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CMS to Start Accepting Suggestions For PQRS Measures and Measure Groups

From June 1st, 2012 to 5PM ET on August 1st, 2012, CMS will be accepting suggestions for Measures and/or Measure Groups in the Physicians Quality Reporting System. This is your chance to make your voice heard on the quality measures that will determine performance!

For more information on the PQRS Call for Measures, visit the CMS page here.

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New Rules Finalized by Health and

Human Services to Cut Regulations for Hospitals and Health Care Provider

HHS Finalizes New Rules to Cut Regulations for Hospitals and Health Care Providers, Savings More Than $5 Billion

Changes Will Reduce Costs and Allow More Focus on Medical Care

On May 9, HHS Secretary Kathleen Sebelius announced significant steps to reduce unnecessary, obsolete, or burdensome regulations on American hospitals and health care providers. These steps will help achieve the key goal of President Obama's regulatory reform initiative to reduce unnecessary burdens on business and save nearly $1.1 billion across the health care system in the first year and more than $5 billion over five years.

The new rules were issued on May 9 by CMS. The first rule revises the Medicare Conditions of Participation (CoPs) for hospitals and critical access hospitals (CAHs). CMS estimates that annual savings to hospitals and CAHs will be approximately $940 million per year.

The second, the Medicare Regulatory Reform rule, will produce savings of $200 million in the first year by promoting efficiency. This rule eliminates duplicative, overlapping, and outdated regulatory requirements for health care providers.

Among other changes, the final rules will:

- Increase flexibility for hospitals by allowing one governing body to oversee multiple hospitals in a single health system;
- Let CAHs partner with other providers so they can be more efficient and ensure the safe and timely delivery of care to their patients;

- Require that all eligible candidates, including advanced practice registered nurses and physician assistants, be reviewed by medical staff for potential appointment to the hospital medical staff and then be granted all of the privileges, rights, and responsibilities accorded to appointed medical staff members; and
- Eliminate obsolete regulations, including outmoded infection control instructions for ambulatory surgical centers; outdated Medicaid qualification standards for physical and occupational therapists; and duplicative requirements for governing bodies of organ procurement organizations.

View the Medicare CoPs final rule and the Medicare Regulatory Reform final rule. For additional information on the Hospital and other CoPs, visit the Conditions for Coverage (CfCs) & Conditions of Participations (CoPs) website.

Full text of this excerpted CMS press release (issued May 9).

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Denise Buenning from CMS Answers the Industry's Top Questions about the Version 5010 Upgrade

Upgrading to Version 5010 involves significant planning and preparation. The Version 5010/4010A electronic standards upgrade deadline was January 1, 2012. However, CMS enacted an enforcement discretion period through June 30, 2012 for all HIPAA-covered entities. It you haven't upgraded to Version 5010, it is important to begin testing now.

Denise Buenning, MsM, Acting Deputy Director, Office of E-

health Standards & Services (OESS) recently took time to answer some of the industry's top questions on the Version 5010 upgrade.

Is the industry up to date with the Version 5010 upgrade and taking steps to prepare for the ICD-10 transition?

Yes, we are hearing that the industry is progressing with Version 5010 implementation. We also continue to see from the Medicare Fee-For-service (FFS) group consistent increases across the board for 5010 transaction volumes and number of 5010 submitters. We are also hearing that the industry is continuing to take steps to prepare for ICD-10. ICD-10 is a major undertaking for providers, payers, and vendors. It will drive business and systems changes throughout the health care industry, from large national health plans to smaller provider offices, laboratories, hospitals, and more. The updates will go much more smoothly for organizations that plan ahead and prepare now. A successful upgrade to Version 5010 now and transition to ICD-10 later will be vital to transforming our nation's health care system.

What steps should I take if I am behind in the upgrade to Version 5010?

There are a number of things that HIPAA-covered entities should do now. Communication among plans, providers, clearinghouses, and vendors, as well as other trading partners, is critical. Below outlines three steps providers can take now:

- Reach out to clearinghouses for assistance and/or take advantage of any free or low cost software that may be available from payers.
- Check with payers now to see what plans they will have in place to handle incoming claims, and what

interim alternatives are available.

- Consider contacting financial institutions to establish lines of credit to get through any possible temporary interruptions in claims reimbursement as a result of not being Version 5010 compliant.
- CMS has developed a fact sheet for health care providers, which discusses the risk mitigation steps in more detail.

How is CMS helping the industry prepare?

o The Workgroup for Electronic Data Interchange (WEDI) and CMS are holding a webinar on ASCX12 5010 implementation and problem solving on May 23 from 1-2:30pm ET. Registration is free. These online presentations are designed to gather feedback, track challenges and provide guidance to correcting ASC X12 5010 implementation-related issues.

o WEDI and CMS previously held a webinar on ASCX12 5010 implementation, and a replay of the webinar with the slides presented is located online.

o Additionally, the CMS website has official resources to help the industry prepare for Version 5010 and ICD-10. CMS will continue to add new tools and information to the site throughout the course of the transition. Sign up for ICD-10 Email Updates and follow @CMSgov on Twitter for the latest news and resources.

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Last Chance to Register for National Provider Call – Physician Quality Reporting System & Electronic Prescribing (eRx)

CMS will host a National Provider Call with question and answer session. CMS subject matter experts will provide an overview of the 2013 Electronic Prescribing Payment Adjustment and an overview of the 2012 Physician Quality Reporting System Medicare EHR Incentive Pilot.

Target Audience: All Medicare Fee-For-Service Providers, Medical Coders, Physician Office Staff, Provider Billing Staff, Electronic Health Records Staff, and Vendors

Registration Information: In order to receive call-in information, you must register for the call on the CMS Upcoming National Provider Calls webpage. 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.

Providers and suppliers can now submit their enrollment applications 30 days sooner. CMS-855 enrollment applications and Internet-based PECOS applications may now be submitted 60 days prior to the effective date.

NOTE: This does not apply to providers and suppliers submitting a Form CMS-855A application, Ambulatory Surgical Centers (ASCs), or Portable X-ray Suppliers (PXRSs).

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CMS to Release a Comparative Billing Report on Evaluation and Management Services

On June 4, CMS will release a national provider Comparative Billing Report (CBR) addressing Evaluation and Management Services.

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

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

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

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New and Revised Articles Posted to MLN Matters

Examining the Difference between a National Provider Identifier (NPI) and a Provider Transaction Access Number (PTAN) http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1216.pdf

Negative Pressure Wound Therapy Interpretive Guidelines

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1222.pdf

Assigned Codes for Home Oxygen Use for Cluster Headache (CH) in a Clinical Trial (ICD-10)

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7820.pdf

July 2012 Integrated Outpatient Code Editor (I/OCE) Specifications Version 13.2

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7841.pdf

July Quarterly Update for 2012 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7822.pdf

Calendar Year 2013 and After Payments to Home Health Agencies That Do Not Submit Required Quality Data

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7833.pdf

Revised: Reporting of Recoupment for Overpayment on the Remittance Advice (RA) with Patient Control Number

http://www.cms.gov/Outreach-and-Education/Medicare--Learning-Network-MLN/MLNMattersArticles/Downloads/MM7499.pdfs

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Updates from the Medicare Learning Network

From the MLN: New Fast Fact and Archive on MLN Provider Compliance Webpage – A new fast fact is now available on the MLN Provider Compliance webpage. This webpage provides the latest Medicare Learning Network® (MLN) products designed to help Medicare Fee-For-Service providers understand – and avoid – common billing errors and other improper activities. You can now view previous fast facts on the MLN Provider Compliance Fast Fact Archive page. Please bookmark this page and check back often as a new fast fact is added each month.

From the MLN: "Negative Pressure Wound Therapy Interpretive Guidelines" MLN Matters® Article Released – MLN Matters® Special Edition Article #SE1222, "Negative Pressure Wound Therapy Interpretive Guidelines" has been released and is now available in downloadable format. This article is designed to provide education on CMS-approved guidelines that accrediting organizations can use to accredit suppliers that provide Negative Pressure Wound Therapy (NPWT) equipment to Medicare beneficiaries. It includes a list of relevant local coverage determinations and standards to help DMEPOS suppliers comply with standards and guidelines for NPWT equipment.

From the MLN: "Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Quality Standards" Booklet Revised – Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Quality Standards Booklet (ICN 905700)

has been revised and is now available in downloadable and hard copy format. This booklet is designed to provide education on durable medical equipment, prosthetics, orthotics and supplies (DMEPOS). It includes DMEPOS quality standards as well as information on Medicare deemed Accreditation Organizations (AOs) for DMEPOS suppliers.

From the MLN: "Quick Reference Information: Preventive Services" and "Quick Reference Information: Medicare Immunization Billing" Revised – The MLN has revised the recently updated Quick Reference Information: Preventive Services (ICN 006559) and Quick Reference Information: Medicare Immunization Billing (ICN 006799) educational tools. We have updated these charts to include the recently released flu code Q2034. All other information remains the same.

From the MLN: "Medicare Fraud & Abuse: Prevention, Detection, and Reporting" Web-Based Training – New – This Web-Based Training (WBT) course is designed to provide education on how to identify Medicare fraud and abuse and understand the related laws and penalties. It includes information on what entities and safeguards protect against and detect fraud and abuse, as well as how you can help prevent and report it. Continuing education credit is available for this course. To access a new or revised WBT course, visit the MLN Products webpage and click on "Web-Based Training (WBT) Courses" under "Related Links" at the bottom of the webpage.

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May is Hepatitis Awareness Month

and May 19 is National Hepatitis Testing Day

The month of May has been designated Hepatitis Awareness Month and May 19 is the first ever National Hepatitis Testing Day. Every year, approximately 15,000 Americans die from liver cancer or chronic liver disease associated with viral hepatitis. Despite this, viral hepatitis is not well known. In fact, as many as 75 percent of the millions of Americans with chronic viral hepatitis don't know they're infected. Please join CMS in support of the Centers for Disease Control and Prevention's "Know More Hepatitis" national education initiative aimed to decrease the burden of chronic viral hepatitis by increasing awareness about this hidden epidemic and encouraging people who may be chronically infected to get tested.

Medicare provides coverage of the hepatitis B vaccine and its administration for certain individuals at high or intermediate risk.

Increased provider knowledge has been shown to improve delivery of preventive services, including those for viral hepatitis. By educating yourself on this hidden epidemic, you can help save lives and decrease this epidemic's burden. As a healthcare provider for people with Medicare, discuss with eligible patients who may be at high or intermediate risk, whether the hepatitis B vaccine is appropriate.

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Medicare is Auditing You! What To Do Next?

There are a number of different audits that are carried out by Medicare-contracted auditors. It's important to know the differences and have a plan for responding.

CERT stands for Comprehensive Error Rate Testing and CERT audits were initiated in 2000. The program is responsible for measuring improperly paid claims. The CERT Program uses the following OIG-approved methodology:

1. A sample of approximately 120,000 submitted claims is randomly selected;
2. medical records from providers who submitted the claims are requested; and
3. the claims and medical records are reviewed for compliance with Medicare coverage, coding and billing rules.

RAC stands for Recovery Audit Contractor and began in early 2009. The RACs detect and correct past improper payments so that CMS and Carriers, FIs, and MACs can implement actions to stop future improper payments. RAC is currently focusing on inpatient services and physical therapy services. As of the date this post was published RAC was not focusing on physician services.

ZPIC (Zone Program Integrity Contractors) replaces the Medicare Program Safeguard Contractors (PSCs) and Medicare Drug Integrity Contractors (MEDICs) that are currently in use by CMS. ZPICs are be responsible for detection and deterrence of fraud, waste and abuse across all claim types. ZPICs have access to CMS National Claims History data, which can be used to look at the entire history of a patient's treatment no matter where claims were processed. Being able to look at the overall picture will enable them to more readily spot over

billing and fraudulent claims. Among other things, ZPICs will look for billing trends or patterns that make a particular provider stand out from the other providers in that community. Once a ZPIC identifies a case of suspected fraud and abuse, the issue is referred to the Office of Inspector General (OIG) for consideration and possible initiation of criminal or civil prosecution. **ZPIC is widely considered to be the greatest threat to physician practices.**

Seven ZPIC zones have been identified. The zones include the following states and/or territories and most have been assigned contractors:

- Zone 1 – CA, NV, American Samoa, Guam, HI and the Mariana Islands **http://www.safeguard-servicesllc.com/zpic.asp**
- Zone 2 – AK, WA, OR, MT, ID, WY, UT, AZ, ND, SD, NE, KS, IA, MO **AdvanceMed was just purchased by NCI** – site not current
- Zone 3 – MN, WI, IL, IN, MI, OH and KY – not awarded
- Zone 4 – CO, NM, OK, TX. **HealthIntegrity**
- Zone 5 – AL, AR, GA, LA, MS, NC, SC, TN, VA and WV **AdvanceMed was just purchased by NCI** – site not current
- Zone 6 – PA, NY, MD, DC, DE and ME, MA, NJ, CT, RI, NH and VT – not awarded
- Zone 7 – FL, PR and VI **http://www.safeguard-servicesllc.com/zpic.asp**

How should you respond to a Medicare audit?

1. Log all requests for records from all payers. Time and date all communications received and all communications sent.
2. Scan all records sent and include a cover letter itemizing contents of response.

3. Send records via certified mail.
4. If you get a request for a large amount of records at one time, consider getting advice from a consultant or attorney who specializes in Medicare audits as a large scale record request may cripple the practice operations.

How can you be proactive before you get an audit letter?

1. Check the audit sites monthly to see if your specialty or any services you provide are being targeted for an audit.
    - **CERT – www.cms.hhs.gov/cert**
    - Check the ZPIC site for your zone above
    - **OIG – www.oig.hhs.gov/reports.html**
    - Check your RAC site in my post **here**
2. Conduct an internal assessment to identify if you are in compliance with Medicare rules or hire a third-party to conduct an audit for you.
3. Identify corrective actions to promote compliance.
4. Appeal when necessary

Excellent resource site **http://www.willyancey.com/sampling-claims.html**