Table of Contents for Thursday, February 7, 2013

National Provider Call: How to Avoid a 2014 eRx and 2015 PQRS Payment Adjustment — Registration Now Open [↑]

Tuesday, February 19; 1:30-3pm ET

The CMS Provider Communications Group will host a National Provider Call on the Physician Quality Reporting System (PQRS) and Electronic Prescribing (eRx) Incentive Program. Subject matter experts will discuss how to avoid a 2014 eRx and 2015 PQRS payment adjustment.

Agenda:

- Welcome and Announcements
- How to Avoid 2014 eRx and 2015 PQRS Payment Adjustment Presentation
- Resources & Who to Contact for Help
- Question and Answer Session

Target Audience: Eligible Professionals, Medical coders, physician office staff, provider billing staff, health records staff, vendors, and all other interested Medicare FFS healthcare professionals

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 will be posted prior to the call 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: End-Stage Renal Disease Quality Incentive Program - Payment Year 2015 Final Rule — Registration Now Open [↑]
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 will be posted prior to the call 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.

ICD-9-CM Coordination and Maintenance Committee Meeting — Registration Now Open [↑]
Tuesday, March 5

Register for the March 5 ICD-9-CM Coordination and Maintenance Committee Meeting. This meeting is being webcast via CMS.gov LIVE. By your attendance, you are giving consent to the use and distribution of your name, likeness, and voice during the meeting. You are also giving consent to the use and distribution of any personally identifiable information that you or others may disclose about you during the meeting.

- The agenda for the diagnosis topics will be posted in February on the CDC website.
- The agenda for the procedure topics will be posted in February on the CMS website:

Preventing Heart Disease and Increasing Awareness of its Affects [↑]

February is American Heart Month, a time to draw attention to cardiovascular disease and educate people on what we can do to live heart-healthy lives. Cardiovascular disease—including heart disease and stroke—is the leading cause of death for men and women in the United States. The good news is that risk factors such as hypertension, high cholesterol, smoking, and obesity are preventable and controllable. However, many people don't know they are at risk for cardiovascular disease and are therefore unaware that lifestyle changes such as weight control, blood pressure and cholesterol control, and smoking cessation could reduce their risk or prevent a heart attack or stroke. Making lifestyle changes—whether trying to reduce, prevent, or manage disease is not easy. Medicare provides the following benefits for Medicare patients that meet certain eligibility criteria that can help identify risk factors and provide your Medicare patients with tools to help them make heart-healthy lifestyle changes:

- Initial Preventive Physical Exam (IPPE, also known as the "Welcome to Medicare" Preventive Visit)
- Annual Wellness Visit providing Personalized Prevention Plan Services
- Cardiovascular Disease Screening Blood Tests (total cholesterol, high-density lipoproteins, and triglycerides tests)
- Diabetes Screening
- Intensive Behavioral Therapy for Cardiovascular Disease
- Intensive Behavioral Therapy for Obesity
- Tobacco-use Cessation Counseling Services

What Can You Do?

- Help seniors and others with Medicare identify and better understand their risk factors for heart disease and stroke.
- Talk with your patients about lifestyle changes they can make to reduce, eliminate, or control their cardiovascular disease risk factors.
- Encourage the appropriate use of Medicare preventive benefits that can help your patients reach their goals.
- Learn more about, and take advantage of information provided by campaigns like American Heart Month and *Million Hearts™,* a national initiative to prevent 1 million heart attacks and strokes by 2017.

For More Information

- CMS Medicare Learning Network® (MLN) Preventive Services web page for provider resources including coverage, coding, and billing information
- Medicare.gov Preventive and Screening Services web page for beneficiary resources
- CDC Division for Heart Disease and Stroke Prevention
- HHS Million Hearts™ Campaign

Flu Season Isn't Over—Continue to Recommend Vaccination [↑]

While each flu season is different, flu activity typically peaks in February. Yet, even in February, the flu vaccine is still the best defense against the flu. The Centers for Disease Control and Prevention recommends yearly flu vaccination for everyone 6 months of age and older; and although anyone can get the flu, adults 65 years and older are at greater risk for serious flu-related complications that can lead to hospitalization and death. Each year in the United States, about 9 out of 10 flu-related deaths and more than 6 out of 10 flu-related hospital stays occur in people 65 years and older. Every office visit is an opportunity to check your patients' vaccination status and encourage flu vaccination when appropriate.

Getting vaccinated is just as important for health care personnel, like you, for many reasons. You can get sick with the flu and spread it to your family, colleagues and patients without knowing or having symptoms. Be an example by getting your flu vaccine and know that you're helping to reduce the spread of flu in your community.

Note: – influenza vaccines and their administration fees are covered Part B benefits. 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 nearby 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

Affordable Care Act "Sunshine" Rule Increases Transparency in Health Care [↑]

On February 1, CMS announced a final rule that will increase public awareness of financial relationships between drug and device manufacturers and certain health care providers. Called the "National Physician Payment Transparency Program: Open Payments," this is one of many steps in the Affordable Care Act designed to create greater transparency in the health care market.

This rule finalizes the provisions that require manufacturers of drugs, devices, biologicals, and medical supplies covered by Medicare, Medicaid, or the Children's Health Insurance Program (CHIP) to report payments or other transfers of value they make to physicians and teaching hospitals to CMS. CMS will post that data to a public website. The final rule also requires manufacturers and group purchasing organizations (GPOs) to disclose to CMS physician ownership or investment interests.

This increased transparency is intended to help reduce the potential for conflicts of interest that physicians or teaching hospitals could face as a result of their relationships with manufacturers. This new reporting will apply to applicable manufacturers and GPOs. These organizations, as well as the physicians and teaching hospitals, will have an opportunity to review and correct reported information prior to its publication.

In order to give applicable manufacturers and applicable GPOs sufficient time to prepare, data collection will begin on August 1, 2013. Applicable manufacturers and applicable GPOs will report the data for August through December of 2013 to CMS by March 31, 2014 and CMS will release the data on a public website by September 30, 2014. CMS is developing an electronic system to facilitate the reporting process.

The final rule can be downloaded from the Federal Register.

Full text of this excerpted CMS press release (issued February 1).

Reforms of Regulatory Requirements to Save Health Care Providers $676 Million Annually [↑]

Reforms to Medicare regulations identified as unnecessary, obsolete, or excessively burdensome on hospitals and health care providers would save nearly $676 million annually and $3.4 billion over five years through a rule proposed on February 4 by CMS. The proposed rule supports President Obama's call on federal agencies to modify and streamline regulations on business.

The proposed rule is designed to help health care providers to operate more efficiently by getting rid of regulations that are out of date or no longer needed. Many of the rule's provisions streamline the standards health care providers must meet in order to participate in the Medicare and Medicaid programs without jeopardizing beneficiary safety.

For example, a key provision reduces the burden on very small critical access hospitals, as well as rural health clinics and federally qualified health centers by eliminating the requirement that a physician be held to an excessively prescriptive schedule for being onsite once every two weeks. This provision seeks to address the geographic barriers and remoteness of many rural facilities and recognize telemedicine improvements and expansions that allow physicians to provide many types of care at lower costs, while maintaining high-quality care.

Among other provisions, the proposed rule would:

- Save hospitals significant resources by permitting registered dietitians to order patient diets

independently, which they are trained to do, without requiring the supervision or approval of a physician or other practitioner. This frees up time for physicians and other practitioners to care for patients.
- Eliminate unnecessary requirements that ambulatory surgical centers must meet in order to provide radiological services that are an integral part of their surgical procedures, permitting them greater flexibility for physician supervision requirements.
- Permit trained nuclear medicine technicians in hospitals to prepare radiopharmaceuticals for nuclear medicine without the supervising physician or pharmacist constantly being present, which helps speed services to patients, particularly during off hours.
- Eliminate a redundant data submission requirement and an unnecessary survey process for transplant centers while maintaining strong federal oversight.

As part of the President's regulatory reform initiative, CMS issued final rules in May last year that also reduce burdensome or unnecessary regulations for hospitals and additional health care providers. Those rules are saving nearly $1.1 billion across the health care system in the first year and more than $5 billion over five years.

- Proposed Rule
- May 2012 Final Rules

Full text of this excerpted CMS press release (issued February 4).

CMS Announces New Initiative to Improve End-Stage Renal Disease Care [↑]
New Model Will Support Providers and Suppliers in Testing Innovative Ways to Improve Care for Beneficiaries with End-Stage Renal Disease

On February 4, CMS announced a new initiative designed to identify, test, and evaluate new ways to improve care for Medicare beneficiaries with End-Stage Renal Disease (ESRD). Through the Comprehensive ESRD Care initiative, CMS will partner with health care providers and suppliers to test the effectiveness of a new payment and service delivery model in providing these beneficiaries with patient-centered, high-quality care.

Those with ESRD have significant health care needs. These beneficiaries constituted 1.3% of the Medicare population and accounted for an estimated 7.5% of Medicare spending, totaling over $20 billion in 2010. These high costs are often the result of underlying disease complications and multiple co-morbidities, such as coronary artery disease and hypertension, which often lead to high rates of hospital admission and readmissions, as well as a mortality rate that is much higher than the general Medicare population.

Through the Comprehensive ESRD Care Initiative, CMS will enter into agreements with groups of health care providers and suppliers called ESRD Seamless Care Organizations, who will work together to provide beneficiaries with a more patient-centered, coordinated care experience. Participating organizations must include at least a dialysis facility, a nephrologist, and one other Medicare provider or supplier. This initiative is being run through the CMS Innovation Center, which was created by the Affordable Care Act to test new models of delivering health care that can potentially lower costs and improve patient care.

Participating organizations will assume clinical and financial responsibility for a group of beneficiaries with ESRD, based on where these beneficiaries receive services. Beneficiaries will retain the right to see any Medicare provider they choose and these organizations will be evaluated on their performance on quality measures, which include beneficiary health and experience. Those organizations successful in

improving beneficiary health outcomes and lowering the per capita cost of care for beneficiaries will have an opportunity to share in Medicare savings with CMS.

This initiative was developed through consultation with advocates and beneficiaries living with ESRD, health care providers, and nonprofit organizations, among others.

Interested applicants are required to file non-binding letters of intent, which are due on March 15, 2013. Applications to participate in the model are due May 1, 2013. For more information, and to see the request for application, visit the Comprehensive ESRD Care Initiative web page.

Full text of this excerpted CMS press release (issued February 4).

2013 ICD-10-CM Present on Admission Exempt Code List Now Available [↑]

The 2013 ICD-10-CM Present on Admission (POA) exempt code list has been posted on the 2013 ICD-10-CM and GEMs web page and the ICD-10 MS-DRG Conversion Project web page. This file is a complete list of all 2013 ICD-10-CM codes that are exempt from the requirement to report POA Indicators for specific diagnosis codes on inpatient bills. The list of codes is based on the ICD-10-CM Official Coding Guidelines, which is available on the CDC website (see pages 107 – 111 of the guidelines). Additional information on POA Indicators can be found on the Hospital-Acquired Conditions website.

As a reminder, ICD-10 codes will be implemented for discharges effective on or after October 1, 2014.

Hospice Quality Reporting Program Structural Measure Deadline has Passed: NQF #0209 Deadline is April 1 [↑]

The structural measure deadline for the Hospice Quality Reporting Program (HQRP) was January 31, 2013. Since the deadline has passed, providers cannot return to the data entry site to submit or correct any errors in structural measure (QAPI) data. Although the structural measure deadline has passed, providers can still access the NQF #0209 portion of the data entry site to submit and attest to NQF #0209 data.

In order to be fully compliant with this year's reporting requirements, in addition to structural measure data, providers will also need to submit and attest to NQF #0209 data by April 1, 2013 in order to avoid a reduction in Annual Payment Update (APU). In case of technical difficulty or general data entry questions, it is highly recommended that providers begin entering their NQF #0209 data now. Providers should not wait until the deadline to enter their data.

Providers that fail to meet either of the required HQRP reporting deadlines (January 31 for the structural measure; April 1 for the NQF #0209 Pain Measure) will receive a two percentage point reduction in their 2014 APU.

DMEPOS Competitive Bidding — Fact Sheet Revised [↑]

Program Reminder
As a reminder, on January 1, 2011, the Round 1 Rebid of The DMEPOS Competitive Bidding Program (The Program) was successfully implemented in nine areas.

On July 1, 2013, Round 2 of The Program is targeted to go into effect in 91 metropolitan statistical areas (MSAs). In addition, CMS will be implementing a national mail-order program for diabetic testing supplies at the same time as Round 2. The national mail-order program will include all parts of the United States, including the 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, and American Samoa.

"The DMEPOS Competitive Bidding Program: A Better Way for Medicare to Pay for Medical Equipment" Fact Sheet—Revised
The "DMEPOS Competitive Bidding Program: A Better Way for Medicare to Pay for Medical Equipment" Fact Sheet (ICN 903624) was revised and is now available in downloadable format. This fact sheet is designed to provide education on the Round 1 Rebid and Round 2 of the DMEPOS Competitive Bidding Program. It includes an overview of the program, how the program benefits beneficiaries, and lists of product categories and competitive bidding areas affected by those two rounds of the program.

The fact sheet is appropriate for DMEPOS suppliers and all provider types who order, refer, or provide DMEPOS items to their patients.

Additional information
For more information about The Program, visit the CMS website.

Diabetic Testing Supplies Provisions of the American Taxpayer Relief Act of 2012 [↑]

Section 636 of the American Taxpayer Relief Act of 2012 revises the Medicare non-mail order fee schedule amounts for diabetic testing supplies. For more information on the changes, please visit the CMS Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule web page.

February 28th is the Last Day for EPs to Submit Medicare Part B Claims for the EHR Incentive Programs [↑]

February 28, 2013, is the deadline for eligible professionals (EPs) to submit any pending Medicare Part B claims from CY 2012, as CMS allows 60 days after December 31, 2012 for all pending claims to be processed. This means that EPs have 60 days in 2013 to submit claims for allowed charges incurred in 2012.

Medicare Electronic Health Record (EHR) incentive payments to EPs are based on 75% of the Part B allowed charges for covered professional services furnished by the EP during the entire payment year. If the EP did not meet the $24,000 threshold in Part B allowed charges by the end of CY 2012, CMS expects to issue an incentive payment for the EP in March 2013 for 75% of the EP's Part B charges from 2012.

Reminder: EPs who participated in the EHR Incentive Program in 2012 must also complete attestation for the 2012 program year by February 28, 2013. In order to be eligible to attest you must have completed your 2012 reporting period by December 31, 2012.

Medicaid Participants: Please contact your State Medicaid Agency for more details about payment.

Want more information about the EHR Incentive Programs?
Make sure to visit the EHR Incentive Programs website for the latest news and updates on the EHR Incentive Programs.

From the MLN: "Medicare Quarterly Provider Compliance Newsletter [Volume 3, Issue 2]" Educational Tool — Released [↑]

The "Medicare Quarterly Provider Compliance Newsletter [Volume 3, Issue 2]"Educational Tool (ICN 908424) was released and is now available in downloadable format. This educational tool is designed to provide education on how to avoid common billing errors and other erroneous activities when dealing with the Medicare Program. It highlights the top issues of the particular Quarter.

An index of Recovery Audit and Comprehensive Error Rate Testing (CERT) findings from current and previous newsletters is available. This index is customized by provider type to identify those findings that impact specific providers. Visit the Medicare Quarterly Provider Compliance Newsletter Archive page to download the index and view an archive of previous newsletters.

From the MLN: "Long Term Care Hospital Prospective Payment System" Fact Sheets — Revised [↑]

The fact sheets below provide education on the Long Term Care Hospital Prospective Payment System (LTCH PPS) and are available from the Medicare Learning Network®:

- "The Long Term Care Hospital Prospective Payment System: News Fact Sheet (ICN 006393) was revised and is now available in downloadable format. This fact sheet is designed to provide education about news and updates relevant to the Long Term Care Hospital Prospective Payment System (LTCH PPS). It includes updates on annual payment rates and information on payment policy for the LTCH PPS.
- "The Long Term Care Hospital Prospective Payment System: Interrupted Stay" Fact Sheet (ICN 006395) was revised and is now available in downloadable format. This fact sheet is designed to provide education on the interrupted stay policy under the Long Term Care Hospital Prospective Payment System (LTCH PPS). It includes information about the different types of interrupted stays, case examples, and a list of additional resources.
- "The Long term Care Hospital Prospective Payment System: Short-Stay Outliers" Fact Sheet (ICN 006394) was revised and is now available in downloadable format. This fact sheet is designed to provide education on the Short-Stay Outlier (SSO) policy under the Long Term Care Hospital Prospective Payment System (LTCH PPS). It includes information on the identification and payment of SSO cases, and a list of available resources.
- "The Long Term Care Hospital Prospective Payment System: High Cost Outliers" Fact Sheet (ICN 006396) was revised and is now available in downloadable format. This fact sheet is designed to provide education on the calculation of high cost outliers under the Long Term Care Hospital Prospective Payment System (LTCH PPS). It includes information on how to identify high cost outlier cases, payment calculation, and a list of available resources.
- "The Long Term Care Hospital Prospective Payment System: Payment Adjustment Policy" Fact Sheet (ICN 006956) was revised and is now available in downloadable format. This fact sheet is designed to provide education on the payment adjustment policy under the Long Term Care Hospital Prospective Payment System (LTCH PPS). It includes information about which discharge payments are excluded from the 25 percent threshold adjustment and a list of resources.

From the MLN: "Medicare Fraud & Abuse: Prevention, Detection, and Reporting" Fact Sheet — Reminder [↑]

The "Medicare Fraud & Abuse: Prevention, Detection, and Reporting" Fact Sheet (ICN 006827) is now available as an electronic publication and through a QR code. This fact sheet is designed to provide

education on how to ensure Medicare enrollment records are up-to-date and secure. It includes information on the actions physicians and non-physician practitioners should take to protect their Medicare enrollment information.

The e-publication format is available under the "Related Links" section of the publication's detail page and as a QR code. Instructions for downloading the e-publication and how to scan a QR code are available in How To Download A Medicare Learning Network® (MLN) Electronic Publication.

From the MLN: "Physician Quality Reporting System: Physician Compare" Fact Sheet [↑]

The "Physician Quality Reporting System: Physician Compare" Fact Sheet" (ICN 908025) is now available as an electronic publication and through a QR code. This fact sheet is designed to provide guidance to Medicare beneficiaries to help them make informed choices about health care they receive from Medicare providers.

The e-publication format is available under the "Related Links" section of the publication's detail page and as a QR code. Instructions for downloading the e-publication and how to scan a QR code are available in How To Download A Medicare Learning Network® (MLN) Electronic Publication.

Medicare Learning Network®
Official CMS Information for Medicare Fee-For-Service Providers

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.