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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 Tue Apr 10, 2012 includes...

#### NATIONAL PROVIDER CALLS

- Tue Apr 17 – [Physician Quality Reporting System & eRx 2011 10-Month Feedback Report – Register Now](#)
- Wed Apr 25 – [Current Status of Medicare FFS Implementation of HIPAA Version 5010 and D.0 – Register Now](#)

#### ANNOUNCEMENTS AND REMINDERS

- [April is Alcohol Awareness Month](#)
- [New Affordable Care Act Program to Improve Care, Control Medicare Costs, Off to a Strong Start](#)
- [New Health Care Law Provisions Cut Red Tape, Save up to \\$4.6 Billion – ICD-10 Compliance Delayed Until Oct 1, 2014](#)
- [Take a Look at the Version 5010 FAQs and View CMS' Version 5010 Page and Resources](#)
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#### CLAIMS, PRICER, AND CODE UPDATES

- [Quarterly Update for HCPCS Codes Effective Sun July 1](#)
- [Inpatient Psych Prospective Payment System FY2012 Pricer File Update](#)
- [Instructions for FIs/MACs to Hold Claims Containing CPT Code 33249 and HCPCS Code C1882](#)

#### UPDATES FROM THE MEDICARE LEARNING NETWORK®

- [“Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians”, Web-Based Training Now Available](#)
- [Submit Feedback on MLN Products and Services](#)

**National Provider Call: Physician Quality Reporting System & eRx 2011 10-Month Feedback Report – Register Now** [[↑](#)]

Tue Apr 17; 1:30-3pm ET

CMS will host a National Provider Call with question and answer session. CMS subject matter experts will provide an overview of the Electronic Prescribing 10-

## Month Feedback Report.

*Target Audience:* All Medicare Fee-For-Service Providers, Medical Coders, Physician Office Staff, Provider Billing Staff, Electronic Health Records Staff, and Vendors

### *Agenda:*

- Opening Remarks
- Program Announcements
- Overview of the Electronic Prescribing 10-Month Feedback Report
- Question & 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 in advance at <http://www.CMS.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/CMSSponsoredCalls.html>. In addition, the presentation will be emailed to all registrants on the day of the call.

## **National Provider Call: Current Status of Medicare FFS Implementation of HIPAA Version 5010 and D.0 – Register Now** [[↑](#)]

*Wed Apr 25; 2-3:30pm ET*

CMS is hosting a National Provider Call regarding the current status of Medicare FFS implementation of HIPAA Version 5010 and D.0. This National Provider Call focuses on addressing the current 5010/D.0 metrics, addressing recommendations made by Medicare FFS, as well possible outstanding fixes impacting the Part A and Part B Version 5010 transition.

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

### *Agenda:*

- Current 5010/D.0 metrics
- Addressing recommendations made by Medicare FFS
- Possible outstanding fixes impacting the Part A and Part B Version 5010 transition
- Q&A 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 and Webinar:* The presentation for this call will be posted at least one day in advance at <http://www.CMS.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events-Items/042512-NPC-Call.html>. In addition, the presentation will be emailed to all registrants on the day of the call. CMS will be using an optional webinar feature as part of this National Provider Call. Complete details on this feature are available on the call registration page.

## **April is Alcohol Awareness Month** [[↑](#)]

Alcohol Awareness Month is a nationwide campaign intended to raise awareness of the health and social problems excessive alcohol consumption can cause, not only for individuals, but their families, friends, and communities as well. According to the United States Preventive Services Task Force (2004), alcohol misuse includes risky/hazardous and harmful drinking which place individuals at risk for future problems. Harmful drinking describes those persons currently experiencing physical, social, or psychological harm from alcohol use, but who do not meet criteria for dependence. Alcohol can interact with certain medications, impair a person's ability to engage in activities that require attention, skill, or coordination (e.g., driving), exacerbate a medical condition (e.g., gastritis), and overtime alcohol misuse can lead to cancer, liver disease, and heart problems. More than 18 million American men and women suffer from alcohol-use disorders—there are countless millions of individuals, family members, and children who experience the devastating effects of the alcohol problem of someone in their life.

The good news is Medicare now provides coverage for *Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse* for eligible beneficiaries who, if determined by a primary care physician or other primary care practitioner, may need help in reducing or abstaining from alcohol consumption.

Medicare provides coverage for annual alcohol screening, and for those that screen positive, up to four brief, face-to-face, behavioral counseling interventions per year for Medicare beneficiaries, including pregnant women:

- Who misuse alcohol, but whose levels or patterns of alcohol consumption do not meet criteria for alcohol dependence (defined as at least three of the following: tolerance, withdrawal symptoms, impaired control, preoccupation with acquisition and/or use, persistent desire or unsuccessful efforts to quit, sustains social, occupational, or recreational disability, use continues despite adverse consequences); and
- Who are competent and alert at the time that counseling is provided; and,
- Whose counseling is furnished by qualified primary care physicians or other primary care practitioners in a primary care setting.

*For More Information:*

- [National Coverage Determination \(NCD\) for Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse](#)
- [The ABCs of Providing the Initial Preventive Physical Examination \(IPPE, or “Welcome to Medicare” visit\) Quick Reference Chart](#)
- [The ABCs of Providing the Medicare Annual Wellness Visit \(AWV\) Quick Reference Chart](#)
- [The MLN Preventive Services Educational Products Webpage](#)
- [Substance \(Other Than Tobacco\) Abuse Structured Assessment and Brief Intervention \(SBIRT\) Services fact sheet](#)
- [CDC Alcohol Awareness Month website](#)
- [National Council on Alcoholism and Drug Dependence, Inc. website](#)

Thank you for joining CMS in raising awareness of the negative effects of alcohol use on one's health and personal life, associated risk factors, and related preventive benefits covered by Medicare.

### **New *Affordable Care Act* program to Improve Care, Control Medicare Costs, Off to a Strong Start [\[↑\]](#)**

*Over 1.1 Million Beneficiaries Now Served by Accountable Care Organizations*

A new program that will help physicians, hospitals, and other health care providers work together to improve care for people with Medicare is off to a strong start.

Under the new Medicare Shared Savings Program (Shared Savings Program), 27 Accountable Care Organizations (ACOs) have entered into agreements with CMS, taking responsibility for the quality of care furnished to people with Medicare in return for the opportunity to share in savings realized through improved care. The Shared Savings Program and other initiatives related to Accountable Care Organizations are made possible by the *Affordable Care Act*, the health care law of 2010. Participation in an ACO is purely voluntary for providers and beneficiaries and people with Medicare retain their current ability to seek treatment from any provider

they wish.

The first 27 Shared Savings Program ACOs will serve an estimated 375,000 beneficiaries in 18 States. This brings the total number of organizations participating in Medicare shared savings initiatives on Sun Apr 1 to 65, including the 32 Pioneer Model ACOs that were announced last December, and six Physician Group Practice Transition Demonstration organizations that started in January, 2011. In all, as of Sun Apr 1, more than 1.1 million beneficiaries are receiving care from providers participating in Medicare shared savings initiatives.

CMS also announced today that five ACOs are participating in the Advance Payment ACO Model beginning Sun Apr 1. This model will provide advance payment of expected shared savings to rural and physician-based ACOs participating in the Shared Savings Program that would benefit from additional start-up resources. These resources will help build the necessary care coordination infrastructure necessary to improve patient outcomes and reduce costs, such as new staff or information technology systems. CMS is reviewing more than 50 applications for Advance Payments that start in July. For more information on the Advanced Payment ACO Model, including the participating ACOs, visit <http://innovations.CMS.gov/initiatives/ACO/Advance-Payment/>.

*The full text of this excerpted CMS press release (issued Tue Apr 10) can be found at <http://www.CMS.gov/apps/media/press/release.asp?Counter=4333>, and a media fact sheet can be found at <http://www.CMS.gov/apps/media/press/factsheet.asp?Counter=4334>.*

### **New Health Care Law Provisions Cut Red Tape, Save up to \$4.6 Billion [\[↑\]](#)**

*ICD-10 Compliance Delayed Until Oct 1, 2014*

HHS Secretary Kathleen Sebelius today announced a proposed rule that would establish a unique health plan identifier under the *Health Insurance Portability and Accountability Act of 1996 (HIPAA)*. The proposed rule would implement several administrative simplification provisions of the *Affordable Care Act*.

The proposed changes would save health care providers and health plans up to \$4.6 billion over the next ten years, according to estimates released by the HHS today. The estimates were included in a proposed rule that cuts red tape and simplifies administrative processes for doctors, hospitals, and health insurance plans.

The rule simplifies the administrative process for providers by proposing that health plans have a unique identifier of a standard length and format to facilitate routine use in computer systems. This will allow provider offices to automate and simplify their processes, particularly when processing bills and other transactions.

The proposed rule also delays required compliance by one year—from Oct 1, 2013 to Oct 1, 2014—for new codes used to classify diseases and health problems. These codes, known as the International Classification of Diseases, 10<sup>th</sup> Edition (ICD-10) diagnosis and procedure codes will include new procedures and diagnoses and improve the quality of information available for quality improvement and payment purposes.

The proposed rule announced today is the third in a series of administrative simplification rules in the new health care law. HHS released the first in July of 2011 and the second in January of 2012, and plans to announce more in the coming months.

More information on the proposed rule is available on fact sheets at [http://www.CMS.gov/apps/media/fact\\_sheets.asp](http://www.CMS.gov/apps/media/fact_sheets.asp).

The proposed rule may be viewed at [www.ofr.gov/inspection.aspx](http://www.ofr.gov/inspection.aspx). Comments are due 30 days after publication in the *Federal Register*.

*The full text of this excerpted CMS press release (issued Mon Apr 9) can be found at <http://www.CMS.gov/apps/media/press/release.asp?Counter=4329>.*

**Take a Look at the Version 5010 FAQs and View CMS' Version 5010 Page and Resources [\[↑\]](#)**

CMS will not initiate enforcement action against *HIPAA*-covered entities for an additional three months, through Sat June 30, 2012, for the updated *HIPAA* transaction standards (ASC X12 Version 5010, NCPDP Versions D.0 and 3.0). CMS is aware that there are still challenges and issues affecting an industry wide upgrade. To help *HIPAA*-covered entities with the upgrade, CMS continues to update and improve their Version 5010 resources.

#### *Updated FAQ System*

CMS has updated the FAQ system and the way it is organized. There are now three ways to more easily find Version 5010 FAQs by going to the [CMS FAQs Page](#) and:

- Click on the Topic *HIPAA Administrative Simplification* on the left side of the page
  - Click on the Subtopic *Versions 5010 and D.0* that will appear as a dropdown under the topic (FAQs on Version 5010 and D.0 will be listed on the right side of the page)
- Click on the Topic *Coding* on the left side of the page
  - Click on the Subtopic *ICD-10* that will appear as a dropdown under the topic (FAQs on Version 5010 will be listed out on the right side of the page)
- Entering the search term “Version 5010” in the *Search* box on the upper left side of the page

CMS’ Version 5010 and D.0 FAQs can also be found on the [Version 5010 page](#) of the ICD-10 website, on the [FAQs: Versions 5010 and D.0 Transition Basics fact sheet](#). The newest FAQ recently added by CMS is:

*Question:* Is my Version 5010 837 claim compliant if it includes situational data that the TR3 Report does not prohibit, and is not needed or used by a specific health plan?

*Answer:* Yes. If a submitter sends claim information to a primary payer that may not be needed by that payer, but is needed by a secondary or tertiary payer, the primary payer should disregard the unneeded information and accept the compliant claim. For example:

- A data element in the TR3 Report has situational usage and language that says “If not required by this implementation guide, do not send.”
- The submitter submits that data element because it is needed for processing by a particular payer that may be secondary or tertiary to the primary payer.
- A payer that does not need or use that data element cannot reject a claim because it contains a data element or information that it does not need or use, provided usage of the data element is compliant with the TR3 Report.

#### *Version 5010 Testing Readiness Fact Sheet*

CMS also has a [Version 5010 Testing Readiness Fact Sheet](#), which explains the Version 5010 upgrade and necessary Phase I Internal and Phase II External testing. This fact sheet can help providers to determine steps to successfully complete testing phases for Version 5010.

#### *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!

#### **CMS has Posted the Proposed CQMs under the Stage 2 NPRM on the CMS Website [\[↑\]](#)**

CMS has posted the full set of [proposed Clinical Quality Measures \(CQMs\) for 2014](#) as part of the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs Stage 2 Notice of Proposed Rule Making (NPRM). The public can review the CQMs and submit feedback online.

#### *Proposed CQMs*

The proposed CQMs are outlined in two tables that describe each measure and provide additional information for eligible professionals (EPs), eligible hospitals, and

critical access hospitals (CAHs) beyond the descriptions listed on the National Quality Forum (NQF) website. Some of these measures are still in development; therefore, the descriptions provided in these tables may change before the final rule is published. When possible, links have been provided for measures that have corresponding information on the NQF website. If a measure does not have an NQF number, it means that measure has not yet been endorsed.

#### *Public Comment*

Public comments regarding these measures should be submitted using the same method required for all comments related to the proposed rule. You can submit public comments online through the [federal regulations website](#). The deadline for public comments relating to the proposed CQMs and other aspects of the Stage 2 NPRM is *Mon May 7, 2012*.

#### *Want more information about the EHR Incentive Programs?*

Make sure to visit the EHR Incentive Programs website at <http://www.cms.gov/EHRIncentivePrograms> for the latest news and updates on the EHR Incentive Programs.

#### **CMS.gov Website Upgrade Completed—Check your Bookmarks [\[↑\]](#)**

CMS has completed the upgrades to the [www.CMS.gov](http://www.CMS.gov) website. Bookmarked links to items posted in the “Downloads” sections on the CMS website have not been affected, but other bookmarked URLs are redirected to the index webpage for that topic. For example, if you bookmarked the page containing National Provider Calls and Events, you will be taken to the index page for National Provider Calls. On the index page, select the webpage you’d like to view from the left-hand side. Once you open the correct page, you can create a new bookmark. We appreciate your understanding and apologize for any inconvenience during this process.

#### **Quarterly Update for HCPCS Codes Effective Sun July 1 [\[↑\]](#)**

CMS is pleased to announce the scheduled release of modifications to the Healthcare Common Procedure Coding System (HCPCS) code set. These changes have been posted to the HCPCS website at [http://www.CMS.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS\\_Quarterly\\_Update.html](http://www.CMS.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS_Quarterly_Update.html). Changes are effective on the date indicated on the update.

In response to shortage of liposomal doxorubicin (Doxil), the Food and Drug Administration is permitting the temporary importation of Lipodox, a brand of liposomal doxorubicin hydrochloride; visit <http://www.FDA.gov/NewsEvents/Newsroom/PressAnnouncements/ucm292658.htm> for additional information. The CMS HCPCS Quarterly Update includes two new codes (Q2048 and Q2049) for liposomal doxorubicin that will become effective Sun July 1. The code descriptors are worded in a manner that distinguishes Lipodox and Doxil. As of Sun July 1, HCPCS code J9001 will not be used for Medicare billing. CMS will release a Change Request (CR) with additional instructions in the near future.

#### **Inpatient Psychiatric Prospective Payment System FY2012 Pricer File Update [\[↑\]](#)**

The FY2012 Inpatient Psych Prospective Payment System (IPF PPS) PC Pricer has been updated with revised comorbidity logic, and is now available on the CMS website at <http://www.CMS.hhs.gov/Medicare/Medicare-Fee-for-Service-Payment/PCPricer/inppsy.html>. This Pricer is for claims dated from Oct 1, 2011 to Sep 30, 2012, and the update is dated Wed Apr 4, 2012.

## Instructions for FIs/MACs to Hold Claims Containing CPT Code 33249 and HCPCS Code C1882 [\[↑\]](#)

The procedure-to-device edit files included in the January 2012 (V13.0) and April 2012 (V13.1) Integrated Outpatient Code Editor (I/OCE) do not allow the device described by the Healthcare Common Procedure Coding System (HCPCS) code C1882 (Cardioverter-defibrillator, other than single or dual chamber (implantable)) to satisfy the edit in place for CPT code 33249 (Insertion or replacement of permanent pacing cardioverter-defibrillator system with transvenous lead(s), single or dual chamber). The July 2012 I/OCE (V13.2) will be updated with a new procedure-to-device edit file that will allow HCPCS code C1882 to be billed with CPT code 33249. Medicare contractors will hold claims with dates of service between Sun Jan 1, 2012 and Sat June 30, 2012, for the device described by HCPCS code C1882 when used in conjunction with the procedure described by CPT code 33249, until V13.2 of the I/OCE is installed by contractors on Mon July 2, 2012, so these claims may be processed for payment.

## From the MLN: “Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians”, Web-Based Training Now Available [\[↑\]](#)

This web-based training is designed to provide education on fraud and abuse related to physicians. It includes definitions, laws exclusions, civil monetary penalties, case examples, and resources.

To access a new or revised web-based training course, visit <http://www.CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/index.html> and click on “Web-Based Training (WBT) Courses” under “Related Links” at the bottom of the webpage.

## From the MLN: Submit Feedback on MLN Products and Services [\[↑\]](#)

The Medicare Learning Network® (MLN) is interested in what you have to say! Visit the [MLN Opinion Page](#) to submit an anonymous evaluation about specific MLN products and resources. Your feedback is important in developing and improving future MLN products and services.

### More Helpful Links...

Check out CMS on



[Twitter](#), [LinkedIn](#), [YouTube](#), and [Flickr](#)!

The Medicare Learning Network

[www.CMS.gov/MLNGenInfo](http://www.CMS.gov/MLNGenInfo)

Archive of Provider e-News Messages

[www.CMS.gov/FFSProvPartProg/EmailArchive](http://www.CMS.gov/FFSProvPartProg/EmailArchive)