



CMS Medicare FFS Provider e-News

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National Provider Call: National Physician Payment Transparency Program (OPEN PAYMENTS) - What You Need To Know — Register Now

Wednesday, May 22; 2:30-4pm ET

The National Physician Payment Transparency Program (OPEN PAYMENTS), Section 6002 of the Affordable Care Act, 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. For the purposes of OPEN PAYMENTS, a “physician” is any of the following types of professionals that are legally authorized to practice, regardless of whether they are Medicare, Medicaid, or Children's health Insurance Program (CHIP) providers:

- Doctor of Medicine
- Doctor of Osteopathy
- Doctor of Dentistry
- Doctor of Dental Surgery
- Doctor of Podiatry
- Doctor of Optometry
- Doctor of Chiropractic Medicine

Note: Medical residents are excluded from the definition of physicians for the purpose of this program. More information is available on the [OPEN PAYMENTS](#) website.

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 — Register Now

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.

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

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

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National Provider Call: Getting Started with PQRS Reporting: Implications for the Value-based Payment Modifier — Register Now

Wednesday, June 5; 1:30-2:30pm ET

This National Provider Call will cover how to obtain an Individuals Authorized Access to the CMS Computer Services (IACS) account in order for (1) physician group practices to select their CY 2013 Physician Quality Reporting System (PQRS) Group Reporting Mechanism, and if applicable, elect quality tiering to calculate their CY 2015 Value-based Payment Modifier; and (2) individual eligible professionals to select the Administrative Claims reporting mechanism for CY 2013. A question and answer session will follow the presentation.

Please note that while this call is scheduled for 60 minutes. CMS experts will be available to stay on the line for an additional 30 minutes to take outstanding questions, should they exist, at the end of the scheduled call time. Participants can remain on the line until the conclusion of the call or refer to the call transcript and audio recording (to be posted 7-10 business days after the call) if they are unable to participate beyond the 60 minute scheduled duration.

Agenda:

- Introductions and opening remarks
- IACS registration walkthrough
- Question and answer session

Target Audience: Physicians, physician group practices, practitioners, therapists, practice managers, medical and specialty societies, payers, insurers.

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 Calls: Medicare Shared Savings Program Application Process — Register Now

Thursday, June 20; 1:30-3pm ET— Application Review

Thursday, July 18; 1-2:30pm ET— Application Question and Answer Session

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 on the Shared Savings Program application process.

On Thursday, June 20, CMS subject matter experts will provide an overview and updates to the Shared Savings Program application process for the January 1, 2014 start date. A question and answer session will follow the presentations.

On Thursday, July 18, CMS subject matter experts will be available to answer questions about the Shared Savings Program and application process for the January 1, 2014 start date.

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.

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National Provider Call: Medicare and Medicaid EHR Incentive Programs National Provider Call Series

The Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs paid out over \$13.7

billion in incentives through March of this year. Don't be left out. CMS will be holding a series of National Provider Calls (NPCs) about different aspects of the EHR incentive programs. Don't miss these opportunities to learn from the experts.

[Register](#) for the Stage 1 call for Medicare and Medicaid Eligible Professionals on May 30.

Mark your calendars for these upcoming NPCs. Registration will be announced:

Medicare and Medicaid Eligible Professionals, Eligible Hospitals, and Critical Access Hospitals:

- June 27; 2:30-3:45 — Certification
- July 23; 1:30-3 — Clinical Quality Measures
- July 24; 1:30-3 — Stage 2

Medicare Eligible Professionals, Eligible Hospitals, and Critical Access Hospitals

- August 13; 1:30-3 — Hardship Exceptions
- August 15; 1:30-3 — Payment Adjustments

National Provider Call: Audio Recording and Written Transcript from April 24 “ESRD Low-Volume Payment Adjustment” Call Now Available

The audio recording and written transcript from the April 24 End-Stage Renal Disease (ESRD) Low-Volume Payment Adjustment call are now available on the [April 24](#) call web page in the “Call Materials” section.

Raise Awareness About Mental Health

May is Mental Health Month. This year's theme, *Pathways to Wellness* —calls attention to strategies and approaches that help all Americans achieve wellness and good mental and overall health. Just as you check your patients' blood pressure and recommend appropriate screenings, it's a good idea to take periodic readings of their emotional well-being also. Medicare provides payment for several services that can help you check your patients' emotional well-being.

Mental Health Services Payable by Medicare:

Depression Screening: Medicare covers annual screening for adults for depression in the primary care setting that have staff-assisted depression care supports in place to assure accurate diagnosis, effective treatment, and follow-up.

- For the purposes of this screening benefit, Medicare defines a primary care setting as one in which there is provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Emergency departments, inpatient hospital settings, ambulatory surgical centers, independent diagnostic testing facilities, skilled nursing facilities, inpatient rehabilitation facilities, and hospice are not considered primary care settings under this definition.
- For more information, refer to the Medicare Learning Network® (MLN) booklet, [Screening for Depression](#).

Preventive Visits:

- Medicare provides payment for:
- The Initial Preventive Physical Examination (IPPE), commonly referred to as the “Welcome to Medicare” Preventive Visit – available one time when the beneficiary is new to Medicare (within

- the first 12 months of Medicare Part B enrollment), and
- The Annual Wellness Visit (AWV) – available once per year if the beneficiary has been enrolled in Medicare Part B for longer than 12 months.
 - For more information about the elements included in these preventive visits, refer to the following MLN quick reference charts:
 - [The ABCs of Providing the Initial Preventive Physical Examination](#)
 - [The ABCs of Providing the Annual Wellness Visit](#)

For additional information, visit:

- [MLN Preventive Services Educational Products for Health Professionals](#)
- [CMS Prevention](#) website
- [Mental Health America](#) – Mental Health Month sponsor

Reminder: DMEPOS Competitive Bidding Program: Grandfathering Requirements and Fact Sheet

CMS would like to remind all non-contract suppliers furnishing rented durable medical equipment or oxygen and oxygen equipment in a Round 2 competitive bidding area that they must decide if they will elect to become grandfathered suppliers and notify beneficiaries of their grandfathering decisions at least 30 business days before July 1, 2013. For more information about grandfathering requirements, please review the “[DMEPOS Competitive Bidding Program: Grandfathering Requirements for Non-Contract Suppliers](#)” Fact Sheet (ICN 900923). This fact sheet is available in downloadable format and includes a definition of grandfathered suppliers, beneficiary notification requirements, and rules and policies related to grandfathering.

DMEPOS Competitive Bidding Program: Beneficiary and Provider Mailings

The Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (the Program) was successfully implemented in nine areas on January 1, 2011. Round 2 of the Program is scheduled to go into effect in 91 Metropolitan Statistical Areas (MSAs) on July 1, 2013. Medicare will implement a national mail-order program for diabetic testing supplies at the same time as Round 2. The national mail-order program will include all parts of the United States, including the 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, and American Samoa.

As part of the ongoing education and outreach efforts for the Program, CMS will begin mailing information to approximately 5.7 million people with Medicare about The Program. Recipients include Medicare beneficiaries in the 91 Round 2 bid areas who use the items included in The Program ([letter 1](#)) as well as those who use diabetic testing supplies across the country ([letter 2](#)).

Health care providers who order and refer DMEPOS Competitive Bidding Program items for beneficiaries residing in or traveling to a competitive bidding area will be receiving a letter from CMS with more information on The Program. Review the referral agent [letter](#) which also includes a [fact sheet](#) for referral agents.

For information about The Program and to view additional educational resources, visit the [CMS](#) website. If you refer Medicare beneficiaries for DMEPOS, [subscribe](#) to the Referral Agent Electronic Mailing List.

HQRP Paperwork Reduction Act Package and Proposed Rule Available for Public Comment

Comment period will end on June 28

Hospice providers can review the Hospice Quality Reporting Program (HQRP)-related proposed rule [[CMS-1449-P](#)] and the Paperwork Reduction Act (PRA) [Package](#). Section III(B1-B7) of the Proposed Rule outlines current HQRP requirements and proposes future HQRP requirements for Payment Year (PY) 2016 and PY 2017. The PRA package includes details about the Hospice Item Set (HIS), a hospice patient-level data set designed to collect and submit standardized data about each patient admitted to hospice. The HIS is proposed for use in the HQRP beginning in PY 2016.

The public has the opportunity to comment on proposals in the rule and/or the PRA package. The public comment period for the proposed rule and the PRA package will end on June 28, 2013. The process for submitting comments on either the proposed rule or the PRA package is outlined within the proposed rule. After the comment period ends, CMS will respond to comments and finalize HQRP requirements in the Final Rule.

CMS to Release a Comparative Billing Report on Evaluation and Management Services — Target Release May 20

On May 20, 2013, CMS will release a national provider Comparative Billing Report (CBR) addressing Evaluation and Management Services.

CBRs produced by SafeGuard Services under contract with CMS, contain actual data-driven tables and graphs with an explanation of findings that compare providers' billing and payment patterns to those of their peers located in the state and across the nation.

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

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

Guidance for EPs: How to Participate in Both the Medicare EHR Incentive Program and PQRS in 2013 and Beyond

Providers who treat Medicare patients and bill for Part B services on the Medicare Physician Fee Schedule (PFS) may be eligible for two incentive programs at CMS: the [Medicare EHR Incentive Program](#) and the [Physician Quality Reporting System \(PQRS\)](#) program. CMS encourages you to read more to learn about the opportunity to participate in both.

About EHR

The Medicare EHR Incentive Program provides incentive payments to [eligible professionals](#) (EPs) that successfully demonstrate meaningful use of certified EHR technology.

About PQRS

PQRS is a reporting program that provides incentive payments to promote reporting of quality

information by [EPs](#).

Participating in Both in 2013

EPs who successfully participate in PQRS and EHR can receive an incentive in 2013 and avoid the 2015 payment adjustment for both programs. To successfully demonstrate meaningful use for the Medicare EHR Incentive Program, EPs are required to report clinical quality measures (CQMs) as well as meaningful use measures. In 2013, EPs may satisfy the meaningful use objective to report CQMs to CMS by reporting them through:

- Medicare and Medicaid EHR Incentive Programs' web-based [Registration and Attestation System](#)
 - EPs who choose to report CQMs through the CMS Attestation system must still report information on individual quality measures or measure groups using one of the [four reporting options](#) in order to also participate in PQRS.
- Participation in the [PQRS-Medicare EHR Incentive Pilot](#), which utilizes the 2013 PQRS EHR Measure Specifications .
 - EPs who participate in the pilot may submit their meaningful use objectives through the [CMS Attestation system](#), and then complete a single submission of CQMs to receive credit for both programs.

Participating in Both in 2014 and Beyond

In 2014, the PQRS and EHR programs have overlapping participation guidelines, including the same quality measures, the same reporting criteria, and the option to use the same reporting mechanism. The goal of this "alignment" is to simplify participation in both programs.

Here are some key considerations for PQRS and EHR alignment in 2014:

- PQRS and EHR programs will align on the same set of eCQMs (64 total) and the same electronic specifications
- All Medicare-EPs beyond their first year of demonstrating meaningful use will be required to electronically report their CQM data to CMS for the EHR program
- Submitting data electronically using 2014 certified EHR technology will meet the standards for both EHR and PQRS programs
- Participating EPs will have the option to submit patient-level data (via QRDA I) or aggregate data (via QRDA III) using the same reporting mechanism for electronic reporting for both programs

CMS hopes you will take action and participate in both programs this year. Learn more about PQRS and EHR on the [eHealth](#) website.

Adjustment of Certain Institutional Claims

The Shared System Maintainer (SSM) for the Fiscal Intermediary Shared System (FISS) corrected an issue which went into production on April 14, 2013. Medicare Administrative Contractors (MACs) will adjust claims with "through dates" on or after April 1, 2013, that processed between April 1 and April 14, 2013, with the following criteria:

- Value Code 73
- A deductible applied (A1, B1 or C1 Value Code) and
- Negative reimbursement (at the line level for outpatient claims or negative reimbursement at the claim level for inpatient claims)

MACs will process the following claim types, as they were previously held and do not require adjustments:

- Critical Access Hospital (CAH) claims: TOB 85X with a deductible applied (A1, B1 or C1 Value

- Code)
- Rural Health Clinic RHC outpatient claims: TOB 71X with a deductible applied (A1, B1 or C1 Value Code)

All adjustments will be completed by June 30, 2013. No further action by the provider is required.

Temporary Billing Guidelines for Annual Wellness Visits and Initial Preventive Physical Examinations for Rural Health Clinics

CMS identified an issue with the January 2013 quarterly release that is impacting the payment to Rural Health Clinics (RHCs) for Annual Wellness Visits (AWV) and Initial Preventive Physical Examinations (IPPE) services.

Although, AWV and IPPE are covered services for RHCs, the Fiscal Intermediary Shared System (FISS) is currently preventing the processing of these services at the all-inclusive payment rate.

Until system changes can be implemented in FISS, RHCs should follow the billing instructions outlined below to ensure there is no further delay in your Medicare payments:

- AWV services should be submitted to the Medicare claims administration contractor with revenue code 052X and HCPCS code G0438 or G0439. Please ensure no other services are reported on the claim with the same line item date of service as the AWV.
- IPPE services should be submitted by itself on a separate claim to the Medicare contractor. When billing for an encounter/visit on the same day as an IPPE service, submit the first claim with revenue code 052X and no HCPCS/CPT code. The second claim should be submitted with revenue code 052X and HCPCS code G0402.

Your Medicare contractor may have been holding these claims waiting for a system fix. Therefore, in order to prevent further delay in payments, your contractor will soon begin to return these claims to you. Please resubmit the claims using the billing guidelines as described above.

RHC providers should follow these billing guidelines until further instructions are given. Please contact your Medicare contractor if you have additional questions.

2014 ICD-10-PCS Files Now Available

ICD-10 Code Updates

The 2014 ICD-10-PCS (procedure) files are now available and posted on the [2014 ICD-10 PCS and GEMs](#) web page. [2014 Version — What's New](#) describes the four new procedure codes created for new technologies.

CMS will post the 2014 ICD-10-CM (diagnosis) files once we receive them from the Centers for Disease Control (CDC) in June. A 2014 ICD-10-CM and GEMs web page will be created on the [ICD-10](#) website for these files.

The ICD-10-PCS and ICD-10-CM 2014 General Equivalence Mappings (GEMs) and the 2014 Reimbursement Mappings will be posted on the 2014 ICD-10-PCS and GEMs and 2014 ICD-10-CM and GEMs web pages in October.

FY 2014 ICD-9-CM Procedure Code Addendum Now Available

The FY 2014 ICD-9-CM procedure code addendum is posted on the [Updates and Revisions to ICD-9-CM Procedure Codes](#) web page. There will not be a FY 2014 ICD-9-CM diagnosis addendum, as CDC is not updating ICD-9-CM diagnosis codes for FY 2014.

Clarification on the Use of External Cause and Unspecified Codes in ICD-10-CM

External Cause Codes

Just as with ICD-9-CM, there is no national requirement for mandatory ICD-10-CM external cause code reporting. Unless a provider is subject to a state-based external cause code reporting mandate or these codes are required by a particular payer, reporting of ICD-10-CM codes in Chapter 20, External Causes of Morbidity, is not required. If a provider has not been reporting ICD-9-CM external cause codes, the provider will not be required to report ICD-10-CM codes in Chapter 20, unless a new state or payer-based requirement regarding the reporting of these codes is instituted. Such a requirement would be independent of ICD-10-CM implementation. In the absence of a mandatory reporting requirement, providers are encouraged to voluntarily report external cause codes, as they provide valuable data for injury research and evaluation of injury prevention strategies.

Sign/Symptom/Unspecified Codes

In both ICD-9-CM and ICD-10-CM, sign/symptom and “unspecified” codes have acceptable, even necessary, uses. While specific diagnosis codes should be reported when they are supported by the available medical record documentation and clinical knowledge of the patient’s health condition, there are instances when signs/symptoms or unspecified codes are the best choices for accurately reflecting the healthcare encounter. Each healthcare encounter should be coded to the level of certainty known for that encounter.

If a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for sign(s) and/or symptom(s) in lieu of a definitive diagnosis. When sufficient clinical information isn’t known or available about a particular health condition to assign a more specific code, it is acceptable to report the appropriate “unspecified” code (e.g., a diagnosis of pneumonia has been determined, but not the specific type). In fact, unspecified codes should be reported when they are the codes that most accurately reflects what is known about the patient’s condition at the time of that particular encounter. It would be inappropriate to select a specific code that is not supported by the medical record documentation or conduct medically unnecessary diagnostic testing in order to determine a more specific code.

Dates of Service: Is It ICD-9 or ICD-10?

With the October 1, 2014, ICD-10 deadline approaching, you may be wondering how you will code a claim that you are submitting in October 2014 for a service that your practice provided in September 2014.

Even if you submit your claim on or after the ICD-10 deadline, if the date of service was before the October 1, 2014, deadline, you will use ICD-9 to code the diagnosis.

For dates of service on or after the October 1, 2014, deadline, you will use ICD-10. You may not be able

to use ICD-9 and ICD-10 codes on the same claim based on your payers' instructions. This may mean splitting services that would typically be captured on one claim into two claims: one claim with ICD-9 diagnosis codes for services provided before October 1, 2014, and another claim with ICD-10 diagnosis codes for services provided on or after October 1, 2014.

Some trading partners may request that ICD-9 and ICD-10 codes be submitted on the same claim when dates of service span the compliance date. Trading partner agreements will determine the need for split claims.

Here's an example of a split claim:

A patient has an appointment on September 27, 2014, and is diagnosed with bronchitis. He returns for a follow-up appointment on October 3, 2014. In this case, a practice will submit a claim with an ICD-9 diagnosis code for the first visit and another claim with an ICD-10 diagnosis code for the follow-up visit. Make sure that your systems, third-party vendors, billing services, and clearinghouses can handle both ICD-9 and ICD-10 codes depending on the dates of service in the months following October 1, 2014.

Please note that future ICD-10 Email Updates will explore how Medicare will handle dates of service for inpatient settings (e.g., a hospital inpatient stay that begins before the transition date and ends after the transition date will be coded on a single claim with ICD-10). Stay tuned for details.

Keep Up to Date on ICD-10

Visit the CMS [ICD-10](#) website for the latest news and resources and the [ICD-10 continuing medical education modules](#) developed by CMS in partnership with Medscape to help you prepare for the *October 1, 2014*, deadline.

From the MLN: “Remittance Advice Information: An Overview” Fact Sheet — Released

The “[Remittance Advice Information: An Overview](#)” Fact Sheet (ICN 908325) was released and is now available in downloadable format. This fact sheet is designed to provide education on the Remittance Advice (RA). It includes general information about the RA, the benefits of using the electronic RA, what kind of information is in an RA, and what to do once you get one.

From the MLN: “Remittance Advice Resources” Fact Sheet — Released

The “[Remittance Advice Resources](#)” Fact Sheet (ICN 908329) was released and is now available in downloadable format. This fact sheet is designed to provide education on electronic remittance advice (ERA) software. It includes information on commercial and free software options.

From the MLN: “ICD-10-CM/PCS Myths and Facts” Fact Sheet — Revised

The “[ICD-10-CM/PCS Myths and Facts](#)” Fact sheet (ICN 902143) was revised and is now available in downloadable format. This fact sheet is designed to provide education on the International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS). It includes responses to myths about ICD-10-CM/PCS and resource information.

From the MLN: “Sole Community Hospital” Fact Sheet – Revised

The "[Sole Community Hospital](#)" Fact sheet (ICN 006399) was revised and is now available in downloadable format. This fact sheet is designed to provide education on Sole Community Hospitals (SCH). It includes the following information: SCH classification criteria, SCH payments, and urban to rural hospital reclassifications.



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](#).