

C Medicare A CONNECTION



A Newsletter for MAC Jurisdiction 9 Providers

January 2012



Health care professionals selected for the new innovation advisors program to improve care for patients

The Centers for Medicare & Medicaid Services (CMS) announced that it has selected 73 individuals from 27 states and the District of Columbia for its innovation advisors program.

A list of innovation advisors can be found at <http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4240>.

The initiative, launched by the CMS Innovation Center in October 2011, will help health professionals deepen skills that will drive improvements to patient care and reduce costs. After an initial orientation phase, innovation advisors will work with the CMS Innovation Center to test new models of care delivery in their own organizations and communities. They will also create partnerships to find new ideas that work and share them regionally and across the United States.

Funding for this initiative was made possible by the Affordable Care Act.

“There has been an incredible groundswell of interest in becoming an innovation advisor. It’s clear that doctors, hospitals and health care providers are enthusiastic about implementing the Affordable Care Act and strengthening our health care system,” said CMS Acting Administrator Marilyn Tavenner.

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The 73 individuals were selected from 920 applications through a competitive process, and include clinicians, allied health professionals, health administrators and others. By attending in-person meetings as well as remote sessions to expand their skills and applying what they learn, the advisors will be able to deepen their knowledge in health care economics and finance, population health, systems analysis, and operations research.

“We’re looking to these innovation advisors to be our partners – we want them to discover and generate new ideas that will work and help us bring them to every corner of the United States,” said CMS Innovation Center Director Rick Gilfillan, M.D.

Among other duties, the advisors will be expected to support the Innovation Center in testing new models of care delivery, to form partnerships with local organizations to drive delivery system reform, and to improve their own health systems so their communities will have better health and better care at a lower cost.

Each innovation advisor’s home organization will receive a stipend of up to \$20,000. The stipend will support an individual’s activities while serving as an innovation advisor.

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WHEN EXPERIENCE COUNTS & QUALITY MATTERS

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Innovation...continued

More information about the innovation advisors program, including a fact sheet and list of participants and their home organization, can be found at: <http://innovations.cms.gov/initiatives/innovation-advisors/index.html>.

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Source: CMS PERL 201201-04

President Obama signs the Temporary Payroll Tax Cut Continuation Act of 2011

New law includes physician update fx through February 2012

On Friday, December 23, 2011, President Obama signed into law the Temporary Payroll Tax Cut Continuation Act of 2011 (TPTCCA). This new law prevents a scheduled payment cut for physicians and other practitioners who treat Medicare patients from taking effect immediately. While the negative update for the 2012 Medicare physician fee schedule is now scheduled to take effect on March 1, 2012, the administration remains strongly opposed to letting this cut take effect. As he has repeatedly made clear, President Obama is committed to a permanent solution to eliminating the sustainable growth rate's cut. We will continue to work with Congress to achieve this goal.

The Centers for Medicare & Medicaid Services (CMS) has also recently implemented several important changes for Medicare providers and beneficiaries, and it would like to remind physicians and practitioners of some of these key changes for 2012. For many of your patients, Medicare costs will go down. Medicare cost-sharing for Part B services will decline in some cases and, for the first time, the Part B deductible will decrease, by \$22, to \$140.

Additionally, health care professionals will be paid more to provide certain important services for people with Medicare. CMS has increased the payment amount for the initial and annual wellness visit – which has no cost sharing for patients – to account for the introduction of health risk assessment (HRA). CMS believes it is important to balance the comprehensiveness of the HRA with the potential burden on patients and health professional time constraints. As such, in 2012, CMS will allow for variation in the content of the HRA.

The Medicare Part D prescription drug program has also been enhanced for 2012, with the coverage gap being further reduced as it is phased-out over the next several years. These improvements to the drug benefit from the Affordable Care Act have already saved millions of seniors nearly \$2 billion.

CMS wishes to remind physicians and practitioners about the primary care incentive program. Again in

2012, primary care physicians, nurse practitioners, clinical nurse specialists, and physician assistants may be eligible to receive an incentive payment equal to 10 percent of their allowed charges for primary care services under Medicare Part B. This incentive is paid in addition to any physician incentive payments for services furnished in Health Professional Shortage Areas. Please remember that if a practitioner has reassigned his or her benefits to another entity, such as a group practice, Medicare will pay that entity and not the individual practitioner.



The Affordable Care Act created the Center for Medicare and Medicaid Innovation that offers physicians, practitioners and other health care leaders the opportunity to propose innovative payment and service delivery models to lower costs, improve quality, and improve health. More information can be found at www.innovations.cms.gov.

Below please find summaries of key provisions of the TPTCCA along with some information about how these changes may affect providers and provider billing.

Physician payment update

Section 301 of the TPTCCA prevents a payment cut for physicians that would have taken effect on January 1, 2012. An update of zero percent is effective for claims with dates of service January 1, 2012, through February 29, 2012. While the physician fee schedule update will be zero percent, other changes

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Payroll...continued

to the relative value units used to calculate the fee schedule rates must be budget neutral. To make those changes budget neutral, the conversion factor must be adjusted for 2012. CMS is currently developing the 2012 Medicare Physician Fee Schedule (MPFS) to implement the zero percent update. As previously advised, Medicare claims administration contractors will be holding new, January 2012 claims for up to 10 business days in order to effectively test and implement the new 2012 MPFS. We expect these claims to be released into processing no later than January 18, 2012. Claims with dates of service prior to January 1, 2012, are unaffected. Finally, Medicare contractors will be posting the new rates on their websites no later than January 11, 2012.

Extension of Medicare physician work geographic adjustment floor

Current law requires payment rates under the MPFS to be adjusted geographically to reflect area differences in the cost of practice. The following three components of the MPFS payment are adjusted: physician work, practice expense, and malpractice expense. Section 303 of the TPTCCA extends the existing 1.0 floor on the physician work geographic practice cost index, through February 29, 2012. As with the physician payment update, this change will be accomplished through a revised 2012 MPFS.

Extension of physician fee schedule mental health add-on payments

For calendar year 2011, certain mental health services' payment rates continued to be increased by five percent over what they would otherwise be paid using the standard MPFS payment methodology. Section 307 of the TPTCCA extends the five percent increase in payments for these mental health services, through February 29, 2012. Similar to the zero percent update and the physician work geographic adjustment floor extension, the five percent increase will be reflected in the revised 2012 MPFS.

Extension of Medicare Modernization Act section 508 reclassifications

Section 302 of the TPTCCA extends section 508 reclassifications and certain special exception wage indexes for 2 months, from October 1, 2011, through November 30, 2011. For the period beginning on October 1, 2011, and ending on November 30, 2011, Section 302 also requires removing section 508 and special exception wage data from the calculation of the reclassified wage index if doing so raises the reclassified wage index. All hospitals affected by section 302 of the TPTCCA shall be assigned a special wage index effective for only October and November 2011. We will apply the provision to both inpatient and

outpatient hospital payments. For hospital outpatient payments, a special exception wage index will be applicable from January 1, 2012, through February 29, 2012.

Extension of exceptions process for Medicare therapy caps

Section 304 of the TPTCCA extends the exceptions process for outpatient therapy caps. Outpatient therapy service providers may continue to submit claims with the KX modifier, when an exception is appropriate, for services furnished on or after January 1, 2012, through February 29, 2012.

The therapy caps are determined on a calendar year basis, so all patients begin a new cap year January 1, 2012. For physical therapy and speech language pathology services combined, the limit on incurred expenses is \$1,880. For occupational therapy services, the limit is \$1,880. Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached, and also apply for services above the cap where the KX modifier is used.

Extension of moratorium on independent laboratory billing for the technical component (TC) of physician pathology services furnished to hospital patients

In the final physician fee schedule regulation published in the *Federal Register* November 2, 1999, CMS finalized a policy to pay only the hospital for the TC of physician pathology services furnished to hospital patients. Under prior policy, independent laboratories continued to be paid for the technical component of a pathology service provided to a hospital patient. At the request of the industry, to allow those independent laboratories that were separately paid for the technical component of a physician pathology service provided to a hospital patient sufficient time to negotiate new arrangements with hospitals, the implementation of this rule was administratively delayed until 2001. Subsequent legislation formalized a moratorium on the implementation of the rule.

Although the most recent extension of the moratorium expired at the end of 2011, section 305 of the TPTCCA restores the moratorium through February 29, 2012. Therefore, those independent laboratories that are eligible may continue to submit claims to Medicare for the TC of physician pathology services furnished to patients of a hospital, regardless of the beneficiary's hospitalization status (inpatient or outpatient) on the date that the service was furnished. This policy is effective for claims with dates of service on or after January 1, 2012, through February 29, 2012.

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Payroll...continued

Extension of ambulance add-on payments

The provisions that were extended by section 306 of the TPTCCA are:

1. The three percent increase in the ambulance fee schedule amounts for covered ground ambulance transports that originate in rural areas and the two percent increase for covered ground ambulance transports that originate in urban areas;
2. The provision relating to air ambulance services that considers any area that was designated as a rural area as of December 31, 2006, shall continue to be treated as a rural area for purposes of making payments under the ambulance fee schedule for such air ambulance services; and
3. The provision relating to payment for ground ambulance services where the base rate of the fee schedule is increased when the ambulance transport originates in an area that is included in those areas comprising the lowest 25th percentile of all rural populations arrayed by population density.

All of these payment provisions are extended through February 29, 2012. As previously advised, Medicare claims administration contractors will be holding new,

January 2012 ambulance claims for up to 10 business days in order to effectively implement the new 2012 ambulance fee schedule. We expect these claims to be released into processing no later than January 18, 2012. Claims with dates of service prior to January 1, 2012, are unaffected.

Extension of outpatient hold harmless provision

Section 308 of the TPTCCA extends the outpatient hold harmless provision, effective for dates of service on and after January 1, 2012, through February 29, 2012, to rural hospitals with 100 or fewer beds and to all sole community hospitals and essential access community hospitals regardless of bed size.

Extension of minimum payment for bone mass measurement

Section 309 of the TPTCCA extends through February 29, 2012, the 2011 payment rate for bone mass measurement. Similar to the zero percent update and other provisions, this extension will be reflected in the revised 2012 MPFS.

Note: If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser.

Source: CMS PERL 201201-01

Quarterly provider update

The Centers for Medicare & Medicaid Services (CMS) publishes the quarterly provider update (QPU) at the beginning of each quarter to inform the public about:

- Regulations and major policies currently under development during this quarter.
- Regulations and major policies completed or canceled.
- New/revised manual instructions.

CMS regulations establish or modify the way CMS administers the Medicare program. These regulations impact providers and suppliers providing services to Medicare beneficiaries. Providers may access the QPU by going to the CMS website at <http://www.cms.gov/QuarterlyProviderUpdates/>. Providers may join the CMS-QPU electronic mail to ensure timely notification of all additions to the QPU.

2012 annual participation enrollment program extension

Attention health professionals

The Centers for Medicare & Medicaid Services (CMS) is anticipating congressional action to avert the negative update for the 2012 Medicare physician fee schedule. Therefore, CMS is extending the 2012 annual participation enrollment period through February 14, 2012. The enrollment period now runs November 14, 2011, through February 14, 2012.

However, the effective date for any participation status change during the extension remains January 1, 2012, and will be in force for the entire year.

Contractors will accept and process any participation elections or withdrawals made during the extended enrollment period that are post-marked on or before February 14, 2012.

Source: CMS PERL 201112-47

All Medicare provider and supplier payments to be made EFT

Existing regulations at 42 CFR 424.510(e)(1)(2) require that at the time of enrollment, enrollment change request, or revalidation, providers and suppliers that expect to receive payment from Medicare for services provided must also agree to receive Medicare payments through electronic funds transfer (EFT). Section 1104 of the Affordable Care Act (ACA) further expands Section 1862 (a) of the Social Security Act by mandating federal payments to providers and suppliers only by electronic means. As part of the Centers for Medicare & Medicaid Services' (CMS) revalidation efforts, all suppliers and providers who are not currently receiving EFT payments will be identified and will be required to submit the CMS-588 EFT form with their provider enrollment revalidation application, or at the time any change is being made to the provider enrollment record by the provider or supplier, or delegated official..

For more information about provider enrollment revalidation, review the *Medicare Learning Network's special edition article #SE1126*, titled "Further Details on the Revalidation of Provider Enrollment Information."

Source: CMS PERL 201201-36

CMS announces delays in the implementation of two demonstration projects due to provider feedback

On November 15, 2011, the Centers for Medicare & Medicaid Services (CMS) announced the prepayment review and prior authorization for power mobility devices (PMD) demonstration and the recovery audit prepayment review demonstration. These demonstrations were scheduled to begin January 1, 2012. However, CMS received many comments/suggestions regarding these demonstrations and is carefully considering these comments. Therefore, CMS will delay implementation of these demonstrations. CMS will provide at least 30-day's notice before the demonstrations begin.

However, the Part A to Part B rebilling demonstration will begin January 1, 2012, as scheduled.

Please continue to check <http://go.cms.gov/cert-demos> for updated information.

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Source: CMS PERL 201112-59

Recovery audit program: MAC-issued demand letters

Note: This article was revised on January 9, 2012, to reflect the revised CR 7436 issued on January 6, 2012. In the article, the CR release date, transmittal number, and the Web address for accessing CR 7436 were revised. All other information is the same. This information was previously published in the August 2011 *Medicare A Connection*, Page 38.

Provider types affected

This article is for all physicians, providers, and suppliers who bill Medicare claims processing contractors (carriers, fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), and Medicare administrative contractors (MACs)).

Provider action needed

Stop – impact to you

This article is based on change request (CR) 7436 which announces that Medicare’s recovery auditors will no longer issue demand letters to you as of January 3, 2012.

Caution – what you need to know

Recovery auditors will, however, submit claim adjustments to your Medicare contractor, who will perform the adjustments based on the recovery auditor’s review, and issue an automated demand letter to you.

Go – what you need to do

See the *Background* and *Additional information* sections of this article for further details regarding these changes.

Background

As of January 3, 2012, the Centers for Medicare & Medicaid Services (CMS) is transferring the responsibility for issuing demand letters to providers from its recovery auditors to its claims processing contractors. This change was made to avoid any delays in demand letter issuance. As a result, when a

recovery auditor finds that improper payments have been made to you, they will submit claim adjustments to your Medicare (claims processing) contractor. Your Medicare contractor will then establish receivables and issue automated demand letters for any recovery auditor identified overpayment. The Medicare contractor will follow the same process as is used to recover any other overpayment from you.

The Medicare contractor will then be responsible for fielding any administrative concerns you may have such as timeframes for payment recovery and the appeals process. However, the Medicare contractor will include the name of the initiating recovery auditor and his/her contact information in the related demand letter. You should contact that recovery auditor for any audit specific questions, such as their rationale for identifying the potential improper payment.

Additional information

If you have questions, please contact your Medicare contractor at their toll-free number, which may be found at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>.

To see the official instruction (CR 7436) issued to your Medicare contractor, see <http://www.cms.gov/Transmittals/downloads/R202FM.pdf>.

MLN Matters® Number: MM7436 Revised
 Related Change Request (CR) #: 7436
 Related CR Release Date: January 6, 2012
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 Related CR Transmittal #: R202FM
 Implementation Date: January 3, 2012

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Medicare A Connection subscription

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To order an annual subscription, complete the *Medicare A Connection Subscription Form*.

Register now for DMEPOS competitive bidding



If you are a supplier interested in participating in the round 2 and national mail-order competitions 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), the Centers for Medicare & Medicaid Services (CMS) strongly recommends that a BAO register no later than Thursday, January 12, 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 (www.DMECompetitiveBid.com). To register, visit the [CBIC website](#) and click on “Registration is Open” above the registration clock on the home page. You will also find a registration checklist and quick step guides on the [CBIC website](#). 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.

The deadline has now passed for AO registration. If the AO for your company has not already registered and obtained a user ID and password, CMS cannot guarantee that he or she will be able to complete the registration process before the registration window closes on Thursday, February 9, 2012, at 9 p.m. 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, CMS encourages 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, date of birth, 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 Thursday, February 9, 2012, at 9 p.m. Eastern Time – no AOs, BAOs, or EUs will be able to register after registration closes.

Remember that 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 round 2 and the national mail-order competition, including bidder education materials, please refer to the resources located under the “Bidding Suppliers: Round 2 & National Mail-Order” menu on the CBIC website.

Note: If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser.

Source: CMS PERL 201201-13

DMEPOS competitive bidding announcements

The Centers for Medicare & Medicaid Services (CMS) has several announcements of interest to suppliers that are considering participating in the round 2 and national mail-order competitions of the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program.

- The competitive bidding implementation contractor (CBIC) has issued a new fact sheet providing anti-trust guidance for bidders. To view the fact sheet, please go to the CBIC website at www.dmecompetitivebid.com and select "Bidding Suppliers: Round 2 & National Mail-Order" and then choose "Fact Sheets."
- Four adjustable seat cushion codes have been removed from the round 2 standard wheelchair product category. CMS is in the process of deleting these codes from the educational materials on the CBIC website. A follow-up listserv notice will be sent when the updates to the educational materials are complete.
- The bid limits in the round 2 rebid preparation worksheets have been revised for 14 Healthcare Common Procedure Coding System (HCPCS) codes for power wheelchairs (K0813 through K0829). The previous bid limits listed in the worksheet were erroneously based on 150 percent of the actual bid limits.
- CMS has made three clarifying updates to the list of glucose monitors on the 50 percent compliance form, a required bid document for the national mail-order competition:
 1. ASCENSIA AUTO DISC has been consolidated with ASCENSIA BREEZE 2. (ASCENSIA AUTO DISC is no longer manufactured but uses the same test strips as the ASCENSIA BREEZE 2.)
 2. FREESTYLE FLASH has been consolidated with FREESTYLE and FREESTYLE FREEDOM. (FREESTYLE FLASH is no longer manufactured but uses the same test strips as FREESTYLE and FREESTYLE FREEDOM.)
 3. PROTÉGÉ has been consolidated with SMARTTEST. (PROTÉGÉ is no longer manufactured but uses the same test strips as SMARTTEST.)
- CMS would like to remind potential bidders that four adjustable seat cushion codes (E2622 through E2625) have been removed from the round 2 standard wheelchairs product category. The competitive bidding implementation contractor (CBIC) has deleted these codes from the bidder education materials.



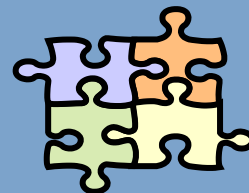
All of these updates are now available on the CBIC website, www.dmecompetitivebid.com/.

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Source: CMS PERL 201201-12, 201112-53

Puzzled about your enrollment status?

Put the pieces together using the enrollment status lookup. View all active applications, specific applications, and confirm if you have been sent a revalidation request at <http://medicare.fcso.com/Enrollment/PEStatus.asp>



Learn about the DMEPOS competitive bidding program with CMS' new on-demand webcasts

Several new educational webcasts for the round 2 and national mail-order competition of the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program are now available on the competitive bidding implementation contractor (CBIC) website (at www.DMECompetitiveBid.com).

- “National Mail-Order Competition for Diabetic Supplies,” covers rules that apply specifically to this competition and provides resources to assist you with bidding.
- “Program Rules,” explains important rules detailed in the request for bids (RFB) instructions that you should understand before you prepare your bids. The webcast also provides resources to assist you with bidding.
- “How a Bid is Evaluated,” goes over each step of the bid evaluation process, from receipt of electronic bid data and hardcopy documents through awarding of contracts. The webcast also provides resources to assist you with bidding.
- “Financial Documentation Requirements,” goes over the rules and requirements for the financial documents that you must submit in addition to your online bid.

These webcasts are available on demand to view at your convenience – 24 hours a day, seven days a week. There is no charge to view the webcasts, and transcripts are also posted on the website. To view the webcasts, please go to the [CBIC website](#), select “Bidding Suppliers: Round 2 & National Mail-Order,” and choose “Education Events.”

The Centers for Medicare & Medicaid Services (CMS) will be issuing one more webcast that will address how to submit a bid in the online bidding system, DBidS. CMS will announce its availability with an email update. If you have not already done so, please register on the [CBIC website](#) to receive this announcement and other updates about the competitive bidding program.

If you have any questions or need assistance, please contact the CBIC customer service center toll-free at 877-577-5331 from 9 a.m. to 9 p.m. ET, Monday through Friday, throughout the registration and bidding periods.

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Source: CMS PERL 201201-44, 201201-38, 201201-25, 201201-14

Credit report/score requirements for DMEPOS competitive bidding

The Centers for Medicare & Medicaid Services (CMS) has issued the following clarification to assist suppliers bidding in the round 2 and national mail-order competitions of the Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. This information will also be posted on the competitive bidding implementation contractor (CBIC) website. If you have any questions, please contact the CBIC customer service center at 877-577-5331 between 9 a.m. and 9 p.m. ET during the registration and bidding periods.

Q. The request for bids instructions say that suppliers must submit a copy of a credit report with numerical score that was prepared within 90 days prior to the opening of the bid window. Does this mean I can't submit a credit report and score that is dated after bidding opens but before bidding closes?

A. No. Credit reports and scores must not be prepared earlier than 90 days prior to the opening of the bid window, but they can be prepared after bidding opens as long as they are received by the competitive bidding implementation contractor (CBIC) by the close of the bid window. When bidding opens, CMS will post the specific date that is 90 days prior to the opening of the bid window on the CBIC website. Credit reports and scores that are older than this date will not be accepted.

Source: CMS PERL 201201-43

Medicare Shared Savings Program video slideshows and podcasts

Do you want to learn more about the Medicare Shared Savings Program (Shared Savings Program) and how to apply? The Centers for Medicare & Medicaid Services (CMS) has posted new resources on the “Shared Savings Program CMS Teleconferences and Events” Web page at http://www.cms.gov/sharedsavingsprogram/40_Events.asp.

Medicare Shared Savings Program overview

A YouTube Video Slideshow Presentation

On December 7, John Pilotte, Director of the Performance-Based Payment Policy Group at CMS gave an overview of the Medicare Shared Savings Program, followed by a question and answer session. A video slideshow presentation of this call with audio and captioning is now available on the [CMS YouTube Channel](#).

Medicare Shared Savings Program: “Application Process and Overview of the Advance Payment Model Application” national provider call

A YouTube Video Slideshow Presentation

Did you miss the November 15 national provider call on the “Medicare Shared Savings Program: Application Process and Overview of the Advance Payment Model Application”? The call presentation is available on the [CMS YouTube Channel](#) as a video slideshow. It includes the call audio and is captioned.

Podcasts

Limited on time? Podcasts are perfect for the office, in the car, or anywhere you carry a portable media player or smartphone. The following podcasts from the November 15 Shared Savings Program call are also available:

- Podcast 1 of 4: Introduction by Dr. Donald Berwick
- Podcast 2 of 4: Medicare Shared Savings Program application process
- Podcast 3 of 4: Advance payment model
- Podcast 4 of 4: Question and answer session

You can find links to these podcasts with corresponding written transcripts, as well as links to the YouTube video slideshow presentations, complete audio recording, and complete written transcript on the Shared Savings Program CMS Teleconferences and Events Web page at http://www.cms.gov/sharedsavingsprogram/40_Events.asp.

Note: If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser.

Source: CMS PERL 201201-08

Medicare Shared Savings Program 2012 ACO Narrative Quality Measures Specifications Manual and application crosswalks

The Centers for Medicare & Medicaid Services (CMS) has added new information to the Medicare Shared Savings Program (Shared Savings Program) website at www.cms.gov/sharedsavingsprogram.

A new Web page on quality measures and performance standards at http://www.cms.gov/sharedsavingsprogram/37e_Quality_Measures_Standards.asp has the latest information on Medicare accountable care organization (ACO) quality measures. The *2012 ACO Narrative Quality Measures Specifications Manual* provides guidance about the 33 required quality measures that are part of the quality performance standard.

Two crosswalks have been added to the Shared Savings Program Application Web page at http://www.cms.gov/sharedsavingsprogram/37_Application.asp. Organizations who submitted an application under the pioneer ACO model or have been participating in the physician group practice (PGP) transition demonstration, who would like to submit a Shared Savings Program application, scroll down the page for links to these two application crosswalks.

Note: If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser.

Source: CMS PERL 201201-06

Medicare Shared Savings Program and Rural Providers fact sheet available

The new "*Medicare Shared Savings Program and Rural Providers*" fact sheet (ICN 907408) is designed to provide education on how the Medicare shared savings program impacts rural providers. It includes information on federally qualified health centers, rural health clinics, critical access hospitals, and how this program impacts them.

Source: CMS PERL 201201-35

Incentive Programs

Available 2012 eRx incentive program educational products

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce the posting of 2012 Electronic Prescribing (eRx) Incentive Program educational products to the eRx Web page at <http://www.cms.gov/ERxIncentive>.

To access the 2012 eRx Incentive Program educational products, visit the Spotlight section on the eRx incentive program Web page at http://www.cms.gov/ERxIncentive/02_Spotlight.asp for the listing of educational products and their corresponding section pages where they can be found.

- *2012 Electronic Prescribing (eRx) Incentive Program Measure Specifications and Release Notes* – provides guidance on the 2012 eRx measure specifications for claims or registry-based reporting and release notes describing changes from the 2011 eRx measure specifications.
- *Claims-Based Reporting Principles for the 2012 Electronic Prescribing (eRx) Incentive Program* – provides guidance on the principles for reporting the eRx measure on claims for the 2011 eRx incentive program.
- *2012 Electronic Prescribing (eRx) Incentive Program CMS-1500 Claim Example* – a detailed sample of an individual NPI reporting the eRx measure on a CMS-1500 form
- *2012 Electronic Health Record (EHR) Measure Specifications for Electronic Prescribing (eRx) Incentive Program and Release Notes* – provides guidance on the 2012 EHR measure specifications for eRx and release notes. In addition, the specifications contain a detailed description of data element names and codes.
- *2012 Electronic Health Record (EHR) Downloadable Resource Table and Release Notes* – an Excel spreadsheet and release notes listing 2012 EHR information.
- *2012 Electronic Prescribing (eRx) Incentive Program GPRO Measure Specifications and Release Notes* – provides guidance on the specifications for the eRx measure for use in 2012 eRx GPRO and release notes.

Further information on the 2012 physician quality reporting system may be found in the final 2012 Medicare physician fee schedule rule with comment period that was published in the *Federal Register* on November 28, 2011.

Further information on the 2012 eRx incentive program may be found in the final 2012 Medicare physician fee schedule rule that was published in the *Federal Register* on November 28, 2011. The final rule can be found on the "Statute/Regulations/Program Instructions" section at http://www.cms.gov/ERxIncentive/04_Statute_Regulations_Program_Instructions.asp.

Note: If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser.

Source: CMS PERL 201201-11

Upcoming dates for the Medicare EHR incentive program and information on the payment threshold for eligible professionals

As 2012 begins, the Centers for Medicare & Medicaid Services (CMS) wants to remind eligible professionals (EPs) participating in the Medicare electronic health record (EHR) incentive program of important approaching deadlines and what can still be completed in 2012 in order to receive an incentive payment for calendar year (CY) 2011.

Important Medicare EHR incentive program dates

On Saturday, December 31, 2011, the reporting year ended for EPs who participated in the Medicare EHR incentive program in 2011. What does this mean? For participating EPs, they must have completed their 90-day reporting period by the end of 2011.

However, EPs have until Wednesday, February 29, 2012, to actually register and attest to meeting meaningful use to receive an incentive payment for CY 2011 through the [Medicare & Medicaid EHR incentive program registration and attestation system](#).

Payment threshold information

Wednesday, February 29, 2012, is also the deadline for EPs to submit any pending Medicare Part B claims from CY 2011, as CMS allows 60 days after Saturday, December 31, 2011, for all pending claims to be processed. This means that EPs have 60 days in 2012 to submit claims for allowed charges incurred in 2011.

Medicare EHR incentive payments to EPs are based on 75 percent of the Part B allowed charges for covered professional services furnished by the EP during the entire payment year. If the EP did not meet the \$24,000 threshold in Part B allowed charges by the end of CY 2011, CMS expects to issue an incentive payment for the EP in April 2012 for 75 percent of the EP's Part B charges from 2011.

Note for Medicaid participants: Medicaid incentives will be paid by the states, but the timing will vary according to state. Please contact your state's Medicaid agency for more details about payment.

Want more information about the EHR incentive programs? Visit the [EHR Incentive Programs](#) website for the latest news and updates on the EHR incentive programs.

Source: CMS PERL 201201-31

Health professional shortage area (HPSA) bonus payment policy reminders

Provider types affected

This *Medicare Learning Network (MLN) Matters*[®] special edition article is intended for physicians and providers submitting claims to Medicare carriers, Medicare administrative contractors (A/B MACs), and/or fiscal intermediaries (FIs) for services furnished to Medicare beneficiaries in areas designated as geographic health professional shortage areas (HPSAs).

Provider action needed

Stop – impact to you

Physicians who furnish services to Medicare beneficiaries in areas designated as primary care geographic HPSAs by the Health Resources and Services Administration (HRSA) as of December 31, 2011, are eligible for a 10 percent bonus payment for services furnished from January 1, 2012, to December 31, 2012. If an area does not have a geographic primary care HPSA designation, but does have a geographic mental health HPSA designation, then only psychiatrists furnishing services to Medicare beneficiaries in the designated area are eligible for the ten percent bonus.

Caution – what you need to know

The physician must determine whether a service is furnished in a geographic primary care (or mental health) HPSA. Eligibility is determined annually based on the status of the designation, as of December 31 of the prior

continued on next page

HPSA...continued

year. That is, a physician who was eligible for the 10 percent bonus in 2011 may not be eligible for the bonus in 2012. A physician or provider that was not eligible for the 10 percent bonus in 2011 may be eligible for the bonus in 2012. Information about designated areas is available from HRSA. The following web pages may help you determine whether an area is a geographic primary care or mental health HPSA:

- The “Shortage Designation Advisor” page identifies areas located in an HPSA by entering a valid address. It is available at <http://datawarehouse.hrsa.gov/GeoAdvisor/ShortageDesignationAdvisor.aspx>.
- The “HPSA State & County Search” page identifies HPSA designation with a state and is available at <http://hpsafnd.hrsa.gov/HPSASearch.aspx>.
- The “Geocoding System” page identifies census tracts by entering a valid address and is available at <http://www.ffec.gov/Geocode/default.aspx>.

**Go – what you need to know**

The Centers for Medicare & Medicaid Services (CMS) publishes an annual list of ZIP codes that automatically receive the HPSA bonus. Only areas where the entire ZIP code falls within the designated area at the time the list is developed are listed. Services provided in eligible areas that are not listed for automatic bonus payment must use the AQ modifier to receive the bonus.

Only physicians who furnish services in areas designated as a geographic primary care HPSA, as of December 31, 2011, and whose ZIP code is not on the list should use the modifier. Only psychiatrists, who furnish services in areas that are not designated as primary care HPSAs, as of December 31, 2011, but are designated as a geographic mental health HPSA, should use the modifier if the ZIP code is not on the list for automatic payment.

Information about the Medicare physician bonus program, including the list of ZIP codes eligible for automatic payment of the bonus, is available at http://www.cms.gov/hpsapsaphysicianbonuses/01_overview.asp. An *MLN Matters*® article, MM7517, on this issue can be found at <http://www.cms.gov/MLNMattersArticles/downloads/MM7517.pdf>.

Additional information

For more information about the Medicare physician bonus program, including the list of ZIP codes eligible for automatic bonus payment, visit the HPSA/PSA physician bonuses Web page at http://www.cms.gov/hpsapsaphysicianbonuses/01_overview.asp.

MLN Matters® article MM7517, titled, “2012 Annual Update for the Health Professional Shortage Area (HPSA) Bonus Payments,” is available at <http://www.cms.gov/MLNMattersArticles/downloads/MM7517.pdf>.

The *MLN* fact sheet titled, “Health Professional Shortage Area,” which is designed to provide education on the HPSA payment system, is available at <http://www.cms.gov/MLNProducts/downloads/HPSAfactsht.pdf>.

If you have questions, please contact your Medicare Carrier, FI or A/B MAC at their toll-free number, which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>.

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