Medicare Update for the New Year – Paycut Averted, PQRS, ICD-10, 5010, Medicare Enrollment, eRx, IDTF, EFT & RA

Here is a collection of the latest Medicare updates to get your New Year off to a ~~good~~ informed start:

Pay Cut: Physicians continue to receive 2011 pay rates for an additional two months while lawmakers seek a compromise on a package that could last through the remainder of 2012 (jump to story)

PQRS – National Provider Call on Physician Quality Reporting System & Electronic Prescribing Incentive Program (jump to story)

ICD-10: Did you miss the November 17th National Provider Call on ICD-10? YouTube Slideshow, Podcasts here (jump to story)

5010: New FAQs for 90 Day Discretionary Enforcement Period of ASC X12 Version 5010 (jump to story

Medicare Enrollment: Having trouble committing to Medicare this year? You have five more weeks to think about it. (jump to story)

eRx: The 2012 Electronic Prescribing (eRx) Incentive Program payment adjustment feedback report ain't gonna happen due to the huge volume of exemptions filed.(jump to story)

IDTF: Did you get your accreditation to be able to perform the technical component of MRIs, CTs and Nuclear Medicine tests for Medicare patients? (jump to story)

PQRS: CMS announces the posting of 2012 Physician Quality Reporting System educational products (jump to story)

EFT & RA: Interim Final Rule Standards for the Health Care Electronic Funds Transfers (EFT) and Remittance Advice transaction (RA) (jump to story)

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Physician Pay Cut Delayed Until March 1, 2012

Medicare pay cut averted After a nearly weeklong standoff over a payroll tax cut package containing a temporary Medicare physician payment patch, Congress on Friday approved a bill that delays the scheduled pay cut from Jan. 1 to March 1. The pay patch means physicians will continue to receive 2011 pay rates for an additional two months while lawmakers seek a compromise on a package that could last through the remainder of 2012. **Click here for the rest of the story that led up to the delay – from amednew.com.**

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National Provider Call on Physician Quality Reporting System & Electronic Prescribing Incentive Program

Tuesday, January 17, 1:30-3pm ET

The Centers for Medicare & Medicaid Services (CMS) will host a national provider call on the Physician Quality Reporting System & Electronic Prescribing Incentive Program. Subject matter experts will provide an overview on how the 2012 electronic prescribing (eRx) payment adjustment will appear on your remittance advice, as well as, an overview of the self nomination process.. A question and answer session will follow the presentation.

Target Audience: Medicare fee-for-service (FFS) providers, Medical coders, Physician office staff, Provider billing staff and Vendors

Agenda:

- Opening Remarks
- Program Announcements
- Overview on how the 2012 Electronic Prescribing (eRx) Incentive Program payment adjustment will appear on your remittance advice
- Overview of the self nomination process
- Question & Answer Session

Registration Information – Please visit http://www.eventsvc.com/blhtechnologies/ to register for this informative session. Registration will close at 12:00 p.m. ET on January 17, 2012, or when available space has been filled. No exceptions will be made. Please register early.

Presentation: The presentation will be posted at least one day before the call at: http://www.cms.gov/PQRS/04_-CMSSponsoredCalls.asp in the **"Downloads"** section on the CMS

website.

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Miss the November 17th National Provider Call on ICD-10? YouTube Slideshow and Podcasts are available.

The Centers for Medicare & Medicaid Services (CMS) has released a YouTube video slideshow presentation and podcasts from the November 17, 2011 National Provider Call on "ICD-10 Implementation Strategies and Planning."

Did you miss the November 17th ICD-10 National Provider Call? The call presentation is now available on the CMS YouTube Channel as a video slideshow that includes the call audio with captions.

Limited on time? Podcasts are perfect for the office, in the car, or anywhere you carry a portable media player or smartphone. The following podcasts are now available from the November 17th ICD-10 call:

- Podcast 1 of 4: Introduction, General ICD-10 Requirements, and CMS Implementation Planning
- Podcast 2 of 4: General Implementation Planning and Strategies
- Podcast 3 of 4: NCVHS Meeting Update and Medicare FFS Claims Processing, Billing, and Reporting Guidelines
- Podcast 4 of 4: Question and Answer Session

The podcasts are now available on the CMS website at http://www.cms.gov/ICD10/Tel10/itemdetail.asp?itemID=-CMS1253081.

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New FAQs for 90 Day Discretionary Enforcement Period of ASC X12 Version 5010

Medicare Fee-For-Service (FFS) issued an announcement Wednesday, December 14, 2011 regarding its plan for the 90 Day Discretionary Enforcement Period for non-compliant HIPAA covered entities. CMS has published six FAQ items related to this plan. These new FAQs can be found at: http://www.cms.gov/Versions5010andD0/Downloads/-QandA_for_90_day_announcement.pdf.

For more information on ASC X12 Version 5010, NCPDP D.0, and NCPDP 3.0; please visit www.CMS.gov/Versions5010andD0.

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Attention Health Professionals: 2012 Annual Participation Enrollment Program Extension

CMS is anticipating Congressional action to avert the negative update for the 2012 Medicare Physician Fee Schedule. Therefore, CMS is extending the 2012 Annual Participation Enrollment Period through Tuesday, February 14, 2012. The enrollment period now runs Monday, November 14, 2011 through Tuesday, February 14, 2012.

The effective date for any participation status change during the extension, however, remains Sunday, January 1, 2012, and will be in force for the entire year.

Contractors will accept and process any participation elections or withdrawals made during the extended enrollment period that are post-marked on or before Tuesday, February 14,

2012.

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The 2012 Electronic Prescribing (eRx) Incentive Program payment adjustment feedback report ain’t gonna happen due to the huge volume of exemptions filed.

CMS would like to advise providers, due to the high volume of significant hardship exemption requests received it is no longer technically feasible for CMS to provide a 2012 Electronic Prescribing (eRx) Incentive Program payment adjustment feedback report as originally intended.

As CMS continues to explore alternative means to notify eligible professionals that they are subject to the 2012 eRx payment adjustment, we urge you to review your remittance advices for claims submitted for dates of services on or after Sunday, January 1, 2012.

Eligible professionals and group practices (GPRO) participating in the eRx GPRO that receive the 2012 eRx payment adjustment will see the term “LE” on their remittance advice for all Medicare Part B services rendered Sunday, January 1, 2012 through Monday, December 31, 2012.

The remittance advice will also contain the following Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC):

§ *CARC 237* – Legislated/Regulatory Penalty. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).

§ *RARC N545* – Payment reduced based on status as an unsuccessful e-prescriber per the Electronic Prescribing (eRx)

Incentive Program.

If an eligible professional or group practice that participated in the eRx GPRO receives the payment adjustment in error (e.g., the eligible professional or group practice submitted a hardship exemption request that is ultimately approved by CMS), the claim will be reprocessed to return the 1.0% and the remittance advice for the reprocessed claim will include the following codes and messages:

§ *CARC 237* – Legislated/Regulatory Penalty. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).

§ *RARC N546* – Payment represents a previous reduction based on the Electronic Prescribing (eRx) Incentive Program.

For more information on how the 2012 eRx payment adjustment will be assessed and applied, please refer to MLN Matters Article SE1141 for additional information, or visit the eRx Incentive Program webpage at http://www.cms.gov/erxincentive.

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Did you get your accreditation to be able to perform the technical component of MRIs, CTs and Nuclear Medicine tests for Medicare patients?

Suppliers of the technical component of Advanced Diagnostic Imaging that are billing with a service date on or after Sunday, January 1, 2012 must evidence an active accreditation date for diagnostic imaging of CPT codes attached to an MRI, CT, and Nuclear Medicine claim. The professional component claims are not affected by the accreditation requirements and must be processed as usual. Refer to Transmittal #380, http://www.cms.gov/transmittals/downloads/R380PI.pdf or MLN

Matters 7177, http://www.cms.gov/MLNMattersArticles/downloads/-MM7177.pdf for further information on claims processing.

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CMS announces the posting of 2012 Physician Quality Reporting System educational products

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce the posting of 2012 Physician Quality Reporting System educational products at http://www.cms.gov/PQRS on the CMS website.

· ***2012 Physician Quality Reporting System Measures List*** – this document identifies and explains the measures used in Physician Quality Reporting, including information on the reporting options/methods, measure developers and their contact. **Please note that this document was updated and re-posted on 1/05/2012.

· ***2012 Physician Quality Reporting System Quality-Data Code (QDC) Categories*** – a table that outlines, for each measure, each QDC that should be reported for a corresponding quality action performed by the individual eligible professional as noted in the measures specification. This determines how each code will be used when calculating performance rates. This also clarifies those measures that require two or more QDCs to report satisfactorily. Insufficiently reporting the QDCs (as specified in the *2012 Physician Quality Reporting System Measure Specifications Manual*) will result in invalid reporting.

· ***2012 Physician Quality Reporting System Single Source Code Master*** – this file includes a numerical listing of all codes included in 2012 Physician Quality Reporting for incorporation into billing software.

· ***2012 Physician Quality Reporting System Measure Specifications Manual for Claims and Registry Reporting of Individual Measures*** – the 2012 measure specifications include codes and reporting instructions for the 210 Physician Quality Reporting System measures for claims and/or registry-based reporting. **Please note that this document was revised and re-posted on 1/05/2012.

· ***2012 Physician Quality Reporting System Measure Specification Release Notes*** – outlines changes from the *2011 Physician Quality Reporting System Measure Specifications Manual* in the form of Release Notes. **Please note that this document was revised and re-posted on 1/05/2012.

· ***2012 Physician Quality Reporting System Implementation Guide*** – provides guidance about how to select measures for reporting, how to read and understand a measure, and outlines the reporting options available for 2012 Physician Quality Reporting System. The *Implementation Guide* also details how to implement claims-based reporting of measures to facilitate satisfactory reporting of quality-data codes by eligible professionals.

· ***2012 Physician Quality Reporting System Measures Groups Specifications Manual*** – measures group specifications are different from those of the individual measures that form the group. Therefore, the specifications and instructions for measures group reporting are provided in a separate manual. The 2012 measures groups specifications include codes and reporting instructions for the 22 Physician quality Reporting System measures groups for claims or registry-based reporting.

· ***2012 Physician Quality Reporting Measures Groups Release Notes*** – this document outlines changes from the *2011 Physician Quality Reporting System Measures Groups Specifications Manual* in the form of release notes.

· ***Getting Started with 2012 Physician Quality***

Reporting System of Measures Groups – provides guidance on implementing the 2012 Physician Quality Reporting System measures groups.

· ***2012 Physician Quality Reporting Measures Groups Single Source Code Master*** – this file includes a numerical listing of all codes included in 2012 Physician Quality Reporting System Measures Groups for incorporation into billing software.

· ***2012 Physician Quality Reporting System Measure-Applicability Validation Process for Claims-Based Reporting of Individual Measures*** – provides guidance for those eligible professionals who satisfactorily submit quality-data codes for fewer than three Physician Quality Reporting measures, and how the measure-applicability validation process will determine whether they should have submitted QDCs for additional measures.

· ***2012 Physician Quality Reporting Measure-Applicability Validation Process Release Notes*** – the release notes for the changes occurring for the 2015 Physician Quality Reporting Measure-Applicability Validation Process (MAV).

· ***2012 Physician Quality Reporting System Measure-Applicability Validation Process Flow*** – a chart that depicts the Measure-Applicability Validation Process (MAV).

· ***Group Practice Reporting Option (GPRO) Requirements for Submission of 2012 Physician Quality Reporting System Data*** – provides guidance on how a group practice of over 25 eligible professionals can self-nominate to participate in GPRO for 2012 data submission.

· ***2012 Physician Quality Reporting System Group Practice Reporting Option (GPRO) Measures List*** – a document containing a list of the 2012 Physician Quality Reporting GPRO Measures.

· ***2012 Physician Quality Reporting GPRO Narrative Measure Specifications and Release Notes*** – this document contains descriptions of the 2012 Physician Quality Reporting GPRO measures and changes in the program since the 2011 reporting year.

· ***2012 EHR Direct Vendor Qualification Requirements*** – provides guidance on how EHR Direct Vendors can self-nominate and qualify to submit Physician Quality Reporting System measures data for 2012.

· ***2012 EHR Data Submission Vendor Qualification Requirements*** – provides guidance on how EHR Data Submission Vendors can self-nominate and qualify to submit Physician Quality Reporting System measures data for 2012.

· ***2012 EHR Documents for Eligible Professionals*** – this zipped file contains the following:

– ***2012 Physician Quality Reporting System EHR Measure Specifications*** – the detailed description of data element names and codes related to each of 51 2012 Physician Quality Reporting System quality measures available for electronic submission.

– ***2012 Physician Quality Reporting System Physician Quality Reporting System EHR Measure Specifications – Release Notes*** – the corresponding release notes for the 2012 EHR Measure Specifications.

– ***2012 EHR Downloadable Resource Table***

– ***2012 EHR Downloadable Resource Table – Release Notes***

· ***2012 EHR Documents for Vendors*** – this zipped file contains the following:

– ***Data Submission Specifications Utilizing HL7 QRDA Implementation Guide Based on HL7 CDA Release 2.0***

– ***Updated EHR Data Submission Specifications Utilizing QRDA – Release Notes*** – release notes for Data Submission Specifications Utilizing HL7 Quality Reporting Document Architecture Based on HL7 CDA Release 2.0

– ***2012 EHR Downloadable Resource Table***

– ***2012 EHR Downloadable Resource Table – Release Notes***

– ***Updated EHR Data Submission Specifications Utilizing QRDA Header Errors and Edits***

– ***Updated EHR Data Submission Specifications Utilizing QRDA Body Errors and Edits***

– ***2012 CMS EHR QRDA Data Submission Specifications and Errors Edits Release Notes***

To access the 2012 Physician Quality Reporting System educational products, visit the *Spotlight* page at http://www.cms.gov/PQRI/02_Spotlight.asp on the CMS website for the listing of educational products and the corresponding section page where they can be found.

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Interim Final Rule Announced for the Health Care Electronic Funds Transfers (EFT) and Remittance Advice transaction (RA) Standards

The Centers for Medicare & Medicaid Services (CMS) today announced an interim final rule with comment period (IFC) (CMS-0024-IFC) under which the Department of Health and Human Services (HHS) adopts standards for the Health Care Electronic Funds Transfers (EFT) and Remittance Advice transaction (RA) under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Section 1104 of the Patient Protection and Affordable Care Act of 2010 requires CMS to issue a series of regulations over the next five years that are designed to streamline health care administrative transactions, encourage greater use of standards by providers, and make existing standards work more efficiently. On July 8, 2011, CMS published the first regulation, an IFC that puts in place operating rules for two electronic health care transactions that make it easier for providers to determine whether a patient is eligible for coverage and the status of a health care claim submitted to a health insurer.

The regulation announced today is the second in the series and establishes EFT standards that, when implemented by health plans, will save physician practices and hospitals between of $3 billion to $4.5 billion over the next ten years. Further environmental benefits from the use of an electronic payment in contrast to payments made by paper checks will result in an estimated 800,000 pounds of paper saved and 2.2 million pounds of greenhouse gases avoided over ten years.

Future administrative simplification rules will address adoption of:

- A standard unique identifier for health plans;
- A standard for claims attachments; and
- Requirements that health plans certify compliance with all HIPAA standards and operating rules.

BACKGROUND

Congress addressed the need for a consistent framework for electronic health care transactions and other administrative simplification issues through the Health Insurance Portability and Accountability Act of 1996 (HIPAA), enacted on August 21, 1996. HIPAA amended the Social Security Act (the Act) by adding Part C—Administrative Simplification—to Title XI of the

Act, requiring the Secretary of the Department of Health and Human Services (DHHS) to adopt standards for certain transactions to enable health information to be exchanged more efficiently and to achieve greater uniformity in the transmission of health information.

Section 1104(b)(2)(A) of the Patient Protection and Affordable Care Act (Pub. L. 111-148) amended section 1173(a)(2) of the Act by adding the electronic funds transfers (EFT) transaction to the list of electronic health care transactions for which the Secretary must adopt a standard under HIPAA.

In general, the savings and benefits related to use of EFT for business and consumer payments are well established. The most common savings are in paper, printing, and postage costs, as well as savings in staff time to manually process and deposit paper checks. Yet adoption and use of EFT by the health care industry has been low, resulting in administrative savings that go unrealized. The obstacles to greater use of EFT by the health care industry can be lessened by standardization of the EFT transaction. Beyond the material and administrative time savings for health care providers and health plans, the time and resources that physician practices and hospitals spend on billing and related tasks will be better spent on delivering health care to patients.

On December 3, 2010, the National Committee on Vital and Health Statistics (NCVHS) Subcommittee on Standards held a hearing and from it gathered a comprehensive review of the health care payment and remittance advice transaction for purposes of making a recommendation to the Secretary. Participants represented a cross section of the health care industry. On February 17, 2011, the NCVHS sent a letter to the Secretary that contained recommendations for adoption of a "health care EFT" standard.

Based on that recommendation, HHS is adopting two standards for the health care EFT that a health plan must comply with in

order to transmit health care claim payments to providers via EFT. The first is a standard format for when a health plan orders, authorizes, or initiates an EFT with its financial institution. The second standard specifies the data content to be contained within the EFT.

The goal for adopting these standards is to ensure that a trace number that connects the payment to the electronic remittance advice is inputted into a standard EFT format and that is received without error by the health care provider. This can be best achieved by requiring that a single electronic file format (CCD+Addenda) be used by all health plans that transmit health care EFT to their financial institutions and by requiring that data elements are consistent and ordered according to clear implementation specifications.

PROVISIONS OF THE IFC ANNOUNCED TODAY

HHS is adopting two standards for the health care EFT: the CCD+Addenda implementation specifications in the 2011 National Automated Clearing House Association (NACHA) Operating Rules & Guidelines, and the TRN Segment implementation specifications in the X12 835 TR3 for the data content of the Addenda Record of the CCD+Addenda.

COSTS/BENEFITS

Although all covered entities are required to comply with the adopted standards of HIPAA transactions, the health care EFT standards are expected to have the most substantial cost and benefit impacts on physician practices, hospitals, and commercial and government health plans.

We estimate that many health plans will have direct costs associated with implementing and using the health care EFT standards. However, those costs are expected to be comparably small software investments, approximately $18 million to $28 million overall for all commercial health plans, and $400,000

to $600,000 for Medicaid, the Children's' Health Insurance Program (CHIP), and the Indian Health Service (IHS). The savings for commercial health plans could be as much as $40 million over ten years, $31 million for Medicaid, CHIP, and IHS.

For physician practices and hospitals, there is little to no cost to implement the health care EFT standards, as providers are the receivers of the standardized transaction and not the senders. Overall, physician practices and hospitals should see savings of $3 billion to $4.5 billion over the next ten years as health plans implement the health care EFT standards.

We can also expect a modest environmental benefit from the use of an electronic payment in contrast to payments made by paper checks, including an estimated 800,000 pounds of paper saved and 2.2 million pounds of greenhouse gases avoided over ten years.

REGULATION EFFECTIVE DATE/ STANDARDS COMPLIANCE DATE

The effective date of this regulation is January 1, 2012. Under the Affordable Care Act, HIPAA-covered entities must be in compliance with the standards (in other words, use the health care EFT standards) on January 1, 2014.

The rule (CMS-0024-IFC) is on display today and may be viewed at www.ofr.gov/inspection.aspx. A news release on the rule may be viewed at *http://www.hhs.gov/news*.

Accreditation Countdown: If You Are Billing Medicare the Technical Component for Advanced Diagnostic Imaging, You Better Get Started

Image via Wikipedia

If you are a physician, non-physician practitioner or Independent Diagnostic Testing Facility (IDTF) who supplies imaging services and submits claims for the Technical Component (TC) of Advanced Diagnostic Imaging (ADI) procedures to Medicare contractors (carriers and A/B Medicare Administrative Contractors (MACs)), you should know that you must be accredited by *Sunday, January 1, 2012*. If your facility uses an accredited mobile facility, and you bill for the TC of ADI, you must also be accredited. The accreditation requirement is attached to the biller of the services.

Those not accredited by that deadline will not be able to bill Medicare until they become accredited.

For those planning on seeking accreditation to continue performing the technical component of ADI services, know that accreditation is dependent on the demonstration of quality standards, including (but not limited to):

- Qualifications and responsibilities of medical directors and supervising physicians;

- Qualifications of medical personnel who are not physicians;
- Procedures to ensure that equipment used meets performance specifications;
- Procedures to ensure the safety of beneficiaries;
- Procedures to ensure the safety of person who furnish the imaging; and
- Establishment and maintenance of a quality assurance and quality control program to ensure the reliability, clarity and accuracy of the technical quality of the image.

Additionally, the accreditation process may include:

- Unannounced, random site visits;
- Review of phantom images;
- Review of staff credentialing records and maintenance records;
- Review of beneficiary complaints and patient records;
- Review of quality data and ongoing data monitoring; and
- Triennial surveys.

Frequently Asked Questions

Q: What are ADIs?

A: ADI procedures are defined as MRI, CT and Nuclear Medicine/PET.

Q: As a supplier, what information will I need to transmit to CMS when I become accredited for the TC of advanced imaging?

A: The designated accreditation organization (AO) will transmit the findings of all accreditation decisions to CMS or its contractor when the decision becomes final. The information will include identifying information, the accreditation effective date and those modalities that are included in the accreditation.

Q: What is the process for denying claims after January 1, 2012?

A: Contractors will deny claims with a date of service on or after January 1, 2012, submitted for the TC of the ADI codes with denial code N290 ("Missing/incomplete/invalid rendering provider primary identifier.") when the provider is not enrolled or accredited by a designated CMS accreditation organization. Contractors shall deny claims with codes submitted with a date of service on or after January 1, 2012, for the TC if the code is not listed on the provider's eligibility file using claim adjustment reason code (CARC)185 (The rendering provider is not eligible to perform the service billed.)

Q: What happens if I am already accredited and will be up for re-accreditation in 2012?

A: In the case of a supplier that is accredited before January 1, 2010 by one of the designated accreditation organizations, the supplier is considered to have been accredited by an organization for the period such accreditation is in effect. The supplier would have had to remain in good standing and have an active accreditation on 1/1/2012 and must apply for reaccreditation within the time frame specified by the accreditation organization.

Q: Do hospitals have to receive imaging accreditation for the Technical Component (TC) of advanced imaging that is performed under the prospective payment system?

A: Hospitals are generally exempt from this requirement. In

Section 1834(e) of the Social Security Act and codified in §414.68(a), it is stated that the imaging accreditation requirement applies only to suppliers of the TC of advanced diagnostic imaging services for which payment is made under the physician fee schedule. Since hospitals generally are not paid pursuant to such schedule, this accreditation rule is inapplicable. Thus, providers will list ADI equipment and CPT code information in their initial and updated enrollment applications. Accreditation status will be provided to the Medicare Administrative Contractors by the ACO's.

Q: Do the accreditation requirements apply to the radiologists that interpret the images?

A: The accreditation will apply only to the suppliers producing the images themselves, and not to the physician's interpretation of the image. However, all interpreting physicians must meet the accreditation organizations published standards for qualifications and responsibilities of medical directors and supervising physicians, such as training in advanced diagnostic imaging services in a residency program and expertise obtained through experience or continuing medical education. Oral surgeons and dentists must be accredited if they perform the Technical Component of MRI, CT or Nuclear Medicine for the technical component of the codes that require ADI accreditation.

Q: Is Fluoroscopy covered under the new accreditation requirement?

A: MIPPA (Section 135 (a) of the Medicare Improvements for Patients and Providers Act of 2008) expressly excludes from the accreditation requirement x-ray, ultrasound, screening and diagnostic mammography and fluoroscopy procedures. The law also excludes from the CMS accreditation requirement diagnostic and screening mammography which are subject to quality oversight by the Food and Drug Administration under the Mammography Quality Standards Act.

Q: How do I choose which AO to accredit my organization?

A: As a supplier, you will need to contact each of the three designated organizations to determine which accrediting organization meets your specific business model and philosophy for patient care. Some of the factors affecting your decision should be review of the quality standards, accreditation cycle, accreditation processes and price.

Q: Who are the accreditation organizations recognized by CMS to comply with the MIPPA accreditation requirement?

A: The Centers for Medicare & Medicaid Services (CMS) approved three national accreditation organizations – the American College of Radiology, the Intersocietal Accreditation Commission, and The Joint Commission – to provide accreditation services for suppliers of the TC of advanced diagnostic imaging procedures.

Q: What does it cost to be accredited?

A: The accreditation costs vary by accreditation organization. The average cost for one location and one modality is approximately $3,500 every 3 years.

Q: How do I contact the accreditation organizations (AOs)?

A: Call or e-mail each of the accreditation organizations to determine the one
that best fits your business needs. The accreditation organizations each have
their own published standards. Follow all of the application requirements so that your application is not delayed. It may take up to 5 months to be accredited. So, **you really must start now** to be sure to meet the January 1, 2012, date.To obtain additional information about the accreditation process, please contact the accreditation organizations shown below.

American College of Radiology (ACR)

1891 Preston White Drive
Reston, VA 20191-4326

www.acr.org

1-800-770-0145

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Intersocietal *Accreditation* Commission (IAC)
6021 University Boulevard, Suite 500
Ellicott City, MD 21043

www.intersocietal.org

1-800-838-2110

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The Joint Commission (TJC)
Ambulatory Care *Accreditation* Program
One Renaissance Boulevard
One Renaissance, IL 60181

www.jointcommission.org

1-630-792-5286

For more information about the enrollment procedures, see the Medicare Learning Network® (MLN) article MM7177, "Advanced Diagnostic Imaging Accreditation Enrollment Procedures," available **here.**

If you are a physician or non-physician practitioner supplying the Technical
Component of ADI, see the MLN article MM7176, "Accreditation for Physicians and Non-Physician Practitioners Supplying the Technical Component (TC) of Advanced Diagnostic Imaging (ADI) Service," available **here.**

My Notes from the CMS Open Door Forum on May 19, 2010: PECOS, DMEPOS and Blue Ink on Paper Forms

CMS held a two-hour Open Door Forum today and there was so much good information shared that I thought I'd pass my notes from the call along to you.

New EFT Form

The revised EFT (Electronic Funds Transfer) authorization form 588 is available **here** (pdf.) The old form will still work for a few months longer before it becomes invalid.

Changes to the Medicare Program Integrity Manual

The Program Integrity Manual (publication 100-08) will have revisions related to the changes in provider enrollment. The online-only manual **here** will have content moved from Chapter 10 to Chapter 15 and the provider enrollment information will be easier to understand.

The Question on Everyone's Lips

How do I know if I'm listed in PECOS (Provider Enrollment and Chain/Ownership System) and how do I know if others are listed in PECOS? A new downloadable file is now available **here** (12,000 pages!) and everyone listed in this Ordering/Referring file has approved enrollment status. Anyone not appearing on this list is not in approved status, or has opted completely out of the Medicare program.

Advanced Diagnostic Imaging

Beginning in January 2012, all diagnostic magnetic resonance imaging (MRI), computed tomography (CT), and nuclear medicine imaging such as positron emission tomography (PET) must be performed in a facility accredited by the American College of Radiology (ACR), The Joint Commission (TJC) or the Intersocietal Accreditation Commission (IAC) for the technical component of the test to be reimbursed by Medicare. This rule does not apply to x-rays, ultrasound, fluoroscopy, mammography or DEXA scans and does not apply to any professional component.

Hospital Revalidations

Hospitals not enrolled in PECOS or not receiving EFT (Electronic Funds Transfer) will be contacted by CMS in an attempt to get all hospitals revalidated.

PECOS (pronounced "pay-cose")

CMS recommends that anyone with questions or just getting started in PECOS read the "Getting Started Guide", of which there are two versions, both available **here** in pdf form. One is for providers and one is for suppliers of DMEPOS (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies.) You need to know your corporate structure before getting started because the business must enroll before the providers can assign benefits to the business. The 855I is for individual/solos providers and the 855B is for non-individuals (multiple owners) billing Medicare Part B and assigning benefits to a legal entity/corporation. Dentists and pediatricians who order or refer services for Medicare patients are required to have an enrollment record in the PECOS. Residents and interns are exempt from the enrollment requirement, but an attending physician needs to be identified on the claim when a service is ordered or referred. The main page for enrollment is

https://www.cms.gov/MedicareProviderSupEnroll/

Two Ways to Get Into PECOS

One is to complete the paper form **in BLUE INK (and if time is of the essence CMS suggests that you use the paper form)** and let the MAC enter it into PECOS for you. The other is to use the internet-PECOS system directly, and sign, date and mail the certification statement to complete the process. Submit the participation form or EFT form if required. The certification form for the paper process is NOT the same as the certification from for the internet-PECOS process.

What is the 30-day rule?

The 30-day rule states that you can bill for services provided to Medicare patients up to 30 days prior to your filing date. The filing date is the date your enrollment is accepted, not the date you mailed it. Online it will say "Status Approved", and you will receive an email, and then a letter confirming it. You will appear on the Ordering/Referring file on the CMS website.

What happens to payments for patients that were referred by a provider not enrolled on PECOS?

Even though you are enrolled, if the referring physician is not enrolled, you will not be paid for that patient's services. However, if that referrer becomes enrolled, you can resubmit the claim and it will be paid.

~~What happens on July 6, 2010?~~ When does this happen?

~~July 6, 2010~~ The compliance date for Part A providers (hospitals, skilled nursing homes and home health agencies) and Part B providers (physicians, ambulance) must be enrolled in PECOS as ordering/referring physicians for payments to be made **has been delayed indefinitely!**

~~What happens on July 13, 2010?~~

~~DMEPOS (pronounced "demmy-pos") providers must be enrolled in PECOS to receive Medicare payments.~~

What should be done if a provider leaves a group?

The provider or his Authorized Official (CEO, CFO, Manager) should file a 855R or make the change in PECOS as soon as possible.

Why do provider offices still request UPINs from our office?

Unclear. UPINs were no longer required as of May 23, 2008. The NPI is the only number accepted on Medicare claims.

Should the information submitted on a 855 be the same information in PECOS?

Yes, if it isn't, contact the Help Desk. Their toll-free number is 1-866-484-8049 and their e-mail address is eussupport@cgi.com.

For more information on the nuts and bolts of PECOS, see my post **here.**