Health Information Compliance Alert

Industry Notes: CMS Extends 5010 Compliance Period

Providers get another 3-month 5010 delay. Expect more technical assistance with the new claim format. Right after confirming that implementation of the HIPAA-compliant 5010 claim format would become required April 1, CMS has eaten its words. Practices that were sweating the April 1 deadline for 5010 compliance can breathe a little easier, thanks to a March 15 CMS announcement that the agency will once again be pushing enforcement up the road.

CMS first planned to require the 5010 format Jan. 1, but last November it announced a three-month delay, CMS notes in a message to providers. Now CMS is putting off 5010 enforcement another three months, to June 30.

Providers and other claims submitters "have been making steady progress," CMS said in its announcement. "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."

But some technical glitches are still plaguing the new format. "There are still a number of outstanding issues and challenges impeding full implementation," CMS admits. CMS's Office of E-Health Standards and Services "believes that these remaining issues warrant an extension of enforcement discretion to ensure that all entities can complete the transition."

CMS plans "to expand technical assistance opportunities and eliminate remaining barriers," the agency pledges.

Neglect CAHPS Participation At Your Financial Peril

Unless you want to receive 2 percent less in Medicare payments in 2014, you'd better make sure you're completing the Home Health Care Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) survey requirements.

Home health agencies must participate in CAHPS "for patients served in April 2012 and after to be eligible for the full market basket payment increase for CY2014," CMS explains in a message to providers. "Therefore, it is in your agency's best interest to participate in HHCAHPS so that your agency can receive the full annual payment update."

The CAHPS site is online at https://homehealthcahps.org.

Double-Check Your Revalidation Status

If you think you don't have to worry about revalidating your Medicare enrollment because you didn't receive a request letter from your MAC, you might want to double-check -- or face losing your Medicare billing privileges.

You can look for your name on CMS's revalidation list online at www.CMS.gov/MedicareProviderSupEnroll/11_Revalidations.asp, the agency says in a new listserv message to providers. CMS will post revalidation letters sent in February sometime this month.

Not too late: All is not lost if you missed HHH MAC CGS's February revalidation deadline.

"If you have not submitted your revalidation information, you are still able to request a one-time 60-day extension," CGS says in its March newsletter for providers. "The 60 day extension will begin the day the extension request is received." Details on how to submit the request are at www.cgsmedicare.com/hhh/pubs/news/2012/0312/WR534.html.

Monitor Your Employees Or Risk Theft

Keep a close eye on your employees with purchasing power, or you may end up bilked of hundreds of thousands of

dollars like one New York state hospice.

From January 2003 to March 2011, Jeffrey Mohamed was chief of information technology for the Hospice Care Network headquartered in Woodbury, N.Y., reports Newsday newspaper in Long Island, N.Y. Nassau County prosecutors say he embezzled more than $243,000 from his employer by making unauthorized purchases of computers, televisions and other electronic equipment. Mohamed made the purchases through the hospice's accounts and then returned the items for a credit to his personal account or by selling the equipment and keeping the proceeds. Managers at Hospice Care Network discovered the theft during a review of open orders for IT equipment from a vendor, according to Newsday.

Don't Waste Your Time With An Extra Face-To-Face Visit When You Don't Have To

That's the takeaway from a question-and-answer issued by Medicare Administrative Contractor NHIC. "If a home health patient is admitted twice within the same 90-day period for the same reason, can the first face-to-face encounter documentation be used for both admissions?" asked a home health agency in NHIC's Aug. 3 Ask the Contractor Teleconference.

"In this instance, the same face-to-face encounter could be utilized for both home health admissions," NHIC replies in the ACT summary.

But home health agencies may not like another of NHIC's answers to a F2F question quite as much. "If a home health patient was scheduled to have the face-to-face encounter on day 10, but transferred to hospice on day eight, and is now refusing to go to the doctor for the home health face-to-face encounter, would this be considered an exceptional circumstance?" a provider asked in the conference.

"The face-to-face encounter is a requirement for payment," NHIC says. "The home health services could not be billed if it does not occur."

NHIC also reminds providers that they must have the signed F2F documentation in hand before billing Medicare for an episode. "You cannot bill Medicare until you have the signed documentation," NHIC explains. "The face-to-face encounter is part of the re-certification."

Resource: The four-page ACT summary is online at www.medicarenhic.com/RHHI/billing/J14%20HHH%20ACT8311QAs.pdf.