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.

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National Provider Call: New Medicare Preventive Services — Last Chance to Register [↑]
Wednesday, August 15; 2-3:30pm 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"
- "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: Medicare Fee-For-Service Recovery Auditor Prepayment Review Demonstration [↑]
Thursday, August 9; 2-4pm ET

CMS will hold a Special Open Door Forum (ODF) to discuss the recently approved Recovery Auditor Prepayment Review Demonstration that will begin August 27, 2012.

This Special ODF is designed specifically for Medicare Fee-For-Service providers who may be subject to Recovery Auditor review in the 11 approved demonstration states: FL, CA, MI, TX, NY, LA, IL, PA, OH, NC, and MO. Recovery Auditors will review claims before they are paid to ensure that the provider complied with all Medicare payment rules. These reviews will focus on certain types of claims that historically result in high rates of improper payments. Initially, Recovery Auditors will review short stay inpatient hospital claims. This demonstration will also help lower the error rate by preventing improper payments, rather than the traditional "pay and chase" methods of looking for improper payments after they have been made.

During this ODF, CMS will provide an overview of the Recovery Auditor Prepayment Review Demonstration, including:

- Why the Demonstration is being implemented;
- How it will impact providers in the affected states;
- Specific operational details regarding the reviews; and
- Where to find additional information.

After the presentation, participants will have an opportunity to ask questions. Discussion materials for this Special ODF will be available to download on August 8.

Special Open Door Participation Instructions:

- Dial: 866-501-5502 & Conference ID: 16834984
- 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 beginning on or around August 16 and will be available for 30 days.

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.

Obama Administration Issues New Rules to Cut Red Tape for Doctors and Hospitals, Saving up to $9 Billion [↑]

On August 7, HHS Secretary Kathleen Sebelius announced the release of a new rule that will cut red tape for doctors, hospitals, and health plans. In combination with a previously issued regulation, the rule will save up to $9 billion over the next ten years. The regulation adopts operating rules for making health care claim payments electronically and describing adjustments to claim payments.

Studies have found that the average physician spends three weeks a year on billing and insurance related tasks, and, in a physician's office, two-thirds of a full-time employee per physician is necessary to conduct these tasks. Many physician practices and hospitals receive and deposit paper checks, and manually post and reconcile the health care claim payments in their accounting systems. By receiving payments electronically and automating the posting of the payments, a physician practice and hospital's administrative time and costs can be decreased.

The operating rules build upon industry-wide health care electronic fund transfer (EFT) standards that HHS adopted in January of this year. Together, the previously issued EFT standards and the EFT and electronic remittance advice (ERA) operating rules announced today are projected to save between $2.7 billion and more than

$9 billion in administrative costs over ten years by reducing inefficient manual administrative processes for physician practices, hospitals, and health plans.

Operating rules include best business practices on how electronic transactions are transmitted and often target obstacles that physician practices and health insurers have with using electronic transactions. For instance, the rule announced today requires insurers to offer a standardized, online enrollment for EFT and ERA so that physicians and hospitals can more easily enroll with multiple health plans to receive those transactions electronically. The rule also requires health plans to send the EFT within a certain amount of days of the ERA, which helps providers reconcile their accounts more quickly.

Today's rule, Administrative Simplification: Adoption of Operating Rules for Health Care Electronic Funds Transfers (EFT) and Remittance Advice Transactions were developed through extensive discussions with industry stakeholders. The rule adopts the Council for Affordable Quality Healthcare's Committee on Operating Rules for Information Exchange (CAQH CORE) Phase III EFT & ERA Operating Rule Set, including the CORE v5010 Master Companion Guide Template, with the exception of Requirement 4.2 of the Phase III CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule. Collectively, these rules are referred to as the EFT & ERA Operating Rule Set.

The regulation announced today may be viewed at the Federal Register Electronic Public Inspection Desk and will be effective upon its publication in the Federal Register on August 10, 2012. The comment period closes on October 9, 2012.

The compliance date for operating rules for the health care electronic funds transfers and remittance advice transaction is January 1, 2014.

A fact sheet is available with technical information on the rule.

Full text of this excerpted CMS press release (issued August 7).

Important Announcements Regarding the Long Term Care Hospital Quality Reporting Program and the October 1, 2012 Implementation [↑]

- *June 28 vendor call:* Minutes and QAs which include information specifically related to LASER are posted on the QTSO.COM Vendor page.
- *July 18, 2012:* The long term care hospital (LTCH) CARE Data Submission Specifications have been updated and posted. The new version is V1.00.3. This version addresses all of the issues that were addressed in the errata document that was posted in June, 2012. These data specifications are effective for October, 2012. The previous version (v1.00.2) and its errata document have been removed from the Downloads section. The specifications can be found on the LTCH Quality Reporting website.
- The *LTCH Validation Utility tool* is now available on the QTSO Vendor site.
    - The Validation Utility Tool (VUT) is a software utility that can be used to validate LTCH submission files in XML format. The VUT attempts to enforce the edits that are mapped to the LTCH items, as published in the LTCH Data Specifications. The initial VUT release incorporates the V1.00.3 Specifications. A Readme file which provides installation instructions is also available.
- *July 26th LTCH Special Open Door Forum* Transcript will be provided this month on the CMS LTCH Quality Reporting website.
- The *training power point slides from the May 2012 National Train-the Trainer Conference* are now posted on the CMS LTCH Quality Reporting website.
- A listing of important *FAQs* related to the *LTCH quality reporting (QRP)* will be posted on the LTCH Quality Reporting website in mid- August.
- The final LTCH QRP Manual is currently being posted on the LTCH Quality Reporting website:
- The following trainings related to the LTCH CARE Data Set and LASER will be available for downloading at www.qtso.com.

- CMSNet and QIES User ID Registration Training – Recorded WebEx posted week of August 6
- LTCH Assessment Submission Process – Recorded WebEx posted week of August 27
- LTCH Assessment and Validation Reports – Recorded WebEx posted week of August 27
- LASER Login Process – Recorded WebEx posted by the week of August 20
- LASER Patient and Assessment Entry – Recorded WebEx posted by the week of August 20
- LASER Import and Export Process – Recorded WebEx posted by the week of August 20
- LASER Reports – Recorded WebEx posted by the week of August 20
- LASER Demonstration Recorded WebEx posted the week of August 20

Inpatient Psychiatric Facilities Prospective Payment System-Update for Fiscal Year Beginning October 1, 2012 (FY 2013) [↑]

CMS issued a notice that updates the prospective payment rates for Medicare inpatient hospital services provided by inpatient psychiatric facilities (IPFs). These changes are applicable to IPF discharges occurring during the fiscal year (FY) beginning October 1, 2012 through September 30, 2013. The notice appears in the August 7 Federal Register. For more information, please see the Inpatient Psychiatric Facility PPS website.

Final National Coverage Determination Issued for Autologous Blood-Derived Products for Chronic Non-Healing Wounds [↑]

CMS issued a final National Coverage Determination on a request for coverage of the therapy. Chronic wounds are common with many diseases affecting seniors, including diabetes and vascular insufficiency and people with mobility problems. Additional information is available in the decision memo.

October 3rd is the Last Day for EPs to Begin their 90-Day Reporting Period for 2012 [↑]

Wednesday, October 3rd, is the last day for eligible professionals (EPs) to begin their 90-day reporting period for calendar year (CY) 2012 for the Medicare EHR Incentive Program. For EPs, this means that they must begin their consecutive 90-day reporting period by October 3rd in order to attest to meeting meaningful use and be eligible to receive an incentive payment for CY 2012.

For EPs who have already completed their reporting period, CMS has a number of tools available to help prepare for attestation. EPs can use the CMS Eligible Professional Attestation Worksheet to record their meaningful use measures to have as a reference when attesting for the Medicare EHR Incentive Program in CMS' web-based Registration and Attestation System. The Meaningful Use Attestation Calculator and Attestation User Guide for Eligible Professionals can also help EPs to successfully attest to meeting meaningful use.

CMS encourages EPs not to miss the opportunity to participate in the Medicare EHR Incentive Program this year. Begin your reporting period by October 3rd to get on the path to payment for CY 2012.

Looking Ahead
Take a look at all of the other EHR Incentive Program important dates that are coming up by going to our CMS Medicare and Medicaid EHR Incentive Programs

Milestone Timeline, or reviewing the "Important Dates" section of the EHR Incentive Programs' Overview page.

Want more information about the EHR Incentive Programs?
Make sure to visit the EHR Incentive Programs website for the latest news and updates on the EHR Incentive Programs.

CMS to Release a Comparative Billing Report on Skilled Nursing Facility Billing Practices—Target Release August 31 [↑]

On August 31, CMS will release a national provider Comparative Billing Report (CBR) addressing Skilled Nursing Facility Billing Practices.

CBRs produced by SafeGuard Services under contract with CMS, contain actual data-driven tables and graphs with an explanation of findings that compare provider's billing and payment patterns to those of their peers located in the state and across the nation.

These reports are not available to anyone except the providers who receive them. To ensure privacy, CMS presents only summary billing information. No patient or case-specific data is included. These reports are an example of a tool that helps providers better understand applicable Medicare billing rules and improve the level of care they furnish to their Medicare patients. CMS has received feedback from a number of providers that this kind of data is very helpful to them and encouraged us to produce more CBRs and make them available to providers.

For more information and to review a sample of the Skilled Nursing Facility Billing Practices CBR, please visit the CBR Services website or call the SafeGuard Services' Provider Help Desk, CBR Support Team at 530-896-7080.

Hospices to Receive PEPPER; Register Now for Training [↑]

Beginning in late August 2012, CMS will make available free hospice-specific comparative data reports for hospices nationwide. The Program for Evaluating Payment Patterns Electronic Report (PEPPER) includes hospice-specific data statistics for Medicare claims that may be at risk for improper Medicare payments. Hospices can use the data to support internal auditing and monitoring activities. The Hospice PEPPER is a free report comparing a hospice's Medicare billing practices with other hospices in the state, Medicare Administrative Contractor (MAC) jurisdiction and nation. CMS has contracted with TMF® Health Quality Institute to develop and distribute the reports.

PEPPER will be distributed to hospices in hard copy format via FedEx addressed to the CEO, with FedEx delivery in late August, 2012. TMF will conduct a Web-based training session for hospice staff, providing information on PEPPER and how to use it, on Thursday, September 13 at 1pm CT. To register for the training, hospice staff should visit the TMF website. Because registration is limited, hospices are encouraged to coordinate internally to prevent duplicate registrations per facility. The training session will be recorded and posted on PEPPERresources.org in the Hospice "Training and Resources" section.

For more information visit the PEPPER website. Hospice staff are encouraged to join the e-mail list on this website to receive important notifications about upcoming PEPPER distribution and training opportunities.

Partial Hospitalization Programs to Receive PEPPER; Register Now for Training [↑]

Beginning in late August 2012, CMS will make available free provider-specific comparative data reports for partial hospitalization programs (PHPs) nationwide. The Program for Evaluating Payment Patterns Electronic Report (PEPPER) provides PHP-specific data statistics for Medicare services that may be at risk for improper Medicare payments. PHPs can use the data to support internal auditing and monitoring activities. PEPPER is a free report comparing a PHP's Medicare billing practices with other PHPs in the state, Medicare Administrative Contractor (MAC) or Fiscal Intermediary (FI) jurisdiction and nation. CMS has contracted with TMF® Health Quality Institute to develop and distribute the reports.

PEPPER will be distributed in hard copy format via FedEx addressed to the CEO, with FedEx delivery in late August 2012 to PHPs administered through community mental health centers, free-standing inpatient psychiatric facilities (IPFs), free-standing inpatient rehabilitation facilities and children's hospitals. PEPPER will be distributed electronically to PHPs administered through short-term acute care hospitals and IPF distinct part units of short-term acute care hospitals through a My QualityNet secure file exchange to hospital QualityNet Administrators and user accounts with the PEPPER recipient role. TMF will conduct a Web-based training session for PHP staff, providing information on PEPPER and how to use it, on Tuesday, September 11 at 1pm CT. To register for the training, PHP staff should visit the TMF website. Because registration is limited, PHPs are encouraged to coordinate internally to prevent duplicate registrations per PHP. The training session will be recorded and posted on PEPPERresources.org in the PHP "Training and Resources" section.

For more information visit the PEPPER website. PHP staff are encouraged to join the e-mail list on this website to receive important notifications about upcoming PEPPER distribution and training opportunities.

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 MLN: "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.

From the MLN: "Global Surgery" Fact Sheet—Released [↑]

The "Global Surgery" Fact Sheet (ICN 907166) was released and is now available in downloadable and hard copy format. This fact sheet is designed to provide education on the components of a global surgery package. It includes information on billing and payment rules for surgeries, endoscopies, and global surgical packages that are split between two or more physicians.

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.

From the MLN: "Tobacco-Use Cessation Counseling Services" Brochure — Reminder [↑]

The "Tobacco-Use Cessation Counseling Services" Brochure (ICN 006767) is available in downloadable format. This brochure is designed to provide education on tobacco-use cessation counseling services. It includes coverage information for both symptomatic and asymptomatic beneficiaries as well as information on tobacco-use cessation counseling.

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

The MLN is happy to announce that the latest continuing education association to accept Medicare Learning Network® (MLN) courses is the American Association of Medical Audit Specialists (AAMAS). AAMAS joins the American Association of Medical Assistants (AAMA), AAPC, the American Medical Billing Association (AMBA), the Medical Association of Billers (MAB), and the National Academy of Ambulance Coding (NAAC). For more information about continuing education associations that accept MLN courses, visit the Association Approvals for WBT Credits web page on the CMS website.

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

Check out CMS on

More helpful links…

The Medicare Learning Network

Archive of Provider e-News Messages