CMS Extends Delay for 5010 Enforcement to June 30, 2012

The Centers for Medicare & Medicaid Services' Office of E-Health Standards and Services (OESS) is announcing that it will not initiate enforcement action for an additional three (3) months, through June 30, 2012, against any covered entity that is required to comply with the updated transactions standards adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA): ASC X12 Version 5010 and NCPDP Versions D.0 and 3.0.

On November 17, 2011, OESS announced that, for a 90-day period, it would not initiate enforcement action against any covered entity that was not compliant with the updated versions of the standards by the January 1, 2012 compliance date. This was referred to as enforcement discretion, and during this period, covered entities were encouraged to complete outstanding implementation activities including software installation, testing and training.

Health plans, clearinghouses, providers and software vendors have been making steady progress: the Medicare Fee-for-Service (FFS) program is currently reporting successful receipt and processing of over 70 percent of all Part A claims and over 90 percent of all Part B claims in the Version 5010 format. Commercial plans are reporting similar numbers. State Medicaid agencies are showing progress as well, and some have made a full transition to Version 5010.

Covered entities are making similar progress with Version D.0. At the same time, OESS is aware that there are still a number of outstanding issues and challenges impeding full implementation. OESS believes that these remaining issues warrant an extension of enforcement discretion to ensure that

all entities can complete the transition. OESS expects that transition statistics will reach 98 percent industry wide by the end of the enforcement discretion period.

Given that OESS will not initiate enforcement actions through June 30, 2012, industry is urged to collaborate more closely on appropriate strategies to resolve remaining problems. OESS is stepping up its existing outreach to include more technical assistance for covered entities. OESS is also partnering with several industry groups as well as Medicare FFS and Medicaid to expand technical assistance opportunities and eliminate remaining barriers. Details will be provided in a separate communication.
The Medicare FFS program will continue to host separate provider calls to address outstanding issues related to Medicare programs and systems. The Medicare Administrative Contractors (MAC) will continue to work closely with clearinghouses, billing vendors or health care providers requiring assistance in submitting and receiving Version 5010 compliant transactions. If any entity is experiencing difficulty reaching a MAC, please contact Karen Jackson at Karen.Jackson1@cms.hhs.gov.

The Medicaid program staff at CMS will continue to work with individual States regarding their program readiness. Issues related to implementation problems with the States may be sent to Medicaid5010@cms.hhs.gov. OESS strongly encourages industry to come together in a collaborative, unified way to identify and resolve all outstanding issues that are impacting full compliance, and looks forward to seeing extensive engagement in the technical assistance initiative to be launched over the next few weeks.

Stark, False Claims and Anti-Kickback Laws: Easy Ways to Stay Compliant with the Big Three in Healthcare

In health care, we are "*blessed*" with an abundance of rules, policies, standards and laws. In Health Care Regulation in America: Complexity, Confrontation, and Compromise, **Robert I. Field**, professor of health management and policy at Drexel University School of Public Health, observes the following:

> *"**Regulation shapes all aspects** of America's fragmented health care industry, from the flow of dollars to the communication between physicians and patients. It is the engine that translates public policy into action. While the health and lives of patients, as well as almost one-sixth of the national economy depend on its effectiveness, health care regulation in America is bewilderingly complex."*

Here are some of the most important regulations in health care that you should not only know about, but should be actively managing with a robust compliance plan.

Stark Law (Physician Self-Referral)

When: Section 1877 of the Social Security Act, also known as the physician self-referral law, is commonly referred to as the Stark Law. When enacted in 1989, it applied only to physician referrals for clinical laboratory services. In 1993 and 1994, Congress expanded the prohibition to the additional designated health services listed below.

What: Stark Law "prohibits physicians from making referrals for designated health services (DHS) payable by Medicare to an entity with which he or she (or an immediate family member) has a financial relationship (ownership, investment, or compensation), unless an exception applies," according to the Centers of Medicare & Medicaid Services (CMS). Specifically covered designated health services include:

- Clinical laboratory services
- Physical therapy services
- Occupational therapy services
- Outpatient speech-language pathology services
- Radiology and certain other imaging services
- Radiation therapy services and supplies
- Durable medical equipment (DME) and supplies
- Parenteral and enteral nutrients, equipment, and supplies
- Prosthetics, orthotics, and prosthetic devices and supplies
- Home health services
- Outpatient prescription drugs
- Inpatient and outpatient hospital services

Penalties: Penalties for violating the Stark Law include denial of payment, refund of payment, imposition of a $15,000 per service civil monetary penalty, and imposition of a $100,000 civil monetary penalty for each arrangement considered to be a circumvention scheme.

*The following will help you **remain compliant with the Stark Law:***

1. Offer all patients a written list of choices for obtaining the care your physicians are recommending.

2. Disclose any financial relationship with any entity that is on the list offered to patients.

False Claims Act

When: Originally enacted during the Civil War, and sometimes known as the Lincoln Law, the False Claims Act (FCA) as we know it today was signed by President Reagan in 1986.

What: Under the FCA, those who knowingly submit – or cause another person or entity to submit – false claims for payment of government funds will be subject to liability. The FCA contains qui tam, or "whistleblower," provisions.

Penalties: Medicare and Medicaid fraud and abuse prohibit the knowing and willful making of a false statement that affects reimbursement under a federal health program. That provision imposes felony penalties of up to five years' imprisonment and/or fines up to $250,000 for an individual and $500,000 for an organization.

In addition to criminal penalties, the Office of Inspector General (OIG) may impose civil penalties under the Civil Monetary Penalties Act for submitting false claims. Civil penalties can be up to $11,000, plus three times the amount claimed. According to the Telehealth Resource Center, "The Civil Monetary Claims Act prohibits claims for services not provided as claimed; false or fraudulent claims; claims for physician services not furnished by physicians; or claims for services provided by an excluded physician or provider. The False Claims Act gives the federal government, as well as any person, a cause of action against any person who submits false claims to the government."

*To help your practice **remain compliant with the False Claims Act**, keep the following in mind:*

1. Perform background checks and obtain references on all potential employees, making sure they are not sanctioned by the OIG.

2. Have an audit performed by a third-party biannually to make

sure that your billing department is following your compliance policy to the letter.

Anti-Kickback Statute

When: Congress enacted the anti-kickback statute, 42 U.S.C. § 1320a-7b(b), in 1977 as a prohibition against the payment of kickbacks in any form.

What: The anti-kickback statute states that criminal penalties will be issued for individuals or entities that knowingly and willfully offer, pay, solicit, or receive remuneration intended to induce or reward referral of business reimbursable under any of the federal health care programs (Medicare, Medicaid, etc.)

Penalties: The anti-kickback statute is a criminal statute, the violation of which constitutes a felony punishable by a fine of not more than $25,000 per offense and/or imprisonment for up to five years. A conviction also will lead to mandatory exclusion from participation in federal health care programs. The OIG also may impose civil monetary penalties of up to $50,000 for each violation, plus damages of three times the amount of the remuneration.

*To help you **remain compliant the anti-kickback statute**:*

1. Seek the advice of an experienced health care attorney before entering into any agreements with parties to pay or receive payment for goods or services where a kickback might be construed.

2. Make sure your compliance plan addresses the acceptance of gifts by physicians and staff.

Put It All Together: Your Compliance Plan

A compliance plan does not have to be long or overly complex. The federal government recommends a **seven-component compliance plan** that covers the critical points in a simple and easy-to-understand way:

1. **Designate a compliance officer**, which can be the manager or a staff member.

2. **Implement compliance and practice standards**, and have all employees sign an agreement to comply with the standards. Make compliance training a part of new employee orientation and conduct annual re-training for all staff.

3. **Conduct initial compliance training** and education for physician and staff. Training can be outsourced, and is also available online. Document all training.

4. **Oversee internal monitoring and auditing**, and document the results.

5. **Respond appropriately to detected offenses** and develop corrective action plans. Document offenses and responses.

6. **Develop open lines of communication** and encourage employees to discuss compliance at staff meetings, or in one-on-one meetings.

7. **Enforce disciplinary standards** through well-publicized guidelines.

Make sure that your compliance plan is not just a binder on the shelf! *All employees must understand the seriousness of the penalties (There are lots of examples online to illustrate this.) and the importance of compliance to the success of your practice.*

Common Sense Billing and Coding Compliance

Compliance can be a little tricky to define, but in the context of health care billing and coding, compliance is all about what we don't do, rather than what we do. Here are 16 common sense and simply-worded rules:

1. Don't bill what wasn't documented.

2. Don't bill what wasn't done, thinking it probably was or will be.

3. Don't provide unnecessary services.

4. Don't name someone in the medical record or on the claim who wasn't there.

5. Don't double bill the payer.

6. Don't change the place of service to maximize payment.

7. Don't unbundle services that are part of a single service.

8. Don't charge for related services during the global period.

9. Don't upcode or downcode services.

10. Don't neglect or misuse modifiers that would change the payment.

11. Don't discount care to patients for referring other patients.

12. Don't waive patient balances unless a financial need is documented.

13. Don't keep the money if a patient or payer overpays.

14. Don't change the diagnosis to achieve payment if the payer denies payment based on the diagnosis.

15. Don’t accept money or gifts to prescribe drugs, refer patients, or order procedures or tests.

16. Don’t direct patients to the facility that you own for a necessary test or procedure without disclosing that you own part or all of the facility.

Do you have any compliance tips, guidelines, or maxims that help keep your group on track? Share them in the comments below!

The Best of Manage My Practice – October, 2011 Edition

As we finish off another month here at MMP, we wanted to go back over some of our most popular posts from the month and get ready for another busy, productive, and meaningful month. Presenting, **The Best of Manage My Practice, October 2011**!

- Are you ready for the holidays? How about the New Year? Even though it’s still a few months off, make sure you don’t see an interruption in your practice’s cashflow by getting ready for the January 1st 5010 deadline!
- CMS has released the Premiums and Deductibles for Medicare patients for 2012, so you can start informing staff and patients now. More importantly, will 2012 be the year that you get serious about collecting deductibles at the time of service?
- Mary Pat’s “Collection Basics”series about the

fundamentals of Revenue Cycle Management in Physician offices is now at part three! Check out Patient Collections Basics: Developing a Financial Assistance Program.

- One of Healthcare's most misunderstood and underutilized documents– the Medicare Advance Beneficiary Notice- is changing for 2012. Make sure you're ready.
- And finally, the Office of the Inspector General (OIG) of he department of Health and Human services has released its 2012 Work Plan for areas it will concentrate on investigating. Better safe than sorry! Mary Pat goes over the highlights here.

We've started this monthly wrap-up to make sure you don't miss any of the great stuff we post throughout the month on Manage My Practice, but we also want to hear from you! What were your favorite posts and discussions this month? Did we skip over your favorite from October? Let us know in the comments!

CMS Announces Medicare Providers Must Begin to Revalidate Enrollment By March 2013

Announcement from CMS:

All providers and suppliers who enrolled in the Medicare program **prior to Friday, March 25, 2011**, will be required to revalidate their enrollment under new risk screening criteria

required by the *Affordable Care Act* (section 6401a). Providers/suppliers who enrolled on or after Friday, March 25, 2011 have already been subject to this screening, and need not revalidate at this time.

New Screening Criteria

In the continued effort to reduce fraud, waste, and abuse, CMS implemented new screening criteria to the Medicare provider/supplier enrollment process beginning in March 2011. Newly-enrolling and revalidating providers and suppliers are placed in one of three screening categories – limited, moderate, or high – each representing the level of risk to the Medicare program for the particular category of provider/supplier, and determining the degree of screening to be performed by the Medicare Administrative Contractor (MAC) processing the enrollment application. More information on the screening categories is **here**.

Notices Will Be Sent to Providers/Suppliers

Between now and March 2013, MACs will be sending notices to individual providers/suppliers; **please begin the revalidation process as soon as you hear from your MAC**. Upon receipt of the revalidation request, providers and suppliers have 60 days from the date of the letter to submit complete enrollment forms. Failure to submit the enrollment forms as requested may result in the deactivation of your Medicare billing privileges. The easiest and quickest way to revalidate your enrollment information is by using Internet-based PECOS (Provider Enrollment, Chain, and Ownership System), at https://pecos.CMS.hhs.gov.

Fees Levied

Section 6401a of the *Affordable Care Act* requires

institutional providers and suppliers to pay an application fee when enrolling or revalidating ("institutional provider" includes any provider or supplier that submits a paper Medicare enrollment application using the CMS-855A; CMS-855B, **not including physician and non-physician practitioner organizations**; CMS-855S; or associated Internet-based PECOS enrollment applications); these fees may be paid via www.Pay.gov.

In order to reduce the burden on the provider, CMS is working to develop innovative technologies and streamlined enrollment processes – including Internet-based PECOS. Updates will continue to be shared with the provider community as these efforts progress.

For more information about provider revalidation, review the Medicare Learning Network's Special Edition Article #SE1126, titled "Further Details on the Revalidation of Provider Enrollment Information."

How Do You Get That Stimulus Money for Using an Electronic Medical Record? (You Register!)

Image via Wikipedia

Note: see my latest post on registering and attesting for the EHR Incentive Program here.

Registration opens on January 3, 2011 for the Medicare and Medicaid EHR Incentive Programs

1. Register as soon as possible after January 3, 2011.
2. You can register before you have a certified EHR, but you will have to have an EHR when you attest.
3. You can register even if you do not have an enrollment record in PECOS.
4. A link to the Incentive Registration will be available **here** when it is published.
5. Not all states will be ready to participate in the Medicaid program on January 3rd. Information by state is **here**.

What do you have to have to register?

1. **A National Provider Identifier (NPI)** All eligible professionals, eligible hospitals, and critical access hospitals (CAHs) must have a National Provider Identifier (NPI) to participate in the Medicare and Medicaid EHR Incentive Programs.
2. **An enrollment record in the Provider Enrollment, Chain and Ownership System (PECOS)** All eligible hospitals and Medicare eligible professionals must have an enrollment record in PECOS to participate in the EHR Incentive Programs. Eligible professionals who are only participating in the Medicaid EHR Incentive Program are not required to be enrolled in PECOS. If you do not have an enrollment record in PECOS, you should still register for the Medicare and Medicaid EHR Incentive Programs.
3. **CMS Identity and Access Management (I&A) User ID and**

Password

- **Eligible Professionals:** Eligible professionals can use the same User ID and Password they use for the National Plan and Provider Enumeration System (NPPES). This is also the same User ID and Password that is used to access PECOS. If you do not have an active User ID and Password for NPPES or PECOS, request them **here**. You will need your type 2 NPI, your Taxpayer Identification Number (TIN), and your address from IRS Form CP-575. You will also need to mail a copy of IRS Form CP-575 as directed.
- **Hospitals/Critical Access Hospitals:** Authorized Officials can use the same User ID and Password they use to access PECOS. If you do not have an Authorized Official with access to PECOS, request a User ID and Password **here**. You will need your type 2 NPI, your Taxpayer Identification Number (TIN), and your address from the IRS Form CP-575. You will need to mail a copy of the IRS Form CP-575 as directed. Additional hospital staff will need to request access to the "EHR Incentive Programs" application **here** and be approved by the Hospital's Authorized Official.

What else do you need to know about registration?

Hospitals:

1. Hospitals that are eligible for EHR incentive payments under both Medicare and Medicaid should select "Both Medicare and Medicaid" during the registration process, even if they plan to apply only for a Medicaid EHR incentive payment by adopting, implementing, or upgrading certified EHR technology. Dually-eligible hospitals can then attest through CMS for their Medicare

EHR incentive payment at a later date, if they so desire. It is important for a dually-eligible hospital to select “Both Medicare and Medicaid” from the start of registration in order to maintain this option.

2. Hospitals that register only for the Medicaid program (or only the Medicare program) will not be able to manually change their registration (i.e., change to “Both Medicare and Medicaid” or from one program to the other) after a payment is initiated and this may cause significant delays in receiving a Medicare EHR incentive payment.

Eligible Professionals:

1. Eligible professionals eligible for both the Medicare and Medicaid EHR Incentive Programs must choose which incentive program they wish to participate in when they register.
2. Before 2015, an eligible professional may switch programs only once after the first incentive payment is initiated. Most eligible professionals will maximize their incentive payments by participating in the Medicaid EHR Incentive Program.

The Electronic Health Record (EHR) Information Center is open to assist the EHR Provider Community with inquiries.

Hours of operation are:
8:30 a.m. ”“ 4:30 p.m. (Central Time) Monday through Friday (except federal holidays)
1-888-734-6433 (primary number) or 888-734-6563 (TTY number)

Image via Wikipedia

New Deadline (Sigh) Set for Medicare Claim Denial If Ordering/Referring Providers Not in PECOS

NOTE April 2011: CMS recently announced that July 5, 2011 will **not** be the date that claim editing will begin.

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If you **read my post** on November 29th, you already know that CMS delayed pulling the trigger on January 1, 2011 to require PECOS enrollment for ordering and referring providers and enforcing nonpayment of claims that fail the ordering/referring provider edits.

CMS has just announced a new implementation date (calling it "a placeholder future implementation") of ~~July 5, 2011~~ – unknown.

As a refresher, the only providers who can order/refer Medicare beneficiary services are:

doctor of medicine or osteopathy;
dental medicine;
dental surgery;
podiatric medicine;
optometry;
chiropractic medicine;
physician assistant;
certified clinical nurse specialist;
nurse practitioner;
clinical psychologist;
certified nurse midwife;

clinical social worker

Claims that are the result of an order or a referral must contain the National Provider Identifier (NPI) and the name of the ordering/referring provider and the ordering/referring provider must be in PECOS or in the Medicare carrier's or Part B MAC's claims system with one of the above types/specialties.

The claim editing that will begin on ~~July 5, 2011~~ date not known **will verify the ordering/referring provider on a claim is eligible to order/refer and is enrolled in Medicare.**

The process to be used to determine if the ordering/referring provider on the claim matches the provider in the national PECOS file or in the contractor's master provider file is as follows:

- MCS (Multi-Carrier System) will verify the National Provider Identifier (NPI) of the ordering/referring provider reported on the claim against the national PECOS file.
- If a match is not found, the MCS will verify the NPI of the ordering/referring provider on the claim against the MCS master provider file.
- If a match is found, the MCS will then compare the first letter of the first name and the first 4 letters of the last name of the matched record.
- If the names match, the ordering/referring provider on the claim is considered verified.

If you've not verified that your providers are properly enrolled in PECOS, you have yet another chance to get it figured out.

Here's the Cheat Sheet:

1. Check to see if your provider is enrolled by reviewing the Ordering and Referring file found in the download section of the "OrderingReferringReport" tab (**click**

here) on the Medicare Provider and Supplier Web Site. The report is currently more than 15,000 pages but you can view it on the screen.

2. If not enrolled, you can get your provider enrolled by paper or electronically. The Internet-based PECOS application is **here.**
3. After submitting an enrollment application via Internet-based PECOS, you must:
    - Print, sign and date (blue ink recommend) the Certification Statement(s), and
    - Mail the Certification Statement(s) and applicable supporting documentation to the designated Medicare contractor (no later than 7 days after you complete the online portion.)

    NOTE: The Medicare contractor will not be able to begin to process your enrollment application until it receives a signed and dated Certification Statement.

For more detailed information on PECOS, click on the PECOS category on the right-hand side of this web page.

CMS Never Sleeps! Version 5010, ICD-10, an Education Call, Twitter and YouTube

I am fortunate to be serving on the North Carolina MGMA Medicare Committee this year. When we met yesterday, the members were asked why we wanted to be on the committee. I said I couldn't believe any practice manager **wouldn't** want to be on the Medicare Committee! I want to be on the front lines, asking questions and trying to understand the massive

changes hitting our practices daily. Don't you? If you're not a member of your local or state manager's group and you're not volunteering on one or more committees, why not?

Important Information and Reminders About the Upcoming Version 5010 and ICD-10 Transitions

CMS has resources for providers, vendors, and payers to prepare for the transition. Fact sheets available for educating staff and others about the transition include:

The ICD-10 Transition: An Introduction

Talking to Your Vendors About ICD-10 and Version 5010: Tips for Medical Practices

Talking to Your Customers About ICD-10 and Version 5010: Tips for Software Vendors

Compliance timelines, materials from CMS-sponsored calls and conferences, links to resources and sign up for email updates here

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Medicare FFS 5010 Program: Taking EDI to the Next Level- Ninth National Education Call on Medicare Fee-For-Service (FFS) Implementation of HIPAA Version 5010 and D.0 Transactions

August 25, 2010
2:00pm To 3:30pm EST

The Centers for Medicare & Medicaid Services (CMS) will host its ninth national education call regarding Medicare FFS's

implementation of HIPAA Version 5010 and D.0 transaction standards on August 25, 2010. This session will focus on the 835 Electronic Remittance Advice transaction. Subject matter experts will review Medicare FFS specific changes as well as general information to help the audience prepare for the transition; the presentation will be followed by a Q&A session.

Registration will close at 2:00 p.m. EST on August 24, 2010, or when available space has been filled.

Target Audience: Vendors, clearinghouses, and providers who will need to make Medicare FFS specific changes in compliance with HIPAA version 5010 requirements.

Subject: Medicare Fee-For-Service (FFS) Implementation of HIPAA Version 5010 835 Electronic Remittance Advice Transaction

Agenda:

* General Overview

* Medicare Specific Changes

* Timelines and Deadlines

* What you need to do to prepare

* Transaction Specific Issues

* Q & A

Conference call details:

Date: August 25, 2010

Conference Title: Ninth National Education Call on Medicare Fee-For-Service (FFS) Implementation of HIPAA Version 5010 and D.0 Transactions

Time: 2:00 p.m. – 3:30 p.m. ET

In order to receive the call-in information, you must register for the call. It is important to note that if you are planning to sit in with a group, only one person needs to register to receive the call-in data. This registration is solely to reserve a phone line, NOT to allow participation.

Registration will close at 2:00 p.m. ET on August 24, 2010, or when available space has been filled. No exceptions will be made, so please be sure to register prior to this time.

1. To register for the call participants click **here**.

2. Fill in all required data.

3. Verify your time zone is displayed correctly the drop down box.

4. Click “Register”.

5. You will be taken to the “Thank you for registering” page and will receive a confirmation email shortly thereafter.
Note: Please print and save this page, in the event that your server blocks the confirmation emails. If you do not receive the confirmation email, please check your spam/junk mail filter as it may have been directed there.

6. If assistance for hearing impaired services is needed the request must be sent to medicare.ttt@palmettogba.com no later than 3 business day before the event.

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Social Media

The Centers for Medicare & Medicaid Services (CMS) continues to break new ground and to enhance their outreach efforts to the public. CMS is now using social media outlets to get information out to their audience as fast as possible.

Twitter: For CMS & Medicare Learning Network updates, **click here**. You'll need a Twitter account first if you don't already have one – here are instructions:

- Go to **www.twitter.com** and sign up for FREE (choose a name and a password)
- You can use Twitter on the web or on your phone "" you can look at it once a day (you don't have to look at it and respond to it instantly.)
- Once you're signed up, you can start "following" people and they can "follow" you. I am following people who have interesting things to say about healthcare, and also people who are writing blogs like me.
- Start by following me (@mpwhaley) and I'll be glad to follow you.

YouTube: Log on to the official **CMS YouTube channel** to view several videos currently available and more to come in the upcoming months. See an example of a CMS video below.

CMS Releases Record Retention Guidelines

A updated post on record retention with a simple record retention schedule can be found **here.**

State laws generally govern how long medical records are to be retained.

However, the Health Insurance Portability and Accountability Act (HIPAA) of 1996 administrative simplification rules require a covered entity, such as a physician billing Medicare, to retain **required documentation for six years from**

the date of its creation or the date when it last was in effect, whichever is later. HIPAA requirements preempt State laws if they require shorter periods. Your State may require a longer retention period.

While the HIPAA **Privacy** Rule does not include medical record retention requirements, it does require that covered entities apply appropriate administrative, technical, and physical safeguards to protect the privacy of medical records and other protected health information (PHI) for whatever period such information is maintained by a covered entity, including through disposal.

The Centers for Medicare & Medicaid Services (CMS) requires records of **providers submitting cost reports to be retained in their original or legally reproduced form for a period of at least 5 years after the closure of the cost report**.

CMS requires Medicare managed care program providers to retain records for 10 years.

Image via Wikipedia

Additional information:

1. Providers/suppliers should maintain a medical record for each Medicare beneficiary that is their patient.
2. Medical records must be accurately written, promptly completed, accessible, properly filed and retained.
3. Using a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries is a good practice.
4. The Medicare program **does not have requirements for the media formats for medical records.** However, the medical

record needs to be in its original form or in a legally reproduced form, which may be electronic, so that medical records may be reviewed and audited by authorized entities.
5. Providers must have a medical record system that ensures that the record may be accessed and retrieved promptly.
6. Providers may want to obtain legal advice concerning record retention after CMS-required time periods.

Independent Diagnostic Testing Facilities (IDTFs) Can Expect Quarterly Letters From Medicare A/B MACs About January 2012 Accreditation Requirement

For more information on the Medicare accreditation requirement for entities billing the technical component for advanced diagnostic imaging (CT, MRI, PET/Nuclear Medicine) effective January 1, 2012, read my post **here.**

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Medicare Learning Network (MLN) just released MM6912, effective August 2, 2010: Mailing To All Individual Practitioners, Medical Groups and Clinics and Independent

Diagnostic Testing Facilities (IDTF) Who Are Billing or Have Billed For The Technical Component of Advanced Diagnostic Imaging Services

What exactly is an IDTF?

Some suppliers that perform diagnostic tests, other than clinical laboratory or pathology tests, are required to enroll with Medicare as an Independent Diagnostic Testing Facility (IDTF). Not all suppliers that perform these diagnostic tests are required to enroll as an IDTF. Generally, entities can bill for the technical component of the diagnostic tests without an IDTF enrollment if it has the following characteristics:

- A physician practice that is owned, directly or indirectly, by one or more physicians or by a hospital
- A facility that primarily bills for physician services and not for diagnostic tests
- A facility that furnishes diagnostic tests primarily to patients whose medical conditions are being treated or managed on an ongoing basis by one or more physicians in the practice
- The diagnostic tests are performed and interpreted at the same location where the practice physicians also treat patients for their medical conditions
- If a substantial portion of the facility’s business involves the performance of diagnostic tests, the diagnostic testing services may be a sufficient separate business to require enrollment as an IDTF. In that case, the physician or physician group practice can continue to be enrolled as a physician or physician group practice but are also required to enroll as an IDTF. The physician or group can bill for professional fees and the diagnostic tests they perform on their patients using their billing number. Therefore, the practice must bill as an IDTF for diagnostic tests furnished to

Medicare beneficiaries who are not regular patients of the physician or group practice.

Who will receive a mailing?

Enrolled physicians, non-physician practitioners, including single and multi- specialty clinics, and IDTFs who have billed the Medicare program for the **technical component of advanced diagnostic testing services** within the preceding six month period and who continue to have Medicare billing privileges with Medicare contractors (carriers and Part A/B Medicare Administrative Contractors (A/B MACs)) are affected.

Image via Wikipedia

If you have billed the Medicare program for the technical component of advanced diagnostic testing services within the preceding six month period and continue to have Medicare billing privileges with Medicare contractors, you will receive a letter from your Medicare contractor advising you of the need to become accredited by January 1, 2012, in order to continue to provide these services and bill Medicare.

When more than one physician or non-physician practitioner is operating within a group, such as a single specialty or multispecialty clinic, only the group will receive the letter, not each of the individual physicians or non-physician practitioners working for the group.

What will the mailing say?

You must be accredited by one of the three Centers for Medicare & Medicaid
Services (CMS) approved national accreditation organizations

by January 1, 2012,
in order to be eligible to continue to furnish the technical component of advanced
diagnostic testing services to Medicare beneficiaries and submit claims for those
services to your Medicare contractor.

Your contractor will be mailing the letter quarterly beginning with July 2010 through July 2011. If necessary, **follow the instructions in the letter to become accredited by January 1, 2012, in order to continue billing for the technical component of advance diagnostic imaging services.** Make sure that your office staffs are aware of these new accreditation requirements and begin the accreditation process as soon as possible to protect your Medicare billing rights for these services.

Why do IDTFs have to become accredited now?

Section 135(a) of the Medicare Improvements for Patients and Providers Act of
2008 (MIPPA) amended section 1834(e) of the Social Security Act and required
the Secretary, Health and Human Services, to designate organizations to accredit
suppliers, including but not limited to physicians, non-physician practitioners and
Independent Diagnostic Testing Facilities, that furnish the technical component
(TC) of advanced diagnostic imaging services.

What qualifies as an advanced

diagnostic imaging procedure?

MIPPA specifically defines advanced diagnostic imaging procedures as including:
”¢ Diagnostic magnetic resonance imaging (MRI),
”¢ Computed tomography (CT), and
”¢ Nuclear medicine imaging, such as positron emission tomography (PET).

MIPPA expressly excludes from the accreditation requirement x-ray, ultrasound,
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.

How long does it take to become accredited?

Since CMS expects that it may take as much as nine months from the time you initiate the accreditation process to completion, you should begin the accreditation process for advanced diagnostic imaging services as soon as possible, but not later than March 2011.

Who are the accrediting organizations?

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. The accreditation will apply only to

the suppliers of the images themselves, and not to the physician interpreting
the image. All accreditation organizations have quality standards that address the safety of the equipment as well as the safety of the patients and staff.

If you have questions, contact your Medicare carrier and/or A/B MAC at
their toll-free number, which may be found **here** (zip file.)

Image via Wikipedia

The letter will look like this:

[DATE]

[Supplier Name and Address]

Dear Physician/Non-Physician Practitioner/IDTF owner:

In accordance with Section 135(a) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), suppliers, including but not limited to physicians, non-physician practitioners and Independent Diagnostic Testing Facilities that furnish the technical component (TC) of advanced diagnostic imaging services must be accredited by January 1,

2012 in order to continue to furnish these services to Medicare beneficiaries.

Our records indicate that you have furnished advanced diagnostic imaging procedures such as diagnostic magnetic resonance imaging (MRI), computed tomography (CT), and nuclear medicine imaging such as positron emission tomography (PET) within the last six months. If you are not accredited by one of the organizations shown below by January 1, 2012, you will not be eligible to bill the Medicare program for advanced diagnostic imaging services. This letter requests that you take the necessary action to become accredited by the January 1, 2012 deadline. Since we expect it can take up to nine months from the time you initiate the accreditation process to completion, we urge you to begin the accreditation process for advanced diagnostic imaging services as soon as possible.

MIPPA expressly excludes from the accreditation requirement x-ray, ultrasound, and fluoroscopy procedures. The law also excludes from the CMS accreditation requirement diagnostic and screening mammography which are already subject to quality oversight by the Food and Drug Administration under the Mammography Quality Standards Act.

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. The accreditation will apply only to the suppliers of the images themselves, and not to the physician interpreting the image. All accreditation organizations have quality standards that address the safety of the equipment as well as the safety of the patients and staff. The accrediting organization that issues your accreditation will notify Medicare once your accreditation is complete and approved.

To obtain additional information about the accreditation process, please contact the accreditation organizations shown below.

Image by Jon Olav via Flickr

American College of Radiology (ACR)
1891 Preston White Drive
Reston, VA 20191-4326
1-800-770-0145

Intersocietal Accreditation Commission (IAC)
6021 University Boulevard, Suite 500
Ellicott City, MD 21043
1-800-838-2110

The Joint Commission (TJC)
Ambulatory Care Accreditation Program
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
1-630-792-5286

If you have questions about this letter, contact [carrier or A/B MAC phone number/contact person].

Sincerely,

[Name of carrier or A/B MAC]

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Supplier Billed Advanced Medical Imaging CPT codes for Section 135 (a) of the MIPPA to Receive Accreditation Requirement Notification Letter

70336 70540 71250 72125 73200 74150
70450 70542 71260 72126 73201 74160
70460 70543 71270 72127 73202 74170
70470 70544 71275 72128 73206 74175
70480 70545 71550 72129 73218 74181
70481 70546 71551 72130 73219 74182
70482 70547 71552 72131 73220 74183
70486 70548 71555 72132 73221 74185
70487 70549 72133 73222
70488 70551 72141 73223
70490 70552 72142 73225
70491 70553 72146 73700
70492 70554 72147 73701
70496 70555 72148 73702
70498 70557 72149 73706

70558 72156 73718

70559 72157 7371972158 73720
72159 73721
72191 73722
72192 73723
72193 73725
72194
72195
72196
72197
72198
72200
75557 76360 77011 78000 78811
75559 76376 77012 78001 78812
75561 76377 77021 78003 78813
75563 76380 77058 78006 78814
76390 77059 78007 78815
76497 77078 78010 78816
76498 77079 78011 78891
78015

78016
78018
78020
78070
78075
78099

CMS Offers Surprise Limited Opportunity for Physicians To Participate With Medicare

Image via Wikipedia

Providers have the opportunity to participate with Medicare once annually. This period called “Open Enrollment” is usually from mid-November to the end of the calendar year. **Providers who may have declined to participate with Medicare for the 2010 calendar year due to the anticipated deep cuts in the physician Medicare fee schedule now have a special opportunity to jump on board between now and July 16, 2010.** Here is the announcement:

Dear Medicare Part A and Part B Providers,

Opportunity for Nonparticipating Physicians/Practitioners to Become Participating

In consideration of the recent enactment of the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010, which established a 2.2 percent update to the Medicare Physician Fee Schedule (MPFS), the Centers for Medicare & Medicare Services (CMS) is offering physicians and other practitioners, whose current participation status is non-participating, the opportunity to become participating (PAR). This opportunity is being offered only to those physicians/practitioners whose current PAR status is non-participating. This opportunity is available through July 16, 2010.

Non-participating physicians/practitioners who would like to become a participating physician/practitioner should download and complete the Medicare Participating Physician or Supplier Agreement (Form CMS-460). The form can be obtained by using the following CMS web site link: http://www.cms.gov/cmsforms/downloads/cms460.pdf.

Any new CMS-460 form received during this limited enrollment period will be retroactive for claims with dates of service of January 1, 2010, and later. However, the change in participation status will only apply to new MPFS claims submitted after your new status as a participating physician/practitioner is processed. Claims previously submitted and processed will not be adjusted for only a change in participation status.

Medicare claims administration contractors (Medicare Administrative Contractors and carriers) will accept and process requests to become a participating physician/practitioner that are submitted on the CMS-460 form and are post-marked on or before July 16, 2010.