

MOA MEMBERS

FROM SUE A. WEINGARTNER, EXECUTIVE DIRECTOR

JANUARY 10, 2011

CMS Medicare FFS Provider e-News for Fri Jan 7

Here is information direct from CMS. Note that the physician compare website, also known as the physician directory tool at www.medicare.gov, has multiple problems and AOA is working with CMS on improvements.

From: CMS FFS Provider Relations [<mailto:ffsproviderrelations@cms.hhs.gov>]

Sent: Friday, January 07, 2011 3:21 PM

Subject: CMS Medicare FFS Provider e-News for Fri Jan 7



CMS Medicare FFS Provider e-News
CMS Information for the Medicare Fee-For-Service Provider Community

The e-News for the week of Fri Jan 7 includes...

MEETINGS AND CALLS

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UPDATES FROM THE MEDICARE LEARNING NETWORK

- [“DMEPOS Competitive Bidding Procedures for Upgrades” Fact Sheet](#)
- [“New Home Health Claims Reporting Requirements for G Codes Related to Therapy and Skilled Nursing Services”](#)
- [“Rural Health Clinics and Federally Qualified Health Centers Billing Guide”](#)

National Provider Teleconference on Preparing for ICD-10 Implementation in 2011 [[↑](#)]

Wed Jan 12, 1-3pm EST

The Centers for Medicare & Medicaid Services (CMS) will host a national provider teleconference on “Preparing for ICD-10 Implementation in 2011.” Subject matter experts will review basic information on the transition to ICD-10 and discuss implementation planning and preparation strategies for this year. A question-and-answer session will follow the presentations.

Target Audience: Medical coders, physician office staff, provider billing staff, health records staff, vendors, educators, system maintainers, and all Medicare fee-for-service providers

The following topics will be discussed:

- Planning for transition to ICD-10 – “A call to action”
- ICD-10 implementation for services provided on and after Tue Oct 1, 2013 – No grace periods or delays
- Date of service implementation requirements

Tools for converting codes – 2011 General Equivalence Mappings (GEMs)

Partial freeze of ICD-9-CM and ICD-10 code updates, except for new technologies and diseases

Use of unspecified codes in both ICD-9-CM and ICD-10

Updating payment and coverage policies for ICD-10

Differences between ICD-9-CM and ICD-10

Internal planning groups and organizational strategies

Awareness, educational strategies, and assessing training needs

Implementation plan development and impact assessment

Determining vendor readiness

Coding gap analysis – What needs to be done for your coding staff

Assessing quality of medical record documentation

Developing an ICD-10 budget

Consequences of poor preparation

Registration will close at 1pm EST on Tue Jan 11 or when available space has been filled; no exceptions will be made and space is limited, so please register early. For more information and to register for this informative session, please visit

<http://www.cms.gov/ICD10/Tel10/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=1&sortOrder=descending&itemID=CMS1242831&intNumPerPage=10>.

For those of who will be unable to attend, a written and audio transcript of the call will be available a week or two after the call at the above-listed webpage.

National Provider Call on 2011 Physician Quality Reporting System & Electronic Prescribing Incentive Program [\[↑\]](#)

Tue Jan 18, 1:30-3pm EST

The Centers for Medicare & Medicaid Services' Provider Communications Group will host a national provider conference call on the 2011 Physician Quality Reporting System and Electronic Prescribing (eRx) Incentive Program. The Physician Quality Reporting System is voluntary quality reporting program that provides an incentive payment to identified individual eligible professionals (EPs), and beginning with the 2010 Physician Quality Reporting System, group practices who satisfactorily report data on quality measures for covered Physician Fee Schedule (PFS) services furnished to Medicare Part-B Fee-For-Service (FFS) beneficiaries. The Physician Quality Reporting System was first implemented in 2007 as a result of section 101 of the *Tax Relief and Health Care Act of 2006 (TRHCA)*, and further expanded as a result of the *Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA)*, and the *Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)*. The eRx Incentive Program is an incentive program for eligible professionals initially implemented in 2009 as a result of section 132(b) of the MIPPA. The eRx Incentive Program promotes the adoption and use of eRx systems by individual eligible professionals and beginning with the 2010 eRx Incentive Program, group practices.

Agenda:

- Electronic Prescribing (eRx) Incentive Program Payment Adjustment
- Centers for Medicare & Medicaid (CMS) Incentive Program Differences
- Electronic Health Record (EHR) Submission
- Q & A with CMS Physician Quality Reporting System and eRx subject matter experts

Educational products are available on the Physician Quality Reporting System and the eRx Incentive Program at <http://www.cms.gov/PQRI> and <http://www.cms.gov/eRxIncentive>, respectively. Feel free to download the resources prior to the call so that you may ask questions of the CMS presenters.

CMS will be adding a webinar as part of this national conference call (details follow below). This feature will allow participants who are on the internet the ability to follow the presentation online as it is given as well as the opportunity to answer polling questions during the presentation. This will not have any effect on those participants who are only dialing in to the audio portion of the call. Participants who are not participating in the webinar should be sure to download the presentation for the call in advance from the CMS website at

http://www.cms.gov/PQRI/04_CMSSponsoredCalls.asp.

In order to receive the call-in information, you must register for the call. (Note that if you are planning to sit in with a group, only one person needs to register to receive the call-in information.) *Registration will close at 1:30pm EST on Mon Jan 17*, or when available space has been filled; no exceptions will be made, so please register early. To register for the call:

- Visit <http://www.eventsvc.com/palmettogba/011811>.

Fill in all required information and click "Register."

You will be taken to the "Thank you for registering" page and will receive a confirmation email shortly thereafter. Please save this page, in the event that your server blocks the confirmation emails. (If you do not receive the confirmation email, please check your spam/junk mail filter as it may have been directed there.)

- If assistance for hearing impaired services is needed, the request must be sent to medicare.ttt@palmettogba.com no later than 3 business days before the event.

At the time of the call, first dial in for the call audio, then (if you are participating in the webinar) direct your browser to <https://webinar.CMS.hhs.gov/PQRSandERX> and sign in as a guest (using your first and last name).

For those of who will be unable to attend, a written and audio transcript of the call will be available at least one week after the call at <http://www.cms.hhs.gov/PQRI>.

National Education Call on Medicare Fee-For-Service Implementation of HIPAA Version 5010 and D.0 Transactions

[↑]

Wed Jan 19, 2-3:30pm EST

The Centers for Medicare & Medicaid Services (CMS) will host its fourteenth national education call regarding Medicare Fee-For-Service (FFS) implementation of HIPAA Version 5010 and D.0 transaction standards on Wed Jan 19. This session will focus on the errata impact to HIPAA transactions and the Medicare FFS companion guides. Subject matter experts will review how Medicare FFS is implementing the errata, review the Medicare FFS companion guide, and provide information to help the audience through the transition to implementation; the presentation will be followed by a Q&A session.

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

Agenda:

- General overview

Medicare FFS implementation of the errata

Medicare FFS Companion Guide

What you need to do

Q & A

CMS will be adding a webinar as part of this national conference call (details follow below). This feature will allow participants who are on the internet the ability to follow the presentation online as it is given as well as the opportunity to answer polling questions during the presentation. This will not have any effect on those participants who are only dialing in to the audio portion of the call. Participants who are not participating in the webinar should be sure to download the presentation for the call in advance from the CMS website at

<http://www.cms.gov/Versions5010andD0/V50/list.asp>.

Registration will close at 2pm EST on Tue Jan 18 or when available space has been filled; no exceptions will be made, so please register early. (Note that if you are planning to sit in with a group, only one person needs to register.) To register for the call (and receive dial-in information):

- Visit <http://www.eventsvc.com/palmettogba/011911>.
- Fill in all required information and click "Register."
- You will be taken to the "Thank you for registering" page and will receive a confirmation email shortly thereafter. Please save this page in the event that your server blocks the confirmation emails. (If you do not receive the confirmation email, please check your spam/junk mail filter as it may have been directed there.)
- If assistance for hearing impaired services is needed, the request must be sent to medicare.ttt@palmettogba.com no later than 3 business days before the event.

At the time of the call, first dial in for the call audio, then (if you are participating in the webinar) direct your browser to <https://webinar.CMS.hhs.gov/MedicareFFS5010> and sign in as a guest (using your first and last name).

Physician Quality Reporting System Town Hall Meeting [[↑](#)]

Wed Feb 9, 10am-4pm EST

The Centers for Medicare & Medicaid Services (CMS) will host a Town Hall Meeting to discuss the Physician Quality Reporting System (formerly known as the Physician Quality Reporting Initiative, or PQRI). The purpose of the Town Hall Meeting is to solicit input from participating stakeholders on individual quality measures and measures groups being considered for possible inclusion in the proposed set of quality measures for use in the 2012 Physician Quality Reporting System and key components of the design of the Physician Quality Reporting System. The opinions and alternatives provided during this meeting will assist CMS in developing the Physician Quality Reporting System for 2012.

Interested parties are invited to participate, either onsite at CMS headquarters (Central Building, 7500 Security Boulevard, Baltimore, Maryland 21244) or via teleconference. The meeting is open to the public; however, attendance is limited to space and teleconference lines available. CMS anticipates posting an audio download and/or transcript of the Town Hall meeting at <http://www.cms.hhs.gov/PQRI> and <http://www.USQualityMeasures.org> following the meeting.

Additional Details:

- Registration opens on Mon Dec 20, 2010. For security reasons, registration and requests for special accommodations must be completed no later than 5pm EST on Fri Jan 28, 2011.

Anyone interested in attending the meeting or participating by teleconference must register online at <http://www.USQualityMeasures.org>.

For more information, please see the Federal Register meeting notice posted at <http://edocket.access.gpo.gov/2010/pdf/2010-31301.pdf>.

To learn more about the 2012 Physician Quality Reporting System Call for Measures, please visit http://www.cms.gov/MMS/13_CallForMeasures.asp.

The CMS Measures Management System website link in the Federal Register meeting notice has been updated. The correct link is http://www.cms.gov/MMS/13_CallForMeasures.asp.

No Date Set for Expanded Ordering/Referring Provider Claim Edits [[↑](#)]

Due to recent inquiries, the Centers for Medicare & Medicaid Services (CMS) is clarifying its policy regarding expanded ordering/referring provider claim edits. CMS has not yet decided when it will begin to reject claims if an ordering/referring provider does not have a record in the Provider Enrollment, Chain, and Ownership System (PECOS). CMS will give providers ample notice before claim rejections begin. Recent revisions to CRs #6417 and #6421 require MACs to delay rejecting claims until receiving further direction from CMS.

Registration Now Open for Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs [[↑](#)]

The Centers for Medicare & Medicaid Services encourages eligible professionals, eligible hospitals, and critical access hospitals to register for the Medicare and/or Medicaid EHR Incentive Program(s) as soon as possible. You can register before you have a certified EHR, and should register even if you do not have an enrollment record in the Provider Enrollment, Chain, and Ownership System (PECOS).

The Registration and Attestation page on the EHR website (which you can reach by clicking the button below) now contains:

- instructions to promote a smooth registration process,
- user guides, and
- a link to the registration site.

Note: More general information on the EHR Incentive Programs may also be found using the tabs on the left of the page.



CMS Expands Healthcare Provider Directory, Launches first Phase of *Physician Compare* Website [[↑](#)]

The Centers for Medicare & Medicaid Services has enhanced the Physician Directory tool at www.Medicare.gov with new information about physicians and other healthcare workers in their communities and the services those professionals provide. The new feature, called *Physician Compare*, expands and updates CMS's Healthcare Provider Directory, which has helped millions of beneficiaries find Medicare-participating doctors online for over a decade. The new tool expands the doctor-specific information into the suite of informational tools for Medicare beneficiaries and other consumers.

“The new *Physician Compare* tool begins to fill an important gap in our online tools by providing more information about physicians and other healthcare workers,” said Donald Berwick, MD, CMS administrator. “This helps to pave the way for consumers to have similar information about their physicians as they have for nursing homes, home health agencies, and health and drug plans.”

The new site, at www.Medicare.gov/find-a-doctor, which was required by the *Affordable Care Act of 2010*, contains information about physicians enrolled in the Medicare program, which include Doctors of Medicine, Osteopathy, Optometry, Podiatric Medicine, and Chiropractic Medicine. The site also contains information about other types of health professionals who routinely care for Medicare beneficiaries, including nurse practitioners, clinical psychologists, registered dietitians, physical therapists, physician assistants, and

occupational therapists.

The *Physician Compare* website is designed to be consumer-friendly and help all patients – whether on Medicare or not – locate health professionals in their communities. The information on the site includes contact and address information for offices, the professional’s medical specialty, where the professional completed his or her degree as well as residency or other clinical training, whether the professional speaks a foreign language, and the professional’s gender. The tool can also help Medicare beneficiaries identify which physicians participate in the Medicare program.

In addition to information about the physician’s practice, *Physician Compare* also shows consumers whether the practice reported certain data to CMS through the Physician Quality Reporting System, formerly known as the Physician Quality Reporting Initiative (PQRI). Currently, the PQRI reporting system is a voluntary reporting program that rewards physicians and other eligible healthcare professionals for reporting data on quality measures related to services furnished to Medicare beneficiaries. These quality measures are based on the best available medical evidence and designed to help professionals improve care for patients. In 2009, more than 200,000 professionals reported data to CMS through the Physician Quality Reporting System.

Later in 2011, CMS plans a second phase of the website which will indicate whether professionals chose to participate in a voluntary effort with the Agency to encourage doctors to prescribe medicines electronically, rather than through traditional paper-based prescription methods.

In future years, the *Physician Compare* website will be expanded with information about the quality of care Medicare beneficiaries receive from physicians and the other healthcare professionals profiled on the site. The expansion will include information on quality of care and patient experience that can help consumers learn more about the care provided by Medicare-participating physicians. CMS is required by the *Affordable Care Act* to develop a plan to implement this expansion by 2013.

“Today’s release of *Physician Compare* moves us closer towards CMS’s goal to improve the quality of healthcare for people with Medicare in all the places where they receive care, including the doctor’s office,” said Berwick. “By using a considered, step-wise approach to spotlighting quality of care, we can create a tool that will help doctors and patients for decades to come.”

CMS has been working closely with healthcare stakeholders as it develops its future plans for the *Physician Compare* website, and will continue to do so through public meetings and forums, as well as through the regular processes to update the Physician Fee Schedule.

To learn more about the quality information CMS already collects through Medicare’s Physician Quality Reporting System, visit <http://www.cms.gov/pqri>. To visit the *Physician Compare* website, visit www.Medicare.gov/find-a-doctor or click on the “Compare” tab at www.Healthcare.gov.

CMS Launches the 2011 Medicare Contractor Provider Satisfaction Survey [[↑](#)]

It’s that time again... time for you to let your voice be heard! The Centers for Medicare & Medicaid Services (CMS) has launched its annual Medicare Contractor Provider Satisfaction Survey (MCPSS). This survey offers Medicare FFS providers and suppliers an opportunity to give CMS feedback on their interactions with Medicare FFS contractors related to seven key business functions: Provider Inquiries, Provider Outreach & Education, Claims

Processing, Appeals, Provider Enrollment, Medical Review, and Provider Audit & Reimbursement.

The survey was sent to a random sample of approximately 30,000 Medicare FFS providers and suppliers. Those who were selected to participate in the 2011 MCPSS were notified in December 2010. CMS understands that providers and suppliers themselves may not be able to respond directly to the survey, but may have a staff member who can act as a proxy to respond on their behalf. The respondent can be anyone within the provider's organization that is knowledgeable of the Medicare claims process and is designated to respond to the MCPSS. If you are selected to participate, please take the time to complete this important survey. CMS encourages providers and suppliers to complete the survey on the internet via a secure website. Other modes of participation are available by mail, fax, or telephone. It will take no more than 20 minutes. CMS is listening and wants to hear from you.

To learn more about the MCPSS, please visit the CMS website at <http://www.cms.gov/MCPSS>. If you have any questions or concerns, please call our toll-free MCPSS Provider Helpline number at 800-654-1431 or email us at MCPSS_survey@scimetrika.com.

2011 Electronic Prescribing (eRx) Incentive Program Update [\[↑\]](#)

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

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

How to Avoid the 2012 eRx Payment Adjustment:

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

Group Practices – For group practices that are participating in eRx GPRO I or GPRO II during 2011, the group practice **MUST** become a successful e-prescriber.

- Depending on the group's size, the group practice must report the eRx measure for 75-2500 unique eRx events for patients in the denominator of the measure.

For additional information, please visit the "Getting Started" webpage at <http://www.cms.gov/erxincentive>, or download the *Medicare's Practical Guide to the Electronic Prescribing (eRx) Incentive Program* under Educational Resources on the same website.

2011 Electronic Prescribing (eRx) Incentive Program Educational Products Are Now Available! [↑]

CMS has posted a variety of 2011 Electronic Prescribing (eRx) Incentive Program educational products to the eRx webpage. The following materials, and more detailed descriptions of each, are available at http://www.cms.gov/ERxIncentive/02_Spotlight.asp.

- 2011 eRx Measure Specifications and Release Notes
- Claims-Based Reporting Principles for the 2011 eRx Incentive Program
- 2011 EHR Measure Specifications for eRx and Release Notes
- 2011 EHR Downloadable Resource Table and Release Notes
- 2011 eRx Incentive Program GPRO I Measure Specifications and Release Notes

Further information on the 2011 eRx Incentive Program may be found in the final 2011 Medicare Physician Fee Schedule rule with comment period (75 FR 73490 through 73610) that was published in the Federal Register on Mon Nov 29, 2010, which can be found on the Statute/Regulations/Program Instructions section page at http://www.cms.gov/ERxIncentive/04_Statute_Regulations.asp.

Reminder: Reporting for the 2011 eRx began Sat Jan 1, 2011. There is no need to sign up or pre-register in order to participate.

2011 Physician Quality Reporting System Educational Products Are Now Available! [↑]

CMS has posted a variety of 2011 Physician Quality Reporting System educational products on the CMS website. The following materials, and more detailed descriptions of each, are available at http://www.cms.gov/PQRI/02_Spotlight.asp.

- 2011 Physician Quality Reporting System Measures List
- 2011 Physician Quality Reporting System Quality-Data Code (QDC) Categories
- 2011 Physician Quality Reporting System Single Source Code Master
- 2011 Physician Quality Reporting System Measure Specifications Manual for Claims and Registry Reporting of Individual Measures and Release Notes
- 2010 Physician Quality Reporting System Implementation Guide
- 2011 Physician Quality Reporting System Measures Groups Specifications Manual and Release Notes
- Getting Started with 2011 Physician Quality Reporting System of Measures Groups
- 2011 Physician Quality Reporting System Measure-Applicability Validation Process for Claims-Based Reporting of Individual Measures
- 2011 Physician Quality Reporting Measure-Applicability Validation Process Release Notes

- 2011 Physician Quality Reporting System Measure-Applicability Validation Process Flow
- Group Practice Reporting Option I (GPRO I) Requirements for Submission of 2011 Physician Quality Reporting System Data
- 2011 Physician Quality Reporting System Group Practice Reporting Option I (GPRO I) Measures List
- 2011 Physician Quality Reporting GPRO I Narrative Measure Specifications and Release Notes
- Group Practice Reporting Option II (GPRO II) Requirements for Submission of 2011 Physician Quality Reporting System Data
- Qualified EHR Vendors for the 2011 Physician Quality Reporting System and Electronic Prescribing (eRx) Incentive Programs
- 2011 EHR Documents for Eligible Professionals
- 2011 EHR Documents for Vendors

Further information on the 2011 Physician Quality Reporting System may be found in the final 2011 Medicare Physician Fee Schedule rule with comment period (75 FR 73377 through 73621) that was published in the Federal Register on Mon Nov 29, 2010, which can be found on the Statute/Regulations/Program Instructions section page at http://www.cms.gov/PQRI/05_StatuteRegulationsProgramInstructions.asp.

From the Medicare Learning Network: “DMEPOS Competitive Bidding Procedures for Upgrades” Fact Sheet [[↑](#)]

The “Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Billing Procedures for Upgrades” Fact Sheet is now available to download, free of charge, from the Medicare Learning Network®.

Once the DMEPOS Competitive Bidding Program becomes effective on Sat Jan 1, 2011, beneficiaries with Original Medicare who obtain competitively bid items in competitive bidding areas (CBAs) must obtain these items from a contract supplier for Medicare to pay, unless an exception applies. This fact sheet contains helpful information on Competitive Bidding Program rules that apply when a beneficiary wants to obtain an upgrade – that is, an item or a component of an item that exceeds the beneficiary’s medical need. It includes information on which DMEPOS suppliers can provide the item, how the item will be paid, beneficiary liability, and Advance Beneficiary Notice (ABN) requirements.

To view the fact sheet, please visit the DMEPOS Competitive Bidding Educational Resources page at http://www.cms.gov/DMEPOSCompetitiveBid/04_Educational_Resources.asp. Scroll to “Downloads” and select “DMEPOS Competitive Bidding Fact Sheets.”

From the Medicare Learning Network: “New Home Health Claims Reporting Requirements for G Codes Related to Therapy and Skilled Nursing Services” [[↑](#)]

The Medicare Learning Network® has released MLN Matters Article #MM7182, “New Home Health Claims Reporting Requirements for G Codes Related to Therapy and Skilled Nursing Services,” to inform home health agencies that they are required to report additional, and more specific, data about therapy nursing visits in home health claims. This requirement is based on Change Request #7182 and is effective for home health episodes beginning on or after Sat Jan 1, 2011. For more details, please read the article at <http://www.cms.gov/MLNMattersArticles/downloads/MM7182.pdf>.

From the Medicare Learning Network: “Rural Health Clinics and Federally Qualified Health Centers Billing Guide”



The Medicare Learning Network® has released MLN Matters Special Edition Article #SE1039, “Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Billing Guide,” to explain how RHCs should bill for certain preventive services under the *Affordable Care Act* and what information is required to develop and implement a Prospective Payment System (PPS) for Medicare FQHCs. This article is based on Change Requests #7038 and #7208 and is available at <http://www.cms.gov/MLNMattersArticles/downloads/SE1039.pdf>.

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CMS on the Web

www.CMS.gov

The Medicare Learning Network

www.CMS.gov/MLNGenInfo