Medicare This Week: June 8th, 2012, 4010 Ends July 1st, ePrescribing Hardship Exemptions, Improvements to PECOS

- **Starting July 1, 2012, Medicare Fee For Service Will Reject 4010 Transactions: Are You Ready? plus How to Avoid Common 5010 Rejections (jump to story)**
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Starting July 1, 2012, Medicare Fee For Service Will Reject 4010 Transactions: Are You Ready?

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

Claims (837 I and P)

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

Avoid Common 5010 Beginner's

Mistakes

…A few things to keep in mind for processing your Version 5010 claims, which should help avoid unnecessary rejections:

1. *ZIP Code:* You need to include a complete 9-digit ZIP code for the billing provider and service facility location. You should work with your vendor to make sure that your system captures the full 9-digit ZIP.
2. *Billing Provider Address:* You need to use a physical address for your Billing Provider Address. Version 5010 does not allow for use of a PO Box address for either professional or institutional claim formats. You can still use a PO Box, however, as your address for payments and correspondence from payers as long as you report this location as a pay-to address.
3. *National Provider Identifier (NPI):* You were previously allowed to report an Employer's Identification Number (Tax ID) or Social Security Number (SSN) as a primary identifier for the billing provider. For Version 5010 claims, however, you are only allowed to report an NPI as a primary identifier.

For additional help with your Version 5010 upgrade and Medicare claims, you can contact your Medicare Administrative Contractor (MAC). The MACs work closely with clearinghouses, billing vendors, and health care providers who require assistance in submitting and receiving Version 5010 compliant transactions. If you experience difficulty reaching a MAC, you should send a message describing your issue to ProviderFeedback@cms.hhs.gov with "5010 Extension" in the subject line.

The Medicare Fee-For-Service group has created a fact sheet that provides guidance to help providers troubleshoot some of the difficulties they may experience with Version 5010 claims processing and links to each of the MAC websites, including lists of the top 10 edits for Version 5010 claims.

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Are You Facing a 1.5% Medicare ePrescribing Payment Adjustment in 2013? Find Out If You Qualify For a Hardship Exemption

In 2009, CMS implemented the Electronic Prescribing (eRx) Incentive Program, which is a program that uses incentive payments and payment adjustments to encourage the use of qualified electronic prescribing systems.

From calendar year (CY) 2012 through 2014, a payment adjustment that increases each calendar year will be applied to an eligible professional's Medicare Part B Physician Fee Schedule (PFS) covered professional services for not becoming a successful electronic prescriber. **The payment adjustment of 1.0% in 2012, 1.5% in 2013, and 2.0% in 2014 will result in an eligible professional or group practice participating in the eRx Group Practice Reporting Option (eRx GPRO) receiving 99.0%, 98.5%, and 98.0% respectively of their Medicare Part B PFS amount for covered professional services.**

Exclusion Criteria

The 2013 eRx payment adjustment only applies to certain individual eligible professionals. CMS will **automatically exclude** those individual eligible professionals who meet the following criteria:

- The eligible professional is a successful electronic prescriber during the 2011 eRx 12- month reporting period (January 1, 2011 through December 31, 2011).
- The eligible professional is not an MD, DO, podiatrist, Nurse Practitioner, or Physician Assistant by June 30,

2012, based on primary taxonomy code in the National Plan and Provider Enumeration System (NPPES).

- The eligible professional does not have at least 100 Medicare Physician Fee Schedule (MPFS) cases containing an encounter code in the measure's denominator for dates of service from January 1, 2012 through June 30, 2012.
- The eligible professional does not have 10% or more of their MPFS allowable charges (per TIN) for encounter codes in the measure's denominator for dates of service from January 1, 2012 through June 30, 2012.
- The eligible professional does not have prescribing privileges and reported G8644 on a billable Medicare Part B service at least once on a claim between January 1, 2012 and June 30, 2012.

Avoiding the 2013 eRx Payment Adjustment

Individual eligible professionals and CMS-selected group practices participating in eRx GPRO who were not successful electronic prescribers in 2011 can avoid the 2013 eRx payment adjustment by meeting the specified reporting requirements between January 1 and June 30, 2012.

6-month Reporting Requirements to Avoid the 2013 Payment Adjustment:

- **Individual Eligible Professionals – 10** eRx events via claims
- **Small eRx GPRO – 625** eRx events via claims
- **Large eRx GPRO – 2,500** eRx events via claims

For more information on individual and eRx GPRO reporting requirements, please see the MLN Article SE1206 – 2012 Electronic Prescribing (eRx) Incentive Program: Future Payment Adjustments.

CMS may exempt individual eligible professionals and group practices participating in eRx GPRO from the 2013 eRx payment adjustment if it is determined that compliance with the

requirements for becoming a successful electronic prescriber would result in a significant hardship.

Significant Hardships

The significant hardship categories are as follows:

- The eligible professional is unable to electronically prescribe due to local, state, or federal law, or regulation
- The eligible professional has or will prescribe fewer than 100 prescriptions during a 6-month reporting period (January 1 through June 30, 2012)
- The eligible professional practices in a rural area without sufficient high-speed Internet access (G8642)
- The eligible professional practices in an area without sufficient available pharmacies for electronic prescribing (G8643)

Submitting a Significant Hardship Code or Request

To request a significant hardship, individual eligible professionals and group practices participating in eRx GPRO must submit their significant hardship exemption requests through the Quality Reporting Communication Support Page (Communication Support Page) on or between March 1 and June 30, 2012. Please remember that CMS will review these requests on a case-by-case basis. All decisions on significant hardship exemption requests will be final.

Significant hardships associated with a G-code may be submitted via the Communication Support Page or on at least one claim during the 2013 eRx payment adjustment reporting period (January 1 through June 30, 2012). If submitting a significant hardship G-code via claims, it is not necessary to request the same hardship through the Communication Support Page.

For additional information and resources, please visit the E-

Prescribing Incentive Program webpage.

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

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Major Improvements to Medicare PECOS Online Enrollment System

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

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

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Register Early for Maximum Benefits from the EHR Incentive Program

CMS recommends that all eligible professionals (EPs) register as early as possible for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs.

By registering early you can verify that your information is up to date in all of the CMS systems and resolve any issues so that you can participate in the EHR Incentive Programs. If you do not resolve registration problems in time, you will not be able to attest and could potentially miss out on a payment year. Registering does not mean you are required to participate – so register today.

Register Today to Receive Maximum Incentives

This is the last year for Medicare EPs to start participating in the EHR Incentive Programs in order to receive their full Medicare incentive payments. For more information on registration in the EHR Incentive Programs, visit the Registration page of the EHR website.

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Medicare News for Week of April 17, 2012: CMS Website Upgraded, 2 National Provider

Calls, Proposed CQMs for MU Stage 2 and 27 ACOs are Announced

(Website) CMS.gov Website Upgrade Completed-Check your Bookmarks (jump to story)

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(PQRS & eRx) National Provider Call: Physician Quality Reporting System & eRx 2011 10-Month Feedback Report – Register Now (jump to story)

–

(5010) National Provider Call: Current Status of Medicare FFS Implementation of HIPAA Version 5010 and D.0 – Register Now (jump to story)

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(MU) CMS has Posted the Proposed CQMs

under the Stage 2 NPRM on the CMS Website (jump to story)

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(EFT) All Medicare Provider and Supplier Payments to be Made by Electronic Funds Transfer (jump to story)

–

(ACOs) New *Affordable Care Act* Program to Improve Care, Control Medicare Costs, Off to a Strong Start (jump to story)

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(5010) A Look at the Newest Version 5010 FAQs and View CMS' Version 5010 Page and Resources (jump to story)

–

(MLN) Medicare Learning Matters Updates (jump to story)

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CMS.gov Website Upgrade Completed-Check your Bookmarks

CMS has completed the upgrades to the www.CMS.gov website. Bookmarked links to items posted in the "Downloads" sections

on the CMS website have not been affected, but other bookmarked URLs are redirected to the index webpage for that topic. For example, if you bookmarked the page containing National Provider Calls and Events, you will be taken to the index page for National Provider Calls. On the index page, select the webpage you'd like to view from the left-hand side. Once you open the correct page, you can create a new bookmark. We appreciate your understanding and apologize for any inconvenience during this process.

Home Health:

http://www.cms.gov/Center/Provider-Type/Home-Health--Agency-HHA-Center.html

Hospice:

http://www.cms.gov/Center/Provider-Type/Hospice-Center.html
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National Provider Call: Physician Quality Reporting System & eRx 2011 10-Month Feedback Report – Register Now

Tuesday, April 17, 2012; 1:30-3pm ET

CMS will host a National Provider Call with question and answer session. CMS subject matter experts will provide an overview of the Electronic Prescribing 10-Month Feedback Report.

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

Agenda:

- Opening Remarks

- Program Announcements
- Overview of the Electronic Prescribing 10-Month Feedback Report
- Question & Answer Session

Registration Information: In order to receive call-in information, you must register for the call at http://www.eventsvc.com/blhtechnologies. Registration will close at 12pm on the day of the call or when available space has been filled; no exceptions will be made, so please register early.

Presentation: The presentation for this call will be posted at least one day in advance at http://www.CMS.gov/Medicare/-Quality-Initiatives-Patient-Assessment-Instruments/PQRS/-CMSSponsoredCalls.html. In addition, the presentation will be emailed to all registrants on the day of the call.

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National Provider Call: Current Status of Medicare FFS Implementation of HIPAA Version 5010 and D.0 – Register Now

Wednesday April 25, 2012; 2-3:30pm ET

CMS is hosting a National Provider Call regarding the current status of Medicare FFS implementation of *HIPAA* Version 5010 and D.0. This National Provider Call focuses on addressing the current 5010/D.0 metrics, addressing recommendations made by Medicare FFS, as well possible outstanding fixes impacting the Part A and Part B Version 5010 transition.

Target Audience: Vendors, clearinghouses, and providers who need to make Medicare FFS-specific changes in compliance with *HIPAA* Version 5010 requirements

Agenda:

- Current 5010/D.0 metrics
- Addressing recommendations made by Medicare FFS
- Possible outstanding fixes impacting the Part A and Part B Version 5010 transition
- Q&A session

Registration Information: In order to receive call-in information, you must register for the call at http://www.eventsvc.com/blhtechnologies. Registration will close at 12pm on the day of the call or when available space has been filled; no exceptions will be made, so please register early.

Presentation and Webinar: The presentation for this call will be posted at least one day in advance at http://www.CMS.gov/Outreach-and-Education/Outreach/NPC/-National-Provider-Calls-and-Events-Items/042512-NPC-Call.-html. In addition, the presentation will be emailed to all registrants on the day of the call. CMS will be using an optional webinar feature as part of this National Provider Call. Complete details on this feature are available on the call registration page.

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CMS has Posted the Proposed CQMs under the Stage 2 NPRM on the CMS Website

CMS has posted the full set of proposed Clinical Quality Measures (CQMs) for 2014 as part of the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs Stage 2 Notice of Proposed Rule Making (NPRM). The public can review the CQMs and submit feedback online.

Proposed CQMs

The proposed CQMs are outlined in two tables that describe each measure and provide additional information for eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) beyond the descriptions listed on the National Quality Forum (NQF) website. Some of these measures are still in development; therefore, the descriptions provided in these tables may change before the final rule is published. When possible, links have been provided for measures that have corresponding information on the NQF website. If a measure does not have an NQF number, it means that measure has not yet been endorsed.

Public Comment

Public comments regarding these measures should be submitted using the same method required for all comments related to the proposed rule. You can submit public comments online through the federal regulations website. The deadline for public comments relating to the proposed CQMs and other aspects of the Stage 2 NPRM is *Mon May 7, 2012.*

Want more information about the EHR Incentive Programs?

Make sure to visit the EHR Incentive Programs website at http://www.cms.gov/EHRIncentivePrograms for the latest news and updates on the EHR Incentive Programs.

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All Medicare Provider and Supplier Payments to be Made by Electronic Funds Transfer

Existing regulations at 42 CFR 424.510(e)(1)(2) require that at the time of enrollment, enrollment change request, or revalidation, providers and suppliers that expect to receive

payment from Medicare for services provided must also agree to receive Medicare payments through electronic funds transfer (EFT). Section 1104 of the *Affordable Care Act* further expands Section 1862(a) of the *Social Security Act* by mandating federal payments to providers and suppliers only by electronic means. As part of CMS's revalidation efforts, all suppliers and providers who are not currently receiving EFT payments *are required to submit the CMS-588 EFT form with the Provider Enrollment Revalidation application, or at the time any change is being made to the provider enrollment record by the provider or supplier, or delegated official.* For more information about provider enrollment revalidation, review the MLN Matters® Special Edition Article #SE1126, "Further Details on the Revalidation of Provider Enrollment Information."

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New *Affordable Care Act* Program to Improve Care, Control Medicare Costs, Off to a Strong Start

Over 1.1 Million Beneficiaries Now Served by Accountable Care Organizations

A new program that will help physicians, hospitals, and other health care providers work together to improve care for people with Medicare is off to a strong start.

Under the new Medicare Shared Savings Program (Shared Savings Program), 27 Accountable Care Organizations (ACOs) have entered into agreements with CMS, taking responsibility for the quality of care furnished to people with Medicare in return for the opportunity to share in savings realized through improved care. The Shared Savings Program and other initiatives related to Accountable Care Organizations are made possible by the *Affordable Care Act*, the health care law of

2010. Participation in an ACO is purely voluntary for providers and beneficiaries and people with Medicare retain their current ability to seek treatment from any provider they wish.

The first 27 Shared Savings Program ACOs will serve an estimated 375,000 beneficiaries in 18 States. This brings the total number of organizations participating in Medicare shared savings initiatives on Sun Apr 1 to 65, including the 32 Pioneer Model ACOs that were announced last December, and six Physician Group Practice Transition Demonstration organizations that started in January, 2011. In all, as of Sun Apr 1, more than 1.1 million beneficiaries are receiving care from providers participating in Medicare shared savings initiatives.

CMS also announced today that five ACOs are participating in the Advance Payment ACO Model beginning Sun Apr 1. This model will provide advance payment of expected shared savings to rural and physician-based ACOs participating in the Shared Savings Program that would benefit from additional start-up resources. These resources will help build the necessary care coordination infrastructure necessary to improve patient outcomes and reduce costs, such as new staff or information technology systems. CMS is reviewing more than 50 applications for Advance Payments that start in July. For more information on the Advanced Payment ACO Model, including the participating ACOs, visit http://innovations.CMS.gov/-initiatives/ACO/Advance-Payment/.

The full text of this excerpted CMS press release (issued Tue Apr 10) can be found at http://www.CMS.gov/apps/media/-press/release.asp?Counter=4333, *and a media fact sheet can be found at* http://www.CMS.gov/apps/media/-press/factsheet.asp?Counter=4334.

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A Look at the Newest Version 5010 FAQs and View CMS' Version 5010 Page and Resources

CMS will not initiate enforcement action against *HIPAA*-covered entities for an additional three months, through Sat June 30, 2012, for the updated *HIPAA* transaction standards (ASC X12 Version 5010, NCPDP Versions D.0 and 3.0). CMS is aware that there are still challenges and issues affecting an industry wide upgrade. To help *HIPAA*-covered entities with the upgrade, CMS continues to update and improve their Version 5010 resources.

Updated FAQ System

CMS has updated the FAQ system and the way it is organized. There are now three ways to more easily find Version 5010 FAQs by going to the CMS FAQs Page and:

- Click on the Topic *HIPAA Administrative Simplification* on the left side of the page
    - Click on the Subtopic *Versions 5010 and D.0* that will appear as a dropdown under the topic (FAQs on Version 5010 and D.0 will be listed on the right side of the page)
- Click on the Topic *Coding* on the left side of the page
    - Click on the Subtopic *ICD-10* that will appear as a dropdown under the topic (FAQs on Version 5010 will be listed out on the right side of the page)
- Entering the search term "Version 5010" in the *Search* box on the upper left side of the page

CMS' Version 5010 and D.0 FAQs can also be found on the

Version 5010 page of the ICD-10 website, on the FAQs: Versions 5010 and D.0 Transition Basics fact sheet. The newest FAQ recently added by CMS is:

Question: Is my Version 5010 837 claim compliant if it includes situational data that the TR3 Report does not prohibit, and is not needed or used by a specific health plan?

Answer: Yes. If a submitter sends claim information to a primary payer that may not be needed by that payer, but is needed by a secondary or tertiary payer, the primary payer should disregard the unneeded information and accept the compliant claim. For example:

- A data element in the TR3 Report has situational usage and language that says "If not required by this implementation guide, do not send."
- The submitter submits that data element because it is needed for processing by a particular payer that may be secondary or tertiary to the primary payer.
- A payer that does not need or use that data element cannot reject a claim because it contains a data element or information that it does not need or use, provided usage of the data element is compliant with the TR3 Report.

Version 5010 Testing Readiness Fact Sheet

CMS also has a Version 5010 Testing Readiness Fact Sheet, which explains the Version 5010 upgrade and necessary Phase I Internal and Phase II External testing. This fact sheet can help providers to determine steps to successfully complete testing phases for Version 5010.

Keep Up to Date on Version 5010 and ICD-10

Please visit the ICD-10 website for the latest news and resources to help you prepare, and to download and share the implementation widget today!

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Medicare Learning Matters Updates

Information on the CMS Fraud Prevention: Automated Provider Screening and National Site Visit Initiatives – MLN Matters® Special Edition Article #SE1211, "Information on the Centers for Medicare & Medicaid Services (CMS) Fraud Prevention: Automated Provider Screening and National Site Visit Initiatives" has been released and is now available in downloadable format.

This article is designed to provide education on the CMS National Fraud Prevention Program (NFPP) and processes used to prevent Medicare fraud and abuse. It includes information about two new initiatives that CMS uses as part of the provider enrollment process – automated provider screenings and national site visit contractors that conduct site visits for certain providers and suppliers.

Information for Medicare Fee-For-Service Providers About the Middle Class Tax Relief and Job Creation Act of 2012 – MLN Matters® Special Edition Article #SE1215, "Information for Medicare Fee-For-Service Providers About the Middle Class Tax Relief and Job Creation Act of 2012" has been released and is now available in downloadable format.

This article includes an overview of the provisions that impact Medicare Fee-For-Service providers, including Section 3003, which extends the current zero percent update for claims with dates of service on or after Thu Mar 1, 2012 through Mon Dec 31, 2012.

Redesigned Medicare Summary Notices – MLN Matters® Special Edition Article #SE1218, "Redesigned Medicare Summary Notices" has been released and is now available in downloadable format.

This article is designed to provide education on the redesigned Medicare Summary Notice (MSN), which is part of the "Your Medicare Information: Clearer, Simpler, At Your Fingerprints" initiative. It includes information about key features and enhancements to the redesigned MSN and steps CMS will take to make benefits, provider, and claims information clearer and more accessible.

Avoiding Medicare Fraud & Abuse: A Roadmap for Physician, Web-Based Training Now Available – This web-based training is designed to provide education on fraud and abuse related to physicians. It includes definitions, laws exclusions, civil monetary penalties, case examples, and resources.

To access a new or revised web-based training course, visit http://www.CMS.gov/Outreach-and-Education/Medicare--Learning-Network-MLN/MLNProducts/index.html and click on "Web-Based Training (WBT) Courses" under "Related Links" at the bottom of the webpage.

Submit Feedback on MLN Products and Services –

The Medicare Learning Network® (MLN) is interested in what you have to say! Visit the MLN Opinion Page to submit an anonymous evaluation about specific MLN products and resources. Your feedback is important in developing and improving future MLN products and services.

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HHS Releases a Proposed Rule

for ICD-10 Go-Live October 2014

Today HHS announced a proposed rule **(complete rule here – 175 page pdf)** that would delay the go live for ICD-10 from October 1, 2013 to October 1, 2014. What follows are excerpts from the proposed rule.

Why Has HHS Proposed a Change to the Live Date for ICD-10-CM and ICD-10-PCS?

The final rule adopting ICD-10-CM and ICD-10-PCS (collectively, "ICD-10") as HIPAA standard medical data code sets was published in the Federal Register on January 16, 2009. The ICD-10 final rule requires covered entities to use ICD-10 beginning October 1, 2013.

In late 2011 and early 2012, **three issues** emerged that led Secretary of HHS Kathleen Sebelius to reconsider the compliance date for ICD-10:

1. The industry transition to Version 5010 did not proceed as effectively as expected;
2. Providers expressed concern that other statutory initiatives are stretching their resources; and
3. Surveys and polls indicated a lack of readiness for the ICD-10 transition.

The Transition to Version 5010

As the industry approached the January 1, 2012 Version 5010 compliance date, a number of implementation problems emerged, some of which were unexpected. These included–

- Trading partners were **not ready** to test the Version 5010 standards due to vendor delays in delivering and installing Version 5010-compliant software to their provider clients;
- Version 5010 errata were issued to correct **typographical mistakes** and other maintenance issues that were discovered as the industry began its internal testing of the standards, which delayed vendor delivery of compliant products and external testing;
- Differences between address requirements in the "provider billing address" and "pay to" address fields adversely affected **crossover claims processing;**
- **Inconsistent payer interpretation** of standard requirements at the front ends of systems resulted in rejection of claims, as well as other technical and standard misinterpretation issues;
- Edits made in test mode that were later **changed** when claims went into production without adequate notice of the change to claim submitters; and
- **Insufficient end to end testing** with the full scope of edits and business rules in place to ensure a smooth transition to full production.

Given concerns that industry would not be compliant with the Version 5010 standards by the January 1, 2012 compliance date, the HHS announced on November 17, 2011 that they would not initiate any enforcement action against any covered entity that was not in compliance with Version 5010 until March 31, 2012, to enable industry adequate time to complete its testing and software installation activities. **On March 15, 2012, this date was extended an additional 3 months, until June 30, 2012.**

The ICD-10 final rule set October 1, 2013 as the compliance date, citing industry testimony presented to NCVHS (National Committee on Vital and Health Statistics) and many of the over 3,000 industry comments received on the ICD-10 proposed rule.

The analysis in the ICD-10 final rule with regard to setting a

compliance date emphasized the interdependency between implementation of ICD-10 and Version 5010, and the need to balance the benefits of ICD-10 with the need to ensure adequate time for preparation and testing before implementation.

As noted in the ICD-10 final rule, "[w]e cannot consider a compliance date for ICD-10 without considering the dependencies between implementing Version 5010 and ICD-10. We recognize that any delay in attaining compliance with Version 5010 would negatively impact ICD-10 implementation and compliance." (74 FR 3334) Based on NCVHS recommendations and industry feedback received on the proposed rule, we determined that "24 months (2 years) is the minimum amount of time that the industry needs to achieve compliance with ICD-10 once Version 5010 has moved into external (Level 2) testing." (74 FR 3334) In the ICD-10 final rule, we concluded that the October 2013 date provided the industry adequate time to change and test systems given the 5010 compliance date of January 1, 2012.

As implementation of ICD-10 is predicated on the successful transition of industry to Version 5010, we are concerned that the delays encountered in Version 5010 have affected ICD-10 planning and transition timelines.

Providers have Expressed Concern that Other Statutory Initiatives are Stretching Their Resources

Since publication of the ICD-10 and Modifications final rules, a number of other statutory initiatives were enacted, requiring health care provider compliance and reporting. Providers are concerned about their ability to expend limited resources to implement and participate in the following initiatives that all have similar compliance timeframes:

1. **The EHR Incentive Program** was established under the Health Information Technology for Economic and Clinical Health (HITECH) Act, a part of the American Recovery and Reinvestment Act of 2009 (Pub. L. 111-5). Medicare and Medicaid incentive payments are available to eligible professionals and hospitals for adopting electronic health record (EHR) technology and demonstrating meaningful use of such technology. Eligible professionals and hospitals that fail to meaningfully use EHR technology could be subject to Medicare payment adjustments beginning in FY 2015.
2. **The Physician Quality Reporting System** is a voluntary reporting program that provides incentives payments to eligible professionals and group practices that satisfactorily report data on quality measures for covered Physician Fee Schedule services furnished to Medicare Part B Fee-for-Service beneficiaries.
3. **The eRx Incentive Program** is a reporting program that uses a combination of incentive payments and payment adjustments to encourage electronic prescribing by eligible professionals. Beginning in 2012 through 2014, eligible professionals who are not successful electronic prescribers are subject to a payment adjustment.
4. Finally, section 1104 of the Affordable Care Act imposes **additional HIPAA Administrative Simplification requirements** on covered entities.

<u>January 1, 2013</u>

• Operating rules for eligibility for a health plan and health care claim status transactions

<u>December 31, 2013</u>

• Health plan compliance certification requirements for health care electronic funds transfers (EFT) and remittance advice, eligibility for a health plan, and health care claim status transactions

<u>January 1, 2014</u>

- Standards and operating rules for health care electronic funds transfers (EFT) and remittance advice transactions

December 31, 2015

- Health plan compliance certification requirements for health care claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, health care claims attachments, and referral certification and authorization transactions

January 1, 2016

- Standard for health care claims attachments
- Operating rules for health care claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, referral certification and authorization transactions

Proposed October 1, 2014

- Unique health plan identifier

Current State of Industry Readiness for ICD-10

It is crucial that all segments of the health care industry transition to ICD-10 at the same time because the failure of any one industry segment to successfully implement ICD-10 has the potential to affect all other industry segments. Ultimately, such failure could result in returned claims and provider payment delays that disrupt provider operations and negatively impact patient access to care.

In early 2012, it became evident that sectors of the health care industry would not be prepared for the October 1, 2013 ICD-10 compliance date. Providers in particular voiced concerns about their ability to meet the ICD-10 compliance date as a result of a number of factors, including obstacles they experienced in transitioning to Version 5010 HIPAA Requirements from the Affordable Care Act and the other

initiatives that stretch their resources. A CMS survey conducted in November and December 2011 (hereinafter referred to as the CMS readiness survey) found that 26 percent of providers surveyed indicated that they are at risk for not meeting the October 1, 2013 compliance date.

Given the evidence that segments of the health care industry will likely not meet the October 1, 2013 compliance date, the reasons for that likelihood, and the likelihood that a compliance date delay would significantly improve the successful and concurrent implementation of ICD-10 across the health care industry, we are proposing to extend the compliance date for ICD-10.

One-Year Delay Justification

The HHS is proposing to extend the compliance date for ICD-10 for 1 year, from October 1, 2013 to October 1, 2014. This change would be reflected in the regulations at 45 CFR 162.1002. While a number of alternatives were considered for the delay, as discussed in the Impact Analysis of this proposed rule, it is believed a 1-year delay would provide sufficient time for small providers and small hospitals to become ICD-10 compliant and would be the least financially burdensome to those who had planned to be compliant on October 1, 2013.

To determine the new compliance date for ICD-10, the need for additional time for small providers and small hospitals to become compliant was balanced with the financial burden of a delay on entities that have developed budgets and planned process and system changes around the October 1, 2013 compliance date. Entities that have started planning and working toward an October 1, 2013 implementation would incur costs by having to reassess and adjust implementation plans and maintain contracts to manage the transition beyond October 1, 2013. We concluded that a 1-year delay would strike a reasonable balance by providing sufficient time for small

providers and small hospitals to become compliant and would minimize the financial burden on those entities that have been actively planning and working toward being compliant on October 1, 2013.

Finally, in its March 2, 2012 letter to the Secretary on a possible delay of the ICD-10 compliance date, the NCVHS urged that any delay should be announced as soon as possible and should not be for more than 1 year. The NCVH made this recommendation in consideration of its belief that a delay would cause a significant financial burden "that accrues with each month of delay."

The HHS believes that a 1-year delay would benefit all covered entities, even those who had are actively planning and striving for a 2013 implementation. A 1-year delay would enable the industry as a whole to test more robustly and implement simultaneously, which would foster a smoother and more coordinated transition to ensure the continued and uninterrupted flow of health care claims and payment.

Therefore, the HHS is proposing that covered entities must comply with ICD-10 on October 1, 2014.

Bonus: Some Interesting Data I Found in the ICD-10 Proposed Rule:

- The total number of health care claims in 2013 is projected to be 5.8 billion.
- The cost to health plans for manually processing a pended claim is $2.30 per claim.
- According to the Medical Group Management Association (MGMA), the staff time required to manually process a returned claim is 15 minutes, at a cost of approximately $4.14 for labor, a factor derived from the Bureau of Labor Statistics. This includes staff time spent to correct the error and resubmit claims that are returned.
- Using the experience of one university's bachelor's-

level health information management program, students take the ICD coding course in the spring of their junior year. Students enrolling in Spring 2012 courses will graduate in May 2013. Anticipating the October 1, 2013 compliance date, the university started offering ICD-10 courses this spring in place of ICD-9 with the understanding that it will be preparing students for employment after graduating in 2013. If ICD-10 is delayed a year, as proposed in this rule, the 30 students in the program will have to take ICD-9 courses in addition to their ICD-10 courses in order to obtain the ICD-9 competencies to get jobs. The extra course will cost each of the 30 students approximately $2,000 (in-state tuition) or a total of $61,000.

- Total cost of a 1-year delay in the compliance date of ICD-10 = $3,808M (mean average)
- According to the U.S. Census Bureau, Detailed Statistics, 2007 Economic Census, there are approximately 220,100 physician practices.. The U.S. Census Bureau data indicates that two percent of physician practices have revenues of $10 million or more, therefore approximately 4,400 physician practices are not small entities.
- According to the Small Business Administration’s size standards, a small entity is defined as follows according to health care categories: Offices of Physicians are defined as small entities if they have revenues of $10 million or less; most other health care providers (dentists, chiropractors, optometrists, mental health specialists) are small entities if they have revenues of $7 million or less; hospitals are small entities if they have revenues of $34.5 million or less.
- The 2007 Census Bureau reports that there are approximately 6,500 hospitals. The data indicates that 85 percent of hospitals have sales/receipts/revenues of $10 million or more.
- Statistics cost of delaying ICD-10 to 2014 were based

on:

- Physician practices with less than 50 physicians = 233,239
- Physician practices with 50 to 100 physicians = 590
- Physician practices with more than 100 physicians = 393
- Hospitals with less than 100 beds = 2757
- Hospitals with 100 to 400 beds = 2486
- Hospitals with more than 400 beds = 521

Haven’t Started Your ICD-10 Preparations Yet?

Start your plan by reviewing the resources below:

- Centers for Medicare and Medicaid Services (CMS) ICD-10 overview
- American Health Information Management Association (AIHMA) ICD-10 implementation
- American Academy of Professional Coders (AAPC) ICD-10 implementation

Manage My Practice offers ICD-10 transition help to physician practices, focusing on documentation improvement to support ICD-10 coding. For more information, please complete the contact form ***here.***

The Medicare News You Can Use This Week: eRx Exemptions for 2012 and 2013, Billing Education, and eSignatures

(PECOS) You Can Now Sign Your Medicare Enrollment Application Electronically

(jump to story)

(PPACA) New CME Module on CMS Healthcare Delivery Reform Available on Medscape (jump to story)

(Release of Information) Authorization to Disclose Information to the Social Security Administration (jump to story)

(5010) ICD-10: It's Closer Than It Seems – Have You Completed Your 5010 Implementation? (jump to story)

(eRx) 2012 eRx Payment Adjustment Update (jump to story)

(eRx) Medicare ePrescribing Penalty: Phone Lines Now Open (jump to story)

(eRx) Hardship Exemptions for 2013 Electronic Prescribing Payment Adjustment (jump to story)

(PQRS) Medicare Quality Reporting Incentive Programs Manual Update (jump to story)

(HCPCS) April Update to the Calendar Year (CY) 2012 Medicare Physician Fee Schedule Database (jump to story)

(Codes G0442 & G0443) Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse (jump to story)

(Billing) Medicare Billing Certificate Programs for Part A and Part B Providers (jump to story)

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You Can Now Sign Your Medicare Enrollment Application Electronically

Internet-based PECOS (Provider Enrollment, Chain, and Ownership System) now allows providers to sign Medicare enrollment applications electronically. Save time and expedite review of your application by using internet-based PECOS. *This feature does not change who is required to sign the application.*

Any *Organizational Provider applications* that are submitted via internet-based PECOS will require the user completing the application to provide an email address for the authorized signer of the application as part of the submission process. The authorized signer can then follow the instructions in the email and electronically sign the application. This applies to applications using the following forms:

- 855-A for Institutional Providers
- 855-B for Clinics, Group Practices, and Certain Other Suppliers, and
- 855-S for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers

In internet-based PECOS, all *Individual Provider applications* submitted by the individual provider that do not include new reassignments may be e-signed as part of the submission process. This applies to applications using the following forms:

- 855-I for Physicians and Non-Physician Practitioners, and
- 855-O for Eligible Ordering and Referring Physicians and Non-physician Practitioners

Any Individual Provider application (855-I) containing new reassignments (855-R) can be electronically signed as part of the submission process; however, you must select the Authorized Official / Delegated Official (AO/DO) for the Organization that is accepting the reassignment and enter that official's email address. The official then will be required to follow the instruction in the email and electronically sign the application.

If an individual provider or AO/DO does not want to make use of the e-signature process, they can simply follow the current process of printing and signing the certification statement (which then needs to be mailed to the appropriate contractor).

Questions concerning a system issue regarding PECOS should be referred to the CMS EUS Help Desk at 866-484-8049 or EUSSupport@cgi.com.

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New CME Module on CMS Healthcare Delivery Reform Available on Medscape

On Thu Mar 22, a new CME module was posted on Medscape. This module provides information and continuing medical education (CME) about CMS's healthcare delivery system reform efforts

and can be accessed on Medscape (with a free registration) at http://www.Medscape.org/viewarticle/760133.

This is actually a nice synopsis of all the different efforts underway and a good read for anyone!

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Authorization to Disclose Information to the Social Security Administration

On Thu Mar 22, Commissioner Astrue signed an Open Letter to Healthcare Providers, Health Information Managers, and Medical Records Administrators about Social Security's new electronic signature process for Form SSA-827, "Authorization to Disclose Information to the Social Security Administration." This means many future records requests coming from Social Security will not be accompanied by the traditional patient signature (sometimes referred to as "wet-signed") – they will be electronically signed, although the form itself will look the same.

To see this important message, visit http://go.usa.gov/EUu. To learn about Social Security's new electronic signature process, visit http://go.usa.gov/P7V.

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ICD-10: It's Closer Than It Seems – Have You Completed Your 5010 Implementation?

Recently, CMS announced it will not initiate enforcement action against any *HIPAA*-covered entity for an additional three months, through Sat June 30, for the updated *HIPAA* transaction standards (ASC X12 Version 5010, NCPDP Versions

D.0 and 3.0). Although much progress has been made in the successful receipt and processing of claims in the Version 5010 format, CMS is aware that there are still challenges and issues impeding an industry-wide upgrade.

During these additional 90 days during which CMS will not initiate enforcement penalties, you should collaborate more closely with trading partners on appropriate strategies to resolve any remaining problems. Two steps providers can take to ensure a smooth upgrade include:

- Establish a line of credit: To avoid potential cash flow disruptions, providers should consider establishing or increasing a line of credit. By doing so, they can prepare for possible delays and denials in payer claims reimbursements if noncompliant Version 5010 transactions are submitted.
- Check partner readiness: Because a provider's Version 5010 upgrade can be dependent upon his or her vendor, it is important for providers to be aware of their vendor's transition status. If your vendor is behind schedule for Version 5010 adoption, get confirmation of their timeline to be compliant, and encourage them to take action so that your system will be prepared to handle your claims.

Other steps to prepare for the Version 5010 upgrade can be found in the "Version 5010: Ensuring a Smooth Transition" factsheet, which provides an overview of several actions providers can take to maintain continuity of operations for their practices as they prepare to complete Version 5010 testing.

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2012 eRx Payment Adjustment Update

CMS continues to receive inquiries about the Medicare Electronic Prescribing (eRx) Incentive Program and the 2012 eRx payment adjustment. This message seeks to clarify the issues CMS has heard from physicians and other healthcare professionals.

Statutory Authority/Background

CMS is required to adjust the payments of eligible professionals who are not successful electronic prescribers beginning in 2012. This requirement is outlined in Section 132 of the *Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)*.

CMS listed the requirements for being a successful e-prescriber for purposes of avoiding the 2012 payment adjustment in the 2011 Physician Fee Schedule final rule. In February 2012, all eligible professionals who did not meet these requirements were sent a letter notifying them of this fact.

Significant Hardship Exemption Requests

In response to stakeholder feedback, CMS also published a standalone eRx rule on Tue Sep 6, 2011, to provide additional circumstances under which eligible professionals would qualify for hardship exemptions. Eligible professionals initially had until Tue Nov 1, 2011, to submit a request for a hardship exemption for the 2012 eRx payment adjustment via the newly-created Quality Reporting Communication Support Page; this deadline was later extended to Tue Nov 8, 2011. CMS finished its review of these requests in February 2012 and continues to notify requestors via email whether their request was approved or denied.

Questions and Concerns

Although there is no appeal or review process established for the eRx Incentive Program and payment adjustment, CMS encourages eligible professionals with questions or concerns about the eRx payment adjustment and hardship exemption requests to contact the QualityNet Help Desk. Through the QualityNet Help Desk, CMS is working with eligible professionals and CMS-selected group practices that have questions about eRx payment adjustments and/or hardship exemption decisions. CMS is handling all hardship exemption requests and any questions or concerns on a case-by-case basis. Contact the QualityNet Help Desk if you have issues relating to the eRx payment adjustment and/or the rationale for denial of your hardship exemption request.

The QualityNet Help Desk can be reached Mon – Fri, 7am-7pm CMT, at 866-288-8912 or QNetSupport@sdps.org.

2013 & 2014 eRx Payment Adjustment

Please note that payment adjustments under the eRx Incentive Program run until 2014. For information on how to avoid the 2013 and 2014 eRx payment adjustments, please visit the Electronic Prescribing Incentive Program webpage and review MLN Matters Article #SE1206.

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Medicare ePrescribing Penalty: Phone Lines Now Open (Courtesy of the AMA)

CMS has confirmed that the QualityNet Help Desk is now prepared to take calls from physicians on the Medicare ePrescribing penalty. We understand that physicians have already attempted in the past few weeks to contact the Help Desk to discuss their individual situation which resulted in a

2012 penalty, but in many cases were turned away. CMS has been working diligently with the Help Desk to ensure that a physician's case is adequately reviewed. CMS wants physicians to know that the issues they are having are being examined.

As CMS has indicated late last week, although there is no formal appeals or review process for the ePrescribing penalty, they encourage physicians with questions or concerns about their penalty and/or hardship exemption request to contact CMS' QualityNet Help Desk as soon as possible. CMS is handling all penalty and/or hardship exemption requests and any questions or concerns on a case-by-case basis.

Physicians should continue to contact the QualityNet Help Desk if they have issues relating to the ePrescribing penalty. If a physician has previously contacted the QualityNet Help Desk and their case has been resolved to their satisfaction, the physician does not need to contact the QualityNet Help Desk again.

The QualityNet Help Desk can be reached M-F; 7:00 am – 7:00 pm CMT at 866-288-8912 or via email at qnetsupport@sdps.org.

NOTE: If a physician continues to experience problems with the Help Desk, CMS is encouraging physicians to email their concerns directly to Medicare at eRx_hardship@cms.hhs.gov.

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Hardship Exemptions for 2013 Electronic Prescribing Payment Adjustment

On Thursday, March 1, CMS reopened the Quality Reporting Communication Support Page to allow individual eligible professionals and *CMS-selected* group practices the opportunity to request a significant hardship exemption for the 2013

Electronic Prescribing (eRx) payment adjustment. The Communication Support Page will accept hardship exemption requests now *through Sat June 30, 2012*.

The Quality Support Page User Manual is available to assist individual eligible professionals and CMS-selected group practices in submitting their request for a hardship exemption and can also be accessed from the "Help" icon on the Communication Support Page.

For additional information on the 2013 eRx payment adjustment, including who is subject to the payment adjustment and how to avoid the payment adjustment, visit the eRx Incentive Program website at www.CMS.gov/eRxIncentive. Specifically, eligible professionals should review MLN Matters Article SE1206: "2012 eRx Incentive Program: Future Payment Adjustments."

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New MLN Matters Article (MM7727) – Medicare Quality Reporting Incentive Programs Manual Update

The new chapter describes the yearly payment instructions used by the Medicare contractors when making incentive payments described in the "Medicare Quality Reporting Incentives Manual."

http://www.cms.gov/MLNMattersArticles/Downloads/MM7727.pdf

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Revised MLN Matters Article (MM7745) – April Update to the Calendar Year (CY) 2012 Medicare Physician Fee Schedule Database (MPFSDB)

- HCPCS Codes with Revised Medicare Physician Fee Schedule Payment Indicators
- New HCPCS Codes to be added with the Effective Date of April 1, 2012
- New HCPCS Codes to be added with the Effective Date of January 1, 2012
- New HCPCS Codes to be added with the Effective Date of July 1, 2011
- HCPCS codes to be discontinued effective April 1, 2012

http://www.cms.gov/MLNMattersArticles/Downloads/MM7745.pdf

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Revised MLN Matters Article (MM7633) – Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse

Two new G codes, G0442 (Annual Alcohol Misuse Screening, 15 minutes), and G0443 (Brief face-to-face behavioral counseling for Alcohol Misuse, 15 minutes), are effective October 14, 2011, and will appear in the January quarterly update of the Medicare Physician Fee Schedule Database (MPFSDB) and Integrated Outpatient Code Editor (IOCE). For claims with Dates of Service on or after October 14, 2011, through December 31, 2011, your Medicare contractor will use their pricing to pay for G0442 and/or G0443. Deductible and

coinsurance do not apply. Contractors will hold institutional claims received prior to April 2, 2102, with TOBs 13X, 71X, 77X, and 85X and release those claims beginning April 2, 2012.

http://www.cms.gov/MLNMattersArticles/Downloads/MM7633.pdf

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Medicare Billing Certificate Programs for Part A and Part B Providers

From the MLN: Now Available – Medicare Billing Certificate Programs for Part A and Part B Providers– Learn about the Medicare Program, and the specifics for your provider type with a special focus on Medicare billing, and receive a certificate in Medicare billing from CMS for successful completion of the Program. Successful completion consists of completion of all required web-based training courses, required readings, and a 75-percent or higher score on the post-assessment.

To participate in either the Part A or Part B provider type program, visit http://www.CMS.gov/MLNproducts and click on 'Web-Based Training Modules' under 'Related Links Inside CMS."

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The Week of March 5, 2012 in Healthcare: CMS National Provider Call on MU Stage 2, 5010 Issue Update, the Blunt Amendment and More

(5010) Important Update Regarding HIPAA Version 5010/D.0 Implementation (jump to story)

(Affordable Care Act) Statement by HHS Secretary Kathleen Sebelius on the Blunt Amendment (jump to story)

(PECOS) Were You Sent a Request to Revalidate Your Medicare Enrollment? (jump to story)

(MU Stage 2) National Provider Call: Overview and Listening Session: Stage 2 Requirements for the Medicare and Medicaid EHR Incentive Programs (jump to story)

(Resources) MLN Fact Sheets on ESRD, ZPICS and Mass Immunizers/Roster Billing (jump to story)

(FAQs on MU) CMS Has New FAQS on Meaningful Use and Attestation (jump to story)

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Important Update – "HIPAA Version 5010/D.0 Implementation" Document has been Updated

Updates have been made to the recently-posted document titled "Important Update Regarding *HIPAA* Version 5010/D.0

Implementation" – specifically, CMS has modified information related to the Diagnosis Related Group (DRG) code. The document can be found at the top of the *HIPAA* Versions 5010 & D.0 Overview webpage, at http://www.CMS.gov/-versions5010andd0/01_overview.asp.

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Statement by HHS Secretary Kathleen Sebelius on the Blunt Amendment

Earlier this month, the Department of Health and Human Services reported that over 20 million American women in private health insurance plans have already gained access to at least one free preventive service because of the health care law. Without financial barriers like co-pays and deductibles, women are better able to access potentially life-saving services, and cancers are caught earlier, chronic diseases are managed and hospitalizations are prevented.

A proposal being considered in the Senate this week would allow employers that have no religious affiliation to exclude coverage of any health service, no matter how important, in the health plan they offer to their workers. This proposal isn't limited to contraception nor is it limited to any preventive service. Any employer could restrict access to any service they say they object to. This is dangerous and wrong.

The Obama administration believes that decisions about medical care should be made by a woman and her doctor, not a woman and her boss. We encourage the Senate to reject this cynical attempt to roll back decades of progress in women's health.

NOTE: On Thursday, March 1, 2012, the dangerous Blunt Amendment failed to pass the U.S. Senate. The amendment, which would have enabled employers to pick and choose what services

they would cover under insurance on moral grounds, was defeated.

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Were You Sent a Request to Revalidate Your Medicare Enrollment?

Lists of providers sent notices to revalidate their Medicare enrollment may be found on the CMS website at http://www.CMS.gov/MedicareProviderSupEnroll/11_-Revalidations.asp and in the links below. Information on revalidation letters sent in February will be posted in late March.

- Revalidations Mailed September through October 2011
- Revalidations Mailed November through December 2011

CMS is working to make this information available in Internet-based PECOS (Provider Enrollment, Chain, and Ownership System) in mid April.

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National Provider Call: Overview and Listening Session: Stage 2 Requirements for the Medicare and Medicaid EHR Incentive Programs

Mon Mar 12; 12:30-2pm ET

More than $3.2 billion in Medicare and Medicaid electronic health record (EHR) incentive payments have been made since the program began last year; more than 191,000 eligible

professionals, eligible hospitals, and critical access hospitals are actively registered. On Thu Feb 23, CMS announced a proposed rule for Stage 2 requirements and other changes to the program, which will be published on Wed Mar 7.

This National Provider Call will provide an overview of the proposed rule, so you can learn what you need to know to receive EHR incentive payments. (CMS plans to hold another National Provider Call on program basics for Eligible Professionals on Tue Mar 27; more information about this call will be available soon.)

The CMS proposed rule can be found at http://www.OFR.gov/OFRUpload/OFRData/2012-04443_PI.pdf. For more information on the EHR Incentive Programs, visit http://www.CMS.gov/EHRIncentivePrograms.

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

Eligibility Requirements for Professionals

Eligibility Requirements for Hospitals

Agenda:

- Extension of Stage 1
- Changes to Stage 1 Criteria for Meaningful Use
- Proposed Medicaid policies
- Stage 2 Meaningful Use Overview
- Stage 2 Clinical Quality Measures
- Medicare Payment Adjustments and Exceptions
- Question and Answers about the incentive programs (note that we cannot answer questions on the rule beyond what is proposed)

Registration Information: Registration for this call will be available soon at http://www.eventsvc.com/blhtechnologies.

Presentation: The presentation for this call will be posted at least one day before the call at http://www.CMS.gov/NPC/-Calls.

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MLN Fact Sheets on ESRD, ZPICS and Mass Immunizers/Roster Billing

From the MLN: "Mass Immunizers and Roster Billing" Fact Sheet Available in Hardcopy – The "Mass Immunizers and Roster Billing" fact sheet (ICN 907664) is now available in hardcopy. This fact sheet is designed to provide education on mass immunizers and roster billing, and includes information on simplified billing procedures for the influenza and pneumococcal vaccinations. To place your order for any of Medicare Learning Network® products available in print, visit http://www.CMS.gov/MLNProducts and click on 'MLN Product Ordering Page' under 'Related Links Inside CMS' at the bottom of the webpage.

From the MLN: February 2012 Version of Medicare Learning Network Products Catalog Now Available – The February 2012 version of the MLN Products Catalog is now available. The MLN Products Catalog is a free interactive downloadable document that links you to online versions of MLN products or the product ordering page for hardcopy materials. Once you have opened the catalog, you may either click on the title of an individual product or on "Formats Available." The catalog can be found at http://www.CMS.gov/MLNProducts/downloads/-MLNCatalog.pdf.

From the MLN: "Recovery Auditors Findings Resulting from Medical Necessity Reviews of Renal and Urinary Tract Disorders" MLN Matters Article Released – MLN Matters Special

Edition Article #SE1210, "Recovery Auditors Findings Resulting from Medical Necessity Reviews of Renal and Urinary Tract Disorders," has been released and is available in downloadable format. This article is designed to provide education on Recovery Audit review findings related to renal and urinary tract disorders, and includes a description of the problems found and guidance on how providers can avoid them in the future.

From the MLN: "The Role of the Zone Program Integrity Contractors, Formerly the Program Safeguard Contractors" MLN Matters Article Revised – MLN Matters Special Edition Article #SE1204, "The Role of the Zone Program Integrity Contractors (ZPICs), Formerly the Program Safeguard Contractors (PSCs)," has been revised is now available in downloadable format. This article is designed to provide education on the roles and responsibilities of Zone Program Integrity Contractors (ZPICs), and includes an overview of the various program integrity functions that ZPICs perform and each of their seven designated zones. The article was revised to change information cited in the table on page 2; all other information remains the same.

From the MLN: "Substance (Other Than Tobacco) Abuse Structured Assessment and Brief Intervention" Fact Sheet Available in Hardcopy –

The revised "Substance (Other Than Tobacco) Abuse Structured Assessment and Brief Intervention (SBIRT)" fact sheet (ICN 904084) is designed to provide education on Substance (Other Than Tobacco) Abuse Structured Assessment and Brief Intervention (SBIRT), and includes an early intervention approach that targets those with nondependent substance use to provide effective strategies for intervention prior to the need for more extensive or specialized treatment. To order hardcopies of this fact sheet, visit http://www.CMS.gov/MLNProducts and click on the 'MLN Product Ordering Page' under 'Related Links Inside CMS' at the bottom

of the webpage.

From the MLN: "Composite Rate Portion of the End-Stage Renal Disease Prospective Payment System" Fact Sheet Revised – The "Composite Rate Portion of the End-Stage Renal Disease Prospective Payment System" fact sheet (ICN 006469) has been revised and is now available in downloadable format. It includes information about the End-Stage Renal Disease Prospective Payment System (ESRD PPS) transition, the basic case-mix adjusted composite rate, separately billable items and services, and the ESRD Quality Incentive Program.

From the MLN: "End-Stage Renal Disease Prospective Payment System" Fact Sheet Revised – The "End-Stage Renal Disease Prospective Payment System" fact sheet (ICN 905143) has been revised and is now available in downloadable format. It includes background information, as well as information on transition period, payment rates for adult and pediatric patients, outlier adjustments, transition budget neutrality factor, home dialysis, laboratory services and drugs, beneficiary deductible and coinsurance, and the ESRD Quality Incentive Program.

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CMS Has New FAQS on Meaningful Use and Attestation

CMS has recently added five new FAQs on meaningful use and attestation. Take a minute and review them below:

1. For meaningful use objectives of the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs that require a provider to test the transfer of data, such as "capability to exchange key clinical information" and testing submission of data to public

health agencies, can the eligible professional (EP), eligible hospital or critical access hospital (CAH) conduct the test from a test environment or test domain of its certified EHR technology in order to satisfy the measures of these objectives? Read the answer.

2. For meaningful use objectives of the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs that require a provider to test the transfer of data, such as “capability to exchange key clinical information” and testing submission of data to public health agencies, if multiple eligible professionals (EPs) are using the same certified EHR technology across several physical locations, can a single test serve to meet the measures of these objectives? Read the answer.
3. For the meaningful use objective of “provide summary care record for each transition of care or referral ” for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, should transitions of care between eligible professionals (EPs) within the same practice who share certified EHR technology be included in the numerator or denominator of the measure? Read the answer.
4. For the “Incorporate clinical lab-test results” menu objective of the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, how should a provider attest if the numerator displayed by their certified EHR technology is larger than the denominator? Read the answer.
5. How can I change my attestation information after I have attested and/or received an incentive payment under the Medicare Electronic Health Record (EHR) Incentive Program? Read the answer.

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Guest Consultant Donald Tex Bryant on Plan-Do-Check-Act

Recently I was talking to one of my clients about self-improvement. I asked him, “How many people get up in the morning and think about how they could be better today than they were the day before?” He answered, “Not enough.” Later as I considered his answer, I agreed that many do indeed live lives that lack direction and purpose, just getting by day to day, trying to survive their challenges.

In some ways I think that these conclusions also apply to businesses, including healthcare. Many organizations do not try or do not understand how to improve outcomes, whether a service or product for their clients. They do not keep a focus on their mission and strategic plan. Rather, they face their challenges in a rather haphazard fashion, sometimes succeeding but often failing. For instance, from a recent poll by the Medical Group Managers Association, most of their member sites have not checked to see if they are compliant with the new HIPAA standards that were to be in place on January 1, 2012.

Some businesses do focus on being a better organization each day and know how to solve their challenges. Many of these organizations have tools and processes which they consistently employ to help them improve, such as Total Quality Management and Lean Six Sigma. At the heart of each of these is the **Plan-Do-Check-Act** cycle (PDCA). The PDCA cycle can be implemented as a problem solving technique by most organizations with some brief training or study. There are many excellent books and articles that focus on this problem solving approach; a good

source of them is the web site of the **American Society for Quality**. Short training sessions with experts can help a staff achieve fluency in its use.

I will briefly describe and illustrate the Plan phase of PDCA in the remainder of this article. It can be used to solve challenges such as the implementation of an EHR, implementing evidence based practices, and designing processes which improve the outcomes for your patients while helping staff and physicians find more time to get important things done, such as spending more face time with patients.

Know Your Goals.

The first thing to identify is your goals. Do you want to improve the outcomes for patients with chronic diseases? Do you want to find more time to do things you deem important in your practice, such as creating a positive work environment? Some goals are dictated by challenges forced upon providers by outside organizations, such as using ePrescribing.

Prioritize Your Challenges.

Leaders in management and senior physicians should work on challenges that have an impact on more staff, which are more complex and which may require greater funds to solve, though high costs can sometimes be avoided. For instance, the leadership team would be responsible for the adoption of EHRs. Other staff can focus on challenges which affect them but are not readily apparent to all staff. For instance, the receptionist, front office staff and office manager at a small ambulatory site can work on organizing supplies and making sure that there are no unexpected disruptions in their availability.

Once staff and physicians have identified the challenges it should prioritize them. Focus first on those that affect patient safety and outcomes as well as the bottom line.

Form a Team to Design a Solution.

Very few challenges can be solved by just one staff person effectively. Thus, it will be necessary to form a team comprised of staff who are currently involved with the challenge. For instance, in the case of 5010 an IT staff person or staff member in charge of software, office manager, physician, and billing staff should be involved at a medium sized primary care site. A manager or physician should identify a leader of this team. This person will be responsible for the work of the team and for the implementation of the plan that it develops. It is very important that one person be in charge and responsible for the outcomes. It is not necessary for the leader to be a senior staff member, just someone who is respected by other staff and is energetic.

Collect Data.

How will you know if you are advancing towards your goals? You should collect data! First decide what you will measure. If you are adopting ePrescribing, you would want to see how much time each day is spent by staff and physicians providing prescription services, including time taken for refills and for faxing back and forth to pharmacies. Then, as you implement an ePrescribing system, measure how much time these services take at various stages of implementation. As staff become more fluent with the software and as they develop new workflows, the time taken should decrease significantly.

Design a Plan.

The team working on the challenge should create a document which lists the goals of the of the PDCA project, who is responsible for the project, the steps to take to reach the end and a timeline for completion. If the project is large, I would advise breaking it into smaller, sequential projects

that are easier to manage and easier to achieve. For instance, in the adoption of an EHR the first project would involve research into finding ones that meet the needs of the staff. After an EHR is purchased, the second cycle of the PDCA project would be the implementation of some of the features of the EHR into the daily work of the physicians and staff.

Plan-Do-Check-Act is a rational process that businesses can effectively use to solve their challenges. It is based upon the scientific method, which is the basis of much of the work of medicine. One physician recently described on KevinMD.com that he uses this approach frequently with his patients. It makes sense, then, to adopt this technique for the improvement of the services and work of all staff at a healthcare site. If you are not using such an approach now, you should Plan to do so.

Donald Tex Bryant *is a consultant who brings the training and experience of quality improvement from many fields and has worked with both healthcare and service providers to improve their outcomes and services. Mr. Bryant is certified by the University of Michigan as a Lean Healthcare facilitator. You can find out more about his services at* ***Bryant's Healthcare Solutions.***

CMS Roundup of 17 Announcements: More Information Than You Can

Shake a Stick At!

Hospital Wage Index Reform Call

Special Open Door Forum: Presentation and Listening Session on Hospital Wage Index Reform

Tuesday, April 12, 2011, 1:30 PM – 3:00 PM ET.

Section 3137(b) of the Affordable Care Act requires CMS to submit to Congress, by December 31, 2011, a report that includes a plan to reform the wage index under the Medicare hospital inpatient prospective payment system (IPPS). CMS acquired the services of Acumen, LLC to assist in its study of the wage index. During the first part of this special open door forum, Acumen will present its concept of an alternative methodology for the wage index. The second part will be a listening session, during which CMS would like to hear from you regarding your opinions about Acumen's concept, as well as any suggestions on alternative methods for computing the wage index. If you wish to participate via conference call, dial **1-800-837-1935** Conference ID 50101623. Please see the full participation announcement in the Downloads section **here**.

Electronic Health Record Incentive Program Attestation Begins This Week

Attestation for the Medicare Electronic Health Record (EHR) Incentive Program begins on Monday, April 18, 2011. In order to receive your Medicare EHR incentive payment, you must attest through CMS's web-based Medicare and Medicaid EHR Incentive Programs Registration and Attestation System.

You can **preview selected screenshots** of the Attestation System to help you understand what the attestation process will involve. Please note that these screenshots are only examples – the final appearance and language may incorporate additional changes. CMS will release additional information about the Medicare attestation process soon, including User Guides that provide step-by-step instructions for completing attestation and educational webinars that describe the attestation process in depth.

You need to understand the required meaningful use criteria to successfully attest. Meaningful use requirements for eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) participating in the Medicare EHR Incentive Program are different:

- EP Meaningful Use Criteria – Must report on 15 core measures, 5 of 10 menu measures, and 6 clinical quality measures, consisting of 3 required core measures and 3 additional measures.
    - Visit the **Stage 1 EHR Meaningful Use Specification Sheets for EPs** for information on core and menu measures for EPs.
    - Visit the **Clinical Quality Measures page** for information on the required clinical quality measures for EPs.
- Eligible Hospital and CAH Meaningful Use Criteria – Must report on 14 core measures, 5 of 10 menu measures, and 15 clinical quality measures.
    - Visit the **Stage 1 EHR Meaningful Use Specification Sheets for Eligible Hospitals and CAHs** for information on core and menu measures for eligible hospitals and CAHs.
    - Visit the **Clinical Quality Measures page** for information on the required clinical quality

measures for eligible hospitals and CAHs.

You should also make sure that you begin your 90-day reporting period in time to attest and receive a Medicare payment in 2011. The last days to begin 90-day reporting periods for 2011 incentive payments are:

- Sunday, July 3, 2011, for eligible hospitals and CAHs; and
- Saturday, October 1, 2011, for EPs.

Under the Medicaid EHR Incentive Programs, the date when participants can begin attestation for adopting, implementing, upgrading, or demonstrating meaningful use of certified EHR technology varies by state. Visit the **Medicaid State EHR Incentive Program web-tool** for more information about your state's participation in the Medicaid EHR Incentive Program.

Want more information about the EHR Incentive Programs? Make sure to visit the **CMS EHR Incentive Programs website** for the latest news and updates on the EHR Incentive Programs; also read the new EHR Incentive Program **FAQs from CMS.**

Preventive Services, Preventive Physical Examinations and Annual Wellness Visits Quick Reference Charts

The ABCs of Providing the Initial Preventive Physical Examination Quick Reference Chart provides Medicare Fee-For-Service providers a list of the elements of the IPPE, as well as coverage and coding information. View the chart **here.**

The ABCs of Providing the Annual Wellness Visit Quick Reference Chart provides Medicare Fee-For-Service providers a list of the elements of the AWV, as well as coverage and

coding information. View the chart **here.**

The *Medicare Preventive Services* Quick Reference Chart provides Medicare Fee-For-Service providers coverage, coding, and payment information on the variety of preventive services covered by Medicare. View the chart **here.**

A hardcopy booklet containing all three charts, as well as the *Quick Reference Information: Medicare Immunization Billing* chart, will be available at a later date.

Latest HCPCS Code Set Changes

The Centers for Medicare & Medicaid Services is pleased to announce the scheduled release of modifications to the Healthcare Common Procedure Coding System (HCPCS) code set. These changes have been posted to the HCPCS web page **here**. Changes are effective on the date indicated on the update.

Revisions to ASP Pricing Files

The Centers for Medicare and Medicaid Services (CMS) has posted revised October 2010 and January 2011 ASP (average sales price) files, which are available for download **here** (see left menu for year-specific links).

Physician or NPP Signatures on Lab Requisitions

In the Monday, November 29, 2010, Medicare Physician Fee Schedule final rule, the Centers for Medicare & Medicaid Services (CMS) finalized its proposed policy to require a physician’s or qualified non-physician practitioner’s (NPP)

signature on requisitions for clinical diagnostic laboratory tests paid under the clinical laboratory fee schedule effective Saturday, January 1, 2011. (A requisition is the actual paperwork, such as a form, which is provided to a clinical diagnostic laboratory that identifies the test or tests to be performed for a patient.)

On Monday, December 20, 2010, CMS informed its contractors of concerns that some physicians, NPPs, and clinical diagnostic laboratories are not aware of or do not understand this policy. As such, CMS indicated that it will focus in the first quarter of 2011 on developing educational and outreach materials to educate those affected by this policy. CMS indicated that once the first quarter educational campaign is fully underway, it will expect requisitions to be signed.

After further input from community, CMS has decided to focus for the remainder of 2011 on changing the regulation that requires signatures on laboratory requisitions because of concerns that physicians, NPPs, and clinical diagnostic laboratories are having difficulty complying with this policy.

Face-to-Face Encounter Requirements for Home Health and Hospice

Effective April 1, 2011, the Centers for Medicare & Medicaid Services (CMS) expects home health agencies and hospices have fully established internal processes to comply with the face-to-face encounter requirements mandated by the Affordable Care Act (ACA) for purposes of certification of a patient's eligibility for Medicare home health services and of recertification for Medicare hospice services.

Section 6407 of the ACA established a face-to-face encounter requirement for certification of eligibility for Medicare home health services, by requiring the certifying physician to document that he or she, or a non-physician practitioner

working with the physician, has seen the patient. **The encounter must occur within the 90 days prior to the start of care, or within the 30 days after the start of care.** Documentation of such an encounter must be present on certifications for patients with starts of care on or after January 1, 2011.

Similarly, section 3131(b) of the ACA requires a hospice physician or nurse practitioner to have a face-to-face encounter with a hospice patient prior to the patient's 180th-day recertification, and each subsequent recertification. The encounter must occur no more than 30 calendar days prior to the start of the hospice patient's third benefit period. The provision applies to recertifications on and after January 1, 2011.

On December 23, 2010, due to concerns that some providers needed additional time to establish operational protocols necessary to comply with face-to-face encounter requirements mandated by the Affordable Care Act (ACA) for purposes of certification of a patient's eligibility for Medicare home health services and of recertification for Medicare hospice services, CMS announced that it will expect full compliance with the requirements, beginning with the second quarter of CY2011.

Throughout the first quarter of 2011, CMS has continued outreach efforts to educate providers, physicians, and other stakeholders affected by these new requirements. CMS has posted guidance materials including a MLN Matters article, questions and answers documents, training slides, and manual instructions which are available via CMS' Home Health Agency Center and Hospice webpages. CMS' Office of External Affairs and Regional Offices contacted state and local associations for physicians and home health agencies and advocacy groups to ensure awareness about the face-to-face encounter laws, and to distribute the educational materials.

CMS will continue to address industry questions concerning the new requirements, and will update information on the Web site here for **home health** and here for **hospice**.

Federally Qualified Health Center Fact Sheet Revised

The revised publication titled *Federally Qualified Health Center* (revised March 2011) is now available in downloadable format from the Medicare Learning Network® **here**. This fact sheet is designed to provide education about Federally Qualified Health Centers (FQHC), including background; FQHC designation; covered FQHC services; FQHC preventive primary services that are not covered; FQHC Prospective Payment System; FQHC payments; and *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* provisions that impact FQHCs.

Avoiding the Adjustment 2012 Medicare Payment Adjustment for Not ePrescribing in 2011

In November 2010, the Centers for Medicare & Medicaid Services announced that, beginning in calendar year 2012, eligible professionals who are not successful electronic prescribers based on claims submitted between Sat Jan 1 and Thu June 30, 2011, may be subject to a payment adjustment on their Medicare Part-B Physician Fee Schedule-covered professional services. Section 132 of the *Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)* authorizes CMS to apply this payment adjustment whether or not the eligible professional is planning to participate in the eRx Incentive Program.

From 2012 through 2014, the payment adjustment will increase each calendar year. In 2012, the payment adjustment for not being a successful electronic prescriber will result in an eligible professional or group practice receiving 99% of their Medicare Part-B PFS amount that would otherwise apply to such services. In 2013, an eligible professional or group practice will receive 98.5% of their Medicare Part-B PFS-covered professional services for not being a successful electronic prescriber in 2011 or as defined in a future regulation. In 2014, the payment adjustment for not being a successful electronic prescriber is 2%, resulting in an eligible professional or group practice receiving 98% of their Medicare Part-B PFS-covered professional services. (The payment adjustment does not apply if less than 10% of an eligible professional's or group practice's allowed charges for the Sat Jan 1, 2011 through Thu June 30, 2011, reporting period are comprised of codes in the denominator of the 2011 eRx measure.) Also note that earning an eRx incentive for 2011 will NOT necessarily exempt an eligible professional or group practice from the payment adjustment in 2012.

How to Avoid the 2012 eRx Payment Adjustment:

- Eligible professionals – An eligible professional can avoid the 2012 eRx Payment adjustment if (s)he:
    - Is not a physician (MD, DO, or podiatrist), nurse practitioner, or physician assistant as of Thu June 30, 2011, based on primary taxonomy code in NPPES;
    - Does not have prescribing privileges. Note that (s)he must report **G8644** at least one time on an eligible claim prior to Thu June 30, 2011;
    - Does not have at least 100 cases containing an encounter code in the measure denominator;
    - Becomes a successful e-prescriber; and reports the eRx measure for at least 10 unique eRx events for

patients in the denominator of the measure.

NOTE: Group Practices – For group practices that are participating in eRx GPRO-I or GPRO-II during 2011, the group practice MUST become a successful e-prescriber. Depending on the group's size, the group practice must report the eRx measure for 75-2500 unique eRx events for patients in the denominator of the measure. For additional information, please visit the "Getting Started" webpage **here** or download the "Medicare's Practical Guide to the Electronic Prescribing (eRx) Incentive Program" under "Educational Resources" on the same website.

Implementation of Errata for Version 5010 of HIPAA Transactions

BTW, **errata** is a list or lists of errors and their corrections. Errata is plural and the singular is erratum.

CMS does not have a version 4010A1 direct data entry and a separate version 5010 direct data entry. The Priority (Type) of Admission or Visit code is now required on all version 4010A1 institutional claims submitted or corrected via direct data entry, as well as on version 5010 institutional claims, regardless of how they are submitted. Providers that are unsure which code to use are to use code 9 (Information not Available). Additional Priority (Type) of Admission or Visit code values and descriptions are available from the **National Uniform Billing Committee** or from your servicing MAC. The Priority (Type) of Admission or Visit code is not required on 4010A1 institutional claims submitted or corrected via an 837. More information on Version 5010 **here.**

IMPORTANT 5010/D.0 IMPLEMENTATION ITEMS

REMINDER – 5010/D.0 Errata requirements and testing schedule can be found here

REMINDER – Contact your MAC for their testing schedule

READINESS ASSESSMENT – Have you done the following to be ready for 5010/D.0?

READINESS ASSESSMENT – What do you need to have in place to test with your MAC?

READINESS ASSESSMENT – Do you know the implications of not being ready?

New Mental Health Services Booklet

A new publication titled "Mental Health Services" is now available in downloadable format from the Medicare Learning Network® **here**. This booklet is designed to provide education on mental health services, including covered mental health services, mental health services that are not covered, mental health professionals, outpatient psychiatric hospital services, and inpatient psychiatric hospital services.

Ambulance Fee Schedule Fact Sheet Revised

The revised publication titled "Ambulance Fee Schedule" (revised March 2011) is now available in downloadable format from the Medicare Learning Network® **here**. This fact sheet is designed to provide education about the Ambulance Fee Schedule including background, ambulance providers and suppliers, ambulance services payments, and how payment rates are set.

Health Professional Shortage Area Fact Sheet Revised

The revised publication titled “Health Professional Shortage Area” (revised March 2011) is now available in downloadable format from the Medicare Learning Network® **here**. This fact sheet is designed to provide education on the Health Professional Shortage Area (HPSA) payment system and includes an overview of the program and general requirements.

Medicare Disproportionate Share Hospital Fact Sheet Revised

The revised publication titled “Medicare Disproportionate Share Hospital” (revised March 2011) is now available in downloadable format **here**. This fact sheet is designed to provide education on Medicare Disproportionate Share Hospitals (DSH) including background; methods to qualify for the Medicare DSH adjustment; *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* and *Deficit Reduction Act of 2005* provisions that impact Medicare DSHs; number of beds in hospital determination; and Medicare DSH hospital payment adjustment formulas.

G0431QW is Deleted and G0434QW is Added to CLIA Waived Test Schedule

The Centers for Medicare & Medicaid Services (CMS) is updating the status of two codes on the Clinical Laboratory Fee Schedule (CLFS).

- Effective April 1, 2011, code G0431QW is deleted from the CLFS. Code G0431 describes a high complexity test, and should not be reported with a QW modifier; the QW modifier indicates a CLIA waived test.
- Effective April 1, 2011, code G0434QW is added to the CLFS. Code G0434 can describe a CLIA waived test. The use of the QW modifier to indicate a CLIA waived test is necessary for accurate claims processing.

Codes G0431 and G0434 will remain on the CLFS.

CMS Launches a Dedicated Web Page for the Medicare Shared Savings Program/Requirements for ACOs

On March 31, 2011, The Centers for Medicare & Medicaid Services (CMS) published in the Federal Register proposed rule ***CMS-1345-P, Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations*** that implements the Medicare Shared Savings Program (Shared Savings Program) and establishes the requirements for Accountable Care Organizations. CMS has launched a dedicated web page **here** for Medicare FFS providers and other providers of services and suppliers. Bookmark the web page and check back often, as CMS continues to add information on the program.

Program for Evaluating Payment Patterns Electronic Report (PEPPER)

for CAHs

Beginning in April 2011, the Centers for Medicare & Medicaid Services (CMS) will make available free hospital-specific comparative data reports for critical access hospitals (CAHs) nationwide. The Program for Evaluating Payment Patterns Electronic Report (PEPPER) provides hospital-specific data statistics for Medicare discharges at risk for improper payments. Hospitals can use the data to support internal auditing and monitoring activities. PEPPER is the only free report comparing a CAH's Medicare billing practices with other CAHs by state, Medicare Administrative Contractor (MAC) or Fiscal Intermediary (FI) jurisdiction and the nation. CMS has contracted with TMF Health Quality Institute to develop and distribute the reports.

PEPPER will be distributed electronically to CAH QualityNet Administrators and those who have basic user accounts with the PEPPER Recipient role on or about Monday, April 25, via a My QualityNet secure file exchange. In preparation for receiving and downloading PEPPER from My QualityNet, these individuals should verify that their computer systems are equipped with the software and configuration required to use My QualityNet by following the steps at **www.qualitynet.org** (see "Getting Started With QualityNet" and "Test Your System.") Additional information about downloading PEPPER from My QualityNet can be found **here** (includes System Setup and Test Guide, Troubleshooting Tips and a guide for Configuration Changes for Compatibility with QualityNet).

CAHs may work with their Quality Improvement Organization (QIO) to obtain a QualityNet administrator account by visiting **www.qualitynet.org** and clicking on the Hospitals – Inpatient link. Obtaining a My QualityNet account may take several weeks; CAHs should plan accordingly.

TMF will conduct a web-based training session for CAH staff

providing information on PEPPER and how to use it on Thursday, April 28, at 1 p.m. central time. To register for the training, CAH staff should visit https://tmfevents.webex.com. The training will be recorded and posted on http://www.pepperresources.org.

For more information, including the PEPPER distribution schedule, a sample PEPPER for CAHs and information about QualityNet accounts, visit the PEPPER website. CAH staff are encouraged to join the e-mail list on this website to receive important notifications about upcoming PEPPER distribution and training opportunities.

Image by The Library of Congress via Flickr