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 25, 2012

NATIONAL PROVIDER CALLS

- Medicare Shared Savings Program and Advance Payment Model Application Process — Register Now
- CMS Proposals for the Physician Value-Based Payment Modifier Under the Medicare Physician Fee Schedule — Register Now
- Medicare Preventive Services National Provider Call: New Medicare Preventive Services — Registration Now Open

OTHER CALLS, MEETINGS, AND EVENTS

- Special Open Door Forum on ACA Section 3004: Quality Reporting Program for Inpatient Rehabilitation Facilities (IRFs)
- Special Open Door Forum for Long-Term Care Hospitals

ANNOUNCEMENTS AND REMINDERS

- One Week to Transition to Version 5010 for the Remittance Advice (835)
- Medicare Announces Updated, Enhanced Tools for Patients to Compare Hospitals and Nursing Homes
- Did you know that you can now submit your CQM data for the Medicare EHR Incentive Program electronically?
- How to Prepare for Documentation Changes and Improvements with ICD-10
- 2013 ICD-10 CM Codes and Mapping Files are Now Available
- 2012 Physician Quality Reporting System Program Reminder
- All Medicare Provider and Supplier Payments To Be Made By Electronic Funds Transfer
- CMS is Currently Accepting Suggestions for Potential Physician Quality Reporting System Measures and/or Measures Groups
- Get Ready for DMEPOS Competitive Bidding
- From the CDC: Life-Threatening Outbreaks Due To Injection Practices
- New Shared Saving Program FAQs Posted to the CMS Website
- Medscape CME/CE Module on HIV Launched

- Act Now to Avoid Claim Denials for Ordered/Referred Services

CLAIMS, PRICER, AND CODE UPDATES

- Quarterly Provider Specific Files for the Prospective Payment System are Now Available
- HHAs Must Use Individual Practitioner NPIs to Bill for Ordered/Referred Services

MLN EDUCATIONAL PRODUCTS UPDATE

- "Advance Beneficiary Notice of Noncoverage (ABN) Part A and Part B" – Revised
- "The Basics of Medicare Enrollment for Institutional Providers" Fact Sheet – Revised
- "Substance (Other than Tobacco) Abuse Structured Assessment and Brief Intervention (SBIRT)" Fact Sheet – Reminder
- "Medicare Podiatry Services: Information for Medicare Fee-For-Service Health Care Professionals" Fact Sheet – Reminder
- "The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Physicians and Non-Physician Practitioners" Fact Sheet – Revised
- MLN Matters® Search Tips
- Submit Feedback on MLN Products and Services
- Get Connected with the Medicare Learning Network!

National Provider Call: Medicare Shared Savings Program and Advance Payment Model Application Process — Register Now [↑]
Tuesday, July 31; 1:30-3pm 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 registration website. 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: CMS Proposals for the Physician Value-Based Payment Modifier Under the Medicare Physician Fee Schedule — Register Now [↑]
Wednesday, August 1; 2:30-4 pm ET

CMS will provide an overview of its proposals for the physician value-based payment modifier. CMS has proposed to phase-in application of the value modifier, starting in 2015 with groups of physicians with 25 or more eligible professionals. The value modifier for these groups would be based on performance during 2013. The presentation will describe the options these groups have on how the Value Modifier would be calculated based on whether they participate in the Physician Quality Reporting System (PQRS). For groups of 25 or more that do not participate in the PQRS, CMS is proposing to set their Value Modifier at a 1.0 percent payment reduction. For groups that wish to have their payment adjusted according to their performance on the value modifier, the rule proposes a system whereby groups with higher quality and lower costs would be paid more, and groups with lower quality and higher costs would be paid less.

A question and answer session will follow the presentation.

Target Audience: Physicians, physician group practices, practice managers, medical and specialty societies, payers, insurers.

Registration Information: In order to receive call-in information, you must register for the call on the CMS Upcoming National Provider Calls registration website. 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.

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National Provider Call: Medicare Preventive Services National Provider Call: New Medicare Preventive Services — Registration Now Open [↑]
Wednesday, August 15; 2-3:30 pm ET

Did you know that five new preventive services are now covered by Medicare?

- Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse – Effective 10/14/11
- Screening for Depression in Adults – Effective 10/14/11
- Intensive Behavioral Therapy for Cardiovascular Disease – Effective 11/8/11
- Screening for Sexually Transmitted Infections (STIs) and High-Intensity Behavioral Counseling (HIBC) to Prevent STIs – Effective 11/8/11
- Intensive Behavioral Therapy for Obesity– Effective 11/29/11

CMS experts will provide an overview of these new services, when to perform them, who can perform each service, who is eligible, and how to code and bill for each service, followed by a question and answer session.

Call participants are encouraged to review the following materials on these preventive services prior to the call:

- From the MLN: "Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse" Booklet
- From the MLN: "Screening for Depression" Booklet
- National Coverage Determination: Intensive Behavioral Therapy for Cardiovascular Disease
- National Coverage Determination: Screening for Sexually Transmitted Infections (STIs) and High-Intensity Behavioral Counseling (HIBC) to prevent STIs
- From the MLN: "Intensive Behavioral Therapy (IBT) for Obesity" Booklet

Target Audience: Physicians, physician assistants, nurse practitioners, clinical nurse specialists, health educators, registered dietitians, nutrition professionals, medical billers and coders, and other interested health care professionals

Registration Information: In order to receive call-in information, you must register for the call on the CMS Upcoming National Provider Calls registration website. 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.

Special Open Door Forum on ACA Section 3004: Quality Reporting Program for Inpatient Rehabilitation Facilities (IRFs) [↑]
Thursday, July 26; 1-2:30pm ET

Join CMS for the first in a 4-part series of IRF Special Open Door Forums. The main purpose of this Open Door Forum Series is to present information on various topics related to the Affordable Care Act (ACA) Section 3004 IRF Quality Reporting Program, so that IRFs can be better prepared when the program goes live on October 1, 2012.

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 October 1, 2012.

Agenda Topics for the Series will Include:

- An overview of the legislative requirements of the ACA Section 3004 statute
- An assessment of pressure ulcers in IRF patients
- An overview of the Quality Indicator section of the IRF-PAI
- How to properly document pressure ulcer data in the Quality Indicator section of the IRF-PAI
- How to report CAUTI data to NHSN

- Information about upcoming technical WebEx presentations
- Discussion of major topics from "IRF Frequently Asked Questions"

Program Background:
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 August 5, 2011 (Vol. 76, No. 151).

The IRF Quality Reporting Program requires that beginning on October 1, 2012, IRF's must begin to submit quality measure data to CMS on two measures. These measures include:
- A urinary catheter-associated urinary tract (CAUTI) infection measure
- 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-PAI instrument. The IRF-PAI has been in use in 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.

Presentation: To read more about the IRF Quality Reporting Program and to view presentation materials, visit the IRF Quality Reporting web page.

Participation Instructions:
- Audio lines are available by calling the Conference Call line at the time of the event:
- Dial: 1-800-837-1935
- Conference ID: 13189170
- 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 posted to the Special Open Door Forum website as soon as they are available.

For automatic emails of Open Door Forum schedule updates (email list subscription) and to view Frequently Asked Questions please visit the Open Door Forums website.

Special Open Door Forum for Long-Term Care Hospitals [↑]
Thursday, July 26; 2:30pm-4pm ET

Join CMS for this Special Open Door Forum which will cover a variety of topics of interest to Long-Term Care Hospitals (LTCHs).

Agenda Topics will Include:
- Information specifically pertaining to the free downloadable Software LASER (LTCH Assessment Submission Entry &Reporting)

- Questions and Answers Related to LASER
- Updates related to the free, upcoming technical trainings related to the submission of the LTCH CARE Data Set
- Updates related to the LTCH Quality Reporting Manual Release and FAQs
- Updates related to the posting of the May, 2012 LTCH QRP Train-the Trainer Conference Training Materials
- Additional information about trainings
- General Questions and Answers

Target Audience: LTCH Providers, as well as LTCH Software developers, are highly encouraged to attend

Instructions to Access Teleconference:
Audio lines are available by calling the Conference Call line at the time of the event.
- Dial in Number: 800-837-1935
- Conference ID: 13198135

One Week to Transition to Version 5010 for the Remittance Advice (835) [↑]

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 23, 2012:
- One week remaining to transition to the Accredited Standards Committee (ASC) X12 Version 5010 (5010) Remittance Advice (835)
- Remittance Advice (835) Closeout Activities

One Week Remaining To Transition to Version 5010 for the Remittance Advice (835):
Providers are encouraged to test with Medicare and transition to version 5010 for remittance advice now! The new version 5010 introduces some significant improvements over the current version ASC X12 Version 4010; e.g., in version 5010, the Health Policy Segment will report the National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs). In addition, the 835 also will have the website where the specific LCD/NCD code is explained. Providers will have access to the code as well as the code description. The 5010 version of the 835 also will contain technical contact information not currently in version 4010. Version 5010 contains new segments such as coverage expiration date and claim received date which will help provider's access important information without manual intervention.

If you haven't already finished testing, please contact your Medicare contractor and begin testing so that you are ready on or before August 1, 2012. If you have already finished testing, contact your Medicare contractor and start receiving the version 5010 835s NOW.

Remittance Advice Closeout Activities (835):
Beginning August 1, 2012, the Medicare FFS program shall produce only the 835 remittance advice transaction in the ASC X12 Version 5010. 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.

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

Medicare Announces Updated, Enhanced Tools for Patients to Compare Hospitals and Nursing Homes [↑]

Two websites that help Americans make informed choices about hospitals and nursing homes have been redesigned and will make more information available to the public, CMS announced on July 19.

The two sites – Hospital Compare and Nursing Home Compare – have been enhanced to make navigation easier by users, and have added important new comparison tools like findings from nursing home inspections.

Both sites contain important data on how well these facilities perform on quality measures – such as the frequency of infections that develop in the hospital, how often patients have to be readmitted to the hospital, and the percentage of nursing residents who report having moderate to severe pain while staying in the nursing homes. Researchers will now be able to access the data on both of these sites through mobile ready applications**.**

On both websites, navigation has been improved for consumers, who will find large and easy to use maps for pinpointing hospitals, and new search functionalities that allow the user to input the name of a hospital. Glossaries and web resources have been enhanced to make the information easier to understand.

In addition, new information is available on each of the websites. Updates to Nursing Home Compare include:

- Narratives that detail specific findings from inspections of nursing home facilities;
- Two new measures that report a nursing home's use of antipsychotic medications;
- Updated data for quality measures previously available on the site; and
- Information on nursing home ownership available thanks to the Affordable Care Act.

Additions to Hospital Compare include:

- Two new measures that cover potential health risks of imaging services, such as exposure to unnecessary radiation; and
- Updated data for existing quality measures.

These two consumer tools are highly popular with patients, their families, and caregivers. In the first half of 2012 there were over 1.2 million visits to the Hospital Compare site, and over 500,000 visits to Nursing Home Compare. The sites can be found at Hospital Compare and Nursing Home Compare. The Eldercare Locator can be found at www.eldercare.gov. This public service of the Administration on Community Living is a nationwide service that connects older adults and their caregivers with information on senior services.

Full text of this excerpted CMS press release (issued July 19).

Did you know that you can now submit your CQM data for the Medicare EHR Incentive Program electronically? [↑]

The Physician Quality Reporting System (PQRS) Medicare Electronic Health Record (EHR) Incentive Pilot allows eligible professionals to meet the clinical quality measure (CQM) reporting objective of meaningful use requirements for the EHR Incentive Program through electronic submission while also reporting for the PQRS program.

A provider who wishes to participate in the electronic reporting pilot must submit *12 months* of clinical quality measures data. Eligible professionals must submit the data between *January 1, 2013* and *February 28, 2013*.

CQM data for the electronic reporting pilot must be derived from certified EHR technology. If you decide to submit the data directly from your EHR, your EHR also needs to be PQRS "qualified." You can also have a PQRS-qualified data submission vendor submit quality measures data for the electronic reporting pilot on your behalf.

A list of the 2012 PQRS-qualified EHR and data-submission vendors is posted on the PQRS website.

You can register for the electronic reporting pilot program while attesting for the EHR Incentive Program on the online registration page. Simply check "Yes" on the eReporting page as you go through the attestation process.

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.

How to Prepare for Documentation Changes and Improvements with ICD-10 [↑]

Although the final rule on the proposed ICD-10 deadline change has not been published yet, it is important to continue planning for the transition. ICD-10 will require an increased granularity and specificity in documentation of patient encounters. This change will mean that providers and payers need to adjust how they document patient visits but will create more detailed data that can be used to improve patient care. More specific code sets can also assist providers avoid delays in reimbursement payments by identifying why certain claims are being rejected or denied by payers.
You will need to prepare for these changes in clinical documentation by taking certain steps:

1. *Inventory Systems and Identify Discrepancies:* You should review your systems that currently use ICD-9 in order to identify areas in your revenue cycle, reimbursement rates, health information management, electronic medical records, and clinical systems that will eventually use ICD-10. These systems will be affected by the increased specificity of documentation as well as the increase in number of codes used in ICD-10. Your systems inventory will need to evaluate any potential gaps in clinical conditions or work flow processes that could be affected by increased documentation. Once you have identified any discrepancies, you can update and modify your systems and processes prior to transitioning to the new code sets. This will save your organization time by finding incomplete or non-specific data and ensuring that they do not cause a delay with coding and billing when you finalize implementing ICD-10.
2. *Evaluate Current Software Systems:* As you conduct your systems inventory, you may realize that some of your systems have become out-of-date or are redundant. You will need to determine if it is more cost-effective and efficient to upgrade these systems or centralize and replace them before ICD-10 implementation.

3. *Train and Educate Staff:* Your organization should identify staff members, from providers to coders, who currently use ICD-9 codes. Staff who will now be using ICD-10 will need training to become familiar with the increased documentation standards necessary with the new code sets. Training will help staff members become comfortable with both the heightened specificity and increased number of code sets that they will be using frequently.
4. *Test the Documentation Process:* Finally, your organization will need to test each stage of the new documentation process in a trial setting. Staff members should simulate a typical patient encounter in its entirety to ensure that data is being documented thoroughly and consistently. This will also help identify any areas that still require improvement in the coding process.

Keep Up to Date on ICD-10:
Please visit the ICD-10 website for the latest news and resources to help you prepare.

2013 ICD-10 CM Codes and Mapping Files are Now Available [↑]

The 2013 ICD-10-CM codes and mapping files are now posted on the 2013 ICD-10-CM and GEMs web page. The files contain information on the new diagnosis coding system, ICD-10-CM, that is being developed as a replacement for ICD-9-CM, Volumes 1 and 2. This posting includes the following 2013 files:

- Tabular and index of ICD-10-CM
- Addenda (changes since the 2012 version)
- Complete list of ICD-10-CM code titles – long and abbreviated
- General Equivalence Mappings
- Reimbursement Mappings
- Duplicate ICD-9-CM and ICD-10-CM codes

As a reminder, CMS recently posted the 2013 ICD-10-PCS files to the 2013 ICD-10-PCS and GEMs web page. CMS also posted the ICD-10 Medicare Code Editor v 29 (MCE v29 to be used with v29 Definitions Manual) on the ICD-10 MS-DRG Conversion Project web page, along with additional files for the the ICD-10 MS-DRG conversion project.

2012 Physician Quality Reporting System Program Reminder [↑]

It is not too late to start participating in the 2012 Physician Quality Reporting System (PQRS) and potentially qualify to receive an incentive payment equal to 0.5% of an eligible professional's total Medicare Part B allowed charges for services furnished during the reporting period. A new six month reporting period using the registry submission option began on July 1, 2012. In addition, there are still ways to participate in the 12-month reporting period using claims, registry or EHR submission.

The 2012 PQRS has two reporting periods: 12-months (January 1-December 31, 2012) and 6-months (July 1-December 31, 2012).

You can use one of the following options to report PQRS data for services furnished January 1 – December 31, 2012:

- EHR-based reporting (Direct EHR or Data Submission Vendor) of at least three PQRS measures for 80% or more of the applicable Medicare Part B FFs patients

- EHR-based reporting (Alignment with Medicare EHR Incentive Program) of all three Medicare EHR Incentive Program core measures OR up to 3 Medicare EHR Incentive Program alternate core measures AND 3 additional measures for the Medicare EHR Incentive Program
- Registry-based reporting of at least three PQRS measures for 80% or more of the applicable Medicare Part B FFS patients
- Registry-based reporting of at least one measures group for 30 or more applicable Medicare Part B FFS patients
- Registry-based reporting of at least one measures group for 80% or more of applicable Medicare Part B FFS patients (with a minimum of 15 patients)
- Claims-based reporting of at least one measures group for 30 or more applicable Medicare Part B FFS patients

To report PQRS data for services furnished July 1-December 31, 2012 use the following option:

- Registry-based reporting of one measures group for 80% or more of applicable Medicare Part B FFS patients (with a minimum of 8 patients)

Eligible professionals do not need to sign up or pre-register to participate in the 2012 PQRS. Submission of the appropriate quality data codes (QDCs) for individual PQRS measures or for a measures group to CMS on Part B claims will indicate intent to participate. Eligible professionals who intend to participate via registry or EHR mechanisms should work with their registry or EHR vendor on transmitting their 2012 PQRS measure data to CMS in early 2013.

Although there is no requirement to register prior to submitting the data, there are some preparatory steps that eligible professionals should take prior to undertaking PQRS reporting. CMS has created many educational products that provide information about how to get started with PQRS reporting. To access all available educational resources on PQRS please visit the PQRS website. Eligible professionals are encouraged to visit the PQRS webpage often for the latest information and downloads on PQRS.

Eligible professionals also should note that 2012 is the last reporting year tied exclusively to an incentive payment. Beginning in 2015, CMS will apply a negative payment adjustment to eligible professionals who do not satisfactorily report data on quality measures for covered professional services. Reporting during the 2013 PQRS program year will be used to determine whether a PQRS payment adjustment applies in 2015. The proposed criteria for satisfactorily reporting data on quality measures to avoid the 2015 PQRS payment adjustment is detailed in the 2013 Medicare Physician Fee Schedule Proposed Rule, which went on public display on July 6, 2012. A link to the proposed rule is provided in the resources section below.

Resources:

- 2012 PQRS Implementation Guide and Measures List
- Phase I Qualified Registries for 2012 PQRS Reporting (final list of 2012 Qualified Registries will be posted at the end of July 2012)
- Phase I Qualified EHR Direct Vendors for 2012 PQRS Reporting (final list of 2012 Qualified EHR Direct Vendors and Data Submission Vendors to be posted later this summer)
- 2013 Medicare Physician Fee Schedule Proposed Rule

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."

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 into 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.

From the CDC: Life-Threatening Outbreaks Due To Injection Practices [↑]

On July 13, the Centers for Disease Control (CDC) released a report detailing two life-threatening outbreaks that occurred when healthcare providers used medication from single-dose/single-use vials for multiple patients undergoing treatment for pain. At least 10 patients contracted severe staph or MRSA infections and had to be hospitalized. An additional patient died, and although MRSA was not listed as the cause of death, it could not be ruled out.

These breaches of basic infection control practices are a stark reminder that CDC recommendations for injection safety must be followed closely with every patient, even during times of medication shortages. In circumstances when individually packaged and appropriately sized single-dose/single-use vials are unavailable (e.g., during national shortage) contents from unopened vials can be packaged into multiple single-use vehicles, provided that the repackaging is

performed in accordance with all standards in United States Pharmacopeia General Chapter <797 >.

The CDC encourages clinicians to double check their practices against CDC's Injection Safety Recommendations. In addition, CDC offers healthcare providers a toolkit featuring a narrated PowerPoint presentation that is ideal for staff meetings, seminars, and other education opportunities.

New Shared Saving Program FAQs Posted to the CMS Website [↑]

CMS has posted new Medicare Shared Savings Program Frequently Asked Questions (FAQs) to the CMS Shared Savings Program website. In response to questions from industry stakeholders, the FAQs have been updated to provide additional guidance to all Medicare Shared Savings Program applicants and future applicants about the requirements under 42 CFR part 425 related to mergers and acquisitions. The new FAQs cover the following topic categories: General, Accountable Care Organization (ACO) Participant List, Form CMS-588 Electronic Funds Transfer, and Governing Body. To learn more about the Shared Saving Program, please visit the CMS Shared Savings Program website.

Medscape CME/CE Module on HIV Launched [↑]

On July 20, a CME/CE Clinical Anthology entitled "Obtaining and Paying for Care for HIV-infected Patients" was made available. This anthology includes three parts:

- Part 1 – Getting Started: Basics of HIV Therapy Initiation and Disease Monitoring
- Part 2 – Getting HIV-Infected Patients Into Care: What Are the Barriers?
- Part 3 – Obtaining Payment for HIV Care: Payment Options and Impact of the Affordable Care Act

Please note, you must login to Medscape in order to view the items linked above.

Act Now to Avoid Claim Denials for Ordered/Referred Services [↑]

CMS will soon begin denying Part B, DME, and Part A HHA claims that fail the ordering/referring provider edits. These edits ensure that physicians and others who order and refer items or services have established their Medicare enrollment records and are of a specialty that is eligible to order and refer. CMS will provide 60-day advanced notice prior to turning on the Ordering/Referring edits. CMS does not have a date at this time.

If you order or refer items or services for Medicare beneficiaries, or bill for these services, please read these CMS resources to be sure you are following Medicare requirements.

MLN Matters® Articles:

- #SE1221 Phase 2 of Ordering and Referring Requirement,
- #SE1011 Edits on the Ordering/Referring Providers in Medicare Part B, DME and Part A HHA Claims

MLN Fact Sheets:

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

All providers may also confirm whether or not an eligible ordering or referring provider is enrolled in Medicare by reviewing the Ordering and Referring File on the CMS website.

Quarterly Provider Specific Files for the Prospective Payment System are Now Available [↑]

The July 2012 Provider Specific Files (PSF) are now available for download from the CMS website in SAS or Text format. The files contain information about the facts specific to the provider that affect computations for the Prospective Payment System. The SAS data files are available on the Provider Specific Data for Public Use In SAS Format web page, and the Text data files are available on the Provider Specific Data for Public Use in Text Format web page. The Text data files are available in two versions. One version contains the provider records that were submitted to CMS. The other version also includes name and address information for providers at the end of the records.

HHAs Must Use Individual Practitioner NPIs to Bill for Ordered/Referred Services [↑]

Regional Home Health Intermediaries (RHHIs) and A/B MACS with home health workloads will be contacting home health agencies (HHAs) that submitted claims using both a group name and national provider identifier (NPI) as the attending NPI for ordered or referred services. The physician's name and NPI, not a group name and NPI, must be used as the attending name and NPI on the claim. Once CMS turns on the edits for ordering/referring services, claims using a group NPI will be denied.

Please note, CMS recently sent a message to remind physicians to provide their individual NPI to HHAs upon request. Physicians may verify their individual NPI using the NPI Registry on the CMS website.

"Advance Beneficiary Notice of Noncoverage (ABN) Part A and Part B" – Revised [↑]

The "Advance Beneficiary Notice of Noncoverage (ABN) Part a and Part B" booklet has been revised and is now available in downloadable format. This booklet is designed to provide education on the Advanced Beneficiary Notice (ABN). It includes information on when an ABN should be used and how it should be completed.

"The Basics of Medicare Enrollment for Institutional Providers" Fact Sheet – Revised [↑]

"The Basics of Medicare Enrollment for Institutional Providers" Fact Sheet (ICN 903783) has been revised and is now available in downloadable format. This fact sheet is designed to provide education on basic Medicare enrollment information and how to ensure institutional providers are qualified and eligible to

enroll in the Medicare Program. It includes information on how to enroll in the Medicare Program, how to report changes, and a list of resources.

"Substance (Other than Tobacco) Abuse Structured Assessment and Brief Intervention (SBIRT)" Fact Sheet – Reminder [↑]

The "Substance (Other Than Tobacco) Abuse Structured Assessment and Brief Intervention (SBIRT)" Fact Sheet, ICN (904084) is available in downloadable and hard copy format. This fact sheet includes an early intervention approach that targets those with nondependent substance use to provide effective strategies for intervention prior to the need for more extensive or specialized treatment.

"Medicare Podiatry Services: Information for Medicare Fee-For-Service Health Care Professionals" Fact Sheet – Reminder [↑]

The Medicare Podiatry Services: Information for Medicare Fee-For-Service Health Care Professionals Fact Sheet (ICN 006948) is available in downloadable format. This fact sheet is designed to provide education on Medicare-covered podiatry services. It includes a list of services that are not covered by Medicare, billing guidelines, and a list of resources.

"The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Physicians and Non-Physician Practitioners" Fact Sheet – Revised [↑]

"The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Physicians and Non-Physician Practitioners" Fact Sheet (ICN 903764) has been revised and is now available in downloadable format. This fact sheet is designed to provide education on how physician and non-physician practitioners should enroll in the Medicare Program and maintain their enrollment information using Internet-based PECOS. It includes information on how to complete an enrollment application using Internet-based PECOS and a list of frequently asked questions and resources.

MLN Matters® Search Tips [↑]

Looking for the latest new and revised MLN Matters® articles? The Medicare Learning Network® offers several ways to search and quickly find articles of interest to you:

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- MLN Matters® Dynamic Lists: an archive of previous and current articles organized by year with the ability to search by keyword, transmittal number, subject, article number, and release date. To view and search articles, select the desired year from the left column on the MLN Matters® Articles web page.

- *MLN Matters® Electronic Mailing List:* This free electronic notification service sends an email message when new and revised MLN Matters® articles are

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Archive of Provider e-News Messages