Preventive Skin Screenings: Are they Billable under Obamacare?

The Patient Protection and Affordable Care Act (PPACA), commonly called Obamacare or the ACA, is a federal statute signed into law by President Barack Obama on March 23, 2010. It represents the most important overhaul of the U.S. healthcare system since the 1965 enactment of Medicare and Medicaid. PPACA is aimed at decreasing the number of Americans who are uninsured and decreasing the overall costs of health care. It provides mechanisms to employers and individuals to increase access to health insurance. Its reforms are aimed at improving healthcare outcomes and streamlining the delivery of health care.

A PPACA provision that has caused confusion for dermatology practices has been the provision that makes certain preventative services available without co-payments, co-insurance and deductibles, depending on the payer. Often dermatology patients who request a skin screening assume that this preventative service falls under the PPACA and therefore they need not submit co-payment, co-insurance or deductible. However, skin screenings do not fall under the PPACA definition of preventative services. The PPACA defines preventive services as one of 10 categories of “essential benefits package.” Preventative services that fall under this law are those which have been rated Level A or Level B by the U.S. Preventive Services Task Force (USPSTF). The USPSTF is an independent panel of clinical experts in prevention and evidence-based medicine comprised mostly of primary care providers who conduct scientific reviews of clinical preventive health care services and develop recommendations.

Unfortunately, the USPSTF doesn’t include skin screenings in their Level A or Level B listings as a preventive service. They have found insufficient evidence to recommend melanoma skin screenings for asymptomatic persons. They also found insufficient evidence to determine whether clinician counseling has affected challenging patient behaviors to reduce skin cancer risk. Counseling patients may increase the use of sunscreen for children but there is little evidence to determine the effect of counseling on other preventive behaviors such as wearing protective clothing, reducing excessive sun exposure, avoiding sun lamp/tanning beds, or practicing skin self-examination and little evidence on potential harm. The USPSTF report is lengthy and notes that additional data is needed.

While the PPACA’s elimination of co-payments, co-insurance and/or deductibles does not extend to skin screening, if the screening is performed as part of a routine annual exam with a primary care physician that has not been prompted by a previous diagnoses, then it may be covered under PPACA as part of prevention examination. Finally, it is important to review the patient’s insurance to determine whether the insurer has chosen to define a dermatological skin screen as preventive.

—— see OBAMACARE on page 2

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IMPORTANT Please Route to:
___ Dermatologist ___ Office Mgr ___ Coding Staff ___ Billing Staff
Letter from the Editor

Dear Derm Coding Consult Reader

The recent threat of a 26.5% reduction in Medicare reimbursement has been averted. However, Medicare physician payments as well as other health programs remain vulnerable to additional cuts under the “fiscal cliff deal.” This issue will clarify the current Medicare fee schedule “one year fix” and provide insight into steps the AAD/A is taking on behalf of membership.

In response to the Patient Protection and Affordable Care Act (PPACA) that is a part of Obamacare, Preventive screening visits have become a hot topic in recent months. Coding staff addresses how the PPACA affects dermatology and answers the question, “Can we bill a preventive visit for a skin screening?”

Additionally, we have expanded the Coding FAQ section. I receive very positive feedback regarding this section of the newsletter from both members and their office staff. The question and answer format works well to synthesize the information through a practical demonstration of real-life scenarios. This edition, topics range from billing for suture removal to the appropriate use of locum tenens for mid-level practitioners.

Additionally, staff received numerous inquiries regarding the revised preventive screening rule. Instead of just adding this into the FAQ list, we decided to include a full article to clarify the use of the 99381-99387 CPT codes when billing skin screening exams.

Your feedback and input is critical in developing and maintaining this valuable resource. I appreciate all of your comments and suggestions. The AAD goal is to provide members with information that is current, up-to-date, and relevant to their practice.

Best,

Cynthia A. Bracy, RHIA, CCS-P, Editor

Preventive Skin Screenings: Are they Billable under Obamacare?

How should skin screenings be reported? The preventive Medicine code (9938x-9939x) should not be used. As there is no specific CPT code for skin screening, there are two potential options. Practices can report the appropriate level of Evaluation and Management service code (99201-99215) with a V70.0, wellness diagnosis or V76.43, melanoma skin screening. Alternatively, practices can report the unspecified E/M code, 99499 making a comment in the CMS-1500 remark box 18 that the service is a “skin screening.” The diagnosis would be the same as above.

Medicare Physician Fee Schedule Update

SGR Fix/Fiscal Cliff Deal Impact Medicare Reimbursement

In January, President Obama signed “fiscal cliff” legislation (H.R. 8). The newly enacted “American Taxpayer Relief Act of 2012” (ATRA) delays for one year the 26.5% sustainable growth rate (SGR) reduction to Medicare physician reimbursement rates and freezes reimbursement rates for physician services provided from January 1, 2013, through December 31, 2013 at current levels. The flawed SGR formula, designed to restrain growth of Medicare spending on physician services, was established in the Balanced Budget Act of 1997.

With this one-year “fix” of the SGR formula, the 2013 conversion factor is $34.0230—only marginally different from the 2012 conversion factor of $34.0376.

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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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Medicare Physician Fee Schedule Update  
— continued from page 2

It is important to note any reductions and adjustments made under the final 2013 Medicare Physician Fee Schedule, including changes to relative value units for particular services, continue to move forward as presented in the final rule. The Centers for Medicare & Medicaid Services (CMS) revised the 2013 Physician Fee Schedule to reflect the ATRA’s requirements as well as technical corrections identified since publication of the final rule in November 2012. In addition, CMS required regional Medicare administrative contractors (MACs) to post on their Websites the new 2013 Physician Fee Schedule, reflecting the SGR fix and the resulting 2013 conversion factor no later than January 23.

In summary, relevant ATRA provisions include:

• One-year fix of the SGR, avoiding 26.5% scheduled reduction in the Medicare conversion factor for physician payments through December 31, 2013.
• Defers 2% across-the-board cuts to government programs, including Medicare, for 2-months; should Congress not act prior to March 1, a 2% cut in Medicare payments is scheduled to take effect.
• Preserves ability of dermatologists to provide pathology services. While once rumored for possible inclusion, H.R. 8 does not repeal the in-office ancillary services exception provided under the Stark law.
• Increases the statute of limitations to recover Medicare overpayments from 3 to 5 years.

AADA Submits Comments on 2013 Physician Fee Schedule

On Dec. 31, the American Academy of Dermatology Association (AADA) submitted its comment letter on the 2013 Physician Fee Schedule final rule to CMS.

In its comment letter, the AADA acknowledged that CMS accepted the majority of the AMAs Specialty Society Relative Value Scale Update Committee (RUC) recommendations on approximately 30 dermatology codes that were surveyed in 2012, but expressed concern that CMS did not accept several critical RUC recommendations and altered them without giving adequate reason or rationale. Specifically, the AADA opposed CMS’s reductions in relative value units (RVU) — particularly practice expenses — that were in excess of the RUC recommendations.

As discussed in my 2013 Physician Fee Schedule update in the last issue of DCC, the final 2013 Fee Schedule included a significant reduction in reimbursement for the technical component (TC) of surgical pathology code 88305. Additionally, the Fee Schedule included reductions to complex repair codes 13152 and 13132 — which were mostly due to a cut in physician work RVUs. A table showing the impact on dermatology codes also is on AADA Website at http://www.aad.org/member-tools-and-benefits/aada-advocacy/regulatory-affairs/payment-policy/2013-fee-schedule. In addition, the AADA 2013 Medicare Physician Fee Schedule final rule comment letter is posted on the AADA Website at http://www.aad.org/member-tools-and-benefits/aada-advocacy/regulatory-affairs/payment-policy.

Impact of “Fiscal Cliff” Deal

Under the “fiscal cliff” deal, Medicare physician payments as well as other health programs remain vulnerable to cuts. Sequestration cuts were delayed by two months, until March 1, and accordingly, the reprieve is only temporary. To avert the 2 percent Medicare reimbursement sequestration cut now scheduled to take effect on March 1, Congress and the Administration must agree on how to reappropriate sequestration, fund the federal government for 2013, and raise the debt ceiling. It is likely that Medicare spending will play a big role in these debates. Moreover, funding for both medical research and graduate medical education (GME) are at risk. Under sequestration, certain non-Medicare health programs, such as clinical research and health professions funding, would be cut by 7.8% for 2013.

Medicare Granted More Time to Recover Physician Overpayments

Part of the legislation Congress passed January 1 to avoid the “Fiscal Cliff” included additional time for the Medicare program to recoup non-fraudulent Medicare overpayments. Previously, the statute of limitations on non-fraudulent Medicare overpayments was only three (3) years from the date of claim processing. Section 638 of the American Taxpayer Relief Act of 2012 ‘Removing Obstacles to Collection of Overpayments’ now provides Medicare contractors five years to collect on errors in Medicare payments.


CMS urges Providers to continue planning for ICD-10 transition

The Centers for Medicare and Medicaid Services (CMS) is urging all healthcare providers to continue planning for ICD-10 transition. All claims for health care services provided on or after October 1, 2014, must contain ICD-10 codes.
Dermatologists and healthcare providers should note that the switch from ICD-9-CM to ICD-10-CM will impact clinical documentation and coding resources in the practice. Dermatologists are urged to review and compare the current ICD-9-CM with ICD-10-CM, to identify what changes and education will be required in order to be ready for the transition.

The American Academy of Dermatology (AAD) will continue to introduce code families of new dermatologic ICD-10-CM codes in comparison to the current ICD-9-CM codes. For more information on ICD-10-CM, please visit our website at http://www.aad.org/ICD-10.

Below are some commonly used dermatology codes you need to know:

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
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<tbody>
<tr>
<td><strong>Category:</strong> Other and unspecified malignant neoplasm of skin</td>
<td>Other and unspecified malignant neoplasm of skin</td>
</tr>
<tr>
<td><strong>173</strong></td>
<td><strong>C44</strong></td>
</tr>
<tr>
<td>Includes malignant neoplasm of sebaceous glands sweat glands</td>
<td>Includes malignant neoplasm of sebaceous glands sweat glands</td>
</tr>
<tr>
<td>Excludes1 Kapo-si’s sarcoma (176.0–176.9)</td>
<td>Excludes1 Kapo-si’s sarcoma (176.0–176.9)</td>
</tr>
<tr>
<td>Malignant melanoma of skin (172.0–172.9)</td>
<td>Malignant melanoma of skin (172.0–172.9)</td>
</tr>
<tr>
<td>Merkel cell carcinoma of skin (209.31–209.36)</td>
<td>Merkel cell carcinoma of skin (209.31–209.36)</td>
</tr>
<tr>
<td>Malignant neoplasm of skin of genital organs (184.0–184.9, 187.1–187.9)</td>
<td>Malignant neoplasm of skin of genital organs (184.0–184.9, 187.1–187.9)</td>
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<thead>
<tr>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
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<tbody>
<tr>
<td><strong>173.0x</strong></td>
<td><strong>C44.0x</strong></td>
</tr>
<tr>
<td>Other and unspecified malignant neoplasm of skin of lip</td>
<td>Other and unspecified malignant neoplasm of skin of lip</td>
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<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>173.1x</strong></td>
<td><strong>C44.1xx</strong></td>
</tr>
<tr>
<td>Other and unspecified malignant neoplasm of eyelid, including canthus</td>
<td>Other and unspecified malignant neoplasm of eyelid, including canthus</td>
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</table>

**Coding Q&A**

Q: Is there a CPT code for suture removal, and when is it appropriate to use it?

A: This is a commonly asked question. There is no CPT code for suture removal, but there is a HCPCS Level II code one can use if the sutures were placed by a provider different from the provider removing the sutures.

Code S0630 states, “Removal of sutures: by a physician other than the physician who originally closed the wound.” It is important to note this
Code is listed as non Medicare covered code and as a result, may not be covered by many other private payers.

The common practice is to report a low level evaluation and management (E/M) code based on the extent of the wound assessment and medical necessity required to support the level of service to be reported. Usually, the encounter is just for suture removal of a healed wound. However, if there is an infection or concern that an infection may arise and antibiotics are involved, the documentation may support a higher level of service for a non Medicare patient. In this circumstance, the encounter is more focused on the wound assessment rather than the suture removal. Please note that Medicare does not reimburse for services such as suture removal or wound assessment that are complications from a previous surgery performed by the same provider, as those services are considered part of the surgical package. Therefore, when a provider uses sutures to close a wound during surgery, provider must remove those sutures once the wound has healed at no extra charge or reimbursement.

If the same provider is the one removing the sutures and there is no concern for wound infection, one can also consider using CPT code 99024 – postoperative follow-up visit – normally included in the surgical package, to indicate that an E/M service was performed during the postoperative period for a reason related to the original procedure (this is a zero dollar/non-reimbursable code but appropriate for data tracking).

Q: I need some clarification on how to post multiple Mohs on same body area. A patient had 3 stages of Mohs on the right nasal sidewall (superior)-basal cell carcinoma and 3 stages of Mohs on the right nasal sidewall (inferior)-basal cell carcinoma. Both procedures are reported with ICD9 173.31, Basel Cell Carcinoma of the nose. How would I code the multiple stages for each part of the nose? What modifiers would I use? Do I use units for the additional stages or list Mohs codes separately? The codes are as follows: 17311, 17312; 17311, 17312

A: There are many coding issues to be aware of when reporting multiple “like” procedures. Quantity unit reporting advises if units can be used on a claim line, and Medical Unlikely Edits advises what is considered medical necessity limit to those units reported. Since commercial payers have their own editing system, this answer will reflect Medicare published guidelines.

Quantity unit reporting dictates the multiple units of the second stage Mohs, 17312 which will be reported as accumulation for both sides of the nose.

17311
17311-59
17312 x 4

Q. Regarding online PECOS signature requirements - if we complete PECOS registration on behalf of our doctor, is there a way to “pend” the application so they can login and approve/sign the application after they review it? If so, how long does the application stay in “pend” before we have to start all over?

A. Currently there is no way to pend an application. Per CMS requirements, the provider is supposed to be completing the entire application.

Q. We have a mid-level provider who is going on maternity leave. Can we use and bill for a locum tenens mid-level provider while she is gone?

A. Locum tenens and reciprocal billing is only available for MD/DO. If you are hiring a temporary replacement for your mid-level provider you will need to enroll the new person with Medicare. You can find more information in the Centers for Medicare & Medicaid Services (CMS) Internet Only Manual (IOM) Publication 100-04, Chapter 12, Section 30.2.11. at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf

Q. Are the 3 evaluation and management (E/M) components (history of present illness, exam, medical decision making) and the chief complaint required to be documented in the medical record when a procedure is performed during the patient encounter?

A. Documentation for procedures is somewhat different from that of an E/M encounter. Instead of focusing on the three E/M components (History, Exam & MDM), procedure documentation should include a description of the pre-, intra- and post- services provided.

The pre-service period includes physician services provided on the day of the procedure which may include review of records in the patient’s chart, general and surgical history update including current medications and allergies, communicating with other professionals, patient and family. Discussing operative risks and benefits, obtaining consent for the procedure and other pre-operative work which include positioning patient, surgical site examination and preparing needed equipment for the operative procedure and other “non-physician to patient” work are also included in the pre-service period.
The intra-service period includes a description of the “physician to patient” work that is a necessary to perform the surgical procedure.

The post-service period includes discussing the aftercare with the patient/family on wound care, when to call the office should complications arise, prescriptions, scheduling the next follow-up visit and communicating with other professionals (including written and telephone reports and orders).

These are general requirements that would be more specific to documentation as part of the surgical report.

Q. Have you ever heard of a practice getting approval and payment for laser hair removal (say for pseudofolliculitis)? If so, what CPT code would be billed?

A. A practice should get prior approval (pre authorization) for borderline (cosmetic vs. medical) procedures. CPT does not have a specific laser code for pseudofolliculitis. You would bill the unspecified CPT code 17999. Add in the notes section that there is no specific code applicable to the procedure performed but the procedure is similar to the 17106 port wine series codes. Please check each individual payer website for additional guidance. There may be a medical policy available.

Q. We received a denial on a patient who is in hospice care. How do we reconcile this type of denial?

A. If treatment was unrelated to the hospice care, report the service to CMS with a Modifier GW. If treatment is related to the hospice care, the service is considered paid under the Part A hospice capitation. This should be billed through the hospice/nursing home. You should contact the hospice/nursing home to negotiate payment directly from them for services provided to their patient.

Q. We use an out of state lab to process the technical component for pathology. When we get the slides back, we bill the commercial payers globally and Medicare the professional component only. What DOS should be assigned? The day we put the specimen “in the jar” and sent it to the outside lab, the day our provider reads the slide and renders her opinion, or other?

A. According to Medicare’s MedLearn 6018 updated August, 2012, the specimen is reported the day it is taken from the patient and put in the bottle. The path report needs to include this date, which is the billing date and the date the slide was read. The MedLearn can be found on CMS website: http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6018.pdf

HIPAA Omnibus Rule
Updates to the Health Care Portability and Accountability Act effective March 26, 2013 include a number of provisions that will impact dermatology practices. Practice and other entities affected must be in compliance with the final rule until Sept. 23, 2013.

Among the provisions that affect dermatology practices is one requiring that any improper use or disclosure of personal health information is considered a breach that triggers official notification requirements unless the organization in question carries out a risk assessment and determines otherwise.

In addition, the final rule:
• Extends the requirements of the privacy and security rules to physicians’ business associates and their subcontractors;
• Establishes new limitations on the use of personal health information for marketing and fundraising purposes;
• Prohibits the sale of a patient’s personal health information without specific individual authorization to do so;
• Expands patients’ rights to request and receive electronic copies of their personal health information; and
• Broadens patients’ ability to restrict, in some instances, disclosure of their personal health information to health insurance plans.

Covered Entities
Individuals, organizations, and agencies that meet the definition of a covered entity under HIPAA must comply with the rules’ requirements to protect the privacy and security of health information and must provide patients certain rights with respect to their health information.

See HIPAA on page 7

AAD Coding and Reimbursement Webinars
The AAD hosts live webinars to provide in-service training opportunities to physicians and practice management staff. Make a date with coding and practice management staff the third Thursday of the month for 1 hour webinars on key dermatology issues. Check out the schedule and register at: http://www.aad.org/webinars.

Upcoming 2013 Webinars!
Moving from Paper to Beyond:
Transiting to an EHR 05/16/13
Get the Mohs Out of Coding 09/19/13
Could you be a Target of the OIG? 10/17/13
2014 Coding and Reimbursement Update 11/21/13

Coding Q&A
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HIPAA Omnibus Rule
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If a covered entity engages a business associate to help it carry out its health care activities and functions, the covered entity must have a written business associate contract or other arrangement with the business associate that establishes specifically what the business associate has been engaged to do and requires the business associate to comply with the rules’ requirements to protect the privacy and security of protected health information.

In addition to these contractual obligations, business associates are directly liable for compliance with certain provisions of the HIPAA Rules. Covered entities can fall into one or more of the following three categories:

<table>
<thead>
<tr>
<th>Health Care Provider</th>
<th>Health Plan</th>
<th>Business Associate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor</td>
<td>Health Insurance Company</td>
<td>Clearinghouses</td>
</tr>
<tr>
<td>Clinic</td>
<td>HMO</td>
<td>Data miners</td>
</tr>
<tr>
<td>Psychologist</td>
<td>Company Health Plan</td>
<td>HIT service provider</td>
</tr>
<tr>
<td>Dentist</td>
<td>Government Programs</td>
<td>Health care attorneys</td>
</tr>
<tr>
<td>Pharmacy</td>
<td></td>
<td>Accountants</td>
</tr>
<tr>
<td>Nursing Home</td>
<td></td>
<td>Consultants</td>
</tr>
</tbody>
</table>

*List not inclusive, other health care providers, health plans, and vendors may be affected. “Business associate” refers specifically to a person or organization that conducts business with the covered entity that involves the use or disclosure of individually identifiable health information.

The Centers for Medicare and Medicaid Services (CMS) have developed an easy to understand guide that assists in determining whether or not you are considered a covered entity under HIPAA. This guide can be downloaded on the CMS website by visiting:


Notice of Privacy Practice
The rule also requires covered entities to modify and redistribute their individual notice of privacy practices. The Department of Health and Human Services (HHS) has not released an updated “Notice of Privacy Practices” to include the new Omnibus rule at the time of this publication. Please check periodically for this new information to be available either on the HHS website at http://www.hhs.gov/.

Additional resources
The American Academy of Dermatology is developing resources to help members prepare for compliance by the Sept. 23 deadline. Watch for future communications from the Academy as these resources become available and check the AAD webpage www.aad.org/hipaa for updates.
**In The Know.....**

**Do you know what the 2013 Medicare beneficiary annual deductible is?**

### 2013 Medicare Annual Deductible

<table>
<thead>
<tr>
<th>Part</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part B</td>
<td>$147.00</td>
</tr>
<tr>
<td>Part A</td>
<td>$1,184.00 (Inpatient Hospital)</td>
</tr>
</tbody>
</table>

The 2013 deductible change represents an increase of $7.00 for Medicare part B and an increase of $28.00 for Medicare part A.

**Know when to collect the deductible up-front!**

If your practice is certain that the patient’s deductible has not been met at the time of service (TOS), there is nothing prohibiting you from collecting the deductible before the patient leaves the office. However, even though it is legal to collect the patient’s deductible at the TOS, it may not be a good business practice. The patient may have received other services from another healthcare provider which may have resulted in that encounter being applied to patient deductible.

With the improvements Medicare has made to the claim reimbursement timeline, the other healthcare provider’s claim may have been submitted and adjudicated with remark code “1 – Deductible Amount” before your claim is submitted to Medicare.

In this circumstance, your claim would be adjudicated normally and paid because the patient would have met the annual deductible through services rendered by the other healthcare provider. Your practice would have to refund any amounts paid to the patient, resulting in additional administrative time and expense to your practice.

**Now you are in the know!**

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**Retraction**

In the 2012 Winter edition of *Derm Coding Consult* erroneous guidance was given regarding United Health Care and AARP claim denials. DCC advised that these should be resolved by faxing claims to Melanie Xiao, in care of Ms. Ayanna Bubsy-Jackson. The Academy has been informed by CMS that this process is inappropriate.

The appropriate process for denied claim resolution is:

- Provider’s first point-of-contact for claim issues is the Medicare Advantage Plan.
- Contracted providers must follow the appeals and dispute resolution process per the terms of their contract.
- Non-contracted providers must submit payment disputes to the Independent Payment Dispute Resolution Contractor.
- Services denied for coverage must be sent to the appropriate Medicare Part C Independent Review Entity for processing.
- Complaints about UHC’s claim process must be submitted directly to 1-800-MEDICARE.