. After receiving the remittance advice, the RHC sent the patient a bill for \$100.

The patient claims the RHC is overcharging and he is only going to pay \$75 based on the estimated cost listed on the ABN. Assuming no state laws affect the amount collected by the provider, how much may the RHC bill the patient?

**Analysis:** The patient is liable for \$100. The cost estimate was made in good faith because it is within the greater of \$100 or 25% of the final cost to the patient.

#### Case Study 4

**Facts:** A Medicare patient presented to the hospital for a minor non-cosmetic surgical procedure related to varicose veins. Under an applicable LCD, the procedure is not considered medically necessary for patients with a diagnosis of varicose veins. A properly prepared ABN was reviewed with the patient.

The patient refused to sign the ABN, but still wants to proceed with the procedure based on the recommendation of his physician. Two witnesses acknowledged in writing on the ABN form that the ABN had been reviewed with the patient, but that he refused to sign it. May the hospital bill the patient for the procedure, even though they did not sign the ABN?

**Analysis:** Under the "LOL" provisions, an ABN does not need to be signed to be effective as long as the patient read and understood the notice. Two witnesses should document the patient's refusal to sign, which was done in this case. <Medicare Claims Processing Manual, Chapter 30 § 40.2.2, B and 50.6, A.2.>

Version 03/15/2025  
Check for Updates

# Local Coverage Determination (LCD): 5-27 Benign Skin Lesion Removal (Excludes Actinic Keratosis, and Mohs) (L33979)

Links in PDF documents are not guaranteed to work. To follow a web link, please use the MCD Website.

## Contractor Information

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATE(S)
Noridian Healthcare Solutions, LLC	A and B MAC	02101 - MAC A	J - F	Alaska
Noridian Healthcare Solutions, LLC	A and B MAC	02102 - MAC B	J - F	Alaska
Noridian Healthcare Solutions, LLC	A and B MAC	02201 - MAC A	J - F	Idaho
Noridian Healthcare Solutions, LLC	A and B MAC	02202 - MAC B	J - F	Idaho
Noridian Healthcare Solutions, LLC	A and B MAC	02301 - MAC A	J - F	Oregon
Noridian Healthcare Solutions, LLC	A and B MAC	02302 - MAC B	J - F	Oregon
Noridian Healthcare Solutions, LLC	A and B MAC	02401 - MAC A	J - F	Washington
Noridian Healthcare Solutions, LLC	A and B MAC	02402 - MAC B	J - F	Washington
Noridian Healthcare Solutions, LLC	A and B MAC	03101 - MAC A	J - F	Arizona
Noridian Healthcare Solutions, LLC	A and B MAC	03102 - MAC B	J - F	Arizona
Noridian Healthcare Solutions, LLC	A and B MAC	03201 - MAC A	J - F	Montana
Noridian Healthcare Solutions, LLC	A and B MAC	03202 - MAC B	J - F	Montana
Noridian Healthcare Solutions, LLC	A and B MAC	03301 - MAC A	J - F	North Dakota
Noridian Healthcare Solutions, LLC	A and B MAC	03302 - MAC B	J - F	North Dakota
Noridian Healthcare Solutions, LLC	A and B MAC	03401 - MAC A	J - F	South Dakota
Noridian Healthcare Solutions, LLC	A and B MAC	03402 - MAC B	J - F	South Dakota
Noridian Healthcare Solutions, LLC	A and B MAC	03501 - MAC A	J - F	Utah
Noridian Healthcare Solutions, LLC	A and B MAC	03502 - MAC B	J - F	Utah
Noridian Healthcare Solutions, LLC	A and B MAC	03601 - MAC A	J - F	Wyoming
Noridian Healthcare Solutions, LLC	A and B MAC	03602 - MAC B	J - F	Wyoming

## LCD Information

### Document Information

**LCD ID**  
L33979

**Original Effective Date**

For services performed on or after 10/01/2015

**LCD Title**

Benign Skin Lesion Removal (Excludes Actinic Keratosis, and Mohs)

**Revision Effective Date****5-28**

For services performed on or after 10/01/2019

**Proposed LCD in Comment Period**

N/A

**Revision Ending Date**

N/A

**Source Proposed LCD**

DL33979

**Retirement Date**

N/A

**AMA CPT / ADA CDT / AHA NUBC Copyright Statement**

CPT codes, descriptions and other data only are copyright 2020 American Medical Association. All Rights Reserved. Applicable FARS/HHSARS apply.

**Notice Period Start Date**

07/28/2016

**Notice Period End Date**

09/14/2016

Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

Current Dental Terminology © 2020 American Dental Association. All rights reserved.

Copyright © 2013 - 2020, the American Hospital Association, Chicago, Illinois. Reproduced by CMS with permission. No portion of the American Hospital Association (AHA) copyrighted materials contained within this publication may be copied without the express written consent of the AHA. AHA copyrighted materials including the UB-04 codes and descriptions may not be removed, copied, or utilized within any software, product, service, solution or derivative work without the written consent of the AHA. If an entity wishes to utilize any AHA materials, please contact the AHA at 312-893-6816. Making copies or utilizing the content of the UB-04 Manual, including the codes and/or descriptions, for internal purposes, resale and/or to be used in any product or publication; creating any modified or derivative work of the UB-04 Manual and/or codes and descriptions; and/or making any commercial use of UB-04 Manual or any portion thereof, including the codes and/or descriptions, is only authorized with an express license from the American Hospital Association.

To license the electronic data file of UB-04 Data Specifications, contact Tim Carlson at (312) 893-6816. You may also contact us at ub04@aha.org.

## CMS National Coverage Policy

Title XVIII of the Social Security Act, §1862(a)(1)(A). Allows coverage and payment for only those services that are considered to be medically reasonable and necessary.

Title XVIII of the Social Security Act, §1833(e). Prohibits Medicare payment for any claim, which lacks the necessary information to process the claim.

CMS Manual System, Pub. 100-03, *Medicare National Coverage Determinations Manual*, Chapter 1, Part 4, §250.4.

## Coverage Guidance

### Coverage Indications, Limitations, and/or Medical Necessity

This policy applies to the following: seborrheic keratoses, skin tags, milia, molluscum contagiosum, sebaceous (epidermoid) cysts, moles (nevi), acquired hyperkeratosis (keratoderma) and viral warts (excluding condyloma acuminatum). The treatment of actinic keratosis is covered by NCD 250.4. This policy does not address routine foot care or the treatment of other skin lesions, e.g., ulcers, abscess, malignancies, dermatoses or psoriasis.

Benign skin lesions are common in the elderly and are frequently removed at the patient's request to improve appearance. Removal of benign skin lesions that do not pose a threat to health or function is considered cosmetic and as such is not covered by the Medicare program. Cosmesis is statutorily non-covered and no payment may be made for such lesion removal.

Medicare will consider the removal of benign skin lesions as medically necessary, and not cosmetic, if one or more of the following conditions is present and clearly documented in the medical record:

- A. The lesion has one or more of the following characteristics:
  1. bleeding
  2. intense itching
  3. pain
- B. The lesion has physical evidence of inflammation, e.g., purulence, oozing, edema, erythema.
- C. The lesion obstructs an orifice or clinically restricts vision.
- D. The clinical diagnosis is uncertain, particularly where malignancy is a realistic consideration based on lesional appearance (e.g. non-response to conventional treatment, or change in appearance). **However, if the diagnosis is uncertain, either biopsy or removal may be more prudent than destruction.**
- E. A prior biopsy suggests or is indicative of lesion malignancy or premalignancy.
- F. The lesion is in an anatomical region subject to recurrent physical trauma and there is documentation that such trauma has in fact occurred.
- G. Wart removals will be covered under (a) through (f) above. In addition, wart destruction will be covered when the following clinical circumstance is present:

- Periocular warts associated with chronic recurrent conjunctivitis thought secondary to lesional virus shedding
- Evidence of spread from one body area to another, particularly in immunocompromised/immunosuppressed patients.

If the beneficiary wishes one or more benign asymptomatic lesions removed for cosmetic purposes, the beneficiary becomes liable for the service(s) rendered.

**Regarding other Malignancy:**

If a diagnosis of malignancy has already been established for a specific lesion, a shave biopsy would not be medically reasonable and necessary.

Compliance with the provisions in this policy may be subject to monitoring by post payment data analysis and subsequent medical review.

**Summary of Evidence**

N/A

**Analysis of Evidence  
(Rationale for Determination)**

N/A

---

**General Information****Associated Information**

N/A

**Sources of Information**

National Model Policy developed by CMD Workgroup

**Bibliography**

N/A

---

**Revision History Information**

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
10/01/2019	R10	<p>As required by CR 10901, all billing and coding information has been moved to the companion article, this article is linked to the LCD.</p> <p>At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.</p>	<ul style="list-style-type: none"> <li>• Revisions Due To Code Removal</li> </ul>
10/01/2019	R9	<p>Revised the following statement in Indications and Limitations to include D48.5, "When a diagnosis of malignancy has not yet been established at the time the biopsy procedure was performed, the correct diagnosis code to list on the claim would most likely be D48.5 or D49.2." This diagnosis was already included in the ICD-10 codes supporting medical necessity.</p> <p>At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.</p>	<ul style="list-style-type: none"> <li>• Other (Provided clarity for coding a yet established malignancy at the time of biopsy.)</li> </ul>
10/01/2018	R8	<p>09.05.18: At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.</p> <p>The following ICD-10 codes were deleted from the ICD-10 Codes that Support Medical Necessity field: C4A.11; C4A.12; C44.102; C44.109; C44.112; C44.119; C44.122; C44.129;C44.192; C44.199; D04.11;D04.12 were deleted from Group 4 and D22.11; D22.12; D23.11 D23.12 were deleted from group 2.</p> <p>The following ICD-10 Codes were added to the ICD-10 Codes that Support Medical Necessity field to group four:C4A.111;C4A.112;C4A.121;C4A.122; C44.1021;C44.1022;C44.1091;C44.1092;C44.1121; C44.1122; C44.1191;C44.1192; C44.1221; C44.1222; C44.1291; C44.1292; C44.1921; C44.1922; C44.1991; C44.1992; D03.111;D03.112; D03.121; D03.122; D04.111;</p>	<ul style="list-style-type: none"> <li>• Revisions Due To ICD-10-CM Code Changes</li> </ul>

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
		D04.112; D04.121; D04.122; Added to Group II: D22.111; D22.112; D22.121; D22.122; D23.111; D23.112; D23.121; D23.122. This revision is due to the Annual ICD-10 Code Update and becomes effective October 1, 2018.	
10/01/2016	R7	L72.3 is listed both in Group I and Group II codes. It is removed from Group I. L91.0 is moved from Group I and added to Group II. L91.8 is added to Group II. It was added to the previous JF LCD but was not included in the draft or final LCD when JE and JF contracts were combined making the policy consistent between the two contracts.	<ul style="list-style-type: none"> <li>Reconsideration Request</li> </ul>
10/01/2016	R6	This LCD was revised to include the following diagnosis codes effective 10/1/16: D49.511, D49.512, D49.519, D49.59 to Group 1. Diagnosis code D49.5 is deleted in Group 1.	<ul style="list-style-type: none"> <li>Revisions Due To ICD-10-CM Code Changes</li> </ul>
09/15/2016	R5	This LCD version was created as a result of DL33979 being released to a Final LCD.	<ul style="list-style-type: none"> <li>Creation of Uniform LCDs Within a MAC Jurisdiction</li> </ul>
10/01/2015	R4	Diagnosis L82.0 is added back to Group I diagnoses from Group II.	<ul style="list-style-type: none"> <li>Reconsideration Request</li> </ul>
10/01/2015	R3	Removed CPT code 96567 from the LCD as this service is not addressed in the LCD. Removed L82.0 and L91.0 from Group 1 stand-alone diagnoses. Added L82.0 and L91.8 to Group II diagnoses. L91.0 was already noted in Group II diagnoses. The change in diagnosis groupings makes the coding consistent with the verbiage in Indications and Limitations and Associated Information.	<ul style="list-style-type: none"> <li>Other (Changes in CPT codes, diagnosis addition and movement from one diagnosis grouping to another. )</li> </ul>
10/01/2015	R2	Added the following diagnoses to Group 1 effective 10/1/15: L72.11, L72.12.	<ul style="list-style-type: none"> <li>Revisions Due To ICD-10-CM Code Changes</li> </ul>
10/01/2015	R1	This LCD is revised to remove the paragraph, "When requesting an individual consideration through the written redetermination (formerly appeal) process, providers must include all relevant medical records and any pertinent peer-reviewed literature that supports the request. At a minimum two (2) Phase II studies (human studies of efficacy, pivotal) or one (1) Phase III study (evidence of safety and efficacy, pivotal) must be submitted for the Medical Director's review." from the Associated Information field.	<ul style="list-style-type: none"> <li>Other (Removed the paragraph, "When requesting an individual consideration through the written redetermination (formerly appeal) process, providers must include all relevant medical</li> </ul>

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
			<p style="text-align: right;">5.33</p> <p>records and any pertinent peer-reviewed literature that supports the request. At a minimum two (2) Phase II studies (human studies of efficacy, pivotal) or one (1) Phase III study (evidence of safety and efficacy, pivotal) must be submitted for the Medical Director's review.”)</p>

## Associated Documents

### Attachments

N/A

### Related Local Coverage Documents

Article(s)

A57162 - Billing and Coding: Benign Skin Lesion Removal (Excludes Actinic Keratosis, and Mohs)

A55155 - Response to Comments: Benign Skin Lesion Removal (Excludes Actinic Keratosis, and Mohs)

### Related National Coverage Documents

N/A

### Public Version(s)

Updated on 09/18/2019 with effective dates 10/01/2019 - N/A

Some older versions have been archived. Please visit the MCD Archive Site to retrieve them.

## Keywords

- skin
- lesion
- basal
- carcinoma
- squamous
- neoplasm
- malignant
- squamous



**Medicare National Coverage  
Determinations (NCD)  
Coding Policy Manual and  
Change Report (ICD-10-CM)**

**\*January 2022**



## *Clinical Diagnostic Laboratory Services*

**U.S. Department of Health & Human Services  
Centers for Medicare & Medicaid Services**

7500 Security Boulevard  
Baltimore, MD 21244

CMS Email Point of Contact:

[CAG\\_Lab\\_NCD@cms.hhs.gov](mailto:CAG_Lab_NCD@cms.hhs.gov)

TDD 410.786.0727

**Fu Associates, Ltd.**



### Non-covered ICD-10-CM Codes for All Lab NCDs

This section lists codes that are never covered by Medicare for a diagnostic lab testing service. If a code from this section is given as the reason for the test, the test may be billed to the Medicare beneficiary without billing Medicare first because the service is not covered by statute, in most instances because it is performed for screening purposes and is not within an exception. The beneficiary, however, does have a right to have the claim submitted to Medicare, upon request.

The ICD-10-CM codes in the table below can be viewed on CMS' website as part of Downloads: Lab Code List, at <http://www.cms.gov/Medicare/Coverage/CoverageGenInfo/LabNCDsICD10.html>

Code	Description
R99	Ill-defined and unknown cause of mortality
Z00.00	Encounter for general adult medical examination without abnormal findings
Z00.01	Encounter for general adult medical examination with abnormal findings
Z00.110	Health examination for newborn under 8 days old
Z00.111	Health examination for newborn 8 to 28 days old
Z00.121	Encounter for routine child health examination with abnormal findings
Z00.129	Encounter for routine child health examination without abnormal findings
Z00.5	Encounter for examination of potential donor of organ and tissue
Z00.6	Encounter for examination for normal comparison and control in clinical research program
Z00.70	Encounter for examination for period of delayed growth in childhood without abnormal findings
Z00.71	Encounter for examination for period of delayed growth in childhood with abnormal findings
Z00.8	Encounter for other general examination
Z02.0	Encounter for examination for admission to educational institution
Z02.1	Encounter for pre-employment examination
Z02.2	Encounter for examination for admission to residential institution
Z02.3	Encounter for examination for recruitment to armed forces
Z02.4	Encounter for examination for driving license

**\*January 2022 Changes**  
**ICD-10-CM Version – Red**



Code	Description
Z02.5	Encounter for examination for participation in sport
Z02.6	Encounter for examination for insurance purposes
Z02.71	Encounter for disability determination
Z02.79	Encounter for issue of other medical certificate
Z02.81	Encounter for paternity testing
Z02.82	Encounter for adoption services
Z02.83	Encounter for blood-alcohol and blood-drug test
Z02.89	Encounter for other administrative examinations
Z02.9	Encounter for administrative examinations, unspecified
Z04.6	Encounter for general psychiatric examination, requested by authority
Z04.81	Encounter for examination and observation of victim following forced sexual exploitation
Z04.82	Encounter for examination and observation of victim following forced labor exploitation
Z04.89	Encounter for examination and observation for other specified reasons
Z04.9	Encounter for examination and observation for unspecified reason
Z11.0	Encounter for screening for intestinal infectious diseases
Z11.1	Encounter for screening for respiratory tuberculosis
Z11.2	Encounter for screening for other bacterial diseases
Z11.3	Encounter for screening for infections with a predominantly sexual mode of transmission
Z11.4	Encounter for screening for human immunodeficiency virus [HIV]
Z11.51	Encounter for screening for human papillomavirus (HPV)
<b>*Z11.52</b>	<b>*Encounter for screening for COVID-19</b>
Z11.59	Encounter for screening for other viral diseases
Z11.6	Encounter for screening for other protozoal diseases and helminthiases
Z11.7	Encounter for testing for latent tuberculosis infection
Z11.8	Encounter for screening for other infectious and parasitic diseases
Z11.9	Encounter for screening for infectious and parasitic diseases, unspecified

**\*January 2022 Changes**  
**ICD-10-CM Version – Red**



Code	Description
Z12.0	Encounter for screening for malignant neoplasm of stomach
Z12.10	Encounter for screening for malignant neoplasm of intestinal tract, unspecified
Z12.13	Encounter for screening for malignant neoplasm of small intestine
Z12.2	Encounter for screening for malignant neoplasm of respiratory organs
Z12.6	Encounter for screening for malignant neoplasm of bladder
Z12.71	Encounter for screening for malignant neoplasm of testis
Z12.72	Encounter for screening for malignant neoplasm of vagina
Z12.73	Encounter for screening for malignant neoplasm of ovary
Z12.79	Encounter for screening for malignant neoplasm of other genitourinary organs
Z12.81	Encounter for screening for malignant neoplasm of oral cavity
Z12.82	Encounter for screening for malignant neoplasm of nervous system
Z12.83	Encounter for screening for malignant neoplasm of skin
Z12.89	Encounter for screening for malignant neoplasm of other sites
Z12.9	Encounter for screening for malignant neoplasm, site unspecified
Z13.0	Encounter for screening for diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism
Z13.21	Encounter for screening for nutritional disorder
Z13.220	Encounter for screening for lipid disorders
Z13.228	Encounter for screening for other metabolic disorders
Z13.29	Encounter for screening for other suspected endocrine disorder
Z13.30	Encounter for screening examination for mental health and behavioral disorders, unspecified
Z13.31	Encounter for screening for depression
Z13.32	Encounter for screening for maternal depression
Z13.39	Encounter for screening examination for other mental health and behavioral disorders
Z13.40	Encounter for screening for unspecified developmental delays
Z13.41	Encounter for autism screening
Z13.42	Encounter for screening for global developmental delays (milestones)

\*January 2022 Changes  
ICD-10-CM Version – Red



**Medicare National Coverage Determinations (NCD)  
Coding Policy Manual and Change Report (ICD-10-CM)**

<b>Code</b>	<b>Description</b>
Z13.49	Encounter for screening for other developmental delays
Z13.5	Encounter for screening for eye and ear disorders
Z13.71	Encounter for nonprocreative screening for genetic disease carrier status
Z13.79	Encounter for other screening for genetic and chromosomal anomalies
Z13.810	Encounter for screening for upper gastrointestinal disorder
Z13.811	Encounter for screening for lower gastrointestinal disorder
Z13.818	Encounter for screening for other digestive system disorders
Z13.820	Encounter for screening for osteoporosis
Z13.828	Encounter for screening for other musculoskeletal disorder
Z13.83	Encounter for screening for respiratory disorder NEC
Z13.84	Encounter for screening for dental disorders
Z13.850	Encounter for screening for traumatic brain injury
Z13.858	Encounter for screening for other nervous system disorders
Z13.88	Encounter for screening for disorder due to exposure to contaminants
Z13.89	Encounter for screening for other disorder
Z13.9	Encounter for screening, unspecified
Z36.0	Encounter for antenatal screening for chromosomal anomalies
Z36.1	Encounter for antenatal screening for raised alphafetoprotein level
Z36.2	Encounter for other antenatal screening follow-up
Z36.3	Encounter for antenatal screening for malformations
Z36.4	Encounter for antenatal screening for fetal growth retardation
Z36.5	Encounter for antenatal screening for isoimmunization
Z36.81	Encounter for antenatal screening for hydrops fetalis
Z36.82	Encounter for antenatal screening for nuchal translucency
Z36.83	Encounter for fetal screening for congenital cardiac abnormalities
Z36.84	Encounter for antenatal screening for fetal lung maturity
Z36.85	Encounter for antenatal screening for Streptococcus B
Z36.86	Encounter for antenatal screening for cervical length

**\*January 2022 Changes  
ICD-10-CM Version – Red**



**Medicare National Coverage Determinations (NCD)  
Coding Policy Manual and Change Report (ICD-10-CM)**

Code	Description
Z36.87	Encounter for antenatal screening for uncertain dates
Z36.88	Encounter for antenatal screening for fetal macrosomia
Z36.89	Encounter for other specified antenatal screening
Z36.8A	Encounter for antenatal screening for other genetic defects
Z36.9	Encounter for antenatal screening, unspecified
Z40.00	Encounter for prophylactic removal of unspecified organ
Z40.01	Encounter for prophylactic removal of breast
Z40.02	Encounter for prophylactic removal of ovary(s)
Z40.09	Encounter for prophylactic removal of other organ
Z40.8	Encounter for other prophylactic surgery
Z40.9	Encounter for prophylactic surgery, unspecified
Z41.1	Encounter for cosmetic surgery
Z41.2	Encounter for routine and ritual male circumcision
Z41.3	Encounter for ear piercing
Z41.8	Encounter for other procedures for purposes other than remedying health state
Z41.9	Encounter for procedure for purposes other than remedying health state, unspecified
Z46.1	Encounter for fitting and adjustment of hearing aid
Z56.0	Unemployment, unspecified
Z56.2	Threat of job loss
Z56.3	Stressful work schedule
Z56.4	Discord with boss and workmates
Z56.5	Uncongenial work environment
Z56.6	Other physical and mental strain related to work
Z56.81	Sexual harassment on the job
Z56.82	Military deployment status
Z56.89	Other problems related to employment
Z56.9	Unspecified problems related to employment
Z57.0	Occupational exposure to noise

**\*January 2022 Changes  
ICD-10-CM Version – Red**



Code	Description
Z57.1	Occupational exposure to radiation
Z57.2	Occupational exposure to dust
Z57.31	Occupational exposure to environmental tobacco smoke
Z57.39	Occupational exposure to other air contaminants
Z57.4	Occupational exposure to toxic agents in agriculture
Z57.5	Occupational exposure to toxic agents in other industries
Z57.6	Occupational exposure to extreme temperature
Z57.7	Occupational exposure to vibration
Z57.8	Occupational exposure to other risk factors
Z57.9	Occupational exposure to unspecified risk factor
Z59.0	Homelessness
Z59.1	Inadequate housing
Z59.2	Discord with neighbors, lodgers and landlord
Z59.3	Problems related to living in residential institution
Z59.4	Lack of adequate food and safe drinking water
Z59.5	Extreme poverty
Z59.6	Low income
Z59.7	Insufficient social insurance and welfare support
Z59.8	Other problems related to housing and economic circumstances
Z59.9	Problem related to housing and economic circumstances, unspecified
Z60.2	Problems related to living alone
Z62.21	Child in welfare custody
Z71.0	Person encountering health services to consult on behalf of another person
Z74.1	Need for assistance with personal care
Z74.2	Need for assistance at home and no other household member able to render care
Z74.3	Need for continuous supervision
Z74.8	Other problems related to care provider dependency
Z74.9	Problem related to care provider dependency, unspecified

**\*January 2022 Changes  
ICD-10-CM Version – Red**



Code	Description
Z75.5	Holiday relief care
Z76.0	Encounter for issue of repeat prescription
Z76.1	Encounter for health supervision and care of foundling
Z76.2	Encounter for health supervision and care of other healthy infant and child
Z76.3	Healthy person accompanying sick person
Z76.4	Other boarder to healthcare facility
Z76.81	Expectant parent(s) prebirth pediatrician visit
Z80.1	Family history of malignant neoplasm of trachea, bronchus and lung
Z80.2	Family history of malignant neoplasm of other respiratory and intrathoracic organs
Z80.49	Family history of malignant neoplasm of other genital organs
Z80.51	Family history of malignant neoplasm of kidney
Z80.52	Family history of malignant neoplasm of bladder
Z80.59	Family history of malignant neoplasm of other urinary tract organ
Z80.6	Family history of leukemia
Z80.7	Family history of other malignant neoplasms of lymphoid, hematopoietic and related tissues
Z80.8	Family history of malignant neoplasm of other organs or systems
Z80.9	Family history of malignant neoplasm, unspecified
Z81.0	Family history of intellectual disabilities
Z81.1	Family history of alcohol abuse and dependence
Z81.2	Family history of tobacco abuse and dependence
Z81.3	Family history of other psychoactive substance abuse and dependence
Z81.4	Family history of other substance abuse and dependence
Z81.8	Family history of other mental and behavioral disorders
Z82.0	Family history of epilepsy and other diseases of the nervous system
Z82.1	Family history of blindness and visual loss
Z82.2	Family history of deafness and hearing loss
Z82.3	Family history of stroke
Z82.41	Family history of sudden cardiac death

\*January 2022 Changes  
ICD-10-CM Version – Red



**Medicare National Coverage Determinations (NCD)  
Coding Policy Manual and Change Report (ICD-10-CM)**

Code	Description
Z82.49	Family history of ischemic heart disease and other diseases of the circulatory system
Z82.5	Family history of asthma and other chronic lower respiratory diseases
Z82.61	Family history of arthritis
Z82.62	Family history of osteoporosis
Z82.69	Family history of other diseases of the musculoskeletal system and connective tissue
Z82.71	Family history of polycystic kidney
Z82.79	Family history of other congenital malformations, deformations and chromosomal abnormalities
Z82.8	Family history of other disabilities and chronic diseases leading to disablement, not elsewhere classified
Z83.0	Family history of human immunodeficiency virus [HIV] disease
Z83.1	Family history of other infectious and parasitic diseases
Z83.2	Family history of diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism
Z83.3	Family history of diabetes mellitus
Z83.41	Family history of multiple endocrine neoplasia [MEN] syndrome
Z83.49	Family history of other endocrine, nutritional and metabolic diseases
Z83.511	Family history of glaucoma
Z83.518	Family history of other specified eye disorder
Z83.52	Family history of ear disorders
Z83.6	Family history of other diseases of the respiratory system
Z83.71	Family history of colonic polyps
Z83.79	Family history of other diseases of the digestive system
Z84.0	Family history of diseases of the skin and subcutaneous tissue
Z84.1	Family history of disorders of kidney and ureter
Z84.2	Family history of other diseases of the genitourinary system
Z84.3	Family history of consanguinity

**\*January 2022 Changes  
ICD-10-CM Version – Red**



Code	Description
Z84.81	Family history of carrier of genetic disease
Z84.89	Family history of other specified conditions

Version 03/15/2023  
Check for Updates



## 190.15 - Blood Counts

### Other Names/Abbreviations

CBC

### Description

Blood counts are used to evaluate and diagnose diseases relating to abnormalities of the blood or bone marrow. These include primary disorders such as anemia, leukemia, polycythemia, thrombocytosis and thrombocytopenia. Many other conditions secondarily affect the blood or bone marrow, including reaction to inflammation and infections, coagulopathies, neoplasms and exposure to toxic substances. Many treatments and therapies affect the blood or bone marrow, and blood counts may be used to monitor treatment effects.

The complete blood count (CBC) includes a hemogram and differential white blood count (WBC). The hemogram includes enumeration of red blood cells, white blood cells, and platelets, as well as the determination of hemoglobin, hematocrit, and indices.

The symptoms of hematological disorders are often nonspecific, and are commonly encountered in patients who may or may not prove to have a disorder of the blood or bone marrow. Furthermore, many medical conditions that are not primarily due to abnormalities of blood or bone marrow may have hematological manifestations that result from the disease or its treatment. As a result, the CBC is one of the most commonly indicated laboratory tests.

In patients with possible hematological abnormalities, it may be necessary to determine the hemoglobin and hematocrit, to calculate the red cell indices, and to measure the concentration of white blood cells and platelets. These measurements are usually performed on a multichannel analyzer that measures all of the parameters on every sample. Therefore, laboratory assessments routinely include these measurements.

### HCPCS Codes (Alphanumeric, CPT® AMA)

Code	Description
85004	Blood count, automated differential white blood cell (WBC) count
85007	Blood count; blood smear, microscopic examination with manual differential WBC count
85008	Blood count; blood smear, microscopic examination without manual differential WBC count
85013	Blood count, Spun microhematocrit
85014	Blood count, hematocrit (Hct)
85018	Blood count, Hemoglobin
85025	Blood count, complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count
85027	Blood count, complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)
85032	Blood count; manual cell count (erythrocyte, leukocyte, platelet) each

NCD 190.15

\*January 2022 Changes  
ICD-10-CM Version – Red

Fu Associates, Ltd.

January 2022



Code	Description
85048	Blood count, leukocyte (WBC), automated
85049	Blood count; platelet, automated

### ICD-10-CM Codes Covered by Medicare Program

Any ICD-10-CM code not listed in either the non-covered section or the medical necessity section.

### Indications

Indications for a CBC or hemogram include red cell, platelet, and white cell disorders. Examples of these indications are enumerated individually below.

1. Indications for a CBC generally include the evaluation of bone marrow dysfunction as a result of neoplasms, therapeutic agents, exposure to toxic substances, or pregnancy. The CBC is also useful in assessing peripheral destruction of blood cells, suspected bone marrow failure or bone marrow infiltrate, suspected myeloproliferative, myelodysplastic, or lymphoproliferative processes, and immune disorders.

2. Indications for hemogram or CBC related to red cell (RBC) parameters of the hemogram include signs, symptoms, test results, illness, or disease that can be associated with anemia or other red blood cell disorder (e.g., pallor, weakness, fatigue, weight loss, bleeding, acute injury associated with blood loss or suspected blood loss, abnormal menstrual bleeding, hematuria, hematemesis, hematochezia, positive fecal occult blood test, malnutrition, vitamin deficiency, malabsorption, neuropathy, known malignancy, presence of acute or chronic disease that may have associated anemia, coagulation or hemostatic disorders, postural dizziness, syncope, abdominal pain, change in bowel habits, chronic marrow hypoplasia or decreased RBC production, tachycardia, systolic heart murmur, congestive heart failure, dyspnea, angina, nailbed deformities, growth retardation, jaundice, hepatomegaly, splenomegaly, lymphadenopathy, ulcers on the lower extremities).

3. Indications for hemogram or CBC related to red cell (RBC) parameters of the hemogram include signs, symptoms, test results, illness, or disease that can be associated with polycythemia (for example, fever, chills, ruddy skin, conjunctival redness, cough, wheezing, cyanosis, clubbing of the fingers, orthopnea, heart murmur, headache, vague cognitive changes including memory changes, sleep apnea, weakness, pruritus, dizziness, excessive sweating, visual symptoms, weight loss, massive obesity, gastrointestinal bleeding, paresthesias, dyspnea, joint symptoms, epigastric distress, pain and erythema of the fingers or toes, venous or arterial thrombosis, thromboembolism, myocardial infarction, stroke, transient ischemic attacks, congenital heart disease, chronic obstructive pulmonary disease, increased erythropoietin production associated with neoplastic, renal or hepatic disorders, androgen or diuretic use, splenomegaly, hepatomegaly, diastolic hypertension.)

4. Specific indications for CBC with differential count related to the WBC include signs, symptoms, test results, illness, or disease associated with leukemia, infections or inflammatory processes, suspected bone marrow failure or bone marrow infiltrate, suspected myeloproliferative, myelodysplastic or lymphoproliferative disorder, use of drugs that may cause

NCD 190.15

\*January 2022 Changes  
ICD-10-CM Version – Red



leukopenia, and immune disorders (e.g., fever, chills, sweats, shock, fatigue, malaise, tachycardia, tachypnea, heart murmur, seizures, alterations of consciousness, meningismus, pain such as headache, abdominal pain, arthralgia,odynophagia, or dysuria, redness or swelling of skin, soft tissue bone, or joint, ulcers of the skin or mucous membranes, gangrene, mucous membrane discharge, bleeding, thrombosis, respiratory failure, pulmonary infiltrate, jaundice, diarrhea, vomiting, hepatomegaly, splenomegaly, lymphadenopathy, opportunistic infection, such as oral candidiasis.)

5. Specific indications for CBC related to the platelet count include signs, symptoms, test results, illness, or disease associated with increased or decreased platelet production and destruction, or platelet dysfunction (e.g., gastrointestinal bleeding, genitourinary tract bleeding, bilateral epistaxis, thrombosis, ecchymosis, purpura, jaundice, petechiae, fever, heparin therapy, suspected DIC, shock, pre-eclampsia, neonate with maternal ITP, massive transfusion, recent platelet transfusion, cardiopulmonary bypass, hemolytic uremic syndrome, renal diseases, lymphadenopathy, hepatomegaly, splenomegaly, hypersplenism, neurologic abnormalities, viral or other infection, myeloproliferative, myelodysplastic, or lymphoproliferative disorder, thrombosis, exposure to toxic agents, excessive alcohol ingestion, autoimmune disorder (SLE, RA).

6. Indications for hemogram or CBC related to red cell (RBC) parameters of the hemogram include, in addition to those already listed, thalassemia, suspected hemoglobinopathy, lead poisoning, arsenic poisoning, and spherocytosis.

7. Specific indications for CBC with differential count related to the WBC include, in addition to those already listed, storage diseases; mucopolysaccharidoses, and use of drugs that cause leukocytosis such as G-CSF or CM-CSF.

8. Specific indications for CBC related to platelet count include, in addition to those already listed, May-Hegglin syndrome and Wiskott-Aldrich syndrome.

### **Limitations**

1. Testing of patients who are asymptomatic, or who do not have a condition that could be expected to result in a hematological abnormality, is screening and is not a covered service.

2. In some circumstances it may be appropriate to perform only a hemoglobin or hematocrit to assess the oxygen carrying capacity of the blood. When the ordering provider requests only a hemoglobin or hematocrit, the remaining components of the CBC are not covered.

3. When a blood count is performed for an end-stage renal disease (ESRD) patient, and is billed outside the ESRD rate, documentation of the medical necessity for the blood count must be submitted with the claim.

4. In some patients presenting with certain signs, symptoms or diseases, a single CBC may be appropriate. Repeat testing may not be indicated unless abnormal results are found, or unless there is a change in clinical condition. If repeat testing is performed, a more descriptive diagnosis code (e.g., anemia) should be reported to support medical necessity. However, repeat



testing may be indicated where results are normal in patients with conditions where there is a continued risk for the development of hematologic abnormality.

**ICD-10-CM Codes That Do Not Support Medical Necessity**

The ICD-10-CM codes in the table below can be viewed on CMS' website as part of Downloads: Lab Code List, at <http://www.cms.gov/Medicare/Coverage/CoverageGenInfo/LabNCDsICD10.html>

Code	Description
A18.59	Other tuberculosis of eye
A63.0	Anogenital (venereal) warts
B07.0	Plantar wart
B07.8	Other viral warts
B07.9	Viral wart, unspecified
D00.00	Carcinoma in situ of oral cavity, unspecified site
D00.01	Carcinoma in situ of labial mucosa and vermilion border
D00.02	Carcinoma in situ of buccal mucosa
D00.03	Carcinoma in situ of gingiva and edentulous alveolar ridge
D00.04	Carcinoma in situ of soft palate
D00.05	Carcinoma in situ of hard palate
D00.06	Carcinoma in situ of floor of mouth
D00.07	Carcinoma in situ of tongue
D00.08	Carcinoma in situ of pharynx
D04.0	Carcinoma in situ of skin of lip
D04.10	Carcinoma in situ of skin of unspecified eyelid, including canthus
D04.111	Carcinoma in situ of skin of right upper eyelid, including canthus
D04.112	Carcinoma in situ of skin of right lower eyelid, including canthus
D04.121	Carcinoma in situ of skin of left upper eyelid, including canthus
D04.122	Carcinoma in situ of skin of left lower eyelid, including canthus
D04.20	Carcinoma in situ of skin of unspecified ear and external auricular canal
D04.21	Carcinoma in situ of skin of right ear and external auricular canal
D04.22	Carcinoma in situ of skin of left ear and external auricular canal
D04.30	Carcinoma in situ of skin of unspecified part of face
D04.39	Carcinoma in situ of skin of other parts of face

Version 03/15/2023  
Check for Updates