



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 Issues Information and Resources for H1N1 Vaccinations

CMS wants all beneficiaries to be immunized against the various forms of influenza threatening Americans this fall and winter. Medicare and Medicaid will pay for the regular seasonal flu shots and immunization for the new H1N1 flu strain.

Most people will need both shots, although children and pregnant women are high priority for both the H1N1 and for the seasonal flu vaccines. As part of the outreach and education efforts about the flu, CMS is providing [a fact sheet for Medicare beneficiaries](#) and [another for those enrolled in Medicaid and the Children's Health Insurance Program \(CHIP\)](#).

Note that Medicare will pay for seasonal flu vaccinations even if the vaccinations are rendered earlier in the year than normal. CMS understands that such preparations are critical for the flu season, especially in planning for the influenza A (H1N1) vaccine.

Though Medicare typically pays for one vaccination per year, if more than one vaccination

per year is medically necessary (i.e., the number of doses of a vaccine and/or type of influenza vaccine), then Medicare will pay for those additional vaccinations. Furthermore, Medicare beneficiaries that need both a seasonal flu vaccination and an influenza A (H1N1) vaccination will be covered for both.

Please be advised that if either vaccine is provided free of charge to the health care provider, then Medicare will only pay for the vaccine's administration (not for the vaccine itself).

Much more detailed information is available on the [flu page of the CMS website](#). Providers and billers who need more information regarding billing guidelines should download the [MLN Matters Article](#). Also, [a comprehensive list of updated Qs & As](#) is available and answers inquiries coming in from members of all parts of the industry.

DHHS Announces Special Waivers for H1N1

The Secretary of Health and Human Services Kathleen Sebelius has invoked her waiver authority under Section 1135 of the Social Security Act. This allows for the waiver or modification of certain Medicare, Medicaid, and Children's Health Insurance Program requirements to ensure that sufficient healthcare items and services are available to meet the needs of individuals enrolled in Social Security Act programs in the emergency area and for the time periods covered by the 1135 authority.

Requests by providers to operate under the flexibilities afforded by the waiver should be sent to the state survey agency or CMS Regional Office. Please visit our website for a [detailed paper](#) outlining the 1135 waiver process.

Further information on the 1135 Waiver process can be found on the [CMS website](#).



2010 Annual Participation Enrollment Deadline Extended

Due to recent revisions that were made to the 2010 Medicare Physician Fee Schedule, CMS has extended the 2010 Annual Participation Enrollment Program end date from December 31, 2009, to **January 31, 2010** – therefore, the enrollment period now runs from November 13, 2009, through January 31, 2010.

The effective date for any participation status change during the extension, however, remains January 1, 2010, 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 received or post-marked on or before January 31, 2010.

The Participation Agreement (CMS Form 460) is available on the CD-ROM that is sent out annually by your Medicare contractor during the Annual Participation Enrollment period. Contractors will also make the Participation Agreement available on their websites with participation enrollment (and termination) instructions.

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Fourth Annual Provider Satisfaction Survey Results

The [Medicare Contractor Provider Satisfaction Survey](#) (MCPSS), conducted by CMS for the fourth year, is designed to gather and report quantifiable data on provider satisfaction with the fee-for-service (FFS) contractors who process and pay Medicare claims and provide associated services. The results from previous surveys have enabled CMS to establish performance standards for Medicare contractors and incorporate results into contractor incentive plans.

The 2009 MCPSS queried more than 32,000 randomly selected providers and targeted Medicare FFS contractors. Questions focused on seven contractor business functions that underlie the provider-contractor relationship: Provider Outreach & Education, Provider Inquiries, Claims Processing, Appeals, Provider Enrollment, Medical Review, and Provider Audit & Reimbursement.

The 2009 MCPSS survey questions use a rating scale of 1 to 6, with 1 representing “not at all satisfied” and 6 representing “completely satisfied.” Across all responding providers, 81 percent scored their contractors between 4.0 and 6.0 on the overall satisfaction question. For the third consecutive year, contractors’ handling of provider inquiries was cited as the top indicator of satisfaction – with the linkage even stronger compared to last year.

Go to the CMS website for [full survey results](#).

New Rebid Period for Round One of DMEPOS Competitive Bid Program Now Underway

Medicare-approved medical equipment suppliers will have until December 21, 2009, to submit bids for the Round One Rebid of the Medicare Competitive Bidding Program for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) in nine communities.

CMS has begun accepting bids from accredited and bonded medical equipment suppliers after implementing a number of important modifications to the program and conducting an intensive supplier outreach and education effort. Currently 93 percent of all medical equipment suppliers across the country, including those in the competitive bidding areas, have met Medicare’s accreditation requirements.

Suppliers in the [nine communities](#) (including Pittsburgh in Region 3) who bid will find that CMS has made a number of changes to help them successfully submit a bid and ensure that suppliers that are awarded contracts are those best able to serve beneficiaries. These changes include an early comprehensive bidder education program, a user-friendly bid submission process, enhanced scrutiny of bidders, and an updated bid evaluation process.

Suppliers that have completed the bidder registration process may now access the online bidding system and begin the process of submitting their bids. Information and materials may be found at www.dmecompetitivebid.com.

and a special toll-free help line (1-877-577-5331) has been established to assist bidders with questions and concerns.

The Round One Rebid will include [the same items as the first Round One](#), except negative pressure wound therapy items and Group 3 complex rehabilitative power wheelchairs.

The DMEPOS competitive bidding program, combined with Medicare’s accreditation and quality standard requirements, will help to ensure that high quality items and services continue to be available to beneficiaries who need medical equipment and supplies. Beneficiaries living in the competitive bidding areas won’t need to take any action before the program begins in 2011.

The Medicare Improvements for Patients and Providers Act (MIPPA) required CMS to terminate contracts awarded in Round One and to conduct the competition for the Round One Rebid in 2009. MIPPA also delayed competition for Round Two in 70 additional MSAs until 2011 and in additional areas of the country until after 2011.

For additional information about the Medicare DMEPOS Competitive Bidding Program, please visit the [DMEPOS page](#) of the CMS website.

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For Your Patients: Caregivers’ Resources

The holiday season is a joyous and giving time of year – and a time when we try to do just a bit more for those who mean the most to us. The 44 million Americans who have taken on the responsibility of caring for seriously ill, disabled, or aged family members and friends deserve our heartfelt thanks and support.

With this in mind, we hope you can share information about *Ask Medicare*, a web-based resource developed by CMS.

[Ask Medicare](#) offers tools and information that helps caregivers and those they care for make informed health decisions. The site also offers a

[free e-newsletter](#), personal stories and tips from caregivers, and important insights on challenging issues, such as transitioning a loved one to an assisted living facility, selecting and paying for care, coping with a chronic illness, and helping with hospitalization.

Medicare Open Enrollment occurs from now until December 31, and offers an important opportunity to ensure that beneficiaries have the drug and health plans that will best meet their needs for the coming year.

HHS Announces Grants for CHIP Program

HHS Secretary Kathleen Sebelius announced \$40 million in grants to 69 grantees in 42 states and the District of Columbia to help them find and enroll children who are uninsured but eligible for either Medicaid or the Children's Health Insurance Program (CHIP).

Recognizing that millions of children are eligible for Medicaid or CHIP, but are therefore needlessly uninsured, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) set aside \$100 million for fiscal years 2009-2013 expressly to help find and enroll eligible children. Of the total outreach amount, \$80 million will be given to states and other organizations, \$10 million to tribal organizations and \$10 million for a national outreach effort. The awards are for a two year period ending December 31, 2011, which will then be followed by a second round of \$40 million in new grants.

As called for in CHIPRA, grants were awarded to applicants whose outreach, enrollment, and retention efforts will target geographic areas with high rates of eligible but uninsured children, particularly those with racial and ethnic minority groups who are uninsured at higher-than-average rates.

The grant awards require that recipients show actual increases in enrollment and retention of children already in the programs. Both CHIP and Medicaid state agencies will report to CMS the number of new enrollees and those who retained coverage that are directly attributable to the grant activities. Grantees also will report activities they believe were the most effective in finding, enrolling, and maintaining children in these benefit programs.

Additional information is available at the [CMS website](#).

Program Safeguard Contractors to Transition to New Zone Program Integrity Contractors

CMS program integrity efforts were assigned originally to CMS fiscal intermediaries and carriers. In 1999, CMS began transferring the responsibility to Program Safeguard Contractors, which are transitioning to the Zone Program Integrity Contractors (ZPICs). The enactment of section 911 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) mandated a change in CMS' contracting structure by phasing out the fiscal intermediaries and carriers and phasing in the Medicare Administrative Contractors (MAC) for CMS Medicare claims processing.

As a result of the adoption of the MAC strategy, CMS is reassigning the ZPIC jurisdictions so that workloads align with the new MACs. The intent of these realignments is to have one ZPIC responsible for the detection and deterrence of fraud, waste, and abuse across all claim types. CMS anticipates that the ability of a ZPIC to analyze data across all claims types will vastly improve identification of potential fraud.

CMS has established seven jurisdictional zones for the ZPICs that are designed to align effectively with multiple MAC jurisdictions (DE, DC, MD & PA in

Jurisdiction 6; VA & WV in Jurisdiction 5). ZPICs are required to use a variety of techniques, both proactive and reactive, to address any potentially fraudulent practices. These proactive techniques will include the ZPIC IT systems that will combine claims data and other data to create a platform for conducting complex data analysis. By combining data from various sources, the ZPIC will be expected to present an entire picture of a beneficiary's claim history regardless of where the claim was processed. The primary source of this data will be the CMS National Claims History.

Some of the benefits of the ZPIC strategy include:

- improved efficiencies to look at providers across all benefit categories;
- economies of scale through the consolidation of contractor management, data/IT requirements, facility costs, etc.;
- streamlined CMS costs in acquisition, management and oversight;
- better coordination and less resources required for the States; and
- increased security of personal health information due to fewer contractors handling data.

Recovery Audit Contractor Activity Underway

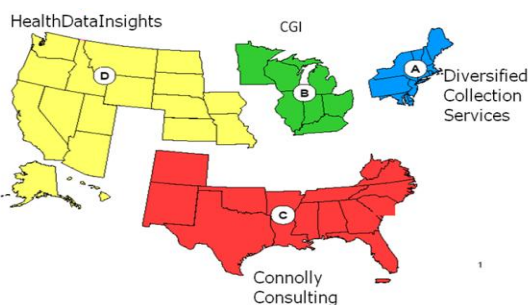
CMS has implemented the Recovery Audit Contractor (RAC) program across the nation. Currently, all four RACs are fully operational covering the jurisdictions shown on the map to the left.

CMS and the RACs encourage all providers to contact the RAC operating in their state to provide their precise mailing address that should be used for a Medical Records Request letter. CMS and the RACs also encourage providers to identify a specific

contact person who will be in charge of responding to RAC Medical Records Requests and tracking any such requests. Contact information for the four RACs is listed in the table below.

For additional information and resources concerning the RAC Program, please visit the [RAC page](#) on the CMS website.

RAC Jurisdictions



RAC	Website	e-Mail	Telephone
Region A: DCS Healthcare Services	dcsrac.com	info@dcsrac.com	866-201-0580
Region B: CGI Federal Inc.	racb.cgi.com	racb@cgi.com	877-316-7222
Region C: Connolly Healthcare	connollyhealthcare.com/RAC	RACinfo@connollyhealthcare.com	866-360-2507
Region D: HealthDataInsights	racinfo.healthdatainsights.com	racinfo@emailhdi.com	Part A: 866-590-5598 Part B: 866-376-2319

Preparing for ICD-10-CM/PCS

October 1, 2013, marks the compliance date for implementing the International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS). All HIPAA-covered entities must implement the new code sets with dates of service or dates of discharge for inpatients that occur on or after that date. The new system, which replaces ICD-9-CM, will update medical terminology and classification of diseases and provide better data for clinical decision making, claims processing, research, tracking public health, and more.

ICD-10-CM offers many critical advantages over ICD-9-CM because it will allow for more accurate payment for services, improved quality by facilitating evaluation of medical processes and outcomes, increased flexibility for additions of emerging diagnoses and procedures, and greater precision in identifying diagnoses and procedures. Significantly, the improved and more logically structured ICD-10-CM/PCS makes it easier to use than ICD-9-CM.

Many resources are available now to help you prepare for this transition. A [quick overview](#) also can be found on the CMS website, as well as an [extensive set of Internet materials](#) that will answer your questions and provide support. You should develop your implementation strategy, an education plan, and a budget to facilitate your transition.

Keep in mind: A prerequisite for implementing ICD-10-CM/PCS is being ready also to implement HIPAA 5010 by January 1, 2012. For information about HIPAA 5010, go to the [CMS website](#) and read the related [MLN Matters article](#).

Updated Calculation of Medicare Error Rate a Better Tool for Combating Fraud, Waste and Abuse

As part of the Obama Administration's goal of reducing waste, fraud, and abuse in Medicare, the Department of Health and Human Services (HHS) and CMS significantly revised and improved its calculations of Medicare fee-for-service error rates in 2009, reflecting a more complete accounting of Medicare's improper payments than in past years. These improvements will provide CMS with more complete information about errors so that the Agency can better target improper payments.

The Medicare, Medicaid and Children's Health Insurance Program improper payment rates are issued annually as part of HHS' Agency Financial Report.

While improper payment rates are not necessarily an indicator of fraud in Medicare or any other federal health care program, they do provide HHS, CMS, and its partners who are responsible for the oversight of Medicare and Medicaid funds a more complete assessment of how many errors need to be fixed.

"As we move forward in our review of the Medicare and Medicaid error rate data, we expect to be able to determine if there are specific trends

that can better help us identify weaknesses in our programs or systems," said Acting CMS Administrator Charlene Frizzera. "We hope to be able to use data available through the use of new electronic health record reporting that can help in the design of new and innovative approaches to finding emerging trends and vulnerabilities in high risk areas such as durable medical equipment and home health."

HHS and CMS will be investing more time and resources into working with providers to eliminate errors through increased and improved training and education outreach.

"It's important that we continue to work closely with doctors, hospitals, and other healthcare providers to make sure they understand and follow the more comprehensive fee-for-service requirements," said Frizzera. "We are committed to working closely with them to reduce the rate of improper payments."

Go to the CMS website to see the full [Press Release](#).

CMS Pays More than \$92 Million in PQRI Incentive Payments in 2008

More than 85,000 physicians and other eligible professionals who successfully reported quality-related data to Medicare under the 2008 Physician Quality Reporting Initiative (PQRI) received incentive payments totaling more than \$92 million, well above the \$36 million paid in 2007.

The number of eligible professionals who earned an incentive payment increased by one-third

from 2007, when 56,700 eligible professionals earned an incentive payment.

CMS recently announced its plan for the 2010 PQRI Program as part of the Medicare Physician Fee Schedule final rule. A [fact sheet](#) on the 2010 PQRI Program is available online.

More information about the PQRI program is on the [CMS website](#).

In the Spotlight... Health IT Blogs



[Health IT Buzz Blog](#)

[Federal Advisory Committee Blog](#)

Professional Meetings in Region III

The Philadelphia Regional Office hosted the Region III Medical Societies and Hospital Associations in two one-day meetings for each group on November 17-18, 2009. The meetings marked the first time that the Regional Office hosted the two groups in nearly three years. Representatives from five of the six Region III states were present each day and actively participated in the discussions that followed from each presentation. An internal regional workgroup was established to create a robust agenda for each meeting, which included sessions that touched on all areas of the Medicare and Medicaid programs.

Among the topics that were discussed on each day were: health information technology, DMEPOS Competitive Bidding program, recovery audit contracting, Medicaid Integrity Program audits, H1N1 prep and outreach, Medicare fraud, waste, and abuse, among many others. Specific to the Medical Societies, issues included Medicare Advantage non-renewals, provider enrollment and revalidation activities, and an update on the 2010 physician fee schedule. The Hospital Associations heard about observation care and provider-based status requirements. The evaluations were very positive, and participants were grateful for the face time with CMS and look forward to future meetings.

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Region III Participates in Rural Health Preceptorship in Seneca, Kansas

A collaborative effort involving the CMS Regional Office in Kansas City, the Kansas Hospital Association, and the Nebraska Hospital Association produced a Rural Health Preceptor Program that attracted fifteen federal officials from both CMS and the Health Resources & Services Administration. The basic objective of the program was to give officials involved in rural health policy and regulatory matters a personal glimpse into rural health care delivery and an opportunity to see how the consequences of their professional activities and decisions play out in the actual delivery of health care in rural America.

The Rural Health Preceptor Program was conducted over three days beginning on the afternoon of November 3 with an orientation session, and concluding on the afternoon of November 5. The orientation and wrap up sessions were conducted at the Alegent Lakeside Hospital in Omaha, Nebraska. A panel of rural health experts representing state offices of rural health, university health policy programs, and

primary care physicians briefed participants on various aspects of rural health care as part of the orientation session.

Pairs of participants were assigned to one of the following host preceptor hospitals located in Auburn, Seward, and West Point, Nebraska; and Horton, Onaga, Seneca, and Wamego/Manhattan, Kansas. Following the trip from Omaha to their host rural community, participants spent an entire day "shadowing" a variety of administrators, physicians, and other providers in a variety of rural health care delivery settings. The final day involved concluding discussions and clarifications with host hospital officials, as well as a drive back to Omaha for the wrap up session involving staff from the two state hospital associations and the National Rural Health Association.

Participant feedback about the rural preceptorship was very favorable, giving the impression that the experience contributed to a better understanding of rural healthcare providers and patients.

Region III Welcomes New Pharmacist to the Philadelphia Office

CMS Region 3 welcomes Lieutenant Commander Matthew D. Febbo as our new Regional Pharmacist. As Regional Pharmacist, LCDR Febbo is responsible for assisting Medicare and Medicaid beneficiaries, medical providers, and CMS staff with pharmacy-related issues, including beneficiary enrollment, formulary development, billing concerns, quality improvement, and the low income subsidy.

LCDR Febbo graduated from Temple University School of Pharmacy in May 1997 with a B.S. in Pharmacy. A native of Philadelphia, Matthew worked as a community pharmacy manager for a national drug chain until being called to active duty

with the United States Public Health Service in August 2002, with the Division of Immigration Health Service (DIHS) in San Pedro, CA. He continued his Public Health Service career as chief pharmacist with the Federal Bureau of Prisons in Terminal Island, CA from August 2004 through August 2006.

While not fulfilling his obligation as Regional Pharmacist, LCDR Febbo continues to practice as a community pharmacist. On November 10 of this year, he was blessed by the birth of his first child, Thomas Aiden.

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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