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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, June 13, 2012

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- [“Questionable Billing By Suppliers of Lower Limb Prostheses” MLN Matters® Article Revised](#)
- [New Fast Fact on MLN Provider Compliance Web Page](#)

National Provider Call: Physician Quality Reporting System & Electronic Prescribing Incentive Program – Register Now [\[↑\]](#)

Tuesday, June 19; 1:30-3pm ET

CMS will host a National Provider Call with question and answer session. CMS subject matter experts will provide an overview of “The 2010 Physician Quality Reporting System and Electronic Prescribing (eRx) Incentive Program Reporting Experience Including Trends (2007-2011).”

Target Audience: All Medicare Fee-For-Service Providers, Medical Coders, Physician Office Staff, Provider Billing Staff, Electronic Health Records Staff, and Vendors

Agenda:

- Opening Remarks
- Program Announcements
- Overview of “The 2010 Physician Quality Reporting System and eRx Incentive Program Reporting Experience Including Trends (2007-2011)”
- Question & Answer Session

Registration Information: In order to receive call-in information, you must register for the call on the [CMS Upcoming National Provider Calls](#) web page. 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 prior to the call on the [FFS National Provider Calls](#) web page. In addition, a link to the slide presentation will be emailed to all registrants on the day of the call.

National Provider Call: EHR Incentive Programs and Certified EHR Technology — Save the Date [\[↑\]](#)

Wednesday, June 27; 2-3:30pm ET

Join CMS and the Office of the National Coordinator for Health Information Technology (ONC) for a National Provider Call providing an overview of the Medicare and Medicaid EHR Incentive Programs, including the use of certified EHR technology to meet meaningful use. Learn about the different types of certification and what certification actually tests. As of April 30, \$5 billion has been paid in EHR incentives under both programs. This is the last year Medicare eligible professionals can begin to participate to earn the full Medicare Electronic Health Record (EHR) incentive payments.

Target Audience: [Eligible Professionals](#) and [Eligible Hospitals](#) as defined by the Medicare and Medicaid EHR Incentive Programs.

Agenda:

- Overview of the EHR Incentive Programs
- How and Why of Certification
- Which EHR Products are Certified
- Resources
- Q&A with CMS and ONC experts

National Provider Call: Hospital Value-Based Purchasing – Register Now [[↑](#)]

Wednesday, July 11; 1:30-3pm ET

CMS will host a National Provider Call with a question and answer session on the FY2014 Hospital Value-Based Purchasing (VBP) Program. The purpose of this call is to provide an overview of the FY2014 Program and to review the differences between the FY2013 and FY2014 Programs, primarily the addition of the Outcome domain in the FY2014 Program.

Target Audience: Hospitals, Quality Improvement Organizations (QIOs), Medical coders, physician office staff, provider billing staff, health records staff, vendors, and all Medicare fee-for-service (FFS) providers.

Agenda:

- Opening Remarks
- Program Announcements
- Overview of Fiscal Year 2014 Hospital Value-Based Purchasing Program
- Review of the differences between the FY 2013 and FY 2014 Programs
- Question & Answer Session

Registration Information: In order to receive call-in information, you must register for the call on the [CMS Upcoming National Provider Calls](#) web page. 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 prior to the call on the [FFS National Provider Calls](#) web page. In addition, a link to the slide presentation will be emailed to all registrants on the day of the call.

Special Open Door Forum: Suggested Electronic Clinical Template for Power Mobility Devices [[↑](#)]

Thursday June, 14; 2-3pm ET

Conference Call Only

CMS will host a series of Special Open Door Forum (ODF) calls to provide an opportunity for suppliers and physicians to provide feedback on the Suggested Electronic Clinical Template for Power Mobility Devices for Medicare purposes for possible nationwide use.

CMS is exploring the development of a Suggested Electronic Clinical Template that would allow electronic health record vendors to create prompts to assist physicians when documenting the Power Mobility Device face-to-face encounter for Medicare purposes. You can find the proposed document on the [Electronic Clinical Template](#) web page. Comments on the document can be sent to eclinicaltemplate@cms.hhs.gov.

Special Open Door Participation Instructions:

- Dial: (800) 837-1935 & Conference ID: 69287910
- Note: TTY Communications Relay Services are available for the Hearing Impaired. For TTY services dial 7-1-1 or 1-800-855-2880. A Relay Communications Assistant will help.

A transcript and audio recording of this Special ODF will be posted to the [Special Open Door Forum](#) website and will be accessible for downloading.

For automatic emails of Open Door Forum schedule updates (E-Mailing list subscriptions) and to view Frequently Asked Questions please visit the [Open Door Forum](#) website.

Special Open Door Forum: Medicare's Prior Authorization for Power Mobility Devices Demonstration [[↑](#)]

Thursday, June 28; 3-4pm ET

Conference Call Only

The purpose of this Special Open Door Forum (ODF) is to provide an opportunity for *suppliers and providers* to hear more and ask questions about the Demonstration.

CMS will conduct a demonstration that will implement a prior authorization process for certain medical equipment for all people with Medicare who reside in seven states with high populations of fraud- and error-prone providers (California, Florida, Illinois, Michigan, New York, North Carolina, and Texas). This is an important step toward paying appropriately for certain medical equipment that has a high error rate. This demonstration will help ensure that a beneficiary's medical condition warrants their medical equipment under existing coverage guidelines. Moreover, the program will assist in preserving a Medicare beneficiary's right to receive quality products from accredited suppliers.

CMS received many comments/suggestions on the Prior Authorization of Power Mobility Devices (PMDs) demonstration. CMS has considered these comments carefully. In response to comments received from stakeholders, CMS has made a number of modifications to the Prior Authorization of PMD demonstrations.

To read more about the Demonstration visit the [Prior Authorization of Power Mobility Devices Demonstration](#) web page.

Participants may submit questions prior to the Special ODF to pademo@cms.hhs.gov.

We look forward to your participation.

Special Open Door Participation Instructions:

- Dial: (866) 501-5502 & Conference ID: 61960445

- Note: TTY Communications Relay Services are available for the Hearing Impaired. For TTY services dial 7-1-1 or 1-800-855-2880. A Relay Communications Assistant will help.

A transcript and audio recording of this Special ODF will be posted to the [Special Open Door Forum](#) website and will be accessible for downloading.

For automatic emails of Open Door Forum schedule updates (E-Mailing list subscriptions) and to view Frequently Asked Questions please visit the [Open Door Forum](#) website.

Informational Call for Inpatient Rehabilitation Facility Patient Assessment Instrument Software Vendors and Developers [[↑](#)]

Thursday, July 12; 2-3pm ET

CMS will host an Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) informational call for IRF-PAI software vendors and developers on Thursday, July 12, 2012. The vendor call will pertain to the final IRF-PAI Data Specifications for October 2012.

- Vendors may submit questions specific to the IRF-PAI October 1, 2012 release to the IRF Tech Issues mailbox at IRFTECHIssues@cms.hhs.gov. Please include "VENDOR CALL" in the subject line. Questions must be emailed prior to 6pm ET on Thursday, July 5, 2012.
- Please note that this call will only cover questions specific to the IRF-PAI data specifications and technical information. This call will not cover clinical coding, quality reporting requirements or policies, and payment policies. If you are not a software vendor or developer, do not attend this call.
- Call-in information is as follows:
 - *Conference Call Number:* 866-712-2205
 - **Conference Code:** 4260581739

If you have any questions concerning this information, please contact the QTSO Help Desk at help@qtso.com or 800-339-9313. *CMS strongly recommends that all vendors attend this call.*

- Vendors are encouraged to register to receive future information regarding IRF-PAI technical updates. Vendors may register on the [IRF vendor page](#).
- With registration, vendors will provide current vendor contact information, including an email address, to which future communication can be sent.

Get Ready for DMEPOS Competitive Bidding [[↑](#)]

The Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program Round 1 Re compete is coming soon.

Summer 2012

- CMS announces bidding schedule
- CMS begins bidder education program
- Bidder registration period to obtain user ID and password begins

Fall 2012

- Bidding begins

If you are a supplier interested in bidding, prepare now – don't wait.

- **Update Your Contact Information:** The following contact information in your enrollment file at the National Supplier Clearinghouse (NSC) must be up-to-date before you register to bid. If your file is not current, you may experience delays and/or be unable to register and bid. If you want to bid, you will need to register even if you registered for a previous round. DMEPOS suppliers should review and update:
 - The name, Social Security number, and date of birth for all authorized official(s) (if you have only one authorized official listed on your enrollment file, consider adding one or more authorized officials to help with registration and bidding); and
 - The correspondence address.

DMEPOS suppliers can update their enrollment file via the internet-based Provider Enrollment, Chain and Ownership System (PECOS) or by using the July 11, 2011 version of the CMS-855S enrollment form. Suppliers not currently using PECOS can learn more about this system by accessing the [PECOS](#) website or reviewing the [PECOS fact sheet](#). Information and instructions on how to submit a change of information via the hardcopy CMS-855S enrollment form may be found in the [Change of Information Guide](#) on the NSC website.

- **Get Licensed:** Contracts are only awarded to suppliers that have all required state licenses at the time of bidding. Therefore, if you are bidding for a product category in a competitive bidding area (CBA), you must ensure that all required state licenses for that product category are either on file with the NSC or *received* by the NSC by the close of bidding. Every location must be licensed in each state in which it provides services. If you have only one location and are bidding in a CBA that includes more than one state, you must have all required licenses for every state in that CBA. If you have more than one location and are bidding in a CBA that includes more than one state, your company must have all required licenses for the product category for every state in that CBA. Make sure that current versions of all required licenses are with the NSC *before* you bid. If any required licenses are expired or missing from your enrollment file, your bid(s) may be rejected.
- **Get Accredited:** Suppliers must be accredited for all items in a product category in order to submit a bid for that product category. If you are interested in bidding for a product category and are not currently accredited for that product category, take action *now* to get accredited for that product category. Your accreditation organization will need to report any accreditation updates to the NSC. CMS cannot contract with suppliers that are not accredited for all items in the product category.

More information about the DMEPOS accreditation requirements may be found on the [CMS](#) website.

The Competitive Bidding Implementation Contractor (CBIC) is the official information source for bidders. Stay informed – visit the [CBIC](#) website to subscribe to email updates and for the latest information about the DMEPOS Competitive Bidding Program.

Medicare Fee-For-Service Version 5010/D.0 Update for the Week of June 11, 2012 [[↑](#)]

In its continuing effort to help trading partners transition to the new versions of standards adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for electronically exchanging health care transactions, Medicare Fee-For-Service (FFS) has the following updates for the week of June 11, 2012:

- Deadlines for using the new versions of HIPAA standards

- A webinar announcement

Deadlines

Inbound Transactions: After close of business, June 29, 2012, you must submit only the following versions when sending Medicare FFS inbound transactions:

- Accredited Standards Committee (ASC) X12 Version 005010 (5010)
 - Health Care Claim: Professional (837P)
 - Health Care Claim: Institutional (837I)
 - Health Care Claim Status Request (276)
- National Council for Prescription Drug Program (NCPDP) Version D.0 Claim

Any inbound Medicare FFS transaction received by Medicare Administrative Contractors (MACs) in either version 4010/A1 or NCPDP 5.1 formats after normal close of business on June 29 will be rejected back to the submitter. If a claim transaction is rejected, the specific message you will receive will depend on the specific MAC receiving your claim file(s). Please visit the CMS [Important 4010 - 5.1 Rejection Information](#) website for a detailed list of rejection error messages.

Outbound Transactions: In addition, beginning July 1, 2012, the Coordination of Benefits (outbound ASC X12 837) and Health Care Claim Status Response (ASC X12 277) transactions will be sent in version 5010 only.

Medicare FFS will be allowing an additional 30 days to complete the transition to the ASC X12 Health Care Claim Payment/Advice (835), also called the Remittance Advice. Therefore, as of August 1, 2012, Medicare FFS will be generating only the 5010 version of the 835 Remittance Advice for all trading partners.

Please ensure you have tested with your MAC to successfully receive and process a parallel version 5010 835 Remittance Advice transaction during this transition period.

Webinar Announcement

CMS is offering regional webinars on Version 5010/D.0 conversion on June 20, 2012. The CMS Eastern webinar is set for 10am ET; Central webinar, 12pm CT; and Mountain-Pacific webinar, 1pm PT. Please [register](#) to attend a webinar.

More Information

For more information on ASCX12 Version 5010 and NCPDP Version D.0, please visit the [Versions 5010 and D.0](#) website.

Attention Teaching Hospitals: Electronic Method for Submitting Medicare Graduate Medical Education Affiliation Agreements [\[↑\]](#)

Under the regulations at section 42 CFR §413.79(f) for direct Graduate Medical Education (GME) and section 42 CFR §412.105(f)(1)(vi) for Indirect Medical Education (IME), hospitals that cross-train residents in approved medical residency training programs may enter into Medicare GME Affiliation Agreements to elect to apply their direct GME and/or IME Full Time Equivalent (FTE) resident caps on an aggregate basis, and may adjust their FTE

resident caps to reflect the rotation of residents among affiliated hospitals during an academic year. In the August 16, 2010 Inpatient Prospective Payment System (PPS) final rule (75 FR 50299), CMS finalized a policy to allow hospitals to submit Medicare GME Affiliation Agreements to CMS electronically. Hospitals wishing to affiliate for the July 1, 2012 - June 30, 2013 academic year should submit their Medicare GME Affiliation Agreements to CMS Central Office using the following email address: Medicare_GME_Affiliation_Agreement@cms.hhs.gov.

Medicare GME Affiliation Agreements for the July 1, 2012 - June 30, 2013 academic year must be received by the email address above by 11:59pm ET on July 1, 2012. If received by this time, you should receive an automatic reply indicating that your affiliation agreement submission was received timely for the July 1, 2012 academic year.

We encourage all teaching hospitals that wish to submit Medicare GME Affiliation Agreements to CMS to do so using this email address. Faxes are not allowed. In addition, we encourage teaching hospitals to send modifications to Medicare GME Affiliation Agreements for the academic year July 1, 2011 - June 30, 2012 electronically as well. (Modifications of the July 1, 2011 - June 30, 2012 affiliation agreements may be submitted to the above email address by June 30, 2012). Please indicate clearly in your email whether the particular document you are sending is a Medicare GME Affiliation Agreement for July 1, 2012 - June 30, 2013, or if the document is an amendment to a July 1, 2011 - June 30, 2012 agreement. For example, in the subject line of your email, you may indicate "Medicare GME Affiliation Agreement – new for July 1, 2012 - June 30, 2013," and for an amendment, you may indicate "Medicare GME Affiliation Agreement – amendment for July 1, 2011 - June 30, 2012."

With regard to Medicare GME Affiliation Agreements that you may already have in place that are set to automatically renew on July 1, 2012, you may, but are not required to, send in by July 1 an electronic copy of the applicable Medicare GME Affiliation Agreement to Medicare_GME_Affiliation_Agreement@cms.hhs.gov.

In addition, please note that you are to continue to submit the "contractor copy" of your Medicare GME Affiliation Agreements to your Medicare contractor using the procedures your Medicare contractor has specified, either hard copy mail or by e-mail, as applicable. Medicare_GME_Affiliation_Agreement@cms.hhs.gov is a CMS email address only, and is not linked to the Medicare contractors.

New Information Available on the Inpatient Rehabilitation Facility Prospective Payment System Website [\[↑\]](#)

The final Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) Data Submission Specifications (version 1.10.1), effective October 1, 2012, is available for download from the [Software](#) web page.

- The IRF-PAI free, downloadable software, Inpatient Rehabilitation Validation and Entry system (jIRVEN), will be made available for download from the Software web page in the late summer, 2012.
- CMS intends to provide training specific to IRF-PAI data submission and data submission reports, in addition to jIRVEN user tool-related training, in the late summer, 2012. Additional information related to these trainings will be forthcoming on the Software web page.

Submit a Notice of Intent to Apply for the Medicare Shared Savings Program January 1, 2013 Start Date – Date Extended to June 29 [\[↑\]](#)

If you are interested in applying for participation for the January 1, 2013 start date of the Medicare Shared Savings Program, please submit a Notice of Intent to Apply (NOI) by June 29, 2012. For more information, visit the [Shared Savings Program Application](#) web page.

Advance Payment ACO Model: New Opportunity To Apply [[↑](#)]

The [Advance Payment ACO Model](#) is an Innovation Center initiative for participants in the Medicare Shared Savings Program. It's designed for physician-based and rural providers who have come together voluntarily to give coordinated high quality care to the Medicare patients they serve. Through the Advance Payment ACO Model, selected participants will receive upfront and monthly payments, which they can use to make important investments in their care coordination infrastructures.

CMS announced last October that applications would only be accepted for April 1, 2012 and July 1, 2012 start dates.

However, the Innovation Center has now announced that beginning August 1, 2012, it will be accepting applications for an additional *round of Advance Payment ACOs that would begin on January 1, 2013*.

Organizations interested in the Advance Payment ACO Model should start their application process by submitting a Notice of Intent to [apply for the Medicare Shared Savings Program](#) performance period that begins January 1, 2013. *This Notice of Intent (NOI) is due June 29, 2012*. Organizations that submit this NOI will then have the opportunity to submit applications to both the Medicare Shared Savings Program and the Advance Payment ACO Model.

The Advance Payment ACO Model is an important part of the CMS Innovation Center's work to help providers at all levels of readiness.

The CMS Innovation Center was created by the Affordable Care Act to test innovative payment and service delivery models that have the potential to reduce program expenditures while preserving or enhancing the quality of care. More information is at innovation.cms.gov.

Take a Look at CMS' EHR Testimonial Videos from the 2012 HIMSS Annual Conference [[↑](#)]

CMS has posted a series of new videos to the [CMS YouTube channel](#) featuring health care professionals' experiences with electronic health records (EHRs) and the Medicare and Medicaid EHR Incentive Programs.

CMS spoke with ten conference attendees at the 2012 HIMSS Annual Conference this past February and filmed discussions with health care professionals who are participating in the EHR Incentive Programs. Provider testimonial videos, like [Dr. John Bender's EHR Story from the 2012 HIMSS Conference](#), highlight the experiences of providers and health care professionals with the EHR Incentive Programs and how they navigated the different steps of the programs.

CMS previously filmed testimonials of attendees at the American Osteopathic Association (AOA) Annual Medical Conference and Exposition and of the experiences of providers who have received their incentive payments for 2011. [Watch the videos](#) to listen to their stories and learn how their experiences may be similar to your own.

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.

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](#) web page.

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

Inpatient Prospective Payment System PC Pricer Updated [\[↑\]](#)

The FY2012 Inpatient Prospective Payment System (PPS) PC Pricer has been updated with AUTOLITT Tech Add On Logic. The latest version is now available on the [Inpatient PPS PC Pricer](#) website in the “Downloads” section. This PC Pricer is for claims dated from October 1, 2011 to September 30, 2012.

July 2012 Average Sales Price Files Now Available [\[↑\]](#)

CMS has posted the July 2012 Average Sales Price (ASP) and Not Otherwise Classified (NOC) pricing files and crosswalks. All are available for download on

the [2012 ASP Drug Pricing Files](#) web page.

Appeals for Denied Claims Submitted by an Ordering and Referring Opt-out Physician/Non-physician Practitioners Who Are Excluded by the Office of Inspector General (OIG)” MLN Matters® Article Released [\[↑\]](#)

[MLN Matters® Special Edition Article #SE1223](#), “Appeals for Denied Claims Submitted by an Ordering and Referring Opt-out Physician/Non-physician Practitioners Who Are Excluded by the Office of Inspector General (OIG),” was released and is now available in downloadable format. This article is designed to provide education on how opt-out physicians and non-physician practitioners, who elect to order and refer and have been excluded by the OIG, can file an appeal. It includes guidelines on Medicare requirements for opting out of the Medicare Program.

“Questionable Billing By Suppliers of Lower Limb Prostheses” MLN Matters® Article Revised [\[↑\]](#)

[MLN Matters® Special Edition Article #SE1213](#), “Questionable Billing By Suppliers of Lower Limb Prostheses,” was revised and is now available in downloadable format. This article is designed to provide education on major findings cited in the August 2011 Department of Health and Human Services, Office of Inspector General (OIG) report titled “Questionable Billing By Suppliers of Lower Limb Prostheses.” It includes an overview of the study and major OIG findings, and recommendations related to Medicare requirements for lower limb prostheses.

New Fast Fact on MLN Provider Compliance Web Page [\[↑\]](#)

A new fast fact is now available on the [MLN Provider Compliance](#) web page. This web page provides the latest Medicare Learning Network® (MLN) products designed to help Medicare Fee-For-Service providers understand – and avoid – common billing errors and other improper activities. A list of previous fast facts is available on the [MLN Provider Compliance Fast Fact Archive](#) page. Please bookmark this page and check back often as a new fast fact is added each month.

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