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: 11 Stories About Balance Billing, eRX, PQRS, 5010,

EHR, and Revalidation

- Medicare Enrollment/Revalidation: Requests for the IRS Form CP 575 (jump to story)

- Were You Sent a Request to Revalidate Your Medicare Enrollment? (jump to story)

- Submit Your Medicare Enrollment Application Up to 60 Days Before the Effective Date (jump to story)

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

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

- Medicare Electronic Prescribing Payment Adjustment Hardship Exemption (jump to story)

- New Data Provides Info on EPs who Participated in the Medicare EHR

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- **National Provider Call – Physician Quality Reporting System & Electronic Prescribing (jump to story)**
- **Additional Information on Home Health Face-to-Face Encounter Requirements (jump to story)**
- **Providers who Receive Error Codes H20203 and H45255 Need to Balance Bill (jump to story)**
- **Major Improvements to Medicare Online Enrollment System (jump to story)**

Medicare Enrollment/Revalidation: Requests for the IRS Form CP 575

The IRS Form CP 575 is an Internal Revenue Service (IRS) generated letter you receive from the IRS granting your Employer Identification Number (EIN). A copy of your CP 575 may be required by the Medicare contractor to verify the provider or supplier's legal business name and EIN.

When is the CP 575 is required to be submitted to the Medicare contractor?

- If the applicant is enrolling as a professional

corporation, professional association, or limited liability corporation
- If the applicant is enrolling as a sole proprietor using an EIN
- If the Medicare contractor determines a discrepancy between the provider or supplier's legal business name and EIN provided in Section 2 of the CMS-855 form
- The CP 575 May be requested by the CMS External User Services (EUS) Help Desk, for verification, when the Authorized Official (AO) of the provider or supplier organization registers for Internet-based PECOS access.

If you do not have a form CP 575: contact the IRS on 1-800-829-4933 from 7am to 7pm.
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Were You Sent a Request to Revalidate Your Medicare Enrollment-?

At this time, the quickest way to see if a revalidation letter was mailed to you is to check the "Downloads" on the Revalidation page on the cms.gov website. You can now view:

- Medicare Part A/B Revalidation Letters Mailed February – March 2012
- Medicare Part A/B Revalidation Letters Mailed January 2012
- Medicare Part A/B Revalidation Letters Mailed November – December 2011
- Medicare Part A/B Revalidation Letters Mailed September – October 2011
- NSC Revalidation Letters Mailed

Later this year, CMS plans to implement a faster process for allowing users to see the date the revalidation notice was

sent directly on the “My Enrollments” page within PECOS.
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Submit Your Medicare Enrollment Application Up to 60 Days Before the Effective Date

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

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

Wednesday, May 16; 2-3:30pm ET

CMS is hosting a National Provider Call regarding the current status of Medicare FFS implementation of HIPAA Version 5010 and D.0. This National Provider Call will address the current 5010/D.0 metrics, and discuss recommendations made by Medicare

FFS, and possible outstanding fixes impacting the Part A and Part B Version 5010 transition.

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

Agenda:

§ Current 5010/D.0 metrics

§ Addressing recommendations made by Medicare FFS

§ Possible outstanding fixes impacting the Part A and Part B Version 5010 transition

§ Q&A session

Registration Information: In order to receive call-in information, you must register for the call 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.

Presentation: The presentation for this call will be posted at least one day in advance on the FFS National Provider Calls webpage. In addition, a link to the slide presentation will be emailed to all registrants on the day of the call.
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Updates from the Medicare Learning Network

From the MLN: Acute Inpatient Prospective Payment System Hospital Web-Based Training Course Now Available – This web-based training (WBT) course is designed to provide an overview

of acute care hospital coverage and payment under the acute Inpatient Prospective Payment System (IPPS). It is designed to present a basic explanation of inpatient hospital coverage, billing, and payment for beneficiaries enrolled in Original Medicare.

To access a web-based training course please go to the MLN Products webpage, and in the "Related Links" section at the bottom of the page, click on web-based training courses.

From the MLN: "Quick Reference Information: Preventive Services" Revised – Quick Reference Information: Preventive Services (ICN 006559) has been revised and is now available in downloadable format. This educational tool is designed to provide education on the Medicare-covered preventive services. It includes coverage, coding, and payment information.

From the MLN: "Quick Reference Information: The ABCs of Providing the Annual Wellness Visit" Revised – Quick Reference Information: The ABCs of Providing the Annual Wellness Visit (ICN 905706) has been revised and is now available in downloadable format. This educational tool is designed to provide education on the Annual Wellness Visit (AWV). It includes a list of the required elements in the initial and subsequent AWVs, as well as coverage and coding information.

From the MLN: "Quick Reference Information: The ABCs of Providing the Initial Preventive Physical Examination" Revised – Quick Reference Information: The ABCs of Providing the Initial Preventive Physical Examination (ICN 006904) has been revised and is now available in downloadable format. This educational tool is designed to provide education on the Initial Preventive Physical Examination, also known as the IPPE. It includes a list of elements that must be included in the IPPE, as well as coverage and coding information.

From the MLN: "Health Professional Shortage Area (HPSA) Physician Bonus, HPSA Surgical Incentive Payment, and Primary

Care Incentive Payment Programs" Fact Sheet Revised – The "Health Professional Shortage Area (HPSA) Physician Bonus, HPSA Surgical Incentive Payment, and Primary Care Incentive Payment Programs" fact sheet (previously titled Health Professional Shortage Area) (ICN 903196) has been revised and is now available in downloadable format. It includes an overview of the HPSA Physician Bonus, HPSA Surgical Incentive Payment, and Primary Care Incentive Payment Programs.

From the MLN : "Quick Reference Information: Medicare Immunization Billing" Revised – "Quick Reference Information: Medicare Immunization Billing" (ICN 006799) has been revised and is now available in downloadable format. This educational tool is designed to provide education on Medicare-covered preventive immunizations. It includes coverage, coding and billing information on the influenza, pneumococcal and Hepatitis B vaccines and their administration.

From the MLN: "Medicare Quarterly Provider Compliance Newsletter [Volume 2, Issue 3]" Released – The "Medicare Quarterly Provider Compliance Newsletter [Volume 2, Issue 3]", Educational Tool (ICN 907927) has been released and is now available in downloadable format. This educational tool is designed to provide education on how to avoid common billing errors and other erroneous activities when dealing with the Medicare Program. It highlights the top issues of the particular Quarter. Please visit the Medicare Quarterly Provider Compliance Newsletter Archive to download, print, and search an archive of previously-issued newsletters.

From the MLN: "Correction to Processing of Hospice Discharge Claims" MLN Matters® Article Revised – MLN Matters® Article #MM7473, "Correction to Processing of Hospice Discharge Claims" has been revised and is now available in downloadable format. This article is designed to provide education on Medicare's hospice discharge claims processing policy, as outlined in Change Request (CR) 7473. It includes information about changes to chapter 11 of the Medicare Claims Processing

Manual, which provides detailed instructions for hospices to use in coding claims. The article was revised to emphasize that the implementation of this policy is effective for claims on or after January 1, 2012.
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Medicare Electronic Prescribing Payment Adjustment 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 more information on how to navigate the Communication Support Page, please reference the following documents:

§ Quality Reporting Communication Support Page User Guide

§ Tips for Using the Quality Reporting Communication Support Page

For additional information and resources, please visit the E-Prescribing Incentive Program 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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New Data Provides Info on EPs who Participated in the Medicare EHR Incentive Program in 2011

CMS has posted the 2011 Medicare Electronic Health Record (EHR) Incentive Program Eligible Professionals Public Use File (PUF) to the EHR website. This new file contains data on Eligible Professionals (EPs) who participated in the Medicare EHR Incentive Program in 2011.

The CMS 2011 Medicare EHR Incentive Program Eligible

Professionals PUF provides detailed information about EPs who attested as of December 22, 2011, including each provider's type, specialty, and his/her responses to the meaningful use core and menu measures. The PUF excludes data from hospitals in the Medicare EHR Incentive Program, which will be posted at a later date. There is no 2011 data available for participants in the Medicaid EHR Incentive Program, who received incentive payments in 2011 only for adopting, implementing, or upgrading to certified EHR technology.

Additional information on the PUF can be found on the Data and Reports page of the EHR website.
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National Provider Call – Physician Quality Reporting System & Electronic Prescribing (eRx) – Register Now

National Provider Call – Physician Quality Reporting System & Electronic Prescribing (eRx) – Register Now

Tuesday, May 22; 1:30-3pm ET

CMS will host a National Provider Call with question and answer session. CMS subject matter experts will provide an overview of the 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

Agenda:

- Opening Remarks
- Program Announcements
- Overview of the 2013 Electronic Prescribing Payment Adjustment
- Overview of the 2012 Physician Quality Reporting System Medicare EHR Incentive Pilot
- Question & Answer Session

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.

Presentation: The presentation for this call will be posted at least one day in advance on the FFS National Provider Calls webpage. In addition, a link to the slide presentation will be emailed to all registrants on the day of the call.
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Additional Information on Home Health Face-to-Face Encounter Requirements

On May 7, CMS released an MLN article designed to provide education on the contents of the home health certification, including homebound criteria and requirements for the face-to-face encounter and documentation. It includes guidance that physicians, non-physician practitioners, physician support personnel, and home health agencies can use to ensure that all certification requirements are understood and met. In addition, on May 4, updated face-to-face encounter Questions & Answers were posted and are available through the CMS Home Health Agency (HHA) spotlight page.

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Providers who Receive Error Codes H20203 and H45255 Need to Balance Bill

Providers who receive rejection codes H20203 and/or H45255 will need to balance bill their patients' supplemental payers for any balances left after Medicare. CMS deeply regrets that these error conditions have arisen.

On February 29, 2012, CMS alerted Medicare physicians/practitioners, providers, and suppliers to three (3) edits that they may be seeing reflected on special provider notification letters that they receive from their local Fiscal Intermediary (FI), Carrier, A/B Medicare Administrative Contractor (MAC), or Durable Medical Equipment MAC (DME MAC). These edits had resulted, or are still resulting, from defects within our coordination of benefits (COB) *HIPAA* 837 compliance editing. The defects associated with the firing of edits H51108 and H20203 at the Coordination of Benefits Contractor (COBC) were resolved on January 16 and February 27, respectively. CMS has the following additional information updates to offer regarding edits H20203 and H45255:

- *H20203*: Element CLM16 is present though marked 'Not Used'
    - Update: Medicare was able to repair all affected 837 professional claims right after February 27, 2012. Unfortunately, due to more highly critical *HIPAA* 5010 fixes that were needed to the version 5010 837 institutional COB/crossover claims process, the Fiscal Intermediary Shared System

(FISS) was unable to resend 837 institutional claims that incorrectly rejected with error code H20203. Fortunately, the overall volume of affected claims was determined to be very low. Providers that received rejection code H20203 on their provider notification letters issued from their FI or A/B MAC will need to balance bill their patients' supplemental payers for any balances left after Medicare.

H45255: The Other Subscriber Primary Identifier (2330A NM109) Cannot be the same as the group or policy number (2320 SBR03)

- Resolution: COBC's translation routine will scrub the duplicate identifier that is present in 2320 SBR03.
- Updated confirmed fix date: May 18, 2012
- Scope of Impact: The current problem seems to only be impacting *HIPAA* 5010A1 837 professional claims billed to Medicare by physicians/practitioners and DMEPOS suppliers. The error is principally impacting crossover claims that would have been transferred to North Dakota Medicaid. (*Note:* This is due to its reporting of the Medicare Health Insurance Claim Number (HICN) as the policy number for crossover claim purposes).
- Update: Because certain Carriers, A/B MACs, and DME MACs have been holding generation of their provider notification letters tied to rejection code H45255 since February 2012, CMS has determined that a future claim repair action after May 18, 2012, would not be viable. Therefore, physicians/practitioners and suppliers may be seeing error H45255 on their provider notification letters. If physicians/practitioner and supplier offices see this rejection code, they will need to balance bill their patients' supplemental payer for any balances remaining after Medicare.

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Major Improvements to Medicare Online Enrollment System

Over the last year, CMS has listened to your feedback about the Medicare online enrollment system (PECOS) and made improvements to:

- Incorporate search capabilities on the My Enrollments page
- Increase access to information, and
- Allow electronic signature of the Certification Statement and Electronic Funds Transfer Agreement.

The following upgrades are now available:

Overall Usability

Users will now have a search and filter feature that will allow the user to filter enrollments on the My Enrollments Page. Users will be able to filter the enrollments shown on the My Enrollments Page based on: Medicare ID, National Provider Identifier (NPI), or by selecting an Enrollment Type, Enrollment Status, or State. Additional data has been added to the enrollment data on the My Enrollments Page, i.e. Enrollment Type, Medicare ID, and Practice Location.

Access to More Information

Users will also be able to see if a request for revalidation has been sent by the Medicare Administrative Contractor (MAC). A "Revalidation Notice Sent" date will be displayed on the My Enrollments page. This will reflect the date in which the Revalidation Letter was mailed by the MAC to the provider/supplier. The date will be displayed on the My Enrollments page for 120 days.

In addition, users will be able to identify those enrollments that are accredited for Advanced Diagnostic Imaging (ADI)

Services. An ADI Services indicator will be visible on the My Enrollments page as either a “Yes” or “No”.

Electronic Submission and Signature of Electronic Funds Transfer (EFT) Agreement

Users can now complete and submit EFT Agreements electronically with the option to e-sign the document. If the provider/supplier submits the EFT agreement electronically and chooses not to e-sign, they shall include a hardcopy form of the completed and signed EFT agreement with its supporting documentation to the contractor. Providers/suppliers are still required to physically mail confirmation of account information on bank letterhead, or a voided check whether the EFT is submitted electronically or via the paper version. Along with the documentation, it is also important that the provider/supplier print and mail the enrollment submission confirmation page containing the web tracking ID. This will ensure that the supporting documents mailed to your MAC get associated with your electronic application submission.

Did you know?

All FFS providers, including Federally Qualified Health Centers (FQHCs), End Stage Renal Disease (ESRD) Facilities, and Rural Health Clinics (RHCs) can take advantage of Internet-Based PECOS to check and update Medicare enrollment information.

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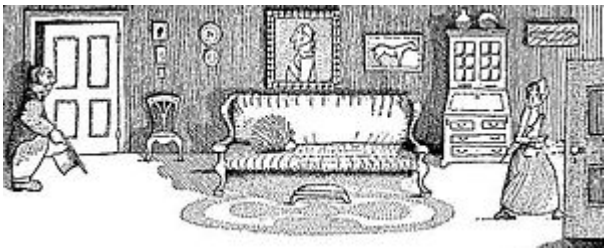
The Medicare News You Can Use This Week: eRx Exemptions for 2012 and 2013, Billing Education, and eSignatures



(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)

(eRx) 2012 eRx Payment Adjustment Update (jump to story)

(eRx) Medicare ePrescribing Penalty: Phone Lines Now Open (jump to story)

(eRx) Hardship Exemptions for 2013 Electronic Prescribing Payment Adjustment (jump to story)

(PQRS) Medicare Quality Reporting Incentive Programs Manual Update (jump to story)

(HCPCS) April Update to the Calendar Year (CY) 2012 Medicare Physician Fee Schedule Database (jump to story)

(Codes G0442 & G0443) Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse (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 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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Medicare Physician Revalidation Extended Two Years to March 2015 and a Sample Revalidation Letter

The Centers for Medicare & Medicaid Services (CMS) has extended the revalidation period for another 2 years. This will allow for a smoother process for provider and contractors. **Revalidation notices will now be sent through March of 2015.**

> ***IMPORTANT: This does not affect those providers which have already received a revalidation notice. If you have received a revalidation notice from your contractor, respond to the request by completing the application either through internet-based PECOS or completing the appropriate 855 application form.***

The first set of revalidation notices went to providers who are billing, but are not currently in the Provider Enrollment, Chain and Ownership System (PECOS). To identify these providers, contractors searched their local systems and if a Provider Transaction Access Number (PTAN) for a physician was not in PECOS, a revalidation request for that physician was sent. CMS asks all providers who receive a request for revalidation to respond to that request.

For providers NOT in PECOS – the revalidation letter will be sent to the special payments or primary practice address because CMS doesn't have a correspondence address. For providers in PECOS – the revalidation letter will be sent to the special payments and correspondence addresses simultaneously; if these are the same it will also be mailed

to the primary practice address. If you believe you are not in PECOS and have not yet received a revalidation letter, contact your Medicare contractor. Contact information may be found **here**.

Institutional providers (i.e., all providers except physicians, non-physician practitioners, physician group practices and non-physician practitioner group practices) must submit the application fee with their revalidation. In mid-September, CMS revised the revalidation letter that contractors sent to providers to clarify who must pay the fee.

CMS plans to post a list of providers who were sent requests to revalidate. They will make an announcement via CMS listservs when this information is posted.

See sample revalidation letter below.

THIS IS A REVALIDATION REQUEST IMMEDIATELY SUBMIT AN UPDATED PROVIDER ENROLLMENT PAPER APPLICATION 855 FORM OR REVIEW, UPDATE AND CERTIFY YOUR INFORMATION VIA THE INTERNET-BASED PECOS SYSTEM

PROVIDER/SUPPLIER NAME

ADDRESS 1,

ADDRESS 2

CITY STATE ZIP CODE

NPI:

PTAN:

Dear Provider/Supplier Name:

In accordance with the Patient Protection and Affordable Care Act, Section 6401 (a), all new and existing providers must be reevaluated under the new screening guidelines in Section

6028. Medicare requires all enrolled providers & suppliers to revalidate enrollment information every five years (reference 42 CFR § 424.57(e)). To ensure compliance with these requirements, existing regulations at 42 CFR § 424.515(d) provide that CMS is permitted to conduct off-cycle revalidations for certain program integrity purposes. Upon the CMS request to revalidate its enrollment, the provider/supplier has 60 days from the date of this letter to submit complete enrollment information using one of the following methods:
Providers and suppliers can enroll in the Medicare program using either the:

(1) Internet-based Provider Enrollment, Chain, and Ownership System (PECOS).
To revalidate via the Internet-based PECOS, go to https://pecos.cms.hhs.gov. This system allows you to review information currently on file, update and submit your revalidation via the internet. Once submitted, be sure to print, sign, date, and mail the certification statement along with all required supporting documentation. In order for us to process the revalidation, the original signature and documentation must be received within 15 days of internet submission.

Physicians and non-physician practitioners will access Internet-based PECOS with the same User ID and password that they use for NPPES. For assistance in establishing an NPPES User ID and password, or if you have forgotten your ID or password or wish to change your NPPES password, contact the NPI Enumerator at 1-800-465-3203 or TTY 1- 800-692-2326, or send an e-mail to customerservice@npienumerator.com

For provider/supplier organizations, your Authorized Official must register with the PECOS Identification and Authentication system. If you have not registered, do so now by going to (https://pecos.cms.hhs.gov). This registration process can take up to three (3)weeks. If additional time is required to

complete the revalidation, you may request one 60-day extension, which will begin on the date of the request.

To avoid any registration issues, review the internet-based PECOS related documents available on the CMS Web site (www.cms.hhs.gov/MedicareProviderSupEnroll).

(2) Paper Application Process
To revalidate by paper, download the appropriate and current CMS-855 Medicare Enrollment application from the CMS Web site at www.cms.hhs.gov/cmsforms. Mail your completed application and all required supporting documentation to the [insert contractor name], at the address below.

[Insert application return address]

With the exception of physicians, non-physicians practitioners, physician group practices and non-group practices, providers and suppliers that are revalidating their enrollment information must submit with their application an application fee.

The 2011 application fee of $505 or a request for hardship exception must be included with the provider enrollment application. Submit the enrollment fee via Pay.Gov prior to submitting the application (reference 42 CFR 424.514). You can submit your application fee by electronic check, debit or credit card. If you feel you qualify for a hardship exception waiver, submit a letter and financial statements to request a waiver in lieu of the enrollment fee along with your application or certification statement. Revalidations are processed only when fees have cleared or the hardship waiver has been granted. You will be notified by mail if your waiver request has been granted or if a fee is required.

For more information on the application fees and other screening requirements under the PPACA view the MLN Matters Article at http://www.cms.gov/MLNMattersArticles/downloads/MM7350.pdf.

You are required by regulations found at 42 CFR 424.516 to submit updates and changes to your enrollment information in accordance with specified timeframes. Reportable changes include, but are not limited to changes in: (1) legal business name (LBN)/tax identification number (TIN), (2) practice location, (3) ownership, (4) authorized/delegated officials, (5) changes in payment information such as changes in electronic funds transfer information and (6) final adverse legal actions, including felony convictions, license suspensions or revocations of a health care license, an exclusion or debarment from participation in Federal or State health care program, or a Medicare revocation by a different Medicare contractor.

Failure to submit complete enrollment application(s) and all supporting documentation within 60 calendar days of the postmark date of this letter may result in your Medicare billing privileges being deactivated.

If you have any questions regarding this letter, please call [contractor telephone number will be inserted here] between the hours of [contractor telephone hours will be inserted here] or visit our Web site at [insert Web site] for additional information regarding the enrollment process or the [insert application type].

Provider Revalidation: CMS Answers Your Questions on October 27th National

Provider Call

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

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

The agenda will include:

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

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

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

here.

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

CMS 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)

How Do You Get That Stimulus Money for Using an Electronic Medical Record? (You Register!)

Image via Wikipedia

Note: see my latest post on registering and attesting for the EHR Incentive Program here.

Registration opens on January 3, 2011 for the Medicare and Medicaid EHR Incentive Programs

1. Register as soon as possible after January 3, 2011.

2. You can register before you have a certified EHR, but you will have to have an EHR when you attest.
3. You can register even if you do not have an enrollment record in PECOS.
4. A link to the Incentive Registration will be available **here** when it is published.
5. Not all states will be ready to participate in the Medicaid program on January 3rd. Information by state is **here**.

What do you have to have to register?

1. **A National Provider Identifier (NPI)** All eligible professionals, eligible hospitals, and critical access hospitals (CAHs) must have a National Provider Identifier (NPI) to participate in the Medicare and Medicaid EHR Incentive Programs.
2. **An enrollment record in the Provider Enrollment, Chain and Ownership System (PECOS)** All eligible hospitals and Medicare eligible professionals must have an enrollment record in PECOS to participate in the EHR Incentive Programs. Eligible professionals who are only participating in the Medicaid EHR Incentive Program are not required to be enrolled in PECOS. If you do not have an enrollment record in PECOS, you should still register for the Medicare and Medicaid EHR Incentive Programs.
3. **CMS Identity and Access Management (I&A) User ID and Password**
    - **Eligible Professionals:** Eligible professionals can use the same User ID and Password they use for the National Plan and Provider Enumeration System (NPPES). This is also the same User ID and Password that is used to access PECOS. If you do not have an active User ID and Password for NPPES or PECOS, request them **here**. 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.

- **Hospitals/Critical Access Hospitals:** Authorized Officials can use the same User ID and Password they use to access PECOS. If you do not have an Authorized Official with access to PECOS, request a User ID and Password **here**. You will need your type 2 NPI, your Taxpayer Identification Number (TIN), and your address from the IRS Form CP-575. You will need to mail a copy of the IRS Form CP-575 as directed. Additional hospital staff will need to request access to the "EHR Incentive Programs" application **here** and be approved by the Hospital's Authorized Official.

What else do you need to know about registration?

Hospitals:

1. Hospitals that are eligible for EHR incentive payments under both Medicare and Medicaid should select "Both Medicare and Medicaid" during the registration process, even if they plan to apply only for a Medicaid EHR incentive payment by adopting, implementing, or upgrading certified EHR technology. Dually-eligible hospitals can then attest through CMS for their Medicare EHR incentive payment at a later date, if they so desire. It is important for a dually-eligible hospital to select "Both Medicare and Medicaid" from the start of registration in order to maintain this option.
2. Hospitals that register only for the Medicaid program (or only the Medicare program) will not be able to manually change their registration (i.e., change to "Both Medicare and Medicaid" or from one program to the other) after a payment is initiated and this may cause significant delays in receiving a Medicare EHR incentive

payment.

Eligible Professionals:

1. Eligible professionals eligible for both the Medicare and Medicaid EHR Incentive Programs must choose which incentive program they wish to participate in when they register.
2. Before 2015, an eligible professional may switch programs only once after the first incentive payment is initiated. Most eligible professionals will maximize their incentive payments by participating in the Medicaid EHR Incentive Program.

The Electronic Health Record (EHR) Information Center is open to assist the EHR Provider Community with inquiries.

Hours of operation are:
8:30 a.m. ”“ 4:30 p.m. (Central Time) Monday through Friday (except federal holidays)
1-888-734-6433 (primary number) or 888-734-6563 (TTY number)

Image via Wikipedia

New Deadline (Sigh) Set for Medicare Claim Denial If Ordering/Referring Providers Not in PECOS

NOTE April 2011: CMS recently announced that July 5, 2011 will **not** be the date that claim editing will begin.

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If you **read my post** on November 29th, you already know that CMS delayed pulling the trigger on January 1, 2011 to require PECOS enrollment for ordering and referring providers and enforcing nonpayment of claims that fail the ordering/referring provider edits.

CMS has just announced a new implementation date (calling it "a placeholder future implementation") of ~~July 5, 2011~~ – unknown.

As a refresher, the only providers who can order/refer Medicare beneficiary services are:

doctor of medicine or osteopathy;
dental medicine;
dental surgery;
podiatric medicine;
optometry;
chiropractic medicine;
physician assistant;
certified clinical nurse specialist;
nurse practitioner;
clinical psychologist;
certified nurse midwife;
clinical social worker

Claims that are the result of an order or a referral must contain the National Provider Identifier (NPI) and the name of the ordering/referring provider and the ordering/referring provider must be in PECOS or in the Medicare carrier's or Part B MAC's claims system with one of the above types/specialties.

The claim editing that will begin on ~~July 5, 2011~~ date not known **will verify the ordering/referring provider on a claim is eligible to order/refer and is enrolled in Medicare.**

The process to be used to determine if the ordering/referring provider on the claim matches the provider in the national PECOS file or in the contractor's master provider file is as follows:

- MCS (Multi-Carrier System) will verify the National Provider Identifier (NPI) of the ordering/referring provider reported on the claim against the national PECOS file.
- If a match is not found, the MCS will verify the NPI of the ordering/referring provider on the claim against the MCS master provider file.
- If a match is found, the MCS will then compare the first letter of the first name and the first 4 letters of the last name of the matched record.
- If the names match, the ordering/referring provider on the claim is considered verified.

If you've not verified that your providers are properly enrolled in PECOS, you have yet another chance to get it figured out.

Here's the Cheat Sheet:

1. Check to see if your provider is enrolled by reviewing the Ordering and Referring file found in the download section of the "OrderingReferringReport" tab (**click here**) on the Medicare Provider and Supplier Web Site. The report is currently more than 15,000 pages but you can view it on the screen.
2. If not enrolled, you can get your provider enrolled by paper or electronically. The Internet-based PECOS application is **here.**
3. After submitting an enrollment application via Internet-based PECOS, you must:
    - Print, sign and date (blue ink recommend) the Certification Statement(s), and
    - Mail the Certification Statement(s) and applicable

supporting documentation to the designated Medicare contractor (no later than 7 days after you complete the online portion.)

NOTE: The Medicare contractor will not be able to begin to process your enrollment application until it receives a signed and dated Certification Statement.

For more detailed information on PECOS, click on the PECOS category on the right-hand side of this web page.