# 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, August 1, 2012**

- "The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Provider and Supplier Organizations" Fact Sheet – Revised
- Medicare Learning Network® Exhibit Schedule

**National Provider Call: New Medicare Preventive Services — Register Now** [↑]
*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 MLN materials on these preventive services prior to the call:

- "Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse" Booklet
- "Screening for Depression" Booklet
- MLN Matters® Article, " Intensive Behavioral Therapy (IBT) for Cardiovascular Disease (CVD)"
- MLN Matters® Article, "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.

**National Provider Call: Audio Recording and Written Transcript from July 11 Hospital Value-Based Purchasing Call Now Available** [↑]

The audio recording and written transcript from the July 11 Hospital Value-Based Purchasing National Provider Call are now available on the July 11 call page in the "Presentation" section.

**Special Open Door Forum: Manual Medical Review of Therapy Claims** [↑]
*Tuesday August 7; 2-3:30pm ET*
*Conference Call Only*

The purpose of this Special Open Door Forum (ODF) is to provide an opportunity for *providers* to ask questions about the mandated manual medical review of therapy services from October 1-December 31, 2012 that was enacted by the Middle Class Tax Relief and Job Creation Act of 2012.

During this Special Open Door Forum, CMS will discuss the implementation of a process to request exceptions from manual medical review, and what the process entails. CMS requests provider's participation who orders or provides therapy services nationally. See below for more background and who will be impacted.

The statutory Medicare Part B outpatient therapy cap for Occupational Therapy (OT) is $1,880 for 2012, and the combined cap for Physical Therapy (PT) and Speech-Language Pathology Services (SLP) is also $1,880 for 2012. This is an annual per beneficiary therapy cap amount determined for each calendar year. Medicare allowable charges, which includes both Medicare payments to providers and beneficiary coinsurance, are counted toward the therapy cap. In outpatient settings, Medicare will pay for 80 percent of allowable charges and the beneficiary is responsible for the remaining 20 percent of the amount. The therapy cap applies to all Part B outpatient therapy settings and providers including:

- private practices,
- skilled nursing facilities,
- home health agencies,
- outpatient rehabilitation facilities, and
- comprehensive outpatient rehabilitation facilities.

Beginning this year, the therapy cap will also apply to therapy services furnished in hospital outpatient departments (HOPDs) until December 31, 2012. Before 2012, therapy provided in hospital outpatient departments did not count towards the therapy cap.

Participants may submit questions prior to the Special ODF to therapycapreview@cms.hhs.gov. We look forward to your participation.

*Special Open Door Participation Instructions:*

- Dial: (800) 603-1774 & Conference ID: 16032541
- Note: TTY Communications Relay Services are available for the Hearing Impaired. For TTY services dial 7-1-1 or 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 and will be accessible for downloading.

For automatic emails of Open Door Forum schedule updates (E-Mailing list subscriptions) and to view Frequently Asked Questions please visit the Open Door

Forum website.

**Effective Today August 1, Medicare to Automatically Convert Format 4010A1 Electronic Remittance Advice (835) to X12 Version 5010** [↑]

*Effective today, August 1, 2012,* the Medicare Fee-For-Service (FFS) program will only create the electronic remittance advice transactions in the X12 Version 5010 format. If the computer software you use to open/translate the electronic remittance advice X12 Version 5010 format has not been updated to support the X12 Version 5010 format remittance advice, you may not be able to open and read the electronic remittance advice to review payments, adjustments, and denials, as well as post payments to patient accounts.

If you use a clearinghouse, billing service or vendor to obtain the electronic remittance advice, any issue with opening/translating the electronic remittance advice X12 Version 5010 format effective August 1 should be addressed with your vendor, clearinghouse, or billing service *before* contacting your Medicare contractor.

Providers should be advised that any billing staff or representatives that make inquiries related to Medicare payment on his/her behalf will need a copy of the remittance advice before contacting the MAC helpdesk for questions on the adjustments made to the claim payment from Medicare FFS.

Please note that CMS supported software, PC Print and Medicare Remit Easy Print (MREP), does accept the electronic remittance advice X12 Version 5010 format to view and print remittances. Institutional providers who use PC Print, and professional providers/suppliers who use MREP, are reminded that any issues with opening/translating the electronic remittance advice X12 Version 5010 format on or after August 1, 2012 should be addressed with your vendor, clearinghouse, or billing service, if you use one of these entities for receipt of the electronic remittance advice, before contacting your Medicare contractor.

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

**CMS Issues Final Inpatient Payment Rule** [↑]
*Final Rule Increases Payments to Hospitals; Strengthens Link to Quality Care*

On August 1, CMS issued a final rule that updates fiscal year (FY) 2013 Medicare payment policies and rates for inpatient stays at general acute care and long-term care hospitals (LTCHs), and builds on the Obama Administration's work to slow growth in future health care costs by improving patient care.

The final rule also implements key elements of the Affordable Care Act's hospital value-based purchasing and hospital readmissions reduction programs. The rule advances Administration efforts to tie Medicare payments to quality health care across the delivery system, with new quality reporting measures for general acute care hospitals in FY 2015 and FY 2016; new measures for long-term care hospitals in FY 2016, and new quality reporting programs for psychiatric hospitals and cancer hospitals. In addition, the rule establishes new reporting and other requirements for the Ambulatory Surgical Center Quality Reporting (ASCQR) Program.

*FY 2013 Payment Update*

Under the final rule, payment rates to general acute care hospitals will increase by 2.8 percent in FY 2013. The 2.8 percent is a net update after the market basket update, improvements in productivity, a statutory adjustment factor, and adjustments for hospital documentation and coding changes. The rate increase, together with other policies in the final rule, would increase Medicare's operating payments to acute care hospitals by approximately 2.3 percent in FY 2013. After taking into account the expiration of certain statutory provisions that provided special temporary increases in payments to hospitals, and other changes to IPPS payment policies, CMS projects that total Medicare spending on inpatient hospital services will increase by about $2 billion in FY 2013 relative to FY 2012.

Under the final rule LTCH payments are expected to increase by approximately $92 million or 1.7 percent in FY 2013 relative to FY 2012, this reflects a 1.8 percent payment rate update. As explained further below, in addition to this 1.8 percent update for inflation (adjusted as required by the statute), to LTCH payment rates will be reduced to 0.5 percent due to the one-time budget neutrality adjustment for discharges on or after December 29, 2012.

*Provisions Promoting Improved Patient Care*

To provide hospitals with an incentive to reduce hospital readmissions and improve care coordination, the Affordable Care Act created a Hospital Readmissions Reduction Program that will reduce payments beginning in FY 2013 (for discharges on or after October 1, 2012) to certain hospitals that have excess readmissions for three selected conditions: heart attack, heart failure and pneumonia. Today's rule finalizes a methodology and the payment adjustment factors to account for excess readmissions for these three conditions.

The final rule strengthens the Hospital Value-Based Purchasing Program (VBP program) to reward efficient, high-quality care. This program, which was created by the Affordable Care Act, will adjust hospital payments beginning in FY 2013 and annually thereafter based on how well hospitals perform or improve their performance on a set of quality measures.
The final rule includes a new outcome measure in the VBP program that rewards hospitals for avoiding certain kinds of life-threatening blood infections that can develop during inpatient hospital stays. This measure, the central line-associated bloodstream infection measure, supports ongoing work by CMS and other hospital safety leaders to reduce healthcare-associated infections through the Partnership for Patients initiative.

The final rule also strengthens the Inpatient Quality Reporting (IQR) program. Specifically, CMS is including measures for perinatal care and readmissions, including overall readmissions and readmissions relating to hip and knee replacement procedures, as well as a measure related to whether hospitals use surgery checklists. CMS is also adding a new survey measure to the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) measures to assess the quality of care for patients as they transition from one care setting to another.

The final rule builds on CMS' quality reporting initiatives by adopting the measures that will be used for LTCHs for the FY 2015 and FY 2016 quality-based payment determinations and establishing quality reporting for psychiatric hospitals and psychiatric units that are paid under the Inpatient Psychiatric Facilities Prospective Payment System and for PPS-exempt cancer hospitals. Reporting and other requirements are also finalized for the ASCQR program.

*Documentation and Coding*
The final rule would complete all documentation and coding adjustments for FY 2008 and FY 2009 as required by the TMA, Abstinence Education, and QI Programs Extension Act of 2007. The net effect of final documentation and coding adjustments for FY 2013 is an aggregate rate increase of 1.0 percent, a 0.8 percentage point increase from the proposed rule.

*Expiration of Medicare, Medicaid, and SCHIP Extension Act Moratorium*
In the Medicare, Medicaid, and SCHIP Extension Act of 2007, Congress imposed a three-year moratorium that prevented CMS from implementing certain payment policies affecting certain LTCHs and LTCH satellite facilities. At the same time, the law imposed a moratorium on establishing new LTCHs and LTCH satellite facilities, and on increasing the number of patient beds in existing LTCHs and LTCH satellite facilities, unless an exception applied. These moratoria were extended for two years in the Affordable Care Act.
In this rule, CMS is finalizing:

- An extension of the existing moratorium on the "25 percent threshold" policy as well as a providing a supplemental moratorium for certain LTCHs and LTCH satellite facilities, pending results of an on-going research initiative to re-define the role of LTCHs in the Medicare program.
- A 1.3 percent reduction (first year of a three-year phase-in) for a permanent prospective budget neutrality adjustment. The reduction would not apply to discharges occurring on or before December 28, 2012, because the law prohibits its application before that date. The budget neutrality adjustment reduces the update from 1.8 percent to 0.5 percent.

The statutory moratorium on new LTCHs and LTCH satellite facilities as well as an increase in beds in existing LTCHs and LTCH satellite facilities will expire on December 29, 2012. The five-year statutory delay in the application of the "IPPS comparable" per diem payment option under the short stay outlier policy will also expire for discharges occurring on or after December 29, 2012.

*For more information:*

- Final Rule
- Fact Sheet: Final Policy and Payment Changes for Inpatient Stays in Acute-Care Hospitals and Long-Term Care Hospitals in FY 2013
- Fact Sheet: CMS Makes Changes to Improve Quality of Care During Hospital Inpatient Stays

Full text of this excerpted CMS press release (issued August 1).

**Prior Authorization of Power Mobility Devices Demonstration to Begin September 1** [↑]

On August 1, CMS displayed a Federal Register Notice announcing a September 1, 2012 start date of the Power Mobility Devices (PMD) demonstration. The start date of the demonstration is based on the date of the written order. CMS believes this demonstration will lead to reductions in improper payments for power mobility devices, which will help ensure the sustainability of the Medicare Trust Funds and protect beneficiaries who depend upon the Medicare program. In addition, this demonstration is designed to develop and demonstrate improved methods for the investigation and prosecution of fraud in the provision of care or services under the health programs established by the Social Security Act.

*Demonstration Description*
CMS will implement a Prior Authorization process for scooters and power wheelchairs for people with Fee-For-Service Medicare who reside in seven states with high populations of fraud- and error-prone providers (CA, IL, MI, NY, NC, FL and TX). In addition to the benefits mentioned above, this demonstration will help ensure that a beneficiary's medical condition warrants their medical equipment under existing coverage guidelines. Moreover, the program will assist in preserving a Medicare beneficiary's ability to receive quality products from accredited suppliers. Additional information is available on the Prior Authorization of Power Mobility Devices Demonstration web page.

**CMS Announces Provider Compliance Interactive Map** [↑]

On August 1, CMS will release the Provider Compliance Interactive Map, a new tool for providers and stakeholders. The purpose of the map and new webpage is to give providers and stakeholders information on the following Contractors: Payment Error Rate Measurement (PERM), Comprehensive Error Rate Testing (CERT), Medicare Recovery Audit Operations (RACs), and Medicare Administrative Contractor (MACs). In addition, the map and website will contain contact information for various state organizations; emails and websites for the different organizations within the state selected; as well as information on other U.S. territories.

The Interactive Map webpage will apply to all 50 states as well as U.S. territories Puerto Rico, Virgin Islands, Guam, Northern Mariana Island, and American Samoa. The webpage features benefits that allow not only physicians, but beneficiaries, to gather information about CMS review contractors in a specific state. The Interactive Map will simplify concerns regarding who to contact with questions or concerns about Medicare and Medicaid services. The Interactive Map includes vital telephone numbers and email addresses to several key organizations.

Providers can submit questions regarding the Interactive Map.

**August is National Immunization Awareness Month** [↑]

National Immunization Awareness Month presents a great opportunity to educate seniors and other people with Medicare on the importance of disease control and prevention through immunization and the vaccines covered by Medicare that help prevent disease. Vaccine-preventable disease levels are at or near record lows, yet many adults remain under-immunized, missing opportunities to protect themselves against diseases such as hepatitis B, seasonal influenza, and pneumococcal disease. Vaccines are even more important for people with chronic health conditions. An underlying health condition can make a person more susceptible to contracting a disease or have a more serious outcome if they do contract a disease.

*Medicare Part B Immunization Benefits:*
Medicare provides coverage for seasonal influenza, pneumococcal, and hepatitis B vaccines and their administration for qualified beneficiaries as preventive immunizations.

- *Seasonal Influenza Immunization*: Medicare covers one seasonal influenza virus vaccine per influenza season; a beneficiary could get more than one seasonal influenza virus vaccination in a 12-month period. Medicare may cover additional influenza vaccinations, if medically necessary.
- *Pneumococcal Immunization*: Medicare generally covers pneumococcal vaccination once in a lifetime for all Medicare beneficiaries. Medicare may cover additional vaccinations based on risk or uncertainty of beneficiary pneumococcal vaccination status.
- *Hepatitis B Immunization*: Medicare covers the hepatitis B vaccinations that are reasonable and necessary for the prevention of illness for those individuals who are at high or intermediate risk of contracting hepatitis B virus.

CMS asks healthcare providers who provide care to seniors and others with Medicare to join us during National Immunization Awareness Month to help protect your Medicare patients from vaccine-preventable diseases. This can be done by ensuring their immunizations are up-to-date, educating them on risk factors, and encouraging their use of appropriate Medicare-covered immunizations.

*Resources from CMS for Healthcare Professionals:*

- The Guide to Medicare Preventive Services, Chapter 5
- Medicare Immunization Billing Quick Reference Chart
- Preventive Immunizations Brochure
- Mass Immunizers and Roster Billing Factsheet
- CMS Immunizations Web Page
- CMS Medicare Learning Network® (MLN) Preventive Services Educational Products Web Page

*More Information for Healthcare Professionals:*

- The CDC Vaccines and Immunizations Web Page
- National Immunization Awareness Month 2012 Toolkit
- Immunization Action Coalition Website

**Obama Administration Announces Ground-Breaking Public-Private Partnership to Prevent Health Care Fraud** [↑]

On July 26, HHS Secretary Kathleen Sebelius and Attorney General Eric Holder announced the launch of a ground-breaking partnership among the federal government, State officials, several leading private health insurance organizations, and other health care anti-fraud groups to prevent health care fraud. This voluntary, collaborative arrangement uniting public and private organizations is the next step in the Obama administration's efforts to combat health care fraud and safeguard health care dollars to better protect taxpayers and consumers.

The new partnership is designed to share information and best practices in order to improve detection and prevent payment of fraudulent health care billings. Its goal is to reveal and halt scams that cut across a number of public and private payers. The partnership will enable those on the front lines of industry anti-fraud efforts to share their insights more easily with investigators, prosecutors, policymakers and other stakeholders. It will help law enforcement officials to more effectively identify and prevent suspicious activities, better protect patients' confidential information and use the full range of tools and authorities provided by the Affordable Care Act and other essential statutes to combat and prosecute illegal actions.

One innovative objective of the partnership is to share information on specific schemes, utilized billing codes and geographical fraud hotspots so that action can be taken to prevent losses to both government and private health plans before they occur. Another potential goal of the partnership is the ability to spot and stop payments billed to different insurers for care delivered to the same patient on the same day in two different cities. A potential long-range goal of the partnership is to use sophisticated technology and analytics on industry-wide healthcare data to predict and detect health care fraud schemes.

The Executive Board, the Data Analysis and Review Committee, and the Information Sharing Committee will hold their first meeting in September. Until then, several public-private working groups will continue to meet to finalize the operational structure of the partnership and develop its draft initial work plan.

The partnership builds on existing tools provided by the Affordable Care Act, resulting in:

- Tougher sentences for people convicted of health care fraud. Criminals will receive 20 to 50 percent longer sentences for crimes that involve more than $1 million in losses;
- Enhanced screenings of Medicare and Medicaid providers and suppliers to keep fraudsters out of the program.

- Suspended payments to providers and suppliers engaged in suspected fraudulent activity.

The administration's efforts to date have already resulted in a record-breaking $10.7 billion in recoveries of health care fraud over the last three years. For more information on this partnership and the Obama administration's work to combat health care fraud, please visit the Stop Medicare Fraud web page.

Full text of this excerpted CMS press release (issued July 26).

**Tips for Small Provider Practices to Plan for the ICD-10 Transition** [↑]

Although the final rule on the proposed ICD-10 deadline change has yet to be published, it is important to continue planning for the transition to ICD-10. The switch to the new code set will affect every aspect of how your organization provides care, but with adequate planning and preparation, you can ensure a smooth transition for your practice.
You should consider the following checklist to help keep your efforts on track with your transition:

- Educate staff and leadership about ICD-10
  - Appoint an ICD-10 coordination manager and delegate a steering committee to manage the transition
  - Train staff on changes in documentation requirements from health plans and how this will affect work flow
- Perform an impact assessment
  - Examine existing uses of ICD-9 codes in order determine aspects of work flow and business practices that ICD-10 will potentially change. Be sure to evaluate planned and ongoing projects as well
  - Create a list of staff members who need ICD-10 resources and training, such as billing and coding staff, clinicians, management, and IT staff
- Plan a realistic and comprehensive budget
  - Estimate a budget that includes costs such as software, hardware, staff training, and any initial change in patient volume
- Coordinate with external partners
  - Contact system vendors, clearinghouses, and billing services to assess their readiness and evaluate current contracts
  - Ask your vendors how they will support you in the transition to ICD-10 and request a timeline and cost estimate
  - Analyze existing health plan trading partner agreements
- Get ready for testing
  - Request a testing plan to schedule from your vendor
  - Conduct internal testing within your clinical practice as well external testing with payers and other external business partners after you have completed the planning stages

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

**Assembling an ICD-10 Project Team** [↑]

Assembling an ICD-10 Project Team to oversee your organization's shift to ICD-10 is instrumental to a successful transition. This team will be responsible for

overseeing the ICD-10 planning and implementation process.

*Select Your Team*

Since ICD-10 will affect nearly all areas of your practice, project teams should consist of representatives from key areas of your organization, including:

- Senior Management
- Health Information Management/Coding
- Billing/Finance
- Compliance
- Revenue Cycle Management
- Information Systems and Technology

This multi-disciplinary team provides the cooperative environment necessary to address your organization's needs. If you run a small business or practice, several of these functional areas may rest with the same individuals, making your transition team smaller.

*Appoint a Project Manager*
Once members of the project team have been selected, appoint one team member to serve as the project manager. As the manager, he or she will be responsible for establishing accountability across the ICD-10 implementation team and making business, policy, and technical decisions.

*Your Team's Initial Tasks*
With an established project team and a designated project lead, you'll be ready to begin planning for ICD-10 implementation. Project teams should:

- *Establish regular check-in meetings* to discuss progress and address any issues.
- *Conduct an ICD-10 impact assessment* to help you determine how the transition to ICD-10 will affect your organization, and allow you to schedule and budget for all ICD-10 activities.
- *Plan a comprehensive and realistic budget.* This should include costs such as software upgrades and training needs.
- *Identify and ensure involvement and commitment of all internal and external stakeholders.* Contact vendors, physicians, affiliated hospitals, clearinghouses, and others to determine their plans for ICD-10 transition.
- *Develop and adhere to a well-defined implementation timeline* that makes sense for your organization.

*Communicate Regularly*
Remember to communicate regularly with your entire ICD-10 project team. Keeping the lines of communication open will help make sure everyone is kept up to date on the implementation progress. It may be helpful to establish and circulate a calendar of internal tasks, milestones, and deadlines to help keep day-to-day activities running smoothly and on schedule.

*Keep Up to Date on ICD-10.*
Please visit the ICD-10 website for the latest news and resources to help you prepare! Also sign up to receive ICD-10 Email Updates.

**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.

**Corrections to the Skilled Nursing Facility Consolidated Billing File for Healthcare Common Procedure Coding System Code J9033** [↑]

In January 2012, procedure code J9033 (Injection, bendamustine hcl, 1 mg) was erroneously listed as subject to Skilled Nursing Facility Consolidated Billing. The Centers for Medicare & Medicaid Services (CMS) will be correcting this problem with its October, 2012 systems release.

Until the fix can be implemented, any claims for this service for a SNF inpatient should be forwarded to your Medicare Administrative Contractor (MAC) for special handling. If you believe you have had a claim for this service erroneously denied for this reason or if you have received a letter identifying as an overpayment a claim for this service that was previously paid, you should contact your MAC and request that the situation be reopened.

We thank you for your cooperation and apologize for any inconvenience.

**CY 2012 Outpatient Prospective Payment System Pricer File Update** [↑]

The Outpatient Prospective Payment System (PPS) Pricer webpage was recently updated to include the July, 2012 update for outpatient provider data. Access the July provider data update on the Outpatient PPS Pricer Code webpage by selecting "2012" and then downloading the "3rd Quarter 2012 Files."

**From the MLN: "The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Provider and Supplier Organizations" Fact Sheet – Revised** [↑]

"The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Provider and Supplier Organizations Fact Sheet" (ICN 903767) has been revised and is now available in downloadable format. This fact sheet is designed to provide education on how provider and supplier organizations 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.

**Medicare Learning Network® Exhibit Schedule** [↑]

*Just A Reminder:* The Medicare Learning Network® will exhibit at the following healthcare provider conferences in September:

- HealthCare Billing & Management Association
  - September 12 through September 14
    Gaylord National Resort & Convention Center on the Potomac
    National Harbor, Maryland 20745
    Booth # 516
- American Health Information Management

- September 29- October 4
  McCormick Place Convention Center
  Chicago, IL 60616
  Booth # 646

*Mark Your Calendars:* The Medicare Learning Network® will be exhibiting at the following healthcare provider conferences in October:

- American College of Surgeons
  - October 1 through October 3
    McCormick Place Convention Center
    Chicago, IL 60616
    Booth #1640
- Congress of Neurologic Surgeons
  - October 6 through October 10
    McCormick Place Convention Center
    Chicago, IL 60616
    Booth # 425

Please make a note of these dates and locations and add them to your calendar. If you are interested in having a Medicare Learning Network® Exhibit at your event, please contact us at MLNexhibits@cms.hhs.gov.

**Check out CMS on**


**More helpful links…**

**The Medicare Learning Network**

**Archive of Provider e-News Messages**