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

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 — 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.

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National Provider Call: Hospital Value-Based Purchasing Fiscal Year 2015 Overview — Registration Now Open [↑]
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.

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.

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Don't Miss DMEPOS Competitive Bidding Webinars for All Provider Types in Upcoming Weeks [↑]

CMS will host several webinars for referral agents and other providers on the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. The DMEPOS Competitive Bidding Program is a change to the Medicare program that is scheduled to go into effect for Medicare beneficiaries with Original Medicare in 91 competitive bidding areas (CBAs) across the country starting on July 1, 2013. Under this program, CMS will be awarding contracts to suppliers for certain categories of DMEPOS in the CBAs. It is important that physicians, social workers, discharge planners, and anyone else who refers beneficiaries for DMEPOS supplies understand this new program so that they can help Medicare patients get covered medical equipment and supplies.

For information about these free webinars, and for further information about the DMEPOS competitive

bidding program, sign up for the new CMS DME Referral Agent Electronic Mailing List.

Date and Location Changes for Advisory Panel Meeting on Hospital Outpatient Payments [↑]
New: March 11 only; 1-5pm ET

The meeting dates and venue location for the March 11-12 Advisory Panel on Hospital Outpatient Payment (HOP Panel) meeting are changing. As a result of an unexpected low response to requests for presentations, the meeting will take place *only* on Monday, March 11 from 1-5pm ET.

The meeting location will *not* be onsite at CMS. Instead, the meeting will be conducted electronically (i.e. webcast, teleconference, and/or webinar). The format of the meeting including presentations, recommendations, and public questions/comments will remain the same. CMS is in the process of finalizing the meeting venue type.

All meeting information, including meeting website URLs, teleconference telephone numbers, agenda, and presentations will be posted on the CMS website as they become available.

We anticipate that a Federal Register meeting notice correction identifying the change in meeting venue and dates will be published before the end of February.

Persons wishing to participate in this meeting are encouraged to access the CMS website hyperlink above for the latest information. Thank you for your patience and understanding.

Departments of Justice and HHS Announce Record-Breaking Recoveries Resulting from Joint Efforts to Combat Health Care Fraud [↑]
Government Teams Recovered $4.2 Billion in FY 2012

On February 11, Attorney General Eric Holder and HHS Secretary Kathleen Sebelius released a new report showing that for every dollar spent on health care-related fraud and abuse investigations in the last three years, the government recovered $7.90. This is the highest three-year average return on investment in the 16-year history of the Health Care Fraud and Abuse (HCFAC) Program.

The government's health care fraud prevention and enforcement efforts recovered a record $4.2 billion in taxpayer dollars in FY 2012, up from nearly $4.1 billion in FY 2011, from individuals and companies who attempted to defraud federal health programs serving seniors and taxpayers or who sought payments to which they were not entitled. Over the last four years, the administration's enforcement efforts have recovered $14.9 billion, up from $6.7 billion over the prior four-year period. Since 1997, the HCFAC Program has returned more than $23 billion to the Medicare Trust Funds.

These findings, released today in the annual HCFAC Program report, are a result of President Obama making the elimination of fraud, waste and abuse, particularly in health care, a top priority for the administration.

The success of this joint Department of Justice and HHS effort was made possible by the Health Care Fraud Prevention and Enforcement Action Team (HEAT), created in 2009 to prevent fraud, waste and abuse in the Medicare and Medicaid programs and to crack down on individuals and entities that are abusing the system and costing American taxpayers billions of dollars. These efforts to reduce fraud will continue to improve with new tools and resources provided by the Affordable Care Act.

About $4.2 billion stolen or otherwise improperly obtained from federal health care programs was recovered and returned to the Medicare Trust Funds, the Treasury and others in FY 2012. This is an unprecedented achievement for the HCFAC Program, a joint Justice Department and HHS effort to coordinate federal, state and local law enforcement activities to fight health care fraud and abuse. The administration is also using tools authorized by the Affordable Care Act to fight fraud, including enhanced screenings and enrollment requirements, increased data sharing across the government, expanded recovery efforts for overpayments and greater oversight of private insurance abuses.

Since 2009, the Justice Department and HHS have improved their coordination through HEAT and increased the number of Medicare Fraud Strike Force teams to nine. The Justice Department's enforcement of the civil False Claims Act and the Federal Food, Drug and Cosmetic Act have produced similar record-breaking results. These combined efforts coordinated under HEAT have expanded local partnerships and helped educate Medicare beneficiaries about how to protect themselves against fraud. In FY 2012, the two departments continued their series of regional fraud prevention summits, and the Justice Department hosted a training conference for federal prosecutors, FBI agents, HHS Office of Inspector General agents and others.

The strike force teams use advanced data analysis techniques to identify high-billing levels in health care fraud hot spots so that interagency teams can target emerging or migrating schemes as well as with chronic fraud by criminals masquerading as health care providers or suppliers. In July, Attorney General Holder and Secretary Sebelius announced the launch of a ground-breaking partnership among the federal government, state officials, leading private health insurance organizations and other health care anti-fraud groups to share information and best practices to improve detection of and prevent payments to scams that cut across public and private payers.

In FY 2012, the Justice Department opened 1,131 new criminal health care fraud investigations involving 2,148 potential defendants, and a total of 826 defendants were convicted of health care fraud-related crimes during the year. The department also opened 885 new civil investigations.
The strike force coordinated a takedown in May 2012 that involved the highest number of false Medicare billings in the history of the strike force program. The takedown involved 107 individuals, including doctors and nurses, in seven cities, who were charged for their alleged participation in Medicare fraud schemes, involving about $452 million in false billings. As a part of the May 2012 takedown, HHS also suspended or took other administrative action against 52 providers using authority under the health care law to suspend payments until an investigation is complete.

Strike force operations in the nine cities where teams are based resulted in 117 indictments, informations, and complaints involving charges against 278 defendants who allegedly billed Medicare more than $1.5 billion in fraudulent schemes. In FY 2012, 251 guilty pleas and 13 jury trials were litigated, with guilty verdicts against 29 defendants, in strike force cases. The average prison sentence in these cases was more than 48 months.

The new authorities under the Affordable Care Act granted to HHS and CMS were instrumental in clamping down on fraudulent activity in health care. In FY 2012, CMS began the process of screening all 1.5 million Medicare-enrolled providers through the new Automated Provider Screening system that quickly identifies ineligible and potentially fraudulent providers and suppliers prior to enrollment or revalidation to verify the data. As a result, nearly 150,000 ineligible providers have already been eliminated from Medicare's billing system.

CMS also established the Command Center to improve health care-related fraud detection and investigation, drive innovation and help reduce fraud and improper payments in Medicare and Medicaid.

From May 2011 through the end of 2012, more than 400,000 providers were subject to the new screening requirements and nearly 150,000 lost the ability to bill the Medicare program due to the Affordable Care Act requirements and other proactive initiatives.

The Department of Justice and HHS also continued their successes in civil health care fraud enforcement during FY 2012. The Justice Department's Civil Division Fraud Section, with their colleagues in U.S. Attorneys' offices throughout the country, obtained settlements and judgments of more than $3 billion in FY 2012 under the False Claims Act (FCA). These matters included unlawful pricing by pharmaceutical manufacturers, illegal marketing of medical devices and pharmaceutical products for uses not approved by the Food and Drug Administration, Medicare fraud by hospitals and other institutional providers, and violations of laws against self-referrals and kickbacks. This marked the third year in a row that more than $2 billion has been recovered in FCA health care matters. Additionally, the Civil Division's Consumer Protection Branch, working with U.S. Attorneys' offices, obtained nearly $1.5 billion in fines and forfeitures, and obtained 14 convictions in matters pursued under the Federal Food, Drug and Cosmetic Act.

The HCFAC annual report is available on the Office of Inspector General website. For more information on the joint DOJ-HHS Strike Force activities, visit Stop Medicare Fraud. More information on the fraud prevention accomplishments under the Affordable Care Act is available on HealthCare.gov.

Full text of this excerpted HHS press release (issued February 11).

Revalidating your Medicare Enrollment Information [↑]

Providers and Suppliers can revalidate their Medicare enrollment information by using either:

- Internet-based Provider Enrollment, Chain and Ownership System (PECOS), or
- The CMS 855 paper form.

The most efficient way to submit your revalidation information is by using Internet-based PECOS on the CMS website. PECOS allows you to review information currently on file, update, submit and electronically sign your revalidation application via the Internet.

If revalidating via the CMS 855 paper form, providers and suppliers are required to complete the form in its entirety. Failure to submit a completed 855 form could result in your revalidation application being delayed and/or deactivation of your Medicare billing privileges.

ICD-10: WEDI's Survey on Industry Progress Now Open [↑]

The Workgroup for Electronic Data Interchange (WEDI) is conducting its latest online ICD-10 Industry Progress Survey. The survey will help CMS and WEDI:

- Measure the health care industry's ICD-10 progress
- Evaluate challenges and identify areas where industry needs more education and assistance

The survey is open to all individuals associated with health care organizations, including vendors, health plans, providers, and payers. Before taking the online survey, please scroll to the link at the end of the WEDI survey press release to preview the questions. The press release also includes a link to the online survey form. The online survey will close on Wednesday, February 20. Please direct any questions to Samantha Holvey of WEDI at sholvey@wedi.org or 202-618-8803.

Keep Up to Date on ICD-10
Visit the CMS ICD-10 website for the latest news and resources to help you prepare for the October 1, 2014, deadline. For practical transition tips:

- Read recent ICD-10 email update messages
- Access the ICD-10 continuing medical education modules developed by CMS in partnership with Medscape

The deadline for ICD-10 is *October 1, 2014.*

51MUE Adjustment Process for Possible Overpayment [↑]

In 2011, Medicare incorrectly denied some HCPCs as Medically Unlikely. An effort has been underway to identify the claims with inappropriate 51MUE/52MUE denials and the Medicare Administrative Contractors (MACs) are preparing to create adjustments that will adjust the claims and correct the payments made to the submitting facilities.

While testing the correction, one of the MACs identified some situations where the newly adjusted claims will create an overpayment. The overpayment is due to the way that certain HCPCs are coded on the Medically Unlikely Edits file that the System Maintainer is dependent upon to systemically identify the claims for adjustment. At this time, two HCPCs have been identified, but research is ongoing to determine the full impact. The identified HCPCs are 90804 and 94760.

Because the first priority of CMS is to correct any underpayments that the providers have been subject to, it was decided that the MACs should proceed with the adjustment process. This means that you may potentially receive an overpayment on one or more of your claims that are adjusted. At this time it is not necessary for you to take any action on the overpayments. CMS is working with the System Maintainer on a solution and fully expects to recoup the overpayments systemically in the near future.

From the MLN: "Federally Qualified Health Center" Text-Only Fact Sheet — Released [↑]

To assist rural providers who have limited internet access, the "Federally Qualified Health Center Text-Only" Fact Sheet is now available. This fact sheet is designed to provide education on Federally Qualified Health Centers (FQHC). It includes the following information: background, FQHC designation, covered FQHC services, FQHC preventive primary services that are not covered, FQHC Prospective Payment System, and FQHC payments.

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The Medicare Learning Network® (MLN) is the home for education, information, and resources for the Medicare FFS provider community. Sign up for both of the electronic mailing lists below to stay informed about the latest MLN Educational Products and MLN Matters® Articles. You will receive an email when new and revised products and articles are released.

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