



# CMS Medicare FFS Provider e-News

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**National Provider Call: Preparing for Therapy Functional Reporting Implementation in CY 2013 — Register Now [↑]**

*Wednesday, December 12; 1:30-3pm ET*

CMS will hold a National Provider Call on “Preparing for Therapy Functional Reporting Implementation in CY 2013.” This presentation will cover the new functional reporting requirements for outpatient therapy services, including physical therapy (PT), occupational therapy (OT), and speech language pathology (SLP) services, effective January 1, 2013.

Participants will also learn how to report patient functional limitation information on claims using the 42 new nonpayable functional G-codes and seven new severity/complexity modifiers on claims for PT, OT, and SLP services. These G-codes and modifiers will be required on selected claims for all outpatient therapy services. In addition, the G-codes and severity modifiers used in the functional reporting are required to be documented in the patient's medical record of therapy services.

*Target Audience:* Those who furnish or bill for outpatient therapy services including PT, OT, and SLP services

*Agenda:*

- Overview of the new functional reporting requirement, including effective dates
- Professionals and providers affected
- Nonpayable G-codes used to report functional limitations
- Modifiers used to report the severity of functional limitations
- When reporting is required
- Documentation requirements
- Question and answer session

*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: PQRS and eRx Incentive Program —Registration Now Open [↑]**

*Tuesday, December 18; 1:30-3pm ET*

This National Provider Call will provide an overview of the Program Year 2012 data submission for the Physician Quality Reporting System (PQRS) and Electronic Prescribing (eRx) Incentive Program Pilot and Program Year 2013 self-nomination process for group practice reporting options (GPROs), registries, maintenance of certification, and electronic health record (EHR) data submission vendors.

*Target Audience:* Eligible Professionals, medical coders, physician office staff, provider billing staff,

health records staff, vendors and all other interested Medicare FFS health care professionals

*Agenda:*

- Announcements
- Program Year 2012 Data Submission for the PQRS-EHR Incentive Program Pilot
- Program Year 2013 Self-Nomination Process for GPROs, Registries, Maintenance of Certification & EHR Data Submission Vendors
- Resources & Who to Contact for Help
- Question and Answer Session

*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: Implementation of Section 3133 of the Affordable Care Act: Improvement to Medicare DSH Payments — Save the Date [\[↑\]](#)**

*Tuesday, January 8; 1:30-3:30pm ET*

CMS will host a National Provider Call on “Implementation of Section 3133 of the Affordable Care Act: Improvement to Medicare Disproportionate Share Hospital (DSH) Payments.” The agenda and registration information will be available soon on the [CMS Upcoming National Provider Calls](#) registration website.

**National Provider Call: Meaningful Use: Stage 1 and Stage 2 — Save the Date [\[↑\]](#)**

*Wednesday, January 16; 2-3:30pm ET*

CMS will host a National Provider Call on the first 2 stages of Meaningful Use under the Medicare and Medicaid EHR Incentive Programs On January 16. The agenda and registration information will be available soon on the [CMS Upcoming National Provider Calls](#) registration website.

**Flu Season is Here [\[↑\]](#)**

According to the Centers for Disease Control and Prevention, flu activity is beginning to increase and further increases are expected in the coming weeks and months. Now is the time to protect against flu before activity increases in the community. About 5 to 20 percent of the population gets the flu each year and more than 200,000 people are hospitalized because of flu-related complications. Make each office visit an opportunity to talk with your patients about the importance of getting an annual flu vaccination and a pneumococcal vaccination according to the recommended schedule. This message

also serves as a reminder for you to get your seasonal flu vaccination to protect yourself, your family, and your patients.

Remember – the Influenza and pneumococcal vaccines and their administration fees are covered Part B benefits. Influenza and pneumococcal vaccines are NOT Part D-covered drugs.

*For More Information:*

- CMS has posted the 2012-2013 [Seasonal Influenza Vaccines Pricing](#) list. You may also refer to the [MLN Matters® Article #MM8047](#), “Influenza Vaccine Payment Allowances - Annual Update for 2012-2013 Season.”
- Please visit the [CMS Medicare Learning Network® Preventive Services Educational Products](#) and [CMS Immunizations](#) web pages for more information on coverage and billing of the flu and pneumococcal vaccines and their administration fees.
- While some providers may offer the flu vaccine, those who don’t can help their patients locate a vaccine provider within their local community. The [HealthMap Vaccine Finder](#) is a free, online service where users can find nearby locations offering flu vaccines.

### **What are Quality and Resource Use Reports and the Value-Based Payment Modifier, and How Do They Affect Physicians? [\[↑\]](#)**

As part of ongoing efforts by CMS to improve the quality and efficiency of medical care, the CMS Physician Feedback/Value-Based Modifier program is providing comparative performance information to physicians, called Physician Quality and Resource Use Reports (QRURs).

This reporting was initiated under Section 131 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), and was expanded by section 3003 of the Affordable Care Act of 2010. The Affordable Care Act directs CMS to provide information to physicians and medical practice groups about the resource use and quality of care they provide to their Medicare patients, including quantification and comparisons of patterns of resource use/cost among physicians and medical practice groups.

The idea behind these reports is to provide meaningful and actionable information so physicians can improve the care they furnish, and a move toward physician reimbursement that rewards value rather than volume. This effort will transform Medicare from a passive payer to an active purchaser of higher quality, more efficient healthcare. Most resource use and quality information in the QRURs is displayed as relative comparisons of performance among similar physicians (i.e., a peer group).

Section 3007 of the Affordable Care Act also mandates that, by 2015, CMS begin applying a Value-based Payment Modifier (Value Modifier) under the Medicare Physician Fee Schedule. The 2011 QRURs previews some of the quality and cost data that could be used by CMS to calculate the Value Modifier.

*Educational Resources:*

- More detailed information on the Physician Feedback Program, QRURs, and the Value Modifier can be found on the [Medicare FFS Physician Feedback Program/Value-Based Payment Modifier](#) website.
  - Specific information of interest includes:
    - [The Value Modifier](#)
    - [QRURs for Individual Physicians Practicing in Groups](#)

- CMS will host periodic QRUR and Value Modifier National Provider Calls to educate the provider community—stay tuned for details on [upcoming events](#).

### **Informal Review for the 2013 eRx Incentive Program Payment Adjustment Begins December 10 [\[↑\]](#)**

CMS has implemented an informal review process for the 2013 electronic prescribing (eRx) payment adjustment. Beginning in December 2012, eligible professionals subject to the 2013 eRx payment adjustment will begin receiving notification from CMS via mail. Eligible professionals who believe they should not be subject to the 2013 eRx payment adjustment should visit the Quality Reporting Communication Support web page ([Communication Support Page](#)) to request a significant hardship exemption (if applicable and not previously requested) or submit an informal review request.

#### *Using the Communication Support Page to request a significant hardship exemption*

There is still time to avoid the 2013 eRx payment adjustment. As a reminder, on November 1, CMS re-opened the [Communication Support Page](#) to allow individual eligible professionals and group practices the opportunity to request a significant hardship exemption for the 2013 eRx payment adjustment. Significant hardship requests should be submitted via the Communication Support Page on or between November 1, 2012 and January 31, 2013. Please remember that CMS will review these requests on a case-by-case basis. All decisions on significant hardship exemption requests will be final. The following eRx hardship exemption categories are available for request on the Communication Support Page:

- Inability to electronically prescribe due to state, or federal law, or local law or regulation;
- The eligible professional prescribes fewer than 100 prescriptions during a 6-month payment adjustment reporting period;
- The eligible professional practices in a rural area without sufficient high-speed Internet access (G8642); and
- The eligible professional practices in an area without sufficient available pharmacies for electronic prescribing (G8643)

For more information on how to navigate the Communication Support Page:

- [PQRS & eRx Quality Reporting Communication Support Page User Manual](#)
- [Tips for Using the Quality Reporting Communication Support Page](#)

Also available, as stated in the Medicare CY 2013 Physician Fee Schedule Final Rule, are two additional hardship exemption categories for eligible professionals participating in the Electronic Health Record (EHR) Incentive Program. These two hardship exemption categories are as follows:

- Eligible Professionals who achieve meaningful use during certain eRx timeframes. For the 2013 eRx payment adjustment, this will include any eligible professional who achieved meaningful use during January 1, 2011 through June 30, 2012 and has attested to this by January 31, 2013.
- Eligible Professionals who demonstrate intent to participate in the EHR Incentive Program and adoption of Certified EHR Technology by registering for the EHR Incentive Program by January 31, 2013. Please note: EHR Incentive Program participants must provide their entire EHR Certification Number to receive this hardship exemption.

To receive a significant hardship exemption from the 2013 eRx payment adjustment under one of these two categories, an eligible professional must either register to participate in the EHR Incentive Program

(including providing the entire EHR Certification Number in their registration) or attest to meaningful use in the [EHR Incentive Program Registration and Attestation System](#) by January 31, 2013. For questions relating to participation in the Medicare and Medicaid EHR Incentive Program, please contact the EHR Incentive Program Information Center at 888-734-6433 (TTY 888-734-6563).

#### *Submitting an Informal Review Request*

Eligible professionals should submit their eRx informal review request via email to the informal review mailbox at [ERxInformalReview@cms.hhs.gov](mailto:ERxInformalReview@cms.hhs.gov). Please include your individual rendering National Provider Identifier (NPI) contact information (email, telephone, mailing address) and justification as to why you are requesting an informal review. Please note: Eligible professionals should not provide their Tax Identification Number (TIN) via email. CMS will contact eligible professionals if additional information is needed. Informal Review request will be accepted beginning December 10, 2012 through February 28, 2013.

*Questions?* Please contact the QualityNet Help Desk at 866-288-8912 (TTY 877-715-6222) or via [qnetsupport@sdps.org](mailto:qnetsupport@sdps.org). They are available Monday through Friday from 7am through 7pm CT.

#### **New Information on Hospital Outpatient Payments Available on the CMS Website [\[↑\]](#)**

[Medicare Program; Semi-Annual Meeting of the Advisory Panel on Hospital Outpatient Payment \(HOP Panel\)—March 11 and 12, 2013](#) has been published in the Federal Register. The CMS Final Decisions on the August 2012 recommendations of the HOP panel on supervision levels for select services, as well as the special instructions for submitting a supervision presentation for the HOP Panel meeting are also available on the [Advisory Panel on HOP](#) web page.

Hospital outpatient therapeutic services with general supervision and non-surgical extended duration therapeutic services (NSEDTS) updates are available in the "downloads" section of the [Hospital Outpatient PPS](#) website.

#### **Hospice Quality Reporting Program Website Updated [\[↑\]](#)**

Section 3004 of the Affordable Care Act mandates the establishment of quality reporting requirements for Hospice Programs. The following updates are now available on the [Hospice Quality Reporting](#) website.

- A WebEx training on Hospice Quality Reporting Program Data Entry and Submission will be re-posted by December 7
  - This training will help hospices prepare for web-based data entry and submission of quality data affecting the FY 2014 payment determination.
  - Hospices can access additional details about the WebEx on the [Spotlight & Announcements](#) web page.
- Minor revisions to the [Hospice QRP Q+A](#) and an errata sheet for the User Guide for Hospice Quality Reporting Data Collection are now available on the [Spotlight & Announcements](#) web page.
  - These documents have been modified to further clarify the timing of the follow-up question for the NQF #0209 Pain Measure
- An updated version of the [Technical User Guide for Hospice Quality Reporting Data Entry](#)

[and Submission, Version 1.2](#) and vendor third/party data submission information is now available on the [Data Submission](#) web page.

- In order to have the most up-to-date information, providers should download the updated version of the User Guide.

### **Direct GME and IME Slots Awarded under Section 5506 of the Affordable Care Act [\[↑\]](#)**

On Friday, November 30, CMS released the results of its decisions regarding which teaching hospitals are receiving increases to their Direct Graduate Medical Education (DGME) and Indirect Medical Education (IME) full-time equivalent (FTE) resident caps under Round 2 of section 5506 of the Affordable Care Act. Section 5506 directed CMS to develop a process to permanently preserve and redistribute the Medicare funded residency slots from teaching hospitals that close. Priority is given to hospitals located in the same or contiguous CBSA as the closed hospital, and that met other criteria.

Round 2 of section 5506 redistributes the residency slots of St. Vincent's Medical Center in New York City, which closed on October 31, 2010. A list of hospitals reviewed under Round 2 of section 5506 is available on the [Direct Graduate Medical Education](#) web page. Select the "Section 5506 Cap Increases Round 2 – Applications due Dec 1, 2011" link in the "Downloads" section.

### **Verify Your Registration with PECOS, the MAC, and the EHR Registration System [\[↑\]](#)**

CMS recommends you take the following step in order to successfully register for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs.

- Enroll in [the Provider Enrollment, Chain and Ownership System \(PECOS\)](#).

Your registration status with the EHR Incentive Programs will remain in "issue pending" until you have an active enrollment record in PECOS. You will need the following information to successfully enroll with PECOS:

- An active NPI
- NPPES User ID and password. Internet-based PECOS can be accessed with the same User ID and password that a physician or non-physician practitioner uses for NPPES
- Personal identifying information (legal name, Social-Security Number, and date of birth)
- School information (name of school and graduation year)
- Professional license/certification information
- Practice location information
- Information about any final adverse action(s), if applicable
- Drug Enforcement Agency (DEA) number

If you are already enrolled, confirm your information is correct.

- Ensure your information with your Medicare Administrative Contractors (MAC) is up-to-date and matches your information in the CMS EHR Registration & Attestation System. The MAC processes your claims. Use [this list](#) to find your MAC and confirm your information is correct.
- [Register early for the EHR Incentive Programs](#). This helps to more easily resolve any issues that may affect your incentive payment.

### *Participation Resources*

CMS developed registration user guides for [Medicare eligible professionals](#) (EPs), [Medicaid EPs](#), and [Medicare and Medicaid eligible hospitals](#). You can also read the [CMS Registration, Attestation, and PECOS Checklist](#) for more information.

### *Want more information about the EHR Incentive Programs?*

Make sure to visit the [Medicare and Medicaid EHR Incentive Programs](#) website for the latest news and updates on the EHR Incentive Programs.

### *Learn the Basics of enrolling in Internet-based PECOS*

Take a look at [The Basics of Internet-based Provider Enrollment, Chain and Ownership System \(PECOS\) for Physicians and Non-Physician Practitioners](#), a helpful fact sheet series that provides education to physicians and non-physician practitioners on how to use Internet-based PECOS and includes a list of Frequently Asked Questions (FAQs).

## **Planning for ICD-10: Working with Clearinghouses and Billing Services [[↑](#)]**

All claims for health care services provided on or after October 1, 2014, must contain ICD-10 codes. As you prepare for the ICD-10 transition, contact any third-party billing services that you use to make sure they are actively planning for ICD-10.

As you reach out to your clearinghouse or billing service, you may want to ask:

- Are you prepared to meet the ICD-10 deadline of October 1, 2014? Where is your organization in the transition process?
- Can you verify that you have updated your system to Version 5010 standards for electronic transactions? (Only systems with [Version 5010](#) can accept ICD-10 codes; systems with the older, Version 4010 standards cannot accommodate ICD-10.)
- Who will be my primary contact at your organization for the ICD-10 transition?
- Can we set up regular check-in meetings to keep progress on track?
- What are your plans for testing claims containing ICD-10 codes? How will you involve your clients, such as my practice, in that process?
- Can my practice send testclaims with ICD-10 codes to see if they are accepted? If so, when will you begin accepting test claims?
- Can you provide guidance or training on how my clinical documentation will have to change to support ICD-10 coding?
- Do you anticipate any pricing changes for your services due to the switch to ICD-10?

If you do not currently use a clearinghouse or billing service, you may want to enlist one to help you with your transition. Consider asking other health care providers in your area if they have established relationships or contacts they recommend. Act soon so you have plenty of time to select the service that best meets your ICD-10 needs and budget.

### *Keep Up to Date on ICD-10*

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

For practical transition tips:

- Read [past ICD-10 email update messages](#)
- Access the [ICD-10 continuing medical education modules](#) developed by CMS in partnership with Medscape

**“Implementation of Provider Enrollment Provisions in CMS-6028-FC” MLN Matters® Article — Revised [\[↑\]](#)**

[MLN Matters® Article #MM7350](#), “Implementation of Provider Enrollment Provisions in CMS-6028-FC” was revised and is now available in downloadable format. This article is designed to provide education on how Medicare will implement certain provisions cited in CMS-6028-FC, as outlined in Change Request (CR) 7350. It includes an overview of the effective provisions, which include: (1) establishment of provider enrollment screening categories; (2) submission of application fees; (3) suspensions of payment based on credible allegations of fraud; and (4) authority to impose a temporary moratorium on the enrollment of new Medicare providers and suppliers of a particular type in a geographic area. The article was revised to provide the application fee amount of \$532.00 for Calendar Year (CY) 2013, as reflected in CMS-6044-N, which CMS published in the *Federal Register* on Friday, November 30, 2012.

**“Further Details on the Revalidation of Provider Enrollment Information” MLN Matters® Special Edition Article — Revised [\[↑\]](#)**

[MLN Matters® Special Edition Article #SE1126](#), “Further Details on the Revalidation of Provider Enrollment Information” was revised and is now available in downloadable format. This article is designed to provide education on the Medicare provider enrollment revalidation process. It includes information on what providers and suppliers must do when they receive notice from their Medicare Administrative Contractor (MAC) to revalidate their enrollment. The article was revised to provide the application fee amount of \$532.00 for CY 2013, as reflected in CMS-6044-N, which CMS published in the *Federal Register* on Friday, November 30, 2012.

**From the MLN: “Federally Qualified Health Center” Fact Sheet — Revised [\[↑\]](#)**

The “[Federally Qualified Health Center](#)” Fact Sheet (ICN 006397) was revised and is now available in downloadable format. This fact sheet is designed to provide education on Federally Qualified Health Centers (FQHC). It includes the following information: background, FQHC designation, covered FQHC services, FQHC preventive primary services that are not covered, FQHC Prospective Payment System, and FQHC payments.

**From the MLN: “Swing Bed Services” Fact Sheet — Revised [\[↑\]](#)**

The “[Swing Bed Services](#)” Fact Sheet (ICN 006951) was revised and is now available in downloadable format. This fact sheet is designed to provide education on swing bed services. It includes the following information: background, requirements that apply to hospitals and Critical Access Hospitals, and payments.

**“Health Insurance Portability and Accountability Act (HIPAA) Electronic Data Interchange (EDI) Standards” Web-Based Training Course — Reminder [\[↑\]](#)**

The “[Health Insurance Portability and Accountability Act \(HIPAA\) Electronic Data Interchange \(EDI\) Standards](#)” Web-Based Training (WBT) Course (ICN C00140) is now available. This web-based training course is designed to provide education on electronic billing, transaction standards, and code sets. It includes an overview of the steps involved in the Medicare electronic data interchange process.

### **Subscribe to the MLN Educational Products and MLN Matters® Electronic Mailing Lists [[↑](#)]**

The [Medicare Learning Network](#)® (MLN) is the home for education, information, and resources for the Medicare FFS provider community. Sign up for both of the electronic mailing lists below to stay informed about the latest MLN Educational Products and MLN Matters® Articles. You will receive an e-mail when new and revised products and articles are released.

- [MLN Educational Products Electronic Mailing List](#) – MLN Products are designed to provide education on a variety of Medicare-related topics, such as provider supplier enrollment, preventive services, provider compliance, and Medicare payment policies. All products are free of charge and offered in a variety of formats to meet your educational needs.
- [MLN Matters® Articles Electronic Mailing List](#) – MLN Matters® are national articles that educate Medicare FFS Providers about important changes to the Medicare Program. Articles explain complex policy information in plain language to help providers reduce the time it takes to incorporate these changes into their Medicare-related activities.

### **Submit Feedback on MLN Educational Products [[↑](#)]**

The Medicare Learning Network® (MLN) is interested in what you have to say! Visit the [MLN Opinion](#) web page to submit an anonymous evaluation about specific MLN educational products. Your feedback is important and helps us develop quality MLN products that meet your educational needs.



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