The CMS ICD-10 Announcement: What It Means to Your Practice

First, the game-changing announcement below means that a sigh of relief is in order. Some of the anxiety surrounding potential financial disaster should be abated. CMS announced:

> *"Medicare review contractors [MACs and RACs] will not deny physician or other practitioner claims billed under the Part B physician fee schedule through either automated medical review or complex medical record review based solely on the specificity of the ICD-10 diagnosis code as long as the physician/practitioner used a* ***valid code from the right family****." (see FAQ2 below)*

Second, we think it means that the sword rattling coming from the AMA and other individuals should subside. The fact that the CMS changes are based on recommendations from the AMA, which has been adamantly opposed to the ICD-10 mandate for years, is no less unexpected than the lion laying down with the lamb.

Regardless of the changes, the AMA's previous assertion that ICD-10 "will create significant burdens on the practice of medicine with no direct benefit to individual patients' care" still stands. The transition is inevitable, in my mind, but the changes **will** lessen the burden on physicians.

In the announcement from CMS, the clarification was made that

> *"In accordance with the coming transition, the Medicare claims processing systems will not have the capability to*

> *accept ICD-9 codes for dates of services after September 30, 2015, nor will they be able to accept claims for both ICD-9 and ICD-10 codes.”*

Third, CMS will name a CMS ICD-10 Ombudsman to triage and answer questions about the submission of claims. The ICD-10 Ombudsman will be located at CMS’s ICD-10 Coordination Center.

Also, mark your calendars! CMS will have a provider call on August 27th to discuss these changes.

See the answers below provided by CMS in their new FAQs published this week.

Q1. What if I run into a problem with the transition to ICD-10 on or after October 1st 2015?

A1. CMS understands that moving to ICD-10 is bringing significant changes to the provider community. CMS will set up a communication and collaboration center for monitoring the implementation of ICD-10. This center will quickly identify and initiate resolution of issues that arise as a result of the transition to ICD-10. As part of the center, CMS will have an ICD-10 Ombudsman to help receive and triage physician and provider issues. The Ombudsman will work closely with representatives in CMS’s regional offices to address physicians’ concerns. As we get closer to the October 1, 2015, compliance date, CMS will issue guidance about how to submit issues to the Ombudsman.

Q2. What happens if I use the wrong ICD-10 code, will my claim be denied?

A1. While diagnosis coding to the correct level of specificity is the goal for all claims, for 12 months after ICD-10 implementation, Medicare review contractors will not deny physician or other practitioner claims billed under the Part B physician fee schedule through either automated medical review

or complex medical record review based solely on the specificity of the ICD-10 diagnosis code as long as the physician/practitioner used a valid code from the right family. However, a valid ICD-10 code will be required on all claims starting on October 1, 2015. It is possible a claim could be chosen for review for reasons other than the specificity of the ICD-10 code and the claim would continue to be reviewed for these reasons. This policy will be adopted by the Medicare Administrative Contractors, the Recovery Audit Contractors, the Zone Program Integrity Contractors, and the Supplemental Medical Review Contractor.

Q3. What happens if I use the wrong ICD-10 code for quality reporting? Will Medicare deny an informal review request?

A3. For all quality reporting completed for program year 2015 Medicare clinical quality data review contractors will not subject physicians or other Eligible Professionals (EP) to the Physician Quality Reporting System (PQRS), Value Based Modifier (VBM), or Meaningful Use 2 (MU) penalty during primary source verification or auditing related to the additional specificity of the ICD-10 diagnosis code, as long as the physician/EP used a code from the correct family of codes. Furthermore, an EP will not be subjected to a penalty if CMS experiences difficulty calculating the quality scores for PQRS, VBM, or MU due to the transition to ICD-10 codes. CMS will not deny any informal review request based on 2015 quality measures if it is found that the EP submitted the requisite number/type of measures and appropriate domains on the specified number/percentage of patients, and the EP's only error(s) is/are related to the specificity of the ICD-10 diagnosis code (as long as the physician/EP used a code from the correct family of codes). CMS will continue to monitor the implementation and adjust the timeframe if needed.

Q4. What is advanced payment and how can I access this if needed?

A4. When the Part B Medicare Contractors are unable to process claims within established time limits because of administrative problems, such as contractor system malfunction or implementation problems, an advance payment may be available. An advance payment is a conditional partial payment, which requires repayment, and may be issued when the conditions described in CMS regulations at 42 CFR Section 421.214 are met. To apply for an advance payment, the Medicare physician/supplier is required to submit the request to their appropriate Medicare Administrative Contractor (MAC). Should there be Medicare systems issues that interfere with claims processing, CMS and the MACs will post information on how to access advance payments. CMS does not have the authority to make advance payments in the case where a physician is unable to submit a valid claim for services rendered.

NOTE: *Watch for upcoming posts on ICD-10 websites and apps that I am rating for their usefulness. We will also be producing free webinars on translating the diagnoses on your superbills, picklists and cheat sheets for ICD-10 – stay tuned!*

Photo Credit: Tojosan via Compfight cc

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.

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."

Do You Use a Mac? Safeguard It Against "MacDefender" Malware by Understanding the

Scam and Getting the Fix!

Apple announced last night that it would be sending an update to its OS X operating system that would protect users from and **remove** a program called “MacDefender” (alias “MacProtector” or “MacSecurity”) that had been finding its way onto some consumer’s machines. The program is a piece of malicious software (or “Malware“), that is ultimately designed to get you to send your credit card number to a company to sell you a program to “fix” the problem.

Here’s how MacDefender works:

- You are browsing Google Images and when you click on an image, you are redirected to a fake “security alert” webpage.
- The security alert webpage informs you that you have been infected with a virus, and recommends you download a free program – MacDefender – to solve the issue.
- MacDefender pops up on your computer as an offering. If you click OK, you’ve just invited the malware onto your system.
- Here’s where it gets malicious. The installed malware begins to make your system appear as if it has become infected with a virus.
- The program regularly opens up new browser windows to pornographic websites. Needless to say, this is very embarrassing, as well as making computer very hard to use.
- At this point you are probably thinking “well, I just installed a new anti-virus program”, and you try to run the MacDefender program. Now it gets really nasty.

Screenshot of MacDefender

- When you runs “MacDefender” your fears are confirmed – the program does find a nasty virus – but you have another problem.
- The software is “unregistered” aka “unpaid for” so the software can only detect the malware, but not delete it. The only way to delete it is to “register” the program by sending your credit card number to pay for the software. Of course, once the Bad Guys have your credit card info, I doubt they’ll stop at registering your software.

Although people had been reporting problems with the malware for a few weeks now, Apple only publicly acknowledged the problem today, and according to some reports, had been instructing support representatives to not acknowledge the problem.

Of course, Windows users have been having to deal with trojan horse programs like MacDefender for years. Traditionally Macs haven’t been the target of malware, as the vast majority of the problem was with Windows machines, but why that is is a matter of opinion. Mac users say that they don’t get malware because the OS X operating system has fewer security holes, and is harder to attack. Windows users generally counter that since Apple machines take up so little market share, there’s no economic incentive for malware writers – who are only after money – to focus on Apple users.

So the fact that Apple had to respond to the threat with an update to its OS X, and acknowledge that malware is a problem for their system is both a good and a bad sign for Apple. Bad in that they now have to support users against malware, and provide security updates to its OS, but good in that Mac-specific malware is definitely a sign of the platform’s growing popularity.

As the Naked Security blog said in a post today “Dear Apple: Welcome to team anti-malware“.

CMS Starts Screening Providers and Suppliers and Adds Site Visits and Fingerprint-based Criminal Background Checks to the Process

The Centers for Medicare & Medicaid Services (CMS) has the continuing goal of reducing fraud, waste, and abuse through all available avenues. The *Affordable Care Act* requires CMS to determine the level of screening to be conducted during provider and supplier enrollment based on the **level of risk posed to the Medicare system.** With the enactment of the *Affordable Care Act*, CMS has the increased ability to focus efforts on prevention, rather than simply acting after the fact. The use of risk categories and associated screening levels will help ensure that only legitimate providers and suppliers are enrolled in Medicare, Medicaid, and CHIP, and that only legitimate claims are paid.

Effective Friday, March 25, 2011, newly-enrolling and revalidating providers and suppliers will be placed in one of three screening categories ”“ limited, moderate, or high. These categories represent the level of risk for fraud, waste, and abuse to the Medicare program for the particular category of provider/supplier, and determine the degree of screening to be performed by the Medicare Administrative Contractor (MAC) processing the enrollment application.

Providers/suppliers in the “limited” screening category will include:

o Physicians

o Non-physician practitioners other than physical therapists

o Medical groups or clinics

o Ambulatory surgical centers

o Competitive Acquisition Program / Part B Vendors

o End-Stage Renal Disease facilities

o Federally-Qualified Health Centers

o Histocompatibility laboratories

o Hospitals (including Critical Access Hospitals, Department of Veterans Affairs hospitals, and other federally-owned hospital facilities)

o Health programs operated by an Indian Health Program (as defined in section 4(12) of the *Indian Health Care Improvement Act*) or an urban Indian organization (as defined in section 4(29) of the *Indian Health Care Improvement Act*) that receives funding from the Indian Health Service pursuant to Title V of

the *Indian Health Care Improvement Act*

- Mammography screening centers
- Mass immunization roster billers
- Organ procurement organizations
- Pharmacies that are newly enrolling or revalidating via the CMS-855B application
- Radiation Therapy Centers
- Religious non-medical health care institutions
- Rural Health Clinics
- Skilled Nursing Facilities

Providers in the "moderate" screening category will include:

- Ambulance service suppliers
- Community Mental Health Centers (CMHCs)
- Comprehensive Outpatient Rehabilitation Facilities (CORFs)
- Hospice organizations
- Independent clinical laboratories
- Independent Diagnostic Testing Facilities (IDTFs)
- Physical therapists enrolling as individuals or as group practices
- Portable x-ray suppliers (PXRS)
- Revalidating Home Health Agencies (HHAs)
- Revalidating DMEPOS suppliers

Providers in the "high" screening category will include:

o Newly-enrolling DMEPOS suppliers

o Newly-enrolling Home Health Agencies (HHAs)

o Providers and suppliers reassigned from the "limited" or "moderate" categories due to triggering events.

Triggering events include the following instances:

- imposition of a payment suspension within the previous 10 years;
- a provider or supplier has been terminated or is otherwise precluded from billing Medicaid;
- exclusion by the OIG;
- a provider or supplier has had billing privileges revoked by a Medicare contractor within the previous 10 years and such provider/supplier is attempting to establish additional Medicare billing privileges by enrolling as a new provider or supplier or establish billing privileges for a new practice location;
- a provider or supplier has been excluded from any federal health care program;
- a provider or supplier has been subject to any final adverse action (as defined in 42 CFR 424.502) within the past 10 years; or
- instances in which CMS lifts a temporary moratorium for a particular provider or supplier type and a provider or supplier that was prevented from enrolling based on the moratorium, applies for enrollment as a Medicare provider or supplier at any time within 6 months from the date the moratorium was lifted.

The enrollment screening procedures will vary depending upon

the categories described above. Screening procedures for the "limited" screening category will largely be the same as those currently in use; screening procedures for the "moderate" screening category will include all current screening measures, as well as a **site visit**; screening procedures for the "high" screening category will include all current screening measures, as well as a site visit and, at a future date a **fingerprint-based criminal background check**.

CMS will continuously evaluate whether a change of the assignment of categories of providers and suppliers to the various risk categories is necessary. If CMS assigns certain groups of providers and/or suppliers to a different category, this change will be proposed in the *Federal Register*. However, CMS will not publish a notice or a proposed rule in the *Federal Register* that would include instances in which an individual provider/supplier is reassigned based upon meeting one or more of the triggering events.

Medicare is Auditing You! What To Do Next?

There are a number of different audits that are carried out by Medicare-contracted auditors. It's important to know the differences and have a plan for responding.

CERT stands for Comprehensive Error Rate Testing and CERT audits were initiated in 2000. The program is responsible for measuring improperly paid claims. The CERT Program uses the following OIG-approved methodology:

1. A sample of approximately 120,000 submitted claims is randomly selected;

2. medical records from providers who submitted the claims are requested; and
3. the claims and medical records are reviewed for compliance with Medicare coverage, coding and billing rules.

RAC stands for Recovery Audit Contractor and began in early 2009. The RACs detect and correct past improper payments so that CMS and Carriers, FIs, and MACs can implement actions to stop future improper payments. RAC is currently focusing on inpatient services and physical therapy services. As of the date this post was published RAC was not focusing on physician services.

ZPIC (Zone Program Integrity Contractors) replaces the Medicare Program Safeguard Contractors (PSCs) and Medicare Drug Integrity Contractors (MEDICs) that are currently in use by CMS. ZPICs are be responsible for detection and deterrence of fraud, waste and abuse across all claim types. ZPICs have access to CMS National Claims History data, which can be used to look at the entire history of a patient's treatment no matter where claims were processed. Being able to look at the overall picture will enable them to more readily spot over billing and fraudulent claims. Among other things, ZPICs will look for billing trends or patterns that make a particular provider stand out from the other providers in that community. Once a ZPIC identifies a case of suspected fraud and abuse, the issue is referred to the Office of Inspector General (OIG) for consideration and possible initiation of criminal or civil prosecution. **ZPIC is widely considered to be the greatest threat to physician practices.**

Seven ZPIC zones have been identified. The zones include the following states and/or territories and most have been assigned contractors:

- Zone 1 – CA, NV, American Samoa, Guam, HI and the

Mariana Islands **http://www.safeguard-servicesllc.com/zpic.asp**

- Zone 2 – AK, WA, OR, MT, ID, WY, UT, AZ, ND, SD, NE, KS, IA, MO **AdvanceMed was just purchased by NCI** – site not current
- Zone 3 – MN, WI, IL, IN, MI, OH and KY – not awarded
- Zone 4 – CO, NM, OK, TX. **HealthIntegrity**
- Zone 5 – AL, AR, GA, LA, MS, NC, SC, TN, VA and WV **AdvanceMed was just purchased by NCI** – site not current
- Zone 6 – PA, NY, MD, DC, DE and ME, MA, NJ, CT, RI, NH and VT – not awarded
- Zone 7 – FL, PR and VI **http://www.safeguard-servicesllc.com/zpic.asp**

How should you respond to a Medicare audit?

1. Log all requests for records from all payers. Time and date all communications received and all communications sent.
2. Scan all records sent and include a cover letter itemizing contents of response.
3. Send records via certified mail.
4. If you get a request for a large amount of records at one time, consider getting advice from a consultant or attorney who specializes in Medicare audits as a large scale record request may cripple the practice operations.

How can you be proactive before you get an audit letter?

1. Check the audit sites monthly to see if your specialty or any services you provide are being targeted for an audit.
    - **CERT – www.cms.hhs.gov/cert**

    - Check the ZPIC site for your zone above
    - **OIG – www.oig.hhs.gov/reports.html**
    - Check your RAC site in my post **here**
2. Conduct an internal assessment to identify if you are in compliance with Medicare rules or hire a third-party to conduct an audit for you.
3. Identify corrective actions to promote compliance.
4. Appeal when necessary

Excellent resource site **http://www.willyancey.com/sampling-claims.html**

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.**

CMS Announces Delay in PECOS Use Until January 3, 2011

NOTE: The date has been ~~changed to July 5, 2011.~~delayed indefinitely.

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A collective sigh of relief was heard across the land as it was revealed today during the CMS Open Door Forum that the requirement for providers to be enrolled in PECOS has been delayed until January 3, 2011.

Part B MACs (Medicare Administrative Contractors) will be sending revalidation letters to all providers who have not updated their Medicare enrollment since November of 2003, asking them to submit a paper enrollment form or to use the electronic enrollment system PECOS (Provider Enrollment, Chain and Ownership System.) This proactive stance on the part of CMS should help the many managers who have been desperately trying to determine if their providers are in PECOS or not.

An audio recording of today's call will be available on the ODF website **here** and will be accessible for downloading on or around Monday March 1, 2010 and available for 30 days.

For automatic emails of Open Door Forum schedule updates (E-Mailing list subscriptions) and to view Frequently Asked Questions click **here.**

Is Your Practice Ready for the 60-Day PECOS Countdown?

NOTE: The date has been ~~changed to July 5, 2011.~~ delayed indefinitely.

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~~As of April 5, 2010~~ ~~As of January 3, 2011~~, ~~As of July 6, 2010~~, if the ordering/referring provider of goods and services on the CMS-1500 claim is not listed in PECOS and eligible to order/refer, the claim will not be paid. Your patients may not be able to get the items they need, they may have problems with rented items (going three years back) and hospital discharges may be delayed. Even if your practice doesn't fall into any of these categories, you will fall into some Medicare category sooner or later, particularly if you need to inform CMS of any practice changes.

If your providers aren't in the PECOS database, you should bite the bullet and **GET STARTED TODAY!**

Some terminology I use in this article:

AO = Authorized Official

CMS = Centers for Medicare & Medicaid Services

EUS – External User Services (for CMS PECOS) Help Desk

MAC = Medicare Administrative Contractor

NPPES = National Plan and Provider Enumeration System (the system that assigns the National Provider Identifier (NPI)

Providers = physicians and non-physician practitioners (I know physicians hate being called "providers", but there it is.)

Type I NPI = National Provider Identifier for a physician or non-physician practitioner

Type II NPI = National Provider Identifier for a practice or organization

WHAT is PECOS?

PECOS stands for the Provider Enrollment and Chain/Ownership System. It was created by CMS as an electronic portal for Medicare enrollment of physicians, non-physician practitioners, and provider and supplier organizations.

Even though some providers are enrolled in Medicare, their enrollment records might not be in PECOS. If they have not sent in a Medicare application to report any changes to their Medicare enrollment information within the past 5 years, they probably do not have an enrollment record in PECOS. These individuals will need to submit a Medicare enrollment application. To see if a provider is enrolled in PECOS, **check here.** If the name is not there, the PECOS enrollment is incomplete or missing.

PECOS is designed to electronically:

- Enroll in the Medicare program
- Make changes to Medicare enrollment information
- View existing Medicare enrollment information
- Withdraw from the Medicare program
- Check the status of an Internet-submitted Medicare enrollment application

While PECOS supports most enrollment application actions, there are some limitations. Providers cannot use PECOS to:

- Change his/her name or Social Security Number, or changes in Taxpayer Identification Number (TIN). These must be done using the paper enrollment application

(CMS-855)

- Change an existing business structure or changes in Legal Business Name (LBN). These must be done using the paper enrollment application (CMS-855). An example of a change to a business structure is:
    - A sole owner of an enrolled Professional Association, Professional Corporation, or Limited Liability Company cannot change the business structure to a sole proprietorship; or
    - An enrolled sole proprietorship cannot be changed to a solely-owned Professional Association, Professional Corporation, or Limited Liability Company.
- Reassign benefits to another supplier if that supplier does not have a current Medicare enrollment record in PECOS.
- An enrolled Medicare Part A provider or supplier organization wants to enroll with a Medicare carrier or A/B Medicare Administrative Contractor (MAC) to bill for Part B services. This must be done using the paper enrollment application (CMS-855).

WHY should I use PECOS?

Described as being 50% faster than paper, PECOS will alert the applicant when a response is inadequate or unacceptable, thereby decreasing the possibility of a rejected application.

Going forward, Medicare providers are required to notify Medicare of reportable events within a specific timeframe or risk losing their ability to bill for services provided to Medicare patients. A reportable event is any change that affects information in a Medicare enrollment record. A reportable event may affect claims processing, claims payment, or a provider’s eligibility to participate in the Medicare program.

Effective April 4, 2010, providers are required to report the following changes within **30 days** of the following reportable events:

- Change in ownership
- Change in practice location, and
- Final adverse action.

A final adverse action includes: (1) a Medicare imposed revocation of any Medicare billing privileges; (2) suspension or revocation of a license to provide health care by any State licensing authority; (3) revocation or suspension by an accreditation organization; (4) a conviction of a Federal or State felony offense (as defined in 42 CFR 424.535(a)(3)(i)) within the last ten years preceding enrollment, revalidation, or re-enrollment; or (5) an exclusion or debarment from participation in a Federal or State health care program.

Providers are required to report the following changes immediately, but not later than **90 days**, after the reportable event:

- Change in practice status (e.g., retirement, voluntary surrender of medical license or voluntary withdrawal from the Medicare program)
- Change of business structure, Legal Business Name or Taxpayer Identification Number
- Banking arrangements or payment information
- A change in the correspondence or special payments address

Hopefully, PECOS should make this reporting easier by:

- Reducing the time necessary for provider and supplier organizations to enroll or make a change in their Medicare enrollment information;
- Streamlining the Medicare enrollment process for provider and supplier organizations;
- Allowing provider and supplier organizations to view

their Medicare enrollment information to ensure that it is accurate; and
- Reducing the administrative burden associated with completing and submitting enrollment information to Medicare.

So far the above has not been the case, but let's move on.

WHO needs to enroll in PECOS?

- If you are not enrolled in the Medicare program and want to become enrolled, you do.
- If you enrolled more than 6 years ago and have not submitted any updates or changes to your enrollment information in more than 6 years, you do. If a provider who is currently enrolled in the Medicare program has not submitted a complete Medicare enrollment application (CMS-855) since November 2003, the Medicare contractor will require the individual or organization to submit a complete CMS-855 in order to update or make a change in their enrollment information.

In order to continue to order or refer items or services for Medicare beneficiaries, you will have to submit an initial enrollment application, which you may do in one of two ways:

1. Using Internet-based PECOS (which transmits your enrollment application to the MAC) AND BE SURE to mail the signed and dated Certification Statement to the carrier or A/B MAC immediately after submitting the application.
2. Filling out the appropriate paper Medicare provider enrollment application(s) (CMS-855I and CMS-855R , if appropriate) and mailing the application, along with any required additional supplemental documentation, to the local Medicare carrier or A/B MAC, who will enter your information into PECOS and process your enrollment

application. Information on how to enroll in Medicare is found on the Medicare provider/supplier enrollment web site.

If you are already enrolled in Medicare, make sure you have a current enrollment record in PECOS. You can find out by:

- Calling your designated carrier or A/B MAC (recommended). **Find out who your A/B MAC is here.**
- Using PECOS to view your enrollment record.
- Going to Medicare.gov and searching for the provider

If you are a dentist or a physician with a specialty such as a pediatricians who is eligible to order or refer items or services for Medicare beneficiaries but have not enrolled in Medicare because the services you provide are not covered by Medicare or you treat few Medicare beneficiaries, you need to enroll in Medicare in order to continue to order or refer items or services for Medicare beneficiaries.

WHICH paper enrollment form should be used?

CMS uses five different provider and supplier enrollment applications:

- Part A providers are required to use the CMS-855A to enroll or update their enrollment information;
- Part B suppliers (except suppliers of Durable Medical Equipment, and Prosthetics, Orthotics, and Supplies (DMEPOS)) are required to use the CMS-855B to enroll or update their enrollment information;
- Physicians and non-physician practitioners are required to use the CMS-855I to enroll or change their enrollment information;
- DMEPOS suppliers are required to use the CMS-855S to enroll or update their enrollment information.

- Individual practitioners who would like to reassign their benefits to an eligible provider or supplier or terminate an existing reassignment agreement would use the CMS-855R.

You should file a CMS-855A (pdf) with the designated MAC if you would like to enroll your organization in the Medicare program as one of the following types of providers.

- Community Mental Health Center
- Comprehensive Outpatient Rehabilitation Facility
- End-Stage Renal Disease Facility
- Federally Qualified Health Center
- Histocompatibility Laboratory
- Home Health Agency
- Hospital
- Hospice
- Indian Health Services Facility
- Organ Procurement Organization
- Outpatient Physical Therapy/Occupational Therapy/Speech Pathology Services
- Religious Non-Medical Health Care Institution
- Rural Health Clinic
- Skilled Nursing Facility

You should file a CMS-855B (pdf) with the designated MAC if you would like to enroll in the Medicare program as one of the following types of suppliers:

- Ambulance Service Supplier
- Ambulatory Surgical Center (site visit or state survey typically required)
- Clinic and Group Practices
- Hospital Departments
- Multi-Specialty Clinic
- Public Health/Welfare Agency
- Physical/Occupational Therapy Group in Private Practice
- Single Specialty

- Independent Clinical Laboratory
- Independent Diagnostic Testing Facility (site visit or state survey typically required)
- Mammography Center
- Mass Immunization – roster biller only
- Portable X-ray Facility (site visit or state survey typically required)
- Radiation Therapy Center
- Slide Preparation Facility
- Voluntary Healthy/Charitable Agency

You should file a CMS-855I (pdf) with the designated MAC if you would like to enroll in the Medicare program as one of the following types of providers.

- Physicians (all specialties)
- Non-Physicians
    - Anesthesiology Assistant
    - Audiologist
    - Certified Nurse Midwife
    - Certified Nurse Specialist
    - Certified Register Nurse Anesthetist
    - Clinical Social Worker
    - Mass immunization, roster biller (individual only)
    - Nurse Practitioner
    - Occupational Therapist in private practice
    - Physical Therapist in private practice
    - Physician Assistant
    - Psychologist, Clinical
    - Psychologist, billing independently
    - Registered Dietitian or Nutrition Professional

NOTE!! If you are enrolled in Medicare and your NPPES record is correct, you are not re-enrolling, you are revalidating, an important distinction in terminology. The word on the street is that it seems to be easier to revalidate via paper by completing the CMS-855 and writing "REVALIDATION" in the upper margin of the first page.

WHAT information is needed for a PECOS enrollment?

Below is a list of the types of information needed to complete an initial enrollment action using PECOS. This information is similar to the information needed to complete a paper Medicare enrollment application. You may find it useful to print and review the CMS-855 paper enrollment application before initiating an Internet-based PECOS enrollment action.

- An active National Provider Identifier (NPI).
- The NPI of the Practice (PA, PC, or LLC)
- National Plan and Provider Enumeration System (NPPES) User ID and password.
- Personal identifying information. This includes legal name on file with the Social Security Administration, date of birth, Social Security Number
- Professional license and certification information. This includes information regarding the physician's or non-physician practitioner's professional license, professional school degrees or certificates.
- Practice location information. This information includes information regarding the practitioner's medical practice location, the legal business name of a solely-owned Professional Association, Professional Corporation, or Limited Liability Company (LLC) on file with the Internal Revenue Service and appearing on the IRS CP575
- Any Federal, State, and/or local (city/county) business licenses, certifications and/or registrations specifically required to operate as a health care facility.
- A photocopy of the CP-575 form;
- If applicable, information regarding any final adverse actions. A final adverse action includes: (1) a

Medicare-imposed revocation of any Medicare billing privileges; (2) suspension or revocation of a license to provide health care by any State licensing authority; (3) revocation or suspension by an accreditation organization; (4) a conviction of a Federal or State felony offense (as defined in 42 CFR 424.535(a)(3)(A)(i)) within the last ten years preceding enrollment, revalidation, or re-enrollment; or (5) an exclusion or debarment from participation in a Federal or State health care program.

The following forms are routinely submitted with an enrollment application:

- Electronic Funds Transfer (EFT) Authorization Agreement (Form CMS 588)
- Medicare Participating Physician or Supplier Agreement (Form CMS 460)

HOW do you enroll in PECOS?

There are three basic steps to completing an enrollment action using Internet-based PECOS. Providers must:

1. Have an active National Provider Identifier (NPI) and have a web user account (User ID/Password) established. For security reasons, providers should change passwords periodically, at least once a year. If you/your provider needs help in changing your password, contact the NPI Enumerator at 1-800-465-3203 or send an email to customerservice@npienumerator.com.
2. Go to Internet-based PECOS by clicking on **this link** and complete, review, and submit the electronic enrollment application via Internet-based PECOS.
3. Print, sign and date the 2-page Certification Statement for each enrollment application submitted and mail the Certification Statement and all supporting paper

documentation to the Medicare contractor within 7 days of electronic submission. Note: A Medicare contractor will not process an Internet enrollment application without the signed and dated Certification Statement. In addition, the effective date of filing an enrollment application is the date the Medicare contractor receives the signed Certification Statement that is associated with the Internet submission. The Certification Statement must be signed by the provider enrolling or making changes to enrollment information. Signatures must be original and in ink (blue ink recommended). Copied or stamped signatures will not be accepted. NOTE: CMS encourages providers to print and retain a copy of the enrollment application for their records, however providers should only mail the 2-page Certification Statement and supporting documentation to the designated Medicare contractor.

HOW can managers facilitate the enrollment?

- Look at your original Medicare application to see who is the "authorized official". The Authorized Official (AO) may be theprovider, or may be the owner of the practice, or the CFO of the hospital, in the case of a hospital-owned practice. The AO (in an original application) may be registered through PECOS and an approval email will be issued in 3-4 weeks. Print the screen that provides the tracking ID. You will need to refer to it in the future.
- If you do not have a copy of your organization's original Medicare enrollment information and do not know who has been designated as your organization's "authorized official", an owner of your practice must submit a written letter on the organization's letterhead

to your Medicare contractor authorizing the release of that information. Medicare contractors are not allowed to release such information over the telephone or in an e-mail, and neither are they allowed to release it to practice staff.

- The organization AO goes into PECOS Identification & Authentication (I & A) and registers. As part of this process, the AO must mail a photocopy of the CP-575 to the CMS EUS Help Desk so that the Help Desk can verify the organization provider/supplier. Print the screen that provides the tracking ID. You will need to refer to it in the future.
- The Help Desk verifies both the organization provider/supplier and the AO, and approves the AO's registration. The AO receives a system-generated e-mail indicating that the registration has been approved.
- Once the AO receives this notification, the AO can let the end-user know that he/she can register in PECOS.
- The end-user goes into PECOS I&A and registers. The registration request will be directed to the AO of the provider/supplier organization.
- The AO must approve or reject the end-user in PECOS I&A.
- Once the end-user has been approved in PECOS I&A by the AO for access on behalf of the organization provider/supplier, the end-user will receive a system-generated e-mail indicating that he/she has been approved.
- The end-user then logs into PECOS and downloads the Security Consent Form. He or she fills it out, obtains the signature/date of signature of the AO, and mails the completed Security Consent Form to the CMS EUS Help Desk at P.O. Box 792750, San Antonio, TX 78216.
- The Help Desk verifies the information on the Security Consent Form and also calls the AO to verify that the AO did, in fact, sign the Security Consent Form.
- Once the information on the security Consent Form has been confirmed, the Help Desk approves the Security

Consent Form in PECOS and an e-mail is sent to the AO notifying the AO that the end user's organization has been approved to use Internet-based PECOS on behalf of the organization provider/supplier.

- It is the AO's responsibility to notify the end-user's organization that the end-user can now use Internet-based PECOS. An e-mail is sent to the AO (step 9) because the AO is ultimately responsible for the enrollment information and who has access to that enrollment information. It is the AO's responsibility to inform the end-user that the Security Consent Form has been approved.

TO RECAP:

- Providers, if you search for yourself at Medicare.gov and cannot find your record, you do not have a PECOS record – it is either missing or incomplete. Call Provider Enrollment at Medicare or your MAC for help.
- If you do not have a PECOS record, send in a paper enrollment or complete the online (PECOS) enrollment.
- The prerequisite for getting a PECOS record is to have a NPPES record. Make sure you have your NPPES login and password and that your record (Type I NPI) is correct. Your organization also needs an NPPES record (Type II NPI), and make sure your organization name on the NPPES record matches the name on your IRS letter.

RESOURCES

Read about PECOS in downloadable documents section: **Downloads for PECOS**

The AMA and MGMA have published an absolutely excellent resource: "The Medicare Provider Enrollment Toolkit"

available **here for MGMA members**. Enter “Medicare Enrollment” in the search box.

The CMS External User Services (EUS) Help Desk contact information for providers and suppliers using PECOS can be found **here** (pdf) on the CMS website. The Help Desk hours of operation are Monday ”“ Friday, from 6 a.m. to 6 p.m. Central Standard Time. The Help Desk toll-free number is 1-866-484-8049 and their e-mail address is eussupport@cgi.com. Questions about accessing and using PECOS should be directed to the CMS EUS Help Desk, although I have heard lots of complaints about long wait times and conflicting advice.

Readers: Please share any clarifying information or tips from your enrollment experiences with everyone. Leave a comment and share the wealth!