This issue of the e-News will be made available in PDF format no later than 24 hours after its release, and can be found 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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Colleagues—

Today's e-News is full of important information from CMS. I'd like to call special attention to two time sensitive messages. First, see our weekly update about Medicare Fee-For-Service Version 5010/D.0. Second, don't forget — there are only 10 days left to request a Medicare Electronic Prescribing Payment Adjustment Hardship Exemption.

Hope your summer is off to a great start.

—Robin

e-News for Wednesday, June 20, 2012

National Provider Calls

- Medicare & Medicaid EHR Incentive Programs: Certified EHR Technology — Registration Now Open
- Medicare Shared Savings Program and Advance Payment Model Application Process — Registration Now Open
- Hospital Value-Based Purchasing — Register Now
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- Audio Recording and Written Transcript from June 7 Medicare & Medicaid EHR Incentive Programs; Registration and Attestation for Eligible Professionals Call Now Available

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- More Than 100,000 Health Care Providers Paid for Using Electronic Health Records
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- "Health Professional Shortage Area (HPSA) Physician Bonus, HPSA Surgical Incentive Payment, and Primary Care Incentive Payment Programs" Fact Sheet Revised
- "Medicare Fraud & Abuse: Prevention, Detection, and Reporting" Podcast Released
- "Phase 2 of Ordering and Referring Requirement" MLN Matters® Article Released
- "Edits on the Ordering/Referring Providers in Medicare Part B, DME and Part A HHA Claims (Change Requests 6417, 6421, 6696, and 6856)" MLN Matters® Article Revised
- "Requirement for Ambulance Suppliers" MLN Matters® Article Revised

National Provider Call: Medicare and Medicaid EHR Incentive Programs: Certified EHR Technology — Registration Now Open [↑]
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 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, over $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 Meaningful Use
- How and Why of Certification
- Which EHR Products are Certified
- Resources
- Q&A with CMS and ONC experts

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: Medicare Shared Savings Program and Advance Payment Model Application Process — Registration Now Open [↑]
Monday, July 16; 1:30-3 pm ET

On October 20, 2011, CMS issued a final rule under the Affordable Care Act to establish the Medicare Shared Savings Program (Shared Savings Program), along with a notice for the Advance Payment Model that will provide additional support to physician-led and rural Accountable Care Organizations (ACOs) participating in the Shared Savings Program. These two initiatives will help providers participate in ACOs to improve quality of care for Medicare patients.

On Monday, July 16, 2012, CMS is hosting a National Provider Call, where subject matter experts will provide an overview and updates to the Shared Savings Program application and Advance Payment Model application processes for the January 1, 2012 Shared Savings Program start date. A question and answer session will follow the presentations.

The Shared Savings Program Application and the Advance Payment Model web pages have important information, dates, and materials on the application process. Call participants are encouraged to review the applications and materials prior to the call.

Target Audience: Medicare Fee-For-Service (FFS) providers

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: 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.

National Provider Call: Audio Recording and Written Transcript from May 31 Inpatient Rehabilitation Facility Prospective Payment System Coverage Requirements Call Now Available [↑]

The audio recording and written transcript from the May 31 Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS) Coverage Requirements National Provider Call are now available on the May 31 IRF PPS call page in the "Presentation" section.

National Provider Call: Audio Recording and Written Transcript from June 7 Medicare & Medicaid EHR Incentive Programs; Registration and Attestation for Eligible Professionals Call Now Available [↑]

The audio recording and written transcript from the June 7 Medicare & Medicaid EHR Incentive Programs; Registration and Attestation for Eligible Professionals National Provider Call are now available on the June 7 EHR call page in the "Presentation" section.

CMS to Host End Stage Renal Disease Network Bidders Conference [↑]
Thursday, June 21; 12-1:30pm ET

CMS is excited to announce an End Stage Renal Disease (ESRD) Network Bidders Conference for those interested in submitting proposals for consideration of an ESRD Network Organization Program contract. CMS is seeking solicitations for nine separate competitions for Network areas 1, 2, 4, 7, 10, 11, 13, 16, and 18.

The Request for Proposals for the ESRD Network Organization Contract, which begins on January 1, 2013, has been posted on the FedBizOpps website under Solicitation Number, "CMS-2012-ESRD-FFPCOMP."

How to Join:
Meeting participation may occur via Adobe Connect (Webinar). *Pre-registration is not required.*

Instructions on how to register via Adobe Connect:
- Please follow this link access the Webinar Thursday, June 21st.
- Once you have entered your name/organization, please wait for the conference to begin.

Instructions to access Teleconference:
- Audio lines are available by calling the Conference Call line at the time of the event:
- Dial in Number: 877-267-1577; Meeting ID: 5709
- We ask that you please share conference lines whenever possible.

Background:
The purpose of the Statement of Work (SOW) beginning January 1, 2013, is to delineate tasks to be conducted by each ESRD Network contractor in support of achieving national quality improvement goals and statutory requirements as set forth in Section 1881 of the Social Security Act and the

Omnibus Budget Reconciliation Act of 1986. The term "Network" is used in this SOW to refer to the ESRD Network contractor. The tasks described in the SOW are intended to align Network activities with the HHS National Quality Strategy (NQS), the CMS Three Aims, and other CMS priorities designed to result in improvements in the care of individuals with ESRD.

Learn more about the CMS ESRD Network Program online on the ESRD Network Organizations web page.

Special Open Door Forum: End-Stage Renal Disease Quality Incentive Program; Reviewing Your Facility's Payment Year 2013 Performance Data [↑]
Thursday, June 21; 2-3:30pm ET
Conference Call Only

On June 21, 2012, the CMS Office of Clinical Standards and Quality (OCSQ) will host a special Open Door Forum (ODF) on the End-Stage Renal Disease (ESRD) Quality Incentive Program (QIP). The ESRD QIP is a pay-for-performance initiative that ties a facility's quality scores to a payment percentage reduction over the course of a payment year (PY).

This ODF will focus on the steps dialysis facilities need to take to review the data CMS will use to evaluate performance as part of the PY2013 program.

On July 15, 2012, CMS will make available to each facility a preliminary PY2013 Performance Score Report (PSR) that "previews" how well it scored on the quality measures CMS will use for determining any payment reductions.

CMS encourages every dialysis facility to carefully review its PSR before CMS makes the information available publicly at the end of 2012. Facilities will have from July 15, 2012 through August 15, 2012, to complete this important review.

Also during this period, facilities will have an opportunity to ask questions about how their scores were calculated, and also have the ability to submit *one* formal inquiry if they find or suspect an error in the score calculations.

After this ODF, participants should know:

- How to access and review their facility's PSR;
- How CMS calculated their facility's ESRD QIP performance score using quality data;
- What the performance score means to their facility's PY 2013 payment rates;
- When and where to ask questions regarding their PSR, including how to submit *one* formal inquiry;
- Their duty and responsibility to make ESRD QIP performance data transparent to patients; and
- Where to access help and additional information.

After the CMS presentation, participants will have an opportunity to ask questions.

Power point slides for this Special ODF will be available to download on the ERSD Quality Improvement Initiative website by June 19, 2012.

We look forward to your participation and comments.

Special Open Door Forum Participation Instructions:

- Dial: 866-501-5502 (toll free)
- Reference Conference ID#: 92188526
- Note: TTY Communications Relay Services are available for the Hearing Impaired. For TTY services dial 7-1-1 or 800-855-2880. A Relay Communications Assistant will help.

An audio recording and transcript of this Special Open Door Forum will be posted to the Special Open Door Forum website and will be accessible for downloading beginning on or around July 2, 2012 and will be available for30 days.

Medicare Fee-For-Service Version 5010/D.0 Update for the Week of June 18, 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 update:

Version 5010/D.0 Only Accepted By Medicare FFS Effective July 1, 2012
Effective July 1, 2012 only ASC X12 Version 5010 (Version 5010) or NCPDP Telecom D.0 (NCPDP D.0) formats will be accepted by Medicare FFS. Providers that are still conducting one or more of the Version 4010 transactions electronically, such as submitting a claim or checking claim status, or rely on a software vendor, billing service, or clearinghouse to do this on their behalf, are affected by this change. Now is the time to contact your software vendor, billing service, or clearinghouse, when applicable, if you have not done so already to insure you are ready. Transactions conducted by Medicare Administrative Contractor (MAC), fiscal intermediary (FI) or carrier telephone interactive voice response (IVR) systems, Direct Data Entry (DDE) and Internet Portals, for those contractors with Internet Portals, are not impacted.

Version 5010/D.0 Transition Statistics

The Medicare FFS version 5010 transition statistics are available on the CMS website. These statistics represent the transition of transaction standards adopted under HIPAA from ASC X12 4010 to 5010 and from NCPDP 5.1 to D.0. The transition statistics cover the following:

- Part A claims and remittances
- Part B/DME claims and remittances
- NCPDP claims
- Eligibility inquiries and responses
- Claim status inquiries and responses

In addition, Medicare FFS has recently published information by provider specialty related to the transition to ASC X12 Version 5010.

More Information
For more information on ASCX12 Version 5010 and NCPDP Version D.0, please visit the Versions 5010 and D.0 website.

National HIV Testing Day

June 27 is National HIV Testing Day (NHTD). This annual health observance is part of an ongoing effort to combat the growing HIV epidemic. The theme of this year's NHTD is a call for those at risk to *"Take the Test, Take Control,"* as there are powerful reasons for learning one's HIV status.

CMS asks that you join the national effort to draw attention to this growing epidemic and encourage HIV Screening. Urge at-risk Medicare beneficiaries to get tested, and use office visits as an opportunity to help patients understand the dynamics contributing to their risk factors — your support can help further the efforts to decrease the occurrence of HIV/AIDS among Medicare beneficiaries.

Medicare provides coverage of both standard and Food and Drug Administration-approved HIV rapid screening tests as a Medicare Part B benefit, subject to coverage and eligibility requirements.

- For beneficiaries at increased risk for HIV infection per the United States Preventive Task Force (USPSTF) guidelines (described below), Medicare Part B covers one, annual voluntary HIV screening.
- For Medicare beneficiaries that are pregnant, Medicare Part B covers a maximum of three voluntary HIV screenings

Beneficiaries with any known diagnosis of a HIV-related illness are not eligible for this screening test. Eligible Medicare beneficiaries may receive this screening without any cost sharing (no deductible, co-payment, or co-insurance).

The USPSTF guidelines identify the following persons as being at increased risk for HIV infection:

- Men who have sex with men after 1975
- Men and women having unprotected sex with more than one partner
- Past or present injection drug users
- Men and women who exchange sex for money or drugs, or have sex partners who do
- Individuals whose past or present sex partners were HIV-infected, bisexual, or injection drug users
- Persons being treated for sexually transmitted diseases
- Persons with a history of blood transfusion between 1978 and 1985
- Persons who request an HIV test despite reporting no individual risk factors, since this group is likely to include individuals not willing to disclose high-risk behaviors

Resources from the MLN:

- The MLN Guide to Medicare Preventive Services, Chapter 13
- The MLN HIV Screening Brochure
- MLN Matters® Article MM6786, "Screening for HIV"

More Information for Healthcare Professionals:

- CMS National Coverage Determination (NCD) for Screening for HIV
- US Preventive Services Task Force (USPSTF) – Screening for HIV Recommendation Statement
- Healthcare Reform and HIV/AIDS
- Henry J. Kaiser Family Foundation "Medicaid and HIV/AIDS" Fact Sheet
- NAPWA National HIV Testing Day

More Than 100,000 Health Care Providers Paid for Using Electronic Health Records [↑]
CMS and ONC Surpass 2012 Goals for EHR Adoption and Use

More than 100,000 health care providers are using electronic health records that meet federal standards and have benefitted from the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, CMS and the Office of the National Coordinator for Health Information Technology (ONC) announced on June 19.

Only three months ago, CMS Acting Administrator Marilyn Tavenner and National Coordinator for Health Information Technology Farzad Mostashari, M.D., Sc.M., declared an ambitious goal of getting 100,000 health care providers to adopt or meaningfully use EHRs by the end of 2012. Today, that goal has already been met and surpassed.

Acting Administrator Tavenner first proposed the 100,000 provider goal in a blog in March with Dr. Mostashari that declared 2012 the "Year of Meaningful Use."

The EHR Incentive Programs, which began in 2011, provide incentive payments to eligible professionals, hospitals, and critical access hospitals as they adopt, implement, upgrade, or meaningfully use certified EHR technology in ways that improve care. Eligible professionals include physicians, nurse practitioners, certified nurse midwives, and some physician assistants. The program was established by the Health Information for Clinical and Economic Health Act of 2009 (HITECH), one of President Obama's first priorities enacted upon taking office.

As of the end of May 2012:

- More than 110,000 eligible professionals and over 2,400 eligible hospitals have been paid by the Medicare and Medicaid EHR Incentive Programs.
- Approximately 48 percent of all eligible hospitals and critical access hospitals in the U.S. have received an incentive payment for adopting, implementing, upgrading, or meaningfully using an EHR.
- One out of every 5 Medicare and Medicaid eligible professionals in the U.S. has received an incentive payment for adopting, implementing, upgrading, or meaningfully using an EHR.
- Over $5.7 billion in EHR Incentive Program payments were made.
- More than $3 billion in Medicare EHR Incentive Program payments were made between May 2011 (when the first payments were released) and the end of May 2012.
- More than $2.6 billion in Medicaid EHR Incentive Program payments were made between January 2011 (when the first states launched their programs) and the end of May 2012.

Through the end of May 2012, over 133,000 primary care providers and 10,000 specialists were partnering with Regional Extension Centers (RECs) to overcome common EHR adoption barriers. Of these providers, 70 percent of small practice providers in rural areas as well as 74 percent of critical access hospitals are working with RECs. These regional organizations work to ensure these clinicians meet meaningful use and receive incentive payments through the Medicare and Medicaid EHR Incentive Programs, Over 12,000 providers working with RECS have already received their incentive payments.

The Medicare and Medicaid EHR Incentive Programs provide incentive payments for using EHR technology in "meaningful" ways that lead to higher quality care, improved patient safety, and shared decision making by patients and physicians. Under both the Medicare and Medicaid EHR Incentive Programs, eligible hospitals and critical access hospitals can receive support and financial incentives for implementing and meaningfully using certified EHR

technology.

Forty-four states are participating in the Medicaid EHR Incentive Program as of May 2012. For more information on which states are participating, please visit the EHR Incentive Programs website. CMS expects the remaining states to launch their Medicaid EHR Incentive Programs by the end of 2012.

Full text of this excerpted CMS press release (issued June 19).

HHS Announces 81 Health Care Innovation Awards [↑]
Providers, Tech Companies, and Local Organizations Expected to Lower Costs; Improve Quality

On June 15, HHS Secretary Kathleen Sebelius announced the recipients of 81 new Health Care Innovation Awards made possible by the health care law, the Affordable Care Act. The awards will support innovative projects nationwide designed to deliver high-quality medical care, enhance the health care workforce, and save money. Combined with the awards announced last month, HHS has awarded 107 projects that, according to awardees, intend to save the health care system an estimated $1.9 billion over the next three years.

The awards are notable for their geographic diversity; projects will be located in urban and rural areas, all 50 states, the District of Columbia and Puerto Rico. Projects include:

Sepsis Early Recognition and Response Initiative in Texas, a project of the Methodist Hospital Research Institute in Houston, is a novel approach to identify and treat sepsis before it progresses. Sepsis is the sixth most common reason for hospitalization and typically requires double the average time in the hospital. It leads to complications such as renal failure and cognitive decline; one out of 20 patients with sepsis die within 30 days. Methodist Hospital's novel initiative will lead to fewer cases of organ failure, improved patient outcomes, shorter stays in the hospital, and lower costs.

Awardees were chosen for their innovative solutions to the health care challenges facing their communities and for their focus on creating a well-trained health care workforce that is equipped to meet the need for new jobs in the 21st century health system. CMS at HHS contracted with an external organization with extensive experience in managing independent grant review processes to administer the award review process to ensure an objective review of each application.

The Center for Medicare and Medicaid Innovation within CMS will administer the awards through cooperative agreements over three years.

For more information on the awards announced today, go to the Health Care Innovation Awards: Project Profiles web page. To learn more about other innovative models being tested by the Innovation Center, please visit: innovations.cms.gov.

Full text of this excerpted HHS press release (issued June 15).

NPPES Issues Resolved, NPI Registry Tip [↑]

The latency and performance issues experienced with the National Plan and Provider Enumeration System (NPPES) have been resolved. The National

Provider Identifier (NPI) Registry is fully operational again.

NPI Registry Tip: Users of the NPI Registry are encouraged to exit the NPI Registry search and search results pages once they have completed their searches. Users who do not exit off of the NPI Registry search pages will get a "servlet error message" as a result of the timed out session (if session is idle). Please be advised that a user can access the NPI Registry again after being timed out and receiving the servlet error message. If users receive the servlet error message, they will need to click on the "Home" or "Logoff" link at the top right-hand corner of the webpage in order to get back to the NPPES homepage and access the NPI Registry again to conduct additional NPI Registry searches. Again, users should exit out of the NPI Registry once they have completed their searches in order to avoid the timed out session and servlet error messages.

2013 ICD-10 PCS Files Now Available [↑]

The 2013 ICD-10-PCS files have been posted on the 2013 ICD-10 PCS and GEMs web page. This includes the 2013 Index and Tabular files, guidelines, code titles, addendum to reference manual, and slides. The 2013 ICD-10-PCS files contain information on the new procedure coding system, ICD-10-PCS, that is being developed as a replacement for ICD-9-CM, Volume 3.

The 2013 General Equivalent Mappings (GEMs), Reimbursement Mappings, and Reference Manual will be posted at a later date.

Previews of Skilled Nursing Facility Minimum Data Set 3.0 Quality Measure Scores and 5 Star Ratings Now Available [↑]

Beginning Monday, June 18, previews will be available on your Minimum Data Set (MDS) State Welcome page for MDS 3.0 quality measure scores and 5 Star ratings, as well as information about facility ownership reported to the CMS PECOS system. Nursing Home Compare will display this information on July 19. The provider 5 Star Help line at 800-839-9290 will be open for an extended period from June 18 through August 3. Provider questions may also be addressed to bettercare@cms.hhs.gov.

Two New Fraud and Abuse CME Modules Posted on Medscape [↑]

In early June, Medscape posted two new CME modules entitled, "Reducing Medicare and Medicaid Fraud and Abuse: Protecting Practices and Patients" and "How CMS Is Fighting Fraud: Major Program Integrity Initiatives." These modules highlight efforts by CMS to fight fraud and abuse and how health care professionals can be part of those efforts.

CMS is Currently Accepting Suggestions for Potential Physician Quality Reporting System Measures and/or Measures Groups [↑]

CMS is currently 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, *all required documentation* must be completed for each measure submitted for consideration to PHYSICIAN_REPORTING_TEMP@cms.hhs.gov, *no later than 5:00 p.m. EST August 1, 2012.*

Required information includes:

- National Quality Form (NQF) Measure Endorsement Status
- Measure Submitted for Consideration Form
- Measure Specifications (measure title, description, numerator and denominator, including exclusions, exceptions, and inclusions)
- Electronic Specification and Data Tables for 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.

Only 10 Days Left: 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 qnetsupport@sdps.org. They are available Monday through Friday from 7am to 7pm CST.

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

The Outpatient Prospective Payment System (OPPS) Pricer web page has been updated with new payment files for the July 2012 Update to the OPPS. The files are ready for download from the "3rd Quarter 2012 Files" section of the OPPS Pricer Code web page.

From the MLN: "Mental Health Services" Booklet Revised [↑]

The Mental Health Services Booklet (ICN 903195) has been revised and is now available in downloadable and hard copy format. This booklet is designed to provide education on mental health services. It includes the following information: covered mental health services, mental health services that are not covered, eligible professionals, outpatient psychiatric hospital services, and inpatient psychiatric hospital services. To access a new or revised product available for order in *hard copy* format, go to MLN Products and click on "MLN Product Ordering Page" under "Related Links" at the bottom of the web page.

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

The Health Professional Shortage Area (HPSA) Physician Bonus, HPSA Surgical Incentive Payment, and Primary Care Incentive Payment Programs Fact Sheet (ICN 903196) (previously titled Health Professional Shortage Area) has been revised and is now available in downloadable and hard copy format. This fact sheet is designed to provide education on three Medicare programs. It includes an overview of the Health Professional Shortage Area (HPSA) Physician Bonus, HPSA Surgical Incentive Payment, and Primary Care Incentive Payment Programs. To access a new or revised product available for order in *hard copy* format, go to MLN Products and click on "MLN Product Ordering Page" under "Related Links" at the bottom of the web page.

From the MLN: "Medicare Fraud & Abuse: Prevention, Detection, and Reporting" Podcast Released [↑]

The Medicare Fraud & Abuse: Prevention, Detection, and Reporting Podcast (ICN 906509) has been released and is now available in downloadable format. This podcast is designed to provide education on preventing, detecting and reporting Medicare fraud and abuse. It includes information from the Medicare Learning Network® fact sheet titled "Medicare Fraud & Abuse: Prevention, Detection, and Reporting," which describes relevant laws, regulations, and partnerships designed to combat fraud and abuse.

"Phase 2 of Ordering and Referring Requirement" MLN Matters® Article Released [↑]

MLN Matters® Special Edition Article #SE1221, "Phase 2 of Ordering and Referring Requirement," was released and is now available in downloadable format. This article is designed to provide education on phase 2 of the requirement by which CMS will deny Part B, DME, and Part A HHA claims that fail ordering/referring provider edits, as outlined in final rule CMS-6010-F, which CMS published on April 24, 2012. It includes additional resources and information about phases 1 and 2 of the requirement and which types of providers are eligible to order or refer items or services to Medicare

beneficiaries. *Note: CMS has not announced a date when the edits for Phase 2 will become active. CMS will give the provider community at least 60 days notice prior to turning on these edits.*

"Edits on the Ordering/Referring Providers in Medicare Part B, DME and Part A HHA Claims (Change Requests 6417, 6421, 6696, and 6856)" MLN Matters® Article Revised [↑]

MLN Matters® Special Edition Article #SE1011, "Edits on the Ordering/Referring Providers in Medicare Part B, DME and Part A HHA Claims (Change Requests 6417, 6421, 6696, and 6856)," was revised and is now available in downloadable format. This article is designed to provide education on phases 1 and 2 of the edits CMS will perform on certain claims submitted by providers who order/refer services to Medicare beneficiaries. It includes a list of questions and answers related to the edits and how they will impact providers. *Note: CMS has not announced a date when the edits for Phase 2 will become active. CMS will give the provider community at least 60 days notice prior to turning on these edits.*

"Requirement for Ambulance Suppliers" MLN Matters® Article Revised [↑]

MLN Matters® Special Edition Article #SE1029, "5010 Requirement for Ambulance Suppliers," was revised and is now available in downloadable format. This article is designed to provide education on how ambulance suppliers should submit their claims electronically in light of the new 837P, version 5010 diagnosis code reporting requirement. It includes options that ambulance suppliers can use to comply with the new requirement.

More Helpful Links…

Check out CMS on

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The Medicare Learning Network

www.CMS.gov/MLNGenInfo

Archive of Provider e-News Messages

www.CMS.gov/FFSProvPartProg/EmailArchive