

# AcSel Advisor

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**MAY IS...  
 AMERICAN STROKE  
 AWARENESS MONTH**



American Heart Association | American Stroke Association  
 Learn and Live.



**IMPORTANT INFORMATION FOR ALL PROVIDERS**

**CMS- E Prescribing Incentive Program**

It is not too late to start participating in the 2010 Electronic Prescribing Incentive Program (eRx). Providers may still qualify to receive a full-year incentive payment for 2011. Beginning 2012, CMS will apply payment adjustments to eligible professionals who are not electronic prescribers under the eRx Incentive Program. To avoid the 2012 eRx payment adjustment, eligible providers 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.



Eligible providers 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. Eligible providers must have a “qualified” electronic prescribing system in order to be

able to report the electronic prescribing measure.

Providers can begin reporting electronic prescribing data for January 1 – December 31, 2011 using any of the following three options for purposes of qualifying for the 2011 incentive:

- 1. Claims-based reporting** of the electronic prescribing measure. **Report only one G-code (G8553) for 2011.**
- 2. Registry-based reporting** using a CMS-selected registry to submit 2011 data to CMS during the first quarter of 2012.
- 3. EHR-based reporting** using a CMS-selected electronic health record product, submitting 2011 data to CMS during the first quarter of 2012.

**Providers must report electronic prescribing data for January 1, 2011 through June 30, 2011 via claims to avoid a possible payment reduction.**

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## E-Prescribing continued from page 1

### How To Report the Measure:

**Step 1:** Did you bill one of the CPT or HCPCS G codes noted in the following list for the patient?

**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

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

**YES:** Proceed to Step 2.

**Step 2:** 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.**

**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.** Just begin submitting the G-code on your claims appropriately, or, for eligible professionals attempting to qualify 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.



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**CMS— E-Prescribing continued from page 2**

**Get started with eRx now and avoid the 2012 -2014 eRx Payment Adjustments**

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 1% reduction of the Medicare Part B PFS amount that would otherwise apply to such services. In 2013, eligible providers will receive a 1.50% reduction 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%.

The payment adjustment does not apply if <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.



**For More Information relating to EHR and the Eprescribe, contact Mark Schalow at AcSel (800) 366-3038.**

**PALMETTO GBA  
MEDICARE J11  
Part B for North  
Carolina Providers**



The implementation date for North Carolina Part B to transition to the Jurisdiction 11 (J11) A/B Mac is May 28, 2011. Providers may have received a welcome letter from Palmetto or electronic data interchange (EDI) and electronic fund transfer (EFT) forms from AcSel. It is important to return these forms as soon as possible in order to ensure that there is no interruption in Medicare claims transactions and payments. Palmetto has posted FAQs and other important information on their website. For more information go to [www.PamettoGBA.com/J11B](http://www.PamettoGBA.com/J11B)

**Palmetto Jurisdiction 11 Part B  
Update to the 2011 Medicare  
Physician Fee Schedule Database**

Effective April 4, 2011, for services performed on or after January 1, 2011, the Center for Medicare and Medicaid Services (CMS) has made changes to the following CPT codes on the 2011 Medicare Physicians Fee Schedule Database (MPFSDB)

**Virginia**

CPT Code	Par Amount	Nonpar Amount	Limiting Charge
93224	102.44	97.32	111.92
93225	30.47	28.95	33.29
93226	45.09	42.84	49.27
93503	129.48	123.01	141.46



### Preventative Care Coverage Update

Cigna has made changes in how preventative care claims are administered to better align with the preventative care policy. Previously, services not included in CIGNA’s list of covered preventative services may have been paid at the preventative care benefit level when submitted with a preventative care claim. CIGNA has changed its policy so that regardless of whether these charges are submitted separately or as part of a preventive care claim, services that are not on the list of preventative services will be considered for coverage under the patient’s available non-preventative care benefits, and patient cost-sharing may apply. Services **NOT** Covered as Preventative Care:

<p>Effective October 1, 2010 as plans renew:</p> <ul style="list-style-type: none"> <li>Chest x-ray</li> <li>Vitamin D testing</li> <li>General health panels</li> <li>Comprehensive metabolic panels</li> <li>Basic metabolic panels</li> </ul>	<p>Effective May 15, 2011 for plans that renewed on or after October 1, 2010:</p> <ul style="list-style-type: none"> <li>Electrocardiogram (EKG)</li> <li>Urinalysis</li> </ul>
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For all other plans, coverage changes to EKG and Urinalysis will become effective on the renewal date.

For more information about eligibility and benefits for patients with CIGNA coverage go to [www.cignaforhcp.com](http://www.cignaforhcp.com)

### TRICARE Referral and Authorization Changes Effective April 1, 2011



There are major changes in affect:

- \* Specialty Care Referrals- Prime beneficiaries regardless of where they live, will require a Health Net referral to civilian specialty providers.
- \* Durable Medical Equipment- Active Duty Service Members (ADSMs) enrolled to a military treatment facility (MTF) or network primary care manager (PCM) require referrals from their PCM and Health Net for durable medical equipment (DME).
- \* TRICARE Prime and TRICARE Prime Remote Active Duty Family Members must have all DME ordered by a PCM or by the Health Net-approved physician to whom they were referred.
- \* TRICARE Prime Remote Active Duty Family Members not enrolled to a civilian PCM must have a physician order and a referral from Health Net. For more information go to: [www.hnfs.com](http://www.hnfs.com)

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### TRICARE NORTH- Health Net Federal Services NEW Contract as of April 1, 2011

Health Net Federal Services has transitioned to the new TRICARE North Region contract as of April 1, 2011. In the latest issue of TRICARE Provider News, providers are assured that they will experience few changes with the new contract, and that TRICARE has developed several new enhancements to the TRICARE program. More information regarding the changes to TRICARE North can be found at [www.hnfs.com](http://www.hnfs.com).



### Can You Code It ...??

What diagnosis code would you use to report thoracoabdominal aortic ectasia?

**LAST MONTHS ANSWER:** 99224-99226

### CareFirst BlueCross BlueShield- Federal Employee Program (FEP) New Member ID Cards

Beginning April 30, 2011, FEP will issue new cards to all Carefirst members. Providers should note that the information on the new member ID cards may vary depending on the member’s coverage.