

Internal Medicine Coding Alert

Rural Health: Revalidation Letters and Diagnostic Imaging Requirements Affect payment

Understand how CMS changes affect healthcare service

CMS officials discussed several issues of interest to rural health providers -- including revalidation letters and the advanced diagnostic imaging program -- during an Open Door Forum call on October 18. Read on for a few highlights that your practice might need to know.

Watch for Your Revalidation Letter From CMS

As part of the Patient Care and Affordable Care Act (section 6401 a), all new and existing Medicare providers must be reevaluated under new screening criteria that went into effect March 25, 2011. All enrolled providers and suppliers must revalidate their enrollment information every five years, to ensure that Medicare has the most current information on file.

"If your physician is newly enrolled on or after March 25, 2011, you're not affected by this effort," **Sabeen Chong, CPI**, said during the call.

Revalidation letters will be sent on a regular basis until March 23, 2013. "Phase one is in effect, and the first group of providers and suppliers have received their letters," Chong said.

Consequence: Failure to submit complete enrollment application(s) and supporting documentation within 60 calendar days of receiving your revalidation letter could result in Medicare billing privileges being deactivated. Physicians shouldn't be so anxious to comply that they jump the gun, however.

"Don't try to revalidate until you hear from your contractor," Chong warned. "If you respond in a timely manner once you hear from the contractor, it shouldn't interrupt your payment cycle."

Providers and suppliers can enroll in the Medicare program by paper application or by using the Internet-based Provider Enrollment, Chain, and Ownership System (PECOS).

Follow up: CMS will be posting a list of providers who should have received their notices on the CMS website. "You can check the list to be sure you're acting on things appropriately," Chong said.

Cost: Prepare now for a bottom-line hit when your practice goes through the Medicare revalidation process. "It will cost about \$500 per provider," says **Barbara Berg**, clinic administrator for Lake Chelan Clinic in Chelan, Wash.

Verify if You're On Track for Diagnostic Imaging

Sandra Bastinelli, CPI, of CMS also updated participants on the advanced diagnostic imaging program.

Important: In order to provide the technical component (designated by using modifier TC) of advanced diagnostic imaging services for Medicare beneficiaries, physicians must be accredited by Jan. 1 2012.

Definition: Advanced diagnostic imaging procedures include diagnostic MRI, CT, and nuclear medicine imaging such as PET. Standard X-ray, ultrasound, and fluoroscopy procedures do not belong in the "advanced" imaging category. The law also excludes diagnostic and screening mammography from the CMS accreditation requirement because those services are subject to oversight from the Food and Drug Administration (FDA) under the Mammography Quality Standards Act.

"If you're reimbursed under the Medicare Physician Fee Schedule, this accreditation applies to you," Bastinelli said. Physicians must gain accreditation for billing the technical component of advanced diagnostic imaging procedures if:

- The physician provides the service and bills Medicare
- The physician provides the technical component by way of someone else (such as a contractor who doesn't bill Medicare on your physician's behalf)
- The physician is not accredited and wants to provide and bill for the technical component.

"It takes several months to become accredited, so if your physician isn't accredited yet he probably won't be on time," Bastinelli said. "But you can still start the process."

Information: For more details on accreditation for advanced diagnostic imaging procedures, contact one of the national organizations approved by CMS. Visit www.cms.gov, and search for "advanced diagnostic imaging accreditation."