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Health Information Compliance Alert

Industry Notes: EMR Signature Must Translate to Printed Copy, One Medicare Contractor Says

Electronic medical records (EMRs) can be a terrific complement to a medical practice in terms of creating thorough documentation. But if your physician isn't signing the record, you could say goodbye to reimbursement.

CGS Medicare, a Part B payer in Kentucky and Ohio, issued an alert last month noting that errors in this category have increased recently, leading to stalled claims and slashed reimbursement.

"When signing medical records electronically, the electronic signature MUST appear in the records when printed or your claim will be in error," CGS notes. "One common error we see is that although the physician signs off on his/her notes in the electronic medical record, when printed the signature does not appear on the printed copy which causes an error."

Therefore, you should ensure that your EMR is configured to print not only your record itself but also the practitioner's signature.

To read more on this issue, visit CGS's web site at http://cgsmedicare.com/ohb/pubs/mb_J15/2012/05_2012/index.html#006.

Claims Sent to Wrong MAC Will Now Be 'Returned As Unprocessable'

If your practice routinely sees patients from various states, you're all too familiar with the hassle of dealing with multiple Medicare Administrative Contractors (MACs). CMS has taken steps to streamline its processes when dealing with claims submitted to the wrong MAC, and it could result in additional rejections for your practice.

Background: In the past, if you submitted a claim to the wrong MAC, the carrier would handle the situation in one of two ways: It returned assigned claims as "unprocessable" and denied unassigned claims for Part B services sent to the incorrect MAC.

New way: Effective July 20, MACs will "return all Form CMS-1500 and electronic misdirected claims as unprocessable, regardless of their unassigned/assigned status" when submitted to the wrong MAC, according to Transmittal 2474, issued on May 18.

Best bet: Keep a list of the local MAC jurisdictions near your claims processing department to ensure that you submit your claims to the right carrier the first try. That way you can avoid delayed reimbursement for these services.

To read about the new directive, visit www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2474CP.pdf

Keep An Eye Out For Looming PECOS Edit Date

The upcoming Medicare claims edits that will check for referring physicians' PECOS enrollment may make you nervous, but at least they won't drop on you at a moment's notice.

Background: In a rule published in the April 27 Federal Register, the Centers for Medicare & Medicaid Services announced its intentions to move forward with the so-called PECOS edits that were postponed last year. The edits could bring some facilities' and home health agencies' cash flow to a screeching halt if their docs are not enrolled in Medicare's online enrollment system.

Providers who miss revalidating their Medicare enrollment will face CMS revoking their billing privileges. You can head off

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the problem by checking the agency's master list of who it sent revalidation notice letters. The lists are in the "Downloads" section at www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Revalidations.html.

No date to activate the PECOS edits has been set, a CMS official has told the National Association for Home Care & Hospice. And the agency will provide a minimum advance notice of 60 days before activating the edits, NAHC reports.

Tip: For home health agencies to get paid, the ordering physician will have to be enrolled in PECOS for the entire episode of care, CMS reportedly told NAHC.

Do this: "Home health agencies should immediately begin checking every physician's Medicare enrollment status in the Ordering and Referring Physician report," NAHC urged when the final rule came out. "The reports will be updated weekly." The report is at www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/MedicareOrderingandReferring.html under the "Downloads" section.

Differentiate Your PTAN From Your NPI

Medicare maintains so many acronyms that it can be a full-time job to keep track of them. CMS aims to dispel confusion between at least two of their common abbreviations with new MLN Matters article SE1216, which breaks down the difference between National Provider Identifiers (NPIs) and Provider Transaction Access Numbers (PTANs). Some practices have used these numbers interchangeably, or confused them, which prompted CMS to issue the clarification.

According to the article, your NPI is the ten-digit number that you enter on your claims to identify your practice as an entity eligible to bill Medicare for services performed.

The PTAN, however, is a number that authenticates you when you contact Medicare contractors. Both numbers are important, but cannot be used interchangeably. Think of the NPI as similar to your bank account number (identifying your specific account), and the PTAN being similar to the PIN number you use to access your money (which identifies that you are who you say you are).

To read the complete article, visit www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1216.pdf.

Observe 5010 Deadline for June 30, 2012

If you've been taking advantage of CMS's 5010 enforcement "discretion period," your time's almost up. The 5010 claim format was required Jan. 1, but CMS delayed enforcement until June 30. Now that date is less than a month away.

Remember: After the discretion period is over, "Medicare claims submitted in any format other than the ASC X12 v5010 and NCPDP D.0 will be rejected," Medicare Administrative Contractor Palmetto GBA stresses on its website. "Rejected claims will not be processed or paid."

More info: CMS's regional offices will hold a webinar about 5010 on June 20 from 10 a.m. to 11 a.m. EST. The webinar will cover topics ranging from conversion statistics to operational concerns to preparations for the final 5010 cutover. The ROs will issue registration information soon.

Director Fired For HIPAA Slip

If you're not paying too much attention to information security at your organization, prepare for your head to roll when trouble arises.

That's what happened to Utah Department of Technology Services director **Stephen Fletcher** when hackers swiped Social Security numbers and other data from health department Medicaid eligibility servers back in March. The breach, which affected data from 780,000 people, was related to the failure to change a default password.

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Utah Gov. **Gary Herbert** fired Fletcher May 15. Two other DTS security personnel may also be fired, and Herbert terminated a software contractor, according to press reports.

Enroll A Month Earlier

You can get a jump on enrollment paperwork, thanks to new 855 submission deadlines.

"Providers and suppliers can now submit their enrollment applications 30 days sooner," CMS explains in a message to providers. "CMS-855 enrollment applications and Internet-based PECOS applications may now be submitted 60 days prior to the effective date."

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