This issue of the e-News will be made available in PDF format no later than 24 hours after its release, and can be found in the archive with other past issues.

CMS Medicare FFS Provider e-News

CMS Information for the Medicare Fee-For-Service Provider Community

CMS asks that you share the following important information with all of your association members and state and local chapters. Thank you!

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The e-News for Tue Feb 21 includes…

National Provider Call: Hospital Value-Based Purchasing Program – Register Now [↑]
Tue Feb 28; 1:30-3pm ET

CMS will be creating hospital-specific performance reports that simulate the FY2013 Hospital Value-Based Purchasing Program for each hospital to review; the simulated reports will employ hospital data from prior years to construct each hospital's baseline period and performance period scores. To prepare providers for interpreting the simulated report, this National Provider Call will discuss a sample report that shows what hospitals can expect when they receive their own reports.

Target Audience: Hospitals, Quality Improvement Organizations, medical coders, physician office staff, provider billing staff, health records staff, vendors, and all Medicare Fee-For-Service providers

Agenda:

- Opening Remarks
- Program Announcements
- Overview of the Hospital Value-Based Purchasing Program
- Presentation and Walkthrough of the Hospital-Specific Report
- Question & Answer Session

Registration Information: In order to receive the call-in information, you must register for the call. *Registration will close at 12pm on the day of the call* or when available space has been filled; no exceptions will be made, so please register early. For more details, including instructions on registering for the call, please visit http://www.eventsvc.com/blhtechnologies.

Presentation: The presentation for this call will be posted at least one day in advance at http://www.CMS.gov/Hospital-Value-Based-Purchasing, in the "Downloads" section of the page.

Special National Provider Call Series: Physician Value-Based Payment Modifier Program: Experience from Private Sector Physician Pay-for-Performance Programs – Register Now [↑]
Wed Feb 29; 2:30-4pm ET

Section 3007 of the *Affordable Care Act* requires CMS to apply a Value Modifier, which compares the quality of care furnished to the cost of that care, to physician payment rates under the Medicare Physician Fee Schedule starting with specific physicians and physician groups in 2015 and expanding to all physicians by 2017.

This National Provider Call is in support of the efforts of CMS to implement the Medicare Physician Feedback and Physician Value-Based Payment Modifier Programs. This call is one of a series of calls CMS will hold to engage the public in dialogue about physician level value-based purchasing and obtain stakeholder input on how best to implement the physician value modifier.

This National Provider Call will include presentations from a panel of three private sector experts who have had experiences in implementing physician-level pay-for-performance programs. The second call in the series, scheduled for Wed Mar 14, will feature three additional private sector

experts.

Target Audience: Medicare Fee-for-Service physicians, specialty medical societies, and other interested parties.

Agenda:

- Opening Comments and Background – Sheila Roman, MD, MPH; CMS
  - Background on the Value-Based Payment Modifier
  - Introduction of Speakers
- Using Physician Pay-for-Performance to Improve Care – R. Adams Dudley, MD, MBA; University of California, San Francisco
- Quality Measurement: Physician & Practice Performance – Ted von Glahn, MPH; Pacific Business Group on Health
- Physician Pay-for-Performance and Other Incentive Programs: Lessons From The Field – Francois de Brantes, MS, MBA; Health Care Incentives Improvement Institute
- CMS Questions and Comment
- General Question and Answer Session
- Closing – Sheila Roman, MD, MPH; CMS

Registration Information: In order to receive the call-in information, you must register for the call. *Registration will close at 12pm on the day of the call* or when available space has been filled; no exceptions will be made, so please register early. For more details, including instructions on registering for the call, please visit http://www.eventsvc.com/blhtechnologies.

National Provider Call: Medicare Shared Savings Program and Advance Payment Model Application Process – Registration Now Open [↑]
Thu Mar 1; 1:30-3pm ET

On Thu Oct 20, 2011, CMS issued a final rule under the *Affordable Care Act* to establish the Medicare Shared Savings Program, along with a notice for the Advance Payment Model that will provide additional support to physician-led and rural Accountable Care Organizations (ACOs) participating in the Medicare Shared Savings Program. These two initiatives will help providers participate in ACOs to improve quality of care for Medicare patients.

On Thu Mar 1, CMS is hosting a National Provider Call, during which subject matter experts will provide an overview and updates to the Medicare Shared Savings Program application and Advance Payment Model application processes. A question and answer session will follow the presentations.

The Medicare Shared Savings Program Application and Advance Payment Model webpages have important information, dates, and materials on the application process. Call participants are encouraged to review the applications and materials prior to the call.

Target Audience: Medicare Fee-For-Service (FFS) providers

Registration Information: In order to receive the call-in information, you must register for the call. *Registration will close at 12pm on the day of the call* or when available space has been filled; no exceptions will be made, so please register early. For more details, including instructions on registering for the call, please visit http://www.eventsvc.com/blhtechnologies.

Visit the CMS Booth and Attend CMS Presentations at HIMSS 2012 [↑]
Tue Feb 21 through Fri Feb 24
Booth #14624

CMS is participating in this year's Healthcare Information and Management Systems Society (HIMSS) Annual Conference & Exhibition in Las Vegas, Nevada from Tue Feb 21 to Fri Feb 24. Representatives from the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs will be at Booth #14624 during exhibit hall hours to discuss all of your questions about the programs. There will also be computers available at the booth so attendees can work with a CMS representative to register for the programs on site.

Join the Twitter Conversation! CMS will be tweeting from HIMSS12 about our EHR presentations and other HIMSS12 news. Make sure to join the discussion by following the @CMSgov Twitter handle and looking for tweets with the hashtags #CMSevent and #HIMSS12.

Want more information about the EHR Incentive Programs? Make sure to visit the EHR Incentive Programs website at http://www.CMS.gov/EHRIncentivePrograms for the latest news and updates on the EHR Incentive Programs.

Reminder: Vendor Call on the Inpatient Rehabilitation Facility Patient Assessment Instrument [↑]
Thu Feb 23; 1-2pm ET

An informational Vendor Call on the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) is scheduled for Thu Feb 23, 1-2pm. *Topics covered* during this call will include:

- Data specification updates for October 2012 release
- New process to submit IRF-PAI records to the Assessment Submission Processing (ASAP) System
- Discussion of submitted questions
- Vendor registration on QTSO website
- Email address for IRF Tech Issues mailbox

To facilitate this call, we are requesting that vendors review the draft technical specifications prior to this call and submit any comments or questions related to the technical aspects of the IRF-PAI to IRFTechIssues@cms.hhs.gov by 6pm on Thu Feb 16.

Technical specifications can be found in the "Downloads" section of the webpage at http://www.CMS.gov/InpatientRehabFacPPS/06_Software.asp. Additional information about the Thu Feb 23 Vendor Call, specifically, can be found in the February Vendor Call Memo document found in the "Downloads" section of the page at http://www.CMS.gov/InpatientRehabFacPPS/11_TechInfo.asp.

Call-in information: At the time of the call, dial 866-712-2205 and use conference code 4260581739.

New Short-Term PEPPER to be Released in February [↑]

A new release of the Short-Term Acute Care Program for Evaluating Payment Patterns Electronic Report (ST PEPPER), with statistics through the fourth quarter of FY2011, will soon be available for short-term acute care hospitals (STACHs) nationwide. This release of PEPPER includes a new target area, "Spinal Fusions."

The PEPPER provides hospital-specific data statistics for Medicare discharges in 30 areas that may be at risk for improper Medicare payments. Hospitals can use PEPPER to support internal auditing and monitoring activities. The PEPPER is a free report comparing a hospital's Medicare billing practices with other hospitals in the state, Medicare Administrative Contractor (MAC) or Fiscal Intermediary (FI) jurisdiction, and nation. CMS has contracted with TMF Health Quality Institute to develop and distribute the reports.

The PEPPER will be distributed electronically to STACHs through a My QualityNet secure file exchange to hospital QualityNet Administrators and user accounts with the PEPPER recipient role by Fri Feb 24. Users can access the ST PEPPER User's Guide for more information.

Note: For this PEPPER release, target area "PTCA with Stent" statistics are suppressed due to problems identified in the national Medicare claims data warehouse.

CMS encourages hospitals to provide feedback on PEPPER so that the reports can be continually improved.

HHS Secretary Sebelius Announces Major Progress in Doctors and Hospital Use of Health IT [↑]

On Fri Feb 17, US Department of Health and Human Services' Secretary Kathleen Sebelius announced the number of hospitals using health information technology (IT) has more than doubled in the last two years. She also announced new data showing nearly 2000 hospitals and more than 41,000 doctors have received $3.1 billion in incentive payments for ensuring meaningful use of health IT, particularly certified Electronic Health Records (EHR).

The announcement details information from a new survey conducted by the American Hospital Association and reported by the HHS Office of the National Coordinator for Health IT, which found that the percentage of US hospitals that had adopted EHRs has more than doubled from 16 to 35 percent between 2009 and 2011. Additionally, 85 percent of hospitals now report that by 2015 they intend to take advantage of the incentive payments made available through the Medicare and Medicaid EHR Incentive Programs.

The announcement also highlights new data from CMS, detailing $3.12 billion in incentive payments the agency has made to physicians, hospitals, and other healthcare providers who have started to meaningfully use EHRs to improve the quality of patient care. In January alone, CMS provided $519 million to eligible providers. EHR incentive payments can total as much as $44,000 under the Medicare EHR Incentive Program and $63,750 under the Medicaid EHR Incentive Program.

To meet the demand for workers with health IT experience and training, the Obama Administration has also launched four workforce training programs. Training is provided through 82 community colleges and nine universities nationwide. As of January 2012, more than 9000 community college students have been trained for health IT careers and another 8706 students have enrolled. As of February 2012, participating universities have enrolled more than 1200 students and graduated nearly 600 post-graduate and masters-level health IT professionals, with more than 1700 expected to graduate by the summer of 2013.

For more information on how health IT can lead to safer, better, and more efficient care, visit http://www.HealthIT.gov. For more information about the Medicare and Medicaid EHR Incentive Programs, visit http://www.CMS.gov/EHRIncentivePrograms. For more information about the HHS Recovery Act health IT programs, visit http://www.HHS.gov/recovery/announcements/by_topic.html#hit.

The full text of this excerpted HHS press release (issued Fri Feb 17) can be found at http://www.HHS.gov/news/press/2012pres/02/20120217a.html.

It's Not Too Late to Give and Get the Flu Vaccine [↑]

Take advantage of each office visit and protect your patients against the seasonal flu. Medicare will continue to pay for the seasonal flu vaccine and its administration for all Medicare beneficiaries through the entire flu season. The Centers for Disease Control and Prevention also recommends that patients, healthcare workers, and caregivers be vaccinated against the seasonal flu. Protect your patients. Protect your family. Protect yourself. Get the Flu Vaccine – Not the Flu.

Remember – The flu vaccine plus its administration are covered Part B benefits. CMS has posted the 2011-2012 seasonal flu vaccine payment limits at http://www.CMS.gov/McrPartBDrugAvgSalesPrice/10_VaccinesPricing.asp. Note that the flu vaccine is NOT a Part D-covered drug.

For more information on coverage and billing of the flu vaccine and its administration, as well as related educational provider resources, visit http://www.CMS.gov/MLNProducts/35_PreventiveServices.asp and http://www.CMS.gov/immunizations.

- Additional material related to Preventive Health Services in today's e-News… [next]

Reprocessing Advanced Diagnostic Imaging Claims Denied in Error [↑]

CMS has received reports that providers are receiving denials for advanced diagnostic imaging (ADI) services they are accredited to perform. We have taken action to correct the situation. CMS has instructed all contractors to review each ADI claim denial, and reprocess those claims that were deemed to be incorrectly denied in a timely manner. Providers do not need to take any action in this situation.

Resolution of the 5010 Electronic Claims Submission 496 Edit [↑]

With the implementation of Accredited Standards Committee (ASC) X12 Version 5010, the Medicare Administrative Contractors (MACs) have received a large increase in calls from billers regarding the 496 edit, more commonly referred to as "the linkage problem." In some cases, the problem may be the result of a provider not being properly linked to a clearinghouse/vendor submitter in Medicare's system; however, the problem may also be the result of billing errors. The tips that follow will assist you in determining the reason for receipt of a 496 edit and help you understand the resolution of the edit.

Since the 4010 versus 5010 electronic claim formats are not the same, you cannot assume a successful provider and clearinghouse/vendor submitter linkage in 4010 means you should be successfully linked in 5010. Some linkages were initially made nearly a decade ago. We have found that several

large clearinghouses that have been repeatedly bought, sold, and combined are now using new submitter numbers.

Prior to the implementation of the Common Edits and Enhancement Module (CEM) software, Medicare contractors maintained their own electronic data interchange (EDI) edits. Now that the 5010 format has a definitive CEM edit to ensure that all linkages are valid, invalid submitter IDs are being stopped for bad linkage.

In addition to the provider and clearinghouse/vendor linkage issue, the 496 edit can also occur because of the following National Provider Identifier (NPI) billing issues:

- Using a Rendering Provider's NPI instead of the Billing Provider NPI (Rendering Provider is not associated with the clearinghouse/vendor submitter)
- Billing Part B services for a provider associated with a Group under his/her Individual NPI when it should be billed under the Group NPI

Resolution of the 496 edit requires evaluation of the Health Care Claims Acknowledgement message (277CA) and all edits incurred in addition to it. While generally a 496 edit may indicate a simple linkage issue, additional edits might focus on the submission of an inappropriate or incorrect NPI as a result of improper billing.

The 277CA, if delivered back to the provider from the clearinghouse/vendor, will have the following message components in the Status Segment (STC) related to a 496 edit:

- First part: Claim Status Category Code = "A8" – Acknowledgement / Rejected for relational field error
- Second part: Claim Status Code = "496" – Submitter not approved for electronic claim submissions on behalf of this entity
- Third part: Entity Identifier Code = "85" – Billing Provider

This message, "A8:496:85," utilizes the Washington Publishing Company (WPC)-maintained National Code values and relays that the claim was rejected for a relationship error between the submitter and the Billing Providers NPI. You will receive this same set of codes for a linkage problem and an improper billing problem (use of rendering versus billing provider NPI, for example, as described above).

Clearinghouse/Vendor evaluation of all edits received should be completed before asking for linkage problem resolution from your MAC.

Contact your MAC EDI support line after researching the nature of your 496 edits for assistance with the provider and clearinghouse/vendor submitter linkage and the collection of the CMS-required Provider Authorization to bill for each customer. The MAC EDI support lines are available at http://www.CMS.gov/ElectronicBillingEDITrans/03_EDISupport.asp.

From the MLN: "Tobacco-Use Cessation Counseling Services" Brochure Revised [↑]

The "Tobacco-Use Cessation Counseling Services" brochure (ICN 006767) has been revised and is now available for download. This brochure is designed to provide education on tobacco-use cessation counseling services, and includes coverage information for both symptomatic and asymptomatic beneficiaries as well as information on tobacco-use cessation counseling.

- Additional material related to Preventive Health Services in today's e-News… [previous]

From the MLN: MLN Matters Articles Search Tips [↑]

Looking for the latest new and revised MLN Matters® articles? The Medicare Learning Network® offers several ways to search and quickly find articles of interest to you:

- *MLN Matters Search Engine* – An advanced search feature that allows you to search MLN Matters articles from 2004 to the current year. For more information and introductions on how to use the search engine, visit the MLN Matters Search Tips webpage at http://www.CMS.gov/MLNMattersArticles/02_Search.asp.
- *MLN Matters Index* – A list of common keywords and phrases contained within MLN Matters articles. Each index is organized by year with the ability to search by specific keywords and topics. Most indices link directly to the related article(s). For a list of available indices, visit http://www.CMS.gov/MLNMattersArticles/01_Overview.asp and scroll to the 'Downloads' section of the page.
- *MLN Matters Dynamic Lists* – An archive of previous and current articles organized by year with the ability to search by keyword, transmittal number, subject, article number, and release date. To view and search articles, select the desired year from the left column on the MLN Matters Article webpage at http://www.CMS.gov/MLNMattersArticles.
- *MLN Matters Electronic Mailing List* – A free notification of new and revised MLN Matters articles as they are released. For more information, including how to subscribe to the service, visit http://www.CMS.gov/MLNMattersArticles/downloads/What_Is_MLNMatters.pdf. You can also view and search an archive of previous messages at http://list.nih.gov/cgi-bin/wa.exe?A0=MLNMATTERS-L.

More Helpful Links…

Check out CMS on

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The Medicare Learning Network

www.CMS.gov/MLNGenInfo

Archive of Provider e-News Messages

www.CMS.gov/FFSProvPartProg/EmailArchive