June 21, 2010

Ms. Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-6010-IFC
7500 Security Boulevard
Baltimore, MD 21244-8013

RE: Interim Final Rule with Comment Period Medicare and Medicaid Programs; Changes in Provider and Supplier Enrollment, Ordering and Referring, and Documentation Requirements; and Changes in Provider Agreements

Dear Ms. Tavenner:

The undersigned organizations appreciate this opportunity to comment on the Centers for Medicare & Medicaid Services’ (CMS) Interim Final Rule with Comment Period Medicare and Medicaid Programs; Changes in Provider and Supplier Enrollment, Ordering and Referring, and Documentation Requirements; and Changes in Provider Agreements released in the May 5, 2010 Federal Register.

Enrollment in PECOS

We understand that the Patient Protection and Affordable Care Act (PPACA) mandates that fee-for-service providers and suppliers include their national provider identifier (NPI) on Medicare enrollment applications, on Medicare electronic and paper claims, and on Medicaid claims. However, the radiology community is concerned that the interim final rule (IFR) carries an effective date of July 6, 2010 for the requirement that ordering and referring physicians must have a valid enrollment record (or a valid opt-on record) in the Provider Enrollment, Chain and Ownership System (PECOS) in order for claims for certain ordered and referred services not to be rejected by Medicare. In addition, while section 6405 of PPACA does mandate that only Medicare-enrolled physicians may order and refer for home health and durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), it does not specify that such enrollment status can only be satisfied by having an enrollment record in PECOS nor does it require a July effective date with respect to services such as the Part B claims for covered services of imaging suppliers, which CMS is electing to add to the list of services affected by the “ordering and referring” policy.

Further, we note that the July 6, 2010 effective date of the IFR is especially confusing considering that providers had previously been told through transmittal that claims for services not meeting the ordering and referring physician requirement would not be rejected before January 3, 2011. The undersigned organizations see no reason why CMS could not defer the effective date, at least for imaging and other services other than home health and DMEPOS, until January 1, 2011 at the earliest, and we would also recommend that the agency use whatever discretion it has to defer claim rejection beyond the July 6 effective date for all services affected
by the “ordering and referring” policy in order to give ordering and referring physicians more
time to satisfy applicable Medicare enrollment requirements.

We also note that in electing to apply the “ordering and referring” policy to “Part B claims for
covered services of…imaging suppliers,” CMS provided no additional explanation regarding
what is meant by this, that is what imaging services and service settings are affected. For
example, by referring to imaging suppliers, does CMS mean to imply that claims for imaging
services provided in the hospital outpatient setting would not be affected? Further, does the
policy apply only to claims for the technical component of imaging services (or global services)
or would it also apply to claims for the professional component of imaging services? The lack of
clarity in the IFC about the applicability of the “ordering and referring” policy is troubling.

We are also very concerned that CMS says in the rule that “the agency clearly understands that
there is a considerable risk that providers and suppliers of ordered or referred services will not be
paid by Medicare if the ordering or referring physician or other health professional does not have
an approved enrollment record.” The radiology community has made huge efforts to educate its
referring and ordering physicians and has found that most of our referring physicians are not
aware of the deadline, or of the downstream impact of their failure to have an enrollment record
in PECOS. Radiology practices estimate that between 20 to 30 percent of their
referring/ordering physicians do not have an enrollment record in PECOS. In addition, those
that are required to meet this deadline are not the ones who will face the consequences of non-
enrollment. Ordering and referring physicians lacking an enrollment record in PECOS can still
order and refer, and their patients can still receive the requested items and services. However,
even if the radiology providers are properly enrolled in PECOS, if the ordering or referring
physician is not, the radiologist will be the one whose claim is rejected. Therefore, those who
are not in compliance face no consequence for their actions.

As noted earlier, we request that CMS use its discretion to refrain from implementing claim
rejections until at least January 1, 2011 (especially in the case of services which the agency is
adding at its own discretion). We also ask that CMS, effective for claims with a date of service
from and after July 6, 2010, clearly flag any claims which would have been denied because the
ordering/referring physicians are not enrolled in PECOS. More importantly, not only should
details be communicated to the imaging provider, but CMS or its contractors should use
this information for targeted outreach to un-enrolled referring/ordering providers or those
enrolled whose information is not correct in PECOS. In addition, we request that CMS update
the list of enrolled providers on a more frequent basis and insure the reliability of the information
on the reason and remark codes. Radiology practices are already receiving warnings of claim
rejections and some of these relate to referring/ordering physicians who have a valid enrollment
record in PECOS but where the claim is identified as having other technical problems with
respect to the name of the ordering and referring physician.

For Example: In PECOS there are three segments in the claim specifications for first
middle and last names of the referring physician that need to be reported. They are
defined by a notice in CR 6417. When Medicare receives a claim, the system is
looking at the name of the ordering or referring physician and trying to verify a
perfect match. Radiology practices are receiving warning messages (reimbursement
is not affected at this time) from Medicare. When they inquired about the warning
messages they were advised that the name had to match between the National Plan
and Provider Enumeration System (NPPES) and PECOS.
It is not clear that referring/ordering physicians who were previously enrolled and must re-enroll are aware of the sensitivity of the two systems and that there must be a perfect match. We suggest that CMS instead try to match the NPI number as mandated in the PPACA as the vital piece of information. The names could be valid in both systems but slightly different such as John J. Doe, M.D. in NPPES and J. James Doe, M.D. in PECOS but the NPI number should be the same. We believe it is unfair for CMS to reject the claims of specialists who provide ordered or referred services because of a simple mismatch of information between these two systems for which they are not responsible or accountable to provide.

In our letter of March 2, 2010, the undersigned organizations made several suggestions, in response to change request (CR) 6417/6421, of ways that CMS could provide effective outreach to physicians who have not yet enrolled in PECOS. For your convenience, we are restating these recommendations in attachment A and request that CMS seriously consider how to best communicate with physician practices in all settings, including, without limitation, those engaged in office/freestanding, Public Health Service, Department of Defense, Department of Veterans Affairs, dental, and pediatric practice settings, as well as teaching physicians in an academic setting and those who have opted out of Medicare, all of whom are not currently enrolled in Medicare but who may, perhaps rarely, act as the ordering or referring physician for Medicare-covered services. Above all, we emphasize the importance of giving all of these individuals more time to fulfill Medicare-enrollment requirements relating to the “ordering and referring” policy.

**PPACA Requirement for Written Orders**

We understand that the PPACA requires that providers and suppliers maintain and, upon request, provide to the Secretary, access to documentation relating to written orders or requests for payment for Medicare-covered home health services and DMEPOS and also authorizes the application of the same policy to other services; CMS has elected to apply these requirements to laboratory, imaging, and specialist services. We appreciate CMS including electronic storage of said orders, such as in a Picture Archiving and Communication System (PACS), Health Information System (HIS) or Radiology Information System (RIS). We further agree that record retention starts on the date of service, since that is the current standard. Finally, we concur with retaining orders for seven years consistent with CMS’ decision in the 2009 Medicare fee schedule final rule and the Program Integrity Manual (PIM, 100-08, Chapter 5).

However, the responsibility for maintaining documentation should rest solely on the imaging facility (i.e., technical component provider) and not the ordering/referring provider or the interpreting physician. Imaging centers and hospitals already capture and maintain order information in their systems. The requirement that the ordering/referring provider retain this information is an unnecessary duplication of effort and expense; and many such providers are currently ill-equipped to do so. It would be equally burdensome and detrimental to patient care to require written orders for the professional component of imaging studies and to require interpreting physicians to maintain records of such written orders. Put simply ordering physicians do not differentiate between the TC and PC orders – they assume both will occur based on their order.

The undersigned organizations support efforts to reduce fraud and abuse in the Medicare and Medicaid programs. We also support appropriate documentation for radiology services. We ask that CMS seriously consider the administrative and financial burdens that this interim final rule will impose if CMS’ efforts are not implemented in a careful and fundamentally fair manner to
all specialties affected. If you have any questions or require additional information, please contact any of the individuals listed.

Sincerely,

Radiology Business Management Association
Michael R. Mabry, Executive Director, 888-224-7262 Ext 13363 or mike.mabry@rbma.org

Association for Quality Imaging
Maggie Sayre, Executive Director

Healthcare Billing & Management Association
Bradley J. Lund, Executive Director, 877-640-4262 Ext 203 or brad@hbma.org

American College of Radiology
Bibb Allen, Jr., MD, Chairman, ACR Commission on Economics

AHRA: The Association for Medical Imaging Management
Edward J. Cronin, Jr., CAE, Chief Executive Officer, 978-443-7591 Ext 222 or ECronin@ahraonline.org

cc: James Bossenmeyer, CMS
Patricia Peyton, CMS
Kim Brandt, CMS
Wayne Blank, AQI
Melody Muliak, AHRA
Pam Kassing, ACR
Maurine Dennis, ACR
Attachment A

Recommendations from our March 2, 2010 letter outlining proactive steps that CMS can take to increase the number of enrollments in PECOS and ease the administrative burden upon referral-based specialties or industries such as imaging:

1. **CMS-initiated contact to non-PECOS enrolled providers** – We recommend and strongly encourage CMS to send letters, as announced during the Forum, to providers who have neither enrolled in, nor have a current application pending in, PECOS. It is our experience that referring/ordering providers, particularly those who have few Medicare beneficiaries, are unaware of the PECOS requirements or believe their previous applications are current. We acknowledge that more than one mailing may be necessary. As was voiced on the Forum call, many small provider offices often struggle with such changes.

2. **Provide the list of enrolled providers in Microsoft Excel, Microsoft Access, or other common database-friendly, searchable and manipulable electronic format** – CMS’ release of its enrolled provider list is helpful in distinguishing referring/order providers who have enrolled in PECOS from those who have not. The usefulness of the list, however, is limited because of its Portable Document Format (PDF). Providing the list in Microsoft Excel or Microsoft Access will enhance greatly the usefulness of the file by allowing it to be analyzed in multiple ways.

3. **Have Medicare Administrative Contractors (MACs) utilize their Carrier Provider Outreach and Education Advisory Groups (CPOE), newsletters, and other mechanisms (e.g., Town Hall meetings, conference calls, webinars) to educate providers on the need to enroll or update their PECOS enrollments.**

4. **Provide more information about Medicare’s legacy claims system and how providers can access it** – Being in Medicare’s legacy claims system is the other pathway, besides PECOS, for ordering/referring providers to be in compliance with CR 6417/6421. The medical community largely is unaware of this pathway, let alone how to access Medicare’s legacy system to verify that providers are present.

5. **Have CMS’ Website feature a look-up function that can search based on: (1) multiple providers instead of one at a time and (2) group practices and report National Provider Identification (NPI) number, PECOS enrollment, and if the provider is on the multi-carrier list.**