This issue of the e-News will be available in PDF format within 24 hours of its release 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—

In recognition of the July 4 holiday, we will be sending the e-News on an as-needed basis next week. Our normal e-News schedule will resume on Wednesday, July 11.

Hope you enjoy your Independence Day!

—Robin

The e-News for Wednesday, June 27, 2012

NATIONAL PROVIDER CALLS

- Medicare Shared Savings Program and Advance Payment Model Application Process — Register Now
- Hospital Value-Based Purchasing — Register Now
- Video Slideshow Presentation and Podcasts from March 28 Call on the Initial Preventive Physical Exam and Annual Wellness Visit Now Available

OTHER CALLS, MEETINGS, AND EVENTS

- Public Meeting Regarding Inherent Reasonableness of Medicare Fee Schedule Amounts for Non-Mail Order (Retail) Diabetic Testing Supplies

ANNOUNCEMENTS AND REMINDERS

- Medicare Fee-For-Service (FFS) Version 4010 Closeout Activities for the Week of June 25
- Only 2 Days Left: Medicare Electronic Prescribing Payment Adjustment Hardship Exemption
- Get Ready for DMEPOS Competitive Bidding
- All Medicare Provider and Supplier Payments To Be Made By Electronic Funds Transfer
- Submit a Notice of Intent to Apply for the Medicare Shared Savings Program January 1, 2013 Start Date – Deadline Extended to June 29
- Nursing Home Providers Given Opportunity to Participate in Landmark Quality Improvement Initiative

CLAIMS, PRICER, AND CODE UPDATES

- Corrections to Skilled Nursing Facility Consolidated Billing File
- Upcoming Medicare Fix to Address HIPAA 5010 837 Professional Crossover Issue Tied to Edit H46201
- 2013 ICD-10 PCS Files Now Available

MLN EDUCATIONAL PRODUCTS UPDATE

- "The Basics of Medicare Enrollment for Physicians Who Infrequently Receive Medicare Reimbursement" Fact Sheet — Revised
- "Medicare Enrollment Guidelines for Ordering/Referring Providers" Fact Sheet — Revised

National Provider Call: Medicare Shared Savings Program and Advance Payment Model Application Process — Register Now [↑]
Monday, July 16; 1:30-3 pm ET

On October 20, 2011, CMS issued a final rule under the Affordable Care Act to establish the Medicare Shared Savings Program (Shared Savings Program), along with a notice for the Advance Payment Model that will provide additional support to physician-led and rural Accountable Care Organizations (ACOs) participating in the Shared Savings Program. These two initiatives will help providers participate in ACOs to improve quality of care for Medicare patients.

On Monday, July 16, 2012, CMS is hosting a National Provider Call, where subject matter experts will provide an overview and updates to the Shared Savings Program application and Advance Payment Model application processes for the January 1, 2013 Shared Savings Program start date. A question and answer session will follow the presentations.

The Shared Savings Program Application and the Advance Payment Model web pages have important information, dates, and materials on the application

process. Call participants are encouraged to review the applications and materials prior to the call.

Target Audience: Medicare Fee-For-Service (FFS) providers

Registration Information: In order to receive call-in information, you must register for the call on the CMS Upcoming National Provider Calls web page. 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 prior to the call on the FFS National Provider Calls web page. In addition, a link to the slide presentation will be emailed to all registrants on the day of the call.

National Provider Call: Hospital Value-Based Purchasing – Register Now [↑]
Wednesday, July 11; 1:30-3pm ET

CMS will host a National Provider Call with a question and answer session on the FY2014 Hospital Value-Based Purchasing (VBP) Program. The purpose of this call is to provide an overview of the FY2014 Program and to review the differences between the FY2013 and FY2014 Programs, primarily the addition of the Outcome domain in the FY2014 Program.

Target Audience: Hospitals, Quality Improvement Organizations (QIOs), Medical coders, physician office staff, provider billing staff, health records staff, vendors, and all Medicare fee-for-service (FFS) providers.

Agenda:

- Opening Remarks
- Program Announcements
- Overview of Fiscal Year 2014 Hospital Value-Based Purchasing Program
- Review of the differences between the FY 2013 and FY 2014 Programs
- Question & Answer Session

Registration Information: In order to receive call-in information, you must register for the call on the CMS Upcoming National Provider Calls web page. 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 prior to the call on the FFS National Provider Calls web page. In addition, a link to the slide presentation will be emailed to all registrants on the day of the call.

Video Slideshow Presentation and Podcasts from March 28 Call on the Initial Preventive Physical Exam and Annual Wellness Visit Now Available [↑]

CMS has released a YouTube video slideshow presentation and podcasts from the March 28, 2012 Medicare Preventive Services National Provider Call on the Initial Preventive Physical Exam and the Annual Wellness Visit.

YouTube Video Slideshow Presentation:

The call presentation is now available on the CMS YouTube Channel as a video slideshow that includes the call audio.

Podcasts:
Limited on time? Podcasts are perfect for the office, in the car, or anywhere you carry a portable media player or smartphone. The following podcasts are now available on the National Provider Calls and Events March 28, 2012 web page.

- Podcast 1 of 3: The Initial Preventive Physical Exam
- Podcast 2 of 3: The Annual Wellness Visit
- Podcast 3 of 3: Question and Answer Session

Visit the National Provider Calls and Events March 28, 2012 web page for access to all of the related call materials including the slide presentation, audio recording, and written transcripts.

Public Meeting Regarding Inherent Reasonableness of Medicare Fee Schedule Amounts for Non-Mail Order (Retail) Diabetic Testing Supplies [↑]
Monday, July 23; 9am-1pm ET

CMS has announced that it will host a public meeting that provides an opportunity for consultation with representatives of suppliers and other interested parties regarding options to adjust the Medicare payment amounts for non-mail order diabetic testing supplies. This meeting will provide the public an opportunity to offer oral and written comments.

For more information about the meeting, please view the meeting notice, *Public Meeting Regarding Inherent Reasonableness of Medicare Fee Schedule Amounts for Non-Mail Order (Retail) Diabetic Testing Supplies* (CMS-1445-N), published in the *Federal Register* on June 26, 2012.

If you would like to attend the meeting, you must register on the CMS website.

Meeting attendees should allow plenty of time to ensure access to the CMS facility. CMS security procedures require that all visitors are subject to a vehicular search and can only gain access through the Central Building Main Lobby. All visitors must also be in possession of a valid, government-issued form of photo identification, such as a driver's license, age of majority card, passport, or visa.

Medicare Fee-For-Service (FFS) Version 4010 Closeout Activities for the Week of June 25 [↑]

In its continuing effort to help trading partners transition to the new versions of standards adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for electronically exchanging health care transactions, Medicare FFS has the following closeout updates for the week of June 25, 2012:

- Remittance Advice (835)
- Claims (837I and P)
- Claim Status (276/277)
- Coordination of Benefits (837)

Remittance Advice (835)

Medicare FFS has stated in previous communications that trading partners would be allowed an additional 30 days to complete the 835 remittance advice transaction transition. Medicare FFS' internal processes related to closeout activities for the 835 remittance transaction include the generation of the last Accredited Standards Committee (ASC) X12 Version 4010A1 835 data on July 31, 2012. Remittance Advice files from the last processing cycle will be available for retrieval upon conclusion of the July 31, 2012 batch cycle. Beginning August 1, 2012, the Medicare FFS program shall only produce the 835 remittance advice transaction in the ASC X12 Version 5010.

Claims (837 I and P)
All claims received after normal close of business cutoff times on June 29th must be in the ASC X12 Version 5010 or NCPDP Version D.0. Any Medicare FFS claims received in ASC X12 Version 4010 or NCPDP Version 5.1 after normal close of business cutoff times on June 29th will be rejected back to the submitter. The specific message you receive if a claim is rejected will depend on your MAC. A detailed list of 4010 rejection error messages by MAC has been posted.

Claim Status (276/277)
The last Claim Status Inquiry will be accepted in version 4010 at the end of the business day on Friday, June 29th, 2012. Following that date, all Claim Status activity will be in ASC X12 Version 5010.

Coordination of Benefits (837)
CMS has directed its MACs, FIs and carriers to begin sending all claims to the Coordination of Benefits Contractor (COBC) in version 5010 as of June 29, 2012. This will ensure that all claims that the COBC will issue to COB payers as of its Monday July 2, 2012 evening crossover claims cycle will be properly transmitted in the version 5010 format. Therefore, all COB payers will have to be in version 5010 COB production by June 29, 2012.

More Information:
For more information on ASCX12 Version 5010 and NCPDP Version D.0, please visit the Versions 5010 and D.0 website.

Only 2 Days Left: Medicare Electronic Prescribing Payment Adjustment Hardship Exemption [↑]

In 2009, CMS implemented the Electronic Prescribing (eRx) Incentive Program, which is a program that uses incentive payments and payment adjustments to encourage the use of qualified electronic prescribing systems.

From calendar year (CY) 2012 through 2014, a payment adjustment that increases each calendar year will be applied to an eligible professional's Medicare Part B Physician Fee Schedule (PFS) covered professional services for not becoming a successful electronic prescriber. The payment adjustment of 1.0% in 2012, 1.5% in 2013, and 2.0% in 2014 will result in an eligible professional or group practice participating in the eRx Group Practice Reporting Option (eRx GPRO) receiving 99.0%, 98.5%, and 98.0% respectively of their Medicare Part B PFS amount for covered professional services.

Exclusion Criteria:
The 2013 eRx payment adjustment only applies to certain individual eligible professionals. CMS will automatically exclude those individual eligible professionals who meet the following criteria:

- The eligible professional is a successful electronic prescriber during the 2011 eRx 12- month reporting period (January 1, 2011 through December 31, 2011).
- The eligible professional is not an MD, DO, podiatrist, Nurse Practitioner, or Physician Assistant by June 30, 2012, based on primary taxonomy code in the National Plan and Provider Enumeration System (NPPES).

- The eligible professional does not have at least 100 Medicare Physician Fee Schedule (MPFS) cases containing an encounter code in the measure's denominator for dates of service from January 1, 2012 through June 30, 2012.
- The eligible professional does not have 10% or more of their MPFS allowable charges (per TIN) for encounter codes in the measure's denominator for dates of service from January 1, 2012 through June 30, 2012.
- The eligible professional does not have prescribing privileges and reported G8644 on a billable Medicare Part B service at least once on a claim between January 1, 2012 and June 30, 2012.

Avoiding the 2013 eRx Payment Adjustment:
Individual eligible professionals and CMS-selected group practices participating in eRx GPRO who were not successful electronic prescribers in 2011 can avoid the 2013 eRx payment adjustment by meeting the specified reporting requirements between January 1 and June 30, 2012.

6-month Reporting Requirements to Avoid the 2013 Payment Adjustment:
- Individual Eligible Professionals – 10 eRx events via claims
- Small eRx GPRO – 625 eRx events via claims
- Large eRx GPRO – 2,500 eRx events via claims

For more information on individual and eRx GPRO reporting requirements, please see the MLN Article SE1206 - 2012 Electronic Prescribing (eRx) Incentive Program: Future Payment Adjustments.

CMS may exempt individual eligible professionals and group practices participating in eRx GPRO from the 2013 eRx payment adjustment if it is determined that compliance with the requirements for becoming a successful electronic prescriber would result in a significant hardship.

Significant Hardships:
The significant hardship categories are as follows:
- The eligible professional is unable to electronically prescribe due to local, state, or federal law, or regulation
- The eligible professional has or will prescribe fewer than 100 prescriptions during a 6-month reporting period (January 1 through June 30, 2012)
- The eligible professional practices in a rural area without sufficient high-speed Internet access (G8642)
- The eligible professional practices in an area without sufficient available pharmacies for electronic prescribing (G8643)

Submitting a Significant Hardship Code or Request:
To request a significant hardship, individual eligible professionals and group practices participating in eRx GPRO must submit their significant hardship exemption requests through the Quality Reporting Communication Support Page (Communication Support Page) on or between March 1 and June 30, 2012. Please remember that CMS will review these requests on a case-by-case basis. All decisions on significant hardship exemption requests will be final.

Significant hardships associated with a G-code may be submitted via the Communication Support Page or on at least one claim during the 2013 eRx payment adjustment reporting period (January 1 through June 30, 2012). If submitting a significant hardship G-code via claims, it is not necessary to request the same hardship through the Communication Support Page.

For more information on how to navigate the Communication Support Page, please reference the following documents:
- Quality Reporting Communication Support Page User Guide
- Tips for Using the Quality Reporting Communication Support Page

For additional information and resources, please visit the E-Prescribing Incentive Program web page.

If you have questions regarding the eRx Incentive Program, eRx payment adjustments, or need assistance submitting a hardship exemption request, please contact the QualityNet Help Desk at 866-288-8912 (TTY 877-715-6222) or via qnetsupport@sdps.org. They are available Monday through Friday from 7am to 7pm CST.

Get Ready for DMEPOS Competitive Bidding [↑]

The Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program Round 1 Recompete is coming soon.

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. If you want to bid, you will need to register even if you registered for a previous round. 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 July 11, 2011 version of the CMS-855S enrollment form. Suppliers not currently using PECOS can learn more about this system by accessing the PECOS 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 in the Change of Information Guide 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 competitive bidding area (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 the 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 that are not accredited for all items in the product category.

More information about the DMEPOS accreditation requirements may be found on the CMS website.

The Competitive Bidding Implementation Contractor (CBIC) is the official information source for bidders. Stay informed – visit the CBIC website to subscribe to email updates and for the latest information about the DMEPOS Competitive Bidding Program.

All Medicare Provider and Supplier Payments To Be Made By Electronic Funds Transfer [↑]

Existing regulations at 42 CFR 424.510(e)(1)(2) require that at the time of enrollment, enrollment change request, or revalidation, providers and suppliers that expect to receive payment from Medicare for services provided must also agree to receive Medicare payments through electronic funds transfer (EFT). Section 1104 of the *Affordable Care Act* further expands Section 1862(a) of the *Social Security Act* by mandating federal payments to providers and suppliers only by electronic means. As part of CMS's revalidation efforts, all suppliers and providers who are not currently receiving EFT payments *are required to submit the CMS-588 EFT form with the Provider Enrollment Revalidation application, or at the time any change is being made to the provider enrollment record by the provider or supplier, or delegated official.*

For more information about provider enrollment revalidation, review the Medicare Learning Network's Special Edition Article #SE1126, titled "Further Details on the Revalidation of Provider Enrollment Information."

Submit a Notice of Intent to Apply for the Medicare Shared Savings Program January 1, 2013 Start Date – Deadline Extended to June 29 [↑]

If you are interested in applying for participation for the January 1, 2013 start date of the Medicare Shared Savings Program, please submit a Notice of Intent to Apply (NOI) *by June 29, 2012*. For more information, visit the Shared Savings Program Application web page.

Nursing Home Providers Given Opportunity to Participate in Landmark Quality Improvement Initiative [↑]

CMS is giving nursing home providers the opportunity to participate in a bold, new quality improvement initiative mandated through the Affordable Care Act. The Affordable Care Act requires CMS to establish standards relating to Quality Assurance and Performance Improvement (QAPI) and provide technical assistance (TA) to facilities on the development of best practices for QAPI.

CMS QAPI Initiatives:

- *Five Elements:* CMS has identified the following key concepts that are found throughout effective quality systems and are the framework for establishing a QAPI program: Design and Scope; Governance and Leadership; Feedback, Data Systems, and Monitoring; Performance Improvement Projects; and Systematic Analysis and Systemic Action.
- *QAPI Tools and Resources:* CMS, in collaboration with their contractors, University of Minnesota and subcontractor Stratis Health, are continuing to identify and design effective QAPI tools and resources specifically for nursing homes.
- *Technical Assistance:* CMS contractors are testing QAPI tools, resources, and approaches to providing TA in a multi-year demonstration project with a

small group of nursing homes. These materials will be made available to all nursing homes following testing.

- *The Nursing Home Quality Improvement Questionnaire:* In another collaborative effort, CMS' contractor, Abt Associates, Inc., and their subcontractor, the Colorado Foundation for Medical Care, designed a questionnaire to identify the quality systems and processes nursing homes currently have in place, as well as assess the extent to which these systems and processes function to help nursing homes recognize and address quality issues. This information will help CMS and our contractors refine the QAPI components.

The Nursing Home Quality Improvement Questionnaire will be administered to a representative sample of 4,200 randomly selected nursing homes in two waves:

- Summer 2012: First wave of data collection
  - *Objective:* Establish a baseline of QAPI practices in nursing homes and gather information on the challenges and barriers to implementing effective QAPI programs
- 2013-2014: Second wave of data collection
  - *Objective:* Assess the development of QAPI systems, determine what types of TA to make available to nursing homes in the future, and determine the potential impact of TA in advancing QAPI in nursing homes

Nursing home providers participating in the data collection effort will be given the option of completing an electronic questionnaire available via the internet or a hard copy questionnaire mailed directly to their facility. The questionnaire will take approximately 20 minutes to complete. Nursing homes participating in the data collection *will not be identified* by name or any other identifying information.

Your participation in this survey effort is crucial to the goals of CMS in aligning QAPI Technical Assistance with provider needs. Check your Quality Improvement & Evaluation System (QIES) mailbox for notification that you have been selected to participate in this important information gathering.

CMS is being supported in this effort through partnership with the following organizations: American College of Health Care Administrators, American Health Care Association, Leading Age, Advancing Excellence in America's Nursing Homes, American Medical Director's Association, and National Association of Directors of Nursing Administration in Long Term Care.

Corrections to Skilled Nursing Facility Consolidated Billing File [↑]

When the 2012 Annual Update of Healthcare Common Procedure Code System (HCPCS) Codes for Skilled Nursing Facility Consolidated Billing was implemented in January 2012, the code J9033 was not included in file # 1-*Physician Services*. The Medicare claims processing system will update the edit associated with this file on October 1, 2012. The updated edit will be effective for services provided in 2012.

Providers may choose to refrain from billing for 2012 services with this code until the update is effective on October 1. However, if the service is billed and denied prior to October 1, contact your Medicare Administrative Contractor or carrier to have the claim reopened and reprocessed. If you have any additional questions please contact your Medicare Administrative Contractor or carrier.

Upcoming Medicare Fix to Address a Health Insurance Portability and Accountability Act (HIPAA) 5010 837 Professional Crossover Issue Tied to Edit H46201 [↑]

Billing vendors for physicians/practitioners may have noted a moderately high incidence of the following HIPAA compliance rejection code being returned on provider notification letters issued to them by their servicing A/B MAC or Carrier for situations where various Part B claims could not be crossed over: "H46201: The Contact Name is required only in the first iteration of the Contact Information Segment"

Since January, a systems problem has caused this defect for a sub-set of 5010 837 professional crossover claims. The identified fix date for this issue is July 2, 2012.

Billing vendors that receive provider notification letters containing H46201 will need to submit the balances remaining on the affected claims to the indicated patients' supplemental insurers. Letters should cease reflecting the H46201 error prior to July 10, 2012.

2013 ICD-10 PCS Files Now Available [↑]

The 2013 ICD-10-PCS files have been posted on the 2013 ICD-10 PCS and GEMs web page. This includes the 2013 Index and Tabular files, guidelines, code titles, addendum to reference manual, and slides. The 2013 ICD-10-PCS files contain information on the new procedure coding system, ICD-10-PCS, that is being developed as a replacement for ICD-9-CM, Volume 3.

The 2013 General Equivalent Mappings (GEMs), Reimbursement Mappings, and Reference Manual will be posted at a later date.

"The Basics of Medicare Enrollment for Physicians Who Infrequently Receive Medicare Reimbursement" MLN Fact Sheet — Revised [↑]

The Basics of Medicare Enrollment for Physicians Who Infrequently Receive Medicare Reimbursement Fact Sheet (ICN 006881) was revised and is now available in downloadable format. This fact sheet is designed to provide education on general Medicare enrollment information for those physicians who are required to enroll in Medicare for the sole purpose of certifying or ordering services for Medicare beneficiaries. It includes information on frequently asked questions and resources.

"Medicare Enrollment Guidelines for Ordering/Referring Providers" MLN Fact Sheet – Revised [↑]

The Medicare Enrollment Guidelines for Ordering/Referring Providers Fact Sheet (ICN 906223) was revised and is now available in downloadable format. This fact sheet is designed to provide education on the Medicare enrollment requirements for eligible ordering/referring providers. It includes information on the three basic requirements for ordering and referring and who may order and refer for Medicare Part A Home Health Agency, Part B, and DMEPOS beneficiary services.

More Helpful Links…

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