and take back to the staff. I also got some of them actively involved in memberships with AHRA. I became involved both regionally and nationally, serving as member and chairwoman on various committees. I also got involved in officers positions and became a board member. All my years as membership chairwoman were so rewarding when I would hear from a new member how the lectures had helped him or her, and hearing about the information and association with others all having the same problems would lead to finding answers. These committees, for example, provided me the opportunity to sell the educational benefits of AHRA across the country. I was further involved with formation of Fellow status to recognize the members who have become involved with many aspects of education in lecturing, mentoring, writing, etc.

"Some of the things that stick out in my mind and I hold so dear are when I received the Gold Award for activities within the field of radiology, the AHRA association, etc. Also I was deeply honored when the AHRA Education Foundation informed me that they were forming a scholarship in my name to provide funding annually to several AHRA members to use in the furthering of their education.

"While an active member, I had the opportunity to lead a group of members to Russia in 1988 to visit hospitals and exchange lectures. Theirs were very enlightening and interesting. In addition, I led four groups of AHRA members to China during the 1980s and 1990s. These were all under the program set up by the Chinese Ministry of Health. We exchanged lectures and knowledge. We visited hospitals that were very basic to start and each progressive hospital was a little more furnished. We found hospitals doing wet film processing and hanging their films up who had never heard of or seen an automatic processor. Our third visit took us into Tibet to a brand new hospital that had the very latest of equipment, some of which was not yet in our American hospitals. Radiologists who had traveled out of the country were assigned there for a two year period to train with the radiologists who did not have the opportunity to go abroad to the US or other countries.

"My last trip there was by special invitation of the Chinese government to people of all walks of life who had led previous trips. It was composed of 20 representatives of medicine, lawyers, accountants, bankers, business people, teachers, clergy, etc, to try and promote tourism following the tragedy of Tiananmen Square.

"Finally, in lectures and discussions I always stressed how much education can do for an individual as well as how participation can be self educating and fun. I know my active years with the AHRA were what helped me be a success. The education, comradery, and mentoring were invaluable. I have made lifelong friendships that blend into my retirement years. My 50+ years of work would not have turned out as well without the involvement of AHRA."

I trust that each of you is noticing the trend from our heritage members: Louise, Monte Clinton, Loretta Hanwell, and others you may know. Each has been or currently is promoting our profession here and abroad. They were well ahead of our current thoughts on how to expand globally, and clearly they are still leading with their passion and purpose. My hope is that each of us infuses purpose in all that we do.

Invest in meaningfulness (and of course our Education Foundation!).

Best,
RR

Regulatory Review

Medicare Screening Requirements Finalized, Mandatory Compliance Programs Still Pending

By Adrienne Dresevic, Esq. and Carey F. Kalmowitz, Esq.

The October 2010 Regulatory Review column [insert link] addressed the September 23, 2010 Centers for Medicare and Medicaid Services (CMS) proposed rule for establishing new screening requirements for enrollees in Medicare, Medicaid, and the Children's Health Insurance Programs (CHIP) pursuant to Section 6401(a) of the Patient Protection and Affordable Care Act (PPACA). The final rule, to be published in the Federal Register on February 2, 2011, is slightly more stringent, with respect to providers and suppliers of radiology services. The Final Rule will be effective on March 25, 2011 for both newly enrolling providers and suppliers as well as currently enrolled providers and suppliers whose revalidation cycle ends between March 25, 2011 and March 25, 2012. For all other currently enrolled providers and suppliers, the effective date for this final rule will be March 25, 2012.

Consistent with the proposed rule, the final rule solidified the three-tiered screening for providers and suppliers, categorizing them as either "limited," "moderate," or "high" risk. In establishing these risk levels and the providers and suppliers assigned to them, CMS drew from its experience, as well as the experience of Medicare contractors, in identifying and investigating fraudulent billing practices. Depending on the level of risk assigned to a provider or supplier type, the Medicare contractor will impose different screening measures to account for those categorical risks. As with the proposed rule, radiology providers and suppliers pose either "limited" or "moderate" risk; however, no provider or supplier is immune from having its risk level increased.

The radiology providers and suppliers in the "limited" risk category include, for example, physicians or nonphysician practitioners and medical groups or clinics, radiation therapy centers, ambulatory surgical centers, federally qualified health centers, hospitals, mammography screening centers, and rural health clinics. For providers or suppliers posing "limited" risk, Medicare contractors will verify that the provider or supplier meets all of the applicable federal and state regulations, conduct license verifications (including licensure verifications across state lines), and conduct database checks on a pre and post enrollment basis to ensure providers and suppliers continue to meet the enrollment criteria.

Radiological providers and suppliers posing "moderate" risk include, for example, independent diagnostic testing facilities (IDTFs) and portable x-ray suppliers. "Moderate" risk providers and suppliers will be subject to all of the "limited" screening requirements as well as an onsite visit.

The "high" risk category does not contain any radiology providers and suppliers; however, as is explained below, radiology providers and suppliers cannot ignore the "high" risk screening requirements. In screening "high" risk providers and suppliers, Medicare contractors will perform all of the "moderate" screening measures, and require the submission of a set of fingerprints for a national background check and an FBI criminal history record check from all individuals who maintain a 5% or greater direct or indirect ownership interest in the provider or supplier.

The most notable difference between the proposed and final rule for providers and suppliers of radiology services is that portable x-ray suppliers have been increased from "limited" risk to "moderate" risk. In its comments, CMS states that "unusual claims patterns . . . raise concerns about the integrity of payments to certain portable x-ray suppliers. Based on this, and combined with the fact that there are low barriers to entry for this type of supplier, portable x-ray suppliers will be placed in the moderate screening level." This increase in risk is an indication that CMS is and will be more closely scrutinizing radiology providers and suppliers in the future.

Although radiology providers and suppliers are not specifically named in the "high" risk category, the final rule allows CMS to adjust a screening level from "limited" or "moderate" to "high" upon the occurrence of specific events. CMS has the authority to adjust a provider or supplier's screening level if the provider or supplier (i) has had a payment suspension at any time in the last 10 years; (ii) has been excluded from Medicare by the Office of Inspector General (OIG); (iii) has had its billing privileges revoked by a Medicare contractor within the last 10 years and is attempting to establish additional Medicare billing privileges; (iv) has been terminated or otherwise precluded from billing Medicaid; (v) has been excluded from any federal healthcare program; or (vi) has been subject to any final adverse action (as defined in 42 CFR 424.502) within the last 10 years. Finally, those providers and suppliers that were prevented from enrolling based on a temporary moratorium imposed on a particular provider or supplier type, and apply for enrollment as a Medicare provider within six months of CMS lifting the moratorium, will experience a higher level of screening for the six months following the lifting of the temporary moratorium.

The final rule also addressed the compliance program requirement as set forth in Section 6401 of PPACA, which prescribes that, as a condition of enrolling in Medicare, Medicaid, or CHIP, providers and suppliers must establish compliance programs that meet certain "core elements." Notably, at this time, CMS did not finalize any rules related to mandatory compliance. Instead, CMS continues to do further rulemaking and will "advance specific proposals at some time in the future." The proposed rule solicited comments on these "core elements." While the final rule did not finalize the compliance plan requirements, all radiology provider and suppliers should remain attentive to the developments of the core elements to ensure full compliance with the future rule.

Even though the final rule does not differ significantly from the proposed rule for most providers and suppliers, CMS' increase in screening level for portable x-ray providers indicates that CMS continues to scrutinize radiology providers and suppliers. Providers and suppliers of radiology services should remain alert for adjustments in screening level, the imposition of temporary moratoria, and the compliance plan requirements.

Commentary

What Would You Do?

By AHRA Staff

Every month, a hypothetical industry and management related situation is posted. You are encouraged to share your thoughts (in the Comment box below) on how you would resolve the issue. Be sure to check out others' responses and join the discussion.

Here is this month's scenario:

You suspect that a newly installed process is being sabotaged by someone in your department. How do you deal with this situation and prevent a possible incident, especially when you do not have clear evidence or it is not openly apparent—just a gut feeling?