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The Compliance Matters Team
CMS ICD-10 Readiness and Testing

The Department of Health and Human Services (HHS) mandates that all covered entities under the Health Insurance Portability and Accountability Act (HIPAA) must transition from the International Classification of Diseases, 9th Edition (ICD-9-CM), to the International Classification of Diseases, 10th Edition (ICD-10-CM/PCS) code sets for medical diagnoses and inpatient procedures for dates of service on and after October 1, 2014.

To help Medicare Fee-For-Service (FFS) providers prepare for the ICD-10-CM implementation in October, CMS is taking a comprehensive four-tiered approach to testing to ensure readiness.

The four-tiered approach includes:
- CMS internal testing of its claims processing systems;
- Provider-initiated Beta testing tools;
- Acknowledgement testing; and
- End-to-end testing.

CMS Internal Testing of Its Claims Processing Systems

CMS has a very mature and rigorous testing program for its Medicare FFS claims processing systems that supports the implementation of four quarterly releases per year. Each release is supported by a three-tiered and time-sensitive testing methodology:
- Alpha testing is performed by each FFS claims processing system maintainer for 4 weeks;
- Beta testing is performed by a separate Integration Contractor for 8 weeks; and
- Acceptance testing is performed by each MAC for 4 weeks to ensure that local coverage requirements are met and the systems are functioning as expected.

CMS began installing and testing system changes to support ICD-10 in 2011. As of October 1, 2013, all Medicare FFS claims processing systems were ready for ICD-10 implementation. CMS continues to test its ICD-10 software changes with each quarterly release.

Provider-Initiated Beta Testing Tools

To help you prepare for ICD-10, CMS recommends that you leverage the Beta versions of its software that include ICD-10 codes.

The following testing tools are available for download:
- The ICD-10 Medicare Severity-Diagnosis Related Groups (MS-DRGs) conversion project (along with payment logic and software replicating the current MS-DRGs), which used the General Equivalence Mappings to convert ICD-9 codes to International Classification of Diseases, 10th Edition, Clinical Modification (ICD-10-CM) codes, located at http://cms.hhs.gov/Medicare/Coding/ICD10/ICD-10-MS-DRG-Conversion-Project.html on the CMS website.
  On this web page, you can also find current versions of the ICD-10-CM MS-DRG Grouper, Medicare Code Editor (available from National Technical Information Service), and MS-DRG Definitions Manual that will allow you to analyze any payment impact from the conversion of the MS-DRGs from ICD-9-CM to ICD-10-CM codes and to compare the same version in both ICD-9-CM and ICD-10-CM; and

Acknowledgement Testing

CMS offered ICD-10 acknowledgement testing during the week of March 3-7, 2014. This testing allowed all providers, billing companies, and clearinghouses the opportunity to determine whether CMS will accept their ICD-10 code claims.

Although test claims will not be arbitrated, the Medicare Administrative Contractors (MACs) will confirm receipt to the submitter (a 277A) as to whether the submitted test claims were accepted.
Further information pertaining to acknowledgement testing can be found on your MAC’s website.

CMS plans to offer a second week of acknowledgement testing in early May 2014. For more details and information regarding announcements, updates, and future registration, sign up for your MAC listserv and/or contact your MAC directly.

To find your MAC, click this link for the interactive map:

**End-to-End Testing Select Group of Providers/Volunteers**

In late July 2014, CMS will offer end-to-end testing. This testing will include submission of test claims to CMS with ICD-10 codes and the provider’s receipt of a Remittance Advice (RA) that explains the final decision of the claim. An RA is a notice of payments and adjustments Medicare Contractors send to providers, billers, and suppliers after a claim is processed.

The purpose of end-to-end testing is to validate that:

- Submitters are able to successfully submit ICD-10 code claims to the Medicare FFS claims systems
- CMS software changes made to support ICD-10 result in appropriately finalized claims
- Accurate RA’s are issued

Only about 500 volunteers will be selected nationwide to participate in end-to-end testing. See your MAC’s ICD-10 website area to complete and submit an ICD-10 Volunteer Testing Form.

Read the entire MedLearn Matters® Articles here:

[ CMS ICD-10 Testing Approach ]

[ International Classification of Diseases, Tenth Revision (ICD-10) Limited End to End Testing with Submitters ]

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**2014 OIG Work Plan Include Medical Devices and PHI**

On January 31, 2014 the Department of Health and Human Services (HHS) Office of the Inspector General (OIG) released its 2014 work plan. The OIG work plan includes a list of the issues the OIG intends to review in the upcoming year to address concerns about improper billing and/or payments. This year The OIG has listed 3 specific security topics for review, 2 of which are new.

**Information Technology Security, Protected Health Information, and Data Accuracy**

*Controls over networked medical devices at hospitals (new)*

Protected Health Information. Determine whether hospitals’ security controls over networked medical devices are sufficient to effectively protect associated electronically protected health information (ePHI) and ensure beneficiary safety.

Context—Computerized medical devices, such as dialysis machines, radiology systems, and medication dispensing systems that are integrated with EMRs and the larger health network, pose a growing threat to the security and privacy of personal health information. Such medical devices use hardware, software, and networks to monitor a patient’s medical status and transmit and receive related data using wired or wireless communications.

To participate in the Medicare program, providers such as hospitals are required to secure medical records and patient information, including ePHI. (42 CFR § 482.24(b).) Medical device manufacturers provide Manufacturer Disclosure Statement for Medical Device Security (MDS2) forms to assist health care providers in assessing the vulnerability and risks associated with ePHI that is transmitted or maintained by a medical device. (OAS; W-00-14-42020; various reviews; expected issue date: FY 2014; new start)

**Accuracy of the Physician Compare Web site (new)**

Data Accuracy. Review of CMS’s efforts to ensure that the Physician Compare Web site contains accurate information on health care providers.
Context—CMS was required by law to create the Physician Compare Web site, which is intended to help Medicare beneficiaries make informed choices about their health care by providing them with information about health care providers. (Affordable Care Act, § 10331.)

CMS repurposed its Provider Enrollment, Chain, and Ownership System (PECOS) as its data source for provider information on Physician Compare. However, prior OIG work found that the provider information in PECOS was often inaccurate and, at times, incomplete.

Security of portable devices containing personal health information

Protected Health Information. Review of security controls implemented by Medicare and Medicaid contractors and at hospitals to prevent the loss of protected health information (PHI) stored on portable devices and media, such as laptops, jump drives, backup tapes, and equipment considered for disposal.

Context—Recent breaches related to Federal computers, including one involving a CMS contractor, have heightened concerns about protecting sensitive information. We will assess and test contractors’ and hospitals’ policies and procedures for electronic health information protections, access, storage, and transport

Click here to read the complete OIG Fiscal Year 2014 Work Plan.

Midnight Rule Enforcement Delay

Recently the Centers for Medicare & Medicaid Services (CMS) announced that they will delay auditing and enforcement of the 2 midnight rule until after September 30, 2014. This will allow the agency time to continue to review the impact of the rule, issue additional guidance and allow hospitals additional time to implement changes to their policies, procedures and processes in order to comply with the rule.

Click here to read this announcement.

Medicaid Fraud Control Units 2013 Annual Report from OIG

Medicaid Fraud Control Units (MFCU) investigate and prosecute Medicaid fraud as well as patient abuse and neglect in health care facilities. Currently, MFCUs operate in 49 States and in the District of Columbia. Forty-four of the MFCUs are located as part of Offices of State Attorneys General; the remaining 6 are in other State agencies.

OIG certifies, and annually recertifies, each MFCU. OIG collects information about MFCU operations and assesses whether they comply with statutes, regulations, and OIG policy. OIG also analyzes MFCU performance based on 12 performance standards and recommends program improvements where appropriate.

The MFCUs share common characteristics:

- MFCUs must be “single, identifiable” entities whose professional staff are required to work full-time on MFCU duties.
- States administer the MFCUs, but they are jointly funded on a matching basis with the Federal Government. (The Federal Government pays 90 percent of a Unit’s costs for the first 3 years of a Unit’s operation and 75 percent for subsequent years; the States pay the remaining portion.)
- MFCUs operate on an interdisciplinary model and must employ investigators, auditors, and attorneys.
- The MFCUs are required to have statewide authority to prosecute cases or to have formal procedures to refer suspected criminal violations to an office with such authority.
- The MFCUs’ investigative authority extends to Medicaid-funded facilities and to “board and care” facilities that do not receive Medicaid funding. OIG, or another agency’s Inspector General, may in some circumstances permit the Units to investigate fraud in Medicare or other Federal programs.
In FY 2013, MFCUs nationwide reported a total of 1,341 criminal convictions in cases involving Medicaid fraud and patient abuse and neglect, and criminal recoveries reached nearly $1 billion.

- Criminal convictions involved a variety of provider types, most notably home health agencies. MFCUs also obtained 879 civil settlements and judgments in FY 2013, and civil recoveries totaled over $1.5 billion.
- Civil settlements and judgments involved a variety of provider types, most notably pharmaceutical companies.
- MFCUs are an important source of referrals to the OIG for purposes of provider exclusions; for over 1,000 Medicaid providers convicted in MFCU cases, OIG took further action to exclude them from all Federal health care programs, including Medicare, in FY 2013.

The OIG found that a lack of fraud referrals to MFCUs from Medicaid managed care organizations (MCOs) presents challenges; Unit officials expressed concern that some MCOs may not have incentive to refer providers suspected of fraud.

The OIG also found that recent provider payment suspension rules enacted by the Patient Protection and Affordable Care Act (ACA) require more coordination between MFCUs and State Medicaid agencies.

Finally, in its oversight role during FY 2013, OIG conducted 10 onsite reviews of Units, published 8 reports on onsite reviews, issued regulations to allow data mining by MFCUs, and proposed additional authorities for Units to investigate allegations of patient abuse and neglect.

To view the State Medicaid Fraud Control Units Statistical Data for Fiscal Year 2013

- Interactive Map
- Chart

HHS Strengthens Patients’ Right to Access Lab Test Reports

As part of an ongoing effort to empower patients to be informed partners with their health care providers, the Department of Health and Human Services (HHS) has taken action to give patients or a person designated by the patient a means of direct access to the patient’s completed laboratory test reports.

“The right to access personal health information is a cornerstone of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule,” said Secretary Kathleen Sebelius. “Information like lab results can empower patients to track their health progress, make decisions with their health care professionals, and adhere to important treatment plans.”

The final rule announced today amends the Clinical Laboratory Improvement Amendments of 1988 (CLIA) regulations to allow laboratories to give a patient, or a person designated by the patient, his or her “personal representative,” access to the patient’s completed test reports on the patient’s or patient’s personal representative’s request.

At the same time, the final rule eliminates the exception under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule to an individual’s right to access his or her protected health information when it is held by a CLIA-certified or CLIA-exempt laboratory.

While patients can continue to get access to their laboratory test reports from their doctors, these changes give patients a new option to obtain their test reports directly from the laboratory while maintaining strong protections for patients’ privacy.

The final rule is issued jointly by three agencies within HHS: the Centers for Medicare & Medicaid Services (CMS), which is generally responsible for laboratory regulation under CLIA, the Centers for Disease Control and Prevention (CDC), which provides scientific and technical advice to CMS related to CLIA, and the Office for Civil Rights (OCR), which is responsible for enforcing the HIPAA Privacy Rule.
Under the HIPAA Privacy Rule, patients, patient’s designees and patient’s personal representatives can see or be given a copy of the patient’s protected health information, including an electronic copy, with limited exceptions. In doing so, the patient or the personal representative may have to put their request in writing and pay for the cost of copying, mailing, or electronic media on which the information is provided, such as a CD or flash drive. In most cases, copies must be given to the patient within 30 days of his or her request.

**CMS/WEDI Implementation Success Initiative**

The Workgroup for Electronic Data Interchange (WEDI) is partnering with CMS and other public and private organizations to develop the ICD-10 Implementation Success Initiative. The goal of this initiative is to ensure a successful ICD-10 transition by October 1, 2014, for all stakeholders, including health care providers, payers, clearinghouses, and vendors.

The first part of the Implementation Success Initiative, a searchable database of ICD-10 issues is open to the public for submission. WEDI, CMS, and industry partners will update the database with information and resources to help health care organizations who submit issues understand how the new codes and standards will affect reporting of diagnoses and inpatient procedures. Click here for submissions or to review issues.

### 2013 FDA New Drug Approvals

Each year, the FDA Center for Drug Evaluation and Research approves a wide array of drugs and biologic products. Among these are new molecular entities (NMEs), many of which contain an active moiety that has not been approved previously. The 27 NMEs approved in 2013 are described below:

**Drugs by Specialty**

**Hematology/Oncology (8 Newly Approved)**

**Ibrutinib (Imbruvica)**
For treatment of mantle-cell lymphoma in patients who have received at least one prior therapy.

**Obinutuzumab (Gazyva)**
Approved for use in combination with chlorambucil to treat patients with previously untreated chronic lymphocytic leukemia.

**Afatinib (Gilotrif)**
For treatment of metastatic non–small-cell lung cancers that are associated with an epidermal growth factor receptor (EGFR) mutation consisting of a deletion at exon 19 or an L858R point mutation at exon 21.

**Trametinib (Mekinist)**
One of two drugs approved for the treatment of metastatic or unresectable melanoma; trametinib is for the treatment of tumors with the BRAF V600E or BRAF V600K mutation.

**Dabrafenib (Tafinlar)**
One of two drugs approved for the treatment of metastatic or unresectable melanoma; dabrafenib is for the treatment of tumors with the BRAF V600E mutation.

**Radium Ra 223 dichloride (Xofigo)**
For treatment of symptomatic metastatic castration-resistant prostate cancer that has spread to bones but not to other organs.

**Ado-trastuzumab emtansine (Kadcyla)**
For treatment of HER2-positive metastatic breast cancer in patients who have been previously treated with trastuzumab and taxanes.

**Pomalidomide (Pomalyst)**
For treatment of multiple myeloma in patients who have received at least two prior therapies, including lenalidomide and bortezomib, and whose disease has progressed within 60 days after the last treatment.
Endocrinology (3 Newly Approved)

Canagliflozin (Invokana)
A sodium glucose transporter 2 (SGL T2) inhibitor for improving glycemic control in adults with Type 2 diabetes

Alogliptin (Nesina)
For use with a healthful diet and exercise to improve blood-sugar control in adults with type 2 diabetes. Also approved are alogliptin and metformin hydrochloride (Kazano) and alogliptin and pioglitazone (Oseni).

Mipomersen sodium (Kynamro)
For use with lipid-lowering medications and a healthful diet to treat patients with homozygous familial hypercholesterolemia.

Diagnistics (3 Newly Approved)

Flutemetamol F 18 injection (Vizamyl)
A radioactive diagnostic drug for visualizing beta amyloid on positron-emission tomographic (PET) imaging of the brain in adults being evaluated for Alzheimer’s disease and dementia.

Gadoterate meglumine (Dotarem)
A gadolinium-based contrast agent for use with magnetic resonance imaging of the brain, spine, or associated tissues in patients 2 years of age or older.

Technetium Tc 99m tilmanocept (Lymphoseek)
A radioactive diagnostic-imaging agent for preoperative lymph-node mapping in patients with breast cancer or melanoma.

Gastroenterology (2 Newly Approved)

Sofosbuvir (Sovaldi)
For treatment of chronic hepatitis C virus infection.

Simeprevir (Olysio)
For treatment of chronic hepatitis C virus infection.

Infectious Disease (2 Newly Approved)

Dolutegravir (Tivicay)
For treatment of HIV infection in adults and children 12 years of age or older (who weigh ≥40 kg) who have or have not received previous treatment and who have not taken other integrase strand transfer inhibitors.

Luliconazole (Luzu)
For treatment of interdigital tinea pedis, tinea cruris, and tinea corporis, caused by the organisms Trichophyton rubrum and Epidermophyton floccosum, in patients 18 years of age or older.

Pulmonary/Critical Care (2 Newly Approved)

Umeclidinium and vilanterol (Anoro Ellipta)
Once-daily administration for long-term maintenance treatment of airflow obstruction in patients with chronic obstructive pulmonary disease.

Fluticasone furoate and vilanterol (Breo Ellipta)
Once-daily administration for long-term maintenance treatment of airflow obstruction in patients with chronic obstructive pulmonary disease (COPD).

Cardiology (2 Newly Approved)

Macitentan (Opsumit)
For treatment of adults with pulmonary arterial hypertension.

Riociguat (Adempas)
For treatment of adults with chronic thromboembolic pulmonary hypertension or pulmonary arterial hypertension that is idiopathic, inherited, or associated with connective-tissue diseases.

Obstetrics/Gynecology (2 Newly Approved)

Conjugated estrogens and bazedoxifene (Duavee)
For treatment of moderate-to-severe vasomotor symptoms associated with menopause in women with a uterus, and for prevention of osteoporosis after menopause.

Ospemifene (Osphena)
For treatment of moderate-to-severe dyspareunia in postmenopausal women.

Neurology/Neurosurgery (2 Newly Approved)

Eslicarbazepine acetate (Aptiom)
For use as an add-on medication to treat partial seizures associated with epilepsy.

Dimethyl fumarate (Tecfidera)
For treatment of adults with relapsing forms of multiple sclerosis.

Psychiatry (1 Newly Approved)

Vortioxetine (Brintellix)
For treatment of adults with major depressive disorder.

Click here to review the FDA 2013 Summary.
CMS Proposes 2015 Payment & Policy Updates for Medicare Health & Drug Plans

Greater quality and value for Medicare beneficiaries and improved payment accuracy

Beneficiaries can get greater protections, value, and care in the Medicare services they receive through the proposed policies released today by the Centers for Medicare & Medicaid Services (CMS). The 2015 Advance Notice and draft Call Letter takes important steps to improve payment accuracy for Medicare Advantage (Part C) for 2015. The proposed changes for 2015 are smaller than those implemented in 2014 – a year in which CMS expects to exceed its 5 percent enrollment growth projection in Medicare Advantage for 2014.

Since the Affordable Care Act was passed in 2010, Medicare Advantage premiums have fallen by 10 percent and enrollment has increased by nearly 33 percent to an all-time high of approximately 15 million beneficiaries. Today, nearly 30 percent of Medicare beneficiaries are enrolled in a Medicare Advantage plan. Furthermore, enrollees are benefiting from greater quality as over half of enrollees are now in plans with 4 or more stars, a significant increase from 37 percent of enrollees in such plans in 2013.

“The Affordable Care Act helps strengthen Medicare Advantage and the Prescription Drug Program by providing improved benefits and keeping costs low for Medicare beneficiaries,” said Jonathan Blum, CMS principal deputy administrator. “We believe that plans will continue their strong participation in the Medicare Advantage program in 2015 and beneficiaries will continue to have a wide array of high quality, high value, low cost options available to them while at the same time we are making certain that plans are providing value to Medicare and taxpayers.”

Proposed guidance in today’s Advance Notice and draft Call Letter increases value and protections for beneficiaries:

Lower Out-of-Pocket Drug Spending:
Beneficiaries in the Part D prescription drug coverage gap, or “donut hole,” will benefit from greater savings on prescription drugs. As a result of the Affordable Care Act, in 2015, enrollees with liability in the donut hole will receive coverage and discounts of 55 percent on covered brand name drugs and 35 percent on covered generic drugs, an increase from 52.5 percent and 28 percent, respectively, in 2014. The Affordable Care Act’s Coverage Gap Discount Program has provided discounts to more than 7 million Medicare beneficiaries, an average of $1,200 each.

Improved Notification for Beneficiaries Regarding Changes in Medicare Advantage Plan Networks:
The call letter identifies as a best practice greater notification to enrollees regarding any changes to provider networks and indicates CMS’ intention to consider rulemaking that would broaden its authority to limit such changes to certain times during the year.

Greater Protection for Beneficiaries:
CMS intends to again use its authority, provided by the health care law, to protect Medicare Advantage enrollees from significant increases in costs or cuts in benefits, and, for the 2015 contract year, proposes reducing the permissible amount of increase in total beneficiary cost to $32 per member per month (down from $34 per member per month for the 2014 contract year).

CMS proposes to maintain existing limits on beneficiaries’ out-of-pocket spending, but clarifies existing guidance that enrollees’ dollar contributions towards these limits are transferable when they move to any plan, regardless of plan type, offered by the same organization. CMS also continues to require plans to refine their offerings so that beneficiaries can easily identify the differences between their options.
**Improving Access to Preferred Cost-Sharing:**
CMS may request that Part D plans increase the number of pharmacies offering preferred, or lower, cost sharing as we are concerned that some plans that offer preferred cost sharing do not provide beneficiaries with sufficient access to the lower cost sharing at select network pharmacies. The intent of this policy will be to ensure that beneficiaries are not misled into enrolling in a plan only to discover that they do not have meaningful access to the advertised lower cost sharing.

**Improved Coordination of Care:**
CMS intends to expand plans’ ability to use technologies that enable health care providers to deliver care to beneficiaries in remote locations. The use of remote access technologies as a care delivery option for Medicare Advantage enrollees may improve access to and timeliness of needed care, increase communications between providers and beneficiaries, and enhance care coordination.

Other proposals include those aiming to closely align payments in Medicare Advantage with fee-for-service Medicare (Parts A and B), and to improve payment accuracy:

- Preliminary estimate of the combined effect of the Medicare Advantage growth percentage and the fee-for-service growth percentage is estimated to be -1.9 percent. This historically low growth in Medicare per-capita spending is tied, in part, to successful initiatives undertaken to promote value over volume and help curb fraud, waste, and abuse in the Medicare fee-for-service program in recent years.

- Continue to implement changes under the Affordable Care Act to reduce overpayments and improve quality, by phasing in alignment of MA benchmarks with Medicare fee-for-service (FFS) costs. Before the Affordable Care Act, Medicare Advantage plans were overpaid by more than 10 percent compared to traditional Medicare, costing the program more than $1,000 per person each year, while quality and health outcomes were similar to those enrolled in traditional Medicare. The changes underway reduce overpayments to Medicare Advantage plans, while incentivizing quality improvements by basing part of Medicare Advantage payment on plan quality performance.

- Change in how we estimate the annual trend used to adjust for risk score growth to account for the increasing proportion of baby boomers entering Medicare, who overall tend to be younger and healthier than the general Medicare population.

- Continue to adjust for diagnostic coding differences between Medicare Advantage plans and Medicare fee-for-service providers. In compliance with statutory requirements, CMS proposes applying a 5.16 percent adjustment for 2015 to MA plan payments, a 0.25 percentage point increase over 2014.

- Continue to calculate risk scores in 2015 using the same methodology in effect in 2014.

The Advance Notice and draft Call Letter may be viewed through: [http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/](http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/) and selecting “Announcements and Documents.” Comments on the proposed Advance Notice and draft Call Letter are invited from the industry and the public and must be submitted by March 7, 2014.

The final 2015 Rate Announcement and Call Letter including the final Medicare Advantage and FFS growth percentage and final benchmarks will be published on Monday, April 7, 2014.
MAC Update-MAC JN

On February 11, 2014, CMS made a contract award for the Jurisdiction N A/B MAC to First Coast Service Options, Inc. (First Coast).

The Jurisdiction N A/B MAC will administer Medicare Part A and Part B claims for covered services in the State of Florida as well as Puerto Rico and the U.S. Virgin Islands.

In addition to processing Part A and Part B claims, First Coast will perform other critical Medicare operational functions, including enrolling, educating, and auditing Medicare providers. First Coast holds the expiring A/B MAC contract for this same geographical area (previously Jurisdiction 9).

CMS issued the solicitation for the new Jurisdiction N A/B MAC contract in December 2012. Inclusive of all options, the awarded contract has an estimated value of $313.3 million.

On February 25, 2014, CMS was notified that a protest was filed against the Jurisdiction N A/B MAC contract award that was made to First Coast Service Options, Inc. (FCSO), on February 11, 2014.

In keeping with federal procurement law, CMS issued a stop work order for the Jurisdiction N contract, to allow the Government Accountability Office to review the procurement record. This review is projected to take up to 100 days, and resolution is expected by early June 2014. While the protest is in progress, Medicare providers in Florida, Puerto Rico and the US Virgin Islands, will continue to file their Medicare claims with the incumbent A/B MAC for J9 (FCSO).

Click here for more information about the Jurisdiction N contract award.

Diagnosis Codes to be Included in Medicare Beneficiary Database (MBD) file; Modifying the Daily Common Working File (CWF)

On February 5, CMS issued a change request that instructs the CWF to send up to 25 iterations of diagnosis codes associated with MSP no-fault, liability, and workers’ compensation records for inclusion on the HETS 271 response transaction.

Although most MSP information from the MSP record is currently included on the HETS 271 response transaction, International Classification of Diseases (ICD), Clinical Modification (CM), diagnosis codes are not included.

The Centers for Medicare & Medicaid Services (CMS) believes it would be beneficial for CWF to include ICD-CM diagnosis codes, as derived from MSP no-fault, liability, and workers’ compensation MSP auxiliary records, on the interface file that it sends to MBD.

Through a separate Medicare Advantage Prescription Drug CR, CMS will ensure that the MBD table information that is exchanged with HETS will be modified to include ICD diagnosis codes to be implemented October 6, 2014.

Thereafter, the diagnosis codes will be included in the HETS 271 response transaction that CMS makes available to providers, physicians, and suppliers. Since the HETS 271 response transaction can only accommodate up to 8 diagnosis codes, CR8456 instructs CWF to send up to 25 iterations of diagnosis codes associated with MSP no-fault, liability, and workers’ compensation records for inclusion on the HETS 271 response transaction.

The HETS 270/271 process is used by providers, physicians, and other suppliers to receive individual beneficiary eligibility information under the Medicare program, including information found on the CWF MSP auxiliary file.

Click here to view Transmittal R2336OTN.

Click here to view the Medlearn Matters® Article.
since they often submit multiple claims for a single incident of illness - for example, submitting claims for several episodes for home health services or several months for hospice care.

If the contractor determines one claim does not meet Medicare payment criteria, any related claim could also be denied - such as when an episode is denied because it fails to meet the F2F encounter criteria. Claims for subsequent episodes could also be automatically denied.

Click here to read the entire CMS Transmittal.

The Centers for Medicare and Medicaid Services (CMS) has issued Change Request (CR) 8425 entitled Removing Prohibition, which will allow contractors to make a determination or take action on claims not under review but related to claims submitted for review.

The MAC, RAC and ZPIC contractors now have the discretion to automatically deny claims submitted that are related to other claims where non-coverage or non-payment decisions have been determined through medical record review.

In the CR, CMS provides the following examples and notes that claims with other scenarios may be considered “related” as well.

- An inpatient claim and associated documentation is reviewed and determined to be not reasonable and necessary and therefore the physician claim can be determined to be not reasonable and necessary.
- A diagnostic test claim and associated documentation is reviewed and determined to be not reasonable and necessary and therefore the professional component can be determined to be not reasonable and necessary.

This policy change could have significant implications for home health and hospice providers.

Manual CorrectionRegarding Advance Beneficiary Notice of Noncoverage

Change request (CR) 8597 removes incorrect language in the Medicare Claims Processing Manual issued in CR 8404 dated September 6, 2013. It also clarifies the manual instructions regarding home health agency issuance of the advance beneficiary notice of noncoverage (ABN) to dual-eligible beneficiaries.

Click here for the MLN Matters® article MM8597.
Are you currently receiving the following error messages on your Remittance Advices (RAs)?

Effective January 6, 2014, claims missing necessary referring/ordering physician information will be denied:

- N264 – Missing/incomplete/invalid ordering provider name
- N265 – Missing/incomplete/invalid ordering provider primary identifier

CMS instructed contractors to turn on Phase 2 denial edits on January 6, 2014. These edits check the following claims for a valid individual National Provider Identifier (NPI) and deny the claim when this information is invalid:

- Claims from clinical laboratories for ordered tests;
- Claims from imaging centers for ordered imaging procedures;
- Claims from suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) for ordered DMEPOS; and
- Claims from Part A Home Health Agencies (HHAs).


Omnicare Inc., an Ohio-based long-term care pharmacy, has agreed to pay the government $4.19 million to settle allegations that it engaged in a kickback scheme in violation of the False Claims Act, the Justice Department announced today. Omnicare provides pharmaceuticals and services to long-term care facilities and residents and other senior populations.

The settlement resolves allegations that Omnicare solicited and received kickbacks from the drug manufacturer Amgen Inc. in return for implementing “therapeutic interchange” programs that were designed to switch Medicaid beneficiaries from a competitor drug to Amgen’s product Aranesp. The government alleged that the kickbacks took the form of performance-based rebates that were tied to market-share or volume thresholds, as well as grants, speaker fees, consulting services, data fees, dinners and travel.

“Kickbacks are designed to influence decisions by health care providers, such as which drugs to prescribe,” said Assistant Attorney General for the Justice Department’s Civil Division Stuart F. Delery. “Americans who rely on federal health care programs, particularly vulnerable patients in skilled nursing facilities, are entitled to feel confident that decisions about their medical care are not tainted by improper financial arrangements.”

“The District of South Carolina has devoted significant resources over the last three years to pursuing claims under the False Claims Act, and this settlement is the latest example of this office’s successful efforts,” said U.S. Attorney for the District of South Carolina William Nettles. “I am very proud of the work this office has done in this area.”

This civil settlement resolves a lawsuit filed under the qui tam, or whistleblower, provision of the False Claims Act, which allows private citizens...
with knowledge of false claims to bring civil actions on behalf of the government and to share in any recovery. The relator’s share in this case is $397,925.

“Kickbacks corrode our federal health care programs,” said Derrick L. Jackson, Special Agent in Charge of the Office of Inspector General, U.S. Department of Health and Human Services in the region covering South Carolina. “OIG is committed to unveiling these illegal reciprocal relationships, and companies making or receiving such payments can expect serious consequences.”

The settlement with Omnicare Inc. was the result of a coordinated effort among the Civil Division, the U.S. Attorney’s Office for the District of South Carolina and the U.S. Department of Health and Human Services Office of Inspector General. This settlement illustrates the government’s emphasis on combating health care fraud and marks another achievement for the Health Care Fraud Prevention and Enforcement Action Team (HEAT) initiative, which was announced in May 2009 by Attorney General Eric Holder and Secretary of Health and Human Services Kathleen Sebelius.

The partnership between the two departments has focused efforts to reduce and prevent Medicare and Medicaid financial fraud through enhanced cooperation. One of the most powerful tools in this effort is the False Claims Act. Since January 2009, the Justice Department has recovered a total of more than $19 billion through False Claims Act cases, with more than $13.4 billion of that amount recovered in cases involving fraud against federal health care programs.

The claims settled by this agreement are allegations only; there has been no determination of liability.

The False Claims Act lawsuit was filed in the U.S. District Court for the District of South Carolina and is captioned United States ex rel. Kurnik v. Amgen Inc., et al.

2014 Release of ICD-10-CM Now Available

The National Center for Health Statistics (NCHS), the Federal agency responsible for use of the International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) in the United States, has developed a clinical modification of the classification for morbidity purposes. The ICD-10 is used to code and classify mortality data from death certificates, having replaced ICD-9 for this purpose as of January 1, 1999. ICD-10-CM is planned as the replacement for ICD-9-CM, volumes 1 and 2.

The ICD-10 is copyrighted by the World Health Organization (WHO), which owns and publishes the classification. WHO has authorized the development of an adaptation of ICD-10 for use in the United States for U.S. government purposes. As agreed, all modifications to the ICD-10 must conform to WHO conventions for the ICD.

Although this release of ICD-10-CM is now available for public viewing, the codes in ICD-10-CM are not currently valid for any purpose or use. The effective implementation date for ICD-10-CM (and ICD-10-PCS) is October 1, 2014. Updates to this version of ICD-10-CM are anticipated prior to its implementation.

On January 16, 2009 HHS published a final rule adopting ICD-10-CM (and ICD-10-PCS) to replace ICD-9-CM in HIPAA transactions, effective implementation date of October 1, 2013.

The implementation of ICD-10 was delayed from October 1, 2013 to October 1, 2014 by final rule CMS-0040-F issued on August 24, 2012.

Until that time the codes in ICD-10-CM are not valid for any purpose or use.

Click here to review the latest documents.
ICD-10 Education and Information From CMS

On October 1, 2014, the ICD-9 code sets used to report medical diagnoses and inpatient procedures will be replaced by ICD-10 code sets. No delay or grace period is anticipated at this time. The transition to ICD-10 is required for everyone covered by the Health Insurance Portability Accountability Act (HIPAA). Please note, the change to ICD-10 does not affect CPT coding for outpatient procedures and physician services. CMS has resources available to assist with the transition to ICD-10; please see a sampling of their library below:

ICD-10 Coding Basics MLN Connects™ Video
Are you ready to transition to ICD-10 on October 1, 2014? In this MLN Connects™ video on ICD-10 Coding Basics Sue Bowman from the American Health Information Management Association (AHIMA) provides a basic introduction to ICD-10 coding, including:
- Similarities and differences from ICD-9
- ICD-10 code structure
- Coding process and examples
  » 7th Character
  » Placeholder “x”
  » Excludes notes
Click here to view the video.

Understanding the Basics
These fact sheets will introduce you to ICD-10, explain why it’s necessary, and give you the information you’ll need to get started on your transition.
- Intro Guide to ICD-10
- ICD-10 FAQs
- The ICD-10 Transition: An Introduction
- ICD-10 Basics for Medical Practices
- Talking to Your Vendors About ICD-10: Tips for Medical Practices
- ICD-10 and CMS eHealth: What's the Connection?

ICD-10 Basics for Small and Rural Practices

CMS eHealth University
CMS eHealth University is a resource to help providers understand, implement, and successfully participate in ICD-10 and other programs, features a full curriculum of materials and information, all in one location. The education modules are organized by level, from beginner to advanced, and simplify complex information in a variety of formats, including fact sheets, guides, videos, checklists, webinar recordings, and more.

As part of eHealth University, CMS is offering resources to help you prepare for the October 1, 2014, ICD-10 compliance date. Visit the eHealth University website to find these resources.

CMS Releases “Road to 10” Online Resource for Small Practices
CMS has released “Road to 10,” an online resource built with the help of providers in small practices. This tool is intended to help small medical practices jumpstart their ICD-10 transition.

“Road to 10” includes specialty references and gives providers the capability to build ICD-10 action plans tailored for their practice needs.

Conferences, Meetings, and Webinars
CMS has partnered with PAHCOM, the Health Resources and Services Administration, the National Association of Community Health Centers, and the National Association of Rural Health Clinics to offer a series of webinars for providers on preparing for ICD-10. Recordings of these webinars are available on the CMS YouTube channel:
- Practice Managers Guide to ICD-10
- ICD-10, The Provider Perspective
- CMS Presents - ICD-10 training to assist small physician practice managers - Overview
- Clinical documentation: Supporting good patient care and proper coding in an ICD-10 environment
- Impact of ICD-10 on Safety Net Providers
- Navigating ICD-10, the Provider Perspective
- ICD-10 Rural or Urban: It Impacts All Providers
National Colorectal Cancer Awareness Month

A statement by Assistant Secretary for Health Dr. Howard K. Koh

March is Colorectal Cancer Awareness Month. Colorectal cancer is the nation’s second leading cancer killer of men and women in the United States and a cause of considerable suffering among the 137,000 adults diagnosed with colorectal cancer each year. In 2010, over 52,000 Americans died from this cancer1 however, when colorectal cancer is detected early, illness and death can be prevented. The U.S. Department of Health and Human Services is committed to boosting public awareness about the importance of screening and treatment for colorectal cancer.

Colorectal cancer poses the greatest risk to adults over the age of 50, and the United States Preventive Services Task Force (USPSTF) recommends that all individuals aged 50-75 be screened for colorectal cancer as part of routine preventive health care. Currently, about 1 in 3 adults between the ages of 50 and 75 are not receiving recommended screening. These are most likely to be Hispanics, those aged 50-64, men, American Indian or Alaska natives, those who don’t live in a city, and people with lower education and income.

With the implementation of the Affordable Care Act, a major barrier to regular screening—cost of access to preventive care—has been removed. For the first time in our nation’s history, many Americans can receive without cost sharing high value preventive services, such as screening for colorectal cancer and other diseases that threaten health and shorten lives.

Colorectal cancer and death from this disease can be prevented thanks to effective screening tools. Many people do not realize that three tests—colonoscopy, highly sensitive stool tests (FOBT, fecal occult blood test, or FIT, fecal immunochemical test) and flexible sigmoidoscopy—are all effective at finding cancer early, and the best test is the test that gets done.

In summary, colorectal cancer screening has been proven to save lives. We are committed to eliminating colorectal cancer as a major public health problem. Increasing the nation’s screening rate to 80 percent by the year 2018 is absolutely possible, but there is much work to be done, especially in communities where those without insurance can’t regularly access the health care system. We need greater national efforts to inform and remind appropriate patients that they are due for colorectal cancer screening, and ensure that all Americans between the ages of 50 and 75 receive this important life-saving intervention.


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