CMS Medicare FFS Provider e-News

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National Provider Call: PQRS Group Practice Reporting Option and Registry Reporting — Register Now

Tuesday, April 16; 1:30-3pm ET

Register now for the upcoming CMS National Provider Call (NPC) on the 2013 Physician Quality Reporting System (PQRS) and Electronic Prescribing (eRx) claims-based reporting. This NPC will provide

an overview to eligible professionals on reporting requirements and criteria for satisfactorily reporting for Group Practice Reporting Option (GPRO) and Registry Reporting. The presentation will include how to participate, how to report through a registry, tips for successful participation, and information about the 2013 PQRS group option for reporting data through registries for purposes of earning the 2013 PQRS incentive payment and avoiding the 2015 PQRS payment adjustment. A question and answer session will follow the presentation.

Agenda:

- Announcements
- Overview on the 2013 PQRS GPRO and Registry Reporting
- Question & 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 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: Begin Transitioning to ICD-10 in 2013 — Register Now
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.

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National Provider Calls: Medicare Shared Savings Program Application Process: Tips on Completing a Successful Application — Register Now
Tuesday, April 23; 1:30-3pm ET

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 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 will be 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.

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National Provider Call: ESRD Low-Volume Payment Adjustment — Register Now
Wednesday, April 24; 1:30-3pm ET

Does your dialysis facility qualify for Medicare's low-volume payment adjustment (LVPA) available under the End-Stage Renal Disease (ESRD) Prospective Payment System? Please join us for this important call.

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) required CMS to implement a LVPA for services furnished on or after January 1, 2011 to increase the payment rate for facilities that provide a low volume of dialysis treatments. The payment adjustment was intended to offset the higher costs of care that these facilities incur when furnishing dialysis services. In addition, MIPPA also required that the United States Government Accountability Office (GAO) review Medicare claims and report on payment accuracy.

On March 1, the GAO published a report, "CMS Should Improve Design and Strengthen Monitoring of Low-Volume Adjustment." During this National Provider Call, CMS subject matter experts will discuss the GAO report and Medicare's LVPA payment policies, including eligibility requirements and reporting responsibilities. A question and answer session will follow the presentation.

Target Audience: ESRD facilities and 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.

Presentation: The presentation for this call will be 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.

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National Provider Call: Transcript and Audio File from March 13 2013 ESRD Quality Incentive Program - Payment Year 2015 Final Rule Call Now Available

The written transcript and MP3 audio file from the March 13 National Provider Call (NPC), "End-stage Renal Disease Quality Incentive Program - Payment Year 2015 Final Rule" are available on the March 13 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.

National Provider Call: Transcript and Audio File from March 14 HVBP FY 2015 Overview National Provider Call Now Available

The written transcript and MP3 audio file from the March 14 National Provider Call (NPC), "Hospital Value-Based Purchasing Fiscal Year 2015 Overview" are available on the March 14 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.

LTCH Quality Reporting Program Requirements for FY 2014 and 2015
May 15 Deadline for FY 2014 Data Submission

Long-Term Care Hospital (LTCH) providers should currently be engaging in two activities for the LTCH Quality Reporting (LTCHQR) Program: data *submission* for the FY 2014 payment update determination and data *collection* and *submission* for the FY 2015 payment update determination.

FY 2014 Payment Update Determination—Deadline for Data Submission: May 15, 2013

In the FY 2012 IPPS/LTCH PPS Final Rule (76 FR 51743 through 51756, and 51780 through 51781), three measures were adopted for data collection and reporting for October 1 through December 31, 2012 for

the FY 2014 Payment Update Determination:

- Percent of Residents with Pressure Ulcers That Are New or Worsened (NQF #0678)
- Urinary Catheter-Associated Urinary Tract Infection (CAUTI) (NQF #0138)
- Central Line Catheter-Associated Bloodstream Infection (CLABSI) (NQF #0139)

To avoid a 2-percentage-point reduction in their Annual Payment Update, providers must submit data for all three measures *by the May 15, 2013 deadline*. Current definitions for the three LTCH quality measures are available in the LTCHQR Program Manual in the "Downloads" section of the LTCHQR Program website.

The Percent of Residents with Pressure Ulcers That Are New or Worsened (NQF #0678) measure requires use of the LTCH Continuity Assessment Record and Evaluation (CARE) Data Set Version 1.01, approved on April 24, 2012, by the Office of Management and Budget (OMB) in accordance with the Paperwork Reduction Act (PRA). The OMB Control Number is 0938-1163, Expiration Date April 30, 2013. Please note that while the current PRA approval of the LTCH CARE Data set has an expiration date of April 30, 2013, the subsequent version of the data set is currently in the PRA approval process with the OMB; this acts to extend the PRA deadline of April 30, 2013 until the currently submitted PRA package receives approval. Details on the LTCH CARE Data Set technical submission specifications can be found at LTCHQR Program Technical Information web page.

For the submission of data for CAUTI and CLABSI measures, the deadline for enrollment in Centers for Disease Control and Prevention's (CDC's) National Health Safety Network (NHSN) was December 31, 2012. If you have not registered with the NHSN, please visit the NHSN LTCH web page, and contact the NHSN at NHSN@cdc.gov for additional guidance. Frequently asked questions about the NHSN enrollment process are available on the CDC website.

Fiscal Year 2015 Payment Update Determination

In addition to engaging in data *submission* activities for the FY 2014 Payment Update Determination, LTCHs should be engaging in data *collection* and *submission* activities for the FY 2015 Payment Update Determination. Per the FY 2013 IPPS/LTCH PPS Final Rule (77 FR 53614 through 53637, and 53667 through 53672), data on three measures will be collected from January 1 through December 31, 2013:

- Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (NQF #0678)
- NHSN CAUTI Outcome Measure (NQF #0138)
- NHSN CLABSI Outcome Measure (NQF #0139),

For the four quarters in CY 2013 (i.e., January through March 2013, April through June 2013, July through September 2013, and October through December 2013), the final deadlines for data submission are August 15, 2013, November 15, 2013, February 15, 2014, and May 15, 2014, respectively for FY 2015 Payment Update Determination.

LTCH CARE Data Set Technical Submission Specification Changes Effective April 21, 2013

A change has been made to the LTCH data submission specifications scheduled to take effect on April 21, 2013. An errata document for V1.00.3 of the data submission specifications is posted in the "Downloads" section of the under the Downloads section of the LTCHQR Program Technical Information web page.

CDC Message to Health Care Providers: Ordering Flu Vaccine for 2013-2014

The 2013-2014 influenza vaccine can be ordered at this time from manufacturers and distributors. As the 2012-2013 flu season has shown, it is important to pre-book vaccine as soon as it is available. Most of the flu vaccine offered for the 2013-2014 season will be trivalent (three component).

- Trivalent vaccine offers important protection from flu.

- Some quadrivalent (four-component) vaccine will be available as well according to manufacturers; however, supplies are expected to be limited.
- All nasal spray vaccine is expected to be quadrivalent, however, this makes up only a small portion of total vaccine availability.
    - Ordering flu vaccine should not be delayed if quadrivalent flu vaccine is not available.

More information is available on the CDC website.

CMS to Begin Accepting Suggestions for Potential PQRS Measures and Measures Groups in May

In May, CMS will begin accepting quality measure suggestions for potential inclusion in the proposed set of quality measures in the Physician Quality Reporting System (PQRS) for future rule-making years. CMS is seeking a quality set of measures that are outcome-based and fall into one of the National Quality Strategy (NQS) Priorities domains where there are known measure and performance gaps. The measure gaps that CMS most wishes to fill include clinical outcomes, patient-reported outcomes, care coordination, safety, appropriateness, efficiency, and patient experience and engagement.

Measures submitted for consideration will be assessed to ensure that they meet the needs of the Physician Quality Reporting Program. In addition, CMS encourages eligible providers to submit measures that do not have an adequate representation within the program for participation. When submitting measures for consideration, please ensure that your submission is not duplicative of another existing or proposed measure. Each measure submitted for consideration must include all required supporting documentation. Documentation requirements will be posted on the Measures Management System Call for Measures web page on or around May 1, 2013. Only those measures submitted in the provided format will be accepted for consideration.

Suggested measures must address the CMS measure selection core criteria to be considered for inclusion in the PQRS. Measure submissions omitting the required core criteria will be disqualified from consideration.

- Measure addresses an important condition/topic with a performance gap and has a strong scientific evidence base to demonstrate that the measure, when implemented, can lead to the desired outcomes and/or more appropriate costs (i.e., the National Quality Forum's Importance criteria)
- Measure addresses one or more of the six NQS Priorities:
    - Patient Safety
    - Person and Caregiver-Centered Experience and Outcomes
    - Communication and Care Coordination
    - Effective Clinical Care
    - Community/Population Health
    - Efficiency and Cost Reduction
- Promotes alignment with specific program attributes and across CMS and HHS programs
- Program measure set includes consideration for health care disparities
- Measure reporting is feasible

This Call for Measures will run from May 1 through July 1, 2013. All required documentation must be completed for each measure submitted for consideration no later than 5pm ET July 1, 2013.

Note: Suggesting individual measures or measures for a new or existing measures group does not guarantee the measure(s) will be included in the proposed or final sets of measures of any Proposed or Final Rules that address the PQRS. CMS will determine which individual measures and measures group(s) to include in the proposed set of quality measures, and after a period of public comment, the

agency will make the final determination with regard to the final set of quality measures for the PQRS.

What Providers Need to Know about EHR Audits

All eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) attesting to receive an incentive payment for either the Medicare or Medicaid Electronic Health Record (EHR) Incentive Program may be subject to an audit.

Pre- and Post-Payment Audits
CMS and its contractor, Figliozzi and Company, perform audits on Medicare and dually-eligible (Medicare and Medicaid) providers who are participating in the EHR Incentive Programs. States perform audits on Medicaid providers participating in the Medicaid EHR Incentive Program. In addition to the post-payment audits that have been conducted since 2012, CMS began pre-payment audits this year, starting with attestations submitted during and after January 2013.

New Resources to Prepare for Audits
For those providers selected for pre-payment or post-payment audits, CMS and its contractor will request supporting documentation to validate submitted attestation data. To help providers prepare for a potential audit, CMS created the new Supporting Documentation for Audits Fact Sheet. The fact sheet and a sample audit request letter for both EPs and eligible hospitals are also available on the Educational Resources web page of the EHR Incentive Programs website.

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

Read Updated EHR FAQ for Eligible Professionals on Selecting Menu Objectives

CMS had posted an updated FAQ on selecting menu objectives for the Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs. We encourage eligible professionals (EPs) to stay informed by taking a few minutes to review the updated information, including guidance for 2014 and Stage 2.

Question: *How should EPs select menu objectives for the Medicare and Medicaid EHR Incentive Programs?*

Answer: EPs participating in Stage 1 of the EHR Incentive Programs are required to report on a total of 5 meaningful use objectives from the menu set of 10. When selecting five objectives from the menu set, EPs must choose at least one option from the public health menu set. If an EP is able to meet the measure of one of the public health menu objectives but can be excluded from the other, the EP should select and report on the public health menu objective they are able to meet. If an EP can be excluded from both public health menu objectives, the EP should claim an exclusion from only one public health objective and report on four additional menu objectives from outside the public health menu set.

EPs participating in Stage 2 are required to report 3 meaningful use objectives from the menu set of 6.

We encourage EPs to select menu objectives that are relevant to their scope of practice, and claim an exclusion for a menu objective only in cases where there are no remaining menu objectives for which they qualify or if there are no remaining menu objectives that are relevant to their scope of practice. For example, we hope that EPs will report on 5 measures, if there are 5 measures that are relevant to their

scope of practice and for which they can report data, even if they qualify for exclusions in the other objectives.

Starting in 2014 for both Stage 1 and Stage 2, meeting the exclusion criteria will no longer count as reporting a meaningful use objective from the menu set. An EP must meet the measure criteria for 5 objectives in Stage 1 (3 objectives in Stage 2) or report on all of the menu set objectives through a combination of meeting exclusion and meeting the measure.

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

"The Basics of Medicare Enrollment for Institutional Providers" Fact Sheet — Revised

"The Basics of Medicare Enrollment for Institutional Providers" Fact Sheet (ICN 903783) was revised and is now available in downloadable format. This fact sheet is designed to provide education on basic Medicare enrollment information and how to ensure institutional providers are qualified and eligible to enroll in the Medicare Program. It includes information on how to enroll in the Medicare Program, how to report changes, and a list of resources.

"The Basics of Internet-based PECOS for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers" Fact Sheet — Revised

"The Basics of Internet-based PECOS for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers" Fact Sheet (ICN 904283) has been revised and is now available in downloadable format. This fact sheet is designed to provide education on how DMEPOS suppliers should enroll in the Medicare Program and maintain their enrollment information on 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.

"A Physician's Guide to Medicare Part D Medication Therapy Management Programs" Podcast — Released

The "A Physician's Guide to Medicare Part D Medication Therapy Management Programs" Podcast (ICN 903694) was released and is now available in downloadable format. This podcast is designed to provide education on the Medicare Part D Medication Therapy Management Programs. It includes information from MLN Matters® Article #SE1229 titled "A Physician's Guide to Medicare Part D Medication Therapy Management Programs."

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