

CMS Update

**Louisiana Rural Health Association
RHC & Rural Health Spring
Conference – April 26, 2010**

New Administration Brings Rural Leadership

- New HHS Secretary from Kansas – Kathleen Sebelius
- HRSA Administrator – Dr. Mary Wakefield – former director Center for Rural Health, University of North Dakota
- U.S. Surgeon General --
Dr. Regina Benjamin (founder/CEO of Alabama RHC)

What's New?

- No CMS Administrator named (no confirmed Administrator since 2006) but rumors abound!
- Central Office is realigning structure to be able to provider better service and be in position to implement health care reform
- Uncertainty? Economy, regulations, health care reform, EHR?

CMS and Office of National Coordinator for Health Information Technology (ONC) Proposed Rules

- **CMS proposed rule issued 12/30/09** regarding EHR incentives and defining “**meaningful use**” of EHR technology, “eligible professional or eligible hospital” and other requirements. **Comments were due by March 15, 2010**
- **ONC interim final rule issued 12/30/09** describes initial set of **standards** to be met by certified EHR technology
- Neither rule governs applications for grants, HIPAA changes, procedures to become a certifying body and these will be issued later
- **CMS Final Rule will be issued in late Spring 2010** (probably in June)

HealthIT.hhs.gov

- HHS site for all HITECH information, grants, outreach, regulations, standards, etc.
- You can sign up for email notices of news

RHC Regulation? – Not Yet

- Balanced Budget Act of 1997 enacted
- February 2000 – First Proposed Rule
- December 2003 – Final Rule issued, but suspended due to new statutory requirement (MMA of 2003) that no more than 3 years can elapse between a proposed and final rule
- June 2008 – New Proposed Rule issued
- **MMA 2003 requires Final Reg to be published within 3 years of Proposed Rule = June 2011**

Patient Protection and Affordable Care Act (PPACA)

- Many provisions CMS is evaluating, including extensions of some rural provisions that expired on 12/31/09
- Immediate changes implemented first: **Changes timely filing deadline to one year, beginning with services provided on or after 1/1/10, and services provided from 10/1/09 to 12/31/09 must be filed by 12/31/10. At this point, there are no exceptions to the new requirement.**
- Watch Medicare contractor listserv for earliest news on other changes as they become known

AB MAC Implementation

All Contracts Awarded

- The last 5 MAC contractors were selected and announced on January 7, 2009.
- Several are under protest at this time so we are unsure what will be the final outcome for J2, J6, **J7**, J8, J11 and J15 jurisdictions.
- MMA 2003 requires all MACs to be implemented by October 1, 2011

A/B MAC Implementation

- **MMA 2003 requires geographic assignment of providers**
- **All new Part A or Part B providers enroll with the Medicare Administrative Contractor (MAC) serving their state, or with the legacy contractor serving the state if there is no MAC yet**
- **New freestanding RHCs and FQHCs (including FQHC satellites) are no longer assigned to regional or national FIs (only HHA/hospice and DMEPOS are still assigned to regional MACs)**
- **New Freestanding RHCs** now enroll with the MAC for their state, or if the MAC has not been awarded yet, it will enroll with the local Medicare fiscal intermediary in their state
- **New Provider-Based RHCs** and other provider-based entities continue to enroll with the FI/MAC that serves the parent provider

A/B MAC Implementation

- **Existing Out-of-jurisdiction providers** (e.g., those with Mutual/WPS, and providers with former regional or national FIs that are not the MACs for the state where they are located) will not transition to the MAC for their state until after **all** the MAC contracts are fully implemented

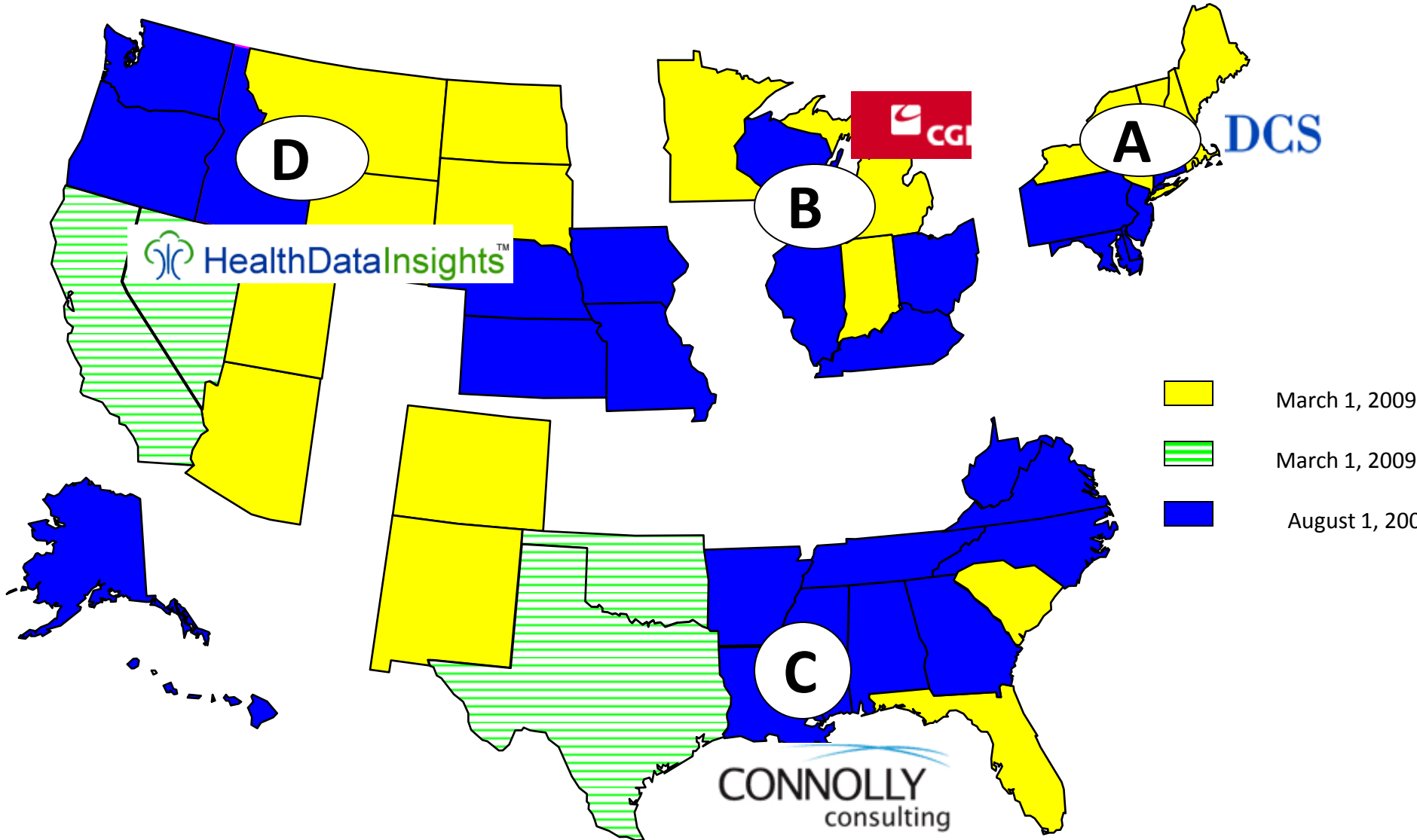
RAC Legislation

- Medicare Modernization Act, Section 306:
 - Required a 3-year RAC demonstration project
- Tax Relief and Healthcare Act of 2006, Section 302:
 - Required a permanent and nationwide RAC program by no later than 2010
 - Both statutes gave CMS authority to pay RACs on a contingency fee basis

Recovery Audit Contractors Awarded

- Region A – Diversified Collection Services, Inc.
- Region B – CGI Technologies and Solutions, Inc.
- Region C – Connolly, Inc.
- Region D – HealthDataInsights, Inc.

RAC Jurisdictions



RAC Review Process

- RACs review claims on a post payment basis
- RACs use the same Medicare policies as FIs, Carriers and MACs
 - NCDs, LCDs & CMS manuals
- Two types of review:
 - Automated (no medical record needed)
 - Complex (medical record required)
- Respond Timely! Records due 45 days from date of letter

Minimize Provider Burden

- Limit the RAC “look-back period” to three years
 - Maximum look back date is October 7, 2007
- RACs will accept imaged medical records on CD/DVD (CMS requirements coming soon)
- Limit the number of medical record requests (based on previous year Medicare volume)

Ensure Accuracy

- Each RAC employs:
 - A physician medical director
 - Certified coders
- CMS' New Issue Review Board provides greater oversight
- RAC Validation Contractor provides annual accuracy scores for each RAC
- If a RAC loses at any level of appeal, the RAC must return the contingency fee

Maximize Transparency

- New issues are posted to the web
- Major Findings are posted to the web
- RAC claim status web interface (2010)
- Detailed Review Results Letter following all Complex Reviews

What Can Providers Do To Get Prepared?

- Know where previous improper payments have been found (OIG, CERT, Demo RAC Reports)
- Know if you are submitting claims with improper payments
- Prepare to respond to RAC medical record requests
- Keep/submit proper documentation
- Appeal when necessary
- Learn from your past experiences

Prepare to Respond to RAC Medical Record Requests

- Call your RAC and tell them the precise address and contact person they should use when sending medical record request letters
- Respond to RAC medical record requests fully and within the required 45 day turn around
- When necessary, call the RAC to check on the status of your medical records (Did you receive them?)
- Communicate, communicate, and communicate

What Are Providers' Options?

- If you agree with the RAC, pay back the overpayment, or
- Allow offset process to take place (recoupment made from future payments), or
- Request or apply for extended repayment plan

What Are Providers' Options?

If you do not agree with the RAC determination,
Appeal Timely

- The appeal process for RAC denials is the same as the appeal process for Carrier/FI/MAC, except demand letter is from RAC
- You may send a “discussion letter” but if you still disagree, be sure to appeal by the 120th day after the demand letter
- Standard Part A/Part B Appeals Process:
 - 1st Level Appeal/Redetermination – within 120 days
 - 2nd Level Appeal/QIC Reconsideration – within 180 days
 - 3rd Level Appeal/Office MC Hearings/Appeals – within 60 days
 - 4th Level Appeal/Medicare Appeals Council – within 60 days
 - 5th Level Appeal/Federal District Court – within 60 days

Contact Information & Resources

Centers for Medicare & Medicaid Services

- CMS RAC Webpage

<http://www.cms.hhs.gov/RAC>

- CMS RAC email

RAC@cms.hhs.gov

Your RAC also has a website and email contact. This information is on the CMS RAC webpage.

Your RAC Contacts

- Connolly Healthcare, Inc.
- <http://www.connollyhealthcare.com/RAC>
- Client Relations (203) 529-2315 or
Toll free (866) 360-2507

CMS National RAC 101 Calls

- RAC 101: April 28, 2010
noon – 1:30 p.m. Central Time
call 1-877-251-0301
- RAC 101 for Physicians: May 12, 2010
noon – 1:30 p.m. Central Time
call 1-877-251-0301
- Other RAC 101 calls for HHA/Hospice and
DMEPOS

Internet-Based PECOS Enrollment

- Available to Part B individuals, groups, organizations and Part A providers
- <https://pecos.cms.hhs.gov>
- **RHCs, FQHCs and ESRD facilities are still not allowed to use the Internet-based PECOS for filing CMS-855A initial applications, changes of ownership, or changes of information.**

Enrollment Changes – Internet PECOS

- Internet PECOS requires that you have your NPI, your NPPES User ID and password, certain personal identifying information, professional license and certification information, practice location information.
- After filing on Internet PECOS, must sign and date the Certification Statement and mail along with all supporting paper documentation to the Medicare contractor. This must be received within 45 days of the Internet submission or the contractor will return the Internet submission.

Rejection of Enrollment Application

- CMS contractors may reject a provider's or supplier's enrollment application if they fail to furnish complete information on the application within 30 calendar days from the date of the contractor's request for the missing information
- After rejection, a provider or supplier must complete and submit a new enrollment application and documentation for review and approval

CY 2009 Physician Fee Schedule Rule Enrollment Changes

- Establishes an effective date of billing for **physicians, non-physician practitioners and physician and NPP organizations** as the later of
 - 1) the filing of an enrollment application that is subsequently approved or
 - 2) the date an enrolled physician or NPP first started furnishing services at a new practice location

CY 2009 Physician Fee Schedule Rule Enrollment Changes

- Permits **physicians and non-physician practitioners** to retrospectively bill for services rendered up to 30 days prior to the effective date, if they met all program requirements or services rendered up to 90 days prior when there is a Presidentially-declared disaster
- No longer unlimited retroactive billing

CY 2009 Physician Fee Schedule Enrollment Changes

- Requires **all providers and suppliers**, including individual practitioners, to maintain ordering and referring documentation for 7 years from the date of service

Enrollment Reportable Events – 30 Day Timeframe

- All providers/suppliers must report a **change in ownership or control** on CMS 855 form within **30** days
- Physicians and non-physician practitioners are required to report the following changes on CMS 855 form within **30** days of these events:
 - 1. Change of ownership
 - 2. Change in practice location
 - 3. Final adverse action

Penalties for Not Meeting 30-Day Reportable Events

- Failure to notify the Medicare contractor of these changes may result in a revocation (termination of billing privileges) and/or overpayment from the date of the reportable change
- Providers/suppliers whose billing privileges are revoked may be barred from re-enrolling in Medicare for 1-3 years

Enrollment Reportable Events – 90 Day Timeframe

- Physician and non-physician practitioners are required to report on CMS 855 form the following changes no later than **90** days after the event:
 - 1) Change in practice status (e.g., retirement)
 - 2) Change of business structure, legal business name or taxpayer ID Number
 - 3) Change of banking arrangements or payment information
 - 4) A change in the correspondence or special payments address

Enrollment Reportable Events – 90 Day Timeframe

- All providers/suppliers must report on CMS 855 form within 90 calendar days of the following changes:
 - Change in practice location
 - Change of any managing employee
 - Change in billing services
 - Other changes

Penalties for Not Meeting 90-Day Reportable Events

- Medicare contractors may deactivate a provider or supplier's Medicare billing privileges for failure to report changes within 90 days of the event, and providers/suppliers must complete and submit a new enrollment application to reactivate Medicare billing privileges

Periodic Revalidation of Medicare Enrollment Information

- Providers/suppliers (other than DMEPOS and ambulance) must resubmit and recertify the accuracy of its enrollment information every 5 years
- CMS Medicare contractors will contact providers and suppliers directly when it is time to revalidate their information
- Providers/suppliers must submit complete application and documentation within 60 calendar days of the notification

Penalty for Failure to Respond to Revalidation Request

- Providers who fail to respond to the CMS Medicare contractor's revalidation request may have billing privileges revoked and may be barred from re-enrolling in Medicare for one year

More Information on Medicare Enrollment

- Go to CMS website
www.cms.gov/MedicareProviderSupEnroll
- CMS Internet Only Manual 100-08, Chapter 10
- Federal Regulations 42 CFR 424.500

Ordering/Referring Update

- **CMS is delaying implementation of CR 6417 and CR 6421 until January 3, 2011** to give all physicians and practitioners time to update their enrollment information in PECOS. Applies to physicians, PA, NP, CNM, CNS, CP and CSW.

Once implemented, Part B CMS 1500 claims for services that were ordered/referred will need to include ordering/referring information. If the ordering/referring physician is not in PECOS, the claim will be rejected and later denied.

Ordering/Referring PECOS File

- www.cms.hhs.gov/MedicareProviderSupEnroll
- Over 800,000 names and NPIs on file in PECOS of physicians and non-physician practitioners eligible to order/refer
- Sorted in alpha order by last name, with NPI

CY 2010 PFS Final Rule

- Implements MIPPA Section 102: Equalizes Coinsurance for Outpatient Therapeutic Psychiatric Services:
- CY 2009 and prior, patient paid 50% coinsurance (Medicare paid 50%)
- **CY 2010 and 2011 patient pays 45% (Medicare pays 55%)**
- CY 2012 = 40/60 CY 2013 = 35/65
CY 2014 = 20/80 just like other Medicare

CY 2010 PFS Final Rule

- Telehealth Benefit:

- 1) CMS adds codes 96150 and 96151 (Health & Behavior Assessment & Intervention)

- 2) CMS changes inpatient telehealth consultation codes (G0406-08) to include SNF as well as Hospital services

“Welcome to Medicare Exam”

- MIPPA extends IPPE to first 12 months of Medicare Part B eligibility, deductible no longer applies, removes mandatory EKG
- Effective with systems change on October 5, 2009, RHCs will need to use HCPCS code G0402 with RC 52X so deductible will not be applied to services rendered on or after January 1, 2009

Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)

- The deductible is waived for dates of service on or after January 1, 2007.
- RHCs providing the professional portion of this service use HCPCS code G0389 with RC 052X

New Preventive Service Added

MIPPA 2008 allows CMS to add coverage of new preventive services without requiring additional legislation, via National Coverage Decision process

Effective for dates of service on and after 12/8/2009, 3 new HCPCS codes G0432, G0433 and G0435 for Voluntary Screening for HIV Infection, implemented April 5, 2010 (Change Request 6786), for annual screening for individuals at increased risk and three screenings for pregnant women

Medicare Advantage Payment Guide

- CMS guidance to MA plans regarding original Medicare payments to providers (for PFFS plan payments and out-of-network provider payments):

<http://www.cms.hhs.gov/MedicareAdvtg>

[SpecRateStats/downloads/oon-payments.pdf](http://www.cms.hhs.gov/MedicareAdvtg/SpecRateStats/downloads/oon-payments.pdf)

Be Prepared – New X12 Standards

- **HIPAA Version 5010 Level I Compliance by 12/31/10** (covered entities demonstrate they can create and receive compliant transactions) and **Level II Compliance by 1/1/12** (covered entities complete testing with all trading partners and are able to operate in production mode with new version of the standards)
- **<http://www.cms.hhs.gov/Versions5010andD0>** (note the last is a zero)

Be Prepared – ICD-10

- 1/16/09 HIPAA Final Rule to adopt ICD-10-CM and ICD-10-PCS by **October 1, 2013** for all covered entities
- <http://www.cms.hhs.gov/ICD10> for info on educational resources, code tables and descriptions, mappings, etc.

CMS/HHS Rural Resources

- **CMS Open Door Forum Calls:**
<http://www.cms.hhs.gov/OpenDoorForums> for information on signing up for Rural Open Door listserv
- **CMS Web site Rural Health Clinic Center**
<http://www.cms.hhs.gov/center/rural.asp>
- **HRSA Office of Rural Health Policy Rural Assistance Center** – one-stop shopping for all Department of HHS rural info
<http://raconline.org>

CMS Rural Resources

- Medicare Learning Network:
<http://www.cms.hhs.gov/MLNGenInfo>
- Medlearn Matters Listserv:
<https://list.nih.gov>
- Sign up for your Medicare contractor's listserv:
<http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> to get web address of your contractor's homepage

QUESTIONS?

- Thank you for all you do to serve Medicare and Medicaid beneficiaries in rural areas!

Becky Peal-Sconce

CMS Regional Rural Health Coordinator

Dallas, Texas

(214) 767-6444

becky.peal-sconce@cms.hhs.gov