

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 Tue Mar 20 includes...

NATIONAL PROVIDER CALLS

- Wed Mar 28 – [Medicare Preventive Services: Initial Preventive Physical Exam and Annual Wellness Visit – Register Now](#)
- Thu Mar 29 – [Medicare & Medicaid EHR Incentive Program Basics for Eligible Professionals – Registration Now Open](#)

OTHER CALLS, MEETINGS, AND EVENTS

- Wed Mar 21 – [Special Open Door Forum: Medicare's Prior Authorization for Power Mobility Devices Demonstration](#)
- Thu Mar 22 – [Webinar: Introduction and Overview of the EHR Incentive Programs](#)
- Thu Mar 29 – [Video Stream Broadcast: Launch of Initiative to Improve Behavioral Health and Reduce Use of Antipsychotic Medications in Nursing Home Residents](#)
- Tue May 1 and Wed May 2 – [“Long Term Care Hospital Quality Reporting Program” Train-the-Trainer Conference – Register by Wed Mar 21](#)

ANNOUNCEMENTS AND REMINDERS

- [Join in a Celebration of Life on Tue Mar 20 for National Native HIV/AIDS Awareness Day](#)
- [March is National Colorectal Cancer Awareness Month – Encourage Your Patients to Get Screened](#)
- [Only 10 Days Left to Bid for the Round 2 and National Mail-Order Competitions of the DMEPOS Competitive Bidding Program](#)
- [Take a Look at New EHR Testimonial Videos from the 2011 AOA Conference](#)
- [Physician Quality Reporting System & eRx Incentive Program Announcements](#)
- [Extension of Enforcement Discretion Period for Updated HIPAA Transaction Standards through June 30, 2012 \(Updated\)](#)
- [CMS.gov Website Upgrade](#)

CLAIMS, PRICER, AND CODE UPDATES

- [April 2012 Average Sales Price Files Now Available](#)
- [Information Regarding the Billing and Payment for Administration of PROVENGE®](#)

- [New Fast Fact on MLN Provider Compliance Webpage](#)
- [“CMS Website Wheel” Educational Tool Revised](#)
- [“Basics of DMEPOS Accreditation” Fact Sheet Revised](#)
- [Home Health Agencies Avoid Payment Reductions and Participate in HHCAHPS](#)

National Provider Call: Medicare Preventive Services: Initial Preventive Physical Exam and Annual Wellness Visit – Register Now [\[↑\]](#)

Wed Mar 28; 2:30-4pm ET

Don't miss this opportunity to get the information you need about the Initial Preventive Physical Exam (IPPE – also known as the “Welcome to Medicare” Preventive Visit) and the Annual Wellness Visit (AWV). This year, the CY2012 Medicare Physician Fee Schedule Final Rule added a Health Risk Assessment to the AWV. CMS experts will be on hand to discuss both the IPPE and AWV, when to perform them, who can perform each service, who is eligible, and how to code and bill for each service, followed by a question and answer session.

Target Audience: Physicians, physician assistants, nurse practitioners, clinical nurse specialists, health educators, registered dietitians, nutrition professionals, medical billers and coders, and other interested healthcare professionals

Registration Information: In order to receive call-in information, you must register for the call at <http://www.eventsvc.com/blhtechnologies>. Registration will close at 12pm on the day of the call or when available space has been filled; no exceptions will be made, so please register early.

Presentation: The presentation for this call will be posted at least one day beforehand at <http://www.CMS.gov/NPC/Calls/itemdetail.asp?itemID=CMS1256439>. In addition, the presentation will be emailed to all registrants on the day of the call.

To learn more about CMS National Provider Calls, visit <http://www.CMS.gov/NPC>. This website includes a list of upcoming and past National Provider Calls and call materials (slide presentations, written transcripts, audio files, podcasts, and video slideshow presentations on the [CMS YouTube Channel](#)). Bookmark this site for newly-listed National Provider Calls and related call materials.

CMS.gov Website Upgrade: Please take note that CMS is in the process of making upgrades to the www.CMS.gov website. If you encounter problems accessing information while on the site, please refresh the page or check back later. We appreciate your understanding and apologize for any inconvenience.

- Additional material related to Preventive Health Services in today's e-News... [\[next\]](#)

National Provider Call: Medicare & Medicaid EHR Incentive Program Basics for Eligible Professionals – Registration Now Open [\[↑\]](#)

Thu Mar 29; 3-4:30pm ET

As of Tue Jan 31, more than \$3.2 billion in Medicare and Medicaid electronic health record (EHR) incentive payments have been made; more than 191,000

eligible professionals, eligible hospitals, and critical access hospitals are actively registered. Learn if you are eligible and, if so, what you need to do to earn an incentive. This session will inform individual practitioners about the basics of the Medicare & Medicaid EHR Incentive Programs. *Remember: This is the last year that eligible professionals can participate in Medicare and get the maximum incentive payment.*

Target Audience: Eligible Professionals (EPs), which include Doctors of Medicine or Osteopathy, Doctors of Dental Surgery or Dental Medicine, Doctors of Podiatric Medicine, Doctors of Optometry, Chiropractors, Nurse Practitioners, Certified Nurse Midwives, and Physician Assistants (PA) who practice at an FQHC/RHC led by a PA. (Note that hospital-based EP's may not participate; an EP is considered hospital-based if 90% or more of the EP's services are performed in a hospital inpatient or emergency room setting.) Medicaid eligible professionals must meet patient-volume criteria, providing services to those attributable to Medicaid or, in some cases, needy individuals.)

Agenda:

- Are you eligible?
- How much are the incentives and how are they calculated?
- How do you get started?
- What are major milestones regarding participation and payment?
- How do you report on meaningful use?
- Where can you find helpful resources?
- Question and Answer Session

Registration Information: In order to receive call-in information, you must register for the call at <http://www.eventsvc.com/blhtechnologies>. Registration will close at 12pm on the day of the call or when available space has been filled; no exceptions will be made, so please register early.

Presentation: The presentation for this call will be posted at least one day beforehand at <http://www.CMS.gov/NPC/Calls>. In addition, the presentation will be emailed to all registrants on the day of the call.

For more information about the Medicare and Medicaid EHR Incentive programs, visit <http://www.CMS.gov/EHRIncentivePrograms>.

To learn more about CMS National Provider Calls, visit <http://www.CMS.gov/NPC>. This website includes a list of upcoming and past National Provider Calls and call materials (slide presentations, written transcripts, audio files, podcasts, and video slideshow presentations on the [CMS YouTube Channel](#)). Bookmark this site for newly-listed National Provider Calls and related call materials.

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- Additional material related to EHR in today's e-News... [\[next\]](#)

Special Open Door Forum: Medicare's Prior Authorization for Power Mobility Devices Demonstration [\[↑\]](#)

Wed Mar 21; 3-4:30pm ET

CMS will conduct a demonstration that will implement a prior authorization process for certain medical equipment for all people with Medicare who reside in seven states with high populations of fraud- and error-prone providers (California, Florida, Illinois, Michigan, New York, North Carolina, and Texas). This is an important step toward paying appropriately for certain medical equipment that has a high error rate. This demonstration will help ensure that a beneficiary's medical condition warrants their medical equipment under existing coverage guidelines. Moreover, the program will assist in preserving a Medicare beneficiary's right to receive quality products from accredited suppliers.

CMS received many comments/suggestions on the Prior Authorization of Power Mobility Devices (PMDs) demonstration and has considered these comments carefully. In response to comments received from stakeholders, CMS has made a number of modifications to the Prior Authorization of PMD demonstrations:

- CMS has completed a separate Paperwork Reduction Act (PRA) notification for this demonstration.
- CMS has removed the 100% Pre-Payment review phase (formerly Phase 1).
- CMS will allow suppliers to perform the administrative function of submitting the prior authorization request on behalf of the physician/ treating practitioner.
- This demonstration will begin only after an OMB PRA control number is obtained. CMS anticipates the *start of this demonstration will be on or after Fri June 1, 2012.*

To read more about the demonstration, visit http://www.CMS.gov/CERT/03_PADemo.asp.

Participation Instructions: Full instructions on participating in this conference call, submitting questions in advance, and accessing audio recordings and transcripts afterward, are available at <http://www.CMS.gov/OpenDoorForums/Downloads/032112SODFMedicarePriorAuthPMDemo.pdf>.

Future Special Open Door Forums on Medicare's Prior Authorization for Power Mobility Devices Demonstration have been scheduled for Thu Apr 26, Thu May 31, Thu June 28, and Fri July 27 at 3pm; call information to be announced.

Webinar: Introduction and Overview of the EHR Incentive Programs [[↑](#)]

Thu Mar 22, 3-4pm ET

CMS and the Professional Association of Health Care Office Management (PAHCOM) are holding a free webinar on the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs. The webinar will provide an overview of how the Medicare and Medicaid EHR Incentive Programs are structured and administered, and will provide key insights for providers regarding their participation and navigation of the programs.

Registration Information: Register [online](#).

Want more information about the EHR Incentive Programs? Make sure to visit the [EHR Incentive Programs website](#) for the latest news and updates on the EHR Incentive Programs.

- Additional material related to EHR in today's e-News... [[next](#) / [previous](#)]

Video Stream Broadcast: Launch of Initiative to Improve Behavioral Health and Reduce Use of Antipsychotic Medications in Nursing Home Residents



premieres Thu Mar 29, 1-2pm ET

On Thu Mar 29, CMS will launch a new initiative aimed at improving behavioral health and safeguarding nursing home residents from unnecessary antipsychotic drug use. As part of the initiative, CMS is developing a national action plan that will use a multidimensional approach including public reporting, raising public awareness, regulatory oversight, technical assistance/training, and research. The action plan will be targeted at enhancing person-centered care for nursing home residents, particularly those with dementia-related behaviors.

Join Patrick Conway (MD, MSc, Chief Medical Officer for CMS and Director of the Office of Clinical Standards and Quality), Shari Ling (MD, CMS, Deputy Chief Medical Officer serving in the Office of Clinical Standards and Quality), and Alice Bonner (PhD, RN, Director for the Division of Nursing Homes in the Office for Clinical Standards and Quality) in the overview of this national initiative and resources for technical assistance, discussion of behavioral health opportunities, and plans for upcoming training sessions. Handouts for the broadcast are available at <http://surveyortraining.CMS.hhs.gov>.

Target Audience: State Survey Agencies, residents and family members, nursing home staff, clinicians, providers, advocates, CMS Regional Offices, and others

Registration and Viewing Instructions: Can be found at <http://surveyortraining.CMS.hhs.gov>. The program will continue to be available for viewing for up to one year following Thu Mar 29.

“Long Term Care Hospital Quality Reporting Program” Train-the-Trainer Conference – Register by Wed Mar 21

Tue May 1 and Wed May 2

Sheraton Baltimore City Center Hotel; 101 West Fayette Street, Baltimore, MD 21201

To support the implementation of the Long Term Care Hospital (LTCH) Quality Reporting Program (QRP), for which data collection begins Mon Oct 1, 2012, CMS is hosting a LTCH QRP Train-the Trainer Conference on Tue May 1 and Wed May 2 (at the Sheraton Baltimore City Center Hotel, 410-742-1100).

This conference is open to all long-term care hospital providers, associations, and organizations that support quality care in the nation’s long-term care hospitals. The goals of the conference are to:

- Introduce the structure of the LTCH Care Data Set, the data collection instrument that will be used by LTCHs to collect data on the measure, Percent of Patients with a Pressure Ulcer That is New or Worsened
- Discuss assessment procedures and coding for key sections
- Discuss and understand data submission specifications
- Presentations by the Centers for Disease Control and Prevention on the Catheter Associated Urinary Tract Infection (CAUTI) and Central Line Associated Blood Stream Infection (CLABSI) measures as well as the use of the National Health Safety Network (NHSN) for submitting data associated with these measures

Registration for the conference ends Wed Mar 21. Hotel registrations will not be accepted until registration begins, at which time reservations may be

made by phone or online.

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

For more information on the LTCH QRP, visit the [Long Term Care Hospital Quality Reporting Program](#) website.

Join in a Celebration of Life on Tue Mar 20 for National Native HIV/AIDS Awareness Day [[↑](#)]

The HIV/AIDS epidemic is a serious health threat to Native communities, and National Native HIV/AIDS Awareness Day recognizes the mounting impact of HIV/AIDS on our country's Native people. Although our country's natives – American Indians, Alaska Natives, and Native Hawaiians – represent only 1 percent of the US population, they have historically suffered high rates of health disparities, including HIV/AIDS. HIV/AIDS continues to increase among Native people as it has over the past decade. Of persons diagnosed with HIV, Native Americans have the shortest overall survival time; only 87% live longer than 3 years, partially due to 26% of HIV-infected Native Americans being unaware of their infection. This suggests that many Native Americans with HIV are not receiving proper counseling or care, placing them at risk for becoming very sick and further spreading the virus.

Medicare covers voluntary HIV screening for:

- Beneficiaries at increased risk for HIV infection, including anyone who asks for the test (covered once every 12 months)
- Beneficiaries that are pregnant (maximum of 3 screenings during pregnancy)

People considered at increased risk for HIV infection include:

- Men who have had sex with men after 1975
- Men and women having unprotected sex with more than one partner
- Past or present injection drug users
- Men and women who exchange sex for money or drugs, or have sex partners who do
- Individuals whose past or present sex partners were HIV-infected, bisexual, or injection drug users
- Persons being treated for sexually-transmitted diseases
- Persons with a history of blood transfusion between 1978 and 1985
- Persons who request the HIV test

What Can You Do?

CMS asks that you join in this national effort to raise awareness of the risks of the disease to Native people and help them understand the dynamics contributing to those risks. As a provider of healthcare services to Native populations, we ask that you help promote HIV/AIDS prevention and early detection by talking with your patients about their risks and the importance of prevention, and encourage them to get screened for HIV. Your support can help further the efforts to decrease the occurrence of HIV/AIDS among Native people.

For More Information:

- [CMS National Coverage Determination for HIV Testing](#)
- [US Preventive Services Task Force Screening for HIV Recommendation statement](#)

- [Indian Health Service HIV/AIDS Program](#)
- [CDC National Native HIV/AIDS Awareness Day](#)
- [National Native American AIDS Prevention Center](#)
- [Healthcare Reform and HIV/AIDS](#)
- [Henry J Kaiser Family Foundation "Medicaid and HIV/AIDS" factsheet](#)

We have the ability to make a difference. Thank you for joining with CMS to help increase awareness and educate about HIV/AIDS-related screening and services covered by Medicare.

- Additional material related to Preventive Health Services in today's e-News... [\[next / previous\]](#)

March is National Colorectal Cancer Awareness Month – Encourage Your Patients to Get Screened [\[↑\]](#)

Studies have repeatedly demonstrated that a physician's recommendation is the most powerful factor in a patient's decision to receive preventive and screening services. March is National Colorectal Cancer Awareness Month; encourage your patients age 50 and older to get screened.

Resources to Support Decision-Making:

Cancer screening decisions, like other medical decisions, require weighing the harms and benefits, especially among chronically-ill patients. These persons may be at risk for adverse screening outcomes or have a life expectancy that is shorter than any survival benefit from cancer screening. In addition, patient preferences and values must be considered in decisions regarding screening and what test is most appropriate. Several articles shed some light on these issues:

- Walters LC, Covinsky KE. Cancer screening in elderly patients: a framework for individualized decision-making. *JAMA*. 2001, Jun 6;285(21):2750-6.
- Walters LC, Lewis CL, Barton MB. Screening for colorectal, breast, and cervical cancer in the elderly: a review of the evidence. *Am J Med*. 2005, Oct;118(10):1078-86.

The American Cancer Society has developed materials to help support practitioners in discussing colorectal cancer screening with their patients. These resources include reminder letters, phone reminder scripts, brochures, and wall charts, and [are available for download or order](#).

The National Colorectal Cancer Roundtable has also published a report that describes the components of a quality screening colonoscopy referral system in primary care practice:

- Sifri R, Wender R, Lieberman D, Potter M, Peterson K, Smith R. "[Developing a Quality Screening Colonoscopy Referral System in Primary Care Practice: A Report from the National Colorectal Cancer Roundtable](#)". *CA Cancer J Clin* 2010;60:40-49; originally published online Dec 18, 2009.

What Can You Do?

Discussing colorectal cancer screening and the various options available can be challenging, especially with older, chronically-ill patients. Engage patients in decision-making regarding their options, as it is important for promoting appropriate screening among older adults. Colorectal cancer is preventable, treatable, and beatable. Encourage your patients to get screened – it could save their lives.

More Information for Healthcare Providers:

- [MLN Guide to Medicare Preventive Services for Healthcare Professionals](#) (see Chapter 11)
 - [MLN Preventive Services Educational Products webpage](#)
 - [MLN Cancer Screenings brochure](#)
 - [MLN Quick Reference Information: Medicare Preventive Services](#)
 - [National Colorectal Cancer Roundtable](#)
 - [National Colorectal Cancer Awareness Month website](#)
 - [The National Cancer Institute website](#)
- Additional material related to Preventive Health Services in today's e-News... [\[previous\]](#)

Only 10 Days Left to Bid for the Round 2 and National Mail-Order Competitions of the DMEPOS Competitive Bidding Program [\[↑\]](#)

The Centers for Medicare & Medicaid Services (CMS) is currently accepting bids for the Round 2 and national mail-order competitions of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. *All bids must be submitted in DBidS, the online bidding system, by 8:59:59pm prevailing Eastern Time on Fri Mar 30, 2012. All required hardcopy documents that must be included as part of the bid package must be RECEIVED by the Competitive Bidding Implementation Contractor (CBIC) on or before Fri Mar 30, 2012.*

Here are some important reminders:

- The Round 2 and national mail-order competitive bidding areas, product categories, DBidS information, bid preparation worksheets, educational materials, and complete Request for Bids (RFB) instructions can be found on the CBIC website at www.DMECompetitiveBid.com. You should review this information prior to submitting your bid(s).
- You must submit your bid in DBidS using the user ID you received during registration. If you have not already logged in to DBidS, we strongly recommend that you do so NOW to have plenty of time to complete your bid. If you have forgotten your user ID and/or password, you may recover them by using the "Forgot your User ID?" and "Forgot your password?" buttons located on the "Individuals Authorized Access to the CMS Computer Services (IACS)" log-in page.
- Your Authorized Official or Backup Authorized Official must approve your Form A and certify your Form B before the close of bidding. If you modify your bid after it has been approved or certified, it will need to be reapproved or recertified. If Form A is not approved or Form B is not certified, your bid cannot be evaluated, and you will not be considered for a contract. You can verify the status of your forms by logging into DBidS and checking the status screen.
- All bidders must submit certain required hardcopy documents as specified in the RFB instructions. It is very important that you review the hardcopy document section and the sample financial statements of the RFB instructions to ensure your documents include the required information. We also encourage you to use the hardcopy document package checklist, which may be found in Appendix B of the RFB. If you have already submitted your financial documents, you may still amend those documents as long as they are RECEIVED by the CBIC on or before Fri Mar 30, 2012. We cannot accept faxed or emailed documents, so you must mail your documents to the CBIC at the address in the RFB instructions.
- All bidders participating in the national mail-order competition for diabetic testing supplies must complete and submit the National Mail-Order 50 Percent Compliance form on the CBIC website. Only one form should be submitted per bidder number. You must not change the printed form in any way. Please ensure that all pages of the form are included in the hardcopy document package. If the form is not RECEIVED on or before Fri Mar 30, 2012, your bid for the national mail-order competition will be disqualified. Please refer to the instructions on the form or the National Mail-Order for Diabetic Supplies factsheet for additional information.

- If you submitted financial documents by the Covered Document Review Date (CDRD) – Wed Feb 29, 2012 – you will receive an email about your financial documents from the CBIC by Mon May 14, 2012. If you did not submit all of the required financial documents, the email will alert you to expect a letter notifying you of the specific missing financial document(s). This letter will be mailed to your organization’s authorized official. You will be required to submit the indicated missing financial document(s) within 10 business days of the notification. If you submitted all required financial documents, the email will confirm that the CBIC received all required financial documents and that no further action from you is required. If you did not submit any financial documents by the CDRD, you will not receive an email or a letter about your financial documents.
- If you did not submit any hardcopy financial documents by the CDRD, you are still required to submit all required hardcopy documents specified in the RFB instructions on or before Fri Mar 30, 2012.

If you have any questions, please contact the CBIC customer service center at 877-577-5331 between 9am and 9pm Eastern Time.

- Additional material related to DMEPOS in today’s e-News... [\[next\]](#)

Take a Look at New EHR Testimonial Videos from the 2011 AOA Conference [\[↑\]](#)

CMS has posted a series of new videos about the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs to the [CMS YouTube channel](#). At the 2011 American Osteopathic Association (AOA) Conference, CMS filmed seven conference attendees who provided their stories about EHRs and the EHR Incentive Programs. In the series, the testimonial videos discuss topics such as benefits of EHRs and navigating the Incentive Programs.

Also take a look at CMS’s additional EHR videos on the [CMS YouTube channel](#), including additional provider testimonials and EHR incentive payment highlights.

Want more information about the EHR Incentive Programs? Make sure to visit the [EHR Incentive Programs website](#) for the latest news and updates on the EHR Incentive Programs.

- Additional material related to EHR in today’s e-News... [\[previous\]](#)

Physician Quality Reporting System & eRx Incentive Program Announcements [\[↑\]](#)

Communication Support Page

On Thu Mar 1, CMS re-opened the Quality Reporting [Communication Support Page](#) to allow individual eligible professionals and *CMS-selected* group practices the opportunity to request a significant hardship exemption for the 2013 Electronic Prescribing (eRx) payment adjustment. The [Communication Support Page](#) will accept hardship exemption requests *now through Sat June 30*. A [user manual](#) is available to assist individual eligible professionals and CMS-selected group practices in submitting their request for a hardship exemption.

For additional information on the 2013 eRx payment adjustment, including who is subject to and how to avoid the payment adjustment, eligible professionals should review the MLN Matters Article #SE1206, “[2012 eRx Incentive Program: Future Payment Adjustments](#),” or visit the [eRx Incentive Program](#) webpage.

2011 eRx 10-Month Feedback Report

Taxpayer Identification Number (TIN)-level Interim 2011 eRx Feedback Reports are available for 2013 Payment Adjustment on the [Physician Quality Reporting System Portal](#). Please note that TIN-level reports require an “Individuals Authorized Access to CMS Computer Services” (IACS) account. Eligible professionals can request their individual National Provider Identifier (NPI)-level reports by submitting a request via the [Quality Reporting Communication Support Page](#).

Feedback Report Request Process

Please be advised that the alternative feedback report request process which enabled individual eligible professionals to request their NPI-level feedback reports through their carrier/MAC ended on Fri Mar 16. This was the last day carrier/MACs would have accepted requests for Physician Quality Reporting System and eRx Incentive Program feedback reports. Individual eligible professionals can request their NPI-level feedback reports through the [Quality Reporting Communication Support Page](#).

EHR Submission

CMS would like to remind all eligible professionals that the [Physician Quality Reporting System Portal](#) for Program Year 2011 Electronic Health Record (EHR) submissions is now open.

Eligible professionals have until Mon Apr 30 to submit their EHR data. Additionally, all eligible professionals submitting EHR data will need to obtain an IACS account. Additional information related to obtaining an IACS account can be found in the Quick Reference Guides on the [Physician Quality Reporting System Portal](#).

Errors with Measure #235

CMS has recently identified an error related to the submission of Measure #235 “Hypertension: Plan of Care” for the 2012 Physician Quality Reporting System. “Hypertension: Plan of Care” is a claims/registry measure with 6 G-codes and 1 Current Procedural Terminology (CPT) II code that are inactive due to an error found on the Healthcare Common Procedure Coding System (HCPCS) tape. Consequently, this has resulted in claims containing the G-codes or CPT II code associated with the measure being rejected by the carrier/MACs or denied.

The G-codes G8675, G8676, G8677, G8678, G8679, G8680 and the CPT II code 4050F will be reactivated with the next update of the HCPCS tape in April 2012. For 2012 claims-based reporting, the Physician Quality Reporting System requires at least 3 measures to each be reported at a 50% reporting rate. In the interim, eligible professionals who had intended to report this measure via claims for the 2012 Physician Quality Reporting System may want to consider taking the following steps:

- Eligible professionals may want to consider reporting additional measures to substitute for #235 “Hypertension: Plan of Care.”
- “Hypertension: Plan of Care” is a per-visit measure, which requires reporting for 50% of eligible patient visits. Therefore, eligible professionals could report the measure on more than 50% of eligible visits from April through December 2012 to increase the likelihood for successful reporting of the measure.

Extension of Enforcement Discretion Period for Updated *HIPAA* Transaction Standards through June 30, 2012 (Updated) [[↑](#)]

Please note that this message, which was first shared in the Thu Mar 15 issue of the e-News, has been updated to reflect a new resource mailbox for

reporting problems reaching a MAC. The updated sentence is included in italics below.

(March 15, 2012) The Centers for Medicare & Medicaid Services' Office of E-Health Standards and Services (OESS) is announcing that it will not initiate enforcement action for an additional three (3) months, through June 30, 2012, against any covered entity that is required to comply with the updated transactions standards adopted under the *Health Insurance Portability and Accountability Act of 1996 (HIPAA)*: ASC X12 Version 5010 and NCPDP Versions D.0 and 3.0.

On November 17, 2011, OESS announced that, for a 90-day period, it would not initiate enforcement action against any covered entity that was not compliant with the updated versions of the standards by the January 1, 2012 compliance date. This was referred to as enforcement discretion, and during this period, covered entities were encouraged to complete outstanding implementation activities including software installation, testing and training.

Health plans, clearinghouses, providers, and software vendors have been making steady progress: the Medicare Fee-for-Service (FFS) program is currently reporting successful receipt and processing of over 70 percent of all Part A claims and over 90 percent of all Part B claims in the Version 5010 format. Commercial plans are reporting similar numbers. State Medicaid agencies are showing progress as well, and some have made a full transition to Version 5010.

Covered entities are making similar progress with Version D.0. At the same time, OESS is aware that there are still a number of outstanding issues and challenges impeding full implementation. OESS believes that these remaining issues warrant an extension of enforcement discretion to ensure that all entities can complete the transition. OESS expects that transition statistics will reach 98 percent industry wide by the end of the enforcement discretion period.

Given that OESS will not initiate enforcement actions through June 30, 2012, industry is urged to collaborate more closely on appropriate strategies to resolve remaining problems. OESS is stepping up its existing outreach to include more technical assistance for covered entities. OESS is also partnering with several industry groups as well as Medicare FFS and Medicaid to expand technical assistance opportunities and eliminate remaining barriers. Details will be provided in a separate communication.

The Medicare FFS program will continue to host separate provider calls to address outstanding issues related to Medicare programs and systems. The Medicare Administrative Contractors (MAC) will continue to work closely with clearinghouses, billing vendors, or healthcare providers requiring assistance in submitting and receiving Version 5010 compliant transactions. *If any entity is experiencing difficulty reaching a MAC, please send a message describing your issue to ProviderFeedback@cms.hhs.gov with "5010 Extension" in the subject line.*

The Medicaid program staff at CMS will continue to work with individual States regarding their program readiness. Issues related to implementation problems with the States may be sent to Medicaid5010@cms.hhs.gov.

OESS strongly encourages industry to come together in a collaborative, unified way to identify and resolve all outstanding issues that are impacting full compliance, and looks forward to seeing extensive engagement in the technical assistance initiative to be launched over the next few weeks.

CMS is in the process of making upgrades to the www.CMS.gov website. If you encounter problems accessing information while on the site, please refresh the page or check back later. We appreciate your understanding and apologize for any inconvenience.

April 2012 Average Sales Price Files Now Available [[↑](#)]

CMS has posted the April 2012 Average Sales Price (ASP) and Not Otherwise Classified (NOC) pricing files and crosswalks. All are available for download at http://www.CMS.gov/McrPartBDrugAvgSalesPrice/01a17_2012ASPFiles.asp.

Information Regarding the Billing and Payment for Administration of PROVENGE® [[↑](#)]

CMS had, on Fri Jan 6, 2012, reissued CR 7431, Transmittal 2380, for autologous cellular immunotherapy (PROVENGE®) treatment of metastatic prostate cancer with clarification regarding payment for the administration of PROVENGE and allowing for separate payment for the cost of administration.

However, there is an issue in the Medicare claims processing system that is causing claims for administration of PROVENGE® not to be paid separately from PROVENGE®. The Current Procedural Terminology (CPT) code 96365 is bundled when billed with Healthcare Common Procedure Coding (HCPCS) code Q2043. Providers of PROVENGE® may be affected by this situation.

To correct this problem, CMS will update current editing to allow CPT code 96365 to be paid separately when HCPCS code Q2043 is present on claims with dates of service on and after Fri July 1, 2011. CMS has instructed Medicare contractors to adjust claims for dates of service on and after Fri July 1 containing CPT code 96365 that were denied and not paid due to the bundle editing, when brought to their attention. Providers may, beginning Sun Apr 1, request contractors to adjust claims for administration of PROVENGE® that were denied for this reason.

From the MLN: New Fast Fact on MLN Provider Compliance Webpage [[↑](#)]

A new fast fact is now available on the [MLN Provider Compliance](#) webpage. This webpage provides the latest Medicare Learning Network products designed to help Medicare Fee-For-Service providers understand – and avoid – common billing errors and other improper activities. Please bookmark this page and check back often as a new fast fact is added each month!

From the MLN: “CMS Website Wheel” Educational Tool Revised [[↑](#)]

The CMS Website Wheel educational tool (ICN 006212) has been revised; this educational tool is available only in hardcopy. It is designed to provide a variety of CMS Medicare related website addresses, including URLs for topics such as ICD-10, E-Prescribing, 5010, and more. To order hardcopies of this product, visit <http://www.CMS.gov/MLNProducts> and click on ‘MLN Product Ordering Page’ under ‘Related Links Inside CMS’ at the bottom of the webpage.

From the MLN: “Basics of DMEPOS Accreditation” Fact Sheet Revised [[↑](#)]

[“The Basics of DMEPOS Accreditation”](#) fact sheet (ICN 905710) has been revised and is now available in downloadable format. This fact sheet is designed to provide education on durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), and includes information so suppliers can meet DMEPOS Quality Standards established by the CMS and become accredited by a CMS-approved independent national Accreditation Organization. It also includes information on the types of providers who are exempt.

- Additional material related to DMEPOS in today’s e-News... [[previous](#)]

From the MLN: Home Health Agencies Avoid Payment Reductions and Participate in HHCAHPS [[↑](#)]

All home health agencies (HHAs) are reminded that they are required to participate in the Home Health Care Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) survey for patients served in April 2012 and after to be eligible for the full market basket payment increase for CY2014. Therefore, it is in your agency’s best interest to participate in HHCAHPS so that your agency can receive the full annual payment update.

Participation by all HHAs will enable people with Medicare and their families to benefit from the availability of HHCAHPS data about patients’ perspectives on care received from Medicare-certified HHAs nationwide. An MLN Matters Article with more details about the HHCAHPS will be issued soon.

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