*This issue of the e-News will be made available in PDF format no later than 24 hours after its release, and can be found in the archive with other past issues.*

**CMS Medicare FFS Provider e-News**

*CMS Information for the Medicare Fee-For-Service Provider Community*

***CMS asks that you share the following important information with all of your association members and state and local chapters. Thank you!***


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**The e-News for Thu Mar 1 includes…**

UPDATES FROM THE MEDICARE LEARNING NETWORK ®

- "Substance (Other Than Tobacco) Abuse Structured Assessment and Brief Intervention" Fact Sheet Available in Hardcopy
- "Composite Rate Portion of the End-Stage Renal Disease Prospective Payment System" Fact Sheet Revised
- "End-Stage Renal Disease Prospective Payment System" Fact Sheet Revised

**National Provider Call: Overview and Listening Session: Stage 2 Requirements for the Medicare and Medicaid EHR Incentive Programs – Save the Date** [↑]
*Mon Mar 12; 12:30-2pm ET*

More than $3.2 billion in Medicare and Medicaid electronic health record (EHR) incentive payments have been made since the program began last year; more than 191,000 eligible professionals, eligible hospitals, and critical access hospitals are actively registered. On Thu Feb 23, CMS announced a proposed rule for Stage 2 requirements and other changes to the program, which will be published on Wed Mar 7.

This National Provider Call will provide an overview of the proposed rule, so you can learn what you need to know to receive EHR incentive payments. (CMS plans to hold another National Provider Call on program basics for Eligible Professionals on Tue Mar 27; more information about this call will be available soon.)

The CMS proposed rule can be found at http://www.OFR.gov/OFRUpload/OFRData/2012-04443_PI.pdf. For more information on the EHR Incentive Programs, visit http://www.CMS.gov/EHRIncentivePrograms.

*Target Audience:* Hospitals, Critical Access Hospitals (CAHs), and professionals eligible for the Medicare and/or Medicaid EHR Incentive Programs. For more details:

- Eligibility Requirements for Professionals
- Eligibility Requirements for Hospitals

*Agenda:*

- Extension of Stage 1
- Changes to Stage 1 Criteria for Meaningful Use
- Proposed Medicaid policies
- Stage 2 Meaningful Use Overview
- Stage 2 Clinical Quality Measures

- Medicare Payment Adjustments and Exceptions
- Question and Answers about the incentive programs (note that we cannot answer questions on the rule beyond what is proposed)

*Registration Information:* Registration for this call will be available soon at http://www.eventsvc.com/blhtechnologies.

*Presentation:* The presentation for this call will be posted at least one day before the call at http://www.CMS.gov/NPC/Calls.

**Inpatient Rehabilitation Facility Patient Assessment Instrument Train-the-Trainer Conference – Register through Fri Mar 16** [↑]
*Wed May 2*
*Sheraton Baltimore City Center Hotel; 101 West Fayette Street, Baltimore, MD 21201)*

To support the implementation of the Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP), for which data collection begins Mon Oct 1, 2012, CMS will host an IRF Patient Assessment Instrument (PAI) Train-the-Trainer Conference on Wed May 2 (at the Sheraton Baltimore City Center Hotel, 410-742-1100).

This conference is open to all Inpatient Rehabilitation Facility providers, associations, and organizations that support quality care in inpatient rehabilitation facilities. The goals of the conference are to:

- Introduce the Quality Indicator item set that has been added to the IRF-PAI
- Discuss assessment procedures and coding for the 2 quality measures:
  - Catheter Associated Urinary Tract Infections (CAUTI), and
  - Pressure Ulcers
- Discuss data submission specifications, including presentations by the Centers for Disease Control and Prevention on the CAUTI, and the use of the National Health Safety Network for submitting data associated with this measure

Registration for the conference will begin Thu Mar 1 and end Fri Mar 16. Hotel reservations will not be accepted until registration has closed, at which time reservations may be made by phone or online; each participant will be limited to one room reservation.

Additional information is available at the conference website at www.NationalConference.info, and questions can be submitted to conference2@totalsolutions-inc.com.

**Important Update – "*HIPAA* Version 5010/D.0 Implementation" Document has been Updated** [↑]

Updates have been made to the recently-posted document titled "Important Update Regarding *HIPAA* Version 5010/D.0 Implementation" – specifically, CMS has modified information related to the Diagnosis Related Group (DRG) code. The document can be found at the top of the *HIPAA* Versions 5010 & D.0 Overview webpage, at http://www.CMS.gov/versions5010andd0/01_overview.asp.

- Additional material related to ICD-10 and Version 5010 in today's e-News… [next]

**ICD-10: It's Closer Than It Seems – Steps to Take to Refine your Version 5010 Upgrade** [↑]

The Version 5010 upgrade deadline was Sun Jan 1. CMS initiated an enforcement discretion period for 90 days, which ends on Sat Mar 31. You should be finalizing your upgrade to Version 5010 if you have not yet done so.

Once you have finished your upgrade to Version 5010, you'll need to ensure your system continues to run properly. Providers should look for the following indicators to make sure there are no problems with their system upgrade:

- *An Increase in Rejections or Denials of* Claims – An increase in rejections or denials of claims may be an indication that there is not sufficient or correct data provided to meet Version 5010 standards. Partners, such as payers, also have a part in correcting this issue, since forwarding, converting, or formatting data can result in rejections or denials. Monitor your claims closely to determine the reasons for rejection or denial of claims and coordinate with payers to ensure that data is properly processed to avoid claim delays.
- *Issues with Non-Electronic Funds Transfer (non-EFT) Payments* – Version 5010 includes changes to claims formatting, including a full nine-digit zipcode and inclusion of provider billing address. Submitting claims with only a five-digit zipcode will result in rejection. If your practice has not submitted the correct billing or mailing address as part of your Version 5010 claim, your non-EFT payments or Explanation of Benefits (EOBs) information may be mailed to the wrong physical location. Make sure to coordinate with your payers to verify how they use enrollment information and process claims data, as this will also be affected by the mailing address on file. Being diligent in tracking your claims and remittances (EOBs) will help identify and address any issues that may arise.
- *Formatting Discrepancies with Partners* – Your trading partners should also have upgraded to Version 5010; however, your organization may interpret the new standards differently than your external partners, which can result in rejected claims. You should coordinate with your payers and/or clearinghouse to determine any gaps or discrepancies in claims submissions. You and your partners should monitor claims that are automatically transferred between payers and address new response formats or data as claims are processed.

Make sure to take a look at the Version 5010 section of the ICD-10 website to find helpful factsheets on the upgrade to Version 5010 and previous listserv messages discussing the Version 5010 upgrade.

*Keep Up to Date on Version 5010 and ICD-10.* Please visit the ICD-10 website for the latest news and resources to help you prepare, and to download and share the implementation widget today!

- Additional material related to ICD-10 and Version 5010 in today's e-News… [previous]

**Reposting of File Containing Direct GME and IME Slots Awarded under Section 5506 of the *Affordable Care Act*** [↑]

On Mon Jan 30, 2012, CMS posted on its website its decisions regarding which teaching hospitals are receiving increases to their direct Graduate Medical Education (GME) and Indirect Medical Education (IME) full-time equivalent (FTE) resident caps under the first round of section 5506 of the *Affordable Care Act* (applications for which were due to CMS by Fri Apr 1, 2011). Section 5506 of the *Affordable Care Act* directed CMS to develop a process to permanently preserve the Medicare-funded residency slots from teaching hospitals that close.

We have since discovered that, although the CMS determinations as to the hospitals that received the slots and the number of slots each received is correct, the file that was posted on CMS's website on Mon Jan 30 inadvertently had a few *inaccurate effective dates*. *We reiterate that the amount of slots awarded to each hospital on the Mon Jan 30 file was and are correct determinations, and has not and will not change.* We have removed the file posted on Mon Jan 30 and have replaced it with a file that has the accurate effective dates for slots received under the first round of section 5506. The total number of direct GME and IME slots each hospital has received is unchanged, although, in some instances, the effective dates of a portion of the hospital's slots may have changed.

To see the file that includes the corrected effective dates for hospitals reviewed under this first round of section 5506, visit http://www.CMS.gov/AcuteInpatientPPS/06_dgme.asp and look for the "Section 5506 Cap Increases Related to Applications Due April 1, 2011 – Posted 2/28/12" file in the Downloads section of the page.

**"Highmark Medicare Services" becoming "Novitas Solutions"** [↑]

Effective Sun Jan 1, 2012, Diversified Service Options, Inc, a wholly-owned subsidiary of Blue Cross and Blue Shield of Florida Inc, acquired Highmark Medicare Services from its parent company, Highmark Inc. As a result, Highmark Medicare Services changed its name to Novitas Solutions, Inc.

Novitas will continue to be the Medicare Administrative Contractor (MAC) for J12 and the Section 1011 Administrative Contractor. Our mission "to provide quality services and responsive solutions in the administration of our contracts according to our core values and in support of the goals of our stakeholders" remains unchanged. We will continue to provide the same great service with our knowledgeable

and experienced staff to which you are accustomed.

As we move through the migration to our new name, Novitas will provide additional announcements covering any potential impacts to our customers; in the near future, our website will be changing to www.Novitas-Solutions.com.

We appreciate your patience as we migrate to our new name.

**Notice: Solicitation of Independent Accrediting Organizations to Participate in the Advanced Diagnostic Imaging Supplier Accreditation Program** [↑]

On Thu Mar 1, 2012, CMS issued a notice in the *Federal Register* inviting independent accreditation organizations to apply to become a CMS-designated accreditation organization for accrediting suppliers furnishing the technical component (TC) of advanced diagnostic imaging services. The notice also includes the application guidelines for approval of organizations wishing to accredit these suppliers. The solicitation is limited to accrediting organizations that have not previously applied to participate in the advanced diagnostic imaging supplier accreditation program. Applications will be accepted through Tue May 1, 2012.

Section 135 of the *Medicare Improvements for Patients and Providers Act* of 2008 *(MIPPA)* required all suppliers of the TC of certain advanced diagnostic imaging services, including diagnostic magnetic resonance imaging, computed tomography, and nuclear medicine – including positron emission tomography, to be accredited by a CMS-designated accreditation organization in order to receive Medicare payment for these services on or after Sun Jan 1, 2012. This accreditation requirement applies only to the suppliers furnishing the imaging services, and not to the physician's interpretation of the images.

On Thu Jan 28, 2010, after reviewing applications from prospective accrediting organizations to participate in the program, CMS announced that it was designating three national accreditation organizations – the American College of Radiology (ACR), the Intersocietal Accreditation Commission (IAC), and The Joint Commission (TJC) – to accredit suppliers of the TC of advanced diagnostic imaging services. The notice issued today allows additional organizations an opportunity to apply to become a CMS-designated accreditation organization under the program. It does not affect the three CMS-designated organizations, which will continue to participate in the program.

**Automatic Reprocessing of Specific Long-Term Care Hospital Short Stay Outlier Claims** [↑]

A payment calculation problem affecting some Long-Term Care Hospital (LTCH) short stay outlier (SSO) claims was discovered in the FY2012 LTCH Pricer. CMS has corrected the problem and reissued a revised Pricer on Tue Jan 17, 2012. Your claims administration contractor will

automatically reprocess any affected FY2012 LTCH claims that were processed before the corrected Pricer was installed.

**Claims Processing Issue Related to Part B Services for Skilled Nursing Facility Patients** [↑]

Because of a claims processing problem, Part B Services related to ambulance code A0425 for Skilled Nursing Facility (SNF) patients submitted to Medicare with dates of service on or after Sun Jan 1 through Wed Feb 22, 2012, may have been erroneously denied by Medicare's claims processing system. In other instances, the claims processing system may have paid and then identified a Medicare "overpayment" on these claims in error. The situation was corrected as of Wed Feb 22.

CMS is working with its Medicare Administrative Contractors (MACs) to identify all claims that were denied in error as well as any erroneously-identified overpayments that generated demand letters, so that appropriate claim adjustments can be made. Your MAC will advise you through its website and listserv messages when it expects to complete this process so that you can anticipate when your claims (along with any notifications for payment recovery) will be adjusted. We thank you for your patience and we apologize for any inconvenience.

If you have any additional questions please contact your Medicare Carrier or Medicare Administrative Contractor.

**From the MLN: "Substance (Other Than Tobacco) Abuse Structured Assessment and Brief Intervention" Fact Sheet Available in Hardcopy** [↑]

The revised "Substance (Other Than Tobacco) Abuse Structured Assessment and Brief Intervention (SBIRT)" fact sheet (ICN 904084) is designed to provide education on Substance (Other Than Tobacco) Abuse Structured Assessment and Brief Intervention (SBIRT), and includes an early intervention approach that targets those with nondependent substance use to provide effective strategies for intervention prior to the need for more extensive or specialized treatment. To order hardcopies of this fact sheet, visit http://www.CMS.gov/MLNProducts and click on the 'MLN Product Ordering Page' under 'Related Links Inside CMS' at the bottom of the webpage.

**From the MLN: "Composite Rate Portion of the End-Stage Renal Disease Prospective Payment System" Fact Sheet Revised** [↑]

The "Composite Rate Portion of the End-Stage Renal Disease Prospective Payment System" fact sheet (ICN 006469) has been revised and is now available in downloadable format. It includes information about the End-Stage Renal Disease Prospective Payment System (ESRD

PPS) transition, the basic case-mix adjusted composite rate, separately billable items and services, and the ESRD Quality Incentive Program.

- Additional material related to End-Stage Renal Disease in today's e-News… [next]

**From the MLN: "End-Stage Renal Disease Prospective Payment System" Fact Sheet Revised** [↑]

The "End-Stage Renal Disease Prospective Payment System" fact sheet (ICN 905143) has been revised and is now available in downloadable format. It includes background information, as well as information on transition period, payment rates for adult and pediatric patients, outlier adjustments, transition budget neutrality factor, home dialysis, laboratory services and drugs, beneficiary deductible and coinsurance, and the ESRD Quality Incentive Program.

- Additional material related to End-Stage Renal Disease in today's e-News… [previous]

**More Helpful Links…**

**Check out CMS on**


Twitter, LinkedIn, YouTube, and Flickr!

**The Medicare Learning Network**
www.CMS.gov/MLNGenInfo
**Archive of Provider e-News Messages**
www.CMS.gov/FFSProvPartProg/EmailArchive