Medicare Part B - Current Updates
January 2014

Disclaimer

Every reasonable effort has been made to ensure the accuracy of this information. However, the provider has the ultimate responsibility for correct submission of claims. WPS Medicare bears no liability for the results or consequences of the misuse of this information. The official Medicare Program provisions are contained in the relevant laws, regulations and rulings.

Comprehensive Error Rate Testing (CERT) Program

CMS uses the CERT program to measure and improve the quality and accuracy of Medicare claims submission, processing and payment.

WPS Medicare uses the error rate information to ensure education will address and prevent the most common billing errors and claim denials.

CMS Comprehensive Error Rate Testing (CERT) Program web page
http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/index.html

Iowa, Kansas, Missouri, and Nebraska
http://www.wpsmedicare.com/j5macpartb/departments/cert/

Indiana and Michigan
http://www.wpsmedicare.com/j8macpartb/departments/cert/

ICD-10 Compliance Date

The compliance deadline for ICD-10 is *October 1, 2014*. Providers and payers need to communicate regularly. Continue to check CMS website for updated materials.

CMS International Classification of Diseases – 10th Revision (ICD-10) web page
http://www.cms.gov/Medicare/Coding/ICD10/index.html

National ICD-10 Trading Partners Week- March 3 through March 7, 2014

The ICD-10 testing week has been created to generate awareness and interest, and to instill confidence in in the provider community that CMS and the MACs are ready and prepared for the ICD-10 implementation.

This testing week will allow trading partners access to MACs and CEDI for testing with real-time help desk support. The event will be conducted virtually and will be posted on each MAC's and the CEDI Web site as well as CMS' Web site.

The testing week will be March 3 through March 7, 2014. Registration is available on our website

Iowa, Kansas, Missouri, and Nebraska
http://www.wpsmedicare.com/j5macpartb/departments/edi_/icd10-testing-day.shtml

Indiana and Michigan
http://www.wpsmedicare.com/j8macpartb/departments/edi_/icd10-testing-day.shtml

Revalidation of Medicare Provider Enrollment Information

Section 6401(a) of the Affordable Care Act established the requirement for providers and suppliers to revalidate their Medicare enrollment information under new enrollment screening criteria.

This requirement applies to providers and suppliers enrolled in Medicare prior to March 25, 2011. Providers and suppliers who submitted their Medicare enrollment on or after March 25, 2011 are not impacted.

Medicare Contractors will send out revalidation notices to the providers and suppliers by March 2015. Providers and suppliers must wait to submit revalidation until after they are asked to do so by their Medicare Contractors.

Get easy access to the revalidation process by scanning the Quick Response (QR) code with your smartphone or visit: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads//SE1126.pdf

Internet-based Provider Enrollment, Chain and Ownership System (PECOS)

Submit your Medicare Enrollment Application Using Internet-based PECOS
Do you need to enroll in the Medicare program? Change or add a practice location? Or revalidate? PECOS is the fastest, easiest way to enroll in the Medicare program or update your Medicare enrollment record.

Get easy access to Internet-based PECOS by scanning the Quick Response (QR) code with your smartphone or visit: http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/InternetbasedPECOS.html

Internet-based PECOS Education Available

CMS has available an informative 14 page CMS publication (ICN 903767), entitled *"The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Provider and Supplier Organizations"* to help you use internet-based PECOS. You can download it here: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_PECOS_ProviderSup_FactSheet_ICN903767.pdf

CMS has available an informative 12 page CMS publication (ICN 903764), entitled *"The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Physicians and Non-Physician Practitioners"* to help you use internet-based PECOS. You can download it here: http://www.cms.gov/outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_Pecos_PhysNonPhys_FactSheet_ICN903764.pdf

eNews

WPS Medicare sends out a weekly eNews Listserv on Monday with the most current and vital information Medicare providers need to know. The weekly e-News contains policy updates, all current Medicare information, and changes as they happen. A second eNews is sent out on Wednesday containing educational opportunities. To sign up, visit the WPS Medicare website and click on "e-News" in the upper right corner. We encourage all individuals at provider's office to subscribe, as there are no restrictions on how many individuals can subscribe.

Get easy access to the sign-up website by scanning the Quick Response (QR) code above with your smartphone or visit: http://corp-ws.wpsic.com/apps/commercial/unauth/medicareListservUserWelcomeLoadAction.do

Electronic Funds Transfer (EFT)

Are you still receiving paper checks? EFT sends your Medicare payments directly to your financial institution, allows faster access to funds, deposits your payments electronically on the next business day and eliminates the risk of Medicare paper checks being lost or stolen.

To set up, please download the authorization agreement for EFT at: http://www.cms.gov/Medicare/CMS-Forms/CMS-forms/downloads//CMS588.pdf

For EFT assistance you may also call: (866) 734-1522.

Sign up for Medicare Learning Network

The Medicare Learning Network® (MLN) is the brand name for official Centers for Medicare & Medicaid Services' national provider educational products. These products are designed to share up-to-date educational information and accompany the release of new or revised Medicare program policies. These educational tools are available through various mechanisms such as National Educational Articles, Brochures, Fact Sheets, Web-Based Training Courses, Videos and Podcasts.

For more details, please visit:
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html

CMS Secure Net Access Portal (C-SNAP)

For C-SNAP Technical Support assistance, please reference the C-SNAP On Demand trainings listed below. The training may provide you with the answer to your question. Also, review our new feature "Help Center".

Iowa, Kansas, Missouri, and Nebraska
http://www.wpsmedicare.com/j5macpartb/training/on_demand/csnap-od.shtml

Indiana and Michigan
http://www.wpsmedicare.com/j8macpartb/training/on_demand/csnap-od.shtml

If you have questions that cannot be resolved after reviewing the C-SNAP On Demand Training, please contact Medicare Customer Service at:
http://www.wpsmedicare.com/contact.shtml

Get easy Access to C-SNAP by scanning the Quick Response (QR) code above with your smartphone or visiting: http://medicareinfo.com

Customer Satisfaction Survey

WPS Medicare strives to continue to improve our website to meet our providers' needs. We use the ForeSee Customer Satisfaction Survey as a primary means to gather your feedback and input and gauge your satisfaction with our website. Please take time to complete the Website Satisfaction Survey that pops up when visiting the WPS Medicare website.

Medicare Quarterly Provider Compliance Newsletter

The Medicare Learning Network® (MLN) Products Provider Compliance page contains educational products that inform Medicare Fee-For-Service (FFS) providers about how to avoid

common billing errors and other improper activities when dealing with the Medicare Program. Since 1996, the Centers for Medicare & Medicaid Services (CMS) have implemented several initiatives to prevent improper payments before a claim is processed and to identify and recoup improper payments after the claim is processed. The overall goal of CMS' claim review programs is to reduce payment error by identifying and addressing billing errors concerning coverage and coding made by providers.

To learn more, visit the CMS Provider Compliance page:
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html

Place of Service (POS) Coding Instructions - Revised and Clarified

CMS SE1104 revised and clarified POS coding instructions. Instructions are provided regarding the assignment of POS for all services paid under the Medicare Physician Fee Schedule and for certain services provided by independent labs. To learn more visit:
Internet - Only Manual (IOM) Publication 100-04, Medicare Claims Process Manual, Chapter 26, Sections 10.5 and 10.6
http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c26.pdf

CR7631
http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads//R2679CP.pdf

MLN Matters Article (MM7631):
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7631.pdf

WPS Medicare Resources Web Page

WPS Medicare offers a wide range of resources to assist providers. We regularly develop and improve our online resources to decrease providers' costs and time spent contacting WPS Medicare. Self-service tools are a way for providers to access Medicare information 24 hours a day, 7 days a week, at a time most suitable to their schedule. The tools allow the user quick and easy access to the most current Medicare information.

Visit the WPS Medicare Resource Web Page:
Iowa, Kansas, Missouri, and Nebraska
http://www.wpsmedicare.com/j5macpartb/resources/

Indiana and Michigan
http://www.wpsmedicare.com/j8macpartb/resources/

Medicare Remit Easy Print (MREP)

Are you still receiving paper Remit Notices? MREP enables providers and suppliers to view and print 835 files, saves time and money, generates several useful reports, makes remittances easy to navigate and view.

Get easy Access to MREP by scanning the Quick Response (QR) code above with your smartphone or visiting the WPS Medicare website below.

Iowa, Kansas, Missouri, and Nebraska
http://www.wpsmedicare.com/j5macpartb/departments/edi_/mrep.shtml
For assistance, please contact the EDI department at (866) 503-9670

Indiana and Michigan
http://www.wpsmedicare.com/j8macpartb/departments/edi_/mrep.shtml
For assistance, please contact the EDI department at (866) 503-9670

CMS Fraud Prevention Training Modules for Providers

To help assist CMS in their efforts to prevent fraud and abuse, CMS created two fraud prevention training modules. Each module provides key information to health care practitioners and professionals on how they can be part of CMS' efforts to fight fraud and abuse.

The first module presents CMS' provider-focused fraud awareness and prevention initiatives that informs providers about how they can reduce the risk of fraud and abuse for their practices and patients. This module is located at: *http://www.medscape.org/viewarticle/764496*

The second module describes recent and on-going strategies that CMS has undertaken to detect and to prevent fraud and abuse in the Medicare and Medicaid programs. The goal of this module is to increase awareness amongst providers about the strategies CMS has undertaken to detect and to prevent fraud and abuse in the Medicare and Medicaid programs. This module is located: *http://www.medscape.org/viewarticle/764791*

A total of 1.25 hours of continuing medical education (CME) credit can be earned for any Medscape user registered as a doctor or health care professional. Medscape accounts are free, and users do not have to be health care professionals to register for them. Registration is on the landing page of www.medscape.com.

Instructions for how to access these modules are as follows:

Step 1: Access the website: www.medscape.org. Medscape accounts are free of charge.

Step 2: Registration is on the upper right hand corner of the home page of www.medscape.org next to the log in field.

Step 3: To access the modules, first enter your membership log in information.

Step 4: To view the "Reducing Medicare and Medicaid Fraud and Abuse: Protecting Practices and Patients" module, use this link: http://www.medscape.org/viewarticle/764496

Step 5: To view the "How CMS Is Fighting Fraud: Major Program Integrity Initiatives" module, use this link: http://www.medscape.org/viewarticle/764791

For assistance, please contact the EDI department at (866) 503-9670

Medicare Incentive Programs

Incentive payments are available to eligible professionals who meet the eligibility and reporting requirements for each program. Eligible professionals may choose to participate in three payment incentive programs.

1. Physician Quality Reporting System – Medicare eligible professionals who satisfactory report data on quality measures for covered professional services furnished to Medicare beneficiaries.

   Find more information on the Physician Quality Reporting System program on the CMS website: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html

2. Electronic Prescribing (eRX) – Medicare Eligible Professionals (EPs) who are successful electronic prescribers. An incentive program separate from and in addition to the Physician Quality Reporting System program.

   Find more information on the eRX Incentive Program on the CMS website: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive/Educational_Resources.html

   Negative Payment Adjustment

   The Medicare Improvements for Patients and Providers Act of 2008 requires CMS to apply a negative payment adjustment to any Eligible Professional (EP) who is not a successful e-prescriber under the eRx Incentive Program.

   Effective January 1, 2012, EPs who are not successful electronic prescribers are subject to a negative payment adjustment. An EP receiving the negative payment adjustment would be paid 1% less than the Medicare Physicians Fee Schedule (MPFS) amount for that service. In 2013, the negative payment adjustment increases to 1.5% and in 2014 the negative payment adjustment is 2%.

   CMS Quick Reference Guide for the 2012 eRx Payment Adjustment: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive/downloads/QRGuide_understanding_2012eRxPayAdj_F01-09-2012_508.pdf

   Posting the Limiting Charge after applying the e-Prescribing (eRx) Negative Adjustment. The hard copy disclosure report will explain the eRx reduced limiting charge by providing the following message: *"Limiting charge reduced based on status as an unsuccessful e-prescriber per the Electronic Prescribing (eRx) incentive Program."*

   MLN Matters Article (MM7877): Posting the limiting Charge after applying the e-Prescribing (eRx) Negative Adjustment: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm7877.pdf

3. Electronic Health Records (EHR) – Medicare eligible professionals, hospitals, and critical access hospitals for the "meaningful use" of certified EHR technology. Medicare eligible

professionals may not earn incentives under the eRX and Electronic Health Records incentive programs at the same time.

Find more information on the EHR Incentive Program on the CMS website:
http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html

Quality and Resource Use Reports (QRUR)

QRUR reports provide confidential information about the quality of care providers furnish, the resources they use to care for their Medicare-fee-for-service patients and provide comparative information so physicians can see their quality of care compared to physicians / practices in similar specialties.

The Program Year 2011 (PY2011) QRURs were available from late December 2012 - April 2013 to physicians practicing within a group of 25 or more eligible professionals within the nine states of California, Iowa, Illinois, Kansas, Michigan, Minnesota, Missouri, Nebraska and Wisconsin. The 2011 reports are no longer available.

In mid-September 2013, CMS will make available the PY 2012 QRURs for groups nationally that consist of 25 or more eligible professionals. The implementation of the Value Based Modifier in 2015, will be based on a 2013 performance period and will impact medical practice groups rather than individual physicians. QRURs for individual physicians will not be produced in 2013.

Information regarding the QRUR, value-based modifier and the Physician Feedback Program can be found on the Physician Feedback Program page of the CMS website at:
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/index.html

Email questions about the physician feedback program to QRUR@cms.hhs.gov

CMS National Physician Payment Transparency Program: Open Payments Training Module for Providers

CMS has produced a training module called "Are You Ready for the National Physician Payment Transparency Program?" Accessible via Medscape (http://www.medscape.org/viewarticle/780900?src=cmsaca), and accredited by the Accreditation Council for Continuing Medical Education, physicians can receive a maximum of 1.00 AMA PRA Category 1 Credit by participating in the activity and receiving a minimum score of 70% on the post-test. Through the activity, participants will learn more about OPEN PAYMENTS, the steps involved in collecting and reporting physician data, key dates for implementation, and actions they can take to verify their information in advance of website publication.

The module features Dr. Peter Budetti, Deputy Administrator and Director of the Center for Program Integrity and Dr. Shantanu Agrawal, Medical Director of the Center for Program Integrity and Director of the Data Sharing and Partnership Group.

Medscape accounts are free and users do not have to be health care professionals to register. Registration is on the landing page of http://www.medscape.com

Advance Beneficiary Notice of Noncoverage (ABN), FORM- R-131 Updates

Home Health Agency (HHA): As of December 9, 2013, Home Health Agencies (HHA) are required to use the Advance Beneficiary Notice of Noncoverage (ABN) CMS Form CMS-R-131 in certain situations. The Home Health Advance Beneficiary Notice of Noncoverage (HHABN) CMS Form CMS-R-296 will no longer be recognized for option 1. The CMS Internet-Only Manual (IOM) Publication 100-04, Chapter 30, Section 50.15.4 gives examples of when an ABN is required and how to complete it for HHAs.

Outpatient Therapy Services:

The American Taxpayer Relief Act (ATRA) provides liability protection for the beneficiary; therefore, providers will be required to give patients an ABN when services are over the Medicare Therapy Cap. CMS suggests using language similar to:

"You have met your physical therapy goals, and physical therapy is no longer medically necessary. Medicare doesn't pay for physical therapy services that aren't medically reasonable and necessary."

CMS doesn't require an ABN if the therapy service is medically necessary. In such a case, the provider should continue to append the KX modifier on claims submitted.

The CMS Internet-Only Manual (IOM) Publication 100-04, Chapter 30, Section 50.15.5 provides clarification on the use of the ABN for outpatient therapy services.

To find more information on using the ABN form, visit the CMS website:
http://cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c30.pdf

To Download the CMS-ABN-R-131 form and instructions:
http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html

Reference the article Advance Beneficiary Notice of Noncoverage (ABN) found on the WPS Medicare website at:

Iowa, Kansas, Missouri, and Nebraska
http://www.wpsmedicare.com/j5macpartb/claims/submission/abn.shtml

Indiana and Michigan
http://www.wpsmedicare.com/j8macpartb/claims/submission/abn.shtml

2014 Appeals Amount in Controversy (AIC) Change

The 3rd and 5th level of the appeals process is affected by the AIC. The AIC is the dollar amount between what Medicare paid and what the provider expects to receive for the service. In 2014, the AIC for the 3rd level of appeal (Qualified Independent Contractor) did not change from $140 in 2013. The 5th level of appeal (Judicial Review in Federal District Court) was increased from $1400 in 2013 to $1430 in 2014. This AIC increase to $1430 is effective for appeals filed in Federal District Court on or after January 1, 2014.

To find more information regarding the Appeals process, visit the CMS website at:
http://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/index.html

CMS Medicare Billing Certificate Program

Learn about the Medicare Program, master the specifics of billing for your provider type, and receive a certificate in Medicare billing from CMS for successful completion. Completion of the program includes: required web-based training courses and readings and a 75% or higher score on the post-assessment. To participate in either the Part A and/or Part B program, or browse the entire list of CMS prepared web-based training courses, refer to the Related Links posted on the CMS Web-Based Training (WBT) web page, located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/WebBasedTraining.html

Manual Updates to Clarify Skilled Nursing Facility (SNF), Inpatient Rehabilitation Facility (IRF), Home Health (HH), and Outpatient (OPT) Coverage Pursuant to Jimmo vs. Sebelius

In accordance with the *Jimmo v. Sebelius* Settlement Agreement, the Centers for Medicare & Medicaid Services (CMS) has agreed to issue revised portions of the relevant program manuals used by Medicare contractors, in order to clarify that coverage of skilled nursing and skilled therapy services "…does not turn on the presence or absence of a beneficiary's potential for improvement, but rather on the beneficiary's need for skilled care." Skilled care may be necessary to improve a patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition. For more information, please see MLN MM 8458 at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8458.pdf

What's New for 2014?

Deductible

Part A
Hospital insurance deductible amount for 2014 is $1216.00
The coinsurance per day for days 61 – 90 is $304.00
The coinsurance per day for days 91 – 150 is $608.00
The coinsurance for per day days 21 – 100 (Skilled Nursing Facility (SNF)) is $152.00
Part B
The basic premium is $104.90 per month
Deductible is $147.00 per year
Coinsurance remains at 20% for most items and services
You can find more information in the Centers for Medicare & Medicaid Services (CMS) Medicare Learning Network (MLN) Matters MM8527

Amount in Controversy

There is no restriction on the amount in controversy (AIC) for an Appeal or a Qualified Independent Contractor. The next level - Administrative Law Judge - must have at least $140.00 before they will reevaluate the information. There is no AIC required for the Medicare Appeals Council. The AIC for a Federal Judicial Review is $1430.00, an increase of $30.00 over 2013.

Interest Amounts

CMS changed the interest rate charged for Medicare overpayment and underpayments to 10.125%. You can find more information in Change Request 8516.

Annual Changes

The Medicare Fee Schedule Relative Value File (Medicare Database), the National Correct Coding Initiative (NCCI) and the Medically Unlikely Edits (MUE) are all updated on a quarterly basis. Changes to these files will be effective for services January 1, 2014 and after.

In addition, the Current Procedural Terminology (CPT) and Health Care Common Procedure Coding System (HCPCs) make many updates each year. Please verify the codes (especially drug codes) used on a regular basis to determine you are billing appropriately for your services.

Single Point of Contact

WPS Medicare will now have a single toll-free number through which to respond to all your Medicare needs. The single number will guide you to Customer Service, Appeals, Electronic Data Interchange (EDI), Reopenings (Part B) and Provider Enrollment. The change will not include other departments of Medicare such as Electronic Funds Transfer, Interactive Voice Response, and Payment Recovery. Those numbers are available on our website under "Contact Us".

The telephone number for J5 is 866-518-3285.

The telephone number for J8 is 866-234-7331.

You can find more information on our website. The URL is in the Resource Section

2014 Medicare Physician Fee Schedule

Congress has made changes in the 2014 fee schedule amounts. There will be a .05% increase in payments rather than the anticipated 24% decrease. These new amounts are effective for dates of service January 1, 2014 through March 31, 2014. We posted these to our website no later than January 3, 2014. We will pay claims based on these amounts. The new conversion factor is $35.8228.

The Geographic Practice Cost Index of the existing 1.0 floor is extended through March 31, 2014.

Therapy Cap

In 2014, the physical therapy and speech language pathology cap is $1920 and the occupational therapy cap is $1920. Providers will continue to use the KX modifier to request an exception to the cap for medically necessary therapy services provided through March 31, 2014. The cap and exception process is also applicable to therapy services provided in a hospital outpatient department. The threshold amount for services provided through March 31, 2014 remains at $3,700 for physical therapy and speech language pathology and $3,700 for occupational therapy.

Ambulance Add-on payment

The new rule extends the 3% increase in ambulance fee schedule amounts for transports originating in a rural area, a 2% increase for transports originating in an urban area and continues the “super rural” bonus through March 31, 2014.

Physician Incentive Payments and Negative Payment Adjustments

There is no incentive program for 2014 under the e-Prescribing program. Physicians who did not meet the exclusion criteria under the e-Prescribing incentive program will receive a 2% negative payment adjustment on all services paid under the physician fee schedule beginning with services dates January 1, 2014 and after. Physicians notified of receiving the 2014 negative payment adjustment will have an opportunity to request an informal review. Instructions are in the Centers for Medicare & Medicaid Services document *2014 eRx payment Adjustment Informal Review Made Simple*.

There is an incentive of 0.5% for 2014 for the Physician Quality Reporting System (PQRS). There is no negative payment adjustment in 2014. The negative amount of 1.5% for those providers not meeting the criteria will begin in 2015.

Providers subject to the Value-Based Payment Modifier (groups of 100 or more under a single tax ID number) will not be affected until 2015.

CMS has sent quality measures to Group Practice Reporting Option (GPRO) providers to review prior to posting on the Physician Compare website. The review must be completed by January 16, 2014. The reporting will be a sub-set of the 2012 PQRS web interface measures.

Ambulatory Surgical Center Quality Reporting Payment Reduction

Transmittal 1280, Change Request 8349, dated August 16, 2013 provides an effective date for the payment reduction for Ambulatory Surgical Centers (ASCs) that did not meet the quality reporting criteria. The reduction is 2%. Providers successfully reporting quality measures from October 1, 2012 through December 31, 2012 are not subject to the adjustment.

Providers subject to this negative payment adjustment have been notified by CMS. Providers may request a reconsideration of the payment adjustment using the instructions in the above Change Request. If CMS determines a provider should not be subject to the payment adjustment, CMS will notify the ASC and the contractor. The contractor will make the additional payments.

Ordering and Referring Providers

Effective for claims processed January 6, 2014 and after, Medicare will verify the requirement for identifying an ordering/referring physician is met. If the claim requires an ordering/referring physician and one is not present, Medicare will reject the claim as unprocessable. If the claim identifies the ordering/referring physician, Medicare will verify the practitioner is enrolled with Medicare and is able to order/refer the service. If the ordering/referring practitioner is not enrolled with Medicare, we will reject the claim and the patient will have no liability.

These edits will compare the National Provider Information (NPI) number along with the first four letters of the last name. When submitting the claim using the CMS 1500 or the CMS 1450 claim format (or the electronic equivalent), please only include the first and last name as it appears on the CMS ordering/referring file. Please do not use middle names, initials, suffixes. The file is located at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/MedicareOrderingandReferring.html

Revisions to the edit for the Technical Component of Pathology Services occurring on the same day as an Outpatient Hospital Visit

Previous to January 1, 2014 when a patient received the technical component of a pathology service and an outpatient service on the same day, Medicare would recoup the payment for the technical component, asking the practitioner to seek payment from the hospital. Effective January 1, 2014, the edit will work differently. If the files show a claim from the physician who ordered the pathology service and the claim shows a non-hospital place of service location, then Medicare can allow the technical component of the pathology service. For more information see MLN Matters MM8399.

Single Code and Payment for Clinic Visits

This provision was listed in the CMS Final rule published on November 27, 2013 and discussed a change in reimbursement for outpatient clinic visits to a single amount for a single procedure

code. This provision does not apply to the professional services of the physician. The physician will continue to determine the appropriate level of coding based on the medical necessity and the documentation of the service.

2 Midnight Rule

Medicare can make payment for an inpatient hospital stay when the physician certifies he/she believes the patient will need inpatient level of care for 2 consecutive midnights. This rule affects the reimbursement for the hospital and affects the certification requirements for physicians.   The payments to the hospital can be affected as dates of admission beginning in October 2013.

Informational Unsolicited Response

The CMS use of Information Unsolicited Responses (IURs) is increasing based on issue and concerns identified by the Recovery Auditor (RA), Medicare Administrative Contractors (MAC) and the Comprehensive Error Rate Testing (CERT) contractor.

Mental Health Parity

Effective for services January 1, 2014 and after there is no mental health treatment limitation. Mental Health services are paid at 80% of the Medicare allowed amount. This is based on the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). The reductions in the limitation were phased in from 2010 to 2013.

Recalcitrant Provider Procedures

Transmittal 495 under Change Request 8394 provides a formal process to address those providers who will not make necessary changes to comply with the Medicare rules and regulations. These are providers who have been identified as billing incorrectly, received education, and still have not made the requested changes. These providers are generally on pre-payment reviews.

CMS has identified a process through which the Fraud and Abuse Sanctions and Suspension (FASS) team should review the case prior to applying civil monetary penalties (CMPs).

8-Digit Clinical Trial Number

Transmittal 2758 Change Request 8401 mandates the use of a clinical trial number on the claim for those services that are covered as part of a clinical trial. The specifications are in the Medicare National Coverage Determination (NCD) Manual 100-03, Section 310.1.

Redaction of Health Insurance Claim Numbers (HICNs) in Medicare Redetermination Notices (MRNs)

Medicare will no longer show the entire HICN on a Medicare Redetermination notice. We will replace the first 5 or more values with XXXX or **** with the last 4 or 5 digits displayed. This is identified in Change Request 8268.

Revised 1500 Claim Form (02/12)

The National Uniform Claim Committee (NUCC) recently revised the 1500 claim form. This revision will accommodate the changes to ICD-10 coming in October 2014, expands the number of diagnosis to 12 and allows for providers to identify ordering, referring and supervising providers. Medicare can accept this new form (for those providers able to bill on paper) beginning January 1, 2014. The new form will be mandatory as of April 1, 2014. Claims sent electronically are subject to the 5010 version of the ASC X12 837 Professional Health Claim Claims standard. These dates are tentative and subject to change. Change Request 8509 identifies the specific changes.

Post Payment Review Notification

Effective January 28, 2014 Medicare contractors will notify physicians of the results of post payment medical reviews. The notifications will include both those claims where overpayments are identified and those paid correctly.

Telehealth Services

CMS is adding Transitional Care Management Services to the list of available telehealth services. The office providing the TCM would be responsible for providing the initial interactive contact, the face-to-face visit (through appropriate communication) and the other services listed as part of the TCM.

Effective January 1, 2014, rural Health Professional Shortage Areas (HPSAs) include HPSAs located outside of a county outside of an Metropolitan Statistical Area (MSA) as well as those located in rural census tracts as determined by the Office of Rural Health Policy.

ICD-10 October 2014

Medicare will require ICD-10 diagnosis codes on the claim form for claims submitted October 1, 2014 and after. CMS has provided instructions in Change Request 8465 for contractors to facilitate testing for ICD-10 verification. Please watch our website for more information.

Committee for Operating Rules Information Exchange (CORE)

The Electronic Remittance Advice (ERA) and the Standard Paper Remittance (SPR) will have some changes based on Change Request 8513. These changes will accommodate the recommendations from the CORE.

CERT Contractor and Diagnostic Services

Change Request 8547 instructs the CERT contractor to request documentation on an ordered/referred service from the ordering/referring physician when the documentation is not submitted by the performing provider. The Medicare Administrative Contractor (MAC), Recovery Auditor (RA), and Zone Program Integrity Contractor (ZPIC) can also request information from the ordering/referring provider. If you receive a request for this information, please respond timely with a copy of your order and the reasons why you believe it was medically necessary for the patient.

Resources

Update to Medicare Deductible, Coinsurance, and Premium Rates for 2014. The Centers for Medicare & Medicaid Services (CMS) Medicare Learning Network (MLN) Matters MM8527 http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8527.pdf

Single Point of Contact

J5 B - http://www.wpsmedicare.com/j5macpartb/departments/customer_service/single-poc.shtml

J8 B - http://www.wpsmedicare.com/j8macpartb/departments/customer_service/single-poc.shtml

Interest Rates - The CMS Change Request (CR) 8516 Notice of New Interest Rate for Medicare Overpayments and Underpayments – 1st qtr. Notification for Fiscal Year (FY) 2014. http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R229FM.pdf

2014 Fees – http://www.wpsmedicare.com>choosejurisdiction>accept CPT license agreement>choose Fees>choose 2014 fee schedule or specialty fee schedule

Single Code – 2014 CMS Final Rule located in the Federal Register dated December 10, 2013 http://www.gpo.gov/fdsys/browse/collection.action?collectionCode=FR&browsePath=2013%2F12%2F12-10%5C%2F3%2FCenters+for+Medicare+%26amp%3B+Medicaid+Services&isCollapsed=false&leafLevelBrowse=false&isDocumentResults=true&ycord=375

2 Midnight Payment Rule – Legislation “Pathway for SGR Reform Act of 2013”

Informational Unsolicited Response –Medicare Learning Network (MLN) 8271 http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8271.pdf

Therapy Cap – Legislation “Pathway for SGR Reform Act of 2013”

Ambulance Payment – Legislation “Pathway for SGR Reform Act of 2013”

Annual Changes – no reference material

Incentive and Negative Payment Adjustments - http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Index.html and http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive/index.html

Technical Component – MLN Matters MM 8399 http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8399.pdf

Ordering/Referring – MLN Matters Special Edition (SE) 1305 http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/se1305.pdf

Mental Health Parity – CMS Internet Only Manual (IOM) Publication 100-04, Chapter 12 Section 210 - http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf

Recalcitrant Providers – MLN Matters MM8394 - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8394.pdf

Clinical Trials – MLN Matters MM8401 http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8401.pdf

ASC Payment Reduction –MLN Matters MM8349 http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8349.pdf

Redact HICN – MLN Matters MM8268 http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8268.pdf

Revised 1500 – MLN Matter MM8509 http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8509.pdf

Post Pay Notification – Change Request - CR 8541 http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R498PI.pdf

ICD-10 – http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8465.pdf

CORE – Change Request - CR 8513 http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2843CP.pdf

Telehealth – MLN Matter MM8533 http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8533.pdf and Change Request - CR 8533 http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2840CP.pdf

Link to CMS Web-Based Training Courses - (includes Medicare Billing Certificate Program for Part A Providers and Medicare Billing Certificate Program for Part B Providers)
https://cms.meridianksi.com/kc/ilc/course_info_enroll_lnkfrm_f1.asp?lgnfrm=wbt&table=crs&function=course_info_enroll&strBuildingID=5&strFunctionID=37&strFunctionPath=37&strFrom=Search&topic=All&keywords=

Online ICD-10 - Implementation Guide
https://implementicd10.noblis.org/
When you choose start for the applicable category (Planning & Analysis, Design, Development, Testing, Implementation), you can choose your role (small physician practice, medium physician practice, large physician practice, small hospital, payer)

On Demand Training - Part A 01/06/2014 - Monday Mornings with Medicare - 2014 Hospital Admission Criteria (2 Midnight Rule) - recording and handout -
http://www.wpsmedicare.com/j8macparta/training/on_demand/ipps-od.shtml

What's New for 2014? Part B January 29,2014 Teleconference - to register, view handout (audio file to be posted about 2 weeks following the call)
http://www.wpsmedicare.com/j8macpartb/training/training_programs/teleconference/whats-new-for-2014.shtml