



Reminder – PECOS – Medicare Enrollment

Effective January 2011, CMS will begin rejecting claims if a provider is not enrolled with Provider Enrollment, Chain and Ownership System (PECOS).

What will happen if the ordering/referring provider is not enrolled in PECOS?

- Any provider who performs a test – **will not be paid by Medicare**, until that referring doctor gets enrolled.
- The provider claims that are **rejected would need to be appealed** with a validation that the referring doctor is now enrolled; this must be done within timely filing limits.
- Hospital-based physicians will be most affected, especially cardiology, hospitalists, pathology, radiology – due to the volume of patients entering the system for tests.
- Other specialists like hematologists, orthopedics, neurology, general and vascular surgeons, etc., who will treat these referred patients will suffer the

same fate.

- This only applies to physicians under Part B Medicare, not hospitals under Part A.

How can I find out if I have an enrollment record in PECOS?

Providers who order or refer may want to verify their enrollment in PECOS. They may do so by accessing Internet-based PECOS at <https://pecos.cms.hhs.gov/pecos/login.do> on the CMS website.

Providers can also review if you have a current enrollment record in PECOS by accessing the **Ordering and Referring Report** at http://www.cms.gov/MedicareProviderSupEnroll/06_MedicareOrderingandReferring.asp#TopOfPage.

I don't have an enrollment record. What should I do?

Internet-based PECOS is the fastest and most efficient way

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to submit your enrollment application. For instructions, see **Basics of Internet-based PECOS for Physicians and Non-Physician Practitioners** at http://www.cms.gov/MLNProducts/downloads/MedEnroll_PECOS_PhysNonPhys_FactSheet_ICN903764.pdf.

If you encounter problems or have questions as you navigate the system, there is help available at http://www.cms.gov/MLNProducts/downloads/MedEnroll_PECOS>Contact_FactSheet_ICN903766.pdf.

Source: www.cms.gov.

Anthem Customized Claim Edits

The implementation date has changed for Edit #189; the revised implementation date is around November 19, 2010. The following information was previously communicated in the August 2010 issue of *Network Update*:

“Edit #189 Magnetic Resonance Imaging, Brain with or without Contrast Material with Magnetic Angiography with or without Contrast Material (Revised).”

Rationale: Anthem used to reimburse separately for 70551, 70552 or 70553 (Magnetic resonance imaging without contrast, with contrast or without contrast followed by contrast) with 70544, 70545 or 70546 (Magnetic angiography with contrast, without contrast and without contrast followed

by contrast) but this will change in September. Anthem will follow a change made in the National Correct Coding Initiative Edits (Version 16.0, January 1, 2010) and bundle these services.”

Edit #189 applies to Blue Access®, Blue Access Choice, Blue Preferred®, Blue Preferred Primary, Blue Preferred Primary Plus, Blue Preferred Plus, Blue PrioritySM Blue Priority Plus, Blue Traditional®, Hospital Surgical (PPO) Blue Traditional®.

Any further revisions to the edit’s production date will be communicated in a *Rapid Update* posted on anthem.com.

Source: Network Update, October 2010, at www.anthem.com.

Cigna Medicare Access® (PFFS)

Individual PFFS Plans will no longer be offered by CIGNA in 2011.

All insurers that wish to offer Medicare Advantage products will be required to have a contracted network of health



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care professionals and hospitals in most parts of the country beginning January 1, 2011.

CIGNA has chosen to focus on other core business initiatives and therefore will not offer an **individual** network-based Medicare Advantage product in 2011.

All current individual PFFS customers will remain fully covered for their current plan with their current benefits intact through December 31, 2010. All current group PFFS customers will be fully covered through the end of their contract term (which for some customers will extend until July 2011).

This decision does not impact our Arizona

Medicare HMO business, which will continue to be offered to individuals and groups.

This decision does not impact our CIGNA Medicare Rx business, which will continue to be offered to individuals in 2011.

All CIGNA individual PFFS customers must elect new coverage for 2011 by either enrolling in another insurer's Medicare Advantage plan or returning to Original Medicare. However, you may still see CIGNA PFFS patients through July 2011 if they are enrolled in a group plan.

Current CIGNA individual PFFS customers will be notified of this change by letter, which should include the

names and phone numbers of other carriers in their area (based on information we receive from CMS) that offer Medicare Advantage plans.

In April, CIGNA announced an alliance with Humana to offer their Medicare Advantage network products to employer groups. For information about Humana Medicare Advantage plans, network contracting, claims, benefits or eligibility, call Humana's Group Medicare Customer Center number located on the back of the patient's Humana Medicare Advantage ID card (for most groups, the number is 1.866.396.8810). For contract and credentialing questions only, go to www.humana.com, or call 1.800.626.2741.

Source: Network News, September 2010, at www.cigna.com.

North Carolina Medicaid – Copayment Changes

On November 1, 2010, DMA will implement two new copayment requirements. A copayment of \$3.00 will be charged for clinic and outpatient services including local health department visits and outpatient behavioral health services. A \$6.00 copayment will be charged for non-emergency visits to a hospital emergency room.

Providers are reminded that they may not charge copayments for

- Dental services provided in

- a health department
- Family planning services
- Federally Qualified Health Center (FQHC) core services
- Health Check (EPSDT)-related services
- Emergency visits to a hospital emergency department, including physician services delivered in the emergency department
- Rural Health Clinic (RHC) core services
- Services covered by both Medicare and Medicaid

- Services provided to Community Alternatives Program participants
- Services related to pregnancy
- Services to individuals under the age of 21

Refer to Section 2 of the Basic Medicaid Billing Guide at <http://www.ncdhhs.gov/dma/basicmed/index.htm> for a complete list of copayments and copayment exceptions.

Source: October 2010 Medicaid Bulletin at www.ncdhhs.gov.