



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 Wed Dec 7 includes...

- [Payment Standardization and Risk Adjustment for the Medicare Physician Feedback and Value Modifier Programs National Provider Call, Wed Dec 21 – Register Now](#)
- [Medicare Claims Processing Issue Related to Part B Services for Skilled Nursing Facility \(SNF\) Patients](#)
- [Proposed Meaningful Use Timeline Changes Encourage Adoption of EHRs](#)
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National Provider Call: Payment Standardization and Risk Adjustment for the Medicare Physician Feedback and Value Modifier Programs – Register Now



Wed Dec 21; 1-3 pm ET

Under the Physician Feedback Program, CMS provides confidential feedback reports to physicians and physician group practices about the resource use and quality of care they provide to their Medicare patients. 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 MPFS starting with specific physicians and physician groups in 2015 and expanding to all physicians by 2017.

During this National Provider Call, CMS subject matter experts will discuss how and why per capita cost measures are adjusted under these programs. This call provides an opportunity to: (1) have a public dialogue about our methodology, (2) obtain stakeholder input, and (3) discuss ways to further improve these cost

adjustment processes.

Target Audience: Physicians, specialty medical society representatives and other interested parties

Agenda:

- Opening Comments and Background
 - Brief overview of the QRUR and Value Modifier Programs
 - Timelines
- Presentation: Standardizing cost data to make fair comparisons
 - General background, purpose, and use
 - Basics of how it applies to Physician Feedback Program/Value Modifier
- Comments and questions from participants
- Presentations: Adjusting cost data for beneficiary health status
 - Background, development, and purpose of the CMS-HCC risk adjustment methodology
 - Application of the risk adjustment to the Physician Feedback program/Value modifier
- Comments and questions from participants
- Closing and next steps

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: A slide presentation will be available prior to the call in the "Downloads" section of the Medicare FFS Physician Feedback Program/Value-Based Payment Modifier CMS Teleconferences and Events webpage at <http://www.CMS.gov/PhysicianFeedbackProgram/PFP/list.asp>. In addition, there is a fact sheet about these programs at: [Value-Based Payment Modifier and the Physician Feedback Program](#).

Medicare Claims Processing Issue Related to Part B Services for Skilled Nursing Facility (SNF) Patients [\[↑\]](#)

A claims processing issue was identified that has affected payment of some Part B claims for SNF patients for dates of service from Sat Oct 1 through Mon Nov 21.

Some Part B claims for SNF patients submitted to Medicare during Oct and Nov 2011 have been erroneously denied by Medicare's claims processing system. In other instances, the claims processing system has paid and then identified a Medicare "overpayment" on these claims in error.

If you submitted a Part B claim for a SNF patient, you may receive a system-generated Demand Letter from Medicare, or you may see a notification for a payment offset on your Remittance Advice.

Your Medicare Claims Administration Contractor is working with CMS to remedy this problem in the claims processing system so that appropriate payment adjustments can be made.

We are asking providers not to appeal these claims at this time. Because these are erroneous adjustments in Medicare's claims processing system, submitting

an appeal may slow down the correct adjustment of your claim.

Your Medicare Claims Administration Contractor will notify you when the adjustment process for these claims is initiated and keep you updated so that you can anticipate when your claims (along with any notifications for payment recovery) will be adjusted. We apologize for any inconvenience.

Proposed Meaningful Use Timeline Changes Encourage Adoption of EHRs [\[↑\]](#)

In response to significant input from multiple stakeholders, expert testimony, and countless hours of review, analysis and deliberation, HHS [announced](#) its intention to delay the start of Stage 2 meaningful use for the Medicare and Medicaid EHR Incentive Programs for a period of one year for those first attesting to [meaningful use](#) in 2011. CMS intends to propose such a delay in the Stage 2 meaningful use Notice of Proposed Rulemaking (NPRM), which is scheduled to be published in February 2012.

Why Did We Make this Decision?

Input from the vendor community and the provider community makes clear that the current schedule for compliance with Stage 2 meaningful use objectives in 2013 poses a challenge for those who are [attesting](#) to meaningful use in 2011.

The current timetable would require EHR vendors to design, develop, and release new functionality, and for providers to upgrade, implement, and begin using the new functionality as early as October 2012.

What are the Benefits to the Proposed Delay?

We believe that a proposed delay will be beneficial for several reasons:

- We hope that this will give vendors added time to develop certified EHR technologies for Stage 2, as well as give providers additional time to implement new software and meet the new requirements of Stage 2.
- We also intend to propose maintaining the current expectation for those first attesting to meaningful use in 2012, so that all providers attesting to meaningful use in 2011 or 2012 will begin Stage 2 in 2014.
- We believe this provides an added incentive for providers to attest to meaningful use in 2011 and rewards early participants.

Under the Medicare and Medicaid EHR Incentive Programs, providers who attest early receive greater incentives. And now those providers who first attest in 2011 are eligible for three payment years for meeting the Stage 1 criteria, while those first attesting in 2012 can only have two payment years under Stage 1 criteria.

Are Medicaid Program Participants Affected?

Because Medicaid providers can receive an incentive payment for adopting, implementing, or upgrading to certified EHR technology in their first year of [Medicaid EHR Incentive Program](#) participation, Medicaid providers will still be able to attest to Stage 1 meaningful use for the next two years (first for a 90-day period, then for a 365-day period).

Therefore, most Medicaid providers do not attest to Stage 2 requirements until 2014 at the earliest.

Want more information about the EHR Incentive Programs?

Make sure to visit the [EHR Incentive Programs website](#) for the latest news and updates on the EHR Incentive Programs.

Face-to-Face Documentation Requirements for Home Health Agency (HHA) Services [\[↑\]](#)

It has come to our attention that some CMS contractors are denying payment for patients who use home health services following an acute or post-acute stay when:

- The HHA uses a single form (i.e., 485) for the plan of care and the certification with a single signature by the community physician who assumes oversight of the patient's home healthcare
- The physician who cared for the patient in the acute or post-acute setting is the certifying physician and has provided and signed attached documentation of the face-to-face encounter

In the CY 2011 HH PPS final rule and in Chapter 7, Section 30.5.1.1 of the Medicare Benefit Policy Manual (BPM), CMS allowed for the following when the patient is admitted to a home health agency following an acute or post-acute stay:

- The physician who cared for the patient during the acute or post-acute stay may certify the patient's eligibility for the Medicare home health benefit, document the encounter based on his or her experience with the patient in the acute or post-acute setting, and initiate and sign the patient's plan of care. The community physician who assumes care for the patient after admission to the HHA would then oversee and update the plan of care as needed.
- A physician who cared for the patient during the acute or post-acute stay may certify the patient's eligibility for the Medicare home health benefit, document the encounter based on his or her experience with the patient in the acute or post-acute setting, and initiate the patient's plan of care. We allow the physician who assumes responsibility for the patient's home healthcare to update the plan of care as needed, and sign the plan of care. This flexibility is allowed because often the acute or post-acute physician is hesitant to sign the home health plan of care since he or she does not follow the patient after acute discharge.

CMS does not require that a specific form be used for the certification or the plan of care. However, many providers have chosen to use the no-longer-required CMS-485 form to satisfy the plan of care and the certification. Since April, providers who use this form typically attach the face-to-face encounter documentation to the CMS-485, as an addendum. The CMS-485 contains only one physician signature line for both the plan of care and the certification of eligibility.

In the case of patients admitted to home health following an acute or post-acute stay, the BPM language allows for one physician to sign the certification and face-to-face documentation, while a different physician can sign the plan of care. If the face-to-face encounter documentation and the CMS-485 form collectively satisfy all of the certification and plan of care content requirements as defined in Chapter 7 Section 30 of the BPM, Medicare contractors shall accept a CMS-485 form signed by the community physician who assumes oversight of the patient's home healthcare with an addendum containing the face-to-face encounter documentation requirements signed by a physician who cared for the patient in an acute or post-acute setting, to satisfy the certification, face-to-face encounter, and plan of care requirements. In this scenario, the certifying physician is the acute or post-acute physician, has initiated content on the CMS-485, and has completed and signed the face-to-face encounter documentation. The physician who signs the CMS-485 assumes care for the patient's home healthcare.

Additionally, it has come to our attention that some contractors are denying claims for failure of the acute or post-acute physician to identify the community physician who will assume care for the patient. CMS has not mandated the acute or post-acute physician to follow a specific documentation protocol to hand-off a patient to the community physician.

For claims that have been previously denied for not having met face-to-face requirements in the scenarios described above, upon receiving a request from the home health agency for reopening of the claim, CMS contractors have been instructed to reopen and determine if face-to-face requirements have been met,

due to their meeting the criteria described in the instruction described above. However, a determination that face-to-face requirements have been met would not result in an automatic pay of the claim. Contractors must subsequently perform a complete and full review to determine if payment should be made.

In summary, assuming all content requirements of the certification and the face-to-face documentation are otherwise met, in the case of patients admitted to home health following an acute or post-acute stay, Medicare contractors have been instructed to accept a CMS-485 form signed by the community physician who assumes oversight of the patient's home healthcare with an addendum containing the face-to-face encounter documentation requirements signed by a physician who cared for the patient in an acute or post-acute setting, to satisfy the requirement of the certification, (which now includes the face-to-face encounter).

Link to the New "How to Use the Searchable Medicare Physician Fee Schedule" Booklet [[↑](#)]

In our Tue Dec 6 issue of the e-News, we provided an incorrect link to the new Medicare Learning Network® (MLN) booklet "How to Use the Searchable Medicare Physician Fee Schedule" (ICN 901344). The correct link to the PDF document is:

http://www.CMS.gov/MLNProducts/downloads/How_to_MPFS_Booklet_ICN901344.pdf. We apologize for the inconvenience.

More Helpful Links...

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The Medicare Learning Network

www.CMS.gov/MLNGenInfo

Archive of Provider e-News Messages

www.CMS.gov/FFSProvPartProg/EmailArchive