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National Provider Call: National Physician Payment Transparency Program (OPEN PAYMENTS) - What You Need To Know — Registration Now Open
Wednesday, May 22; 2:30-4pm ET

The National Physician Payment Transparency Program (OPEN PAYMENTS) requires manufacturers of pharmaceuticals or medical devices to publically report payments made to physicians and teaching hospitals, creating greater transparency around the financial relationships that occur among them. This National Provider Call will give an overview of what you need to know about OPEN PAYMENTS.

Agenda:
- Overview of rule
- Review key program dates
- Your role
- Resources available to you

Target Audience: Physicians & Teaching 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 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: Stage 1 of the Medicare & Medicaid EHR Incentive Programs for Eligible Professionals: First in a Series — Save the Date
Thursday May 30; 1:30-3 PM ET

This session will inform individual practitioners on the basics of Stage 1 of the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs. Learn if you are eligible, and if so, what you need to do to earn an incentive. This is the first in a series of 6 National Provider Calls on the Medicare and Medicaid EHR Incentive Programs. Other topics include: Stage 2, clinical quality measures, hardship exceptions, payment adjustments, and a discussion on certification by the Office of the National Coordinator for Health Information Technology.

Target Audience: Professionals eligible for the Medicare and/or Medicaid EHR Incentive Programs. For more details: Eligibility Requirements for Professionals.

Agenda:
- Are you eligible?

- How much are the incentives and how are they calculated?
- How do you get started?
- What are major milestones regarding participation and payment?
- How do you report on meaningful use?
- Where can you find helpful resources?
- Question and Answer Session

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

National Provider Call: Audio Recording and Written Transcript from April 18 "Begin Transitioning to ICD-10 in 2013" Call Now Available

The audio recording and written transcript from the April 18 "Begin Transitioning to ICD-10 in 2013" call are now available on the April 18 call web page in the "Call Materials" section.

Data.Medicare.Gov Get Started Webinar
Thursday May 16; 1- 2:pm ET

In July 2012, CMS announced that in July 2013, the platform for the downloadable data on the Medicare.gov Compare websites (Dialysis Facility Compare, Home Health Compare, Hospital Compare, and Nursing Home Compare) would be Data.Medicare.Gov.

CMS will be hosting a webinar, "Data.Medicare.Gov: Get Started" to:
- Provide an introduction to Data.Medicare.Gov,
- Demonstrate options for accessing the data, and
- Describe how to make use of the site's tools for exploring and interacting with the data.

The webinar is appropriate for both technical and non-technical users of Compare website data, for example, researchers, health care administrators, and quality improvement professionals.

Webinar Registration Information: In order to receive log-in information, you must register for the webinar. Participants are strongly encouraged to register early because space is limited and to dial in 10 minutes early to ensure that you are able to connect and view the presentation.

If you are unable to join, you can:
- View the video recording in the Help section of Data.Medicare.Gov following the event.
- Visit Data.Medicare.Gov before or after the event and click the Help button. There you can find a variety of useful videos and resources to help you use the site.

CMS Proposes Updates to the Wage Index and Payment Rates for the Medicare Hospice Benefit
Hospice Quality Reporting Program (HQRP) requirements for Payment Years 2016 and 2017

On April 29, CMS issued a proposed rule [CMS-1449-P] that would update FY 2014 Medicare payment rates and the wage index for hospices serving Medicare beneficiaries. The proposed hospice payment rule reflects the ongoing efforts of CMS to support beneficiary access to hospice. As proposed, hospices would see an estimated 1.1 percent ($180 million) increase in their payments for fiscal year (FY) 2014. The hospice payment increase would be the net result of a proposed hospice payment update to the

hospice per diem rates of 1.8 percent (a "hospital market basket" increase of 2.5 percent minus 0.7 percentage point for reductions mandated by law), and a 0.7 percent decrease in payments to hospices due to updated wage data and the fifth year of CMS' seven-year phase-out of its wage index budget neutrality adjustment factor (BNAF). The rule proposes that CMS would update the hospice per diem rates for FY 2014 and subsequent years through the annual hospice rule or notice, rather than solely through a Change Request, as has been done in prior years.

Section III(B1-B7) of proposed rule outlines current Hospice Quality Reporting Program (HQRP) requirements and proposes future HQRP requirements for the Payment Year 2016 and Payment Year 2017.

For more information, see the proposed rule and the Fact Sheet.

A Record of Progress on Health Information Technology

In 2009, the Health Information Technology for Economic and Clinical Health (HITECH) Act, a part of the Recovery Act, created the Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs to promote the adoption of EHRs in support of the ultimate goals of improving the quality of patient care and reducing health costs. Through this program, eligible hospitals and doctors earn incentives by demonstrating "meaningful use" of certified technology, which means that health care providers use EHRs in ways that improve care and lower costs. Examples of "meaningful use" include electronic prescribing of medications and ensuring patients have access to their digital records.

Progress to Date:

- Robust Participation in the EHR Incentive Programs:
  - Hospital Participation: More than 85 percent of eligible hospitals are participating in the Medicare and Medicaid EHR Incentive Programs, and more than 75 percent have received incentive payments for meaningfully using EHR technology as of March 2013.
  - Physicians and other Health Care Provider Participation: More than 388,000 of the nation's eligible professionals have registered to participate in the Medicare and Medicaid EHR Incentive Programs, representing 73 percent of all providers eligible to participate. More than 230,000, or 44 percent of all eligible professionals, have received an EHR incentive payment for meaningfully using EHR technology as of March 2013.
  - Assistance from Regional Extension Centers: HITECH funds established 62 Health Information Technology Regional Extension Centers (RECs) to offer technical assistance and guidance that is critical to accelerating the provider adoption and meaningful use of EHRs, particularly in rural areas and other underserved settings.
    - RECs are providing assistance and support to more than 44 percent (130,000) of primary care providers and 48 percent (20,000) of Nurse Practitioners nationwide.
    - More than 80 percent of all Federally Qualified Health Centers are enrolled with a REC.
  - Effect on the Health IT Marketplace: Federal investment and standard setting have helped to create a robust market for eHealth IT products. As of March 2013, there are 941 vendors providing more than 1,700 unique certified EHR products.
- Rapid Adoption of Advanced Technology: Survey data shows that the HITECH Act has dramatically accelerated providers' use of key health IT capabilities nationwide:
  - E-Prescribing: Office-based physicians' use of e-prescribing has increased from 0.8 percent in December 2006 to 53 percent through January 2013, and more than 94 percent of all pharmacies are now actively e-prescribing.
  - Hospitals: between 2008 and 2012, the number of hospitals using EHR systems with

certain advanced functionalities that go even beyond the requirements of Meaningful Use Stage 1 (including physician clinical notes and electronic imaging results) more than quadrupled from 9.4 percent to 44 percent.

- Doctors: Physician adoption of EHR systems with the same advanced functionalities more than doubled between 2008 and 2012, from 17 percent to 40 percent.

Moving Forward

HHS plans to accelerate health information exchange (HIE) development and build a seamless and secure flow of information essential to transforming the health care system in 2013. Steps include:

- Setting aggressive goals for 2013
- Increasing the emphasis on interoperability
- Enhancing the effective use of EHRs through initiatives similar to the Blue Button Initiative
- Implementing Stage 2 of Meaningful Use
- Highlighting program integrity
- Aligning existing Medicare and Medicaid quality measurement programs through the eHealth initiative

For more information, see the Fact Sheet .

CMS Proposes New Safeguards and Incentives to Reduce Medicare Fraud

On April 24, CMS issued a proposed rule that would increase rewards paid to Medicare beneficiaries and others whose tips about suspected fraud lead to the successful recovery of funds to as high as $9.9 million. In addition, a new funding opportunity released this month supports the expansion of Senior Medicare Patrol activities to educate Medicare beneficiaries on how to prevent, detect, and report Medicare fraud, waste, and abuse. The proposed rule would also strengthen certain provider enrollment provisions including allowing CMS to deny enrollment of providers who are affiliated with an entity that has unpaid Medicare debt, deny, or revoke billing privileges for individuals with felony convictions, and revoke privileges for providers and suppliers who are abusing their billing privileges.
These proposed changes will support the administration's comprehensive approach to program integrity, including the work being done with the Health Care Fraud Prevention and Enforcement Action Team, a joint effort between HHS and the Department of Justice to fight health care fraud. This joint effort recovered a record $4.2 billion in taxpayer dollars in fiscal year 2012.

The Fact Sheet summarizes CMS's proposed changes for the Medicare Incentive Reward Program as well as new provider enrollment provisions outlined in the proposed rule.

FAQs Available for Revised and Clarified Place of Service Coding Instructions Effective April 1

"Revised and Clarified Place of Service (POS) Coding Instructions" became effective April 1, 2013. These instructions revised and clarified national policy for POS code assignment and clarified longstanding policy on reporting the service location for a given service code. Since publication, questions have been raised about the general Medicare requirements for billing the global diagnostic service code, the date of service, the POS for pathology and laboratory services, as well as enrollment, Medicare Administrative Contractor (MAC) jurisdiction, and claims processing requirements.

- A compilation of Frequently asked Questions about these issues and the CMS responses are available on the CMS Physician Center web page.
- MLN Matters® Article #7631, "Revised and Clarified Place of Service (POS) Coding Instructions"

has additional information on the April 1 requirement.

June 30 Deadline to Avoid 2014 eRx Payment Adjustment

In CY 2014, a payment adjustment will be applied to an eligible professional's or group practice's (if participating in the Electronic Prescribing (eRx) Group Practice Reporting Option (GPRO)) Medicare Part B Physician Fee Schedule (PFS) covered professional services for not becoming a successful electronic prescriber. The payment adjustment of 2.0% will result in an eligible professional or group practice participating in eRx GPRO receiving 98.0% of their Medicare Part B PFS amount for covered professional services in 2014. Please note that this message only applies to the 2014 eRx payment adjustment. The reporting period to avoid or submit hardship exemptions for the 2012 and 2013 eRx payment adjustments has ended.

Exclusion Criteria
The 2014 eRx payment adjustment only applies to certain individual eligible professionals and group practices. CMS will automatically exclude those individual eligible professionals and group practices who meet the criteria listed in the Electronic Prescribing (eRx) Incentive Program: 2014 Payment Adjustment Fact Sheet.

Avoiding the 2014 eRx Payment Adjustment
Individual eligible professionals and CMS-selected group practices participating in eRx GPRO who were not successful electronic prescribers in 2012 can avoid the 2014 eRx payment adjustment by meeting the specified reporting requirements between January 1 and June 30, 2013. The 6-month reporting requirements to avoid the 2014 payment adjustment are as follows:

- Individual Eligible Professionals – 10 eRx events via claims
- eRx GPRO of 2-24 Eligible Professionals – 75 eRx events via claims
- eRx GPRO of 25-99 Eligible Professionals – 625 eRx events via claims
- eRx GPRO of 100+ Eligible Professionals – 2,500 eRx events via claims

Significant Hardships
CMS may exempt individual eligible professionals and group practices participating in eRx GPRO from the 2014 eRx payment adjustment if it is determined that compliance with the requirements for becoming a successful electronic prescriber would result in a significant hardship. The significant hardship categories are also listed in the Electronic Prescribing (eRx) Incentive Program: 2014 Payment Adjustment Fact Sheet.

Submitting a Significant Hardship Code or Request

To request a significant hardship, individual eligible professionals and group practices participating in eRx GPRO must submit their significant hardship exemption requests through the Quality Reporting Communication Support Page (Communication Support Page) on or between March 1 and June 30, 2013. Please remember that CMS will review these requests on a case-by-case basis. All decisions on significant hardship exemption requests will be final.

Significant hardships associated with a G-code may be submitted via the Communication Support Page *or* on at least one claim during the 2014 eRx payment adjustment 6-month reporting period (January 1 – June 30, 2013). If submitting a significant hardship G-code via claims, it is not necessary to request the same hardship through the Communication Support Page. The hardship exemptions for achieving Meaningful Use or demonstrating intent to participate by registering in the Medicare or Medicaid Electronic Health Record (EHR) Program by June 30, 2013 will be automatically processed by CMS and

therefore will not be entered as a hardship exemption request through the Communication Support Page.

For more information on how to navigate the Communication Support Page, please reference the following documents:

- Quality Reporting Communication Support Page User Guide
- Tips for Using the Quality Reporting Communication Support Page

eRx Payment Adjustment Resources
Additional information and resources are available on the Electronic Prescribing (eRx) Incentive Program: 2014 Payment Adjustment Fact Sheet and the eRx Incentive Program website. If you have questions regarding the eRx Incentive Program, eRx payment adjustments, or need assistance submitting a hardship exemption request, please contact the QualityNet Help Desk at 866-288-8912 (TTY 1-877-715-6222) or via qnetsupport@sdps.org. They are available Monday through Friday from 7am-7pm CT.

National Partnership to Improve Dementia Care in Nursing Homes Working to Reduce Percentage of Long-Stay Residents Receiving Antipsychotic Medication

Encouraging data trends are evident in the National Partnership to Improve Dementia Care in Nursing Homes. Based on a three quarter average, the change in the percentage of long-stay residents receiving an antipsychotic medication on a national level dropped from 23.9% in Quarters 2 through 4 of 2011, to 22.9% in quarters 2 through 4 of 2012.

However, the three quarter average information does not provide the full picture of the most recent changes. The most recent quarter (Q4 2012) indicates that compared to Q4 2011, there has been a 6.45% reduction in the percentage of long-stay residents receiving an antipsychotic medication. Regions and states vary in the percent reductions, and some states and regions have seen a reduction of greater than 10%.

Although the national goal of reducing the percentage of long-stay nursing home residents who receive antipsychotic medications by 15% by the end of 2012 has not been reached, work towards this goal will continue, with the hope of achieving this level of reduction in the near future. For more information on this national initiative, please send correspondence to dnh_behavioralhealth@cms.hhs.gov.

CMS Announces Teaching Hospital Closure and Round 4 of Section 5506 of the Affordable Care Act

On April 26, CMS issued the FY 2014 Inpatient Prospective Payment System (IPPS) proposed rule, which announced Round 4 of Section 5506 of the Affordable Care Act. Section 5506 authorizes CMS to redistribute residency cap slots after a hospital that trained residents in an approved medical residency program(s) closes. Under Round 4, the resident cap slots of Peninsula Hospital Center, in Far Rockaway, NY, are to be redistributed. First priority in redistributing the slots is given to hospitals located in the same or contiguous Core Based Statistical Areas (CBSAs) as the respective closed hospitals. Hard copy applications from hospitals to receive indirect medical education (IME) and direct graduate medical education (GME) full-time equivalent (FTE) resident slots from Peninsula Hospital Center must be received by CMS Central Office, not postmarked, by 5pm ET on July 25, 2013. The "Section 5506 Application Form" and "Guidelines for Submitting Applications Under Section 5506" are located on the Direct Graduate Medical Education web page, along with links to the rules.

Updated EHR FAQs: Information on Sequestration and Guidance on Attestation

CMS has posted two updated FAQs related to the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs. FAQs include information on how EHR incentive payments will be affected by sequestration, as well as guidance on how to successfully attest following an EHR vendor transition. We encourage you to stay informed by taking a few minutes to review these FAQs.

1. *Question:* Will incentive payments earned in the Medicare and Medicaid Electronic Health Records Incentive programs be affected by sequestration?
   Answer: Incentive payments made through the Medicare EHR Incentive Program are subject to the mandatory reductions in federal spending known as sequestration, required by the Budget Control Act of 2011. The American Taxpayer Relief Act of 2012 postponed sequestration for 2 months. As required by law, President Obama issued a sequestration order on March 1, 2013... Read the full answer here.
2. *Question:* For the Medicare and Medicaid EHR Incentive Programs, how should an EP, eligible hospital, or critical access hospital (CAH) attest if the certified EHR vendor being used is switched to another certified EHR vendor in the middle of the program year?
   Answer: If an EP, eligible hospital or CAH switches from one certified EHR vendor to another during the program year, the data collected for the selected menu objectives and quality measures should be combined from both of the EHR systems for attestation. The count of unique patients does not need to be reconciled when combining from the two EHR systems… Read the full answer here.

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.

ICD-10: Assessing Your Vendors

Vendors are key partners who can help you prepare for ICD-10. When considering how your vendor can assist you in your transition to ICD-10, you should first assess your vendor's capabilities:

- Do your current vendor contracts cover your practice's ICD-10-related needs?
- What is the vendor's timeline for the ICD-10 transition?
- Will your vendor install products well before the October 1, 2014, deadline, so you can begin testing them in 2013?
- Has your vendor scheduled with you to test your system with your trading partners?
- Will all your vendor's current products and applications be updated for ICD-10?
- Has your vendor scheduled training for your staff on the ICD-10 system updates?
- Do products give you the ability to search for codes by the ICD-10 alphabetic and tabular indexes? By clinical concept?
- Will the product allow for coding in both ICD-9 and ICD-10 to accommodate transactions with dates of service before October 1, 2014, and transactions with dates of service after October 1, 2014?

Communication During Your Transition
After assessing your vendor's capabilities, continue to communicate with them throughout the ICD-10 transition:

- Planning. Include your vendor in planning the transition. Communicate your needs and goals to your vendor and ask for your vendor to provide assurance in writing that products and testing plans will fulfill your requirements. Ask your vendor to share some strategies that other clients

have used successfully.
- Implementation and internal testing. Work with your vendors to update and test clinical, financial, actuarial, and reporting processes. Vendors should offer technical support and guidance during and after installation of new software.
- Testing with payers. Find out how your vendor will provide support as you begin testing ICD-10 transactions with payers and other business trading partners. Allow up to a year in advance of the October 1, 2014, ICD-10 deadline for testing with trading partners.
- Resolving testing issues. Determine what role your vendor will play in resolving any testing failures.

For more information on working with vendors and other external business partners, consult the ICD-10 checklists, timelines, and implementation guides available on the CMS website.

Additional Provider Communication Regarding Automatic Adjustments for Erroneous Medically Unlikely Denials

During 2011, Medicare incorrectly denied a group of claims as Medically Unlikely. These claims were denied with an indicator of either 51MUE or 52MUE, although most of the denials during this period of time with those indicators were properly processed.

CMS has created a utility to identify the claims that were incorrectly denied and process adjustments for them. At this time, it is not necessary for you to take any action. Your A/B Medicare Administrative Contractor will advise you via their website when these adjustments have been completed.

Billing for Transitional Care Management Services in Rural Health Clinics and Federally Qualified Health Centers

In the CY 2013 Physician Fee Schedule final rule, CMS recognized two new CPT codes (99495 and 99496) to report physician or qualifying nonphysician practitioner Transitional Care Management (TCM) services for a patient following a discharge from a hospital, Skilled Nursing Facility (SNF) or Community Mental Health Center (CMHC) stay, outpatient observation, or partial hospitalization.

On March 25, CMS posted a list of Frequently Asked Questions (FAQs) for billing Medicare for TCM Services. The FAQs indicate that CPT codes 99495 and 99496 should be used to bill these services by Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs). Although TCM is a covered service for RHCs and FQHCs, the Fiscal Intermediary Shared System (FISS) currently prohibits these services from receiving the all-inclusive payment rate based on the CPT code.

Until system changes can be implemented in FISS, RHCs and FQHCs should bill using the line item date of service that reflects the date of the required face to face component for TCM and should follow the billing instructions outlined below to ensure there is not a delay in their Medicare payments:
- RHCs should submit claims to their Medicare Administrative Contractor (MAC) with a service line containing revenue code 052X and no CPT code.
- FQHCs should submit claims to their MAC with a service line containing revenue code 052X and a valid evaluation and management (E&M) code. An additional service line should be submitted with revenue code 052X and CPT 99495 or 99496.

RHCs and FQHCs providers should follow the above billing guideline until further notice is given. Please contact your MAC should you have additional questions.

TOB 85X Medically Unlikely Edit Claims Adjudication Change

Critical Access Hospital (CAH) Method II providers may have received medically unlikely edit (MUE) denials on claims with dates of service on or after April 1, 2013 because the same HCPCS/CPT code was submitted on two claim lines, one claim line with a revenue code for the hospital service and one claim line with a revenue code for professional services (96X-98X). This issue has been resolved. CAH Method II providers who received MUE claim denials in April may resubmit these claims to their local contractors for re-adjudication.

Inpatient Prospective Payment System PC Pricer Updated

The FY 2013 Inpatient Prospective Payment System (PPS) PC Pricer has been updated with some logic fixes. The latest version is now available on the Inpatient PPS PC Pricer web page in the "Downloads" section.

From the MLN: "Medicare Billing Information for Rural Providers and Suppliers" Booklet — Revised

The "Medicare Billing Information for Rural Providers and Suppliers" Booklet (ICN 006762) was revised and is now available in downloadable format. This booklet is designed to provide education on Medicare rural billing. It includes information for Critical Access Hospitals, Federally Qualified Health Centers, Home Health Agencies, Rural Health Clinics, Skilled Nursing Facilities, and Swing Beds.
To assist rural providers who have limited internet access, the "Medicare Billing Information for Rural Providers and Suppliers Text-Only" Booklet is available in text-only format.

From the MLN: "Medicare Remit Easy Print Software" Fact Sheet — Revised

The "Medicare Remit Easy Print Software" Fact sheet (ICN 006740) was revised and is now available in downloadable format. This fact sheet is designed to provide education about Medicare Remit Easy Print (MREP) software that enables physicians and suppliers to view and print their remittance information. It includes a basic software overview, the benefits of using electronic remittance information, minimum system requirements, and additional resources available on the Internet.

"Questionable Billing By Suppliers of Lower Limb Prostheses" MLN Matters® Article — Revised

MLN Matters® Special Edition Article #SE1213, "Questionable Billing By Suppliers of Lower Limb Prostheses," was revised and is now available in downloadable format. This article is designed to provide education on major findings cited in the August 2011 Department of Health and Human Services, Office of Inspector General (OIG) report titled "Questionable Billing By Suppliers of Lower Limb Prostheses." It includes an overview of the study and major OIG findings, and recommendations related to Medicare requirements for lower limb prostheses. The article was revised to remove information from page 5.

"HIPAA Eligibility Transaction System (HETS) to Replace Common Working File (CWF) Medicare Beneficiary Health Insurance Eligibility Queries" MLN Matters® Article — Revised

MLN Matters® Special Edition Article #SE1249, "HIPAA Eligibility Transaction System (HETS) to Replace Common Working File (CWF) Medicare Beneficiary Health Insurance Eligibility Queries" was revised and is now available in downloadable format. This article is designed to provide education on the transition of CWF Medicare beneficiary eligibility queries to HIPAA HETS. It includes important information and frequently asked questions (FAQs) providers can use to prepare for the transition. The article was revised to update FAQs and related language.

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