



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!

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Colleagues—

I wanted to take a moment to highlight an upcoming deadline that may have a significant impact on your Medicare payments, before it becomes an issue for providers who may not meet it.

As you are likely aware by now, beginning Sun Jan 1, 2012, eligible professionals who have not successfully met the requirements of the eRx incentive program (or, alternately, qualify for a significant hardship exemption) will be subject to the 2012 eRx payment adjustment. The adjustment will reduce Medicare payment rates by 1% of the provider's allowable Medicare Part B charges.

If a provider is interested in requesting a significant hardship exemption for the 2012 Medicare eRx payment adjustment, the deadline to do so is Tue Nov 1. More details on the hardship exemption are available in today's e-News issue [below](#). And for more information on both eRx and the Physician Quality Reporting System, we have a [National Provider Call](#) coming up on Tue Oct 18.

Hope everyone's autumn is off to a pleasant start—

Robin

The e-News for the week of Tue Oct 11 includes...

NATIONAL PROVIDER CALLS

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- [“Medicare Claim Submission Guidelines” Fact Sheet Now Available](#)
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- [“Medicare Billing Information for Rural Providers and Suppliers” Now Available in Hardcopy](#)

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

Tue Oct 18; 1:30-3pm ET

CMS will host a National Provider Call on the Physician Quality Reporting System & Electronic Prescribing Incentive Program.

Target Audience: Eligible professionals, medical coders, physician office staff, provider billing staff, health records staff, vendors, and all other interested Medicare FFS healthcare professionals.

Agenda:

- Opening Remarks
- Program Announcements
- Overview of the Medicare Electronic Prescribing (eRx) Incentive Program Feedback Reports
- 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 Tue Oct 18* 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 will be posted at least one day before the call in the “Downloads” section of the page at http://www.CMS.gov/PQRS/04_CMSSponsoredCalls.asp.

- Additional material related to the Physician Quality Reporting System and eRx in today’s e-News... [[next](#)]

National Provider Call: Revalidation of Medicare Provider Enrollment – Save the Date [[↑](#)]

Thu Oct 27; 12:30-2pm ET

CMS will hold a National Provider Call to discuss the revalidation of Medicare provider enrollment information. Most providers and suppliers who are enrolled in the Medicare program will have to revalidate their enrollment which will be reviewed under the new risk screening criteria required by the *Affordable Care Act* Section 6401(a). Learn what you can expect and how to prepare for this process.

Target Audience: All providers and suppliers enrolled with Medicare prior to Mar 25 and which expect to receive payment from Medicare for services provided.

Agenda will include:

- What is Revalidation?
- ACA Screening Requirements
- Electronic Funds Transfer
- Streamlining the Process
- Phased Revalidation
- Tips on Revalidation
- Question and Answer Session

Registration Information: Will be made available soon, and will be announced in future communications and in the “Spotlight” section of the page at <http://www.CMS.gov/center/provider.asp>.

Presentation: The presentation will be posted at least one day before the call in the “Downloads” section of the page at http://www.CMS.gov/MedicareProviderSupEnroll/01_Overview.asp.

For more information about provider enrollment revalidation, review the Medicare Learning Network’s® Special Edition Article #SE1126, “[Further Details on the Revalidation of Provider Enrollment Information](#),” and #SE1130, “[Implementation of Pay.gov Application Fee Collection Process through PECOS](#).”

- Additional material related to Provider Enrollment and Revalidation in today’s e-News... [[next](#)]

Registration Now Open for Third and Final ACO Accelerated Development Learning Session [[↑](#)]

Thu Nov 17 and Fri Nov 18

Baltimore, MD

The third and final Accountable Care Organization (ACO) Accelerated Development Learning Session (ADLS) will be held in Baltimore, MD on Thu Nov 17 and Fri Nov 18. Registration is free and open for teams of between two and four senior leaders from healthcare delivery organizations interested in forming an ACO or from an existing ACO.

The ADLS is designed to help existing or emerging ACOs understand the steps they can take to improve care delivery and how to develop an action plan for moving toward providing better coordinated care. The content at each ACO Learning Session is repetitive and is not part of an ongoing series.

For more information, to register, or to view the plenary sessions from the first two ADLS sessions, please visit <http://ACOregister.rti.org>.

Deadline to Request Medicare eRx Incentive Program Hardship Exemption for 2012 eRx Payment Adjustment is Tue Nov 1 [↑](#)

CMS would like to remind eligible professionals and group practices participating in the Medicare Electronic Prescribing (eRx) Incentive Program that the deadline to request a hardship exemption for the 2012 eRx payment adjustment is Tue Nov 1.

Eligible professionals and group practices should determine if they are subject to the 2012 eRx payment adjustment by reviewing the MLN Special Edition Article #SE1107, "[2011 Electronic Prescribing Incentive Program Update – Future Payment Adjustments](#)." If you believe that you may be subject to the 2012 eRx payment adjustment, you should determine if you meet any of the hardship exemption categories specified by CMS in the 2011 Medicare Electronic Prescribing (eRx) Incentive Program Final Rule.

In addition, a [Quick Reference Guide](#) is available to help you understand the changes that the eRx Final Rule made to the 2011 Medicare eRx Incentive Program. As a result of changes to the program, eligible professionals and group practices *have until Tue Nov 1 to submit a significant hardship exemption request and rationale*.

Please note, to be considered for an exemption under the significant hardship exemption category "Eligible professionals who register to participate in the Medicare or Medicaid Electronic Health Record (EHR) Incentive Programs and adopt Certified EHR Technology," an eligible professional must:

- Have registered for either the Medicare or Medicaid EHR Incentive Program (for instructions on how to register for one of the EHR Incentive Programs, refer to the Registration and Attestation page of the EHR Incentive Programs section of the CMS website at http://www.CMS.gov/EHRIncentivePrograms/20_RegistrationandAttestation.asp); and
- Providers have to show that they adopted certified EHR technology no later than Oct 1, 2011, and provide identifying information about the certified EHR Technology. Please note that, in order to qualify for an exemption to the 2012 eRx payment adjustment under this significant hardship exemption category, it is not necessary that an eligible professional receive an incentive payment under the Medicare or Medicaid EHR Incentive Program.

Eligible professionals wishing to register for the Medicaid EHR Incentive Program in states that have not yet launched their respective programs may initiate the registration process at the CMS Registration and Attestation System and obtain a registration number, even though they will not be able to successfully complete registration. If a state has not launched its Medicaid EHR Incentive Program, the state name will not appear in the drop-down menu for eligible professionals to choose from. *However, a registration number is assigned even if registration is not successfully completed.*

In order to initiate registration for the Medicaid EHR Incentive Program, please visit <https://EHRincentives.CMS.gov/hitech/login.action> and follow the instructions to begin the registration process. Obtaining a CMS EHR Incentive Programs registration number, even if the registration is not successfully completed, suffices for the purposes of applying for a significant hardship exemption for the 2012 Medicare e-Prescribing payment adjustment.

To request an exemption, individual eligible professionals must submit their hardship exemption requests through the [Quality Communications Support Page](#) and group practices participating under the group practice reporting option (GPRO) must submit hardship exemption requests via a letter to CMS. Please remember that CMS will review these requests on a case-by-case basis. All decisions on significant hardship exemption requests will be final.

For additional information and resources, please visit <http://www.CMS.gov/ERXincentive> and review the new [FAQ](#) on the topic.

- Additional material related to the Physician Quality Reporting System and eRx in today's e-News... [\[previous\]](#)

Medicare's Provider Enrollment Revalidation Process and Improvements to Internet-Based PECOS [\[↑\]](#)

Over the coming months and years, CMS Medicare Administrative Contractors will ask providers to submit a complete and up-to-date enrollment application. You will be able to submit your application via paper (CMS-855 form) or electronically through the internet-based PECOS (Provider Enrollment, Chain, and Ownership System). CMS urges you to use internet-based PECOS for responding to the request for revalidation – and for most other updates that may need to be made to your provider enrollment records.

Between now and April 2012, CMS will continue to improve internet-based PECOS to make it easier for you to update your information and submit your revalidation application. We have already streamlined the application process with fewer screens and new helpful prompts to let you know if information is incomplete. Once enrolled in PECOS, you can review your existing information online, make changes, and submit the revalidated application without having to complete the entire application. You are also able to pay the application fee (if applicable) during the online submission process.

Soon internet-based PECOS will be improved to:

- Allow you to view all application data on a single screen, reducing data entry and duplication of data
- Allow you to easily manage and search your enrollment applications, as well as upload multiple applications at one time
- Simplify the registration process for Authorized Representatives
- Eliminate separate mailing of most documents through digital document upload for support documents

Use internet-based PECOS – it's faster, safe, and secure. To log on, visit <https://PECOS.CMS.hhs.gov>.

- Additional material related to Provider Enrollment and Revalidation in today's e-News... [\[previous\]](#)

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 ACA 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 *will be identified, and required to submit the CMS 588 EFT form with the Provider Enrollment Revalidation application.*

For more information about provider enrollment revalidation, review the Medicare Learning Network's [Special Edition Article #SE1126](#), titled "Further Details on the Revalidation of Provider Enrollment Information."

Make Sure You Know How to Meet Version 5010 Level II Compliance [[↑](#)]

The Version 5010 compliance deadline is less than 90 days away. All entities covered under the *Health Insurance Portability and Accountability Act (HIPAA)* must be ready to implement the Version 5010 transaction standards by Sat Dec 31. In order to meet this compliance deadline, you need to conduct both Level I Internal Testing and Level II External Testing of transactions.

Level I Internal Testing

Level I Internal Testing allows you to identify and address any potential issues that may arise in advance of testing with external business partners. If you have not yet done so, take action now to complete your internal testing as soon as possible. By now, you should have completed Level I Internal Testing, and begun Level II External Testing.

Level II External Testing

For Level II External Testing, you should identify the business partners you currently conduct transactions with, and create a schedule and timeline for external testing with each partner. If you trade with a large number of business partners, identify priority partners to conduct testing with first.

To meet Level II compliance, business partners that should be included in external testing include:

- Billing services
- Clearinghouses
- Pharmacies
- Entities responsible for coverage and benefit determinations
- Payers

To ensure a smooth transition during Level II External Testing, you should first test the transactions you currently use on a daily basis, such as:

- Claims
- Eligibility determinations
- Remittances
- Referral authorizations

After testing your daily transactions, you are ready to test all remaining transactions to ensure that you are fully compliant for Level II External Testing.

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!

Updates on Registration for the EHR Incentive Programs [[↑](#)]

CMS wants to remind eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) of the key registration dates for the Electronic Health Record (EHR) Incentive Programs, and provide information to help them successfully register and start their path to payment for 2011.

Important Registration Dates to Remember

- Wed Nov 30 – Last day for eligible hospitals and CAHs to register and attest to receive an incentive payment for FY2011.
- Wed Feb 29 – Last day for EPs to register and attest to receive an incentive payment for CY2011.

When Should Providers Register?

CMS encourages providers to register for the Medicare and/or Medicaid EHR Incentive Program(s) as soon as possible to avoid payment delays. Note that not all states have launched a Medicaid EHR Incentive Program yet; providers will not be able to complete their registration for the Medicaid EHR Incentive Program until their state's program has launched and that state's site has opened. Providers should check their state's [status](#).

Note, also, that provider can register before they have a certified EHR and can also register if they do not have an enrollment record in PECOS.

Registration Resources

CMS has a number of resources to help providers successfully register for the EHR Incentive Programs:

- Step-by-step registration guides, available on the CMS EHR [Registration page](#)
- A number of [FAQs](#) about registration on the EHR Incentive Programs website
- Webinars on YouTube to help guide providers through the registration process – one for [EPs](#) and one for [hospitals](#)

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.

Crossover Company Name Not Being Displayed on Electronic Remittance Advice [\[↑\]](#)

CMS has determined that Medicare Part B Electronic Remittance Advices (ERAs) in the 4010A1 format issued Mon Oct 3 through Fri Oct 7 are not displaying the crossover company name and accompanying 5-byte COBA ID. To identify that these claims have been automatically crossed over to a supplemental payer, look for remittance advice remark code (RARC) 'MA18' and/or 'N89.' RARC 'MA18' alerts providers that the claims information is being forwarded to the patient's supplemental payer, while RARC 'N89' alerts providers that claim information is being forwarded to multiple supplemental payers. If you see RARC MA18 and/or N89, the patient's claim has automatically been crossed over, even though the crossover company name and COBA ID is not being displayed.

Suppliers that receive the ERA from DME MACs are not affected since this was an MCS systems issue. The problem is now resolved via an emergency change. We apologize for any inconvenience you may experience related to this issue.

From the MLN: Get Connected with the Medicare Learning Network [\[↑\]](#)

Want to stay informed about the latest new and revised MLN products and services? Subscribe to the MLN Educational Products electronic mailing list! For more information about the MLN and how to register for this service, visit http://www.CMS.gov/MLNProducts/downloads/MLNProducts_listserv.pdf and start receiving updates.

From the MLN: "Medicare Claim Submission Guidelines" Fact Sheet Now Available [\[↑\]](#)

The new "[Medicare Claim Submission Guidelines](#)" fact sheet is now available in downloadable format. It includes information about applying for a National Provider Identifier and enrolling in the Medicare Program,

filing Medicare claims, and private contracts with Medicare beneficiaries.

From the MLN: New Podcast Released on Avoiding Medicare Billing Errors [[↑](#)]

The MLN has released the next in a series of podcasts designed to provide education on how to avoid common billing errors and other improper activities when dealing with the Medicare Program. "[Positive Airway Pressure \(PAP\) Devices: Complying with Documentation & Coverage Requirements](#)" discusses the documentation and coverage requirements needed to submit Medicare claims for PAP devices.

Please visit the [MLN Multimedia webpage](#) to download this and other podcasts from the MLN. We also encourage you to visit the [MLN Provider Compliance webpage](#) for the latest educational products designed to help Medicare Fee-For-Service Providers understand – and avoid – common billing errors and other improper activities identified through claim review programs. Stay tuned for future podcasts from the MLN!

From the MLN: "April 2011 Medicare Quarterly Provider Compliance Newsletter" Revised [[↑](#)]

The April 2011 issue of the "Medicare Quarterly Provider Compliance Newsletter," available at http://www.CMS.gov/MLNProducts/downloads/MedQtrlyComp_Newsletter_ICN903696.pdf, has been revised to amend an entry in the "Recovery Audit Finding: Untimed Codes – Excessive Units" section under "Guidance on How Providers Can Avoid These Problems" on page 10. All other information remains the same. This educational tool is issued on a quarterly basis and designed to provide education on how to avoid common billing errors and other erroneous activities when dealing with the Medicare Program.

From the MLN: "Medicare Billing Information for Rural Providers and Suppliers" Now Available in Hardcopy [[↑](#)]

The revised publication "Medicare Billing Information for Rural Providers and Suppliers" is now available in hardcopy. This booklet is designed to provide education on Medicare rural billing, and includes rural billing information about Rural Health Clinics, Federally-Qualified Health Centers, Skilled Nursing Facilities, Home Health Agencies, Critical Access Hospitals, and Swing Beds. To place your order, visit http://www.CMS.gov/MLNProducts/01_Overview.asp, scroll to "Related Links Inside CMS," and select "MLN Product Ordering Page."

More Helpful Links...

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The Medicare Learning Network

www.CMS.gov/MLNGenInfo

Archive of Provider e-News Messages

www.CMS.gov/FFSProvPartProg/EmailArchive