

Health Information Compliance Alert

Industry Notes: Indicators That PECOS Edits May Be Right Around The Corner Are Increasing

Background: In May 2010, CMS published an interim final rule based on the Affordable Care Act, requiring physicians who ordered home health and certain other services to be enrolled in PECOS with a valid National Provider Identifier (NPI) number for claims to be paid. CMS planned to begin editing for docs' NPIs and PECOS information in January 2011. However, CMS postponed those edits indefinitely when physicians had inordinate difficulty enrolling in the system, among other problems.

Last month, CMS issued a final rule restating those requirements and CMS reps reportedly told a trade association that the edits would be coming relatively quickly.

In a new e-mail message to providers, CMS reiterates the requirements for docs to order home health services -- Medicare enrollment, a valid individual NPI, and the correct specialty (Doctors of Medicine or Osteopathy or Doctors of Podiatric Medicine). "Failure to meet the requirements ... will result in denied claims once the automatic edits are activated," CMS warns.

Stay On Track For 5010 Usage: This HHH MAC Frowns on Using 4010 Form

CMS may have delayed 5010 enforcement until July 1, but you'd be wise to adopt the new HIPAA-compliant claim format as quickly as possible.

"Submitters may continue to submit claims in Version 4010" until July 1, allows Home Health & Hospice Medicare Administrative Contractor Palmetto GBA. But "this is highly discouraged by your MAC," Palmetto stresses on its website. "We will do everything possible to assist you in becoming 5010 compliant."

"It's important that all HIPAA-covered entities continue to take the necessary steps to complete the upgrade to Version 5010 as soon as possible," the Centers for Medicare & Medicaid Services urges in a message to providers.

Providers may be behind on the 5010 conversion because they have experienced processing difficulties, CMS admits. "Much progress has been made in the successful receipt and processing of claims in the Version 5010 format, [but] CMS is aware that there are still challenges and issues impeding an industry-wide upgrade," the agency says in a separate message to providers.

For example: Providers who haven't received an appropriate EDI authorization to use 5010 can't submit the new claim format, the agency says in a new factsheet troubleshooting 5010 processing problems. A link to the factsheet, "Important Update Regarding Version 5010/D.0 Implementation," is at www.cms.gov/Regulations-and-Guidance/HIPAAAdministrative-Simplification/Versions5010andD0/.

Tip: "To avoid potential cash flow disruptions, providers should consider establishing or increasing a line of credit," CMS says in a factsheet about the transition. "By doing so, they can prepare for possible delays and denials in payer claims reimbursements if noncompliant Version 5010 transactions are submitted." The factsheet, which includes other tips, is at www.cms.gov/Medicare/Coding/ICD10/Downloads/SmoothTransition.pdf.

HHAs: Avoid Common 855 Pitfalls In Sections 5 And 6

Watch out for re-enrollment form pitfalls when it's your turn to revalidate. "Many Medicare enrollment applications (CMS-855A) are not being completed correctly by home health agencies ... when revalidating their Medicare enrollment information with CGS," the HHH MAC says on its website. "Sections 5 and 6 of the CMS-855A appear to be the most

problematic for HHAs."

Tip: Exact percentages are required for seven data elements in Sections 5 & 6, CGS says.

Plus: Remember that direct ownership can't exceed 100 percent. But "indirect ownership percentages in Section 5 and individual indirect ownership percentages in Section 6 can, and typically will, exceed 100 percent," CGS advises.

More information on filling out the form correctly is at <http://cgsmedicare.com/hhh/pubs/news/2012/0412/629.html>.