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 the week of Tue Dec 13 includes…

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- Wed Dec 21 – Payment Standardization and Risk Adjustment for the Medicare Physician Feedback and Value Modifier Programs – Register Now

OTHER CALLS, MEETINGS, AND EVENTS
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ANNOUNCEMENTS AND REMINDERS
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- Providers Not Required to Supply Advanced Diagnostic Imaging (ADI) Certification Information via Enrollment Process
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- Corrections Made to Inpatient, Inpatient Psychiatric Facility, and Inpatient Rehabilitation Facility 2012 PPS PC Pricers

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- "The Medicare DMEPOS Competitive Bidding Program Repairs and Replacements Fact Sheet" Revised
- "Medicare Disproportionate Share Hospital" Fact Sheet (ICN 006741) Available
- "2012 Electronic Prescribing (eRx) Payment Adjustment: Assessment and Application" MLN Matters® Article Released
- New Podcast on the Medicare Overpayment Collection Process Released
- Clarification: "Medicare Shared Savings Program: Notice of Proposed Rulemaking Fact Sheets" Booklet (ICN 907663) Has

* 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.

National Provider Call: Physician Quality Reporting System & Electronic Prescribing Incentive Program – Register Now [↑]
Tue Dec 20; 1:30-3pm ET

CMS will host a national provider call on the Physician Quality Reporting System (PQRS) & Electronic Prescribing (eRx) Incentive Program. Subject matter experts will provide an overview on electronic health record (EHR) and registry based reporting options that are available for eligible professionals (EPs) participating or looking to participate in the PQRS and/or eRx Incentive Program. A question and answer session will follow the presentation.

Target Audience: Medicare fee-for-service (FFS) providers, Medical coders, physician office staff, provider billing staff and vendors

Agenda:
- Opening Remarks
- Program Announcements
- Overview of electronic health record (EHR) and registry based reporting options; and
- Question & Answer Session

Registration Information: Please visit http://www.eventsvc.com/blhtechnologies/ to register for this informative session. *Registration will close at 12pm ET on Tue Dec 20 or when available space has been filled.* No exceptions will be made. Please register early.

Presentation: The presentation will be posted at least one day before the call at: http://www.CMS.gov/PQRS/04_CMSSponsoredCalls.asp in the "Downloads" section.

  ➢ Additional material related to eRx in today's e-News… [next]

National Provider Call: Payment Standardization and Risk Adjustment for the Medicare Physician Feedback and Value Modifier Programs – Register Now [↑]
Wed Dec 21; 1-3 pm ET

Under the Physician Feedback Program, CMS provides confidential feedback reports to physicians and physician group practices about the resource use and quality of care they provide to their Medicare patients. Section 3007 of the *Affordable Care Act* requires CMS to apply a Value Modifier, which compares the quality of care furnished to the cost of that care, to physician payment rates under the MPFS starting with specific physicians and physician groups in 2015 and expanding to all physicians by 2017.

During this National Provider Call, CMS subject matter experts will discuss how and why per capita cost measures are adjusted under these programs. This call provides an opportunity to: (1) have a public dialogue about our methodology, (2) obtain stakeholder input, and (3) discuss ways to further improve these cost

adjustment processes.

Target Audience: Physicians, specialty medical society representatives and other interested parties

Agenda:
- Opening Comments and Background
    - Brief overview of the QRUR and Value Modifier Programs
    - Timelines
- Presentation: Standardizing cost data to make fair comparisons
    - General background, purpose, and use
    - Basics of how it applies to Physician Feedback Program/Value Modifier
- Comments and questions from participants
- Presentations: Adjusting cost data for beneficiary health status
    - Background, development, and purpose of the CMS-HCC risk adjustment methodology
    - Application of the risk adjustment to the Physician Feedback program/Value modifier
- Comments and questions from participants
- Closing and next steps

Registration Information: In order to receive the call-in information, you must register for the call. *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. For more details, including instructions on registering for the call, please visit http://www.eventsvc.com/blhtechnologies.

Presentation: A slide presentation will be available prior to the call in the "Downloads" section of the Medicare FFS Physician Feedback Program/Value-Based Payment Modifier CMS Teleconferences and Events webpage at http://www.CMS.gov/PhysicianFeedbackProgram/PFP/list.asp. In addition, there is a fact sheet about these programs at: Value-Based Payment Modifier and the Physician Feedback Program.

2012 Minimum Data Set (MDS) 3.0 National Conference – Register by Fri Dec 30 [↑]
Tue and Wed Mar 6-7; Thu and Fri Mar 8-9

The CMS 2012 MDS National Conference is a two-day conference that will be held twice.   A conference will be held on March 6-7, 2012 and repeated on March 8-9, 2012, at the Hyatt Regency St. Louis at the Arch in St. Louis, Missouri.

Conference registration began Mon Nov 14 and will close on Fri Dec 30. Please visit the CMS MDS 3.0 Training Conference Information webpage for additional information.

The Obama Administration and Expanded Efforts to Fight Fraud [↑]

On Tue Dec 13, the Obama Administration announced recovery of over $5.6 billion in fraudulent payments in fiscal year 2011, a 167 percent increase from 2008. President Obama's health care reform law includes new resources and tools to help fight fraud in Medicare and Medicaid, and to protect taxpayer

dollars. In addition, CMS is taking steps to strengthen controls to identify and prevent prescription drug fraud and abuse in the Medicare Part D program.

CMS released a notice to Part D prescription drug plan sponsors that contains information and guidance to immediately take steps to stop prescription drug misuse and fraud. Pain killers like OxyContin are the fifth most filled classes of drugs in Medicare, with spending in 2009 totaling $3.9 billion. Recently, the Government Accountability Office identified evidence of fraud and drug abuse in Medicare for these types of drugs, which pose a threat to public health as well as the federal budget. Among the messages conveyed to the plans:

- Investigate and Stop Payment for Suspect Claims
- Use Tools to Help Manage Proper Utilization of Drugs
- Limit Prescriptions to 30-Day Doses

These efforts build on significant progress already made by the Obama Administration to fight fraud across the health care sector – progress that has been sped up by resources from the *Affordable Care Act*, the healthcare law of 2010. This progress has contributed to the 167 percent increase in fraud recoveries since 2008.

In addition, under a demonstration announced in November, Medicare will implement a prior authorization process for all power mobility device claims in 7 high risk states, guaranteeing that beneficiaries receive access to the services they need but preventing payment in cases where medical need is not established. This will make it more difficult to get fraudulent claims through Medicare's claims payment systems.

To read the full CMS fact sheet issued Tue Dec 13, visit http://www.CMS.gov/apps/media/press/factsheet.asp?Counter=4217.

Providers Not Required to Supply Advanced Diagnostic Imaging (ADI) Certification Information via Enrollment Process [↑]

In January 2012, all Part B suppliers including physicians, and non-physician practitioners performing the technical component of advanced diagnostic imaging services—also known as ADI—who are paid under the Medicare Physician Fee Schedule will need to be accredited by one of the CMS-approved accrediting organizations. The accreditation organization will transmit all necessary data to CMS on an ongoing basis. Your Medicare billing contractor will receive these data from CMS. *Due to this file being received at CMS from the accrediting organizations, it is not necessary for the providers to supply the ADI information on their respective 855 form(s) or in the PECOS enrollment system.*

Reminder: When submitting your information to the accrediting organization, make sure you provide the NPI that you used to register the legal business name of the facility in the National Plan and Provider Enumeration System (NPPES). If you provided the incorrect NPI, please notify your accrediting organization as soon as possible.

See the following MLN articles for more information on the ADI certification requirement :
- Accreditation for Physicians and Non-Physician Practitioners Supplying the Technical Component (TC) of Advanced Diagnostic Imaging (ADI) Services
- Advanced Diagnostic Imaging Accreditation Enrollment Procedures

CMS Has Issued a Final Rule Updating Medical Loss Ratio to Account for ICD-10 Conversion Costs [↑]

The Version 5010 and ICD-10 transitions require significant changes to software and database systems, and may necessitate training for these updated

standards and new coding sets. CMS understands these system conversions can be costly to implement. To help alleviate this financial concern, CMS has released a final rule which addresses medical loss ratio (MLR), which now includes provisions for ICD-10 conversion cost considerations.

What is MLR?
MLR is the ratio of total losses paid in insurance claims divided by the total earned premiums collected by insurers. Regulations of MLR mandate that insurers may only spend 15 or 20 percent of revenue from premiums on expenses that are non-clinical, such as administrative costs, in order to reduce excessive spending. A minimum level of 85 percent of revenue for large group markets and 80 percent for small group markets has been set to be spent only on clinical costs.

How Does this Change Affect ICD-10?
Under this final rule, insurers may shift some of the costs associated with the ICD-10 conversion to the category of clinical cost, which will be considered as quality improvement activity.

This will allow up to 0.3 percent of earned premiums in the relevant state market to be counted as quality improvement activity. This specification of how the MLR is calculated will help covered entities cover some of the cost of ICD-10 implementation. ICD-10 maintenance costs and claims adjudication system costs are still considered to be administrative, and thus will fall under the MLR restriction on non-clinical spending limits.

This final rule will be effective on *Sun Jan 1, 2012,* and will be open for public comment until Fri Jan 6, 2012. The final rule addresses comments made in the interim rule published in January 2011.

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 in today's e-News… [next]

It's a Busy Time of Year – Get the Flu Vaccine, Not the Flu [↑]

Make each office visit an opportunity to talk with your patients about the importance of getting the seasonal flu vaccination and a one-time pneumococcal vaccination. Remember, Medicare pays for these vaccinations for all beneficiaries with no co-pay or deductible. The seasonal flu and invasive pneumococcal disease kill thousands of people in the United States each year, most of them 65 years of age and older. The Centers for Disease Control and Prevention (CDC) also recommends that healthcare workers and caregivers be vaccinated against the seasonal flu. Protect your patients. Protect your family. Protect yourself. *Get the Flu Vaccine—Not the Flu.*

Remember – The flu vaccine plus its administration are covered Part B benefits. CMS has posted the 2011-2012 seasonal flu vaccine payment limits at http://www.CMS.gov/McrPartBDrugAvgSalesPrice/10_VaccinesPricing.asp. Note that the flu vaccine is NOT a Part D-covered drug.

For more information on coverage and billing of the flu vaccine and its administration, as well as related educational provider resources, visit http://www.CMS.gov/MLNProducts/35_PreventiveServices.asp and http://www.CMS.gov/immunizations.

Quality Care Finder Tools Help People with Medicare and their Caregivers Compare Healthcare Options [↑]

CMS has created the Quality Care Finder as a collection of helpful tools on the Medicare.gov website to help consumers research their healthcare options. These online research tools can help your Medicare patients and their caregivers compare healthcare providers, facilities, health and drug plans, equipment suppliers and more.

Quality Care Finder includes the following tools:
- *Hospital Compare:* Compare Medicare-certified hospitals locally and throughout the country based on the quality of their care.
- *Nursing Home Compare:* Find Medicare-certified nursing homes and the special services each nursing home offers, like dementia care, ventilators or rehabilitation. Then compare their star ratings and the quality of care they give.
- *Home Health Compare:* Find Medicare-certified home health agencies based on services like skilled nursing care, physical therapy, speech therapy and home health aides. Then, compare each home health agency based on the quality of their care.
- *Dialysis Facility Compare:* Find Medicare-certified dialysis facilities and their services. Then, compare each facility based on quality of care.
- *Physician Compare:* Find doctors, and other medical professionals, based on location, specialty, clinical training, foreign languages spoken, and more. Check to see if a doctor accepts the Medicare-approved amount as full payment.
- *Medicare Plan Finder:* Get detailed, personalized information about the cost and benefits of available Medicare health and drug plans, and compare the quality of the services they provide.

CMS has developed several publications about the Quality Care Finder tools that can be shared with your Medicare patients and their caregivers:
- Find and Compare High-Quality Healthcare Options (Pub. # 11580)
- Quality Care Finder: Find High-Quality Healthcare Options (Pub. # 11581)

These publications may be downloaded or ordered from the Medicare.gov Publications page.

2012 ICD-10-CM Code Updates Now Available from CMS [↑]

CMS has posted the 2012 ICD-10-CM code updates to the CMS website, including the 2012 ICD-10-CM index and tabular, code titles, addendum, General Equivalence Mappings (GEMs), and reimbursement mappings files. The 2012 ICD-10-CM files contain information on the new diagnosis coding system, ICD-10-CM, that is being developed as a replacement for ICD-9-CM, Volumes 1 and 2. These files are available on the 2012 ICD-10-CM and GEMs webpage at http://www.CMS.gov/ICD10/11b14_2012_ICD10CM_and_GEMs.asp. To access the files, scroll to the bottom of the page to the "Downloads" section.

The 2012 ICD-10-PCS (procedure) files were posted in June on the 2012 ICD-10-PCS and GEMs webpage at http://www.CMS.gov/ICD10/11b15_2012_ICD10PCS.asp.

> ➤ Additional material related to ICD-10 in today's e-News… [previous]

January 2012 Average Sales Price (ASP) Files Are Now Available [↑]

The January 2012 ASP and NOC pricing files and crosswalks, and updated pricing files for October 2011 and July 2011 are available for download at

http://www.CMS.hhs.gov/McrPartBDrugAvgSalesPrice (see left menu for year-specific links).

Corrections Made to Inpatient Hospital, Inpatient Psychiatric Facility, and Inpatient Rehabilitation Facility 2012 PPS PC Pricers [↑]

Please see the links below for the corrected PC Pricers. Please note, the updated pricers can be found in the "Downloads" section of their respective webpages.
- *FY2012 Inpatient PPS PC Pricer,* dated Tue Nov 8, for claims dated from Sat Oct 1 to Sun Sep 30, 2012 is available at http://www.CMS.hhs.gov/PCPricer/03_inpatient.asp.
- *FY2012 Inpatient Rehabilitation Facility PPS PC Pricer*, posted Tue Dec 6, is available at http://www.CMS.gov/PCPricer/06_IRF.asp.
- *RY2012 Inpatient Psychiatric Facility PPS PC Pricer,* posted Wed Dec 7, is available at http://www.CMS.hhs.gov/PCPricer/09_inppsy.asp.

From the MLN: "The Medicare DMEPOS Competitive Bidding Program Repairs and Replacements" Fact Sheet (ICN 905283) Revised [↑]

On Mon Dec 12, CMS announced a revised repairs and replacement policy for the DMEPOS Competitive Bidding Program. The revised policy continues to allow any Medicare enrolled supplier to repair medically necessary, beneficiary-owned equipment when necessary to make the equipment serviceable. The policy now considers repair parts to include components that are needed to repair the base equipment, including batteries and tires. Additionally, the revised fact sheet provides guidance on billing the labor component and parts for the repair for beneficiaries who reside in competitive bid areas.

The revised "The Medicare DMEPOS Competitive Bidding Program Repairs and Replacements" fact sheet (ICN 905283) is designed to provide education on repairs and replacements under the DMEPOS competitive bidding program. It includes information on which items and services can be provided by contract versus non-contract suppliers.

From the MLN: "Medicare Disproportionate Share Hospital" Fact Sheet (ICN 006741) Revised [↑]

The revised "Medicare Disproportionate Share Hospital" fact sheet (ICN 006741) includes the following information: background; methods to qualify for the Medicare disproportionate share hospital (DSH) adjustment; Medicare Prescription Drug, Improvement, and *Modernization Act* of 2003 and *Deficit Reduction Act* of 2005 provisions that impact Medicare DSHs; number of beds in hospital determination; and Medicare DSH payment adjustment formulas.

From the MLN: "2012 Electronic Prescribing (eRx) Payment Adjustment: Assessment and Application" MLN Matters® Article Released [↑]

The new MLN Matters® Special Edition Article "2012 Electronic Prescribing (eRx) Payment Adjustment: Assessment and Application" (#SE1141) is designed to provide education on how the 2012 eRx payment adjustment was calculated and applied for individual eligible professionals, and group practices participating in eRx Group Practice Reporting Option (GPRO).   It includes guidance on how eligible providers should assess and apply the 2012 eRx payment adjustment.

  ➢ Additional material related to eRx in today's e-News… [previous]

From the MLN: New Podcast on the Medicare Overpayment Collection Process Released [↑]

The MLN has released the next in a series of podcasts designed to provide education on how to avoid common billing errors and comply with requirements of the Medicare Program. The new "Medicare Overpayment Collection Process" podcast (ICN 907563), posted Thu Dec 8, is designed to provide education on the Medicare Overpayment Collection Process. It includes information from the MLN fact sheet titled "The Medicare Overpayment Collection Process," which describes the collection of Medicare physician and supplier overpayments.

Please visit the MLN Multimedia webpage to download this and other podcasts from the MLN. We also encourage you to visit the MLN Provider Compliance webpage for the latest educational products designed to help Medicare FFS providers understand–and avoid–common billing errors and other improper activities identified through claim review programs. Stay tuned for future podcasts from the MLN!

Clarification: "Medicare Shared Savings Program: Notice of Proposed Rulemaking Fact Sheets" Booklet (ICN 907663) Has Been Discontinued [↑]

In order to alleviate confusion, the Medicare Learning Network® has decided to discontinue our recently published booklet that contained previously-released fact sheets issued at the time that the Medicare Shared Savings Program (MSSP) Notice of Proposed Rulemaking was released.

However, the MLN has released several fact sheets on the *final rule*:

- "Accountable Care Organizations: What Providers Need to Know"
- "Improving Quality of Care for Medicare Patients: Accountable Care Organizations"
- "Advance Payment Accountable Care Organization (ACO) Mode,"
- "Medicare Shared Savings Program and Rural Providers"
- "Summary of Final Rule Provisions for Accountable Care Organizations under the Medicare Shared Savings Program"
- "Methodology for Determining Shared Savings and Losses under the Medicare Shared Savings Program."