



The Pulse of CMS

“A quarterly regional publication for health care professionals”
Serving Delaware, Maryland, Pennsylvania, Virginia, West Virginia and the District of Columbia.

CMS ANNOUNCES INTERNET-BASED ENROLLMENT SYSTEM FOR MEDICARE PROVIDERS...SEE STORY ON PAGE 2.

Durable Medical Equipment Suppliers Urged to Complete Accreditation Process

CMS wants to ensure that suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) who bill Medicare for Part B services have ample time to complete the accreditation process and thus receive an accreditation decision by the September 30, 2009 deadline. In order to meet this deadline, CMS is encouraging all enrolled DMEPOS suppliers, except those eligible professionals and other persons exempted by law, to submit a complete accreditation application to an accreditation organization as soon as possible.

The accreditation requirement applies to suppliers of durable medical equipment, medical supplies, home dialysis supplies and equipment, therapeutic shoes, parenteral/enteral nutrition, transfusion medicine and prosthetic devices, prosthetics, and orthotics. Pharmacies, pedorthists, mastectomy fitters, orthopedic fitters/technicians, and athletic

trainers must also meet the September 30, 2009 deadline for DMEPOS accreditation. A DMEPOS supplier that wishes to become accredited should contact an accreditation organization and obtain information about the accreditation process.

Certain eligible professionals and other persons are exempted from the accreditation requirement including physicians, physical and occupational therapists, qualified speech-language pathologists, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives, clinical social workers, clinical psychologists, registered dietitians/nutrition professionals, orthotists, prosthetists, opticians, and audiologists.

Further information on the DMEPOS accreditation requirements along with a list of the accreditation organizations may be found at www.cms.hhs.gov/medicareprovidersupenroll.

Next Round of Contractor Satisfaction Surveys

CMS will distribute its annual Medicare Contractor Provider Satisfaction Survey (MCPSS) to a new sample of Medicare providers. The MCPSS offers providers the opportunity to contribute directly to CMS' understanding of contractor performance, as well as aid future process improvement efforts at the contractor level. All Medicare Administrative Contractors (MACs) will be measured against performance targets on the 2009 MCPSS as part of their contract requirements.

CMS is sending the 2009 survey, which can be completed in about 20 minutes, to approximately 30,000 randomly selected providers, including physicians and other health care practitioners, suppliers, and institutional facilities which serve Medicare beneficiaries across the country. Those providers selected to participate in the survey will be notified in December 2008, and providers can submit their responses via a secure website, mail, fax, or over the telephone.

Feedback captured through MCPSS is important, and CMS urges all Medicare providers selected to participate in the MCPSS to complete and return their surveys upon receipt. CMS plans to release a summary report of the 2009 MCPSS data on the CMS website at www.cms.hhs.gov/MCPSS in July 2009.

Inside this Issue...

DMEPOS Interim Final Rule Delayed.....	2
Internet-Based Provider Enrollment.....	2
FDA Recalls Peanut Products.....	2
Personal Health Records.....	2
PQRI Update.....	3
Final MAC Contracts Awarded.....	3
New MLN Products.....	3
New PFFS Dispute Review.....	4
Fraud, Waste, and Abuse Efforts.....	4
5-Star Quality Rating Guide.....	4
Flu Shots.....	4
RAC Protest Resolved.....	5
More E-Prescribing Information.....	5

From the White House...

CMS is currently reviewing the collection of pending HHS regulations that are in various stages of completion to determine which of those fall under the parameters laid out by the White House on January 20, 2009. Until that review is complete, it is not yet possible to determine which ones are affected. More information will be shared when it is made available.

CMS Delays Interim Final Rule for DMEPOS Program

CMS has delayed the effective date for the Interim Final Rule with Comment Period that implements certain provisions of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) for the Round 1 Rebid of the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Acquisition Program. The effective date was originally February 17, 2009 and is now April 18, 2009.

The original comment period on the Interim Final Rule remains unchanged. The public has until March 17, 2009, to submit comments on the substantive policy issues discussed in the rule.

Visit the [CMS website](#) to view additional information.

FDA Recalls Peanut Products

The HHS Office of Public Affairs seeks your assistance in spreading the word about the recall of peanut butter and peanut-containing products by adding a link to the FDA's recall information on your organization's website. By adding the FDA's recall "widget" to your organization's webpage, you can allow your site visitors to check the FDA database to make sure the products in their cabinets are safe to eat.

A "widget" is an application that displays the featured content directly on your web page. Once you've added the widget, there's no technical maintenance. Users can either search for products by brand name or browse product categories through the widget without ever having to leave your website.

Recalled products in the widget will be updated automatically by the FDA so the content will always be current, giving your site access to the most up-to-date recall information. To add this widget to your page, please click on the link below, OR cut and paste the following address into your web browser:

<http://www.fda.gov/oc/opacom/hottopics/salmonellatp/ph/widget.html>

CMS Announces New Internet-Based Enrollment System for Medicare Providers

Now there's a better way for physicians and non-physician practitioners to enroll or make a change in their Medicare enrollment information. The Internet-based Provider Enrollment, Chain and Ownership System (PECOS) will allow physicians and non-physician practitioners to enroll, make a change in their Medicare enrollment, view their Medicare enrollment information on file with Medicare, or check on the status of a Medicare enrollment application via the Internet.

CMS will make Internet-based PECOS available to all organizational providers and suppliers (except durable medical equipment, prosthetics, orthotics, and supplies suppliers) later this year.

Fast: By submitting the initial Medicare enrollment application through Internet-based PECOS, a physician or non-physician practitioner's enrollment application can be processed as much as 50 percent faster than by paper.

Secure: Internet-based PECOS meets all required government security standards in terms of data entry, data transmission, and the electronic storage of Medicare enrollment information. Only authorized individuals can enter enrollment information into PECOS or view PECOS data from the Internet.

Easy: Internet-based PECOS is a scenario-driven application process with front-end editing capabilities and built-in help screens. The

scenario-driven application process will ensure that physicians and non-physician practitioners complete and submit only the information necessary to enroll or make a change in their Medicare enrollment record.

There are three basic steps to completing an enrollment action using Internet-based PECOS. Physicians and non-physician practitioners must:

1. Have an NPPES User ID and password to use Internet-based PECOS.
2. Go to Internet-based PECOS at <https://pecos.cms.hhs.gov> and complete, review, and submit the electronic enrollment application via Internet-based PECOS.
3. Print, sign, and date the Certification Statement (blue ink recommended) and mail the Certification Statement and all supporting paper documentation to the Medicare contractor.

For information about Internet-based PECOS, including important information that physicians and non-physician practitioners should know before submitting a Medicare enrollment application via Internet-based PECOS, go to the [CMS website](#).

For Your Patients: Personal Health Records Now on the Internet

A personal health record (PHR) keeps the medical information of Medicare beneficiaries at their fingertips without the hassle of shuffling through papers. PHRs are a safe and confidential way to store and track one's health history and other important medical information in one place. A PHR can help doctors by providing a complete picture of a patient's health and the information they need to give the best care and avoid duplicate tests and medical errors.



A variety of PHRs are available on the Internet. Medicare provides information about PHRs, some things to consider when looking for a PHR, and links to special PHR projects sponsored by Medicare. Visit the [PHR page of the Medicare website](#) to learn more for your beneficiaries.

Update on Physician Quality Reporting Initiative

The 2007 PQRI Reporting Experience document can be accessed on the [PQRI page of the CMS website](#). This document lists the most common errors responsible for unsuccessful participation. Among the most common errors noted were non-adherence to measure specifications and lack of NPI number on the line with the measure. Because CMS identified and corrected technical issues, measures submitted in 2007 will be re-evaluated for successful reporting.

It is not too late to participate in PQRI 2009. This year's program includes 153 quality measures, which are available on the [PQRI website](#).



New Products

[The Expanded Benefits Brochure \(January 2009\):](#)

This tri-fold brochure provides health care professionals with an overview of Medicare's coverage of three preventive services: the initial preventive physical examination (IPPE), also known as the Welcome to "Medicare Physical" Exam; ultrasound screening for abdominal aortic aneurysms; and cardiovascular screening blood tests.

[The ABC's of Providing the Initial Preventive Physical Examination \(IPPE\) Quick Reference Information \(January 2009 Resource\):](#)

This resource can be used by Medicare fee-for-service physicians and qualified non-physician practitioners as a guide when providing IPPE. The two-sided reference identifies the components and elements of the IPPE; provides eligibility requirements, procedure codes to use when filing claims, FAQs, and suggestions for preparing patients for the IPPE.

2009 Electronic Prescribing Incentive Program Made Simple: This fact sheet provides detailed information on how to participate in the 2009 Electronic Prescribing (E-Prescribing) Incentive Program by reporting the E-Prescribing measure. To access this new educational product, as well as all available E-Prescribing educational resources, visit the [PQRI page of the CMS website](#) and click on the Electronic Prescribing Incentive Program tab, and go to the "Downloads" section.

Final Five A/B Medicare Administrative Contracts Awarded

CMS announced the final five contractors which will process and pay Medicare claims for health care services under the Medicare fee-for-service program. The new contracts, that will be administered for up to five years, will process and pay 36 percent of the national volume of Medicare Part A and Part B claims payments in 14 states, mostly in the South and Midwest. CMS now has met its goal of awarding all 15 Medicare Administrative Contractor (MAC) contracts. (See the chart below for the five newly award contracts.)

The MAC contractors will immediately begin their implementation activities and will assume full responsibility for the claims processing work in their respective jurisdictions no later than March 2010.

As a result of a full and open competitive procurement, the new contractors will take over the claims payment work now performed by numerous fiscal intermediaries and carriers. The MAC contracts, which have an approximate value of \$1.4 billion over five years, will fulfill the requirements of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) contracting reform provisions.

The awards close procurement activities under the MMA that began in April 2005 with the issuance of a request for proposal. This action represented the first time full and open competition has been used to

select Medicare fee-for-service contractors to perform claims administration services.

A total of 19 new contracts have been awarded under MMA provisions. When fully operational, the Part A and Part B MACs will completely replace the fiscal intermediaries and carriers which have administered Medicare since its inception.

All contracts include a base period and four one-year options and will provide the contractors with the opportunity to earn award fees based on their ability to meet or exceed performance requirements set by CMS.

As of February 2, 2009, CMS has received protests on the MAC awards in four of the five jurisdictions where awards were made earlier this year. Jurisdictions 6, 8, 11, and 15 are affected by the contract award protests, and CMS has issued stop-work orders to the awardees in those jurisdictions, pending GAO review. The 100-day review period by GAO extends into mid-May.

A complete list of contractors and the states they cover, along with other information, can be found at the [Medicare Contracting Reform webpage](#).

MAC	Jurisdiction	States	Headquarters
Noridian Administrative Services, LLC (NAS)	J6	Illinois, Minnesota, and Wisconsin	Fargo, N.D
National Government Services (NGS)	J8	Indiana and Michigan	Indianapolis, IN
Cahaba Government Benefit Administrators, LLC (Cahaba GBA)	J10	Alabama, Georgia, and Tennessee	Birmingham, AL
Palmetto Government Benefits Administrators, LLC (Palmetto GBA)	J11	North Carolina, South Carolina, Virginia, and West Virginia	Columbus, OH
Highmark Medicare Services (HMS)	J15	Kentucky and Ohio	Camp Hill, PA

New Review Entity for PFFS Disputes

Effective January 1, 2009, CMS has delegated the adjudication of Medicare Advantage private fee-for-service (MA PFFS) provider payment disputes to an Independent Review Entity (IRE), First Coast Service Option, Inc. (FCSO). Beginning January 1, 2009, after a MA PFFS plan informs a provider in writing that a payment dispute has been denied through the Medicare Advantage organization's provider payment dispute process, a provider or supplier who disagrees with the pricing decision may request the decision be reviewed by an IRE under contract with CMS.

Provider payment disputes include any decisions where there is a dispute that the payment amount made by the MA PFFS plan to deemed providers is less than the payment amount that would have paid under the MA PFFS plan's terms and conditions or the amount to non-contracted providers is less than would have been paid under original Medicare.

A request for an independent payment dispute decision (PDD) must be submitted to FCSO in writing within 180 days of written notice from the MA PFFS plan. All requests must be in writing and should be on a standard PDD form available on FCSO's website. The IRE will issue a decision within 60 days after receiving a PPD appeal unless granted an exception by the IRE.

Medicare Advantage organizations and providers with questions regarding the adjudication process or individual disputes being reviewed by the IRE can contact FCSO at 904-791-6430. Beneficiary and provider appeals of coverage determinations will continue to be handled by the Part C qualified independent contractor, MAXIMUS, and will not be adjudicated under the contract with FCSO.

For more information, visit the [FCSO website](#).

New 5-Star Quality Rating Guide

A new version of the Five-Star Quality Rating Technical Users' Guide and an accompanying Summary of Updates to the Technical Users' Guide document are available on the Five-Star Quality Rating System webpage. See the [CMS website](#) for the latest version of the manual.

CMS Focuses on Efforts to Reduce Fraud, Waste, and Abuse in Medicare

CMS announced it will require certain durable medical equipment suppliers to post a surety bond. In addition, CMS will revoke the billing privileges of more than 1,100 medical equipment suppliers in south Florida and southern California and suspending payments to home health agencies in the Miami-Dade, FL area.

CMS issued a final surety bond regulation, required by the Balanced Budget Act of 1997, that requires certain suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) post a \$50,000 surety bond. Existing suppliers must comply with this requirement by October 2, 2009, while newly enrolling suppliers must meet this requirement by May 4, 2009. This requirement was due in part to the large number of improper and potentially fraudulent payments to medical equipment suppliers for furnishing medical equipment and devices to people with Medicare. The 2007 Medicare error rate report found approximately \$1 billion in improper payments for medical equipment and supplies.

The surety bond requirement is designed to limit the Medicare program risk from fraudulent equipment suppliers and help to ensure that only those suppliers who remain in the program furnish items to Medicare beneficiaries that are considered reasonable and necessary from legitimate DME suppliers.

To prevent fraud, CMS has revoked billing privileges of 1,139 DMEPOS suppliers as part of the DMEPOS High-Risk Suppliers Demonstration. This project began in October

2007 and focuses on DMEPOS suppliers in South Florida and the Los Angeles metropolitan area. These suppliers, who were paid a combined total of \$265 million between calendar years 2005 and 2007, lost their billing privileges for not re-enrolling in the Medicare program and not meeting Medicare's supplier standards.

CMS continues to fight waste, fraud and abuse by home health suppliers in the Dade County, FL, area by suspending payments and taking other payment and review actions. On October 6, 2009, CMS initiated efforts to address potential waste, fraud, and abuse by suspending payments to 10 home health agencies and is continuing to review claims and payments to other agencies as resources allow.

In addition to suspending payment, CMS is:

- Implementing extensive pre- and post-payment review of claims submitted by ordering/referring physicians;
- Validating claims submitted by physicians who order a high number of certain items or services by sending follow-up letters to these physicians;
- Verifying the relationship between physicians who order a large number of home health services and the beneficiaries for whom they ordered those services; and
- Identifying and visiting high risk beneficiaries to ensure they are appropriately receiving the services for which Medicare is being billed.

Click on the [MLN webpage](#) for the new Fraud and Abuse reference guide from CMS.

It's Not Too Late for a Flu Shot!

In the US, the peak of flu season typically occurs anywhere from late December through March; however, flu season can last as late as May. Each office visit presents an opportunity for you to talk with your patients about the importance of getting an annual flu shot and a one time pneumococcal vaccination. Protect yourself, your patients, and your family and friends by getting and giving the flu shot. **Don't Get the Flu. Don't Give the Flu.**

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Recovery Audit Contractor Protest Resolved

On February 4, 2009 the parties involved in the protest of the award of the Recovery Audit Contractor (RAC) contracts settled the protests. The settlement means that the stop work order has been lifted and CMS will now continue with the implementation of the RAC program.

Under the program, the four RACs will contract with subcontractors to supplement their efforts. PRG-Schultz, Inc. will serve as a subcontractor to HDI, DCS and CGI in regions A, B and D. Viant Payment Systems, Inc. will serve as a subcontractor to Connolly Consulting in region C. Each subcontractor has negotiated different responsibilities in each region, including some claim review.

The RAC in each jurisdiction is as follows:

- Region A: Diversified Collection Services (DCS)
- Region B: CGI
- Region C: Connolly Consulting, Inc.
- Region D: HealthDataInsights, Inc.

Section 302 of the Tax Relief and Health Care Act of 2006 makes the RAC Program permanent and requires the Secretary to expand the program to all 50 states by no later than 2010. By 2010, CMS plans to have 4 RACs in place. Each RAC will be responsible for identifying overpayment and underpayments in approximately ¼ of the country.

The RAC demonstration program has proven to be successful in returning dollars to the Medicare Trust Funds and identifying monies that need to be returned to providers. It has provided CMS with a new mechanism for detecting improper payments made in the past, and has also given CMS a valuable new tool for preventing future payments.

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More Information on CMS E-Prescribing Program Now Available

Section 132 of the Medicare Improvements for Patients and Providers Act of 2008 contains the new electronic prescribing (E-Prescribing) incentive provisions which went into effect January 1, 2009.

E-Prescribing is the transmission using electronic media of prescription or prescription-related information between a prescriber, dispenser, pharmacy benefit manager (PBM), or health plan, either directly or through an intermediary, including an e-prescribing network. E-prescribing includes, but is not limited to, two-way transmissions between the point of care and the dispenser. A qualified provider can earn two percent of their total Medicare allowable Part B charges through the CMS E-Prescribing incentive program.

In order to qualify for the provider must HAVE and USE a "qualified" eRx system. A Qualified system is capable of ALL of the following:

- Generating a complete active medication list incorporating electronic data received from applicable pharmacies and PBMs, if available;
- Selecting medications, printing prescriptions, electronically transmitting prescriptions, and conducting all safety checks;
- Providing information related to the availability of lower cost, therapeutically appropriate alternatives, if any (The availability of an e-prescribing system to receive tiered formulary information, if available, would meet this requirement for 2009); and
- Providing information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient's drug plan, if available.

The measure is intended to be reported on for EVERY patient visit in the denominator.

Successful reporting is defined as reporting the measure on at least 50 percent of eligible patients. However, CPT codes that make up the denominator MUST account for at least 10 percent of the provider's total allowed charges for Medicare Part B covered services.

A patient must have an encounter with one of these CPT or G-codes:

90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, G0101, G0108, G0109

MIPPA legislation includes an incentive payment of 2 percent for the first two years, followed by a decrease in the incentive and a penalty for non-users beginning in 2012. See chart below.

Year	Incentive for Successful E-Prescribers	Reduction for Unsuccessful E-Prescribers
2009	2.0%	
2010	2.0%	
2011	1.0%	
2012	1.0%	-1.0%
2013	0.5%	-1.5%
2014		-2.0%

An electronic prescribing summit was held in Boston on October 6-7, 2008, hosted by former Secretary of Health & Human Services Michael Leavitt. The agenda and presentations can be accessed at: www.e-prescribeconference.com. Also, 22.5 CME credits from viewing the presentations can be earned through www.massmed.org/cme/CMS_eprescribing

Information Disclaimer:

The information provided in this newsletter is intended only to be general summary information to the Region III provider community. It is not intended to take the place of either the written law or regulations.

Links to Other Resources:

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