CMS Publishes an Updated Q & A about Attesting with Multiple EHRs

Question: For the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, how should an eligible professional (EP), eligible hospital, or critical access hospital (CAH) that sees patients in multiple practice locations equipped with certified EHR technology calculate numerators and denominators for the meaningful use objectives and measures?

Answer: EPs, eligible hospitals, and CAHs should look at the measure of each meaningful use objective to determine the appropriate calculation method for individual numerators and denominators. The calculation of the numerator and

denominator for each measure is explained in the July 28, 2010 final rule (75 FR 44314).

For objectives that require a simple count of actions (e.g., number of permissible prescriptions written, for the objective of "Generate and transmit permissible prescriptions electronically (eRx)"; number of patient requests for an electronic copy of their health information, for the objective of "Provide patients with an electronic copy of their health information"; etc.), EPs, eligible hospitals, and CAHs can add the numerators and denominators calculated by each certified EHR system in order to arrive at an accurate total for the numerator and denominator of the measure.

For objectives that require an action to be taken on behalf of a percentage of "unique patients" (e.g., the objectives of "Record demographics", "Record vital signs", etc.), EPs, eligible hospitals, and CAHs may also add the numerators and denominators calculated by each certified EHR system in order to arrive at an accurate total for the numerator and denominator of the measure. Previously CMS had advised providers to reconcile information so that they only reported unique patients. However, because it is not possible for providers to increase their overall percentage of actions taken by adding numerators and denominators from multiple systems, we now permit simple addition for all meaningful use objectives.

Keep in mind that patients whose records are not maintained in certified EHR technology will need to be added to denominators whenever applicable in order to provide accurate numbers.

To report clinical quality measures, EPs who practice in multiple locations that are equipped with certified EHR technology should generate a report from each of those certified EHR systems and then add the numerators, denominators, and exclusions from each generated report in order to arrive at a number that reflects the total data output for patient encounters at those locations. To report clinical quality measures, eligible hospitals and CAHs that have multiple systems should generate a report from each of those certified EHR systems and then add the numerators, denominators, and exclusions from each generated report in order to arrive at a number that reflects the total data output for patient encounters in the relevant departments of the eligible hospital or CAH (e.g., inpatient or emergency department (POS 21 or 23)).

Website Update

Please also note that the EHR Incentive Programs' FAQs were reorganized during the CMS.gov website upgrade. The EHR Incentive Programs' FAQs are now incorporated in the same page as other CMS program FAQs. To navigate the EHR Incentive Program FAQs you must go to the FAQ page, and click "Electronic Health Records Incentive Programs" on the blue navigation pane on the left-hand side. We appreciate your understanding and apologize for any inconvenience.

Want more information about the EHR Incentive Programs? Visit the EHR Incentive Programs website.

Photo credit: Wikipedia

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

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

CMS has announced two national calls for attestation.

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

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

CMS is holding conference calls for eligible professionals

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

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

What the Calls Will Cover

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

Instructions on How to Register for a Call
To register for these calls, take the following steps:

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

p.m. ET.

2. Fill in all required information and click “Register.”
3. You will be taken to the “Thank you for registering” page and will receive a confirmation email shortly thereafter. Please save this page in case your server blocks the confirmation email. (If you do not receive the confirmation email, check your spam/junk mail filter as it may have been directed there.)
4. If assistance for hearing impaired services is needed, please email **medicare.ttt@palmettogba.com** no later than 3 business days before the call.

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

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

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

Medicare eligible professionals, eligible hospitals and critical access hospitals will have to demonstrate meaningful use through CMS’ web-based **Registration and Attestation System**. In the Medicare & Medicaid EHR Incentive Program Registration and Attestation System, providers will fill in numerators and denominators for the meaningful use objectives and clinical quality measures, indicate if they qualify for exclusions to specific objectives, and legally *attest* that they have successfully demonstrated meaningful use. A complete EHR system will provide a report of the numerators, denominators and other information. Then you will need to enter that data into our online Attestation System. Providers will qualify for a Medicare EHR incentive payment upon

completing a **successful** online submission through the Attestation System—immediately after you submit your results you will see a summary of your attestation, and whether or not it was successful. The Attestation System for the Medicare EHR Incentive Program will open on April 18, 2011.

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

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

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

When can I attest?

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

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

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

What can I do now to prepare for attestation?

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

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

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

What will I need to login to the Attestation System?

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

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

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

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

What is the CMS EHR Certification Number?

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

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

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

1. Go to the ONC CHPL website.

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

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

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

When will I get paid?

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

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

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

How will I get paid?

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

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

If you receive payments for Medicare services via electronic

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

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

Have questions about your EHR incentive payment?

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

DO: Call the EHR Information Center

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

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

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

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

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

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

Will CMS conduct audits?

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

Overview of the CMS EHR Incentive Programs Audits

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

Preparing for an Audit

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

Details of the Audits

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

Where can I find user guides and other resources?

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

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

The Electronic Health Record (EHR) Information Center is open

to assist the EHR Provider Community with inquiries.

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

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

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

Digging Into the Details of

“Certified EMR” & Tips For Buying an EMR

Steps to digging under the meaning of EMR certification:

Image via Wikipedia

1. Click to see the most recent alphabetical list (by product name not company) of **all products** certified **here**.
2. Find the **company or companies** you are using or are considering using.
3. Check that the exact name of the **product** is what you have or might purchase.
4. Check to find out if a **module or part of the product is certified or if the complete** product is certified.
5. Check to make sure the **version** of the product is the version you have or will have.

If you have questions about each company’s exact criteria met, you are in luck! On the **ONC site here**, you can click on each company’s detail (“View Criteria”) on the far right column labeled “Certification Status” to see what they have and don’t have. Compare this to how you are anticipating using your EMR to meet meaningful use. The more check marks a company has, the better-equipped they are (and more flexible) to meet your practice needs and to qualify for the stimulus money.

The ONC site with the Certified Health IT Product List (CHPL) is Version 1.0. Version 2.0 is now being developed and will provide the Clinical Quality Measures each product was tested on, and the capability to query and sort the data for viewing. The next version will also provide the **reporting number** that will be accepted by CMS for purposes of attestation under the EHR ("meaningful use") incentives programs.

You can tell ONC what you think would be helpful in the new version by emailing your ideas to ONC.certification@hhs.gov, with "CHPL" in the subject line.

If you'd like a list of just outpatient/medical practice EMR products or just inpatient / hospital products, I've split the big list into two smaller printable lists here:

Medical Practice / Outpatient

Hospital / Outpatient

Tips On Buying An EMR

Remember that meeting meaningful use does not tell the whole story – if you are shopping for an EMR be prepared to go beyond a product's certification status to consider:

- **Flexibility** – does it make the practice conform to it or can it conform to the practice? How?
- **Templates and best practices** – are you starting from

scratch in developing protocols, templates and cheat sheets for your practice, or does it have a storehouse of examples to choose from or tweak?

- **Built for the physician, or the billing office, or the nurses**, but doesn't really meet the needs of all three? Make sure the functionality is not too skewed to one user group, but if it is, it should be somewhat skewed to the provider.
- **Interface and integration with your practice management system.** Does the information flow both ways? Do you ever have to re-enter information because one side doesn't speak to the other?
- **Interface with other inside and outside systems:** Labs, imaging, hospital systems, ambulatory surgical center systems?
- **Built-in Resources:** annual upgrade of HCPCS and ICD codes, drug compendium (Epocrates), comparative effectiveness prompting?
- **Mobile applications –** EMR on your providers' phones?
- **Data entry systems** – laptops, notebooks, tablets, iPads, smartphones, voice recognition?
- **Hosting** – in your office? at the hospital? at the vendor's data center? in the cloud of your choice?
- **What's the plan for ICD-10?** Will they provide practice support and education for the change or will they just change the number of characters in the diagnosis code field?
- **Price**, including annual maintenance and additional costs for training, implementation, on-site support during go-live, and additional licenses for providers or staff.