CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 858	**Date: February 4, 2011**
	Change Request 7176

Transmittal 836, dated January 21, 2011, is being rescinded and replaced by Transmittal 858, dated February 4, 2011. The effective date is changed to January 1, 2012, for claims submitted with a date of service on or after January 1, 2012. All other information remains the same.

SUBJECT: Accreditation for Physicians and Non-Physician Practitioners Supplying the Technical Component of Advanced Diagnostic Imaging Services

I. SUMMARY OF CHANGES: Section 135(a) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) amended section 1834(e) of the Social Security Act and required the Secretary to designate organizations to accredit suppliers, including but not limited to physicians, non-physician practitioners and Independent Diagnostic Testing Facilities, that furnish the technical component of advanced diagnostic imaging services.

EFFECTIVE DATE: January 1, 2012
IMPLEMENTATION DATE: July 5, 2011

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs):
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:
One-Time Notification
**Unless otherwise specified, the effective date is the date of service.*

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 858	Date: February 4, 2011	Change Request: 7176

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SUBJECT: Accreditation for Physicians and Non-Physician Practitioners Supplying the Technical Component of Advanced Diagnostic Imaging Services

EFFECTIVE DATE: **January 1, 2012**

IMPLEMENTATION DATE: July 5, 2011

I. GENERAL INFORMATION

A. Background: The Centers for Medicare & Medicaid Services (CMS) approved three national accreditation organizations (AOs) – the American College of Radiology, the Intersocietal Accreditation Commission, and The Joint Commission - to provide accreditation services for suppliers of the technical component (TC) of advanced diagnostic imaging procedures. The accreditation will apply only to the suppliers of the images themselves, and not to the physician's interpretation of the image. This accreditation only applies to those who are paid under the Physician Fee Schedule. All accreditation organizations have quality standards that address the safety of the equipment as well as the safety of the patients and staff. Therefore, this change request (CR) will set the systems parameters for this accreditation requirement. A provider submitting claims for the TC must be accredited by January 1, 2012, to be reimbursed for the claim if the service is performed on or after that date.

Each of these designated AOs submits monthly reports to CMS that list the suppliers of who have been or are accredited, as well as the beginning and end date of the accreditation and the respective modalities for which they receive accreditation.

ADI submitted claims will only be paid if the code is listed on the provider's/supplier's eligibility file in the claims system.

B. Policy: Section 135(a) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) amended section 1834(e) of the Social Security Act and required the Secretary to designate organizations to accredit suppliers, including but not limited to physicians, non-physician practitioners and Independent Diagnostic Testing Facilities, that furnish the TC of advanced diagnostic imaging services.

MIPPA specifically defines advanced diagnostic imaging procedures as including diagnostic magnetic resonance imaging (MRI), computed tomography (CT), and nuclear medicine imaging such as positron emission tomography (PET). The law also authorizes the Secretary to specify other diagnostic imaging services in consultation with physician specialty organizations and other stakeholders.

In order to furnish the TC of advanced diagnostic imaging services for Medicare beneficiaries, suppliers must be accredited by January 1, 2012.

The effective date of previously named regulation is January 1, 2012.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7176.1	Contractors shall deny claims with a date of service on or after January 1, 2012, submitted for the TC of the ADI codes with denial code N290 ("Missing/incomplete/invalid rendering provider primary identifier.") when the provider is not enrolled or accredited by a designated CMS accreditation organization.	X			X			X			
7176.2	Contractors shall deny claims with codes submitted with a date of service on or after January 1, 2012, for the TC if the code is not listed on the provider's eligibility file using claim adjustment reason code (CARC)185 (The rendering provider is not eligible to perform the service billed.)	X			X			X			
7176.3	The Railroad Retirement Board is exempt from the requirements in this CR.										X

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7176.4	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after this CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition,	X			X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in maintaining Medicare provider enrollment data correctly.										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s): August Nemec August.Nemec@cms.hhs.gov or Sandra Bastinelli Sandra.Bastinelli@cms.hhs.gov
Post-Implementation Contact(s): Contact your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs)*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs)*:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically

authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.