



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—

Over the last few weeks, we've received a handful of inquiries from partners and providers about the availability of these e-News messages online, so as to be able to refer others to content that's of interest.

Well, there's good news. The content of all the Provider e-News messages (dating back over years, when these messages went by other titles as well) is archived on the CMS website, and new content is usually available within a day or two of being mailed to e-News subscribers. You can find (and direct others to) the archive at <http://www.CMS.gov/FFSProvPartProg/EmailArchive>.

And in the future, if you're looking for the archive and don't have it bookmarked, you'll always be able to find the URL in the shell of these e-News messages, at the bottom right, below "[More Helpful Links](#)." Go ahead, take a look...

As always, let us know if you have any other questions. We're always available at FFSProviderRelations@cms.hhs.gov.

My best—

Robin Fritter

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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:

- 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.

Open-Door Forum: Hospital Inpatient Value-Based Purchasing Program – FY2013 Proposed Rule Overview [\[↑\]](#)

Thu Feb 10, 1:30-3:30pm, EST

The Centers for Medicare & Medicaid Services will hold a Special Open-Door Forum to discuss the proposed rule for the Hospital Inpatient Value-Based Purchasing (VBP) Program that will go into effect Mon Oct 1, 2012 (for Fiscal Year 2013). This Special ODF is designed specifically for hospitals and hospital quality experts, Medicare beneficiaries, their families, and advocates in an effort to increase awareness and understanding of the proposed rule.

The rule was designed to implement section 3001 of the *Affordable Care Act*, which requires CMS to establish a new Hospital VBP Program that rewards hospitals for providing high-quality, safe care to patients. Under the FY2013 Hospital VBP 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.

During this ODF, CMS staff will highlight the key features of the proposed Hospital VBP Program for FY2013, including but not limited to:

- Brief overview of the program and its provisions under Section 3001 of the *Affordable Care Act*;
- Proposals for the performance period, quality measures, and performance standards;
- Proposed scoring and incentive payment calculation methodology;
- Proposed hospital notification and review processes; and
- Transparency of quality measure performance as part of the Hospital VBP Program framework.

After CMS's presentation, participants will have an opportunity to ask questions. (Because CMS is in formal rulemaking, we will not be able to respond to questions beyond the scope of the proposed rule; we will be in "listen-only" mode for clarifying questions or comments related to proposals that are not already stated within our proposal.) All participants are strongly encouraged to submit comments through the formal rulemaking process.

The proposed rule, which was published in the *Federal Register* on Thu Jan 13, 2011, as well as instruction on submitting comments, can be found online at <http://www.GPO.gov/fdsys/pkg/FR-2011-01-13/pdf/2011-454.pdf>. Discussion materials for this Special ODF will be available to download at <http://www.CMS.gov/hospitalqualityinits> by Thu Feb 3.

Special Open-Door Forum participation instructions:

- Dial 800-837-1935 and use conference ID #39100886.
- For the hearing-impaired, TTY communications relay services are available by dialing 7-1-1 or 800-855-2880.
- An audio recording and transcript of the ODF will be posted on our around Thu Mar 10 (and will be available for 30 days) at http://www.cms.gov/OpenDoorForums/05_ODF_SpecialODF.asp.

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

Tue Feb 15, 2:30-4pm 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 on Tue Feb 15. 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 *MIPPA*. The eRx Incentive Program promotes the adoption and use of eRx systems by individual eligible professionals and group practices.

Agenda:

- Electronic Health Record (EHR) Reporting Made Simple
- eRx Future Payment Adjustment
- Q & A with CMS Physician Quality Reporting System and eRx subject matter experts

Prior to the call, the slideshow presentation that the presenter will be using will be posted online at http://www.cms.gov/PQRI/04_CMSSponsoredCalls.asp for participants to download. 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; you should feel free to download the resources prior to the call so that you may ask questions of the CMS presenters.

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 2:30pm EST on Mon Feb 14*, 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/021511>.
- 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.

Medicare & Medicaid Research Review Call for Papers (Ongoing Submissions Accepted) [[↑](#)]

The *Medicare & Medicaid Research Review (MMRR)* is soliciting studies, policy analyses, and program evaluations that use rigorous, scientific research methods. We are interested in papers addressing changes in coverage, quality, access, the organization and delivery of health services, payment for health services, and innovative methods. (Do not presume from the title that the scope is narrowly defined to include only research directly involving the Medicare, Medicaid, or the Children's Health Insurance Programs. It is not, though manuscripts should have results or conclusions that pertain at least indirectly to these programs.)

Illustrative examples of topics include, but are not limited to:

- Development, use, and effects of quality-based and bundled-service payment models,
- Impact of changes in cost sharing and coverage on care utilization patterns and outcomes,
- Impact of Medicaid eligibility changes on the organization and delivery of care,
- Descriptive analyses of longitudinal utilization and cost patterns among Medicare, Medicaid, and CHIP beneficiaries,
- Impact of changes within the private health care system on Medicare, Medicaid, and CHIP,
- Analyses of the types of health research questions amenable to quick study and implementation, and those questions that are not.

Submitted manuscripts must report the results of original scholarship. Manuscripts that are primarily editorial or opinion-based will not be considered. Manuscripts with results that directly support actionable recommendations will receive priority for publication. All manuscripts must be submitted by email to MMRR-Editors@cms.hhs.gov following the guidelines available at http://www.CMS.gov/MMRR/Downloads/MMRR_Info_for_Authors_20101214.pdf. Criteria for selection of manuscripts include [1] quality, rigor, and originality; [2] significance and usefulness for informing the future of Medicare, Medicaid, and CHIP; and [3] clarity of writing and presentation. Peer Reviewer Guidelines are also available at <http://www.CMS.gov/MMRR/downloads/MMRRPeerRevGuidelines.pdf>.

Questions can be directed to David Bott, PhD, Editor-in-Chief, at MMRR-Editors@cms.hhs.gov.

Have You Started External Testing of Version 5010? [\[↑\]](#)

All *HIPAA*-covered entities that submit transactions electronically are required to upgrade from Version 4010/4010A to Version 5010 transaction standards by Sun Jan 1, 2012.

Testing should be conducted both internally and with external business partners in preparation for the Sun Jan 1, 2012, compliance deadline. Internal testing of Version 5010 should have been completed by Fri Dec 31, 2010. Now is the time to begin external testing. Testing transactions using Version 5010 standards will assure that you are able to send and receive compliant transactions effectively; testing early will allow you to identify any potential issues, and address them in advance.

Stay ahead of the Version 5010 and ICD-10 transitions! Know the deadlines and mark your calendars:

- Sat Jan 1, 2011 – Begin external testing of Version 5010 for electronic claims. CMS begins accepting Version 5010 claims; Version 4010 claims continue to be accepted.
- Sat Dec 31, 2011 – External testing of Version 5010 for electronic claims must be complete to achieve Level-II Version 5010 compliance.
- Sun Jan 1, 2012 – All electronic claims must use Version 5010; Version 4010 claims are no longer accepted.
- Tue Oct 1, 2013 – Claims for services provided on or after this date must use ICD-10 codes for medical diagnosis and inpatient procedures; CPT codes will continue to be used for outpatient services.

CMS has resources that can help you with the Version 5010 and ICD-10 transitions at www.CMS.gov/ICD10. Version 5010 and ICD-10 are coming. Will you be ready?

Revision Requests for the ASC X12 005010 TR3 [\[↑\]](#)

On Sun Jan 1, 2012, all *HIPAA*-covered entities are required to use the adopted ASC X12 Version 5010 (Version 5010)

standard for electronic healthcare transactions, known as the ASC X12 Type-3 Technical Reports (TR3) or implementation guides. Even though Version 5010 has not yet been implemented, the work of the standards organization is ongoing.

At this time, ASC X12 is giving stakeholders an opportunity to review and comment on the Version 5010 implementation guide so that modifications can be made for the next version – 6020. Stakeholder input and consensus is critical to ensure that the standards meet the needs of all who use them, and to increase the use of electronic commerce in healthcare. We encourage all interested parties and stakeholders to submit recommendations for improvements to X12.

Revision requests and recommendations should be submitted through the Designated Standard Maintenance Organization (DSMO) website at <http://www.HIPAA-dsmo.org>. The deadline to submit revision requests for the ASC X12 005010 TR3 is Fri Feb 4, 2011. (It is imperative to have all comments submitted by this deadline for them to be considered in the development of Version 6020.) Please share this notification with others in your own association or network as soon as possible.

While we encourage stakeholders to respond to X12's request and participate in the standards process to the fullest extent feasible, this notification is not an indication of our intent to adopt Version 6020 at this time. New versions of standards must complete the Standard Development Organization (SDO) balloting processing, be considered and recommended by the National Committee on Vital and Health Statistics (NCVHS), and then adopted through the notice and public comment rulemaking process before they can be adopted as HIPAA standards.

For more information, please visit <http://www.x12.org/TR3ChangeRequest> and <http://www.HIPAA-dsmo.org>.

February is American Heart Month [\[↑\]](#)

Heart disease is the leading cause of death for both men and women in the United States. Approximately every 25 seconds, an American will have a coronary event, yet many cases of heart disease can be prevented. The Centers for Medicare & Medicaid Services reminds healthcare professionals that Medicare provides coverage of cardiovascular screening blood tests for eligible Medicare beneficiaries. These tests can help determine a beneficiary's cholesterol and other blood-lipid levels such as triglycerides. CMS recommends that all eligible beneficiaries take advantage of this coverage, which can determine whether beneficiaries may be at risk for cardiovascular disease.

Medicare Coverage – The following cardiovascular screening blood tests are covered by Medicare for eligible beneficiaries for the early detection of cardiovascular disease:

- Total Cholesterol Test
- Cholesterol Test for High-Density Lipoproteins
- Triglycerides Test

These blood tests are covered once every 5 years for people with Medicare who have no apparent signs or symptoms of cardiovascular disease; the tests must be ordered by a physician or qualified non-physician practitioner (physician assistant, nurse practitioner, or clinical nurse specialist) treating the beneficiary.

What Can You Do? – CMS needs your help to ensure that all eligible people with Medicare take advantage of the cardiovascular screening blood tests that can help identify beneficiaries who may be at risk for cardiovascular disease.

More Information – For more information about Medicare coverage of cardiovascular screening blood tests, please

refer to the following resources:

- Expanded Benefits brochure – This Medicare Learning Network® (MLN) brochure provides Medicare Fee-For-Service providers with an overview of the Medicare-covered cardiovascular screening blood tests as well as the “Welcome to Medicare” Visit and the ultrasound screening for abdominal aortic aneurysms. Read at http://www.CMS.gov/MLNProducts/downloads/expanded_benefits.pdf.
- Quick Reference Information: Medicare Preventive Services – This chart provides coverage and coding information on Medicare-covered preventive services including the cardiovascular screening blood tests. Read at http://www.CMS.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf.
- Cardiovascular Disease Screening Webpage – This CMS webpage provides an overview of the cardiovascular screening blood tests covered by Medicare as well as information on educational resources for healthcare providers. Visit <http://www.CMS.gov/CardiovasDiseaseScreening>.
- The MLN Preventive Services Educational Products Webpage – This webpage provides a list of MLN educational products related to Medicare-covered preventive services. These resources are specifically for Medicare Fee-For-Service providers and their staff. Visit at http://www.CMS.gov/MLNProducts/35_PreventiveServices.asp.
- Additionally, visit the Centers for Disease Control and Prevention’s American Heart Month website at http://www.CDC.gov/heartdisease/american_heart_month.htm.

Information for Eligible Professionals about Registration for the Electronic Health Record Incentive Programs [↑]

Designation of a third-party to register – At this time, there is no method available for a third-party to register multiple eligible professionals (EPs) for the Medicare and Medicaid EHR Incentive Programs. Beginning in May, CMS plans to implement functionality that will allow an EP to designate a third-party to register and attest on his or her behalf. We will release detailed information about that process when it is available.

Please be aware that, currently, EPs are NOT permitted to allow a practice manager or any other person to register in their place. Sharing your National Plan and Provider Enumeration System (NPPES) user ID and password with third-parties can place your information at risk. Until CMS implements new functionality in May, each EP should register himself or herself separately for the Medicare and Medicaid EHR Incentive Programs.

Registration for the Medicaid program – Eligible professionals must select between the Medicare and Medicaid EHR Incentive Programs. If you register for the Medicaid EHR Incentive Program, when you select “Medicaid” on the registration screen, you will be asked to select a state from the drop-down menu. Only states with launched programs (ie. states that are prepared to confirm your eligibility and make payments) are listed in that drop-down menu. Each month, CMS will add new states as they launch programs. If you have questions about when your state will launch, visit [Medicaid State Information](#). You may also contact your State Medicaid Agency for more information about the program; visit [State EHR Incentive Program Launch Dates and HIT Websites](#) for the Medicaid EHR Incentive Program links for each State Medicaid Agency.

For more information about the Medicare & Medicaid EHR Incentive Programs and to register, visit <http://www.CMS.gov/EHRIncentivePrograms>.

2011 Electronic Prescribing (eRx) Incentive Program Update – Avoiding the Adjustment [↑]

In November 2010, the Centers for Medicare & Medicaid Services announced that, beginning in calendar year 2012, eligible professionals who are not successful electronic prescribers based on claims submitted between Sat Jan 1 and

Thu June 30, 2011, may be subject to a payment adjustment on their Medicare Part-B Physician Fee Schedule-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 less than 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 2012.

How to Avoid the 2012 eRx Payment Adjustment:

- Eligible professionals – An eligible professional can avoid the 2012 eRx Payment adjustment 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.

February Flu Shot Reminder [\[↑\]](#)

It's Not too Late to Give and Get the Flu Vaccine. Take advantage of each office visit and continue to protect your patients against the seasonal flu. Medicare will continue to pay for the seasonal flu vaccine and its administration for all Medicare beneficiaries through the entire flu season. The Centers for Disease Control and Prevention recommends that patients, healthcare workers, and caregivers be vaccinated against the seasonal flu. Protect your patients. Protect your family. Protect yourself. Get your flu vaccine – not the flu.

Remember: influenza vaccine plus its administration are covered Part-B benefits. Note that influenza vaccine is NOT a Part-D-covered drug. For information about Medicare's coverage of the influenza vaccine and its administration, as well as related educational resources for healthcare professionals and their staff, please visit <http://www.CMS.gov/AdultImmunizations> and http://www.CMS.gov/MLNProducts/Downloads/Flu_Products.pdf.

Medicare Remit Easy-Print Version 2.8 is now Available [[↑](#)]

Version 2.8 of the Medicare Remit Easy-Print (MREP) software is available for download from the CMS website at http://www.CMS.gov/AccessToDataApplication/02_MedicareRemitEasyPrint.asp.

There are two new Medicare Secondary Payer (MSP) / Non-MSP Claims Reports. The MSP Claims Report identifies the X12 835V4010A1 and v5010 claims, within a remittance, that were processed by Medicare as secondary. The Non-MSP Claims Report identifies the X12 835V4010A1 and V5010 claims, within a remittance that were processed by Medicare as primary.

Since changes are being made to the MREP software, the updated Claim Adjustment Reason Codes / Remittance Advice Remark Codes file is included with version 2.8 of the MREP software. However, the separate Codes.ini file is provided when version 2.8 of the MREP software is distributed.

Home Health Prospective Payment System CY2011 PC Pricer Update [[↑](#)]

The CY2011 Home Health Prospective Payment System (HH PPS) PC Pricer has been updated. The new pricer file is now available for download at http://www.CMS.gov/PCPricer/05_HH.asp (in the “Downloads” section).

From the Medicare Learning Network: “Rural Referral Center” Fact Sheet Revised [[↑](#)]

The revised "Rural Referral Center" Fact Sheet (January 2011), which is designed to provide education on the Rural Referral Center Program that was established to support high-volume rural hospitals that treat a large number of complicated cases, is now available in downloadable format from the MLN at http://www.CMS.gov/MLNProducts/downloads/Rural_Referral_Center_Fact_Sheet.pdf.

From the Medicare Learning Network: “Medicare Dependent Hospital” Fact Sheet Revised [[↑](#)]

The revised "Medicare Dependent Hospital" Fact Sheet (January 2011), which is designed to provide education about Medicare Dependent Hospital (MDH) classification criteria and MDH payments, is now available in downloadable format from the Medicare Learning Network® at <http://www.CMS.gov/MLNProducts/downloads/MedDependHospfctsh508.pdf>.

From the Medicare Learning Network: “Expansion of Durable Medical Equipment Supplier Standards” [[↑](#)]

MLN Matters Special Edition Article #SE1032, “Expansion of Durable Medical Equipment (DME) Supplier Standards,” which alerts suppliers that the Centers for Medicare & Medicaid Services has expanded the enrollment standards that Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers must meet in order to establish and/or maintain billing privileges in the Medicare Program, is now available at <http://www.CMS.gov/MLNMattersArticles/downloads/SE1032.pdf>. CMS issued these revisions to ensure that only legitimate DMEPOS suppliers participate in the Medicare program and are providing DMEPOS items to Medicare beneficiaries. The article is informational in nature and supports the DMEPOS Supplier Enrollment Safeguards Final

Rule (CMS-6036-F), which became effective on Mon Sep 27, 2010.

From the Medicare Learning Network: EHR-Related Fact Sheets Now Available in Print [[↑](#)]

The following fact sheets related to Electronic Health Records (EHR) are now available in print format from the Medicare Learning Network[®]. To place an order, visit <http://www.CMS.gov/MLNGenInfo>, scroll to “Related Links Inside CMS,” and select “MLN Product Ordering Page.”

- *EHR Incentive Program for Critical Access Hospitals* (ICN #904627)
- *EHR Incentive Program for Medicare Hospitals* (ICN #904626)
- *Medicare Electronic Health Record Incentive Program for Eligible Professionals* (ICN #903695)
- *Medicaid Electronic Health Record Incentive Payments For Eligible Professionals* (ICN #904763)
- *Medicaid Hospital Incentive Payments Calculations* (ICN #904764)
- *Medicare EHR Incentive Program, Physician Quality Reporting System, and e-Prescribing Comparison* (ICN #903691) – Identifies opportunities for certain Medicare providers to receive incentive payments for participating in important Medicare initiatives.

From the Medicare Learning Network: “Quick Reference Information: Medicare Immunization Billing” Chart Now in Print [[↑](#)]

The “Quick Reference Information: Medicare Immunization Billing” chart, which provides Medicare Fee-For-Service physicians, providers, suppliers, and other healthcare professionals with quick information to assist with filing claims for influenza vaccine, pneumococcal vaccine, and Hepatitis V Virus (HBV) vaccine and their administration, is now available to order in hardcopy, free of charge, from the Medicare Learning Network[®]. To order your copy, visit the Preventive Services Educational products page at http://www.CMS.gov/MLNProducts/35_PreventiveServices.asp, scroll to “Related Links Inside CMS,” and select “MLN Product Ordering Page.”

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The Medicare Learning Network

www.CMS.gov/MLNGenInfo

Archive of Provider e-News Messages

www.CMS.gov/FFSProvPartProg/EmailArchive