

Health Information Compliance Alert

Home Health PECOS: Home Health Agencies: Prepare For Special PECOS Challenges

HHAs may need to refuse referrals rather than face wholesale denials.

Background: Back in 2009, the **Centers for Medicare & Medicaid Services** implemented edits for home health agencies, durable medical equipment suppliers, and physicians detecting when claims contained an invalid ordering or referring provider. Under the edits, the ordering physician for home health agency services must have a valid National Provider Identifier (NPI) number and be enrolled in Medicare's Internet-based Provider Enrollment, Chain, and Ownership System (PECOS).

But the first phase of edits has been informational only, so claims still pay even if the physician information is incorrect. In those cases, home care claims process with this message: N272 ☐ Missing/incomplete/invalid other payer attending provider identifier.

CMS originally intended to implement phase 2 of the denials fairly quickly. But an outcry over PECOS enrollment problems from providers affected by the edits has delayed that phase ☐ until now.

Starting May 1, HHAs will see claims denied with reason codes 37236 or 37237 when the physician's information isn't valid, CMS explains. Affected claims will have a "from" date of May 1 or later.

Claims can run afoul of the edits in two main ways. The referring physician may not appear in the eligible attending physician file from PECOS, CMS notes. Or the physician may be in the PECOS file, "but the name does not match the NPI record." Small differences such as using an initial or nickname instead of a full first name can trigger the latter denial reason. (See preceding article.)

The system also will deny claims if the physician isn't of an eligible specialty to order. For home care services, eligible specialties include Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), or Doctor of Podiatric Medicine (DPM), CMS points out in the MLN Matters article.

Rough PECOS Seas Ahead

HHAs had better pay close attention to the new phase of these edits or risk serious financial burdens. "I am a little concerned about this," says **Rick Ingber** with **Vanta Health Consulting** in Plymouth Meeting, Pa. "Because the threat of denial has been hanging out there so long without being enforced, my worry is that agencies will continue to assume the issue will continue to be pushed down the road."

HHAs that stayed on top of the issue when it first arose may have let their physician PECOS checking slide, experts fear.

Denials Vs. Returns An Important Distinction

Making sure claims comply with this requirement is crucial, because the edits will deny rather than return claims. Denial "is very different from a claim being rejected or returned for corrections, as the claim will have to go through the appeals process to be paid rather than just being corrected and rebilled," points out billing expert **M. Aaron Little** with **BKD** in

Springfield, Mo.

Bottom line: "The appeals process will not only delay cash flow but can also be very costly," Little warns.