



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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Colleagues—

I hope your holiday season is progressing nicely. Over the next 2 weeks, we'll send any urgent information on an as-needed basis. Our normal e-News release schedule will resume on Tue Jan 10, 2012.

Happy holidays, and have a happy New Year!

Robin



The e-News for the week of Tue Dec 20 includes...

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OTHER CALLS, MEETINGS, AND EVENTS

- Wed Dec 21 – [Medicare Fee-For-Service Recovery Auditor Prepayment Review Demonstration](#)
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CMS Launches New Webpage for Fee-For-Service (FFS) National Provider Calls [[↑](#)]

CMS has a new webpage for FFS National Provider Calls located at www.CMS.gov/NPC . National Provider Calls are educational conference calls conducted for the Medicare FFS provider and supplier community that educate and inform participants about new policies and/or changes to the Medicare program.

Learn more about National Provider Calls, and how to register for upcoming calls, at www.CMS.gov/NPC today!

Special Open Door Forum: Medicare Fee-For-Service Recovery Auditor Prepayment Review Demonstration [[↑](#)]

Wed Dec 21; 2-3:30pm ET

The CMS is hosting a Special Open Door Forum (ODF) to discuss the recently approved Recovery Auditor Prepayment Review Demonstration that will begin Sun Jan 1, 2012.

This Special ODF is designed specifically for Medicare Fee-For-Service providers who may be subject to Recovery Auditor review in the 11 approved demonstration states: CA, FL, IL, LA, MI, MO, NC, NY, OH, PA, and TX. Recovery Auditors will review claims before they are paid to ensure that the provider complied with all Medicare payment rules. These reviews will focus on certain types of claims that historically result in high rates of improper payments. Initially, Recovery Auditors will review short stay inpatient hospital claims. This demonstration will also help lower the error rate by preventing improper payments, rather than the traditional “pay and chase” methods of looking for improper payments after they have been made.

Special ODF Participation Instructions:

Dial-in Phone Number: 1-800-837-1935

Reference Conference ID#: 36846735

For more information on the demonstration or the upcoming ODF, please visit <http://go.CMS.gov/cert-demos>. For any additional questions, please contact CMS at RAC@CMS.hhs.gov.

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.

Registration Reminder for DMEPOS Competitive Bidding [↑]

We would like to remind all suppliers interested in participating in the Round 2 and national mail-order competitions of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) competitive bidding program that registration for user IDs and passwords is open. If you are interested in bidding you must designate one Authorized Official (AO) from those listed on the CMS-855S enrollment form to act as your AO for registration purposes, and that AO must register.

We Strongly Urge All AOs to Register No Later Than Thu Dec 22 to Ensure AOs Have Time to Designate Other Supplier Employees to Use the DMEPOS Online Bidding System (DBidS)

When bidding opens, suppliers will need to submit their bids using DBidS. To help ensure bid security and privacy, suppliers interested in bidding must first register all employees that will enter information in DBidS to obtain a user ID and password through the Individuals Authorized Access to

CMS Computer Services (IACS) system. Only supplier employees that have a user ID and password will be able to access DBidS; suppliers that do not register will not be able to bid.

After an AO successfully registers, the AO may designate other authorized officials on the CMS-855S to serve as backup authorized officials (BAO). The AO and BAOs can designate other supplier employees as end users (EU). BAOs and EUs must also register for a user ID and password to be able to use the on-line bidding system. The name, date of birth, and Social Security number (SSN) of the AO and BAOs must match exactly with what is on file with the National Supplier Clearinghouse (NSC) to register successfully.

Registering now allows the AO and/or BAO time to correct the supplier's NSC records if their name, date of birth, and SSN does not match what is on file with the NSC. We recommend that BAOs register no later than Thu Jan 12, 2012 so that they will be able to assist AOs with approving EU registration.

Registration will close on *Thu Feb 9, 2012 at 9 pm ET* – no AOs, BAOs, or EUs can register after registration closes.

To register, go to the Competitive Bidding Implementation Contractor (CBIC) website, www.dmecompetitivebid.com and click on "Registration is Open" above the Registration Clock on the homepage. Please review the IACS Reference Guide posted on the website for step-by-step instructions on registration. You will also find a registration checklist and Quick Step guides on the CBIC website. If you have any questions about the registration process, please contact the CBIC Customer Service Center at 1-877-577-5331.

The CBIC is the official information source for bidders. All suppliers interested in bidding are urged to sign up for email updates on the homepage of the CBIC website. For information about Round 2 and the national mail-order competition, including bidder education materials, please refer to the resources located under "Bidding Suppliers: Round 2 & National Mail-Order" on the [CBIC website](#).

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

Preparing for the Sun Jan 1, 2012 Version 5010 Deadline [\[↑\]](#)

The compliance deadline for the transition to Version 5010 is only two weeks away! Though CMS has announced an enforcement discretionary period of 90 days for Version 5010 compliance, the deadline remains Sun Jan 1, 2012. Enforcement will not be exercised until Sun Apr 1, 2012; however, it is important that organizations continue to complete the transition to Version 5010 as soon as possible, if they have not done so already.

Version 5010 Resources:

CMS is committed to helping organizations make a smooth transition to Version 5010 and ICD-10. The CMS ICD-10 website has been updated to include a [new webpage](#) dedicated to Version 5010 information and resources. CMS has also posted a new [fact sheet](#), which discusses steps providers should be taking now to ensure a timely transition to Version 5010 by Sun Jan 1, 2012.

Other materials on Version 5010 include the following fact sheets:

- [FAQs: Versions 5010 and D.0 Transition Basics](#)
- [Versions 5010, D.0, and 3.0 Overview](#)

- [Version 5010: Testing Readiness, What You Need to Know](#)
- [Talking to Your Vendors About ICD-10 and Version 5010](#)

Additional Resources:

Stay on top of deadlines and action items for Version 5010 and ICD-10 by referencing the following resources on the CMS ICD-10 website:

- [Interactive Widget](#): A user-friendly tool that outlines the steps to take to ensure compliance with Version 5010 and ICD-10.
- Timelines: Printer-friendly checklists that complement the widget, which are available for [large providers](#), [small providers](#), [payers](#), and [vendors](#).
- Implementation Handbooks: Detailed step-by-step guides on how to implement ICD-10, which have been customized for different audiences including [small/medium provider practices](#), [large provider practices](#), [small hospitals](#), and [payers](#).

Keep Up to Date on Version 5010 and ICD-10:

Please visit [the CMS ICD-10 website](#) for the latest news and resources, and to download and share the [implementation widget](#) today!

- Additional material related to Versions 5010 & D.0 in today's e-News... [\[next\]](#)

Affordable Care Act "Sunshine" Rule Increases Transparency in Healthcare [\[↑\]](#)

On Wed Dec 14, CMS announced a proposed rule that will increase public awareness of financial relationships between drug and device manufacturers and certain healthcare providers. This is one of many steps under the *Affordable Care Act* designed to increase transparency in the healthcare system, which can lead to better care at lower costs.

The proposed rule would require manufacturers of drugs, devices, biologicals, and medical supplies covered by Medicare, Medicaid, or the Children's Health Insurance Program to report to CMS payments or other transfers of value they make to physicians and teaching hospitals. The proposed rule would also require manufacturers and group purchasing organizations (GPOs) to disclose to CMS physician ownership or investment interests.

This increased transparency is intended to help reduce the potential for conflicts of interest that physicians or teaching hospitals might face as a result of their relationships with manufacturers.

Drug and biologic manufacturers, medical device or supply manufacturers, and GPOs would be affected by the new reporting requirements. These organizations, as well as the physicians and teaching hospitals, would be allowed an opportunity to review and correct information prior to its publication.

The *Affordable Care Act* provides that violators of the reporting requirements will be subject to civil monetary penalties (CMPs), capped at \$150,000 annually for failing to report, and \$1,000,000 for knowingly failing to report.

CMS is proposing that data collection will not begin on Sun Jan 1, 2012 and that manufacturers and GPOs do not need to begin data collection until final regulations are issued. Depending on the timing of the final rule, CMS is proposing that manufacturers and GPOs will be required to submit a partial year on Sun Mar 31, 2013. Once the data has been submitted, CMS will aggregate manufacturer submissions at the individual physician and

teaching hospital level, provide them with a 45-day period to confidentially review and, if necessary, correct the data, and make the data publicly available by Mon Sep 30, 2013.

CMS will accept comments on the proposed rule until Fri Feb 17, 2012, and will respond to them in a final rule to be published in 2012.

The proposed rule can be downloaded at <http://s3.amazonaws.com/public-inspection.federalregister.gov/2011-32244.pdf>.

New *Affordable Care Act* Demonstration to Provide Care at Home for Medicare Patients [[↑](#)]

Healthcare reform law demonstration to improve care, lower costs for seniors and people with disabilities

Up to 10,000 Medicare patients with chronic conditions will now be able to get most of the care they need at home under a new demonstration announced Tue Dec 20 by CMS.

“This program gives new life to the old practice of house calls, but with 21st Century technology and a team approach,” said CMS Acting Administrator Marilyn Tavenner.

Created by the *Affordable Care Act*, the new Independence at Home Demonstration greatly expands the scope of in-home services Medicare beneficiaries can receive. The Independence at Home Demonstration will provide chronically ill patients with a complete range of primary care services. Participation in the Demonstration is voluntary for Medicare beneficiaries.

“In my days as a practicing nurse, I saw many patients whose health improved when they were happier with their living conditions,” said Tavenner. “When a critically-ill patient can remain in familiar surroundings, the benefits are many: the person retains greater control over their daily lives, families and caregivers report greater satisfaction with the care, and unnecessary hospitalizations are avoided.”

CMS will join with medical practices to test the effectiveness of delivering primary care services in a home setting on improving care for Medicare beneficiaries with multiple chronic conditions. Medical practices led by physicians or nurse practitioners will provide primary care home visits tailored to the needs of beneficiaries with multiple chronic conditions and functional limitations.

The Demonstration will reward healthcare providers that show a reduction in Medicare expenditures through an incentive payment if they succeed in providing high-quality care while reducing costs. CMS will use quality measures to ensure beneficiaries experience high quality care.

Medical practices eligible to participate in the Demonstration must include physicians or nurse practitioners who have experience delivering home-based primary care. Up to 50 practices will be selected and each must serve at least 200 Medicare Fee-For-Service beneficiaries with multiple chronic conditions and functional limitations. Practices in the demonstration will be responsible for coordinating patient care with other health and social service professionals.

The new demonstration is one of a series of CMS initiatives to build a Medicare program that offers beneficiaries better care and better health at an affordable cost. It will be supported by the CMS Innovation Center, which was created by the *Affordable Care Act* to develop and test new models of healthcare delivery and payment, and disperse best practices throughout the healthcare system.

Applications and Letters of Intent, if applicable, are due on Mon Feb 6, 2012. Additional information about this demonstration, including how to apply, can be found at http://www.CMS.gov/DemoProjectsEvalRpts/downloads/IAH_FactSheet.pdf.

Questions on this demonstration may be submitted to CMS at: IndependenceAtHomeDemo@cms.hhs.gov.

CMS Announces First Results for Program to Improve Care for Dialysis Patients [\[↑\]](#)

CMS released the first results for a new Federal pay-for-performance or “value-based purchasing” program for dialysis facilities that is designed to give facilities payment incentives to improve the quality of care furnished to patients diagnosed with End-stage Renal Disease (ESRD). Nearly 70 percent of dialysis facilities that were evaluated under the program will receive no payment reduction in payment year (PY) 2012, while the remaining 30 percent will receive reductions ranging from 0.5 percent to 2.0 percent depending on their final performance scores.

The ESRD Quality Incentive Program (QIP) evaluates dialysis facility performance on a set of quality measures which reflect key areas of dialysis care. Facilities that fail to meet the QIP performance standards during a performance year received a reduction in their payment rates for dialysis services under the ESRD Prospective Payment System (PPS) in the upcoming year.

Authorized by the *Medicare Improvements for Patients and Providers Act* of 2008, the ESRD QIP enables Medicare to pay dialysis facilities based on the quality of care provided to Medicare patients with ESRD, rather than simply based on the amount of care provided. This release includes quality data that reflects the performance of dialysis facilities in 2010 and is designed to complement existing CMS initiatives that seek to incentivize improved clinical outcomes by measuring the quality of care provided to Medicare patients on dialysis.

“The real purpose of value-based purchasing is to raise the bar on quality and that’s exactly what CMS is aiming to do for Medicare patients who have ESRD,” said CMS Acting Administrator Marilyn Tavenner. “This is one of many efforts CMS is making to drive quality improvement in all settings in communities across the country.”

For the PY 2012 program, CMS assessed a facility’s performance during 2010 on a total of three quality measures: two measures of anemia management and one of dialysis adequacy:

- Percentage of Medicare patients with an average hemoglobin less than 10 grams per deciliter (g/dL) (low percentage desired)
- Percentage of Medicare patients with an average hemoglobin greater than 12 g/dL (low percentage desired)
- Percentage of Medicare patients with an average Urea Reduction Ratio (URR) of at least 65 percent (high percentage desired)

For the first year of the ESRD QIP, the performance of each facility on each measure in 2010 was assessed against the lesser of the performance “norm” for dialysis facilities across the country during 2008 or the facility’s own performance during 2007.

Facilities that fail to meet the performance standards will receive a Medicare payment reduction of up to 2 percent during 2012. Medicare patients, as well as their families and caregivers, will benefit from this program and will have access to the performance results through public reporting.

Each dialysis facility is required to post a certificate displaying its performance on the ESRD QIP measures in a prominent location accessible to the

public. In addition, performance information will be posted on the [Dialysis Facility Compare website](#). CMS encourages Medicare beneficiaries to discuss these results with their dialysis care team and hopes that this information will help these patients to make informed decisions about their care.

“The ESRD QIP program’s overarching goal is the continual improvement of dialysis care provided to Medicare beneficiaries nationwide to drive better outcomes,” said Patrick Conway, M.D., Chief Medical Officer and Director of the CMS Office of Clinical Standards and Quality. “The ESRD QIP will evolve over time to include additional measures that promote high quality of care and outcomes for Medicare beneficiaries.”

The data for the PY 2012 ESRD QIP can be found at: <http://www.CMS.gov/center/esrd.asp>.

New Webcast for Round 2 and National Mail-Order Bidders Available [[↑](#)]

The first in a series of educational webcasts for the Round 2 and national mail-order competitions of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program is now available on the Competitive Bidding Implementation Contractor (CBIC) website. This webcast, *Welcome to Round 2 and National Mail-Order*, provides background information on the program and information about the educational resources available to assist you in participating.

The webcast is available on demand to view at your convenience – 24 hours a day, seven days a week. There is no charge to view the webcast, and a transcript is also posted on the website. To view the webcast, please go to the CBIC website at www.dmecompetitivebid.com and select *Bidding Suppliers: Round 2 & National Mail-Order* and then choose “Education Events.”

We will be issuing more webcasts later in the bidder education program. The upcoming webcasts will address topics such as financial documentation requirements, the national mail-order competition, general bidding requirements, and how to submit a bid in the on-line system, DBidS. As each webcast is posted, we will announce its availability through an email update. If you have not already done so, please register on the CBIC website to receive these announcements and other updates about the Competitive Bidding Program.

If you have any questions or need assistance, please contact the CBIC Customer Service Center toll-free at 1-877-577-5331 from 9am-9pm ET, Mon through Fri, throughout the registration and bidding periods.

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

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>.

CMS to Release a Comparative Billing Report on Ordering Durable Medical Equipment: Lower Limb Orthotics [[↑](#)]

On Fri Jan 13, 2012, CMS plans to release a national provider Comparative Billing Report (CBR) addressing Ordering Durable Medical Equipment: Lower Limb Orthotics.

CBRs produced by SafeGuard Services under contract with CMS, contain actual data-driven tables and graphs with an explanation of findings that compare a provider's billing and payment patterns to those of their peers located in their state and across the nation.

These reports are not available to anyone except the providers who receive them. To ensure privacy, CMS presents only summary billing information. No patient or case-specific data is included. These reports are an example of a tool that helps providers better understand applicable Medicare billing rules and improve the level of care they furnish to their Medicare patients. CMS has received feedback from a number of providers that this kind of data is very helpful to them and encouraged us to produce more CBRs and make them available to providers.

For more information and to review a sample of the Ordering Durable Medical Equipment: Lower Limb Orthotics CBR, please visit the CBR Services website www.cbrservices.com, or call the SafeGuard Services' Provider Help Desk, CBR Support Team at 530-896-7080.

***Affordable Care Act* helps 32 Health Systems Improve Care for Patients, Saving up to \$1.1 Billion** [[↑](#)]

Leading healthcare providers will be Pioneer Accountable Care Organizations

Thirty-two leading healthcare organizations from across the country will participate in a new Pioneer Accountable Care Organizations (ACOs) initiative made possible by the *Affordable Care Act*, HHS Secretary Kathleen Sebelius announced Mon Dec 19. The Pioneer ACO initiative will encourage primary care doctors, specialists, hospitals, and other caregivers to provide better, more coordinated care for people with Medicare and could save up to \$1.1 billion over five years.

Under this initiative, operated by the CMS Innovation Center, Medicare will reward groups of healthcare providers that have formed ACOs based on how well they are able to both improve the health of their Medicare patients and lower their healthcare costs.

“Pioneer ACOs are leaders in our work to provide better care and reduce health care costs,” said Secretary Sebelius. “We are excited that so many innovative systems are participating in this exciting initiative – and there are many other ways that healthcare providers can get involved and help improve care for patients.”

The Pioneer ACO initiative is just one of a menu of options for providers looking to better coordinate care for patients and use healthcare dollars more wisely. The Pioneer ACO model is designed specifically for groups of providers with experience working together to coordinate care for patients. The Medicare Shared Savings Program and the Advance Payment ACO Model, both [announced in October 2011](#), are also ACO options for providers. More information about the full menu of options for providers and how to apply to participate is available [here](#).

“We know that health care providers are at different stages in their work to improve care and reduce costs,” said Marilyn Tavenner, acting Administrator of CMS. “That’s why we’ve developed a menu of options for Medicare to meet doctors, hospitals, and other healthcare providers where they are, and begin the conversation of how to enhance the care they are offering to people with Medicare.”

The 32 Pioneer ACOs underwent a rigorous competitive selection process by the Innovation Center, including extensive review of applications and in-person interviews.

The initiative will test the effectiveness of several innovative payment models and how they can help experienced organizations to provide better care for beneficiaries, work in coordination with private payers, and reduce Medicare cost growth. These payment models will allow organizations that are successful in achieving better care and lower cost growth to move away from a payment system based on volume under the fee-for-service model, towards one where the ACO is paid based on the value of care it provides.

The Pioneer ACO model requires ACOs to engage other payers in similar efforts to reward health care providers that deliver high-quality care. The Pioneer ACO model also includes strict beneficiary protections, including the ability for patients to seek care from any Medicare provider they wish.

Selected Pioneer ACOs include physician-led organizations and health systems, urban and rural organizations, and organizations in various geographic regions of the country, representing 18 States and the opportunity to improve care for about 860,000 Medicare beneficiaries.

The first performance period of the Pioneer ACO Model will begin Mon Jan 1, 2012.

For the final list of participating Pioneer ACOs and more information about the Pioneer ACO Model, a fact sheet is posted at https://www.cms.gov/apps/media/fact_sheets.asp, or you can visit <http://innovations.cms.gov/initiatives/aco/pioneer>.

The Pioneer ACO Model is one of several initiatives underway at CMS designed to support the formation of ACOs. For more information, visit www.cms.gov/aco.

For more information about the CMS Innovation Center, visit innovations.cms.gov.

➤ Additional material related to ACOs in today’s e-News... [\[next / previous\]](#)

Medicare Fee-For-Service (FFS) Part B Editing of the National Drug Code (NDC) [[↑](#)]

Effective Fri Dec 9, Medicare FFS turned off the current ASC X12 Version 5010 Common Edit and Enhancements Module (CEM) National Drug Code (NDC) validation edit for Medicare Part B. The specific NDC edit being turned off is the Loop ID 2410 LIN03 and requires that the NDC be validated

against the Food and Drug Administration's (FDA) NDC code list. A replacement NDC edit will be implemented in the Part B CEM for the January 2012 Shared System Quarterly release which will perform syntactical editing only of the NDC submitted in Loop ID 2410 LIN03.

A similar announcement will be disseminated when the Part A NDC edit is deactivated.

NDC Code Background:

The NDC is a unique product identifier used for drugs intended for human use and is used for reporting prescribed drugs and biologics when required by government regulation, or as deemed by the provider to enhance claim reporting or adjudication processes. The *Drug Listing Act* of 1972 requires registered drug establishments to provide the FDA with a current list of all drugs manufactured, prepared, propagated, compounded, or processed by it for commercial distribution. Drug products are identified and reported using the NDC.

The NDC is a unique number expressed in 3-sections. This numeric identifier is assigned to each medication listed under Section 510 of the *US Federal Food, Drug, and Cosmetic Act*. The sections identify the labeler or vendor, the product (within the scope of the labeler), and the type of package (of this product). The ASC X12 TR3 documents stipulate that the 5-4-2 expression of NDC values must be used. However, the FDA does not have a version of the NDC in this (5-4-2) format. Therefore, CMS has created a version of the NDC in the 11-byte numeric NDC derivative, which pads the product code (4 positions) or package code (2 positions) sections of the NDC with a leading zero thus resulting in a fixed length 5-4-2 configuration.

For more information on Version 5010, NCPDP D.0, and NCPDP 3.0; please visit www.CMS.gov/Versions5010andD0.

- Additional material related to Versions 5010 & D.0 in today's e-News... [\[previous\]](#)

Further Information about Medicare Claims Processing Issue Related to Part B Services for Skilled Nursing Facility (SNF) Patients [\[↑\]](#)

Because of a claims processing problem, some Part B claims for SNF patients submitted to Medicare during October and November 2011 have been erroneously denied by Medicare's claims processing system. In other instances, the claims processing system has paid and then identified a Medicare "overpayment" on these claims in error.

CMS is working with its contractors to identify all claims that were denied in error as well as any overpayments that were identified erroneously and resulted in a demand letter. The denied claims will be reprocessed and the erroneous overpayments adjusted so that in most cases there will be no impact upon the provider. Where a demand letter was sent in error, the Medicare Claims Administration Contractor (MAC) will send you an acknowledgement letter that the overpayment was removed.

In a few cases, an overpayment may have been collected prior to the MAC having determined that the demand letter was sent in error. In such instances, the MAC will automatically process an adjustment. We are asking providers not to appeal these claims at this time. Submitting an appeal may slow down the correct adjustment of your claim. (Please note that if another valid overpayment exists, the money collected will first be applied to it and the provider will be notified accordingly.)

Your MAC will advise you through its website and its listservs when it expects to complete this process so that you can anticipate when your claims

will be adjusted or your erroneous overpayments removed. We thank you for your patience and we apologize for any inconvenience.

Medicare Part B Drug Average Sales Price (ASP) Template Revised [\[↑\]](#)

The revised ASP template is now available at <http://www.CMS.gov/McrPartBDrugAvgSalesPrice/>. Manufacturers should use this template for submitting ASP to the CMS beginning January 2012.

From the MLN: “Federally Qualified Health Center” Fact Sheet Revised [\[↑\]](#)

The revised “[Federally Qualified Health Center](#)” fact sheet (ICN 006397) includes the following information: background; FQHC designation; covered FQHC services; FQHC preventive primary services that are not covered; FQHC Prospective Payment System; FQHC payments; and Medicare Prescription Drug, Improvement, and Modernization Act of 2003 provisions that impact FQHCs.

From the MLN: Medicare Preventive Services Series: Part 2, Web-Based-Training Course (WBT) Revised [\[↑\]](#)

This WBT is designed to provide education on Medicare Preventive Services. It includes information on Medicare’s coverage for the initial preventive physical exam (IPPE), ultrasound screening for abdominal aortic aneurysm (AAA), screening electrocardiogram (EKG), Annual Wellness Visit (AWV), cardiovascular screening blood tests, diabetes-related services, human immunodeficiency virus (HIV) screening and smoking and tobacco-use cessation counseling services.

To access the WBT, visit the [MLN Products](#) page, scroll to the “Related Links Inside CMS,” and select the “Web-Based Training (WBT) Courses.”

From the MLN: MLN Guided Pathways (Basic, A, and B) Provider-specific Resource Booklets Revised [\[↑\]](#)

The revised MLN Guided Pathways curriculum is designed to allow learners to easily identify and select resources by clicking on topics of interest. The curriculum begins with basic knowledge for all providers and then branches to information for either those enrolling on the 855B, I, and S forms or on the 855A form (or Internet-based PECOS equivalents). The resource booklets are:

- [MLN Guided Pathways to Medicare Resources – Basic Curriculum for Health Care Professionals, Suppliers, and Providers](#)
- [MLN Guided Pathways to Medicare Resources Intermediate Curriculum for Health Care Providers](#) (Part A)
- [MLN Guided Pathways to Medicare Resources Intermediate Curriculum for Health Care Professionals and Suppliers](#) (Part B)

From the MLN: “MLN Guided Pathways Provider-specific” Resource Booklet Revised [\[↑\]](#)

The Revised [MLN Guided Pathways to Medicare Resources](#) provider-specific resource booklet provides various specialties of healthcare professionals, (physicians, chiropractors, optometrists, podiatrists), nurses (APN, RNCNS, NP, Midwife) PAs, social workers, psychologists, therapists (OT, PT, SLP),

dietitians, nutritionists, *suppliers* (ambulance, ASC, DMEPOS, FQHC, RHC, Labs, mammography, radiation therapy, portable x-ray), and *providers* (CMHC, CORF, ESRD, HHA, hospice, OPT, pathology and SNF) with resources specific to their specialty including Internet-Only Manuals (IOMs), Medicare Learning Network® publications, CMS webpages, and more. This version includes the addition of pathways for Anesthesiology Assistant/Certified Registered Nurse Anesthetist, Anesthesiologist, Ophthalmologist, and Optometrist, along with a fully developed pathway for Mass Immunization Roster Biller.

All of the MLN Guided Pathways booklets above are available at http://www.CMS.gov/MLNEdWebGuide/30_Guided_Pathways.asp.

From the MLN: “Preventive Services Educational Resources for Health Care Professionals” MLN Matters® Article Released [\[↑\]](#)

The new “[Preventive Services Educational Resources for Health Care Professionals](#)” MLN Matters® Special Edition Article (#SE1142) is designed to provide education on available educational resources related to Medicare-covered preventive services. It includes a list of MLN products that can help Medicare FFS providers understand coverage, coding, reimbursement, and billing requirements related to these services.

From the MLN: “Advanced Payment Accountable Care Organization Model” Fact Sheet Available [\[↑\]](#)

The new “[Advanced Payment Accountable Care Organization Model](#)” fact sheet (ICN 907403) is designed to provide education on the advance payment model for Accountable Care Organizations (ACOs). It includes a summary of the Advance Payment ACO Model, background, and information on the structure of payments, recoupment of advance payments, eligibility, and the application process.

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

From the MLN: “Summary of Final Rule Provisions for Accountable Care Organizations Under the Medicare Shared Savings Program” Fact Sheet Available [\[↑\]](#)

The new “[Summary of Final Rule Provisions for Accountable Care Organizations Under the Medicare Shared Savings Program](#)” fact sheet (ICN 907404) is designed to provide education on the provisions of the final rule that implements the Medicare Shared Savings Program with ACOs. It includes background, information on how ACOs impact beneficiaries, eligibility requirements to form an ACO, and information on monitoring and tying payment to improved care at lower costs.

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

From the MLN: “Improving Quality of Care for Medicare Patients: Accountable Care Organizations” Fact Sheet Available [\[↑\]](#)

The new “[Improving Quality of Care for Medicare Patients: Accountable Care Organizations](#)” fact sheet (ICN 907407) is designed to provide education on improving quality of care under ACOs. It includes a table of quality measures under the program.

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

From the MLN: “Medicare Shared Savings Program and Rural Providers” Fact Sheet Available [[↑](#)]

The new “[Medicare Shared Savings Program and Rural Providers](#)” fact sheet (ICN 907408) is designed to provide education on how the Medicare Shared Savings Program impacts rural providers. It includes information on federally qualified health centers, rural health clinics, critical access hospitals, and how this program impacts them.

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The Medicare Learning Network

www.CMS.gov/MLNGenInfo

Archive of Provider e-News Messages

www.CMS.gov/FFSProvPartProg/EmailArchive