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, May 2, 2012

- "Quick Reference Information: The ABCs of Providing the Annual Wellness Visit" Revised
- "Quick Reference Information: The ABCs of Providing the Initial Preventive Physical Examination" Revised

National Provider Call: Current Status of Medicare FFS Implementation of *HIPAA* Version 5010 and D.0 – Save the Date [↑]
Wednesday, May 16; 2-3:30pm ET
Please save the date for a National Provider Call on the Current Status of Medicare FFS Implementation of *HIPAA* Version 5010 and D.0 on May 16. The agenda and registration information will be provided soon on the CMS Upcoming National Provider Calls webpage. For more information on *HIPAA* 5010 and D.0 implementation, visit the Versions 5010 and D.0 website.

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

Slides and Comments from the WEDI-CMS Industry Collaboration and Problem Solving Webinar are Now Posted [↑]

Last week, the Workgroup for Electronic Data Interchange (WEDI) in collaboration with CMS held a webinar on Industry Collaboration and Problem Solving for Version 5010. Officials from CMS, WEDI, and other industry partners discussed and highlighted efforts to resolve ASC X12 5010 implementation issues. If you were unable to attend the webinar, you can watch a replay of the webinar with the slides presented online.

WEDI is also pleased to present the new ASC X12 implementation reporting system, which is available at WEDI Online. This resource can help covered entities in their compliance efforts.

CMS, WEDI, and other industry partners are planning additional webinars for the near future, and will post the dates once they are confirmed. You can post your issues and concerns related to ASC X12 5010 implementation online, and these may be used to inform an upcoming webinar.

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.

Spotlight Women's Health in May in Recognition of Women's Health Week, and Women's Checkup Day [↑]

Mother's Day Sunday, May 13 through Saturday, May 19 is National Women's Health Week — and Monday, May 14 is National Women's Checkup Day. National Women's Health Week brings together communities, businesses, government, health organizations, and other groups in an effort to promote women's health. This year's observance advises women that *"It's Your Time"* to make health a top priority. Please join CMS in honoring women during the Month of May by supporting efforts to promote and protect the health, safety, and quality of life of women.

Did You Know?
The leading causes of death in females in the United States are:

All Females, All Ages

1. Heart Disease 25.1%
2. Cancer 22.1%
3. Stroke 6.7%
4. Chronic Lower Respiratory Diseases 5.5%
5. Alzheimer's Disease 4.3%
6. Unintentional Injuries 3.6%
7. Diabetes 2.9%
8. Influenza and Pneumonia 2.3%
9. Kidney Disease 2.0%
10. Septicemia 1.6%

2007 data. Source – Centers for Disease Control and Prevention Office of Women's Health website

Medicare provides coverage for a range of preventive services that can help women prevent disease, manage their health conditions, and detect disease early. As a result of the *Affordable Care Act*, women and others with Medicare can now receive many preventive services at no additional cost. Below is a list of some of the preventive services covered by Medicare, subject to certain requirements:

- Annual Wellness Visit
- Welcome to Medicare Preventive Visit
- Bone Mass Measurements
- Cancer Screenings such as mammograms, pap tests, pelvic exams (includes a clinical breast exam), and colorectal cancer screenings
- Cardiovascular Disease Screening
- Intensive Behavioral Therapy for Cardiovascular Disease
- Diabetes Screening
- Glaucoma Screening
- HIV Screening
- Immunizations (Seasonal Influenza, Pneumococcal, and Hepatitis B)
- Screening for Sexually Transmitted Infections (STIs) and High-Intensity Behavioral Counseling (HIBC) to prevent STIs
- Tobacco-Use Cessation Counseling
- Screening for Depression in Adults
- Intensive Behavioral Therapy for Obesity

As a provider of healthcare services to people with Medicare and women in particular, this month presents a wonderful opportunity to help women to *Take the Pledge!* to get healthier by recommending steps to improve their physical and mental health, as well as lower their risks for certain diseases by:

- Regular exercise/increased activity
- Healthy food choices
- Attention to mental health, including getting enough sleep and managing stress
- Avoidance of unhealthy behaviors, such as smoking and not wearing a seatbelt or bicycle helmet and
- Taking advantage of appropriate preventive services and screenings

Women are our mothers, sisters, daughters, aunts, wives, friends, neighbors, co-workers, colleagues, and caregivers – Your encouragement can help promote and improve the health, safety, and quality of life for women and just might save their lives.

More Information for Healthcare Professionals:

- The Guide to Medicare Preventive Services for Healthcare Professionals
- CMS Prevention General Information Website
- CMS MLN Preventive Services Products Website
- Quick Reference Information: The ABCs of Providing the Annual Wellness Visit
- MLN Quick Reference Information: Medicare Preventive Services
- National Women's Health Week Website
- National Women's Checkup Day Website

- The Centers for Disease Control and Prevention Women's Health Website

➢ Additional material related to preventive services in today's e-News [next]

The Proposed Rule for Stage 2 Meaningful Use — Comment Period Ends on May 7 [↑]

On March 7, CMS posted the Notice of Proposed Rulemaking (NPRM) for Stage 2 meaningful use to the Federal Register. The proposed rule outlines the requirements for the next stage of the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, which are administered by CMS. Take a look at the NPRM located in the *Federal Register*.

The 60-day comment period for this NPRM ends on Monday, May 7
CMS welcomes your feedback on this rule. Visit the Regulations.gov comment page to comment on this rule.

For more information:
- You can view the Stage 2 Corrections to this NPRM (published April 18)
- CMS has developed an overview of the rule and how Stage 2 expands upon Stage 1 of meaningful use. You can view a slideshow of this overview and a fact sheet.
- A Microsoft Word version of the Stage 2 NPRM is also available.

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.

Major Improvements to Medicare Online Enrollment System [↑]

Over the last year, CMS has listened to your feedback about the Medicare online enrollment system (PECOS) and made improvements to:
- Incorporate search capabilities on the My Enrollments page
- Increase access to information, and
- Allow electronic signature of the Certification Statement and Electronic Funds Transfer Agreement.

The following upgrades are now available:

Overall Usability
Users will now have a search and filter feature that will allow the user to filter enrollments on the My Enrollments Page. Users will be able to filter the enrollments shown on the My Enrollments Page based on: Medicare ID, National Provider Identifier (NPI), or by selecting an Enrollment Type, Enrollment Status, or State. Additional data has been added to the enrollment data on the My Enrollments Page, i.e. Enrollment Type, Medicare ID, and Practice Location.

Access to More Information

Users will also be able to see if a request for revalidation has been sent by the Medicare Administrative Contractor (MAC). A "Revalidation Notice Sent" date will

be displayed on the My Enrollments page. This will reflect the date in which the Revalidation Letter was mailed by the MAC to the provider/supplier. The date will be displayed on the My Enrollments page for 120 days.

In addition, users will be able to identify those enrollments that are accredited for Advanced Diagnostic Imaging (ADI) Services. An ADI Services indicator will be visible on the My Enrollments page as either a "Yes" or "No".

Electronic Submission and Signature of Electronic Funds Transfer (EFT) Agreement
Users can now complete and submit EFT Agreements electronically with the option to e-sign the document. If the provider/supplier submits the EFT agreement electronically and chooses not to e-sign, they shall include a hardcopy form of the completed and signed EFT agreement with its supporting documentation to the contractor. Providers/suppliers are still required to physically mail confirmation of account information on bank letterhead, or a voided check whether the EFT is submitted electronically or via the paper version. Along with the documentation, it is also important that the provider/supplier print and mail the enrollment submission confirmation page containing the web tracking ID. This will ensure that the supporting documents mailed to your MAC get associated with your electronic application submission.

Did you know?
All FFS providers, including Federally Qualified Health Centers (FQHCs), End Stage Renal Disease (ESRD) Facilities, and Rural Health Clinics (RHCs) can take advantage of Internet-Based PECOS to check and update Medicare enrollment information.

To access internet-based PECOS, go to the PECOS website.

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

CMS to Cover New Technology for Medicare Patients with Heart Valve Damage [↑]

CMS will now cover transcatheter aortic valve replacement (TAVR) for Medicare patients under certain conditions. The coverage decision announced on May 1 by CMS Acting Administrator Marilyn Tavenner offers important new technology to some of Medicare's sickest patients.

Aortic valve replacements are used in patients whose aortic heart valves are damaged, causing the valve to narrow – a condition known as "aortic stenosis." Once patients experience symptoms of aortic stenosis, treatment is critical to improve their chances of survival. Until recently, aortic stenosis has been treatable only through invasive surgery. In contrast, TAVR allows doctors to replace a patient's aortic valve through a small opening in the leg. This less invasive procedure gives patients who cannot undergo open heart surgery a new way to repair their damaged heart valve.

This final national coverage decision is one of the first coverage decisions completed under a mutual memorandum of understanding between CMS and the FDA, a joint effort aimed at getting sometimes lifesaving, new technology to patients sooner. Because this technology is still relatively new, it is important that these procedures are performed by highly trained professionals in optimally equipped facilities. Therefore, this decision uses "coverage with evidence development," which, as a condition of coverage, will require certain provider, facility, and data collection criteria to be met. Such requirements are important to ensure beneficiaries receive the safest and most appropriate care.

The decision can be found on the CMS website.

Full text of this excerpted CMS press release (issued May 1).

HHS Announces *New Affordable Care Act* Options for Community Based Care [↑]
Medicaid and Medicare Introduce Greater Flexibility for Beneficiaries to Receive Care at Home or in Settings of Their Choice

New opportunities in Medicaid and Medicare that will allow people to more easily receive care and services in their communities rather than being admitted to a hospital or nursing home were announced on April 26 by HHS Secretary Kathleen Sebelius.

HHS finalized the Community First Choice rule, which is a new state plan option under Medicaid, and announced the participants in the Independence At Home Demonstration program. The demonstration encourages primary care practices to provide home-based care to chronically ill Medicare patients.

Both are made possible by the *Affordable Care Act*. Studies have shown that home — and community-based care can lead to better health outcomes.

The final rule released today on the Community First Choice Option provides states choosing to participate in this option a six percentage point increase in federal Medicaid matching funds for providing community-based attendant services and supports to beneficiaries who would otherwise be confined to a nursing home or other institution.

Also today, the first 16 organizations that will participate in the new Independence at Home Demonstration were announced. They will test whether delivering primary care services in the home can improve the quality of care and reduce costs for patients living with chronic illnesses. These 16 organizations were selected from a competitive pool of more than 130 applications representing hundreds of health care providers interested in delivering this new model of care.

The Independence at Home demonstration, which is voluntary for Medicare beneficiaries, provides chronically ill Medicare beneficiaries with a complete range of in-home primary care services. Under the demonstration, CMS will partner with primary care practices led by physicians or nurse practitioners to evaluate the extent to which delivering primary care services in a home setting is effective in improving care for Medicare beneficiaries with multiple chronic conditions and reducing costs. Up to 10,000 Medicare patients with chronic conditions will be able to get most of the care they need at home.

The demonstration is scheduled to begin on June 1, 2012, and conclude May 31, 2015.

HHS is also seeking comment on a proposed rule that describes a separate Home and Community-Based Services state plan option, which was originally authorized in 2005 then enhanced by the *Affordable Care Act*. Like the Community First Choice Option, this benefit will make it easier for states to provide Medicaid coverage for home and community-based services.

The announcements made today are one part of the Obama administration's efforts to help people with disabilities and those living with chronic illness stay in their own homes when they wish to do so.

For more information:

- Administration for Community Living website
- Community First Choice Option fact sheet

For more information on the Independence at Home demonstration and the organizations selected to participate visit the Center for Medicare & Medicaid

Innovation website.

The rules may be viewed at the Office of the Federal Register website.

Full text of this excerpted CMS press release (issued April 26).

Guidelines for Submitting Applications Under Section 5506 of the *Affordable Care Act* [↑]

Section 5506 of the *Affordable Care Act* directed CMS to develop a process to permanently preserve the Medicare-funded residency slots from teaching hospitals that close. It was evident after CMS reviewed the applications under the first round of section 5506 that there were a number of areas in the application process and in the CMS Evaluation Form that needed clarification and reiteration. Additional procedural guidance to be followed when applying under future rounds of section 5506 is now available in "Guidelines for Submitting Applications Under Section 5506," which is located in the Downloads section of the Acute Inpatient PPS Direct Graduate Medical Education (DGME) webpage.

Medicare Electronic Prescribing Payment Adjustment Hardship Exemption [↑]

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% in 2012, 1.5% in 2013, and 2.0% in 2014 will result in an eligible professional or group practice participating in the eRx Group Practice Reporting Option (eRx GPRO) receiving 99.0%, 98.5%, and 98.0% respectively of their Medicare Part B PFS amount for covered professional services.

Exclusion Criteria
The 2013 eRx payment adjustment only applies to certain individual eligible professionals. CMS will automatically exclude those individual eligible professionals who meet the following criteria:

- The eligible professional is a successful electronic prescriber during the 2011 eRx 12- month reporting period (January 1, 2011 through December 31, 2011).
- The eligible professional is not an MD, DO, podiatrist, Nurse Practitioner, or Physician Assistant by June 30, 2012, based on primary taxonomy code in the National Plan and Provider Enumeration System (NPPES).
- The eligible professional does not have at least 100 Medicare Physician Fee Schedule
- (MPFS) cases containing an encounter code in the measure's denominator for dates of service from January 1, 2012 through June 30, 2012.
- The eligible professional does not have 10% or more of their MPFS allowable charges (per TIN) for encounter codes in the measure's denominator for dates of service from January 1, 2012 through June 30, 2012.
- The eligible professional does not have prescribing privileges and reported G8644 on a billable Medicare Part B service at least once on a claim between January 1, 2012 and June 30, 2012.

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 see the 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 (Communication 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 E-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 866-288-8912 (TTY 877-715-6222) or via qnetsupport@sdps.org. They are available Monday through Friday from 7am to 7pm CST

Use an Individual NPI as the Ordering NPI when Billing Medicare for Part A Home Health Agency Services [↑]

To receive payment for home health services, any Medicare-enrolled Home Health Agency must file claims containing the name and National Provider Identifier (NPI) of the physician who ordered the service. When billing for an ordered home health service:

- The individual physician must be enrolled in Medicare or in an opt-out status. You can verify that the ordering physician is enrolled in Medicare by reviewing the Ordering/Referring Report on the CMS website.
- The NPI used for ordering must be for an individual physician (cannot be a group or organizational NPI).
- The individual physician must be of a specialist type that is eligible to order. These individuals include:
  - Doctors of Medicine or Osteopathy
  - Doctors of Podiatric Medicine

Failure to meet the requirements mentioned above will result in denied claims once the automatic edits are activated. For additional information, review the Medicare Learning Network's "Medicare Enrollment Guidelines for Ordering/Referring Providers" fact sheet.

CY 2012 Outpatient Prospective Payment System Pricer File Update [↑]

The Outpatient Prospective Payment System (PPS) Pricer webpage was recently updated to include the April, 2012 update for outpatient provider data. Access the April provider data update on the Outpatient PPS Pricer Code webpage by selecting 2012, and then downloading the "2st Quarter 2012 Files."

Providers who Receive Error Codes H20203 and H45255 Need to Balance Bill [↑]

Providers who receive rejection codes H20203 and/or H45255 will need to balance bill their patients' supplemental payers for any balances left after Medicare. CMS deeply regrets that these error conditions have arisen.

On February 29, 2012, CMS alerted Medicare physicians/practitioners, providers, and suppliers to three (3) edits that they may be seeing reflected on special provider notification letters that they receive from their local Fiscal Intermediary (FI), Carrier, A/B Medicare Administrative Contractor (MAC), or Durable Medical Equipment MAC (DME MAC). These edits had resulted, or are still resulting, from defects within our coordination of benefits (COB) *HIPAA* 837 compliance editing. The defects associated with the firing of edits H51108 and H20203 at the Coordination of Benefits Contractor (COBC) were resolved on January 16 and February 27, respectively. CMS has the following additional information updates to offer regarding edits H20203 and H45255:

- *H20203*: Element CLM16 is present though marked 'Not Used'
  - Update: Medicare was able to repair all affected 837 professional claims right after February 27, 2012. Unfortunately, due to more highly critical *HIPAA* 5010 fixes that were needed to the version 5010 837 institutional COB/crossover claims process, the Fiscal Intermediary Shared System (FISS) was unable to resend 837 institutional claims that incorrectly rejected with error code H20203. Fortunately, the overall volume of affected claims was determined to be very low. Providers that received rejection code H20203 on their provider notification letters issued from their FI or A/B MAC will need to balance bill their patients' supplemental payers for any balances left after Medicare.

- *H45255*: The Other Subscriber Primary Identifier (2330A NM109) Cannot be the same as the group or policy number (2320 SBR03)
  - Resolution: COBC's translation routine will scrub the duplicate identifier that is present in 2320 SBR03.
  - Updated confirmed fix date: May 18, 2012

- Scope of Impact: The current problem seems to only be impacting *HIPAA* 5010A1 837 professional claims billed to Medicare by physicians/practitioners and DMEPOS suppliers. The error is principally impacting crossover claims that would have been transferred to North Dakota Medicaid. (*Note:* This is due to its reporting of the Medicare Health Insurance Claim Number (HICN) as the policy number for crossover claim purposes).
- Update: Because certain Carriers, A/B MACs, and DME MACs have been holding generation of their provider notification letters tied to rejection code H45255 since February 2012, CMS has determined that a future claim repair action after May 18, 2012, would not be viable. Therefore, physicians/practitioners and suppliers may be seeing error H45255 on their provider notification letters. If physicians/practitioner and supplier offices see this rejection code, they will need to balance bill their patients' supplemental payer for any balances remaining after Medicare.

Provider Taxonomy Code Problem Impacting Outbound *HIPAA* 5010A2 837 Institutional Crossover Claims Fully Resolved — March Medicaid Payments in Selected States Delayed [↑]

The Part A taxonomy code problem affecting *HIPAA* 5010A2 837 institutional crossover claims is now fully resolved.

On March 13, 2012, CMS alerted all institutional providers that it was working expeditiously with its FISS Part A systems maintainer to correct a provider taxonomy mapping problem. CMS had recently uncovered a problem whereby incoming *HIPAA* 5010A2 837 institutional crossover claims contained a provider taxonomy code in 2000A PRV but the resulting Medicare-created version 5010A2 837 institutional crossover claims were devoid of this value.

Update: The FISS systems maintainer corrected this problem on April 2, 2012. *Note: HIPAA* version 5010A2 837 institutional claims that Medicare would have created for claims crossover as of April 2, 2012 would have contained the provider taxonomy code on them if billed to Medicare.

Claims Repair Process Available: FISS also offered CMS the ability to have affected claims that providers would have submitted during March 2012 repaired. The FISS repair job (under PAR FS6736) was elevated to production as of April 23 and has already been activated.

Scope of Repair Process: CMS offered the repair process to State Medicaid Agencies, which utilize the provider taxonomy code to the greatest extent as part of their NPI matching strategy. Alabama, Connecticut, Oregon, and Vermont Medicaid notified CMS recently that they wish to participate in the available *HIPAA* 5010 837 institutional crossover claims repair process. Therefore, institutional providers in those states that billed their Medicare FI or A/B MAC during March, 2012 but that have not received payment from these Medicaid agencies may wish to allow time for the claims repair process to finalize. The latest indications are that the Coordination of Benefits Contractor (COBC) will transmit the repaired claims to the four identified Medicaid programs on Monday evening, May 7.

From the MLN: Acute Inpatient Prospective Payment System Hospital Web-Based Training Course Now Available [↑]

This web-based training (WBT) course is designed to provide an overview of acute care hospital coverage and payment under the acute Inpatient Prospective Payment System (IPPS). It is designed to present a basic explanation of inpatient hospital coverage, billing, and payment for beneficiaries enrolled in Original Medicare.

To access a web-based training course please go to the MLN Products webpage, and in the "Related Links" section at the bottom of the page, click on web-based training courses.

From the MLN: "Quick Reference Information: Preventive Services" Revised [↑]

Quick Reference Information: Preventive Services (ICN 006559) has been revised and is now available in downloadable format. This educational tool is designed to provide education on the Medicare-covered preventive services. It includes coverage, coding, and payment information.

- Additional material related to preventive services in today's e-News [next]

From the MLN: "Quick Reference Information: The ABCs of Providing the Annual Wellness Visit" Revised [↑]

Quick Reference Information: The ABCs of Providing the Annual Wellness Visit (ICN 905706) has been revised and is now available in downloadable format. This educational tool is designed to provide education on the Annual Wellness Visit (AWV). It includes a list of the required elements in the initial and subsequent AWVs, as well as coverage and coding information.

- Additional material related to preventive services in today's e-News [next]

From the MLN: "Quick Reference Information: The ABCs of Providing the Initial Preventive Physical Examination" Revised [↑]

Quick Reference Information: The ABCs of Providing the Initial Preventive Physical Examination (ICN 006904) has been revised and is now available in downloadable format. This educational tool is designed to provide education on the Initial Preventive Physical Examination, also known as the IPPE. It includes a list of elements that must be included in the IPPE, as well as coverage and coding information.

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