CMS Medicare FFS Provider e-News

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Table of Contents for Thursday, March 7, 2013

National Provider Call: End-Stage Renal Disease Quality Incentive Program - Payment Year 2015 Final Rule — Register Now

Wednesday, March 13; 2-3:30pm ET

This National Provider Call will review the CMS final rule for implementing the End-Stage Renal Disease (ESRD) Quality Incentive Program (QIP) in Payment Year (PY) 2015. This final rule was published in the

Federal Register on November 9, 2012.

The performance period for PY 2015 began on January 1, 2013. To help dialysis facilities and other stakeholders understand the program and their responsibilities during the performance period, this call will review:

- The ESRD QIP legislative framework and how it fits into the National Quality Strategy;
- Changes reflected in the final rule based on public comments;
- The measures, standards, scoring methodology, and payment reduction scale that will be applied to the PY 2015 program; and
- Where to find additional information about the program.

Agenda:

- Introductions
- Review of ESRD QIP and National Quality Strategy
- Changes in PY 2015 Final Rule
    - Measures
    - Standards
    - Scoring methodology
    - Payment reduction scale
- Sources for more information

Target Audience: Dialysis clinics and organizations, nephrologists, hospitals with dialysis units, billers/coders, and quality improvement experts.

Registration Information: In order to receive call-in information, you must register for the call on the CMS Upcoming National Provider Calls registration website. Registration will close at 12pm on the day of the call or when available space has been filled; no exceptions will be made, so please register early.

Presentation: The presentation for this call is now posted on the FFS National Provider Calls web page. In addition, a link to the slide presentation will be emailed to all registrants on the day of the call.

Continuing education credit may be awarded for participation in certain CMS National Provider Calls. Visit the Continuing Education Credit Notification web page to learn more.

National Provider Call: Hospital Value-Based Purchasing Fiscal Year 2015 Overview — Register Now
Thursday, March 14; 1:30-3pm ET

This National Provider Call provides an overview of the FY 2015 Hospital Value-Based Purchasing (VBP) Program design and a preview of the FY 2015 Baseline Measures Report in order to help demonstrate how hospitals will be evaluated for each of the FY 2015 domains (measures/dimensions).

Agenda:

- Introduction to the Hospital VBP Program
- FY 2015 Hospital VBP Program
- How Hospitals Will Be Evaluated
- Evaluation Example
- FY 2015 Baseline Measures Report

Target Audience: Quality Improvement Organizations (QIOs) and Inpatient Hospital Stakeholders

Registration Information: In order to receive call-in information, you must register for the call on the CMS Upcoming National Provider Calls registration website. Registration will close at 12pm on the day of the call or when available space has been filled; no exceptions will be made, so please register early.

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National Provider Call: 2013 PQRS and eRx Claims-Based Reporting Made Simple — Save the Date
Tuesday, March 19; 1:30-3pm ET

Please save the date for an upcoming CMS-hosted National Provider Call on the 2013 Physician Quality Reporting System (PQRS) and Electronic Prescribing (eRx) claims-based reporting. This call is relevant to eligible professionals, medical coders, physician office staff, provider billing staff, health records staff, vendors, and all other interested Medicare FFS healthcare professionals.

The agenda will include:

- Welcome and program announcements
- 2013 PQRS and eRx claims-based reporting made simple
- Question & answer session

Registration information will be available soon on the CMS Upcoming National Provider Calls registration website.

National Provider Call: Implementation of Edits on the Ordering/Referring Providers in Medicare Part B, DMEPOS, and Part A Home Health Agency Claims — Save the Date
Wednesday, March 20, 3-4:30 ET

CMS will hold a national provider call on March 20 from 3-4:30 ET on the "Implementation of Edits on the Ordering/Referring Providers in Medicare Part B, DMEPOS, and Part A Home Health Agency Claims." Effective May 1, 2013, CMS will instruct contractors to turn on Phase 2 denial edits. See "Ordering and Referring Denial Edits Will Turn on May 1, 2013" for more information.

Agenda:

- Provider Types Eligible to Order/Refer
- Action Steps for Billing Providers
- Action Steps for Providers Who Order/Refer
- Resources

Target Audience: Part B providers which order, refer and /or bill for these services; HHAs

Registration information will be available soon on the CMS Upcoming National Provider Calls registration website.

Flu Activity Continues: Prompt Antiviral Treatment is Crucial for Seniors Sick with Flu

Influenza can be a very serious disease for people 65 years of age and older, as they are considered to be at high risk for severe flu-related complications. This season, flu activity started early and has placed a significant burden on people 65 years of age and older. In fact, so far this season, CDC has reported nearly four times more hospitalizations among people 65 and older than occurred during the entire 2011-2012 season. This shows just how severe this flu season has been for seniors.

The CDC recommends that vaccination efforts continue as long as influenza viruses are circulating. People 65 years of age and older, as well as their close contacts and caregivers, should be vaccinated; and should seek medical treatment with antiviral drugs as soon as symptoms appear in order to reduce serious complications from flu infection, including hospitalizations, intensive care unit (ICU) admissions and deaths. In addition to vaccination and early treatment, people 65 years of age and older should stay away from others who are or may be sick.

Note: Influenza vaccine and its administration is a Medicare Part B covered benefit. Influenza vaccines are NOT Part D-covered drugs.

For More Information:

- 2012-2013 Seasonal Influenza Vaccines Pricing list.
- MLN Matters® Article #MM8047, "Influenza Vaccine Payment Allowances - Annual Update for 2012-2013 Season".
- Visit the CMS Medicare Learning Network® 2012-2013 Seasonal Influenza Virus Educational Products and Resources and CMS Immunizations web pages for information on coverage and billing of the flu vaccines and their administration fees.
- HealthMap Vaccine Finder is a free, online service where users can find locations offering flu vaccines as well as other vaccines for adults.
- CDC website offers a variety of provider resources for the 2012-2013 flu season.
- CDC article *Seniors among Groups Hardest Hit by Flu this Season*.

Hospice Quality Reporting Program Requirements for Payment Years 2014 and 2015

As part of the Hospice Quality Reporting Program (HQRP) requirements, hospice providers should currently be engaging in two activities: data *submission* activities for the Payment Year 2014 cycle and data *collection* activities for the Payment Year 2015 cycle. Current activities for each cycle are detailed below.

Payment Year 2014 Cycle—Deadline for NQF #0209 is April 1, 2013
For the Payment Year 2014 HQRP reporting cycle, there were two deadlines for the two required measures. The structural measure deadline has passed – January 31, 2013. The NQF #0209 deadline is April 1, 2013. In order to avoid a 2 percentage point reduction in their Annual Payment Update (APU), providers had to submit data for both measures by the deadlines specified above. To meet the NQF #0209 April 1 deadline, providers should currently be entering their Quarter 4 2012 NQF #0209 data through the data entry and submission website. Providers that may have missed the structural measure deadline can still visit the data entry website, create an account, and enter their NQF #0209 data. Information on the data submission process, including a Technical User Guide for Data Entry and Submission and data entry site location, can be found on the Data Submission portion of the CMS HQRP website.

Payment Year 2015 Cycle:
In addition to engaging in data *submission* activities for the Payment Year 2014 reporting cycle,

providers should be engaging in data *collection* activities for the Payment Year 2015 reporting cycle. Two measures will be required for the Payment Year 2015 cycle: the NQF #0209 Pain Measure and the structural measure. For Payment Year 2015 data collection, providers should collect NQF #0209 data on all new admissions January 1 through December 26, 2013. Data for all of 2013 will be reported in 2014, affecting APU determination in 2015. Details regarding the reporting requirements for Payment Year 2015 were finalized in the Home Health Prospective Payment System Rate Update for Calendar Year 2013 Final Rule (77 FR 67068, 67133 (November 8, 2012).

Quality Reporting Communication Support Page Now Available for Medicare eRx 2014 Payment Adjustment Hardship Exemption Requests

In calendar year 2014, a payment adjustment will be applied to an eligible professional's or group practice's (if participating in the Electronic Prescribing (eRx) Group Practice Reporting Option (GPRO)) Medicare Part B Physician Fee Schedule (PFS) covered professional services for not becoming a successful electronic prescriber. The payment adjustment of 2.0% will result in an eligible professional or group practice participating in eRx GPRO receiving 98.0% of their Medicare Part B PFS amount for covered professional services in 2014. Please note that this message only applies to the 2014 eRx payment adjustment. The reporting period to avoid or submit hardship exemptions for the 2012 and 2013 eRx payment adjustments has ended.

Exclusion Criteria
The 2014 eRx payment adjustment only applies to certain individual eligible professionals and group practices. CMS will automatically exclude those individual eligible professionals and group practices who meet the following criteria:

- The eligible professional or eRx GPRO is a successful electronic prescriber during the 2012 eRx 12- month reporting period (January 1 through December 31, 2012).
- The eligible professional is not an MD, DO, podiatrist, Nurse Practitioner, or Physician Assistant by June 30, 2013, based on primary taxonomy code in the National Plan and Provider Enumeration System (NPPES).
- The eligible professional does not have at least 100 Medicare Physician Fee Schedule (MPFS) cases containing an encounter code in the measure's denominator for dates of service from January 1 through June 30, 2013.
- The eligible professional or eRx GPRO does not have 10% or more of their MPFS allowable charges (per Tax Identification Number (TIN)) for encounter codes in the measure's denominator for dates of service from January 1 through June 30, 2013.
- The eligible professional does not have prescribing privileges and reported G8644 on a billable Medicare Part B service at least once on a claim between January 1 and June 30, 2013.

Avoiding the 2014 eRx Payment Adjustment
Individual eligible professionals and CMS-selected group practices participating in eRx GPRO who were not successful electronic prescribers in 2012 can avoid the 2014 eRx payment adjustment by meeting the specified reporting requirements between January 1 and June 30, 2013. For more information on individual and eRx GPRO reporting requirements, please see the Electronic Prescribing (eRx) Incentive Program: 2014 Payment Adjustment Fact Sheet. The 6-month reporting requirements to avoid the 2013 payment adjustment are as follows:

- Individual Eligible Professionals – 10 eRx events via claims
- eRx GPRO of 2-24 Eligible Professionals – 75 eRx events via claims
- eRx GPRO of 25-99 Eligible Professionals – 625 eRx events via claims
- eRx GPRO of 100+ Eligible Professionals – 2,500 eRx events via claims

Significant Hardships

CMS may exempt individual eligible professionals and group practices participating in eRx GPRO from the 2014 eRx payment adjustment if it is determined that compliance with the requirements for becoming a successful electronic prescriber would result in a significant hardship. The significant hardship categories are as follows:

- The eligible professional is unable to electronically prescribe due to local, state, or federal law, or regulation
- The eligible professional has or will prescribe fewer than 100 prescriptions for Medicare patients during a 6-month reporting period (January 1 – June 30, 2013)
- The eligible professional practices in a rural area without sufficient high-speed Internet access (G8642)
- The eligible professional practices in an area without sufficient available pharmacies for electronic prescribing (G8643)
- Eligible professionals and members within a group practice participating in eRx GPRO who achieve Meaningful Use under the Medicare or Medicaid Electronic Health Record (EHR) Incentive Program during the 12-month eRx reporting period (January 1 through December 31, 2012) or the 6-month eRx reporting period (January 1 through June 30, 2013). *Determined by CMS through review of the EHR Incentive Program Attestation and Registration system and will be automatically processed by CMS*
- Eligible professionals and members within a group practice participating in eRx GPRO who demonstrate intent to participate in the Medicare or Medicaid EHR Incentive Program by June 30, 2013. *Determined by CMS through review of the EHR Incentive Program Attestation and Registration system and will be automatically processed by CMS*

Submitting a Significant Hardship Code or Request

To request a significant hardship, individual eligible professionals and group practices participating in eRx GPRO must submit their significant hardship exemption requests through the Quality Reporting Communication Support Page (Communication Support Page) on or between March 1 and June 30, 2013. Please remember that CMS will review these requests on a case-by-case basis. All decisions on significant hardship exemption requests will be final.

Significant hardships associated with a G-code may be submitted via the Communication Support Page *or* on at least one claim during the 2014 eRx payment adjustment reporting period (January 1 – June 30, 2013). If submitting a significant hardship G-code via claims, it is not necessary to request the same hardship through the Communication Support Page. As noted above, the hardship exemptions for achieving Meaningful Use or demonstrating intent to participate by registering (providing EHR certification ID) in the Medicare or Medicaid EHR Program will be automatically processed by CMS and therefore will not be entered as a hardship exemption request through the Communication Support Page.

For more information on how to navigate the Communication Support Page, please reference the following documents:

- Quality Reporting Communication Support Page User Guide
- Tips for Using the Quality Reporting Communication Support Page

For additional information and resources, please visit the eRx Incentive Program website. If you have questions regarding the eRx Incentive Program, eRx payment adjustments, or need assistance submitting a hardship exemption request, please contact the QualityNet Help Desk at 866-288-8912 (TTY 1-877-715-6222) or via qnetsupport@sdps.org. They are available Monday through Friday from 7am-7pm CT.

Ordering and Referring Denial Edits Will Turn on May 1, 2013

Effective May 1, 2013, CMS will instruct contractors to turn on Phase 2 denial edits on the following claims to check for a valid individual National Provider Identifier (NPI) and to deny the claim when this information is missing

- Medicare Part B claims including Durable Medical Equipment, Orthotics, and Supplies (DMEPOS) that have an ordering or referring physician/non-physician provider; and
- Part A Home Health Agency (HHA) claims that require an attending physician provider.

For more information:

- Attend the National Provider Call on March 20 from 3-4:30ET. Registration information will be available soon on CMS Upcoming National Provider Calls
- MLN Matters® Article #SE1305, "Full Implementation of Edits on the Ordering/Referring Providers in Medicare Part B, DME, and Part A Home Health Agency (HHA) Claims (Change Requests 6417, 6421, 6696, and 6856)"

Status of Reprocessing Hospital Value-Based Purchasing Program Claims

Under the Hospital Value-Based Purchasing (VBP) Program, CMS makes payment adjustments for participating hospitals on a per-claim basis, depending on how well they perform on quality measures under the program. The Hospital VBP Program payment adjustments became effective for discharges beginning on October 1, 2012. Due to statutory posting and notification requirements, however, CMS did not implement payment adjustments until January 2013. In the FY 2013 Inpatient Prospective Payment System (IPPS) Final Rule, CMS finalized a policy to reprocess claims for FY 2013 discharges from hospitals participating in the Hospital VBP Program that were paid prior to January 2013, when value-based incentive payment adjustment factors were incorporated into the claims processing system (77 FR 53578). CMS has received inquiries about the deadline for reprocessing those claims. Contractors have until May 31, 2013 to complete the reprocessing of those claims. Hospitals should contact their A/B Medicare Administrative Contractor (MAC) with any specific questions regarding the status of reprocessing their claims.

Problem Impacting Crossover of Medicare Part B Outpatient Therapy Claims

Parties that bill for Medicare participating outpatient therapists, physicians, and non-physician practitioners (NPPs) may have recently noticed an increase in the incidence of the Health Insurance Portability and Accountability Act (HIPAA) rejection codes denoted below on their provider notification letters. Medicare routinely mails these letters out to providers, physicians/practitioners, and suppliers when various identified claims cannot be successfully crossed over to their patients' supplemental insurance companies.

- H51000: The Procedure Code ____ is not a valid CPT or HCPCS Code for this Date of Service
- H51061: 'Procedure Modifier 1' ___ is not a valid CPT or HCPCS Modifier Code
- H51062: 'Procedure Modifier 2'____ is not a valid CPT or HCPCS Modifier Code
- H51063: 'Procedure Modifier 3' ____ is not a valid CPT or HCPCS Modifier Code
- H51064: 'Procedure Modifier 4' ____ is not a valid CPT or HCPCS Modifier Code
- H51108: _____ is not a valid 'Line Level Adjustment Reason Code.'
  Note: Where you see "_____" directly above, the value (for example, G8978; modifier CH; or CARC 246) was reported, when applicable, on the outbound provider notification letter that billing offices would have received.

Unfortunately, the new functional G-codes, new severity/complexity modifiers, and new Claim Adjustment Reason Code (CARC) 246 for the January 2013 Healthcare Common Procedure Coding System (HCPCS) and CARC updates were inadvertently not loaded. As a result, a moderate number of Part B outpatient therapy claims (claims for physical, speech, and occupational therapy) were rejected in error. The newly added severity/complexity modifiers were as follows: CH, CI, CJ, CK, CL, CM, and CN. The new functional G-codes fall within the following ranges:

- G8978—G8999
- G9158—G9176
- G9186

Actions Taken To Remedy the Issue
The Coordination of Benefits Contractor (COBC) HIPAA validation vendor added the new G-codes to its HCPCS table as of January 28, 2013. The vendor then added the new severity/complexity modifiers to its HCPCS table as of February 11. Lastly, the vendor added the new CARC 246 to its table as of February 25. Thus, Medicare participating therapists, physicians, and NPPs should now see a *drastic decrease* in the incidence of error codes H51000, H51061—H51064, and H51108 reflected on their provider notification letters.

Affected Claims Need to be Billed Directly to Supplemental Insurers
If your billing office received a provider notification letter from Medicare indicating that claims could *not* be crossed over due to one of the H-series error messages described above, there unfortunately is *not* a way for Medicare to re-transmit the affected claims to your patients' supplemental insurers. Therefore, you will need to bill your patients' supplemental insurers directly. CMS regrets that this is necessary.

Please know that to help mitigate this kind of problem in the future, CMS will implement a fail-safe strategy well in advance of the scheduled installation of new HCPCS or other code updates. This will ensure that any incorrectly rejected Medicare crossover claims will be repaired by all A/B MACs, thus appropriately minimizing the impact to the provider community.

April 2013 Average Sales Price Files Now Available

CMS has posted the April 2013 Average Sales Price (ASP) and Not Otherwise Classified (NOC) pricing files and crosswalks. All are available for download on the2013 ASP Drug Pricing Files web page.

"Full Implementation of Edits on the Ordering/Referring Providers in Medicare Part B, DME, and Part A Home Health Agency (HHA) Claims (Change Requests 6417, 6421, 6696, and 6856)" MLN Matters® Article — Released

MLN Matters® Special Edition Article #SE1305, "Full Implementation of Edits on the Ordering/Referring Providers in Medicare Part B, DME, and Part A Home Health Agency (HHA) Claims (Change Requests 6417, 6421, 6696, and 6856)" has been released and is now available in downloadable format. This article is designed to educate certain ordering/referring providers on the implementation of the Phase 2 denial edits, and if applicable, the urgency to submit their Medicare enrollment application. It also provides background information; a list of questions and answers relating to the edits and their resulting impact on providers; as well as additional resources regarding the Medicare enrollment process.

From the MLN: "2013 Medicare Part C and Part D Reporting Requirements Data Validation" Web-

Based Training Course — Released

The "2013 Medicare Part C and Part D Reporting Requirements Data Validation" Web-Based Training Course (WBT) was released and is now available. This WBT is designed to provide education on the 2013 Medicare Part C and Part D Reporting Requirements for Data Validation. It includes information on planning, performing, analyzing and completing Data Validation (DV) activities. This activity is designed for Data Validation Contractors and Sponsoring Organization staff members. Continuing education credits are available to learners who successfully complete this course. See course description for more information.

To access a new or revised WBT, go to MLN Products and click on "Web-Based Training Courses" under "Related Links" at the bottom of the web page.

CMS asks that you share this important information with interested colleagues and recommends they subscribe to receive the *e-News* directly.

Previous issues are available in the archive.