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- "Medicare Billing: 837P and Form CMS-1500" Fact Sheet — Revised

National Provider Call: Getting Started with PQRS Reporting: Implications for the Value-based Payment Modifier — Register Now
Wednesday, June 5; 1:30-2:30pm ET

This National Provider Call will cover how to obtain an Individuals Authorized Access to the CMS Computer Services (IACS) account in order for (1) physician group practices to select their CY 2013 Physician Quality Reporting System (PQRS) Group Reporting Mechanism, and if applicable, elect quality tiering to calculate their CY 2015 Value-based Payment Modifier; and (2) individual eligible professionals to select the Administrative Claims reporting mechanism for CY 2013. A question and answer session will follow the presentation.

Please note that while this call is scheduled for 60 minutes. CMS experts will be available to stay on the line for an additional 30 minutes to take outstanding questions, should they exist, at the end of the scheduled call time. Participants can remain on the line until the conclusion of the call or refer to the call transcript and audio recording (to be posted 7-10 business days after the call) if they are unable to participate beyond the 60 minute scheduled duration.

Agenda:
- Introductions and opening remarks
- IACS registration walkthrough
- Question and answer session

Target Audience: Physicians, physician group practices, practitioners, therapists, 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 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 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 Information web page to learn more.

National Provider Call: PQRS and eRx Incentive Program Payment Adjustment — Register Now
Tuesday, June 18; 1:30-3pm ET

This National Provider Call provides a general overview on the Physician Quality Reporting System (PQRS) payment adjustment and the Electronic Prescribing (eRx) Incentive Program payment adjustment, as well as specifics on the 2015 PQRS and 2014 eRx adjustments, including eligibility, how to avoid future payment adjustments, key points, and tips for successful participation. This presentation also provides a list of resources and who to contact for help. A question and answer session follows the presentation.

Agenda:

- Announcements
- Presentation on PQRS and eRx Incentive Program payment adjustment
- Question and answer session

Target Audience: Eligible professionals, medical coders, physician office staff, provider billing staff, health records staff, vendors, and all other interested Medicare FFS healthcare professionals

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.

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National Provider Calls: Medicare Shared Savings Program Application Process — Register Now
Thursday, June 20; 1:30-3pm ET— **Application Review**
Thursday, July 18; 1-2:30pm ET— **Application Question and Answer Session**

On October 20, 2011, CMS issued a final rule under the Affordable Care Act to establish the Medicare Shared Savings Program (Shared Savings Program). This initiative will help providers participate in Accountable Care Organizations (ACOs) to improve quality of care for Medicare patients. CMS will host two National Provider Calls on the Shared Savings Program application process.

On Thursday, June 20, CMS subject matter experts will provide an overview and updates to the Shared Savings Program application process for the January 1, 2014 start date. A question and answer session will follow the presentations.

On Thursday, July 18, CMS subject matter experts will be available to answer questions about the Shared Savings Program and application process for the January 1, 2014 start date.

The Shared Savings Program Application web page has important information, dates, and materials on the application process. Call participants are encouraged to review the application and materials prior to the call.

Target Audience: Medicare FFS providers

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 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.

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National Provider Call: Medicare and Medicaid EHR Incentive Programs and Certified EHR Technology — Registration Opening Soon
Thursday, June 27; 2:30-3:45pm ET

CMS and the Office of the National Coordinator for Health Information Technology (ONC) provide an overview of the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, including the use of certified EHR technology to meet meaningful use. Learn about the different types of certification and what certification actually tests.

Agenda:

- Overview of the EHR Incentive Programs
- ONC Health Information Technology (HIT) Certification Program
- 2014 Edition Testing and Certification
- Resources
- Question and answer with CMS and ONC experts

Target Audience:
Eligible Professionals and Eligible Hospitals as defined by the Medicare and Medicaid EHR 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 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.

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National Provider Call: Medicare and Medicaid EHR Incentive Programs National Provider Call Series — Save the Dates

The Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs paid out over $13.7 billion in incentives through March of this year. Don't be left out. CMS will be holding a series of National Provider Calls (NPCs) about different aspects of the EHR incentive programs. Don't miss these opportunities to learn from the experts.

Registration opening soon for the Certification call for Medicare and Medicaid Eligible Professionals on June 27.

Mark your calendars for these upcoming NPCs. Registration will be announced:

Medicare and Medicaid Eligible Professionals, Eligible Hospitals, and Critical Access Hospitals:

- July 23; 1:30-3 —Clinical Quality Measures
- July 24; 1:30-3 —Stage 2

Medicare Eligible Professionals, Eligible Hospitals, and Critical Access Hospitals

- August 13; 1:30-3 —Hardship Exceptions
- August 15; 1:30-3 —Payment Adjustments

National Provider Call: Video Slideshow Presentation from April 23 Call on the Medicare Shared Savings Program Application Process Now Available

CMS has released a YouTube video slideshow presentation from the April 23 National Provider Call on the Medicare Shared Savings Program Application Process. The call presentation is now available on the CMS YouTube Channel as a video slideshow that includes the call audio.CMS subject matter experts cover tips on completing a successful application, including information on how to submit an acceptable ACO Participant List, Participation Agreement Sample, Executed Participant Agreement pages, and Governing Body Template. Visit the April 23 call web page for access to all of the related call materials, including the slide presentation, complete audio recording, and written transcript.

PERM Cycle 2 Provider Education Webinar/Conference Calls

CMS is hosting Payment Error Rate Measurement (PERM) provider education webinar/conference calls for Medicare providers who also provide Medicaid and CHIP services. Complete details are available in the webinar/conference calls announcement.

Presentations will include:

- The PERM process and provider responsibilities during a PERM review
- Frequent mistakes and best practices
- The Electronic Submission of Medical Documentation, esMD program

To join the meeting:

- Registration is not required, however, space is limited
- All webinars are from 3-4pm ET, except the June 5 webinar, which will begin at 3:30
- Audio: 877-267-1577, Meeting ID# 4964
    - Wednesday, June 5 — Webinar
        - Due to a CMS schedule conflict, the June session is being rescheduled to begin at 3:30 instead of 3pm
    - Tuesday, June 18 — Webinar
    - Tuesday, July 2 — Webinar
    - Wednesday, July 17— Webinar

Doctors and Hospitals' Use of Health IT More Than Doubles Since 2012
More than half of America's doctors have adopted electronic health records

On May 22, HHS Secretary Kathleen Sebelius announced that more than half of all doctors and other eligible providers have received Medicare or Medicaid incentive payments for adopting or meaningfully using electronic health records (EHRs).

HHS has met and exceeded its goal for 50 percent of doctor offices and 80 percent of eligible hospitals to have EHRs by the end of 2013.

Since the Obama administration started encouraging providers to adopt electronic health records, usage has increased dramatically. According to the Centers for Disease Control (CDC) and Prevention survey in 2012, the percent of physicians using an advanced EHR system was just 17 percent in 2008. Today, more than 50 percent of eligible professionals (mostly physicians) have demonstrated meaningful use and

received an incentive payment. For hospitals, just nine percent had adopted EHRs in 2008, but today, more than 80 percent have demonstrated meaningful use of EHRs.

The Obama administration has encouraged the adoption of health IT starting with the passage of the Recovery Act in 2009 because it is an integral element of health care quality and efficiency improvements. Doctors, hospitals, and other eligible providers that adopt and meaningfully use certified electronic health records receive incentive payments through the Medicare and Medicaid EHR Incentive Programs. Part of the Recovery Act, these programs began in 2011 and are administered by CMS and the Office of the National Coordinator of Health Information Technology (ONC).

Adoption of EHRs is also critical to the broader health care improvement efforts that have started as a result of the Affordable Care Act. These efforts – improving care coordination, reducing duplicative tests and procedures, and rewarding hospitals for keeping patients healthier – all made possible by widespread use of EHRs. Health IT systems give doctors, hospitals, and other providers the ability to better coordinate care and reduce errors and readmissions that can cost more money and leave patients less healthy. In turn, efforts to improve care coordination and efficiency create further incentive for providers to adopt health IT.

As of the end of April 2013:

- More than 291,000 eligible professionals and over 3,800 eligible hospitals have received incentive payments from the Medicare and Medicaid EHR Incentive Programs.
- Approximately 80 percent of all eligible hospitals and critical access hospitals in the U.S. have received an incentive payment for adopting, implementing, upgrading, or meaningfully using an EHR.
- More than half of physicians and other eligible professionals in the U.S. have received an incentive payment for adopting, implementing, upgrading, or meaningfully using an EHR.

For more information about the Administration's efforts to promote implementation, adoption and meaningful use of EHRs and health IT systems, visit the EHR Incentive Programs website and at HealthIT.gov.

Full text of this excerpted CMS press release (issued May 22).

Administration Announces $1 Billion Initiative to Launch Health Care Innovation Awards

On May 15, HHS Secretary Kathleen Sebelius announced a nearly $1 billion initiative that will fund awards and evaluation to build on the Obama administration's work to transform the health care system by delivering better care and lowering costs. This second round of Health Care Innovation Awards will fund applicants that have a high likelihood of driving health care system transformation and delivering better outcomes.

Made possible by the Affordable Care Act, the Health Care Innovation Awards provides another opportunity to improve the quality of health care and bring down costs for taxpayers and patients. The health care law includes many tools to avoid costly mistakes and readmissions, keep patients healthy, reward quality instead of quantity, and create health information technology infrastructure that enables new payment and delivery models to work. The provisions in the Affordable Care Act are already working to reduce costs: Medicare spending per beneficiary increased by just 0.4 percent last year, far below historical averages.

Last year, CMS awarded 107 round one Health Care Innovation Awards out of nearly 3,000 applications

to organizations that are currently testing innovative solutions to improve outcomes and reduce costs. Projects are located in urban and rural areas, all 50 states, the District of Columbia and Puerto Rico.

This second round of Health Care Innovation Awards differs from the first round in that CMS is specifically seeking innovations in four areas: rapidly reducing costs for patients with Medicare and Medicaid in outpatient hospital and other settings; improving care for populations with specialized needs; testing improved financial and clinical models for specific types of providers, including specialists; and linking clinical care delivery to preventive and population health. Like the first round, these awards will emphasize results and ensure program integrity. More information, including a fact sheet and Funding Opportunity Announcement is available on the Health Care Innovation Awards initiative website.

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

Application Deadlines for the Medicare Shared Savings Program January 1 Program Start Date
Notice of Intent to Apply Due by May 31

If you are interested in applying for participation for the January 1, 2014 program start date of the Medicare Shared Savings Program, you must submit a Notice of Intent to Apply (NOI) *by May 31, 2013*. For more information, visit the Shared Savings Program Application web page.

Once you submit an NOI, you must submit your "Application for Access to CMS Computer Systems," Form CMS-20037, no later than *June 10, 2013*:

- Use the link and instructions provided in your NOI acknowledgement email.
- Submit Form CMS-20037 as soon as possible. Do not wait until the June 10 deadline.
- Submit via tracked mail (Federal Express, United Parcel Service, etc.).
- If you have already submitted this form, please disregard this notice.

To learn more about the application process, register to attend upcoming National Provider Calls on June 20 and July 18.

Reporting Period to Submit eRx Data and Avoid Adjustment Ends June 30

A major Electronic Prescribing (eRx) Incentive Program deadline is approaching for both individual eligible professionals (EPs) and group practices participating in the Group Practice Reporting Option (GPRO). If you are an EP or an eRx GPRO participant, you must successfully report as an electronic prescriber before June 30, 2013 or you will experience a payment adjustment in 2014 for professional services covered under Medicare Part B's Physician Fee Schedule (PFS.)

The 2013 eRx Incentive Program 6-month reporting period (January 1, 2013 to June 30, 2013) is the final reporting period available to you if you wish to avoid the 2014 eRx payment adjustment. If you do not successfully report, a payment adjustment of 2.0% will be applied, and you will receive only 98.0% of your Medicare Part B PFS amount for covered professional services in 2014.

Avoiding the 2014 eRx Payment Adjustment
Individual EPs and eRx GPRO participants who were not successful electronic prescribers in 2012 can avoid 2014 eRx payment adjustment by meeting specified reporting requirements between January 1, 2013 and June 30, 2013. Below are the 6-month reporting requirements:

- Individual EPs – 10 eRx events via claims
- eRx GPRO of 2-24 EPs – 75 eRx events via claims
- eRx GPRO of 25-99 EPs – 625 eRx events via claims
- eRx GPRO of 100+ EPs – 2,500 eRx events via claims

Exclusions and Hardships Exemptions
Exclusions from the 2014 eRx payment adjustment only apply to certain individual EPs and group practices, and CMS will automatically exclude those individual EPs and group practices who meet the criteria. CMS may exempt individual eligible professionals and group practices participating in eRx GPRO from the 2014 eRx payment adjustment if it is determined that compliance with the requirements for becoming a successful electronic prescriber would result in a significant hardship. Requests for hardship exemptions must be submitted by June 30, 2013. More information on exclusion criteria and hardship exemption categories can be found on the Electronic Prescribing (eRx) Incentive Program: 2014 Payment Adjustment Fact Sheet.

Resources from CMS
To learn more about the eRx Incentive Program, please visit the CMS eRx Incentive Program website. Additional resources on the 2014 payment adjustment are available on the eRx Incentive Program Payment Adjustment Information web page, including the resource Electronic Prescribing (eRx) Incentive Program: Updates for 2013.

Questions about eRx?
If you have questions regarding the eRx Incentive Program, eRx payment adjustments, or need assistance submitting a hardship exemption request, please contact the QualityNet Help Desk at 866-288-8912 (TTY 1-877-715-6222) or via qnetsupport@sdps.org. The Help Desk is available Monday through Friday from 7am-7pm CT.

July 3rd is an Important EHR Deadline for Medicare Eligible Hospitals and CAHs

July 3, 2013 is last day that eligible hospitals and critical access hospitals (CAHs) in their first year of participation of the Medicare EHR Incentive Program can begin their 90-day reporting period to demonstrate meaningful use for FY 2013. Hospitals in their second and third years of participation must demonstrate meaningful use for the full FY.

Looking Ahead
Three other important dates for eligible hospitals and CAHs include:
- September 30, 2013: Last day of the FY 2013, and the end of the reporting year.
- October 1, 2013: First day of FY 2014, and the start of Stage 2 for hospitals in their third or fourth years of participation.
- November 30, 2013: Last day to register and attest to receive an incentive payment for FY 2013.

See other 2013 important dates in the 2012-2014 Health Information Technology timeline.

Want more information about the EHR Incentive Programs?
Make sure to visit the CMS EHR Incentive Programs website for the latest news and updates on the EHR Incentive Programs.

The Role of Clearinghouses in the ICD-10 Transition

Practices preparing for the October 1, 2014, ICD-10 deadline are looking for resources and organizations

that can help them make a smooth transition. It is important to know that while clearinghouses can help, they cannot provide the same level of support for the ICD-10 transition as they did for the Version 5010 upgrade. ICD-10 describes a medical diagnosis or hospital inpatient procedure and must be selected by the provider or a resource designated by the provider as their coder, and is based on clinical documentation.

During the change from Version 4010 to Version 5010, clearinghouses provided support to many providers by converting claims from Version 4010 to Version 5010 format. For ICD-10, clearinghouses can help by:

- Identifying problems that lead to claims being rejected
- Providing guidance about how to fix a rejected claim (e.g., the provider needs to include more or different data)

Clearinghouses cannot, however, help you identify which ICD-10 codes to use unless they offer coding services. Because ICD-10 codes are more specific, and one ICD-9 code may have several corresponding ICD-10 codes, selecting the appropriate ICD-10 code requires medical knowledge and familiarity with the specific clinical event.

While some clearinghouses may offer third-party billing/coding services, many do not. And even third-party billers cannot translate ICD-9 to ICD-10 codes unless they also have the detailed clinical documentation required to select the correct ICD-10 code.

As you prepare for the October 1, 2014, ICD-10 deadline, clearinghouses are a good resource for testing that your ICD-10 claims can be processed—and for identifying and helping to remedy any problems with your test ICD-10 claims.

Keep Up to Date on ICD-10
Visit the CMS ICD-10 website for the latest news and resources to help you prepare for the *October 1, 2014,* deadline. Sign up for CMS ICD-10 Industry Email Updates and follow us on Twitter.

Change in Electronic Remittance Advice (835) for Inpatient Claims

This notice is to inform providers that the Medicare Part A electronic remittance advices generated on or after July 22, 2013 will no longer include service line payment information on inpatient claims. Based on instruction in the 835 Health Care Claim Payment/Advice implementation guide, service line payment information is not supported for inpatient claims. All claim adjustment information will be reported at the claim level. If providers have an automated process for posting inpatient Part A claims, a change may be required on your part to accept the modified remittance advice.

This change is applicable to inpatient claims, type of bill 11X; skilled nursing facility claims, type of bills 18X, 21X, 28X and 51X; and religious non-medical hospital claims, type of bill 41X.

Outpatient Therapy Services Functional Reporting Testing Period Ending June 30

As required by section 3005(g) of the Middle Class Tax Relief and Jobs Creation Act (MCTRJCA) of 2012, CMS implemented a new claims-based data collection system for outpatient therapy services by requiring reporting of functional limitations with 42 new nonpayable G-codes and 7 new modifiers on specified claims for physical therapy (PT), occupational therapy (OT) and speech-language pathology (SLP) services. The claims-based data collection system is effective for outpatient therapy services with

dates of service on and after January 1, 2013.

For functional reporting, a testing period is currently in effect until June 30, 2013. During the testing period, claims without the required G-codes and severity/complexity modifiers will continue to be processed and adjudicated by your carrier or Part B Medicare Administrative Contractor. Beginning April 1, a new Remittance Advice message has been alerting providers about missing information on select therapy claims. Please note: institutional claims will not receive alert messages.

Therapy claims with dates of service on or after July 1, 2013 that do not contain the required functional G-codes and corresponding modifiers will be returned or rejected, as applicable.

Please read the following MLN Matters® articles for more information:

- MM8166 – "Outpatient Therapy Functional Reporting Non-Compliance Alerts"
- MM8005 – "Implementing the Claims-Based Data Collection Requirement for Outpatient Therapy Services — Section 3005(g) of the Middle Class Tax Relief and Jobs Creation Act (MCTRJCA) of 2012"

Inpatient Prospective Payment System PC Pricer Updated

The FY 2013 Inpatient Prospective Payment System (PPS) PC Pricer has been updated with logic fixes. The latest version is now available on the Inpatient PPS PC Pricer web page in the "Downloads" section.

April Quarterly PPS Provider Data Updated

The April 2013 quarterly provider data on the Provider Specific Data for Public Use in Text Format web page has been corrected and is now available in the "Downloads" section.

"Institutional Services Split Claims Billing Instructions for Medicare Fee-For-Service (FFS) Claims that Span the International Classification of Diseases, 10th Edition (ICD-10) Implementation Date" MLN Matters® Article — Released

MLN Matters® Special Edition Article #SE1325, "Institutional Services Split Claims Billing Instructions for Medicare Fee-For-Service (FFS) Claims that Span the International Classification of Diseases, 10th Edition (ICD-10) Implementation Date" has been released and is now available in downloadable format. This article is designed to provide education on processing split claims for certain institutional encounters that span the ICD-10 implementation. It also provides claim examples regarding Emergency Department and Observation Service encounters to help providers better understand the split billing concept.

From the MLN: "Medicare Billing: 837P and Form CMS-1500" Fact Sheet — Revised

The "Medicare Billing: 837P and Form CMS-1500" Fact Sheet (006976) was revised and is now available in downloadable format. This fact sheet is designed to provide guidance to health care professionals and suppliers who transmit health care claims electronically or use paper claim forms. It includes information about Medicare claims submissions, coding, submitting accurate claims, when Medicare will accept a hard copy claim form, timely filing, and where to submit FFS claims.

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