*This issue of the e-News will be made available in PDF format no later than 24 hours after its release, and can be found in the archive with other past issues.*

**CMS Medicare FFS Provider e-News**

*CMS Information for the Medicare Fee-For-Service Provider Community*

***CMS asks that you share the following important information with all of your association members and state and local chapters. Thank you!***


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Colleagues—

Today's edition contains an in-depth message on the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. CMS announced plans to recompete the supplier contracts awarded in the Round 1 Rebid of the DMEPOS Competitive Bidding Program. CMS is required by law to recompete contracts under the DMEPOS Competitive Bidding Program at least once every three years. This information is important for Medicare suppliers and providers in the Round 1 Rebid areas. Referral agents are also a key source for educating beneficiaries of the importance of this program. For more information, please see DMEPOS Competitive Bidding Round 1 Recompete Announced below…

Hope your Spring is off to a great start.

—Robin

**The e-News for Tue Apr 17, 2012 includes…**



**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 on the CMS Upcoming National Provider Calls webpage. 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 on the FFS National Provider Calls webpage. 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 CMS Upcoming National Provider Calls webpage.

**Special Open Door Forum: *Affordable Care Act* Section 3004: Quality Reporting Program for Inpatient Rehabilitation Facilities** [↑]
*Thu Apr 19; 1:30-3pm ET*

The purpose of this Special Open Door Forum (ODF) is to provide information about the various types of training opportunities that will be offered to Inpatient Rehabilitation Facility (IRF) providers between Wed May 2 and Mon Oct 1, 2012, when the new IRF Quality Reporting Program goes live.

This Quality Reporting Program was mandated by Section 3004 of the *Affordable Care Act*. A Final Rule announcing the IRF Quality Reporting Program was published in the *Federal Register* on Aug 5, 2011 (Vol. 76, No. 151).

The IRF Quality Reporting Program requires that beginning on Mon Oct 1, 2012, IRFs must begin to submit quality measure data to CMS on two measures. These measures include:

- A urinary catheter-associated urinary tract (CAUTI) infection measure; and
- A measure for new or worsening pressure ulcers.

Data for the CAUTI measure will be submitted to CMS via the Center for Disease Control's National Healthcare Safety Network (NHSN). Data for the pressure ulcer measure will be collected using the IRF Patient Assessment Instrument (PAI). The IRF-PAI has been in use by IRFs for many years for payment purposes.

IRFs that do not comply with the requirements of the new IRF Quality Reporting Program will see their yearly Federal update payments reduced by two percentage points beginning in rate year 2014 and continuing each subsequent rate year thereafter.

Some IRF providers are unsure of what they need to do to prepare for the start of the new IRF Quality Reporting Program. During this Special Open Door Forum, we will discuss various resources and training opportunities that will be made available to IRF providers before the IRF Quality Reporting Program goes live on Mon Oct 1, 2012.

To read more about the IRF Quality Reporting Program and to view presentation materials, visit the IRF Quality Reporting webpage.

We look forward to your participation.

*Participation Instructions:*
Dial: 1-800-837-1935 & Conference ID: 72722467
Note: TTY Communications Relay Services are available for the Hearing Impaired. For TTY services dial 7-1-1 or 1-800-855-2880. A Relay Communications Assistant will help.

A transcript and audio recording of this Special ODF will be made available on the CMS Open Door Forum website.

Subscriptions to automatic emails of Open Door Forum schedule updates and Frequently Asked Questions are also available on the CMS Open Door Forum website.

Thank you for your interest in CMS Open Door Forums.

**DMEPOS Competitive Bidding Round 1 Recompete Announced** [↑]

CMS announced plans to recompete the supplier contracts awarded in the Round 1 Rebid of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. CMS is required by law to recompete contracts under the DMEPOS Competitive Bidding Program at least once every three years. The Round 1 Rebid contract period for all product categories, except mail order diabetic supplies expires on Dec 31, 2013. The Round 1 Recompete product categories are:

- Respiratory Equipment and Related Supplies and Accessories
  - Includes oxygen, oxygen equipment, and supplies; continuous positive airway pressure (CPAP) devices, respiratory assist devices (RADs), and related supplies and accessories; and standard nebulizers
- Standard Mobility Equipment and Related Accessories
  - Includes walkers, standard power and manual wheelchairs, scooters, and related accessories
- General Home Equipment and Related Supplies and Accessories
  - Includes hospital beds and related accessories, group 1 and 2 support surfaces, transcutaneous electrical nerve stimulation (TENS) devices, commode chairs, patient lifts, and seat lifts
- Enteral Nutrients, Equipment and Supplies
- Negative Pressure Wound Therapy Pumps and Related Supplies and Accessories
- External Infusion Pumps and Supplies

CMS is conducting the Round 1 Recompete in the same competitive bidding areas (CBAs) as the Round 1 Rebid.

A list of the specific items in each product category is available on the Competitive Bidding Implementation Contractor (CBIC) website. The specific ZIP codes in each Round 1 Recompete CBA are also available on the CBIC website.

To ensure that suppliers have ample time to prepare for the competition, CMS announced the following next steps for the program:

- Spring 2012
  - CMS begins pre-bidding supplier awareness program
- Summer 2012
  - CMS announces bidding schedule
  - CMS begins bidder education program
  - Bidder registration period to obtain user ID and password begins
- Fall 2012
  - Bidding begins

If you are a supplier interested in bidding, prepare now – don't wait.

- Update your contact information: The following contact information in your enrollment file at the National Supplier Clearinghouse (NSC) must be up to date before you register to bid. If your file is not current, you may experience delays and/or be unable to register and bid. DMEPOS suppliers should review and update:
  - The name, Social Security number, and date of birth for all authorized official(s). If you have only one authorized official listed on your enrollment file, consider adding one or more authorized officials to help with registration and bidding; and
  - The correspondence address.

DMEPOS suppliers can update their enrollment file via the internet-based Provider Enrollment, Chain and Ownership System (PECOS) or by using the Jul 11, 2011

version of the CMS-855S enrollment form. Suppliers not currently using PECOS can learn more about this system by accessing the Internet-Based PECOS page on the CMS website or reviewing the PECOS fact sheet. Information and instructions on how to submit a change of information via the hardcopy CMS-855S enrollment form may be found on the NSC website.

- Get licensed: Contracts are only awarded to suppliers that have all required state licenses at the time of bidding. Therefore, if you are bidding for a product category in a CBA, you must ensure that all required state licenses for that product category are either on file with the NSC or received by the NSC by close of bidding. Every location must be licensed in each state in which it provides services. If you have only one location and are bidding in a CBA that includes more than one state, you must have all required licenses for every state in that CBA. If you have more than one location and are bidding in a CBA that includes more than one state, your company must have all required licenses for the product category for every state in that CBA. Make sure that current versions of all required licenses are with the NSC before you bid. If any required licenses are expired or missing from your enrollment file, your bid(s) may be rejected.
- Get accredited: Suppliers must be accredited for all items in a product category in order to submit a bid for that product category. If you are interested in bidding for a product category and are not currently accredited for that product category, take action now to get accredited for that product category. Your accreditation organization will need to report any accreditation updates to the NSC. CMS cannot contract with suppliers who are not accredited by a CMS-approved accreditation organization.

More information about the DMEPOS accreditation requirements, including a list of the accreditation organizations and those who are exempt from accreditation, may be found on the DMEPOS Accreditation page on the CMS website.

Visit the DMEPOS Competitive Bidding page on the CMS website for more information about the DMEPOS competitive bidding program. View the Fact Sheet.

**Review Important Questions and Answers about Registration for the EHR Incentive Programs** [↑]

After determining your eligibility for the Electronic Health Record (EHR) Incentive Programs, you should then register as early as possible for the Medicare and/or Medicaid program. CMS' EHR Information Center is open to assist the EHR provider community with registration and other program-related inquiries.

The center can be reached at 1-888-734-6433 (primary number) or 888-734-6563 (TTY number) from 7:30am-6:30pm CT Monday through Friday, except federal holidays.

Here are a few of the Information Center's most frequently asked questions about registration:

- Question: What information should I have ready before I begin the registration process?
  Answer: When you register, you will need:
  - If you are registering as an eligible hospital or Medicare eligible professional, you will need an approved enrollment record in the Provider Enrollment, Chain and Ownership System (PECOS). Medicaid eligible professionals are not required to be enrolled in PECOS.
    - If you do not have a record in PECOS, you should still register for the Medicare and Medicaid EHR Incentive Programs. (Please note –your eligible hospital or Medicare eligible professional registration status will remain in an "issue pending" status until you have an active enrollment record in PECOS.)
  - A National Provider Identifier (NPI)
  - A National Plan and Provider Enumeration System Identity and Access Management ID and password for the individual provider
  - A Payee Tax Identification Number (if you are reassigning your benefits)
  - A Payee NPI (if you are reassigning your benefits)
- Question: Which option do I select when registering on behalf of an eligible professional in the Identity and Access Management System?

Answer: Click on "You are requesting to act on behalf of an individual provider."

- Question: How can I check my registration status in the Registration and Attestation System?
  Answer: Log in to the Registration and Attestation System and click the Status tab to view your registration information.
- Question: How do I re-submit my registration?
  Answer: To re-submit a registration, you will need to:
  - Login to the EHR Incentive Program Registration and Attestation System;
  - Navigate to the Registration tab;
  - Select the Modify action for the registration;
  - Select the Personal Information registration topic; and
  - Save the updated payee information and submit the registration.

CMS provides helpful registration guides and resources on the Registration page of the EHR website. Additionally, FAQs about registration can be found on the FAQs page of the CMS website.

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

**April is National Cancer Control Month** [↑]

This year, an estimated half million Americans will lose their lives to cancer, and three times that many will be diagnosed with this devastating illness. Cancer patients are parents and grandparents, children and cherished friends; the disease touches almost all of us and casts a shadow over families and communities across our Nation. Yet, today, we stand at a critical moment in cancer research that promises significant advances for patients and an accelerated pace of lifesaving discoveries. During National Cancer Control Month this April, we remember those we have lost, support Americans fighting this disease, and recommit to progress toward effective cancer control.

Prevention and screening are our best defenses against cancer. All Americans can reduce their risk by eating a healthy diet, exercising regularly, limiting sun exposure, avoiding excessive alcohol consumption, living tobacco-free, and taking advantage of appropriate regularly scheduled cancer screenings. For those covered by Medicare, regular screening with a healthcare professional can play a key role in preventing cancer and detecting the disease early, when it is often most treatable. Under the *Affordable Care Act*, more people with Medicare can now receive many preventive services at no additional cost.

*Medicare provides coverage of the following cancer screenings:*

- Breast Cancer (mammography and clinical breast exam)
- Cervical and Vaginal Cancer (pap test and pelvic exam (includes the clinical breast exam))
- Prostate cancer (PSA blood test and Digital Rectal Exam)
- Colorectal Cancer
  - Fecal Occult Blood Test
  - Flexible Sigmoidoscopy
  - Colonoscopy
  - Barium Enema

Studies have repeatedly demonstrated that a physician's recommendation is the most powerful factor in a patient's decision to receive preventive and screening

services. By discussing Medicare-covered cancer screenings and other available options, and engaging patients in decision-making regarding their choices, you can help prevent, treat, and beat the disease. Encourage your patients to get screened—it could save their lives.

*More Information for Healthcare Professionals:*

- MLN Guide to Medicare Preventive Services for Healthcare Professionals (see Chapter 11)
- MLN Preventive Services Educational Products Webpage
- MLN Cancer Screenings Brochure
- MLN Quick Reference Information: Medicare Preventive Services
- Tobacco-Use Cessation Counseling Services brochure
- National Cancer Institute website
- Smokefree.gov website

**From the MLN: "Guidance for Correct Claims Submission When Secondary Payers Are Involved" MLN Matters® Article Released** [↑]

MLN Matters® Special Edition Article #SE1217, "Guidance for Correct Claims Submission When Secondary Payers Are Involved" has been released and is now available in downloadable format.

This article is designed to provide education on how providers and suppliers should correctly submit claims associated with a Medicare Secondary Payer (MSP). It includes guidance and tools that providers, physicians, and other suppliers can use to ensure MSP information is captured at the time of billing, so that the appropriate primary payer is billed before Medicare, as required by law.

**From the MLN: New Fast Fact on MLN Provider Compliance Webpage** [↑]

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

**More Helpful Links…**

**Check out CMS on**

Twitter, LinkedIn, YouTube, and Flickr!

**The Medicare Learning Network**

www.CMS.gov/MLNGenInfo

**Archive of Provider e-News Messages**

www.CMS.gov/FFSProvPartProg/EmailArchive