Start PQRS Now! It’s Not As Hard As You Think

NOTE: CMS has just added additional presentations of the webinar below – please check the end of the article for added dates. MPW

What is PQRS?

The Physician Quality Reporting System (Physician Quality Reporting or PQRS) is a CMS reporting program that uses a combination of incentive payments (**carrots**) and payment adjustments (**sticks**) to promote reporting of quality information by eligible professionals.

Program Points:

- **How:** Eligible professionals submit data.
- **What:** Quality measures for covered Physician Fee Schedule (PFS) services
- **Who:** Medicare Part B Fee-for-Service (FFS) beneficiaries (including Railroad Retirement Board and Medicare Secondary Payer)

What are the 2013 Deadlines for

PQRS?

October 15, 2013 – Last day to elect Administrative Claims option to avoid the 2015 payment adjustment!

- A reporting mechanism under which an EP or group practice elects to have CMS analyze claims data to determine which measures an EP or group practice reports
- Deadline for group practices to submit a self-nomination statement via a CMS-developed website
- Group practices consisting of 100+ EPs, beginning in 2015, will be subject to the Value Based Modifier based on PQRS reporting in 2013
- Deadline for groups consisting of 100+ EPs to elect quality tiering approach to VBM

Why Should I Care About Participating in PQRS in 2013?

Beginning in 2015, the program also applies a payment adjustment to eligible professionals who do not satisfactorily report data on quality measures for covered professional services. The 2015 PQRS payment adjustment will be based on 2013 program year data, so if you do not participate in 2013, you will receive less payment for Medicare services in 2015.

STEP 1: Are You Eligible?

Determine if you are eligible to participate for purposes of the PQRS incentive payment and payment adjustment. A list of medical care professionals considered eligible to participate in PQRS is available in **here.** Read this list carefully, as not all entities are considered "eligible professionals" because they are reimbursed by Medicare under other fee schedule methods than the Physician Fee Schedule (PFS).

Individual eligible professionals **do not** need to sign-up or pre-register in order to participate in the Physician Quality Reporting.

STEP 2: What Reporting Method Will You Use?

Determine which PQRS reporting method best fits your practice. PQRS has several methods in which measure data can be reported –

- to CMS on Medicare Part B claims (**more details here** and **claim sample here**)
- to a qualified Physician Quality Reporting registry (**more details here**)
- to CMS via a qualified electronic health record (EHR) product (**more details here**)
- to a qualified Physician Quality Reporting data submission vendor – Group Practice Reporting Option (GPRO) only (**more details here**)

In order to satisfactorily report, it is important to review each method's specific reporting criteria. For additional guidance, refer to the **2013 Physician Quality Reporting System (PQRS) Implementation Guide here** and view the 2013 Physician Quality Reporting System Participation Decision Tree starting on **page 19**.

STEP 3: Will You Report Individual Measures or a Measures Group?

If the chosen method to report is claims-based or registry-based, determine which measure reporting option (individual measures or measures group) best fits your practice. Review the specific criteria for the **chosen reporting option** in order to satisfactorily report.

STEP 4: Choose Three Individual Measures or One Measure Group

If already participating in PQRS, there is no requirement to select new/different measures for the 2013 PQRS.

All PQRS measures and their available reporting methods can be reviewed in the **2013 Physician Quality Reporting System (PQRS) Measures List here.**

Notice that each measure or measure group has a **reporting frequency or timeframe** requirement for each eligible patient seen during the reporting period by each individual eligible professional (NPI). The reporting frequency (i.e., report each visit, once during the reporting period, each episode, etc.) is found in the instructions section of each measure specification or in the Measure Group Overview section. Ensure that all members of the team understand and capture this information in the patients' medical record to facilitate reporting.

Upcoming CMS Webinars

For more information about PQRS and the other ways you can increase your Medicare payments in 2013, or in the years ahead, attend one of two upcoming webinars on "CMS 2013 Medicare Incentives Programs." I've posted the handout from this webinar below.

Wednesday, May 1, 12:30 PM –2:00 PM EDT

http://www.eventbrite.com/event/6060470029#

Friday, May 3, 1:30 PM – 3:00 PM EDT

http://www.eventbrite.com/event/6060698713#

Tuesday, May 7, 2:30 PM – 4:00 PM EDT

http://www.eventbrite.com/event/6534552021

Wednesday, May 8, 11:30 AM – 1:00 PM EDT

http://www.eventbrite.com/event/6534951215

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Thursday, May 9, 7:00 PM – 8:30 PM EDT

http://www.eventbrite.com/event/6535252115

A recording of the CMS 2013 Medicare Incentives Webinar is available in the Adobe webinar room linked below:

https://webinar.cms.hhs.gov/p15399995/

2013 Incentive National Handout from CMS from **ManageMyPractice**

A Guide to Healthcare Buzzwords and What They Mean: Part Two (M through Z)

Meaningful Use (MU)

Meaningful Use is the phrase used in the 2009 HITECH Act to describe the standard providers must achieve to receive incentive payments for purchasing and implementing an EHR system. The term meaningful use combines clinical use of the

EHR (i.e. ePrescribing), health information exchange, and reporting of clinical quality measures. Achieving meaningful use also requires the use of an EHR that has been certified by a body such as CCHIT, Drummond Group, ICSA Laboratories, Inc. or InfoGuard Laboratories, Inc. The term can also apply informally to the process of achieving the standard, for example “How is our practice doing with meaningful use?”

mHealth

An abbreviation for Mobile Health, mHealth is a blanket label for transmitting health services, and indeed practicing medicine, using mobile devices such as cell phones and tablets. mHealth has large implications not only for newer devices like smartphones and high-end tablets, but also for feature phones and low-cost tablets in developing nations. Many different software and hardware applications fit under the umbrella of mHealth so the term is used conceptually to talk about future innovations and delivery systems.

NLP

An acronym for Natural Language Processing, NLP is a field of study and technology that seeks to develop software that can “understand” human speech – not just what words are being said, but what is meant by those words. By “processing” text input into an NLP program, large strings of text can be parsed into more traditionally meaningful data. For example, narrative from a doctor in a medical record could be transferred into data for research and statistical analysis. If we had every medical record and narrative in history, we could search it and look for trends – and possible new cures and symptoms. IBM’s famous Watson machine that could “listen” to Jeopardy! clues and answer is an advanced example of NLP.

ONCHIT

An acronym for “Office of the National Coordinator for Healthcare Information Technology,” the ONCHIT is a division of the Federal Government’s Department of Health and Human Services. The Office oversees the nation’s efforts to advance health information technology and build a secure, private, nationwide health network to exchange information. Although the National Coordinator position was created by executive order in 2004, the Office and its mission were officially mandated in the 2009 HITECH Act as a part of the stimulus package.

Patient Engagement

Patient Engagement is a broad term that describes the process of changing patient behaviors to promote wellness and a focus on preventative care. “Engagement” can roughly be read to describe the patient’s willingness to be an active participant in their own care and to take responsibility for their lifestyle choices. Patient Engagement efforts can be as simple as marketing campaigns for public heath and appointment reminders, and as advanced as wearable monitors that can transmit activity and exercise information so patients can track their fitness. Improving the health system’s ability to engage patients is considered key to lowering healthcare spending and attacking epidemics like obesity and heart disease.

Patient Portal

A patient portal is software that allows patients to interact, generally through an internet application, with their healthcare providers. Portals enable communication between providers and patients in a secure environment with no fear of inappropriate disclosure of the patient’s private healthcare information. Patients can get lab results, request

appointments and review their own records without calling the provider. Patient portals can be sold as a standalone software module or as part of a comprehensive Practice Management/EHR package.

Patient-centered Care

Patient-centered care is a healthcare delivery concept that seeks to use the values and choices of the patient to drive all the care the patient receives. As elementary as it sounds, developing a culture that places the needs and concerns of the patient – the whole patient – at the center of the decision-making process is a new development in the healthcare system. Patient engagement is at the core of patient-centered care, because the patient is the central driver of the decisions – as is only right!

PCMH

An acronym for Patient Centered Medical Home, a PCMH is a model for healthcare delivery where most or all of a patient's services for preventative, acute and chronic primary care are delivered in a single place by a single team to improve patient outcomes and satisfaction as well as lower costs. PCMHs may also operate under a different reimbursement structure, as they can be paid on an outcome basis or on a capitation model as opposed to fee-for-service.

PHR

An acronym for a "Personal Health Record," a PHR is a collection of health data that is personally maintained by the patient for access by caregivers, relatives, and other stakeholders. As opposed to the EHR model, in which a single hospital or system collects all the health information generated in the facility for storage and exchange with other

providers, the PHR is maintained, actively or passively with mobile data capture or sensor devices, by the patient. The PHR can supplement or supplant other health records depending on the way it is used.

PPACA

An acronym for the "Patient Protection and Affordable Care Act," the PPACA was a federal law passed in 2010 to reform the United States healthcare system by lowering costs and improving access to heath insurance and healthcare. The PPACA uses a variety of methods – market reforms to outlaw discrimination based on gender or pre-existing condition, subsidies and tax credits for individuals, families and employers, and an individual mandate forcing the uninsured to pay penalties – to increase access to insurance and lower healthcare costs.

PQRS

An acronym for the "Patient Quality Reporting System," PQRS is a mechanism by which Medicare providers submit clinical quality and safety information in exchange for incentive payments. Physicians who elect not to participate or are found unsuccessful during the 2013 program year, will receive a 1.5 percent Medicare payment penalty in 2015, and 2 percent Medicare payment penalty every year thereafter.

RAC

An acronym for "Recovery Audit Contractor," a RAC is a private company that has been contracted by the Centers for Medicare and Medicaid Services to identify and recover fraudulent or mistaken reimbursements to providers. There are four regions of the United States, each with its own RAC which is authorized to recover money on behalf of the Federal Government. A pilot program between 2005 to 2007 netted nearly

$700 million dollars in repayments and the program was made permanent nationwide in 2010.

REC

An acronym for “Regional Extension Center,” a REC is a organization or facility funded by a federal grant from the Office of the National Coordinator for Health Information Technology to provide assistance and resources to providers who want to adopt an EHR and achieve meaningful use but need technical or deployment support to get their system up and running. There are currently 62 RECs in the United States who focus primarily on small and individual practices, practices without sufficient resources, or critical access and public hospitals that serve those without coverage.

Registry

A Registry is a database of clinical data about medical conditions and outcomes that is organized to track a specific subset of the population. Registries are important to track the efficacy of drugs and treatment, as well as to analyze and identify possible treatment and policy opportunities to improve care. A registry can also be used to report PQRS.

Telehealth

Telehealth is a broad term that describes delivering healthcare and healthcare services through telecommunication technology. Although the terms telehealth and mhealth can be used somewhat interchangeably, “telehealth” tends to focus more on leveraging existing technologies – phone, fax and video conferencing to deliver services over a long distance, or to facilitate communication between providers. Remote evaluation and management and robotics are both examples of care innovations that would fall under the telehealth umbrella.

Value-based Purchasing

Value-based purchasing is a reimbursement model for health care providers that rewards outcomes for patients as opposed to the volume of services provided. Both through increased payments for positive outcomes, and decreased payments for negative ones, value-based purchasing seeks to lower costs by focusing on increasing quality and patient-focus. Accountable Care Organizations and Patient Centered Medical Homes are both examples of delivery systems that rely on value-based purchasing.

CMS Proposes Payment Increases (!) for Family Physicians and Other Primary Care Practitioners

On July 6, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule that would increase payments to family physicians by approximately 7 percent and other practitioners providing primary care services between 3 and 5 percent. The increase in payment to family practitioners is part of the proposed rule that would update payment policies and rates under the Medicare Physician Fee Schedule (MPFS) for calendar year (CY) 2013. Under the MPFS, Medicare pays more than 1 million physicians and nonphysician practitioners that provide vital health services to Medicare beneficiaries.

Primary Care Providers to Get Additional Pay for Care 30 Days After Discharge

The 7 percent increase for family physicians comes from a proposal that continues the Administration's policies to promote high quality, patient-centered care. **For CY2013, CMS is proposing for the first time to explicitly pay for the care required to help a patient transition back to the community following a discharge from a hospital or nursing facility**. The proposals calls for CMS to make a separate payment to a patient's community physician or practitioner to coordinate the patient's care in the 30 days following a hospital or skilled nursing facility stay. The proposed rule also asks for public comment on how Medicare can better recognize the range of services community physicians and practitioners provide as part of treating patients either through face-to-face services in the office or coordinating care outside the office when the patient does not see the physician.

Will the SGR Formula Be Forced Aside in 2013?

As has been the case every year since CY2002, CMS projects a significant reduction in MPFS payment rates under the Sustainable Growth Rate (SGR) methodology due to the expiration of the adjustment made for CY2012 in the statute. For CY2013, CMS projects a reduction of 27 percent and is required by law to include this reduction in these calculations. However, Congress has acted to avert the cuts every year since 2003. The Administration is committed to fixing the SGR formula in a fiscally responsible way.

The Value Modifier

The proposed rule would also continue the careful implementation of the physician value-based payment modifier (Value Modifier) that was included in the Affordable Care Act by providing choices to physicians regarding how to participate. The Value Modifier adjusts payments to individual physicians or groups of physicians based on the quality of care furnished to Medicare beneficiaries compared to costs. The law allows CMS to phase in the Value Modifier over three years from CY2015 to CY2017. For the CY2015 physician payment rates, the proposed rule would apply the Value Modifier to all groups of physician with 25 or more eligible professionals. The proposed rule also provides an option for these groups to choose how the Value Modifier would be calculated based on whether they participate in the Physician Quality Reporting System (PQRS). **For groups of 25 or more that do not participate in the PQRS, CMS is proposing to set their Value Modifier at a 1.0 percent payment reduction.** For groups that wish to have their payment adjusted according to their performance on the value modifier, the rule proposes a system whereby groups with higher quality and lower costs would be paid more, and groups with lower quality and higher costs would be paid less. The performance period for the CY2015 Value Modifier was established as CY2013 in the MPFS Final Rule for CY2012.

Choose Your Program – PQRS, eRx or EHR

The proposed rule continues efforts by CMS to align quality reporting across programs to reduce burden and complexity. The

proposed rule proposes changes to two quality reporting programs that are associated with the MPFS – the PQRS and the Electronic Prescribing (eRx) Incentive Program – as well as the Medicare Electronic Health Records (EHR) Incentive Pilot Program which promotes the use of health information technology. The PQRS proposal includes simplified, lower burden options for reporting and the proposed rule aligns quality reporting across the various programs in support of the National Quality Strategy. The proposed rule also addresses the next phase in a plan to enhance the Physician Compare Website to foster transparency and public reporting of certain information to give beneficiaries more information for purposes of choosing a physician.

The proposed rule also includes:

- A proposal to include additional Medicare-covered preventive services on the list of services that can be provided via an **interactive telecommunications system;**
- A proposal to implement a durable medical equipment **(DME) face-to-face requirement as a condition of payment** for certain high-cost Medicare DME items;
- A proposal to apply a **multiple procedure payment reduction (MPPR) policy to the technical component of the second and subsequent cardiovascular and ophthalmology diagnostic services** furnished by the same doctor to the same patient on the same day;
- A proposal to collect data on patient function to improve how Medicare pays for **physical and occupational therapy, and speech language pathology services;**
- A request for public comments on payment for advanced diagnostic molecular pathology services;
- A proposal to revise a regulation that only allows Medicare to pay for portable x-rays ordered by an MD or DO. The revised regulations would allow **Medicare to pay for portable x-ray services ordered by physicians and**

non-physician practitioners acting within the scope of their Medicare benefit and state law;

- A proposal to clarify when Medicare will pay for **interventional pain management services provided by Certified Registered Nurse Anesthetists (CRNAs)** when permitted by State law. This proposal will foster access to pain management services in areas where states have determined that CRNAs may provide these services.

The proposed rule will appear in the July 30, 2012 Federal Register. CMS will accept comments on the proposed rule until September 4, 2012, and will respond to them in a final rule with comment period to be issued by November 1, 2012.

For more information:

§ Proposed Rule

§ Fact Sheet

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12 Ways to Supercharge Your Practice in 2012: #12 – 9 Ways to Maximize Your Medicare Payments

Medicare has so many programs that have the potential to increase or decrease your payments that practices need a list to keep them straight.

Here’s your list with information on which programs are mutually exclusive and which can be combined.

1. Electronic Health Records (EHR) Incentive Program

- You must be an eligible provider to participate.
- You must be the owner of the EHR, although you do not need to have paid for the EHR.
- The EHR must be certified.
- You can choose to participate in Medicare (federally administered) or Medicaid (state administered) program.
- You must register for the programs.
- You must attest or document that you have adopted, implemented, upgraded or demonstrate meaningful use.
- Eligible professionals choosing to participate the Medicare program can each earn up to $44K over 5 years, and eligible professionals choosing to participate in the Medicaid program can each earn up to $63,750 over 6 years.

2. ePrescribing Incentive Program

- Eligible professionals do not need to register for the program.
- You can participate in one of three ways: via submitting codes on claim forms, via an EHR or via a registry
- Each professional needs to report 10 eRx events for Medicare patients for dates of service before June 30, 2012 OR apply for one of five exclusions or four

exemptions.

- EPs who are successful e-prescribers can qualify to earn an incentive payment based on a percentage of their total estimated Medicare PFS allowed charges processed not later than 2 months after the end of the reporting period. For reporting year 2012, EPs who are successful e-prescribers can qualify to earn an incentive payment equal to 1.0 percent of allowed charges. For reporting year 2013, EPs can qualify to earn an incentive payment of 0.5 percent of allowed charges. Beginning in 2012, EPs who are not successful e-prescribers in 2011 and do not qualify for a hardship exception will be subject to a payment adjustment equal to 1.0 percent of their Medicare PFS allowed charges. The payment adjustment increases to 1.5 percent in 2013 and 2.0 percent in 2014.

3. PQRS (Physician Quality Reporting System)

- Originally called PQRI (Physician Quality Reporting Initiative) is the basis for pay-for-performance models.
- Physicians may report individually or practices may choose a set of three measures that relate to the type of patients they see. Measures are performed and modifiers are attached to claims.
- Bonuses are available until 2014; starting in 2015 practices not participating in PQRS will receive a negative payment adjustment.
- For reporting years 2012 through 2014, EPs who satisfactorily report Physician Quality Reporting System measures will earn an incentive payment equal to 0.5 percent of allowed charges. Additionally, for reporting years 2011 through 2014, EPs who satisfactorily report Physician Quality Reporting System measures can qualify

to earn an additional 0.5 percent incentive payment by, more frequently than is required to qualify for or maintain board certification status, participating in a maintenance of certification program and successfully completing a qualified maintenance of certification program practice assessment. Beginning in 2015, EPs who do not satisfactorily report under the Physician Quality Reporting System will be subject to a payment adjustment equal to 1.5 percent of their Medicare PFS allowed charges. The payment adjustment increases to 2.0 percent in 2016 and beyond.

4. Medicare Wellness Visits

- Many practices are losing money due to the confusion over what Medicare pays for and what Medicare doesn't pay for. Medicare introduced three new visits in 2010 and many providers continue to have trouble understanding and providing them correctly.
- The "Welcome to Medicare" visit is technically called the "Initial Patient Physical Examination" (IPPE), but to everyone's dismay, it is not a physical examination at all, with the exception of basic visits such as height, weight, BMI, blood pressure and pulse, and the potential for an EKG and an Abdominal Aortic Aneurysm screening. The Annual Wellness Visit (AWV) and the Subsequent Annual Wellness Visit are not physical examinations either, yet almost ALL patients believe that Medicare now gives free annual physicals.
- Practices must train all staff and physicians to use the correct terminology first. I suggest everyone stop using the phrases "annual physical" or "complete physical" with Medicare patients. Patients can request and receive:
    - A Welcome to Medicare Visit with no exam (no deductible, no co-insurance)

    - A first annual Wellness Visit with no exam (no deductible, no co-insurance)
    - A Subsequent Annual Wellness Visit with no exam every year thereafter (no deductible, no co-insurance)
- What patients think they want is either a preventive visit, which Medicare will NOT pay for, or a standard Evaluation & Management (E/M) visit, which their deductible and co-insurance will apply to.
- The only way the practice can win is by driving home to patients what Medicare does pay for and doesn't pay for and making sure your documentation matches the code you submit to Medicare.

5. The ABN (Advance Beneficiary Notice)

- Many practices miss revenue when they provide services to Medicare patients that are statutorily excluded from Medicare benefits.
- These may be services that do not meet the Medicare definition of medical necessity or are provided at more frequent intervals than Medicare approves.
- Identifying these non-covered services is the hard thing, however, unless your EMR can alert you to a service that will not be paid by Medicare, and if the patient requests the service and signs an ABN prior to the provision of the service In this case, the practice may collect the full fee from the patient.

6. Primary Care Incentive Payment

Program (PCIP)

- Eligible Providers (Clinical Nurse Specialists, Nurse Practitioners, Physician Assistants, and Physicians who have their primary specialty designation in family medicine, internal medicine, geriatric medicine or pediatric medicine) can receive a 10% incentive payment for services under Part B.
- The PCIP program, which was created by the Patient Protection and Affordable Care Act, requires Medicare to pay primary care providers, whose primary care billings comprise at least 60 percent of their total Medicare allowed charges, a quarterly 10-percent bonus from Jan. 1, 2011, until the end of December 2015.
- Eligible primary care physicians furnishing a primary care service in a Health Professional Shortage Area (HPSA) area may receive both a HPSA and a PCIP payment.

7. HPSA (Health Professional Shortage Area)

- Medicare makes bonus payments annually of 10% to physicians who provide medical care services in geographic areas that lack sufficient health care providers to meet the needs of the population.
- Payments are automatic; there is no need to register or report anything on the claim for
- If services are provided in ZIP code areas that do not fall entirely within a full county HPSA or partial county HPSA, the AQ modifier must be entered on the claim to receive the bonus.

8. HPSA (Health Professional Shortage Area) Surgical Incentive Payment (HSIP)

- The Affordable Care Act of 2010, Section 5501 (b)(4) expands bonus payments for general surgeons in HPSAs. Effective January 1, 2011 through December 31, 2015, physicians serving in designated HPSAs will receive an additional 10% bonus for major surgical procedures with a 10 or 90 day global period.
- Payments are automatic; there is no need to register or report anything on the claim form.
- If services are provided in ZIP code areas that do not fall entirely within a full county HPSA or partial county HPSA, the AQ modifier must be entered on the claim to receive the bonus.

9. NEW! Comprehensive Primary Care Initiative (CPCi)

- Payment model per beneficiary per month (PBPM) for care management of Medicaid and Medicare patients
- Markets in Arkansas, Colorado, New jersey, New York, Ohio/Kentucky, Oklahoma and Oregon for Medicaid patients
- Arkansas, Colorado, Ohio and Oregon are the four states for Medicaid pilots.
- Multiple payers, including CMS, will be paying a monthly care management fee to support the 5 primary care functions of:
    - Risk-stratified care management
    - Access and continuity
    - Planned care for chronic care & preventive care
    - Patient & caregiver engagement
    - Coordination of care across the medical

neighborhood

- Primary care practices in the states and markets can apply from June 15 to July 20, 2012 **(application here.**)

What Medicare Bonus or Incentive Programs Can Be Claimed Together?

- PQRS can claimed with eRx.
- PQRS can be claimed with EHR.
- HPSA and PCIP are automatic and are not affected by any other programs
- EHR and eRx can both be claimed but you cannot earn both an eRx incentive and an EHR incentive in the same year if you elect to receive the EHR incentive payment through Medicare. **NOTE: Just because you cannot claim the eRx bonus in conjunction with EHR incentive, you must still continue to ePrescribe to avoid the eRx penalty!**

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

Revised Medicare Conditions of Participation

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

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

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

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

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

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

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

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

CMS to Start Accepting Suggestions For PQRS Measures and Measure Groups

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

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

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

HHS Finalizes New Rules to Cut Regulations for Hospitals and

Health Care Providers, Savings More Than $5 Billion

Changes Will Reduce Costs and Allow More Focus on Medical Care

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

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

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

Among other changes, the final rules will:

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

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

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

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

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

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

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

Is the industry up to date with the

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

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

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

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

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

5010 compliant.

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

How is CMS helping the industry prepare?

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

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

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

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

Electronic Prescribing (eRx)

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

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

Registration Information: In order to receive call-in information, you must register for the call on the CMS Upcoming National Provider Calls webpage. Registration will close at 12pm on the day of the call or when available space has been filled; no exceptions will be made, so please register early.

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

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

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CMS to Release a Comparative Billing Report on Evaluation and

Management Services

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

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

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

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

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New and Revised Articles Posted to MLN Matters

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

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

Negative Pressure Wound Therapy Interpretive Guidelines

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

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

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

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

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

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

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

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

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

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

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

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Updates from the Medicare Learning Network

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

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

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

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

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

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

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

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

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

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

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

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Medicare News for Week of April 17, 2012: CMS Website Upgraded, 2 National Provider

Calls, Proposed CQMs for MU Stage 2 and 27 ACOs are Announced

(Website) CMS.gov Website Upgrade Completed-Check your Bookmarks (jump to story)

–

(PQRS & eRx) National Provider Call: Physician Quality Reporting System & eRx 2011 10-Month Feedback Report – Register Now (jump to story)

–

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

–

(MU) CMS has Posted the Proposed CQMs

under the Stage 2 NPRM on the CMS Website (jump to story)

–

(EFT) All Medicare Provider and Supplier Payments to be Made by Electronic Funds Transfer (jump to story)

–

(ACOs) New *Affordable Care Act* Program to Improve Care, Control Medicare Costs, Off to a Strong Start (jump to story)

–

(5010) A Look at the Newest Version 5010 FAQs and View CMS' Version 5010 Page and Resources (jump to story)

–

(MLN) Medicare Learning Matters Updates (jump to story)

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CMS.gov Website Upgrade Completed-Check your Bookmarks

CMS has completed the upgrades to the www.CMS.gov website. Bookmarked links to items posted in the "Downloads" sections

on the CMS website have not been affected, but other bookmarked URLs are redirected to the index webpage for that topic. For example, if you bookmarked the page containing National Provider Calls and Events, you will be taken to the index page for National Provider Calls. On the index page, select the webpage you'd like to view from the left-hand side. Once you open the correct page, you can create a new bookmark. We appreciate your understanding and apologize for any inconvenience during this process.

Home Health:

http://www.cms.gov/Center/Provider-Type/Home-Health--Agency-HHA-Center.html

Hospice:

http://www.cms.gov/Center/Provider-Type/Hospice-Center.html
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National Provider Call: Physician Quality Reporting System & eRx 2011 10-Month Feedback Report – Register Now

Tuesday, April 17, 2012; 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 Electronic Prescribing 10-Month Feedback Report.

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 Electronic Prescribing 10-Month Feedback Report
- Question & Answer Session

Registration Information: In order to receive call-in information, you must register for the call at http://www.eventsvc.com/blhtechnologies. 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 at http://www.CMS.gov/Medicare/-Quality-Initiatives-Patient-Assessment-Instruments/PQRS/-CMSSponsoredCalls.html. In addition, the presentation will be emailed to all registrants on the day of the call.

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

Wednesday April 25, 2012; 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 focuses on addressing the current 5010/D.0 metrics, addressing recommendations made by Medicare FFS, as well 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 at http://www.eventsvc.com/blhtechnologies. 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 and Webinar: The presentation for this call will be posted at least one day in advance at http://www.CMS.gov/Outreach-and-Education/Outreach/NPC/-National-Provider-Calls-and-Events-Items/042512-NPC-Call.-html. In addition, the presentation will be emailed to all registrants on the day of the call. CMS will be using an optional webinar feature as part of this National Provider Call. Complete details on this feature are available on the call registration page.

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CMS has Posted the Proposed CQMs under the Stage 2 NPRM on the CMS Website

CMS has posted the full set of proposed Clinical Quality Measures (CQMs) for 2014 as part of the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs Stage 2 Notice of Proposed Rule Making (NPRM). The public can review the CQMs and submit feedback online.

Proposed CQMs

The proposed CQMs are outlined in two tables that describe each measure and provide additional information for eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) beyond the descriptions listed on the National Quality Forum (NQF) website. Some of these measures are still in development; therefore, the descriptions provided in these tables may change before the final rule is published. When possible, links have been provided for measures that have corresponding information on the NQF website. If a measure does not have an NQF number, it means that measure has not yet been endorsed.

Public Comment

Public comments regarding these measures should be submitted using the same method required for all comments related to the proposed rule. You can submit public comments online through the federal regulations website. The deadline for public comments relating to the proposed CQMs and other aspects of the Stage 2 NPRM is *Mon May 7, 2012.*

Want more information about the EHR Incentive Programs?

Make sure to visit the EHR Incentive Programs website at http://www.cms.gov/EHRIncentivePrograms for the latest news and updates on the EHR Incentive Programs.

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All Medicare Provider and Supplier Payments to be Made by Electronic Funds Transfer

Existing regulations at 42 CFR 424.510(e)(1)(2) require that at the time of enrollment, enrollment change request, or revalidation, providers and suppliers that expect to receive

payment from Medicare for services provided must also agree to receive Medicare payments through electronic funds transfer (EFT). Section 1104 of the *Affordable Care Act* further expands Section 1862(a) of the *Social Security Act* by mandating federal payments to providers and suppliers only by electronic means. As part of CMS's revalidation efforts, all suppliers and providers who are not currently receiving EFT payments *are required to submit the CMS-588 EFT form with the Provider Enrollment Revalidation application, or at the time any change is being made to the provider enrollment record by the provider or supplier, or delegated official.* For more information about provider enrollment revalidation, review the MLN Matters® Special Edition Article #SE1126, "Further Details on the Revalidation of Provider Enrollment Information."

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New *Affordable Care Act* Program to Improve Care, Control Medicare Costs, Off to a Strong Start

Over 1.1 Million Beneficiaries Now Served by Accountable Care Organizations

A new program that will help physicians, hospitals, and other health care providers work together to improve care for people with Medicare is off to a strong start.

Under the new Medicare Shared Savings Program (Shared Savings Program), 27 Accountable Care Organizations (ACOs) have entered into agreements with CMS, taking responsibility for the quality of care furnished to people with Medicare in return for the opportunity to share in savings realized through improved care. The Shared Savings Program and other initiatives related to Accountable Care Organizations are made possible by the *Affordable Care Act*, the health care law of

2010. Participation in an ACO is purely voluntary for providers and beneficiaries and people with Medicare retain their current ability to seek treatment from any provider they wish.

The first 27 Shared Savings Program ACOs will serve an estimated 375,000 beneficiaries in 18 States. This brings the total number of organizations participating in Medicare shared savings initiatives on Sun Apr 1 to 65, including the 32 Pioneer Model ACOs that were announced last December, and six Physician Group Practice Transition Demonstration organizations that started in January, 2011. In all, as of Sun Apr 1, more than 1.1 million beneficiaries are receiving care from providers participating in Medicare shared savings initiatives.

CMS also announced today that five ACOs are participating in the Advance Payment ACO Model beginning Sun Apr 1. This model will provide advance payment of expected shared savings to rural and physician-based ACOs participating in the Shared Savings Program that would benefit from additional start-up resources. These resources will help build the necessary care coordination infrastructure necessary to improve patient outcomes and reduce costs, such as new staff or information technology systems. CMS is reviewing more than 50 applications for Advance Payments that start in July. For more information on the Advanced Payment ACO Model, including the participating ACOs, visit http://innovations.CMS.gov/-initiatives/ACO/Advance-Payment/.

The full text of this excerpted CMS press release (issued Tue Apr 10) can be found at http://www.CMS.gov/apps/media/-press/release.asp?Counter=4333, *and a media fact sheet can be found at* http://www.CMS.gov/apps/media/-press/factsheet.asp?Counter=4334.

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A Look at the Newest Version 5010 FAQs and View CMS' Version 5010 Page and Resources

CMS will not initiate enforcement action against *HIPAA*-covered entities for an additional three months, through Sat June 30, 2012, for the updated *HIPAA* transaction standards (ASC X12 Version 5010, NCPDP Versions D.0 and 3.0). CMS is aware that there are still challenges and issues affecting an industry wide upgrade. To help *HIPAA*-covered entities with the upgrade, CMS continues to update and improve their Version 5010 resources.

Updated FAQ System

CMS has updated the FAQ system and the way it is organized. There are now three ways to more easily find Version 5010 FAQs by going to the CMS FAQs Page and:

- Click on the Topic *HIPAA Administrative Simplification* on the left side of the page
    - Click on the Subtopic *Versions 5010 and D.0* that will appear as a dropdown under the topic (FAQs on Version 5010 and D.0 will be listed on the right side of the page)
- Click on the Topic *Coding* on the left side of the page
    - Click on the Subtopic *ICD-10* that will appear as a dropdown under the topic (FAQs on Version 5010 will be listed out on the right side of the page)
- Entering the search term "Version 5010" in the *Search* box on the upper left side of the page

CMS' Version 5010 and D.0 FAQs can also be found on the

Version 5010 page of the ICD-10 website, on the FAQs: Versions 5010 and D.0 Transition Basics fact sheet. The newest FAQ recently added by CMS is:

Question: Is my Version 5010 837 claim compliant if it includes situational data that the TR3 Report does not prohibit, and is not needed or used by a specific health plan?

Answer: Yes. If a submitter sends claim information to a primary payer that may not be needed by that payer, but is needed by a secondary or tertiary payer, the primary payer should disregard the unneeded information and accept the compliant claim. For example:

- A data element in the TR3 Report has situational usage and language that says "If not required by this implementation guide, do not send."
- The submitter submits that data element because it is needed for processing by a particular payer that may be secondary or tertiary to the primary payer.
- A payer that does not need or use that data element cannot reject a claim because it contains a data element or information that it does not need or use, provided usage of the data element is compliant with the TR3 Report.

Version 5010 Testing Readiness Fact Sheet

CMS also has a Version 5010 Testing Readiness Fact Sheet, which explains the Version 5010 upgrade and necessary Phase I Internal and Phase II External testing. This fact sheet can help providers to determine steps to successfully complete testing phases for Version 5010.

Keep Up to Date on Version 5010 and ICD-10

Please visit the ICD-10 website for the latest news and resources to help you prepare, and to download and share the implementation widget today!

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Medicare Learning Matters Updates

Information on the CMS Fraud Prevention: Automated Provider Screening and National Site Visit Initiatives – MLN Matters® Special Edition Article #SE1211, "Information on the Centers for Medicare & Medicaid Services (CMS) Fraud Prevention: Automated Provider Screening and National Site Visit Initiatives" has been released and is now available in downloadable format.

This article is designed to provide education on the CMS National Fraud Prevention Program (NFPP) and processes used to prevent Medicare fraud and abuse. It includes information about two new initiatives that CMS uses as part of the provider enrollment process – automated provider screenings and national site visit contractors that conduct site visits for certain providers and suppliers.

Information for Medicare Fee-For-Service Providers About the Middle Class Tax Relief and Job Creation Act of 2012 – MLN Matters® Special Edition Article #SE1215, "Information for Medicare Fee-For-Service Providers About the Middle Class Tax Relief and Job Creation Act of 2012" has been released and is now available in downloadable format.

This article includes an overview of the provisions that impact Medicare Fee-For-Service providers, including Section 3003, which extends the current zero percent update for claims with dates of service on or after Thu Mar 1, 2012 through Mon Dec 31, 2012.

Redesigned Medicare Summary Notices – MLN Matters® Special Edition Article #SE1218, "Redesigned Medicare Summary Notices" has been released and is now available in downloadable format.

This article is designed to provide education on the redesigned Medicare Summary Notice (MSN), which is part of the "Your Medicare Information: Clearer, Simpler, At Your Fingerprints" initiative. It includes information about key features and enhancements to the redesigned MSN and steps CMS will take to make benefits, provider, and claims information clearer and more accessible.

Avoiding Medicare Fraud & Abuse: A Roadmap for Physician, Web-Based Training Now Available – This web-based training is designed to provide education on fraud and abuse related to physicians. It includes definitions, laws exclusions, civil monetary penalties, case examples, and resources.

To access a new or revised web-based training course, visit http://www.CMS.gov/Outreach-and-Education/Medicare--Learning-Network-MLN/MLNProducts/index.html and click on "Web-Based Training (WBT) Courses" under "Related Links" at the bottom of the webpage.

Submit Feedback on MLN Products and Services –

The Medicare Learning Network® (MLN) is interested in what you have to say! Visit the MLN Opinion Page to submit an anonymous evaluation about specific MLN products and resources. Your feedback is important in developing and improving future MLN products and services.

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HHS Releases a Proposed Rule

for ICD-10 Go-Live October 2014

Today HHS announced a proposed rule **(complete rule here – 175 page pdf)** that would delay the go live for ICD-10 from October 1, 2013 to October 1, 2014. What follows are excerpts from the proposed rule.

Why Has HHS Proposed a Change to the Live Date for ICD-10-CM and ICD-10-PCS?

The final rule adopting ICD-10-CM and ICD-10-PCS (collectively, "ICD-10") as HIPAA standard medical data code sets was published in the Federal Register on January 16, 2009. The ICD-10 final rule requires covered entities to use ICD-10 beginning October 1, 2013.

In late 2011 and early 2012, **three issues** emerged that led Secretary of HHS Kathleen Sebelius to reconsider the compliance date for ICD-10:

1. The industry transition to Version 5010 did not proceed as effectively as expected;
2. Providers expressed concern that other statutory initiatives are stretching their resources; and
3. Surveys and polls indicated a lack of readiness for the ICD-10 transition.

The Transition to Version 5010

As the industry approached the January 1, 2012 Version 5010 compliance date, a number of implementation problems emerged, some of which were unexpected. These included–

- Trading partners were **not ready** to test the Version 5010 standards due to vendor delays in delivering and installing Version 5010-compliant software to their provider clients;
- Version 5010 errata were issued to correct **typographical mistakes** and other maintenance issues that were discovered as the industry began its internal testing of the standards, which delayed vendor delivery of compliant products and external testing;
- Differences between address requirements in the "provider billing address" and "pay to" address fields adversely affected **crossover claims processing;**
- **Inconsistent payer interpretation** of standard requirements at the front ends of systems resulted in rejection of claims, as well as other technical and standard misinterpretation issues;
- Edits made in test mode that were later **changed** when claims went into production without adequate notice of the change to claim submitters; and
- **Insufficient end to end testing** with the full scope of edits and business rules in place to ensure a smooth transition to full production.

Given concerns that industry would not be compliant with the Version 5010 standards by the January 1, 2012 compliance date, the HHS announced on November 17, 2011 that they would not initiate any enforcement action against any covered entity that was not in compliance with Version 5010 until March 31, 2012, to enable industry adequate time to complete its testing and software installation activities. **On March 15, 2012, this date was extended an additional 3 months, until June 30, 2012.**

The ICD-10 final rule set October 1, 2013 as the compliance date, citing industry testimony presented to NCVHS (National Committee on Vital and Health Statistics) and many of the over 3,000 industry comments received on the ICD-10 proposed rule.

The analysis in the ICD-10 final rule with regard to setting a

compliance date emphasized the interdependency between implementation of ICD-10 and Version 5010, and the need to balance the benefits of ICD-10 with the need to ensure adequate time for preparation and testing before implementation.

As noted in the ICD-10 final rule, "[w]e cannot consider a compliance date for ICD-10 without considering the dependencies between implementing Version 5010 and ICD-10. We recognize that any delay in attaining compliance with Version 5010 would negatively impact ICD-10 implementation and compliance." (74 FR 3334) Based on NCVHS recommendations and industry feedback received on the proposed rule, we determined that "24 months (2 years) is the minimum amount of time that the industry needs to achieve compliance with ICD-10 once Version 5010 has moved into external (Level 2) testing." (74 FR 3334) In the ICD-10 final rule, we concluded that the October 2013 date provided the industry adequate time to change and test systems given the 5010 compliance date of January 1, 2012.

As implementation of ICD-10 is predicated on the successful transition of industry to Version 5010, we are concerned that the delays encountered in Version 5010 have affected ICD-10 planning and transition timelines.

Providers have Expressed Concern that Other Statutory Initiatives are Stretching Their Resources

Since publication of the ICD-10 and Modifications final rules, a number of other statutory initiatives were enacted, requiring health care provider compliance and reporting. Providers are concerned about their ability to expend limited resources to implement and participate in the following initiatives that all have similar compliance timeframes:

1. **The EHR Incentive Program** was established under the Health Information Technology for Economic and Clinical Health (HITECH) Act, a part of the American Recovery and Reinvestment Act of 2009 (Pub. L. 111-5). Medicare and Medicaid incentive payments are available to eligible professionals and hospitals for adopting electronic health record (EHR) technology and demonstrating meaningful use of such technology. Eligible professionals and hospitals that fail to meaningfully use EHR technology could be subject to Medicare payment adjustments beginning in FY 2015.
2. **The Physician Quality Reporting System** is a voluntary reporting program that provides incentives payments to eligible professionals and group practices that satisfactorily report data on quality measures for covered Physician Fee Schedule services furnished to Medicare Part B Fee-for-Service beneficiaries.
3. **The eRx Incentive Program** is a reporting program that uses a combination of incentive payments and payment adjustments to encourage electronic prescribing by eligible professionals. Beginning in 2012 through 2014, eligible professionals who are not successful electronic prescribers are subject to a payment adjustment.
4. Finally, section 1104 of the Affordable Care Act imposes **additional HIPAA Administrative Simplification requirements** on covered entities.

<u>January 1, 2013</u>

• Operating rules for eligibility for a health plan and health care claim status transactions

<u>December 31, 2013</u>

• Health plan compliance certification requirements for health care electronic funds transfers (EFT) and remittance advice, eligibility for a health plan, and health care claim status transactions

<u>January 1, 2014</u>

- Standards and operating rules for health care electronic funds transfers (EFT) and remittance advice transactions

December 31, 2015

- Health plan compliance certification requirements for health care claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, health care claims attachments, and referral certification and authorization transactions

January 1, 2016

- Standard for health care claims attachments
- Operating rules for health care claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, referral certification and authorization transactions

Proposed October 1, 2014

- Unique health plan identifier

Current State of Industry Readiness for ICD-10

It is crucial that all segments of the health care industry transition to ICD-10 at the same time because the failure of any one industry segment to successfully implement ICD-10 has the potential to affect all other industry segments. Ultimately, such failure could result in returned claims and provider payment delays that disrupt provider operations and negatively impact patient access to care.

In early 2012, it became evident that sectors of the health care industry would not be prepared for the October 1, 2013 ICD-10 compliance date. Providers in particular voiced concerns about their ability to meet the ICD-10 compliance date as a result of a number of factors, including obstacles they experienced in transitioning to Version 5010 HIPAA Requirements from the Affordable Care Act and the other

initiatives that stretch their resources. A CMS survey conducted in November and December 2011 (hereinafter referred to as the CMS readiness survey) found that 26 percent of providers surveyed indicated that they are at risk for not meeting the October 1, 2013 compliance date.

Given the evidence that segments of the health care industry will likely not meet the October 1, 2013 compliance date, the reasons for that likelihood, and the likelihood that a compliance date delay would significantly improve the successful and concurrent implementation of ICD-10 across the health care industry, we are proposing to extend the compliance date for ICD-10.

One-Year Delay Justification

The HHS is proposing to extend the compliance date for ICD-10 for 1 year, from October 1, 2013 to October 1, 2014. This change would be reflected in the regulations at 45 CFR 162.1002. While a number of alternatives were considered for the delay, as discussed in the Impact Analysis of this proposed rule, it is believed a 1-year delay would provide sufficient time for small providers and small hospitals to become ICD-10 compliant and would be the least financially burdensome to those who had planned to be compliant on October 1, 2013.

To determine the new compliance date for ICD-10, the need for additional time for small providers and small hospitals to become compliant was balanced with the financial burden of a delay on entities that have developed budgets and planned process and system changes around the October 1, 2013 compliance date. Entities that have started planning and working toward an October 1, 2013 implementation would incur costs by having to reassess and adjust implementation plans and maintain contracts to manage the transition beyond October 1, 2013. We concluded that a 1-year delay would strike a reasonable balance by providing sufficient time for small

providers and small hospitals to become compliant and would minimize the financial burden on those entities that have been actively planning and working toward being compliant on October 1, 2013.

Finally, in its March 2, 2012 letter to the Secretary on a possible delay of the ICD-10 compliance date, the NCVHS urged that any delay should be announced as soon as possible and should not be for more than 1 year. The NCVH made this recommendation in consideration of its belief that a delay would cause a significant financial burden "that accrues with each month of delay."

The HHS believes that a 1-year delay would benefit all covered entities, even those who had are actively planning and striving for a 2013 implementation. A 1-year delay would enable the industry as a whole to test more robustly and implement simultaneously, which would foster a smoother and more coordinated transition to ensure the continued and uninterrupted flow of health care claims and payment.

Therefore, the HHS is proposing that covered entities must comply with ICD-10 on October 1, 2014.

Bonus: Some Interesting Data I Found in the ICD-10 Proposed Rule:

- The total number of health care claims in 2013 is projected to be 5.8 billion.
- The cost to health plans for manually processing a pended claim is $2.30 per claim.
- According to the Medical Group Management Association (MGMA), the staff time required to manually process a returned claim is 15 minutes, at a cost of approximately $4.14 for labor, a factor derived from the Bureau of Labor Statistics. This includes staff time spent to correct the error and resubmit claims that are returned.
- Using the experience of one university's bachelor's-

level health information management program, students take the ICD coding course in the spring of their junior year. Students enrolling in Spring 2012 courses will graduate in May 2013. Anticipating the October 1, 2013 compliance date, the university started offering ICD-10 courses this spring in place of ICD-9 with the understanding that it will be preparing students for employment after graduating in 2013. If ICD-10 is delayed a year, as proposed in this rule, the 30 students in the program will have to take ICD-9 courses in addition to their ICD-10 courses in order to obtain the ICD-9 competencies to get jobs. The extra course will cost each of the 30 students approximately $2,000 (in-state tuition) or a total of $61,000.

- Total cost of a 1-year delay in the compliance date of ICD-10 = $3,808M (mean average)
- According to the U.S. Census Bureau, Detailed Statistics, 2007 Economic Census, there are approximately 220,100 physician practices.. The U.S. Census Bureau data indicates that two percent of physician practices have revenues of $10 million or more, therefore approximately 4,400 physician practices are not small entities.
- According to the Small Business Administration’s size standards, a small entity is defined as follows according to health care categories: Offices of Physicians are defined as small entities if they have revenues of $10 million or less; most other health care providers (dentists, chiropractors, optometrists, mental health specialists) are small entities if they have revenues of $7 million or less; hospitals are small entities if they have revenues of $34.5 million or less.
- The 2007 Census Bureau reports that there are approximately 6,500 hospitals. The data indicates that 85 percent of hospitals have sales/receipts/revenues of $10 million or more.
- Statistics cost of delaying ICD-10 to 2014 were based

on:

- Physician practices with less than 50 physicians = 233,239
- Physician practices with 50 to 100 physicians = 590
- Physician practices with more than 100 physicians = 393
- Hospitals with less than 100 beds = 2757
- Hospitals with 100 to 400 beds = 2486
- Hospitals with more than 400 beds = 521

Haven’t Started Your ICD-10 Preparations Yet?

Start your plan by reviewing the resources below:

- Centers for Medicare and Medicaid Services (CMS) ICD-10 overview
- American Health Information Management Association (AIHMA) ICD-10 implementation
- American Academy of Professional Coders (AAPC) ICD-10 implementation

Manage My Practice offers ICD-10 transition help to physician practices, focusing on documentation improvement to support ICD-10 coding. For more information, please complete the contact form ***here.***

Medicare News for the Week of February 13, 2012: PQRS, eRX and EHR, EHR and EHR

(PQRS) AM News Reports 2012 Last Year for Physicians to Voluntarily Report Quality Data (jump to story)

(PQRS & eRX) National Provider Call: Claims-Based Reporting for the Physician Quality Reporting System & Electronic Prescribing Incentive Program(jump to story)

(Purchasing) National Provider Call: Hospital Value-Based Purchasing Program (jump to story)

(eRx) Electronic Prescribing (eRx) Incentive Program: Updates for 2012 (jump to story)

(Observation) Some Medicare Beneficiaries Receive Large Bills Over "Observation Care" Status (jump to story)

CMS Gives Consumers Access to More Details about Infection Rates at America's Hospitals – Data Will Save Lives, Cut Costs (jump to story)

(EHR) CMS Has Updated the EHR Information Center with New Self-Service Options (jump to story)

(EHR) Updated and New FAQs Added to the CMS EHR Website (jump to story)

(EHR) Stay Informed via the CMS EHR Incentive Programs Listserv (jump to story)

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AM News Reports 2012 Last Year for Physicians to Voluntarily Report Quality Data

According to coverage in AM News, "…doctors have only this year to report data to the program voluntarily." …doctors who don't report data will not only not be eligible for a bonus but may be dinged with a 1.5% penalty on their payments in 2015." **Read more in AM News.**

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National Provider Call: Claims-Based Reporting for the Physician Quality Reporting System & Electronic Prescribing Incentive Program – Registration Now Open

Tue Feb 21; 1:30-3pm ET

CMS will host a National Provider Call on the Physician Quality Reporting System & Electronic Prescribing (eRx) Incentive Program. Subject matter experts will provide an overview on claims-based reporting for both programs, followed by a question and answer session.

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 claims-based reporting for the Physician Quality Reporting System
- Overview of claims-based reporting for the eRx Incentive

Program
- Question & Answer Session

Registration Information: In order to receive the call-in information, you must register for the call. *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. For more details, including instructions on registering for the call, please visit **http://www.eventsvc.com/blhtechnologies.**

Presentation: The presentation for this call will be posted at least one day in advance at **http://www.CMS.gov/PQRS/04_-CMSSponsoredCalls.asp** in the "Downloads" section of the page.

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National Provider Call: Hospital Value-Based Purchasing Program – Registration Now Open

Tue Feb 28; 1:30-3pm ET

The Centers for Medicare & Medicaid Services (CMS) will be creating hospital-specific performance reports that simulate the FY2013 Hospital Value-Based Purchasing Program for each hospital to review; the simulated reports will employ hospital data from prior years to construct each hospital's baseline period and performance period scores. To prepare providers for interpreting the simulated report, this National Provider Call will discuss a sample report that shows what hospitals can expect when they receive their own reports.

Target Audience: Hospitals, Quality Improvement Organizations, medical coders, physician office staff, provider billing staff, health records staff, vendors, and all Medicare Fee-For-Service providers.

Agenda:

- Opening Remarks
- Program Announcements
- Overview of the Hospital Value-Based Purchasing Program
- Presentation and Walkthrough of the Hospital-Specific Report
- Question & Answer Session

Registration Information: In order to receive the call-in information, you must register for the call. *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. For more details, including instructions on registering for the call, please visit **http://www.eventsvc.com/blhtechnologies.**

Presentation: The presentation for this call will be posted at least one day in advance at **http://www.CMS.gov/Hospital--Value-Based-Purchasing** in the "Downloads" section of the page.

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Electronic Prescribing (eRx) Incentive Program: Updates for 2012

The Medicare Electronic Prescribing (eRx) Incentive Program, which began January 1, 2009 and is authorized under the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008, provides incentives for eligible professionals who are successful electronic prescribers. A web page dedicated to providing all the latest news on the eRx Incentive Program is available on the Centers for Medicare & Medicaid Services (CMS) website at http://www.cms.gov/ERxIncentive.

Under section 1848(a)(5)(A) of the Social Security Act, for years 2012 through 2014, a Physician Fee Schedule (PFS) payment adjustment applies to eligible professionals who are not successful electronic prescribers at an increasing rate through 2014. Specifically, if the eligible professional is not a successful electronic prescriber for the respective reporting period for the appropriate program year, the PFS amount for covered professional services during the year shall be a percentage less than the PFS amount that would otherwise apply.

The following are key changes for the 2012 eRx Incentive Program:

Group Practice Reporting Option (GPRO) changes

Group practices (who self-nominated and were selected by CMS to participate in the Group Practice Reporting Option) can qualify to earn an eRx incentive if it is determined that the practice is a successful electronic prescriber. This incentive payment is equal to 1.0 percent of the total estimated Medicare Part B PFS allowed charges under the group practice's Taxpayer Identification Number (TIN). The minimum number of times a group must report the eRx measure is 2,500 for large group practices participating in eRx GPRO participants (100 or more individual eligible professionals), 625 for small group practices participating in eRx GPRO (25-99 individual eligible professionals).

Important Changes for the 2013 eRx Payment Adjustment

- Added a second reporting period to avoid the 2013 eRx payment adjustment (6-month reporting period, January 1-June 30, 2012)
- Eligible professionals can report on any billable Medicare Part B PFS service to avoid the 2013 payment adjustment.
- Hardship exemption requests are available for eligible professionals who are unable to report the eRx measure.

Avoiding the 2013 eRx Payment Adjustment

- In order to avoid the 2013 payment adjustment, eligible professionals are now able to report the eRx Quality-Data Code (QDC) on any billable Medicare Part B PFS service. In previous program years, eRx events could only be reported with specified encounter codes. Please note that reporting denominator- eligible events is still required to earn an incentive payment for 2012.
- Additional information on how to avoid future eRx payment adjustments can be found in the Electronic Prescribing (eRx) Incentive Program – Future Payment Adjustments document located on the CMS eRx website at http://www.cms.gov/ERxIncentive.asp, under the "Educational Resources" section.

2012 Hardship Exemption Requests to Avoid the 2013 Payment Adjustment

- Individual eligible professionals requesting hardship exemptions from the 2013 eRx payment adjustment will be able to submit their request using the CMS Quality Reporting Communication Support Page located at https://www.qualitynet.org/portal/server.pt/community/communications_support_system/234.
- CMS will announce when the Quality Reporting Communication Support Page becomes available for requesting a hardship exemption for the 2013 eRx payment adjustment.
- For more information on the 2012 eRx hardship exemption categories and on the process for requesting an exemption visit the CMS Electronic Prescribing Incentive Program at http://www.cms.gov/ERxIncentive.

Additional Information

- For more information on the 2012 eRx Incentive Program, go to

https://www.cms.gov/ERxIncentive/06_E-Prescribing_Measure.asp

- For more information on avoiding future payment adjustments, go to https://www.cms.gov/ERxIncentive/20_Payment_Adjustment_Information.asp

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Some Medicare Beneficiaries Receive Large Bills Over "Observation Care" Status.

CMS, in an effort to reduce spending, requires medical necessity for a patient to be admitted to the hospital. Many times, however, it cannot be determined immediately if patients do require admission to the hospital. In these cases, patients are admitted to observation (today commonly called the CDU, or Clinical Decision Unit) to try to determine if the patient does need to be admitted or can be released. Observation is considered an Outpatient Service (even though the patient is in a hospital bed in the hospital), just as Emergency Room care is considered outpatient service. Patients who have received Observation Care, once they return home and receive a bill, are stunned to find that they are paying according to Medicare Part B. Part B has a deductible plus a 20% co-insurance for all services they received in the hospital as an outpatient. Read more here: **Wall Street Journal**

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CMS Gives Consumers Access to More Details about Infection Rates at America's Hospitals – Data Will Save Lives, Cut Costs

Central line-associated bloodstream infections (CLABSIs) are

among the most serious of all healthcare-associated infections, resulting in thousands of deaths each year and nearly $700 million in added costs to the US healthcare system. On Tue Feb 7, CMS announced that *Hospital Compare* will now include data about how often these preventable infections occur in hospital intensive care units across the country. This step will hold hospitals accountable for bringing down these rates, saving thousands of lives and millions of dollars each year.

The Centers for Disease Control and Prevention estimates that in 2009, there were about 41,000 CLABSIs in US hospitals. Studies show that up to 25 percent of patients who get a CLABSI will die from the infection. Caring for a patient with a CLABSI adds about $17,000 to a hospitalization. These infections prolong hospitalizations and can cause death.

Hospital Compare is one of Medicare's most popular web tools. The site receives about 1 million page views each month and is available in English and in Spanish. More information about *Hospital Compare* is online at **http://www.HospitalCompare.-HHS.gov.**

To view the CMS video of Nancy Foster, Vice President of Quality and Patient Safety Policy at the American Hospital Association, discussing *Hospital Compare*, visit the **CMS YouTube channel.**

The full text of this excerpted CMS press release (issued Tue Feb 7) can be found at **http://www.CMS.gov/apps/media/-press/release.asp?Counter=4260.**

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CMS Has Updated the EHR Information Center with New Self-Service Option

Following months of review and collective input, the Electronic Health Record (EHR) Information Center Interactive Voice Response (IVR) system has been enhanced to provide users with an increased number of options and services to make accessing and reviewing data easier than ever before.

For eligible professionals (EPs), eligible hospitals, or critical access hospitals (CAHs), the revised functionality vastly improves the efficiency in obtaining desired information, while also offering a more varied amount of information and options for callers. CMS is proud to announce that providers can now obtain information through an extensive IVR Self-Service option. Included in this option is a reinforced privacy protection module that requires your individual National Provider Identifier (NPI), the last five digits of your Tax Identification Number (TIN), and your EHR registration ID. Once accepted, this newly enhanced Self-Service tool allows you to:

- Obtain registration status
- Acquire attestation status
- Review payment information
- Check progress towards meeting the $24,000 threshold amount

Users may access these new options by dialing **888-734-6433**, pressing 3 for Self-Service, and entering the authentication elements. These options will be available on the IVR effective Thu Feb 16.

EHR Information Center Hours of Operation: 7:30am-6:30pm CT, Monday through Friday, except federal holidays. (Note that General Information and Self-Service options may be reached via IVR 24 hours a day, except during periods of planned system maintenance or upgrades).

Supplementary information on the program may also be viewed by visiting the **FAQs section of the EHR Incentive Programs**

website, where users can search for any questions they have about the Medicare or Medicaid EHR Incentive Programs.

Want more information about the EHR Incentive Programs? Make sure to visit the **EHR Incentive Programs website** for the latest news and updates on the EHR Incentive Programs.

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Updated and New FAQs Added to the CMS EHR Website

CMS wants to help keep you updated with information on the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, and has recently updated previously-posted FAQs and added new FAQs on several incentive program topics, including reporting periods and incentive payments. Take a minute and review these FAQs:

- For the 2011 payment year, how and when will incentive payments for the Medicare EHR Incentive Programs be made? Read the answer.
- What are the EHR reporting periods for eligible hospitals participating in both the Medicare and the Medicaid EHR Incentive Programs, as well as the requirements for receiving an EHR incentive payment? Read the answer.
- For the Medicare and Medicaid EHR Incentive Programs, how will non-standard (or irregular) cost reporting periods be taken into account in determining the appropriate cost reporting periods to employ during the Medicare and Medicaid EHR Hospital Calculations? Read the answer.
- In order to qualify for payment under the Medicaid EHR Incentive Program for having adopted, implemented, or upgraded to (AIU) certified EHR technology, an eligible professional (EP) working at an Indian Health Services

(IHS) clinic may be asked to submit to their State Medicaid Agency an official letter containing information about the clinic's electronic health record from IHS (which is an Operating Division of the United States Department of Health and Human Services). The information in this letter identifies the EHR vendor, the ONC Certified Heath IT Product List (CHPL) number of the EHR, as well as other information regarding the EHR product version and licensure. Does this letter meet states' documentation requirements for AIU? Read the answer.

- For the Medicaid EHR Incentive Program, how do we determine Medicaid patient volume for procedures that are billed globally, such as obstetrician (OB) visits or some surgeries? Such procedures are billed to Medicaid at a global rate where one global rate might cover several visits. Read the answer.

Want more information about the EHR Incentive Programs? Make sure to visit the **CMS EHR Incentive Programs website** for the latest news and updates on the EHR Incentive Programs.

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Stay Informed via the CMS EHR Incentive Programs Listserv

CMS wants to invite you to join a free email service to receive the latest news on the EHR Incentive Programs. The **CMS EHR Incentive Program listserv** provides timely information on program requirements and changes in the EHR Incentive Programs.

By subscribing to this listserv, you will receive early notification of new program developments, the availability of new resources, and the addition of any new **Frequently Asked Questions** that are published on the CMS EHR Incentive Programs

website. **Join** the listserv and visit the **listserv section** of the EHR Incentive Programs website to take a review some of the recent messages we have sent. We encourage you to let others know about the CMS EHR Incentive Program listserv, and to share its messages.

Want more information about the EHR Incentive Programs? Make sure to visit the **EHR Incentive Programs** website for complete information about the CMS Medicare and Medicaid EHR Incentive Programs.

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My Notes on the March 22, 2011 CMS Open Door Forum on Physician Quality Reporting System (PQRI) for the Beginner

Today's CMS Open Door Forum was a good one. The slides (**pdf here**), although reviewed quickly during the call, are a comprehensive resource for anyone needing in-depth information on qualifying for incentives through PQRI. The information is complex, but anyone can start the process tomorrow and successfully get their check (next year.)

PQRI has been renamed PQRS.

These are the key points of the information presented:

1. You can tell if you are **eligible** for the incentive program by checking the main PQRS site **here**. Scroll down to Downloads and click on “List of Eligible Professionals.”
2. There is **no registration** required to report quality data.
3. PQRS should not be confused with incentives offered for ePrescribing or meaningful use of a certified Electronic Health Record – these are three distinct systems.
4. There are new Physician Quality Reporting Measure Specifications every year – use the correct year.
5. Reporting can be done as **individual eligible providers or as groups,** however groups needed to be self-nominated by January 31, 2011, so that door is closed for this year.
6. Eligible providers can choose to report for 12 months: January 1”“December 31, 2011 or for 6 months: July 1-December 31, 2011 (claims and registry-based reporting only.)
7. There are **two reporting methods for submission of measures groups** that involve a patient sample selection: 30-patient sample method and 50% patient sample method. An “intent G-code” must be submitted for either method to initiate intent to report measures groups via claims. If a patient selected for inclusion in the 30-patient sample did not receive all the quality actions and that patient returns at a subsequent encounter, QDC(s) may be added (where applicable) to the subsequent claim to indicate that the quality action was performed during the reporting period.
   Physician Quality Reporting analysis will consider all QDCs submitted across multiple claims for patients included in the 30-patient samples.

8. Eligible professionals who have contracted with Medicare Advantage (MA) health plans should not include their MA patients in claims-based reporting of measures groups using the 30 unique patient sample method. **Only Medicare Part B FFS patients** (primary and secondary coverage including Railroad Medicare) should be included in claims-based reporting of measures groups.
9. **Choose which group measures** OR individual measures (3 minimum) you want to report on based on your method of reporting. Review your choices **here.**
10. If you plan to report using a registry or EHR, make sure the systems are qualified by checking **here.**
11. Here is the **schedule** for PQRS incentives and "payment adjustments" (financial dings.)

- Incentives (based on the eligible professional's or group's estimated total Medicare Part B PFS allowed charges)
    - 2007 ""1.5% subject to a cap
    - 2008 ""1.5%
    - 2009, 2010 ""2.0%
    - 2011 ""1%
    - 2012, 2013, 2014 ""0.5%
- Payment Adjustments (you lose money)
    - 2015 ""98.5%
    - 2016 and subsequent years ""98.0%

What follows are the Questions and Answers from the listeners.

Q: Do PQRS measures need to be reported once per encounter or once per episode?

A: It depends on the measure. Check the list to see what each measure requires.

Q: Is there a code to submit if we cannot qualify due to low numbers of Medicare patients?

A: No, CMS will calculate this and will know you cannot qualify and you will be exempt from the payment adjustment.

Q: Can both admitting physicians and consulting physicians submit the same quality codes?

A: Yes, all eligible providers working with a patient can report the same code if appropriate.

Q: How do we know if we qualified for the eRx incentive for 2010?

A: Payments will come early fall and feedback reports will be available that break down each provider's incentive.

Q: For the eRx incentive, is it 10 eRxs before June 30, 2011 and 25 before January 31, 2011 for each PROVIDER or each PRACTICE?

A: Each provider.

Q: What is the difference between the numerator and the denominator in PQRS?

A: The numerator is the clinical quality action (for instance, putting a patient on a beta blocker) and the denominator is the group of patients for whom the quality action applies (which patients with appropriate diagnoses are eligible for beta blocker therapy.)

Q: Do all the preventive measures in this group have to be utilized?

A: Not all measures will apply to all patients, for instance mammograms for females only.

Q: Is there a code to be placed on the claim that says a measure is not applicable for this patient?

A: No.

Q: How do you know if a measure code on a claim has been accepted?

A: You will receive a rejection code on your EOB that indicates the code was submitted for information purposes only. Remittance Advice (RA) with denial code N365 is your indication that Physician Quality Reporting codes were passed into the National Claims History (NCH) file for use in calculating incentive eligibility.

Q: How can a new provider get started with quality reporting?

A: Any provider can start any time by reporting through claims, a registry or an EHR.

Q: Should providers bill for PQRI under their individual number or under their group number?

A: Under their individual number.

Q: Can a physician delegate the eRx process to a staff member, just as they might have a nurse write a prescription for them?

A: Yes.

Q: Can you clarify the three incentive programs and which a practice can participate in at the same time?

A: The Physician Quality Reporting System, eRx Incentive Program, and EHR Incentive Program are three distinctly separate CMS programs.

The Physician Quality Reporting System incentive can be received regardless of an eligible professional's participation in the other programs.

There are three ways to participate in the EHR Incentive Program: through Medicare, Medicare Advantage, or Medicaid.

If participating in the EHR Incentive Program through the Medicaid option, eligible professionals are able to also

receive the eRx incentive.

If participating in the Medicare or Medicare Advantage options for the EHR Incentive Program, eligible professionals can still report the eRx measure but are only eligible to receive one incentive payment. Eligible professionals successfully participating in both programs will receive the EHR incentive.

Eligible professionals should continue to report the eRx measure in 2011 even if their practice is also participating in the Medicare or Medicare Advantage EHR Incentive Program because claims data for the first six months of 2011 will be analyzed to determine if a 2012 eRx Payment Adjustment will apply to the eligible professional.

If an eligible professional successfully generates and reports electronically prescribing 25 times (at least 10 of which are in the first 6 months of 2011 and submitted via claims to CMS) for eRx measure denominator eligible services, (s)he would also be exempt from the 2013 eRx payment adjustment.

The transcript and a recording of today’s call will be posted on the CMS website within a few weeks.

Image via Wikipedia