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

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Starting July 1, 2012, Medicare Fee For Service Will Reject 4010 Transactions: Are You Ready?

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

Claims (837 I and P)

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

Avoid Common 5010 Beginner's

Mistakes

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

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

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

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

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

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

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

Exclusion Criteria

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

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

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

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

Avoiding the 2013 eRx Payment Adjustment

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

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

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

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

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

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

Significant Hardships

The significant hardship categories are as follows:

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

Submitting a Significant Hardship Code or Request

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

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

For additional information and resources, please visit the E-

Prescribing Incentive Program webpage.

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

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Major Improvements to Medicare PECOS Online Enrollment System

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

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

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Register Early for Maximum Benefits from the EHR Incentive Program

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

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

Register Today to Receive Maximum Incentives

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

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Guest Author Attorney Jennifer Searfoss: Reading the Tea Leaves – New Cost

Controls on Horizon for Medicare Advanced Imaging Services

It’s a stark reality – at this time in American history, we are at the (or near the) highest level of funding for health care. The Ryan Medicare proposal and continued debate inside the Beltway and by state lawmakers makes it clear that while experts estimate that by 2082 health care spending could be 49% of our gross domestic product, this is not a sustainable reality. Further, as baby boomers retire, the contribution of working aged people through taxes and direct employer contribution to health care costs will fall.

Thus, lawmakers have been investigating ways to reduce health care costs for America’s elderly. A report released by the non-partisan Medicare Payment Advisory Commission (MedPAC) last week includes a number of recommendations for reforms aimed at “explor[ing] every avenue for protecting the access of Medicare beneficiaries to high-quality care while reducing the rate of growth in Medicare expenditures.” Chapter 2 of the report addresses “Improving payment accuracy and appropriate use of ancillary services” with recommendations to the Stark law, interim payment reforms for imaging services and a requirement for “high-use practitioners to participate in a prior authorization program for advanced diagnostic imaging services.”

MedPAC observes that “Physician self-referral of ancillary services leads to higher volume when combined with [fee-for-service] payment systems, which reward higher volume, and the mispricing of individual services, which makes some services more profitable than others.” Known as the Stark law, an exception permits physicians to self-refer Medicare and Medicaid patients to imaging equipment that they own under

certain circumstances. MedPAC chooses in this report to not recommend changes to the Stark law. Instead, “the preferred long term-approach to address self-referral is to develop new payment systems.” However, the Commission notes that in the future, the scope should be limited on the in-office ancillary exception to only physicians in accountable care organization models that have financial incentives to improve quality and reduce unnecessary service volume.

The payment reform recommendations include three changes that MedPAC feels address mispricing and overutilization:

- Bundled payment for like imaging services.
- Multiple procedure payment reduction application to the professional component of diagnostic imaging services when read during the same session by the same practitioner.
- Reduce the work component of relative value units (RVUs) for diagnostic imaging service that are ordered and read by the same practitioner

The final recommendation is to adopt a prior authorization program for advanced imaging services such as MRI, CT and nuclear medicine. Supported by a 2008 Government Accountability Office report, the proposal would target only high volume ordering physicians and high cost services. “The focus on outlier physicians – rather than all physicians – would reduce CMS’ administrative costs and limit the burden on practitioners and beneficiaries.”

The upshot is that your office is familiar with prior authorization programs for commercial patients and Medicare beneficiaries enrolled in Medicare Advantage programs. Therefore, the things to consider as Congress and the Administration evaluate efforts to reduce imaging costs:

- How would revisions to advanced imaging service payment

(bundled payment for like services, multiple procedure reductions and work RVU reductions) affect your office and how you pay your physicians? Are they prepared for take-home pay reductions?

- What clinical guidelines are used for evaluating which services are "medically necessary"? How do these guidelines differ from other payers? How would you implement these requirements in your office?
- How does your office educate patients of services evaluated for medical necessity and what documentation do you use to demonstrate that they knew they would be billed for services that were rendered but determined by their insurer to not be medically necessary?

You can bet that strong lobbying on all sides of this issue will continue over the summer and likely over the next several years. Already, one letter has been sent to MedPAC regarding the report – the Access to Medical Imaging Coalition expressed concern over the prior authorization proposal as it "impedes patient access to needed care, places huge administrative burdens on providers and has not been shown to reduce costs over the long term." I'm going to bring popcorn and find a good sideline seat for the next MedPAC meeting in September.

Personally, I look forward to the industry figuring out how prior authorization can be accomplished electronically rather than by fax. Last time I checked, we are supposed to be a fully electronic industry by 2014. Right?

Read the MedPac Report **here.**

Note these two related stories:

Hospitals Allegedly Performed Double CT Scans On Many Medicare Patients.

The New York Times (6/18, A1, Bogdanich, McGinty, Subscription Publication) reported on its front page that "hundreds of

hospitals across the country needlessly exposed patients to radiation" by giving them CT scans "twice on the same day, according to federal records and interviews with researchers. Performing two scans in succession is rarely necessary, radiologists say, yet some hospitals were doing that more than 80 percent of the time for their Medicare chest patients."

The Washington Post (6/18, Appleby, Rau) noted that "imaging tests are among the fastest growing procedures in health care" and that double CT scans drive up healthcare costs. The Medicare's Hospital Compare website publishes hospital rates of double chest scans in the hope that publicizing the numbers will incentivize hospitals to reduce this practice. The Post also adds that "hospitals and radiologists are paid more for the double scans, so they have a disincentive to crack down on them."

Attorney and Policy Analyst Jennifer Searfoss was formerly the Vice President of External Provider Relations for UnitedHealthcare, a Minnesota-based health insurance company. Between 2001 and 2007, Jennifer worked for the Washington, DC-based Government Affairs Department of the Medical Group Management Association (MGMA), a national trade association based out of Englewood, Colorado. Jennifer received her undergraduate degree in health science and policy from the University of Maryland, Baltimore County and law degree from the University of Maryland. After a brief departure, Jennifer has returned home and lives in Annapolis, Maryland with her Rottweiler, Argus, and her first client of every day – her beloved Quarter Horse – Pressed for Time. She can be contacted **here** or at 410-703-2635, **Searfoss Consulting Group, LLC.**