Table of Contents for Thursday, March 21, 2013

- Pilot Testers Needed
- New MLN Educational Web Guides Fast Fact
- New MLN Provider Compliance Fast Fact

National Provider Calls: Medicare Shared Savings Program Application Process — Registration Now Open
Tuesday, April 9; 2:30-4pm ET— **Preparing to Apply**
Tuesday, April 23; 1:30-3pm ET— **Tips on Completing a Successful Application**

On October 20, 2011, CMS issued a final rule under the Affordable Care Act to establish the Medicare Shared Savings Program (Shared Savings Program). This initiative will help providers participate in Accountable Care Organizations (ACOs) to improve quality of care for Medicare patients. CMS will host two National Provider Calls in April on the Shared Savings Program application process.

On Tuesday, April 9, CMS subject matter experts will provide information on what you can do now to prepare for the Shared Savings Program application process for the January 1, 2014 start date. This National Provider Call will include information on key dates, the Notice of Intent to Apply (NOI) submission, and the first steps in submitting an application. A question and answer session will follow the presentation.

On Tuesday, April 23, CMS subject matter experts will cover tips on completing a successful application, including information on how to submit an acceptable ACO Participant List, Participation Agreement Sample, Executed Participant Agreement pages, and Governing Body Template for the Shared Savings Program application. A question and answer session will follow the presentation.

The Shared Savings Program Application web page has important information, dates, and materials on the application process. Call participants are encouraged to review the application and materials prior to the call.

Target Audience: Medicare FFS providers

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: PQRS Group Practice Reporting Option and Registry Reporting — Save the Date
Tuesday, April 16; 1:30-3pm ET

Please save the date for an upcoming CMS National Provider Call on the 2013 Physician Quality Reporting System (PQRS) and Electronic Prescribing (eRx) claims-based reporting. This call will provide an overview to eligible professionals on reporting requirements and criteria for satisfactorily reporting for Group Practice Reporting Option and Registry. Registration information will be available soon on the

CMS Upcoming National Provider Calls registration website.

National Provider Call: Begin Transitioning to ICD-10 in 2013 — Registration Now Open
Thursday, April 18; 1:30-3pm ET

On September 5, 2012, CMS published a final rule that delays the ICD-10 compliance date from October 1, 2013 to October 1, 2014. Are you ready to transition to ICD-10? Now is the time to prepare. Join us to learn how to prepare in 2013 for the transition.

CMS Subject matter experts will review basic information on the transition to ICD-10 and discuss implementation planning and preparation strategies. A question and answer session will follow the presentations.

Agenda:

- Planning for transition to ICD-10
- Claims processing
- National implementation issues
- National Coverage Decisions
- Outreach

Target Audience: Medical coders, physicians, physician office staff, nurses and other non-physician practitioners, provider billing staff, health records staff, vendors, educators, system maintainers, laboratories, and all Medicare FFS providers

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: Transcript and Audio File from February 19 Call on How to Avoid a 2014 eRx and 2015 PQRS Payment Adjustment Now Available

The written transcript and MP3 audio file from the February 19 National Provider Call (NPC) on "How to Avoid a 2014 eRx and 2015 PQRS Payment Adjustment" are available on the February 19 call web page.

For information from other calls, visit the FFS National Provider Calls web page for content from past and upcoming NPCs on a variety of topics.

Physician Compare Redesign Open Door Forum Registration

In 2012, CMS initiated a full redesign of the Physician Compare website based on feedback from site users, physicians and other healthcare professionals, and other stakeholders. The goal of the redesign was to improve the accuracy and currency of the information available on the website as well as

improve the usability and functionality for all users. Two primary enhancements of the redesign include an overhaul of the underlying database and the addition of a new Intelligent Search functionality.

The redesigned Physician Compare website will be launched soon. You are invited to participate in an Open Door Forum where CMS will unveil the redesign. The Open Door Forum will be conducted via webinar. If you are interesting in participating, please send an email with your name, affiliation, and email address to the Physician Compare team at PhysicianCompare@Westat.com. Please put "ODF" in the subject line. The Physician Compare team will email logistical details and instructions for the webinar to everyone who registers the week of the ODF.

It's National Nutrition Month

CMS reminds healthcare professionals that March is National Nutrition Month® – a campaign focused on the importance of making informed food choices, and developing sound eating and physical activity habits. This year marks the 40th anniversary of National Nutrition Month® with a focus on personalized healthy eating styles that take into account individual food preferences, lifestyle, cultural and ethnic traditions, and health concerns.

Nutrition-related health conditions are prevalent within the Medicare population. Twenty-eight percent of Medicare beneficiaries have diabetes and 15 percent have chronic kidney disease. More than thirty-five percent of American men and women are obese and adult obesity is associated with a number of health conditions including heart disease, hypertension, and diabetes.

Medicare provides coverage for the following nutrition-related health services:

- Intensive Behavioral Therapy (IBT) for Obesity
    - Medicare provides coverage of IBT for Obesity. This coverage includes screening for obesity in adults using measurement of body mass index (BMI). For those beneficiaries that screen positive (whose BMI is equal to or greater than 30 kg/m^2) and meet certain requirements, IBT for obesity includes a dietary (nutritional) assessment, and intensive behavioral counseling and behavioral therapy to promote sustained weight loss through high intensity interventions on diet and exercise. This coverage includes one face-to-face visit every week for the first month; one face-to-face visit every other week for months 2-6; and one face-to-face visit every month for months 7-12, if the beneficiary meets the 3kg (6.6 lbs) weight loss requirement during the first 6 months.
- Intensive Behavioral Therapy (IBT) for Cardiovascular Disease (CVD)
    - Medicare provides coverage of IBT for cardiovascular disease (referred to as a CVD risk reduction visit). The visit, which is covered once per year, consists of the following three components:
        - Encouraging aspirin use for the primary prevention of cardiovascular disease when the benefits outweigh the risks for men age 45-79 years and women 55-79 years;
        - Screening for high blood pressure in adults age 18 years and older; and
        - Intensive behavioral counseling to promote a healthy diet for adults with hyperlipidemia, hypertension, advancing age, and other known risk factors for cardiovascular and diet-related chronic disease.
- Medical Nutrition Therapy (MNT)
    - Medicare provides coverage of MNT *for certain beneficiaries diagnosed with diabetes and/or renal disease**, when referred by the treating physician and provided by a registered dietitian or nutrition professional.
- Diabetes Self-Management Training (DSMT)

    - Medicare provides coverage of DSMT services for beneficiaries who have been diagnosed with diabetes and received an order from the physician or qualified nonphysician practitioner treating the beneficiary for diabetes. DSMT services are intended to educate beneficiaries in the successful self-management of diabetes. A qualified DSMT program includes among other services, education about nutrition, diet, and exercise.
- Annual Wellness Visit
    - The Annual Wellness Visit, which is covered once per year presents an opportunity for health professionals to provide eligible beneficiaries that have had Medicare Part B for longer than 12 months with personalized health advice and referrals, as appropriate, for health education, preventive screening and counseling services, and community-based lifestyle interventions. This visit focuses on reducing health risks and promoting self-management and wellness, including weight loss, physical activity, smoking cessation, fall prevention, and nutrition.

What Can You Do?
You can help your Medicare patients live healthier lives in 2013 by encouraging the use of the above Medicare-covered services. These services present excellent opportunities to begin a dialogue with your Medicare patients about their dietary habits and how their eating habits may affect their health, and make recommendations for preventive services that can help them reach their nutritional and dietary goals. Remember to provide any appropriate written referrals.

More Information for Healthcare Professionals:
- MLN Preventive Services Educational Products for Health Professionals
- CMS Prevention Web Site
- National Diabetes Education Program
- National Institute of Diabetes and Digestive and Kidney Diseases
- Million Hearts™ Campaign Web Site
- National Nutrition Month® Web Site

** Note: for the purpose of MNT services, renal disease means chronic renal insufficiency (a reduction in renal function not severe enough to require dialysis or transplantation [Glomerular Filtration Rate (GFR) 13-50 ml/min/1.73m^2]) or the medical condition of a beneficiary who has been discharged from the hospital after a successful renal transplant for up to 36 months post-transplant.*

DMEPOS Competitive Bidding Video Slideshow Now Available

As you may be aware, Round 2 of the DMEPOS Competitive Bidding Program is targeted to go into effect in 91 Metropolitan Statistical Areas on July 1, 2013. Medicare will also implement a national mail-order program for diabetic testing supplies on July 1, 2013. When the program becomes effective in a competitive bidding area, beneficiaries with Original Medicare who obtain competitively bid items in the area must obtain these items from a contract supplier in order for Medicare to pay, unless an exception applies.

CMS Regional Offices held a number of very successful webinars in January and February of this year. In response to demand, CMS has developed a video slideshow of one of those presentations that helps educate providers and suppliers about the program. This video slideshow is now posted to the CMS You Tube channel.

For further information about the DMEPOS Competitive Bidding Program, see the revised fact sheets

and visit the CMS website.

Proposed Rule and Administrator Ruling Released for Part B Inpatient Billing in Hospitals

On March 13, 2013 CMS released a proposed rule that would allow Medicare to pay for additional hospital inpatient services under Medicare Part B. Specifically, the proposed rule would allow additional Part B payment when a Medicare Part A claim is denied because the beneficiary should have been treated as an outpatient, rather than being admitted to the hospital as an inpatient.

The proposed rule, Medicare Program; Part B Inpatient Billing in Hospitals (CMS-1455-P), proposes that if the beneficiary is enrolled in Part B, Medicare would pay for all reasonable and necessary Part B hospital inpatient services when a Part A inpatient admission is denied as not reasonable and necessary, instead of just the limited list of Part B inpatient services currently allowed in these circumstances. The "reasonable and necessary" standard is a prerequisite for Medicare coverage in the Social Security Act. The statutory timely filing deadline, under which claims must be filed within 12 months of the date of service, would continue to apply to the Part B inpatient claims.

The Federal Register published the Part B Inpatient Billing in Hospitals Proposed Rule on March 18. The comment period ends on May 17, 2013.

Also on March 13, CMS Acting Administrator Marilyn Tavenner issued an Administrator's Ruling (CMS-1455-R) to address the significant number of pending appeals of Part A hospital inpatient reasonable and necessary denials. The Ruling establishes a standard process for handling pending appeals and billing for the additional Part B inpatient services while the proposed new policy goes through notice and comment rulemaking.

Request for Information on the Use of Clinical Quality Measures Reported Under the PQRS and EHR Incentive Program—Comment Period Ends April 8

CMS has published a Request for Information (CMS-3276-NC) that solicits ways in which an eligible professional (EP) might use the clinical quality measures (CQM) data reported to specialty boards, specialty societies, regional health care quality organizations or other non-federal reporting programs to also report under the Physician Quality Reporting System (PQRS), as well as the Electronic Health Record (EHR) Incentive Program. It solicits ways by which the entities already collecting CQM data for other reporting programs can submit this data on behalf of EPs and group practices for reporting under the PQRS and the EHR Incentive Programs. It also requests information regarding section 601(b) of the American Taxpayer Relief Act of 2012 to allow EPs to be treated as satisfactorily submitting data on quality measures for covered professional services if the EP satisfactorily participates in a qualified clinical data registry. The deadline to receive comments is April 8, 2013. A link to the Request for Information is also available on the PQRS web page under "Related Links."

CMS to Release a Comparative Billing Report on Evaluation and Management Services — Target Release March 22

On March 22, 2013, CMS will release a national provider Comparative Billing Report (CBR) addressing Evaluation and Management Services.

CBRs produced by SafeGuard Services under contract with CMS, contain actual data-driven tables and

graphs with an explanation of findings that compare providers' billing and payment patterns to those of their peers located in the state and across the nation.

These reports are only available to the providers who receive them. To ensure privacy, CMS presents only summary billing information. No patient or case-specific data is included. These reports are an example of a tool that helps providers better understand applicable Medicare billing rules and improve the level of care they furnish to their Medicare patients. CMS has received feedback from a number of providers that this kind of data is very helpful to them and encouraged us to produce more CBRs and make them available to providers.

For more information and to review a sample of the Evaluation and Management Services CBR, please visit the CBR Services website or call the SafeGuard Services' Provider Help Desk, CBR Support Team at 530-896-7080.

NQF #0209 Deadline for the Hospice Quality Reporting Program is April 1
Deadline quickly approaching to avoid 2 percentage point reduction to APU for FY 2014

Hospice providers that have not already begun entering their NQF #0209 data for the Payment Year 2014 cycle should begin doing so immediately. Providers must enter and attest to their data on the data entry website no later than 11:59pm ET on April 1, 2013 in order to comply with NQF #0209 requirements. In order to avoid a 2 percentage point reduction in Annual Payment Update (APU) for FY 2014, providers must have submitted data for *both* the structural measure and the NQF #0209 measure by the specified deadlines: January 31, 2013 for the structural measure and April 1, 2013 for the NQF #0209 measure.

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. The link to the data entry site, along with a Technical User Guide giving step-by-step instructions on the data entry process, can be found on the Data Submission portion of the CMS HQRP website.

Hospice providers that anticipate needing a deactivation request for their HQRP user account should submit their account deactivation request to the Technical Help Desk via fax at 888-477-7871 or email at help@QTSO.com prior to March 25, 2013. Any deactivation requests received on or after March 25 puts a hospice organization at risk for missing the April 1 NQF #0209 deadline. *Please note: all data submitted by a user who is deactivated is permanently deleted.*

ICD-10 News: Updated Implementation Guides

CMS has released updated ICD-10 Implementation Guides for small and medium practice providers, large practice providers, small hospitals, and payers. These guides are step-by-step resources for providers and payers looking for help with their ICD-10 transition. They are available on the CMS website along with other materials for providers and payers.

The ICD-10 Implementation Guides provide a complete overview of the importance of ICD-10 and how to prepare for the transition to the new codes. The transition process is broken down into phases: planning, communication and awareness, assessment, implementation, testing, and transition. Each phase is described in detail and includes steps tailored to your practice or organization type. No matter where you are in the transition process, the guides will give you the information and tools you need to make sure you're prepared for ICD-10.

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

January Quarterly Inpatient Provider Specific File for the Prospective Payment System Available

The January 2013 Inpatient Provider Specific File (PSF) has been updated with corrected rural core based statistical area (CBSA) values and other default values and is now available for download from the CMS website in text format. The file contains information about the facts specific to the inpatient provider that affect computations for the Prospective Payment System. The text data file is available on the Provider Specific Data for Public Use in Text Format web page in two versions. One version contains the provider records that were submitted to CMS. The other version also includes name and address information for providers at the end of the records.

"Update on the Medicare Hospice Quality Reporting Program (HQRP)" MLN Matters® Article — Released

MLN Matters® Special Edition Article #SE1306, "Update on the Medicare Hospice Quality Reporting Program (HQRP)" has been released and is now available in downloadable format. This article is designed to provide an educational update on the hospice quality data reporting program and outlines the requirements for the first and second year of reporting for hospice providers. It also provides information on resources available on the Hospice Quality Reporting Program website.

From the MLN: Updated DMEPOS Competitive Bidding Fact Sheets for Round 2

Stay informed. CMS has updated the following three fact sheets for Round 2:

- "The DMEPOS Competitive Bidding Program Billing Procedures for Upgrades" Fact Sheet (ICN 900983) was revised and is now available in downloadable format. This fact sheet is designed to provide education on DMEPOS Competitive Bidding Program procedures. It includes helpful information on the Competitive Bidding Program rules that apply when a beneficiary wants to obtain an upgrade that is an item or a component of an item that exceeds the beneficiary's medical need. It also includes information on which DMEPOS suppliers can provide the item, how the item will be paid, beneficiary liability, and the Advance Beneficiary Notice (ABN) requirements.
- "The DMEPOS Competitive Bidding Program Repairs and Replacements" Fact Sheet (ICN 905282) was revised and is now available in downloadable format. This fact sheet is designed to provide education on repairs and replacements under the DMEPOS competitive bidding program. It includes information on which items and services can be provided by contract versus non-contract suppliers.
- The "DMEPOS Competitive Bidding Program Enteral Nutrition" Fact Sheet (ICN 901005) was revised and is now available in downloadable format. This fact sheet is designed to provide education on requirements for providing enteral nutrition therapy under the DMEPOS competitive bidding program. It also includes information on payment rules.

From the MLN: "The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Provider and Supplier Organizations" Fact Sheet — Revised

"The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Provider and Supplier Organizations" Fact Sheet (ICN 903767) has been revised and is now available in downloadable format. This fact sheet is designed to provide education on how provider and supplier organizations should enroll in the Medicare Program and maintain their enrollment information using Internet-based PECOS. It includes information on how to complete an enrollment application using Internet-based PECOS and a list of frequently asked questions and resources.

From the MLN: "The Basics of Medicare Enrollment for Physicians Who Infrequently Receive Medicare Reimbursement" Fact Sheet — Revised

The Basics of Medicare Enrollment for Physicians Who Infrequently Receive Medicare Reimbursement Fact Sheet (ICN 006881) was revised and is now available in downloadable format. This fact sheet is designed to provide education on general Medicare enrollment information for those physicians who are required to enroll in Medicare for the sole purpose of certifying or ordering services for Medicare beneficiaries. It includes information on frequently asked questions and resources.

From the MLN: "Medicare Billing: 837I and Form CMS-1450" Fact Sheet — Revised

The "Medicare Billing: 837I and Form CMS-1450" Fact Sheet (ICN 006926) was revised and is now available in downloadable format. This fact sheet is designed to provide education for institutional providers as well as other health care professionals and suppliers who transmit health care claims electronically and by using paper claim forms. It includes information about Medicare claims submissions, coding, submitting accurate claims, when Medicare will accept a hard copy claim form, and timely filing.

From the MLN: Pilot Testers Needed

Are you interested in pilot testing or reviewing products for the Medicare Learning Network®? We can always use more volunteers! Please email CMSCE@cms.hhs.gov with your name, provider type, and e-mail address to be included in our database. Thank you.

New MLN Educational Web Guides Fast Fact

A new fast fact is now available on the MLN Educational Web Guides web page. This web page provides information on Evaluation and Management services; Guided Pathways that contain resources and topics of interest; lists of health care management products; and easy-to-understand billing and coding educational products. It is designed to provide educational and informational resources related to certain Medicare FFS initiatives. Please bookmark this page and check back often as a new fast fact is added each month.

New MLN Provider Compliance Fast Fact

A new fast fact is now available on the MLN Provider Compliance web page. This web page provides the latest MLN Education Products and MLN Matters® Articles designed to help Medicare FFS providers understand common billing errors and avoid improper payments. Please bookmark this page and check back often as a new fast fact is added each month.

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.