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!

Robin Fritter, Director
Division of Provider Relations & Outreach
Provider Communications Group
Center for Medicare
Centers for Medicare & Medicaid Services

robin.fritter@cms.hhs.gov
410-786-7485

The e-News for Wednesday, May 23, 2012

National Provider Call: Inpatient Rehabilitation Facility Prospective Payment System Coverage Requirements – Register Now [↑]

Thursday, May 31; 2-3:30 pm ET

Beginning January 1, 2010, all Medicare Fee-For-Service (FFS) inpatient rehabilitation facility (IRF) claims were required to meet new coverage requirements for payment under the IRF prospective payment system (PPS). During this National Provider Call, CMS subject matter experts will provide an overview of the requirements and address questions that providers continue to have as they apply these requirements. Don't miss this opportunity to participate in updated training on the IRF PPS coverage requirements.

Target Audience: Medicare FFS providers, IRF providers, Recovery Audit Contractors, and Medicare Administrative Contractors

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: The presentation for this call will be posted at least one day in advance on the FFS National Provider Calls webpage. In addition, a link to the slide presentation will be emailed to all registrants on the day of the call.

National Provider Call: Medicare & Medicaid EHR Incentive Programs; Registration and Attestation for Eligible Professionals –Save the Date [↑]
Thursday, June 7; 1:30-3pm ET

Did you know that as of March 30, over $1.4 billion has been paid to eligible professionals (EPs) under the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs? Over 222,000 EPs have actively registered to participate in the programs. This is the last year EPs can earn the full Medicare incentive payment — don't let this opportunity pass you by. Learn what you need to do to participate in the program.

Target Audience: Eligible Professionals (EPs): Doctors of Medicine or Osteopathy, Doctors of Dental Surgery or Dental Medicine, Doctors of Podiatric Medicine, Doctors of Optometry, Chiropractors, Nurse Practitioners, Certified Nurse Midwives, Physician Assistants (PA) who practice at an FQHC/RHC led by a PA. (NOTE: Hospital-based EP's may not participate — An EP is considered hospital-based if 90% or more of the EP's services are performed in a hospital inpatient or emergency room setting). For more information, including Medicaid patient volume requirements, visit the EHR Incentive Programs Eligibility webpage.

Agenda:
- Path to Payment
- Highlights of Registration and Attestation Processes
- Third Party Proxy
- Troubleshooting
- Helpful Resources
- Question and Answers

Registration Information:
Registration information will be provided soon on the CMS Upcoming National Provider Calls webpage.

- Additional material related to the EHR Incentive Programs in today's e-News [next]

Provider Education Video Presentations Now Available on the CMS YouTube Channel [↑]

CMS has posted a selection of provider education presentations on a variety of Medicare Program topics to the CMS YouTube Channel, including the following presentations listed below. Click on the title to view the presentation.

Medicare Shared Savings Program

- Medicare Shared Savings Program and Advance Payment Model Application Process — This presentation was presented on March 1, 2012. CMS subject matter experts provide an overview and updates to the Medicare Shared Savings Program application and Advance Payment Model application processes, followed by a question and answer session. Run time: 59 minutes.
- Medicare Shared Savings Program Overview — This presentation was presented on December 7, 2011. John Pilotte, Director of the Performance-Based Payment Policy Group at CMS presents an overview of the Medicare Shared Savings Program, followed by a question and answer session. Run time: 50 minutes.

Hospital Value-based Purchasing

- Hospital Value-based Purchasing: Dry Run of the FY 2013 Hospital VBP Program — This presentation was presented on February 28, 2012. CMS subject matter experts provide an overview and updates on the Hospital Value-Based Purchasing Program for fiscal year 2013 and how hospitals will be evaluated. A question and answer session follows the presentations. Run time: 90 minutes.
- Medicare Spending Per Beneficiary Measure — This presentation was presented on February 9, 2012. CMS subject matter experts provide an overview on the background of the Medicare Spending Per Beneficiary Measure, as well as an explanation of how the measure is calculated, including the approach to risk adjustment and payment standardization. Run time: 84 minutes.

Physician Quality Reporting System and Electronic Prescribing Incentive Program

- Welcome to the Electronic Prescribing eRx Incentive Program — This presentation was recorded on March 28, 2012. CMS subject matter experts provide an overview of the Medicare Electronic Prescribing (eRx) Incentive Program. Highlights include a brief program background, a look at the program website and documentation, high-level steps on how to get started; available resources and who to contact for help. Run time: 16 minutes.
- Welcome to the Physician Quality Reporting System — This presentation was recorded on February 1, 2012. CMS subject matter experts provide an overview of the Medicare Physician Quality Reporting System. Highlights include a brief background of the program, a look at the program website and documentation, high-level steps to get you started, available resources and who to contact for help. Run time: 15 minutes.

Medicare Physician Feedback Program

- Medicare Physician Feedback Program: Payment Standardization and Risk Adjustment – This presentation was presented on December 21, 2011. CMS subject matter experts discuss how and why per capita cost measures are adjusted under the Physician Feedback Program and in the Quality and Resource Use Reports. This call provided an opportunity to: (1) have a public dialogue about our methodology, (2) obtain stakeholder input, and (3) discuss ways to further improve these cost adjustment processes. Run time: 118 minutes.

Skilled Nursing Facility Prospective Payment System

- Skilled Nursing Facility Prospective Payment System Minimum Data Set 3.0 and Resource Utilization Group-Version 4 Policies and Clarifications — This presentation was presented on November 11, 2011. CMS subject matter experts provide a brief overview of the policies, along with clarifications on the SNF PPS FY2012 policies related to the MDS 3.0. A question and answer session follows the presentations. Run time: 83 minutes.

For a full list of available video presentations, please visit the CMS National Provider Calls website.

Honor Our Nation's Seniors in May During Older Americans Month [↑]

Please join CMS in recognizing Older Americans Month — a time to honor the many contributions of our nation's seniors, celebrate their successes, and recommit to supporting them as they shape America's next great generation. Older Americans are living longer and are more active than ever before, yet they are some of our most vulnerable citizens.

This year's theme, "Never Too Old to Play", encourages older Americans to stay active in their own lives and in their communities. We know that preventing disease before it starts helps people live longer, healthier lives. As a result of the Affordable Care Act, more seniors are taking advantage of preventive services covered by Medicare, without cost-sharing. Each office visit is an opportunity to ensure that your Medicare patients are aware of the preventive services covered by Medicare that are appropriate for them. Together we can help our older Americans live longer, and age healthy in their homes and communities.

More Information for Healthcare Professionals:

- HHS Secretary News Release on Older Americans Month
- CMS Prevention General Information website
- Medicare Coverage Database
- MLN Preventive Services Educational Products
- Medicare.gov Preventive Services website

Thank you for supporting Older Americans Month – it's "Never Too Old to Play."

A New Short-Term Acute Care PEPPER to be Released in May [↑]

A new release of the Short-Term (ST) Acute Care Program for Evaluating Payment Patterns Electronic Report (PEPPER), with statistics through the first quarter of fiscal year 2012, will be available for short-term acute care hospitals (STACHs) nationwide in late May.

The PEPPER provides hospital-specific data statistics for Medicare discharges in 30 areas that may be at risk for improper Medicare payments. Hospitals can use PEPPER to support internal auditing and monitoring activities. PEPPER is a free report comparing a hospital's Medicare billing practices with other hospitals in the state, Medicare Administrative Contractor (MAC) or Fiscal Intermediary (FI) jurisdiction and nation. Access the ST PEPPER User's Guide for more information. CMS has contracted with TMF Health Quality Institute to develop and distribute the reports.

PEPPER will be distributed electronically to STACHs through a My QualityNet secure file exchange to hospital QualityNet Administrators and user accounts with the PEPPER recipient role by May 24.

Note: The "Spinal Fusion" denominator in this release contains 14 procedure codes that were inadvertently omitted in the Q4FY11 version (84.59, 84.60 through 84.69, 84.80, 84.82, 84.84). As a result there may be some changes in target area percent and/or outlier status for some hospitals from the prior release.

CMS encourages hospitals to provide feedback on PEPPER through a feedback form so that the reports can be continually improved.

Only 38 days left before Version 5010 Enforcement Discretion Period ends [↑]

Version 5010 Enforcement Discretion Period Ends in 38 days
The deadline for all HIPAA-covered entities to upgrade to Version 5010 electronic standards was January 1, 2012. However, CMS initiated an enforcement discretion period until June 30, 2012 to give the industry additional time to complete testing. CMS made this decision based on industry feedback that many organizations and their trading partners were not yet ready to finalize system upgrades for this transition. If you have not yet finalized your Version 5010 upgrade, you should be working to complete this step as soon as possible.

Version 5010 Resources
CMS is committed to helping you successfully upgrade to Version 5010 and ICD-10 by providing resources on the CMS ICD-10 website to help you understand and manage your upgrade. CMS regularly updates the CMS ICD-10 website, including a webpage dedicated to Version 5010 information and resources. CMS has also posted a fact sheet, which discusses steps providers should be taking now to be compliant with the upgrade to Version 5010 by June 30.

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.

Nebraska Becomes the 44th State to Launch Their Medicaid EHR Incentive Program [↑]

Nebraska launched their Medicaid Electronic Health Record (EHR) Incentive Program on May 7. This means that eligible professionals (EPs) and eligible hospitals in Nebraska can now complete their EHR Incentive Program registration. More information about the Medicaid EHR Incentive Program can be found on the Medicare and Medicaid EHR Incentive Program Basics page of the CMS EHR website.

If you are a resident of Nebraska and are eligible to participate in the Medicaid EHR Incentive Program, visit your State Medicaid Agency website for more information on your state's participation in the Medicaid EHR Incentive Program.

As of May 7, 44 states have launched Medicaid EHR Incentive Programs. For a complete list of states that have already begun participation in the Medicaid EHR Incentive Program, see the Medicaid State Information page on the CMS EHR website. CMS looks forward to announcing the launches of additional states' programs in the coming months.

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.

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

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

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

Give Babies a "Strong Start" on Life [↑]

The Strong Start initiative was launched in February and aims at improving birth outcomes and reducing the risk of significant complications and long-term health problems for both expectant mothers and newborns.

Strong Start consists of two strategies:

1. Building on the work of the Partnership for Patients, test ways to speed the adoption of best practices and support providers in reducing early elective deliveries. CMS will partner with private organizations to increase current public awareness efforts and develop new ones.
2. Testing the effectiveness of three enhanced prenatal care approaches to reduce preterm births for women covered by Medicaid who are at risk for preterm births.

Find out more about the steps we can all take together to get expectant mothers and newborns off to a strong start.

Technical Component of Physician Pathology Services Furnished to Hospital Patients No Longer Covered by Medicare for Certain Pathologists and Independent Labs [↑]

Under previous law, including, most recently, Section 3006 of the Middle Class Tax Relief and Job Creation Act of 2012, a statutory moratorium allowed certain practitioners and suppliers (such as pathologists and Independent Laboratories) meeting specific criteria to bill a carrier or an A/B MAC for the Technical Component (TC) of physician pathology services furnished to hospital patients. This moratorium expires on June 30, 2012. Therefore, pathologists and independent laboratories that provide the TC of physician pathology services furnished to hospital patients may no longer bill for and receive Medicare payment for these services, effective for claims with dates of service on and after July 1, 2012.

For background and policy information regarding payment to pathologists and independent laboratories for the TC of physician pathology services furnished to hospital patients, refer to MLN Matters® Article MM5943 and MLN Matters® Article MM5347.

From the MLN: "Explaining the Difference Between a National Provider Identifier (NPI) and a Provider Transaction Access Number (PTAN)" MLN Matters® Article Released [↑]

MLN Matters® Special Edition Article #SE1216, "Explaining the Difference Between a National Provider Identifier (NPI) and a Provider Transaction Access Number (PTAN)" has been released and is now available in downloadable format. This article is designed to provide education on the differences between a National Provider Identifier (NPI) and a Provider Transaction Access Number (PTAN). It includes information about new enrollees, revalidation, the relationship between the NPI and PTAN, and how providers can protect their identity in the Provider Enrollment Chain & Ownership System (PECOS).

From the MLN: "MLN Products Catalog" Revised [↑]

The MLN has revised the MLN Products Catalog. The May 2012 MLN Products Catalog is a free interactive downloadable document that links you to online versions of MLN products or the product ordering page for hardcopy materials. Once you have opened the catalog, you may either click on the title of an individual product or on "Formats Available."

More Helpful Links…

Check out CMS on

Twitter, LinkedIn, YouTube, and Flickr!

The Medicare Learning Network
Archive of Provider e-News Messages