Medicare News for Week of April 17, 2012: CMS Website Upgraded, 2 National Provider Calls, Proposed CQMs for MU Stage 2 and 27 ACOs are Announced

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

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

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

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

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

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

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

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

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CMS.gov Website Upgrade Completed-Check your Bookmarks

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

Home Health:

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

Hospice:

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

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

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

Target Audience: All Medicare Fee-For-Service Providers,

Medical Coders, Physician Office Staff, Provider Billing Staff, Electronic Health Records Staff, and Vendors

Agenda:

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

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

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

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

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

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

the Part A and Part B Version 5010 transition.

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

Agenda:

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

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

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

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

CMS has posted the full set of proposed Clinical Quality

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

Proposed CQMs

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

Public Comment

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

Want more information about the EHR Incentive Programs?

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

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

Existing regulations at 42 CFR 424.510(e)(1)(2) require that at the time of enrollment, enrollment change request, or revalidation, providers and suppliers that expect to receive payment from Medicare for services provided must also agree to receive Medicare payments through electronic funds transfer (EFT). Section 1104 of the *Affordable Care Act* further expands Section 1862(a) of the *Social Security Act* by mandating federal payments to providers and suppliers only by electronic means. As part of CMS's revalidation efforts, all suppliers and providers who are not currently receiving EFT payments *are required to submit the CMS-588 EFT form with the Provider Enrollment Revalidation application, or at the time any change is being made to the provider enrollment record by the provider or supplier, or delegated official.* For more information about provider enrollment revalidation, review the MLN Matters® Special Edition Article #SE1126, "Further Details on the Revalidation of Provider Enrollment Information."

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

Over 1.1 Million Beneficiaries Now Served by Accountable Care Organizations

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

Under the new Medicare Shared Savings Program (Shared Savings Program), 27 Accountable Care Organizations (ACOs) have entered into agreements with CMS, taking responsibility for the quality of care furnished to people with Medicare in return for the opportunity to share in savings realized through improved care. The Shared Savings Program and other initiatives related to Accountable Care Organizations are made possible by the *Affordable Care Act*, the health care law of 2010. Participation in an ACO is purely voluntary for providers and beneficiaries and people with Medicare retain their current ability to seek treatment from any provider they wish.

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

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

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

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

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

Updated FAQ System

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

- Click on the Topic *HIPAA Administrative Simplification* on the left side of the page
    - Click on the Subtopic *Versions 5010 and D.0* that will appear as a dropdown under the topic (FAQs on Version 5010 and D.0 will be listed on the right side of the page)
- Click on the Topic *Coding* on the left side of the page

    - Click on the Subtopic *ICD-10* that will appear as a dropdown under the topic (FAQs on Version 5010 will be listed out on the right side of the page)
- Entering the search term "Version 5010" in the *Search* box on the upper left side of the page

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

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

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

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

Version 5010 Testing Readiness Fact Sheet

CMS also has a Version 5010 Testing Readiness Fact Sheet, which explains the Version 5010 upgrade and necessary Phase I Internal and Phase II External testing. This fact sheet can

help providers to determine steps to successfully complete testing phases for Version 5010.

Keep Up to Date on Version 5010 and ICD-10

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

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Medicare Learning Matters Updates

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

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

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

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

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

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

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

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

Submit Feedback on MLN Products and Services –

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

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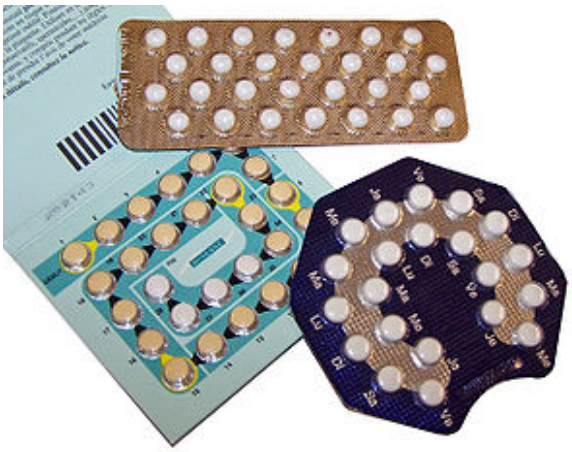
News from Medicare & Other Payers for the Week of January 23, 2012: 5010 National Provider Call This Week; Most Insurances Will Be Required to Cover Birth Control Without Co-Pays



e-RX: Medicare e-prescribing hardship exemptions under review (jump to story)

EFT: suppliers and providers who are not

currently receiving Medicare EFT payments are required to submit the CMS-588 EFT form (jump to story)

SNFs: Allowing Physician Assistants to Perform Skilled Nursing Facility (SNF) Level of Care Certifications and Recertifications (jump to story)

ACA: the final rule on preventive health services will ensure that women with health insurance coverage will have access to the full range of the Institute of Medicine's recommended preventive services, including all FDA -approved forms of contraception. (jump to story)

EHR Incentive Program: what can still be completed in 2012 in order to receive an incentive payment for CY2011 (jump to story)

5010: National Provider Call: Medicare

FFS Implementation of HIPAA Version 5010 and D.0 Transactions **(jump to story)**

Claims Crossovers: Greater instances of Medicare correspondence letters that make reference to error N22226 as the basis for patient claims not crossing over**(jump to story)**

ICD-10: What's Your Plan, Man?**(jump to story)**

MLN: Medicare Learning Network Announcements, Updates and Revisions **(jump to story)**

Medicare e-prescribing hardship exemptions under review

Last fall, physicians had the opportunity to seek hardship exemptions and avoid penalties for failing to successfully participate in Medicare's e-prescribing program. The Centers for Medicare & Medicaid Services (CMS) is reviewing each hardship exemption request on an individual basis and has not yet completed its analysis. Therefore, it is possible that some physicians will be subjected to a 1 percent Medicare payment penalty inappropriately until the backlog of exemption

requests is reviewed. Ultimately, CMS will reprocess the claims.

Read information regarding remittance advice and information on the impact to physician reimbursement and patient copays. More information on the penalty program can be found here.

Find additional electronic prescribing information and resources on the AMA website.

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The ACA (Affordable Care Act) Mandates Federal Payment to Providers and Suppliers Only by Electronic Means

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 Medicare Learning Network's Special Edition Article #SE1126, titled "Further Details on the Revalidation of Provider Enrollment Information."

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Allowing Physician Assistants to Perform Skilled Nursing Facility (SNF) Level of Care Certifications and Recertifications

http://www.cms.gov/MLNMattersArticles/Downloads/MM7701.pdf

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A Statement by U.S. Department of Health and Human Services Secretary Kathleen Sebelius

In August 2011, the Department of Health and Human Services issued an interim final rule that will require most health insurance plans to cover preventive services for women including recommended contraceptive services without charging a co-pay, co-insurance or a deductible. The rule allows certain non-profit religious employers that offer insurance to their employees the choice of whether or not to cover contraceptive services. Today the department is announcing that the final rule on preventive health services will ensure that women with health insurance coverage will have access to the full range of the Institute of Medicine's recommended preventive services, including all FDA -approved forms of contraception. Women will not have to forego these services because of expensive co-pays or deductibles, or because an insurance plan doesn't include contraceptive services. This rule is consistent with the laws in a majority of states which already require contraception coverage in health plans, and includes the exemption in the interim final rule allowing

certain religious organizations not to provide contraception coverage. **Beginning August 1, 2012, most new and renewed health plans will be required to cover these services without cost sharing for women across the country.**

After evaluating comments, we have decided to add an additional element to the final rule. Nonprofit employers who, based on religious beliefs, do not currently provide contraceptive coverage in their insurance plan, will be provided an additional year, until August 1, 2013, to comply with the new law. Employers wishing to take advantage of the additional year must certify that they qualify for the delayed implementation. This additional year will allow these organizations more time and flexibility to adapt to this new rule. We intend to require employers that do not offer coverage of contraceptive services to provide notice to employees, which will also state that contraceptive services are available at sites such as community health centers, public clinics, and hospitals with income-based support. We will continue to work closely with religious groups during this transitional period to discuss their concerns.

Scientists have abundant evidence that birth control has significant health benefits for women and their families, it is documented to significantly reduce health costs, and is the most commonly taken drug in America by young and middle-aged women. This rule will provide women with greater access to contraception by requiring coverage and by prohibiting cost sharing.

This decision was made after very careful consideration, including the important concerns some have raised about religious liberty. I believe this proposal strikes the appropriate balance between respecting religious freedom and increasing access to important preventive services. The administration remains fully committed to its partnerships with faith-based organizations, which promote healthy communities and serve the common good. And this final rule

will have no impact on the protections that existing conscience laws and regulations give to health care providers.

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Receiving an EHR Incentive Program Payment for CY2011

As 2012 begins, CMS wants to remind eligible professionals (EPs) participating in the Medicare Electronic Health Record (EHR) Incentive Program of important deadlines approaching and what can still be completed in 2012 in order to receive an incentive payment for CY2011.

Important Medicare EHR Incentive Program Dates

On Saturday, December 31, 2011, the reporting year ended for EPs who participated in the Medicare EHR Incentive Program in 2011. What does this mean? For participating EPs, they must have completed their 90-day reporting period by the end of 2011.

However, EPs have until Wednesday, February 29, 2012 to actually register and attest to meeting meaningful use to receive an incentive payment for CY2011 through the Medicare & Medicaid EHR Incentive Program Registration and Attestation System.

Payment Threshold Information

Wednesday, February 29, 2012 is also the deadline for EPs to submit any pending Medicare Part B claims from CY2011, as CMS allows 60 days after Saturday, December 31, 2011 for all pending claims to be processed. This means that EPs have 60 days in 2012 to submit claims for allowed charges incurred in 2011.

Medicare EHR incentive payments to EPs are based on 75% of the

Part B allowed charges for covered professional services furnished by the EP during the entire payment year. If the EP did not meet the $24,000 threshold in Part B allowed charges by the end of CY2011, CMS expects to issue an incentive payment for the EP in April 2012 for 75% of the EP's Part B charges from 2011.

Note for Medicaid Participants: Medicaid incentives will be paid by the states, but the timing will vary according to state. Please contact your State Medicaid Agency for more details about payment.

Want more information about the EHR Incentive Programs? Visit the EHR Incentive Programs website for the latest news and updates on the EHR Incentive Programs.

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

Wednesday, January 25, 2012, 2-3:30pm ET

CMS will host a special National Provider Call regarding the Medicare FFS implementation of *HIPAA* Version 5010 and D.0 transaction standards.

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

Agenda (there will be no slide presentation for this call):

- *HIPAA* Version 5010 implementation update

- Question & answer session

If you would like to submit a question related to this topic in advance of, during, or following the call, please email your inquiry to the 5010 FFS Information resource mailbox at 5010FFSinfo@CMS.hhs.gov. Note that this resource box will only accept emails the day before, the day of, and the day after this call; your emailed questions will be answered as soon as possible, and may not be answered during the call.

Registration Information: In order to receive the call-in information, you must register for the call. *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. For more details, including instructions on registering for the call, please visit http://www.eventsvc.com/blhtechnologies.

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Greater instances of Medicare correspondence letters that make reference to error N22226 as the basis for patient claims not crossing over

On Monday, December 5, 2011, CMS issued a Special Edition MLN Matters Article (SE1137) entitled "Additional *Health Insurance Portability and Accountability Act (HIPAA)* 837 5010 Transitional Changes and Further Modifications to the Coordination of Benefits Agreement (COBA) National Crossover Process." CMS issued this guidance for the benefit of physicians/practitioners, providers, and suppliers to help them understand why they were seeing greater instances of Medicare correspondence letters that made reference to error N22226 as the basis for why their patients' claims could not

be crossed over.

CMS has since learned that concern exists in the provider community concerning whether billing of hardcopy CMS 1500 or UB04 claims or *HIPAA* version 4010A1 or National Council for Prescription Drug Programs (NCPDP) version 5.1 batch claims will result in Medicare being unable to cross those claims over to COBA supplemental payers that have cut-over to exclusive receipt of crossover claims in the version 5010 837 claim formats or NCPDP D.0 batch claim formats. This is not true.

During the 90-day Version 5010 non-enforcement period (Sunday, January 1, 2012 through Saturday, March 31, 2012), Medicare will have the systematic capability to perform up- or down-version conversion of incoming claim formats (ie. convert incoming hardcopy formats to *HIPAA* equivalent claim formats and convert incoming version 4010A1 claim formats to 5010 formats and vice-a-versa), in accordance with external supplemental payer specifications concerning production claims format. *This practice will discontinue, however, at the conclusion of the 90-day non-enforcement period, with the exception below.* (This action is controlled by information that the Common Working File receives concerning individual supplemental payers' ability to accept *HIPAA* 5010 or NCPDP D.0 claim formats in "production" mode.)

Note that physicians/practitioners, providers, and suppliers that have authorization under the *Administrative Simplification Compliance Act (ASCA)* to submit claims using a hardcopy format should know that Medicare has the systematic capability to convert keyed claims into outbound-compliant *HIPAA* 837 claim formats for crossover claim transmission purposes. This is true at all times, not just during the 90-day non-enforcement period.

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What's Your Plan, Man?

Is your organization preparing for a smooth transition to ICD-10 on Tuesday, October 1, 2013? ICD-10 National Provider Calls, hosted by the CMS Provider Communications Group, can help you prepare for the US healthcare industry's change from ICD-9 to ICD-10 for diagnosis and inpatient procedure coding.

Video slideshow presentations from the following National Provider Calls are available on the CMS YouTube Channel. These video slideshows include the call slide presentation and audio with captions; each call includes presentations by CMS subject matter experts, followed by a question and answer session.

- *ICD-10 Implementation Strategies and Planning – Thursday, November 17, 2011*

The ICD-9-CM and ICD-10 Cooperating Parties – CMS, the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), and the Centers for Disease Control and Prevention (CDC) – discuss ICD-10 implementation strategies and planning, and the CMS Provider Billing Group discuss the Medicare FFS claims processing guidance issued in August 2011.

- *ICD-10 Implementation Strategies for Physicians – Wednesday, August 3, 2011*

CMS subject matter experts discuss how physician offices can prepare for the change to ICD-10 for medical diagnosis and inpatient procedure coding and provide updates on national ICD-10 implementation issues affecting all providers.

- *CMS ICD-10 Conversion Activities – Wednesday, May 18, 2011*

CMS subject matter experts discuss the ICD-10 conversion

process currently taking place within CMS, including a case study from the Coverage and Analysis Group on their transition to ICD-10 for the lab national coverage determinations (NCDs).

Podcasts, complete audio files, and complete written transcripts for these ICD-10 National Provider Calls are also available on the CMS ICD-10 webpage at http://www.CMS.gov/ICD10/Tel10/list.asp.

Available 24/7, YouTube video presentations and podcasts make learning about the ICD-10 transition easy and convenient. Check them out today.

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Medicare Learning Network Announcements, Updates and Revisions

From the MLN: "Health Professional Shortage Area Bonus Payment Policy Reminders" MLN Matters Article Released – A new MLN Matters® Special Edition Article #SE1202, "Health Professional Shortage Area (HPSA) Bonus Payment Policy Reminders," has been released in downloadable format. This article is designed to provide education on the HPSA Bonus Payment Program, and provides information about the program and resources that providers can use to determine whether they are eligible to receive the bonus payment.

From the MLN: New "Medicare Coverage of Radiology and Other Diagnostic Services" Fact Sheet Released – A new "Medicare Coverage of Radiology and Other Diagnostic Services" fact sheet (ICN 907164) has been released in downloadable format. **This fact sheet is designed to provide education on Medicare coverage and billing information for radiology and other diagnostic services, and includes specific information concerning billing and coding requirements and an overview of**

coverage guidelines.

From the MLN: New Fast Fact on MLN Provider Compliance Webpage – A new fast fact is now available on the MLN Provider Compliance webpage. This page provides the latest educational products designed to help Medicare Fee-For-Service providers understand – and avoid – common billing errors and other improper activities. Please bookmark this page and check back often as a new fast fact is added each month!

From the MLN: "Acute Care Hospital Inpatient Prospective Payment System" Fact Sheet Revised – The "Acute Care Hospital Inpatient Prospective Payment System" fact sheet (ICN 006815) has been revised and is available in downloadable format. This fact sheet includes information on payment background, the basis for the Acute Care Hospital Inpatient Prospective Payment System payment, payment rates, and how payment rates are set.

From the MLN: "Items and Services That Are Not Covered Under the Medicare Program" Booklet and "Medicare Claim Submission Guidelines" Fact Sheet Now Available in Hardcopy – The "Items and Services That Are Not Covered Under the Medicare Program" booklet (ICN 906765), available now in hardcopy, includes information about the four categories of items and services that are not covered under the Medicare program and applicable exceptions to exclusions and the Advance Beneficiary Notice of Noncoverage.

The **"Medicare Claim Submission Guidelines"** fact sheet (ICN 906764), available now in hardcopy as well, includes information about applying for a National Provider Identifier and enrolling in the Medicare program, filing Medicare claims, and private contracts with Medicare beneficiaries.

From the MLN: "Medicare Claim Review Programs" Booklet Revised – The revised "Medicare Claim Review Programs: MR, NCCI Edits, MUEs, CERT, and RAC" booklet (ICN 006973) is

designed to provide education on the different CMS claim review programs and assist providers in reducing payment errors, including, in particular, coverage and coding errors. It includes frequently asked questions, resources, and an overview of the various programs, including Medical Review, Recovery Audit Contractor, and the Comprehensive Error Rate Testing Program.

From the MLN: "Substance (Other Than Tobacco) Abuse Structured Assessment and Brief Intervention (SBIRT)" Fact Sheet Revised – This revised "Substance (Other Than Tobacco) Abuse Structured Assessment and Brief Intervention (SBIRT)" fact sheet (ICN 904084) is designed to provide education on SBIRT, 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.

From the MLN: "Non-Specific Procedure Code Description Requirement for *HIPAA* Version 5010 Claims" MLN Matters Article Released – The new "Non-Specific Procedure Code Description Requirement for *HIPAA* Version 5010 Claims" MLN Matters Special Edition Article (#SE1138) is designed to provide education on the requirements for non-specific procedure codes for *HIPAA* 5010 claims, as established in Change Request 7392. It includes guidance to help providers comply with the requirements and submit *HIPPA*-compliant claims for all non-specific procedure codes.

From the MLN: "Federally Qualified Health Center" Fact Sheet Revised – The revised "Federally Qualified Health Center" fact sheet (ICN 006397) includes the following information: 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.

From the MLN: **Medicare Preventive Services Series: Part 2, Web-Based-Training Course (WBT) Revised –** This WBT is designed to provide education on Medicare Preventive Services. It includes information on Medicare's coverage for the initial preventive physical exam (IPPE), ultrasound screening for abdominal aortic aneurysm (AAA), screening electrocardiogram (EKG), Annual Wellness Visit (AWV), cardiovascular screening blood tests, diabetes-related services, human immunodeficiency virus (HIV) screening and smoking and tobacco-use cessation counseling services. To access the WBT, visit the MLN Products page, scroll to the "Related Links Inside CMS," and select the "Web-Based Training (WBT) Courses."

From the MLN: **MLN Guided Pathways (Basic, A, and B) Provider-specific Resource Booklets Revised** – The revised MLN Guided Pathways curriculum is designed to allow learners to easily identify and select resources by clicking on topics of interest. The curriculum begins with basic knowledge for all providers and then branches to information for either those enrolling on the 855B, I, and S forms or on the 855A form (or Internet-based PECOS equivalents). The resource booklets are:

- MLN Guided Pathways to Medicare Resources – Basic Curriculum for Health Care Professionals, Suppliers, and Providers
- MLN Guided Pathways to Medicare Resources Intermediate Curriculum for Health Care Providers (Part A)
- MLN Guided Pathways to Medicare Resources Intermediate Curriculum for Health Care Professionals and Suppliers (Part B)

From the MLN: **"MLN Guided Pathways Provider-specific" Resource Booklet Revised –** The Revised MLN Guided Pathways to Medicare Resources provider-specific resource booklet provides various specialties of healthcare professionals, (physicians, chiropractors, optometrists, podiatrists), nurses (APN, RNCNS, NP, Midwife) PAs, social workers, psychologists, therapists (OT, PT, SLP), dietitians, nutritionists, *suppliers*

(ambulance, ASC, DMEPOS, FQHC, RHC, Labs, mammography, radiation therapy, portable x-ray), and *providers* (CMHC, CORF, ESRD, HHA, hospice, OPT, pathology and SNF) with resources specific to their specialty including Internet-Only Manuals (IOMs), Medicare Learning Network® publications, CMS webpages, and more. This version includes the addition of pathways for Anesthesiology Assistant/Certified Registered Nurse Anesthetist, Anesthesiologist, Ophthalmologist, and Optometrist, along with a fully developed pathway for Mass Immunization Roster Biller.

All of the MLN Guided Pathways booklets above are available at http://www.CMS.gov/MLNEdWebGuide/30_Guided_Pathways.asp.

From the MLN: "Preventive Services Educational Resources for Health Care Professionals" MLN Matters® Article Released – The new "Preventive Services Educational Resources for Health Care Professionals" MLN Matters® Special Edition Article (#SE1142) is designed to provide education on available educational resources related to Medicare-covered preventive services. It includes a list of MLN products that can help Medicare FFS providers understand coverage, coding, reimbursement, and billing requirements related to these services.

From the MLN: "Advanced Payment Accountable Care Organization Model" Fact Sheet Available – The new "Advanced Payment Accountable Care Organization Model" fact sheet (ICN 907403) is designed to provide education on the advance payment model for Accountable Care Organizations (ACOs). It includes a summary of the Advance Payment ACO Model, background, and information on the structure of payments, recoupment of advance payments, eligibility, and the application process.

From the MLN: "Summary of Final Rule Provisions for Accountable Care Organizations Under the Medicare Shared Savings Program" Fact Sheet Available – The new "Summary of Final Rule Provisions for Accountable Care Organizations Under the Medicare Shared Savings Program" fact sheet (ICN 907404)

is designed to provide education on the provisions of the final rule that implements the Medicare Shared Savings Program with ACOs. It includes background, information on how ACOs impact beneficiaries, eligibility requirements to form an ACO, and information on monitoring and tying payment to improved care at lower costs.

From the MLN: "Improving Quality of Care for Medicare Patients: Accountable Care Organizations" Fact Sheet Available – The new "Improving Quality of Care for Medicare Patients: Accountable Care Organizations" fact sheet (ICN 907407) is designed to provide education on improving quality of care under ACOs. It includes a table of quality measures under the program.

From the MLN: "Medicare Shared Savings Program and Rural Providers" Fact Sheet Available – The new "Medicare Shared Savings Program and Rural Providers" fact sheet (ICN 907408) is designed to provide education on how the Medicare Shared Savings Program impacts rural providers. It includes information on federally qualified health centers, rural health clinics, critical access hospitals, and how this program impacts them.

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Provider Revalidation: CMS Answers Your Questions on

October 27th National Provider Call

CMS will hold a National Provider Call to discuss the revalidation of Medicare provider enrollment information on Thursday, October 27th, 2011; from 12:30 – 2PM Eastern. Most providers and suppliers who are enrolled in the Medicare program will have to revalidate their enrollment which will be reviewed under the new risk screening criteria required by the *Affordable Care Act* Section 6401(a). Learn what you can expect and how to prepare for this process.

Target Audience: All providers and suppliers enrolled with Medicare prior to March 25, 2011 and who expect to receive payment from Medicare for services provided!!!!!! (I had to add those exclamation points – what a statement – if you expect to be paid, you need to revalidate.)

The agenda will include:

1. What is Revalidation?
2. ACA Screening Requirements
3. Electronic Funds Transfer
4. Streamlining the Process
5. Phased Revalidation
6. Tips on Revalidation
7. Question and Answer Session (my favorite!)

***Registration Information*:** In order to receive the call-in information, you must register for the call. Registration will close at 12pm on Thursday, October 27, 2011 or when available space has been filled; no exceptions will be made, so please register early. For more details, including instructions on registering for the call, click **here.** The audio recording and written transcript will be posted after the call.

Presentation: The presentation will be posted at least one day before the call in the "Downloads" section of the page **here.**

For more information about provider enrollment revalidation, review the Medicare Learning Network's® publication **here.**

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.