

**MOA MEMBERS  
FROM SUE A. WEINGARTNER, EXECUTIVE DIRECTOR  
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**MEDICARE UPDATES**

Also look for an update in Friday's AOA First Look about the problems with physician listings in the Physician Compare directory at [www.Medicare.gov](http://www.Medicare.gov).

**CMS Staff to Conduct Follow-up Calls for CERT Program**

The Centers for Medicare and Medicaid Services (CMS) will be conducting follow-up calls to providers for the Comprehensive Error Rate Testing (CERT) program. CMS staff may contact doctors to obtain all necessary medical record documentation for claims reviewed under the CERT program. Although doctors might have already received letters and telephone calls from the CERT contractor, these additional efforts by CMS to obtain adequate documentation could change a claim's status from "improper payment" to "proper payment." This will allow CMS to calculate a more accurate Medicare FFS error rate, while also reducing the amount of improper payments.

The CERT program and other Medicare reviews to determine improper payments rates will treat any undocumented claim as erroneous. It is in the interest of the profession that doctors respond to record requests from CMS so that claims will not be incorrectly labeled "improper" merely because the doctor did not respond. In other words, if optometrists do not respond to these requests by CMS, then the claims will be labeled improper and the optometry "error" rate will suffer.

As we've reported in AOA News:

Effective Friday, March 25, newly-enrolling and revalidating providers and suppliers will be placed in one of three screening categories – limited, moderate, or high. These categories represent the level of risk for fraud, waste, and abuse to the Medicare program for the particular category of provider/supplier, and determine the degree of screening to be performed by the Medicare Administrative Contractor (MAC) processing the enrollment application.

Providers/suppliers in the "limited" screening category will include:

- o Physicians
- o Medical groups or clinics
- o Ambulatory surgical centers

Providers in the "moderate" screening category will include:

- o Revalidating DMEPOS suppliers

Providers in the "high" screening category will include:

- o Newly-enrolling DMEPOS suppliers

The enrollment screening procedures will vary depending upon the categories described above. Screening procedures for the "limited" screening category will largely be the same as those currently in use; screening procedures for the "moderate" screening category will include all current screening measures, as well as a site visit; screening procedures for the "high" screening category will include all current screening measures, as well as a site visit and, at a future date a fingerprint-based criminal background check.

Also effective Friday, March 25, Medicare Administrative Contractors (MACs) and carriers will begin collecting application fees with certain provider/supplier enrollment applications (both paper and online applications) as described below. The application fee is currently \$505 for CY2011. All application fees must be submitted via paper check, until CMS specifies a mechanism for submitting electronic funds at a future date. CMS and its contractors will not be able to process any applications without the proper application fee having been paid and credited to the United States Treasury or an approved hardship exception. If the fee is not submitted, the application will be rejected or billing privileges revoked (as applicable) unless a hardship exception request is subsequently granted. If CMS has denied a hardship exception request, then an institutional provider has thirty days to submit the application fee to the CMS contractor.

Note that these application fees do not apply to physicians and physician organizations enrolling to provide professional services. The fees do apply to all DMEPOS suppliers, including physicians enrolling to supply post-cataract eyeglasses, because CMS has labeled all DMEPOS suppliers as "institutional providers." Thus, an application fee would not be required for doctors submitting CMS-855I, CMS-855B, or CMS-855R forms (on paper or electronically) but will be required for doctors submitting CMS-855S forms. Although the CMS-855S form itself and prior AOA guidance suggest not submitting a re-enrollment application until requested by the National Supplier Clearinghouse, the AOA believes optometrists can re-enroll as DMEPOS suppliers prior to the March 25 deadline to try to avoid imposition of fees.

#### The Sixth Annual Administration of the CMS 2011 Medicare Contractor Provider Satisfaction Survey (MCPSS)

CMS encourages selected providers to take the survey. The survey offers Medicare fee for service providers and suppliers an opportunity to give CMS feedback on their interactions with Medicare contractors related to seven business functions: Provider Inquiries, Provider Outreach & Education, Claims Processing, Appeals, Provider Enrollment, Medical Review, and Provider Audit & Reimbursement. As a result of past survey responses, Medicare FFS Contractors have implemented changes to improve their communication processes and education & training of their staff. This is one opportunity to let CMS know about problems with your carrier/contractor.

The 2011 survey was sent to a random sample of approximately 30,000 Medicare FFS providers and suppliers. Those who were selected to participate in the 2011 MCPSS were notified in December 2010. CMS understands that providers and suppliers themselves may not be able to respond directly to the survey, but may have a staff member who can act as a proxy to respond on their behalf. The respondent can be anyone within the provider's organization that is knowledgeable of the Medicare claims process and is designated to respond to the MCPSS including but not limited to the Business Office manager, Revenue Cycle Director or Medicare Biller. If you have received a survey letter, then you are selected to participate. Please take the time to complete this important survey. CMS encourages providers and suppliers to complete the survey on the Internet via a secure website. Other modes of participation are available by mail, fax, or telephone. It will take no more than 20 minutes.

#### Reprocessing Claims Affected by the Affordable Care Act and 2010 Medicare Physician Fee Schedule Changes

Various provisions of the Affordable Care Act were effective April 1, 2010, or earlier and, therefore, were implemented some time after their effective date. In addition, corrections to the 2010 Medicare Physician Fee Schedule were implemented at the same time as the Affordable Care Act revisions to the MPFS, with an effective date retroactive to January 1, 2010. Among many minor and technical changes in the relative value units of codes, one adjustment that might make a difference for optometrists will be an increase in payments in areas of relatively low practice expense costs. Areas that have lower Medicare payments based on a lower cost of doing business may see payments adjusted higher.

Due to the retroactive effective dates of these provisions and the MPFS corrections, a large volume of Medicare fee-for-service claims will be reprocessed. CMS began to reprocess these claims in February, and expected this reprocessing effort will take some time and will vary depending upon the claim-type, the volume, and each individual Medicare claims administration contractor.

In the majority of cases, physicians will not have to request adjustments because your Medicare claims administration contractor will automatically reprocess your claims. However, any claim that contains services with submitted charges lower than the revised 2010 fee schedule amount (MPFS and ambulance fee schedule) cannot be automatically reprocessed at the higher rates. In such cases, you will need to request a manual reopening/adjustment from your Medicare contractor. While there is normally a one-year time limit for physicians and other providers and suppliers to request the reopening of claims, we believe that these circumstances fall under the "good cause" criteria described in the Claims Processing Manual, Publication 100-04, Chapter 34, Section 10.11 (<http://www.cms.gov/manuals/downloads/clm104c34.pdf>). CMS is, therefore, extending the time period to request adjustment of these claims, as necessary.

Medicare claims administration contractors will follow the normal process for handling any applicable underpayments or overpayments that occur while reprocessing your claims. Underpayments will be included in your next regularly scheduled remittance after the adjustment. When a claim adjustment for a non-institutional provider (e.g., physician, other practitioner, supplier, etc.) results in an overpayment, the Medicare contractor will send a request for repayment. If this overpayment is less than \$10, your contractor will not request repayment until the total amount owed accrues to at least \$10. See the Financial Management Manual, Publication 100-06, Chapter 4, Section 70.16 or Section 90.2 (<http://www.cms.gov/manuals/downloads/fin106c04.pdf>) for more information.

The CMS wants to remind physicians, practitioners, suppliers, and other providers, impacted by the retroactive increases in payment rates for claims affected by the Affordable Care Act and 2010 MPFS changes, of the Office of Inspector General policy related to waiving beneficiary cost-sharing amounts attributable to retroactive increases in payment rates resulting from the operation of new Federal statutes or regulations. The policy may be found at the following link:  
[http://oig.hhs.gov/fraud/docs/alertsandbulletins/Retroactive\\_Beneficiary\\_Cost-Sharing\\_Liability.pdf](http://oig.hhs.gov/fraud/docs/alertsandbulletins/Retroactive_Beneficiary_Cost-Sharing_Liability.pdf)

Although the following webinar addresses LCDs only for National Government Services (the contractor in Connecticut and New York, and the carrier in Kentucky and Ohio), CAC reps in other states may have similar policies and might be interested in the NGS approach.

Medicare Part B LCDs for Ocular Photography and Ophthalmic Scans Webinar

New edits are in development for both of the above listed policies. Providers are encouraged to review the current LCDs for Ocular Photography and Ophthalmic A & B Scans to verify correct coding and coverage criteria for these services to avoid unnecessary denials. LCDs can be accessed from the Medical Policy Center on the NGSMedicare.com Web site.

Date: Thursday, March 17, 2011  
Time: 10:00-11:15 a.m. ET

Registration for this session is now open. Visit [www.NGSMedicare.com](http://www.NGSMedicare.com) Select the 'Go to Home Page' link for your business type and location. Select the Training Events Calendar option under the Education and Training category (on the left hand side). Your registration is complete only when you receive a confirmation at your e-mail address immediately after submitting your registration.