

**MOA MEMBERS
FROM SUE A. WEINGARTNER, EXECUTIVE DIRECTOR
DECEMBER 27, 2010**

CMS WEEKLY READING MATERIALS

Note the correction on DMEPOS claims (the previous message erroneously said the PTAN was required).

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

Wed Feb 9 (2011), 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 Web site link in the Federal Register meeting notice has been updated. The correct link is http://www.cms.gov/MMS/13_CallForMeasures.asp.

CORRECTION: Reminder for DMEPOS Suppliers to Submit Claims with Correct Billing Number / National Provider Identifier [\[↑\]](#)

Please disregard the earlier version of this message that was sent on Mon Dec 20, 2010, entitled “Reminder for DMEPOS Suppliers to Submit Claims with Correct PTAN,” which incorrectly referred to Provider Transaction Access Number (PTAN) instead of the Billing Number / National Provider Identifier (NPI).

The corrected message should instead read:

To ensure accurate claims processing, it is critically important for DMEPOS (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies) suppliers to submit each claim using the billing number / National Provider Identifier (NPI) of the location that furnished the item or service being billed. This has been a long-standing CMS policy. If you submit a claim using a billing number / NPI for a location that is not the location that furnished the item or service, your claim may be denied. This is particularly important in competitive bidding areas, where only contract suppliers, grandfathered suppliers, and suppliers furnishing competitively bid items under a program exception are eligible to furnish and be paid for competitively bid items.

Reminder: Contact Your Medicare Fee-For-Service Contractor for Specific Testing Schedules for HIPAA

Version 5010 & D.0 Transactions



Medicare FFS contractors will be ready to test the Base versions of all transactions in January 2011, and the 5010/D.0 Errata versions in April 2011. Trading Partners should contact their local Medicare FFS

contractor for specific testing schedules. To find a Medicare FFS contractor in your state, visit the “Downloads” section at <http://www.cms.gov/ElectronicBillingEDITrans>. For more information on testing protocols for 2011, visit http://www.cms.gov/Versions5010andD0/downloads/OE_National_Presentation_12-8-10.pdf.

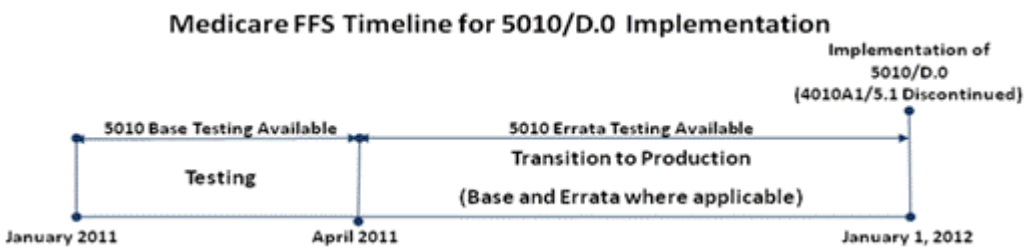
Only the base versions of the transactions will be available for testing in January 2011. Errata versions will be ready for testing in April 2011. A Trading Partner must be tested and approved on the Errata versions before being moved into production.

Background – The Standards Development Organizations have made corrections to the 5010 and D.0 versions of certain transactions. The “Errata” versions replace the Base versions for HIPAA compliance. HIPAA compliance will require the implementation of the Errata versions and the Base versions for those transactions not affected by the Errata, as listed below. The compliance date is January, 2012.

Table 1. Transactions Affected by the Errata - list of Base and Errata versions for 5010 and D.0.

Transactions Affected by the Errata Version	Base Version	Errata Version
270/ 271 Health Care Eligibility Benefit Inquiry and Response	005010X279	005010X279A1
837 Health Care Claim: Professional	005010X222	005010X222A1
837 Health Care Claim: Institutional	005010X223	005010X223A2
999 Implementation Acknowledgment For Health Care Insurance	005010X231	005010X231A1
835 Health Care Claim Payment/Advice	005010X221	005010X221A1
276/277 Status Inquiry and Response	005010X212	N/A
277CA Claim Acknowledgement	005010X214	N/A
National Council for Prescription Drug Programs (NCPDP) Version D.0 of the Telecom Standard	D.0	D.0 April 2009

Figure 1. Medicare FFS Timeline for 5010/D.0 Implementation: [1] Testing on Base Versions to begin in January 2011, [2] Testing and transition to production on Errata version to begin in April 2011, and [3] Implementation of 5010/D.0 on Sun Jan 1, 2012.



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

In November, 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.

ICD-10 GEMs Posted [\[↑\]](#)

The Centers for Medicare & Medicaid Services (CMS) has posted the 2011 versions of the ICD-10-CM and ICD-10-PCS crosswalks, formally referred to as the General Equivalence Mappings (GEMs), on the ICD-10 website at <http://www.cms.gov/ICD10>. See the links on this page for 2011 ICD-10-CM and GEMs and 2011 ICD-10-PCS and GEMs.

These updated files complete the requirements of Section 10109(c) of the Affordable Care Act of 2010. The Affordable Care Act required the Secretary of Health and Human Services to task the ICD-9-CM

Coordination and Maintenance Committee to convene a meeting before Sat Jan 1, 2011 to receive stakeholder input regarding the crosswalks between ICD-9-CM and ICD-10 for the purpose of making appropriate revisions to said crosswalks. Section 10109(c) further requires that these revisions to the crosswalks be posted to the CMS website, and treated as a code set for which the Secretary has adopted a standard.

In addition, CMS also has posted a document, "*ICD-10 GEMs 2011 Version Update, Update Summary.*" This document describes the number of comments we received, the type of changes recommended, the types of changes made based on the comments, and the types of comments not accepted and reasons why some comments were not accepted.

Medicare's Open Enrollment Deadline Nears; Important Beneficiary Outreach Continues [[↑](#)]

As the Fri Dec 31 deadline grows closer for people with Medicare to decide how they wish to get their Medicare health benefits for next year and whether to choose or change a Medicare drug plan, senior advocates and community-based programs are counseling and enrolling thousands of beneficiaries on their choices for the 2011 benefit year.

With just days remaining in the Open Enrollment season, Medicare's popular consumer telephone- and web-based resources (1-800-MEDICARE and www.Medicare.gov) are assisting these partner organizations and families with their efforts to encourage people who have not enrolled in a Medicare drug plan before or who need to make a change in their current coverage to do so as soon possible to ensure seamless and uninterrupted access to their medications at their chosen pharmacy in January 2011. Medicare's Open Enrollment season continues to generate high levels of activity on 1-800-MEDICARE, www.Medicare.gov, and at the thousands of counseling events around the country. To sustain awareness, CMS executed a multi-faceted outreach campaign on the national and local levels to ensure that people with Medicare receive personalized assistance to make a confident decision in health and drug coverage plan selection.

For more information about the Open Enrollment deadline, please see the CMS press release (English & Spanish) issued Wed Dec 22 at https://www.cms.gov/apps/media/press_releases.asp.

Electronic Health Records Incentives Registration Starts Mon Jan 3; CMS & ONC Outline Resources to Assist Eligible EHR Providers [[↑](#)]

On Wed Dec 22, the Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC) announced the availability of registration for the Medicare and Medicaid Electronic Health Record (EHR) incentive programs. CMS and ONC encouraged broad participation and outlined online and in-person resources that are in place to assist eligible professionals and eligible hospitals who wish to participate.

Beginning Mon Jan 3, 2011, registration will be available for eligible health care professionals and eligible hospitals who wish to participate in the Medicare EHR incentive program. On Mon Jan 3, registration in the Medicaid EHR Incentive Program will also be available in Alaska, Iowa, Kentucky,

Louisiana, Oklahoma, Michigan, Mississippi, North Carolina, South Carolina, Tennessee, and Texas. In February, registration will open in California, Missouri, and North Dakota. Other states likely will launch their Medicaid EHR Incentive Programs during the spring and summer of 2011.

“It’s time to get connected,” said David Blumenthal, MD, MPP, National Coordinator for Health Information Technology. “ONC and CMS have worked together over many months to prepare for the start-up. ONC’s [Certified HIT Product List](#) includes more than 130 certified EHR systems or modules and is updated frequently. ONC also has hands-on assistance available across the country through 62 [Regional Extension Centers](#). We look forward to continuing to work with CMS to assist eligible providers in 2011 and future years.”

Eligible professionals and eligible hospitals must register in order to participate in the Medicare and Medicaid EHR incentive programs. They can do so, starting Mon Jan 3, at a registration site maintained by CMS. To prepare for registration, interested providers should first familiarize themselves with the incentive programs’ requirements by visiting CMS’s [Official Web Site for the Medicare and Medicaid EHR Incentive Programs](#). The site provides general and detailed information on the programs, including tabs on the path to payment, eligibility, meaningful use, certified EHR technology, and frequently asked questions.

For more information please read the full CMS press release issued on Wed Dec 22 at <https://www.cms.gov/apps/media/press/release.asp?Counter=3887&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=1%2C+2%2C+3%2C+4%2C+5&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date>.

Important Information About Provider Registration for the EHR Incentive Programs [\[↑\]](#)

Registration begins Mon Jan 3, 2011 – are you ready? The new EHR webpage can help. CMS is happy to announce an updated, reorganized, and more user-friendly website for the EHR incentive programs, still located at www.CMS.gov/EHRIncentivePrograms. Highlights of this update are described later in this message.

We encourage providers to register for the Medicare and/or Medicaid EHR Incentive Programs as soon as possible. You can register before you have a certified EHR, and should do so even if you do not have an enrollment record in PECOS.

- *Hospitals:* Hospitals that are eligible for EHR incentive payments under both Medicare and Medicaid should select "Both Medicare and Medicaid" during the registration process, even if they plan to apply only for a Medicaid EHR incentive payment by adopting, implementing, or upgrading certified EHR technology. Dually-eligible hospitals can then attest through CMS for their Medicare EHR incentive payment at a later date, if they so desire. It is important for a dually-eligible hospital to select "Both Medicare and Medicaid" from the start of registration in order to maintain this option. Hospitals that register only for the Medicaid program (or only the Medicare program) will not be able to manually change their registration (ie. change to "Both Medicare and Medicaid" or from one program to the other) after a payment is initiated and this may cause significant delays in receiving a Medicare EHR incentive payment.
- *Eligible Professionals:* Eligible professionals eligible for both the Medicare and Medicaid EHR Incentive Programs must choose which incentive program they wish to participate in when they register. Until 2015, an eligible professional may switch programs only once after the first

incentive payment is initiated. Most eligible professionals will maximize their incentive payments by participating in the Medicaid EHR Incentive Program.

- *Registration:* Learn how you can prepare at [Registration](#). This is also where you will find the link to register beginning Mon January 3. Information on when registration will be available for Medicaid EHR Incentive Programs in specific States is posted at [Medicaid State Information](#).

Highlights of the web update include:

- [Path to Payment](#) – What steps must you take to receive an EHR incentive payment? Review this page to find out.
- [Meaningful Use](#) – What is “Meaningful Use?” What are the criteria for Meaningful Use? How do I meet the meaningful use requirements? Learn answers to these questions and more. Now includes *Meaningful Use Objectives Specification Sheets* for the Medicare and Medicaid EHR Incentive Programs. These bring together critical information on each objective to help eligible professionals and eligible hospitals/critical access hospitals understand what they need to do to demonstrate meaningful use successfully.
- [Educational Materials](#) – Want to learn about eligibility, payment, and meaningful use? See these educational products to learn more.
- [Frequently Asked Questions](#) – Have questions? See these responses to frequently asked questions on topics including eligibility, program timeline, and meaningful use.

Medicare Rural Health Clinics Waiver of Coinsurance and Deductible Claim Processing Issue [\[↑\]](#)

The Centers for Medicare & Medicaid Services has identified an issue when Healthcare Common Procedure Coding System (HCPCS) codes are reported for preventive services recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B on Rural Health Clinic claims (71X) for dates of service on or after Sat Jan 1, 2011. Since the additional revenue line(s) are not separately payable, the contractors have been instructed to move the charges associated with these revenue lines to the non-covered field and to override reason code 31577. This will allow the claim to continue processing and not delay payments. After the changes for CR7208, transmittal 2122, are implemented on Mon Apr 4, 2011, contractors will mass-adjust these claims to ensure the charges are reflected as covered. Providers should not attempt to resubmit affected claims as their FI or MAC will be initiating adjustments for the sole purpose of correcting the charges. Providers should anticipate the initiation of these adjustments within 30 calendar days after the implementation of CR7208.

From the Medicare Learning Network: “Claims Modifiers for Use in the DMEPOS Competitive Bidding Program” MLN Matters Article [\[↑\]](#)

The Medicare Learning Network® (MLN) has released MLN Matters Special Edition Article #SE1035 (“Claims Modifiers for Use in the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Competitive Bidding Program”) to inform providers about new Healthcare Common Procedure Coding System (HCPCS) modifiers that have been developed for use in the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. It is important that all providers and suppliers who provide DMEPOS affected by the Competitive Bidding program use the appropriate modifiers when submitting claims to the Centers for Medicare & Medicaid Services. For

more details, please read the article at
<http://www.cms.gov/MLN MattersArticles/downloads/SE1035.pdf>.

From the Medicare Learning Network: “DMEPOS Competitive Bidding Program Repairs and Replacements” Fact Sheet [\[↑\]](#)

Once the DMEPOS (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies) 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. One exception occurs when an item of DMEPOS that a beneficiary already owns needs to be repaired.

The “DMEPOS Competitive Bidding Program Repairs and Replacements” Fact Sheet contains helpful information on Competitive Bidding Program rules that apply when an item of DMEPOS that is owned by a beneficiary needs to be repaired or requires replacement parts. It includes information on which items and services non-contract suppliers may provide, and which Healthcare Common Procedure Coding System (HCPCS) codes can be considered replacement parts associated with repair of base equipment. 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 down to “Downloads,” and select “DMEPOS Competitive Bidding Fact Sheets.”