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)

–

(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)

_

(MU) CMS has Posted the Proposed CQMs under the Stage 2 NPRM on the CMS Website (jump to story)

_

(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)

_

(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)

_____

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
(Back to Top)

_____

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.

(Back to Top)

———

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.

(Back to Top)

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.

(Back to Top)

_____

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."

(Back to Top)

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.

(Back to Top)

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!

(Back to Top)

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.

(Back to Top)