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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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Colleagues—

We are releasing a special Friday edition of the e-News to announce the posting of three proposed payment regulations:

- [CMS Proposed Rule Would Increase Payment to Family Physicians by 7 Percent](#)
- [CMS Proposes Policy and Payment Changes for Outpatient Care in Hospitals and Ambulatory Surgical Centers](#)
- [Medicare Program; Home Health Prospective Payment System Rate Update for Calendar Year 2013, Hospice Quality Reporting Requirements, and Survey and Enforcement Requirements for Home Health Agencies](#)

—Robin

## The e-News for Friday, July 6, 2012

### NATIONAL PROVIDER CALLS

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- [Medicare Shared Savings Program and Advance Payment Model Application Process — Date Changed to July 31](#)
- [Frequently Asked Questions from March 28 Call on the Initial Preventive Physical Exam and Annual Wellness Visit Now Available](#)

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### ANNOUNCEMENTS AND REMINDERS

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- [Medicare Program; Home Health Prospective Payment System Rate Update for Calendar Year 2013, Hospice Quality Reporting Requirements, and Survey and Enforcement Requirements for Home Health Agencies](#)
- [CMS to Release a Comparative Billing Report on Outpatient Physical Therapy Services with the KX Modifier — Target Release July 20](#)
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- [Attention Physicians Who Order/Refer Services for Medicare Beneficiaries Residing in Home Health Agencies](#)

### CLAIMS, PRICER, AND CODE UPDATES

- [Implementation of the Paperwork Segment within the 5010 837 Professional and Institutional Electronic Transactions](#)

### **National Provider Call: Physician Quality Reporting System & Electronic Prescribing — Registration Now Open** [[↑](#)]

*Tuesday, July 17; 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 proposed changes to the 2013 Physician Quality Reporting System & Electronic Prescribing Incentive Program as outlined in the Medicare Physician Fee Schedule Proposed Rule.

*Target Audience:* All Medicare fee-for-service (FFS) Providers; Medical Coders, Physician Office Staff, Provider Billing Staff, Electronic Health Records staff, and Vendors.

#### *Agenda:*

Opening Remarks

Program Announcements

Overview of the proposed changes to the 2013 Physician Quality Reporting System & Electronic Prescribing Incentive Program as outlined in the Medicare Physician Fee Schedule Proposed Rule

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.

Continuing education credit may be awarded for participation in certain CMS National Provider Calls. Visit the [Continuing Education Credit Notification](#) web page to learn more.

**National Provider Call: Medicare Shared Savings Program and Advance Payment Model Application Process — Date Changed to July 31** [[↑](#)]

*Tuesday, July 31; 1:30-3 pm ET*

The date for the Medicare Shared Savings Program and Advance Payment Model Application Process National Provider Call has been changed from Monday, July 16 to *Tuesday, July 31*. CMS apologizes for any inconvenience.

On Tuesday, July 31, 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, 2013 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.

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**Frequently Asked Questions from March 28 Call on the Initial Preventive Physical Exam and Annual Wellness Visit Now Available** [[↑](#)]

CMS has posted [Frequently Asked Questions](#) from the March 28, 2012 Medicare Preventive Services National Provider Call on the Initial Preventive Physical Exam and the Annual Wellness Visit.

Visit the [National Provider Calls and Events March 28, 2012](#) web page for access to all of the related call materials including the YouTube video slideshow presentation, podcasts, call presentation, audio recording, and written transcripts.

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

Due to the absence of submitted questions and comments related to the Inpatient Rehabilitation Facility (IRF) Patient Assessment Instrument Technical Submission Specifications, the CMS IRF Vendor Call scheduled for July 12 from 2-3pm ET has been cancelled. Vendors and software developers should submit technical questions to [IRFTECHIssues@cms.hhs.gov](mailto:IRFTECHIssues@cms.hhs.gov).

### **CMS Proposed Rule Would Increase Payment to Family Physicians by 7 Percent** [\[↑\]](#)

On July 6, CMS issued a proposed rule that would increase payments to family physicians by approximately 7 percent and other practitioners providing primary care services between 3 and 5 percent. The increase in payment to family practitioners is part of the proposed rule that would update payment policies and rates under the Medicare Physician Fee Schedule (MPFS) for calendar year (CY) 2013. Under the MPFS, Medicare pays more than 1 million physicians and nonphysician practitioners that provide vital health services to Medicare beneficiaries.

The 7 percent increase for family physicians comes from a proposal that continues the Administration's policies to promote high quality, patient-centered care. For CY2013, CMS is proposing for the first time to explicitly pay for the care required to help a patient transition back to the community following a discharge from a hospital or nursing facility. The proposals calls for CMS to make a separate payment to a patient's community physician or practitioner to coordinate the patient's care in the 30 days following a hospital or skilled nursing facility stay. The proposed rule also asks for public comment on how Medicare can better recognize the range of services community physicians and practitioners provide as part of treating patients either through face-to-face services in the office or coordinating care outside the office when the patient does not see the physician.

As has been the case every year since CY2002, CMS projects a significant reduction in MPFS payment rates under the Sustainable Growth Rate (SGR) methodology due to the expiration of the adjustment made for CY2012 in the statute. For CY2013, CMS projects a reduction of 27 percent and is required by law to include this reduction in these calculations. However, Congress has acted to avert the cuts every year since 2003. The Administration is committed to fixing the SGR formula in a fiscally responsible way.

The proposed rule would also continue the careful implementation of the physician value-based payment modifier (Value Modifier) that was included in the Affordable Care Act by providing choices to physicians regarding how to participate. The Value Modifier adjusts payments to individual physicians or groups of physicians based on the quality of care furnished to Medicare beneficiaries compared to costs. The law allows CMS to phase in the Value Modifier over three years from CY2015 to CY2017. For the CY2015 physician payment rates, the proposed rule would apply the Value Modifier to all groups of physician with 25 or more eligible professionals. The proposed rule also provides an option for these groups to choose how the Value Modifier would be calculated based on whether they participate in the Physician Quality Reporting System (PQRS). For groups of 25 or more that do not participate in the PQRS, CMS is proposing to set their Value Modifier at a 1.0 percent payment reduction. For groups that wish to have their payment adjusted according to their performance on the value modifier, the rule proposes a system whereby groups with higher quality and lower costs would be paid more, and groups with lower quality and higher costs would be paid less. The performance period for the CY2015 Value Modifier was established as CY2013 in the MPFS Final Rule for CY2012.

The proposed rule continues efforts by CMS to align quality reporting across programs to reduce burden and complexity. The proposed rule proposes changes to two quality reporting programs that are associated with the MPFS – the PQRS and the Electronic Prescribing (eRx) Incentive Program – as well as the Medicare Electronic Health Records (EHR) Incentive Pilot Program which promotes the use of health information technology. The PQRS proposal includes simplified, lower burden options for reporting and the proposed rule aligns quality reporting across the various programs in support of the National Quality Strategy. The proposed rule also addresses the next phase in a plan to enhance the Physician Compare Website to foster transparency and public reporting of certain information to give beneficiaries more information for purposes of choosing a physician.

The proposed rule also includes:

- A proposal to include additional Medicare-covered preventive services on the list of services that can be provided via an interactive telecommunications system;
- A proposal to implement a durable medical equipment (DME) face-to-face requirement as a condition of payment for certain high-cost Medicare DME items;
- A proposal to apply a multiple procedure payment reduction (MPPR) policy to the technical component of the second and subsequent cardiovascular and ophthalmology diagnostic services furnished by the same doctor to the same patient on the same day;
- A proposal to collect data on patient function to improve how Medicare pays for physical and occupational therapy, and speech language pathology services;
- A request for public comments on payment for advanced diagnostic molecular pathology services;
- A proposal to revise a regulation that only allows Medicare to pay for portable x-rays ordered by an MD or DO. The revised regulations would allow Medicare to pay for portable x-ray services ordered physicians and non-physician practitioners acting within the scope of their Medicare benefit and state law;
- A proposal to clarify when Medicare will pay for interventional pain management services provided by Certified Registered Nurse Anesthetists (CRNAs) when permitted by State law. This proposal will foster access to pain management services in areas where states have determined that CRNAs may provide these services.

The proposed rule will appear in the July 30, 2012 Federal Register. CMS will accept comments on the proposed rule until September 4, 2012, and will respond to them in a final rule with comment period to be issued by November 1, 2012.

*For more information:*

- [Proposed Rule](#)
- [Fact Sheet](#)

Full text of this excerpted [CMS press release](#) (issued July 6).

### **CMS Proposes Policy and Payment Changes for Outpatient Care in Hospitals and Ambulatory Surgical Centers [\[↑\]](#)**

*Proposals also would enhance beneficiary role in quality of care reviews*

CMS issued a proposed rule on July 6 that would update payment policies and payment rates for services furnished to Medicare beneficiaries in hospital outpatient departments (HOPDs) and ambulatory surgical centers (ASCs) beginning January 1, 2013. The proposals would affect HOPDs in more than 4,000 hospitals, including general acute care hospitals, inpatient rehabilitation facilities, inpatient psychiatric facilities, long-term acute care hospitals, children's hospitals, and cancer hospitals, and approximately 5000 Medicare-participating ASCs.

CMS is proposing to increase HOPD payment rates by 2.1 percent. The increase is based on the projected hospital market basket —an inflation rate for goods and services used by hospitals — of 3.0 percent less statutory reductions totaling 0.9 percent, including an adjustment for economy-wide productivity. CMS is also proposing to increase ASC payment rates by 1.3 percent – the projected rate of inflation of 2.2 percent minus an adjustment required by law for improvements in productivity of 0.9 percent. Medicare uses the consumer price index for urban consumers (CPI-U) as the inflation rate for ASCs. CMS is asking for public comment on potential data that Medicare could collect to develop an inflation index that would explicitly measure ASC cost growth.

The proposed rule also would streamline the operations of the Quality Improvement Organizations (QIOs) and make them more responsive to beneficiary complaints about quality of care. Specifically, the proposals would give beneficiaries more information about the QIO's review process, and would create a new alternative dispute resolution option, called Immediate Advocacy, to resolve beneficiary complaints. The proposed rule would also give QIOs authority to send and receive

secure transmissions of electronic versions of health information. Finally, the proposals would enable QIOs to release more information about the results of their reviews to affected beneficiaries.

The proposed rule would make several changes to the quality reporting programs for HOPDs, ASCs and Inpatient Rehabilitation Facilities (IRFs). Specifically, CMS is not proposing to add measures for the CY2014 and CY2015 payment determinations. Thus, CMS is proposing reporting for 23 measures for the CY2014 payment determination and 24 measures for the CY2015 payment determination. The proposed rule also contains proposals for procedures related to retirement and retention of HOPD measures.

Reporting Program. Specifically, the proposed rule would:

- Adopt updates on a previously adopted measure for the IRF QRP that will affect annual prospective payment amounts in FY2014;
- Adopt a policy that would provide that any measure that has been adopted for use in the IRF QRP will remain in effect until the measure is actively removed, suspended, or replaced; and
- Adopt policies regarding when notice-and-comment rulemaking will be used to update existing IRF QRP measures.

The proposed rule will appear in the July 30, 2012, Federal Register. CMS will accept comments on the proposed rule until September 4, 2012, and will respond to all comments in a final rule to be issued by November 1, 2012.

For more information on the CY2013 proposals for the OPPS and the ASC payment system, as well as proposed changes to the QIO program:

- [Proposed Rule](#)
- [Fact Sheet](#)

Full text of this excerpted [CMS press release](#) (issued July 6).

### **Medicare Program; Home Health Prospective Payment System Rate Update for Calendar Year 2013, Hospice Quality Reporting Requirements, and Survey and Enforcement Requirements for Home Health Agencies** [\[↑\]](#)

[CMS-1358-P](#) was put on display at the Office of the Federal Register on July 6, 2012. This proposed rule updates Medicare's Home Health Prospective Payment System payment rates for Calendar Year 2013. Payments to home health agencies (HHAs) are estimated to decrease by approximately 0.10 percent, or -\$20 million. The rule also proposes to rebase and revise the home health market basket, allow additional regulatory flexibility regarding therapy and face-to-face encounter requirements, and extend certain hospice quality reporting requirements to subsequent years. Lastly, this rule would establish requirements for unannounced, standard, and extended surveys of HHAs and provide a number of alternative (or intermediate) sanctions if HHAs were out of compliance with Federal requirements.

Full text of the [CMS press release](#) (issued July 6).

### **CMS to Release a Comparative Billing Report on Outpatient Physical Therapy Services with the KX Modifier — Target Release July 20** [\[↑\]](#)

On July 20, CMS will release a national provider Comparative Billing Report (CBR) addressing Outpatient Physical Therapy Services with the KX Modifier.

CBRs produced by SafeGuard Services under contract with CMS, contain actual data-driven tables and graphs with an explanation of findings that compare provider'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 providers 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 providers 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 providers that this kind of data is very helpful to them and encouraged us to produce more CBRs and make them available to providers.

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

### **CMS Releases 43 New FAQs Related to the 3 Day Payment Window Policy** [\[↑\]](#)

CMS has posted to the CMS website [43 new Frequently Asked Questions](#) (FAQs) related to MLN Matters® Article [#MM7502](#), “Bundling of Payments for Services Provided to Outpatients Who Later Are Admitted as Inpatient: 3-Day payment Window and the Impacts on Wholly Owned or Wholly Operated Physician Offices.”

The new FAQs for the 3-Day (or 1-day) Payment Window policy as it pertains to physician practices are located in the Downloads section of the CMS [Physician Fee Schedule](#) web page and the [Hospital PPS](#) web page.

### **Attention Physicians Who Order/Refer Services for Medicare Beneficiaries Residing in Home Health Agencies** [\[↑\]](#)

When billing Medicare, Home Health Agencies (HHAs) must use the individual National Provider Identifier (NPI) of the physician who orders/refers services, not the NPI of the physician's group practice. If an HHA asks for your NPI, be sure to provide your *individual* NPI.

Don't know your individual NPI? You may verify your NPI on the [NPI Registry](#) on the CMS website.

### **Implementation of the Paperwork Segment within the 5010 837 Professional and Institutional Electronic Transactions** [\[↑\]](#)

CMS is rescheduling the implementation date of the Paperwork (PWK) segment within the 5010 837 Professional and Institutional electronic transactions to October 1, 2012. The PWK segment provides the “linkage” between electronic claims and additional documentation which is needed for claims adjudication. The PWK was originally due to be implemented on April 1, 2012 but was delayed in order to address system concerns. For additional information, please refer to MLN Matters® Articles [#MM7041](#) and [#MM7306](#).

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