*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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**The e-News for Monday, July 2, 2012**



**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.

Continuing education credit may be awarded for participation in certain CMS National Provider Calls. Visit the Continuing Education Credit Notification web page to learn more.

**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.

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**Presentation Materials from May 2 Inpatient Rehabilitation Facility Quality Reporting Program "Train the Trainer" Conference Now Available** [↑]

CMS is pleased to announce that the PowerPoint slides and presentation handouts from the Inpatient Rehabilitation Facility (IRF) Quality Reporting Program "Train the Trainer" Conference, which took place on May 2 in Baltimore, Maryland are now available on the IRF Quality Reporting Spotlights and Announcements web page in the "Downloads" section.

**Medicare Proposes Revisions to the End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Bad Debt Reductions for All Medicare Providers** [↑]

On Monday, July 2, CMS issued a proposed rule that would update Medicare policies and payment rates for dialysis facilities, while strengthening incentives for improved quality of care and better outcomes for beneficiaries diagnosed with End-Stage Renal Disease (ESRD).The proposals would affect payments for outpatient maintenance dialysis treatments furnished on or after January 1, 2013 under the bundled ESRD Prospective Payment System (PPS) that was implemented in calendar year 2011.

CMS is projecting that payment rates for dialysis treatments will increase by 2.5 percent, representing a projected inflation (or ESRD bundled market basket) increase of 3.2 percent reduced by a projected productivity adjustment of 0.7 percent. CMS estimates that payments to ESRD facilities in 2013 will total $8.7 billion.

The proposed rule also proposes changes to the ESRD Quality Incentive Program (QIP) that provides payment incentives to dialysis facilities to improve the quality of dialysis care. Under the QIP, facilities that do not achieve a high enough total performance score with respect to quality measures established in regulation receive a reduction in their payment rates under the ESRD PPS. Please refer to the ESRD QIP website for more information.

CMS is also proposing to codify the provisions of section 3201 of the Middle Class Tax Extension and Job Creation Act of 2012 (Pub. L. No. 112-96) that requires reductions in bad debt reimbursement to all Medicare providers eligible to receive bad debt reimbursement; these provisions are specifically prescribed by statute and thus, are self-implementing. This reduction in bad debt reimbursement is projected to yield savings to the program of $10.9 billion over 10 years.

The rule (CMS-1352-P) can be viewed on the ESRD Payment Regulations and Notices website.

**Medicare Fee-For-Service Version 5010 July 1, 2012 Implementation Update for the Week of July 2** [↑]

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 Fee-For-Service (FFS) has the following updates for the week of July 2, 2012:

- Business Partner Confirmation for Version 5010

- Claims (837) Rejection Error Messages.
- Remittance Advice (835) Closeout Activities.

*Business Partner Confirmation for Version 5010*
Have you confirmed that your business partner has converted to version 5010 on your behalf? By now all providers should have contacted their clearinghouses, billing services, or vendors that they use to electronically submit Medicare FFS claims to ensure that as of July 1, 2012 all of your claims will be submitted in version 5010. Please contact your clearinghouse, billing service, or vendor before calling your MAC's EDI helpdesk to search for your claims and confirm your transition to version 5010.

*Claim (837 I and P) Rejection Error Message*
Since June 29, all Medicare FFS claims must be sent as Accredited Standards Committee (ASC) X12 Version 5010 or NCPDP D.0. Any Medicare FFS claims received in version 4010 format after normal close of business on June 29 are being rejected back to the submitter. The specific message received if a claim is rejected depends on your specific MAC. A detailed list of 4010 rejection error messages by MAC may be found on the Important 4010 - 5.1 Rejection Information web page.

*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 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.

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

**Hospital 30-day Risk-standardized Acute Myocardial Infarction Mortality eMeasure** [↑]

CMS has contracted with Yale New Haven Health Services Corporation/Center for Outcomes Research and Evaluation (YNHHSC/CORE) to develop a hospital quality measure of acute myocardial infarction (AMI) mortality for use with electronic health record (EHR) data. CMS developed and has implemented an AMI 30-day risk-standardized mortality measure using CMS claims data since 2008. This eMeasure was developed anew (*de novo)* using clinical data elements from a national registry. All data elements were selected based on feasibility of their extraction from EHR data and vetted with clinical and technical experts. The measure is designed for potential use in public reporting in the EHR environment. The measure has undergone eSpecification and its related testing will be completed later in 2012.

CMS is requesting stakeholder review and public comment of this measure. All measure comments are welcome, but we are particularly interested in feedback in the following areas:
- Measure development methodology
- Final model

The measure specifications are outlined in the Measure Justification Form, technical report, and fully eSpecified eMeasure (which includes the human readable .html file, the eMeasure specification .xml file, and the value sets .xls file), all of which are available for download at the link below. Comments on the measure must be *received by July 14, 2012, 11:59pm ET* and may be general or specific to the measure. The comments received will be posted approximately four weeks after the public comment period closes.

Please go to the Measures Management System Public Comment web page to access the CMS public comment system where you may access the documents described above and find instructions on comment submission. Thank you for your support and participation.

**Major Improvements to the Internet-based PECOS system** [↑]

Over the last year, CMS has listened to your feedback about Internet-based PECOS and made improvements to increase access to more information. CMS is pleased to announce that the following upgrades are now available:

*Access to More Information*

The layouts of the Internet-based PECOS homepage and log in screen have been redesigned. The homepage updates provide an easier way for users to register for a PECOS account and update personal information. It also features additional helpful links to allow access to multiple tools and reference information. The helpful links include PECOS enrollment tutorials, the Ordering and Referring List, and the Revalidation Notice Sent List.

- Users will also now be able to see if their revalidation application has been received and processed by the Medicare Administrative Contractor (MAC). In addition to a "Revalidation Notice Sent" date, a "Revalidation Received" date and a "Revalidation Complete" date will be displayed on the My Enrollments page. The "Revalidation Notice Sent" date and the "Revalidation Received" date will display on the My Enrollment page for 120 days. The "Revalidation Complete" date will display on the My Enrollments page indefinitely. (At this time, the quickest way to see if a revalidation letter was mailed to you is to check the Revalidation Notice Sent List link on the PECOS homepage. Later this year, a faster process will be used to update this information on the My Enrollments page.)
- A reassignment report is now available for all organizations and individuals that are accepting reassignments. The option to view this report is only available if the enrollment has current reassignments. The reassignment report is accessible via the Application Questionnaire page and displays the following columns:
    - Provider Name,
    - National Provider identifier (NPI),
    - Current Enrollment Status,
    - Enrollment State,
    - Revalidation Notice Sent Date, and
    - Revalidation Status.

The report displays up to 50 records on the report screen. For reassignment reports containing more than 50 records, the authorized user will be prompted to download the report into an excel spreadsheet by clicking the Generate Report button at the bottom of the screen.

**CMS Has Added an Important New FAQ for EPs on Using Hospital EHR Modules for Meaningful Use** [↑]

CMS wants to help keep you updated with information on the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs. CMS has recently added a new FAQ that discusses the ability for eligible professionals (EPs) in the EHR Incentive Programs to use hospital EHR modules to achieve meaningful use. Take a minute and review the new FAQ below.

*Question:* Can an EP use EHR technology certified for an inpatient setting to meet a meaningful use objective and measure?

*Answer:* Yes. For objectives and measures where the capabilities and standards of EHR technology designed and certified for an inpatient setting are equivalent to or

require more information than EHR technology designed and certified for an ambulatory setting, an EP can use the EHR technology designed and certified for an inpatient setting to meet an objective and measure. There are some EP objectives, however, that have no corollary on the inpatient side. As a result, an EP must possess Certified EHR Technology designed for an ambulatory setting for such objectives. Please reference ONC FAQ 12-10-021-1 and 9-10-017-2 and CMS FAQ 10162 for discussions on what it means to possess Certified EHR Technology, ONC FAQ 6-12-025-1 for a list of affected capabilities and standards, and how that relates to the exclusion and deferral options of meaningful use.

You can find this FAQ in the CMS FAQ system by searching for it by FAQ number. Type in 6421 in the "FAQ # Search" box found at the top, left side of the FAQ page. Choose the "FAQ #" option by clicking the circle and highlighting it in blue.

*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.

**CMS is Currently Accepting Suggestions for Potential Physician Quality Reporting System Measures and/or Measures Groups** [↑]

CMS is currently accepting quality measure suggestions for potential inclusion in the proposed set of quality measures in the Physician Quality Reporting System for future rule-making years. To learn more about the Physician Quality Reporting System Call for Measures, visit the CMS Measures Management System Webpage.

For measures to be considered in the Physician Quality Reporting System, *all required documentation* must be completed for each measure submitted for consideration to PHYSICIAN_REPORTING_TEMP@cms.hhs.gov, *no later than 5:00 p.m. EST August 1, 2012.*

*Required information includes:*
- National Quality Form (NQF) Measure Endorsement Status
- Measure Submitted for Consideration Form
- Measure Specifications (measure title, description, numerator and denominator, including exclusions, exceptions, and inclusions)
- Electronic Specification and Data Tables for EHR-specified candidate measures.

Note: Suggesting individual measures or measures for a new or existing measures group does not guarantee that the measure(s) will be included in the proposed or final sets of measures of any Proposed or Final Rules that address the Physician Quality Reporting System. CMS will determine what individual measures and measures group(s) to include in the proposed set of quality measures, and after a period of public comment, the agency will make the final determination with regard to the final set of quality measures for the Physician Quality Reporting System.

**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.

**Medscape ICD-10 Video Lectures Have Launched** [↑]

In June, three CME modules regarding ICD-10 implementation were posted to Medscape:

- "ICD-10: A Guide for Small and Medium Practices"
- "ICD-10: A Guide for Large Practices"
- "Transition to ICD-10: Getting Started"

**Medscape Healthcare Advisory on Preventive Services Distributed** [↑]

The Medscape Healthcare Advisory "Helping You and Your Patients Take Advantage of Recent Healthcare Provisions" was distributed on June 26.

**New Continuing Education Associations Now Accepting Medicare Learning Network® Courses** [↑]

The Medicare Learning Network (MLN) is happy to announce that the latest continuing education associations to accept MLN courses are the National Academy of Ambulance Coders (NAAC) and the American Association of Medical Assistants (AAMA). NAAC and AAMA join the American Association of Professional Coders (AAPC), the American Medical Billing Association (AMBA), and the Medical Association of Billers (MAB).

For more information about continuing education associations that accept MLN courses, visit the MLN Educational Web Guides website.

If the association you belong to accepts outside credit sources and is not on the list, you should contact them to see if they are interested in working with the MLN. If they are interested, the association should e-mail CE_Issues@cms.hhs.gov .

**More Helpful Links…**

**Check out CMS on**

Twitter, LinkedIn, YouTube, and Flickr!

**The Medicare Learning Network**
**Archive of Provider e-News Messages**