



CMS Medicare FFS Provider e-News *Brought to you by the Medicare Learning Network®*

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.

Colleagues—

As our messaging process evolves, some changes to the *e-News* will be coming your way. Starting next week, your *e-News* will begin arriving on *Thursdays*.

Thanks for your continued help sharing CMS news with Medicare FFS providers.

The e-News for Wednesday, September 26, 2012

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National Provider Call: Hospital Value-Based Purchasing: FY 2013 Actual Percentage Payment Summary Report — Register Now [[↑](#)]
Thursday, October 4, 2012; 1:30-3pm ET

CMS will host a National Provider Call (NPC) with a question and answer session on the FY 2013 Actual Percentage Payment Summary Report. The purpose of this call is to discuss the Actual Percentage Payment Summary Report as well as important operational details for FY 2013—the first year in which value-based incentive payments will be made under the Hospital Value-Based Purchasing Program. Additionally, CMS will discuss a review and corrections process and an appeals process for the program.

Hospitals can submit questions prior to the NPC as part of the registration process described in this message. Participants will also have the opportunity to ask questions at the end of the presentation on October 4. Before you submit questions, CMS encourages you to review the Frequently Asked Questions in the [Hospital-Inpatient Questions and Answers tool](#) available on the [QualityNet](#) website.

If you have not viewed your hospital's FY 2013 *Estimated* Percentage Payment Summary Report, please go to the [QualityNet](#) website. Hospital users with an active My QualityNet account and granted the Hospital Reporting Feedback - Inpatient role can access the reports in their My QualityNet file exchange inbox. For technical questions or issues related to accessing the report, contact the QualityNet Help Desk at the following email address: qnetsupport@sdps.org or call 866-288-8912.

Target Audience: This National Provider Call is intended for hospitals, Quality Improvement Organizations, medical coders, physician office staff, provider billing staff, health records staff, vendors, and all Medicare FFS providers.

Agenda:

- Opening Remarks
- Overview of the FY 2013 Actual Percentage Payment Summary Report
- Discuss the Review and Corrections/Appeals Processes
- Review the Methodology to Convert a Total Performance Score to a Value-Based Multiplier
- Question & Answer Session

Registration Information: In order to receive call-in information, you must register for the call on the [CMS Upcoming National Provider Calls](#) 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: Medicare Provider Enrollment: Updates on Revalidation, Billing for Ordered/Referred Services and PECOS Enhancements — Registration Now Open [\[↑\]](#)

Wednesday, October 10; 1-2:30pm ET

For almost a year, CMS has been revalidating the enrollment of providers and suppliers enrolled in Medicare prior to March 25, 2011 as required by the Affordable Care Act. This revalidation process is being phased in and scheduled for completion by 2015. Find out the latest information about the revalidation effort, including how improvements to the PECOS system make it easier than ever to submit your revalidated enrollment information electronically. Learn what you can expect and how to prepare for this process.

CMS experts will also explain the requirements for billing for services that were ordered or referred by a physician or other eligible professional. Soon CMS will turn on the automated edits that will deny claims which do not meet these requirements. This call will also provide a question and answer session.

Target audience: All Medicare FFS Providers and Suppliers

Agenda:

- Revalidation Update
- Billing for Ordered/Referred Services
- PECOS Highlights from 2012
- Question and Answer Session

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

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One World, One Home, One Heart — World Heart Day [[↑](#)]

Thursday, September 29

Heart disease and stroke are the first and fourth leading causes of death in the United States. Heart disease and stroke are the world's leading cause of death, claiming 17.3 million lives each year and the numbers are rising. Approximately 49 percent of adults have at least one major risk factor for heart disease and stroke. Risk factors include physical inactivity, obesity, high blood pressure, cigarette smoking, high cholesterol and diabetes.

Million Hearts™ is a national initiative that has set an ambitious goal to prevent 1 million heart attacks and strokes by 2017. As providers, you can help empower Americans to make healthy choices such as preventing tobacco use and reducing sodium and trans-fat consumption. Please join CMS in encouraging people with Medicare to use preventive services that can help them reduce their risk for heart disease and stroke, and live heart healthy lives.

Medicare Coverage:

Medicare Part B provides coverage for cardiovascular disease screening blood tests for asymptomatic individuals for the early detection of cardiovascular disease. The cardiovascular disease blood tests covered by Medicare include: a total cholesterol test, a cholesterol test for high density lipoproteins, and a triglycerides test. Medicare also covers tobacco-use cessation counseling services and intensive behavioral therapy for cardiovascular disease for people with Medicare that meet certain eligibility requirements.

Resources from the MLN for Healthcare Professionals:

- [Cardiovascular Disease Services Booklet](#)
- [The Guide to Medicare Preventive Services for Healthcare Professionals](#) (see Chapters 3 & 15)
- [Expanded Benefits Brochure](#)
- [Tobacco-Use Cessation Counseling Services Brochure](#)
- [Quick Reference Information: Medicare Preventive Services Chart](#)

Other Resources for Healthcare Professionals:

- [Million Hearts™ Initiative](#)
- [World Heart Federation's World Heart Day Informational Webpage](#)

Thank you for joining CMS in educating beneficiaries about the preventive services covered by Medicare that can help them reduce their

risk for heart disease and stroke, and live heart healthy lives.

October 3 is the Last Day for EPs to begin 90-day reporting period for the Medicare EHR Incentive Program [[↑](#)]

Wednesday, October 3 marks two important deadlines for the Medicare EHR Incentive Program:

1. *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.
2. *The last day Medicare EPs can start participating and receive their maximum possible Medicare incentive payment.* This is the last year that EPs can begin participation in the EHR Incentive Program and get the full Medicare incentives of \$44,000 per EP. If first-year Medicare EPs have not started their 90-day reporting period by October 3rd, they will not be eligible for a CY 2012 payment, and can only receive \$39,000 in Medicare incentives if they successfully participate in 2013.

For more information on how incentive payments are distributed, take a look at the [EHR Basics](#) page of the newly updated EHR website. For EPs who have already completed their reporting period, CMS has a number of tools available to help prepare for attestation, including the [Meaningful Use Attestation Calculator](#) and [Attestation User Guide for Eligible Professionals](#).

CMS encourages EPs not to miss the opportunity to participate in the Medicare EHR Incentive Program this year and receive the maximum incentive payment.

Looking Ahead

Take a look at all of the other EHR Incentive Program important dates that are coming up by going to our [Health Information Technology Timeline](#).

Want more information about the EHR Incentive Programs?

Make sure to visit the [Medicare and Medicaid EHR Incentive Programs](#) website for the latest news and updates on the EHR Incentive Programs.

Updated Hospital Outpatient Payment Information for Value-Driven Health Care Now Available [[↑](#)]

CMS updated the Hospital Outpatient payment information for Value-Driven Health Care on September 19. The zipped Excel files are now available in the “Related Links” section of the [Hospital Outpatient](#) web page.

Now Available: New Webcast for Round 1 Recompete Bidders [[↑](#)]

A new educational webcast for the Round 1 Recompete of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program is now available on the Competitive Bidding Implementation Contractor (CBIC) website at www.DMECompetitiveBid.com. This webcast, titled *Program Rules*, explains important rules detailed in the *Round 1 Recompete Request for Bids (RFB) instructions* that you should understand before you prepare your bids. The webcast also provides resources to assist you with

bidding.

This webcast is available on demand to view at your convenience – 24 hours a day, seven days a week. There is no charge to view the webcast, and a transcript is also posted on the website. To view the webcast, please go to the [Round 1 Recompete Webinars](#) page on the [CBIC](#) website.

We will be issuing more webcasts later in the bidder education program. The upcoming webcasts will address topics such as financial documentation requirements, how bids are evaluated, and how to submit a bid in the online bidding system, DBidS. As each webcast is posted, we will announce its availability with an email update. If you have not already done so, please register on the [CBIC](#) website to receive these announcements and other updates about the competitive bidding program.

If you have any questions or need assistance, please contact the CBIC customer service center at 877-577-5331 from 9am to 9pm prevailing Eastern Time, Monday through Friday, throughout the registration and bidding periods.

Time is Running Out to Register for DMEPOS Competitive Bidding [\[↑\]](#)

If you are a supplier interested in participating in the Round 1 Recompete of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program and have registered an authorized official (AO) but not a backup authorized official (BAO), CMS strongly recommends that a BAO register no later than *Friday, September 28, 2012*.

It is important to do it now so that the BAO will be able to assist the AO with approving end user (EU) registration. The establishment of a BAO is encouraged, if your company has someone that can occupy the BAO role, to avoid any disruption in the bidding process once the 60-day bid window opens. The individual in the BAO role can also assume the AO role if for some reason the AO can no longer fulfill his or her bidding responsibilities; if there is no BAO and the AO leaves the company, all end users associated with the company will lose access to the bidding system.

Registration is typically a quick and easy process if you follow the step-by-step instructions in the “Individuals Authorized Access to CMS Computer Services (IACS) Reference Guide” posted on the Competitive Bidding Implementation Contractor (CBIC) website at www.DMECompetitiveBid.com. To register, go to the [CBIC](#) website, click on *Round 1 Recompete*, and then click on "REGISTRATION IS OPEN" above the Registration clock. Before you register, we strongly recommend that you review the [IACS Reference Guide](#) with step-by-step instructions and the [Getting Started Registration Checklist](#). Please note that suppliers with multiple locations typically must register only one Provider Transaction Access Number (PTAN) that will submit the bid for all locations.

If you have any questions about the registration process, please contact the CBIC Customer Service Center at 877-577-5331 between 9am and 9pm prevailing Eastern Time, Monday through Friday.

The target deadline has now passed for AO registration. If the AO for your company has not already registered and obtained a user ID and password, we cannot guarantee that he or she will be able to complete the registration process before the registration window closes on *Friday, October 19, 2012 at 9pm* prevailing Eastern Time. This should be of particular concern if the National Supplier Clearinghouse (NSC)

record for your company is not current and accurate. AOs should register now to allow BAOs and EUs time to register. In addition, suppliers whose AOs do not register now run the risk of experiencing delays in accessing the online bidding system to get a bidder number and thereby missing the opportunity to submit financial documents by the covered document review date (CDRD). As a result, we encourage you to register now.

Remember, the AO and BAO must be listed on the CMS-855S enrollment form as an AO. After an AO successfully registers, the AO may designate other authorized officials on the CMS-855S to serve as BAOs; the AO and BAOs can then designate other supplier employees as EUs. BAOs and EUs must also register for a user ID and password to be able to use the online bidding system. The name and Social Security number of the AO and BAOs must match exactly with what is on file with the NSC to register successfully.

Registration will close on *Friday, October 19, 2012 at 9pm* prevailing Eastern Time – *no AOs, BAOs, or EUs can register after registration closes.*

*The CBIC is the official information source for bidders. All suppliers interested in bidding are urged to sign up for “[Email Updates](#)” on the home page of the [CBIC](#) website. For information about the Round 1 Recompete, please refer to the bidder education materials on the CBIC website located under *Round 1 Recompete > Bidding Suppliers*.*

Correct Coding Initiative Edit Files Configuration Change [\[↑\]](#)

Effective October 1, 2012, the number of files available for download from the [NCCI Coding Edits](#) web page will be changing. Due to an increase in the number of records, the Physician CCI edits file and the Hospital CCI edits file will be subdivided into two files each. Please be sure to download both files for each edit in order to get a complete set of edits.

IRF Claims Processing Issue [\[↑\]](#)

Since September 4, 2012, Electronic Data Interchange (EDI) Inpatient Rehabilitation Facility (IRF) Part A claims are rejecting in the Medicare Administrative Contractors' (MACs) front end systems and not advancing into the Part A claims processing systems. These claims have a type of bill (TOB) 11x with Health Insurance Prospective Payment System (HIPPS) codes on the 0024 revenue code line item. CMS is working to correct the issue. Because these claims were rejected prior to getting into the processing system, providers will need to resubmit them once the problem is corrected. Providers with Direct Data Entry (DDE) access (which does not go through the EDI front end) can continue to submit their IRF claims. CMS will provide further instructions after the correction has been installed.

From the MLN: “Communicating With Your Medicare Patients” Fact Sheet — Released [\[↑\]](#)

The “[Communicating With Your Medicare Patients](#)” Fact Sheet (ICN 908063) was released and is now available in downloadable format. This fact sheet is designed to provide education on communicating with your Medicare patients. It includes background information and communication tips that will help you understand and respond to all patients; older patients; and racially, ethnically, and culturally diverse patients.

From the MLN: “Section 1011: Federal Reimbursement of Emergency Health Services to Undocumented Aliens” Fact Sheet — Revised [\[↑\]](#)

The “[Section 1011: Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens](#)” Fact Sheet (ICN 900863) was revised and is now available in downloadable format. This fact sheet is designed to provide education on available funding, eligibility, and program enrollment requirements for undocumented aliens, as detailed in Section 1011 of the Medicare Modernization Act (MMA). It includes information on the states that have exhausted payment and reimbursable services under this program.

From the MLN: “Inpatient Rehabilitation Services: Complying with Documentation Requirements” Fact Sheet — Revised [\[↑\]](#)

The “[Inpatient Rehabilitation Services: Complying with Documentation Requirements](#)” Fact Sheet (ICN 905643) was revised and is now available in downloadable format. This fact sheet is designed to provide education on Comprehensive Error Rate Testing program errors related to inpatient rehabilitation services. It includes common errors identified through the CERT Review Process and information on the documentation needed to support a claim submitted to Medicare for inpatient rehabilitation services.

“Claim Modifier Did Not Prevent Medicare from Paying Millions in Unallowable Claims for Selected Durable Medical Equipment” MLN Matters® Article — Released [\[↑\]](#)

[MLN Matters® Special Edition Article #SE1238](#), “Claim Modifier Did Not Prevent Medicare from Paying Millions in Unallowable Claims for Selected Durable Medical Equipment” was released and is now available in downloadable format. This article is designed to provide education on the supporting documentation Durable Medical Equipment Prosthetic and Supplies (DMEPOS) suppliers must have on file when submitting certain DME claims. It includes information from an April 2012 study conducted by the Office of the Inspector General (OIG) that focused on four categories of DMEPOS containing the KX modifier for Calendar Year 2007.

“Edits on the Ordering/Referring Providers in Medicare Part B, DME and Part A HHA Claims (Change Requests 6417, 6421, 6696, and 6856)” MLN Matters® Article — Revised [\[↑\]](#)

[MLN Matters® Special Edition Article #SE1011](#), “Edits on the Ordering/Referring Providers in Medicare Part B, DME and Part A HHA Claims (Change Requests 6417, 6421, 6696, and 6856)” was revised and is now available in downloadable format. This article is designed to provide education on the codes providers and suppliers will receive if there are problems with claims submitted for ordered/referred services. It includes information on how CMS edits will be implemented and impact providers. The article was revised to show that Clinical Nurse Specialists are eligible to order and refer services for Medicare beneficiaries.

“Important Reminder for Providers and Suppliers Who Provide Services and Items Ordered or Referred by Other Providers and Suppliers” MLN Matters® Article — Revised [\[↑\]](#)

[MLN Matters® Special Edition Article #SE1201](#), “Important Reminder for Providers and Suppliers Who Provide Services and Items Ordered or Referred by Other Providers and Suppliers” was revised and is now available in downloadable format. This article is designed to provide

education on the requirements for billing for ordered and referred services. It includes information about what providers and suppliers who provide services and items ordered or referred by other providers and suppliers should know before submitting a claim to Medicare. The article was revised to show that optometrists may only order and refer laboratory and X-Ray services.

“Phase 2 of Ordering/Referring Requirement” MLN Matters® Article — Revised [\[↑\]](#)

[MLN Matters® Special Edition Article #SE1221](#), “Phase 2 of Ordering/Referring Requirement” was revised and is now available in downloadable format. This article is designed to provide education on phase 2 of the requirement by which CMS will deny Part B, DME, and Part A HHA claims that fail ordering/referring provider edits, as outlined in final rule CMS-6010-F, which CMS published on April 24, 2012. It includes additional resources and information about phases 1 and 2 of the requirement and which types of providers are eligible to order or refer items or services to Medicare beneficiaries. The article was revised to show that Clinical Nurse Specialists are eligible to order and refer services for Medicare beneficiaries.

New MLN Provider Compliance Fast Fact [\[↑\]](#)

A new fast fact is now available on the [MLN Provider Compliance](#) web page. This web page provides the latest [MLN Educational Products](#) and [MLN Matters® Articles](#) designed to help Medicare Fee-For-Service providers understand common billing errors and avoid improper payments. Please bookmark this page and check back often as a new fast fact is added each month.

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The [Medicare Learning Network®](#) (MLN) is the home for education, information, and resources for the Medicare Fee-For-Service (FFS) provider community. Sign up for any of the electronic mailing lists below to stay informed about the latest MLN Educational Products and MLN Matters® Articles. You will receive an email when new and revised products and articles are released.

- [MLN Matters® Articles Electronic Mailing List](#) – MLN Matters® are national articles that educate Medicare FFS Providers about important changes to the Medicare Program. Articles explain complex policy information in plain language to help providers reduce the time it takes to incorporate these changes into their Medicare-related activities.
- [MLN Educational Products Electronic Mailing List](#) – MLN Products are designed to provide education on a variety of Medicare-related topics, such as provider supplier enrollment, preventive services, provider compliance, and Medicare payment policies. All products are free of charge and offered in a variety of formats to meet your educational needs.

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