This issue of the e-News will be available in PDF format within 24 hours of its release in the archive with other past issues.

CMS Medicare FFS Provider e-News

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

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

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The e-News for Wednesday, April 25, 2012

NATIONAL PROVIDER CALLS

- Audio Recording and Written Transcript from March 28 National Provider Call on the Initial Preventive Physical Exam /Annual Wellness Visit Now Available

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UPDATES FROM THE MEDICARE LEARNING NETWORK ®

- "Health Professional Shortage Area (HPSA) Physician Bonus, HPSA Surgical Incentive Payment, and Primary Care Incentive Payment Programs" Fact Sheet Revised
- "Quick Reference Information: Medicare Immunization Billing" Revised
- "Medicare Quarterly Provider Compliance Newsletter [Volume 2, Issue 3]" Released
- "Correction to Processing of Hospice Discharge Claims" MLN Matters® Article Revised

Audio Recording and Written Transcript from March 28 National Provider Call on the Initial Preventive Physical Exam/Annual Wellness Visit Now Available [↑]

The audio recording and written transcript from the March 28 Medicare Preventive Services National Provider Call on the Initial Preventive Physical Exam (IPPE) and the Annual Wellness Visit (AWV) are now available on the March 28 National Provider Calls and Events detail page in the "Presentation Materials" section.

Medicare Proposed Payment Rule Would Promote Improved Inpatient Care [↑]
Proposed Rule Would Strengthen Tie Between Payment and Quality Improvement

On April 24, CMS issued a proposed rule that would update Medicare payment policies and rates for inpatient stays to general acute care hospitals paid under the Inpatient Prospective Payment System (IPPS) and long-term care hospitals (LTCHs) paid under the LTCH Prospective Payment System (PPS). This proposed rule is a continuation of our efforts to promote improvements in hospital care that will lead to better patient outcomes while slowing the long-term health care cost growth.

CMS is projecting that payment rates to general acute care hospitals will increase by 2.3 percent in FY 2013. The 2.3 percent is a net update after inflation, improvements in productivity, a statutory adjustment factor, and adjustments for hospital documentation and coding changes. CMS projects that the rate increase, together with other policies in the proposed rule and projected utilization of inpatient services, would increase Medicare's operating payments to acute care hospitals by approximately 0.9 percent in FY 2013. After taking into account the expiration of certain statutory provisions that provided special temporary increases in payments to hospitals, and other proposed changes to IPPS payment policies, CMS projects that total Medicare spending on inpatient hospital services will increase by about $175 million in FY 2013.

CMS projects that LTCH payments will increase by approximately $100 million or 1.9 percent in FY 2013 under the proposed rule. CMS is proposing an annual update to LTCH payment rates of 2.1 percent. As explained further below, in addition to this update for inflation (adjusted as required by the statute), the 2.1 percent update to LTCH payment rates will be reduced by approximately 1.3 percent to 0.8 percent for the "one-time" budget neutrality adjustment for discharges on or after December 29, 2012.

Improving Patient Care

The proposed rule would strengthen the Hospital Value-Based Purchasing Program (VBP Program) to further Medicare's transformation from a system that rewards volume of service to one that rewards efficient, high-quality care. This program, which was required by the *Affordable Care Act*, will adjust hospital payments beginning in FY 2013 and annually thereafter based on how well they perform or improve their performance on a set of quality measures.

Specifically, CMS is proposing to add the Medicare spending per beneficiary measure to the Hospital VBP Program, which would affect payments beginning in FY 2015. This measure would include all Part A and Part B payments (after removing differences attributable to geographic payment adjustments and other payment factors) from three days prior to an inpatient hospital admission through 30 days post discharge with certain exclusions. The proposed measure would be risk-adjusted for the beneficiary's age and severity of illness.

The proposed rule also includes a new outcome measure that rewards hospitals for avoiding certain kinds of life-threatening blood infections that can develop during inpatient hospital stays.This measure, the central line-associated bloodstream infection measure, supports ongoing work by CMS and other hospital safety leaders to reduce healthcare-associated infections through the Partnership for Patients initiative.

The proposed rule would also strengthen the inpatient quality reporting program (IQR). Specifically, CMS is proposing to include measures for perinatal care and readmissions, including overall readmissions and readmissions relating to hip and knee replacement procedures, and for the use of surgery checklists designed to reduce errors. CMS is also proposing to add a new survey measure to the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) measures to assess the quality of patients' care transitions.

To provide hospitals with an incentive to reduce hospital readmissions and improve care coordination, the *Affordable Care Act* required CMS to implement a Hospital Readmissions Reduction Program that will reduce payments beginning in FY 2013 (that is, for discharges on or after October 1, 2012) to certain hospitals that have excess readmissions for three selected conditions: heart attack, heart failure, and pneumonia. Today's rule proposes a methodology and the payment adjustment factors to account for excess readmissions for these three conditions.

The proposed rule also builds on the CMS quality reporting initiatives by proposing the measures that will be used for LTCHs for the FY 2015 and FY 2016 payment determinations and establishing programs and quality measure reporting for psychiatric hospitals that are paid under the Inpatient Psychiatric Facility Prospective Payment System and PPS-exempt cancer hospitals. Additional reporting requirements are also proposed for the ambulatory surgical center quality reporting program.

Documentation and Coding
The proposed rule would complete all documentation and coding adjustments for FY 2008 and FY 2009 as required by the TMA, Abstinence Education, and QI Programs Extension Act of 2007, while continuing to ensure that the new coding system introduced in 2008 is budget neutral. The net effect of all proposed documentation and coding adjustments is projected to result in an aggregate rate increase of 0.2 percent.

Expiration of Medicare, Medicaid, and SCHIP Extension Act Moratorium
In the Medicare, Medicaid, and SCHIP Extension Act of 2007, Congress imposed a three-year moratorium that prevented CMS from implementing certain payment policies affecting LTCHs. At the same time, the law imposed a moratorium on establishing new LTCHs and LTCH satellite facilities and on increasing the number of patient beds in existing LTCHs, unless an exception applied. The moratorium was extended for two years in the *Affordable Care Act* of 2010. The moratorium will, therefore, expire at various times in 2012.

In this rule, CMS is proposing:

- A one-year extension of the existing moratorium on the "25 percent threshold" policy, pending results of an on-going research initiative to re-define the role of LTCHs in the Medicare program.
- To apply an approximate 1.3 percent reduction (first year of a proposed three-year phase-in) for a one-time prospective budget neutrality adjustment. The proposed reduction would not apply to discharges occurring on or before December 28, 2012, because the law prohibits its application before that date. The budget neutrality adjustment reduces the update from 2.1 percent to 0.8 percent.
- To reduce Medicare payments for very short stay cases in LTCHs to the IPPS comparable per diem amount payment option for discharges occurring on or after December 29, 2012. The law prohibits application of this policy prior to that date.

The legislative moratorium on new LTCHs and satellite facilities will expire at the end of 2012.

CMS will accept comments on the proposed rule until June 25, 2012, and will respond to all comments in a final rule to be issued by August 1, 2012. The proposed rule can be downloaded from the *Federal Register* at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2012-09985.pdf or http://www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1. The proposed rule will appear in the May 11, 2012 *Federal Register*.

Full text of this excerpted CMS press release (issued April 24).

Health Care Law Protects Against Fraud, Saves Nearly $1.6 Billion [↑]
Law Requires Stronger Standards for Ordering and Certifying Medical Services, Equipment, and Supplies

On April 24, CMS announced a final rule that prevents fraud in Medicare and is estimated to save taxpayers nearly $1.6 billion over 10 years.

Today's rule ensures that only qualified, identifiable providers and suppliers can order or certify certain medical services, equipment and supplies for people with Medicare. The rule also helps ensure beneficiaries receive quality care because CMS will verify the credentials of a provider who is ordering or certifying equipment and supplies.

In addition, the final rule continues to require that all providers and suppliers who qualify for a unique identification number – the National Provider Identifier (NPI) — include their NPI on applications to enroll in Medicare and Medicaid and on all reimbursement claims submitted. This gives CMS and States the ability to tie specific claims to the ordering or certifying physician or eligible professional and to check for suspicious ordering activity.

This rule builds on the work CMS is also doing in Medicare Part D by requiring that all prescriptions include an NPI for prescribing physicians. In conjunction with Part D, these efforts will help better safeguard the Medicare Trust Funds by giving CMS the ability to know which providers are ordering, certifying, and prescribing items and services to Medicare beneficiaries.

To see the final rule, visit the Office of the Federal Register website.

Full text of this excerpted CMS press release (issued April 24).

Medicare Stable, But Requires Strengthening [↑]

The Medicare Trustees Report released on April 23 shows that the Hospital Insurance (HI) Trust Fund is expected to remain solvent until 2024, the same as last year's estimate, but action is needed to secure its long-term future. In 2011, the HI Trust Fund expenditures were lower than expected.

Without the *Affordable Care Act*, the HI Trust Fund would expire 8 years earlier, in 2016. The law provides important tools to control costs over the long run such as changing the way Medicare pays providers to reward efficient, quality care. These efforts to reform the healthcare delivery system are not factored into the Trustees projections as many of the initiatives are just launching.

The report projects that the Supplementary Medical Insurance (SMI) Trust Fund is financially balanced because beneficiary premiums and general revenue financing are set to cover expected program costs. Spending from the Part B account of the SMI trust fund grew at an average rate of 5.9 percent over the last 5 years.

SMI Part D, the Medicare prescription drug program, had an average growth rate of 7.2 percent over the last 5 years. Cost projections for Part D are lower

than in the 2011 Trustees report, due to lower spending in 2011 and greater expected use of generic drugs.

HI expenditures have exceeded income annually since 2008 and are projected to continue doing so under current law in all future years. Trust Fund interest earnings and asset redemptions are required to cover the difference. HI assets are projected to cover annual deficits through 2023, with asset depletion in 2024. After asset depletion, if Congress were to take no further action, projected HI Trust Fund revenue would be adequate to cover 87 percent of estimated expenditures in 2024 and 67 percent of projected costs in 2050. In practice, Congress has never allowed a Medicare trust fund to exhaust its assets.

The financial projections for Medicare reflect substantial cost savings resulting from the *Affordable Care Act*, but also show that further action is needed to address the program's continuing cost growth.

The report is now available.

Full text of this excerpted CMS press release (issued April 23).

The 30-Day Comment Period is Now Open for the HHS Proposed Rule to Delay ICD-10 [↑]

On April 9, HHS Secretary Kathleen Sebelius announced a proposed rule that would delay the compliance date for ICD-10 from October 1, 2013 to October 1, 2014. Comments are due to HHS no later than 5:00 pm ET on May 17.

HHS believes the change in the compliance date for ICD-10, as proposed in this rule, will give providers and other covered entities more time to prepare and fully test their systems to ensure a smooth and coordinated transition among all industry segments.
The 30-day comment period for this rule is an important way to provide feedback to HHS about the proposed ICD-10 compliance date change. You can submit comments in the following ways:

- Electronically by following the ''Submit a comment'' instructions on the Regulations.gov website
- By regular mail sent to:
  Centers for Medicare & Medicaid Services
  Department of Health and Human Services
  Attention: CMS–0040–P
  P.O. Box 8013
  Baltimore, MD 21244–8013

More information about the proposed rule can be found in the One-Year Delay of ICD-10 Compliance Date fact sheet, which outlines the background of the ICD-10 compliance date, and highlights provisions of the proposed rule and standards compliance date.

CMS Has an Updated FAQ about Attesting with Multiple Certified EHRs [↑]

CMS has recently updated an FAQ on attesting with multiple certified EHRs.

Question: For the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, how should an eligible professional (EP), eligible hospital, or critical access hospital (CAH) that sees patients in multiple practice locations equipped with certified EHR technology calculate numerators and denominators for the meaningful use objectives and measures?

Answer: EPs, eligible hospitals, and CAHs should look at the measure of each meaningful use objective to determine the appropriate calculation method for individual numerators and denominators. The calculation of the numerator and denominator for each measure is explained in the July 28, 2010 final rule (75 FR 44314).

For objectives that require a simple count of actions (e.g., number of permissible prescriptions written, for the objective of "Generate and transmit permissible prescriptions electronically (eRx)"; number of patient requests for an electronic copy of their health information, for the objective of "Provide patients with an electronic copy of their health information"; etc.), EPs, eligible hospitals, and CAHs can add the numerators and denominators calculated by each certified EHR system in order to arrive at an accurate total for the numerator and denominator of the measure.

For objectives that require an action to be taken on behalf of a percentage of "unique patients" (e.g., the objectives of "Record demographics", "Record vital signs", etc.), EPs, eligible hospitals, and CAHs may also add the numerators and denominators calculated by each certified EHR system in order to arrive at an accurate total for the numerator and denominator of the measure. Previously CMS had advised providers to reconcile information so that they only reported unique patients. However, because it is not possible for providers to increase their overall percentage of actions taken by adding numerators and denominators from multiple systems, we now permit simple addition for all meaningful use objectives.

Please keep in mind that patients whose records are not maintained in certified EHR technology will need to be added to denominators whenever applicable in order to provide accurate numbers.

To report clinical quality measures, EPs who practice in multiple locations that are equipped with certified EHR technology should generate a report from each of those certified EHR systems and then add the numerators, denominators, and exclusions from each generated report in order to arrive at a number that reflects the total data output for patient encounters at those locations. To report clinical quality measures, eligible hospitals and CAHs that have multiple systems should generate a report from each of those certified EHR systems and then add the numerators, denominators, and exclusions from each generated report in order to arrive at a number that reflects the total data output for patient encounters in the relevant departments of the eligible hospital or CAH (e.g., inpatient or emergency department (POS 21 or 23)).

Website Update
Please also note that the EHR Incentive Programs' FAQs were reorganized during the CMS.gov website upgrade. The EHR Incentive Programs' FAQs are now incorporated in the same page as other CMS program FAQs. To navigate the EHR Incentive Program FAQs you must go to the FAQ page, and click "Electronic Health Records Incentive Programs" on the blue navigation pane on the left-hand side. We appreciate your understanding and apologize for any inconvenience.

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.

Complete Signing Your Medicare Enrollment Application Electronically [↑]

Internet-based PECOS (Provider Enrollment, Chain, and Ownership System) now allows providers to sign Medicare enrollment applications electronically. You can save time and expedite review of your application by utilizing the electronic signature process. *This feature does not change who is required to sign the application.*

Authorized officials of the Organization will receive an email providing the steps they need to take to electronically sign the enrollment application. This email will be automatically sent when the enrollment application is submitted. Make sure to add "customerservice-donotreply@cms.hhs.gov" to your safe sender list and check your spam or junk mail folders to ensure you receive the electronic signature email notifications.

An example of the beginning of the email to the authorized official is shown below:

> From: customerservice-donotreply@cms.hhs.gov
> Subject: Pending Medicare E-Signature Request (Tracking ID: XXXXXX0047)
> An application on behalf of Lexa Hospital was recently submitted by:
> Submitters Name: Lexa Smith
> Submitters Phone: 5555555555
> Submitters Email: lexa.smith@lexahospital.com

For more information about signing your Medicare enrollment electronically, see "Sign Your Medicare Enrollment Application Electronically" in the March 29 edition of the e-News .

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 qnetsupport@sdps.org. They are available Monday through Friday from 7am-7pm CST

From the MLN: "Health Professional Shortage Area (HPSA) Physician Bonus, HPSA Surgical Incentive Payment, and Primary Care Incentive Payment Programs" Fact Sheet Revised [↑]

The "Health Professional Shortage Area (HPSA) Physician Bonus, HPSA Surgical Incentive Payment, and Primary Care Incentive Payment Programs" fact sheet (previously titled Health Professional Shortage Area) (ICN 903196) has been revised and is now available in downloadable format. It includes an overview of the HPSA Physician Bonus, HPSA Surgical Incentive Payment, and Primary Care Incentive Payment Programs.

From the MLN : "Quick Reference Information: Medicare Immunization Billing" Revised [↑]

"Quick Reference Information: Medicare Immunization Billing" (ICN 006799) has been revised and is now available in downloadable format. This educational tool is designed to provide education on Medicare-covered preventive immunizations. It includes coverage, coding and billing information on the influenza, pneumococcal and Hepatitis B vaccines and their administration.

From the MLN: "Medicare Quarterly Provider Compliance Newsletter [Volume 2, Issue 3]" Released [↑]

The "Medicare Quarterly Provider Compliance Newsletter [Volume 2, Issue 3]", Educational Tool (ICN 907927) has been released and is now available in downloadable format. This educational tool is designed to provide education on how to avoid common billing errors and other erroneous activities when dealing with the Medicare Program. It highlights the top issues of the particular Quarter. Please visit the Medicare Quarterly Provider Compliance Newsletter Archive to download, print, and search an archive of previously-issued newsletters.

From the MLN: "Correction to Processing of Hospice Discharge Claims" MLN Matters® Article Revised [↑]

MLN Matters® Article #MM7473, "Correction to Processing of Hospice Discharge Claims" has been revised and is now available in downloadable format. This article is designed to provide education on Medicare's hospice discharge claims processing policy, as outlined in Change Request (CR) 7473. It includes information about changes to chapter 11 of the Medicare Claims Processing Manual, which provides detailed instructions for hospices to use in coding claims. The article was revised to emphasize that the implementation of this policy is effective for claims on or after January 1, 2012.

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