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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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Colleagues—

We have decided to return to issuing the e-News once a week. Beginning next week, look for the e-News on *Wednesdays*.

Thanks for your continued help sharing CMS news with Medicare FFS providers.

Best regards,

—Robin

e-News for Thursday, April 19, 2012

NATIONAL PROVIDER CALLS

- April 25 – [Current Status of Medicare FFS Implementation of HIPAA Version 5010 and D.0 – Last Chance to Register](#)

OTHER CALLS, MEETINGS, AND EVENTS

- Webinar Series (begins April 23) – [Reporting Dialysis Events to CDC's National Healthcare Safety Network through Electronic Import Function](#)

ANNOUNCEMENTS AND REMINDERS

- [Consumers Can Now Compare Results from Home Health Agencies Patient Surveys](#)
- [New Report: Competitive Bidding Saving Money for Taxpayers and People with Medicare](#)
- [Quality Reporting Communication Support Page Now Available for Medicare Electronic Prescribing Payment Adjustment Hardship Exemption Requests](#)
- [CMS Inpatient Rehabilitation Facility Software Webpage Updated](#)
- [Louisiana's Medicaid EHR Incentive Program First in Nation to Issue an Incentive Payment for Eligible Professionals for Meaningful Use](#)
- [New Delivery Reform CME Module Posted on Medscape](#)

CODE, CLAIM, AND PRICER

- [Holding of ESRD 72X Claims with HCPCS J3370](#)
- [Holding of CAH Method II Provider 85X Claims With Modifier 22](#)
- [Quarterly Provider Specific Files for the Prospective Payment System are Now Available](#)

UPDATES FROM THE MEDICARE LEARNING NETWORK[®]

- ["Home Health Prospective Payment System" Fact Sheet Revised](#)
- ["Mental Health Services" Booklet Revised](#)

National Provider Call: Current Status of Medicare FFS Implementation of HIPAA Version 5010 and D.0 – Register Now [\[↑\]](#)

Wednesday April 25; 2-3:30pm ET

CMS is hosting a National Provider Call regarding the current status of Medicare FFS implementation of HIPAA Version 5010 and D.0. This National Provider Call focuses on addressing the current 5010/D.0 metrics, addressing recommendations made by Medicare FFS, as well possible outstanding fixes impacting the Part A and Part B Version 5010 transition.

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

Agenda:

- Current 5010/D.0 metrics
- Addressing recommendations made by Medicare FFS

- Possible outstanding fixes impacting the Part A and Part B Version 5010 transition
- Q&A session

Registration Information: In order to receive call-in information, you must register for the call on the [CMS Upcoming National Provider Calls webpage](#). 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.

Presentation and Webinar: The presentation for this call will be posted at least one day in advance on the [FFS National Provider Calls webpage](#). In addition, the presentation will be emailed to all registrants on the day of the call. CMS will be using an optional webinar feature as part of this National Provider Call. Complete details on this feature are available on the [CMS Upcoming National Provider Calls webpage](#).

Webinar Series: Reporting Dialysis Events to CDC's National Healthcare Safety Network through Electronic Import Function [[↑](#)]

Series begins Monday, April 23—register today, spaces are limited

The Centers for Disease Control and Prevention (CDC) is hosting a webinar series for those dialysis organizations and software vendors interested in using an electronic import function to meet CMS End-Stage Renal Disease (ESRD) Quality Incentive Program (QIP) reporting requirements for the Dialysis Event Reporting measure.

In August 2012, a software update to CDC's National Healthcare Safety Network (NHSN) will be released, enabling dialysis facilities to submit NHSN Dialysis Event and denominator data electronically via Health Level Seven's (HL7's) Clinical Document Architecture (CDA) standard. In an effort to provide more information to dialysis electronic medical record software vendors and large dialysis organizations that may wish to update their systems to take advantage of this new capability, NHSN is offering a series of webinars to introduce vendor implementers to the CDA solution for reporting NHSN Dialysis Events. The webinars will provide an introduction to the NHSN Dialysis Event reporting protocol and the technical specifications for the use of CDA in reporting healthcare-associated infection data to NHSN, featuring a review of the NHSN CDA Implementation Guide for Dialysis Event reporting.

The webinar series is directed towards dialysis software vendors and other organizations who wish to submit Dialysis Event data to NHSN on behalf of a collection of individual dialysis facilities. It is intended to explain the requirements to a technical audience for software development and is not targeted at individual dialysis facilities. Individual dialysis facilities interested in learning more about NHSN Dialysis Event Reporting should take advantage of the extensive training library at <http://www.cdc.gov/nhsn/training/>.

The first webinar presentation is scheduled for Monday, April 23rd. For more information about the webinar series, *including instructions on how to register to attend*, please contact nhsncda@cdc.gov.

For general questions about the ESRD QIP not related to this webinar series, please contact ESRDQIP@cms.hhs.gov.

Consumers Can Now Compare Results from Home Health Agencies Patient Surveys [[↑](#)]

CMS to publicly report on consumer experiences with Medicare-certified home health agencies

Results from the CMS national survey that asks patients about their experiences with Medicare-certified home health agencies are now available on the agency's

[Quality Care Finder website.](#)

CMS Acting Administrator Marilyn Tavenner today announced the new tool offering prospective patients, their families and caregivers the chance to compare home health agencies by looking at patient survey results. The Home Health Care Consumer Assessment of Healthcare Providers and Systems (HHCCHPS) Survey, which will be updated every four months with new survey data, will complement the clinical measures already available on the agency's "Home Health Compare" website.

The HHCCHPS is a survey that collects feedback on topics that patients have identified as important to them in determining which home health agencies provide high-quality care. For example, the survey asks patients about the care they received from their home health agency, including such topics as overall care; provider communication skills; whether care was provided in a courteous and respectful way; and whether the agency discussed medicines, pain, and home safety.

A prospective patient or caregiver will be able to review and compare feedback from other patients about Medicare-certified home health agencies' care of patients, communication between providers and patients, as well as the specific care issues identified on the survey. Ratings include an overall rating of home health care and a patient's willingness to recommend the agency to someone else.

The survey results are designed to create incentives for home health agencies to improve quality of care, as well as to give patients additional information so they are aware of the types of care they will receive from a particular agency. Additionally, public reporting enhances accountability in health care by increasing transparency.

For more information on the survey, visit the [Home Health Care CHPS Survey webpage](#).

To access the survey data, visit the [Quality Care Finder tool in Medicare.gov](#) and click on Home Health Compare.

[Full text of this excerpted CMS press release \(issued April 19\)](#)

New Report: Competitive Bidding Saving Money for Taxpayers and People with Medicare [\[↑\]](#)

Health care law expands second round, program will save up to \$42.8 billion

People with Medicare are already saving money on durable medical equipment (DME) through the Medicare competitive bidding program, according to a report issued April 18 by HHS Secretary Kathleen Sebelius.

According to the report, the program saved \$202 million in its first year in nine metropolitan statistical areas – a reduction of 42 percent in costs and, as the program expands under the *Affordable Care Act* and earlier law, it could save up to \$42.8 billion for taxpayers and beneficiaries over the next 10 years.

The report also released results that show, after extensive monitoring by CMS, there have been no negative effects on the health of people on Medicare or their access to needed supplies and services.

Key information in the report:

- Seniors, and people with disabilities in Medicare, will directly save a projected \$17.1 billion due to lower co-insurance for durable medical equipment and lower premiums for Medicare over the next decade, while taxpayers are projected to save an additional \$25.7 billion through the Medicare Supplementary Medical Insurance Trust Fund because of reduced prices.
- In the first year of implementation in nine metropolitan statistical areas, through a combination of lower prices and fewer unnecessary services, the competitive bidding program saved Medicare \$202 million.
- Medicare beneficiaries in the nine areas had substantial reductions in their co-insurance for DME.
- Last year alone, people with Medicare saved up to \$105 on hospital beds, \$168 on oxygen concentrators, and \$140 on diabetic test strips.
- A real-time claims monitoring system, set up to ensure that access to supplies was not compromised, has found that people on Medicare continue to have access to all necessary and appropriate items.

The *Affordable Care Act* expands Round 2 of the DME competitive bidding program from 70 to 91 metropolitan statistical areas across the country. CMS is evaluating bids from suppliers for the 91 areas. By 2016, all areas of the country will benefit from either the competitive bidding program or lower rates based on the competitively bid rates.

[View the full report.](#)

[Full text of this excerpted CMS press release \(issued April 18\)](#)

Quality Reporting Communication Support Page Now Available for Medicare Electronic Prescribing Payment Adjustment Hardship Exemption Requests [\[↑\]](#)

In 2009, CMS implemented the Electronic Prescribing (eRx) Incentive Program, which is a program that uses incentive payments and payment adjustments to encourage the use of qualified electronic prescribing systems.

From calendar year (CY) 2012 through 2014, a payment adjustment that increases each calendar year will be applied to an eligible professional's Medicare Part B Physician Fee Schedule (PFS) covered professional services for not becoming a successful electronic prescriber. The payment adjustment of 1.0 percent in 2012, 1.5 percent in 2013, and 2.0 percent in 2014 will result in an eligible professional or group practice participating in the eRx Group Practice Reporting Option (eRx GPRO) receiving 99.0 percent, 98.5 percent, and 98.0 percent respectively of their Medicare Part B Physician Fee Schedule (PFS) amount for covered professional services.

Avoiding the 2013 eRx Payment Adjustment

Individual eligible professionals and CMS-selected group practices participating in eRx GPRO who were not successful electronic prescribers in 2011 can avoid the 2013 eRx payment adjustment by meeting the specified reporting requirements between January 1 and June 30, 2012.

6-month Reporting Requirements to Avoid the 2013 Payment Adjustment:

- Individual Eligible Professionals – 10 eRx events via claims
- Small eRx GPRO – 625 eRx events via claims
- Large eRx GPRO – 2,500 eRx events via claims

For more information on individual and eRx GPRO reporting requirements, please review [MLN Article SE1206 - 2012 Electronic Prescribing \(eRx\) Incentive](#)

[Program: Future Payment Adjustments.](#)

CMS may exempt individual eligible professionals and group practices participating in eRx GPRO from the 2013 eRx payment adjustment if it is determined that compliance with the requirements for becoming a successful electronic prescriber would result in a significant hardship.

Significant Hardships

The significant hardship categories are as follows:

- The eligible professional is unable to electronically prescribe due to local, state, or federal law, or regulation
- The eligible professional has or will prescribe fewer than 100 prescriptions during a 6-month reporting period (January 1 through June 30, 2012)
- The eligible professional practices in a rural area without sufficient high-speed Internet access (G8642)
- The eligible professional practices in an area without sufficient available pharmacies for electronic prescribing (G8643)

Submitting a Significant Hardship Code or Request

To request a significant hardship, individual eligible professionals and group practices participating in eRx GPRO must submit their significant hardship exemption requests through the [Quality Reporting Communication Support Page](#) (Communications Support Page) on or between March 1 and June 30, 2012. Please remember that CMS will review these requests on a case-by-case basis. All decisions on significant hardship exemption requests will be final.

Significant hardships associated with a G-code may be submitted via the Communication Support Page OR on at least one claim during the 2013 eRx payment adjustment reporting period (January 1 through June 30, 2012). If submitting a significant hardship G-code via claims, it is not necessary to request the same hardship through the Communication Support Page.

For more information on how to navigate the [Communication Support Page](#), please reference the following documents:

- [Quality Reporting Communication Support Page User Guide](#)
- [Tips for Using the Quality Reporting Communication Support Page](#)

For additional information and resources, please visit the [Electronic Prescribing Incentive Program webpage](#).

If you have questions regarding the eRx Incentive Program, eRx payment adjustments, or need assistance submitting a hardship exemption request, please contact the QualityNet Help Desk at 1-866-288-8912 (TTY 1-877-715-6222) or via gnetsupport@sdps.org. They are available Monday through Friday from 7am-7pm CST

CMS Inpatient Rehabilitation Facility Software Webpage Updated [\[↑\]](#)

The [CMS IRF Software webpage](#) has been updated with a note about the version 1.10 data specifications, information about using the current CMG grouper and a set of XML test records for vendor use. Call notes and Questions & Answers from the IRF Vendor Call on February 23 are posted on [the QTSO webpage](#).

Louisiana's Medicaid EHR Incentive Program First in Nation to Issue an Incentive Payment for Eligible Professionals for Meaningful Use [\[↑\]](#)

Louisiana is the first state in the nation to issue an incentive payment to a Medicaid eligible professional (EP) for demonstrating meaningful use of certified electronic health record (EHR) technology for the Medicaid EHR Incentive Program. The Louisiana Department of Health and Hospitals made the payment to the Winn Community Health Center, a federally qualified health center (FQHC), on behalf of three EPs. The Winn Community Health Center, a small rural community center staffed by a physician, a nurse practitioner, and a physician's assistant, was also the first FQHC in Louisiana to enroll with the state health information exchange (HIE).

Through the Medicaid EHR Incentive Program, EPs and eligible hospitals can receive a payment during their first year of participation for adopting, implementing, or upgrading to certified EHR technology. They must [demonstrate meaningful use](#) of certified EHR technology in ways that can be measured significantly in both quality and in quantity to receive continued payments after their first year. Medicaid EPs can earn a total of \$63,000 over six years.

More than 76,000 providers have already received a Medicare or Medicaid EHR incentive payment for successfully adopting, implementing, upgrading, or demonstrating meaningful use of EHRs. Of the total providers paid, more than 30,000 of them participated in the Medicaid EHR Incentive Program. As more Medicaid EPs begin their second year of the EHR Incentive Program and achieve meaningful use in 2012, thousands of additional providers will receive their EHR incentive payments. Visit the [CMS YouTube page](#) for stories from providers about their experiences with meaningful use.

Want more information about the Medicare and Medicaid EHR Incentive Programs?

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

New Delivery Reform CME Module Posted on Medscape [\[↑\]](#)

On April 3, Medscape posted a new CME module entitled, "[CMS and Primary Care: A New World](#)," highlighting the delivery system reforms created by the ACA.

Holding of ESRD 72X Claims with HCPCS J3370 [\[↑\]](#)

Payments for Vancomycin injections (HCPCS code J3370) did not apply coinsurance and deductible correctly for End Stage Renal Disease (ESRD) Prospective Payment System (PPS) providers beginning April 2.

Medicare Contractors have been instructed to hold 72X type of bill (TOB) with dates of service on or after January 1, 2012 billing J3370 with the AY modifier. The FISS maintainer is correcting the coinsurance and deductible application issue; the fix is scheduled to be in production on May 7. Medicare Contractors will release the held claims upon the successful implementation of this fix. No provider action is required.

Holding of CAH Method II Provider 85X Claims With Modifier 22 [\[↑\]](#)

Medicare pays for multiple surgeries by ranking from the highest Medicare Physician Fee Schedule (MPFS) amount to the lowest MPFS amount. When the same physician performs more than one surgical service at the same session, the allowed amount is 100 percent for the surgical code with the highest MPFS amount. The allowed amount for the subsequent surgical codes is based on 50 percent of the MPFS amount. In rare situations these payment rules do not apply and may be bypassed by using modifier 22.

Since April 2, the reduction has been erroneously applied to line items containing modifier 22. Medicare contractors have been instructed to hold 85X type of bills (TOBs), including adjustments, if a 22 modifier is present. Medicare Contractors will release the held claims upon the successful implementation of the fix which is scheduled for June 4. No provider action is required.

Quarterly Provider Specific Files for the Prospective Payment System are Now Available [\[↑\]](#)

The April 2012 Provider Specific Files (PSF) are now available for download from the CMS website in SAS or Text format. The files contain information about the facts specific to the provider that affect computations for the Prospective Payment System. The SAS data files are available on the [Provider Specific Data for Public Use In SAS Format webpage](#), and the Text data files are available on the [Provider Specific Data for Public Use in Text Format webpage](#). The Text data files are available in two versions. One version contains the provider records that were submitted to CMS. The other version also includes name and address information for providers at the end of the records.

From the MLN: “Home Health Prospective Payment System” Fact Sheet Revised [\[↑\]](#)

The “[Home Health Prospective Payment System](#)” fact sheet (ICN 006816) has been revised and is now available in downloadable format. It includes the following information: background, consolidated billing requirements, criteria that must be met to qualify for home health services, coverage of home health services, elements of the HH PPS, updates to the HH PPS, and healthcare quality.

From the MLN: “Mental Health Services” Booklet Revised [\[↑\]](#)

The “[Mental Health Services](#)” booklet (ICN 903195) has been revised and is now available in downloadable format. It includes the following information: covered mental health services, mental health services that are not covered, eligible professionals, outpatient psychiatric hospital services, and inpatient psychiatric hospital services.

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