



## **CMS Medicare FFS Provider e-News** *Brought to you by the Medicare Learning Network®*

*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, August 29, 2012**

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#### MLN EDUCATIONAL PRODUCTS UPDATE

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- [“Hospice Payment System” Fact Sheet — Revised](#)

**National Provider Call: Stage 2 Requirements for the Medicare and Medicaid EHR Incentive Programs – Registration Now Open** [[↑](#)]

*Thursday, September 13, -2-3:30pm ET*

On August 23, CMS announced the final rule for Stage 2 requirements and other changes to the EHR Incentive Programs, which is scheduled to be published on September 4. This National Provider Call will provide an overview of the final rule, so you can learn what you need to know to receive EHR incentive payments.

The final rule can be found at [CMS Stage 2 Final Rule](#). For more information on the EHR Incentive Programs, visit the CMS [EHR Incentive Programs](#) website.

*Target Audience:* Hospitals, Critical Access Hospitals (CAHs), and professionals eligible for the Medicare and/or Medicaid EHR Incentive Programs. For more details:

- [Eligibility Requirements for Professionals](#)
- [Eligibility Requirements for Hospitals](#)

*Agenda:*

- Extension of Stage 1
- Changes to Stage 1 Criteria for Meaningful Use
- Proposed Medicaid policies
- Stage 2 Meaningful Use Overview
- Stage 2 Clinical Quality Measures
- Medicare Payment Adjustments and Exceptions
- Question and Answers about the incentive programs

*Registration Information:* In order to receive call-in information, you must register for the call on the [CMS Upcoming National Provider Calls](#) registration website. 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 August 15 Five New Medicare Preventive Services Call Now Available** [[↑](#)]

The audio recording and written transcript from the August 15 Five New Medicare Preventive Services National Provider Call are now available on the [August 15](#) call web page in the “Call Materials” section.

## **Special Open Door Forum: Long Term Care Hospitals** [\[↑\]](#)

*Thursday, August 30; 2-3:30pm ET*

Please join CMS for a Long Term Care Hospitals (LTCH) Special Open Door Forum during which we will discuss the following:

- Section M Skin Conditions – proper coding of this section will be reviewed with opportunity for providers to ask questions
- FAQs – CMS will review most frequently asked questions related to the LTCH QR Program
- Review of important upcoming dates
- Division of National Systems – DNS will make announcements related to the technical submission of the LTCH CARE Data Set.

All LTCH providers and vendors are encouraged to attend this forum. Slides for this open door call will be posted on the CMS [Special Open Door Forum](#) website.

- Participant Dial in Number: 800-837-1935
- Conference ID Number: 20497757
- Note: In order to join the conference call, you will be required to provide the Conference ID Number listed above.

## **HHS Announces Next Steps to Promote Use of Electronic Health Records and Health Information Exchange** [\[↑\]](#)

On August 23, HHS Secretary Kathleen Sebelius announced the next steps in the Obama administration's work to help doctors and hospitals use electronic health records.

Under the Health Information Technology for Economic and Clinical Health (HITECH) Act, doctors, health care professionals and hospitals can qualify for Medicare and Medicaid incentive payments when they adopt and meaningfully use certified electronic health record (EHR) technology.

More than 120,000 eligible health care professionals and more than 3,300 hospitals have qualified to participate in the program and receive an incentive payment since it began in January 2011. That exceeds a 100,000 goal set earlier this year.

That includes more than half of all eligible hospitals and critical access hospitals and 1 out of every 5 eligible health care professionals. The program is divided into three stages:

- Stage 1 sets the basic functionalities electronic health records must include such as capturing data electronically and providing patients with electronic copies of health information.
- Stage 2 (which will begin as early as 2014) increases health information exchange between providers and promotes patient engagement by giving patients secure online access to their health information.
- Stage 3 will continue to expand meaningful use objectives to improve health care outcomes.

On August 23, CMS and the HHS Office of the National Coordinator for Health IT released final requirements for stage 2 that hospitals and health care providers must meet in order to qualify for incentives during the second stage of the program, and criteria that electronic health records must meet to achieve certification.

The requirements announced today:

- Make clear that stage two of the program will begin as early as 2014. No providers will be required to follow the Stage 2 requirements outlined today before 2014.
- Outline the certification criteria for the certification of EHR technology, so eligible professionals and hospitals may be assured that the systems they use will work, help them meaningfully use health information technology, and qualify for incentive payments.
- Modify the certification program to cut red tape and make the certification process more efficient.
- Allow current “2011 Edition Certified EHR Technology” to be used until 2014.

The CMS final rule also provides a flexible reporting period for 2014 to give providers sufficient time to adopt or upgrade to the latest EHR technology certified for 2014.

- [Fact sheet](#) on the CMS final rule
- [Detailed fact sheet](#) on ONC’s standards and certification criteria final rule
- Medicare and Medicaid Programs; Electronic Health Record Incentive Program--Stage 2 [Final Rule](#)
- Health Information Technology: Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology, 2014 Edition; Revisions to the Permanent Certification Program for Health Information Technology [Final Rule](#)
- More information on the Stage 2 rule can be found at the CMS [EHR Incentive Programs](#) website

Full text of this excerpted [CMS press release](#) (issued August 23).

**Visit the New Stage 2 Web Page on the EHR Incentive Programs Website** [[↑](#)]

On August 23, CMS published the final rule for Stage 2 of the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs. The rule provides new criteria that eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) must meet in order to successfully participate in the EHR Incentive Programs.

CMS recently updated the EHR Incentive Programs website with a new [Stage 2 section](#), which provides helpful information on the Stage 2 final rule and how it affects the EHR Incentive Programs. The Stage 2 page includes an overview of the final rule and links to Stage 2 resources:

- [Stage 2 Overview Tipsheet](#) – Provides an overview of the rule, including important dates, basic requirements, new audiences, and additional Stage 2 resources
- Stage 1 vs. Stage 2 Comparison Tables – Compares basic requirements of Stage 1 versus Stage 2 for both [EPs](#) and [eligible hospitals](#)
- [Stage 1 Changes Tipsheet](#) – Outlines major changes to Stage 1 included in the rule
- Payment Adjustments & Hardship Exceptions Tipsheets – Details the schedule and percentages of the payment adjustments, as well as information about hardship exemptions for both [EPs](#) and [eligible hospitals](#)
- [2014 Clinical Quality Measures Tipsheet](#) – An overview of the 2014 CQM requirements that will apply to all providers, regardless of their stage of meaningful use

CMS will continue to provide resources for providers on [Stage 2 rule](#) and the EHR Incentive Programs. Visit the [Stage 2 page](#) to view upcoming webinars and sessions discussing Stage 2 and the different changes occurring.

*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.

**Now Available: Stage 2 Overview Tipsheet** [[↑](#)]

On August 23, CMS published the final rule for Stage 2 of the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs. The rule provides new criteria that eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) must meet to successfully participate in the EHR Incentive Programs.

CMS developed a [Stage 2 Overview Tipsheet](#), a resource that provides a summary of the Stage 2 final rule and highlights key changes to the EHR Incentive Programs, including:

- Stage 2 Timing – The earliest eligible hospitals and CAHs will demonstrate meaningful use of Stage 2 criteria will be fiscal year 2014, or calendar year 2014 for EPs. Providers who were early demonstrators of meaningful use in 2011 will meet three consecutive years of meaningful use under the Stage 1 criteria before advancing to the Stage 2 criteria in 2014.
- Stage 2 Core and Menu Objectives – Stage 2 retains the Stage 1 core and menu structure for meaningful use objectives. Although some Stage 1 objectives were either combined or eliminated, most of the Stage 1 objectives are now core objectives under the Stage 2 criteria. To demonstrate meaningful use under Stage 2 criteria:
  - EPs must meet 20 measures (17 core and 3 of 6 menu).
  - Eligible hospitals must meet 19 (16 core and 3 of 6 menu).

The end of the tipsheet contains a complete list of the Stage 2 core and menu objectives for both EPs and eligible hospitals and CAHs.

- Reporting Periods in 2014 – All providers, regardless of their stage of meaningful use, are only required to demonstrate meaningful use for a three-month EHR reporting period. CMS is permitting this one-time, three-month reporting period in 2014 only so that all providers who must upgrade to 2014 certified EHR technology will have adequate time to implement their new Certified EHR systems.
- Clinical Quality Measures (CQM) in 2014 – Beginning in 2014, all providers, regardless of their stage of meaningful use, will report on CQMs in the same way.
  - All Medicare EPs and eligible hospitals beyond their first year of demonstrating meaningful use must electronically report their CQM data to CMS.
  - All Medicaid providers that are eligible only for the Medicaid EHR Incentive Program will electronically report their CQM data to their state.
  - Additionally, all providers will complete this number of CQMs in 2014:
    - EPs must report on 9 out of 64 CQMs
    - Eligible hospitals and CAHs must report on 16 out of 29 CQMs.

The tipsheet is available on the [CMS](#) website and should be reviewed in its entirety to effectively prepare for Stage 2 requirements.

*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.

## New Health Care Standards to Save up to \$6 Billion [\[↑\]](#)

On August 24, HHS Secretary Kathleen Sebelius announced a final rule that will save time and money for physicians and other health care providers by establishing a unique health plan identifier (HPID). The rule is one of a series of changes required by the Affordable Care Act to cut red tape in the health care system and will save up to \$6 billion over ten years.

Currently, when a health care provider bills a health plan, that plan may use a wide range of different identifiers that do not have a standard format. As a result, health care providers run into a number of time-consuming problems, such as misrouting of transactions, rejection of transactions due to insurance identification errors, and difficulty determining patient eligibility. The change announced on August 24 will greatly simplify these processes.

The rule also makes final a one-year proposed delay – from October 1, 2013 to October 1, 2014 – in the compliance date for use of new codes that classify diseases and health problems. These code sets, known as the International Classification of Diseases, 10th Edition diagnosis and procedure codes, or ICD-10, will include codes for new procedures and diagnoses that improve the quality of information available for quality improvement and payment purposes.

The rule announced today is the fourth administrative simplification regulation issued by HHS under the health reform law:

- On July 8, 2011, HHS adopted operating rules for two electronic health care transactions to make it easier for health care providers to determine whether a patient is eligible for coverage and the status of a health care claim submitted to a health insurer. The rules will save up to \$12 billion over ten years.
- On January 10, 2012, HHS adopted standards for the health care electronic funds transfers (EFT) and remittance advice transaction between health plans and health care providers. The standards will save up to \$4.6 billion over ten years.
- On August 10, 2012, HHS published an IFC that adopted operating rules for the health care EFT and electronic remittance advice transaction. The operating rules will save up to \$4.5 billion over ten years.

More information:

- [Fact sheet](#)
- Adoption of a Standard for a Unique Health Plan Identifier; Addition to the National Provider Identifier Requirements; and a Change to the Compliance Date for the International Classification of Diseases, 10<sup>th</sup> Edition (ICD-10-CM and ICD-10-PCS) Medical Data Code Sets [Final Rule](#)

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

## HHS Secretary Kathleen Sebelius Announces Compliance Date for ICD-10 [\[↑\]](#)

HHS Secretary Kathleen Sebelius [announced](#) the release of a [rule](#) that makes final a one-year proposed delay—from October 1, 2013 to October 1, 2014—in the compliance date for the industry's transition to ICD-10 codes. Secretary Sebelius first announced the proposed delay in April, as part of President Obama's commitment to reducing regulatory burden.

*The deadline for the transition to ICD-10 is October 1, 2014.*

*Keep Up to Date on ICD-10*

Please visit the [ICD-10](#) website for the latest news and resources to help you prepare.

## Now Available: New Webcast for Round 1 Recompete Bidders [\[↑\]](#)

The first in a series of educational webcasts for the Round 1 Recompete of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program is now available on the Competitive Bidding Implementation Contractor (CBIC) website. This webcast, Welcome to the Round 1 Recompete, provides background information on the program and information about the educational resources available to assist you in participating.

The webcast is available on demand to view at your convenience – 24 hours a day, seven days a week. There is no charge to view the webcast, and a transcript is also posted on the website. To view the webcast, please go to the Round 1 Recompete homepage on the CBIC website at [www.dmecompetitivebid.com](http://www.dmecompetitivebid.com) and select *Educational Information* and then choose *Education Events*.

We will be issuing more webcasts later in the bidder education program. The upcoming webcasts will address topics such as financial documentation requirements, general bidding requirements, how a bid is evaluated and how to submit a bid in the online bidding system, DBidS. As each webcast is posted, we will announce its availability through an email update. If you have not already done so, please [register](#) on the CBIC website to receive these announcements and other updates about the Competitive Bidding Program.

If you have any questions or need assistance, please contact the CBIC customer service center toll-free at 877-577-5331 from 9am to 9pm ET, Monday through Friday, throughout the registration and bidding periods.

## Inpatient Rehabilitation Facilities: Important Announcements [\[↑\]](#)

### jIRVEN

- Updated Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) assessment collection software (jIRVEN) will be available from CMS
- Release Date: Week of August 27
  - Same IRF-PAI submission process will be used

Training related to jIRVEN and IRF Assessment Submissions and CASPER Reports will be posted on the [Quality Improvement and Evaluation System \(QIES\) Technical Support Office website](#):

- 4 recorded WebEx training videos will review key areas of the jIRVEN tool are *now available*:
  - jIRVEN Login - How to login into the tool & how to add facility and user information
  - jIRVEN Patient/Assessment – How to create patient and assessment information
  - jIRVEN Import/Export – How to import and export assessments
  - jIRVEN Reports – Review of the reports available within the jIRVEN tool
- A demonstration, or training, version of the jIRVEN tool is now available for download
  - For practice and training purposes *only*
  - Will not allow you to export any of the assessment data
  - Will not allow you to import any data
  - Certain edits will be disabled
- 2 recorded WebEx training videos will be available the week of September 3 that will review key areas of the Submission System

- IRF Assessment Submission Process: How to submit the IRF-PAI to CMS ASAP
- CASPER Reports for IRFs– IRF-PAI Reports: How to access Facility Validation Reports and other provider reports

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

The FY2012 Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) PC Pricer has been updated to fix a typo. The Pricer revised provider data and fixed typo is now available on the [IPF PPS PC Pricer](#) web page. This Pricer is for claims dated from October 1, 2011 to September 30, 2012, and the update is dated August 23, 2012.

### **“Important Reminder About Medicare Secondary Payer Laws” MLN Matters® Article — Released** [\[↑\]](#)

[MLN Matters® Special Edition Article #SE1227](#), “Important Reminder About Medicare Secondary Payer Laws” was released and is now available in downloadable format. This article is designed to provide education on Medicare Secondary Payer laws, which state that providers must bill Medicare as the secondary payer *after* the primary payer has made payment. It includes a description of the law and what providers should do to comply and bill correctly.

### **“Medicare Demonstration Allows for Prior Authorization for Certain Power Mobility Devices (PMDs)” MLN Matters® Article — Released** [\[↑\]](#)

[MLN Matters® Special Edition Article #SE1231](#), “Medicare Demonstration Allows for Prior Authorization for Certain Power Mobility Devices (PMDs)” was released and is now available in downloadable format. This article is designed to provide education on a 3-year demonstration project that CMS is conducting to ensure that Medicare only pays for Power Mobility Devices (PMDs) that are medically necessary under existing coverage guidelines *beginning with orders written on or after September 1, 2012*. It includes information on the prior authorization process and key points related to the demonstration.

### **From the MLN: “Hospice Payment System” Fact Sheet — Revised** [\[↑\]](#)

The [Hospice Payment System](#) Fact Sheet (ICN 006817) has been revised and is now available in downloadable format. This fact sheet is designed to provide education on the Medicare Hospice Payment System. It includes the following information: background, coverage of Hospice services, certification requirements, election periods, how payment rates are set, patient coinsurance payments, caps on Hospice payments, Hospice option for Medicare Advantage enrollees, and quality reporting.

#### **More helpful links...**

Check out CMS on:



[The Medicare Learning Network](#)

[Archive of Provider e-News Messages](#)