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CMS Medicare FFS Provider e-News
CMS Information for the Medicare Fee-For-Service Provider Community

CMS asks that you share the following important information with all of your association members and state and local chapters. Thank you!

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The e-News for Wednesday, June 6, 2012

NATIONAL PROVIDER CALLS

- [Medicare & Medicaid EHR Incentive Programs; Registration and Attestation for Eligible Professionals – Last Chance to Register](#)
- [Physician Quality Reporting System & Electronic Prescribing \(eRx\) Incentive Program – Register Now](#)

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- [Learn How to Use CMS' Updated FAQ System to get on the Path to Payment for the EHR Incentive Programs](#)
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CLAIMS, PRICER, AND CODE UPDATES

- [Medicare Fee-For-Service to Reject Version 4010 Electronic Transactions July 1, 2012](#)

MLN UPDATES

- ["Explaining the Difference Between a National Provider Identifier \(NPI\) and a Provider Transaction Access Number \(PTAN\)" MLN Matters® Article Revised](#)
- ["How to Use the Searchable Medicare Physician Fee Schedule" MLN Booklet Reminder](#)

National Provider Call: Medicare & Medicaid EHR Incentive Programs; Registration and Attestation for Eligible Professionals – Last Chance to Register [[↑](#)]
Thursday, June 7; 1:30-3pm ET

This is the last year Medicare eligible professionals (EPs) can begin to participate to earn the full Medicare Electronic Health Record (EHR) incentive payments —

don't let this opportunity pass you by. Learn what you need to do to participate in the EHR incentive programs.

Target Audience: Eligible Professionals (EPs): Doctors of Medicine or Osteopathy, Doctors of Dental Surgery or Dental Medicine, Doctors of Podiatric Medicine, Doctors of Optometry, Chiropractors, Nurse Practitioners, Certified Nurse Midwives, Physician Assistants (PA) who practice at an FQHC/RHC led by a PA. (NOTE: Hospital-based EP's may not participate — An EP is considered hospital-based if 90% or more of the EP's services are performed in a hospital inpatient or emergency room setting). For more information, including Medicaid patient volume requirements, visit the [EHR Incentive Programs Eligibility](#) web page.

Agenda:

- Path to Payment
- Highlights of Registration and Attestation Processes
- Third Party Proxy
- Troubleshooting
- Helpful Resources
- Question and Answers

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.

- Additional material related to the EHR Incentive Programs in today's e-News [[next](#)]

National Provider Call: Physician Quality Reporting System & Electronic Prescribing (eRx) Incentive Program – Register Now [[↑](#)]

Tue June 19; 1:30-3pm ET

CMS will host a National Provider Call with question and answer session. CMS subject matter experts will provide an overview of “The 2010 Physician Quality Reporting System and eRx Incentive Program Reporting Experience Including Trends (2007-2011)”.

Target Audience: All Medicare Fee-For-Service Providers, Medical Coders, Physician Office Staff, Provider Billing Staff, Electronic Health Records Staff, and Vendors

Agenda:

- *Opening Remarks*
- *Program Announcements*
- *Overview of “The 2010 Physician Quality Reporting System and eRx Incentive Program Reporting Experience Including Trends (2007-2011)”*
- *Question & Answer Session*

Registration Information: In order to receive call-in information, you must register for the call on the [CMS Upcoming National Provider Calls](#) web page. Registration will close at 12pm on the day of the call or when available space has been filled; no exceptions will be made, so please register early.

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- Additional material related to the Physician Quality Reporting System in today's e-News [\[next\]](#)

Recognizing Men's Health Week, June 11-17 [\[↑\]](#)

Each year, the week leading up to and including Father's Day, is Men's Health Week. Men's Health Week is a great time to focus on keeping our fathers, brothers, uncles, and sons healthy — by educating them on health issues that disproportionately affect men, raising awareness of preventable health problems, and encouraging early detection and treatment of disease.

Did you know?

- Heart disease is the leading cause of death for U.S. men
- More U.S. men die from lung cancer than any other type of cancer
- Prostate cancer and colorectal cancer are the second and third most common causes of cancer death in U.S. men, respectively
- 34% of U.S. adult men are obese, and 32% have hypertension
- Men aged 60 and over are more likely to be obese than younger men

Medicare provides coverage of a wide range of preventive services for certain beneficiaries that meet eligibility and coverage requirements that are especially meaningful to men in helping them prevent and detect disease, including but not limited to:

- Annual Wellness Visit
- Abdominal Aortic Aneurysm Screening
- Alcohol Misuse Screening and Counseling
- Colorectal and Prostate Cancer Screenings
- Cardiovascular Disease Screenings
- Depression Screening
- Diabetes Screening
- HIV Screening
- Immunizations
 - Hepatitis B
 - Influenza
 - Pneumococcal
- Initial Preventive Physical Exam (also commonly referred to as the "Welcome to Medicare" Preventive Visit)
- Intensive Behavioral Therapy for Cardiovascular Disease
- Intensive Behavioral Therapy for Obesity
- Screening for Sexually Transmitted Infections (STIs) and High-Intensity Behavioral Counseling (HIBC) to Prevent STIs
- Tobacco Use Cessation Counseling

Encourage men with Medicare to make the most of their benefits by taking advantage of the preventive services that are most appropriate for them.

Resources from the MLN:

- [Quick Reference Information: Medicare Preventive Services](#)
- [MLN Matters Article MM7070, Annual Wellness Visit, Including Personalized Prevention Plan](#)
- [Quick Reference Information: The ABCs of Providing the Annual Wellness Visit](#)
- [Medicare Learning Network® \(MLN\) Preventive Services Educational Products](#)

More Information for Healthcare Providers:

- [CDC Men's Health Statistics webpage](#)
- [Men's Health Week](#)

HHS Harnesses the Power of Health Data to Improve Health [[↑](#)]

HHS, along with the Institute of Medicine (IoM) and other members of the Health Data Consortium, co-hosted the third annual “Datapalooza” focusing on innovative applications and services that harness the power of open data from HHS and other sources to help improve health and health care.

Announcements made at the Forum June 5 include:

CMS launched an initiative to transform the agency’s approach to data and analytics. The initiative will help guide the agency’s evolution from a fee-for-service based payer to a “value-based purchaser of care” that links payments to quality and efficiency of care, rather than sheer volume of services. To lead the initiative, CMS created a new Office of Information Products and Data Analysis, which will strive to make development, management, use, and dissemination of data and information resources a core function of CMS. The announcement builds upon many of the recent advances in data transparency and accessibility achieved by CMS in the past 12 months.

Over time, the initiative will modernize CMS’ intricate data systems and policies, and help the agency to achieve the greatest improvements in health care delivery. Data and information resources available under CMS’ initiative include:

- Medicare Geographic Variation Trend Data: A unique data set that leverages nearly 5 billion Medicare claims in an easy-to-use data format that provides key metrics at the state and hospital referral region levels.
- Medicare Enrollment Dashboard: An online dashboard that provides a single location with comprehensive statistics on Medicare enrollment (Parts A, B, and D and Medicare Advantage).
- Medicare & Medicaid Research Review: A peer-reviewed online journal on current and future directions of the Medicare, Medicaid and Children’s Health Insurance.
- CMS Data Navigator: A web-based search tool that rapidly connects researchers, policy makers, and the general public to the CMS data resources they need.

For more information, view the [CMS Fact Sheet](#).

The Office for the National Coordinator for Health IT has led national competitions toward the creation of easy-to-use, web-based tools that help patients schedule follow-up appointments after being discharged from a hospital stay. In collaboration with the Partnership for Patients, the “Discharge Follow-Up Appointment Challenge” winners were announced:

- *First place:* MyHealthDIRECT, a web-based solution that enables patients and caregivers to search for, book, and confirm appointments and

- includes reminder and transportation reservation functionality.
- *Second place:* HePak, a tool that integrates appointment-making and reminder functions into its hospital, provider, and patient portals.
- *Third place:* mHealthCoach, a tool that provides calendar syncing and incorporates educational content and HHS data feeds.

Also announced was the Blue Button Mash-Up Challenge (submission period ends September 5, 2012). In conjunction with the Department of Veterans Affairs (VA) and the HHS Office of the National Coordinator announced the Challenge that builds on the VA's existing Blue Button feature to allow patients to download their health information and share it with health care providers, caregivers and others. The challenge requires the development of a tool that will help individuals to use their health information, combined with other types of information, such as cost data or comparative health data, to better understand their own health status and make more informed decisions regarding their health care.

View the complete [Press Release](#) issued June 5.

Major Improvements to Medicare Online Enrollment System [[↑](#)]

CMS listened to your feedback about the Medicare online enrollment system – Internet-based PECOS. CMS has made improvements to the electronic signature process to allow an Authorized Official (AO) or Delegated Official (DO) of an organization to e-sign their application within an authenticated Internet-based PECOS session.

The AO or DO of an organization that is listed in the Individual Control section of an enrollment will be permitted to e-sign the applicable certification and/or authorization statements and CMS 588 (Electronic Funds Transfer) within Internet-based PECOS instead of being directed to a separate PECOS E-signature Application. However, if the AO or DO is not the individual completing the application or if they do not currently have access to PECOS, they will continue to receive an email directing them to the separate PECOS E-signature Application. To see a sample of the email the AO or DO will receive and get helpful tips, see “Complete Signing Your Medicare Enrollment Application Electronically” in the [April 25 edition](#) of the e-News.

Were You Sent a Request to Revalidate Your Medicare Enrollment? [[↑](#)]

At this time, the quickest way to see if a revalidation letter was mailed to you is to check the “Downloads” on the CMS [Revalidation page](#). You will find mailing lists beginning with September 2011 when the first letters were sent. Information is now available for Medicare Part A/B revalidation letters mailed in April and May. Updated listings are also available for A/B revalidation letters mailed in February/March and for revalidation letters mailed by the National Supplier Clearinghouse (NSC). *When information is updated, the link will be revised to show the date the file was updated.*

- [Medicare Part A/B Revalidations Mailed April - May 2012 \[ZIP, 253KB\]](#)
- [Medicare Part A/B Revalidations Mailed February - March 2012 \(UPDATE 06/04/2012\) \[ZIP, 528KB\]](#)
- [NSC Revalidation Letters Mailed \(UPDATE 06/03/2012\) \[ZIP, 429KB\]](#)

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.

Learn How to Use CMS' Updated FAQ System to get on the Path to Payment for the EHR Incentive Programs [[↑](#)]

CMS has upgraded the [Frequently Asked Questions \(FAQs\) section](#) of their website. The EHR Incentive Programs' FAQs are now incorporated in the same page as other CMS program FAQs.

New and Old FAQ Numbers:

CMS has tagged FAQs in the new system with two sets of FAQ numbers. You can now identify an FAQ by its old FAQ number (listed after the word "Keywords" below the answer of the FAQ) or its new FAQ number (at the very bottom of the FAQ in parentheses).

Finding FAQs:

There are a few different ways to find EHR Incentive Programs FAQs:

1. Click on the Topic: *Electronic Health Records Incentive Programs* on the blue navigation panel on the left side of the [FAQ page](#)
 - a. Click on the Subtopic of your choice, such as "Getting Started" or "Registration and Attestation," to see the FAQs related to that area of the programs
2. Search for your FAQ in the system
 - a. Enter a search term such as "EHR" in the Search box on the top, left side of the [FAQ page](#).
 - b. Use the new FAQ numbers
 - i. Enter the new FAQ number 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.
 - If you have already read an FAQ and noted the new number (in parentheses at the bottom of the FAQ), use that number as a reference to quickly find it again
 - c. Use the old FAQ numbers
 - i. Enter the old FAQ number (listed after "Keywords" below the FAQ answer) in the "Text Search box" found at the top, left side of the [FAQ page](#). Choose the "Text" option.

Note: You cannot search by old FAQ number in the "FAQ # Search" box. However, you can search by old FAQ numbers in the "Text Search" box.

You can also download a PDF of all the FAQs for the EHR Incentive Program. Go to the [FAQ page](#) on the EHR Incentive Programs website and click the [link](#) under the Downloads section at the bottom of the page.

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 Delivery Reform CME Module Posted on Medscape [\[↑\]](#)

On May 30, Medscape posted a new CME module entitled, "[CMS Value-based Purchasing Targets Complications, Readmissions](#)," highlighting the delivery system reforms created by the Affordable Care Act, specifically Value-Based Purchasing.

Medicare Fee-For-Service to Reject Version 4010 Electronic Transactions July 1, 2012 [\[↑\]](#)

Effective July 1, 2012 only ASC X12 Version 5010 (Version 5010) or NCPDP Telecom D.0 (NCPDP D.0) formats will be accepted by Medicare Fee-For-Service (FFS). Providers that are still conducting one or more of the Version 4010 transactions electronically, such as submitting a claim or checking claim status, or rely on a software vendor, billing service or clearinghouse to do this on their behalf, are affected by this change. Now is the time to contact your software vendor, billing service or clearinghouse, when applicable, if you have not done so already to ensure you are ready. Transactions conducted by Medicare Administrative Contractor (MAC), fiscal intermediary (FI) or carrier telephone interactive voice response (IVR) systems, Direct Data Entry (DDE) and Internet Portals, for those contractors with Internet Portals, are not impacted.

Claims (837 I and P)

All claims received after normal close of business cutoff times on June 29, 2012 must be sent as ASC X12 version 5010 or NCPDP D.0. Any Medicare FFS claims received in version 4010 format after normal close of business on June 29 will be rejected back to the submitter. The specific message you receive if a claim is rejected will depend on your MAC. A detailed list of 4010 rejection error messages by MAC may be found on the [Medicare Fee-For-Service 5010 and D.0 Technical Documentation page](#).

Claim Status (276/277)

The last Claim Status Inquiry will be accepted in version 4010 at the end of the business day on June 29, 2012. Following that date, all Claim Status activity will be in ASC X12 Version 5010.

Remittance Advice (835)

During the transition period Medicare FFS experienced issues with the Remittance Advice (835); therefore Medicare FFS will be allowing an additional 30 days to complete the 835 transition. Information will be forthcoming concerning the final cutoff and cycle timing for the Remittance Advice.

Coordination of Benefits (837)

CMS has directed its MACs, FIs, and carriers to begin sending all claims to the Coordination of Benefits Contractor (COBC) in version 5010 as of June 29, 2012. This

will ensure that all claims that the COBC will issue to COB payers as of its July 2, 2012 evening crossover claims cycle will be properly transmitted in the version 5010 format. Therefore, all COB payers will have to be in version 5010 COB production by June 29, 2012.

Medicare FFS will continue to coordinate additional outreach and education activities and messages throughout June. In addition, Medicare FFS will be participating in a series of Regional Webinars on Wednesday, June 20. Please watch for listserv messages on registering for these calls.

For more information on ASCX12Version 5010 and NCPDP D.0, please visit the [Versions 5010 and D.0](#) website.

“Explaining the Difference Between a National Provider Identifier (NPI) and a Provider Transaction Access Number (PTAN)” MLN Matters® Article Revised [↑]

[MLN Matters® Special Edition Article #SE1216](#), “Explaining the Difference Between a National Provider Identifier (NPI) and a Provider Transaction Access Number (PTAN)” has been revised and is now available in downloadable format. This article is designed to provide education on the differences between a National Provider Identifier (NPI) and a Provider Transaction Access Number (PTAN). It includes information about new enrollees, revalidation, the relationship between the NPI and PTAN, and how providers can protect their identity in the Provider Enrollment Chain & Ownership System (PECOS). The article was revised to remove a sentence from the last paragraph on page 2. All other information remains the same.

“How to Use the Searchable Medicare Physician Fee Schedule” MLN Booklet Reminder [↑]

A reminder that [How to Use the Searchable Medicare Physician Fee Schedule](#) Booklet, ICN 901344, is available in downloadable format. This booklet is designed to provide education on how to use the Medicare Physician Fee Schedule (MPFS). It includes steps to search for payment information, pricing, Relative Value Units (RVUs), and payment policies. If you like this booklet, check out [How to Use the Medicare Coverage Database](#) and [How to Use the National Correct Coding Initiative \(NCCI\) Tools](#) from the Medicare Learning Network® (MLN).

More Helpful Links...

Check out CMS on

[Twitter](#), [LinkedIn](#), [YouTube](#), and [Flickr](#)!

[The Medicare Learning Network](#)
[Archive of Provider e-News Messages](#)