Medicare This Week: June 22nd, 2012, Only 8 days Left For 2013 eRx Exemption, National Provider Call on Certified EHR Programs, New CME Modules

- **Only 8 Days Left to Apply for a 2013 ePrescribing Exemption: Will You Face a 1.5% Adjustment? (jump to story)**
- **Register Now: CMS National Provider Call on Certified EHR Technology (jump to story)**
- **Two New CME Modules on Medscape: Fraud and Abuse (jump to story)**

If You Are Not Currently ePrescribing, and Have Not Applied for a Hardship Exemption, You Have Until July 1st, 2012 to Do So

Reminder from CMS. All Emphasis Mine.

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 more information on how to navigate the Communication Support Page, please reference the following documents:

- Quality Reporting Communication Support Page User Guide
- Tips for Using the Quality Reporting Communication Support Page

For additional information and resources, please visit the E-Prescribing Incentive Program web page.

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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Registration Open for National Provider Call on Certified EHR Technology

If you are feeling “a little lost” about switching from a paper record, Meaningful Use, and choosing an EHR to get you started, this is the national provider call for you!

Wednesday, June 27; 2-3:30pm ET

Join CMS and the Office of the National Coordinator for Health Information Technology (ONC) for a National Provider Call providing an overview of the use of certified EHR technology to meet meaningful use. Learn about the different types of certification and what certification actually tests. As of April 30, over $5 billion has been paid in EHR incentives under both programs. This is the last year Medicare eligible professionals can begin to participate to earn the full Medicare Electronic Health Record (EHR) incentive payments.

Target Audience: Eligible Professionals and Eligible Hospitals as defined by the Medicare and Medicaid EHR Incentive Programs.

Agenda:

- **Overview of Meaningful Use**
- **How and Why of Certification**
- **Which EHR Products are Certified**
- **Resources**
- **Q&A with CMS and ONC experts**

Registration Information: In order to receive call-in information, you must register for the call on the CMS Upcoming National Provider Calls web page. 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 prior to the call on the FFS National Provider Calls web page. In addition, a link to the slide presentation will be emailed to all registrants on the day of the call.

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Two New CME Modules Now Available on Medscape on Fraud and Abuse

In early June, Medscape posted two new CME modules entitled, “Reducing Medicare and Medicaid Fraud and Abuse: Protecting Practices and Patients” and “How CMS Is Fighting Fraud: Major Program Integrity Initiatives.” These modules highlight efforts by CMS to fight fraud and abuse and how health care professionals can be part of those efforts.

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CMS Starts Screening Providers and Suppliers and Adds Site Visits and Fingerprint-based Criminal Background Checks to the Process

The Centers for Medicare & Medicaid Services (CMS) has the continuing goal of reducing fraud, waste, and abuse through all available avenues. The *Affordable Care Act* requires CMS to determine the level of screening to be conducted during

provider and supplier enrollment based on the **level of risk posed to the Medicare system.** With the enactment of the *Affordable Care Act*, CMS has the increased ability to focus efforts on prevention, rather than simply acting after the fact. The use of risk categories and associated screening levels will help ensure that only legitimate providers and suppliers are enrolled in Medicare, Medicaid, and CHIP, and that only legitimate claims are paid.

Effective Friday, March 25, 2011, newly-enrolling and revalidating providers and suppliers will be placed in one of three screening categories ”“ limited, moderate, or high. These categories represent the level of risk for fraud, waste, and abuse to the Medicare program for the particular category of provider/supplier, and determine the degree of screening to be performed by the Medicare Administrative Contractor (MAC) processing the enrollment application.

Providers/suppliers in the “limited” screening category will include:

- Physicians
- Non-physician practitioners other than physical therapists
- Medical groups or clinics
- Ambulatory surgical centers
- Competitive Acquisition Program / Part B Vendors
- End-Stage Renal Disease facilities
- Federally-Qualified Health Centers
- Histocompatibility laboratories

- Hospitals (including Critical Access Hospitals, Department of Veterans Affairs hospitals, and other federally-owned hospital facilities)
- Health programs operated by an Indian Health Program (as defined in section 4(12) of the *Indian Health Care Improvement Act*) or an urban Indian organization (as defined in section 4(29) of the *Indian Health Care Improvement Act*) that receives funding from the Indian Health Service pursuant to Title V of the *Indian Health Care Improvement Act*
- Mammography screening centers
- Mass immunization roster billers
- Organ procurement organizations
- Pharmacies that are newly enrolling or revalidating via the CMS-855B application
- Radiation Therapy Centers
- Religious non-medical health care institutions
- Rural Health Clinics
- Skilled Nursing Facilities

Providers in the "moderate" screening category will include:

- Ambulance service suppliers
- Community Mental Health Centers (CMHCs)
- Comprehensive Outpatient Rehabilitation Facilities (CORFs)
- Hospice organizations
- Independent clinical laboratories

o Independent Diagnostic Testing Facilities (IDTFs)

o Physical therapists enrolling as individuals or as group practices

o Portable x-ray suppliers (PXRS)

o Revalidating Home Health Agencies (HHAs)

o Revalidating DMEPOS suppliers

Providers in the “high” screening category will include:

o Newly-enrolling DMEPOS suppliers

o Newly-enrolling Home Health Agencies (HHAs)

o Providers and suppliers reassigned from the “limited” or “moderate” categories due to triggering events.

Triggering events include the following instances:

- imposition of a payment suspension within the previous 10 years;
- a provider or supplier has been terminated or is otherwise precluded from billing Medicaid;
- exclusion by the OIG;
- a provider or supplier has had billing privileges revoked by a Medicare contractor within the previous 10 years and such provider/supplier is attempting to establish additional Medicare billing privileges by enrolling as a new provider or supplier or establish billing privileges for a new practice location;
- a provider or supplier has been excluded from any federal health care program;
- a provider or supplier has been subject to any final

adverse action (as defined in 42 CFR 424.502) within the past 10 years; or

- instances in which CMS lifts a temporary moratorium for a particular provider or supplier type and a provider or supplier that was prevented from enrolling based on the moratorium, applies for enrollment as a Medicare provider or supplier at any time within 6 months from the date the moratorium was lifted.

The enrollment screening procedures will vary depending upon the categories described above. Screening procedures for the "limited" screening category will largely be the same as those currently in use; screening procedures for the "moderate" screening category will include all current screening measures, as well as a **site visit**; screening procedures for the "high" screening category will include all current screening measures, as well as a site visit and, at a future date a **fingerprint-based criminal background check**.

CMS will continuously evaluate whether a change of the assignment of categories of providers and suppliers to the various risk categories is necessary. If CMS assigns certain groups of providers and/or suppliers to a different category, this change will be proposed in the *Federal Register*. However, CMS will not publish a notice or a proposed rule in the *Federal Register* that would include instances in which an individual provider/supplier is reassigned based upon meeting one or more of the triggering events.