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National Provider Call: Meaningful Use: Stage 1 and Stage 2 — Register Now [↑]

Wednesday, January 16; 2-3:30pm ET

This National Provider Call will provide an overview of the Stage 2 Final Rule and how it affects Stage 1 and Stage 2 of meaningful use and other requirements of the EHR Incentive Programs This call aims to help providers successfully participate in the EHR Incentive Programs and receive an incentive payment.

Agenda:

- Extension of Stage 1
- Changes to Stage 1 Meaningful Use Criteria
- New and Updated 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

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: 2012 PQRS and eRx Incentive Program Data Submission — Save the Date [↑]
Tuesday, January 22; 1:30-3pm ET

CMS will host a National Provider Call on the Physician Quality Reporting System (PQRS) and Electronic Prescribing (eRx) Incentive Program Data Submission. The agenda will include:

- Welcome and Announcements
- 2012 PQRS Data Submission
    - Individual Eligible Professional Registry, EHR Direct and EHR Data Submission Vendor
    - Group Practice Reporting Option (GPRO) Web Interface
- 2012 eRx Incentive Program Data Submission
    - Individual Eligible Professional Registry, EHR Direct and EHR Data Submission Vendor
- PQRS Maintenance of Certification Program
- Resources and Where to Call for Help
- Question and Answer Session

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

National Provider Call: CMS National Partnership to Improve Dementia Care in Nursing Homes — Register Now [↑]

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:
    - o Ongoing Outreach
    - o Measurement
- Questions and Answers

Target Audience: Consumer and advocacy groups, nursing home providers, surveyor community, prescribers, professional associations, and other interested 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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Help Raise Awareness about the Disease that can Take Away Your Patients' Sight — Glaucoma [↑]

The month of January has been designated as National Glaucoma Awareness Month. We ask you to please join CMS in promoting increased awareness of glaucoma and the glaucoma screening service covered by Medicare.

Over 2.2 million people have glaucoma, half of whom do not know they have this disease. Today, 120,000 people are blind from glaucoma in the United States. Anyone over age 60 is at a higher risk for

glaucoma. You can help protect the vision of your patients who may be at high risk for glaucoma. Please educate your Medicare patients about their risk factors and remind them of the importance of getting an annual glaucoma screening exam covered by Medicare. Through early detection and treatment, we can prevent blindness.

Medicare Coverage:

Medicare provides coverage of an annual glaucoma screening for beneficiaries in at least one of the following high risk groups:

- Individuals with diabetes mellitus
- Individuals with a family history of glaucoma
- African-Americans age 50 and older
- Hispanic-Americans age 65 and older

A Medicare-covered glaucoma screening includes a dilated eye examination with an intraocular pressure (IOP) measurement and direct ophthalmoscopy examination or a slit-lamp biomicroscopic examination.

Educational Resources from the MLN include:

- MLN Glaucoma Screening Brochure
- The MLN Preventive Services Educational Products

For More Information, visit:

- National Eye Institute - National Eye Health Education Program

Thank you for joining CMS in promoting awareness of glaucoma and the glaucoma screening services covered by Medicare.

Major Improvements to the Internet-based PECOS System [↑]

Over the last year, CMS has listened to your feedback about Internet-based PECOS and made improvements to increase access to more information. PECOS is easier to use than ever with the following upgrades that are now available:

- Providers/suppliers now have an easier way to view their enrollment information. PECOS will display the following information:
    - View Approved Enrollment Record – displays the provider/supplier's finalized enrollment information in PECOS,
    - View Submitted Application – displays the provider/supplier's enrollment information pertaining to the last electronic submission, and
    - View New or In-Progress Applications – displays the provider/supplier's enrollment information as its being edited in PECOS

  The provider/supplier can access the enrollment information from the My Enrollments page. The information will display in an HTML view and can be saved and/or printed by the provider/supplier. *Note:* The CMS-855 PDF forms are no longer available and have been replaced with the new HTML views.
- The enrollment tutorial videos, located on the PECOS home page, have been updated to illustrate the most common enrollment scenarios completed by providers/suppliers.
- A new part B provider service has been established for Centralized Flu Billers. In addition, the Centralized Flu Biller Approval letter has been added as a type of Required/Supporting documentation for a CMS 855B enrollment. Centralized Flu Biller enrollments submitted via PECOS will be routed to Novitas Solutions, the designated Medicare Administrative Contractor

(MAC) responsible for enrolling this provider service.

- A new "Durable Medical Equipment (DME) License Information" topic has been added to PECOS. This topic will display the DME license information currently on file for existing suppliers. The information is viewable only and cannot be edited or deleted by the supplier.
  New applications will not display the DME License Information topic.
- The Reassignment Report can now be found under the "View" button on the My Enrollments page in PECOS. The report displays the following information:
  - Provider Name,
  - National Provider identifier (NPI),
  - Current Enrollment Status,
  - Enrollment State,
  - Revalidation Notice Sent Date, and
  - Revalidation Status

  The report displays up to 50 records on the report screen. For reassignment reports containing more than 50 records, the authorized user will be prompted to download the report into an excel spreadsheet by clicking the Generate Report button at the bottom of the screen.

To access internet-based PECOS, go to the PECOS website.

2013 Self-Nomination/Registration for PQRS Group Practice Reporting Option [↑]

Medical group practices comprised of 2 or more eligible professionals can participate in the 2013 Physician Quality Reporting System (PQRS) Group Practice Reporting Option (GPRO) to potentially earn an incentive payment of 0.5% and avoid a negative payment adjustment of -1.0% on Medicare Part B Physician Fee Schedule (PFS) services. CMS defines a group as a single taxpayer identification number (TIN). In order to participate in PQRS – at the group level – an authorized group representative must sign the group up and select one of three group reporting mechanisms:

- the GPRO Web Interface (only for groups with 25 or more eligible professionals),
- a qualified registry, or
- CMS-calculated administrative claims (only for avoiding negative payment adjustments).

New federal regulations require that medical practice groups comprised of 100 or more eligible professionals (as of October 15, 2013) will be subject to the value-based payment modifier based on performance in 2013. Groups of this size that fail to self-nominate/register for PQRS – as a group – will see a 1% negative impact on all physician payment under the Medicare PFS in calendar year 2015. Groups meeting the size threshold must sign-up as a group during one of two sign-up periods to participate in the 2013 PQRS. The first opportunity for group practices to sign-up ends on January 31, 2013. There will be a second opportunity to sign-up July 15, 2013 through October 15, 2013.

First Self-Nomination/Registration Period: (December 1, 2012 – January 31, 2013)

During the December 1, 2012 through January 31, 2013 timeframe, group practices will be able to self-nominate/register and select the GPRO Web Interface or a registry reporting mechanism *only*. Unlike previous program years, group practices will not be able to opt-out of reporting at the group level once they have self-nominated/registered; but groups will be able to change their group reporting mechanism until October 15, 2013.

Groups wishing to participate in the 2013 Electronic Prescribing (eRx) GPRO must self-nominate/register during the December 1, 2012 through January 31, 2013 timeframe. Groups choosing to participate *only* in eRX cannot self-nominate/register online. These groups should email PQRS at Vetting@mathematica-

mpr.com.

Steps for 2013 PQRS GPRO Self-Nomination/Registration Period (December 1, 2012 – January 31, 2013):

1. Sign-in to the Physician and Other Health Professionals Quality Reporting Portal with an Individuals Authorized Access to CMS Computer Services (IACS) account. If you do not have an IACS account you will be able to register for one from the same page.
2. Once you are signed into the Portal, click the "Create Self Nomination Request" link located on the left side of the web page. This will take you to the self-nomination screens on the Communication Support Page.
3. Select "Group Practice Reporting Option {Group Practice}" as the requestor type and hit "submit." Fill out the required fields on the screens that follow. See the user manual for additional information or click the Help icon.

Resources:

- For all PQRS/eRx program related questions and/or help with IACS, contact The QualityNet Help Desk at 866-288-8912 or qnetsupport@sdps.org. The help desk is available Monday through Friday from 7am through 7pm CT.
- Additional information about 2013 PQRS GPRO self-nomination/registration and requirements is located on the PQRS Group Practice Reporting Option web page.
- Additional information about the value-based payment modifier is located on the Value-Based Payment Modifier web page.

CMS will begin accepting PMD Prior Authorization requests through esMD [↑]

Durable Medical Equipment Medicare Administrative Contractors (DME MACs) in Jurisdictions C and D began accepting Power Mobility Devices (PMD) Prior Authorization requests through the CMS Electronic Submission of Medical Documentation (esMD) gateway on January 7, 2013. The DME MAC in Jurisdiction A began accepting PMD Prior Authorization requests through esMD on January 9, 2013. CMS anticipates that the DME MAC in Jurisdiction B will begin accepting esMD transactions in winter 2013. To view a list of Health Information Handlers (HIHs) that offer these services visit the esMD website.

In addition, CMS and the DME MACs have drafted some detailed review results statements for Power Mobility Devices (PMD). These review results statements are currently available for public view on the Prior Authorization Demonstration website under Proposed Reason Statements in the "Downloads" section. We are currently accepting feedback regarding these review reason statements. All comments can be sent to reasonstatements@cms.hhs.gov . Follow us on Twitter @CMSGov look for #CMS_esMD for all esMD updates.

Hospice Quality Reporting Program Data Entry Site Now Available [↑]

The data entry site for Hospice Quality Reporting Program (HQRP) data submission is live and active for provider use. The link to the data entry site is available on the Data Submission portion of the CMS HQRP website under "Related Links."

- Prior to Registering: *Urgent* Hospice Registration Information:
  It is *imperative* that prior to registering for a user account to enter quality data for your hospice, users review the Technical User Guide for Hospice Quality Reporting Data Entry and Submission located on the CMS Hospice Quality Reporting Data Submission web page. This guide provides step by step instruction on registration, data entry, and submission of hospice quality reporting data. Also available is the Hospice Quality Reporting Program Data Entry and Submission WebEx

recording. The recording is available on the Hospice Training page of the QTSO website.

- Registration: Visit the data entry website and create an account:
  Hospice organizations will only be allowed one user account per CMS Certification Number (CCN).
  - *If you do not intend to complete the tasks of registration, data entry, attestation and submission for a specific hospice provider please do not register for an account.*
- After Registering:
  After Registering *if the Hospice Registration Activation E-mail has not been received:*
  If you have registered for a user account to enter quality data for your hospice and have not received an e-mail from hospice.quality.report@GDIT.com to activate your account, please take *the following steps:*
  - If you have more than one e-mail address, check all your email accounts in case you registered with a different account.
  - If no account has the activation e-mail, take the following steps for each account.
    - Check all your Mail folders, not just your inbox.
    - Look in any folders marked Junk or Spam for an e-mail from hospice.quality.report@GDIT.com.
    - If you do not have access to a Junk or Spam folder, check with your e-mail technical support staff to see if your mail server may have trapped the e-mail.
  - If you are unable to locate the e-mail, contact the QIES Help Desk at help@qtso.com for a Deactivation Form.
  - Once you receive the Deactivation Form, fill it out completely and return it to the address on the form. Your registration attempt will be removed and you will be notified when you can register once again. We strongly recommend you use a different e-mail address for the new registration.
- Data Entry:
  Enter Data for the required measures.
- Attestation:
  Attest to and submit data to CMS through the data entry website.
  - Data for the structural measure must be attested to and submitted to CMS no later than January 31, 2013. Data for the NQF #0209 Pain Measure must be attested to and submitted to CMS no later than April 1, 2013.

EHR Incentive Programs: Hospitals and Vendors Encouraged to Respond to RFI on E-Reporting via QRDA [↑]

CMS seeks comments from hospitals, EHR vendors, and other interested parties on a new request for information (RFI) posted on the Federal Register.

Responders are encouraged to provide feedback on their readiness to electronically report patient-level data using Quality Reporting Document Architecture (QRDA) Level 1, starting with CY 2014 discharges.

Aligning CMS Programs to Reduce Provider Burden

CMS wants to increase efficiency and reduce the burden for providers to collect and submit clinical quality measures (CQMs). The responses to this RFI will advise CMS about hospitals' readiness to align quality measurement and reporting, specifically through integration of Hospital Inpatient Quality Reporting (IQR) Program's requirements with hospital CQM reporting requirements using certified EHR technology (CEHRT).

CMS intends to align quality measurement and reporting among CMS programs to streamline CMS reporting programs, increase utilization, and support quality care improvement, among other benefits.

Deadline for Comments
Comments are due by *5pm ET on January 22, 2013*. The notice includes details on how to properly submit comments.

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.

Get Paid for 2012: Medicare EPs Must Attest by February 28 for the EHR Incentive Program [↑]

Eligible professionals (EPs) who participated in the Medicare Electronic Health Record (EHR) Incentive Program in 2012 must 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.

CMS encourages Medicare EPs to register and attest as soon as possible to resolve any potential issues that may delay their payment.

Medicaid EPs should check with their State for their attestation deadline.

Resources from CMS
CMS has several resources located on the EHR Incentive Programs website to help EPs properly meet meaningful use and attest, including:

- A Registration & Attestation web page that includes information on registration and attestation, and links to additional resources.
- The Meaningful Use Attestation Calculator, which allows EPs and eligible hospitals to determine if they have met the Stage 1 meaningful use guidelines before they attest in the system.
- The Attestation User Guide for Medicare Eligible Professionals, providing step-by-step guidance for EPs participating in the Medicare EHR Incentive Program on navigating the attestation system.
- The Attestation Worksheet for Eligible Professionals, allowing users to enter their meaningful use measure values, creating a quick reference tool to use while attesting.

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.

Read New and Updated FAQs about the EHR Incentive Programs [↑]

To keep you updated with information on the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, CMS has recently added eight new and three updated FAQs to the website.

New FAQs:

- Can EPs who are not anesthesiologists, pathologists and radiologists apply for the exception for lack of face to face patient interaction and lack of need for follow-up? Read the answer here.
- Does the inclusion of certified Medical Assistant in the list of professionals who can enter orders into the EHR using CPOE and have them count in the numerator? Read the answer here.

- If I am participating in the Medicaid EHR Incentive Program but also provide care to Medicare patients, am I subject to the Medicare payment adjustments? Read the answer here.
- To meet the third measure of the objective of providing "a summary of care record for each transition of care or referral"… Read the answer here.
- What are the specific medical specialty codes associated with anesthesiology, radiology and pathology for the specialty-based determination for the granting of a hardship exception… Read the answer here.
- For the Medicare EHR Incentive Program, how are incentive payments determined for EPs practicing in a Health Professional Shortage Area (HPSA)? Read the answer here.
- If multiple EPs contribute information to a shared portal or to a patient's online personal health record (PHR), how is it counted for meaningful use… Read the answer here.
- If I participated in the Medicaid EHR Incentive Program last year, am I required to participate in the following year? Read the answer here.

Updated FAQs:

- If an EP sees a patient in a setting that does not have certified EHR technology (CEHRT) but enters all of the patient's information into CEHRT at another practice location…Read the answer here.
- For EPs who see patients in both inpatient and outpatient settings (e.g., hospital and clinic), and where CEHRT is available at each location, should these EPs base their denominators …Read the answer here.
- How should EPs select menu objectives for the Medicare and Medicaid EHR Incentive Programs? Read the answer here.

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.

Looking Back at Version 5010 and Ahead to ICD-10 [↑]

Last year all practices covered by HIPAA were required to upgrade from Version 4010 to Version 5010 standards for electronic health care claims and other transactions.
The Version 5010 upgrade paved the way for ICD-10 and offers valuable insights:

1. Early planning and preparation will smooth your transition to ICD-10. Practices that planned for the Version 5010 upgrade were well prepared and transitioned smoothly. For ICD-10, your office can start planning by developing a checklist of activities that will need to be completed and a timeline for accomplishing these tasks.
2. Communication and coordination must occur not only in your office, but also between your practice and the trading partners you conduct business with – software vendors, clearinghouses and billing companies, commercial and government health plans and other payers.
3. Risk mitigation is important to address any disruptions that may occur as your practice transitions to ICD-10. You may want to consider planning for possible short-term cash flow disruptions and for securing the services of billing companies or clearinghouses.
4. Testing will need to be conducted within your office and with all payers and other companies you work with. You will need to begin ICD-10 testing in 2013 to allow for ample time to test multiple types of transactions, including claims. Share your ICD-10 plans with one another now to ensure you are on track to test at the same time.

If you conduct electronic transactions and have not made the upgrade to Version 5010 standards, get a compliance plan in place right away.

You must use Version 5010 standards before your practice management or billing system can accommodate the structure of ICD-10 codes.

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

Information Regarding CY2013 Ambulatory Surgical Center Claims [↑]

The *American Taxpayer Relief Act of 2012*, enacted on January 2, 2013, provides for a zero percent update to the CY 2013 Medicare Physician Fee Schedule (MPFS) through December 31, 2013. Many Ambulatory Surgical Center (ASC) payment rates under the ASC payment system are established using payment rate information in the MPFS. In compliance with the *American Taxpayer Relief Act of 2012*, CMS released revised ASC payment files to contractors on January 4, 2013. Contractors will begin processing ASC claims that are submitted on or about January 22, 2013 with the new ASC payment files. At that time, the revised ASC payment rates will also be made available on the contractors' websites.

Contractors shall identify and adjust ASC claims with dates of service January 1, 2013, and later that were processed with the incorrect payment files no later than January 29, 2013.

No action is required on the part of ASCs to affect this process.

Home Health Claims Selected for Review with Dates of Service October 1, 2011 through December 31, 2012 [↑]

CMS issued V3210 and V3312 of the Home Health Prospective Payment System (HH PPS) Grouper effective for dates of service October 1, 2011 and later. V3210 and V3312 did not award points for basal and squamous cell carcinoma for home health services. CMS has reexamined the decision to only award points to code category "173" codes containing a 5th digit of 9. In V3413, CMS has added basal, squamous and unspecified malignant cancers retroactive to October 1, 2011. Effective, January 1, 2013 for dates on or after October 1, 2011, the HH PPS Grouper will award points for the entire 173 code category.

Home Health agencies may want to review any claims with dates of service submitted from October 1, 2011 through December 31, 2012 to make a business decision as to whether or not to adjust the claim based upon a different Health Insurance Prospective Payment System (HIPPS) score determination made by V3413 of the HH PPS Grouper.

Regional Home Health Intermediaries (RHHIs) have received technical direction from CMS that provides the necessary information for their use in reviewing home health claims with a date of service between October 1, 2011 and December 31, 2012 that contain a diagnosis for basal or squamous cell skin cancer.

Administrative error exceptions will apply to the timely filing limit to claims adjustments received up to

one month following the date a provider is notified of this correction. Timely filing exceptions will apply to adjustments to HH PPS episode claims with statement covers "From" dates between October 1, 2011 and a year before the date the provider education is released.

From the MLN: "Phase 2 of Ordering/Referring Requirement" Podcast — Released [↑]

The "Phase 2 of Ordering/Referring Requirement" Podcast (ICN 908324) was released and is now available in downloadable format. This podcast is designed to provide education on the documentation required for ordered or referred services for Medicare beneficiaries. It includes information on the categories of physician and non-physician practitioners and the impact to providers.

From the MLN: "Telehealth Services" Fact Sheet — Revised [↑]

The "Telehealth Services" Fact Sheet (ICN 901705) was revised and is now available in downloadable format. This fact sheet is designed to provide education on services furnished to eligible Medicare beneficiaries via a telecommunications system. It includes information about originating sites, distant site practitioners, telehealth services, billing and payment for professional services furnished via telehealth, and billing and payment for the originating site facility fee.

From the MLN: "Medicare Vision Services" Fact Sheet — Revised [↑]

The "Medicare Vision Services" Fact Sheet (ICN 907165) was revised and is now available in downloadable format. This fact sheet is designed to provide education on Medicare coverage and billing information for vision services. It includes specific information concerning coding requirements and an overview of coverage guidelines and exclusions.

From the MLN: "The Basics of Medicare Enrollment for Physicians Who Infrequently Receive Medicare Reimbursement" Fact Sheet — Reminder [↑]

"The Basics of Medicare Enrollment for Physicians Who Infrequently Receive Medicare Reimbursement" Fact Sheet (ICN 006881) 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.