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CMS Medicare FFS Provider e-News

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

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

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The e-News for Wednesday, May 30, 2012

NATIONAL PROVIDER CALLS

- [Inpatient Rehabilitation Facility Prospective Payment System Coverage Requirements – Last Chance to Register](#)
- [Medicare & Medicaid EHR Incentive Programs; Registration and Attestation for Eligible Professionals –Register Now](#)

ANNOUNCEMENTS AND REMINDERS

- [CMS Announces Partnership to Improve Dementia Care in Nursing Homes](#)
- [Health Care Law Saved People With Medicare Over \\$3.5 Billion on Prescription Drugs](#)
- [CMS to Release a Comparative Billing Report on Home Oxygen Services — Target Release June 26](#)
- [How to Avoid Common Version 5010 Claims Rejections](#)
- [Help Ensure Your Success in the EHR Incentive Programs by Registering Early](#)
- [CMS Will Begin Accepting Suggestions for Potential Physician Quality Reporting System Measures and/or Measures Groups](#)
- [Medicare Electronic Prescribing Payment Adjustment Hardship Exemption](#)

CLAIMS, PRICER, AND CODE UPDATES

- [Skilled Nursing Facility Prospective Payment System FY2012 PC Pricer File Update](#)
- [CY 2012 Home Health Prospective Payment System PC Pricer has been Updated](#)
- [Inpatient Rehabilitation Facility Prospective Payment System FY2012 Pricer File Update](#)
- [End Stage Renal Disease Prospective Payment System FY2012 PC Pricer has been Released](#)

National Provider Call: Inpatient Rehabilitation Facility Prospective Payment System Coverage Requirements – Last Chance to Register [[↑](#)]
Thursday, May 31; 2-3:30pm 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 – Register Now [\[↑\]](#)

Thursday, June 7; 1:30-3pm ET

This is the last year Medicare eligible professionals (EPs) can begin to participate to earn the full Medicare Electronic Health Record (EHR) incentive payments — don't let this opportunity pass you by. Learn what you need to do to participate in the EHR incentive programs.

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: 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.

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

CMS Announces Partnership to Improve Dementia Care in Nursing Homes [[↑](#)]

Government Partnering With Providers, Caregivers, Patients to Ensure Appropriate Use of Antipsychotic Medications

On May 30, CMS Acting Administrator Marilyn Tavenner announced the Partnership to Improve Dementia Care, an initiative to ensure appropriate care and use of antipsychotic medications for nursing home patients. This partnership – among federal and state partners, nursing homes and other providers, advocacy groups and caregivers – has set a national goal of reducing use of antipsychotic drugs in nursing home residents by 15 percent by the end of 2012.

Unnecessary antipsychotic drug use is a significant challenge in ensuring appropriate dementia care. CMS data show that in 2010 more than 17 percent of nursing home patients had daily doses exceeding recommended levels.

CMS and industry and advocacy partners are taking several steps to achieve this goal of improved care:

- *Enhanced training:* CMS has developed Hand in Hand, a training series for nursing homes that emphasizes person-centered care, prevention of abuse, and high-quality care for residents. CMS is also providing training focused on behavioral health to state and federal surveyors;
- *Increased transparency:* CMS is making data on each nursing home's antipsychotic drug use available on Nursing Home Compare starting in July of this year, and will update this data;
- *Alternatives to antipsychotic medication:* CMS is emphasizing non-pharmacological alternatives for nursing home residents, including potential approaches such as consistent staff assignments, increased exercise or time outdoors, monitoring and managing acute and chronic pain, and planning individualized activities.

These efforts will help achieve the 15 percent reduction goal by the end of this year. In addition, to address this challenge in the long-term CMS is conducting research to better understand the decision to use or not to use antipsychotic drugs in residents with dementia. A study is underway in 20 to 25 nursing homes, evaluating this decision-making process. Findings will be used to target and implement approaches to improve the overall management of residents with dementia, including reducing the use of antipsychotic drugs in this population.

Full text of this excerpted [CMS press release](#) (issued May 30).

Health Care Law Saved People With Medicare Over \$3.5 Billion on Prescription Drugs [[↑](#)]

In the First Four Months of 2012, More Than 416,000 People With Medicare Saved an Average of \$724 on Prescription Drugs and 12.1 Million Used a Free Preventive Service

Under the new health care law – the Affordable Care Act – seniors and people with disabilities in Medicare have saved a total of \$3.5 billion on prescription drugs in the Medicare drug benefit coverage gap or “donut hole” from the enactment of the law in March 2010 through April of 2012. CMS released data on May 24 showing that, in the first four months of 2012 alone, more than 416,000 people saved an average of \$724 on the prescription drugs they purchased after they hit the prescription drug coverage gap or “donut hole,” for a total of \$301.5 million in savings. These savings build on the

law's success in 2010 and 2011, when more than 5.1 million people with Medicare saved over \$3.2 billion on prescription drugs.

In addition, CMS announced that this year, from January through April, 12.1 million people in traditional Medicare received at least one preventive service at no cost to them – including over 856,000 who have taken advantage of the Annual Wellness Visit provided in the Affordable Care Act. In 2011, over 26 million people in traditional Medicare received one or more preventive benefits free of charge.

People with Medicare who hit the coverage gap “donut hole” in 2010 received a one-time \$250 rebate. In 2011, people with Medicare began receiving a 50 percent discount on covered brand name drugs and 7 percent coverage of generic drugs in the “donut hole.” This year, Medicare coverage for generic drugs in the coverage gap has risen to 14 percent. Coverage for both brand name and generic drugs in the gap will continue to increase over time until 2020, when the coverage gap will no longer exist. For more information on how the Affordable Care Act closes the Medicare drug benefit coverage gap “donut hole,” please visit the [Medicare Drug Discounts webpage](#).

Prior to 2011, people with Medicare faced cost-sharing for many preventive benefits like cancer screenings and smoking cessation counseling. Now, many of these benefits are offered free of charge to beneficiaries, with no deductible or co-pay, so that cost is no longer a barrier for seniors who want to find and treat problems early.

For more information on Medicare-covered preventive services, many of which are now provided without charge to beneficiaries thanks to the Affordable Care Act, please visit the [Medicare Preventive Services webpage](#). To learn what screenings, vaccinations and other preventive services doctors recommend for you and those you care about, please visit the [myhealthfinder tool](#).

Full text of this excerpted [CMS press release](#) (issued May 24).

CMS to Release a Comparative Billing Report on Home Oxygen Services — Target Release June 26 [\[↑\]](#)

On June 26, CMS will release a national provider Comparative Billing Report (CBR) addressing Home Oxygen Services.

CBRs produced by SafeGuard Services under contract with CMS, contain actual data-driven tables and graphs with an explanation of findings that compare supplier's billing and payment patterns to those of their peers located in the state and across the nation.

These reports are not available to anyone except the suppliers who receive them. To ensure privacy, CMS presents only summary billing information. No patient or case-specific data is included. These reports are an example of a tool that helps suppliers better understand applicable Medicare billing rules and improve the level of care they furnish to their Medicare patients. CMS has received feedback from a number of suppliers that this kind of data is very helpful to them and encouraged us to produce more CBRs and make them available to suppliers.

For more information and to review a sample of the Home Oxygen Services CBR, please visit the [CBR Services website](#), or call the SafeGuard Services' Provider Help Desk, CBR Support Team at 530-896-7080.

How to Avoid Common Version 5010 Claims Rejections [\[↑\]](#)

The deadline for the Version 5010 upgrade was January 1, 2012, and the enforcement discretion period for all HIPAA-covered entities to complete their upgrade to the Version 5010 electronic standards ends on June 30, 2012. The Version 5010 transaction standards have different requirements than those of Version 4010 and 4010A. There are a few things to keep in mind for processing your Version 5010 claims, which should help avoid unnecessary rejections:

1. *ZIP Code:* You need to include a complete 9-digit ZIP code for the billing provider and service facility location. You should work with your vendor to make sure that your system captures the full 9-digit ZIP.
2. *Billing Provider Address:* You need to use a physical address for your Billing Provider Address. Version 5010 does not allow for use of a PO Box address for either professional or institutional claim formats. You can still use a PO Box, however, as your address for payments and correspondence from payers as long as you report this location as a pay-to address.
3. *National Provider Identifier (NPI):* You were previously allowed to report an Employer's Identification Number (Tax ID) or Social Security Number (SSN) as a primary identifier for the billing provider. For Version 5010 claims, however, you are only allowed to report an NPI as a primary identifier.

For additional help with your Version 5010 upgrade and Medicare claims, you can contact your Medicare Administrative Contractor (MAC). The MACs work closely with clearinghouses, billing vendors, and health care providers who require assistance in submitting and receiving Version 5010 compliant transactions. If you experience difficulty reaching a MAC, you should send a message describing your issue to ProviderFeedback@cms.hhs.gov with "5010 Extension" in the subject line.

The Medicare Fee-For-Service group has created a [fact sheet](#) that provides guidance to help providers troubleshoot some of the difficulties they may experience with Version 5010 claims processing and links to each of the MAC websites, including lists of the top 10 edits for Version 5010 claims.

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.

Help Ensure Your Success in the EHR Incentive Programs by Registering Early [\[↑\]](#)

CMS recommends that all eligible professionals (EPs) [register](#) as early as possible for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs.

By registering early you can verify that your information is up to date in all of the CMS systems and resolve any issues so that you can participate in the EHR Incentive Programs. If you do not resolve registration problems in time, you will not be able to attest and could potentially miss out on a payment year. Registering does not mean you are required to participate — so register today.

Register Today to Receive Maximum Incentives

This is the last year for Medicare EPs to start participating in the EHR Incentive Programs in order to receive their full Medicare incentive payments. For more information on registration in the EHR Incentive Programs, visit the [Registration page](#) of the EHR website.

Want more information about the EHR Incentive Programs?

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

CMS Will Begin Accepting Suggestions for Potential Physician Quality Reporting System Measures and/or Measures Groups [\[↑\]](#)

CMS will be accepting quality measure suggestions for potential inclusion in the proposed set of quality measures in the Physician Quality Reporting System for future rule-making years. To learn more about the Physician Quality Reporting System Call for Measures, visit the [CMS Measures Management System Webpage](#).

For measures to be considered into the Physician Quality Reporting System, please provide the required documentation for each measure submitted for consideration beginning *June 1, 2012* and no later than *5pm ET August 1, 2012*.

Required documentation includes the Measure Submitted for Consideration Form, measure specifications (measure title, description, numerator and denominator, including exclusions, exceptions, and inclusions) and electronic specification and data tables for Electronic Health Record (EHR)-specified candidate measures.

Note: Suggesting individual measures or measures for a new or existing measures group does not guarantee that the measure(s) will be included in the proposed or final sets of measures of any Proposed or Final Rules that address the Physician Quality Reporting System. CMS will determine what individual measures and measures group(s) to include in the proposed set of quality measures, and after a period of public comment, the agency will make the final determination with regard to the final set of quality measures for the Physician Quality Reporting System.

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 gnetsupport@sdps.org. They are available Monday through Friday from 7am to 7pm CST.

Skilled Nursing Facility Prospective Payment System FY2012 PC Pricer File Update [\[↑\]](#)

The FY 2012 Skilled Nursing Facility (SNF) Prospective Payment System (PPS) PC Pricer has been posted to the [SNF PPS Pricer webpage](#) in the “Downloads” section.

CY 2012 Home Health Prospective Payment System PC Pricer has been Updated [\[↑\]](#)

The CY 2012 Home Health (HH) Prospective Payment System (PPS) PC Pricer data has been updated with April 2012 provider data and is now available on the [HH PPS PC Pricer webpage](#) in the “Downloads” section.

Inpatient Rehabilitation Facility Prospective Payment System FY2012 Pricer File Update [\[↑\]](#)

The FY2012 Inpatient Rehabilitation Facility Prospective Payment System (PPS) PC Pricer has been updated with newer provider data and is now available on the [Inpatient Rehabilitation Facility PPS PC Pricer webpage](#) in the “Downloads” section. This Pricer is for claims dated from October 1, 2011 to September 30, 2012.

End Stage Renal Disease Prospective Payment System FY2012 PC Pricer has been Released [\[↑\]](#)

The 2012 End Stage Renal Disease (ESRD) PC PRICER is now available on the [ESRD PC Pricer webpage](#) in the “Downloads” section.

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