2012 Medicare Fee Schedule – Impact on Dermatology

The big news as always is the announcement by the Centers for Medicare and Medicaid Services in the 2012 Medicare Physician Fee Schedule: Final Rule of the 2012 Conversion Factor. The Conversion Factor (CF) is the multiplier used with the relative value units (RVU) assigned by CMS to each CPT procedure code to determine the dollar amount that will be paid for each service by Medicare.

For 2012, the Medicare Conversion Factor is set at $24.6712.

This is a reduction of -27.4% from the 2011 CF of $33.9764, or

A drop of $9.3052 per RVU.

Every year for the past seven years, CMS has been obligated to announce the Conversion Factor based on the legislative requirements of the Social Security Act. Historically, Congress has moved with varying levels of speed each year to “fix” the conversion factor and avoid any precipitous reduction to physician payment by Medicare.

GAINS IN PRACTICE EXPENSE (PE) RELATIVE VALUE UNITS (RVUS)

Dermatology continues to benefit from the four year phase in of adjustments to the indirect practice expense factors. Dermatology will see a modest +1% increase to the PE/RVUs for dermatology procedures. This phased-in increase is a result of CMS use of updated indirect practice expense data from the AMA Physician Practice Information (PPI) Survey conducted in 2008. CMS believes the PPIS is the most comprehensive source of PE survey information available to date. For 2012, the adjustments are a mix of 75% PPIS data/25% CMS Practice Expense Supplemental Survey (PESS) data.

CMS SCRUTINY OF “POTENTIALLY MISVALUED SERVICES” UNDER THE PHYSICIAN FEE SCHEDULE

The Affordable Care Act (ACA) requires the Secretary of the Department of Health and Human Services (DHHS) to identify (using certain criteria) & review “potentially misvalued codes” and make appropriate adjustments to Medicare payment. CMS is also charged with developing an independent validation process to validate revised RVU values.

To respond to MedPAC, Congress and other stakeholders, the AMA Resource Based/Relative Value Scale Update Committee (AMA RUC) established a Work Group in 2006 to establish criteria for identifying misvalued codes. CMS in accordance with SSA Sec. 1848(c) determines the appropriate adjustments to RVUs, taking into consideration AMA RUC as well as MedPAC recommendations. SSA 1848 authorizes the use of extrapolation and other techniques to determine RVU levels while taking into account consultations with organizations representing physicians.

EVALUATION AND MANAGEMENT CODES

CMS has accepted comments, from many specialty societies as well as the AMA RUC and has removed the proposal to re-survey all 91 of the Evaluation and Management codes. However, of greater concern for dermatology is the CMS comment that:

“in cases where a service is typically furnished with an E/M service on the same day, we believe that there may be overlap between the two services in some of the activities conducted during the pre- and post-service times of the procedure code. Accordingly, in cases where the most recently available Medicare FFS claims data show the code is typically billed with an E/M visit on the same day, and where we believe that the AMA RUC did not adequately account for overlapping activities in the recommended value for the code, we systematically adjusted the physician times for the code to account for the overlap.”

— see MEDICARE FEE SCHEDULE on page 2

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IMPORTANT Please Route to:
___ Dermatologist ___ Office Mgr ___ Coding Staff ___ Billing Staff
2012 Medicare Fee Schedule – Impact on Dermatology

Dear Reader,

The 2012 Medicare Fee Schedule is upon us and the American Academy of Dermatology (AAD) has prepared a 64-page manual to guide you through the changes. Scott Dinehart, MD, FACP, Chair, Health Care Finance Committee, and executive editor of Derm Coding Consult, was key in bringing this to you. He has asked me to share the highlights of the manual with you.

The Medicare Physician Fee Schedule Code Specific Detail can be found on page 3.

CALCULATION OF MALPRACTICE RVUS
CMS has determined that it is not logistically feasible to survey and review malpractice insurance premium data on an annual basis, a comprehensive review of MLV/RVU data will be set at five year intervals. For new and revised CPT codes, PLI RVUs will be cross-walked to similar codes parenthetically. Dermatology is consistently ranked as low risk by malpractice insurers and this valuing is reflected in the PLI/RVU values for dermatology procedures.

MEDICARE TELEHEALTH SERVICES FOR THE PHYSICIAN FEE SCHEDULE
Under the Medicare Telehealth Services provisions, CMS has expanded coverage of telehealth in 2012 to include ongoing cessation counseling (2 codes). CMS has also expanded the criteria for consideration of Category 2 telehealth services; revised the ipetent telehealth consultation codes and increased the originating site fee by 0.6%.

FINALIZING CY 2011 INTERIM AND PROPOSED VALUES FOR CY 2012
CMS has provided a code by code discussion of the AUA RUC reviewed, CMS final decision and CMS decisions on all of the codes reviewed as part of the CMS 4th Five Year Review. Comparison of the 2011 and 2012 MFS: Final Rules reveals that CMS has chosen not to accept the AUA RUC recommendations for a growing number of codes. So far, this has not negatively impacted specific dermatology codes that were reviewed and valued.

INTEGRUMENTARY SYSTEM - CODES REVIEWED
For the following codes, CMS has finalized the RVUs without change to the interim values for the following codes: 11900-11901 – Injections into skin lesions; 12001-12018 – Simple repairs; 12041-12051-12054 – Intermediate repairs; 15120, 15121, 15260, 15823 – Skin grafts

CMS has either retained the interim code value or these codes remain under review in the AUA categories listed above: 13100-13152 – Complex Repair Codes

Other codes determined to be appropriate by the Secretary.

Pre-Service Time

17260 – 17266 – Destruction of malignant lesions

CMS has detailed the accepted and/or revised code values for these codes and also corrected intra-service times for:

Example: when bone is debrided from a 4 sq. cm heel ulcer that is normally reported in conjunction with code 11042 and would not require the use of modifier 59 with either code 11042 or 11044 as applicable. The revised test now directs the use of modifier 59 with either code 11042 or 11044 as appropriate.

Example: when bone is debrided from a 4 sq. cm heel ulcer and from a 10 sq. cm ischial ulcer, report the work with a single code, 11044. When subcutaneous tissue is debrided from a 16 sq. cm, dehisced abdominal wound and a 10 sq. cm, thigh wound, report the work with 11042 for the first 20 sq. cm

Dear Derm Coding Consult Reader

Another year has passed and dermatologists and physicians everywhere are again facing a potential decrease in Medicare reimbursement for 2012. Keep in mind that Medicare will not make payment adjustments to claims submitted with a lower fee schedule should there be a last minute legislative conversion factor increase. Please watch your local Medicare carrier website, join your Medicare carrier listerv, and visit the AAD website for updated information.

The 2012 AAD Coding & Documentation Manual is available for pre-sale and set to mail in January. Order your new and expanded copy to ensure that your coding practices are up to date. The 2012 AAD Coding & Documentation Manual is available for pre-sale and set to mail in January. The CMS finally released the 2012 Medicare Physician Fee Schedule. The major changes for dermatology include: expanded coverage of telehealth in 2012 to include ongoing cessation counseling (2 codes). Dermatology is consistently ranked as low risk by malpractice insurers and this valuing is reflected in the PLI/RVU values for dermatology procedures.

THE 2012 AAD CODING & DOCUMENTATION MANUAL IS AVAILABLE FOR PRE-SALE AND SET TO MAIL IN JANUARY.

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For a comprehensive review of 2012 CPT, ICD and Medicare changes as well as Coding Update Webinar on November and expanded copy to ensure that your coding practices are up to date. The 2012 AAD Coding & Documentation Manual is available for pre-sale and set to mail in January. Order your new and expanded copy to ensure that your coding practices are up to date. The 2012 AAD Coding & Documentation Manual is available for pre-sale and set to mail in January.

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MEDICARE PHYSICIAN FEE SCHEDULE CODE SPECIFIC DETAIL
CMS announced with the publication of the 2012 Medicare Physician Fee Schedule: Proposed Rule that it would no longer include the relevant Appendices in the documentation published in the Federal Register. The display copy of the Final Rule is downloadable at: http://www.ogc.gov/OPFdata/OFRdata/2011.28597.Pdf

All of the appendices for the Medicare Physician Fee Schedule are now downloadable from the CMS website at: http://www.cms.gov/PhysicianFeeSched/PFSRVR/itemdetail.asp?filterType=nore&filterByDID=95&sortOrder=desc&gender=1&mt=10

AMA Unveils CPT Code Revisions and Updates for 2012

At the just ended AMA CPT Symposium in Chicago, Illinois, the American Medical Association (AMA) unveiled revisions and updates to certain dermatology codes for CY 2012. Dermatology practices are encouraged to pay close attention to these revisions as they may ultimately affect the final code selection of service performed.

DEBRIDEMENT

In 2010, Centers for Medicare and Medicaid Services (CMS) identified the debridement codes through the site-of-service anomaly screen and requested that the ARA/RUC review these codes. As a result, codes 11040 and 11041 were deleted, 97597 and 97598 were revised and a set of new and add-on codes were created in an effort to correct this problem (11042-11047).

In the continued effort to provide correct and accurate coding guidelines, the AMA has provided a revision to the debridement code guidelines.

The revised test state, “wound debrideements (11042-11047) are reported by depth of tissue that is removed and by surface area of the wound.” These services may be reported for injuries, infections, wounds and chronic ulcers. When performing debridement of a single wound, report depth using the deepest level of tissue removed. In multiple wounds, sum the surface area of those wounds that are at the same depth, but do not combine sums from different depths.”

The following example in the debridement guidelines was editoially revised to delete 11045 because this is an add-on code that is normally reported in conjunction with code 11042 and would not require the use of modifier 59. The revised test now directs the use of modifier 59 with either code 11042 or 11044 as appropriate.

Example: when bone is debrided from a 4 sq. cm heel ulcer and from a 10 sq. cm ischial ulcer, report the work with a single code, 11044. When subcutaneous tissue is debrided from a 16 sq. cm, dehisced abdominal wound and a 10 sq. cm, thigh wound, report the work with 11042 for the first 20 sq. cm...
AMA Unveils CPT Code Revisions and Updates for 2012
— continued from page 3
and 11045 for the secondary 6 sq. cm. If all 4 wounds were debrided on the same day, use modifier 59 with 11042, 11045 or 11044 as appropriate.

NOTE: Debridement codes are out of sequence, one is encouraged to check the coding manual for the most accurate code selection.

2012 WORK RVUS

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>11042</td>
<td>0.17</td>
<td>0.50</td>
<td>1.01</td>
</tr>
</tbody>
</table>

SKIN REPLACEMENT SURGERY

Skin replacement surgery consists of surgical preparation and topical placement of an autograft (including tissue cultured autograft) or skin substitute graft (i.e. homograft, allograft, xenograft). The graft is anchored using the provider’s choice of fixation. When services are performed in the office, routine dressing supplies are not reported separately.

This subsection of the Integumentary System has been comprehensively expanded to include new guidelines that clarify the reporting of wound care management and skin substitutes. Comprehensive changes were made to the Skin Replacement code section and its sub-heading.

Other changes include:

- deletion of twenty-four codes (15300 – 15431), appropriate cross reference has been provided to direct users to 15271 – 15278 in lieu of 15400 – 15431;
- editorial revision of six codes (15150 – 15157) to remove the term ‘epidermal’ and replace that with ‘skin’;
- addition of two-tier structure of eight new codes (15271 – 15278) to report the application of skin substitute grafts which are distinguished according to the anatomic location and surface are rather than by product description: 2012 INTERMEDIATE REPAIR CODES WORK RVUS

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Size</th>
<th>2011 RVU</th>
<th>2012 RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>12031</td>
<td>2.5 cm or less</td>
<td>2.26</td>
<td>2.00</td>
</tr>
<tr>
<td>12032</td>
<td>2.6 – 7.5 cm</td>
<td>2.75</td>
<td>2.58</td>
</tr>
<tr>
<td>12033</td>
<td>7.6 – 12.5 cm</td>
<td>2.97</td>
<td>2.97</td>
</tr>
<tr>
<td>12035</td>
<td>12.6 - 20 cm</td>
<td>3.47</td>
<td>3.50</td>
</tr>
<tr>
<td>12036</td>
<td>20 - 30 cm</td>
<td>4.06</td>
<td>4.23</td>
</tr>
<tr>
<td>12037</td>
<td>&gt;30 cm</td>
<td>4.77</td>
<td>5.00</td>
</tr>
<tr>
<td>12041</td>
<td>2.5 cm or less</td>
<td>2.42</td>
<td>2.10</td>
</tr>
<tr>
<td>12042</td>
<td>2.6 – 7.5 cm</td>
<td>2.79</td>
<td>2.79</td>
</tr>
<tr>
<td>12044</td>
<td>7.6 – 12.5 cm</td>
<td>3.19</td>
<td>3.19</td>
</tr>
<tr>
<td>12045</td>
<td>12.6 - 20 cm</td>
<td>3.46</td>
<td>3.46</td>
</tr>
<tr>
<td>12046</td>
<td>20 – 30 cm</td>
<td>4.25</td>
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</tr>
<tr>
<td>12047</td>
<td>&gt;30 cm</td>
<td>4.69</td>
<td>4.95</td>
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<td>12051</td>
<td>2.5 cm or less</td>
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<td>12052</td>
<td>2.6 – 7.5 cm</td>
<td>2.85</td>
<td>2.87</td>
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<tr>
<td>12053</td>
<td>7.6 – 12.5 cm</td>
<td>3.17</td>
<td>3.17</td>
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<tr>
<td>12054</td>
<td>12.6 - 20 cm</td>
<td>3.50</td>
<td>3.50</td>
</tr>
<tr>
<td>12055</td>
<td>20 – 30 cm</td>
<td>4.47</td>
<td>4.50</td>
</tr>
<tr>
<td>12056</td>
<td>&gt;30 cm</td>
<td>5.25</td>
<td>5.30</td>
</tr>
</tbody>
</table>

AMA Unveils CPT Code Revisions and Updates for 2012
— continued from page 4

- codes 15271, +15272, 15275 and +15276 describe the application for total wound surface area up to 100 sq. cm;
- codes 15273, +15274, 15277, and +15278 describe the application for total wound surface area that are greater than or equal to 100 sq. cm;
- several new cross-references and instructional notes;
- new add-on code 15777 has been established to report the implantation of biologic implant (i.e. acellular dermal matrix for soft tissue reinforcement e.g. breast, trunk) in addition to the primary procedure.

NOTE: Codes 15271 – 15278 are intended to report topical application of skin substitute grafts. This expansion was effected to achieve greater granularity and consistency for these services e.g. guidelines now instruct that skin replacement surgery consists of surgical preparation and topical placement of an autograft, which includes tissue cultured autograft, or the skin substitute homograft, allograft, and xenograft.

Surgical preparation code guidelines (15002 - 15005) for skin replacement surgery have been revised to describe the initial services related to preparing a clean and viable wound surface for placement of an autograft, flap, skin substitute graft or for negative pressure wound therapy. There have been several new cross-references to the autoplag codes (15040 - 15130).

When selecting the appropriate service codes, avoid reporting 15002 – 15005 for removal of nonviable tissue/debris in a chronic wound (e.g., venous or diabetic) when wound is left to heal by secondary intention. See active wound management codes (97597, 97598) and debridement codes (11024 - 11047) for this service. For necrotizing soft tissue infections in specific anatomic location, see 11004 – 11048.

Delivered to check the coding manual for the most accurate code selection.

2012 INTERMEDIATE REPAIRS (12031 – 12056)

Interim Revisions to CPT codes 12031 – 12056. As a result of this survey, the smaller size repair codes saw a small decrease to the AMA/RUC on CPT codes 12031 – 12057. As a result of 2012 WoRk RVUS, the smaller size repair codes saw a small decrease to the AMA/RUC on CPT codes 12031 – 12057. As a result of 2012 WoRk RVUS, the smaller size repair codes saw a small decrease to the AMA/RUC on CPT codes 12031 – 12057. As a result of 2012 WoRk RVUS, the smaller size repair codes saw a small decrease to the AMA/RUC on CPT codes 12031 – 12057. As a result of 2012 WoRk RVUS, the smaller size repair codes saw a small decrease to the AMA/RUC on CPT codes 12031 – 12057. As a result of 2012 WoRk RVUS, the smaller size repair codes saw a small decrease to the AMA/RUC on CPT codes 12031 – 12057. As a result of 2012 WoRk RVUS, the smaller size repair codes saw a small decrease to the AMA/RUC on CPT codes 12031 – 12057. As a result of 2012 WoRk RVUS, the smaller size repair codes saw a small decrease to the AMA/RUC on CPT codes 12031 – 12057. As a result of 2012 WoRk RVUS, the smaller size repair codes saw a small decrease to the AMA/RUC on CPT codes 12031 – 12057. As a result of 2012 WoRk RVUS, the smaller size repair codes saw a small decrease to the AMA/RUC on CPT codes 12031 – 12057. As a result of 2012 WoRk RVUS, the smaller size repair codes saw a small decrease to the AMA/RUC on CPT codes 2012 intermediate repairs are reported separately because the term ‘epidermal’ and replace that with ‘skin’; addition of two-tier structure of eight new codes (15271 – 15278) to report the application of skin substitute grafts which are distinguished according to the anatomic location and surface are rather than by product description:
MODIFIER 92 - ALTERNATIVE LABORATORY TESTING PLATFORM

When laboratory testing is being performed using a kit or transportable instrument that wholly or in part consists of a single use, disposable analytical chamber, the service may be identified by adding modifier 92 to the appropriate CPT code. This does not apply to all tests that do not require a permanent dedicated space, hence its design may be hand carried or transported to the vicinity of the patient for immediate testing at that site, although location of the testing is not in itself determinative of the use of the modifier.

88104, 88106 - Smears and Simple Filter Preparation

It has been deleted so to report smears and simple filter preparation, see 88104, 88106.

88312 – 88319 Special Stains including Interpretation and Report

The special stains codes (88312 – 88319) have been revised to better define the service and eliminate confusion concerning special stains where procedures overlap two code definitions. Additional instructions and cross reference parenthetical notes have been added to provide a defined hierarchy for codes and define units of service thereof.

CPT Code - Descriptors

88312

Special stain including interpretation and report; Group I for microbiologicals (e.g., aerobic, fastidious). See also 88313-88319.

• Report one unit of 88312 for each special stain, on each surgical pathology block, cytologic specimen, or hematologic smear.

88313

Special stain including interpretation and report; Group II, other (e.g., iron, fibrinogen), except immunohistochemistry and immunochemistry and immunocytochemistry.

• Report one unit of 88313 for each special stain, on each surgical pathology block, cytologic specimen, or hematologic smear.

88314

Special stains including interpretation and report; hematologic; staining with on-frozen sections, toluidine blue, performed during Motra surgery.

• For Immunocytochemistry and immunochemistry, use 88343.

88318

Has been deleted. For determinative histochemistry to identify chemical components, use 88313.

88319

Special stains including interpretation and report; Group III, for enzyme consultant

• For each special stain on each surgical pathology block, cytologic specimen, or hematologic smear, use one unit of 88319.

For determination of antibody or immune complexes, use 88342.

DERMATOLOGY CLINICAL AUDIT

Dermatologists are seeing an increase in audits. Recovery Audit Contractors (RACs) are focusing on Global surgery reported with an Evaluation and Management (E/M) service with or without Modifier -25. Since reporting an E/M office visit with a procedure is common to Dermatology practices, it is important to understand Modifier -25 use and global package definitions.

CMS and AMA CPT define Modifier 25 as Significant, separately identifiable evaluation and management (E/M) service by the same physician on the day of a procedure; and an E/M procedure) can be reported in the same diagnosis.

DERMATOLOGY CLINICAL AUDIT - continued from page 4

For more information on 2012 HCPCS codes, visit CMS at www.cms.gov/HCPCS/Downloads/HCPCS_topicals.pdf. To obtain a detailed list of all the 2012 revised and updated codes, please review the 2012 AAD Coding & Documentation Manual or the AMA CPT code book.

NOTE: Be sure to address the reason the patient gave for the visit in your documentation. This may be difficult for patients referring for skin screening services as they generally do not have a chief complaint and history of present illness.

• The procedure performed must have a global period listed on Medicare Fee Schedule IRV.

• An E/M service may occur on the same day as a procedure and within the post-operative period of a previous procedure. Payment is allowed when the documentation supports the modifier -25 and modifier -24, unrelated E/M during a post op period.

A patient may report a new complaint and/or the provider may make an unexpected new discovery. If the problem or abnormality requires a workup that is separate and identifiable from the procedure, a significant, separately identifiable evaluation and management service note should be documented in the medical record. You should then append a modifier -25 to the E/M code.

AAD staff having the opportunity to review members’ E/M documentation with a procedure, found in many cases a varying use of modifier -25. Each medical record should clearly reflect the chief complaint or the main reason for the visit. This notation is needed for all levels of documentation. It is typical for chief complaint to be copied from the appointment schedule or room; Postoperative Visits – follow-up visits during the postoperative period of the surgery because of complications which do not require additional trips to the operating room;

• Complications Following Surgery – All additional medical or surgical services required of the surgeon during the postoperative period of the surgery because of complications which do not require additional trips to the operating room;

• Postsurgical Pain Management – By the surgeon;

• Complications Following Surgery – All additional medical or surgical services required of the surgeon during the postoperative period of the surgery because of complications which do not require additional trips to the operating room;

• Postsurgical Pain Management – By the surgeon;

• Intra-operative Services – Intra-operative services that are not part of the global period for major procedures and the day of surgery for minor procedures;

• Minor Surgical Procedures – Services which do not require additional trips to the operating room; surgical services required of the surgeon during the postoperative period of the surgery because of complications which do not require additional trips to the operating room;

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• Postsurgical Pain Management – By the surgeon;

• Intra-operative Services – Intra-operative services that are not part of the global period for major procedures and the day of surgery for minor procedures;
Q&A’s

— continued from page 7

ICD-9 codes are not correct, however, because the tumor is either considered viral (condyloma) or of uncertain behavior or carcinoma in situ. It is not appropriate to code for benign neoplasm.

A dermatologist wishing to participate in PQRS must report the following reviews of:

• Appropriate use of certain modifiers (-24 & -79) during the global surgery period.
• Actinic keratosis codes can be appropriate, depending upon the specific actinic keratosis, and I would leave it up to the pathologist to let the coder know which is his/her preference.
• If a patient had Moh’s surgery, a complex repair was performed, and the patient came back two days later complaining of extreme swelling and redness of the surgical site, can I bill for an office visit?

Reviewed by Congress –

Our work plan includes the following reviews of:

• Appropriateness of the use of certain modifiers (-24 & -79) during the global surgery period.

As health care expenses continue to rise and consume a greater portion of federal dollars, the OIG has become more aggressive in pursuit of noncompliance, fraud, and abuse. In 2010, $3.8 billion in expected investiga-
tive receivables were court ordered or paid through civil settlements that resulted from cases developed by OIG investigators; and HHS program managers pursued $1.1 billion in audit receivables as a result of OIG audit disallow-
ance recommendations.

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Advanced Beneficiary Notice of Non-coverage (ABN), Form CMS-R-131: Revised Effective November 1, 2011

The latest version of the ABN (with the release date of March 2011) printed in the lower left hand corner is now available for immediate use. In order for providers and suppliers to have time to transition to using the newly posted notice, mandatory use of this version began on November 1, 2011. The mandatory ‘use’ date has been changed from September to November to accommodate those providers and suppliers with pre-printed stockpiles of ABNs so that they have more time to exhaust any supplies of the outgoing ABN.

All ABNs with the release date of March 2008 that are used on or after November 1, 2011 will be considered invalid.

The newest version of the ABN and instructions is in the AAD 2011 Coding & Documentation Manual on page 468 and can be downloaded at this CMS website: https://www.cms.gov/BNI/02_ABN.asp.

ADDITIoNAL ReSoURCeS:
The Academy has resources to help members with the transition to 5010 version at www.aad.org/member-tools-and-benefits/practice-management-resources/coding-and-reimbursement/icd-10/icd-10-updates.

To view the CMS notification, please visit: www.cms.gov/ICD10/Downloads/CMSStatement5010EnforcementDiscretion111711.pdf

CMS also published a list of frequently asked questions that can be found at: https://questions.cms.hhs.gov/app/answers/list/4w/enforcement/search/1.
In The Know.....

**RAC DEMAND LETTER ISSUANCE NOW RESPONSIBILITY OF CMS**

Centers for Medicare & Medicaid Services (CMS) recently announced that it is transferring the responsibility of issuing demand letters to providers from its Recovery Audit Contractor Auditors (RACs) to its claims processing contractors as of January 3, 2012. CMS states that the *Medicare Administrative Contactor’s (MACs)* will take on the responsibility of performing the adjustments based on the RAC’s review and issue an automated demand letter. MACs will then be responsible for fielding any administrative concerns providers may have such as timeframes for payment, recovery and the appeals process. MACs will include the name of the initiating RAC and contact person information in the related demand letter.

CMS states that this change was initiated to avoid any delays in demand letter issuance. As a result, when a Recovery Auditor finds that improper payments have been made to you, they will submit claim adjustments to your Medicare (claims processing) contractor. Your Medicare contractor will then establish receivables and issue automated demand letters for any Recovery Auditor identified overpayment. The Medicare Contractor will follow the same process as is currently in place to recover any other overpayment from healthcare providers.


Now you are in the know! 👍