Medicare This Week: 11 Stories About Balance Billing, eRX, PQRS, 5010, EHR, and Revalidation

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

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

provider or supplier’s legal business name and EIN.

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

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

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

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

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

- Medicare Part A/B Revalidation Letters Mailed September – October 2011
- NSC Revalidation Letters Mailed

Later this year, CMS plans to implement a faster process for allowing users to see the date the revalidation notice was sent directly on the "My Enrollments" page within PECOS.
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Submit Your Medicare Enrollment Application Up to 60 Days Before the Effective Date

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

NOTE: This does not apply to providers and suppliers submitting a Form CMS-855A application, Ambulatory Surgical Centers (ASCs), or Portable X-ray Suppliers (PXRSs).
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National Provider Call: Current Status of Medicare FFS Implementation of HIPAA Version 5010 and D.0 – Register Now

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

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

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

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

Agenda:

§ Current 5010/D.0 metrics

§ Addressing recommendations made by Medicare FFS

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

§ Q&A session

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

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

From the MLN: Acute Inpatient Prospective Payment System Hospital Web-Based Training Course Now Available – This web-based training (WBT) course is designed to provide an overview of acute care hospital coverage and payment under the acute Inpatient Prospective Payment System (IPPS). It is designed to present a basic explanation of inpatient hospital coverage, billing, and payment for beneficiaries enrolled in Original Medicare.

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

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

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

From the MLN: "Quick Reference Information: The ABCs of Providing the Initial Preventive Physical Examination" Revised – Quick Reference Information: The ABCs of Providing the Initial Preventive Physical Examination (ICN 006904) has been revised and is now available in downloadable format. This

educational tool is designed to provide education on the Initial Preventive Physical Examination, also known as the IPPE. It includes a list of elements that must be included in the IPPE, as well as coverage and coding information.

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

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

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

From the MLN: "Correction to Processing of Hospice Discharge

Claims" MLN Matters® Article Revised – MLN Matters® Article #MM7473, "Correction to Processing of Hospice Discharge Claims" has been revised and is now available in downloadable format. This article is designed to provide education on Medicare's hospice discharge claims processing policy, as outlined in Change Request (CR) 7473. It includes information about changes to chapter 11 of the Medicare Claims Processing Manual, which provides detailed instructions for hospices to use in coding claims. The article was revised to emphasize that the implementation of this policy is effective for claims on or after January 1, 2012.
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Medicare Electronic Prescribing Payment Adjustment Hardship Exemption

In 2009, CMS implemented the Electronic Prescribing (eRx) Incentive Program, which is a program that uses incentive payments and payment adjustments to encourage the use of qualified electronic prescribing systems.

From calendar year (CY) 2012 through 2014, a payment adjustment that increases each calendar year will be applied to an eligible professional's Medicare Part B Physician Fee Schedule (PFS) covered professional services for not becoming a successful electronic prescriber. The payment adjustment of 1.0% in 2012, 1.5% in 2013, and 2.0% in 2014 will result in an eligible professional or group practice participating in the eRx Group Practice Reporting Option (eRx GPRO) receiving 99.0%, 98.5%, and 98.0% respectively of their Medicare Part B PFS amount for covered professional services.

Exclusion Criteria

The 2013 eRx payment adjustment only applies to certain individual eligible professionals. CMS will automatically exclude those individual eligible professionals who meet the following criteria:

§ The eligible professional is a successful electronic prescriber during the 2011 eRx 12- month reporting period (January 1, 2011 through December 31, 2011).

§ The eligible professional is not an MD, DO, podiatrist, Nurse Practitioner, or Physician Assistant by June 30, 2012, based on primary taxonomy code in the National Plan and Provider Enumeration System (NPPES).

§ The eligible professional does not have at least 100 Medicare Physician Fee Schedule (MPFS) cases containing an encounter code in the measure's denominator for dates of service from January 1, 2012 through June 30, 2012.

§ The eligible professional does not have 10% or more of their MPFS allowable charges (per TIN) for encounter codes in the measure's denominator for dates of service from January 1, 2012 through June 30, 2012.

§ The eligible professional does not have prescribing privileges and reported G8644 on a billable Medicare Part B service at least once on a claim between January 1, 2012 and June 30, 2012.

Avoiding the 2013 eRx Payment Adjustment

Individual eligible professionals and CMS-selected group practices participating in eRx GPRO who were not successful electronic prescribers in 2011 can avoid the 2013 eRx payment adjustment by meeting the specified reporting requirements between January 1 and June 30, 2012.

6-month Reporting Requirements to Avoid the 2013 Payment

Adjustment:

§ Individual Eligible Professionals – 10 eRx events via claims

§ Small eRx GPRO – 625 eRx events via claims

§ Large eRx GPRO – 2,500 eRx events via claims

For more information on individual and eRx GPRO reporting requirements, please see the MLN Article SE1206 – 2012 Electronic Prescribing (eRx) Incentive Program: Future Payment Adjustments.

CMS may exempt individual eligible professionals and group practices participating in eRx GPRO from the 2013 eRx payment adjustment if it is determined that compliance with the requirements for becoming a successful electronic prescriber would result in a significant hardship.

Significant Hardships

The significant hardship categories are as follows:

- The eligible professional is unable to electronically prescribe due to local, state, or federal law, or regulation
- The eligible professional has or will prescribe fewer than 100 prescriptions during a 6-month reporting period (January 1 through June 30, 2012)
- The eligible professional practices in a rural area without sufficient high-speed Internet access (G8642)
- The eligible professional practices in an area without sufficient available pharmacies for electronic prescribing (G8643)

Submitting a Significant Hardship Code or Request

To request a significant hardship, individual eligible professionals and group practices participating in eRx GPRO

must submit their significant hardship exemption requests through the Quality Reporting Communication Support Page (Communication Support Page) on or between March 1 and June 30, 2012. Please remember that CMS will review these requests on a case-by-case basis. All decisions on significant hardship exemption requests will be final.

Significant hardships associated with a G-code may be submitted via the Communication Support Page or on at least one claim during the 2013 eRx payment adjustment reporting period (January 1 through June 30, 2012). If submitting a significant hardship G-code via claims, it is not necessary to request the same hardship through the Communication Support Page.

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

§ Quality Reporting Communication Support Page User Guide

§ Tips for Using the Quality Reporting Communication Support Page

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

If you have questions regarding the eRx Incentive Program, eRx payment adjustments, or need assistance submitting a hardship exemption request, please contact the QualityNet Help Desk at 866-288-8912 (TTY 877-715-6222) or via qnetsupport@sdps.org. They are available Monday through Friday from 7am to 7pm CST.
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New Data Provides Info on EPs who

Participated in the Medicare EHR Incentive Program in 2011

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

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

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

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

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

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

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

Agenda:

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

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

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

Health Face-to-Face Encounter Requirements

On May 7, CMS released an MLN article designed to provide education on the contents of the home health certification, including homebound criteria and requirements for the face-to-face encounter and documentation. It includes guidance that physicians, non-physician practitioners, physician support personnel, and home health agencies can use to ensure that all certification requirements are understood and met. In addition, on May 4, updated face-to-face encounter Questions & Answers were posted and are available through the CMS Home Health Agency (HHA) spotlight page.
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Providers who Receive Error Codes H20203 and H45255 Need to Balance Bill

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

On February 29, 2012, CMS alerted Medicare physicians/practitioners, providers, and suppliers to three (3) edits that they may be seeing reflected on special provider notification letters that they receive from their local Fiscal Intermediary (FI), Carrier, A/B Medicare Administrative Contractor (MAC), or Durable Medical Equipment MAC (DME MAC). These edits had resulted, or are still resulting, from defects within our coordination of benefits (COB) *HIPAA* 837 compliance editing. The defects associated

with the firing of edits H51108 and H20203 at the Coordination of Benefits Contractor (COBC) were resolved on January 16 and February 27, respectively. CMS has the following additional information updates to offer regarding edits H20203 and H45255:

- *H20203*: Element CLM16 is present though marked 'Not Used'
    - Update: Medicare was able to repair all affected 837 professional claims right after February 27, 2012. Unfortunately, due to more highly critical *HIPAA* 5010 fixes that were needed to the version 5010 837 institutional COB/crossover claims process, the Fiscal Intermediary Shared System (FISS) was unable to resend 837 institutional claims that incorrectly rejected with error code H20203. Fortunately, the overall volume of affected claims was determined to be very low. Providers that received rejection code H20203 on their provider notification letters issued from their FI or A/B MAC will need to balance bill their patients' supplemental payers for any balances left after Medicare.

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

- Resolution: COBC's translation routine will scrub the duplicate identifier that is present in 2320 SBR03.
- Updated confirmed fix date: May 18, 2012
- Scope of Impact: The current problem seems to only be impacting *HIPAA* 5010A1 837 professional claims billed to Medicare by physicians/practitioners and DMEPOS suppliers. The error is principally impacting crossover claims that would have been transferred to North Dakota Medicaid. (*Note:* This is due to its reporting of the Medicare Health Insurance Claim Number (HICN) as the

policy number for crossover claim purposes).

- Update: Because certain Carriers, A/B MACs, and DME MACs have been holding generation of their provider notification letters tied to rejection code H45255 since February 2012, CMS has determined that a future claim repair action after May 18, 2012, would not be viable. Therefore, physicians/practitioners and suppliers may be seeing error H45255 on their provider notification letters. If physicians/practitioner and supplier offices see this rejection code, they will need to balance bill their patients' supplemental payer for any balances remaining after Medicare.

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Major Improvements to Medicare Online Enrollment System

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

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

The following upgrades are now available:

Overall Usability

Users will now have a search and filter feature that will allow the user to filter enrollments on the My Enrollments Page. Users will be able to filter the enrollments shown on the My Enrollments Page based on: Medicare ID, National Provider Identifier (NPI), or by selecting an Enrollment Type,

Enrollment Status, or State. Additional data has been added to the enrollment data on the My Enrollments Page, i.e. Enrollment Type, Medicare ID, and Practice Location.

Access to More Information

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

In addition, users will be able to identify those enrollments that are accredited for Advanced Diagnostic Imaging (ADI) Services. An ADI Services indicator will be visible on the My Enrollments page as either a "Yes" or "No".

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

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

Did you know?

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

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