Healthcare Reform: Talking to Patients and Staff

> *At Manage My Practice we like to keep our posts informative and actionable – and not political. I've tried to provide the facts about the reforms, and how they could affect your patients and staff in an unbiased and professional manner – exactly how you would present them as an administrator. I hope you find it useful. – Abe*

The process of passing and implementing a law is a long and winding road, but President Obama's Healthcare Reforms cleared a significant hurdle on Thursday when the Supreme Court upheld most of the law as constitutional against challenges from many of the states as well as business organizations. You have probably been getting a lot of questions from employees, patients, friends and relatives, and even your providers and colleagues, and they all basically boil down to this: **How does the law affect me?**

As Managers and Administrators, one of the most basic ways you influence outcomes for your employees, your patients, and ultimately, your organization is **to be informed, and to inform others**. Can you give a basic overview of the law that was passed to a worried patient? Have your staff gotten any information about handling patient questions? Do your providers have a basic idea of how the practice will respond to the changes? Many states and organizations have been delaying plans for the changes in the PPACA because of the court challenges to the law (many were plaintiffs in the suit) or for this November's elections, which could put a President in the White House who has promised to repeal the law. On top

of that, even if President Obama wins another term, a Republican-controlled Congress could choose not to fund certain programs so that the law could not be put into place. For the moment however, **the Affordable Care Act is the law of the land for the immediate future, and something all managers need to have a basic grasp on**.

What's changing for individuals?

The goal of the legislation is to decrease the number of uninsured people in the country by tweaking existing federal programs like Medicaid and Medicare, and issuing new regulations on the health insurance industry as well as on private businesses and individual citizens.

By the year 2014 everyone will have a responsibility to carry some kind of health insurance. If you don't get healthcare coverage through your work or your family, or through an existing program like Medicare, Medicaid, or Tricare, you will have to purchase a minimum level of private insurance or face a penalty. Subsidies to help pay for the required insurance will be available to individuals and families who make up to 400% of the poverty level on a sliding scale.

One example from Wikipedia, of how that would work in real life: A family of four whose income is at 150% of the Federal Poverty Level (~$34,000 a year) would be subsidized so that their monthly premiums would be about 2% of income, or $50.

To further help individuals comply with the mandate to have insurance coverage, by 2014 each state will set up a Health Insurance "Exchange" a marketplace where individuals can compare benefits and premiums for health insurance, and find out if they qualify for federal subsidies.

Are My Taxes Going Up?

In addition to the individual mandate, in 2013 **people with income $200,000 a year or more ($250,000 a year for couples) will have their Medicare Tax increased** from 1.45% to 2.35% on the income above the limit. The Medicare Tax on Net Investment Income over the $200,000 limit will be raised from 2.9% to 3.8%. These increased Medicare taxes on high income individuals account for roughly half of the new income to pay for the bill. Other new taxes on individuals include a **40% excise tax on "Cadillac Plans"** or insurance plans that cost more than $10,200 a year for an individual ($27,500 for a family) starting in 2018, and a **10% sales tax on tanning services** that began in 2010. New restrictions will also be placed on Healthcare Savings Accounts and Medical Expenses taken as tax deductions.

How will Insurance Change?

Although people will be required to carry some form of policy, new regulations on insurance companies should increase the overall benefit to the private citizen for purchasing coverage. For example, **insurance companies can no longer deny (or overcharge for) coverage to people with pre-existing medical conditions, cannot drop someone's coverage who becomes ill, and cannot impose either lifetime or annual caps on how much a policy will pay out in benefits**. Insurance now also has to pay for **basic preventative care like wellness visits without co-pays or deductibles**, and children can stay on their parents' insurance until their 26th birthday- *even if the child is not a financial dependent, or is married*. Insurance companies also have to adhere to a "Medical Loss Ratio", which means that they have to spend a certain amount of the money they collect from your premiums on either medical services or quality improvement. Every year the insurance companies must report how much of the premiums they collect are spent on

these medical losses, and if they spend less than the ratio (80% for individual and small group plans, 85% for large group plans), **the difference is refunded to the policyholder**.

What about Medicare and Medicaid?

Federal Health Plans Medicare and Medicaid will also be changed. Medicare enrollees who hit the “donut hole” in the prescription drug benefit receive a 50% discount on covered name-brand drugs, and the benefit will continue to increase **until the “donut hole” is completely closed in 2020**. Also, federal money will be made available to the states to expand Medicaid coverage to anyone who makes up to 133% of the Federal Poverty Line. At the time of this writing, the governors of two states, Florida and Louisiana, have already indicated that they will not take the additional Medicaid funding from the federal government.

As Managers, Providers and Employees, what are some of the questions you’ve been getting about the ACA, and how have you been answering them?

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

- Starting July 1, 2012, Medicare Fee For Service Will Reject 4010 Transactions: Are You Ready? plus How to Avoid Common 5010 Rejections (jump to story)
- Are You Facing a 1.5% Medicare ePrescribing Payment Adjustment in 2013? Find Out If You Qualify For a Hardship Exemption (jump to story)
- Major Improvements to Medicare PECOS Online Enrollment System (jump to story)
- Register Early for Best Results from the EHR Incentive Program; 2012 Is Your Last Chance to Get Started for Full Benefits (jump to story)

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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Medicare This Week: Private E/M Billing Reports, Two Free Calls on eRx and 5010,

Revised Medicare Conditions of Participation

- CMS to Start Accepting Suggestions for PQRS Measures and Measure Groups (jump to story)

- New Rules Finalized by Health and Human Services to Cut Regulations for Hospitals and Health Care Providers (jump to story)

- Denise Buenning from CMS Answers the Industry's Top Questions about the Version 5010 Upgrade (jump to story)

- Last Chance to Register for National Provider Call – Physician Quality Reporting System & Electronic Prescribing (eRx) (jump to story)

- CMS to Release a Comparative Billing Report on Evaluation and Management Services (jump to story)

- New and Revised Articles Posted to MLN Matters (jump to story)

- **Updates from the Medicare Learning Network** **(jump to story)**

- **May is Hepatitis Awareness Month and May 19 is National Hepatitis Testing Day** **(jump to story)**

CMS to Start Accepting Suggestions For PQRS Measures and Measure Groups

From June 1st, 2012 to 5PM ET on August 1st, 2012, CMS will be accepting suggestions for Measures and/or Measure Groups in the Physicians Quality Reporting System. This is your chance to make your voice heard on the quality measures that will determine performance!

For more information on the PQRS Call for Measures, visit the CMS page here.

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New Rules Finalized by Health and Human Services to Cut Regulations for Hospitals and Health Care Provider

HHS Finalizes New Rules to Cut Regulations for Hospitals and

Health Care Providers, Savings More Than $5 Billion

Changes Will Reduce Costs and Allow More Focus on Medical Care

On May 9, HHS Secretary Kathleen Sebelius announced significant steps to reduce unnecessary, obsolete, or burdensome regulations on American hospitals and health care providers. These steps will help achieve the key goal of President Obama's regulatory reform initiative to reduce unnecessary burdens on business and save nearly $1.1 billion across the health care system in the first year and more than $5 billion over five years.

The new rules were issued on May 9 by CMS. The first rule revises the Medicare Conditions of Participation (CoPs) for hospitals and critical access hospitals (CAHs). CMS estimates that annual savings to hospitals and CAHs will be approximately $940 million per year.

The second, the Medicare Regulatory Reform rule, will produce savings of $200 million in the first year by promoting efficiency. This rule eliminates duplicative, overlapping, and outdated regulatory requirements for health care providers.

Among other changes, the final rules will:

- Increase flexibility for hospitals by allowing one governing body to oversee multiple hospitals in a single health system;
- Let CAHs partner with other providers so they can be more efficient and ensure the safe and timely delivery of care to their patients;
- Require that all eligible candidates, including advanced practice registered nurses and physician assistants, be reviewed by medical staff for potential appointment to the hospital medical staff and then be granted all of the privileges, rights, and responsibilities accorded to appointed medical staff members; and
- Eliminate obsolete regulations, including outmoded

infection control instructions for ambulatory surgical centers; outdated Medicaid qualification standards for physical and occupational therapists; and duplicative requirements for governing bodies of organ procurement organizations.

View the Medicare CoPs final rule and the Medicare Regulatory Reform final rule. For additional information on the Hospital and other CoPs, visit the Conditions for Coverage (CfCs) & Conditions of Participations (CoPs) website.

Full text of this excerpted CMS press release (issued May 9).

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Denise Buenning from CMS Answers the Industry's Top Questions about the Version 5010 Upgrade

Upgrading to Version 5010 involves significant planning and preparation. The Version 5010/4010A electronic standards upgrade deadline was January 1, 2012. However, CMS enacted an enforcement discretion period through June 30, 2012 for all HIPAA-covered entities. It you haven't upgraded to Version 5010, it is important to begin testing now.

Denise Buenning, MsM, Acting Deputy Director, Office of E-health Standards & Services (OESS) recently took time to answer some of the industry's top questions on the Version 5010 upgrade.

Is the industry up to date with the

Version 5010 upgrade and taking steps to prepare for the ICD-10 transition?

Yes, we are hearing that the industry is progressing with Version 5010 implementation. We also continue to see from the Medicare Fee-For-service (FFS) group consistent increases across the board for 5010 transaction volumes and number of 5010 submitters. We are also hearing that the industry is continuing to take steps to prepare for ICD-10. ICD-10 is a major undertaking for providers, payers, and vendors. It will drive business and systems changes throughout the health care industry, from large national health plans to smaller provider offices, laboratories, hospitals, and more. The updates will go much more smoothly for organizations that plan ahead and prepare now. A successful upgrade to Version 5010 now and transition to ICD-10 later will be vital to transforming our nation's health care system.

What steps should I take if I am behind in the upgrade to Version 5010?

There are a number of things that HIPAA-covered entities should do now. Communication among plans, providers, clearinghouses, and vendors, as well as other trading partners, is critical. Below outlines three steps providers can take now:

- Reach out to clearinghouses for assistance and/or take advantage of any free or low cost software that may be available from payers.
- Check with payers now to see what plans they will have in place to handle incoming claims, and what interim alternatives are available.
- Consider contacting financial institutions to establish lines of credit to get through any possible temporary interruptions in claims reimbursement as a result of not being Version

5010 compliant.

- CMS has developed a fact sheet for health care providers, which discusses the risk mitigation steps in more detail.

How is CMS helping the industry prepare?

o The Workgroup for Electronic Data Interchange (WEDI) and CMS are holding a webinar on ASCX12 5010 implementation and problem solving on May 23 from 1-2:30pm ET. Registration is free. These online presentations are designed to gather feedback, track challenges and provide guidance to correcting ASC X12 5010 implementation-related issues.

o WEDI and CMS previously held a webinar on ASCX12 5010 implementation, and a replay of the webinar with the slides presented is located online.

o Additionally, the CMS website has official resources to help the industry prepare for Version 5010 and ICD-10. CMS will continue to add new tools and information to the site throughout the course of the transition. Sign up for ICD-10 Email Updates and follow @CMSgov on Twitter for the latest news and resources.

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Last Chance to Register for National Provider Call – Physician Quality Reporting System &

Electronic Prescribing (eRx)

CMS will host a National Provider Call with question and answer session. CMS subject matter experts will provide an overview of the 2013 Electronic Prescribing Payment Adjustment and an overview of the 2012 Physician Quality Reporting System Medicare EHR Incentive Pilot.

Target Audience: All Medicare Fee-For-Service Providers, Medical Coders, Physician Office Staff, Provider Billing Staff, Electronic Health Records Staff, and Vendors

Registration Information: In order to receive call-in information, you must register for the call on the CMS Upcoming National Provider Calls webpage. 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.

Providers and suppliers can now submit their enrollment applications 30 days sooner. CMS-855 enrollment applications and Internet-based PECOS applications may now be submitted 60 days prior to the effective date.

NOTE: This does not apply to providers and suppliers submitting a Form CMS-855A application, Ambulatory Surgical Centers (ASCs), or Portable X-ray Suppliers (PXRSs).

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CMS to Release a Comparative Billing Report on Evaluation and

Management Services

On June 4, CMS will release a national provider Comparative Billing Report (CBR) addressing Evaluation and Management Services.

CBRs produced by SafeGuard Services under contract with CMS, contain actual data-driven tables and graphs with an explanation of findings that compare provider's billing and payment patterns to those of their peers located in the state and across the nation.

These reports are not available to anyone except the providers who receive them. To ensure privacy, CMS presents only summary billing information. No patient or case-specific data is included. These reports are an example of a tool that helps providers better understand applicable Medicare billing rules and improve the level of care they furnish to their Medicare patients. CMS has received feedback from a number of providers that this kind of data is very helpful to them and encouraged us to produce more CBRs and make them available to providers.

For more information and to review a sample of the Evaluation and Management Services CBR, please visit the CBR Services website or call the SafeGuard Services' Provider Help Desk, CBR Support Team at 530-896-7080.

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New and Revised Articles Posted to MLN Matters

Examining the Difference between a National Provider Identifier (NPI) and a Provider Transaction Access Number

(PTAN) http://www.cms.gov/Outreach-and-Education/Medicare--Learning-Network-MLN/MLNMattersArticles/Downloads/SE1216.pdf

Negative Pressure Wound Therapy Interpretive Guidelines

http://www.cms.gov/Outreach-and-Education/Medicare--Learning-Network-MLN/MLNMattersArticles/Downloads/SE1222.pdf

Assigned Codes for Home Oxygen Use for Cluster Headache (CH) in a Clinical Trial (ICD-10)

http://www.cms.gov/Outreach-and-Education/Medicare--Learning-Network-MLN/MLNMattersArticles/Downloads/MM7820.pdf

July 2012 Integrated Outpatient Code Editor (I/OCE) Specifications Version 13.2

http://www.cms.gov/Outreach-and-Education/Medicare--Learning-Network-MLN/MLNMattersArticles/Downloads/MM7841.pdf

July Quarterly Update for 2012 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule

http://www.cms.gov/Outreach-and-Education/Medicare--Learning-Network-MLN/MLNMattersArticles/Downloads/MM7822.pdf

Calendar Year 2013 and After Payments to Home Health Agencies That Do Not Submit Required Quality Data

http://www.cms.gov/Outreach-and-Education/Medicare--Learning-Network-MLN/MLNMattersArticles/Downloads/MM7833.pdf

Revised: Reporting of Recoupment for Overpayment on the Remittance Advice (RA) with Patient Control Number

http://www.cms.gov/Outreach-and-Education/Medicare--Learning-Network-MLN/MLNMattersArticles/Downloads/MM7499.pdfs

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Updates from the Medicare Learning Network

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

From the MLN: "Negative Pressure Wound Therapy Interpretive Guidelines" MLN Matters® Article Released – MLN Matters® Special Edition Article #SE1222, "Negative Pressure Wound Therapy Interpretive Guidelines" has been released and is now available in downloadable format. This article is designed to provide education on CMS-approved guidelines that accrediting organizations can use to accredit suppliers that provide Negative Pressure Wound Therapy (NPWT) equipment to Medicare beneficiaries. It includes a list of relevant local coverage determinations and standards to help DMEPOS suppliers comply with standards and guidelines for NPWT equipment.

From the MLN: "Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Quality Standards" Booklet Revised – Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Quality Standards Booklet (ICN 905700) has been revised and is now available in downloadable and hard copy format. This booklet is designed to provide education on durable medical equipment, prosthetics, orthotics and supplies (DMEPOS). It includes DMEPOS quality standards as well as

information on Medicare deemed Accreditation Organizations (AOs) for DMEPOS suppliers.

From the MLN: "Quick Reference Information: Preventive Services" and "Quick Reference Information: Medicare Immunization Billing" Revised – The MLN has revised the recently updated Quick Reference Information: Preventive Services (ICN 006559) and Quick Reference Information: Medicare Immunization Billing (ICN 006799) educational tools. We have updated these charts to include the recently released flu code Q2034. All other information remains the same.

From the MLN: "Medicare Fraud & Abuse: Prevention, Detection, and Reporting" Web-Based Training – New – This Web-Based Training (WBT) course is designed to provide education on how to identify Medicare fraud and abuse and understand the related laws and penalties. It includes information on what entities and safeguards protect against and detect fraud and abuse, as well as how you can help prevent and report it. Continuing education credit is available for this course. To access a new or revised WBT course, visit the MLN Products webpage and click on "Web-Based Training (WBT) Courses" under "Related Links" at the bottom of the webpage.

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May is Hepatitis Awareness Month and May 19 is National Hepatitis Testing Day

The month of May has been designated Hepatitis Awareness Month and May 19 is the first ever National Hepatitis Testing Day. Every year, approximately 15,000 Americans die from liver

cancer or chronic liver disease associated with viral hepatitis. Despite this, viral hepatitis is not well known. In fact, as many as 75 percent of the millions of Americans with chronic viral hepatitis don't know they're infected. Please join CMS in support of the Centers for Disease Control and Prevention's "Know More Hepatitis" national education initiative aimed to decrease the burden of chronic viral hepatitis by increasing awareness about this hidden epidemic and encouraging people who may be chronically infected to get tested.

Medicare provides coverage of the hepatitis B vaccine and its administration for certain individuals at high or intermediate risk.

Increased provider knowledge has been shown to improve delivery of preventive services, including those for viral hepatitis. By educating yourself on this hidden epidemic, you can help save lives and decrease this epidemic's burden. As a healthcare provider for people with Medicare, discuss with eligible patients who may be at high or intermediate risk, whether the hepatitis B vaccine is appropriate.

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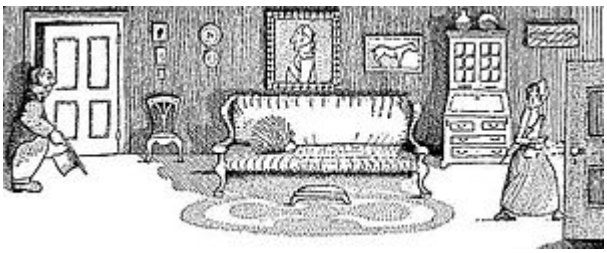
The Medicare News You Can Use This Week: eRx Exemptions for 2012 and 2013, Billing

Education, and eSignatures



(PECOS) You Can Now Sign Your Medicare Enrollment Application Electronically

(jump to story)

(PPACA) New CME Module on CMS Healthcare Delivery Reform Available on Medscape (jump to story)

(Release of Information) Authorization to Disclose Information to the Social Security Administration (jump to story)

(5010) ICD-10: It's Closer Than It Seems – Have You Completed Your 5010 Implementation? (jump to story)

(Billing) Medicare Billing Certificate Programs for Part A and Part B Providers (jump to story)

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You Can Now Sign Your Medicare Enrollment Application Electronically

Internet-based PECOS (Provider Enrollment, Chain, and Ownership System) now allows providers to sign Medicare enrollment applications electronically. Save time and expedite review of your application by using internet-based PECOS. *This feature does not change who is required to sign the application.*

Any *Organizational Provider applications* that are submitted via internet-based PECOS will require the user completing the application to provide an email address for the authorized signer of the application as part of the submission process. The authorized signer can then follow the instructions in the email and electronically sign the application. This applies to applications using the following forms:

- 855-A for Institutional Providers
- 855-B for Clinics, Group Practices, and Certain Other Suppliers, and
- 855-S for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers

In internet-based PECOS, all *Individual Provider applications* submitted by the individual provider that do not include new reassignments may be e-signed as part of the submission process. This applies to applications using the following forms:

- 855-I for Physicians and Non-Physician Practitioners, and

- 855-O for Eligible Ordering and Referring Physicians and Non-physician Practitioners

Any Individual Provider application (855-I) containing new reassignments (855-R) can be electronically signed as part of the submission process; however, you must select the Authorized Official / Delegated Official (AO/DO) for the Organization that is accepting the reassignment and enter that official's email address. The official then will be required to follow the instruction in the email and electronically sign the application.

If an individual provider or AO/DO does not want to make use of the e-signature process, they can simply follow the current process of printing and signing the certification statement (which then needs to be mailed to the appropriate contractor).

Questions concerning a system issue regarding PECOS should be referred to the CMS EUS Help Desk at 866-484-8049 or EUSSupport@cgi.com.

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New CME Module on CMS Healthcare Delivery Reform Available on Medscape

On Thu Mar 22, a new CME module was posted on Medscape. This module provides information and continuing medical education (CME) about CMS's healthcare delivery system reform efforts and can be accessed on Medscape (with a free registration) at http://www.Medscape.org/viewarticle/760133.

This is actually a nice synopsis of all the different efforts underway and a good read for anyone!

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Authorization to Disclose Information to the Social Security Administration

On Thu Mar 22, Commissioner Astrue signed an Open Letter to Healthcare Providers, Health Information Managers, and Medical Records Administrators about Social Security's new electronic signature process for Form SSA-827, "Authorization to Disclose Information to the Social Security Administration." This means many future records requests coming from Social Security will not be accompanied by the traditional patient signature (sometimes referred to as "wet-signed") – they will be electronically signed, although the form itself will look the same.

To see this important message, visit http://go.usa.gov/EUu. To learn about Social Security's new electronic signature process, visit http://go.usa.gov/P7V.

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ICD-10: It's Closer Than It Seems – Have You Completed Your 5010 Implementation?

Recently, CMS announced it will not initiate enforcement action against any *HIPAA*-covered entity for an additional three months, through Sat June 30, for the updated *HIPAA* transaction standards (ASC X12 Version 5010, NCPDP Versions D.0 and 3.0). Although much progress has been made in the successful receipt and processing of claims in the Version 5010 format, CMS is aware that there are still challenges and issues impeding an industry-wide upgrade.

During these additional 90 days during which CMS will not initiate enforcement penalties, you should collaborate more

closely with trading partners on appropriate strategies to resolve any remaining problems. Two steps providers can take to ensure a smooth upgrade include:

- Establish a line of credit: To avoid potential cash flow disruptions, providers should consider establishing or increasing a line of credit. By doing so, they can prepare for possible delays and denials in payer claims reimbursements if noncompliant Version 5010 transactions are submitted.
- Check partner readiness: Because a provider's Version 5010 upgrade can be dependent upon his or her vendor, it is important for providers to be aware of their vendor's transition status. If your vendor is behind schedule for Version 5010 adoption, get confirmation of their timeline to be compliant, and encourage them to take action so that your system will be prepared to handle your claims.

Other steps to prepare for the Version 5010 upgrade can be found in the "Version 5010: Ensuring a Smooth Transition" factsheet, which provides an overview of several actions providers can take to maintain continuity of operations for their practices as they prepare to complete Version 5010 testing.

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2012 eRx Payment Adjustment Update

CMS continues to receive inquiries about the Medicare Electronic Prescribing (eRx) Incentive Program and the 2012 eRx payment adjustment. This message seeks to clarify the issues CMS has heard from physicians and other healthcare professionals.

Statutory Authority/Background

CMS is required to adjust the payments of eligible professionals who are not successful electronic prescribers beginning in 2012. This requirement is outlined in Section 132 of the *Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)*.

CMS listed the requirements for being a successful e-prescriber for purposes of avoiding the 2012 payment adjustment in the 2011 Physician Fee Schedule final rule. In February 2012, all eligible professionals who did not meet these requirements were sent a letter notifying them of this fact.

Significant Hardship Exemption Requests

In response to stakeholder feedback, CMS also published a standalone eRx rule on Tue Sep 6, 2011, to provide additional circumstances under which eligible professionals would qualify for hardship exemptions. Eligible professionals initially had until Tue Nov 1, 2011, to submit a request for a hardship exemption for the 2012 eRx payment adjustment via the newly-created Quality Reporting Communication Support Page; this deadline was later extended to Tue Nov 8, 2011. CMS finished its review of these requests in February 2012 and continues to notify requestors via email whether their request was approved or denied.

Questions and Concerns

Although there is no appeal or review process established for the eRx Incentive Program and payment adjustment, CMS encourages eligible professionals with questions or concerns about the eRx payment adjustment and hardship exemption requests to contact the QualityNet Help Desk. Through the QualityNet Help Desk, CMS is working with eligible professionals and CMS-selected group practices that have questions about eRx payment adjustments and/or hardship exemption decisions. CMS is handling all hardship exemption

requests and any questions or concerns on a case-by-case basis. Contact the QualityNet Help Desk if you have issues relating to the eRx payment adjustment and/or the rationale for denial of your hardship exemption request.

The QualityNet Help Desk can be reached Mon – Fri, 7am-7pm CMT, at 866-288-8912 or QNetSupport@sdps.org.

2013 & 2014 eRx Payment Adjustment

Please note that payment adjustments under the eRx Incentive Program run until 2014. For information on how to avoid the 2013 and 2014 eRx payment adjustments, please visit the Electronic Prescribing Incentive Program webpage and review MLN Matters Article #SE1206.

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Medicare ePrescribing Penalty: Phone Lines Now Open (Courtesy of the AMA)

CMS has confirmed that the QualityNet Help Desk is now prepared to take calls from physicians on the Medicare ePrescribing penalty. We understand that physicians have already attempted in the past few weeks to contact the Help Desk to discuss their individual situation which resulted in a 2012 penalty, but in many cases were turned away. CMS has been working diligently with the Help Desk to ensure that a physician's case is adequately reviewed. CMS wants physicians to know that the issues they are having are being examined.

As CMS has indicated late last week, although there is no formal appeals or review process for the ePrescribing penalty, they encourage physicians with questions or concerns about their penalty and/or hardship exemption request to contact CMS' QualityNet Help Desk as soon as possible. CMS is handling

all penalty and/or hardship exemption requests and any questions or concerns on a case-by-case basis.

Physicians should continue to contact the QualityNet Help Desk if they have issues relating to the ePrescribing penalty. If a physician has previously contacted the QualityNet Help Desk and their case has been resolved to their satisfaction, the physician does not need to contact the QualityNet Help Desk again.

The QualityNet Help Desk can be reached M-F; 7:00 am – 7:00 pm CMT at 866-288-8912 or via email at qnetsupport@sdps.org.

NOTE: If a physician continues to experience problems with the Help Desk, CMS is encouraging physicians to email their concerns directly to Medicare at eRx_hardship@cms.hhs.gov.

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Hardship Exemptions for 2013 Electronic Prescribing Payment Adjustment

On Thursday, March 1, CMS reopened the Quality Reporting Communication Support Page to allow individual eligible professionals and *CMS-selected* group practices the opportunity to request a significant hardship exemption for the 2013 Electronic Prescribing (eRx) payment adjustment. The Communication Support Page will accept hardship exemption requests now *through Sat June 30, 2012*.

The Quality Support Page User Manual is available to assist individual eligible professionals and CMS-selected group practices in submitting their request for a hardship exemption and can also be accessed from the "Help" icon on the Communication Support Page.

For additional information on the 2013 eRx payment adjustment, including who is subject to the payment adjustment and how to avoid the payment adjustment, visit the eRx Incentive Program website at www.CMS.gov/eRxIncentive. Specifically, eligible professionals should review MLN Matters Article SE1206: "2012 eRx Incentive Program: Future Payment Adjustments."

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New MLN Matters Article (MM7727) – Medicare Quality Reporting Incentive Programs Manual Update

The new chapter describes the yearly payment instructions used by the Medicare contractors when making incentive payments described in the "Medicare Quality Reporting Incentives Manual."

http://www.cms.gov/MLNMattersArticles/Downloads/MM7727.pdf

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Revised MLN Matters Article (MM7745) – April Update to the Calendar Year (CY) 2012 Medicare Physician Fee Schedule Database (MPFSDB)

- HCPCS Codes with Revised Medicare Physician Fee Schedule Payment Indicators
- New HCPCS Codes to be added with the Effective Date of April 1, 2012
- New HCPCS Codes to be added with the Effective Date of

January 1, 2012
- New HCPCS Codes to be added with the Effective Date of July 1, 2011
- HCPCS codes to be discontinued effective April 1, 2012

http://www.cms.gov/MLNMattersArticles/Downloads/MM7745.pdf

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Revised MLN Matters Article (MM7633) – Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse

Two new G codes, G0442 (Annual Alcohol Misuse Screening, 15 minutes), and G0443 (Brief face-to-face behavioral counseling for Alcohol Misuse, 15 minutes), are effective October 14, 2011, and will appear in the January quarterly update of the Medicare Physician Fee Schedule Database (MPFSDB) and Integrated Outpatient Code Editor (IOCE). For claims with Dates of Service on or after October 14, 2011, through December 31, 2011, your Medicare contractor will use their pricing to pay for G0442 and/or G0443. Deductible and coinsurance do not apply. Contractors will hold institutional claims received prior to April 2, 2102, with TOBs 13X, 71X, 77X, and 85X and release those claims beginning April 2, 2012.

http://www.cms.gov/MLNMattersArticles/Downloads/MM7633.pdf

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Medicare Billing Certificate Programs for Part A and Part B Providers

From the MLN: Now Available – Medicare Billing Certificate Programs for Part A and Part B Providers– Learn about the Medicare Program, and the specifics for your provider type with a special focus on Medicare billing, and receive a certificate in Medicare billing from CMS for successful completion of the Program. Successful completion consists of completion of all required web-based training courses, required readings, and a 75-percent or higher score on the post-assessment.

To participate in either the Part A or Part B provider type program, visit http://www.CMS.gov/MLNproducts and click on 'Web-Based Training Modules' under 'Related Links Inside CMS."

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The PPACA Supreme Court Challenge: What Every Practice Manager Should Know

The **PPACA (Patient Protection and Affordable Care Act)** reforms that were passed almost two years ago have been contested in court almost from the moment President Obama finished signing the bill.

Several constitutional challenges to the law have rather quickly (in terms of the Supreme Court anyway) made it to the very top of the legal chain. Supporters and those opposed to the new law both want to see a quick decision by the Court on the most controversial components of the law – specifically, the **"individual Mandate"** that requires people not receiving health insurance benefit opportunities from their workplace, or through government programs like Medicare, Medicaid, or Tricare, to purchase health insurance through an exchange with help from government subsidies. Those who do not purchase insurance that meets a minimum standard of coverage would pay a penalty to the Federal Government.

The individual mandate is by far the least popular of the of the pieces of the reform law's so-called **"Three-Legged Stool"** of policies. By regulating insurers so that they cannot:

- deny people coverage based on pre-existing conditions,
- drop them arbitrarily because of new ones,
- or impose lifetime spending caps,

the private market is opened up to people with chronic and congenital conditions that otherwise would be denied, while the mandate ensures that younger and healthier people also participate in the market so that risk is spread, and premiums can be kept low. The Federal Tax Subsidies to new purchasers help to offset the costs to individuals and families that are

new to the market.

The twenty six states bringing suit believe that the federal government can not force an individual to buy insurance through the threat of a fine.

The Federal Government believes that it does have this power based on Article 1, Section 8, Clause 3, better known as the "commerce clause", which enumerates the power to

> *To regulate Commerce with foreign Nations, and among the several States, and with the Indian Tribes.*

This section of the Constitution is the basis for many of the powers granted to the federal government over the states, and the limits of the commerce clause are the foundation of powers declared by, or given back to the states from the Federal Government. Many of the most important questions put before the Supreme Court are cases of the nature of Federal versus State power, so the Commerce Clause is one of the most hotly debated parts of the American Constitution.

The Obama Administration argues that the Individual Mandate is part of the broad powers given to the Federal Government to "tax" individuals in order to regulate interstate commerce.

The states involved in the suit, and conservatives opposed to the Reforms argue that this amounts to the Federal Government requiring individuals, under penalty of law, to purchase a product whether they want to or not – an intrusion on both individual and State freedom.

This week, the Court heard six hours of oral arguments from lawyers representing both the states suing, the federal government, and unbiased outside council brought in to argue positions held by neither side. **Four different challenges** are being considered, including:

- Can the Supreme Court rule on the law before the fine has ever been imposed?
- Is the Individual Mandate constitutional?
- If the Individual Mandate is not upheld, does it invalidate the rest of the law?
- Can the federal government force the states to expand their Medicaid programs, even if the federal government pays for the state program expansion?

Of the nine Justices on the Supreme Court, five were appointed by Republican Presidents and four were appointed by Democrats, including two appointed by Obama. The four democratic appointees – Ginsburg, Breyer, Sotomayor and Kagan- are presumed to vote to uphold the bill, while Clarence Thomas, one of the five Republican appointed justices is presumed to vote to repeal. The other four justices: Scalia, Thomas, Roberts, and Alito are considered to be "swing votes". With mixed or limited records on Commerce Clause cases and Federal Power, many Court observers widely believe that their votes will be the deciding factors.

A decision will be handed down by the Supreme Court in late June.

What does this mean for medical practices as small businesses with more than 50 employees?

If the PPACA is upheld, and the practice does not offer medical insurance benefits to its employees and your employees receive income tax credits for purchasing health insurance

through a state exchange, you will be required to pay a fee of up to $2,000 per FTE for every employee after the first 30.

Currently, practices with 25 or less employees with an average wage of up to $50K annual wages can get a tax credit of up to 35% of the cost of health insurance premiums.

What does this mean to medical practices of all sizes?

If the PPACA is upheld, in 2014 our world will change.

In 2014, we would expect to see patients moving away from the ER as a source of primary care and into practices, and there would literally be no more “Self-Pay” patients in traditional private practices! This will expand the complexity of pre-visit eligibility and claims filing and patients will continue to be confused over benefits, but that is what insurance is all about.

What are your concerns for your practice or business if the PPACA is or is not upheld?

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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Is Your Practice Ready to Be Cash Poor For the Next 30 Days? Here's How to Change That!

January is a tough time for independent medical practices for several reasons:

- In private practices, the physicians typically don't carry over any cash from year to year, so the practice starts in January from a cash position of zero.
- Most deductibles begin in January – if practices don't collect deductibles at time of service, they find themselves hurting because their revenue goes way down.
- The Medicare debacle every year creates improper (lower) reimbursement as Congress struggles to the last possible minute over physician payments. (Here's a simple yet helpful exercise for Congress. Congress, close your eyes and think of your favorite Medicare-age person. Is it you, your wife, your mother, your father, your neighbor or best friend? Now think of that person not being able to see a doctor when they need to because all doctors have opted out of Medicare and the only place they can get care is the local Emergency Room. It is a very ugly picture. What other profession is MADE to accept payment that is less than it costs to provide? Who do you love, Congress, who won't be able to get care?)
- Many annual maintenance contracts come due in January
- Deals on large purchases are good (think EMRs) as vendors try to book revenue in the current year. Practices tend to make commitments to purchases now that will have to be paid for in the new year

What’s a practice to do?

- Pay all bills for 2012 that you reasonably can before the end of 2011 – try to prepay anything you can to avoid having to pay it early in the year.
- Review your tax position to see if you can leave some money in the kitty at the end of the year – most accountants will advise spending down bank accounts or distributing money if possible.
- Secure a line of credit to draw upon – this may be critical if you have a payroll due early in January before you’ve had a chance to build up your bank account.
- COLLECT DEDUCTIBLES at time of service. Don’t wait for the EOB to tell you you have to collect from the patient! If you’ve always billed patients for deductibles, take these simple steps to start collecting:
    - Inform staff the practice will collecting deductibles beginning January 2.
    - Add a message to your on-hold messaging that says something like “The practice will be collecting deductibles beginning January 2, 2012. Please be prepared to pay your deductible, or ask to speak to our Administrator/Biller/Financial Counselor to make payment arrangements.”
    - When confirming appointments, have the script changed to include the fact that patients will be asked to pay co-pays, co-insurance and deductibles at time of service.
    - Hand patients a flyer at check-in to explain deductibles and why the practice has decided to collect them instead of billing for them.
    - Based on what your practice specialty and set-up is, offer patients an electronic payment plan where you automatically draft their credit or

debit card for their deductible.
    - Decide how you will work with patients with high-deductible plans – will you require a certain payment at their first visit of the year, then put them on an electronic payment plan?
    - Other articles I've written on collecting at time of service can be found **here,** **here** and **here**.
- Change your maintenance contracts to space large payables throughout the year.
- Negotiate payments for large end-of-year deals so the practice does not have to pay out any cash until March or April.
- Change your fiscal year so it does not coincide with the calendar year.

What's your advice for getting through these potentially difficult early months in the year?

Texas Medical Association Video: Grandma and the Big Bad SGR

I haven't written much about the impending 29% Medicare physician payment cut. This threatened cut has happened every year for the past 10 years. Every year at the last second, Washington is convinced that if cuts take place, physicians really will stop seeing Medicare patients and they halt the cut.

It's not a bluff. Physicians can't afford to see Medicare patients, TriCare (ex-military) patients and disabled patients with Medicare benefits now, and they will drop out by the tens

of thousands if they get paid any less. Any businessperson worth their salt will tell you that when revenue does not exceed expenses, you do not have a sustainable business model. Physician have cut expenses to the bone, taken deep cuts in their salaries and ultimately have sold their practices when they just can't make it anymore.

But never mind the doctor, what about the patients? What happens to them when physicians stop seeing Medicare patients? **Texas Medical Association** has made an outstanding video that explains it in language we can all understand.

Other organizations that are working to eliminate physician reimbursement being tied to the SGR are **MGMA** and the **AMA**.

The Best of Manage My Practice – October, 2011 Edition

As we finish off another month here at MMP, we wanted to go back over some of our most popular posts from the month and get ready for another busy, productive, and meaningful month. Presenting, **The Best of Manage My Practice, October 2011**!

- Are you ready for the holidays? How about the New Year? Even though it's still a few months off, make sure you don't see an interruption in your practice's cashflow by getting ready for the January 1st 5010 deadline!

- CMS has released the Premiums and Deductibles for Medicare patients for 2012, so you can start informing staff and patients now. More importantly, will 2012 be the year that you get serious about collecting deductibles at the time of service?
- Mary Pat's "Collection Basics"series about the fundamentals of Revenue Cycle Management in Physician offices is now at part three! Check out Patient Collections Basics: Developing a Financial Assistance Program.
- One of Healthcare's most misunderstood and underutilized documents– the Medicare Advance Beneficiary Notice- is changing for 2012. Make sure you're ready.
- And finally, the Office of the Inspector General (OIG) of he department of Health and Human services has released its 2012 Work Plan for areas it will concentrate on investigating. Better safe than sorry! Mary Pat goes over the highlights here.

We've started this monthly wrap-up to make sure you don't miss any of the great stuff we post throughout the month on Manage My Practice, but we also want to hear from you! What were your favorite posts and discussions this month? Did we skip over your favorite from October? Let us know in the comments!

2012 Medicare Deductibles and Premiums: Is This the Year You'll Collect Deductibles at

Time of Service?

CMS just announced the new numbers for premiums and deductibles for 2012. Now is the ideal time to think about Medicare deductibles and what your policy is on collecting deductibles at time of service.

If you've been hesitant to collect deductibles, ask yourself if you can handle the loss or delay of payment of $140 per Medicare patient. Most practices can't. If you are thinking about collecting deductibles and other front-end collection techniques, my book "The Smart Manager's Guide to Collecting at Checkout" is your guide to making it happen for your healthcare group. **Click here** to read more.

MEDICARE PART B (covers a portion of the cost of physicians' services, outpatient hospital services, certain home health services, durable medical equipment, and other items)

- In 2012, the **Part B deductible will be $140**, a decrease of $22 from 2011.
- The standard Medicare Part B monthly premium will be **$99.90 in 2012**, a $15.50 decrease over the 2011 premium of $115.40.
- The standard premium is set to cover one-fourth of the average cost of Part B services incurred by beneficiaries aged 65 and over, plus a contingency margin. The contingency margin is an amount to ensure that Part B has sufficient assets and income to (i) cover Part B expenditures during the year, (ii) cover incurred-but-unpaid claims costs at the end of the year,

(iii) provide for possible variation between actual and projected costs, and (iv) amortize any surplus assets. Most of the remaining Part B costs are financed by Federal general revenues. (In 2012, about $2.9 billion in Part B expenditures will be financed by the fees on manufacturers and importers of brand-name prescription drugs under the Affordable Care Act.)

- The largest factor affecting the contingency margin for 2012 is the current law formula for **physician fees, which will result in a payment reduction of about 29 percent in 2012.** For each year from 2003 through 2011, Congress has acted to prevent smaller physician fee reductions from occurring. The 2012 reduction is almost certain to be overridden by legislation enacted after Part B financing has been set for 2012. In recognition of the strong possibility of increases in Part B expenditures that would result from similar legislation to override the decrease in physician fees in 2012, it is appropriate to maintain a significantly larger Part B contingency reserve than would otherwise be necessary. The asset level projected for the end of 2012 is adequate to accommodate this contingenIn 2012, Social Security monthly payments to enrollees will increase by 3.6 percent. The dollar increase in benefit checks is expected to be large enough on average to cover the increase in the Part B premium of $3.50 that most beneficiaries will experience. For those who were paying the standard premium of $115.40, their benefits checks will only increase.

MEDICARE PART A (inpatient hospital, skilled nursing facility,

and some home health care)

- Approximately 99% of Medicare beneficiaries do not pay a premium since they or their spouses have at least 40 quarters of Medicare-covered employment
- Some enrollees age 65 and over and certain persons with disabilities who have fewer than 30 “quarters of coverage” obtain Part A coverage by paying a monthly premium **($451 for 2012)** set according to a statutory formula.
- Those who have between 30 and 39 “quarters of coverage” may buy into Part A at a reduced monthly premium rate which is **$248 for 2012**, the same amount as in 2011.
- The Part A deductible paid by a beneficiary when admitted as a hospital inpatient will be **$1,156 in 2012**, an increase of $24 from this year’s $1,132 deductible.
- The Part A deductible is the beneficiary’s cost for up to 60 days of Medicare-covered inpatient hospital care in a benefit period. Beneficiaries must pay an additional **$289 per day for days 61 through 90 in 2012**, and **$578 per day for hospital stays beyond the 90th day** in a benefit period.
- For beneficiaries in skilled nursing facilities, the daily co-insurance for days 21 through 100 in a benefit period will be **$144.50 in 2012,** compared to $141.50 in 2011.

MEDICARE PART D (medications)

- The estimate for the average **2012 Part D premium for basic coverage is $30.** This is slightly lower than the actual average for 2011 of $30.76.
- The estimate for the average 2012 Part D premium for supplemental coverage is $8. The estimate for the **average 2012 total Part D premium is $38.**

MEDICARE ADVANTAGE PLANS (replacement for traditional Medicare)

- On average, Medicare Advantage premiums will be 4 percent lower in 2012 than in 2011, and plans project enrollment to increase by 10 percent.
- Of people with Medicare, 99.7 percent continue to enjoy access to a Medicare Advantage plan, and benefits remain consistent with those offered in 2011.
- Those who enroll in Medicare Advantage plans may have different cost-sharing arrangements. On average Medicare Advantage premiums will be 4 percent lower in 2012 than in 2011, and plans project enrollment will increase