May 2011

NOA 3rd Party Newsletter

Nebraska Optometric Association

Volume 11, Issue 5

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Electronic Prescribing (eRx) Incentive Program Update

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 Saturday, January 1 and Thursday, June 30, 2011, may be subject to a payment adjustment on their Medicare Part-B Physician Fee Schedule-covered professional services. [See article in box below.]

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 will result 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 January 1, 2011 through 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 June 30, 2011 based on primary taxonomy code in NPPES *[See article below];*
- Does not have prescribing privileges. Note that (s)he must report G8644 at least one time on an eligible claim prior to 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. download the "Medicare's Practical Guide to the Electronic Prescribing (eRx) Incentive Program" under "Educational Resources" on the same website.

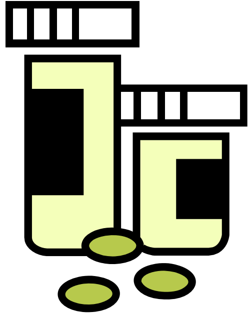
See Also Pages 2 and 3.

CMS Errs, Omits ODs from 2012 Physician e-Rx Penalty

The AOA and Dr. Quack have strongly recommended that optometrists begin e-prescribing as soon as possible, preferably completing 10 e-Rxs before July 1st of this year. However, it has been disclosed that, despite ODs being classified as physicians by Medicare, CMS has apparently not included ODs in the physician requirement of 10 e-Rxs before July 1st to avoid penalties in 2012. According to AOA staff member Rodney Peele JD, CMS was reportedly unaware that ODs have prescriptive authority in all 50 states, and thus erroneously omitted the profession from the 2011 July 1st requirement.

At first glance, this would seem to be favorable to the profession. But it is unknown whether ODs will be penalized in 2013 for e-prescribing actions that took place in both 2011 and 2012. So, despite this omission by CMS, the AOA and Dr. Quack strongly recommend that ODs successfully complete an e-Rx at least 25 times before the end of 2011, and, if possible, complete 10 e-Rxs before July 1st of this year.

eRx: It's Not Too Late To Start.............



e-RX

It's not too late to start participating in the 2010 Electronic Prescribing Incentive Program

It's not too late to start participating in the 2010 Electronic Prescribing Incentive Program (eRx) and potentially qualify to receive a full-year incentive payment for 2011. In addition, beginning 2012, CMS will apply payment adjustments to eligible professional who are not successful electronic prescribers under the eRx Incentive Program. To become successful electronic prescribers for purposes of avoiding the 2012 eRx payment adjustment, eligible professionals must report the electronic prescribing measure for a required minimum number of unique electronic prescribing events via claims between January 1, 2011 and June 30, 2011. The http://www.cms.gov/ERxIncentive/03_How_To_Get_Started.asp#TopOfPage web site is designed to lead you step by step through the process of becoming one of the growing number of eligible professionals who are participating in the program. You may also wish to investigate participating in a separate program known as the Physician Quality Reporting System (formerly known as the Physician Quality Reporting Initiative, or Physician Quality Reporting System). For information on the Physician Quality Reporting System go to the **"Related Links Inside CMS"** section of this page and click on the link titled **Physician Quality Reporting System**.

Eligible professionals may begin reporting the eRx measure at **any time** throughout the 2011 program year of January 1-December 31, 2011 to be incentive eligible, but must do so prior to June 30, 2011 to be exempt from the 2012 eRx payment adjustment (click on **"Payment Adjustment"** link on the left for more information. Click on the **"Eligible Professional"** link on the left to see if you are an eligible professional. *[See article, bottom, P.1.]* Eligible professionals must have adopted a "qualified" electronic prescribing system in order to be able to report the electronic prescribing measure. There are two types of systems.

1) a system for eRx only (stand-alone)
2) an electronic health record (EHR system) with eRx functionality.

Regardless of the type of system used, to be considered "qualified" it must be based on **ALL** of the following capabilities:

• Generating a complete active medication list incorporating electronic data received from applicable pharmacies and pharmacy benefit managers (PBMs) if available.

• Selecting medications, printing prescriptions, electronically transmitting prescriptions, and conducting all alerts.

• Providing information related to lower cost, therapeutically appropriate alternatives (if any). (The availability of an eRx system to receive tiered formulary information, if available, would meet this requirement for 2011)

• Providing information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient's drug plan, if available.

For purposes of the 2012 payment adjustment, you need to report electronic prescribing data for January 1, 2011 through June 30, 2011 via claims. **Before you report this measure, you should ask yourself the following questions:**

QUESTION 1: Do I have an electronic prescribing system/program and am I routinely using it?

QUESTION 2: Is my system capable of performing the functions of a qualified system as described above?

QUESTION 3: Do I expect my Medicare Part B Physician Fee Schedule (PFS) charges for the codes in the denominator of the measure (as noted in List 1) to make up at least 10 percent of my total Medicare Part B PFS allowed charges for 2010?

If the answer to all three questions is YES, you may be eligible for an incentive payment equal to one percent as well as a one percent payment adjustment of your Medicare Part B PFS allowed charges for services furnished during the reporting period and you should report the eRx measure.

If the answer to the first two questions is YES, but the answer to the third question is NO, you may not be eligible for the incentive payment or the payment adjustment. However, we encourage you to report the electronic prescribing measure. In the event that your Medicare Part B PFS charges for the codes in the denominator of the measure (as noted in List 2) do make up at least 10 percent of your total Medicare Part B PFS allowed charges for 2010, you may be eligible for the incentive payment and payment adjustment.

If the answer to either of the first two questions is NO, you cannot report this measure unless you obtain and use a qualified electronic prescribing system as defined in List 1.

List 1: Electronic Prescribing Measure Denominator Codes (Eligible Cases)

Patient visit during the reporting period (Current Procedural Terminology [CPT] or Healthcare Common Procedure Coding System [HCPCS] G-codes):

90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90862, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99345, 99347, 99348, 99349, 99350, G0101, G0108, G0109

CPT only copyright 2010 American Medical Association. All rights reserved.

Once You Have Decided That You Want to Participate in the eRx Incentive Program for 2011, You Should Take the Following Steps to Report the Measure:

STEP 1: Did you bill one of the CPT or HCPCS G-codes noted in List 1for the patient you are seeing?

NO: You do not need to report this measure for this patient for this visit.

YES: Proceed to Step 2.

(Continued on page 3)

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STEP 2: You should report the following G-code (or numerator code) on the claim form that is submitted for the Medicare patient visit.

G8553 - At least one prescription created during the encounter was generated and **transmitted electronically using a qualified electronic prescribing system.**

We encourage you to report the G-code listed in Step 2 above on all of your patient visit claims along with one (or more) of the eligible denominator codes noted in List 1 above. An example of reporting the electronic prescribing measure on the Form CMS-1500 (Health Insurance Claim Form) is available in the **"Downloads"** section of this page. Click on the link titled **"eRx Claims Based Reporting Principles".**

STEP 3: To be a successful electronic prescriber and be eligible to receive an eRx incentive payment, you must generate and report one or more electronic prescriptions associated with a patient visit; a minimum of 25 unique visits per year. To avoid the 2012 eRx payment adjustment, you must report on a minimum of 10 unique visits via claims from January 1, 2011 through June 30, 2011. Each visit must be accompanied by the electronic prescribing G-code attesting that during the patient visit at least one prescription was electronically prescribed. Electronically generated refills do not count and faxes do not qualify as an electronic prescription. New prescriptions not associated with a code in the denominator of the measure specification are not accepted as an eligible patient visit and do not count towards the minimum unique electronic prescribing events.

STEP 4: Additionally, 10 percent of an eligible professional's Medicare Part B PFS charges must be comprised of the codes in the denominator of the measure to be eligible for an incentive or payment adjustment.

There is NO need to register to participate in this reporting program. Simply begin submitting the G-code on your claims appropriately, or, for eligible professionals attempting to quality for the incentive only, report the information required by the measure to a qualified registry, or submit the information required by the measure to CMS via a qualified EHR, if you satisfy the above requirements.

Other ways an eligible professional may avoid the 2012 payment adjustment are if the eligible professional:

- Is not a physician (MD, DO, or podiatrist *[Quack Note: see article, bottom of page 1]*, nurse practitioner, or physician assistant as of June 30, 2011, based on primary taxonomy code in the National Plan and Provider Enumeration System (NPPES);
- Does not have prescribing privileges and reports G-code G8644 (defined as not having prescribing privileges) at least one time on an eligible claim prior to June 30, 2011;
- Does not have at least 100 cases containing an encounter code in the measure denominator
- Does not meet the 10% denominator threshold
- Meets and reports a significant hardship exemption.

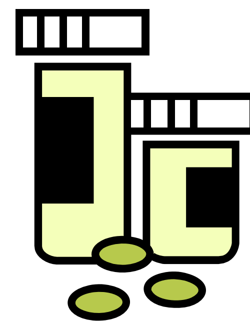
For more information on the eRx payment adjustment, click on the **"Payment Adjustment Information"** link located to the left of this page.

Need Assistance?

QualityNet Help Desk for…

- General CMS Physician Quality Reporting System & E-Prescribing Information
- Physician Quality Reporting System Portal Password Issues
- Physician Quality Reporting System feedback report availability and access

7:00 AM – 7:00 PM CT
Phone: 1-866-288-8912
Email: qnetsupport@sdps.org



e-Rx

To be a successful electronic prescriber and be eligible to receive an eRx incentive payment, you must generate and report one or more electronic prescriptions associated with a patient visit; a minimum of 25 unique visits per year.

FOR ADDITIONAL RESOURCES, GO TO http://www.cms.gov/ERxIncentive/03_How_To_Get_Started.asp#TopOfPage

Downloads
- Introduction to the Electronic Prescribing Incentive Fact Sheet [PDF 180 KB]
- Introduction to the Electronic Prescribing Incentive Fact Sheet-Spanish Version [PDF186 KB]
- 2011 eRx Claims-Based Reporting Principles [PDF 153KB]
- 2011 EHR Qualified Vendors for Physician Quality Reporting System and eRx Incentive Program [PDF 55 KB]
- Requirements for EHR Vendors to Participate in the 2011 PQRI EHR Program [PDF 30KB]
- Physician Quality Reporting System and Electronic Prescribing Quick-Reference Support Guide [PDF 31KB]

Related Links Inside CMS
- Physician Quality Reporting Initiative (Physician Quality Reporting System)
- All eRx FAQs
- 2011 PFS Final Rule -- CMS-1503-FC

Related Links Outside CMS
- Physician Quality Reporting System/eRx Submission Engine Validation Tool User Guide and Portal User Guide

EHR and Meaningful Use

Several new CMS resources can help you successfully navigate the Medicare EHR Incentive Program.

Attestation for the Medicare EHR Incentive Program Has Begun!

This means that eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) can attest through the CMS web-based attestation system and be on their way to receiving Medicare EHR incentive payments.

We can help you successfully attest

Several new CMS resources can help you successfully navigate the Medicare EHR Incentive Program:

- A new attestation page on the CMS EHR website, where participants in the Medicare EHR Incentive Program can find important information on attestation. See https://www.cms.gov/EHRIncentivePrograms/32_Attestation.asp#TopOfPage
- The Meaningful Use Attestation Calculator allows EPs and eligible hospitals to check whether they have met meaningful use guidelines before they attest in the system. The calculator prints a copy of each EP's or eligible hospital's specific measure summary. See adjacent column and also http://www.cms.gov/apps/ehr/
- The Eligible Professional User Guide provides step-by-step guidance for EPs and eligible hospitals on navigating the attestation system. See https://www.cms.gov/EHRIncentivePrograms/Downloads/EP_Attestation_User_Guide.pdf

Coming soon

- Attestation Worksheets for EPs and eligible hospitals allow users to fill out their meaningful use measure values, so they have a quick reference tool to use while attesting.

Attestation Video Webinars will provide a video version of the user guides for EPs, eligible hospitals and CAHs. The videos show EP and eligible hospital representatives completing the attestation process.

If you are not ready to attest, follow these steps to participate in the programs:

- **Make sure you're eligible for the EHR Incentive Programs.** View eligibility guidelines at our Eligibility page at http://www.cms.gov/EHRIncentivePrograms/15_Eligibility.asp and select the program in which you want to participate.
- **Get registered.** Registration is open for EPs, eligible hospitals, and CAHs. For more details, visit the Registration page at http://www.cms.gov/EHRIncentivePrograms/20_RegistrationandAttestation.asp
- **Use certified EHR technology.** To receive incentive payments, make sure the EHR technology you're using or are considering buying has been certified by the Office of the National Coordinator for Health Information Technology. Visit our Certified EHR Technology page at http://www.cms.gov/EHRIncentivePrograms/25_Certification.asp .
- **Be a Meaningful User.** You have to successfully demonstrate "meaningful use" for a consecutive 90-day period in your first year of participation (and for a full year in each subsequent years) to receive EHR incentive payments. Visit the Meaningful Use page at http://www.cms.gov/EHRIncentivePrograms/30_Meaningful_Use.asp to learn about meaningful use objectives and measures.

Attest for incentive payments. To get your EHR incentive payment, you must attest through Medicare's secure website that you've demonstrated meaningful use with certified EHR technology.

Want more information about the EHR Incentive Programs?

Make sure to visit the EHR Incentive Programs website at http://www.cms.gov/EHRIncentivePrograms/ for the latest news and updates on the EHR Incentive Programs.

Try the Meaningful Use Attestation Calculator…

CMS has launched a new attestation resource for the Medicare Electronic Health Record (EHR) Incentive Program.

All eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) participating in the Medicare EHR Incentive Program must attest to having met meaningful use requirements in order to receive their EHR incentive payments.

The Meaningful Use Attestation Calculator found at http://www.cms.gov/apps/ehr/ helps Medicare EPs determine if they have met all of the objectives and their associated measures for meaningful use prior to completing attestation for the Medicare EHR Incentive Program. Note, the tool does not calculate Clinical Quality Measures (CQMs) See https://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp

These measures are reported directly from a certified EHR and will need to be entered in the web-based attestation system in order to receive an incentive payment. This calculator is not the same as the actual attestation; rather it is a tool that allows Medicare EPs to assess their readiness to successfully complete the attestation process.

The Meaningful Use Attestation Calculator will help prepare EPs, eligible hospitals, and CAHs for the attestation system. After entering their core and menu measure meaningful use data, the calculator will display whether a provider has met the necessary criteria for these objectives. The user can then print a copy of the measures they have entered and whether they have passed or failed each specific measure.

The calculator will indicate in red those measures for which the input values did not meet the required thresholds and will mark them as "failed."

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You can find the Meaningful Use Attestation Calculator and more information about the attestation process on the Attestation page of the CMS EHR Incentive Programs website.
https://www.cms.gov/EHRIncentivePrograms/32_Attestation.asp#TopOfPage

In order to better understand the meaningful use criteria, EPs can also review the Stage 1 Meaningful Use Specification Sheets for EPs at

https://www.cms.gov/EHRIncentivePrograms/Downloads/EP-MU-TOC.pdf

These specification sheets contain detailed information on each core and menu meaningful use measure.

Want more information about the EHR Incentive Programs?

Make sure to visit the CMS EHR Incentive Programs website at http://www.cms.gov/EHRIncentivePrograms/

for the latest news and updates on the EHR Incentive Programs.

How do I get paid for the EHR Incentive Programs?

Payments for the Medicare and Medicaid EHR Incentive Programs are distributed based on each year of participation, and follow a specific payment schedule at https://www.cms.gov/EHRIncentivePrograms/35_Basics.asp. Located below are payment details on the Medicare and Medicaid EHR Incentive Programs. For an overview, see the Medicare Learning Network (MLN) Matters Special Edition article (SE1111) – Medicare Electronic Health Record (EHR) Incentive Payment Process at http://www.cms.gov/MLNMattersArticles/Downloads/SE1111.pdf

Medicare EHR Incentive Program

- **Eligible professionals (EPs):** EPs can receive up to $44,000 over five years under the Medicare EHR Incentive Program. There's an additional incentive for EPs who provide services in a Health Professional Shortage Area (HPSA).To get the maximum incentive payment, Medicare EPs must begin participation by 2012.

IMPORTANT NOTE: Medicare Administration Contractors (MACs), carriers, and Fiscal Intermediaries (FIs) will not be making Medicare EHR incentive payments. CMS has contracted with a Payment File Development Contractor to make these payments.

DON'T: Call your MAC/Carrier/FI with questions about your EHR incentive payment.
INSTEAD: Call the EHR Information Center, 7:30 a.m. – 6:30 p.m. (Central Time) Monday through Friday, except federal holidays. 1-888-734-6433 (primary number) or 888-734-6563 (TTY number).

A revised FAQ on payment for the EHR Incentive Programs has been posted to the EHR website

Question: For the 2011 payment year, how and when will incentive payments for the Medicare EHR Incentive Program be made?

Answer: For EPs, incentive payments for the Medicare EHR Incentive Program will be made approximately four to eight weeks after an EP successfully attests that they have demonstrated meaningful use of certified EHR technology. However, EPs will not receive incentive payments within that timeframe if they have not yet met the threshold for allowed charges for covered professional services furnished by the EP during the year. Read the rest of the answer to this FAQ at:

http://questions.cms.hhs.gov/app/answers/detail/a_id/10160/session/L3NpZC9Gb3hCbDRzaw%3D%3D

Payments for the Medicare and Medicaid EHR Incentive Programs are distributed based on each year of participation, and follow a specific payment schedule.

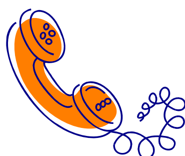
Want more information about the EHR Incentive Programs?
Make sure to visit the EHR Incentive Programs website at http://www.cms.gov/EHRIncentivePrograms for the latest news and updates on the EHR Incentive Programs

PQRI is now PQRS

In the Calendar Year 2011 CMS announced the renaming of the Physician Quality Reporting Initiative (PQRI) to the Physician Quality Reporting System (PQRS). As a result of the name change, the Physician Quality Reporting System's web page URL address has also changed. The new URL address is http://www.cms.gov/pqrs on the CMS website. The previous URL address (http://www.cms.gov/pqri) will automatically redirect to the new URL address.

In order to receive important information on the Physician Quality Reporting System and the Electronic Prescribing (eRx) Incentive Program, subscribe to Medicare Fee-for-Service Physician listserv at https://list.nih.gov/cgi-bin/wa.exe?A0=physicians-l on the internet.

PQRS Provider Call on PQRI and eRX



PQRS & eRx

CMS will host a national provider conference call on the 2011 PQRS and (eRx) Incentive Program.

CMS Provider Communications Group will host a national provider conference call on the 2011 Physician Quality Reporting System and Electronic Prescribing (eRx) Incentive Program. This toll-free call will take place from 1:30 p.m. – 3:00 p.m., EDT, on Tuesday, May 17, 2011. Conference Title: *Physician Quality Reporting System & Electronic Prescribing Incentive Program National Provider Call.* Following the formal presentation that will cover the following:

- Highlights of the 2009 Physician Quality Reporting System and Electronic Prescribing Experience Report;
- Measures vs. Measures Groups; and
- Understanding Measure Numerator and Measure Denominator.

The lines will be opened to allow participants to ask questions of CMS Physician Quality Reporting System and eRx subject matter experts.

A PowerPoint slide presentation will be posted to the Physician Quality Reporting System webpage at http://www.cms.gov/PQRI/04_CMSSponsoredCalls.asp on the CMS website for you to download prior to the call so that you can follow along with the presenter.

Educational products are available on the Physician Quality Reporting System dedicated web page located at http://www.cms.hhs.gov/PQRI .

In order to receive the call-in information, you must register for the call. It is important to note that if you are planning to sit in with a group, only one person needs to register to receive the call-in data. This registration is solely to reserve a phone line, NOT to allow participation.

To register for the call participants need to go to: http://www.eventsvc.com/stage/palmettogba/051711

Please contact the National Government Services CEDI Help Desk at ngs.cedihelpdesk@wellpoint.com or 866-311-9184 if you have any additional questions regarding this initiative.

"Health Professional Shortage Area" Fact Sheet Revised

The revised publication titled "Health Professional Shortage Area" (revised March 2011) is now available in downloadable format from the **Medicare Learning Network**® at

http://www.CMS.gov/MLNProducts/downloads/HPSAfctsht.pdf.

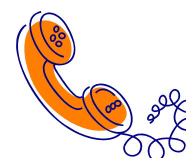
This fact sheet is designed to provide education on the Health Professional Shortage Area (HPSA) payment system and includes an overview of the program and general requirements.

The 2011 Nebraska Zip Codes listed as HPSA are as follows:

68003, 68015, 68017, 68018, 68033, 68040, 68041, 68042, 68050, 68065, 68066, 68070, 68073, 68623, 68628, 68638, 68640, 68648, 68663, 68710, 68717, 68727, 68728, 68732, 68736, 68739, 68745, 68749, 68751, 68753, 68757, 68759, 68768, 68770, 68771, 68774, 68778, 68779, 68784, 68785, 68792, 68816, 68821, 68826, 68827, 68833, 68864, 68920, 68922, 68924, 68926, 68936, 68945, 68946, 68948, 68959, 68966, 68967, 68969, 68971, 68977, 68982, 69022, 69023, 69024, 69025, 69027, 69028, 69032, 69033, 69038, 69039, 69040, 69042, 69043, 69044, 69045, 69046, 69121, 69125, 69128, 69129, 69133, 69135, 69142, 69145, 69147, 69148, 69152, 69154, 69157, 69161, 69163, 69166, 69167, 69190, 69210, 69214, 69217, 69331, 69333, 69334, 69335, 69336, 69339, 69340, 69343, 69345, 69346, 69347, 69350, 69351, 69360, 69365, 69366, 69367

Source: http://www.cms.gov/HPSAPSAPhysicianBonuses/01_Overview.asp

CMS ICD-10 Conversion Activities National Provider Teleconference



CMS will host a national provider teleconference on **"CMS ICD-10 Conversion Activities."** Subject matter experts will discuss the ICD-10 conversion process currently taking place within CMS, including a case study. A question and answer session will follow the presentations.

When: Wednesday, May 18, 2011

Time: 1:00 p.m. – 2:30 p.m. ET

Target Audience: Medical coders, physician office staff, provider billing staff, health records staff, vendors, educators, system maintainers and all Medicare fee-for-service (FFS) providers

The following topics will be discussed:

- ICD-10 overview
- Lab NCDs conversion process from ICD-9-CM to 1CD-10-CM
- Home health conversion
- OASIS and procedure code reporting
- Update on claims spanning the implementation date
- National ICD-10 implementation issues

ICD-9-cm

ICD-10

Registration information: To register for this informative session, please go to

http://www.cms.gov/ICD10/Tel10/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=1&sortOrder=descending&itemID=CMS1246998&intNumPerPage=10

Registration will close at 1:00 p.m. ET on May 17, 2011, or when available space has been filled. No exceptions will be made. Please register early.

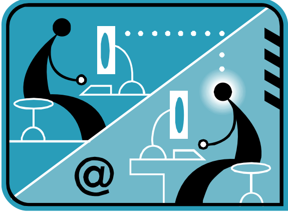
Save the date: The next ICD-10 national provider teleconference will be held on Wednesday, August 3. Registration information will be posted to the CMS ICD-10 Teleconferences web page at

http://www.cms.gov/ICD10/Tel10/list.asp.

New "Signature Requirements" Fact Sheet

A new publication titled "Signature Requirements" is now available in downloadable format from the Medicare Learning Network® at http://www.cms.gov/MLNProducts/downloads/Signature_Requirements_Fact_Sheet_ICN905364.pdf

This fact sheet is designed to provide education on Signature Requirements to healthcare providers, and includes information on the documentation needed to support a claim submitted to Medicare for medical services.



Common Electronic Data Interchange

CEDI Direct Connections No Longer Supported

As of May 1, 2011, direct connections and protocols to the National Government Services CEDI Gateway are no longer supported by National Government Services.

Enrollment Forms do not need to be completed to make the transition to using a Network Service Vendor (NSV). Once setup with the NSV is completed, transmission of files using their connection may begin.

PC-ACE Pro32 Software Users: CEDI will continue to support the PC-ACE Pro32 software; however, suppliers who are using the software must also transition to an NSV for connectivity to continue exchanging electronic transactions with CEDI.

Please contact the National Government Services CEDI Help Desk at ngs.cedihelpdesk@wellpoint.com or 866-311-9184 if you have any additional questions regarding this initiative.

The National Government Services approved NSVs are listed below and can also be found on the CEDI Web site www.NGSCEDI.com under Telecommunications.

Claim Shuttle
Web site: www.claimshuttle.com
Phone: 602-439-2525
E-mail: info@claimshuttle.com

Cortex EDI, Inc.
Web site: www.CortexEDI.com
Customer Service: 800-485-5977

ECC Technologies
Web site: http://www.ecctec.com
Phone: 585-377-1850

IVANS
Web site: http://www.ivans.com
Phone: 800-548-2690

McKesson Care Bridge
Web site: http://www.carebridge.net
Phone: 888-663-6250

MedXpress
Web site: http://www.medxpressclaims.com
Phone: 877-624-3250

Nebo Systems, Inc.
Web site: http://www.nebo.com
Phone: 630-916-8818

Vision Share
Web site: http://www.visionshareinc.com
Phone: 888-895-2649/612-460-4327

CEDI Gateway Self-Service Password Portal

On April 22, 2011, the National Government Services, Inc. Common Electronic Data Interchange (CEDI) began use of a Password Change and Reset portal from our CEDI Web site. This initiative provides a simple and secure Web-based process for changing/resetting passwords for CEDI Trading Partners and will be available 24 hours a day, 7 days a week. CEDI plans to coordinate this with the CEDI Trading Partner Recertification initiative currently taking place.

Part of our Recertification implements a Trading Partner contact e-mail that will be used by CEDI to send an assigned PIN. This PIN will allow the CEDI Trading Partner access to the Web portal to utilize either the Password Change or Password Reset function. Once the Recertification form has been processed and you receive your confirmation e-mail, the CEDI Gateway Self-Service Password Portal will be available for you to use.

CEDI will be conducting webinars and conference calls to walk Trading Partners through this new process and have documentation available on our Web site at www.ngscedi.com

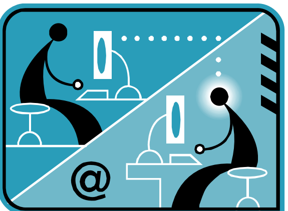
For additional questions, please contact the CEDI Help Desk at 866-311-9184 or you may submit your questions via e-mail at ngs.cedihelpdesk@wellpoint.com.

9 Digit ZIP Code and Address Requirements for Upcoming 5010

In the version 5010A1 format, a change has been made to include the full nine-digit ZIP Code for the Billing Provider (2010AA loop for ANSI claims). It will also be required for any Service Facility locations (2310C loop and 2420C loop for ANSI claims) if they are required to be sent. Providing all zeros in the four-digit extension will cause front end rejections.

The Billing Provider Address (2010AA loop for ANSI claims) will require a physical location address to be reported in 5010A1 claim files. **P.O. Box and lockbox addresses cannot be reported as a billing provider address.** If you would like to send a P.O. Box or lockbox address, it must be reported as a Pay-to Address (2010AB loop for ANSI claims). The Pay-To Provider address is only needed if it is different than the one being used for the Billing Provider. Providers should work with their software vendors to ensure that the correct addresses are captured and sent in the correct locations when they make the transition to sending the 5010A1 format.

Questions regarding these changes should be directed to your software vendor, billing service, or clearinghouse. Be sure to ask when you will be making the transition to the 5010A1 format for claim submission



WPS: CERT Alert - Insufficient Documentation

Comprehensive Error Rate Testing (CERT) error findings related to insufficient documentation continue to have a large impact on paid claims error rates on both a local and national level. Medical record documentation must support the services billed according to Medicare guidelines, the medical necessity of the services, and be legible in order for the CERT contractor to complete a fair review.

To learn how to avoid this type of denial, visit our CERT Error Analysis web page for documentation tips for services commonly billed to Medicare Part B:

http://www.wpsmedicare.com/j5macpartb/departments/cert/cert-error-analysis.shtml

WPS: Medicare Remit Easy Print - April 7, 2011 Update

A new version of the Medicare Remit Easy Print (MREP) Software (Version 2.9) dated April 7, 2011, is available to download from the CMS website listed below. This version includes the latest Code Group Information (Codes.ini 11-1-10): http://www.cms.gov/AccesstoDataApplication/02_MedicareRemitEasyPrint.asp If you are an electronic biller who does not receive the Electronic Remittance Advice (ERA) and would like to, please complete the ERA information sheet, available on the WPS Electronic Data Interchange (EDI) website:

http://www.wpsic.com/edi/pdf/Medicare-provider-authorization-ERA.pdf

If you already receive the ERA and want to try the MREP software, please download the MREP software at

http://www.cms.gov/AccesstoDataApplication/02_MedicareRemitEasyPrint.asp.

If you are not an electronic biller and want to receive ERA to use in the MREP software, you will need to complete a Request for Submitter form, EDI enrollment form, and ERA Request form. Please label MREP only. You can download these forms from the following EDI website list:

http://www.wpsic.com/edi/pdf/medb_profile.pdf
http://www.wpsic.com/edi/pdf/medb_enroll.pdf
http://www.wpsic.com/edi/pdf/Medicare-provider-authorization-ERA.pdf

WPS: Use Global Surgery Modifiers Correctly

Many procedures or services have a global period. Medicare defines the global period for minor procedures as the day of a procedure or the day of a procedure and 10 days after. For major procedures, the global period is the day before the procedure, the day of the procedure, and 90 days following the procedure.

When Medicare reimburses for a procedure that has a global period, the reimbursement includes all services you provide related to the procedure. This includes an evaluation and management (E/M) service, pre- and post-operative care, or treatment for an infection that does not require a return trip to an operating room.

There are exceptions when Medicare may make a separate payment for services other than the procedure. This includes, but is not limited to, unrelated E/M services, an unrelated surgery, or treatment for complications that requires a return trip to the operating room. Questions concerning the use of modifiers and global period denials continue to be one of the top 5 issues at our provider call center. Knowing the correct use of available modifiers will reduce extra work for providers and their billers.

We have extensive information on our website about the correct use of these modifiers. Please take some time to go over this information. You will find a fact sheet on Global Surgery Modifiers as well as individual fact sheets for the modifiers on the following web page:
http://www.wpsmedicare.com/j5macpartb/resources/modifiers/

Beyond The Basics Seminar Coming To Omaha On July 13, 2011

WPS Medicare is pleased to announce a newly scheduled Beyond the Basics seminar designed for providers, coders, and billers. To view the course description, event details, and for easy-access registration, please refer to our website for the schedule:

http://www.wpsmedicare.com/j5macpartb/training/training_programs/seminars/2011-btb.shtml

Required Medicaid Provider Validation and Agreement Form

Nebraska Medicaid wants to share information with you about the required Medicaid Provider Validation currently being performed as part of the Nebraska Medicaid HIPAA 5010 and National Provider Identifier (NPI) Project.

We have begun mailing packets, containing a Provider Validation and Agreement Form, to Medicaid billing providers. The packets contain provider agreement information currently on file and a request to validate this information and provide some additional information, for example, National Provider Identifiers (NPI), taxonomy and nine-digit zip codes. This information is required for the processing and payment of Medicaid claims beginning January 1, 2012. Providers do not need to do anything until they receive the Provider Validation & Agreement Form. Providers will have 30 days to return the requested information or payments will be delayed.

Mailing Schedule:

1. Lancaster County providers were mailed on December 9, 2010.
2. Douglas County providers were mailed on February 4, 2011.
3. Buffalo, Sarpy, Hall, Madison, Scottsbluff, Adams, Dodge, Lincoln, Platte, Gage, Dawson and York Counties……….scheduled for April 6, 2011.
4. Remaining Nebraska Counties……..scheduled for mid-April 2011.
5. Out-of-State Providers….scheduled for early May 2011.
6. Additional runs for any missed above…. scheduled through June 2011 and later as necessary.

This is part of a larger effort to contact all Medicaid Providers in order to gather information needed to convert to the HIPAA 5010 Version of electronic transactions by January 1, 2012.

For those who submit transactions electronically, please work with your billing service, clearinghouse, software vendor, or internal IT department to ensure you are ready for the HIPAA 5010 changes. Please check http://www.dhhs.ne.gov/med/edindex.htm for additional information or contact the EDI Help Desk at 866-498-4357 or 402-471-9461 or Medicaid.edi@dhhs.ne.gov .

If you have questions about the Validation & Agreement Form, please contact the Nebraska Medicaid Provider Validation Customer Service staff at 402-471-7578 or 888-572-5707 or dhhs.ProviderValidation@nebraska.gov.

Politically Incorrect Humor from The Prairie Home Companion "Pretty Good Joke Book"

Lena was competing in the Sons of Norway swim meet. She came in last in the 100 meter breaststroke, and she says to the judges, "I don't mean to complain, but I tink those other two girls were using their arms!"

Did you hear about Ole's cousin Torvald that won the gold medal at the Olympics? He had it bronzed!

Ole' got a cell phone, and on the way home he called Lena. "Hi Lena, I calling you from the freeway with my new cell phone, I am." Lena say, "Oh, Ole', be careful. The radio reports a nut is driving the wrong way on that freeway". And Ole' say, "Some nut? Heck, der are hundreds of them!"

Sven and Ole' were walking home from the bar late one night along the railroad tracks. Sven say, "This is the longest stairway I've ever seen!" Then Ole' say, "Yeah, but it's not the stairs that bother me, it's the low railings!"

Ole' to Sven, "Sven, how many Swedes does it take to grease a combine?" Sven say, "I dunno, Ole', how many?" Ole' say, "Only two, if you run them through real slow…"

Ole' say to Sven, "I bought Lena a piano for her birthday, but I took it back and traded it for a clarinet." Sven say, "why dat, Ole'?" Den Ole' say, "Because, you know, with a clarinet, you can't sing."

Sven: So Ole', I see you got a sign up 'boat for sail'. How's dat, since you don't got a boat? All you got is that old combine and that John Deere tractor." Then Ole' say, "And there boat for sale!"

To access the NOA 3rd Party web page directly:

1. Go to http://nebraska.aoa.org/
2. Click on DOCTORS (gray horizontal bar)
3. Click on THIRD PARTY INDEX (gray bar, left side of screen)
4. Enter your User Name (AOA member #) and Password (DOB MMDDYY) when requested.

Dr. Quentin Quack's Queries and Questionable Quotes

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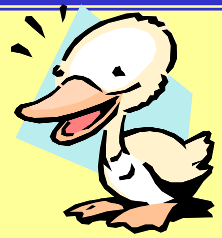
Third Party Questions from NOA Doctors and Staff



Dr. Quentin Quack

Diabetic Code 250.0x, by Itself, No Longer Reimbursable

Dear Dr. Quack,

I have been getting all of my Medicare claims with the diagnosis of 250.00 Diabetes denied. The reasoning is that Loop 2110. Can you tell me why they would all of a sudden be getting denied?

Dr. Quack's Quote:

Despite CMS ostensibly advocating preventative medicine, 250.0x by itself is not reimbursable by Medicare any longer. There must be a manifestation of diabetic retinopathy to be covered (250.5x) along with a description of the retinal changes 362.xx. Sorry!

Nursing Home Code 99310 Denied by Medicare

Dear Dr. Quack,

I have recently had several 99310 codes denied. The reason for denial was stated as being the fact that this code does not appear on the document with this web address: http://www.wpsmedicare.com/j5macpartb/policy/active/local/l32001_ophth503.shtml . As you scroll down this document, it only includes 99307, and 99309. To date, we have been paid on 99307, 99308, 99309, and 99310, with the bulk of what we code for in our follow up visits as 99308

Do you have any information on how to get reimbursed for the 99310s that have been denied?

Dr. Quack's Quote:

When the optometry LCD you refer to was being created, we (representatives from NE, IA, KS, MO, and the AOA) did our best to get the 99310 included. We were unsuccessful. However, just to keep things in perspective: The 99310 level code is the same level as a 99215 (comp hx, comp exam, decision making of high complexity)...a code that would be used very infrequently by an OD except in unusually serious circumstances.
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Better Vision for Nebraskans...

Nebraska Optometric Association

1633 Normandy Court, Suite A
Lincoln, NE 68512
http://nebraska.aoa.org/

The NOA Third Party Newsletter is published monthly by the Nebraska Optometric Association with the assistance of Ed Schneider, O.D., Third Party Consultant.
To reach Ed (aka Dr. Quack):
> BEST to contact via Email at: SchneiderEd@msn.com
> Ed's mobile phone is 402-310-2367. Voicemail available.
> Fax number is 402-464-1214. Call Ed before faxing.

NORIDIAN: Durable Medical Equipment

Refractive Lenses Web-Based Workshop

Join NAS DME Outreach and Education on May 18, 2011 at 3PM Central Time to review the Refractive Lenses Local Coverage Determination (LCD) and Policy Article. The review includes claim submission, coverage, coding, documentation, and more. This workshop is scheduled for 90 minutes.

Registration:
To register, go to
https://www.noridianmedicare.com/dme/train/workshops/docs/2011/051811b.html

NOA Third Party Newsletter—ABSTRACTS OF THIS MONTH'S ISSUE

ELECTRONIC PRESCRIBING (ERX) INCENTIVE PROGRAM UPDATE

Physicians who are not successful electronic prescribers, based on claims submitted in 2011, may be subject to a downward payment adjustment. This may, or may not, entirely apply to ODs. Pp.1-3.

CMS ERRS, OMITS ODs FROM 2012 PHYSICIAN E-RX PENALTY

It has been disclosed that, despite ODs being classified as physicians by Medicare, CMS has apparently not included ODs in the physician requirement of 10 e-Rxs before July 1st to avoid penalties in 2012. However, it is strongly suggested that ODs e-Rx 25 times before the end of 2011. P.1.

EHR AND MEANINGFUL USE

Attestation for the Medicare EHR Incentive Program Has Begun. This means that eligible professionals can attest through the CMS web-based attestation system and be on their way to receiving Medicare EHR incentive payments. P.4.

HOW DO I GET PAID FOR THE EHR INCENTIVE PROGRAMS?

Payments for the Medicare and Medicaid EHR Incentive Programs are distributed based on each year of participation, and follow a specific payment schedule. A link to the schedule is provided. P.5.

PQRI IS NOW PQRS

CMS announced the renaming of the Physician Quality Reporting Initiative (PQRI) to the Physician Quality Reporting System (PQRS). P.6.

PQRS PROVIDER CALL ON PQRI AND E-RX

CMS will host a national provider conference call from 1:30 p.m. – 3:00 p.m., EDT, on Tuesday, May 17, 2011regarding the 2011 Physician Quality Reporting System and Electronic Prescribing (eRx) Incentive Program. P.6.

"HEALTH PROFESSIONAL SHORTAGE AREA" FACT SHEET REVISED

This fact sheet is designed to provide education on the Health Professional Shortage Area (HPSA) payment system and includes an overview of the program and general requirements. P.7.

CMS ICD-10 CONVERSION TELECONFERENCE

CMS will host a national provider teleconference on "CMS ICD-10 Conversion Activities." Subject matter experts will discuss the ICD-10 conversion process currently taking place within CMS, including a case study. P.7.

NEW "SIGNATURE REQUIREMENTS" FACT SHEET

A new publication titled "Signature Requirements" is now available in downloadable format from the Medicare Learning Network® P.7.

CEDI DIRECT CONNECTIONS NO LONGER SUPPORTED

As of May 1, 2011, direct connections and protocols to the National Government Services CEDI Gateway are no longer supported by National Government Services. P.8.

CEDI GATEWAY SELF-SERVICE PASSWORD PORTAL

On April 22, 2011, the National Government Services, Inc. Common Electronic Data Interchange (CEDI) began use of a Password Change and Reset portal from the CEDI Web site. P.8.

9 DIGIT ZIP CODE & ADDRESS REQUIREMENTS FOR UPCOMING 5010

In the upcoming required 5010A1 version format, a change has been made to include the full nine-digit ZIP Code for the Billing Provider. P.8.

CERT ALERT - INSUFFICIENT DOCUMENTATION

Comprehensive Error Rate Testing (CERT) error findings related to insufficient documentation continue to have a large impact on paid claims. P.9.

MEDICARE REMIT EASY PRINT - APRIL 7, 2011 UPDATE

Information on the recent update is provided. P.9.

USE GLOBAL SURGERY MODIFIERS CORRECTLY

When Medicare reimburses for a procedure that has a global period, the reimbursement includes all services you provide related to the procedure. This includes an E/M service, pre- and post-operative care, or treatment for an infection that does not require a return trip to an operating room. P.9.

BEYOND THE BASICS SEMINAR COMING TO OMAHA ON JULY 13, 2011

Information on registering for the course is provided. P.9.

NEW MEDICAID PROVIDER VALIDATION AND AGREEMENT FORM

Nebraska Medicaid wants to share information with you about Medicaid Provider Validation currently being performed as part of the Nebraska Medicaid HIPAA 5010 and National Provider Identifier (NPI) Project. P.10.

DIABETIC CODE 250.0X, BY ITSELF, NO LONGER REIMBURSABLE

Despite CMS ostensibly advocating preventative medicine, 250.xx by itself is no longer reimbursable by Medicare. P.11.

NURSING HOME CODE 99310 DENIED BY MEDICARE

99310 was omitted from the optometry LCD. However, to keep things in perspective, the 99310 level code is the same as a 99215 (comp hx, comp exam, decision making of high complexity)...a code that would be used very infrequently by an OD except in unusually serious circumstances. P.11.