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. Thank you!

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Colleagues—

I am happy to announce that the e-News is now available in PDF format within 24 hours of its release by email at FFS Provider Partnership Program Email Archive. Editions of the e-News issued since Nov 4 are in the archive in PDF format. We're making this new format available in response to feedback from some partners that the PDF format is an easier and more effective way to share news with your members.

Thank you for partnering with us to get important FFS Medicare messages out to the provider community. We are always open to your suggestions for how we could improve our collaboration.

Best wishes for a wonderful Thanksgiving,

Robin

The e-News for the week of Tue Nov 22 includes…

NATIONAL PROVIDER CALLS

- Tue Dec 6 – CMS Hospital Value-Based Purchasing National Provider Call – Registration Open
- Wed Dec 7 – Medicare FFS Implementation of *HIPAA* Version 5010 and D.0 Transaction Standards – Register Now
- Transcript of "Revalidation of Medicare Provider Enrollment" National Provider Call Now Available

Calls, Meetings, and Events

- Tue Nov 29 – Special Open Door Forum: Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP)
- Wed Nov 30 and Thu Dec 8 – Special Open Door Forums: CMS Conducting a Part A to Part B Rebilling Demonstration
- Fri Dec 2 – Special Open Door Forum: Medicare's Prepayment Review and Prior Authorization Demonstration Project for Power Mobility Devices for Suppliers
- Mon Dec 5 – Special Open Door Forum: Medicare's Prepayment Review and Prior Authorization Demonstration Project for Power Mobility Devices for Providers
- Tue Mar 6 to Wed Mar 7, and Thu Mar 8 to Fri Mar 9 – 2012 Minimum Data Set (MDS) 3.0 National Conference

Announcements and Reminders

- Community Based Care Transition Program Awards Funds to Find New Ways to Improve Care for People with Medicare
- Reminder of Upcoming Deadlines and Helpful Resources for Eligible Hospitals and CAHs Participating in the EHR Incentive Programs
- CMS Announces New Demonstrations to Help Curb Improper Medicare, Medicaid Payments
- New Short-Term PEPPER Now Available
- Notification of Final Primary Care Incentive Payment (PCIP) Files for Payment Year 2012
- HHS Expands Initiative to Protect Medicare and Seniors from Fraud
- Updates to the Ordering/Referring Report

Code, Claim, and Pricer Updates

- Systems Issue Impacting Skilled Nursing Facilities (SNF) Which Bill Electronically Using New Health Insurance Prospective Payment System (HIPPS) Codes

Updates from the Medicare Learning Network ®

- "Medicare Physician Guide" Revised and CD ROM Available
- "Medicare Fraud & Abuse: Prevention, Detection, and Reporting" Fact Sheet Revised
- "Guidance on Completing the CMS-855A Enrollment Form" MLN Matters® Article Released
- "Advanced Diagnostic Imaging Accreditation Enrollment Procedures" MLN Matters® Article Revised
- "Important Reminders about HIPAA 5010 & D.0 Implementation" MLN Matters® Article
- "Important Update Regarding 5010 Implementation – Action Needed Now" MLN Matters® Article Available
- "Power Mobility Devices" Fact Sheet Revised
- "Contractor Entities At A Glance" Educational Tool Available in Hard Copy
- "Medicare Information for Advanced Practice Registered Nurses, Anesthesiologist Assistants, and Physician Assistants" Booklet Available
- New Fast Fact on MLN Provider Compliance Webpage

- Medicare Billing Certificate Programs Coming Soon to the Medicare Learning Network®

National Provider Call: CMS Hospital Value-Based Purchasing – Registration Open [↑]
Tue Dec 6; 1:30-3pm ET

CMS is currently conducting a "dry run" of the Hospital Value-Based Purchasing (Hospital VBP) Program in order to simulate the Fiscal Year (FY) 2013 program one year in advance. Hospital VBP is the next step in promoting higher quality care for Medicare beneficiaries and will transform Medicare into an active purchaser of quality healthcare for its beneficiaries. This dry run will provide hospitals with a better understanding of the Hospital VBP Program, how performance will be scored, and will offer hospitals the chance to review their data and ask questions to clarify the Program. As part of the Dry Run, CMS will create simulated, hospital-specific Performance Reports for each hospital to review. The simulated reports will employ hospital data from prior years as the basis for the baseline and performance periods.

The Simulated Hospital VBP Program reports will feature:

The hospital's estimated incentive payment percentage, based on the dry run's baseline and performance periods
The hospital's Total Performance Score and a comparison to national and state Total Performance Scores
The hospital's scores for the Clinical Process of Care domain and the Patient Experience of Care domain
The hospital's individual Clinical Process measure performance and scores
The hospital's individual Patient Experience dimension performance and scores
The hospital's individual Patient Experience domain consistency score
Detailed explanations of every section of the simulated report

To prepare providers for interpreting the dry run simulated report, CMS will be hosting a National Provider Call on Tue Dec 6. The National Provider Call will discuss a sample report that will demonstrate what hospitals can expect when their specific reports are made available through their QualityNet accounts on or after Fri Dec 16. Hospitals that do not meet the eligibility requirements during this dry run simulation will not receive a hospital-specific performance Report for review; however those hospitals are welcome to join the National Provider Call to learn more about this program.

Target Audience: Hospitals, Quality Improvement Organizations (QIOs), physicians, nurses, medical coders, physician office staff, provider billing staff, health records staff, vendors, and all Medicare FFS providers.

Agenda:

Opening Remarks
Program Announcements
Overview of the FY 2013 Hospital Value-Based Purchasing Program
Presentation and walkthrough of a *sample* hospital specific report
Question & Answer Session

Registration information: Please visit http://www.eventsvc.com/blhtechnologies to register for this informative session. *Registration will close at 12pm ET on Tue Dec 6, or when available space has been filled.* No exceptions will be made; please register early.

Please note that questions prior to the call will be taken during registration. Every effort will be made to address questions during or after this call.

Presentation information: A slideshow presentation will be made available in advance of the call at http://www.CMS.gov/Hospital-Value-Based-Purchasing/.

National Provider Call: Medicare FFS Implementation of *HIPAA* Version 5010 and D.0 Transaction Standards – Register Now
Wed Dec 7; 1:30-3pm ET

CMS will host its twenty first National Provider Call regarding Medicare Fee-For-Service (FFS) implementation of *HIPAA* Version 5010 and D.0 transaction standards.

Target Audience: Vendors, clearinghouses, and providers who need to make Medicare FFS-specific changes in compliance with HIPAA Version 5010 requirements.

Agenda

- Top 10 problems impacting the 5010 transition
- Status of current Version 5010 Standard System Maintainer fixes
- Top 10 Version 5010 edits
- Medicaid update

Presentation
There will be a presentation available the week before the call. Please visit the following web page to download the presentation: https://www.CMS.gov/Versions5010andD0/V50/list.asp in the "Downloads" section.

If you would like to submit a question related to this topic in advance of, during, or following the call, please email your inquiry to the 5010 FFS Information resource mailbox at 5010FFSinfo@CMS.hhs.gov. Note that this resource will only accept emails the day before, the day of, and the day after this call; your emailed questions will be answered as soon as possible, and may not be answered during

the call.

Registration Information: In order to receive the call-in information, you must register for the call. *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. For more details, including instructions on registering for the call, please visit http://www.eventsvc.com/blhtechnologies.

Webinar Information

CMS will be using a webinar feature as part of this national provider call. This will not have any effect on those participants who are dialing in. This webinar is an added feature that allows participants who have internet access the ability to follow the presentation online as it is given. To access this Adobe Connect Pro Webinar, please use the following url: https://webinar.CMS.hhs.gov/medicareffs5010/. Sign in as a guest when prompted by entering your first and last name. Please note that you must dial in to the call in order to access the audio portion of the presentation.

IMPORTANT NOTE: This webinar's capacity is limited to 1,000 participants and access is on a first-come, first-served basis. In the event that capacity is reached, you may get an error message. In case of this, we have created a second webinar room for up to 500 additional participants which can be accessed using this url: https://webinar.CMS.hhs.gov/medicareffs5010-2/. The use of this secondary webinar link is no different than the original, and access is also on a first-come, first-served basis. If you get an error message attempting to join this second room as well, capacity has been filled. In this case, simply visit the 5010 National Calls Page, select the 12/07/2011 call from the list, and download the presentation from the bottom of the call information page. You will then be able to follow the presentation manually during the call. You must dial in to the call in order to access the audio portion of the presentation. We thank you for your interest in participating via Adobe Connect Pro.

Transcript of "Revalidation of Medicare Provider Enrollment" National Provider Call Now Available [↑]

All providers and suppliers who enrolled in the Medicare program prior to Fri Mar 25 will be required to revalidate their enrollment under new risk screening criteria required by the *Affordable Care Act* (section 6401a). CMS hosted a National Provider Call on Thu Oct 27 to discuss:

The Revalidation Process
Improvements to the Provider Enrollment, Chain and Ownership System (PECOS)
Advanced Diagnostic Imaging and Accreditation
Application Fees
Changes to the 855A Form

Don't miss this opportunity to hear from CMS experts on this important topic. View the transcript from the National Provider Call on "Revalidation of Medicare Provider Enrollment" here. This transcript contains a number of post call clarifications – such as where to find the listing of providers which have received a notice to revalidate. The audio file will be posted in the near future.

Special Open Door Forum: Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP) [↑]
Tue Nov 29; 2-4pm ET

This call will give an overview of the IRF QRP (http://www.CMS.gov/LTCH-IRF-Hospice-Quality-Reporting), a review of the *Affordable Care Act Section 3004 (b)* and the Quality Reporting Program for IRFs, and quality measures for the IRF QRP. Questions and comments can be sent to LTCH-IRF-Hospice-Quality-ReportingComments@CMS.hhs.gov.

If you wish to participate, dial: 1-800-837-1935 and use Conference ID: 21834666. An audio recording and transcript of this Special Open Door Forum will be posted to the Special Open Door Forum website and will be accessible for downloading on or around Fri Dec 9, and will be available for 30 days.

Please see the Downloads section at the following URL for the full participation announcement: http://www.CMS.gov/OpenDoorForums/18_ODF_Hospitals.asp. Thank you for your continued interest in the CMS Open Door Forums.

Special Open Door Forum: Medicare's Prepayment Review and Prior Authorization Demonstration Project for Power Mobility Devices for Suppliers [↑]
Fri Dec 2; 2-3:30pm ET

The purpose of this Special Open Door Forum (ODF) is to provide an opportunity for suppliers to ask questions about the Demonstration.

CMS will conduct a demonstration that will implement a prior authorization process for certain medical equipment for all people with Medicare who reside in seven states with high populations of fraud-and error-prone providers (California, Florida, Illinois, Michigan, New York, North Carolina, and Texas). This is an important step toward paying appropriately for certain medical equipment that has a high error rate. 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 right to receive quality products from accredited suppliers.

The Prior Authorization demonstration will be implemented in two phases. During the first phase (the first three to nine months), the Medicare Administrative Contractors will conduct prepayment reviews on certain medical equipment claims. The second phase, for the remainder of this three-year demonstration, will implement prior authorization, a tool utilized by private-sector health care payers to prevent improper payments and deter fraud.

To read more about the Demonstration visit: http://go.CMS.gov/cert-demos.
Participants may submit questions prior to the Special ODF to pademo@CMS.hhs.gov by Thu Dec 1, 5pm ET.

Special Open Door Participation Instructions:

Dial: 1-866-501-5502 & Conference ID: 29840167
Note: 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 http://www.CMS.gov/OpenDoorForums/05_ODF_SpecialODF.asp and will be accessible for downloading beginning on or around Tue Dec 13.

For automatic emails of Open Door Forum schedule updates (email list subscriptions) and to view Frequently Asked Questions, please visit http://www.CMS.gov/opendoorforums/.

Special Open Door Forum: Medicare's Prepayment Review and Prior Authorization Demonstration Project for Power Mobility Devices for Providers [↑]
Mon Dec 5; 2-3:30pm ET

The purpose of this Special Open Door Forum (ODF) is to provide an opportunity for providers to ask questions about the Demonstration.

CMS will conduct a demonstration that will implement a prior authorization process for certain medical equipment for all people with Medicare who reside in seven states with high populations of fraud-and error-prone providers (California, Florida, Illinois, Michigan, New York, North Carolina, and Texas). This is an important step toward paying appropriately for certain medical equipment that has a high error rate. 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 right to receive quality products from accredited suppliers.

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To read more about the Demonstration visit: http://go.CMS.gov/cert-demos.
Participants may submit questions prior to the Special ODF to pademo@CMS.hhs.gov by Fri Dec 2, 5pm ET.

Special Open Door Participation Instructions:
Dial: 1-866-501-5502 & Conference ID: 29845811
Note: 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

http://www.CMS.gov/OpenDoorForums/05_ODF_SpecialODF.asp and will be accessible for downloading beginning on or around Wed Dec 14.

For automatic emails of Open Door Forum schedule updates (email list subscriptions) and to view Frequently Asked Questions, please visit http://www.CMS.gov/opendoorforums/.

2012 Minimum Data Set (MDS) 3.0 National Conference [↑
March 6-7 & 8-9

The CMS 2012 MDS National Conference is a two-day conference that will be held twice. A conference will be held on March 6-7, 2012 and repeated on March 8-9, 2012, at the Hyatt Regency St. Louis at the Arch in St. Louis, Missouri.

Conference registration began Mon Nov 14 and will close on Fri Dec 30. Please visit the CMS MDS 3.0 Training Conference Information webpage for additional information.

Special Open Door Forums: CMS Conducting a Part A to Part B Rebilling Demonstration [↑]
Wed Nov 30; 2-3:30pm ET
Thu Dec 8; 2-3:30pm ET

CMS is conducting a 3-year demonstration (from January 2012 through December 2014) to allow 380 providers nationwide to resubmit denied Part A inpatient short stay claims for 90% of the payment for Part B services. Hospital participation will be voluntary and enrollment will be on a first-come, first-serve basis. The 380 participants will be stratified into 3 categories, based on facility size (number of beds), to ensure accurate representation among hospitals. For the purposes of this demonstration, small participants are those with fewer than 100 beds, moderate have 100-299 beds and large participants have 300 beds or greater. This demonstration may include hospitals paid under the Medicare Inpatient Prospective Payment System (IPPS), but excludes facilities receiving periodic interim payments from CMS, psychiatric hospitals paid under the Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS), Inpatient Rehabilitation Facilities (IRFs), Long-Term Care Hospitals (LTCHs), cancer hospitals, Critical Access Hospitals (CAHs), and children's hospitals. Hospitals in this demonstration must agree to several beneficiary and Trust Fund protections when rebilling claims.

CMS has scheduled two (2) Special Open Door Forums to introduce the demonstration and provide instructions on how to request participation. These Open Door Forums will be held on Wed Nov 30 and Thu Dec 8 from 2-3:30pm ET.

For more information on the demonstration or the upcoming Open Door Forums, please visit http://go.CMS.gov/cert-demos. For any additional questions, please contact CMS at ABRebillingDemo@CMS.hhs.gov. Interested providers may also track demonstration updates on twitter at *#rebillingdemonstration*.

Community Based Care Transition Program Awards Funds to Find New Ways to Improve Care for People with Medicare [↑]

On Fri Nov 18, CMS announced the first sites selected for the Community Based Care Transition Program (CCTP). The CCTP is an initiative of the Partnership for Patients, a new public-private partnership created by the *Affordable Care Act*. CCTP's goals are to reduce hospital readmissions, test sustainable funding streams for care transition services, maintain or improve quality of care, and document measureable savings to the Medicare program. The demonstration will be conducted under the authority of Section 3026 of the *Affordable Care Act* of 2010.

The CMS Innovation Center will also be holding a conference call on Tue Nov 29 from 1-2:30pm to allow stakeholders to hear directly from some of the newly selected sites. We will also have CMS staff available to answer questions. Call in number: 1-800-837-1936 Conference ID: 29693317.

Click here for the first site selections for the Community Based Care Transitions Program: http://www.CMS.gov/DemoProjectsEvalRpts/downloads/CCTP_FirstSiteSelections.pdf. Comments or questions can be sent to: CareTransitions@CMS.hhs.gov.

For more information about the Community Based Care Transitions Program, visit http://go.CMS.gov/caretransitions.

Reminder of Upcoming Deadlines and Helpful Resources for Eligible Hospitals and CAHs Participating in the EHR Incentive Programs [↑]

CMS wants to remind eligible hospitals and Critical Access Hospitals (CAHs) of key registration and attestation dates for the EHR Incentive Programs, and provide resources to help them successfully register and start their path to payment for 2011.

Important Registration Details for Medicare and Medicaid:

Medicare: Wed Nov 30 is the last day for Medicare eligible hospitals and CAHs to register and attest to receive an incentive payment for Federal FY2011

Medicaid: Each state has its own attestation deadlines. Please check with your State Medicaid agency to find out the last day you can attest

Registration Resources:

CMS has a number of resources to help providers successfully register for the EHR Incentive Programs, including:

A step-by-step Eligible Hospital and CAH Registration Guide for the Medicare and Medicaid programs

FAQs about registration and other EHR Incentive Programs topics

A video webinar to help guide eligible hospitals and CAHs through the registration process

Attestation Resources:

CMS has an Eligible Hospital and CAH Attestation User Guide, which provides step-by-step instructions for login and completing

attestation. CMS also has a Meaningful Use Attestation Calculator, which allows providers to see if they are able to meet all of the necessary meaningful use measures to successfully attest and qualify for an incentive payment.

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 Announces New Demonstrations to Help Curb Improper Medicare, Medicaid Payments [↑]
Efforts will Build on 2011 Decreases in Medicare, Medicaid Improper Payments

In 2010, the President announced three goals for cutting improper payments by 2012: reducing overall payment errors by $50 billion, cutting the Medicare Fee-For-Service error rate in half, and recovering $2 billion in improper payments.

To help achieve these goals, CMS has announced it will launch demonstration programs beginning in January 2012 targeting some of the most common factors that lead to improper payments.

Cost Saving Projects will Help Protect Medicare and Medicaid:
Beginning on Sun Jan 1, 2012, CMS will conduct demonstration projects that will strengthen Medicare by aiming at eliminating fraud, waste, and abuse. Reductions in improper payments will help ensure the sound future of the Medicare Trust Fund and protect Medicare beneficiaries who depend upon it such as:

Recovery Audit Prepayment Review
Prior Authorization for Certain Medical Equipment
Part A to Part B Rebilling

This past May, HHS announced a pilot project under the Partnership Fund for Program Integrity Innovation to test an automated tool to screen providers for the risk of fraud. Currently, HHS and States lack standardized Medicaid provider data, which hampers detection of potential fraud. If successful, this tool will not only help prevent improper payments by weeding out fraudulent providers, but it will help States focus their resources where fraud is most likely to occur.

New Projects Build on 2011 Savings:
The 2012 projects announced will build on accomplishments in 2011 to reduce Medicare and Medicaid improper payment rates. CMS is also reporting for the first time a composite improper payment rate for the Medicare Part D prescription drug program. The improper payment rate for the Children's Health Insurance Program (CHIP) will not be published until 2012. While improper payment rates are not necessarily an indicator of fraud in Medicare, Medicaid or CHIP, they do provide HHS, CMS and States with a more complete assessment of factors leading to error rates and new ways to help prevent them. CMS is continuing to invest time and resources to work with providers across the country and eliminate errors through increased and improved training, education, and outreach.

The full CMS Fact Sheet issued is available here: http://www.CMS.gov/apps/media/press/factsheet.asp?Counter=4176.

Additional Fact sheets issued Tue Nov 15:
CMS Prior Auth Fact Sheet – https://www.CMS.gov/apps/media/press/factsheet.asp?Counter=4168
CMS Rebilling Fact Sheet – http://www.CMS.gov/apps/media/press/factsheet.asp?Counter=4169
CMS Recovery Audit (RAC) Demo Fact Sheet – http://www.CMS.gov/apps/media/press/factsheet.asp?Counter=4170
CMS Medicaid Fact Sheet – http://www.CMS.gov/apps/media/press/factsheet.asp?Counter=4171
CMS Medicare D fact sheet – http://www.CMS.gov/apps/media/press/factsheet.asp?Counter=4172
CMS Medicare C fact sheet and – http://www.CMS.gov/apps/media/press/factsheet.asp?Counter=4175
CMS Medicare FFS Improper payments Fact Sheet – http://www.CMS.gov/apps/media/press/factsheet.asp?Counter=4174

Also, please see the White House Press Release "We Can't Wait: Agencies Cut Nearly $18 Billion in Improper Payments, Announce New Steps for Stopping Government Waste" at http://www.whitehouse.gov/the-press-office/2011/11/15/we-can-t-wait-agencies-cut-nearly-18-billion-improper-payments-announce-
Agency improper payment data is being updated Tuesday afternoon at www.paymentaccuracy.gov

New Short-Term PEPPER Now Available [↑]

A new release of the Short-Term (ST) Acute Care Program for Evaluating Payment Patterns Electronic Report (PEPPER), with statistics through the third quarter of FY2011, is available for short-term acute care hospitals nationwide open as of Thu Jun 30. PEPPER files were distributed in late November 2011 through a My QualityNet secure file exchange to hospital QualityNet Administrators and user accounts with the PEPPER recipient role. This release of PEPPER includes a new report, the "National High Outlier Ranking Report," which ranks hospitals by the total number of high outliers as compared to all other hospitals in the nation. A new training session reviewing the new report is available at PEPPERresources.org.

About PEPPER:
PEPPER provides hospital-specific data statistics for Medicare severity diagnosis-related groups and discharges at risk for improper payments. It is distributed by TMF® Health Quality Institute under contract with CMS. Visit PEPPERresources.org to access resources for using PEPPER, including user's guides, recorded training sessions, information about QualityNet accounts, frequently asked questions and examples of how other hospitals are using PEPPER.

Do you have questions or comments about PEPPER or need help obtaining your report? Visit our Help Desk, or provide your feedback or suggestions regarding PEPPER through our feedback form.

Notification of Final Primary Care Incentive Payment (PCIP) Files for Payment Year 2012 [↑]

Primary care physicians and non-physician practitioners may confirm 2012 Primary Care Incentive Payment (PCIP) eligibility by identifying their provider NPI on the *PCIP.Payment.CY2012* file found on contractor websites.

HHS Expands Initiative to Protect Medicare and Seniors from Fraud [↑]
Medicare awards grants to expand 52 Senior Medicare Patrol programs

The Department of Health and Human Services (HHS) announced today the award of $9 million from the Centers for Medicare and Medicaid Services (CMS) to help Senior Medicare Patrol (SMP) programs across the nation continue their work fighting Medicare fraud. This is part of President Obama's initiative to educate people with Medicare about how to protect themselves and Medicare from fraud. SMPs rely on approximately 5,000 volunteers nationwide to enhance their efforts.

The SMP program is operated by the Administration on Aging (AOA) in close partnership with CMS and the U.S. Department of Health and Human Services (HHS) Office of Inspector General.

The SMP volunteers work in their communities to educate Medicare beneficiaries, family members, and caregivers about the importance of reviewing their Medicare notices, and Medicaid claims if dually-eligible, to identify errors and potentially fraudulent activity. Program volunteers also encourage seniors to make inquiries to the SMP Program when such issues are identified, so that the project may ensure appropriate resolution or referral.

The 2011 grants will provide additional funds for SMPs to increase awareness among Medicare beneficiaries about how to prevent, detect, and report health care fraud. Increased funding levels for states identified with high-fraud areas will support additional targeted strategies for collaboration, media outreach and referrals. The Administration on Aging will continue to administer these grants in partnership with CMS.

To read the entire HHS released today, Tue Nov 22 click here: http://www.CMS.gov/apps/media/press/release.asp?Counter=4183

Helpful Links:

A list of the grants awarded to each SMP may be found at:
http://www.aoa.gov/AoARoot/AoA_Programs/Elder_Rights/SMP/doc/SMP_Grants_Awards_FY2011.pdf
For more information on fraud prevention efforts, visit:
http://www.stopmedicarefraud.gov/ or http://www.CMS.gov/FraudAbuseforConsumers/.
For information about the SMP program go to: http://aoa.gov/AoARoot/AoA_Programs/Elder_Rights/SMP/index.aspx.

Updates to the Ordering/Referring Report

In response to concerns raised by the provider community, CMS will no longer post the complete NPI on the ordering & referring reports found in the "Downloads" on
http://www.CMS.gov/MedicareProviderSupEnroll/06_MedicareOrderingandReferring.asp#TopOfPage. The following reports will be updated shortly to only contain the last 4 digits of the NPI:

Ordering/Referring Report
Initial Physician Applications Pending Contractor Review
Initial Non Physician Applications Pending Contractor Review

Systems Issue Impacting Skilled Nursing Facilities (SNF) Which Bill Electronically Using New Health Insurance Prospective Payment System (HIPPS) Codes [↑]

CMS recently developed a new Change of Therapy (COT) Other Medicare Required Assessment (OMRA) for the SNF PPS and developed a mechanism to allow providers to report a Resumption of Therapy on an End of Therapy (EOT) OMRA. In addition, several new Assessment Indicators (AIs) were created to identify that a COT OMRA was completed and to distinguish between cases where an EOT OMRA is performed with the resumption items completed and cases where an EOT OMRA is completed without the resumption items completed. The new AIs were introduced in Chapter 6, Section 6.4, of the new Minimum Data Set (MDS) manual located at: http://www.CMS.gov/NursingHomeQualityInits/downloads/MDS30RAIManual.zip.

As a result of these new AIs, CMS must add approximately 1500 new HIPPS codes to the Fiscal Intermediary Shared System (FISS). The HIPPS master list located at http://www.CMS.gov/ProspMedicareFeeSvcPmtGen/02_HIPPSCodes.asp contains these new codes.

As a result of these new AIs, an unforeseen claims processing system issue surfaced for claims that are submitted electronically. The correction for this issue will take place on Mon Dec 5. In the meantime, providers may submit claims that contain these HIPPS codes directly via FISS Direct Data Entry (DDE) screens or hold these claims until after the system fix is implemented on Mon Dec 5.

From the MLN: "Medicare Physician Guide" Revised and CD ROM Available [↑]

The "Medicare Physician Guide" (ICN 005938) has been revised and is available in CD ROM format. This guide includes the following information: an introduction to the Medicare Program, becoming a Medicare provider or supplier, Medicare reimbursement, Medicare services, protecting the Medicare Trust Fund, Medicare overpayments and Fee-For-Service appeals, and provider outreach and education. To place your order, visit the "MLN Products page," scroll to the "Related Links Inside CMS," and select the "MLN Product Ordering Page."

From the MLN: "Medicare Fraud & Abuse: Prevention, Detection, and Reporting" Fact Sheet Revised [↑]

The "Medicare Fraud & Abuse: Prevention, Detection, and Reporting" Fact Sheet (ICN 0006827) is designed to provide education on preventing, detecting and reporting Medicare fraud and abuse. It includes definitions, as well as, information on laws, partnerships with other organizations and resources for additional information.

From the MLN: "Guidance on Completing the CMS-855A Enrollment Form" MLN Matters® Article Released [↑]

The new MLN Matters® Special Edition Article (#SE1135) "Guidance on Completing the CMS-855A Enrollment Form" is designed to provide education on how to complete the Medicare Enrollment Application for Institutional Providers, Form CMS-855A. It provides a brief guide that providers may use when completing the CMS-855A application. Please note, use of this guide is not mandatory and does not ensure Medicare enrollment.

From the MLN: "Advanced Diagnostic Imaging Accreditation Enrollment Procedures" MLN Matters® Article Revised [↑]

The MLN Matters® Article (#MM7177) "Advanced Diagnostic Imaging Accreditation Enrollment Procedures" is designed to provide education on the accreditation requirements for providers who submit claims for advanced diagnostic imaging services, as outlined in Change Request (CR) 7177. It was revised to add a reference to MLN Matters Article #SE1122 for additional information about these requirements.

From the MLN: "Important Reminders about HIPAA 5010 & D.0 Implementation" MLN Matters® Article [↑]

The MLN Matters® Special Edition Article (#SE1106) "Important Reminders about HIPAA 5010 & D.0 Implementation" is designed to provide education on how to prepare for the Health Insurance Portability and Accountability Act (HIPAA) 5010/D.0 implementation. It includes a list of assessment questions and educational materials to help providers prepare for the implementation.

From the MLN: "Important Update Regarding 5010 Implementation – Action Needed Now" MLN Matters® Article Available [↑]

The MLN Matters® Special Edition Article (#SE1131) "Important Update Regarding 5010 Implementation – Action Needed Now" is designed to provide education on the actions providers must take *NOW* to prepare for the Health Insurance Portability and Accountability Act (HIPAA) 5010/D.0 implementation. It includes important action steps and a list of questions that providers can use to determine whether they are at risk of not being able to meet the January 1, 2012, deadline and submit claims.

From the MLN: "Power Mobility Devices" Fact Sheet Revised [↑]

The "Power Mobility Devices (PMDs): Complying with Documentation & Coverage Requirements" Fact Sheet (ICN 905063) is designed to provide education on common Comprehensive Error Rate Testing Program errors related to power mobility devices. It includes a checklist of the documentation needed to support a claim submitted to Medicare for PMDs.

From the MLN: "Contractor Entities At A Glance" Educational Tool Available in Hard Copy [↑]

The "Contractor Entities At A Glance: Who May Contact You About Specific Centers for Medicare & Medicaid Services (CMS) Activities" Educational Tool (ICN 906983) is designed to provide education on the definitions and responsibilities of entities involved in claims adjudication activities. It includes a chart that outlines each entity by type, definitions, responsibilities, and reasons for contacting providers, especially Fee-For-Service providers. To place an order for a hard copy version, go to http://www.CMS.gov/MLNProducts and click on "MLN Product Ordering Page" under "Related Links Inside CMS" at the bottom of the page.

From the MLN: "Medicare Information for Advanced Practice Registered Nurses, Anesthesiologist Assistants, and Physician Assistants" Booklet Available

The revised "Medicare Information for Advanced Practice Registered Nurses, Anesthesiologist Assistants, and Physician Assistants" Booklet (ICN 901623) provides education on services furnished by advanced practice registered nurses, anesthesiologist assistants, and physician assistants. This booklet includes the following information about Medicare requirements for these provider types: required qualifications, coverage criteria, billing, and payment. To place your order, visit the MLN Products page, scroll to the "Related Links Inside CMS," and select the "MLN Product Ordering Page."

From the MLN: New Fast Fact on MLN Provider Compliance Webpage [↑]

A new fast fact on MLN Provider Compliance is now available. This webpage provides the latest educational products designed to help Medicare Fee-For-Service providers understand—and avoid —common billing errors and other improper activities. Please bookmark this page and check back often as a new "fast fact" is added each month.

Medicare Billing Certificate Programs Coming Soon to the Medicare Learning Network® (MLN) [↑]

"The Medicare Billing Certificate Program for Part A Providers," and "The Medicare Billing Certificate Program for Part B Providers" are coming soon to the MLN. Learn about the Medicare Program with a special focus on Medicare Billing specific to your billing or provider type, and receive a certificate in Medicare Billing from CMS. Look for these programs to become available in early 2012.

More Helpful Links…

Check out CMS on

Twitter, LinkedIn, YouTube, and Flickr!

The Medicare Learning Network

www.CMS.gov/MLNGenInfo

Archive of Provider e-News Messages

www.CMS.gov/FFSProvPartProg/EmailArchive