CMS Announces Medicare Providers Must Begin to Revalidate Enrollment By March 2013

Announcement from CMS:

All providers and suppliers who enrolled in the Medicare program prior to Friday, March 25, 2011, will be required to revalidate their enrollment under new risk screening criteria required by the Affordable Care Act (section 6401a). Providers/suppliers who enrolled on or after Friday, March 25, 2011 have already been subject to this screening, and need not revalidate at this time.

New Screening Criteria

In the continued effort to reduce fraud, waste, and abuse, CMS implemented new screening criteria to the Medicare provider/supplier enrollment process beginning in March 2011. Newly-enrolling and revalidating providers and suppliers are placed in one of three screening categories – limited, moderate, or high – each representing the level of risk to the Medicare program for the particular category of provider/supplier, and determining the degree of screening to be performed by the Medicare Administrative Contractor (MAC) processing the enrollment application. More information on the screening categories is here.

Notices Will Be Sent to
Providers/Suppliers

Between now and March 2013, MACs will be sending notices to individual providers/suppliers; please begin the revalidation process as soon as you hear from your MAC. Upon receipt of the revalidation request, providers and suppliers have 60 days from the date of the letter to submit complete enrollment forms. Failure to submit the enrollment forms as requested may result in the deactivation of your Medicare billing privileges. The easiest and quickest way to revalidate your enrollment information is by using Internet-based PECOS (Provider Enrollment, Chain, and Ownership System), at https://pecos.CMS.hhs.gov.

Fees Levied

Section 6401a of the Affordable Care Act requires institutional providers and suppliers to pay an application fee when enrolling or revalidating (“institutional provider” includes any provider or supplier that submits a paper Medicare enrollment application using the CMS-855A; CMS-855B, not including physician and non-physician practitioner organizations; CMS-855S; or associated Internet-based PECOS enrollment applications); these fees may be paid via www.Pay.gov.

In order to reduce the burden on the provider, CMS is working to develop innovative technologies and streamlined enrollment processes – including Internet-based PECOS. Updates will continue to be shared with the provider community as these efforts progress.

For more information about provider revalidation, review the Medicare Learning Network’s Special Edition Article #SE1126, titled “Further Details on the Revalidation of Provider Enrollment Information.”
Robert Anthony from CMS Takes Questions on Stage One Meaningful Use in PhysiciansPractice Webinar

Today, PhysiciansPractice sponsored a webinar with CMS’s Robert Anthony on the topic of “Meaningful Use Stage 1.” Robert Anthony is a Health Insurance Specialist in the Office of E-Health Standards and Services (OESS) at the Centers for Medicare & Medicaid Services (CMS), where he focuses on the EHR Incentive Programs. Robert had a very pleasant voice to listen to, and he gets my vote for the best CMS Employee Speaker that I’ve heard!

I was not familiar with the OESS before, so I looked it up and found out what they do: Provide the overall leadership for and coordinate the implementation of Title IV of the HITECH Act. (Title IV = Medicare and Medicaid Health Information Technology)

Robert briefly reviewed what has happened to date with the EHR Incentive Program and the terms of the Medicare and Medicaid programs. The three main differences in the two programs are:

1. The types of providers that are eligible for each program – information here.
2. The volume of each type of patient needed to participate: no volume needed to participate in the Medicare program and 30% Medicaid patients for all eligible practitioners except pediatricians who only need 20% Medicaid patients.
3. The tasks in year one in which the certified EHR is
adopted. For Medicaid the practice only needs to attest that they have adopted, implemented or upgraded an EHR. In year one for Medicare the practice needs to attest to meaningful use for 90 days, which means data is collected and input into the attestation system.

The majority of the webinar was devoted to FAQs (my favorite part of any CMS-related education session!)

**FAQs**

**Q:** Can entities participate in the Medicare EHR Demonstration Project, and the Medicare or Medicaid EHR Incentive programs too?

A: Yes. The demonstration projects are about to be sunsetted (completed.)

**Q:** What information must be provided to patients to meet the requirement for a clinical summary at the end of each visit?

A: If system is certified, it will automatically provide the appropriate information for the clinical summary, which includes the patient’s problem list, medication list, medication allergy list, and diagnostic test results.

Robert suggested looking at the answer online at the CMS FAQ which I posted below:

In our final rule, we defined “clinical summary” as: an after-visit summary that provides a patient with relevant and actionable information and instructions containing, but not limited to, the patient name, provider’s office contact information, date and location of visit, an updated medication list, updated vitals, reason(s) for visit, procedures and other instructions based on clinical discussions that took place during the office visit, any updates to a problem list, immunizations or medications administered during visit, summary of topics covered/considered during visit, time and
location of next appointment/testing if scheduled, or a recommended appointment time if not scheduled, list of other appointments and tests that the patient needs to schedule with contact information, recommended patient decision aids, laboratory and other diagnostic test orders, test/laboratory results (if received before 24 hours after visit), and symptoms.

The EP must include all of the above that can be populated into the clinical summary by certified EHR technology. If the EP’s certified EHR technology cannot populate all of the above fields, then at a minimum the EP must provide in a clinical summary the data elements for which all EHR technology is certified for the purposes of this program (according to §170.304(h)):

- Problem List
- Diagnostic Test Results
- Medication List
- Medication Allergy List

Q: How and when are incentive payments made?

A: After the online attestation is made (attestation thresholds must be attained), provider information is verified, then in 6 to 8 weeks a payment is generated. Payments are made in whatever way the entity typically gets CMS payments.

Q: What if patients do not routinely receive prescriptions during an office visit? How can the threshold be met? (Referring to computerized provider order entry (CPOE) for medication orders.)

A: For attestation, practices need to do this for 30% or more of all unique patients with at least one medication in their medication list. Note that patients with no medications in their medication list are excluded, so CMS believes this core initiative is realistic.
Q: For the Medicaid program, do you count the patient visit or the number of services (e.g. patient visit plus two tests equals three patient ticks) during the visit?

A: This question needs follow-up and if you send an email to editor@physicianspractice.com, they will be sent to CMS for the answer. Here is additional information from the CMS FAQ:

When calculating Medicaid patient volume or needy patient volume for the Medicaid EHR Incentive Program, are eligible professionals (EPs) required to use visits, or unique patients?

There are multiple definitions of encounter in terms of how it applies to the various requirements for patient volume. Generally stated, a patient encounter is any one day where Medicaid paid for all or part of the service or Medicaid paid the co-pays, cost-sharing, or premiums for the service. The requirements differ for EPs and hospitals. In general, the same concept applies to needy individuals. Please contact your State Medicaid agency for more information on which types of encounters qualify as Medicaid/needy individual patient volume.

Q: We are a new practice and plan on getting an EMR in the next 3 months. Can you walk me through the time lines?

A: If you haven’t chosen an EMR yet, your first year in either program will probably be 2012. In the first year of Medicare participation, you will need to use the EMR meaningfully for 90 days during calendar year 2012, and you have up to 60 days after the close of the calendar year to attest to your use. In the first year of Medicaid participation, you will need to adopt (acquire, install), implement (commence utilization of EHR such as train, data entry), or upgrade (expand) a certified EHR and attest to your activity at any time during the calendar year.
Q: What validation or oversight will CMS provide for the attestation process?

A: Before any payment is made, checks of provider eligibility and information will be done. Keep in mind that attestation is a legal process. Random audits will be put in place in the near future.

Q: Should a practice register if we don’t know which program we are going to use?

A: You can register at any time, and you can change from one program to the other prior to attesting, so you can register for one program and change before you begin the attestation.

Q: If your first year of attestation is in 2012, can you get the full 44K over the course of the program?

A: Yes.

Q: Can you verify if Physician Assistants are eligible for one of the programs?

A: Physician Assistants (PAs) are only eligible under the Medicaid program and must be the lead provider for a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) to qualify.

Q: Does a radiology practice have to provide a clinical summary for patients?

A: No practice type is excluded from clinical summary mandate. CMS has not heard of any practice type having a problem with this so far. Remember, to achieve meaningful use, you must provide clinical summaries to patients for more than 50 percent of office visits within three business days. Exclusion: Any EP who has no office visits during the period of EHR reporting.

Q: Is the problem list supposed to be related to the chief
**compliant of the office visit?**

A: Not necessarily. Practices are required to maintain an up-to-date problem list of current and active diagnoses based on ICD-9-CM or SNOMED CT (Systematized Nomenclature of Medicine – Clinical Terms) codes. To comply, at least 80 percent of all unique patients seen by eligible providers must have at least one entry (or an indication of none) recorded as structured data.

**Q: What if questions were not able to be answered during the webinar?**

A: Please e-mail Physicians Practice and we’ll get your answers from CMS. This could take several days, so please be patient. We will post your answers and all post-webinar questions at [http://www.physicianspractice.com](http://www.physicianspractice.com) and notify you via e-mail as well.

**Resources**

A great list of additional resources were provided by Robert Anthony and Physicians Practice:

**Resources from CMS**

- EHR Incentive Programs website
- ONC website
- FAQs
- Listserv
- Meaningful Use Specification Sheets
- EHR Information Center
- Registration & Attestation User Guides
- EHR Hotline: 888-734-6433 / -6563 (TTY)

**Resources from PhysiciansPractice.com**

- Topic Resource Centers
  - EHR
Meaningful Use

Tools

- Are You Ready? Quiz
- Pricing Worksheet
- Preparation Checklist
- Meaningful Use Stage 1 Crib Sheet

You can also listen to an archived video of today’s webinar here.

Other Posts I have written on this topic:

Step by Step Directions for Getting the EHR Incentive Money:
My Notes From Last Week’s CMS Call

CMS Holds National Provider Calls for the Medicare EHR Incentive Program and EHR Attestation Q & A

Digging Into the Details of “Certified EMR” & Tips For Buying an EMR

How Do You Get That Stimulus Money for Using an Electronic Medical Record? (You Register!)

How My Practice Knew We Were Ready for EMR

10 Ways to Get More Out of Your PM, EMR or Any Medical Software
CMS Proposes NEW Additional Preventive Services for Screening for Alcohol Misuse and Depression and Conditions of Participation for Community Mental Health Centers

Alcohol Misuse Screening and Depression Screening

On July 19th, the Centers for Medicare & Medicaid Services (CMS) proposed to add alcohol screening and behavioral counseling, and screening for depression, to the comprehensive package of preventive services now covered by Medicare. These proposed national coverage determinations (NCDs) are issued under authority granted by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), which allows CMS to add coverage of new preventive benefits that are recommended by the U.S. Preventive Services Task Force and are appropriate for Medicare beneficiaries.

Under the new proposals, Medicare would cover:

- annual alcohol misuse screening by a beneficiary’s primary care provider,
- four behavioral counseling sessions per year if a beneficiary screens positive for alcohol misuse, and
- annual screening for depression in primary care settings that offer staff-assisted depression care.
Public comments are invited on the proposed decisions for 30 days. CMS will issue final coverage decisions later this year. The proposal for screening and counseling for alcohol misuse is available on the CMS website here. The proposal for screening and counseling for depression is available on the CMS website here.

Community Mental Health Centers

The previous announcement comes on the heels of a separate proposal addressing mental health needs of Medicare beneficiaries by establishing conditions of participation for community mental health centers (CMHCs).

From the proposed rule:

In 2007, 224 certified Community Mental Health Centers (CMHCs) billed Medicare for partial hospitalization services for 25,087 Medicare beneficiaries. Currently, there are no Conditions of Participation (CoPs) in place for Medicare-certified CMHCs. As such, no regulatory basis exists to ensure basic levels of quality and safety for CMHC care. The Federal government, as the single largest payer of health care services in the United States, administers many statutory and regulatory requirements on the delivery and quality of health care furnished under its programs. Therefore, we are proposing for the first time a set of requirements that Medicare-certified CMHCs must meet in order to participate in the Medicare program. The CoPs that we are proposing would help to ensure the quality and safety of CMHC care for all
clients served by the CMHC, regardless of payment source.

Requirements for CMHC services would encompass:

- Personnel qualifications
- Client rights
- Admission
- Initial evaluation
- Comprehensive assessment
- Discharge or transfer of the client
- Treatment team, active treatment plan, and coordination of services
- Quality assessment and performance improvement
- Organization, governance, administration of services, and partial hospitalization services.

CMS is accepting public comments on the proposed rule until Aug. 16. Those interested in commenting should go [here](#).

Image by Giara via Flickr

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**Accreditation Countdown: If You Are Billing Medicare the Technical Component for Advanced Diagnostic Imaging, You Better Get Started**
If you are a physician, non-physician practitioner or Independent Diagnostic Testing Facility (IDTF) who supplies imaging services and submits claims for the Technical Component (TC) of Advanced Diagnostic Imaging (ADI) procedures to Medicare contractors (carriers and A/B Medicare Administrative Contractors (MACs)), you should know that you must be accredited by Sunday, January 1, 2012. If your facility uses an accredited mobile facility, and you bill for the TC of ADI, you must also be accredited. The accreditation requirement is attached to the biller of the services.

*Those not accredited by that deadline will not be able to bill Medicare until they become accredited.*

For those planning on seeking accreditation to continue performing the technical component of ADI services, know that accreditation is dependent on the demonstration of quality standards, including (but not limited to):

- Qualifications and responsibilities of medical directors
and supervising physicians;

- Qualifications of medical personnel who are not physicians;

- Procedures to ensure that equipment used meets performance specifications;

- Procedures to ensure the safety of beneficiaries;

- Procedures to ensure the safety of person who furnish the imaging; and

- Establishment and maintenance of a quality assurance and quality control program to ensure the reliability, clarity and accuracy of the technical quality of the image.

Additionally, the accreditation process may include:

- Unannounced, random site visits;

- Review of phantom images;

- Review of staff credentialing records and maintenance records;

- Review of beneficiary complaints and patient records;

- Review of quality data and ongoing data monitoring; and

- Triennial surveys.

Frequently Asked Questions

**Q: What are ADIs?**

**A:** ADI procedures are defined as MRI, CT and Nuclear Medicine/PET.
Q: As a supplier, what information will I need to transmit to CMS when I become accredited for the TC of advanced imaging?

A: The designated accreditation organization (AO) will transmit the findings of all accreditation decisions to CMS or its contractor when the decision becomes final. The information will include identifying information, the accreditation effective date and those modalities that are included in the accreditation.

Q: What is the process for denying claims after January 1, 2012?

A: Contractors will deny claims with a date of service on or after January 1, 2012, submitted for the TC of the ADI codes with denial code N290 (“Missing/incomplete/invalid rendering provider primary identifier.”) when the provider is not enrolled or accredited by a designated CMS accreditation organization. Contractors shall deny claims with codes submitted with a date of service on or after January 1, 2012, for the TC if the code is not listed on the provider’s eligibility file using claim adjustment reason code (CARC)185 (The rendering provider is not eligible to perform the service billed.)

Q: What happens if I am already accredited and will be up for re-accreditation in 2012?

A: In the case of a supplier that is accredited before January 1, 2010 by one of the designated accreditation organizations, the supplier is considered to have been accredited by an organization for the period such accreditation is in effect. The supplier would have had to remain in good standing and have an active accreditation on 1/1/2012 and must apply for reaccreditation within the time frame specified by the accreditation organization.

Q: Do hospitals have to receive imaging accreditation for the Technical Component (TC) of advanced imaging that is performed
under the prospective payment system?

A: Hospitals are generally exempt from this requirement. In Section 1834(e) of the Social Security Act and codified in §414.68(a), it is stated that the imaging accreditation requirement applies only to suppliers of the TC of advanced diagnostic imaging services for which payment is made under the physician fee schedule. Since hospitals generally are not paid pursuant to such schedule, this accreditation rule is inapplicable. Thus, providers will list ADI equipment and CPT code information in their initial and updated enrollment applications. Accreditation status will be provided to the Medicare Administrative Contractors by the ACO’s.

Q: Do the accreditation requirements apply to the radiologists that interpret the images?

A: The accreditation will apply only to the suppliers producing the images themselves, and not to the physician’s interpretation of the image. However, all interpreting physicians must meet the accreditation organizations published standards for qualifications and responsibilities of medical directors and supervising physicians, such as training in advanced diagnostic imaging services in a residency program and expertise obtained through experience or continuing medical education. Oral surgeons and dentists must be accredited if they perform the Technical Component of MRI, CT or Nuclear Medicine for the technical component of the codes that require ADI accreditation.

Q: Is Fluoroscopy covered under the new accreditation requirement?

A: MIPPA (Section 135 (a) of the Medicare Improvements for Patients and Providers Act of 2008) expressly excludes from the accreditation requirement x-ray, ultrasound, screening and diagnostic mammography and fluoroscopy procedures. The law also excludes from the CMS accreditation requirement
diagnostic and screening mammography which are subject to quality oversight by the Food and Drug Administration under the Mammography Quality Standards Act.

Q: How do I choose which AO to accredit my organization?

A: As a supplier, you will need to contact each of the three designated organizations to determine which accrediting organization meets your specific business model and philosophy for patient care. Some of the factors affecting your decision should be review of the quality standards, accreditation cycle, accreditation processes and price.

Q: Who are the accreditation organizations recognized by CMS to comply with the MIPPA accreditation requirement?

A: The Centers for Medicare & Medicaid Services (CMS) approved three national accreditation organizations – the American College of Radiology, the Intersocietal Accreditation Commission, and The Joint Commission – to provide accreditation services for suppliers of the TC of advanced diagnostic imaging procedures.

Q: What does it cost to be accredited?

A: The accreditation costs vary by accreditation organization. The average cost for one location and one modality is approximately $3,500 every 3 years.

Q: How do I contact the accreditation organizations (AOs)?

A: Call or e-mail each of the accreditation organizations to determine the one that best fits your business needs. The accreditation organizations each have their own published standards. Follow all of the application requirements so that your application is not delayed. It may take up to 5 months to be accredited. So, you really must start now to be sure to meet the January 1, 2012, date. To
obtain additional information about the accreditation process, please contact the accreditation organizations shown below.

American College of Radiology (ACR)
1891 Preston White Drive
Reston, VA 20191-4326

www.acr.org
1-800-770-0145

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Intersocietal Accreditation Commission (IAC)
6021 University Boulevard, Suite 500
Ellicott City, MD 21043

www.intersocietal.org
1-800-838-2110

—

The Joint Commission (TJC)
Ambulatory Care Accreditation Program
One Renaissance Boulevard
One Renaissance, IL 60181

www.jointcommission.org
1-630-792-5286

For more information about the enrollment procedures, see the Medicare Learning Network® (MLN) article MM7177, “Advanced Diagnostic Imaging Accreditation Enrollment Procedures,” available here.

If you are a physician or non-physician practitioner supplying the Technical Component of ADI, see the MLN article MM7176, “Accreditation for Physicians and Non-Physician Practitioners Supplying the
My Notes on Today’s CMS Call on the Initial Preventive Physical Exam (Not a Physical Exam) and the Annual Wellness Visit

Today’s CMS call reviewed the guidelines for the IPPE (Initial Preventive Physical Exam) and the AWV (Annual Wellness Visit), what they include and how to code for them.

What is the IPPE (also called the “Welcome to Medicare Visit”)?

The IPPE is a one-time visit, covered within 12 months after the effective date of Part B coverage and including:

- Review of medical and social history.
- Review of risk factors for depression.
- Review of functional ability and level of safety.
- Measurement of height, weight, body mass index, blood pressure, visual acuity, and other factors deemed appropriate.
- Discussion of end-of-life planning, if agreed upon by the patient.
- Education, counseling and referrals based on results of review and evaluation services performed during the visit, including a brief written plan such as a checklist, and if appropriate, education, counseling and referral for obtaining an electrocardiogram (a/k/a EKG, ECG).
- Note that although the IPPE has the word “exam” in it, there is NO physical exam associated with it. Most practices attempt to call it the **Welcome to Medicare Visit** and try never to use the word “exam” in association with it.

**Who can provide the IPPE?**

- Physician (doctor of medicine or osteopathy)
- Qualified non-physician practitioner including nurse practitioner physician assistant or Clinical nurse specialist

**How is the IPPE Billed?**

**G0402**
Initial preventive physical examination (not really an examination); face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment, plus ONE of the following if a electrocardiogram is done.

**G0403**
Electrocardiogram, routine ECG with 12 leads; performed as a screening for the initial preventive physical examination with interpretation and report.

**G0404**
Electrocardiogram, routine ECG with 12 leads; tracing only, without interpretation and report, performed as a screening for the initial preventive physical examination.

**G0405**
Electrocardiogram, routine ECG with 12 leads; interpretation
and report only, performed as a screening for the initial preventive physical examination.

What if the IPPE is provided in a facility?

These services typically are provided in a physician office, however, when the services are provided in a facility, the following institutions can bill as follows:

- Hospitals for inpatients (TOB 12X) and outpatients (TOB 13x)
- Skilled Nursing Facilities for inpatients (TOB 22X)
- Rural Health Centers (TOB 71X)
- Federally Qualified Health centers (TOB 77X)
- Critical Access Hospitals (TOB 85X)

What diagnosis code should be used?

Although a diagnosis code must be reported on the claim, there are no specific International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis codes that are required for the IPPE; therefore, Medicare providers should choose an appropriate ICD-9-CM diagnosis code.

How often can the IPPE and the screening EKG be performed?

The IPPE (G0402) is a one-time benefit that must be provided within 12 months of the effective date of a beneficiary’s Medicare Part B coverage. The screening EKG (G0403, G0404, G0405), when done as a referral from an IPPE, is also only covered once during a beneficiary’s lifetime.
How does the provider collect for the IPPE at time of service?

Effective for dates of services on or after January 1, 2011, the coinsurance or copayment and deductible are waived for the IPPE (G0402) only. The deductible and coinsurance still applies to the screening EKG.

What about screening for the abdominal aortic aneurysm (AAA)?

A one-time only ultrasound screening for an Abdominal Aortic Aneurysm (AAA) can be done as the result of a referral from an IPPE for Medicare beneficiaries with certain risk factors. The code for billing the AAA ultrasound screening is:

G0389

Ultrasound, B-scan and or real time with image documentation; AAA screening

Effective for dates of services on or after January 1, 2011, the co-insurance or co-payment and deductible are waived for the AAA ultrasound screening (G0389). For more information on the AAA ultrasound screening done as the result of a referral from an IPPE, please see the CMS Internet-Only Manual Pub. 100-04, chapter 18, section 110 on the CMS web site.

Please Note!
- The IPPE is a preventive wellness visit and not a routine physical examination.
- Medicare does not provide coverage for routine physical exams.
What if other services are provided during the IPPE?

If other evaluation and management services are provided in conjunction with the IPPE, use CPT Modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) as follows:

- Append to the additional E & M service denoting a separate Evaluation and Management (E/M) service furnished with an IPPE.
- Cost sharing (coinsurance, copayment and deductible) applies to the additional (E/M) service.
- CPT codes 99201-99215 may be reported depending on the clinical appropriateness of the circumstances.
- Preventive services identified in CPT code range 99381 through 99397 are not covered by Medicare.
- CMS speakers noted that they hoped physician offices would let patients know when they could incur out-of-pocket expenses.

NOTE: Some of the components of a medically necessary E/M service (e.g., a portion of history or physical exam portion) may have been part of the IPPE and should not be included when determining the most appropriate level of E/M service to be billed for the medically necessary, separately identifiable, E/M service.

What is the patient’s role in preparing for the IPPE?

Providers should encourage patient to come prepared with the following information:

- Medical records, including immunization records if the
provider doesn’t already have them;
- Family health history in as much detail as possible; and
- A full list of medications and supplements, including calcium and vitamins – how often and how much of each is taken. (Many providers ask patients to bring their actual medication and supplement bottles to every visit so a medication reconciliation can take place and improved communication about medication can take place.)

**What is the AWV?**

The Annual Wellness Visit (AWV) was created by the Affordable Care Act (ACA) and is a new benefit for 2011. Medicare beneficiaries are eligible for one AWV every 12 months after they have had Medicare Part B for more than 12 months. This is a “visit” and not a physical examination. Patients have a tendency to hear the word “Annual” and think they are getting an annual physical.

The beneficiary does not need to receive an IPPE to be eligible for an AWV. However, if the beneficiary did receive an IPPE, s/he is eligible for an AWV 12 months following the IPPE.

**What is included in the AWV?**

Medical/family history

- List of current providers/supplier.
- Blood pressure, height, weight, and other routine measurements.
- Detection of any cognitive impairment.
- Review (potential) risk factors for depression, functional ability, and level of safety.
- A written screening schedule (such as a checklist) for next 5-10 years.
- Documentation of risk factors and conditions where
interventions are recommended.
- Personalized health advice and referrals for health education and preventive counseling.

Subsequent AWVs:

- Update of medical/family history.
- Update of list of current providers/suppliers.
- Measurement of weight, blood pressure, and other routine measurements.
- Detection of any cognitive impairment.
- Update to the written screening schedule.
- Update to the list of risk factors and conditions where interventions have been recommended.
- Update to the personalized health advice and referrals for health education and preventive counseling.

Who can provide an AWV?

A “health professional” meaning a:

- Physician
- Physician assistant
- Nurse practitioner
- Clinical nurse specialist
- Medical professional (including a health educator, a registered dietitian, or nutrition professional, or other licensed practitioner) or a team of such medical professionals, working under the direct supervision of a physician

How should the AWV be coded?

The following G-codes identify the AWV for Medicare payment: G0438

Annual wellness visit, including Personalized Prevention Plan
Who can bill for the AWV?

These services typically are provided in a physician office. When the services are provided in a facility, the following institutions can bill:

- Hospital inpatients (TOB 12X) and outpatients (TOB 13x)
- Skilled Nursing Facilities inpatients (TOB 22X) and outpatients (23X)
- Rural Health Centers (TOB 71X)
- Federally Qualified Health centers (TOB 77X)
- Critical Access Hospitals (TOB 85X)

Note: Medicare makes a single fee schedule payment for a beneficiary’s AWV when provided in a physician office or hospital outpatient department.

What diagnosis should be used for the AWV?

Although a diagnosis code must be reported on the claim, there are no specific International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis codes that are required for the AWV; therefore, Medicare providers should choose an appropriate ICD-9-CM diagnosis code or contact the local Medicare contractor for guidance.

How often can the AWV be performed

- First visit (G0438) – once in a lifetime
- Subsequent (G0439) - annually (after 12 full months have
What should be collected at the time of service?

Effective for dates of services on or after January 1, 2011 co-payment or co-insurance and the Medicare Part B deductible are waived.

Please Note! AWV is a preventive wellness visit and not a routine physical examination. Medicare does not provide coverage for routine physical exams.

What if additional services are provided at the same time as the AWV:

If other evaluation and management services are provided in conjunction with the AWV, use CPT Modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) as follows:

- Append to the additional E & M service denoting a separate Evaluation and Management (E/M) service furnished with an IPPE.
- Cost sharing (co-insurance, co-payment and deductible) applies to the additional (E/M) service.
- CPT codes 99201 –99215 may be reported depending on the clinical appropriateness of the circumstances.
- Preventive services identified in CPT code range 99381 through 99397 are not covered by Medicare.
- CMS speakers noted that they hoped physician offices would let patients know when they could incur out-of-pocket expenses.
NOTE: Some of the components of a medically necessary E/M service (e.g., a portion of history or physical exam portion) may have been part of the AWV and should not be included when determining the most appropriate level of E/M service to be billed for the medically necessary, separately identifiable, E/M service.

What is the patient’s role in preparing for the AWV?

Providers should encourage patient to come prepared with the following information:

- Medical records, including immunization records if the provider doesn’t already have it;
- Family health history in as much detail as possible; and
- A full list of medications and supplements, including calcium and vitamins –how often and how much of each is taken. (Many providers ask patients to bring their actual medication and supplement bottles to every visit so a medication reconciliation can take place and improved communication about medication can take place.)

What is the proposed refinement to the AWV?

Medicare Physician Fee Schedule CY 2012 Proposed Rule suggests incorporating the use and results of a Health Risk Assessment into the provision of personalized prevention plan services during the AWV.

- The proposed rule text is available here.
- We welcome public comments before 5pm on August 30, 2011.
- Electronically through www.regulations.gov
- Hard copy (see instructions in the proposed rule)
CMS staff cannot discuss this topic on today’s call.

Q & A From the listeners (my favorite!)

Q: As a RHC, we usually submit one line item for all services provided on a UB92. How are we supposed to bill this if we are providing both a preventive service and an E & M on the same day?

A: This question was not able to be answered. The listener was asked to send the question to the following email nationalprovidercall@cms.hhs.gov with the subject line reading “IPPE/AWV Call Question.”

Q: We are an Article 28 Institution (place of service 22) – do we still bill the APC separately from the facility?

A: There is not a separate facility payment available, so a single payment is made to the physician or the facility.

Q: We are a Critical Access Hospital – when we receive an order for an EKG or ultrasound AAA, what diagnosis is supposed to come from the physician so that it will pass muster in a review?

A: The initial answer said the EKG should have a screening diagnosis and the AAA should have a risk factor diagnosis, but after a discussion, the listener was asked to send the question to the following email: nationalprovidercall@cms.hhs.gov with the subject line reading “IPPE/AWV Call Question.”

Q: Does the IPPE have a physical exam as a component? If a physical exam is provided, should it be billed as a separate E & M?
A: No physical examination is included. If it is provided, it should be coded separately.

Q: Are there specific identified screening tools that must be used for the depression or mental acuity screening?

A: The physician may choose the screening tool for depression or mental acuity.

Q: We do provider-based billing and our system automatically splits the G code between facility and professional fees. How will we recoup the facility portion?

A: Only one payment is made based on the physician fee schedule.

Q: If Physician Assistants can perform IPPEs and AWVs, does this mean that the patient must be established since mid-level providers cannot care for new Medicare patients?

A: This question was not able to be answered. The listener was asked to send the question to the following email nationalprovidercall@cms.hhs.gov with the subject line reading “IPPE/AWV Call Question.”

Q: Is the EKG and AAA screening benefits on the IPPE visit only? Will CMS ever add the EKG and AAA screening benefits to the AWV since so many patients don’t take advantage of the IPPE?

A: We will take this under advisement.

Q: Can G0102 (digital rectal exam) be billed with an AWV?

A: Yes.

Q: RE: Referrals to personalized health advice, health education, etc? Are these services covered under Medicare or would these be out-of-pocket expenses for Medicare patients?

A: Would be out-of-pocket unless a covered service.
Q: Will mid-level providers performing AWVs be reimbursed the same as a physician providing the service?

A: This question was not able to be answered. The listener was asked to send the question to the following email nationalprovidercall@cms.hhs.gov with the subject line reading “IPPE/AWV Call Question.”

Q: Will everyone get the answers that were not provided today or just the person who sent the email?

A: CMS will not be compiling the answers, but will post frequently asked questions on their website.

Q: We are getting edits when billing the EKG with the IPPE and the EKG is being denied.

A. This question was not able to be answered. The listener was asked to send the question to the following email nationalprovidercall@cms.hhs.gov with the subject line reading “IPPE/AWV Call Question.”

Q: Can V70.5 (unspecified health examination) be used as a diagnosis for IPPE or AWV?

A: Yes, any diagnosis can be used.

Q: Can a medically-necessary EKG (93000) be billed with a IPPE or AWV?

A: Yes.

Q: What should we do when a Medicare patient refuses the AWV and wants a traditional preventive visit? Do we get an ABN signed and charge the 99397 per the patient’s request?

A: Yes. Treat the preventive service the way you would any other non-covered service.

Q: Can an IPPE be provided with a pap and pelvic?
A: Yes.

Q: If providing an IPPE, pap and pelvic, breast exam and a physical examination to a Medicare beneficiary, can the physician choose NOT to bill the patient for the physical exam?

A: This question was not able to be answered. The listener was asked to send the question to the following email nationalprovidercall@cms.hhs.gov with the subject line reading “IPPE/AWV Call Question.”

Q: We are having problems with Medicare beneficiaries turning down the IPPE or AWV, asking for an annual physical examination (preventive service), then getting a bill, then calling Medicare and the Medicare rep telling the patient that they should never have been charged.

A: The speakers asked for details about the caller’s experience in an email to: nationalprovidercall@cms.hhs.gov with the subject line reading “IPPE/AWV Call Question.”

Q: On the Medicare Preventive Physical Exam form, what is the “Up and Go” test?

A: This question was not able to be answered due to the form not being recognized. The listener was asked to send the form to the following email nationalprovidercall@cms.hhs.gov with the subject line reading “IPPE/AWV Call Question.”

Q: We are having problems with patients asking for the AWV, but presenting with medical issues. The patients want the service without having to pay the deductible or co-insurance.

A: You can bill for an E & M in addition to the AWV, but the deductible and co-insurance will apply.

Note: if you have a question that was not answered today, you can send it to the following email nationalprovidercall@cms.hhs.gov with the subject line reading...
“IPPE/AWV Call Question.” Every question will not be able to be answered, but they will try to answer as many as possible.

Mary Pat’s Suggestions to CMS for future calls:

1. Don’t make presenters with laryngitis participate.
2. Coach all presenters in speaking for an audio presentation – speak slowly, speak loudly, don’t move your head around (causes volume spikes and dips) and be cautious of the auditory disruption turning papers and coughing causes, OR
3. Have a professional or experienced speaker present the slides – no commentary is being given so the CMS experts aren’t needed to speak through the slides.
4. Have one facilitator delegating each question to a specific expert to answer it.

Step by Step Directions for Getting the EHR Incentive Money: My Notes From Last Week’s CMS Call

First the facts on what has taken place so far in the 2011 EHR Incentive Programs.

- As of June 30th, the total of Medicare EHR Incentive Program payments is over $94 million.
- As of June 30th, over $166 million has been paid in Medicaid EHR incentives since the program began in January. In May and June, four states launched Medicaid EHR Incentive Programs – Indiana, Ohio, Pennsylvania,
and Washington, bringing the total states with Medicaid EHR Incentive Programs to 21. More states will launch in July.

- There are 68,001 active registrations of eligible professionals and eligible hospitals for the Medicare and Medicaid EHR Incentive Programs.

If your group hasn’t received a check and hasn’t registered for the Medicare or Medicaid Incentive Program, then this blog post is for you! For anyone who is really just beginning their EHR journey, today’s presentation clarified previous information given by CMS, as well as giving listeners new information about the programs.

The two primary steps to obtaining incentive payments are:

1. **Register** for the EHR Incentive Program
2. **Attest** to meeting all the incentive payment eligibility criteria

Let’s start with information on the two different incentive programs. Remember that an eligible professional (EP) is defined differently for Medicare than it is for Medicaid.
Step One: Are You Eligible for the EHR Incentive Programs?

Medicare Eligible Professionals:

- Must be a physician (defined as MD, DO, DDM/DDS, optometrist, podiatrist, or chiropractor) – mid-levels do not qualify
- Must have Part B Medicare allowed charges
- Must not be hospital-based which is defined as having 90% or more of their covered professional services in either an inpatient (POS 21) or emergency room (POS 23) of a hospital
- Must be enrolled in PECOS
- Must be living (Social Security records are examined)

Medicaid Eligible Professionals:

- Must be a MD, DO, DDM/DDS or a Nurse Practitioner, a Certified Nurse Midwife, OR a Physician Assistant who is the lead provider for a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC).
- Must either have 30% or more Medicaid patient volume (pediatricians must have 20% or more Medicaid patient volume) OR must practice predominantly in a FQHC or RHC with 30% or more needy individual patient volume. Needy is defined as patients who are Medicaid, Medicare, uninsured, under-insured, charity care and indigent care.
- Must be licensed and credentialed
- Must have no OIG exclusions
- Must be living (Social Security records are examined)
- Must not be hospital-based, which is defined as having 90% or more of their covered professional services in either an inpatient (POS 21) or emergency room (POS 23) of a hospital
Step Two: How much EHR Incentive Money is Available From the Two Programs?

Medicare Incentive Payments:

- First eligible year for the program is 2011.
- Incentive amounts are based on the EP’s Medicare Fee-for-Service allowable charges.
- Maximum incentives are $44,000 over 5 years.
- Incentives decrease if the EP does not start until after 2012.
- EPs must begin using an EHR by 2014 to receive incentive payments.
- Last payment year is 2016.
- An extra 10% bonus amount based on actual payments from Medicare, not allowables, is available for EPs practicing predominantly in a Health Professional Shortage Area (HPSA). Go here to see if you practice in a HPSA.
- EPs will receive only 1 incentive payment per year.

Medicaid Incentive Payments:

- First eligible year for the program is 2011.
How Do You Choose Which Program to Qualify For?

1. First, determine which programs you can qualify for based on the **type of eligible professional** you are.
2. Then, determine which programs you can qualify for based on **your patient population**.
3. Next, review the **requirements and potential payments and/or reductions** for each program – get your calculator out!
   - Once an eligible professional has demonstrated meaningful use in the first participation year, they may receive an incentive payment equal to 75% of Medicare allowable charges for covered professional services furnished by the eligible professional in a payment year **VERSUS** Once an eligible professional has demonstrated adoption,
implementation, upgrading, or meaningful use of certified EHR technology in the first participation year, they may receive an incentive payment of $21,250 from Medicaid. Remember the payments are for each provider. Don’t forget the 10% HPSA bonus if you participate in the Medicare program.

- Medicare requires EPs to escalate meaningful use participation and reporting and ultimately plans to impose payment reductions for EPs not engaged in using a certified EHR and implementing meaningful use. For Medicaid, each state has some leeway in defining the criteria for eligibility for incentives and there are no plans for payment reductions as a part of the program.

4. If you not up to speed on meaningful use and want to collect incentive money for 2011, it will be easier to you to meet the requirements of the Medicaid program than the Medicare program, if you are eligible for the Medicaid program and there is one offered in your state.

5. Remember that EPs can switch programs once after their first year in either program.
Getting Ready for the Registration Process

1. Make sure you have your provider’s **National Plan and Provider Enumeration System (NPPES)** User ID and Password. If the provider does not know this information, s/he will have to call and get the information. **The NPI, NPPES User ID and password are the basis for everything else.** While you’re in that record, make sure all the provider’s information is correct and completely up-to-date. You’ll have an opportunity to update this information during the registration process, but it will not backfill the NPPES record.

2. Make sure your provider’s enrollment record in the **Provider Enrollment, Chain and Ownership System (PECOS)**. You can see if s/he has a record in PECOS here – scroll down this page to “OrderingReferringReport”. This is a 16,000+ page pdf file and as of this post it was updated June 27, 2011. (Note: Eligible professionals who are only participating in the **Medicaid** EHR Incentive Program are not required to be enrolled in PECOS.)

3. If you do not have an active User ID and Password for NPPES or PECOS, request them via **Identity & Access Management**. You will need your type 2 NPI, your Taxpayer Identification Number (TIN), and your address from IRS.
Form CP-575. You will also need to mail a copy of IRS Form CP-575 as directed.

4. Payee Tax Identification Number (if you are reassigning your benefits to a group or a hospital).
5. Payee National Provider Identifier (NPI) if you are reassigning your benefits. Note that many independent physicians are reassigning their benefits to their practice and almost all hospital-sponsored physicians are reassigning their benefits to the hospital.

Step by Step Directions to Register for the Medicare/Medicaid EHR Incentive Programs

NOTE! You can register before you have a certified EHR. Register even if you do not have an enrollment record in PECOS which is required for all Medicare eligible professionals. If you plan to register for the Medicaid program, your state’s Medicaid program must be up and running. Check to see if your state has launched a Medicaid EHR Incentive Program here.

1. Go to the registration site here. The Login page instructs the user on what is required for a valid User ID and Password combination. EPs are required to have an active NPI and must have a National Plan and Provider
Enumeration System (NPPES) user account to login. For users who do not have either of these requirements, click on the link provided to you in the program.

2. A link to the Identity and Access Management System, I&A, is also provided. The I&A system allows EP users use to reset their passwords and edit their account information. Any additional login issues can be resolved by contacting the help desk (see info at the bottom of this post.) At the bottom of the page the user enters their User ID and Password combination. Please keep in mind that both of the fields are case-sensitive.

3. Once the user has logged into the system, the links and tabs displayed in the top right hand corner are shown on every page.
   - The Home hyperlink navigates the user to the Welcome page.
   - The Help hyperlink opens a PDF User Manual that assists the user throughout the Registration process.
   - If at anytime you wish to logout of the system, click the Log Out link and select yes in the pop-up window.
   - The Instructions section on the Welcome page describes the actions that can be performed under each of the tabs. The EP submits and maintains their registration under the Registration tab and completes their Attestation under the Attestation tab.
   - The Status Tab provides a snapshot of the user’s current standing in the EHR Incentive Program. This includes the status of their registration and any attestations and payments associated with their account.
   - The Account Management tab allows the user to proceed to the I&A system in order to change their account information.
   - Clicking the Registration tab will reveal a set of
instructions about the actions that can be performed. These options will differ depending on the status of the registration.

4. The EP’s name, social security number, and NPI are retrieved from their NPPES account. If they have not started their registration, the status will be blank and **Register** will be the only available action.

5. Select the **Register** link to begin.

6. The Registration ID is displayed on the “Topics for this Registration” page. **Write this number down** for tracking purposes.

7. There are three topics that an Eligible Professional must complete before submitting their Registration. They are EHR Incentive Program, Personal Information, and Business Address and Phone. The “Begin Submission” button cannot be selected until all of the topics are complete. Select the **“Start Registration”** button to navigate to the first topic.

8. On the EHR Incentive Program page, EPs are given the option to receive either a **Medicare or Medicaid EHR Incentive Payment**. For additional information about the two EHR Incentive Programs select the link that is provided. By selecting the Medicare option and clicking the “Apply” button, the EP type field page cursor moves across screen to highlight information. Provider Types that are eligible in the Medicare EHR Incentive Program are displayed in the dropdown. Selecting the Medicaid option and then the “Apply” button refreshes the page with two fields, Medicaid State/Territory and Eligible Professional Type. Only those states and territories participating in the Medicaid EHR Incentive Program are displayed in the Medicaid State/Territory dropdown. Provider types that are eligible for the Medicaid EHR Incentive Program are displayed in the dropdown.

9. Two additional links on the EHR Incentive Program page provide the user with information on certified EHRs and the EHR Certification Number. The Eligible
Professional is required to indicate whether they are currently using a certified EHR. A provider's EHR system is not required to be certified prior to registration; however, an EHR Certification Number will be required at the time of attestation. See the Certified Health IT Product List (CHPL) for a listing of "certified" EHR products and to identify a product's corresponding certification number. Select the "Save and Continue" button to navigate to the next topic.

10. The Name and Identifiers displayed on the Personal Information page are retrieved from the user's NPI record on the NPPES system. These fields cannot be modified in the EHR Incentive Program System. The Payee TIN Type field provides the user with two options in terms of who receives the EHR Incentive Payments. If the payments should be sent directly to the Eligible Professional, the SSN tab should be selected in the Payee TIN Type field. If the payments should be sent to a group associated with the Eligible Professional, the user should select E-I-N in the Payee TIN Type field and then select the "Apply" button. After the page is refreshed, three additional fields are displayed.

11. The next step is to select the Group that should receive the payments. A Group Name will only appear in the dropdown if the EP's Medicare enrollment in the Provider Enrollment, Chain, and Ownership System, or PECOS, has reassigned benefits to the Group. After the Group Name is selected, the Group's TIN is retrieved from PECOS and displayed in the Payee TIN field. It is also required that the user enters the NPI associated with the Group in the Payee NPI field. If the user had selected to register for the Medicaid EHR Incentive Program, the system requires the user to manually enter the Group Name, Payee TIN, and Payee NPI. A dropdown list of Group Names would not be provided. Select the "Save and Continue" button to navigate to the next topic.
12. The address and phone number displayed on the Business Address and Phone page is consistent with the Practice Location on the Eligible Professional’s NPI record. Unlike the Personal Information page, the address and phone number fields can be modified here. However, if changes are made to the address and phone number in the EHR Incentive Program System, the changes will not be reflected on the Eligible Professional’s NPI record. E-mail Address is also a required field and must be entered with the correct email address format. Select the “Save and Continue” button to complete the last topic.

13. Once the user has entered the required registration information, all three of the topics are marked as completed. To initiate the submission process, select the “Begin Submission” button.

14. The Verify Registration page displays a summary of the registration information. It displays Personal Information, Business Address, as well as the Incentive Program that was chosen for this registration. The “Reason for Submission” section describes the action that the user is currently performing on the registration. If any of the information on this page is incorrect, the user should select the “Previous Page” button and make the appropriate modification.

15. After verifying that all of the information is correct, please select the “Submit” button to proceed. Before the registration can be submitted, the user must review and agree to the Registration Disclaimer. Agreeing to the legal notice means that the EP is certifying that the information provided in the registration is true and accurate. Please take the time to review each line of the disclaimer. Select the “Agree” button to proceed.

16. If the registration passes all validations, the submission will be successful. Please keep in mind that things like a non-approved Medicare enrollment in PECOS or OIG Exclusions can result in registration failure.
Contact the help desk to resolve any of these issues.

17. The Submission Receipt page reminds users that they will not receive an e-mail confirmation and that attestation information must be submitted in order to qualify for an incentive payment. **Print the Submission Receipt page** by selecting the “Print” button at the bottom of the page. Select the “Return to Home” button to proceed.

18. A registration must be Active in order to proceed with Attestation and Payment. If any changes need to be made to the registration, the user would select the Modify link and navigate back to the topics page. The registration can also be cancelled, which would end the Eligible Professional’s participation in the EHR Incentive Program.

19. Selecting the Status tab navigates the user to the Status Summary page. The Select link navigates to the Status Detail page which displays all of the registration information in one location. The Additional Information link expands to display more registration information and the status of validations that are performed during submission.
Q & A from the listeners (always the best part!)

Q: Do you have to have paid for an EHR to receive the money? Can you use a Free EHR and still receive the incentive money?

A: Yes, you can use a free EHR and still receive the incentive money. The incentive money is to assist EPs implement EHRs and is not intended to be used only to purchase the software. Remember that the EHR must be certified by one of the certifying bodies and must be certified for ambulatory care.

Q: Is there a certain amount of time after registering that an EP must attest for Medicaid?

A: Once an EP registers, there is no deadline for attesting. Once an EP has attested, payment will be received in 45 days or less.

Q: Is the denominator for the meaningful use measures all patients that an EP sees, or just all Medicare or Medicaid patients seen during a specific period?

A: The denominator is all patients that the EP sees during the applicable period.

Q: Are radiologists eligible?
A: Yes. The radiologist must use a certified ambulatory care EHR. There is no guideline as to where the information going into the EMR comes from, with the exception of the CPOE measure. Many radiologists have expressed concerns as they do not actually “see” patients – CMS will be addressing this in the future.

Q: Where does the certification number needed for the EHR Incentive Program registration come from?

A: The certification number comes from the CHPL website. Get the EHR Vendor’s certification number, enter that number into the CHPL site and a registration/attestation number will be provided from the CHPL program to enter into the registration/certification program.

nursing home visits

Q: Is attestation the last step after completing the 90-day reporting period and collecting the data for the Medicare meaningful use program?

A: Yes.

Q: Do visits count if an EP sees patients in nursing homes?

A. Nursing home visits can count if a certified ambulatory EHR is being used, for instance if the EP carries a laptop with him, or if the visit information is later entered into the EP’s EHR.

Q: Can an administrator or other third party complete the registration and attestation?

A: Yes, if the third party goes through the Identity and Authority Management system, they can register and attest. The system will ask for the third party’s social security number as they will be legally attesting to the information entered.

Q: What is the latest 90-day period an EP can use a certified
EHR to receive an incentive payment for 2011?

A: October 1, 2011 – December 31, 2011 is the latest 90-day period. EPs must start using a certified EHR by October 1, 2011 and must demonstrate meaningful use by providing data via the attestation process before 60 days after the close of the 2011 calendar year.

Q: What if due to the EP’s specialty none of the meaningful use measures can be met?

A: The EP must exhaust all core, alternate and menu measures by answering “0”, exhausting all 38 of the measures by attesting “0” to all 38.

Q: If state does not accept any electronic submission of public health information, is the EP excluded from having to meet this requirement?

A: Yes.

Resources:

EHR Information Center

Hours of Operation: 7:30 a.m. – 6:30 p.m. (Central Time) Monday through Friday, except federal holidays.
1-888-734-6433 (primary number) or 888-734-6563 (TTY number)
Jennifer Searfoss: Reading the Tea Leaves – New Cost Controls on Horizon for Medicare Advanced Imaging Services

It’s a stark reality – at this time in American history, we are at the (or near the) highest level of funding for health care. The Ryan Medicare proposal and continued debate inside the Beltway and by state lawmakers makes it clear that while experts estimate that by 2082 health care spending could be 49% of our gross domestic product, this is not a sustainable reality. Further, as baby boomers retire, the contribution of working aged people through taxes and direct employer contribution to health care costs will fall.

Thus, lawmakers have been investigating ways to reduce health care costs for America’s elderly. A report released by the non-partisan Medicare Payment Advisory Commission (MedPAC) last week includes a number of recommendations for reforms aimed at “explor[ing] every avenue for protecting the access of Medicare beneficiaries to high-quality care while reducing the rate of growth in Medicare expenditures.” Chapter 2 of the report addresses “Improving payment accuracy and appropriate use of ancillary services” with recommendations to the Stark law, interim payment reforms for imaging services and a requirement for “high-use practitioners to participate in a prior authorization program for advanced diagnostic imaging services.”

MedPAC observes that “Physician self-referral of ancillary services leads to higher volume when combined with [fee-for-service] payment systems, which reward higher volume, and the
mispricing of individual services, which makes some services more profitable than others.” Known as the Stark law, an exception permits physicians to self-refer Medicare and Medicaid patients to imaging equipment that they own under certain circumstances. MedPAC chooses in this report to not recommend changes to the Stark law. Instead, “the preferred long term-approach to address self-referral is to develop new payment systems.” However, the Commission notes that in the future, the scope should be limited on the in-office ancillary exception to only physicians in accountable care organization models that have financial incentives to improve quality and reduce unnecessary service volume.

The payment reform recommendations include three changes that MedPAC feels address mispricing and overutilization:

- Bundled payment for like imaging services.
- Multiple procedure payment reduction application to the professional component of diagnostic imaging services when read during the same session by the same practitioner.
- Reduce the work component of relative value units (RVUs) for diagnostic imaging service that are ordered and read by the same practitioner.

The final recommendation is to adopt a prior authorization program for advanced imaging services such as MRI, CT and nuclear medicine. Supported by a 2008 Government Accountability Office report, the proposal would target only high volume ordering physicians and high cost services. “The focus on outlier physicians – rather than all physicians – would reduce CMS’ administrative costs and limit the burden on practitioners and beneficiaries.”

The upshot is that your office is familiar with prior authorization programs for commercial patients and Medicare beneficiaries enrolled in Medicare Advantage programs. Therefore, the things to consider as Congress and the
Administration evaluate efforts to reduce imaging costs:

- How would revisions to advanced imaging service payment (bundled payment for like services, multiple procedure reductions and work RVU reductions) affect your office and how you pay your physicians? Are they prepared for take-home pay reductions?
- What clinical guidelines are used for evaluating which services are “medically necessary”? How do these guidelines differ from other payers? How would you implement these requirements in your office?
- How does your office educate patients of services evaluated for medical necessity and what documentation do you use to demonstrate that they knew they would be billed for services that were rendered but determined by their insurer to not be medically necessary?

You can bet that strong lobbying on all sides of this issue will continue over the summer and likely over the next several years. Already, one letter has been sent to MedPAC regarding the report – the Access to Medical Imaging Coalition expressed concern over the prior authorization proposal as it “impedes patient access to needed care, places huge administrative burdens on providers and has not been shown to reduce costs over the long term.” I’m going to bring popcorn and find a good sideline seat for the next MedPAC meeting in September.

Personally, I look forward to the industry figuring out how prior authorization can be accomplished electronically rather than by fax. Last time I checked, we are supposed to be a fully electronic industry by 2014. Right?

Read the MedPac Report [here](#).

Note these two related stories:
Hospitals Allegedly Performed Double CT Scans On Many Medicare Patients.

The New York Times (6/18, A1, Bogdanich, McGinty, Subscription Publication) reported on its front page that “hundreds of hospitals across the country needlessly exposed patients to radiation” by giving them CT scans “twice on the same day, according to federal records and interviews with researchers. Performing two scans in succession is rarely necessary, radiologists say, yet some hospitals were doing that more than 80 percent of the time for their Medicare chest patients.”

The Washington Post (6/18, Appleby, Rau) noted that “imaging tests are among the fastest growing procedures in health care” and that double CT scans drive up healthcare costs. The Medicare’s Hospital Compare website publishes hospital rates of double chest scans in the hope that publicizing the numbers will incentivize hospitals to reduce this practice. The Post also adds that “hospitals and radiologists are paid more for the double scans, so they have a disincentive to crack down on them.”

Attorney and Policy Analyst Jennifer Searfoss was formerly the Vice President of External Provider Relations for UnitedHealthcare, a Minnesota-based health insurance company. Between 2001 and 2007, Jennifer worked for the Washington, DC-
based Government Affairs Department of the Medical Group Management Association (MGMA), a national trade association based out of Englewood, Colorado. Jennifer received her undergraduate degree in health science and policy from the University of Maryland, Baltimore County and law degree from the University of Maryland. After a brief departure, Jennifer has returned home and lives in Annapolis, Maryland with her Rottweiler, Argus, and her first client of every day – her beloved Quarter Horse – Pressed for Time. She can be contacted here or at 410-703-2635, Searfoss Consulting Group, LLC.

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CMS Hosts National Provider Call on Accreditation Requirements for Advanced Diagnostic Imaging Technical Suppliers

CMS will host a national provider call on the upcoming mandatory accreditation program for all suppliers that furnish the technical component of advanced diagnostic imaging on Thursday, June 23, 2011 from 2:30 – 4:00 p.m. EST. Subject matter experts will discuss what the requirements are to meet the Sunday, January 1, 2012, deadline; who these requirements effect; and how to become accredited. CMS will update information previously discussed on Open Door Forums that will streamline the requirements. See my original post on this topic here.

The target audience for this call includes physician office
staff and all Medicare fee-for-service providers; the agenda will include:

- the law;
- deadlines;
- suppliers effected;
- the accreditation process;
- the enrollment process; and
- a question and answer session

In order to receive the call-in information, you must register for the call. **Registration will close at 2:30pm on Wednesday, June 22, 2011** or when available space has been filled; no exceptions will be made, so please register early. For more details, including instructions on registering for the call, please visit [this site](#).

**Continuing Education Credits**

Continuing education credits may be awarded by the American Academy of Professional Coders (AAPC) or the American Health Information Management Association (AHIMA) for participation in CMS National Provider Conference Calls. **If you plan to request continuing education credit from your professional organization and if this organization requires proof of registration, you will personally need to register so that you receive a confirmatory e-mail.**

**Continuing Education Information for American Academy of Professional Coders (AAPC)**

If you have attended or are planning to attend a CMS National Provider Conference Call, you should be aware that CMS does not provide certificates of attendance for these calls. Instead, the AAPC will accept your e-mailed confirmation and call description as proof of participation. Please retain a copy of your e-mailed confirmation for these calls as the AAPC will request them for any conference call you entered into your CEU Tracker if you are chosen for CEU verification.
Members are awarded one (1) CEU per hour of participation.

Continuing Education Information for American Health Information Management Association (AHIMA)
AHIMA credential-holders may claim 1 CEU per 60 minutes of attendance at an educational program. Maintain documentation about the program for verification purposes in the event of an audit. A program does not need to be pre-approved by AHIMA, nor does a CEU certificate need to be provided, in order to claim AHIMA CEU credit. For detailed information about AHIMA’s CEU requirements, see the Recertification Guide on AHIMA’s web site.

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ePrescribing Survival Guide: Getting Your Ten Electronic Prescriptions Done in the Next 30 Days

Image via Wikipedia
This is a busy time for most practices. Managers are preparing for the annual juggling act of getting staff and physicians coordinated for summer vacations. Practices are ramping up for new doctors joining their practice at the traditional end of residency programs in the summer. Many practices are in the midst of shopping for, negotiating for or implementing EMRs. And most everyone without an existing EMR is struggling with the e-prescribing deadline looming in 30 days. Read my first post on this topic here.

As a reminder:

- Eligible professionals who are not successful e-prescribers, based on claims submitted between January 1, 2011 and June 30, 2011, may be subject to a “payment adjustment” (read payment cut) in their Medicare Part B Physician Fee Schedule (PFS) for covered professional services in 2012.
- Those that do not e-prescribe as a part of 10 Medicare patient encounters by June 30, 2011 will only receive 99% of their Medicare payment for all encounters in 2012.
- Those that do not e-prescribe as a part of 25 encounters by December 31, 2011, will only receive 98.5% of their Medicare payments for all encounters in 2013 and only 98% of their Medicare payments for encounters during 2014 and going forward.

Here are the problems practices have encountered trying to get their ten:

- Physicians seeing patients in facilities and using the codes that are eligible for eRx, but not having the ability to e-prescribe during the visit
• Physicians in specialties not prescribing many medications
• Physicians in specialties prescribing predominantly controlled drugs, which are not currently eligible for electronic prescribing

Today, the AMA released this announcement

May 31, 2011

On May 26 the Center for Medicare and Medicaid Services (CMS) responded to AMA concerns about the e-prescribing penalty program and issued a proposed rule that makes significant changes to it by adding more exemption categories. These changes will assure that physicians are not unfairly penalized for failing to meet the requirements under the 2012 e-prescribing penalty program.

Physicians are still required to e-prescribe using a qualifying e-prescribing system and report the G8553 code on at least 10 Medicare Part B claims from Jan. 1, 2011, through June 30, 2011, to avoid the 2012 e-prescribing penalty.

However, to avoid the 2012 e-prescribing penalty, physicians now will have an opportunity to attest through an on-line web portal that they are eligible for one of the following penalty exemptions:

• Physician’s practice is located in a rural area without high speed internet access
• Physician’s practice is located in an area without sufficient available pharmacies for electronic prescribing
• Physician is registered to participate in the Medicare or Medicaid EHR Incentive Program and has adopted certified EHR technology (New)
- Physician is unable to electronically prescribe due to local, State, or Federal law or Regulation (e.g., prescribes controlled substances) *(New)*
- Physician infrequently prescribes (e.g., prescribe fewer than 10 prescriptions between January 1, 2011 –June 30, 2011) *(New)*
- There are insufficient opportunities to report the e-prescribing measure due to program limitations (e.g., surgeons) *(New)*

Physicians will have to apply for an exemption from the 2012 e-prescribing penalty via the web-portal tool by Oct. 1.

**What if you don’t fall into one of these new categories?**

It’s time to tap into one of the free electronic prescribing packages available. Here are two choices:

1. [The National ePrescribing Patient Safety Initiative (NEPSI)](#) – Free, Allscripts Software
2. [Practice Fusion](#) – Free, probably will have advertising and your data will be mined (all 10 prescriptions!) but you may be able to get it up and running very quickly

**Some other thoughts on getting your ten done**

1. Prescribe over-the-counter drugs including stool softeners and anti-emetics.
2. Prescribe Tylenol3 or another non-controlled pain reliever – patients do not need to pick these prescriptions up or pay for them.
3. Ask your Medicare patients if they have any
prescriptions they would like you to refill while they are in the office. Over-the-phone refills do not count as there is no associated face-to-face service.

CMS Holds National Provider Calls for the Medicare EHR Incentive Program and EHR Attestation Q & A

Note: See my latest post on registering and attesting for the EHR Incentive Program here.

CMS has announced two national calls for attestation.

Tue May 3, 2-3:30pm ET (for Eligible
Hospitals)

Thu May 5, 1:30-3pm ET (for Eligible Professionals)

CMS is holding conference calls for eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) participating in the Medicare Electronic Health Record (EHR) Incentive Program to provide information on the attestation process. Mark your calendars for one of the calls below.

- **Tuesday, May 3, 2:00 – 3:30 p.m. ET** – Register to join this call if you are an eligible hospital or CAH who wants to learn more about the attestation process for the Medicare EHR Incentive Program.
- **Thursday, May 5, 1:30 – 3:00 p.m. ET** – Register to join this call if you are an EP who wants to learn more about the attestation process for the Medicare EHR Incentive Program.

**What the Calls Will Cover**

- Path to Payment – Highlighting the steps you need to take to receive your incentive payment
- Walkthrough of the Attestation Process – Guiding you through CMS’ web-based attestation system
- Troubleshooting – Helping you successfully attest through CMS’ system
- Helpful Resources – Reviewing CMS’ resources available on the EHR website
- Q&A – Answering your questions about the attestation process

**Instructions on How to Register for a Call**

To register for these calls, take the following steps:
1. Visit either:
   - The registration site for the Tuesday, May 3 eligible hospital and CAH call. Registration closes Monday, May 2, 2:00 p.m. ET.
   - The registration site for the Thursday, May 5 EP call. Registration closes Wednesday, May 4, 1:30 p.m. ET.

2. Fill in all required information and click “Register.”
3. You will be taken to the “Thank you for registering” page and will receive a confirmation email shortly thereafter. Please save this page in case your server blocks the confirmation email. (If you do not receive the confirmation email, check your spam/junk mail filter as it may have been directed there.)

4. If assistance for hearing impaired services is needed, please email medicare.ttt@palmettogba.com no later than 3 business days before the call.

Prior to each call, presentation materials will be available in the Upcoming Events section of the Spotlight Page on the CMS EHR website.

Registration closes when all available space has been filled, or 24 hours before each call; no exceptions will be made, so please register early.

How will I attest for the Medicare and Medicaid Incentive Programs?

Medicare eligible professionals, eligible hospitals and critical access hospitals will have to demonstrate meaningful use through CMS’ web-based Registration and Attestation System. In the Medicare & Medicaid EHR Incentive Program Registration and Attestation System, providers will fill in numerators and denominators for the meaningful use objectives and clinical quality measures, indicate if they qualify for
exclusions to specific objectives, and legally attest that they have successfully demonstrated meaningful use. A complete EHR system will provide a report of the numerators, denominators and other information. Then you will need to enter that data into our online Attestation System. Providers will qualify for a Medicare EHR incentive payment upon completing a successful online submission through the Attestation System—immediately after you submit your results you will see a summary of your attestation, and whether or not it was successful. The Attestation System for the Medicare EHR Incentive Program will open on April 18, 2011.

For the Medicaid EHR Incentive Program, providers will follow a similar process using their state’s Attestation System. Check here to see states’ scheduled launch dates for their Medicaid EHR Incentive Programs.

Do you have questions about the EHR Incentive Programs? Do you want to find out if you are eligible, how much of an incentive payment you can earn, and learn more details about the program and what you need to do to qualify?

- Visit the Path to Payment page for a program overview
- Visit the Meaningful Use page

When can I attest?

To attest for the Medicare EHR Incentive Program in your first year of participation, you will need to have met meaningful use for a consecutive 90-day reporting period. If your initial attestation fails, you can select a different 90-day reporting period that may partially overlap with a previously reported 90-day period. To attest for the Medicare EHR Incentive Program in subsequent years, you will need to have met meaningful use for a full year. Please note the reporting period for eligible professionals must fall within the calendar year, while the reporting period for eligible hospitals and critical access hospitals must fall during the
Federal fiscal year.

April 18, 2011, is the earliest an eligible professional, eligible hospital or critical access hospital can attest that they have demonstrated meaningful use of certified EHR technology under the Medicare EHR Incentive Program.

Under the Medicaid EHR Incentive Program, providers can attest that they have adopted, implemented or upgraded certified EHR technology in their first year of participation to receive an incentive payment. Medicaid EHR Incentive Program participants should check with their state to find out when they can begin participation.

What can I do now to prepare for attestation?

Visit the Registration page and get registered for the EHR Incentive Programs right now. If you haven’t previously registered, you can complete the registration and attestation process at the same time.

Also, review the Attestation User Guides, which provide step-by-step instructions for login and completing attestation. You can find separate Attestation User Guides for eligible professionals and eligible hospitals in the Resources section below.

Finally, you can enter your information in our Meaningful Use Attestation Calculator prior to submitting your attestation to see if you would be able to meet all of the necessary measures to successfully demonstrate meaningful use and qualify for an EHR incentive payment.
What will I need to login to the Attestation System?

If you are an eligible professional, you’ll need:

- Your Type 1 National Provider Identifier (NPI)
- The same user ID and password you used to register

If you are working on behalf of an eligible hospital or critical access hospital, you’ll need:

- An active National Provider Identifier (NPI)
- The same user ID and password you used to register
- An EHR Certification Number from Office of the National Coordinator
- If you did not register the facility, you’ll need an Identity and Access Management system (I&A) Web user account (User ID/Password) and be associated to the organization NPI, if you’re a user working on behalf of an eligible hospital or critical access hospital. Create a login in the I&A System if you’re working on behalf of an eligible hospital or Critical Access Hospital and don’t have an I&A web user account.

What is the CMS EHR Certification Number?

During attestation, CMS requires each eligible professional, eligible hospital and critical access hospital to provide a CMS EHR Certification ID or Number that identifies the certified EHR technology being used to demonstrate meaningful use. This unique CMS EHR Certification ID or Number can be obtained by entering the certified EHR technology product information at the Certified Health IT Product List (CHPL) on the ONC website here.

NOTE: The ONC CHPL Product Number issued to your vendor for each certified technology is different than the CMS EHR
Certification ID. Only a CMS EHR Certification ID obtained through the CHPL will be accepted at attestation.

Eligible professionals, eligible hospitals and critical access hospitals can obtain a CMS EHR Certification ID or Number by following these steps:

1. Go to the ONC CHPL website.
2. Select your practice type by selecting the Ambulatory or Inpatient buttons.
3. Search for EHR Products by browsing all products, searching by product name or searching by criteria met.
4. Add product(s) to your cart to determine if your product(s) meet 100% of the CMS required criteria.
5. Request a CMS EHR Certification ID for CMS attestation. **NOTE:** The “Get CMS EHR Certification ID” button will not be activated until the products in your cart meet 100% of the CMS required criteria. If the EHR product(s) do not meet 100% of the CMS required criteria to demonstrate Meaningful Use, a CMS EHR Certification ID will not be issued.
6. The CMS EHR Certification ID contains 15 alphanumeric characters.

I’m an Eligible Professional (EP). Can I designate a third party to register and/or attest on my behalf?

In April 2011, CMS implemented functionality that allows an EP to designate a third party to register and attest on his or her behalf. To do so, users working on behalf of an EP must have an Identity and Access Management System (I&A) web user account (User ID/Password), and be associated to the EP’s NPI. If you are working on behalf of an EP(s), and do not have an I&A web user account, please visit [I&A Security Check](#) to
create one. States will not necessarily offer the same functionality for attestation in the Medicaid EHR Incentive Program. Check with your State to see what functionality will be offered.

**When will I get paid?**

Incentive payments for the Medicare EHR Incentive Program will be made approximately four to six weeks after an eligible professional, eligible hospital or critical access hospital meets the program requirements and successfully attests they have demonstrated meaningful use of certified EHR technology. CMS expects that Medicare incentive payments will begin in May 2011. Payments will be held for eligible professionals until the eligible professional meets the $24,000 threshold in allowed charges.

Eligible hospitals and critical access hospitals attesting in April 2011 could receive their initial payments as early as May 2011. Final payment will be determined at the time of settling the hospital Medicare cost report.

Medicaid incentives will be paid by the states and are expected also to begin in 2011. States are required to issue incentive payments within 45 days of providers successfully attesting to having adopted, implemented or upgraded certified EHR technology during their first year of participation in the Medicaid EHR Incentive Program. Launch date for the Medicaid EHR Incentive Program varies by state, so the earliest date attestation can begin also varies by state. Several states have disbursed incentive payments as early as April 2011.
How will I get paid?

Payments to Medicare providers will be made to the taxpayer identification number (TIN) you selected at the time you registered for the Medicare EHR Incentive Program.

CMS will deposit payment in the first bank account on file. It will appear on your bank statement as “EHR Incentive Payment”

If you receive payments for Medicare services via electronic funds transfer, you will receive Medicare EHR Incentive Program payment the same way. If you currently receive Medicare payments by paper check, you will also receive your first Medicare EHR Incentive Program payment by paper check.

IMPORTANT: Medicare Administrative Contractors (MACs), carriers and fiscal intermediaries will not be making these payments. CMS has contracted with a Payment File Development Contractor to make these payments.

Have questions about your EHR incentive payment?

DON’T: Call your MAC/carrier/fiscal intermediary with questions

DO: Call the EHR Information Center

1-888-734-6433. TTY users should call 1-888-734-6563

Hours of Operation: 7:30 a.m. – 6:30 p.m. (Central Time) Monday through Friday, except federal holidays

Why the payment amount may be less than you thought: The Medicare & Medicaid EHR Incentive Program Registration and Attestation System contains a Status tab at the top which will contain the amount of the incentive payment, the amount of tax or nontax offsets applied, and the remittance advice reason code containing the reason for any reduction.

For those receiving paper checks, there will be a tear-off pay
stub which identifies offsets made to the incentive payment.

**Where you can find more information about the offsets:** For more information about tax offsets, call the Internal Revenue Service (IRS) at 1-800-829-3903.

For more information about non tax offsets, call the Department of the Treasury, Financial Management Service (FMS) at 1-800-304-3107.

**Will CMS conduct audits?**

Any provider attesting to receive an EHR incentive payment for either the Medicare EHR Incentive Program or the Medicaid EHR Incentive Program potentially may be subject to an audit. Here’s what you need to know to make sure you’re prepared:

**Overview of the CMS EHR Incentive Programs Audits**

- All providers attesting to receive an EHR incentive payment for either Medicare or Medicaid EHR Incentive Programs should retain ALL relevant supporting documentation (in either paper or electronic format used in the completion of the Attestation Module responses). Documentation to support the attestation should be retained for six years post-attestation. Documentation to support payment calculations (such as cost report data) should continue to follow the current documentation retention processes.
- CMS, and its contractors, will perform audits on Medicare and dually-eligible (Medicare and Medicaid) providers.
- States, and their contractors, will perform audits on Medicaid providers.
- CMS and states will also manage appeals processes.

**Preparing for an Audit**
- To ensure you are prepared for a potential audit, save the supporting electronic or paper documentation that support your attestation. Also save the documentation to support your Clinical Quality Measures (CQMs). Hospitals should also maintain documentation to support their payment calculations.
- Upon audit, the documentation will be used to validate that the provided accurately attested and submitted CQMs, as well as to verify that the incentive payment was accurate.

Details of the Audits

- There are numerous pre-payment edit checks built into the EHR Incentive Programs’ systems to detect inaccuracies in eligibility, reporting and payment.
- Post-payment audits will also be completed during the course of the EHR Incentive Programs.
- If, based on an audit, a provider is found to not be eligible for an EHR incentive payment, the payment will be recouped.
- CMS will be implementing an appeals process for eligible professionals, eligible hospitals and critical access hospitals that participate in the Medicare EHR Incentive Program. More information about this process will be posted to the CMS Web site soon.
- States will implement appeals processes for the Medicaid EHR Incentive Program. For more information about these appeals, please contact your State Medicaid Agency.

Where can I find user guides and other resources?

Below are step-by-step Attestation User Guides to help you attest for the Medicare EHR Incentive Program. You can also use our Attestation Worksheet, Meaningful Use Attestation
Calculator, and educational webinar to help you prepare for and complete the attestation process:

- [Attestation User Guide for Eligible Hospitals](#)
- [Attestation User Guide for Medicare Eligible Professionals](#)
- [Meaningful Use Attestation Calculator (version 1)](#)
- [Electronic Specifications for clinical quality measures (CQM)](#)

The Electronic Health Record (EHR) Information Center is open to assist the EHR Provider Community with inquiries.

1-888-734-6433. TTY users should call 1-888-734-6563.

**EHR Information Center Hours of Operation:** 7:30 a.m. – 6:30 p.m. (Central Time) Monday through Friday, except federal holidays.