Your Guide to the 2012 OIG Work Plan: Does Anything on This List Worry You?

Here are some highlights from the new OIG Work Plan for FY 2012. There are more items that apply to practices, as well as items for hospitals, nursing facilities, home health, and medical equipment and supplies. The link to the complete plan is at the end of the article.

Compliance With Assignment Rules

If you accept assignment with Medicare (i.e. you accept what Medicare allows as payment for a service), the OIG wants to know if you are adhering to the allowable and not collecting more than the patient's deductible and co-insurance.

Physicians-Owned Distributors of Spinal Implants (New)

Do physician-owned distributors (PODs) of spinal implants have a conflict of interest when they sell implants to hospitals? The OIG will investigate.

Place-of-Service Errors

Because there is a payment differential between a service provided in a hospital outpatient department or ASC and the same service provided in the physician's office, the OIG wants to know if you provided the service where you claimed you did.

Physicians: Incident-To-Services (New)

Incident-to services are reported on the honor system – the claim does not reflect that a mid-level provider performed the service under the supervision of a physician. The OIG will dig under the claims to see if practices really understand and follow the incident-to rules.

Physicians: Impact of Opting Out of Medicare (New)

The OIG will be checking that physicians who opted out of Medicare are not filing claims for services, and also monitor disruption of service to Medicare patients due to opt-outs.

Evaluation and Management Services: Trends in Coding of Claims

If you provided E/M services in 2009, you received part of the $32 billion paid out as 19% of all part B payments. Did you pick a code and hope your documentation was up to the task, or did you review your documentation and choose the code that reflected what was there?

Evaluation and Management Services: Provided During Global Surgery Periods

Are physicians correctly ascertaining which services are part of the global surgery period or are they mistakenly charging for services that are wrapped into the procedure or surgery? The OIG knows.

Evaluation and Management Services: Use of Modifiers During the Global Surgery Periods (New)

Check those modifiers used during the global period. This item refers to services provided during the global period that were unrelated to the original service and thereby billable.

Evaluation and Management Services: Potentially Inappropriate Payments

This is the review we've all been talking about. The OIG will be inspecting electronic records to see if identical documentation appears serialized in the records.

The original work plan can be found **here.**

Have You Been Ignoring the January 1, 2012 Deadline for 5010? Wake Up – It's Time to Get Serious!

Just in case you haven't had a chance (what have you been doing?) to focus on the January 1, 2012 deadline for the transition to 5010, take 5 minutes to read this post and make sure your healthcare group is on track. It is critical to have **NO interruption in cash flow in January** – a time when cash

flow is already lower due to the new deductibles in play for many plans including Medicare.

The American Medical Association (AMA), in its **"5010 Implementation Steps: Getting the Work Done in Time for the Deadline"** recommends the following to protect your cash in January:

- Submit as many transactions as possible before Jan. 1, 2012.
- Decrease expenses before Jan. 1, 2012, to increase cash reserves.
- Consider establishing a line of credit with a financial institution.
- Research payers' advance payment policies.
- Consider using manual or paper processes to complete transactions until the electronic transactions are fixed.

Note that HIPAA standards, including the ASC X12 Version 5010 and Version D.0 standards are national standards and apply to your **transactions with all payers**, not just with FFS Medicare. Therefore, you must be prepared to implement these transactions for your non-FFS Medicare business.

Beginning January 1, 2012 all electronic claims, eligibility and claim status inquiries must use Version 5010 or D.O.

Version 4010/5.1 claims and related transactions will no longer be accepted. The electronic remittance advice will only be available in 5010. For Part B and DME providers, download the free Medicare Remit Easy Print (MREP) software to view and print compliant HIPAA 5010 835 remittance advices, available **here.**

How Does the Transition to Version 5010

Relate to the Adoption of the ICD-10-CM and ICD-10-PCS Code Sets?

Version 5010 is essential to the adoption of the ICD-10 codes and includes the following infrastructure changes in preparation for the ICD-10 codes:

- Increases the field size for ICD codes from 5 bytes to 7 bytes;
- Adds a one-digit version indicator to the ICD code to indicate Version 9 versus Version 10;
- Increases the number of diagnosis codes allowed on a claim; and
- Includes additional data modification in the standards adopted by Medicare FFS.

What are the Improvements in Version 5010?

Version 5010 improvements in front matter, technical, structural, and data content, include the following:

- Standardizes the business information related to the transaction
- Utilizes Technical Reports Type 3 (TR3) guidelines that represent data consistently and are less confusing;
- Is more specific in defining what data needs to be collected and transmitted;
- Accommodates the reporting of clinical data, such as ICD-10-CM diagnosis codes and ICD-10-PCS procedure codes;
- Distinguishes between principal diagnosis, admitting diagnosis, external cause of injury, and patient reason for visit codes;
- Supports monitoring of certain illness mortality rates,

outcomes for specific treatment options, some hospital length of stays, and clinical reasons for care; and

- Addresses currently unmet business needs, such as an indicator on institutional claims for conditions that were “present on admission.”

Are you at risk of not being able to access electronic information and file claims?

If you can answer NO to any of the following questions, you are at risk of not being able to meet the January 1, 2012, deadline and **not being able to submit claims**:

1. Have you contacted your software vendor to ensure that they are on track to meet the deadline OR if you are submitting claims directly to Medicare, contacted your MAC to get the free Version 5010 software (PC-Ace Pro32)?

2. Alternatively, have you contacted clearinghouses or billing services to have them translate your Version 4010 transactions to Version 5010 (if not converting your older software)?

3. Have you identified changes to data reporting requirements?

4. Have you started to test with your trading partners – practice management software vendor, clearinghouses, or billing service?

5. Have you started testing with your MAC, **which is required before being able to submit bills** with the Version 5010?

6. Have you updated MREP software to view and print compliant HIPAA 5010 835 remittance advices?

If you answered NO, it's time to get started!

Resources for 5010 and Version D.O.

Educational Resources & Downloads

"**5010 Implementation Steps: Getting the Work Done in Time for the Deadline**" American Medical Association

If you have questions, contact your Medicare contractor (carrier, FI, A/B MAC, HH+H MAC, and DME MACs) at their toll-free number, which may be found **here.**

The Right Way to Do Write-offs

- A write-off is an amount that a practice deducts from a charge and does not expect to collect, thereby "writing it off" the accounts receivable or list of monies owed them by payers or patients.

There are lots of reasons why write-offs are taken, and it is common practice to divide write-offs into two major categories.

Necessary or Approved Write-offs

These are write-offs that you have agreed to, either in the context of a contract, or in terms of your practice philosophy.

Contractual write-offs are the difference between the practice fee schedule and the allowable fee schedule you've agreed to accept.

Charity write-offs are the difference between the practice fee schedule and anything collected. Charity write-offs may be in accordance with a community indigent care effort, a policy adhered to in a faith-led healthcare system, or a financial assistance program.

Small balance write-offs are amounts left on the patient's account that may not warrant the cost of sending a bill, which has been estimated to cost about $12.00 each, taking into account the statement process, as well as the cost to receive the check, post it, and deposit it. Many practices write off the small balance (usually $15 or less) and collect it when the patient returns. Others run a special small balance statement run once a quarter.

Prompt payment discounts and **self-pay (no insurance) discounts** are write-offs for patients paying in full at time of service, and/or patients who receive a discount off the retail price because they do not have insurance coverage.

Unnecessary Write-offs

These are write-offs that you have not agreed to and you reluctantly reduce the charge based on billing mistakes or situations that you should have been able to control, but were not.

Timely filing write-offs are caused by filing the claim past the date required by the payer. Medicare requires that claims be filed no later than 12 months after the date of service to be paid. Medicaid varies from state-to-state. Commercial payers usually have very tight timely filing limits and most

average three months. (Make sure you know your timely filing limits for each payer.)

Uncredentialed provider write-offs are those caused by filing a claim for a provider before they are credentialed with the payer.

Administrative write-offs are those approved by the manager based on service issues. For instance, if the practice assures the patient that they are participating with the patient's insurance, then it turns out that the practice is not in-network, the manager may approve a write-off based on the practice's error. If the patient has a very bad experience in the practice, the manager may want to discount the service or to write-off the charge completely. If you do discount the service, remember to submit the claim for the altered fee, as you cannot discount the fee to patient and charge the payer the full fee.

Bad debt write-offs are balances that you have decided to write-off and not pursue further. These are balances that for whatever reason, you are forgiving forever.

Collection agency write-offs are those that are written off the main A/R (accounts receivable) and transferred to a third-party collection agency to collect on your behalf. These balances are not forgiven. Some PM (practice management) systems maintain a separate collection bucket or A/R and others do not maintain collection accounts in the system. Most practices do not schedule appointments with patients that have a collection balance until that balance is satisfied or the patient is committed to a reasonable payment plan.

Some guidelines for managing write-

offs

1. Start with the basic write-offs but add write-off categories as the need arises.
2. Decide which write-offs require managerial approval. Do not make staff get approval for routine write-offs, but do not completely relinquish approval for all write-offs as this is one place where staff could abuse their authority. Make sure write-offs are addressed in your compliance plan so staff understand their responsibilities.
3. Review all write-off categories monthly and pay attention to unusual spikes as well as creeping trends. Keep in mind that if you raise your fees and don't renegotiate your contracts, your contractual write-offs are going to escalate, and you'll need to account for that difference in your evaluation.
4. Audit write-offs periodically to make sure that they are being done correctly. Staff will know that their work is being checked and you can be sure the numbers you are making business decisions on are sound.
5. Best practices for unnecessary write-offs are no more than 5% of your total expected collections. The formula for expected collections is gross charges minus necessary/approved write-offs.

CMS Releases Pricing and Codes for 2011 – 2012 Flu

Vaccine Given After September 1, 2011

NOTE: The 2012 – 2013 flu shot codes can be found here.

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Today the Centers for Medicare and Medicaid Services (CMS) released the new pricing for flu shots for Medicare patients for the 2011-2012 flu season. The Medicare Part B payment allowance limits for seasonal influenza and pneumococcal vaccines are 95% of the Average Wholesale Price (AWP) as reflected in the published compendia except where the vaccine is furnished in a hospital outpatient department. When the vaccine is furnished in the hospital outpatient department, payment for the vaccine is based on reasonable cost.

What do Medicare patients have to pay for the flu shot?

Annual Part B deductible and coinsurance amounts **do not apply** for the influenza virus and the pneumococcal vaccinations. All physicians, non-physician practitioners, and suppliers who administer these vaccinations must take assignment on the claim for the vaccine. **Do not collect from Medicare patients for the vaccine or the administration of a flu shot.**

What will Medicare pay for the flu shot?

The payment allowances below reflect the annually updated payment allowance for the listed CPT codes and Q-codes when the vaccines are furnished outside the hospital outpatient department.

Allowables Effective for Dates of Service between September 1, 2011 and August 31, 2012

CPT 90654: $18.383
CPT 90655: $15.705
CPT 90656: $12.375
CPT 90657: $6.653
CPT 90660: $22.316
CPT 90662: $30.923

Q2035 (Afluria): $11.543
Q2036 (Flulaval): locally priced
Q2037 (Fluvirin): $13.652
Q2038 (Fluzone): $13.306
Q2039 (N.O.S.): locally priced

How should the flu shot be coded?

1. Choose the Q code or CPT code that is appropriate for the brand of vaccine you are giving or the special circumstances (pediatric dose, regular dose, high dose, preservative free, etc.)
2. Use the Administration Code G0008
3. Use the Diagnosis Code: V04.81

Choose one code for the vaccine:

90655 – Influenza virus vaccine, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use

90656 – Influenza virus vaccine, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use

90657 – Influenza virus vaccine, split virus, when administered to children 6-35 months of age, for intramuscular use

90660 – Influenza virus vaccine, live, for intranasal use

90662 – Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use

Q2035 – Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Afluria)

Q2036 – Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Flulaval)

Q2037 – Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Fluvirun)

Q2038 – Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Fluzone)

Q2039 – Influenza virus vaccine, split virus, when administered to individuals3 years of age and older, for intramuscular use (Not Otherwise Specified)

How many flu shots will Medicare pay for?

Medicare will pay for one flu shot per influenza season in the fall or winter. Medicare may cover additional seasonal influenza virus vaccinations if medically necessary.

What is different if the patient gets the flu shot somewhere besides the physician's office?

Institutional Providers: Additional Billing Information

Hospitals, other than Indian Health Service (IHS) Hospitals and Critical Access Hospitals (CAHs) 12X, 13X
CAHs: Method I and II and IHS CAHs 85X
IHS Hospitals 12X, 13X
Skilled Nursing Facilities (SNFs) 22X, 23X
Home Health Agencies (HHAs) 34X
Comprehensive Outpatient Rehabilitation Facilities (CORFs) 75X

Revenue Codes: 0636 – vaccine
0771 – administration

Rural Health Clinics (RHCs) 71X

Federally Qualified Health Centers (FQHCs) – 77X (for dates of service on or after April 1, 2010)

Do providers that only provide immunizations need to enroll in the Medicare Program?

Yes. Providers must enroll in the Medicare Program even if immunizations are the only service they will provide to beneficiaries. They should enroll as provider specialty type 73, Mass Immunization Roster Biller, by completing Form CMS-855I for individuals or Form CMS-855B for a group.

Click **here** to locate these forms.

What is a mass immunizer?

A mass immunizer offers seasonal influenza virus and/or pneumococcal vaccinations to a large number of individuals and may be a traditional Medicare provider or supplier or a nontraditional provider or supplier (such as a senior citizens' center, a public health clinic, or a community pharmacy). Mass immunizers must submit claims for immunizations on roster bills and must take assignment on both the vaccine and its
administration. A mass immunizer should enroll with the Medicare Contractor prior to influenza season.

What is Roster Billing?

(Influenza & Pneumococcal Vaccinations Only)

The simplified roster billing process was developed to enable Medicare beneficiaries to participate in mass PPV and influenza virus vaccination programs. (Medicare has not developed roster billing for hepatitis B or other vaccinations.) Roster billing can also substantially lessen the administrative burden on physician practices by allowing them to submit one claim for all of the Medicare beneficiaries that received either the PPV or influenza vaccine on a given day. Medicare will often refer to these providers, who utilize roster billing, as "Mass Immunizers."

For Medicare Part B submission, physician practices and other "Mass Immunizers" must submit a separate pre-printed CMS-1500 paper claim form or bill electronically for each type of vaccination (either influenza or PPV) and attach a roster list containing information for 2 or more Medicare beneficiaries. When "mass immunizers" choose to conduct roster billing electronically, they are required to use the HIPAA-adopted ASC X12N 837 claim standard. Local Medicare Carriers may offer low or no-cost software to help providers utilize roster billing

electronically, however, this software is not currently available nationwide so check with your local carrier for specifics in your area.

All entities that submit claims on roster bills must accept assignment.

Roster bills submitted by providers to a Medicare carrier must contain more than one patient and the date of service for each vaccination administered must be the same. (Medicare policy was changed July 1, 1998, and the requirement that a minimum of five beneficiaries be vaccinated per day in order to roster bill was reduced to two beneficiaries per day.)

To further minimize the administrative burden of roster billing, the following blocks can be preprinted on a CMS-1500:

Block 1: Medicare
Block 2: See Attached Roster
Block 11: None
Block 20: No

Block 21: V04.81 for influenza or V03.82 for pneumococcal
Block 24B: ALL entities should use POS code “60” for roster billing. (POS code “60” = Mass Immunization Center.)

Block 24D: Use appropriate vaccine and administration codes (separate line items for each)

Block 24E: Use “1” for lines 1 and 2
Block 24F: Use the unit cost of the particular vaccine (Contractors will replicate the claim for each beneficiary listed on the roster.)
Block 27: Yes
Block 29: $0.00
Block 31: Signature
Block 32: Enter the name, address and zip code of the location where service was provided

Block 32a: NPI of the service facility
Block 33: Provider Identification Number or NPI when required
Block 33a: NPI of the billing provider or group

A separate CMS-1500 for each type of vaccination must have an attached roster that includes the
following information:
• Patient Name and Address
• Health Insurance Claim Number
• Date of Birth
• Sex
• Date of Service
• Provider’s Name and Identification Number
• Signature or stamped “Signature on File”
• Control number for the contractor

A “signature on file stamp” or notation qualifies as a signature on a roster claim form in cases where the provider has access to a signature on file in the beneficiary’s record (e.g., when the vaccine is administered in a physician’s office).

The format of the beneficiary roster can be modified to meet the needs of individual providers. It is the responsibility of the carrier to develop suitable roster formats that meet provider and carrier needs and contain the minimum data necessary to satisfy claims processing requirements for these claims.

How to Apply Online for the

CMS Hardship Exemption from the 2012 eRx Medicare Payment Reduction

UPDATE: CMS has announced a second window for applying for the 2013 hardship exemption from 11/1/2012 through 1/31/2013. Click Here for more info.

UPDATE: CMS has released information for applying for the 2013 hardship exemption. Check out our "Medicare This Week" post from 6/8/2012 for more info.

UPDATE: The submission period for applying for a 2012 hardship exemption for failing to e-prescribe in 2011 is over.

CMS has just announced the process for applying for a hardship exemption from the 2012 1% Medicare payment adjustment (i.e. reduction.)

If you are participating as an individual Eligible Professional…

…use the new CMS provider webpage, called the **Quality Reporting Communication Support Page**, to enter the request and supporting rationale. Your request must be submitted by **November 1, 2011.** A Quality Communications Support Page User Manualis available to answer questions eligible professionals may have.

If you are participating using the Group Practice Reporting Option

(GPRO)…

…Group practices selected for and participating in the 2011 GPRO I or II reporting option wishing to submit a 2012 exemption request should submit a letter to: Significant Hardship Exemptions, Centers for Medicare & Medicaid Services, Office of Clinical Standards and Quality, Quality Measurement and Health Assessment Group, 7500 Security Boulevard, Mail Stop S3-02-01, Baltimore, MD 21244-1850. This letter must be postmarked no later than **November 1, 2011**.

To help eligible professionals and group practices understand the key provisions and impact of the 2011 Medicare Electronic Prescribing (eRx) Incentive Program Final Rule, **A Quick Reference Guide** has been posted to the eRx Incentive Program website on the **"Educational Resources"** page. Frequently asked questions (FAQs) addressing the 2011 eRx Final Rule, as well as other information and resources about the eRx Incentive Program can be found at the eRx Incentive Program website **here.**

The CMS Bundled Payment Initiative: Providers Can Apply to Participate in a Mini-ACO Initiative

Last week the U.S. Department of Health and Human Services (HHS) announced a new initiative to help improve care for patients while they are in the hospital and after they are discharged. Doctors, hospitals, and other health care

providers can now apply to participate in a new program known as the Bundled Payments for Care Improvement initiative (Bundled Payments initiative). Made possible by the Affordable Care Act, it will align payments for services delivered across an episode of care, such as heart bypass or hip replacement, rather than paying for services separately. Bundled payments will give doctors and hospitals new incentives to coordinate care, improve the quality of care and save money for Medicare.

"Patients don't get care from just one person – it takes a team, and this initiative will help ensure the team is working together," said HHS Secretary Kathleen Sebelius. "The Bundled Payments initiative will encourage doctors, nurses and specialists to coordinate care. It is a key part of our efforts to give patients better health, better care, and lower costs.

Payment bundling is the future

In Medicare currently, hospitals, physicians and other clinicians who provide care for beneficiaries bill and are paid separately for their services. This Centers for Medicare & Medicaid Services (CMS) initiative will bundle care for a package of services patients receive to treat a specific medical condition during a single hospital stay and/or recovery from that stay – this is known as an **episode of care.** By bundling payment across providers for multiple services, providers will have a greater incentive to coordinate and ensure continuity of care across settings, resulting in better care for patients. **Better coordinated care can reduce unnecessary duplication of services, reduce preventable medical errors, help patients heal without harm, and lower costs.**

The Bundled Payments initiative is being launched by the new Center for Medicare and Medicaid Innovation (Innovation Center), which was created by the Affordable Care Act to carry out the critical task of finding new and better ways to

provide and pay for health care to a growing population of Medicare and Medicaid beneficiaries.

Four bundled payment models

Released today, the Innovation Center's Request for Applications (RFA) outlines four broad approaches to bundled payments. Providers will have flexibility to determine which episodes of care and which services will be bundled together. By giving providers the flexibility to determine which model of bundled payments works best for them, it will be easier for providers of different sizes and readiness to participate in this initiative.

Three models involve a retrospective bundled payment arrangement, and one model would pay providers prospectively. Through the Bundled Payments initiative, providers have great flexibility in selecting conditions to bundle, developing the health care delivery structure, and determining how payments will be allocated among participating providers.

"This Bundled Payment initiative responds to the overwhelming calls from the hospital and physician communities for a flexible approach to patient care improvement," said CMS Administrator Donald Berwick, M.D. "All around the country, many of the leading health care institutions have already implemented these kinds of projects and seen positive results."

Cost savings for Medicare and for patients

The Bundled Payments initiative is based on research and previous demonstration projects that suggest this approach has tremendous potential. For example, a Medicare heart bypass surgery bundled payment demonstration saved the program $42.3 million, or roughly 10 percent of expected costs, and saved patients $7.9 million in coinsurance while improving care and

lowering hospital mortality.

“From a patient perspective, bundled payments make sense. You want your doctors to collaborate more closely with your physical therapist, your pharmacist and your family caregivers. But that sort of common sense practice is hard to achieve without a payment system that supports coordination over fragmentation and fosters the kinds of relationships we expect our health care providers to have,” said Dr. Berwick.

Letter of Intent to participate due in September

Organizations interested in applying to the Bundled Payments for Care Improvement initiative must submit a Letter of Intent (LOI) no later than September 22, 2011 for Model 1 and November 4, 2011 for Models 2, 3, and 4. For more information about the various models and the initiative itself, please see the Bundled Payments for Care Improvement initiative web site **here**.

Resources

Interested parties may obtain answers to specific questions by e-mailing CMS at **BundledPayments@cms.hhs.gov**.

This initiative is part of a broader effort by the Obama Administration to improve health, improve care, and lower costs. A brief summary of other efforts, including those authorized by the Affordable Care Act, can be found **here.**

For more information about the CMS Innovation Center **click here**.

Additional information:

HHS fact sheet

Federal Register Posting

Collections Basics – Part 1: Know Your Payers

In a traditional healthcare setting, the revenue cycle begins with the insurance companies who pay the majority of the bill. There are multitudes of payers and each payer can have many plans. How can a healthcare organization catalog this information, keep this information updated and make this information easily accessible to staff so they can discuss payments with patients in an informed and confident way?

Start by breaking your payers into five main categories as a logical way to organize the data.

1. Payers with whom you have a contract
2. Payers with whom you do not have a contract
3. State and Federal government payers (Medicare, Medicaid, TriCare)
4. Medicare Advantage payers
5. Patients

Payers with whom you have a contract

Your organization has signed a contract with a payer and you have agreed to accept a discounted fee called an allowable, and to abide by their rules. What is the information you need to collect?

- A copy of the contract
- A detailed fee schedule, or a basis for the fees, such as “150% of the 2008 Medicare fee schedule.”
- Any information about the fees being increased periodically based on economic indicators, or rules (notification, timeline, appeals) on how the payer can

change the fee schedule.
- The process and a contact name for appealing incorrect payments.
- Information on what can be collected at time of service. Hopefully your contract does not have any language that prohibits collections at time of service, but you must know what the contract states.
- Process for checking on patients' eligibility and benefits: representative by phone, interactive voice response (IVR), website or third-party access.

The contract allowables should be loaded into your practice management system so you can calculate the patient's responsibility at check-out and you can identify incorrect payments at the time of check-posting. If your practice management system does not have this feature, you will need a cheat sheet for each contracted payer, showing the most common services, the allowables, and the percentages of the allowables for fast calculation of the patient's portion at check-out. The same or a modified cheat sheet will work for the check posters so they can verify the payer is reimbursing according to the contract.

Your cheat sheet should look like this:

Plan A							
Service	Allowable	20%	40%	50%	60%	80%	90%
99213	75.00	15.00	30.00	37.50	45.00	60.00	67.50

The check-out staff will write the patient's portion on the encounter form (you may call it a charge ticket, fee ticket, rounding slip, or superbill), add the numbers together and give the patient the total. Alternately, the computer system will total the patient's portion based on the payer and the plan for the check-out person.

The balance of the information collected will be used to develop a payer matrix that might look something like this:

Payer	Employers	Collectible At TOS	Elig/Benefit Verification	Plan Year	Contract Dates	How to Notify
XYZ	WalMart	Deductible & Co-Pay	website	July-June –	Exp Dec 2013, must neg. <Aug1, 2012	Call June Jones at 1-800-555-1212
	State Employees	Deductible & Co-Ins.	Website	Jan –Dec	same	same

Another excellent way your organization can catalog payer and plan information is electronically in a document management system such as **FileConnect,** which I use and recommend.

FileConnect is an electronic filing cabinet with many great attributes, one of which is particularly helpful in this scenario. Every time there is a change in a payer contract, or a new plan is added by a local employer, you can update the staff's spreadsheet tools simultaneously and the newest version will be instantly available on their desktops.

Payers with whom you do not have a contract

Your primary payers in your community or region will most likely offer you a contract. Payers with less covered lives will not find it worthwhile to contract with healthcare providers, so you must decide how you will work with these companies and with these patients.

You are not required to file claims with payers that you are not contracted with. Most healthcare providers do file claims with non-contracted payers to ensure patient satisfaction. Where providers may differ, however, is whether or not they will ask patients with non-contracted payers to pay in full at time of service, and assign the payment to the patient OR ask the patient to pay only the expected patient portion at time of service and assign the payment to the provider. This decision will be made as part of your Financial Policy

(covered in Part 2.)

State and Federal government payers (Medicare, Medicaid, TriCare)

There has been a tremendous discussion in healthcare for the last several years about physicians limiting how many Medicare patients they will see, or even discontinuing to see Medicare patients completely. The rate at which Medicare pays is not enough to support the provision of services in most ambulatory practices, so some physicians do not participate in the Medicare program but still see Medicare patients (the fee they can charge Medicare patients is federally controlled and is called the "limiting" charge) or have opted out of the Medicare program altogether and will see Medicare patients on a cash basis only.

If a practice does accept Medicare patients, whether participating or not, there are set amounts to be collected from patients with Medicare – deductibles and co-insurance, as well as services that are never covered by Medicare.

Make sure that current Medicare allowables for your locality are loaded into your computer to do the math for you. You can use the same type of spreadsheet shown above to develop a cheat sheet of 80% of the Medicare allowable.

Service	Medicare Allowable	20% Owed by Patient
99213	66.74	13.34

What is confusing to most providers is what an insurance that is secondary to Medicare will pay. Many providers do not collect any fees at time of service for Medicare patients with a secondary payer, as there may or may not be any balance left that is the patient's responsibility.

Medicaid pays less than Medicare does, and based on the very

low fee schedule, many ambulatory providers will not accept Medicaid patients. Many Medicaid patients must depend on health departments, hospital clinics, federally-qualified health centers (FQHCs) and rural health clinics (RHCs) for care.

Tricare may be accepted on a case-by-case basis. A healthcare provider does not need to accept the health insurance for retired military across the board, and may decide individually whether to accept a Tricare patient or not.

Medicare Advantage

Medicare Advantage Plans, formerly called Medicare Choice + and now called Medicare replacement plans or Medicare Part C, are plans offered by non-government payers which replicate Medicare benefits for seniors, sometimes offering enhanced benefits as part of the package. There are several types of Medicare Advantage Plans, but the main types are local or regional HMO plans which require you to sign a contract, and the Private Fee For Service Plans (PFFS), for which no contract is required. If you see a Medicare Advantage PFFS patient, you have in essence agreed to accept their terms. The one thing you should ask prior to accepting a Medicare Advantage PFFS plan/patient, is what percentage and what year of Medicare rates are they paying.

Patients

So we finally arrive at the payer with whom most healthcare entities have the most difficulties – the patient. Why is it so difficult to collect from patients?

First, as we have seen throughout this article, insurance can be very confusing. Without a plan for organizing and sharing information, a healthcare provider may have significant difficulty assessing the patient’s payment responsibility.

Second, it has been a cultural norm until recently that patients do not have to pay at time of service, with the exception of their co-pay, and will be billed for their portion after insurance pays.

We know now that we must collect the correct payment at time of service. This is the only way to reduce the administrative expense of billing the patient for the balance and/or refunding the patient if too much has been collected. This is also the only way to maintain adequate cash flow as much of what used to be paid to the providers from insurance companies has now become the responsibility of the patient. Higher co-pays, higher co-insurance and most of all, extremely high deductible plans have left patients owing much more out-of-pocket and largely being unprepared to pay it at time of service.

In the next part of this series, Collections Basics Part 2: Develop Your Financial Policy, we will discuss setting up your financial policy so both patients and your staff can understand it, and how to collect from patients according to your policy.

CMS Announces Medicare Providers Must Begin to Revalidate Enrollment By March 2013

Announcement from CMS:

All providers and suppliers who enrolled in the Medicare program **prior to Friday, March 25, 2011**, will be required to revalidate their enrollment under new risk screening criteria required by the *Affordable Care Act* (section 6401a). Providers/suppliers who enrolled on or after Friday, March 25, 2011 have already been subject to this screening, and need not revalidate at this time.

New Screening Criteria

In the continued effort to reduce fraud, waste, and abuse, CMS implemented new screening criteria to the Medicare provider/supplier enrollment process beginning in March 2011. Newly-enrolling and revalidating providers and suppliers are placed in one of three screening categories – limited, moderate, or high – each representing the level of risk to the Medicare program for the particular category of provider/supplier, and determining the degree of screening to be performed by the Medicare Administrative Contractor (MAC) processing the enrollment application. More information on the screening categories is **here**.

Notices Will Be Sent to Providers/Suppliers

Between now and March 2013, MACs will be sending notices to individual providers/suppliers; **please begin the revalidation process as soon as you hear from your MAC**. Upon receipt of the revalidation request, providers and suppliers have 60 days from the date of the letter to submit complete enrollment forms. Failure to submit the enrollment forms as requested may result in the deactivation of your Medicare billing privileges. The easiest and quickest way to revalidate your enrollment information is by using Internet-based PECOS (Provider Enrollment, Chain, and Ownership System), at

https://pecos.CMS.hhs.gov.

Fees Levied

Section 6401a of the *Affordable Care Act* requires institutional providers and suppliers to pay an application fee when enrolling or revalidating ("institutional provider" includes any provider or supplier that submits a paper Medicare enrollment application using the CMS-855A; CMS-855B, **not including physician and non-physician practitioner organizations**; CMS-855S; or associated Internet-based PECOS enrollment applications); these fees may be paid via www.Pay.gov.

In order to reduce the burden on the provider, CMS is working to develop innovative technologies and streamlined enrollment processes – including Internet-based PECOS. Updates will continue to be shared with the provider community as these efforts progress.

For more information about provider revalidation, review the Medicare Learning Network's Special Edition Article #SE1126, titled "Further Details on the Revalidation of Provider Enrollment Information."

Step by Step Directions for Getting the EHR Incentive Money: My Notes From Last

Week's CMS Call

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

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

If your group hasn't received a check and hasn't registered for the Medicare or Medicaid Incentive Program, then this blog post is for you! For anyone who is really just beginning their EHR journey, today's presentation clarified previous information given by CMS, as well as giving listeners new information about the programs.

The two primary steps to obtaining incentive payments are:

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

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

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

Medicare Eligible Professionals:

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

Medicaid Eligible Professionals:

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

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

Medicare Incentive Payments:

- First eligible year for the program is 2011.
- Incentive amounts are based on the EP's Medicare Fee-for-Service allowable charges.
- Maximum incentives are $44,000 over 5 years.
- Incentives decrease if the EP does not start until after 2012.
- EPs must begin using an EHR by 2014 to receive incentive payments.
- Last payment year is 2016.
- An extra 10% bonus amount based on actual payments from Medicare, not allowables, is available for EPs practicing predominantly in a Health Professional Shortage Area (HPSA). **Go here to see if you practice in a HPSA.**
- EPs will receive only 1 incentive payment per year.

Medicaid Incentive Payments:

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

How Do You Choose Which Program to Qualify For?

1. First, determine which programs you can qualify for based on the **type of eligible professional** you are.
2. Then, determine which programs you can qualify for based on **your patient population**.
3. Next, review the **requirements and potential payments and/or reductions** for each program – get your calculator out!
    - Once an eligible professional has demonstrated meaningful use in the first participation year, they may receive an incentive payment equal to 75% of Medicare allowable charges for covered professional services furnished by the eligible professional in a payment year **VERSUS** Once an eligible professional has demonstrated adoption, implementation, upgrading, or meaningful use of certified EHR technology in the first participation year, they may receive an incentive payment of $21,250 from Medicaid. Remember the payments are for each provider. Don't forget the 10% HPSA bonus if you participate in the Medicare program.
    - Medicare requires EPs to escalate meaningful use participation and reporting and ultimately plans to impose payment reductions for EPs not engaged in using a certified EHR and implementing meaningful use. For Medicaid, each state has some leeway is defining the criteria for eligibility for incentives and there are no plans for payment reductions as a part of the program.
4. If you not up to speed on meaningful use and want to collect incentive money for 2011, it will be easier to

you to meet the requirements of the Medicaid program than the Medicare program, if you are eligible for the Medicaid program and there is one offered in your state.
5. Remember that EPs can switch programs once after their first year in either program.

Getting Ready for the Registration Process

1. Make sure you have your provider's **National Plan and Provider Enumeration System (NPPES)** User ID and Password. If the provider does not know this information, s/he will have to call and get the information. **The NPI, NPPES User ID and password are the basis for everything else.** While you're in that record, make sure all the provider's information is correct and completely up-to-date. You'll have an opportunity to update this information during the registration process, but it will not backfill the NPPES record.
2. Make sure your provider's enrollment record in the **Provider Enrollment, Chain and Ownership System (PECOS).** You can see if s/he has a record in PECOS here – scroll down this page to "OrderingReferringReport". This is a 16,000+ page pdf file and as of this post it was updated June 27, 2011. (Note: Eligible professionals who are only participating in the **Medicaid** EHR Incentive Program are not required to be enrolled in PECOS.)
3. If you do not have an active User ID and Password for NPPES or PECOS, request them via **Identity & Access Management**. You will need your type 2 NPI, your Taxpayer Identification Number (TIN), and your address from IRS Form CP-575. You will also need to mail a copy of IRS Form CP-575 as directed.
4. Payee Tax Identification Number (if you are reassigning

your benefits to a group or a hospital).

5. Payee National Provider Identifier (NPI) if you are reassigning your benefits. Note that many independent physicians are reassigning their benefits to their practice and almost all hospital-sponsored physicians are reassigning their benefits to the hospital.

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

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

1. Go to the **registration site here**. The Login page instructs the user on what is required for a valid User ID and Password combination. EPs are required to have an active NPI and must have a National Plan and Provider Enumeration System (NPPES) user account to login. For users who do not have either of these requirements, click on the link provided to you in the program.
2. A link to the Identity and Access Management System, I&A, is also provided. The I&A system allows EP users use to reset their passwords and edit their account information. Any additional login issues can be resolved by contacting the help desk (see info at the bottom of this post.) At the bottom of the page the user enters their User ID and Password combination. Please keep in mind that both of the fields are case-sensitive.
3. Once the user has logged into the system, the links and

tabs displayed in the top right hand corner are shown on every page.

- The **Home** hyperlink navigates the user to the Welcome page.
- The **Help** hyperlink opens a PDF User Manual that assists the user throughout the Registration process.
- If at anytime you wish to logout of the system, click the **Log Out** link and select yes in the pop-up window.
- The **Instructions** section on the Welcome page describes the actions that can be performed under each of the tabs. The EP submits and maintains their registration under the Registration tab and completes their Attestation under the Attestation tab.
- The **Status Tab** provides a snapshot of the user's current standing in the EHR Incentive Program. This includes the status of their registration and any attestations and payments associated with their account.
- The **Account Management** tab allows the user to proceed to the I&A system in order to change their account information.
- Clicking the **Registration** tab will reveal a set of instructions about the actions that can be performed. These options will differ depending on the status of the registration.

4. The EP's name, social security number, and NPI are retrieved from their NPPES account. If they have not started their registration, the status will be blank and **Register** will be the only available action.
5. Select the **Register** link to begin.
6. The Registration ID is displayed on the "Topics for this Registration" page. **Write this number down** for tracking purposes.
7. There are three topics that an Eligible Professional

must complete before submitting their Registration. They are EHR Incentive Program, Personal Information, and Business Address and Phone. The "Begin Submission" button cannot be selected until all of the topics are complete. Select the **"Start Registration"** button to navigate to the first topic.

8. On the EHR Incentive Program page, EPs are given the option to receive either a **Medicare or Medicaid EHR Incentive Payment**. For additional information about the two EHR Incentive Programs select the link that is provided. By selecting the Medicare option and clicking the "Apply" button, the EP type field page cursor moves across screen to highlight information. Provider Types that are eligible in the Medicare EHR Incentive Program are displayed in the dropdown. Selecting the Medicaid option and then the "Apply" button refreshes the page with two fields, Medicaid State/Territory and Eligible Professional Type. Only those states and territories participating in the Medicaid EHR Incentive Program are displayed in the Medicaid State/Territory dropdown. Provider types that are eligible for the Medicaid EHR Incentive Program are displayed in the dropdown.
9. Two additional links on the EHR Incentive Program page provide the user with information on certified EHRs and the EHR Certification Number. The Eligible Professional is required to indicate whether they are currently using a certified EHR.
   A provider's EHR system is not required to be certified prior to registration; however, an EHR Certification Number will be required at the time of attestation. See the **Certified Health IT Product List (CHPL)** for a listing of "certified" EHR products and to identify a product's corresponding certification number.Select the "Save and Continue" button to navigate to the next topic.
10. The Name and Identifiers displayed on the Personal Information page are retrieved from the user's NPI

record on the NPPES system. These fields cannot be modified in the EHR Incentive Program System. The Payee TIN Type field provides the user with two options in terms of who receives the EHR Incentive Payments. If the payments should be sent directly to the Eligible Professional, the SSN tab should be selected in the Payee TIN Type field. If the payments should be sent to a group associated with the Eligible Professional, the user should select E-I-N in the Payee TIN Type field and then select the "Apply" button. After the page is refreshed, three additional fields are displayed.

11. The next step is to select the Group that should receive the payments. A Group Name will only appear in the dropdown if the EP's Medicare enrollment in the Provider Enrollment, Chain, and Ownership System, or PECOS, has reassigned benefits to the Group. After the Group Name is selected, the Group's TIN is retrieved from PECOS and displayed in the Payee TIN field. It is also required that the user enters the NPI associated with the Group in the Payee NPI field. If the user had selected to register for the Medicaid EHR Incentive Program, the system requires the user to manually enter the Group Name, Payee TIN, and Payee NPI. A dropdown list of Group Names would not be provided. Select the "Save and Continue" button to navigate to the next topic.
12. The address and phone number displayed on the Business Address and Phone page is consistent with the Practice Location on the Eligible Professional's NPI record. Unlike the Personal Information page, the address and phone number fields can be modified here. However, if changes are made to the address and phone number in the EHR Incentive Program System, the changes will not be reflected on the Eligible Professional's NPI record. E-mail Address is also a required field and must be entered with the correct email address format. Select the "Save and Continue" button to complete the last topic.

13. Once the user has entered the required registration information, all three of the topics are marked as completed. To initiate the submission process, select the “Begin Submission” button.
14. The Verify Registration page displays a summary of the registration information. It displays Personal Information, Business Address, as well as the Incentive Program that was chosen for this registration. The “Reason for Submission” section describes the action that the user is currently performing on the registration. If any of the information on this page is incorrect, the user should select the “Previous Page” button and make the appropriate modification.
15. After verifying that all of the information is correct, please select the “Submit” button to proceed. Before the registration can be submitted, the user must review and agree to the Registration Disclaimer. Agreeing to the legal notice means that the EP is certifying that the information provided in the registration is true and accurate. Please take the time to review each line of the disclaimer. Select the “Agree” button to proceed.
16. If the registration passes all validations, the submission will be successful. Please keep in mind that things like a non-approved Medicare enrollment in PECOS or OIG Exclusions can result in registration failure. Contact the help desk
    to resolve any of these issues.
17. The Submission Receipt page reminds users that they will not receive an e-mail confirmation and that attestation information must be submitted in order to qualify for an incentive payment. **Print the Submission Receipt page** by selecting the “Print” button at the bottom of the page. Select the “Return to Home” button to proceed.
18. A registration must be Active in order to proceed with Attestation and Payment. If any changes need to be made to the registration, the user would select the Modify link and navigate back to the topics page. The

registration can also be cancelled, which would end the Eligible Professional's participation in the EHR Incentive Program.

19. Selecting the Status tab navigates the user to the Status Summary page. The Select link navigates to the Status Detail page which displays all of the registration information in one location. The Additional Information link expands to display more registration information and the status of validations that are performed during submission.

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

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

A: Yes, you can use a free EHR and still receive the incentive money. The incentive money is to assist EPs implement EHRs and is not intended to be used only to purchase the software. Remember that the EHR must be certified by one of the certifying bodies and must be certified for ambulatory care.

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

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

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

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

Q: Are radiologists eligible?

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

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

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

nursing home visits

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

A: Yes.

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

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

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

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

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

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

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

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

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

A: Yes.

Resources:

EHR Information Center

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

CMS Roundup of 17 Announcements: More Information Than You Can Shake a Stick At!

Hospital Wage Index Reform Call

Special Open Door Forum: Presentation and Listening Session on Hospital Wage Index Reform

Tuesday, April 12, 2011, 1:30 PM – 3:00 PM ET.

Section 3137(b) of the Affordable Care Act requires CMS to submit to Congress, by December 31, 2011, a report that includes a plan to reform the wage index under the Medicare hospital inpatient prospective payment system (IPPS). CMS acquired the services of Acumen, LLC to assist in its study of the wage index. During the first part of this special open door forum, Acumen will present its concept of an alternative methodology for the wage index. The second part will be a listening session, during which CMS would like to hear from you regarding your opinions about Acumen's concept, as well as any suggestions on alternative methods for computing the wage index. If you wish to participate via conference call, dial **1-800-837-1935** Conference ID 50101623. Please see the full participation announcement in the Downloads section **here**.

Electronic Health Record Incentive

Program Attestation Begins This Week

Attestation for the Medicare Electronic Health Record (EHR) Incentive Program begins on Monday, April 18, 2011. In order to receive your Medicare EHR incentive payment, you must attest through CMS's web-based Medicare and Medicaid EHR Incentive Programs Registration and Attestation System.

You can **preview selected screenshots** of the Attestation System to help you understand what the attestation process will involve. Please note that these screenshots are only examples – the final appearance and language may incorporate additional changes. CMS will release additional information about the Medicare attestation process soon, including User Guides that provide step-by-step instructions for completing attestation and educational webinars that describe the attestation process in depth.

You need to understand the required meaningful use criteria to successfully attest. Meaningful use requirements for eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) participating in the Medicare EHR Incentive Program are different:

- EP Meaningful Use Criteria – Must report on 15 core measures, 5 of 10 menu measures, and 6 clinical quality measures, consisting of 3 required core measures and 3 additional measures.
    - Visit the **Stage 1 EHR Meaningful Use Specification Sheets for EPs** for information on core and menu measures for EPs.
    - Visit the **Clinical Quality Measures page** for information on the required clinical quality measures for EPs.

- Eligible Hospital and CAH Meaningful Use Criteria – Must report on 14 core measures, 5 of 10 menu measures, and 15 clinical quality measures.
    - Visit the **Stage 1 EHR Meaningful Use Specification Sheets for Eligible Hospitals and CAHs** for information on core and menu measures for eligible hospitals and CAHs.
    - Visit the **Clinical Quality Measures page** for information on the required clinical quality measures for eligible hospitals and CAHs.

You should also make sure that you begin your 90-day reporting period in time to attest and receive a Medicare payment in 2011. The last days to begin 90-day reporting periods for 2011 incentive payments are:

- Sunday, July 3, 2011, for eligible hospitals and CAHs; and
- Saturday, October 1, 2011, for EPs.

Under the Medicaid EHR Incentive Programs, the date when participants can begin attestation for adopting, implementing, upgrading, or demonstrating meaningful use of certified EHR technology varies by state. Visit the **Medicaid State EHR Incentive Program web-tool** for more information about your state's participation in the Medicaid EHR Incentive Program.

Want more information about the EHR Incentive Programs? Make sure to visit the **CMS EHR Incentive Programs website** for the latest news and updates on the EHR Incentive Programs; also read the new EHR Incentive Program **FAQs from CMS.**

Preventive Services, Preventive Physical Examinations and Annual

Wellness Visits Quick Reference Charts

The ABCs of Providing the Initial Preventive Physical Examination Quick Reference Chart provides Medicare Fee-For-Service providers a list of the elements of the IPPE, as well as coverage and coding information. View the chart **here.**

The ABCs of Providing the Annual Wellness Visit Quick Reference Chart provides Medicare Fee-For-Service providers a list of the elements of the AWV, as well as coverage and coding information. View the chart **here.**

The *Medicare Preventive Services* Quick Reference Chart provides Medicare Fee-For-Service providers coverage, coding, and payment information on the variety of preventive services covered by Medicare. View the chart **here.**

A hardcopy booklet containing all three charts, as well as the *Quick Reference Information: Medicare Immunization Billing* chart, will be available at a later date.

Latest HCPCS Code Set Changes

The Centers for Medicare & Medicaid Services is pleased to announce the scheduled release of modifications to the Healthcare Common Procedure Coding System (HCPCS) code set. These changes have been posted to the HCPCS web page **here**. Changes are effective on the date indicated on the update.

Revisions to ASP Pricing Files

The Centers for Medicare and Medicaid Services (CMS) has posted revised October 2010 and January 2011 ASP (average sales price) files, which are available for download **here** (see

left menu for year-specific links).

Physician or NPP Signatures on Lab Requisitions

In the Monday, November 29, 2010, Medicare Physician Fee Schedule final rule, the Centers for Medicare & Medicaid Services (CMS) finalized its proposed policy to require a physician's or qualified non-physician practitioner's (NPP) signature on requisitions for clinical diagnostic laboratory tests paid under the clinical laboratory fee schedule effective Saturday, January 1, 2011. (A requisition is the actual paperwork, such as a form, which is provided to a clinical diagnostic laboratory that identifies the test or tests to be performed for a patient.)

On Monday, December 20, 2010, CMS informed its contractors of concerns that some physicians, NPPs, and clinical diagnostic laboratories are not aware of or do not understand this policy. As such, CMS indicated that it will focus in the first quarter of 2011 on developing educational and outreach materials to educate those affected by this policy. CMS indicated that once the first quarter educational campaign is fully underway, it will expect requisitions to be signed.

After further input from community, CMS has decided to focus for the remainder of 2011 on changing the regulation that requires signatures on laboratory requisitions because of concerns that physicians, NPPs, and clinical diagnostic laboratories are having difficulty complying with this policy.

Face-to-Face Encounter Requirements

for Home Health and Hospice

Effective April 1, 2011, the Centers for Medicare & Medicaid Services (CMS) expects home health agencies and hospices have fully established internal processes to comply with the face-to-face encounter requirements mandated by the Affordable Care Act (ACA) for purposes of certification of a patient's eligibility for Medicare home health services and of recertification for Medicare hospice services.

Section 6407 of the ACA established a face-to-face encounter requirement for certification of eligibility for Medicare home health services, by requiring the certifying physician to document that he or she, or a non-physician practitioner working with the physician, has seen the patient. **The encounter must occur within the 90 days prior to the start of care, or within the 30 days after the start of care.** Documentation of such an encounter must be present on certifications for patients with starts of care on or after January 1, 2011.

Similarly, section 3131(b) of the ACA requires a hospice physician or nurse practitioner to have a face-to-face encounter with a hospice patient prior to the patient's 180th-day recertification, and each subsequent recertification. The encounter must occur no more than 30 calendar days prior to the start of the hospice patient's third benefit period. The provision applies to recertifications on and after January 1, 2011.

On December 23, 2010, due to concerns that some providers needed additional time to establish operational protocols necessary to comply with face-to-face encounter requirements mandated by the Affordable Care Act (ACA) for purposes of certification of a patient's eligibility for Medicare home health services and of recertification for Medicare hospice services, CMS announced that it will expect full compliance

with the requirements, beginning with the second quarter of CY2011.

Throughout the first quarter of 2011, CMS has continued outreach efforts to educate providers, physicians, and other stakeholders affected by these new requirements. CMS has posted guidance materials including a MLN Matters article, questions and answers documents, training slides, and manual instructions which are available via CMS' Home Health Agency Center and Hospice webpages. CMS' Office of External Affairs and Regional Offices contacted state and local associations for physicians and home health agencies and advocacy groups to ensure awareness about the face-to-face encounter laws, and to distribute the educational materials.

CMS will continue to address industry questions concerning the new requirements, and will update information on the Web site here for **home health** and here for **hospice**.

Federally Qualified Health Center Fact Sheet Revised

The revised publication titled *Federally Qualified Health Center* (revised March 2011) is now available in downloadable format from the Medicare Learning Network® **here**. This fact sheet is designed to provide education about Federally Qualified Health Centers (FQHC), including background; FQHC designation; covered FQHC services; FQHC preventive primary services that are not covered; FQHC Prospective Payment System; FQHC payments; and *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* provisions that impact FQHCs.

Avoiding the Adjustment 2012 Medicare Payment Adjustment for Not ePrescribing in 2011

In November 2010, the Centers for Medicare & Medicaid Services announced that, beginning in calendar year 2012, eligible professionals who are not successful electronic prescribers based on claims submitted between Sat Jan 1 and Thu June 30, 2011, may be subject to a payment adjustment on their Medicare Part-B Physician Fee Schedule-covered professional services. Section 132 of the *Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)* authorizes CMS to apply this payment adjustment whether or not the eligible professional is planning to participate in the eRx Incentive Program.

From 2012 through 2014, the payment adjustment will increase each calendar year. In 2012, the payment adjustment for not being a successful electronic prescriber will result in an eligible professional or group practice receiving 99% of their Medicare Part-B PFS amount that would otherwise apply to such services. In 2013, an eligible professional or group practice will receive 98.5% of their Medicare Part-B PFS-covered professional services for not being a successful electronic prescriber in 2011 or as defined in a future regulation. In 2014, the payment adjustment for not being a successful electronic prescriber is 2%, resulting in an eligible professional or group practice receiving 98% of their Medicare Part-B PFS-covered professional services. (The payment adjustment does not apply if less than 10% of an eligible professional's or group practice's allowed charges for the Sat Jan 1, 2011 through Thu June 30, 2011, reporting period are comprised of codes in the denominator of the 2011 eRx measure.) Also note that earning an eRx incentive for 2011 will NOT necessarily exempt an eligible professional or group practice from the payment adjustment in 2012.

How to Avoid the 2012 eRx Payment Adjustment:

- Eligible professionals – An eligible professional can avoid the 2012 eRx Payment adjustment if (s)he:
  - Is not a physician (MD, DO, or podiatrist), nurse practitioner, or physician assistant as of Thu June 30, 2011, based on primary taxonomy code in NPPES;
  - Does not have prescribing privileges. Note that (s)he must report **G8644** at least one time on an eligible claim prior to Thu June 30, 2011;
  - Does not have at least 100 cases containing an encounter code in the measure denominator;
  - Becomes a successful e-prescriber; and reports the eRx measure for at least 10 unique eRx events for patients in the denominator of the measure.

NOTE: Group Practices – For group practices that are participating in eRx GPRO-I or GPRO-II during 2011, the group practice MUST become a successful e-prescriber. Depending on the group's size, the group practice must report the eRx measure for 75-2500 unique eRx events for patients in the denominator of the measure. For additional information, please visit the "Getting Started" webpage **here** or download the "Medicare's Practical Guide to the Electronic Prescribing (eRx) Incentive Program" under "Educational Resources" on the same website.

Implementation of Errata for Version 5010 of HIPAA Transactions

BTW, **errata** is a list or lists of errors and their corrections. Errata is plural and the singular is erratum.

CMS does not have a version 4010A1 direct data entry and a separate version 5010 direct data entry. The Priority (Type)

of Admission or Visit code is now required on all version 4010A1 institutional claims submitted or corrected via direct data entry, as well as on version 5010 institutional claims, regardless of how they are submitted. Providers that are unsure which code to use are to use code 9 (Information not Available). Additional Priority (Type) of Admission or Visit code values and descriptions are available from the **National Uniform Billing Committee** or from your servicing MAC. The Priority (Type) of Admission or Visit code is not required on 4010A1 institutional claims submitted or corrected via an 837. More information on Version 5010 **here.**

IMPORTANT 5010/D.0 IMPLEMENTATION ITEMS

REMINDER – 5010/D.0 Errata requirements and testing schedule can be found here

REMINDER – Contact your MAC for their testing schedule

READINESS ASSESSMENT – Have you done the following to be ready for 5010/D.0?

READINESS ASSESSMENT – What do you need to have in place to test with your MAC?

READINESS ASSESSMENT – Do you know the implications of not being ready?

New Mental Health Services Booklet

A new publication titled "Mental Health Services" is now available in downloadable format from the Medicare Learning Network® **here**. This booklet is designed to provide education on mental health services, including covered mental health services, mental health services that are not covered, mental health professionals, outpatient psychiatric hospital services, and inpatient psychiatric hospital services.

Ambulance Fee Schedule Fact Sheet Revised

The revised publication titled "Ambulance Fee Schedule" (revised March 2011) is now available in downloadable format from the Medicare Learning Network® **here**. This fact sheet is designed to provide education about the Ambulance Fee Schedule including background, ambulance providers and suppliers, ambulance services payments, and how payment rates are set.

Health Professional Shortage Area Fact Sheet Revised

The revised publication titled "Health Professional Shortage Area" (revised March 2011) is now available in downloadable format from the Medicare Learning Network® **here**. This fact sheet is designed to provide education on the Health Professional Shortage Area (HPSA) payment system and includes an overview of the program and general requirements.

Medicare Disproportionate Share Hospital Fact Sheet Revised

The revised publication titled "Medicare Disproportionate Share Hospital" (revised March 2011) is now available in downloadable format **here**. This fact sheet is designed to provide education on Medicare Disproportionate Share Hospitals

(DSH) including background; methods to qualify for the Medicare DSH adjustment; *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* and *Deficit Reduction Act of 2005* provisions that impact Medicare DSHs; number of beds in hospital determination; and Medicare DSH hospital payment adjustment formulas.

G0431QW is Deleted and G0434QW is Added to CLIA Waived Test Schedule

The Centers for Medicare & Medicaid Services (CMS) is updating the status of two codes on the Clinical Laboratory Fee Schedule (CLFS).

- Effective April 1, 2011, code G0431QW is deleted from the CLFS. Code G0431 describes a high complexity test, and should not be reported with a QW modifier; the QW modifier indicates a CLIA waived test.
- Effective April 1, 2011, code G0434QW is added to the CLFS. Code G0434 can describe a CLIA waived test. The use of the QW modifier to indicate a CLIA waived test is necessary for accurate claims processing.

Codes G0431 and G0434 will remain on the CLFS.

CMS Launches a Dedicated Web Page for the Medicare Shared Savings Program/Requirements for ACOs

On March 31, 2011, The Centers for Medicare & Medicaid

Services (CMS) published in the Federal Register proposed rule ***CMS-1345-P, Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations*** that implements the Medicare Shared Savings Program (Shared Savings Program) and establishes the requirements for Accountable Care Organizations. CMS has launched a dedicated web page **here** for Medicare FFS providers and other providers of services and suppliers. Bookmark the web page and check back often, as CMS continues to add information on the program.

Program for Evaluating Payment Patterns Electronic Report (PEPPER) for CAHs

Beginning in April 2011, the Centers for Medicare & Medicaid Services (CMS) will make available free hospital-specific comparative data reports for critical access hospitals (CAHs) nationwide. The Program for Evaluating Payment Patterns Electronic Report (PEPPER) provides hospital-specific data statistics for Medicare discharges at risk for improper payments. Hospitals can use the data to support internal auditing and monitoring activities. PEPPER is the only free report comparing a CAH's Medicare billing practices with other CAHs by state, Medicare Administrative Contractor (MAC) or Fiscal Intermediary (FI) jurisdiction and the nation. CMS has contracted with TMF Health Quality Institute to develop and distribute the reports.

PEPPER will be distributed electronically to CAH QualityNet Administrators and those who have basic user accounts with the PEPPER Recipient role on or about Monday, April 25, via a My QualityNet secure file exchange. In preparation for receiving and downloading PEPPER from My QualityNet, these individuals should verify that their computer systems are equipped with the software and configuration required to use My QualityNet by following the steps at **www.qualitynet.org** (see "Getting

Started With QualityNet" and "Test Your System.") Additional information about downloading PEPPER from My QualityNet can be found **here** (includes System Setup and Test Guide, Troubleshooting Tips and a guide for Configuration Changes for Compatibility with QualityNet).

CAHs may work with their Quality Improvement Organization (QIO) to obtain a QualityNet administrator account by visiting **www.qualitynet.org** and clicking on the Hospitals – Inpatient link. Obtaining a My QualityNet account may take several weeks; CAHs should plan accordingly.

TMF will conduct a web-based training session for CAH staff providing information on PEPPER and how to use it on Thursday, April 28, at 1 p.m. central time. To register for the training, CAH staff should visit https://tmfevents.webex.com. The training will be recorded and posted on http://www.pepperresources.org.

For more information, including the PEPPER distribution schedule, a sample PEPPER for CAHs and information about QualityNet accounts, visit the PEPPER website. CAH staff are encouraged to join the e-mail list on this website to receive important notifications about upcoming PEPPER distribution and training opportunities.

Image by The Library of Congress via Flickr