Thursday, June 27, 2013

New name, same information that you rely on each week. We are pleased to announce "MLN Connects ™"; connecting health care professionals to trusted CMS program news and information. MLN Connects is a part of the Medicare Learning Network® (MLN), a registered trademark of the Centers for Medicare & Medicaid Services (CMS) and the brand name for official information health care professionals can trust.

The following education and outreach programs have been renamed as follows:

- CMS Medicare FFS Provider e-News is now the MLN Connects Provider eNews
- MLN National Provider Calls (NPCs) are now MLN Connects National Provider Calls
- MLN Provider Partnership Program is now MLN Connects Provider Association Partnerships

The newsletter, calls, and provider association partnership now form MLN Connects. We encourage you to visit any of the websites listed above for more information.

MLN Connects™ National Provider Calls

CMS National Partnership to Improve Dementia Care in Nursing Homes — Register Now

Medicare Shared Savings Program Application Process Question and Answer Session — Register Now

CMS Proposals for PQRS and Physician Value-Based Payment Modifier under the Medicare Physician Fee Schedule 2014 Proposed Rule — Registration Now Open

Choosing Your PQRS Group Reporting Mechanism and Implications for the Value-based Payment Modifier — Register Now

Medicare and Medicaid EHR Incentive Programs National Provider Call Series — Save the Dates

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How Will ICD-10 Affect Clinical Documentation?

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MLN Education Products Update

"How to Protect Your Identity Using the Provider Enrollment, Chain and Ownership System (PECOS)" Fact Sheet — Revised

"Centers for Medicare & Medicaid Services (CMS) Electronic Mailing Lists: Keeping Health Care Professionals Informed" Fact Sheet — Revised

New Continuing Education Association Now Accepting Medicare Learning Network® (MLN) Courses

New MLN Provider Compliance Fast Fact

MLN Connects™ National Provider Calls

CMS National Partnership to Improve Dementia Care in Nursing Homes — Register Now

Wednesday, July 10; 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 continue 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 progress that has been made during the implementation of this national partnership, its successes, and next steps. Additional speakers will share some personal success stories from the field. A question and answer session will follow the presentation.

Agenda:

- National partnership overview: Success through data
- Stories from the field: State coalitions, providers, clinicians
- Next Steps
    - Provider feedback
    - What outreach strategies have been successfully implemented and have led to meaningful change in nursing homes?
- Question and answer session

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.

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 Information web page to learn more.

Medicare Shared Savings Program Application Process Question and Answer Session — Register Now
Thursday, July 18; 1-2:30pm 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. During this National Provider Call, 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.

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 Information web page to learn more.

CMS Proposals for PQRS and Physician Value-Based Payment Modifier under the Medicare Physician Fee Schedule 2014 Proposed Rule — Registration Now Open
Thursday, July 25; 1:30-3pm ET

This National Provider Call will provide an overview of the 2014 Physician Fee Schedule (PFS) Proposed Rule. This presentation will cover potential program updates to the Physician Quality Reporting System (PQRS).The topics covered will include changes to reporting mechanisms, individual measures, and measures groups for inclusion in 2014, criteria for satisfactorily reporting for incentive, criteria for avoiding future payment adjustments, requirements for Medicare incentive program alignment and satisfactory participation under the qualified clinical data registry option, which will be established in the PQRS as a result of the American Taxpayer Relief Act of 2012.

The presentation will also provide an overview of the proposals for the value-based payment modifier including how CMS proposes to continue to phase in and expand application of the value-based payment modifier in 2016 based on performance in 2014. The presentation will also describe how the value-based payment modifier is aligned with the reporting requirements under the PQRS.

Lastly, this presentation will provide information on the 2014 PFS Proposed Rule comment period, which allows the public to post comments and suggestions to proposed program requirements.

Agenda:

- Introduction
- Review of the proposed PQRS policies under the 2014 PFS Proposed Rule
- Review of the proposed value-based payment modifier policies under the 2014 PFS Proposed Rule
- Question and answer session

Target Audience: Physicians, physician group practices, 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.

Continuing education credit may be awarded for participation in certain CMS National Provider Calls. Visit the Continuing Education Credit Information web page to learn more.

Choosing Your PQRS Group Reporting Mechanism and Implications for the Value-based Payment Modifier — Register Now

Wednesday, July 31; 2:30-3:30pm ET

This National Provider Call will walk through the Physician Value (PV) - Physician Quality Reporting System (PQRS) Registration System. The PV-PQRS Registration System is a new application to serve the Physician Value Modifier and PQRS programs. The PV-PQRS Registration system will allow: (1) physician group practices to select their CY 2013 PQRS Group Reporting Mechanism, and if the group has 100 or more eligible professionals, elect quality tiering to calculate their CY 2015 Value-based Payment Modifier; and (2) individual eligible professionals to select the CMS-calculated Administrative Claims reporting mechanism for CY 2013 in order to avoid the PQRS negative payment adjustment in CY 2015. A question and answer session will follow the presentation. The PV-PQRS Registration System will be open from July 15, 2013 to October 15, 2013.

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:

- Introduction/opening remarks
- PV-PQRS registration walkthrough
- Question and answer session

Target Audience: Physicians, physician group practices, 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.

Continuing education credit may be awarded for participation in certain CMS National Provider Calls. Visit the Continuing Education Credit Information web page to learn more.

Medicare and Medicaid EHR Incentive Programs National Provider Call Series — Save the Dates

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

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

- 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

Other Calls, Meetings, & Events

Medicare Shared Savings Program Application Submission Call: Training on the Health Plan Management System

Tuesday, July 9; 2:30-4pm ET

CMS will host a call to discuss how to submit your application for the Medicare Shared Savings Program through the Health Plan Management System (HPMS). Information about the application process is available on the Shared Savings Program Application web page. Call participants are encouraged to review application materials and log into HPMS prior to the call.

Participation Instructions:

- No registration is necessary for this call.
- In order to participate, dial 877-267-1577 and use Meeting ID: 5924. The conference line will open 15 minutes prior to the call.
- A presentation will be posted before the call on the CMS Teleconferences Events web page.

PERM Cycle 2 Provider Education Webinar/Conference Calls

CMS is hosting Payment Error Rate Measurement (PERM) provider education webinar/conference calls for Medicare providers who also provide Medicaid and CHIP services. Complete details are available in the webinar/conference calls announcement.

Presentations will include:

- The PERM process and provider responsibilities during a PERM review
- Frequent mistakes and best practices
- The Electronic Submission of Medical Documentation, esMD program

To join the meeting:

- Registration is not required, however, space is limited

- All webinars are from 3-4pm ET
- Audio: 877-267-1577, Meeting ID# 4964
    - Tuesday, July 2 — Webinar
    - Wednesday, July 17— Webinar

Announcements and Reminders

Revised CMS 1500 Paper Claim Form: Version 02/12

The National Uniform Claim Committee (NUCC), an industry organization in which CMS participates, maintains the CMS 1500 claim form and periodically revises it according to industry needs. The NUCC recently revised this form (version 02/12). The NUCC changed the form to adequately accommodate and implement ICD-10-CM diagnosis codes, although the form does include other changes as well. More information is available on the NUCC website.

On June 10, 2013, the White House Office of Management and Budget (OMB) approved the revised CMS 1500 claim form, version 02/12, OMB control number, 0938-1197. The CMS 1500 claim form is the required format for submitting claims to Medicare on paper.

Features of the Revised Form
The revised form, among other changes, notably adds the following functionality:

- Indicators for differentiating between ICD-9-CM and ICD-10-CM diagnosis codes.
- Expansion of the number of possible diagnosis codes to 12.
- Qualifiers to identify the following provider roles (on item 17):
    - Ordering
    - Referring
    - Supervising

Instructions for Completing the Revised Form
CMS is updating the *Medicare Claims Processing Internet Only Manual* (IOM, Pub. 100-04) Chapter 26 to instruct contractors and providers regarding how to complete the revised form. CMS will post this information on the CMS website when it is available.

Tentative Timeline for Implementing the Revised Form for Medicare Claims
Medicare anticipates implementing the revised CMS 1500 claim form (version 02/12) as follows:

- January 6, 2014: Medicare begins receiving and processing paper claims submitted on the revised CMS 1500 claim form (version 02/12).
- January 6 through March 31, 2014: Dual use period during which Medicare continues to receive and process paper claims submitted on the old CMS 1500 claim form (version 08/05).
- April 1, 2014: Medicare receives and processes paper claims submitted only on the revised CMS 1500 claim form (version 02/12).

These dates are tentative and subject to change. CMS will provide more information as it is available.

Note: The Administrative Simplification Compliance Act (ASCA) requires that Medicare claims be sent electronically unless certain exceptions are met. Some Medicare providers qualify for these exceptions and send their claims to Medicare on paper. For more information about ASCA exceptions, please contact the Medicare contractor who processes your claims. Claims sent electronically must abide by the standards adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The current standard adopted under HIPAA for electronically submitting professional health care claims is the 5010 version of the ASC X12 837 Professional Health Care Claim standard and its implementation specification, Technical Report 3 (TR3). More information about the ASC X12 and TR3 is available on the ASC X12 website.

DMEPOS Competitive Bidding Program: July 1 Implementation- Supplier Resources

Educational Resources Reminder
Round 2 of the DMEPOS Competitive Bidding Program will go into effect in 91 Metropolitan Statistical Areas on July 1, 2013. Medicare also will implement a national mail-order program for diabetic testing supplies on July 1, 2013. When the program becomes effective in a competitive bidding area, beneficiaries with Original Medicare who obtain competitively bid items in the area must obtain these items from a contract supplier in order for Medicare to pay, unless an exception applies. Educational resources for suppliers are available on the CMS website. Materials to assist you with beneficiary inquiries about the program are also available.

CBIC Liaison Reminder
Competitive Bidding Implementation Contractor (CBIC) liaisons are available to assist suppliers, referral agents, and other key stakeholders with questions and concerns about the Medicare DMEPOS Competitive Bidding Program. The liaisons can provide assistance with issues such as:

- the quality of services or items,
- suspected fraud or abuse,
- guidelines on particular policies,
- information on regulations,
- general information about the program, and
- educational materials.

There is a dedicated CBIC liaison assigned in each of several regional geographic territories consisting of Round 1, Round 2, and national mail-order competitive bidding areas. For more information and to see a listing of the CBIC liaisons, visit the DMEPOS Competitive Bidding website.

Hospice Quality Reporting Program Reconsideration Process

Hospices found to be non-compliant with the Hospice Quality Reporting requirements have been notified by CMS of the potential impact to their FY 2014 payment update. This notification includes direction on how the hospice may request a reconsideration of this determination and describes appropriate supporting documentation.
Hospices that believe they were identified for a payment reduction in error may submit a request for reconsideration to CMS via email within 30 days of the date of the non-compliance notification. Hospices should assure that their request for reconsideration email is:

- Sent to HospiceQRPReconsiderations@cms.hhs.gov within 30 days of the date of the non-compliance notification
    - *CMS will not accept any reconsideration requests submitted after the 30 day deadline nor will CMS accept any reconsideration request sent to an email address other than the address specified above*
- Has a the subject line "ACA 3004 Reconsideration Request," along with the hospice's CMS Certification Number (CCN)
- Includes all supporting documentation as specified on the CMS HQRP Reconsideration web page.

CMS Releases New FAQ Document Related to Functional Reporting of PT, OT, and SLP Services

CMS has posted a new document containing 22 new Frequently Asked Questions (FAQs) on the required Functional Reporting of physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP) services. Functional Reporting for outpatient therapy services requires reporting functional limitations and severity/complexity levels with 42 G-codes and seven modifiers on specified claims for PT, OT, and SLP services. For more information on the Functional Reporting requirements, view MLN Matters® Article #MM8005 – "Implementing the Claims-Based Data Collection Requirement for Outpatient Therapy Services — Section 3005(g) of the Middle Class Tax Relief and Jobs Creation Act (MCTRJCA) of 2012." In addition to the direct link above, the new FAQ document is also available in the Downloads section of the CMS Therapy Services website.

Reporting Period to Submit eRx Data and Avoid Adjustment Ends June 30

A major Electronic Prescribing (eRx) Incentive Program deadline is approaching for both individual eligible professionals (EPs) and group practices participating in the Group Practice Reporting Option (GPRO). If you are an EP or an eRx GPRO participant, you must successfully report as an electronic prescriber before June 30, 2013 or you will experience a payment adjustment in 2014 for professional services covered under Medicare Part B's Physician Fee Schedule (PFS).

The 2013 eRx Incentive Program 6-month reporting period (January 1, 2013 to June 30, 2013) is the final reporting period available to you if you wish to avoid the 2014 eRx payment adjustment. If you do not successfully report, a payment adjustment of 2.0% will be applied, and you will receive only 98.0% of your Medicare Part B PFS amount for covered professional services in 2014.

Avoiding the 2014 eRx Payment Adjustment
Individual EPs and eRx GPRO participants who were not successful electronic prescribers in 2012 can avoid 2014 eRx payment adjustment by meeting specified reporting requirements between January 1, 2013 and June 30, 2013. Below are the 6-month reporting requirements:

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

Exclusions and Hardships Exemptions
Exclusions from the 2014 eRx payment adjustment only apply to certain individual EPs and group practices, and CMS will automatically exclude those individual EPs and group practices who meet the criteria. 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. Requests for hardship exemptions must be submitted by June 30, 2013. More information on exclusion criteria and hardship exemption categories can be found on the Electronic Prescribing (eRx) Incentive Program: 2014 Payment Adjustment Fact Sheet.

Resources from CMS
To learn more about the eRx Incentive Program, please visit the CMS eRx Incentive Program website. Additional resources on the 2014 payment adjustment are available on the eRx Incentive Program Payment Adjustment Information web page, including the resource Electronic Prescribing (eRx) Incentive Program: Updates for 2013.

Questions about eRx?
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. The Help Desk is available Monday through Friday from 7am-7pm CT.

PQRS Call for Measures Ends July 1

CMS is currently 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. Suggested measures must address the CMS measure selection core criteria listed on the Measures Management System Call for Measures web page to be considered for inclusion in the PQRS.

Each measure must be submitted in the required format and must include all required supporting documentation to be accepted for consideration. The Measures Submitted for Consideration Excel Form is posted on the Measures Management System Call for Measures web page. Please note that full specifications are not requested at this time. When the Call for Measures closes, CMS will review all of the submitted measures to determine those that will move forward. For selected measures, measure stewards will be asked to provide full specifications.

This Call for Measures runs from May 1 through July 1, 2013. Completed documentation must be submitted electronically to PHYSICIAN_REPORTING_TEMP@cms.hhs.gov no later than 5pm ET on July 1, 2013. Questions about this Call for Measures or the required documentation may be submitted to PHYSICIAN_REPORTING_TEMP@cms.hhs.gov.

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.

July 3rd is an Important EHR Deadline for Medicare Eligible Hospitals and CAHs

July 3, 2013 is last day that eligible hospitals and critical access hospitals (CAHs) in their first year of participation of the Medicare EHR Incentive Program can begin their 90-day reporting period to demonstrate meaningful use for FY 2013. Hospitals in their second and third years of participation must demonstrate meaningful use for the full FY.

Looking Ahead
Three other important dates for eligible hospitals and CAHs include:

- September 30, 2013—Last day of the FY 2013, and the end of the reporting year.
- October 1, 2013—First day of FY 2014, and the start of Stage 2 for hospitals in their third or fourth years of participation.
- November 30, 2013—Last day to register and attest to receive an incentive payment for FY 2013.

See other 2013 important dates in the 2012-2014 Health Information Technology timeline.

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

LTCH FY 2015 Payment Update Determination: Data Submission Deadlines

Long-Term Care Hospitals (LTCH) should be *collecting* and *submitting* data for the FY 2015 payment update determination required by the LTCH Quality Reporting (LTCHQR) Program.

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 for FY 2015 Payment Update Determination:

- 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)

The deadlines for final data submission for FY 2015 Payment Update Determination are:

- August 15, 2013: January through March 2013 data
- November 15, 2013: April through June 2013 data
- February 15, 2014: July through September 2013 data
- May 15, 2014: October through December 2013 data

Reminder: The submission deadline of May 15, 2013 for October through December 2012 data that will affect the FY 2014 Payment Update Determination has passed.

How Will ICD-10 Affect Clinical Documentation?

As practices prepare for the October 1, 2014, transition to ICD-10, there's been a good deal of discussion about the many new codes ICD-10 offers and how clinical documentation will be affected. Just as with ICD-9, complete documentation is essential for patient care and accurate selection of ICD-10 codes.

ICD-10 Captures Familiar Clinical Concepts

Concepts that are new to ICD-10 are not new to clinicians, who are already documenting a patient's chart with more clinical information than an ICD-9 code can capture about:

- Initial Encounter, Subsequent Encounter, or Sequelae
- Acute or Chronic
- Right or Left
- Normal Healing, Delayed Healing, Nonunion, or Malunion

Many ICD-10 codes—more than one-third—are identical except for indicating laterality, or whether the right or left side of the body is affected. The advantage of ICD-10 codes is that they enable clinicians to capture laterality and other concepts in a standardized way that supports data exchange and interoperability for a more efficient health care system.

Verifying Your Documentation Is ICD-10-Ready
While ICD-10 should not require providers to change documentation practices, reviewing documentation will help you understand how ICD-10 will affect your practice. Understanding the scope of the ICD-10 transition will reduce the likelihood that you will overlook areas that need updates for ICD-10. Testing ICD-10, from documentation all the way through communication with billing services, is vital to making sure you have worked out any snags in the process before the October 1, 2014, transition date.

Take a look at documentation for the most often-used ICD-9 codes in your practice and work with coding staff to select the appropriate corresponding ICD-10 codes. Identifying these codes will help reinforce the information to highlight when documenting patient diagnoses for ICD-10.

Keep Up to Date on ICD-10
Visit the CMS ICD-10 website for the latest news and resources to help you prepare for the *October 1, 2014*, deadline.

Claims, Pricer, and Code Updates

Mandatory Claims Submission Reminder for Oxygen and Oxygen Equipment Suppliers

The Social Security Act (Section 1848(g)(4)) requires, in part, that claims be submitted for all Medicare patients for services rendered on or after September 1, 1990. This submission requirement applies to suppliers furnishing oxygen and oxygen equipment to Medicare beneficiaries and is applicable throughout the 36-month rental cap period. Per regulation (42 CFR 414.226), the supplier that furnishes oxygen equipment for the first month during which payment is

made must continue to furnish the equipment for the entire 36-month period of continuous use, unless medical necessity ends or a specific exception applies. Further, the supplier that furnishes the oxygen and oxygen equipment during the 36th month of continuous use must continue to furnish the oxygen and oxygen equipment after the cap for any period of medical need for the remainder of the reasonable useful lifetime of the equipment. In cases after the 36th rental month where the beneficiary relocates to an area that is outside the normal service area of the supplier, the supplier can arrange for furnishing the oxygen equipment with another supplier, but the original supplier is still responsible for making sure the beneficiary receives the oxygen and oxygen equipment and must bear the costs of making these arrangements when necessary. Failure to bill Medicare in the latter months of the rental period in order to avoid the statutory requirements associated with receiving payment for the 36th month of continuous use is inconsistent with these requirements and could result in penalties.

For more information on mandatory submission of claims requirements, please see the MLN Matters® Article, "Mandatory Claims Submission and its Enforcement."

2013 PQRS and/or eRx Incentive Program: Stripped N365 Remark Code

For those eligible professionals participating in the 2013 Physician Quality Reporting System (PQRS) and/or Electronic Prescribing (eRx) Incentive Program via claims, CMS is aware the Remittance Advice (RA)/Explanation of Benefits (EOBs) may not be displaying the N365 remark code for program quality-data codes (QDCs) for claims processed April 2013 through July 2013. The N365 remark code will reappear again starting for claims that are processed in July 2013. QDCs submitted on Medicare Part B Physician Fee Schedule (PFS) claims with $0.00 line items have been (and will be) processed into the National Claims History (NCH) file even though the RA/EOB did not indicate the N365 remark code, given the claim was in final-action status and not pended, rejected, etc.

What should I do if I don't see the N365 Remark Code?
The N365 remark code on the RA/EOB is an indication that the QDC is associated with current program year PQRS and/or eRx Incentive Program specifications, but does not confirm whether the QDC was accurately reported per program requirements. If the QDC $0.00 line item shows on the RA, but without the N365, it is possible the QDC is not within current program year specifications. It is also possible that the N365 is simply missing due to reporting using the $0.00 line item. All submitted QDCs on fully processed claims are forwarded to the NCH for analysis by the PQRS and/or eRx programs, so providers will first want to be sure they do see the QDC line item on the RA/EOB, regardless of whether the N365 appears. If there is no QDC line item, it is possible that the provider's claims software has stripped any $0.00 line items, and this will need to be corrected, either within the software, or by adding a $0.01 charge rather than $0.00.

Adding the $0.01 charge to the QDC line item will help generate the N365 remark code, which will indicate whether the QDC is current. Providers may work with their vendors/billing systems/clearing houses to determine whether the option to submit a $0.00 or $0.01 charge for QDC line items will work best for their practice.

Tips for Reporting
CMS would like to remind providers that no PQRS/eRx Incentive Program reporting validation or analysis occurs at the Carrier or A/B Medicare Administrative Contractor (MAC) claims level, beyond forwarding QDCs to the NCH. So it is imperative that providers make sure they are coding claims with the current program year measure specifications, either for individual measures or measures groups. They will want to verify that the patient they are reporting on falls within the measure's denominator for age/gender, as well as diagnosis and service/encounter when applicable. Then be sure to follow the specifications showing the available numerator QDC reporting options, and report the one(s) that best describes the quality action performed.

Again, CMS is aware that RA/EOBs may not display the N365 remark codes for $0.00 QDC line items and is actively working with Carrier/Medicare Administrative Contractors (MACs) to resolve this issue. The N365 remark code will reappear again with claims that are processed after July 2013.

MLN Education Products Update

"How to Protect Your Identity Using the Provider Enrollment, Chain and Ownership System (PECOS)" Fact Sheet — Revised

The "How to Protect Your Identity Using the Provider Enrollment, Chain and Ownership System (PECOS)" Fact Sheet (ICN 905103) was revised and is now available in downloadable format. This fact sheet is designed to provide education on identity protection when using Internet-based PECOS. It includes step-by-step instructions on how providers can protect their identity while using Internet-based PECOS.

"Centers for Medicare & Medicaid Services (CMS) Electronic Mailing Lists: Keeping Health Care Professionals Informed" Fact Sheet — Revised

The "Centers for Medicare & Medicaid Services (CMS) Electronic Mailing Lists: Keeping Health Care Professionals Informed" Fact Sheet (ICN 006785) was revised and is now available in downloadable format. This fact sheet is designed to provide education on the various CMS electronic mailing lists available to health care professionals. It includes information about how to register for the service and receive the latest news regarding important initiatives in the Medicare program.

New Continuing Education Association Now Accepting Medicare Learning Network® (MLN) Courses

The MLN is happy to announce that the latest continuing education association to accept MLN courses is the California Certifying Board for Medical Assistants (CCBMA). CCBMA joins the AAPC, American Association of Medical Assistants (AAMA), the American Association of Medical Audit Specialists (AAMAS), the American Medical Billing Association (AMBA), the Healthcare Billing and Management Association (HBMA), the Medical Association of Billers (MAB), and the National Academy of Ambulance Coding (NAAC).

New MLN Provider Compliance Fast Fact

A new fast fact is now available on the MLN Provider Compliance web page. This web page provides the latest MLN Education Products and MLN Matters® Articles designed to help Medicare FFS providers understand common billing errors and avoid improper payments. Please bookmark this page and check back often as a new fast fact is added each month.

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