# 12 Ways to Supercharge Your Practice in 2012: #12 – 9 Ways to Maximize Your Medicare Payments


Medicare has so many programs that have the potential to increase or decrease your payments that practices need a list to keep them straight.

Here's your list with information on which programs are mutually exclusive and which can be combined.

## 1. Electronic Health Records (EHR) Incentive Program

- You must be an eligible provider to participate.
- You must be the owner of the EHR, although you do not need to have paid for the EHR.
- The EHR must be certified.
- You can choose to participate in Medicare (federally administered) or Medicaid (state administered) program.
- You must register for the programs.
- You must attest or document that you have adopted, implemented, upgraded or demonstrate meaningful use.
- Eligible professionals choosing to participate the Medicare program can each earn up to $44K over 5 years, and eligible professionals choosing to participate in

the Medicaid program can each earn up to $63,750 over 6 years.

## 2. ePrescribing Incentive Program

- Eligible professionals do not need to register for the program.
- You can participate in one of three ways: via submitting codes on claim forms, via an EHR or via a registry
- Each professional needs to report 10 eRx events for Medicare patients for dates of service before June 30, 2012 OR apply for one of five exclusions or four exemptions.
- EPs who are successful e-prescribers can qualify to earn an incentive payment based on a percentage of their total estimated Medicare PFS allowed charges processed not later than 2 months after the end of the reporting period. For reporting year 2012, EPs who are successful e-prescribers can qualify to earn an incentive payment equal to 1.0 percent of allowed charges. For reporting year 2013, EPs can qualify to earn an incentive payment of 0.5 percent of allowed charges. Beginning in 2012, EPs who are not successful e-prescribers in 2011 and do not qualify for a hardship exception will be subject to a payment adjustment equal to 1.0 percent of their Medicare PFS allowed charges. The payment adjustment increases to 1.5 percent in 2013 and 2.0 percent in 2014.

## 3. PQRS (Physician Quality Reporting System)

- Originally called PQRI (Physician Quality Reporting Initiative) is the basis for pay-for-performance models.

- Physicians may report individually or practices may choose a set of three measures that relate to the type of patients they see. Measures are performed and modifiers are attached to claims.
- Bonuses are available until 2014; starting in 2015 practices not participating in PQRS will receive a negative payment adjustment.
- For reporting years 2012 through 2014, EPs who satisfactorily report Physician Quality Reporting System measures will earn an incentive payment equal to 0.5 percent of allowed charges. Additionally, for reporting years 2011 through 2014, EPs who satisfactorily report Physician Quality Reporting System measures can qualify to earn an additional 0.5 percent incentive payment by, more frequently than is required to qualify for or maintain board certification status, participating in a maintenance of certification program and successfully completing a qualified maintenance of certification program practice assessment. Beginning in 2015, EPs who do not satisfactorily report under the Physician Quality Reporting System will be subject to a payment adjustment equal to 1.5 percent of their Medicare PFS allowed charges. The payment adjustment increases to 2.0 percent in 2016 and beyond.

## 4. Medicare Wellness Visits

- Many practices are losing money due to the confusion over what Medicare pays for and what Medicare doesn't pay for. Medicare introduced three new visits in 2010 and many providers continue to have trouble understanding and providing them correctly.
- The "Welcome to Medicare" visit is technically called the "Initial Patient Physical Examination" (IPPE), but to everyone's dismay, it is not a physical examination at all, with the exception of basic visits such as

height, weight, BMI, blood pressure and pulse, and the potential for an EKG and an Abdominal Aortic Aneurysm screening. The Annual Wellness Visit (AWV) and the Subsequent Annual Wellness Visit are not physical examinations either, yet almost ALL patients believe that Medicare now gives free annual physicals.

- Practices must train all staff and physicians to use the correct terminology first. I suggest everyone stop using the phrases “annual physical” or “complete physical” with Medicare patients. Patients can request and receive:
    - A Welcome to Medicare Visit with no exam (no deductible, no co-insurance)
    - A first annual Wellness Visit with no exam (no deductible, no co-insurance)
    - A Subsequent Annual Wellness Visit with no exam every year thereafter (no deductible, no co-insurance)
- What patients think they want is either a preventive visit, which Medicare will NOT pay for, or a standard Evaluation & Management (E/M) visit, which their deductible and co-insurance will apply to.
- The only way the practice can win is by driving home to patients what Medicare does pay for and doesn’t pay for and making sure your documentation matches the code you submit to Medicare.

## 5. The ABN (Advance Beneficiary Notice)

- Many practices miss revenue when they provide services to Medicare patients that are statutorily excluded from Medicare benefits.
- These may be services that do not meet the Medicare

definition of medical necessity or are provided at more frequent intervals than Medicare approves.

- Identifying these non-covered services is the hard thing, however, unless your EMR can alert you to a service that will not be paid by Medicare, and if the patient requests the service and signs an ABN prior to the provision of the service  In this case, the practice may collect the full fee from the patient.

## 6. Primary Care Incentive Payment Program (PCIP)

- Eligible Providers (Clinical Nurse Specialists, Nurse Practitioners, Physician Assistants, and Physicians who have their primary specialty designation in family medicine, internal medicine, geriatric medicine or pediatric medicine) can receive a 10% incentive payment for services under Part B.
- The PCIP program, which was created by the Patient Protection and Affordable Care Act, requires Medicare to pay primary care providers, whose primary care billings comprise at least 60 percent of their total Medicare allowed charges, a quarterly 10-percent bonus from Jan. 1, 2011, until the end of December 2015.
- Eligible primary care physicians furnishing a primary care service in a Health Professional Shortage Area (HPSA) area may receive both a HPSA and a PCIP payment.

## 7. HPSA (Health Professional Shortage Area)

- Medicare makes bonus payments annually of 10% to physicians who provide medical care services in

geographic areas that lack sufficient health care providers to meet the needs of the population.

- Payments are automatic; there is no need to register or report anything on the claim for
- If services are provided in ZIP code areas that do not fall entirely within a full county HPSA or partial county HPSA, the AQ modifier must be entered on the claim to receive the bonus.

## 8. HPSA (Health Professional Shortage Area ) Surgical Incentive Payment (HSIP)

- The Affordable Care Act of 2010, Section 5501 (b)(4) expands bonus payments for general surgeons in HPSAs. Effective January 1, 2011 through December 31, 2015, physicians serving in designated HPSAs will receive an additional 10% bonus for major surgical procedures with a 10 or 90 day global period.
- Payments are automatic; there is no need to register or report anything on the claim form.
- If services are provided in ZIP code areas that do not fall entirely within a full county HPSA or partial county HPSA, the AQ modifier must be entered on the claim to receive the bonus.

## 9. NEW! Comprehensive Primary Care Initiative (CPCi)

- Payment model per beneficiary per month (PBPM) for care management of Medicaid and Medicare patients
- Markets in Arkansas, Colorado, New jersey, New York,

Ohio/Kentucky, Oklahoma and Oregon for Medicaid patients

- Arkansas, Colorado, Ohio and Oregon are the four states for Medicaid pilots.
- Multiple payers, including CMS, will be paying a monthly care management fee to support the 5 primary care functions of:
    - Risk-stratified care management
    - Access and continuity
    - Planned care for chronic care & preventive care
    - Patient & caregiver engagement
    - Coordination of care across the medical neighborhood
- Primary care practices in the states and markets can apply from June 15 to July 20, 2012 (**application here.**)

# What Medicare Bonus or Incentive Programs Can Be Claimed Together?

- PQRS can claimed with eRx.
- PQRS can be claimed with EHR.
- HPSA and PCIP are automatic and are not affected by any other programs
- EHR and eRx can both be claimed but you cannot earn both an eRx incentive and an EHR incentive in the same year if you elect to receive the EHR incentive payment through Medicare. **NOTE: Just because you cannot claim the eRx bonus in conjunction with EHR incentive, you must still continue to ePrescribe to avoid the eRx penalty!**

# Physicians Speak About Their EHR Experiences on YouTube

Did you know that CMS has its own YouTube channel?

CMS has just posted YouTube videos of physicians discussing their experiences with EHRs and Meaningful Use. The videos were taken during the recent 2012 **HIMSS** (Healthcare Information Management and System Society) conference. Below is one from a physician practice that readers might find interesting.

In the video, Dr. John Bender, CEO and family physician at Miramont Family Medicine in Colorado, an 8-physician practice, talks about his experience using electronic health records (EHRs), how EHRs and the EHR Incentive Programs have financially benefited his practice, and how EHRs help him provide better care.

Here's the link to the **CMS YouTube channel** for more videos.

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

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

- As of June 30th, the total of ***Medicare*** EHR Incentive Program payments is over $94 million.
- As of June 30th, over $166 million has been paid in ***Medicaid*** EHR incentives since the program began in January. In May and June, four states launched Medicaid EHR Incentive Programs – Indiana, Ohio, Pennsylvania, and Washington, bringing the total states with Medicaid EHR Incentive Programs to 21. More states will launch in July.
- There are 68,001 active registrations of eligible professionals and eligible hospitals for the Medicare and Medicaid EHR Incentive Programs.

If your group hasn't received a check and hasn't registered for the Medicare or Medicaid Incentive Program, then this blog

post is for you! For anyone who is really just beginning their EHR journey, today's presentation clarified previous information given by CMS, as well as giving listeners new information about the programs.

The two primary steps to obtaining incentive payments are:

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

Let's start with information on the two different incentive programs. Remember that an eligible professional (EP) is defined differently for Medicare than it is for Medicaid.

# Step One: Are You Eligible for the EHR Incentive Programs?

**Medicare Eligible Professionals:**

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

**Medicaid Eligible Professionals:**

- Must be a MD, DO, DDM/DDS or a Nurse Practitioner, a Certified Nurse Midwife, **OR** a Physician Assistant who is the lead provider for a Federally Qualified Health

Center (FQHC) or Rural Health Clinic (RHC).
- Must either have 30% or more Medicaid patient volume (pediatricians must have 20% or more Medicaid patient volume) **OR** must practice predominantly in a FQHC or RHC with 30% or more needy individual patient volume. Needy is defined as patients who are Medicaid, Medicare, uninsured, under-insured, charity care and indigent care.
- Must be licensed and credentialed
- Must have no OIG exclusions
- Must be living (Social Security records are examined)
- Must not be hospital-based, which is defined as having 90% or more of their covered
  professional services in either an inpatient (POS 21) or emergency room (POS 23) of a hospital

# Step Two: How much EHR Incentive Money is Available From the Two Programs?

**Medicare Incentive Payments:**

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

Shortage Area (HPSA). **Go here to see if you practice in a HPSA.**

- EPs will receive only 1 incentive payment per year.

**Medicaid Incentive Payments:**

- First eligible year for the program is 2011.
- Maximum incentives are $63,750 over 6 years.
- Incentives are the same regardless of the year started.
- The first year's payment is $21,250.
- Must begin by 2016 to receive incentive payments.
- No extra bonus for health professional shortage areas.
- Incentives are available through 2021.
- EPs will receive only 1 incentive payment per year.

# How Do You Choose Which Program to Qualify For?

1. First, determine which programs you can qualify for based on the **type of eligible professional** you are.
2. Then, determine which programs you can qualify for based on **your patient population**.
3. Next, review the **requirements and potential payments and/or reductions** for each program – get your calculator out!
    - Once an eligible professional has demonstrated meaningful use in the first participation year, they may receive an incentive payment equal to 75% of Medicare allowable charges for covered professional services furnished by the eligible professional in a payment year **VERSUS** Once an eligible professional has demonstrated adoption, implementation, upgrading, or meaningful use of certified EHR technology in the first participation year, they may receive an incentive

payment of $21,250 from Medicaid. Remember the payments are for each provider. Don’t forget the 10% HPSA bonus if you participate in  the Medicare program.

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

4. If you not up to speed on meaningful use and want to collect incentive money for 2011, it will be easier to you to meet the requirements of the Medicaid program than the Medicare program, if you are eligible for the Medicaid program and there is one offered in your state.
5. Remember that EPs can switch programs once after their first year in either program.

# Getting Ready for the Registration Process

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

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

3. If you do not have an active User ID and Password for NPPES or PECOS, request them via **Identity & Access Management**. You will need your type 2 NPI, your Taxpayer Identification Number (TIN), and your address from IRS Form CP-575. You will also need to mail a copy of IRS Form CP-575 as directed.
4. Payee Tax Identification Number (if you are reassigning your benefits to a group or a hospital).
5. Payee National Provider Identifier (NPI) if you are reassigning your benefits. Note that many independent physicians are reassigning their benefits to their practice and almost all hospital-sponsored physicians are reassigning their benefits to the hospital.

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

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

1. Go to the **registration site here**. The Login page instructs the user on what is required for a valid User

ID and Password combination.  EPs are required to have an active NPI and must have a National Plan and Provider Enumeration System (NPPES) user account to login. For users who do not have either of these requirements, click on the link provided to you in the program.

2. A link to the Identity and Access Management System, I&A, is also provided. The I&A system allows EP users use to reset their passwords and edit their account information. Any additional login issues can be resolved by contacting the help desk (see info at the bottom of this post.) At the bottom of the page the user enters their User ID and Password combination.  Please keep in mind that both of the fields are case-sensitive.
3. Once the user has logged into the system, the links and tabs displayed in the top right hand corner are shown on every page.
    - The **Home** hyperlink navigates the user to the Welcome page.
    - The **Help** hyperlink opens a PDF User Manual that assists the user throughout the Registration process.
    - If at anytime you wish to logout of the system, click the **Log Out** link and select yes in the pop-up window.
    - The **Instructions** section on the Welcome page describes the actions that can be performed under each of the tabs.  The EP submits and maintains their registration under the Registration tab and completes their Attestation under the Attestation tab.
    - The **Status Tab** provides a snapshot of the user's current standing in the EHR Incentive Program. This includes the status of their registration and any attestations and payments associated with their account.
    - The **Account Management** tab allows the user to proceed to the I&A system in order to change their

account information.
    - Clicking the **Registration** tab will reveal a set of instructions about the actions that can be performed. These options will differ depending on the status of the registration.
4. The EP's name, social security number, and NPI are retrieved from their NPPES account. If they have not started their registration, the status will be blank and **Register** will be the only available action.
5. Select the **Register** link to begin.
6. The Registration ID is displayed on the "Topics for this Registration" page. **Write this number down** for tracking purposes.
7. There are three topics that an Eligible Professional must complete before submitting their Registration. They are EHR Incentive Program, Personal Information, and Business Address and Phone. The "Begin Submission" button cannot be selected until all of the topics are complete. Select the **"Start Registration"** button to navigate to the first topic.
8. On the EHR Incentive Program page, EPs are given the option to receive either a **Medicare or Medicaid EHR Incentive Payment**. For additional information about the two EHR Incentive Programs select the link that is provided. By selecting the Medicare option and clicking the "Apply" button, the EP type field page cursor moves across screen to highlight information. Provider Types that are eligible in the Medicare EHR Incentive Program are displayed in the dropdown. Selecting the Medicaid option and then the "Apply" button refreshes the page with two fields, Medicaid State/Territory and Eligible Professional Type. Only those states and territories participating in the Medicaid EHR Incentive Program are displayed in the Medicaid State/Territory dropdown. Provider types that are eligible for the Medicaid EHR Incentive Program are displayed in the dropdown.
9. Two additional links on the EHR Incentive Program page

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

10. The Name and Identifiers displayed on the Personal Information page are retrieved from the user's NPI record on the NPPES system. These fields cannot be modified in the EHR Incentive Program System. The Payee TIN Type field provides the user with two options in terms of who receives the EHR Incentive Payments. If the payments should be sent directly to the Eligible Professional, the SSN tab should be selected in the Payee TIN Type field. If the payments should be sent to a group associated with the Eligible Professional, the user should select E-I-N in the Payee TIN Type field and then select the "Apply" button. After the page is refreshed, three additional fields are displayed.
11. The next step is to select the Group that should receive the payments. A Group Name will only appear in the dropdown if the EP's Medicare enrollment in the Provider Enrollment, Chain, and Ownership System, or PECOS, has reassigned benefits to the Group. After the Group Name is selected, the Group's TIN is retrieved from PECOS and displayed in the Payee TIN field. It is also required that the user enters the NPI associated with the Group in the Payee NPI field. If the user had selected to register for the Medicaid EHR Incentive Program, the system requires the user to manually enter the Group Name, Payee TIN, and Payee NPI. A dropdown list of Group

Names would not be provided. Select the “Save and Continue” button to navigate to the next topic.

12. The address and phone number displayed on the Business Address and Phone page is consistent with the Practice Location on the Eligible Professional’s NPI record. Unlike the Personal Information page, the address and phone number fields can be modified here. However, if changes are made to the address and phone number in the EHR Incentive Program System, the changes will not be reflected on the Eligible Professional’s NPI record. E-mail Address is also a required field and must be entered with the correct email address format. Select the “Save and Continue” button to complete the last topic.
13. Once the user has entered the required registration information, all three of the topics are marked as completed. To initiate the submission process, select the “Begin Submission” button.
14. The Verify Registration page displays a summary of the registration information. It displays Personal Information, Business Address, as well as the Incentive Program that was chosen for this registration. The “Reason for Submission” section describes the action that the user is currently performing on the registration. If any of the information on this page is incorrect, the user should select the “Previous Page” button and make the appropriate modification.
15. After verifying that all of the information is correct, please select the “Submit” button to proceed. Before the registration can be submitted, the user must review and agree to the Registration Disclaimer. Agreeing to the legal notice means that the EP is certifying that the information provided in the registration is true and accurate. Please take the time to review each line of the disclaimer. Select the “Agree” button to proceed.
16. If the registration passes all validations, the submission will be successful. Please keep in mind that

things like a non-approved Medicare enrollment in PECOS or OIG Exclusions can result in registration failure. Contact the help desk
to resolve any of these issues.

17. The Submission Receipt page reminds users that they will not receive an e-mail confirmation and that attestation information must be submitted in order to qualify for an incentive payment. **Print the Submission Receipt page** by selecting the “Print” button at the bottom of the page. Select the “Return to Home” button to proceed.
18. A registration must be Active in order to proceed with Attestation and Payment. If any changes need to be made to the registration, the user would select the Modify link and navigate back to the topics page. The registration can also be cancelled, which would end the Eligible Professional’s participation in the EHR Incentive Program.
19. Selecting the Status tab navigates the user to the Status Summary page. The Select link navigates to the Status Detail page which displays all of the registration information in one location. The Additional Information link expands to display more registration information and the status of validations that are performed during submission.

# Q & A from the listeners (always the best part!)

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

A: Yes, you can use a free EHR and still receive the incentive money. The incentive money is to assist EPs implement EHRs and is not intended to be used only to purchase the software.

Remember that the EHR must be certified by one of the certifying bodies and must be certified for ambulatory care.

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

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

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

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

***Q: Are radiologists eligible?***

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

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

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

nursing home visits

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

A: Yes.

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

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

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

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

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

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

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

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

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

A: Yes.

**Resources:**

**EHR Information Center**

Hours of Operation: 7:30 a.m. – 6:30 p.m. (Central Time)
Monday through Friday, except federal holidays.
1-888-734-6433 (primary number) or 888-734-6563 (TTY number)

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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.