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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 Thu Mar 8 includes...

NATIONAL PROVIDER CALLS

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- Wed Mar 14 – [Physician Value-Based Payment Modifier Program: Experience from Private Sector Physician Pay-for-Performance Programs – Register Now](#)
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National Provider Call: Overview and Listening Session: Stage 2 Requirements for the Medicare and Medicaid EHR Incentive Programs – Last Chance to Register [[↑](#)]

Mon Mar 12; 12:30-2pm ET

More than \$3.2 billion in Medicare and Medicaid electronic health record (EHR) incentive payments have been made since the program began last year; more than 191,000 eligible professionals, eligible hospitals, and critical access hospitals are actively registered. On Thu Feb 23, CMS announced a proposed rule for Stage 2 requirements and other changes to the program, which will be published on Wed Mar 7.

This National Provider Call will provide an overview of the proposed rule, so you can learn what you need to know to receive EHR incentive payments. (CMS plans to hold another National Provider Call on program basics for Eligible Professionals on Tue Mar 27; more information about this call will be available soon.)

The CMS proposed rule can be found at <http://www.GPO.gov/fdsys/pkg/FR-2012-03-07/pdf/2012-4443.pdf>. For more information on the EHR Incentive Programs, visit <http://www.CMS.gov/EHRIncentivePrograms>.

Target Audience: Hospitals, Critical Access Hospitals (CAHs), and professionals eligible for the Medicare and/or Medicaid EHR Incentive Programs. For more details:

- [Eligibility Requirements for Professionals](#)
- [Eligibility Requirements for Hospitals](#)

Agenda:

- Extension of Stage 1
- Changes to Stage 1 Criteria for Meaningful Use
- Proposed Medicaid policies
- Stage 2 Meaningful Use Overview
- Stage 2 Clinical Quality Measures
- Medicare Payment Adjustments and Exceptions
- Question and Answers about the incentive programs (note that we cannot answer questions on the rule beyond what is proposed)

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 beforehand at <http://www.CMS.gov/NPC/Calls>. In addition, the presentation will be emailed to all registrants on the day of the call.

- Additional material related to Electronic Health Records in today's e-News... [[next](#)]

Programs – Register Now [[↑](#)]

Wed Mar 14; 1:30-3pm 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 last in 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.

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

Agenda:

- Opening Comments and Background
 - Background on the Value-Based Payment Modifier
 - Introduction of Speakers
- Private Sector Presentations
- General Question and Answer Session
- CMS Comments & Closing

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 beforehand at <http://www.CMS.gov/PhysicianFeedbackProgram/PFP/list.asp>. In addition, the presentation will be emailed to all registrants on the day of the call.

National Provider Call: Physician Quality Reporting System & eRx: Million Hearts Initiative [[↑](#)]

Tue Mar 20; 1:30-3pm ET

CMS will host a National Provider Call on the Physician Quality Reporting System and Electronic Prescribing (eRx) Incentive Program, during which subject matter experts will provide an overview of the HHS [Million Hearts Initiative](#).

Target Audience: All Medicare FFS providers, medical coders, physician office staff, provider billing staff, Electronic Health Records staff, and vendors

Agenda:

- Opening remarks
- Program announcements

- Overview of Million Hearts Initiative
- 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 beforehand at http://www.CMS.gov/PQRS/04_CMSSponsoredCalls.asp.

Visit the CMS Booth at the AMGA 2012 Annual Conference [[↑](#)]

Wed Mar 7 through Sat Mar 10

Booth #802

CMS will be at the American Medical Group Association 2012 Annual Conference from Wed Mar 7 to Sat Mar 10. Representatives from the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs will be at Booth #802 during exhibit hall hours to discuss your questions about the programs and to provide helpful resources and fact sheets to assist you with registration, meaningful use, attestation, and other areas of the incentive programs.

Be sure to also join the [Office of the National Coordinator for Health Information Technology](#) (ONC) and Dr Farzad Mostashari, the National Coordinator for Health IT, on Sat Mar 10, 12-1:45pm. Dr Mostashari will discuss the strategies ONC is undertaking to help physicians receive their meaningful use incentive payments in 2012. In addition, he will outline ONC's national strategy for advancing the secure exchange of health information as well as efforts within HHS to connect the dots on payment reform, quality incentives, and health IT. More information about this presentation can be found on the [AMGA website](#).

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.

- Additional material related to Electronic Health Records in today's e-News... [[previous](#)]

“Long Term Care Hospital Quality Reporting Program” Train-the-Trainer Conference – Register by Wed Mar 21 [[↑](#)]

Tue May 1 and Wed May 2

Sheraton Baltimore City Center Hotel; 101 West Fayette Street, Baltimore, MD 21201

To support the implementation of the Long Term Care Hospital (LTCH) Quality Reporting Program (QRP), for which data collection begins Mon Oct 1, 2012, CMS is hosting a LTCH QRP Train-the Trainer Conference on Tue May 1 and Wed May 2 (at the Sheraton Baltimore City Center Hotel, 410-742-1100).

This conference is open to all long-term care hospital providers, associations, and organizations that support quality care in the nation's long-term care hospitals. The goals of the conference are to:

- Introduce the structure of the LTCH Care Data Set, the data collection instrument that will be used by LTCHs to collect data on the measure, Percent of Patients with a Pressure Ulcer That is New or Worsened
- Discuss assessment procedures and coding for key sections
- Discuss and understand data submission specifications

- Presentations by the Centers for Disease Control and Prevention on the Catheter Associated Urinary Tract Infection (CAUTI) and Central Line Associated Blood Stream Infection (CLABSI) measures as well as the use of the National Health Safety Network (NHSN) for submitting data associated with these measures

Registration for the conference ends Wed Mar 21. Hotel registrations will not be accepted until registration begins, at which time reservations may be made by phone or online.

Additional information is available at the conference website at www.totalsolutions-inc.com/natconference, and questions can be submitted to conference2@totalsolutions-inc.com.

For more information on the LTCH QRP, visit the [Long Term Care Hospital Quality Reporting Program](#) website.

“Inpatient Rehabilitation Facility Patient Assessment Instrument New Quality Indicators Section” Train-the-Trainer Conference – Register by Fri Mar 16 [[↑](#)]
Wed May 2

Sheraton Baltimore City Center Hotel; 101 West Fayette Street, Baltimore, MD 21201

To support the implementation of the Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP), for which data collection begins Mon Oct 1, 2012, CMS will host an “IRF Patient Assessment Instrument (PAI) New Quality Indicators” Train-the-Trainer Conference on Wed May 2 (at the Sheraton Baltimore City Center Hotel, 410-742-1100).

This conference is open to all Inpatient Rehabilitation Facility providers, associations, and organizations that support quality care in inpatient rehabilitation facilities. The goals of the conference are to:

- Introduce the Quality Indicator item set that has been added to the IRF-PAI
- Discuss assessment procedures and coding for the 2 quality measures:
 - Catheter Associated Urinary Tract Infections (CAUTI), and
 - Pressure Ulcers
- Discuss data submission specifications, including presentations by the Centers for Disease Control and Prevention on the CAUTI, and the use of the National Health Safety Network for submitting data associated with this measure

Note that this training is specific to the new Quality Indicators Section of the IRF-PAI and the reporting of CAUTI data to the CDC. The training will not cover the IRF-PAI in its entirety.

Registration for the conference ends Fri Mar 16. Hotel reservations will not be accepted until registration has closed, at which time reservations may be made by phone or online; each participant will be limited to one room reservation.

Additional information is available at the conference website at www.totalsolutions-inc.com/natconference, and questions can be submitted to conference2@totalsolutions-inc.com.

Raise Awareness in March about Kidney Disease – National Kidney Disease Month and World Kidney Day [[↑](#)]

Please join CMS during National Kidney Month and World Kidney Day (on Thu Mar 8) in raising awareness about chronic kidney disease. Millions of Americans are at risk for chronic kidney disease and diabetes, and may be able to prevent the need for dialysis and kidney transplantation with early identification and a dedication to healthy lifestyle habits. Early disease detection is key, and the kidney disease-related services covered by Medicare are a great starting point for beneficiaries.

The incidence of kidney failure, or end-stage renal disease (ESRD), is rising fast in America, with more than 546,000 patients currently receiving treatment. Medicare covers a range of related services for eligible Medicare beneficiaries including diabetes screening tests, diabetes self-management training, medical nutrition therapy, kidney disease education services, dialysis, and transplant services.

What Can You Do?

- Use services like the “Welcome to Medicare” Preventive Visit and the Annual Wellness Visit as opportunities to talk with your Medicare patients about their risk factors for disease, and to provide referrals, as appropriate.
- Help them to understand that the early detection and treatment of kidney disease can prevent or delay many associated illnesses and complications.
- Help protect the health of your Medicare-covered patients by informing them of Medicare-covered kidney disease and diabetes-related services, as appropriate.
- Remember, many of these services require an order or referral for coverage by Medicare; please ensure that you provide your Medicare patients with the appropriate documentation so they can receive the services needed to help prevent, treat, and manage kidney disease and its complications.

More Information for Healthcare Professionals:

- [The Guide to Medicare Preventive Services](#)
 - Chapter 1: Initial Preventive Physical Exam (commonly known as the “Welcome to Medicare” Preventive Visit)
 - Chapter 4: Annual Wellness Visit
 - Chapter 6: Diabetes-related services
- [Medicare Preventive Services Quick Reference Information Chart](#)
- [MLN Diabetes-Related Services factsheet](#)
- [End-Stage Renal Disease Prospective Payment System factsheet series](#)
- [National Kidney Foundation website](#)
- [National Kidney Foundation – “Chronic Kidney Disease on the Rise”](#)
- [National Diabetes Education Program Healthcare Professionals website](#)
- [2011 National Diabetes factsheet](#)

Thank you for joining with CMS to help increase awareness and educate about kidney and diabetes-related services covered by Medicare.

- Additional material related to Preventive Health Services in today’s e-News... [\[next\]](#)

March is National Nutrition Month [\[↑\]](#)

CMS reminds healthcare professionals that March is National Nutrition Month® – a campaign focused on the importance of making informed food choices, and developing sound eating and physical activity habits. More than 35 percent of American men and women are obese, and adult obesity is associated with a number of serious health conditions, including heart disease, hypertension, diabetes, and some cancers.

Medicare provides coverage for the following nutrition-related health services:

- Intensive Behavioral Therapy (IBT) for Obesity – *Effective Tue Nov 29, 2011*
 - Medicare provides coverage of Intense Behavioral Therapy for Obesity for qualifying beneficiaries whose body mass index (BMI) is equal or greater than 30 kg/m². This coverage includes Screening for obesity in adults using measurement of BMI, a Dietary (nutritional) assessment, and intensive behavioral counseling and behavioral therapy to promote sustained weight loss through high intensity interventions on diet and exercise. This coverage includes one face-to-face visit every week for the first month, one face-to-face visit every other week for months 2-6, and one face-to-face visit every month for months 7-12, if the beneficiary meets the 3kg (6.6 lbs) weight loss requirement during the first 6 months.
- Intensive Behavioral Therapy for Cardiovascular Disease – *Effective Tue Nov 8, 2011*
 - Medicare provides coverage of IBT for cardiovascular disease (referred to as a CVD risk reduction visit). The visit consists of the following three components:
 - Encouraging aspirin use for the primary prevention of cardiovascular disease when the benefits outweigh the risks for men age 45-79 years and women 55-79 years;
 - Screening for high blood pressure in adults age 18 years and older; and
 - Intensive behavioral counseling to promote a healthy diet for adults with hyperlipidemia, hypertension, advancing age, and other known risk factors for cardiovascular and diet-related chronic disease.
- Medical Nutrition Therapy (MNT)
 - Medicare provides coverage of MNT *for certain beneficiaries diagnosed with diabetes and/or renal disease**, when referred by the treating physician and provided by a registered dietitian or nutrition professional.
- Diabetes Self-Management Training (DSMT)
 - Medicare provides coverage of DSMT services for beneficiaries who have been diagnosed with diabetes. DSMT services are intended to educate beneficiaries in the successful self-management of diabetes. A qualified DSMT program includes among other services education about nutrition, diet, and exercise.
- Annual Wellness Visit
 - The Annual Wellness Visit presents an opportunity for health professionals to provide eligible beneficiaries with personalized health advice and referrals, as appropriate, to health education, preventive counseling services, and community-based lifestyle interventions, focusing on reducing health risks and promoting self-management and wellness, including weight loss, physical activity, smoking cessation, fall prevention, and nutrition.

What Can You Do?

You can help your Medicare patients live healthier lives in 2012 by encouraging the use of the above Medicare-covered services. These services present excellent opportunities to begin a dialogue with your Medicare patients about their dietary habits and how their eating habits may affect their health, and make recommendations for preventive services that can help them reach their nutritional and dietary goals. Remember to provide any appropriate written referrals.

More Information for Healthcare Professionals:

- [MLN Guide to Medicare Preventive Services](#) (see Chapter 6)
- [MLN Diabetes-Related Services factsheet](#)
- [National Coverage Determination \(NCD\) for Medical Nutrition Therapy](#)
- [National Diabetes Education Program](#)
- [National Nutrition Month website](#)
- [Nutrition Education Resources](#)
- [Million Hearts™ campaign website](#)

* Note that, for the purpose of this benefit, renal disease means chronic renal insufficiency or the medical condition of a beneficiary who has been discharged from the hospital after a successful renal transplant for up to 36 months post transplant. Chronic renal insufficiency means a reduction in renal function not severe enough to require dialysis or transplantation [Glomerular Filtration Rate (GFR) 13-50 ml/min/1.73m2].

- Additional material related to Preventive Health Services in today's e-News... [\[previous\]](#)

Medicare Redesigns Claims and Benefits Statement [\[↑\]](#)

As part of National Consumer Protection Week, the CMS Acting Administrator, Marilyn Tavenner, announced the redesign of the statement that informs Medicare beneficiaries about their claims for Medicare services and benefits. The redesigned statement, known as the Medicare Summary Notice (MSN), will be available online and, starting in 2013, mailed out quarterly to beneficiaries.

This MSN redesign is part of a new initiative – “Your Medicare Information: Clearer, Simpler, At Your Fingertips” – which aims to make Medicare information clearer, more accessible, and easier for beneficiaries and their caregivers to understand. CMS will take additional actions this year to make information about benefits, providers, and claims more accessible and easier to understand for seniors and people with disabilities who have Medicare. This MSN redesign reflects more than 18 months of research and feedback from beneficiaries to provide enhanced customer service and respond to suggestions and input.

To see a side-by-side comparison of the former and redesigned MSNs, please visit http://www.CMS.gov/apps/files/msn_changes.pdf.

Starting later this week, the redesigned MSN will be available to beneficiaries on www.MyMedicare.gov, Medicare's secure online service for personalized information regarding Medicare benefits and services; in early 2013, paper copies of the redesigned MSN will start to replace the current version being mailed.

The full text of this excerpted CMS press release (issued Wed Mar 7) can be found at <http://www.CMS.gov/apps/media/press/release.asp?Counter=4298>.

Health Reform Law Ends Lifetime Limits for 105 Million Americans [\[↑\]](#)

HHS Secretary Sebelius released a new report on Mon Mar 5 on how the health reform law has eliminated lifetime limits on coverage for more than 105 million Americans. Before health reform, many Americans with serious illnesses such as cancer risked hitting the lifetime limit on the dollar amount their insurance companies would cover for their healthcare benefits.

The end of lifetime limits is one of many new consumer rights and protections in the law for Americans nationwide. In the report, HHS provides data on the number of people in each state that benefit from this component of the law. The Obama administration also released updated state data on other ways the new law has impacted Americans, including the number of people with Medicare receiving new preventive benefits and the various grants awarded to states.

While some plans provided coverage without dollar limits on lifetime benefits, 105 million Americans were previously in health plans that had lifetime limits. HHS estimates that 70 million people in large employer plans, 25 million people in small employer plans, and 10 million people with individually-purchased health insurance had lifetime limits on their health benefits prior to the passage of the *Affordable Care Act*. This includes 39.5 million women and 28 million children; 11.8 million Latinos and 10.4 million African Americans.

To view the report on lifetime limits, visit <http://aspe.HHS.gov/health/reports/2012/LifetimeLimits/ib.shtml>. To view additional state-by-state data on the

benefits of health reform, visit <http://www.WhiteHouse.gov/blog/2012/03/04/new-data-affordable-care-act-your-state>.

The full text of this excerpted HHS press release (issued Mon Mar 5) can be found at <http://www.HHS.gov/news/press/2012pres/03/20120305a.html>.

Ordering/Referring Reports Now Contain Complete National Provider Identifier [\[↑\]](#)

In response to concerns raised by the provider community, CMS is including the complete NPI on the following ordering & referring reports found on the CMS website at http://www.CMS.gov/MedicareProviderSupEnroll/06_MedicareOrderingandReferring.asp (in the 'Downloads' section of the page):

- Ordering/Referring Report
- Initial Physician Applications Pending Contractor Review
- Initial Non Physician Applications Pending Contractor Review

Medicare Claims Must be Submitted in 5010 Format Beginning Sun Apr 1 [\[↑\]](#)

CMS is pleased to report that the vast majority of provider claims are being sent to Medicare in 5010 format. Given these favorable results, we are taking the next step towards full implementation of 5010 in Medicare Fee-For-Service (FFS).

Effective Sun Apr 1, 2012, your Medicare FFS transactions must be in 5010 format. Transactions placed in 4010 formatting will be returned as unprocessable. Failure to submit 5010 formatting will result in your claim being unpaid/denied.

Medicare FFS transition statistics are available for download at http://www.CMS.gov/EDIPerformanceStatistics/10_5010Statistics.asp. These statistics represent the transition from the current *Health Insurance Portability and Accountability Act (HIPAA)*-adopted Accredited Standards Committee (ASC) X12 Version 4010A1 and the National Council for Prescription Drug Programs (NCPDP) Version 5.1 transactions to the updated *HIPAA* ASC X12 version 5010 and NCPDP version D.0 transactions. The transition statistics cover the following:

- Part A Claims and Remittances
- Part B/DME Claims and Remittances
- NCPDP Claims
- Eligibility Inquiries and Responses
- Claim Status Inquiries and Responses

For more information on 5010, please visit <http://www.CMS.gov/Versions5010andD0>.

January 2012 Updates to the Physician Compare Website [\[↑\]](#)

On Thu Jan 26, CMS released its quarterly enhancement to the Physician Compare website. Improvements were based on recommendations made during July 2011 testing as well as suggestions from users and stakeholders. This is part of the Agency's ongoing effort to improve the Physician Compare website's data accuracy and ease of use.

What's New?

- *Page updates:* Home, results, and profile pages were updated and content reorganized to make it easier for providers and beneficiaries to find information. For example, a new menu option, “Provider Resources,” is a direct link providers can use to find information about updating their PECOS information.
- *Improved feedback tool:* The tool now allows providers and beneficiaries to contact Physician Compare administrators directly with questions or concerns.

For additional information on future new releases and updates visit the [Physician Compare website](#).

Comment Period Extended for Off-The-Shelf Orthotic HCPCS Codes [[↑](#)]

CMS has announced an extension of time for submitting comments on the list of HCPCS codes initially designated as off-the-shelf orthotics (OTS).

Comments on the list of OTS HCPCS codes may be submitted until close of business on Fri Mar 16, 2012, via email to OTSComments@cms.hhs.gov.

This extension is being granted in response to a request from stakeholders.

For more information and to view the list of OTS HCPCS codes, please visit http://www.CMS.gov/DMEPOSFeeSched/04_OT_Orthotics.asp.

From the MLN: “Important Information Concerning Medicare Outreach Efforts to Supplemental Payers Directing Their Payments to Incorrect Addresses” MLN Matters Article Released [[↑](#)]

MLN Matters Special Edition Article #SE1212, “[Important Information Concerning Medicare Outreach Efforts to Supplemental Payers Directing Their Payments to Incorrect Addresses](#),” has been released and is now available in downloadable format. This article is designed to provide education on issues related to supplemental payers directing payment to incorrect addresses, and includes different scenarios to illustrate these issues and guidance providers can use to avoid them.

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