

MOA MEMBERS
FROM SUE A. WEINGARTNER, EXECUTIVE DIRECTOR
JANUARY 14, 2011

CMS MEDICARE FFS PROVIDER WEEKLY UPDATE



CMS Medicare FFS Provider e-News

CMS Information for the Medicare Fee-For-Service Provider Community

CMS asks that you share the following important information with all of your association members and State and local chapters. Thank you!

The e-News for Fri Jan 14 includes...

MEETINGS AND CALLS

- [National Provider Call on 2011 Physician Quality Reporting System & Electronic Prescribing Incentive Program \[Tue Jan 18\]](#)
- [National Education Call on Medicare Fee-For-Service Implementation of HIPAA Version 5010 and D.0 Transactions \[Wed Jan 19\]](#)
- [Physician Quality Reporting System Town Hall Meeting \[Wed Feb 9\]](#)

ANNOUNCEMENTS AND REMINDERS

- [New Health Coverage Option for the Uninsured – The Pre-Existing Condition Plan](#)
- [Affordable Care Act's Hospital Inpatient Value-Based Purchasing Program Would Promote High-Quality Care](#)

CODE, PRICER, AND CLAIMS UPDATES

- [Healthcare Common Procedure Coding System Code Set Modifications – April 2011 Quarterly Update](#)
- [Healthcare Common Procedure Coding System \(HCPCS\) Collection Instrument](#)
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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). *PLEASE MAKE EXPLICIT NOTE of this webinar URL, as a previous message may have been distributed that included an incorrect URL address that won't work on Wed Jan 19.*

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.

New Health Coverage Option for the Uninsured – The Pre-Existing Condition Plan [↑]

Are you providing care to uninsured patients who have a pre-existing condition and can't find health coverage? If so, a new federal program – the Pre-Existing Condition Insurance Plan – can change or save the lives of your patients who've been locked out of the health coverage market because of a medical condition.

This program does not base eligibility on income and enrollees receive comprehensive health coverage at the same price that healthy people pay.

To qualify for the program, applicants must:

- Be a citizen of the United States or residing here legally;

Have been uninsured for at least 6 months; and

Have a pre-existing condition or have been denied coverage because of a medical condition.

The Pre-Existing Condition Insurance Plan covers physician and hospital services and prescription drugs. All insurance benefits are available to enrollees – even to treat a pre-existing condition. Premiums vary by state and annual out-of-pocket expenses for enrollees are capped.

Each state may use different methods to determine whether a person applying for the Pre-Existing Condition Insurance Plan has a pre-existing condition or whether he or she has been denied health coverage. As such, people need to check on how to establish eligibility in their state. For more information about the Pre-Existing Condition Insurance Plan and how to apply, visit www.PCIP.gov or, between the hours of 8am and 11pm EST, call 866-717-5826 (TTY: 866-561-1604).

We hope you will tell your patients and colleagues about this important new health coverage option.

Affordable Care Act's Hospital Inpatient Value-Based Purchasing Program Would Promote High-Quality Care [[↑](#)]

CMS has issued a proposed rule that would establish a new hospital value-based purchasing program that would reward hospitals for providing high-quality, safe care for patients. Under the program, hospitals that perform well on quality measures relating both to clinical process of care and to patient experience of care, or those making improvements in their performance on those measures, would receive higher payments under the program.

“Today’s proposal is a huge leap forward in improving the quality and safety of America’s hospitals for both Medicare beneficiaries and all Americans,” said CMS Administrator Donald Berwick, MD. “The hospital value-based purchasing program will reward hospitals for improving patients’ experiences of care, while making care safer by reducing medical mistakes.”

The hospital value-based purchasing program, which would apply beginning in FY2013 to payments for discharges occurring on or after Oct 1, 2012, would make value-based incentive payments to acute care hospitals, based either on how well the hospitals perform on certain quality measures or how much the hospitals’ performance improves on certain quality measures from their performance during a baseline period. The higher a hospital’s performance or improvement during the performance period for a fiscal year, the higher the hospital’s value-based incentive payment for the fiscal year would be.

The program, which was required by the *Affordable Care Act*, would apply to Medicare payments under the Inpatient Prospective Payment System (IPPS) for inpatient stays in more than 3000 acute care hospitals. The financial incentives would be funded by a reduction in the base operating DRG payments for each discharge, which under the statute will be 1% in FY2013, rising to 2% by FY2017. The hospital value-based purchasing program is one of multiple reforms that are dramatically changing how Medicare pays hospitals. Other changes that will increasingly tie payments to how effectively hospitals deliver quality care for patients include incentives for implementing electronic health records, and payment adjustments based on hospitals rates of hospital-acquired conditions and rates of readmissions. It would be a permanent part of the IPPS and would make it possible for all hospitals paid under the

IPPS to receive value-based incentive payments.

CMS has been collecting quality and patient experience information from acute care hospitals on a voluntary basis since 2004, the initial year of the Hospital Inpatient Quality Reporting (IQR) Program. The IQR program was authorized by section 501(b) of the *Medicare Prescription Drug, Improvement, and Modernization Act of 2003*, and amended by Section 5001(b) of the *Deficit Reduction Act of 2005*. In recent years, a vast majority of hospitals chose to participate in the program in order to be eligible for the full annual percentage increase each year, as a result of legislation requiring Medicare to reduce the annual percentage increase for hospitals that did not participate in the reporting program. More than 95-percent of eligible hospitals have participated successfully in this Hospital Inpatient Quality Reporting program, formerly called Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU), receiving their full annual percentage increase each year since the program went into effect.

“The hospital value-based purchasing program proposal expands upon CMS’s long-standing pay-for-reporting program to reward hospitals not just for reporting data, but for the results of that data,” said Administrator Berwick. “Value-based purchasing repositions Medicare from an observer of nationwide hospital quality to a formidable force in shaping quality going forward.”

CMS will accept comments on the Hospital Value-Based Purchasing Program proposed rule until Tue Mar 8, and will respond to them in a final rule to be issued next year. The proposed rule has been placed on display at the *Federal Register* and can be found under Special Filings at www.OFR.gov/inspection.aspx#special. For more information, visit www.CMS.gov/HospitalQualityInits. More information about the proposed rule, including the measures CMS proposes to use in the program, as well as CMS’s proposed scoring methodology, is included in a Fact Sheet posted on our Web page at www.CMS.gov/apps/media/fact_sheets.asp.

Healthcare Common Procedure Coding System Code Set Modifications – April 2011 Quarterly Update [[↑](#)]

The Centers for Medicare and Medicaid Services is pleased to announce the scheduled release of modifications to the Healthcare Common Procedure Coding System (HCPCS) code set. These changes have been posted to the HCPCS website at http://www.CMS.gov/HCPCSReleaseCodeSets/02_HCPCS_Quarterly_Update.asp. Changes are effective on the date indicated on the update.

Healthcare Common Procedure Coding System (HCPCS) Collection Instrument [[↑](#)]

CMS would like to inform you that the Healthcare Common Procedure Coding System (HCPCS) collection instrument has been published in the Federal Register Notice for a 60-day comment period as part of the *Paperwork Reduction Act (PRA)* process, and can be found at <http://edocket.access.gpo.gov/2010/pdf/2010-31071.pdf>. To obtain copies of the supporting statement and any related forms for the HCPCS collection, visit <http://www.cms.gov/PaperworkReductionActof1995>. If you have comments regarding the proposed revision of this paperwork collection, please follow the instructions in the Federal Register Notice. To be assured consideration, comments and recommendations must be submitted by Tue Feb 8. (Please note that while the form includes our proposed changes for 2013, the form is inadvertently dated 2012. CMS will correct the date prior to the 30-day comment period.)

From the Medicare Learning Network: “Sole Community Hospital” Fact Sheet Available in Hard Copy [\[↑\]](#)

The revised fact sheet titled “Sole Community Hospital” (October 2010), which provides information about Sole Community Hospital (SCH) classification criteria and SCH payments, is now available in print format from the Medicare Learning Network®. To place an order, visit <http://www.cms.gov/MLNGenInfo>, scroll down to “Related Links Inside CMS,” and select “MLN Product Ordering Page.”

From the Medicare Learning Network: “Home Health Face-to-Face Encounter: New Home Health Certification Requirement” [\[↑\]](#)

The Medicare Learning Network® (MLN) has released MLN Matters Special Edition Article #SE1038, “Home Health Face-to-Face Encounter: A New Home Health Certification Requirement,” to remind physicians who certify a patient’s eligibility for home health benefits that the *Affordable Care Act* mandates that they, or an allowed non-physician practitioner (NPP), document that they have had a face-to-face encounter with the patient. Documentation regarding these encounters must be present on certifications for patients whose care started on and after Sat Jan 1. This article is informational in nature and supports the Home Health Prospective Payment System (HHPPS) Final Rule (CMS-1510-F), as published in the Federal Register on Wed Nov 17, 2010. For more details, please read the article at <http://www.cms.gov/MLNMattersArticles/downloads/SE1038.pdf>.

More Helpful Links...

Check out CMS



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CMS on the Web

www.CMS.gov

The Medicare Learning Network

www.CMS.gov/MLNGenInfo

HIPAA 5010 & D.O Implementation Calendar and Important Reminders

During the transition to HIPAA Versions 5010 and D.O, we will periodically remind you of important items and dates that may be of specific interest to the Medicare Fee-for-Service (FFS) provider/supplier community. Please see below to learn about current, upcoming, and past events that have taken place during this implementation process.

IMPORTANT 5010/D.0 IMPLEMENTATION REMINDERS

1. ANNOUNCEMENT – January 1, 2011 marked the beginning of the 501/D.0 transition year!
2. READINESS ASSESSMENT – [Have you done the following to be ready for 5010/D.0?](#)
3. READINESS ASSESSMENT – [What do you need to have in place to test with your MAC?](#)
4. REMINDER – [5010/D.0 Errata requirements and testing schedule can be found here](#)
5. REMINDER – [Contact your MAC for their testing schedule](#)

5010/D.0 IMPLEMENTATION CALENDAR

CURRENT ITEMS:

January 2010

- 1st Beginning of Transition Year
- 11th [HIMSS 5010 Industry Readiness Update*](#)
- 19th [5010 National Call – Errata/Companion Guides](#)
- 25th - 27th [4th WEDI 5010 and ICD-10 Implementation Forums – Advancing Down the Implementation Highway: Moving Forward with Testing to Attain Implementation*](#)

UPCOMING ITEMS:

February 2011

- 20th - 24th [HIMSS 11th Annual Conference & Exhibition*](#)

March 2011

- 30th 5010 National Call – Provider Testing and Readiness

April 2011

- TBD MAC Hosted Outreach and Education Session - Are You Ready to Test?

May 2011

- 2nd - 5th [20th Annual WEDI National Conference*](#)
- 25th 5010 National Call – Topic TBD

June 2011

- TBD National MAC Testing Day (for Vendors, Clearinghouses, and Billing Services, etc)

July 2011

- TBD MAC Hosted Outreach and Education Session - Troubleshooting with your MAC

August 2011

- 31st 5010 National Call – MAC Panel
- TBD National MAC Testing Day (For Providers)

October 2011

TBD
24th - 27th MAC Hosted Outreach and Education Session (last push for implementation)
[WEDI 2011 Fall Conference](#)*

December 2011

31st End of the transition year, and the beginning of 5010 production environment!

PAST ITEMS:

June 2010

15th [5010 National Call – ICD-10/5010 National Provider Call](#)
30th [5010 National Call – 837 Institutional Claim Transaction](#)

July 2010

28th [5010 National Call – 276/277 Claim Status Inquiry & Response Transaction Set](#)

August 2010

25th [5010 National Call – 835 Remittance Advice Transaction](#)

September 2010

27th [5010 National Call – Acknowledgement Transactions \(TA1, 999, 277CA\)](#)

October 2010

13th [5010/D.0 Errata requirements and testing schedule released](#)
27th [5010 National Call – NCPDP Version D.0 Transaction](#)

November 2010

4th [Version 5010 Resource Card](#) published
8th [WEDI 2010 Fall Conference](#)*
17th [5010 National Call – Coordination of Benefits \(COB\)](#)

December 2010

8th [5010 National Call – MAC Outreach and Education Activities and Transaction-Specific Testing Protocols](#)

For older National Call information, please visit the [5010 National Calls section of our Versions 5010 & D.0 website](#).