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.

This issue of the e-News will be available in PDF format within 24 hours of its release in the archive with other past issues.

The e-News for Wednesday, July 18, 2012

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- CMS Proposals for the Physician Value-Based Payment Modifier Under the Medicare Physician Fee Schedule — Registration Now Open
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- Take a Look at CMS' New Medicaid EHR Incentive Program Guide for Eligible Professionals; Remember to Register Now for the EHR Incentive Programs
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MLN EDUCATIONAL PRODUCTS UPDATE

- "How to Protect Your Identify Using the Provider Enrollment, Chain and Ownership System (PECOS)" Fact Sheet

— Revised
- "The Basics of Medicare Enrollment for Physicians and Other Part B Suppliers" Fact Sheet — Revised
- "Medicare Secondary Payer for Provider, Physician, and Other Supplier Billing Staff" Fact Sheet — Revised
- "Intensive Behavioral Therapy (IBT) for Obesity" Booklet — New
- "Screening for Depression" Booklet — New
- "Medicare Quarterly Provider Compliance Newsletter [Volume 2, Issue 4]" Educational Tool — New
- New MLN Provider Compliance Fast Fact

National Provider Call: Medicare Shared Savings Program and Advance Payment Model Application Process — Register Now [↑]
Tuesday, July 31; 1:30-3pm 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 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.

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: CMS Proposals for the Physician Value-Based Payment Modifier Under the Medicare Physician Fee Schedule — Registration Now Open [↑]
Wednesday, August 1; 2:30-4 pm ET

CMS will provide an overview of its proposals for the physician value-based payment modifier. CMS has proposed to phase-in application of the value

modifier, starting in 2015 with groups of physicians with 25 or more eligible professionals. The value modifier for these groups would be based on performance during 2013. The presentation will describe the options these groups have on 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.

A question and answer session will follow the presentation.

Target Audience: Physicians, physician group practices, practice managers, medical and specialty societies, payers, insurers.

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: Audio Recording and Written Transcript from June 27 Medicare & Medicaid EHR Incentive Programs and Certified EHR Technology Call Now Available [↑]

The audio recording and written transcript from the June 27 Medicare & Medicaid EHR Incentive Programs and Certified EHR Technology National Provider Call are now available on the June 27 call page in the "Presentation" section.

Inpatient Rehabilitation Facility Quality Reporting Program Special Open Door Forum Series [↑]

CMS will be hosting a series of monthly Inpatient Rehabilitation Facility (IRF) Special Open Door Forums from July through October. The purpose of these Open Door Forums will be to address issues related to the upcoming implementation of the IRF Quality Reporting Program.

CMS will present various topic and guest speakers each month. A question and answer session will take place at the end of each Open Door Forum.

CMS would love to know about topics that you would like addressed at these Open Door Forums. Please e-mail your ideas to: IRF.questions@CMS.hhs.gov

The IRF Special Open Door Forums will be held on the following dates and times:

- Thursday, July 26; 1-2:30pm ET

- Thursday, August 16; 1-2:30pm ET
- Thursday, September 20; 1-2:30pm ET
- Thursday, October 18; 1-2:30pm ET

Medicare Fee-For-Service Version 5010 July 1, 2012 Implementation Update for the Week of July 16 [↑]

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 July 16:

- Why Transition to Accredited Standards Committee (ASC) X12 Version 5010 (5010) Remittance Advice (835)?
- Remittance Advice (835) Closeout Activities.

Why Transition to Version 5010 for the Remittance Advice (835)?
Providers are encouraged to test with Medicare and transition to version 5010 for remittance advice now. The new version 5010 introduces some significant improvements over the current version ASC X12 Version 4010; e.g., in version 5010, the Health Policy Segment will report the National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs). In addition, the 835 also will have the website where the specific LCD/NCD code is explained. Providers will have access to the code as well as the code description. The 5010 version of the 835 also will contain technical contact information not currently in version 4010. Version 5010 contains new segments such as coverage expiration date and claim received date which will help provider's access important information without manual intervention.

If you haven't already finished testing, please contact your Medicare contractor and begin testing so that you are ready on or before August 1, 2012. If you have already finished testing, contact your Medicare contractor and start receiving the version 5010 835s *now*.

Remittance Advice Closeout Activities (835)
Beginning August 1, 2012, the Medicare FFS program shall produce only the 835 remittance advice transaction in the ASC X12 Version 5010. Medicare FFS has stated in previous communications that trading partners would be allowed an additional 30 days to complete the 835 remittance advice transaction transition. Medicare FFS' internal processes related to closeout activities for the 835 remittance transaction include the generation of the last Accredited Standards Committee (ASC) X12 Version 4010A1 835 data on July 31, 2012. Remittance Advice files from the last processing cycle will be available for retrieval upon conclusion of the July 31, 2012, batch cycle.

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

Proposed Rule Related to the Inpatient Rehabilitation Facility Quality Reporting Program Update [↑]

A proposed rule pertaining to the Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP) has been placed into the FY 2013 Hospital Outpatient Prospective Payment Proposed Rule. This proposed rule was displayed in the Federal Register on Friday, July 6.

CMS decided to add IRF QRP information to the Hospital Outpatient Prospective Payment Proposed Rule so the public would have an opportunity to comment. The IRF QRP proposed rule, "CMS-1589-P (Display Date: July 6, 2012) is available on the Hospital Outpatient PPS web page in the "Related Links" section. The comment period ends September 14.

PQRS and eRx Educational Video Presentations Available [↑]

Need to have a basic understanding of the Physician Quality Reporting System (PQRS) and the Electronic Prescribing (eRx) Incentive Program or want to learn more in-depth information about PQRS and eRx? The following video slideshow presentations on PQRS and the eRx Incentive Program are available to view on the CMS YouTube Channel. Click on the title to view.

Welcome to the Physician Quality Reporting System
This presentation provides an overview of the Medicare Physician Quality Reporting System. Highlights include a brief background of the program, a look at the program website and documentation, high-level steps to get you started, available resources and who to contact for help. Target Audience: Medicare Fee-For-Service providers. Run Time: 15 minutes.

Welcome to the Electronic Prescribing (eRx) Incentive Program
This presentation provides an overview of the Medicare Electronic Prescribing (eRx) Incentive Program. Highlights include a brief program background, a look at the program website and documentation, high-level steps on how to get started; available resources and who to contact for help. Run Time: 17 minutes.

November 8, 2011 PQRS & eRx National Provider Call
CMS subject matter experts provide an overview of the Medicare Physician Fee Schedule to Address the 2012 Physician Quality Reporting System & Electronic Prescribing Incentive Program followed by a question and answer session. Run Time: 84 minutes.

December 20, 2011 PQRS & eRx National Provider Call
CMS subject matter experts provide a brief overview on electronic health record (EHR) and registry based reporting options that are available for eligible professionals participating or looking to participate in the Physician Quality Reporting System and/or Electronic Prescribing Incentive Program. A question and answer session follows the presentations. Run time: 80 minutes.

January 17, 2012 PQRS & eRx National Provider Call
CMS subject matter experts provide a brief overview on how the 2012 Electronic Prescribing (eRx) payment adjustment will appear on the remittance advice, as well as an overview of the self nomination process. A question and answer session follows the presentations. Run time: 88 minutes.

February 21, 2012 PQRS and eRx National Provider Call
CMS subject matter experts provide a brief overview on claims-based reporting for both the Physician Quality Reporting System and Electronic Prescribing Incentive Program. Run time: 30 minutes.

Please visit the CMS National Provider Calls Video Presentations web page for a list of other video slideshow presentations currently available on a variety of Medicare topics.

Steps to Assess How the ICD-10 Transition will Affect your Organization [↑]

Although the final rule on the proposed ICD-10 deadline change has yet to be published, it is important to continue planning for the transition to ICD-10. The switch to the new code set will affect every aspect of how your organization provides care, from registration and referrals, to software/hardware upgrades and clinical documentation.

A critical step in planning for the transition is to conduct an impact assessment of how the new code sets will affect your organization. Your impact assessment should include:

- *Documentation Changes:* You will need to consider the increased specificity of ICD-10 codes compared to ICD-9 codes, and ensure that patient encounters are documented with appropriately comprehensive clinical descriptions. You should:
  - Train staff to accommodate the substantial increase and specificity in code sets
  - Consider physician workflow and patient volume changes
  - Revise forms, documents, and encounter forms to reflect ICD-10 codes
  - Evaluate processes for ordering and reporting lab/diagnostic services to health plans
- *Reimbursement Structures:* You should coordinate with payers on contract negotiations and new policies that reflect the expanded code sets, since they can affect reimbursement schedules.
- *Systems and Vendor Contracts:* Ensure your vendors can accommodate your ICD-10 needs. Find out how and when your vendor plans to update your existing systems. You will need to review existing and new vendor contracts and to evaluate vendor offerings and capabilities against your organization's expectations. Work with your vendors to draft a schedule for needed tasks.
- *Business Practices:* Once you have implemented ICD-10, you will need to determine how the new codes affect your processes for referrals, authorizations/pre-certifications, patient intake, physician orders, and patient encounters.
- *Testing:* Work with your vendors to determine the amount of time needed for testing and schedule accordingly.

ICD-10 will affect nearly all areas of your practice, but with a thorough impact assessment, you can keep your day-to-day activities running smoothly while you transition to ICD-10.

Keep Up to Date on ICD-10.
Please visit the ICD-10 website for the latest news and resources to help you prepare.

CMS Has Added an Important New FAQ for CAHs on Costs for Certified EHR Technology [↑]

CMS wants to help keep you updated with information on the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs. CMS has recently revised an FAQ with new guidance that discusses whether critical access hospitals (CAHs) in the Medicare EHR Incentive Program can include costs for capital leases of certified EHR technology. Take a minute and review the new FAQ below.

Question: Can a Critical Access Hospital (CAH) include costs to lease/rent certified EHR technology in the Medicare EHR incentive payment?
Answer: Under the statute and the regulations, the CAHs EHR incentive payment shall only include reasonable costs for the purchase of certified EHR technology to which purchase depreciation (excluding interest) would apply. There are two types of lease agreements that a CAH may enter into to administer their EHR system… an operating lease or a capital lease.

For the rest of this FAQ, visit the CMS FAQ system and search for it by FAQ number. Type in 3387 in the "FAQ # Search" box found at the top, left side of the FAQ page. Choose the "FAQ #" option by clicking the circle and highlighting it in blue.

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.

Take a Look at CMS' New Medicaid EHR Incentive Program Guide for Eligible Professionals; Remember to Register Now for the EHR Incentive Programs [↑]

CMS has created a new comprehensive guide, An Introduction to the Medicaid EHR Incentive Program for Eligible Professionals, to help walk Eligible Professionals (EPs) through all of the phases of the Medicaid program. This guide includes chapters on:

- An overview of the Medicaid Electronic Health Record (EHR) Incentive Program
- Eligibility determination
- Registration through CMS and eligibility verification at the state level
- Meaningful use and picking appropriate measures
- Attestation
- Helpful resources on the Medicaid EHR Incentive Programs

EPs can use this guide as their source for any information they need on the Medicaid EHR Incentive Program. The guide can be found on the Educational Materials section of the EHR website along with several other helpful tools and resources for participants in the Medicare and Medicaid EHR Incentive Programs, including the guide, An Introduction to the Medicare EHR Incentive Program for Eligible Professionals, that CMS previously created.

Register Today to Receive Maximum Incentives

CMS recommends that all EPs register as early as possible for the Medicare and Medicaid 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.

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.

Latest Version of MREP for Medicare Fee-For-Service Professional Providers and Suppliers [↑]

The latest Claim Adjustment Reason Codes and Remittance Advice Remark Codes are available in the Codes.ini file for the Medicare Remit Easy Print (MREP) software. You can access this file in the Zipped folder for "Medicare Remit Easy Print - Version 3.2.4" on the MREP web page of the CMS website.

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.

Get Ready for DMEPOS Competitive Bidding [↑]

The Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program Round 1 Recompete 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.

From the MLN: "How to Protect Your Identify Using the Provider Enrollment, Chain and Ownership System (PECOS)" Fact Sheet — Revised [↑]

The "How to Protect Your Identify Using the Provider Enrollment, Chain and Ownership System (PECOS)" Fact Sheet (ICN 905103) has been revised and is now available in downloadable format. This fact sheet is designed to provide education on identity protection when using Internet-based PECOS. It includes

step-by-step instructions on how providers can protect their identity while using Internet-based PECOS.

From the MLN: "The Basics of Medicare Enrollment for Physicians and Other Part B Suppliers" Fact Sheet — Revised [↑]

"The Basics of Medicare Enrollment for Physicians and Other Part B Suppliers" Fact Sheet (ICN 903768) has been revised and is now available in downloadable format. This fact sheet is designed to provide education on basic Medicare enrollment information and how to ensure physicians and other Part B suppliers are qualified and eligible to enroll in the Medicare Program. It includes information on how to enroll in the Medicare Program, how to report changes, and a list of resources.

From the MLN: "Medicare Secondary Payer for Provider, Physician, and Other Supplier Billing Staff" Fact Sheet — Revised [↑]

The "Medicare Secondary Payer for Provider, Physician, and Other Supplier Billing Staff" Fact Sheet, (ICN 006903) was revised and is now available in downloadable format. This fact sheet is designed to provide education on the Medicare Secondary Payer provisions. It includes information on Medicare Secondary Payer (MSP) basics, common situations when Medicare may pay first or second, Medicare conditional payments, and the role of the Coordination of Benefits Contractor.

From the MLN: "Intensive Behavioral Therapy (IBT) for Obesity" Booklet — New [↑]

The "Intensive Behavioral Therapy (IBT) for Obesity" Booklet (ICN 907800) has been released and is now available in downloadable format. This booklet is designed to provide education on intensive behavioral therapy for obesity. It includes information about obesity rates, approaches on treating obesity, and other resources on obesity.

From the MLN: "Screening for Depression" Booklet — New [↑]

The "Screening for Depression" Booklet (ICN 907799) has been released and is now available in downloadable format. This booklet is designed to provide education on screening for depression. It includes coverage, coding, billing, and payment information.

From the MLN: "Medicare Quarterly Provider Compliance Newsletter [Volume 2, Issue 4]" Educational Tool — New [↑]

The "Medicare Quarterly Provider Compliance Newsletter [Volume 2, Issue 4]" Educational Tool (ICN 908064) was released and is now available in downloadable format. This educational tool is designed to provide education on how to avoid common billing errors and other erroneous activities when dealing with the Medicare Program. It highlights the top issues of the particular Quarter. Visit the Medicare Quarterly Provider Compliance Newsletter Archive to download, print, and search an index of previously-issued newsletters.

New MLN Provider Compliance Fast Fact [↑]

A new fast fact is now available on the MLN Provider Compliance 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.

Check out CMS on

More helpful links…

The Medicare Learning Network

Archive of Provider e-News Messages