



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.

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.

The e-News for Wednesday, July 11, 2012

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- [“Publications for Medicare Beneficiaries” Fact Sheet Revised](#)
- [“Medicare Fee-For-Service \(FFS\) Physicians and Non-Physician Practitioners: Protecting Your Privacy – Protecting Your Medicare Enrollment Record” Fact Sheet — Revised](#)
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- [“Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse” Booklet — New](#)
- [“MLN Guided Pathways to Medicare Resources” Web Page — Revised](#)

National Provider Call: Physician Quality Reporting System & Electronic Prescribing — Register Now [[↑](#)]

Tuesday, July 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 proposed changes to the 2013 Physician Quality Reporting System & Electronic Prescribing Incentive Program as outlined in the Medicare Physician Fee Schedule Proposed Rule.

Target Audience: All Medicare fee-for-service (FFS) Providers; Medical Coders, Physician Office Staff, Provider Billing Staff, Electronic Health Records staff, and Vendors.

Agenda:

- Opening Remarks
- Program Announcements
- Overview of the proposed changes to the 2013 Physician Quality Reporting System & Electronic Prescribing Incentive Program as outlined in the Medicare Physician Fee Schedule Proposed Rule
- 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.

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: Medicare Shared Savings Program and Advance Payment Model Application Process — Register Now [[↑](#)]

Tuesday, July 31; 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 Tuesday, July 31, 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.

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Vendor Call for Inpatient Rehabilitation Facility Patient Assessment Instrument Software Vendors and Developers —Canceled [\[↑\]](#)

Due to the absence of submitted questions and comments related to the Inpatient Rehabilitation Facility (IRF) Patient Assessment Instrument Technical Submission Specifications, the CMS IRF Vendor Call scheduled for July 12 from 2-3pm ET has been cancelled. Vendors and software developers should submit technical questions to IRFTECHIssues@cms.hhs.gov.

Public Meeting Regarding Inherent Reasonableness of Medicare Fee Schedule Amounts for Non-Mail Order (Retail) Diabetic Testing Supplies — Reminder [\[↑\]](#)

Monday, July 23; 9am-1pm ET

CMS

7500 Security Boulevard

Baltimore, Maryland 21244

On June 22, CMS 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), which is now on display at the [Federal Register](#).

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.

Special Note: The statute requires that the first step of the inherent reasonableness process is to obtain supplier consultation *before* making a determination that a fee schedule amount is not inherently reasonable. Consequently, the purpose of the meeting is to obtain supplier consultation on whether the fee schedule amounts for non-mail order diabetic testing supplies are grossly excessive and therefore not inherently reasonable and whether to pursue special inherent reasonableness payment limits versus competitive bidding in achieving more appropriate pricing for these items. Decisions regarding whether to propose inherent reasonableness payment limits for these items and services, what data and pricing information to use, and when such limits would take effect will be examined by CMS and made after the meeting and would be included in a proposed notice for public comment published in the Federal Register.

Medicare Fee-For-Service (FFS) Version 5010 July 1, 2012 Implementation Update for the Week of July 9 [↑](#)

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 updates for the week of July 9, 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 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 ASC X12 Version 5010 or NCPDP D.0. Any Medicare FFS claims received in version 4010 format after normal close of business on June 29th 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 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.

More Information

For more information on ASCX12 Version 5010 and NCPDP Version D.0, please visit the [Versions 5010 and D.0](#) website.

More Than 16 Million People With Medicare Get Free Preventive Services in 2012 [\[↑\]](#)

Affordable Care Act made many preventive services no cost to beneficiaries

The Affordable Care Act – the new health care law – helped over 16 million people with original Medicare get at least one preventive service at no cost to them during the first six months of 2012, HHS Secretary Kathleen Sebelius announced on July 10. This includes 1.35 million who have taken advantage of the Annual Wellness Visit provided by the Affordable Care Act. In 2011, 32.5 million people in Medicare received one or more preventive benefits free of charge.

Prior to 2011, people with Medicare faced cost-sharing for many preventive benefits such as cancer screenings. Through the Affordable Care Act, preventive benefits are offered free of charge to beneficiaries, with no deductible or co-pay, so that cost is no longer a barrier for seniors who want to stay healthy and treat problems early.

The law also added an important new service for people with Medicare — an Annual Wellness Visit with the doctor of their choice— at no cost to beneficiaries.

For more information on Medicare-covered preventive services, please visit [Healthcare.gov](#).

To learn what screenings, vaccinations and other preventive services doctors recommend for you and those you care about, please visit the myhealthfinder tool at [healthfinder.gov](#).

Full text of this excerpted [CMS press release](#) (issued July 10).

CMS Proposes Claims-Based Data Collection Strategy for Therapy Services [\[↑\]](#)

CMS issued proposed rule, CMS-1590-P, on July 6 that includes a proposal to collect data on patient function related to physical and occupational therapy, and speech language pathology services. Section 3005(g) of the Middle Class Tax Relief and Jobs Creation Act (MCTRJA) requires CMS to implement, beginning on January 1, 2013, “. . . a claims-based data collection strategy that is designed to assist in reforming the Medicare payment system for

outpatient therapy services subject to the limitations of section 1833(g) of the Act. Such strategy shall be designed to provide for the collection of data on patient function during the course of therapy services in order to better understand patient condition and outcomes.”

The proposed rule will appear in the July 30, 2012 Federal Register. CMS will accept comments on the proposed rule until September 04, 2012, and will respond to them in a final rule with comment period to be issued by November 1, 2012.

Raise Blood Pressure Control and Cardiovascular Disease Awareness this Summer as Part of the *Million Hearts*™ Campaign [\[↑\]](#)

More than 68 million Americans are living with high blood pressure, and many of them don't know it. High blood pressure increases the risk for heart disease and stroke, leading causes of death in the U.S. The good news is that you can help fight against cardiovascular disease and the “silent killer, high blood pressure.

On September 13, 2011, the Department of Health and Human Services, with several key partners, launched the [Million Hearts](#)™ initiative. The goal of this campaign is to prevent 1 million heart attacks and strokes over the next 5 years. *Million Hearts*™ focuses on empowering Americans to make healthy choices and on improving care by addressing the major risk factors for cardiovascular disease. As a health care professional, you can help save thousands of lives over the next 5 years by participating in this critical campaign.

Medicare provides coverage for a variety of preventive services that can help your Medicare patients prevent and detect certain health conditions that can contribute to cardiovascular disease. These include, but are not limited to:

- Cardiovascular Disease Screening (total cholesterol, high-density lipoproteins, and triglycerides tests)
- Intensive Behavioral Therapy for Cardiovascular Disease
- Tobacco-use cessation counseling services
- Initial Preventive Physical Exam (also commonly referred to as the “Welcome to Medicare” Preventive Visit)
- Annual Wellness Visit, providing a Personalized Prevention Plan Service
- Intensive Behavioral Therapy for Obesity
- Diabetes Screening

As you talk with your Medicare patients about their risk factors for cardiovascular disease, and the steps they can take to help lower and control their blood pressure and cholesterol, please discuss these important services with them and encourage utilization as appropriate.

Many people's lives are endangered by heart disease—utilization of these Medicare covered services can help save those lives.

Resources from the Medicare Learning Network® (MLN):

- [Expanded Benefits brochure](#)
- [Tobacco-Use Cessation Counseling Services brochure](#)
- [The ABCs of Providing the Initial Preventive Physical Examination \(IPPE\), or "Welcome to Medicare Preventive Visit" quick reference chart](#)
- [The ABCs of Providing the Annual Wellness Visit \(AWV\) quick reference chart](#)

More Information for Healthcare Professionals:

- [National Coverage Determination \(NCD\) for Intensive Behavioral Therapy for Cardiovascular Disease](#)
- [Million Hearts™ Initiative website](#)

HHS Announces 89 New Accountable Care Organizations [\[↑\]](#)

2.4 million people with Medicare to receive better, more coordinated care

On July 9, HHS Secretary Kathleen Sebelius announced that as of July 1, 89 new Accountable Care Organizations (ACOs) began serving 1.2 million people with Medicare in 40 states and Washington, D.C. ACOs are organizations formed by groups of doctors and other health care providers that have agreed to work together to coordinate care for people with Medicare.

These 89 new ACOs have entered into agreements with CMS, taking responsibility for the quality of care they provide to people with Medicare in return for the opportunity to share in savings realized through high-quality, well-coordinated care.

Participation in an ACO is purely voluntary for providers. The Medicare Shared Savings Program (MSSP), and other initiatives related to ACOs, is made possible by the 2010 Affordable Care Act. Federal savings from this initiative could be up to \$940 million over four years.

The 89 ACOs announced on July 9 bring the total number of organizations participating in Medicare shared savings initiatives to 154, including the 32 ACOs participating in the testing of the Pioneer ACO Model by CMS's Center for Medicare and Medicaid Innovation (Innovation Center) announced last December, and six Physician Group Practice Transition Demonstration organizations that started in January 2011. In all, as of July 1, more than 2.4 million beneficiaries are receiving care from providers participating in Medicare shared savings initiatives.

The selected ACOs operate in a wide range of areas of the country and almost half are physician-driven organizations serving fewer than 10,000 beneficiaries, demonstrating that smaller organizations are interested in operating as ACOs. Their models for coordinating care and improving quality vary in response to the needs of the beneficiaries in the areas they are serving.

To ensure that savings are achieved through improving care coordination and providing care that is appropriate, safe, and timely, an ACO must meet quality standards. For 2012, CMS has established 33 quality measures relating to care coordination and patient safety, appropriate use of preventive health services, improved care for at-risk populations, and patient and caregiver experience of care.

Beginning this year, new ACO applications will be accepted annually. The application period for organizations that wish to participate in the MSSP beginning in January 2013 is from August 1 through September 6, 2012. More information, including application requirements, is available on the [Shared Savings Program Application](#) web page.

To learn more about the ACOs announced today, see the [Fact Sheet](#).

Full text of this excerpted [CMS press release](#) (issued July 9).

Get Ready for DMEPOS Competitive Bidding [[↑](#)]

The Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program Round 1 Reopen 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.

“The Supplemental Security Income (SSI) Ratios for Fiscal Year (FY) 2006 through FY 2009 for Inpatient Prospective Payment System (IPPS) Hospitals, Inpatient Rehabilitation Facilities (IRFs), and Long Term Care Hospitals (LTCHs)” MLN Matters® Article —Released [\[↑\]](#)

[MLN Matters® Special Edition Article #SE1225](#), “The Supplemental Security Income (SSI) Ratios for Fiscal Year (FY) 2006 through FY 2009 for Inpatient Prospective Payment System (IPPS) Hospitals, Inpatient Rehabilitation Facilities (IRFs), and Long Term Care Hospitals (LTCHs),” was released and is now available in downloadable format. This article is designed to provide education on how SSI ratio ratios are calculated for IPPS hospitals, IRFs, and LTCHs, as outlined in the April 28, 2010, CMS Ruling No. CMS-1498-R. It includes information about how providers can obtain data used to calculate their FY 2006 through FY 2009 SSI ratios and how Medicare contractors plan to settle the backlog of cost reports awaiting SSI ratios.

“Reminder of Importance of Correct Place-of-Service Coding on Medicare Part B Claims” MLN Matters® Article — Released [\[↑\]](#)

[MLN Matters® Special Edition Article #SE1226](#), “Reminder of Importance of Correct Place-of-Service Coding on Medicare Part B Claims,” was released and is now available in downloadable format. This article is designed to provide education on the importance of correctly coding the place-of-service on Medicare Part B claims. It includes information about what providers are required to do when identifying the place-of-service on Medicare claim forms. The article also provides a summary of the 2009 Office of Inspector General (OIG) audit that was conducted to determine whether physicians correctly coded place-of-service on a sample of Medicare Part B claims.

“Publications for Medicare Beneficiaries” Fact Sheet Revised [\[↑\]](#)

The [Publications for Medicare Beneficiaries](#) Fact Sheet (ICN905183) has been revised and is now available in downloadable format. This fact sheet is designed to provide education on the variety of beneficiary-related publications available to assist providers in answering patients' questions. It includes a list of products with information you can print out and provide to your Medicare beneficiaries.

“Medicare Fee-For-Service (FFS) Physicians and Non-Physician Practitioners: Protecting Your Privacy – Protecting Your Medicare Enrollment Record” Fact Sheet — Revised [\[↑\]](#)

The [Medicare Fee-For-Service \(FFS\) Physicians and Non-Physician Practitioners: Protecting Your Privacy - Protecting Your Medicare Enrollment Record](#) Fact Sheet (ICN 903765) has been revised and is now available in downloadable format. This fact sheet is designed to provide education on how to ensure Medicare enrollment records are up-to-date and secure. It includes information on the actions physicians and non-physician practitioners should take to protect their Medicare enrollment information.

“Internet-based Provider Enrollment, Chain and Ownership System (PECOS) Contact Information” Fact Sheet — Revised [\[↑\]](#)

The [Internet-based Provider Enrollment, Chain and Ownership System \(PECOS\) Contact Information](#) Fact Sheet (ICN 903766) has been revised and is now available in downloadable format. This fact sheet is designed to provide contact information for technical assistance with Internet-based PECOS. It includes a list of contacts and other resources.

“Quick Reference Information: Medicare Immunization Billing” Educational Tool — Revised [\[↑\]](#)

The [Quick Reference Information: Medicare Immunization Billing](#) Educational Tool was revised and is now available in downloadable and hard copy format. This educational tool is designed to provide education on Medicare-covered preventive immunizations. It includes coverage, coding and billing information on the influenza, pneumococcal and Hepatitis B vaccines and their administration.

To access a new or revised product available for order in *hard copy* format, go to [MLN Products](#) and click on “MLN Product Ordering Page” under “Related Links” at the bottom of the web page.

“Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse” Booklet — New [\[↑\]](#)

The [Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse](#) Booklet (ICN 907798) was released and is now available in downloadable format. This brochure is designed to provide education on screening and behavioral counseling interventions in primary care to reduce alcohol abuse. It includes information about risky/hazardous and harmful drinking.

“MLN Guided Pathways to Medicare Resources” — Revised [\[↑\]](#)

The [MLN Guided Pathways to Medicare Resources](#) have been revised and are now available in downloadable format. The MLN Guided Pathways curricula contain brief descriptions and links to many CMS resources. These products are designed to allow users to quickly and easily scan or search the resources and click on topics of interest. They are also designed so you can move directly to a specific section by using bookmarks or the Table of Contents.

More helpful links...

Check out CMS on



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[The Medicare Learning Network](#)

[Archive of Provider e-News Messages](#)