CMS Medicare FFS Provider e-News

Brought to you by the Medicare Learning Network®

Make a New Year's resolution to join CMS in making sure Medicare beneficiaries are taking full advantage of the preventive health services available to them. Read all about it in 2013 Resolutions – Help Your Patients Live a Healthier Life in 2013.

Again, wishing everyone a very Happy New Year!

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National Provider Call: Implementation of Section 3133 of the Affordable Care Act: Improvement to

Medicare DSH Payments — Last Chance to Register [↑]
Tuesday, January 8; 1:30-3:30pm ET

CMS will host a National Provider Call on "Implementation of Section 3133 of the Affordable Care Act: Improvement to Medicare Disproportionate Share Hospital (DSH) Payments." This presentation will cover a review of Medicare DSH payment methodology under Section 3133 of the Affordable Care Act, which is effective in fiscal year 2014. CMS commissioned Dobson DaVanzo & Associates, LLC and KNG Health Consulting, LLC to provide technical assistance. They will present findings of their analyses identifying possible data sources and definitions for measuring the change in uninsured and uncompensated care. Participants will also have an opportunity to provide comments.

Agenda:

- Review of Section 3133
- Analytic Methods
- Uninsured Definitions and Data Sources
- Uncompensated Care Definitions and Data Sources
- Conclusions
- Next Steps
- Discussion: Public Comments

Target Audience: 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 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: Meaningful Use: Stage 1 and Stage 2 — Registration Now Open [↑]
Wednesday, January 16; 2-3:30pm ET

On Thursday August 23, 2012, CMS announced the final rule for Stage 2 requirements and other changes to the Medicare and Medicaid EHR Incentive Programs. This National Provider Call will provide an overview of the final rule. Learn what you need to do to receive EHR incentive payments.

Agenda:

- Extension of Stage 1
- Changes to Stage 1 Criteria for Meaningful Use
- Medicaid policies
- Stage 2 Meaningful Use Overview
- Stage 2 Clinical Quality Measures
- Medicare Payment Adjustments and Exceptions
- Question and Answers about the incentive Programs

Target Audience: Hospitals, Critical Access Hospitals (CAHs), and professionals eligible for the Medicare and/or Medicaid EHR Incentive Programs. For more details: Eligibility Requirements for Professionals and Eligibility Requirements for Hospitals

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National Provider Call: CMS National Partnership to Improve Dementia Care in Nursing Homes — Registration Now Open [↑]
Thursday, January 31; 1:30-3pm ET

CMS has developed a national partnership to improve the quality of care provided to individuals with dementia living in nursing homes. This partnership is focused on delivering health care that is person-centered, comprehensive and interdisciplinary. By improving dementia care through the use of individualized, person-centered care approaches, CMS hopes to reduce the use of unnecessary antipsychotic medications in nursing homes and eventually other care settings as well. The partnership promotes a systematic process to evaluate each person and identify approaches that are most likely to benefit that individual. While antipsychotic medications are the initial focus of the partnership, CMS recognizes that attention to other potentially harmful medications is also an important part of this initiative.

During this National Provider Call, CMS subject matter experts will discuss the mission of the national partnership, its goals, quality measures, and ongoing outreach efforts. A question and answer session will follow the presentation.

Agenda:

- Welcome and Opening Comments
- National Partnership Mission
  - Goals for 2012 and Beyond
  - The Three R's: Rethink, Reconnect, Restore
  - Multidimensional Approach: public reporting; partnership and state-based coalitions; research; training for providers and surveyors; revised surveyor guidance
- Next Steps:
  - Ongoing Outreach
  - Measurement
- Questions and Answers

Target Audience: Consumer and advocacy groups, nursing home providers, surveyor community, prescribers, professional associations, and other interested stakeholders

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2013 Resolutions – Help Your Patients Live a Healthier Life in 2013 [↑]

The New Year is quickly approaching, and the turn of the calendar typically marks another arbitrary date when many people promise to change and make improvements in their health. Relatively few people, however, actually stick to their resolutions and accomplish their goals.

CMS Needs Your Help
Now is the perfect time to remind your patients that Medicare covers a broad range of preventive services and screenings that can help beneficiaries prevent, detect, or manage their illness and disease and promote a healthy lifestyle.

Preventive Services and Screenings Covered by Medicare:

- Abdominal Aortic Aneurysm Screening
- Alcohol Misuse Screening and Behavioral Counseling Interventions in Primary Care
- Annual Wellness Visit
- Bone Mass Measurements
- Mammograms
- Cardiovascular Disease Screening
- Cervical and Vaginal Cancer Screenings
    - Pap Test
    - Pelvic Exam (includes clinical breast exam)
- Colorectal Cancer Screenings
    - Screening Fecal Occult Blood Test
    - Screening Flexible Sigmoidoscopy
    - Screening Colonoscopy
    - Screening Barium Enema
- Diabetes Screening
- Diabetes Self-Management Training
- Glaucoma Screening
- Human Immunodeficiency Virus (HIV) Screening
- Immunizations (Seasonal flu, pneumococcal, and hepatitis B)
- Initial Preventive Physical Examination (IPPE) (also commonly referred to as the "Welcome to Medicare" Preventive Visit)
- Intensive Behavioral Therapy for Cardiovascular Disease
- Intensive Behavioral Therapy for Obesity
- Medical Nutrition Therapy (for beneficiaries with diabetes or renal disease)
- Prostate Cancer Screening (PSA blood test and Digital Rectal Exam)
- Screening for Depression in Adults
- Screening for Sexually Transmitted Infections (STIs) and High-Intensity Behavioral Counseling (HIBC) to prevent STIs

- Tobacco-Use Cessation Counseling

Schedule Your Eligible Medicare Patients for an Annual Wellness Visit Today
This visit presents an excellent opportunity for you to talk with your Medicare patients about their health and recommend preventive services and screenings they should take advantage of. Remember to provide the appropriate documentation for your recommendations and don't forget to follow-up with patients on all screening results.

For More Information, Visit:

- The 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.

Flu Season is Here [↑]

Flu season is here but it is not too late to protect your patients against the flu. The Centers for Disease Control and Prevention (CDC) recommends that everyone 6 months of age and older get a yearly flu vaccine. As the occurrence of the flu continues to be reported around the country, remember, every office visit is an opportunity to check your patients' vaccination status and encourage a yearly flu vaccine for those that have not yet taken action to protect themselves and their loved ones from the flu. Vaccination is especially important for those at high risk for flu-related complications (please refer to the People at High Risk web page). Additionally, research shows that a strong provider recommendation for yearly flu vaccination increases a patient's willingness to get vaccinated themselves.

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: – the influenza and pneumococcal vaccines and their administration fees are covered Part B benefits. Influenza and pneumococcal vaccines are NOT Part D-covered drugs.

For More Information:

- CMS has posted the 2012-2013 Seasonal Influenza Vaccines Pricing list. You may also refer to the MLN Matters® Article #MM8047, "Influenza Vaccine Payment Allowances - Annual Update for 2012-2013 Season."
- Please visit the CMS Medicare Learning Network® Preventive Services Educational Products and CMS Immunizations web pages for more information on coverage and billing of the flu and pneumococcal vaccines and their administration fees.
- While some providers may offer the flu vaccine, those who don't can help their patients locate a vaccine provider within their local community. The HealthMap Vaccine Finder is a free, online service where users can find nearby locations offering flu vaccines.
- The CDC website offers a variety of provider resources for the 2012-2013 flu season.

CMS Announces 90-Day Period of Enforcement Discretion for Compliance with Eligibility and Claim Status Operating Rules [↑]

On January 2, the CMS Office of E-Health Standards and Services (OESS) announced that to reduce the potential of significant disruption to the health care industry, it will not initiate enforcement action until

March 31, 2013, with respect to Health Insurance Portability & Accountability Act (HIPAA) covered entities (including health plans, health care providers, and clearinghouses, as applicable) that are not in compliance with the operating rules adopted for the following transactions as required by the Affordable Care Act: eligibility for a health plan and health care claim status. Notwithstanding OESS' discretionary application of its enforcement authority, the compliance date for using the operating rules remains January 1, 2013.

Industry feedback suggests that HIPAA covered entities have not reached a threshold whereby a majority of covered entities would be able to be in compliance with the operating rules by January 1, 2013. This enforcement discretion period does not prevent applicable HIPAA covered entities that are prepared to conduct transactions using the adopted operating rules from doing so, and all applicable covered entities are encouraged to determine their readiness to use the operating rules as of January 1, 2013 and expeditiously become compliant. Although enforcement action will not be taken, OESS will accept complaints associated with compliance with the operating rules beginning January 1, 2013. If requested by OESS, covered entities that are the subject of complaints (known as "filed-against entities") must produce evidence of either compliance or a good faith effort to become compliant with the operating rules during the 90-day period. HHS will continue to work to align the requirements under Section 1104 of the Affordable Care Act to optimize industry's ability to achieve timely compliance.

OESS is the HHS component that enforces compliance with HIPAA transaction and code set standards, including operating rules, identifiers and other standards required under HIPAA by the Affordable Care Act.

For copies of the operating rules for the eligibility for a health plan and health care claim status transactions, visit the Council for Affordable Quality Healthcare (CAQH) CORE website. Links to information on the operating rules for eligibility for a health plan and health care claim status are available on the Operating Rules for Eligibility and Claims Status web page.

Simple Steps to Improve Clinical Documentation for ICD-10 [↑]

On October 1, 2014, your practice and the clearinghouses, payers, and billing companies that you work with will need to use ICD-10 codes. One way to help your practice prepare for ICD-10 is to work on improving how you document your clinical services. This will help you and your coding staff become more accustomed to the specific, detailed clinical documentation needed to assign ICD-10 codes.

Take a look at documentation for the most often used codes in your practice, and work with your coding staff to determine if the documentation would be specific and detailed enough to select the best ICD-10 codes. For example, laterality is expanded in ICD-10-CM. Therefore, clinical documentation for diagnoses should include information on which side of the body is affected (i.e., right, left, or bilateral).

Below are additional examples of the specific information needed to accurately code the following common diagnoses:

- Diabetes Mellitus:
    - Type of diabetes
    - Body system affected
    - Complication or manifestation
    - If type 2 diabetes, long-term insulin use
- Fractures:
    - Site
    - Laterality

    - Type
    - Location
- Injuries:
    - External cause – Provide the cause of the injury; when meeting with patients, ask and document "how" the injury happened.
    - Place of occurrence – Document where the patient was when the injury occurred; for example, include if the patient was at home, at work, in the car, etc.
    - Activity code – Describe what the patient was doing at the time of the injury; for example, was he or she playing a sport or using a tool?
    - External cause status – Indicate if the injury was related to military, work, or other.

Remember, ICD-10 will not affect the way you provide patient care. It will just be important to make your documentation as detailed as possible since ICD-10 gives more specific choices for coding diagnoses. This information is likely already being shared by the patient during your visit—it's just a matter of recording it for your coding staff. Good documentation will also help reduce the need to follow-up on submitted claims—saving you time and money.

Keep Up to Date on ICD-10
Visit the CMS ICD-10 website for the latest news and resources to help you prepare.

Listening Sessions on End-to-End Testing for ICD-10 Slated for January [↑]

Beginning in January, National Government Services (NGS), under contract to CMS, will host a series of listening sessions to gather insights and feedback from the health care industry on the best practices and lessons learned from the Version 5010 upgrade.

The upgrade to Version 5010 for electronic transactions pointed to the importance of ample testing, as well as the need for clear, commonly understood definitions of testing, readiness, and compliance. Therefore CMS and NGS will use listening sessions to help:

- Define industry standards for "end-to-end testing," "readiness," and "compliance," to ensure health care organizations are meeting transition criteria, such as completing testing within your organization and successfully testing with external business trading partners before the October 1, 2014, deadline.
- Develop step-by-step guidance for testing implementation of Administrative Simplification initiatives, which aim to standardize data and bring efficiencies to electronic transactions like payment of claims. Such initiatives include the ICD-10 transition and operating rules for electronic funds transfers and remittance advice transactions.

CMS and NGS look forward to receiving insights from:

- Small Providers on January 3 and January 10
- Large Providers on January 3 and January 15
- Vendors on January 8
- Payers on January 8

The NGS contract with CMS also includes a pilot test, using ICD-10 as the business case, to validate a defined universal testing process that can be used throughout the health care industry.
To learn more, please visit the end-to-end testing page on the CMS website.

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

Revised October 2012 Outpatient Prospective Payment System Pricer File Update [↑]

The Outpatient Prospective Payment System (OPPS) Pricer web page has been updated with revised payment files for October 2012. The payment files are available for use and may be downloaded from the OPPS Pricer web page under "4th Quarter 2012 Files."

January 2013 Outpatient Prospective Payment System Pricer File Update [↑]

The Outpatient Prospective Payment System (OPPS) Pricer web page has been updated with revised payment files for January 2013. The payment files are available for use and may be downloaded from the OPPS Pricer web page under "1st Quarter 2013 Files."

New MLN Educational Web Guides Fast Fact [↑]

A new fast fact is now available on MLN Educational Web Guides. 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.

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.