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!

Robin Fritter, Director
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Colleagues—

Happy New Year! I hope the new year is off to a great start for you all, and business is getting back underway smoothly.

The end of December sure was busy for us here. Since Tue Dec 20, when we released the last regularly-scheduled e-News issue, we wound up sending six more standalone and combined e-News messages to make sure urgent and time-sensitive announcements – including news of activity around the Agency and in Congress – reached you. Combine that with how busy things can get during the holidays, and I'm sure it all may have seemed a bit hectic. In case you missed any of the news that came from CMS around the end of the year (or anytime last year, for that matter), we've made sure archived copies of all e-News issues are available on our website at www.CMS.gov/FFSProvPartProg/EmailArchive. And of course, if you have any questions or need help finding any material you think you may have missed, you can always reach us at FFSProviderRelations@cms.hhs.gov.

And while we're on the topic, you might make one of your New Year resolutions to join CMS in making sure Medicare beneficiaries are educated about and taking full advantage of the preventive health services available to them. Read all about preventive health services below…

Again, wishing everyone a very Happy New Year! Very best wishes—

Robin

The e-News for the week of Tue Jan 10 includes…

National Provider Calls

- Tue Jan 17 – Physician Quality Reporting System & Electronic Prescribing Incentive Program National Provider Call – Register Now
- Wed Jan 25 – Medicare FFS Implementation of *HIPAA* Version 5010 and D.0 Transactions National Provider Call – Register Now
- Video Slideshow Presentation of the Tue Nov 8 National Provider Call on "Overview of the Medicare Physician Fee Schedule to Address the 2012 Physician Quality Reporting System & Electronic Prescribing Incentive Program" Now Available
- Video Slideshow Presentation and Podcasts of the Thu Nov 17 National Provider Call on "ICD-10 Implementation Strategies and Planning" Now Available
- Medicare Shared Savings Program Video Slideshow Presentations and Podcasts Now Available

Announcements and Reminders

- Three DMEPOS Competitive Bidding Announcements
- Time is Running Out to Register for DMEPOS Competitive Bidding
- New Webcast for National Mail-Order Bidders Now Available
- All Medicare Provider and Supplier Payments To Be Made By Electronic Funds Transfer
- Stay on Track and Complete Your Version 5010 Upgrade
- HHS Adopts Standards for Electronic Funds Transfers / Remittance Advice
- 2012 Electronic Prescribing Incentive Program Educational Products Are Now Available
- 2012 Physician Quality Reporting System Educational Products Are Now Available
- Healthcare Professionals Selected for the New Innovation Advisors Program to Improve Care for Patients
- Medicare Shared Savings Program 2012 ACO Narrative Quality Measures Specifications Manual and Application Crosswalks Now Available
- Growth in US Health Spending Remains Slow in 2010
- New Year's Resolution: Educate Medicare Beneficiaries about Preventive Services Now Covered by Medicare
- Flu Season is Here! Get the Flu Vaccine – Not the Flu

Code, Pricer, and Claims Updates

- Outpatient Prospective Payment System CY2012 Pricer File Update
- Extension of Moratorium That Allows Independent Laboratories to Bill for the Technical Component of Physician Pathology Services Furnished to Hospital Patients
- Temporary Workaround for the Assessment Reference Date Reason Code 31742 for Skilled Nursing Facility and Swing Bed Claims
- Healthcare Common Procedure Coding System Code Set Update
- Claims Reprocessing for Section 508 Extension and Special Exception Hospitals Reclassifications

Updates from the Medicare Learning Network ®

- "Medicare Claim Review Programs" Booklet Revised
- "Substance (Other Than Tobacco) Abuse Structured Assessment and Brief Intervention (SBIRT)" Fact Sheet Revised
- "Non-Specific Procedure Code Description Requirement for *HIPAA* Version 5010 Claims" MLN Matters Article Released
- Provider Exhibit Program – Reminder

National Provider Call: Physician Quality Reporting System & Electronic Prescribing Incentive Program – Register Now [↑]
Tue Jan 17; 1:30-3pm ET

CMS will host a national provider call on the Physician Quality Reporting System (PQRS) & Electronic Prescribing (eRx) Incentive Program, during which subject matter experts will provide an overview on how the 2012 eRx payment adjustment will appear on your remittance advice, as well as an overview of the self-nomination process.

Target Audience: Medicare Fee-For-Service (FFS) providers, Medical coders, Physician office staff, Provider billing staff, and Vendors

Agenda:

- Opening Remarks
- Program Announcements
- Overview of on how the 2012 Electronic Prescribing (eRx) Incentive Program payment adjustment will appear on your remittance advice
- Overview of the self-nomination process
- Question & Answer Session

Registration Information: Please visit http://www.eventsvc.com/blhtechnologies to register for this informative session. Registration will close at 12pm ET on Tue Jan 17, or when available space has been filled. No exceptions will be made. Please register early.

Presentation: The presentation will be posted at least one day before the call, in the "Downloads" section of the page at http://www.CMS.gov/PQRS/04_CMSSponsoredCalls.asp.

- Additional material related to PQRS in today's e-News… [next]
- Additional material related to eRx in today's e-News… [next]

National Provider Call: Medicare FFS Implementation of *HIPAA* Version 5010 and D.0 Transactions – Register Now [↑]
Wed Jan 25; 2-3:30pm ET

CMS will host a special national provider call regarding the Medicare FFS implementation of *HIPAA* Version 5010 and D.0 transaction standards.

Target Audience: Vendors, clearinghouses, and providers who need to make Medicare FFS specific changes in compliance with *HIPAA* Version 5010 requirements

Agenda (there will be no slide presentation for this call):

- HIPAA Version 5010 Implementation Update
- Question & Answer Session

If you would like to submit a question related to this topic in advance of, during, or following the call, please email your inquiry to the 5010 FFS Information resource mailbox at 5010FFSinfo@CMS.hhs.gov. Note that this resource box will only accept emails the day before, the day of, and the day after this call; your emailed questions will be answered as soon as possible, and may not be answered during the call.

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.

➢ Additional material related to 5010 in today's e-News… [next]

National Provider Call: Video Slideshow Presentation of the Tue Nov 8 National Provider Call on "Overview of the Medicare Physician Fee Schedule to Address the 2012 Physician Quality Reporting System & Electronic Prescribing Incentive Program" Now Available [↑]

CMS has released a YouTube video slideshow presentation from the Tue Nov 8 National Provider Call on "Overview of the Medicare Physician Fee Schedule to Address the 2012 Physician Quality Reporting System (PQRS) & Electronic Prescribing (eRx) Incentive Program."

Did you miss the Tue Nov 8 PQRS & eRx Incentive Program National Provider Call? The call presentation is now available on the CMS YouTube Channel as a video slideshow that includes the call audio with captions. Available 24/7, YouTube video presentations make learning about the PQRS & eRx Incentive Program easy and convenient. Check them out today!

For additional program information and educational products on both programs visit the Physician Quality Reporting System & Electronic Prescribing Incentive Program webpages.

➢ Additional material related to PQRS in today's e-News… [next / previous]
➢ Additional material related to eRx in today's e-News… [next / previous]

National Provider Call: Video Slideshow Presentation and Podcasts of the Thu Nov 17 National Provider Call on "ICD-10 Implementation Strategies and Planning" Now Available [↑]

YouTube Video Slideshow Presentation:
Did you miss the Thu Nov 17 ICD-10 National Provider Call? The call presentation is now available on the CMS YouTube Channel as a video slideshow that includes

the call audio with captions. Available 24/7, YouTube video presentations and podcasts make learning about the ICD-10 transition easy and convenient. Check them out today!

Podcasts:
Limited on time? Podcasts are perfect for the office, in the car, or anywhere you carry a portable media player or smartphone. The following podcasts are now available from the Thu Nov 17 ICD-10 call:

1. Introduction, General ICD-10 Requirements, and CMS Implementation Planning
2. General Implementation Planning and Strategies
3. NCVHS Meeting Update and Medicare FFS Claims Processing, Billing, and Reporting Guidelines
4. Question and Answer Session

The podcasts are now available at http://www.CMS.gov/ICD10/Tel10/itemdetail.asp?itemID=CMS1253081. The 4 podcasts with corresponding written transcripts, as well as the complete audio file and complete written transcript can be accessed by scrolling to the "Downloads" section at the bottom of the webpage. To access the YouTube video slideshow presentation, select the link in the "Related Links Outside CMS" section of the webpage.

National Provider Call: Medicare Shared Savings Program Video Slideshow Presentations and Podcasts Now Available [↑]

Do you want to learn more about the Medicare Shared Savings Program (Shared Savings Program) and how to apply? CMS has posted new resources on the Shared Savings Program CMS Teleconferences and Events webpage at http://www.CMS.gov/SharedSavingsProgram/40_Events.asp.

"Medicare Shared Savings Program Overview" YouTube Video Slideshow Presentation – On Wed Dec 7, John Pilotte, Director of the Performance-Based Payment Policy Group at CMS gave an overview of the Medicare Shared Savings Program, followed by a question and answer session. A video slideshow presentation of this call with audio and captioning is now available on the CMS YouTube Channel.

"'Medicare Shared Savings Program: Application Process and Overview of the Advance Payment Model Application' National Provider Call" YouTube Video Slideshow Presentation – Did you miss the Thu Nov 15 National Provider Call on the "Medicare Shared Savings Program: Application Process and Overview of the Advance Payment Model Application"? The call presentation is available on the CMS YouTube Channel as a video slideshow. It includes the call audio and is captioned.

Podcasts
Limited on time? Podcasts are perfect for the office, in the car, or anywhere you carry a portable media player or smartphone. The following podcasts from the Thu Nov 15 Shared Savings Program call are also available:

1. Introduction by Dr. Donald Berwick
2. Medicare Shared Savings Program Application Process
3. Advance Payment Model
4. Question and Answer Session

You can find links to these podcasts with corresponding written transcripts, as well as links to the YouTube video slideshow presentations, complete audio recording, and complete written transcript on the Shared Savings Program CMS Teleconferences and Events webpage at http://www.CMS.gov/SharedSavingsProgram/40_Events.asp.

Three DMEPOS Competitive Bidding Announcements [↑]

CMS has three announcements for suppliers that are interested in participating in the Round 2 and national mail-order competitions of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program.

First, bid limits in the Round 2 Bid Preparation Worksheets have been revised for 14 Healthcare Common Procedure Coding System (HCPCS) codes for power wheelchairs (K0813 through K0829). The previous bid limits listed in the worksheet were erroneously based on 150 percent of the actual bid limits.

Second, we have made three clarifying updates to the list of glucose monitors on the 50 Percent Compliance Form, a required bid document for the national mail-order competition:

- ASCENSIA AUTO DISC has been consolidated with ASCENSIA BREEZE 2. (ASCENSIA AUTO DISC is no longer manufactured but uses the same test strips as the ASCENSIA BREEZE 2.)
- FREESTYLE FLASH has been consolidated with FREESTYLE and FREESTYLE FREEDOM. (FREESTYLE FLASH is no longer manufactured but uses the same test strips as FREESTYLE and FREESTYLE FREEDOM.)
- Protégé has been consolidated with SMARTEST. (Protégé is no longer manufactured but uses the same test strips as SMARTEST.)

Third, CMS would like to remind potential bidders that four adjustable seat cushion codes (E2622 through E2625) have been removed from the Round 2 standard wheelchairs product category. The Competitive Bidding Implementation Contractor (CBIC) has deleted these codes from the bidder education materials.

All of these updates are now available on the CBIC website at www.DMECompetitiveBid.com.

➢ Additional material related to DMEPOS CB in today's e-News… [next]

Time is Running Out to Register for DMEPOS Competitive Bidding [↑]

If you are a supplier interested in participating in the Round 2 and national mail-order competitions of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) competitive bidding program and have registered an Authorized Official (AO) but not a Backup Authorized Official (BAO), CMS strongly recommends that a BAO register no later than *Thu Jan 12*. It is important to do it now so that the BAO will be able to assist the AO with approving End User (EU) registration. The establishment of a BAO is encouraged, if your company has someone that can occupy the BAO role, to avoid any disruption in the bidding process once the 60-day bid window opens. The individual in the BAO role can also assume the AO role if for some reason the AO can no longer fulfill his or her bidding responsibilities; if there is no BAO and the AO leaves the company, all end users associated with the company will lose access to the bidding system.

Registration is typically a quick and easy process if you follow the step-by-step instructions in the "Individuals Authorized Access to CMS Computer Services (IACS) Reference Guide" posted on the Competitive Bidding Implementation Contractor (CBIC) website (at www.DMECompetitiveBid.com). To register, visit the CBIC website and click on "REGISTRATION IS OPEN" above the Registration Clock on the homepage. You will also find a registration checklist and Quick Step guides on the CBIC website. Please note that suppliers with multiple locations typically must register only one Provider Transaction Access Number (PTAN) that will submit the bid for all locations. If you have any questions about the registration process, please contact the CBIC Customer Service Center at 877-577-5331.

The deadline has now passed for AO registration. If the AO for your company has not already registered and obtained a user ID and password, we cannot guarantee that he or she will be able to complete the registration process before the registration window closes on *Thu Feb 9, 2012 at 9pm (prevailing Eastern Time).* This should be of particular concern if the National Supplier Clearinghouse (NSC) record for your company is not current and accurate. AOs should register now to allow BAOs and EUs time to register. In addition, suppliers whose AOs do not register now run the risk of experiencing delays in accessing the online bidding system to get a bidder number and thereby missing the opportunity to submit financial documents by the Covered Document Review Date (CDRD). As a result, we encourage you to register now.

Remember, the AO and BAO must be listed on the CMS-855S enrollment form as an AO. After an AO successfully registers, the AO may designate other authorized officials on the CMS-855S to serve as BAOs; the AO and BAOs can then designate other supplier employees as EUs. BAOs and EUs must also register for a user ID and password to be able to use the online bidding system. The name, date of birth, and Social Security Number of the AO and BAOs must match exactly with what is on file with the NSC to register successfully.

Registration will close on *Thu Feb 9, 2012 at 9pm (prevailing Eastern Time)* – no AOs, BAOs, or EUs will be able to register after registration closes.

Remember that the CBIC is the official information source for bidders. All suppliers interested in bidding are urged to sign up for email updates on the homepage of the CBIC website. For information about Round 2 and the national mail-order competition, including bidder education materials, please refer to the resources located under the "Bidding Suppliers: Round 2 & National Mail-Order" menu on the CBIC website.

- Additional material related to DMEPOS CB in today's e-News… [next / previous]

New Webcast for National Mail-Order Bidders Now Available [↑]

A new educational webcast for the national mail-order competition of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program is now available on the Competitive Bidding Implementation Contractor (CBIC) website at www.DMECompetitiveBid.com. This webcast, *National Mail-Order Competition for Diabetic Supplies*, covers rules that apply specifically to this competition and provides resources to assist you with bidding.

This webcast is available on demand to view at your convenience – 24 hours a day, seven days a week. There is no charge to view the webcast, and a transcript is also posted on the website. To view the webcast, please visit the CBIC website, select *Bidding Suppliers: Round 2 & National Mail-Order*, and choose *Education Events*.

We will be issuing more webcasts later in the bidder education program. Upcoming webcasts will address topics such as financial documentation requirements, how bids are evaluated, and how to submit a bid in the online bidding system, DBidS. As each webcast is posted, we will announce its availability with an email update. If you have not already done so, please register on the CBIC website to receive these announcements and other updates about the competitive bidding program.

If you have any questions or need assistance, please contact the CBIC customer service center toll-free at 877-577-5331 from 9am to 9pm (prevailing Eastern Time), Monday through Friday, throughout the registration and bidding periods.

- Additional material related to DMEPOS CB in today's e-News… [previous]

All Medicare Provider and Supplier Payments To Be Made By Electronic Funds Transfer [↑]

Existing regulations at 42 CFR 424.510(e)(1)(2) require that at the time of enrollment, enrollment change request, or revalidation, providers and suppliers that expect to receive payment from Medicare for services provided must also agree to receive Medicare payments through electronic funds transfer (EFT). Section 1104 of the *Affordable Care Act* further expands Section 1862(a) of the *Social Security Act* by mandating federal payments to providers and suppliers only by electronic means. As part of CMS's revalidation efforts, all suppliers and providers who are not currently receiving EFT payments *are required to submit the CMS-588 EFT form with the Provider Enrollment Revalidation application, or at the time any change is being made to the provider enrollment record by the provider or supplier, or delegated official.*

For more information about provider enrollment revalidation, review the Medicare Learning Network's Special Edition Article #SE1126, titled "Further Details on the Revalidation of Provider Enrollment Information."

- Additional material related to EFT in today's e-News… [next]

Stay on Track and Complete Your Version 5010 Upgrade [↑]

As 2012 begins, it is important to keep your focus on compliance with Version 5010 and beginning to plan for the transition to ICD-10.

The Version 5010 deadline was on Sun Jan 1; however, because of the 90-day enforcement discretion period for all *HIPAA*-covered entities upgrading to Version 5010 (ASC X12 Version 5010), CMS will not initiate enforcement action until Sun Apr 1. CMS made this decision based on industry feedback that many organizations and their trading partners were not yet ready to finalize system upgrades to be compliant.

CMS encourages you to continue internal testing as well as external testing of Version 5010 transactions with trading partners to ensure compliance for Version 5010. Although enforcement action will not be taken prior to Sun Apr 1, it is important that you continue to move forward to meet Version 5010 requirements as soon as possible. In addition to testing, if you have not yet created a plan for Version 5010, you should do so in order to meet these compliance deadlines.

To find out about steps to take toward a successful upgrade, consult the new CMS fact sheet: "Version 5010: How Healthcare Providers Can Ensure a Smooth Transition."

Remember: Upgrading to Version 5010 is a critical first step for the nationwide transition to ICD-10 that will take place on Tue Oct 1, 2013. It is important that you finish this process, so that you can continue to prepare your organization for the ICD-10 transition.

Keep Up to Date on Version 5010 and ICD-10. Please visit the ICD-10 website for the latest news and resources to help you prepare, and to download and share the implementation widget today!

- Additional material related to 5010 in today's e-News… [next / previous]

HHS Adopts Standards for Electronic Funds Transfers / Remittance Advice [↑]
Affordable Care Act Provision Cuts Red Tape, Saves up to $4.5 Billion

New standards for Electronic Funds Transfers (EFT) in healthcare, required by the *Affordable Care Act*, will reduce up to $4.5 billion of administrative costs for doctors and hospitals, private health plans, states, and other government health plans, over the next ten years, according to estimates included in new rules published today by the US Department of Health and Human Services (HHS). The standards build upon regulations published earlier this year that set industry-wide standards for how health providers use electronic systems to quickly and easily determine a patient's eligibility for health coverage and check on the status of a health claim.

Together, the two regulations implementing the Administrative Simplification provisions of the *Affordable Care Act* and the *Health Insurance Portability and Accountability Act (HIPAA)* are projected to save the healthcare industry more than $16 billion over the next 10 years. These savings come from the adoption of electronic standards that will help eliminate inefficient manual processes and reduce costs.

A May 2010 study in the journal *Health Affairs* found that physicians spend nearly 12 percent of every dollar they receive from patients to cover the costs of filling out forms and performing other excessively complex administrative tasks. The study found that simplifying these systems could save four hours-per-week of professional time per physician and five hours of support staff time every week – time that could be better spent on patient care.

Today's rule – the Adoption of Standards for Healthcare EFTs and Remittance Advice – adopts streamlined standards for the format and data content of the transmission a health plan sends to its bank when it wants to pay a claim to a provider electronically (through an EFT) and to issue a Remittance Advice notice. Remittance Advice is a notice of payment sent to providers that may or may not accompany the payment the provider receives.

For example, currently when a provider submits a claim electronically for payment, a health plan often sends a Remittance Advice separately from the EFT payment. The disconnect between the two makes it difficult or sometimes impossible for the provider to match up the bill and the corresponding payment. Today's rule addresses this by requiring the use of a trace number that automatically matches the two. The new tracking system will allow healthcare providers to eliminate costly manual reconciliation that must currently be done.

Future administrative simplification rules will address adoption of a standard unique identifier for health plans; a standard for claims attachments; and requirements that health plans certify compliance with all *HIPAA* standards and operating rules.

The regulation is effective Sun Jan 1. All health plans covered under *HIPAA* must comply by Wed Jan 1, 2014.

The full text of this excerpted news release can be found on the HHS News Release website.

To view the Interim Final Regulation with comment period, visit http://www.Regulations.gov. For more information on the June 2011 *HIPAA* Administrative regulation, "Adoption of Operating Rules for Eligibility for a Health Plan and Healthcare Claim Status," visit http://www.HHS.gov/news/press/2011pres/06/20110630a.html.

- Additional material related to EFT in today's e-News… [previous]

2012 Electronic Prescribing Incentive Program Educational Products Are Now Available [↑]

CMS is pleased to announce the posting of the following 2012 Electronic Prescribing (eRx) Incentive Program educational products to the eRx webpage at http://www.CMS.gov/ERxIncentive.

- *2012 eRx Incentive Program Measure Specifications and Release Notes* – provides guidance on the 2012 eRx measure specifications for claims or registry-based reporting and release notes describing changes from the *2011 eRx Measure Specifications*.
- *Claims-Based Reporting Principles for the 2012 eRx Incentive Program* – provides guidance on the principles for reporting the eRx measure on claims for the 2011 eRx Incentive Program.
- *2012 eRx Incentive Program CMS-1500 Claim Example* – a detailed sample of an individual NPI reporting the eRx measure on a CMS-1500 form
- *2012 Electronic Health Record (EHR) Measure Specifications for eRx Incentive Program and Release Notes* – provides guidance on the 2012 EHR measure specifications for eRx and release notes. In addition, the specifications contain a detailed description of data element names and codes.
- *2012 Electronic Health Record (EHR) Downloadable Resource Table and Release Notes* – an Excel spreadsheet and release notes listing 2012 EHR information.
- *2012 eRx Incentive Program GPRO Measure Specifications and Release Notes* – provides guidance on the specifications for the eRx measure for use in 2012 eRx GPRO and release notes.

To access the 2012 eRx Incentive Program educational products, visit the *Spotlight* section on the eRx Incentive Program webpage at http://www.CMS.gov/ERxIncentive/02_Spotlight.asp to view the listing of educational products and their corresponding section pages.

Further information on the 2012 eRx Incentive Program may be found in the final 2012 Medicare Physician Fee Schedule rule that was published in the *Federal Register* on Mon Nov 28. The final rule can be found on the Statute/Regulations/Program Instructions section page at http://www.CMS.gov/ERxIncentive/04_Statute_Regulations_Program_Instructions.asp.

- Additional material related to eRx in today's e-News… [previous]

2012 Physician Quality Reporting System Educational Products Are Now Available [↑]

CMS is pleased to announce the posting of the following 2012 Physician Quality Reporting System (PQRS) educational products at http://www.CMS.gov/PQRS.

- *2012 PQRS Measures List* – this document identifies and explains the measures used in Physician Quality Reporting, including information on the reporting options/methods, measure developers and their contact. (Please note that this document has been updated and re-posted as of Thu Jan 5.)
- *2012 PQRS Quality-Data Code (QDC) Categories* – a table that outlines, for each measure, each QDC that should be reported for a corresponding quality action performed by the individual eligible professional as noted in the measures specification. This determines how each code will be used when calculating performance rates. This also clarifies those measures that require two or more QDCs to report satisfactorily. Insufficiently reporting the QDCs (as specified in the *2012 PQRS Measure Specifications Manual*) will result in invalid reporting.
  2012 PQRS Single Source Code Master – this file includes a numerical listing of all codes included in 2012 Physician Quality Reporting for incorporation into billing software.

- *2012 PQRS Measure Specifications Manual for Claims and Registry Reporting of Individual Measures* – the 2012 measure specifications include codes and reporting instructions for the 210 PQRS measures for claims and/or registry-based reporting. (Please note that this document has been revised and re-posted as of Thu Jan 5.)
- *2012 PQRS Measure Specification Release Notes* – outlines *changes from the 2011 PQRS Measure Specifications Manual* in the form of Release Notes. (Please note that this document has been revised and re-posted as of Thu Jan 5.)
- *2012 PQRS Implementation Guide* – provides guidance about how to select measures for reporting, how to read and understand a measure, and outlines the reporting options available for 2012 PQRS. The *Implementation Guide* also details how to implement claims-based reporting of measures to facilitate satisfactory reporting of quality-data codes by eligible professionals.
- *2012 PQRS Measures Groups Specifications Manual* – Measures group specifications are different from those of the individual measures that form the group; therefore, the specifications and instructions for measures group reporting are provided in a separate manual. The 2012 measures groups specifications include codes and reporting instructions for the 22 PQRS measures groups for claims or registry-based reporting.
- *2012 PQRS Measures Groups Release Notes* – this document outlines changes from the *2011 PQRS Measures Groups Specifications Manual* in the form of release notes.
  Getting Started with 2012 PQRS of Measures Groups – provides guidance on implementing the 2012 PQRS measures groups.
  2012 PQRS Measures Groups Single Source Code Master – this file includes a numerical listing of all codes included in 2012 PQRS Measures Groups for incorporation into billing software.
  2012 PQRS Measure-Applicability Validation Process for Claims-Based Reporting of Individual Measures – provides guidance for those eligible professionals who satisfactorily submit quality-data codes for fewer than three PQRS measures, and how the measure-applicability validation process will determine whether they should have submitted QDCs for additional measures.
- *2012 PQRS Measure-Applicability Validation Process Release Notes* – the release notes for the changes occurring for the 2015 PQRS Measure-Applicability Validation Process (MAV).
  2012 PQRS Measure-Applicability Validation Process Flow – a chart that depicts the Measure-Applicability Validation Process (MAV).
  Group Practice Reporting Option (GPRO) Requirements for Submission of 2012 PQRS Data – provides guidance on how a group practice of over 25 eligible professionals can self-nominate to participate in GPRO for 2012 data submission.
  2012 PQRS Group Practice Reporting Option (GPRO) Measures List – a document containing a list of the 2012 PQRS GPRO Measures.
  2012 PQRS GPRO Narrative Measure Specifications and Release Notes – this document contains descriptions of the 2012 PQRS GPRO measures and changes in the program since the 2011 reporting year.
  2012 EHR Direct Vendor Qualification Requirements – provides guidance on how EHR Direct Vendors can self-nominate and qualify to submit PQRS measures data for 2012.
  2012 EHR Data Submission Vendor Qualification Requirements – provides guidance on how EHR Data Submission Vendors can self-nominate and qualify to submit PQRS measures data for 2012.
  2012 EHR Documents for Eligible Professionals – this zipped file contains the following:
    - 2012 PQRS EHR Measure Specifications – the detailed description of data element names and codes related to each of 51 2012 PQRS quality measures available for electronic submission.
    - 2012 PQRS EHR Measure Specifications, Release Notes – the corresponding release notes for the 2012 EHR Measure Specifications.
    - 2012 EHR Downloadable Resource Table
    - 2012 EHR Downloadable Resource Table, Release Notes
- *2012 EHR Documents for Vendors* – this zipped file contains the following:
    - Data Submission Specifications Utilizing HL7 QRDA Implementation Guide Based on HL7 CDA Release 2.0
    - Updated EHR Data Submission Specifications Utilizing QRDA , Release Notes – release notes for Data Submission Specifications Utilizing HL7 Quality

Reporting Document Architecture Based on HL7 CDA Release 2.0
- 2012 EHR Downloadable Resource Table
- 2012 EHR Downloadable Resource Table, Release Notes
- Updated EHR Data Submission Specifications Utilizing QRDA Header Errors and Edits
- Updated EHR Data Submission Specifications Utilizing QRDA Body Errors and Edits
- 2012 CMS EHR QRDA Data Submission Specifications and Errors Edits, Release Notes

To access the 2012 PQRS educational products, visit the *Spotlight* page at http://www.CMS.gov/PQRI/02_Spotlight.asp for the listing of educational products and the corresponding section page where they can be found.

Further information on the 2012 PQRS may be found in the final 2012 Medicare Physician Fee Schedule rule with comment period that was published in the *Federal Register* on Mon Nov 28, which can be found at http://www.CMS.gov/PQRS/05_StatuteRegulationsProgramInstructions.asp.

- Additional material related to PQRS in today's e-News… [previous]

Healthcare Professionals Selected for the New Innovation Advisors Program to Improve Care for Patients [↑]

On Tue Jan 3, CMS announced that it has selected 73 individuals from 27 States and the District of Columbia for its Innovation Advisors program. A list of these Innovation Advisors can be found at http://www.CMS.gov/apps/media/press/factsheet.asp?Counter=4240.

The initiative, launched by the CMS Innovation Center in October 2011, will help health professionals deepen skills that will drive improvements to patient care and reduce costs. After an initial orientation phase, Innovation Advisors will work with the CMS Innovation Center to test new models of care delivery in their own organizations and communities. They will also create partnerships to find new ideas that work and share them regionally and across the United States.

Funding for this initiative was made possible by the *Affordable Care Act*.

"There has been an incredible groundswell of interest in becoming an Innovation Advisor. It's clear that doctors, hospitals, and healthcare providers are enthusiastic about implementing the *Affordable Care Act* and strengthening our healthcare system," said CMS Acting Administrator Marilyn Tavenner.

The 73 individuals were selected from 920 applications through a competitive process, and include clinicians, allied health professionals, health administrators, and others. By attending in-person meetings as well as remote sessions to expand their skills and applying what they learn, the Advisors will be able to deepen their knowledge in healthcare economics and finance, population health, systems analysis, and operations research.

"We're looking to these Innovation Advisors to be our partners – we want them to discover and generate new ideas that will work and help us bring them to every corner of the United States," said CMS Innovation Center Director Rick Gilfillan, MD.

Among other duties, the Advisors will be expected to support the Innovation Center in testing new models of care delivery, to form partnerships with local organizations to drive delivery system reform, and to improve their own health systems so their communities will have better health and better care at a lower cost.

Each Innovation Advisor's home organization will receive a stipend of up to $20,000. The stipend will support an individual's activities while serving as an Innovation Advisor.

More information about the Innovation Advisors Program, including a fact sheet and list of participants and their home organization, can be found at http://Innovations.CMS.gov/initiatives/innovation-advisors/index.html.

Medicare Shared Savings Program 2012 ACO Narrative Quality Measures Specifications Manual and Application Crosswalks Now Available [↑]

CMS has added new information to the Medicare Shared Savings Program website at http://www.CMS.gov/SharedSavingsProgram.

A new webpage on Quality Measures and Performance Standards at http://www.CMS.gov/SharedSavingsProgram/37e_Quality_Measures_Standards.asp has the latest information on Medicare Accountable Care Organization (ACO) quality measures. The 2012 ACO Narrative Quality Measures Specifications Manual provides guidance about the 33 required quality measures that are part of the quality performance standard.

Two crosswalks have been added to the Shared Savings Program Application webpage at http://www.CMS.gov/SharedSavingsProgram/37_Application.asp. Organizations that submitted an application under the Pioneer ACO Model or have been participating in the PGP Transition Demonstration, that would like to submit a Shared Savings Program application, scroll down the page for links to these two application crosswalks.

Growth in US Health Spending Remains Slow in 2010 [↑]
Health spending growth at historic lows for second consecutive year

US healthcare spending experienced historically low rates of growth in 2009 and 2010 according to the annual report of national health expenditures (NHE) published in the January issue of the journal *Health Affairs.*

Analysts at CMS report in the article that the increase in spending for 2009 represents the lowest rate of increase in the entire 51 year history of the NHE. The low rate of growth, the data show, reflects lower utilization in healthcare than in previous years. The report notes that US healthcare spending grew only 3.9 percent in 2010, reaching $2.6 trillion or $8,402 per person, just 0.1 percentage point faster than in 2009.

In 2010, as health spending growth remained low, growth in US economy as reflected in gross domestic product (GDP) (4.2 percent) rebounded. As such in 2010, the health spending share of the overall economy was unchanged at 17.9 percent. In the past, this share has increased, rising over time from 5.2 percent in 1960.

The NHE report, prepared annually by the CMS Office of the Actuary, summarizes recent trends in healthcare spending based on the most current data sources. Available historically since 1960, the NHE represents the official estimates of total healthcare spending in the United States and measures annual health spending by the types of goods and services delivered (hospital care, physician services, retail prescription drugs, etc), by the programs and payers that pay for that care (private health insurance, Medicare, Medicaid, etc), and by the sponsors who are ultimately responsible for financing that care (private business, households, and governments).

Additional information in this report can be found at http://www.CMS.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp. The entire CMS

press release issued Mon Jan 9 and other key findings can be found at http://www.CMS.gov/apps/media/press/release.asp?Counter=4245.

New Year's Resolution: Educate Medicare Beneficiaries about Preventive Services Now Covered by Medicare [↑]

Each New Year brings resolutions and promises of change and improvement, which makes the beginning of 2012 a perfect time to remind you that Medicare now provides payment for a broader range of preventive services and screenings that can help your Medicare patients prevent, detect, or control and manage their illness and disease. Thanks to the *Affordable Care Act*, more seniors and others with Medicare can now take advantage of many recommended preventive benefits from Medicare participating healthcare providers without paying the Medicare Part B deductible and 20 percent coinsurance.

Medicare Now Provides Payment for the following Preventive Services and Screenings:

- Annual Wellness Visit Providing Personalized Prevention Plan Services
- Bone Mass Measurement
- Cancer Screenings
    - Breast Cancer (mammography and clinical breast exam)
    - Cervical and Vaginal Cancer (pap test and pelvic exam, including the clinical breast exam)
    - Colorectal Cancer
        - Fecal Occult Blood Test
        - Flexible Sigmoidoscopy
        - Colonoscopy
        - Barium Enema
- Cardiovascular Disease Screening
- Diabetes Screening
- Diabetes Self-Management Training
- Glaucoma Screening
- Human Immunodeficiency Virus (HIV) Screening
- Immunizations (Seasonal Influenza, Pneumococcal, and Hepatitis B)
- Initial Preventive Physical Examination (IPPE) also known as the "Welcome to Medicare" Preventive Visit (includes a referral for an ultrasound screening for Abdominal Aortic Aneurysm for eligible beneficiaries)
- Intensive Behavioral Therapy for Cardiovascular Disease – *Effective 201-11-08*
- Intensive Behavioral Therapy for Obesity – *Effective 2011-11-29*
- Medical Nutrition Therapy (for beneficiaries with diabetes or renal disease)
- Prostate (PSA blood test and Digital Rectal Exam)
- Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse – *Effective 2011-10-14*
- Screening for Depression in Adults – *Effective 2011-10-14*
- Screening for Sexually Transmitted Infections (STIs) and High-Intensity Behavioral Counseling (HIBC) to prevent STIs – *Effective 2011-11-08*
- Tobacco-Use Cessation Counseling

While Medicare now provides coverage for more preventive benefits, many seniors are not receiving all recommended preventive services that they may be eligible for; even with frequent visits to physician offices. Reasons for this vary, but Medicare beneficiaries may not fully understand how to take advantage of these

services. As a healthcare professional who provides healthcare services to people with Medicare, CMS needs your help to ensure that Medicare beneficiaries are aware of and take advantage of the Medicare preventive benefits that are appropriate for them.

The "Welcome to Medicare" Preventive Visit, for people new to Medicare, and the Annual Wellness Visit, present excellent opportunities for you to talk with your Medicare patients about their health and recommend preventive services and screenings they should take advantage of. Remember to provide the appropriate documentation for your recommendations and don't forget to follow up with patients on all screening results, even negative ones – everyone likes to hear good news. You can help your Medicare patients live a healthier life in 2012 – encourage use of Medicare-covered preventive benefits.

For More Information:

- CMS Prevention General Information Website – general information for healthcare professionals
- MLN Preventive Services Products Website – educational resources for healthcare professionals
- Medicare Coverage Database – contains all National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs), local articles, and proposed NCD decisions
- Medicare.gov Preventive Services Website – information for people with Medicare

Thank You!

Flu Season is Here! Get the Flu Vaccine – Not the Flu [↑]

While seasonal flu outbreaks can happen as early as October, flu activity usually peaks in January. Remind your patients that annual vaccination is recommended for optimal protection. Medicare pays for the seasonal flu vaccine and its administration for seniors and others with Medicare with no co-pay or deductible. Healthcare workers, who may spread the flu to high-risk patients, should get vaccinated too. Don't forget to immunize yourself and your staff. Protect your patients. Protect your family. Protect yourself.

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.

Outpatient Prospective Payment System CY2012 Pricer File Update [↑]

The Outpatient Prospective Payment System (OPPS) Pricer webpage has been updated with new payment files for the 2012 Update to the OPPS, as specified in Change Request (CR) 7672. The files are ready for download from the "1st Quarter 2012 Files" section of the OPPS Pricer webpage at http://www.CMS.gov/PCPricer/OutPPS/list.asp.

Extension of Moratorium That Allows Independent Laboratories to Bill for the Technical Component of Physician Pathology Services Furnished to Hospital

Patients [↑]

On Fri Dec 23, President Obama signed into law the *Temporary Payroll Tax Cut Continuation Act of 2011 (TPTCCA)*. This new legislation contains a number of Medicare provisions which change or extend Medicare Fee-For-Service policies. Included in these provisions is an extension of a moratorium that allows certain practitioners and suppliers (such as pathologists and Independent Laboratories) to bill for the Technical Component (TC) of physician pathology services furnished to hospital patients through Wed Feb 29.

Under previous law, including, most recently, §105 of the *Medicare & Medicaid Extenders Act* of 2010, a statutory moratorium allowed certain pathologists and independent laboratories meeting specific criteria to bill a carrier or an A/B MAC for the TC of physician pathology services furnished to hospital patients. This moratorium was set to expire on Sat Dec 31. However, Section 305 of the *TPTCCA* extends that moratorium beginning Sun Jan 1 through Wed Feb 29. Therefore, qualified pathologists and independent laboratories that provide the TC of physician pathology services furnished to hospital patients may continue to bill for and receive Medicare payment for these services. This policy is effective for claims with dates of service Sun Jan 1 through Wed Feb 29.

For background and policy information regarding payment to independent laboratories for the TC of physician pathology services furnished to hospital patients, refer to CR 5347, Transmittal 1221, issued on Wed Apr 18, 2007, and CR 5943, Transmittal 1440, issued on Thu Feb 7, 2008.

Temporary Workaround for the Assessment Reference Date Reason Code 31742 for Skilled Nursing Facility and Swing Bed Claims [↑]

CMS has developed a workaround for Skilled Nursing Facility (SNF) and Swing Bed (SB) claims incorrectly returned to the provider for assessment reference date (ARD) reason code 31742 to allow these claims to process. Providers with claims returned due to the incorrect application of this reason code should send them back to Medicare for processing. Be sure to bill the correct ARDs with occurrence code 50 prior to sending these claims to Medicare for processing.

Healthcare Common Procedure Coding System Code Set Update [↑]

CMS is pleased to announce the scheduled release of modifications to the Healthcare Common Procedure Coding System (HCPCS) code set. These changes have been posted to the HCPCS website at http://www.CMS.gov/MedHCPCSGenInfo. Changes are effective on the date indicated on the update.

Claims Reprocessing for Section 508 Extension and Special Exception Hospitals Reclassifications [↑]

Section 302 of the *Temporary Payroll Tax Cut Continuation Act of 2011 (TPTCCA)* extends Section 508 reclassifications and certain special exception wage indexes for 2 months, from October 1, 2011, through November 30, 2011. For the period beginning on October 1, 2011, and ending on November 30, 2011, Section 302 also requires removing Section 508 and special exception wage data from the calculation of the reclassified wage index if doing so raises the reclassified wage index. All hospitals affected by Section 302 of the TPTCCA shall be assigned a special wage index effective for only October and November 2011. We will apply the provision to both inpatient and outpatient hospital payments. For hospital outpatient payments only, special exception hospitals and other reclassified hospitals that would have a higher wage index based on the removal of section 508 and special exception hospitals' wage data will receive a special exception wage index from January 1, 2012, through February 29, 2012.

IPPS and OPPS claims from section 508 hospitals, IPPS special exception hospitals and IPPS non section 508 hospitals affected by section 302 with discharge dates on or after October 1, 2011, through November 30, 2011, will be reprocessed no later than December 31, 2012, in accordance with the *TPTCCA*.

OPPS claims for hospitals reclassified for special exceptions and other affected reclassified hospitals that completed processing before the wage index was updated will be reprocessed by early February, 2012.

Please note that for OPPS hospitals, a section 508 hospital that has geographic reclassification extended from October 1, 2011, to November 30, 2011, will revert to its previously scheduled October 1, 2011, reclassification or its home area wage index from December 1, 2011, to December 31, 2011. OPPS special exception hospitals and reclassified hospitals that benefit based on removal of section 508 and special exception hospital data shall revert to the CY2012 rule wage index, beginning March 1, 2012. IPPS hospitals shall revert to their wage index promulgated in the FY2012 rule located on our website at http://www.CMS.gov/AcuteInpatientPPS/FR2012/itemdetail.asp?itemID=CMS1250520.

From the MLN: "Medicare Claim Review Programs" Booklet Revised [↑]

The revised "Medicare Claim Review Programs: MR, NCCI Edits, MUEs, CERT, and RAC" booklet (ICN 006973) is designed to provide education on the different CMS claim review programs and assist providers in reducing payment errors, including, in particular, coverage and coding errors. It includes frequently asked questions, resources, and an overview of the various programs, including Medical Review, Recovery Audit Contractor, and the Comprehensive Error Rate Testing Program.

From the MLN: "Substance (Other Than Tobacco) Abuse Structured Assessment and Brief Intervention (SBIRT)" Fact Sheet Revised [↑]

This revised "Substance (Other Than Tobacco) Abuse Structured Assessment and Brief Intervention (SBIRT)" fact sheet (ICN 904084) is designed to provide education on SBIRT, an early intervention approach that targets those with nondependent substance use to provide effective strategies for intervention prior to the need for more extensive or specialized treatment.

From the MLN: "Non-Specific Procedure Code Description Requirement for *HIPAA* Version 5010 Claims" MLN Matters Article Released [↑]

The new "Non-Specific Procedure Code Description Requirement for *HIPAA* Version 5010 Claims" MLN Matters Special Edition Article (#SE1138) is designed to provide education on the requirements for non-specific procedure codes for *HIPAA* 5010 claims, as established in Change Request 7392. It includes guidance to help providers comply with the requirements and submit *HIPPA*-compliant claims for all non-specific procedure codes.

- Additional material related to 5010 in today's e-News… [previous]

From the MLN: Provider Exhibit Program – Reminder [↑]

Mark your calendars! The Medicare Learning Network will be exhibiting at the following healthcare provider conferences in the coming weeks:

- *American College of Preventive Medicine 2012*

Wed Feb 22 through Sat Feb 25
Buena Vista Palace; Orlando, FL
Booth #11

- *American Medical Group Association (AMGA) 2012 Annual Conference*
  Wed Mar 7 through Sat Mar 10
  Manchester Grand Hyatt; San Diego, CA
- *American Medical Student Association*
  Thu Mar 8 through Sun Mar 11
  Hyatt Regency Houston; Houston, TX
  Booth #12
- *American College of Cardiology (ACC.12) 61st Annual Scientific Session & Expo*
  Sat Mar 24 through Mon Mar 26
  Chicago, IL
- *National Hospice and Palliative Care Organization*
  Thu Mar 29 through Sat Mar 31
  National Harbor, MD

Please make a note of these dates and locations and add them to your calendar! If you are interested in having a CMS Medicare Learning Network Exhibit at your event, contact us at MLNexhibits@cms.hhs.gov.

More Helpful Links…

Check out CMS on

Twitter, LinkedIn, YouTube, and Flickr!

The Medicare Learning Network
www.CMS.gov/MLNGenInfo
Archive of Provider e-News Messages
www.CMS.gov/FFSProvPartProg/EmailArchive