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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 Jan 24 includes...

NATIONAL PROVIDER CALLS

- Wed Jan 25 – [National Provider Call: Medicare FFS Implementation of HIPAA Version 5010 and D.O Transactions – Last Chance to Register](#)

ANNOUNCEMENTS AND REMINDERS

- [Third Anniversary of ICD-10 Rule](#)
- [New Information on the Appeals Process for Medicare and Medicaid EHR Incentive Programs on the EHR Website](#)
- [New Webcast for Round 2 and National Mail-Order Bidders Now Available](#)
- [CMS to Release Comparative Billing Report on Advanced Diagnostic Imaging](#)
- [Flu Season is Here! Get the Flu Vaccine – Not the Flu](#)

CLAIMS, PRICER, AND CODE UPDATES

- [Medicare FFS Version 5010 Requirement Changes for Non-Specific Procedure Codes](#)
- [Update to the Primary Care Incentive Payment Program for Critical Access Hospital Providers Paid Under Optional Method](#)
- [Updates to “Intern and Resident Information System \(IRIS\)” Software](#)
- [Outpatient Prospective Payment System CY2012 Pricer File Update](#)
- [January 2012 Quarterly Provider-Specific Files Available](#)

UPDATES FROM THE MEDICARE LEARNING NETWORK®

- [“Medicare Quarterly Provider Compliance Newsletter \[Volume 2, Issue 2\]” Released](#)
- [“Important Reminder for Providers and Suppliers Who Provide Services and Items Ordered or Referred by Other Providers and Suppliers” MLN Matters Article Released](#)
- [“Additional HIPAA 837 5010 Transitional Changes and Further Modifications to COBA National Crossover Process” MLN Matters Article Revised](#)
- [“Non-Specific Procedure Code Description Requirement for HIPAA Version 5010 Claims” MLN Matters Article Revised](#)
- [“Medicare Physician Fee Schedule” Fact Sheet Revised](#)
- [“Ambulatory Surgical Center Fee Schedule” Fact Sheet Revised](#)
- [“Hospital Value-Based Purchasing Program” Fact Sheet Available in Hardcopy](#)

National Provider Call: Medicare FFS Implementation of HIPAA Version 5010 and D.0 Transactions – Last Chance to Register [[↑](#)]

Wed Jan 25; 2-3:30pm ET

CMS will host a special National Provider Call regarding the Medicare FFS implementation of HIPAA Version 5010 and D.0 transaction standards.

Target Audience: Vendors, clearinghouses, and providers who need to make Medicare FFS-specific changes in compliance with HIPAA Version 5010 requirements.

Agenda (there will be no slide presentation for this call):

- HIPAA Version 5010 implementation update
- Question & answer session

If you would like to submit a question related to this topic in advance of, during, or following the call, please email your inquiry to the 5010 FFS Information resource mailbox at 5010FFSinfo@CMS.hhs.gov. Note that this resource box will only accept emails the day before, the day of, and the day after this call; your emailed questions will be answered as soon as possible, and may not be answered during the call.

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>.

- Additional material related to HIPAA Version 5010 in today's e-News... [[next](#)]

Third Anniversary of ICD-10 Rule [[↑](#)]

Three years ago – on Fri Jan 16, 2009 – the US Department of Health and Human Services published final rules mandating that all organizations covered by *HIPAA* upgrade to Version 5010 by *Sun Jan 1, 2012* and transition to ICD-10 coding sets by *Tue Oct 1, 2013*. As a result of the enforcement discretion period for Version 5010, all organizations must complete their Version 5010 upgrade by no later than *Sat Mar 31, 2012*. Upgrading to Version 5010 is an important step to take before transitioning to ICD-10, which is quickly approaching.

To help with this transition, CMS has developed a number of resources, which available on the CMS ICD-10 website. These resources include:

- *Factsheets*, including [Ensuring a Smooth Transition to Version 5010](#), [ICD-10 Transition: An Introduction](#), [ICD-10 Basics for Medical Practices](#), [ICD-10 FAQs](#), and [Talking to Your Vendors about the Transition to ICD-10](#).
- *An Implementation Widget*, which outline the steps to take to ensure compliance with Version 5010 and ICD-10, available in a [widget](#) format. CMS encourages you to download or share the widget and take advantage of printer-friendly versions of the timelines available for [small provider practices](#), [large provider practices](#), [payers](#), and [vendors](#).
- *Timelines*, including printer-friendly checklists that complement the widget and which are available for [small providers](#), [large providers](#), [payers](#), and [vendors](#).

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!

New Information on the Appeals Process for Medicare and Medicaid EHR Incentive Programs on the EHR Website [\[↑\]](#)

CMS has added new information to the [Attestation section](#) of the EHR website about the appeals process for the Medicare and Medicaid Electronic Health Records (HER) Incentive Programs.

On Thu Dec 1, 2011, CMS began accepting appeals for eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs). To help EPs, eligible hospitals, and CAHs, the CMS Office of Clinical Standards and Quality (OCSQ) is providing guidance on how to file an appeal. *Note that the filing deadline for an eligibility appeal for an eligible hospital has been extended from Fri Dec 30, 2011, to Mon Jan 30, 2012.*

OCSQ's Division of Health Information Technology released the first informal review decision for the EHR Incentive Program on Mon Jan 19. Beginning in February, this informal review decision and other appeal decisions will be posted on the [OCSQ Appeals](#) website. Starting in March, providers may find their decisions by visiting the [Appeals Portal](#).

For general questions and for information on how to file an appeal, EPs, eligible hospitals, CAHs, and Medicare Advantage Organizations may contact OCSQ's designated appeal support contractor, Provider Resources Inc, at:

- Toll-free number: 855-796-1515 (Between 9am and 5pm ET, Monday through Friday), or
- Email: OCSQappeals@provider-resources.com

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

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

A new educational webcast 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 at www.DMECompetitiveBid.com. This webcast, titled “How a Bid is Evaluated,” goes over each step of the bid evaluation process, from receipt of electronic bid data and hardcopy documents through awarding of contracts. The webcast also provides resources to assist you with bidding.

This 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 visit the [CBIC website](#), select *Bidding Suppliers: Round 2 & National Mail-Order*, and choose [Education Events](#).

We will be issuing more webcasts later in the bidder education program. Upcoming webcasts will address topics such as financial documentation requirements and how to submit a bid in the online bidding system, DBidS. As each webcast is posted, we will announce its availability with 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 877-577-5331 from 9am to 9pm (prevailing Eastern Time), Monday through Friday, throughout the registration and bidding periods.

CMS to Release Comparative Billing Report on Advanced Diagnostic Imaging [\[↑\]](#)

On Thu Feb 16, CMS will release a national provider Comparative Billing Report (CBR) addressing Advanced Diagnostic Imaging.

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 Advanced Diagnostic Imaging CBR, please visit the CBR Services website at www.CBRservices.com or call the SafeGuard Services' Provider Help Desk, CBR Support Team at 530-896-7080.

Flu Season is Here! Get the Flu Vaccine – Not the Flu [\[↑\]](#)

While seasonal flu outbreaks can happen as early as October, flu activity usually peaks in January. Remind your patients that annual vaccination is recommended for optimal protection. Medicare pays for the seasonal flu vaccine and its administration for seniors and others with Medicare with no co-pay or deductible. Healthcare workers, who may spread the flu to high-risk patients, should get vaccinated too. Don't forget to immunize yourself and your staff. Protect your patients. Protect your family. Protect yourself.

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>.

Medicare FFS Version 5010 Requirement Changes for Non-Specific Procedure Codes [\[↑\]](#)

Medicare Fee-for-Service (FFS) has amended the Not-Otherwise-Classified (NOC) code set listing effective Mon Jan 16, 2012. Thus, it has been determined that anesthesia codes that include the phrase “not otherwise specified” in their code descriptors (procedure codes 00100 through 01996) do not meet the criteria of a non-specified procedure code and do not require a description to be supplied in the SV101-7/SV202-7 data elements. Anesthesia procedure code 01999, “Unlisted anesthesia procedure(s)” meets the requirements of a non-specified code and continues to require additional information to be supplied in the SV101-7 data element.

Additionally, various pathology and laboratory codes identified in procedure code section 8800 and a variety of other NOC codes have been removed. These codes do not meet the criteria of a non-specified procedure code and do not require a description to be supplied in the SV101-7/SV202-7 data elements.

The majority of procedure codes impacted and removed from the NOC code list are anesthesia codes, laboratory/pathology codes, and Physicians Quality

Reporting System codes.

Medicare FFS's complete listing of the NOC codes can be found at http://www.CMS.gov/ElectronicBillingEDITrans/40_FFSEditing.asp. Medicare will be updating the code set, at minimum, on a quarterly basis (January, April, July, and October) as the NOC list is refined and the parent code sets are updated. Please check back to the [website](#) frequently for the most updated list.

For more information on Version 5010 and D.O, please visit <http://www.CMS.gov/Versions5010andD0>.

- Additional material related to *HIPAA* Version 5010 in today's e-News... [[next](#) / [previous](#)]

Update to the Primary Care Incentive Payment Program for Critical Access Hospital Providers Paid Under Optional Method [[↑](#)]

On Tue Nov 15, 2011, CMS issued a listserv message with billing instructions for Critical Access Hospitals (CAHs) paid under the Optional Method regarding the Primary Care Incentive Payment (PCIP) Program. The message instructed CAH providers to continue submitting their National Provider Identifiers (NPIs) using the "other provider" field located in loop 2310C on the current electronic claim format.

After further research, CMS has determined that, in addition to reporting the NPI in loop 2310C, CAH providers will need to report the same NPI as well as the information that is required in loop 2310B defined as "operating physician." This will ensure CAH claims submitted using the Accredited Standards Committee (ASC X12) version 5010A2 will continue to receive their PCIP bonus without any interruption.

Change Request 7686 has been created and will be implemented by contractors to update the Medicare systems to assign the PCIP bonus payments based on the NPI from loop 2310D, "rendering physician." However, until the successful implementation of CR7686 – expected to take place in July – the reporting of the NPI for the PCIP bonus payments should continue as described above.

Updates to "Intern and Resident Information System (IRIS)" Software [[↑](#)]

The provider community and teaching hospitals shall take notice of three updated files (medical school codes, residency type codes, and IRISV3 Operating Instructions as of December 2011) in the IRIS software programs (IRISV3 and IRISEDV3) for collecting and reporting information on resident training in hospital and non-hospital settings:

- CMS added sixty-two new IRIS residency type codes to the IRIS Residency Code Table; forty-seven of these codes are revised codes for forty-eight obsolete allopathic and osteopathic residency type codes. Providers may begin using the revised codes for cost reporting periods beginning before Sun

July 1, 2012; however, these codes shall be used for cost-reporting periods beginning on or after Sun July 1, 2012.

- CMS also added fifteen new IRIS medical school codes to the IRIS Medical School Code Table.
- Providers may begin using the new medical school and residency type codes in the IRIS programs for cost reporting periods ending on or after Fri Sep 30, 2011.

The IRIS programs are available for download at <http://www.CMS.gov/IRIS>.

Outpatient Prospective Payment System CY2012 Pricer File Update [[↑](#)]

The Outpatient Prospective Payment System (OPPS) Pricer webpage was recently updated to include the January 2012 update for outpatient provider data. The updated files are ready for download from the Outpatient PPS Pricer webpage at <http://www.CMS.gov/PCPricer/OutPPS/itemdetail.asp?itemID=CMS1255203>.

January 2012 Quarterly Provider-Specific Files Available [[↑](#)]

The January 2012 Quarterly Provider-Specific Files (PSF) are now available on the CMS website. The SAS data files are available at http://www.CMS.gov/ProspMedicareFeeSvcPmtGen/04_psf_SAS.asp and the text data files (with name and address information at the end of the record) are available at http://www.CMS.gov/ProspMedicareFeeSvcPmtGen/03_psf_text.asp, both in the “Downloads” section. A new version of the text files has been added with name and address information at the end of the record.

From the MLN: “Medicare Quarterly Provider Compliance Newsletter [Volume 2, Issue 2]” Released [[↑](#)]

The new “[Medicare Quarterly Provider Compliance Newsletter \[Volume 2, Issue 2\]](#)” (ICN 907703) has been released in downloadable format. This educational tool is designed to provide education on how to avoid common billing errors and other erroneous activities when dealing with the Medicare Program, and highlights the top issues of the particular quarter. Please visit http://www.CMS.gov/MLNProducts/downloads/MedQtrlyCompNL_Archive.pdf to download, print, and search an archive of previously-issued newsletters.

From the MLN: “Important Reminder for Providers and Suppliers Who Provide Services and Items Ordered or Referred by Other Providers and Suppliers” MLN Matters Article Released [[↑](#)]

MLN Matters Special Edition Article #SE1201, “[Important Reminder for Providers and Suppliers Who Provide Services and Items Ordered or Referred by Other](#)

[Providers and Suppliers](#),” has been released in downloadable format. This article is designed to provide education on policy that says Medicare will only pay for specific items or services that are ordered or referred by providers or suppliers who are enrolled in Medicare and authorized to do so. It includes information about what providers should know before submitting a claim and limitations to the policy.

From the MLN: “Additional HIPAA 837 5010 Transitional Changes and Further Modifications to COBA National Crossover Process” MLN Matters Article Revised [\[↑\]](#)

MLN Matters Special Edition Article #SE1137, “[Additional Health Insurance Portability and Accountability Act \(HIPAA\) 837 5010 Transitional Changes and Further Modifications to the Coordination of Benefits Agreement \(COBA\) National Crossover Process](#),” has been revised and is available in downloadable format. This article is designed to provide education on the HIPAA 5010 COBA National Crossover Process for supplemental payers, and includes important information and examples to assist providers with the transition. The article was revised to add a section to clarify the crossover impact for providers who are permitted to submit claims using the CMS 1500 or UB04 hardcopy formats.

- Additional material related to HIPAA Version 5010 in today’s e-News... [\[next / previous\]](#)

From the MLN: “Non-Specific Procedure Code Description Requirement for HIPAA Version 5010 Claims” MLN Matters Article Revised [\[↑\]](#)

MLN Matters Special Edition Article #SE1138, “[Non-Specific Procedure Code Description Requirement for HIPAA Version 5010 Claims](#),” has been revised and is available in downloadable format. This article is designed to provide education on the requirements for non-specific procedure codes for HIPAA 5010 claims, as established in Change Request 7392. It includes guidance to help providers comply with the requirements and submit HIPAA-compliant claims for all non-specific procedure codes. The article was revised to clarify that claims will *not* be rejected if ‘Not Otherwise Classified’ is submitted as the code description.

- Additional material related to HIPAA Version 5010 in today’s e-News... [\[previous\]](#)

From the MLN: “Medicare Physician Fee Schedule” Fact Sheet Revised [\[↑\]](#)

The “[Medicare Physician Fee Schedule](#)” fact sheet (ICN 006814) has been revised and is now available in downloadable format. It includes information on physician services, therapy services, Medicare Physician Fee Schedule (PFS) payment rates, and the Medicare PFS rates formula.

From the MLN: “Ambulatory Surgical Center Fee Schedule” Fact Sheet Revised [\[↑\]](#)

The “[Ambulatory Surgical Center Fee Schedule](#)” fact sheet (ICN 006819) has been revised and is now available in downloadable format. It includes information on the definition of an Ambulatory Surgical Center Fee Schedule (ASC), ASC payment, how payment rates are determined, and healthcare quality.

From the MLN: “Hospital Value-Based Purchasing Program” Fact Sheet Available in Hardcopy [\[↑\]](#)

The “[Hospital Value-Based Purchasing Program](#)” fact sheet (ICN 907664) is now available in hardcopy. This fact sheet is designed to provide education on the Hospital Value-Based Purchasing Program, and includes information on how Medicare will make incentive payments to hospitals in FY2013 based on performance and scoring of Clinical Process of Care Measures and Patient Experience of Care Dimensions. To order hardcopies of this fact sheet, visit <http://www.CMS.gov/MLNProducts> and click on ‘MLN Product Ordering Page’ under ‘Related Links Inside CMS’ at the bottom of the webpage.

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