



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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With Father's Day approaching in the next few weeks, did you know that June is [Men's Health Month](#)? And that the week of June 13 is [National Men's Health Week](#)?

We all want the men in our lives – whether it's fathers, brothers, sons, or patients – to be as healthy and live as comfortably as possible, and CMS wants to help. Please take a few moments to [review some great information](#) about the [variety of men's health-related benefits CMS covers](#) for Medicare beneficiaries and the educational resources available for healthcare providers. And thanks for joining with CMS as we strive to improve the quality of health for men and others covered by Medicare.

Also, have any thoughts on the educational products you read about from the Medicare Learning Network? We're always [looking for feedback](#), so feel free to let us know what we can do better.

Have a great week—

Robin

The e-News for the week of Tue June 7 includes...

MEETINGS, CALLS, AND EVENTS

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- [Special Open Door Forum: Shared Savings Program Advance Payment Initiative \[Tue June 14\]](#)
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- ["Guide to Medicare Preventive Services, Fourth Edition" Now Available](#)
- ["Foot Care Coverage" MLN Matters Article Revised](#)
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Quality Improvement and Evaluation System Vendor Call [[↑](#)]

Thu June 9, 2-3:30pm ET

CMS will host a Minimum Data Set (MDS) 3.0 informational call for vendors, covering topics such as:

- Item for IRF and Swing Bed Providers
 - CMSNet Migration
- MDS 3.0 Items for Swing Bed Providers
 - Data Specification Updates
 - Section S Items
 - State Required Section S and Additional NQ and NP Items
 - ASAP System Enhancements
 - New/Updated Error Messages
 - Discussion of Submitted Q & A's

The full agenda for this call is available on the QIES Technical Support Office (QTSO) website at <http://www.QTSO.com/vendorsmets.html>. Questions concerning this call can be directed to the QTSO Help Desk at help@qtso.com or 888-477-7876.

To participate in this call, dial 866-712-2205 and use conference code #4260581739

Special Open Door Forum: Shared Savings Program Advance Payment Initiative [[↑](#)]

Tue June 14, 2-3:30pm ET

The CMS Innovation Center is considering an Advance Payment Initiative for those ACOs entering the Medicare Shared Savings Program to test whether and how pre-paying a portion of future shared saving could increase participation in the Shared Savings Program. More information is available on the Innovation Center website at <http://innovations.CMS.gov>.

Following the presentation, the lines will be opened to allow participants to ask questions of the CMS subject matter experts.

To participate, dial 866-501-5502 and use conference ID #71725238. (Note that TTY Communications Relay Services are available for the people who are hearing impaired by dialing 7-1-1 or 800-855-2880.) An audio recording and transcript of this Special Forum will be posted to the Innovation Center [website](#) when it becomes available.

CMS Announces National Version 5010 Testing Days [[↑](#)]

Wed June 15 and Wed Aug 24

The Version 5010 compliance date – Sun Jan 1, 2012 – is fast approaching. All *HIPAA*-covered entities should be taking steps now to get ready, including conducting external testing to ensure timely compliance. Are you prepared for the transition? Medicare Fee-for-Service (FFS) trading partners are encouraged to contact their Medicare Administrative Contractors (MACs) now and facilitate testing to gain a better understanding of MAC testing protocols and the transition to Version 5010.

To assist in this effort, CMS, in conjunction with the Medicare FFS Program, announces National 5010 Testing Days to be held Wed June 15 and Wed Aug 24, 2011. The National 5010 Testing Days are an opportunity for trading partners to come together and test compliance efforts that are already underway with the added benefit of real-time help desk support and direct and immediate access to MACs.

CMS encourages all trading partners to participate in the National 5010 Testing Days. This includes:

- Providers;
- Clearinghouses; and
- Vendors

More details concerning transactions to be tested are forthcoming from your local MAC. Additionally, there are several State Medicaid Agencies that will be participating in the National 5010 testing days; more details will follow from them as well.

Again, CMS National 5010 Testing Days do not preclude trading partners from testing transactions immediately with their MAC. Don't wait. You are encouraged to begin working with your MAC now to ensure timely compliance. Note that successful testing is required before a trading partner may be placed into production.

We hope all trading partners will join us on Wed June 15 and Wed Aug 24 and take advantage of this great

opportunity to ensure testing and transition efforts are on track! For more information on *HIPAA* Version 5010, please visit <http://www.CMS.gov/Versions5010andD0>.

Sign Up Today for Free ACO Learning Sessions [[↑](#)]

Mon June 20 through Wed June 22

Minneapolis, MN

The Center for Medicare and Medicaid Innovation is offering free [Accelerated Development Learning Sessions](#) (ADLS) for providers interested in learning more about how to coordinate patient care through Accountable Care Organizations (ACOs). *Four* ACO Accelerated Development Learning Sessions are being offered in 2011, with the first session scheduled for June 20-22 in Minneapolis, MN. Each session will teach providers interested in becoming ACOs what steps they can take to improve care delivery and how to develop an action plan for moving toward providing better coordinated care.

Registration for the first session is now open for teams of between two and four senior leaders from healthcare delivery organizations interested in forming an ACO or from an existing ACO. In addition, the plenary sessions will be made available via webcast and all materials from the sessions will be publicly available on the [Innovation Center Website](#). Individuals wishing to attend the Mon June 20 through Wed June 22 ADLS in Minneapolis may register for free at <http://ACORregister.rti.org>.

The benefits of attending an Accelerated Development Learning Session include:

- [Access to faculty with ACO experience](#) – Faculty at each ADLS will be senior leadership from organizations that have already developed many of the characteristics of an ACO. These practitioners have first-hand experience with what is working and not working in the field.
- [Deep understanding of ACO core competencies](#) – The ADLS will cover several core competencies and strategies for building ACO capacities. Individual sessions and faculty will help participants complete corresponding sections of a comprehensive ACO implementation plan, including defining ACO goals and an action plan for establishing ACO core competencies.
- [Guided start to developing an implementation plan](#) – Participants are encouraged to complete a comprehensive implementation plan for establishing the core competencies of an ACO, based on an understanding of their current readiness and gap analysis. Each organization will begin the crucial process of identifying specific goals for care improvement. Resources, toolkits, and faculty support will be provided to help participants complete, update, and prepare to implement a comprehensive implementation plan that includes benchmarks for developing each core competency over the next one to three years.

For more information, please see our [Frequently Asked Questions page](#).

National Provider Call on Physician Quality Reporting System & Electronic Prescribing Incentive Program

[[↑](#)]

Tue June 21, 1:30-3pm ET

CMS will host a national provider call on the Physician Quality Reporting System & Electronic Prescribing Incentive Program. Subject matter experts will provide an overview of the [proposed rule](#) (CMS-3248-P, released on Thu May 26, 2011), which addresses the proposed changes to the Medicare Electronic Prescribing (eRx) Incentive Program; a question and answer session will follow the presentation. The target audience for

this call includes medical coders, physician office staff, provider billing staff, health records staff, vendors, and all Medicare fee-for-service providers.

In order to receive the call-in information, you must register for the call. *Registration will close at 1:30pm on Mon June 20* 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.CMS.gov/PQRI/04_CMSSponsoredCalls.asp.

National Provider Call on Accreditation Requirements for Advanced Diagnostic Imaging Technical Suppliers



Thu June 23, 2:30-4pm ET

CMS will host a national provider call on the upcoming mandatory accreditation program for all suppliers that furnish the technical component of advanced diagnostic imaging. Subject matter experts will discuss what the requirements are to meet the Sun Jan 1, 2012, deadline; who these requirements effect; and how to become accredited. CMS will update information previously discussed on Open Door Forums that will streamline the requirements.

The target audience for this call includes physician office staff and all Medicare fee-for-service providers; the agenda will include:

- the law;
- deadlines;
- suppliers effected;
- the accreditation process;
- the enrollment process; and
- a question and answer session.

A slideshow presentation will be made available in advance of the call at

http://www.CMS.gov/MedicareProviderSupEnroll/03_AdvancedDiagnosticImagingAccreditation.asp.

In order to receive the call-in information, you must register for the call. *Registration will close at 2:30pm on Wed June 22* 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/palmettogba/062311>.

Save the Date: National Provider Call on Medicare FFS Implementation of HIPAA Version 5010 and D.0 Transactions



Wed June 29, 1:30-3:00pm ET

CMS will host its seventeenth national education call regarding Medicare FFS's implementation of *HIPAA* Version 5010 and D.0 transaction standards on Wed June 29. The target audience for this call includes vendors, clearinghouses, and providers who need to make Medicare FFS-specific changes in compliance with *HIPAA* Version 5010 requirements. The agenda will include:

- *HIPAA* Version 5010 Status Update
- Question and Answer Session

If you would like to submit a question in advance of, during, or following the call, please email your inquiry to our 5010 FFS Information resource mailbox at 5010FFSinfo@cms.hhs.gov. Please note that this resource box will only accept emails the day before, the day of, and the day after this call; your emailed questions will be answered as soon as possible, and may not be answered during the call.

Registration information and instructions will be made available shortly. (There will not be a slide presentation for this call.)

Transcript for Tue May 24 Medicare Shared Savings Program Proposed Rule Overview National Provider Call Now Available [[↑](#)]

On Tue May 24 CMS held a national provider call on the Medicare Shared Savings Program proposed rule CM-1345-P, which implements the Shared Savings Program and establishes the requirements for Accountable Care Organizations, as established under section 3022 of the *Affordable Care Act*. This call was one in a variety of calls and listening sessions held by CMS during the proposed rule 60-day comment period. CMS subject matter experts gave an overview of the proposed rule to help the public understand how CMS is proposing to administer the program and to ensure that the public understands how to participate in the formal comment process, then held a question and answer session. The written transcript of this call is now available at http://www.CMS.gov/SharedSavingsProgram/40_Events.asp.



Men's Health Month and National Men's Health Week [[↑](#)]

June is Men's Health Month and Mon June 13 marks the beginning of this year's National Men's Health Week, which culminates appropriately on Father's Day, Sun Jun 19. The theme for this year is "Awareness, Prevention, Education, and Family."

The purpose of Men's Health Month and Week is to heighten public awareness of preventable health problems and encourage the early detection and treatment of diseases among men and boys. While Medicare now provides coverage for a wider array of preventive services and screenings, many men covered by Medicare are not fully using these services that can make a difference in the quality of their health. We need your help. Please join CMS in helping men with Medicare learn how they can live longer, healthier lives through disease prevention, early detection, and lifestyle modifications that support a healthier life.

Medicare provides coverage of many preventive services and screenings that are especially meaningful to men, including but not limited to:

- Colorectal and Prostate Cancer Screenings
- Cardiovascular Disease Screenings
- Diabetes Screening, Diabetes Self-Management Training, and Medical Nutrition Therapy
- HIV Screening
- Immunizations, including:
 - Hepatitis B
 - Influenza
 - Pneumococcal

- Smoking Cessation Counseling
- Annual Wellness Exam (*new for 2011*)

Note that while coverage by Medicare is subject to certain eligibility criteria, many preventive services and screenings can now be received with no out-of-pocket costs to the beneficiary.

What Can You Do? As a healthcare professional who provides care to men covered by Medicare you can help protect the health of your Medicare patients who may be at risk for certain health issues by educating them about their risk factors and encouraging them to take advantage of the preventive services and screenings that are appropriate for them. (Many preventive services and screenings covered by Medicare require a referral.)

For More Information:

- [Quick Reference Information: Medicare Preventive Services](#)
- [MLN Matters Article MM7070 – “Annual Wellness Visit, Including Personalized Prevention Plan”](#)
- [Quick Reference Information: The ABCs of Providing the Annual Wellness Visit](#)
- [Medicare Learning Network Preventive Services Educational Products](#)
- [Men's Health Month website](#)
- [Men's Health Week website](#)

First Medicare EHR Incentive Payments Issued, Totaling \$75 Million; Providers Offered Flexibility in Adopting eRx [\[↑\]](#)

CMS announced on Thu June 2 that the first payments of the Medicare EHR Incentive Program were distributed on Thu May 19. As part of the *American Recovery and Reinvestment Act*, the Medicare EHR Incentive Program provides payments to eligible professionals (EPs) and hospitals that demonstrate meaningful use of certified EHR technology.

CMS Administrator Donald Berwick, MD, explained in a statement that the payments are a crucial part of the nation’s future, “We can bring America’s healthcare system into the 21st century by adopting electronic health records and using electronic prescribing systems. Today’s announcements are steps on the right path – toward the health IT system America needs, which will save lives, save money.” CMS noted that in addition to the \$75 million given to providers participating in the Medicare program, fifteen states have initiated their Medicaid EHR Incentive Programs since January 2011, and, to date, over \$83 million in incentive payments have been made to qualified Medicaid providers.

The National Coordinator for Health Information Technology, Farzad Mostashari, MD, ScM, said in a statement, “Through the EHR Incentive Programs, we are helping eligible providers invest in their technology infrastructure. But this isn’t just about technology. The goal is better and safer healthcare, and that means it’s about patients — about their healthcare and protection of their information.” CMS also announced proposals for new flexibilities to help providers phase in the use of electronic prescribing. This program provides financial incentives, including payment adjustments beginning Sun Jan 1, 2012, for EPs to encourage electronic prescribing (eRx).

The full press release for this announcement can be found on the CMS website at <http://www.cms.gov/apps/media/press/release.asp?Counter=3968>. Detailed fact sheets on both the [e-prescribing proposed rule](#) and the [EHR incentive payments](#) can be found in the [fact sheet section](#) of the CMS

website.

Six New Electronic Health Records FAQs Posted on Clinical Quality Measures and Meaningful Use [\[↑\]](#)

We want to keep you updated with the latest resources on the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs. Six new FAQs on clinical quality measures (CQMs) and meaningful use have been added to our website:

1. For the Medicare and Medicaid EHR Incentive Programs, if the certified EHR technology possessed by an eligible professional (EP) generates zero denominators for all CQMs in the additional set that it can calculate, is the EP responsible for determining whether they have zero denominators or data for any remaining CQMs in the additional set that their certified EHR technology is not capable of calculating? [Read the answer.](#)
2. For the Medicare and Medicaid EHR Incentive Programs, if certified EHR technology possessed by an EP includes the ability to calculate CQMs from the additional set that are not indicated by the EHR developer or on the Certified Health Information Technology Product List (CHPL) as tested and certified by an ONC - Authorized Testing and Certification Body (ONC-ATCB), can the EP submit the results of those CQMs to CMS as part of their meaningful use attestation? [Read the answer.](#)
3. To meet the meaningful use objective “provide patients with an electronic copy of their health information,” how should the numerator and denominator be calculated for patients who see multiple eligible professionals (EPs) in the same practice (ie. in a multi-specialty group practice)? [Read the answer.](#)
4. What information must an EP provide in order to meet the measure of the meaningful use objective for “provide patients with an electronic copy of their health information”? [Read the answer.](#)
5. When a patient is only seen by a member of the EP’s clinical staff during the EHR reporting period and not by the EP themselves, do those patients count in the EP’s denominator? [Read the answer.](#)
6. How does an EP determine whether a patient has been “seen by the EP” in cases where the service rendered does not result in an actual interaction between the patient and the EP, but minimal consultative services such as just reading an EKG? Is a patient seen via telemedicine included in the denominator for measures that include patients “seen by the EP”? [Read the answer.](#)

For more information about the Clinical Quality Measures, take a look at the [CQM page](#) of the [EHR website](#).

Want more information about the EHR Incentive Programs? Visit the [CMS EHR Incentive Programs website](#) for the latest news and updates on the EHR Incentive Programs; also sign up for the [EHR Incentive Programs email update listserv](#).

Three Reminders to Medicare Providers for Billing Correctly for Ordered/Referred Services [\[↑\]](#)

Any Medicare-enrolled Part B organizational provider, DMEPOS supplier, or Part A Home Health Agency (HHA) provider may file claims with ordering or referring information.

1. There are three basic requirements for ordering and referring:
 - The physician or non-physician practitioner must be enrolled in Medicare or in an opt-out status.
 - The National Provider Identifier (NPI) used for ordering/referring must be for an individual physician or non-physician practitioner (cannot be an organizational NPI).
 - The physician or non-physician practitioner must be of a specialist type that is eligible to order

and refer.

If you don't meet the three basic requirements listed above, refer to item #3 below on how to obtain an NPI and enroll in Medicare for ordering and referring purposes.

2. Only Medicare-enrolled individual physicians and non-physician providers of a certain specialist type are eligible to order/refer for Part B and DMEPOS Medicare beneficiary services. (Organizational providers cannot order and refer.) Eligible individual physicians and non-physician providers include:
 - Doctor of Medicine or Osteopathy
 - Doctor of Dental Medicine
 - Doctor of Dental Surgery
 - Doctor of Podiatric Medicine
 - Doctor of Optometry
 - Doctor of Chiropractic Medicine
 - Physician Assistant
 - Certified Clinical Nurse Specialist
 - Nurse Practitioner
 - Clinical Psychologist
 - Certified Nurse Midwife
 - Clinical Social Worker

Only Medicare-enrolled individual physicians of a certain specialist type are eligible to order/refer for Part A when a plan of treatment is needed and submitted from an HHA for beneficiary services. These individuals include:

- Doctor of Medicine or Osteopathy
- Doctor of Podiatric Medicine

3. In order to order/refer, the provider must have an enrollment record in PECOS.
 - Providers who order or refer should *verify their enrollment* in PECOS. Note that receiving payments from Medicare does not necessarily mean you have an enrollment record in PECOS. The easiest way to check on enrollment status is by visiting internet-based PECOS at <https://pecos.cms.hhs.gov> and navigating to the "My Enrollments" page; if no record is displayed, you do not have an enrollment record in PECOS. (More detailed instructions on accessing and navigating internet-based PECOS are available [here](#).) Another option is to check the [Ordering and Referring Report](#).
 - If you believe an enrollment application has been submitted but no enrollment record exists in PECOS, check the list of *pending applications*, available at http://www.cms.gov/MedicareProviderSupEnroll/06_MedicareOrderingandReferring.asp (scroll to the "Initial Physician Applications Pending Contractor Review" in the Downloads section of the page).
 - Providers with neither an enrollment record in PECOS nor an entry on the list of pending applications should make arrangements to submit their enrollment application. Internet-based PECOS is the fastest and most efficient way to do so. For instructions, review the [Basics of Internet-based PECOS for Physicians and Non-Physician Practitioners](#).

For additional information, review the Medicare Learning Network's "Medicare Enrollment Guidelines for Ordering/Referring Providers" fact sheet at

http://www.cms.gov/MLNProducts/downloads/MedEnroll_OrderReferProv_FactSheet_ICN906223.pdf.

Proposed Changes to the 2011 Electronic Prescribing Incentive Program [\[↑\]](#)

On Thu May 26, CMS released a proposed rule (CMS-3248-P) on changes to the Medicare Electronic Prescribing (eRx) Incentive Program. The proposed rule would address concerns that stakeholders have expressed about implementation of the 2012 electronic prescribing payment adjustment. Specifically, CMS has received requests to better align the eRx Incentive Program with the Medicare & Medicaid Electronic Health Records (EHR) Incentive Programs, as well as suggestions to expand the significant hardship exemption categories.

To address these concerns, the proposed rule would do the following:

- Modify the existing 2011 eRx measure to also recognize certified EHR technology as defined at 45 CFR 170.102 as a “qualified” eRx prescribing system.
- Provide additional significant hardship exemption categories for the 2012 e-Rx payment adjustment. The eligible professional or group practice would need to, in its significant hardship exemption request, demonstrate that one of the following four situations applies to the respective practice:
 - Eligible professionals who register to participate in the Medicare EHR Incentive Program or the Medicaid EHR Incentive Program and adopt certified EHR technology;
 - Inability to electronically prescribe due to local, state, or federal law or regulation;
 - Limited prescribing activity; or
 - Insufficient opportunities to report the electronic prescribing measure due to limitations of the measure’s denominator.

CMS proposed that eligible professionals would have until Sat Oct 1, 2011, to submit a request for a hardship exemption from the 2012 eRx payment adjustment.

The proposed rule may be viewed in the *Federal Register* at [2011 eRx Proposed Rule – CMS-3248-P](#). The public has until Mon July 25, 2011, to provide comments on the proposed rule. Upon consideration of the public comments received, CMS will need to publish a final rule before these proposed changes would go into effect.

For an overview of this proposed rule, plan to attend the [Physician Quality Reporting System and eRx Incentive Program National Provider Call](#) on Tue June 21, more information about which is available at http://www.CMS.gov/PQRI/04_CMSSponsoredCalls.asp.

CMS Seeks Comments on Vascular Readmissions Measure – Comments Accepted through Thu June 30 [\[↑\]](#)

CMS has contracted with Yale New Haven Health Services Corporation / Center for Outcomes Research and Evaluation (YNHHSC/CORE) to develop a readmission measure for patients undergoing vascular procedures. This measure is being developed using Medicare Part A inpatient and outpatient administrative claims data and is designed for potential use in public reporting.

CMS is calling for public comment on the measure currently in development, titled “Hospital-Level 30-Day All-Cause Risk-Standardized Readmission Rate (RSRR) following Vascular Procedures.” CMS is requesting stakeholder review and public comment of this measure. All measure comments are welcome, but we are particularly interested in feedback in the following areas:

- Definition of the cohort;
- Definition of the outcome;
- Risk adjustment; and
- Technical Expert Panel (TEP) comments.

The measure specifications are outlined in the Measure Information Form (MIF); you may also review the TEP Summary Report (both available at https://www.CMS.gov/MMS/17_CallforPublicComment.asp).

Comments on the measures must be received by Thu June 30, 11:59 pm ET and may be general or specific to the measure. The comments received will be posted approximately four weeks after the public comment period closes.

The CMS public comment system, including links to the documents described above and instructions on comment submission, can be found at http://www.CMS.gov/MMS/17_CallforPublicComment.asp.

Applications Now Available for Federally-Qualified Health Center Medical Home Demonstration [\[↑\]](#)

The CMS Innovation Center is pleased to announce that it is currently accepting applications from Federally-Qualified Health Centers (FQHCs) to participate in the Medicare Federally-Qualified Health Center Advanced Primary Care Practice demonstration project. This demonstration is a new *Affordable Care Act* initiative and is being conducted by CMS in partnership with the Health Resources and Services Administration (HRSA).

This 3-year demonstration project will test the effectiveness of doctors and other health professionals working in teams to coordinate and improve care for up to 195,000 Medicare patients. It will show how the patient-centered medical home model can improve quality of care, promote better health, and lower costs.

CMS and HRSA invite eligible FQHCs to submit an application to participate in this demonstration. Participating FQHCs are expected to achieve Level 3 patient-centered medical home recognition, help patients manage chronic conditions, and actively coordinate care for patients. To help participating FQHCs make these investments in patient care and infrastructure, they will be paid a monthly care management fee for each eligible Medicare beneficiary receiving primary care services; in return, FQHCs agree to adopt care coordination practices that are recognized by the National Committee for Quality Assurance (NCQA). CMS and HRSA will provide technical assistance to help FQHCs achieve these goals.

CMS will be accepting applications through 11:59pm ET on Fri Aug 12. Details about the demonstration and the application process can be found at <http://www.CMS.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS1230557> or on the [CMS Innovation Center website](#); complete details and instructions for applying and participating in the demonstration can be found at <http://www.FQHCMedicalHome.com>. Questions should be directed to fqhc_med_home@cms.hhs.gov.

A recent press release on the announcement of the FQHC medical home demonstration project can be found on the HHS website at <http://www.HHS.gov/news/press/2011pres/06/20110606a.html>. Additionally, a CMS fact sheet on the topic can be found at <http://www.CMS.gov/apps/media/press/factsheet.asp?Counter=3978>.

Major New Effort to Give Consumers and Employers Better Information About Quality of Care [\[↑\]](#)

Affordable Care Act provision provides new opportunity for the use of Medicare and private sector claims data in evaluating the performance of physicians, other providers, and suppliers.

On Fri June 3, CMS proposed rules that will enable consumers and employers to select higher-quality, lower-cost physicians, hospitals, and other healthcare providers in their area. The new rules will allow organizations that meet certain qualifications access to patient-protected Medicare data to produce public reports on physicians, hospitals, and other healthcare providers. These reports will combine private sector claims data with Medicare claims data to identify which hospitals and doctors provide the highest quality, most cost-effective care. This initiative is part of a broader effort by the Obama Administration, made possible by the *Affordable Care Act*, to improve care and lower costs.

“Making more Medicare data available can make it easier for employers and consumers to make smart decisions about their healthcare,” said CMS Administrator Donald Berwick, MD. “Performance reports that include Medicare data will result in higher quality and more cost effective care. And making our healthcare system more transparent promotes competition and drives costs down.”

The proposed rule is on display in the *Federal Register* at <http://www.Archives.gov/federal-register/public-inspection/index.html> or (after Wed June 8) <http://www.GPOaccess.gov/fr/browse.html>.

The full text of this excerpted press release can be found on the CMS website at <https://www.CMS.gov/apps/media/press/release.asp?Counter=3977>.

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

The Centers for Medicare & Medicaid Services (CMS) has not yet determined when it will begin to apply the expanded edit for ordering/referring provider claims. These edits are applicable to ordering/referring providers that do not have a record in the Provider Enrollment, Chain, and Ownership System (PECOS). As previously stated, CMS will give providers ample notice before the ordering/referring provider claim edit is applied.

For information on the requirements for billing for ordering/referred services, review the Medicare Learning Network’s “Medicare Enrollment Guidelines for Ordering/Referring Providers” fact sheet at http://www.CMS.gov/MLNProducts/downloads/MedEnroll_OrderReferProv_FactSheet_ICN906223.pdf.

From the MLN: “National Coverage Determination for Percutaneous Transluminal Angioplasty (20.7) Concurrent with Carotid Artery Stenting in Patients at High Risk for Carotid Endarterectomy” MLN Matters Article Released [[↑](#)]

MLN Matters® Special Edition Article #SE1119 – titled “National Coverage Determination (NCD) for Percutaneous Transluminal Angioplasty (PTA) (20.7) Concurrent with Carotid Artery Stenting (CAS) in Patients at High Risk for Carotid Endarterectomy” – which reinforces that NCD 20.7 for PTA of the carotid artery concurrent with stenting is not changed by new FDA-approved indications, is now available at <http://www.CMS.gov/MLNMattersArticles/downloads/SE1119.pdf>. This article is informational and supports current PTA and CAS policies.

From the MLN: “Guide to Medicare Preventive Services, Fourth Edition” Now Available [↑]

The Guide to Medicare Preventive Services, Fourth Edition,” which is designed to provide education on Medicare’s Preventive benefits, has been updated to reflect *Affordable Care Act* provisions and is now available in downloadable format free of charge from the Medicare Learning Network®. To view, print, or download this product, visit http://www.CMS.gov/MLNProducts/downloads/MPS_guide_web-061305.pdf.

From the MLN: “Foot Care Coverage” MLN Matters Article Revised [↑]

MLN Matters® Special Edition Article #SE1113 – titled “Foot Care Coverage” – which clarifies routine care of the foot and care related to underlying systematic conditions, is now available at <http://www.CMS.gov/MLNMattersArticles/downloads/SE1113.pdf>. This article, originally released in February 2007 as MLN Matters® Article #SE0707, was updated to reflect changes in policy related to Medicare coverage of podiatry services.

From the MLN: “Protect Your Identity Using the Provider Enrollment, Chain, and Ownership System” Fact Sheet Revised [↑]

The publication titled “How to Protect Your Identity Using the Provider Enrollment, Chain, and Ownership System (PECOS)” has been revised and is now available in downloadable format from the Medicare Learning Network® at http://www.CMS.gov/MLNProducts/downloads/MedEnroll_ProvID_FactSheet_ICN905103.pdf. This fact sheet is designed to provide education and step-by-step instructions on identity-protection when using Internet-based PECOS.

From the MLN: “Hospital Outpatient Prospective Payment System” Fact Sheet Available in Hard Copy [↑]

The publication titled “Hospital Outpatient Prospective Payment System” (March 2011) is now available in print format from the Medicare Learning Network®. This fact sheet is designed to provide education on the Hospital Outpatient Prospective Payment System (OPPS), including background, ambulatory payment classifications, how payment rates are set, and payment rates under the OPPS. To place your order, visit <http://www.CMS.gov/MLNGenInfo>, scroll to “Related Links Inside CMS,” and select “MLN Product Ordering Page.”

From the MLN: MLN Matters® – Feedback Requested [↑]

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