Thursday, July 4, 2013

MLN Connects™ National Provider Calls

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- Medicare Shared Savings Program Application Process Question and Answer Session — Register Now
- Medicare and Medicaid EHR Incentive Programs for Eligible Professionals: In-depth Overview of Clinical Quality Measures for Reporting Beginning in 2014 — Registration Now Open
- CMS Proposals for PQRS and Physician Value-Based Payment Modifier under the Medicare Physician Fee Schedule 2014 Proposed Rule — Register Now
- Choosing Your PQRS Group Reporting Mechanism and Implications for the Value-based Payment Modifier — Register Now
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- ESRD Quality Incentive Program: Reviewing Your Facility's Payment Year 2014 Performance Data – Save the Date
- OPEN PAYMENTS — Policy Updates on Payments & the Physician Resource Toolkit — Save the Date

Previous MLN Connects Calls: New Materials Available

- Audio Recording and Written Transcript from June 18 "PQRS and eRx Incentive Program Payment Adjustment" Call Now Available
- Audio Recording and Written Transcript from June 20 "Medicare Shared Savings Program Application Process: Application Review" Call Now Available

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"Detailed Written Orders and Face-to-Face Encounters" MLN Matters® Article — Revised
"Payment Related to Prior Authorization for Power Mobility Devices (PMD)" MLN Matters® Article — Revised
"Medicare Physician Fee Schedule" Fact Sheet — Revised
"DMEPOS Competitive Bidding Program: Physicians and Other Treating Practitioners Who Are Enrolled as Medicare DMEPOS Suppliers" Fact Sheet — Revised
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"The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Physicians and Non-Physician Practitioners" Fact Sheet — Revised

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 MLN Connects 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 MLN Connects Upcoming 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 MLN Connects Calls and Events 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 MLN Connects 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 MLN Connects 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 MLN Connects Upcoming 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 MLN Connects Calls and Events 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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Medicare and Medicaid EHR Incentive Programs for Eligible Professionals: In-depth Overview of Clinical Quality Measures for Reporting Beginning in 2014 — Registration Now Open
Tuesday, July 23; 1:30-3pm ET

This call will give eligible professionals an in-depth overview of clinical quality measures (CQMs) included in the final rule for Stage 2 of Meaningful Use for the Medicare and Medicaid Electronic Health Records (EHR) Incentive Program. Details on the measures, the recommended core set for reporting purposes, and the 2014 electronic specifications for the Medicare EHR Incentive Program will be provided. Participants will be given an opportunity to engage CMS subject matter experts with questions on CQMs.

Agenda:

- Review background information on the EHR Incentive Program: Meaningful Use
- Present Stage 2 requirements, focusing on clinical quality measures
- Explain components of eMeasures in Stage 2
- Provide additional resources for more information
- 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 MLN Connects Upcoming 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 MLN Connects Calls and Events 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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CMS Proposals for PQRS and Physician Value-Based Payment Modifier under the Medicare Physician Fee Schedule 2014 Proposed Rule — Register Now

Thursday, July 25; 1:30-3pm ET

This MLN Connects 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 MLN Connects Upcoming 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 MLN Connects Calls and Events 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 MLN Connects 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 MLN Connects 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 MLN Connects Upcoming 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 MLN Connects Calls and Events 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 MLN Connects Calls. Visit the Continuing Education Credit Information web page to learn more.

Medicare and Medicaid EHR Incentive Programs National Provider Call Series — Update

The Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs paid out over $14.7 billion in incentives through May of this year. Don't be left out. CMS will be holding a series of MLN Connects Calls about different aspects of the EHR incentive programs. Don't miss these opportunities to learn from the experts. Register for the July 23 call on Clinical Quality Measures for Medicare and Medicaid Eligible Professionals, Eligible Hospitals, and Critical Access Hospitals.

Note: the 2 calls scheduled for August have been combined into one. Mark your calendars for these upcoming calls. Registration will be announced soon:

- Medicare and Medicaid Eligible Professionals, Eligible Hospitals, and Critical Access Hospitals:
  - July 24; 1:30-3 —Stage 2
- Medicare Eligible Professionals, Eligible Hospitals, and Critical Access Hospitals
  - August 15; 1:30-3 —Payment Adjustments and Hardship Exceptions – 2 calls combined

ESRD Quality Incentive Program: Reviewing Your Facility's Payment Year 2014 Performance Data – Save the Date
Wednesday, August 7; 3-4pm ET

CMS will host an MLN Connects Call on the End-Stage Renal Disease (ESRD) Quality Incentive Program (QIP). The ESRD QIP is a pay-for-performance initiative that ties a facility's quality scores to a payment percentage reduction over the course of a payment year (PY). This MLN Connects call will focus on the steps dialysis facilities need to take to review the

data CMS will use to evaluate performance as part of the PY 2014 program. Don't miss this opportunity to learn from the experts. Mark your calendars, as registration will be announced soon.

OPEN PAYMENTS — Policy Updates on Payments & the Physician Resource Toolkit — Save the Date

Thursday, August 8; 1:30-3pm ET

OPEN PAYMENTS (Physician Payment Sunshine 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. It is important to know that data collection will begin on August 1, 2013. This MLN Connects Call for physicians and teaching hospitals will give an update on program policy, with a focus on third party payments and indirect payments as well as the Physician Resource Toolkit. Don't miss these opportunities to learn from the experts. Mark your calendars, as registration will be announced soon.

Previous MLN Connects Calls: New Materials Available

Audio Recording and Written Transcript from June 18 "PQRS and eRx Incentive Program Payment Adjustment" Call Now Available

The audio recording and written transcript from the June 18 "Getting Started with PQRS Reporting: Implications for the Value-based Payment Modifier" call are now available on the June 18 call web page in the "Call Materials" section.

Audio Recording and Written Transcript from June 20 "Medicare Shared Savings Program Application Process: Application Review" Call Now Available

The audio recording and written transcript from the June 20 "Medicare Shared Savings Program Application Process: Application Review" call are now available on the June 20 call web page in the "Call Materials" section.

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.

Hospice Software Developer/Vendor Call

Tuesday, July 16; 2-3:30pm ET

CMS will host a Hospice technical informational call for software vendors and developers for the Hospice Item Set. Participation instructions and the agenda are available in the call announcement.

Announcements and Reminders

Medicare Proposes Provisions for the ESRD Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies

On Tuesday, July 2, CMS issued a proposed rule that would update Medicare policies and payment rates for End-Stage Renal Disease (ESRD) facilities, while strengthening incentives for improved quality of care and better outcomes for beneficiaries diagnosed with ESRD. The provisions would affect payments for outpatient maintenance dialysis treatments furnished on or after January 1, 2014 under the bundled ESRD Prospective Payment System.

CMS is projecting that overall estimated payments to ESRD facilities for renal dialysis services will decrease by 9.4 percent, representing a projected inflation (or ESRD bundled market basket) increase of 2.9 percent reduced by a projected productivity adjustment of 0.4 percent and a proposed drug utilization adjustment -12 percent. The proposed drug utilization adjustment of -12 percent is to account for changes in utilization of ESRD-related drugs and biologicals as required by section 1881(b)(14)(I) of the Social Security Act, as added by section 632(a) of the American Taxpayer Relief Act of 2012. While the 9.4 percent decrease represents an approximate $780 million reduction in Medicare payments, CMS estimates that payments to ESRD facilities in 2014 will total $8 billion.

The rule also makes changes to the ESRD Quality Incentive Program (QIP) that provides payment incentives to dialysis facilities to improve the quality of dialysis care. Under the ESRD QIP, facilities are evaluated on a number of quality measures, which form the basis for calculating a Total Performance Score. Facilities that do not achieve a minimum Total Performance Score receive a reduction in their payment rates under the ESRD PPS of up to 2 percent. The rule proposes to expand the criteria used to evaluate quality of dialysis care by introducing five new quality measures. Please refer to the ESRD Quality Improvement Initiative website.

CMS is also proposing to clarify the 3-year minimum lifetime requirement (MLR) for Durable Medical Equipment (DME) and the definition of routinely purchased DME. This rule also proposes the implementation of budget-neutral fee schedules for splints and casts, and intraocular lenses (IOLs) inserted in a physician's office. Finally, this rule would make a few technical amendments and corrections to existing regulations related to payment for DMEPOS items and services.

The rule (CMS-1526-P) can be viewed on the ESRD Payment website.

CMS Proposes Payment Changes for Medicare Home Health Agencies for 2014

On June 27, CMS announced proposed changes to the Medicare home health prospective payment system (HH PPS) for CY 2014 that would foster greater efficiency, flexibility, payment accuracy, and improved quality. Based on the most recent data available, CMS estimates that approximately 3.5 million beneficiaries received home health services from nearly 12,000 home health agencies, costing Medicare approximately $18.2 billion in 2012.

In the rule, CMS projects that Medicare payments to home health agencies in calendar year CY 2014 will be reduced by 1.5 percent, or $290 million based on the proposed policies. The proposed decrease reflects the effects of the 2.4 percent home health payment update percentage ($460 million increase), the rebasing adjustments to the national, standardized 60-day episode payment rate, the national per-visit payment rates, and the non-routine medical supplies (NRS) conversion factor ($650 million decrease), and the effects of ICD-9-CM coding adjustments ($100 million decrease).

In addition, the rule proposes routine updates to the HH PPS payment rates such as updating the payment rates by the HH PPS payment update percentage and updating the home health wage index for 2014. The proposed rule includes:

- HH PPS grouper refinements and ICD-10-CM conversion
  Rebasing the 60-day episode rate

- Rebasing per-visit amounts
- Rebasing and updating other components of the HH PPS
  Quality reporting
- Cost allocations for Home Health Agency surveys

CMS will accept comments on the proposed rule until August 26, 2013. For additional information about the HH PPS proposed rule:

- Home Health PPS website.
- HH PPS proposed rule
- Fact Sheet

Compare Website Redesigned to Help Consumers Search for Physicians

Physician Compare, a website that allows consumers to search and compare information about hundreds of thousands of physicians and other health care professionals, has been redesigned to make the site easier to use and provide new information for consumers. CMS Administrator Marilyn Tavenner announced the redesign, which includes an improved search function and more frequently updated information.

Physician Compare was improved based on user and partner feedback, as part of improvements in the Affordable Care Act. The redesign includes new information on physicians, such as:

- Information about specialties offered by doctors and group practices;
- Whether a physician is using electronic health records;
- Board certification; and
- Affiliation with hospitals and other health care professionals.

Physician Compare is also now connected to the most consistently updated database so that consumers will find the most accurate and up-to-date information available. In 2014 quality data will be added, and this will help users choose a medical professional based on performance ratings.

Visit the Physician Compare website. You can also go to www.medicare.gov and click on "Find doctors & other health professionals." A video highlighting the main features of the redesign is available.

Full text of this excerpted CMS press release (issued June 27).

Medicare Contracting Reform Website: New Name and URL Starting July 11

CMS is announcing that the "Medicare Contracting Reform" website will have a name change effective July 11, 2013. The new name will be "Medicare Administrative Contractors" (MACs). The website has been reorganized and where applicable, the content has been updated. With this name change, you may need to save this new web address as a favorite on your computer. We hope that you will visit the website to view the changes on July 11. An additional eNews announcement will be published with the new link on July 18.

Update to a 2014 eCQM Measure for Eligible Professionals

An issue was identified in measure CMS182 of the updated 2014 eCQMs for eligible professionals (EPs) that were released on June 17. CMS and Office of the National Coordinator for Health Information Technology (ONC) have corrected the measure, and uploaded it as CMS 182v3.

This measure is now included in the 2014 Clinical Quality Measure (CQM) specification package for EPs on the CMS eCQM Library web page. The following June 2013 documents have also been updated:

- Table of 2014 EP Measure Versions
- 2014 eCQM Specifications for EP Release June 2013
- Technical Release Notes 2014 eCQM for EP Release June 2013
- 2014 eCQM Measure Logic Guidance v1.4 Release June 2013

In order for the Cypress system to be as complete and accurate as possible, ONC decided not to release the Cypress system in June 2013 with the release of the updated versions of the 2014 eCQMs for EPs.The Cypress system and test cases will be released on July 11, 2013.

For questions regarding certification and the updated 2014 eCQMs, please refer to ONC's frequently asked question on certification for 2014.

The ICD-10 Deadline is October 1, 2014

The compliance deadline for ICD-10 is *October 1, 2014*. CMS Administrator Marilyn Tavenner has affirmed the ICD-10 deadline and encourages providers, payers, and vendors across the health care industry to prepare to use the new codes for services provided on or after October 1, 2014. The CMS website offers a variety of resources targeted to payers, providers, vendors, and others to help you with your transition to ICD-10. Timelines, checklists, fact sheets, and in-depth guides are all available to help you and your organization plan for a smooth transition.

Claims, Pricer, and Code Updates

Additional Time to Establish Protocols for Newly Required Face-to-Face Encounters for DME

Due to concerns that some providers and suppliers may need additional time to establish operational protocols necessary to comply with face-to-face encounter requirements mandated by the Affordable Care Act (ACA) for certain items of Durable Medical Equipment (DME), CMS will start actively enforcing and will expect full compliance with the DME face-to-face requirements beginning on October 1, 2013.

Section 6407 of the ACA established a face-to-face encounter requirement for certain items of DME. The law requires that a physician must document that a physician, nurse practitioner, physician assistant, or clinical nurse specialist has had a face-to-face encounter with the patient. The encounter must occur within the 6 months before the order is written for the DME.

Although many DME suppliers and physicians are aware of and are able to comply with this policy, CMS is concerned that some may need additional time to establish operational protocols necessary to comply with this new law. As such, CMS expects that during the next several months, suppliers and physicians who order certain DME items will continue to collaborate and establish internal processes to ensure compliance with the face-to-face requirement. CMS expects durable medical equipment suppliers to have fully established such internal processes and have appropriate documentation of required encounters by October 1, 2013.

CMS will continue to address industry questions concerning the new requirements and will update information on our Medical Review and Education website. CMS and its contractors will also use other communication channels to ensure that the provider community is properly informed of this announcement.

Medicare Secondary Payment Adjustment Information

CMS was notified on March 20, 2013 of an error in the Fiscal Intermediary Shared System (FISS) that caused the Medicare Secondary Payment (MSP) full recovery indicator to set incorrectly when the primary payer payment was not greater than:

- the obligated to accept as payment in full (OTAF) amount,
- the Medicare covered charges, or
- Medicare reimbursement amount.

As a result, the MSPPAY module zeroed out coinsurance days as part of its calculation; also, some claims were processed incorrectly as "full recovery" claims that reflected zero Medicare payment. Medicare secondary payments should have been made for both institutional Part A and Part B provider claims.

On May 6, 2013, FISS was updated to apply the OTAF amount and full recovery indicator correctly. This fix also allows the system to correctly identify this MSP savings type as a "full recovery" when claims meet all the criteria for MSP fully paid claims.

The FISS maintainer is developing a utility to identify and systematically adjust claims that were incorrectly processed due to the issue identified above. In the interim, providers that feel their claims were processed incorrectly can initiate adjustment claims in lieu of waiting for the FISS utility to automatically create the appropriate adjustments for the affected claims.

FDG Positron Emission Tomography for Solid Tumors and Myeloma: Data Collection Ends Under the National Oncologic PET Registry

Effective June 11, 2013, CMS ended the coverage with evidence development (CED) requirement for F-18 fluorodeoxyglucose positron emission tomography (FDG PET) and FDG PET/CT for all oncologic indications contained in section 220.6.17 of the Medicare National Coverage Determinations (NCD) Manual. This removes the current requirement for prospective data collection by the National Oncologic PET Registry (NOPR) for oncologic indications of *FDG only.*

Effective for claims with dates of service on or after June 11, 2013, FDG PET and FDG PET/CT claims, (codes 78608, 78811, 78812, 78813, 78814, 78815, 78816 and HCPCS A9552), for all oncologic conditions, no longer require the following modifier and diagnosis code:

- Q0 (zero): Investigational clinical service provided in a clinical research study that is an approved clinical research study.
- V70.7: Examination of participant in clinical research:

These changes only apply to services using FDG (HCPCS A9552) as the radiopharmaceutical. *This does not apply to services using NaF-18 (HCPCS A9580)*. The changes also *do not* affect use of the following modifiers, which are still required on claims.

- PI (initial treatment strategy)
- PS (subsequent treatment strategy)

Note: This decision does not change coverage for use of PET or PET/CT using radiopharmaceuticals NaF-18 (fluorine-18 labeled sodium fluoride), ammonia N-13, or rubidium-82 (Rb-82).

CED continues under NOPR for NaF-18 PET and PET/CT for bone metastasis per section 220.6.19 of the NCD Manual.

The Internet Only Manuals will be updated soon to reflect these changes. See the CMS final decision memorandum for more detailed information.

2014 ICD-10-CM Code Updates Now Available

CMS has posted the 2014 ICD-10-CM code updates on the 2014 ICD-10-CM and GEMs web page, including the tabular and index sections, which comprise the complete ICD-10-CM code book in electronic format. Also included in this update:

- The 2014 ICD-10-CM code descriptions (code titles) have been posted in the correct tabular order.
- The 2014 ICD-10-CM Addendum document in the "Related Links" section contains strikeout text to depict what is being deleted in the files.
    - If you are visually impaired and are unable to detect the strikeout text, please contact NCHSED at nchsed@cdc.gov or by calling 301-458-4688.

The 2104 General Equivalence Mappings (GEMs) will be posted in October, 2013 on the 2014 ICD-10-CM and GEMs web page.

Updates to DMEPOS Competitive Bidding Program Fact Sheets: Hospital and Physician Exceptions

CMS has updated the list of Healthcare Common Procedure Coding System (HCPCS) codes that qualify for the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program hospital and physician/treating practitioner exceptions. Please see the updated MLN fact sheets:

- Hospitals That Are Not Contract Suppliers
- Physicians and Other Treating Practitioners Who Are Enrolled Medicare DMEPOS Suppliers

MLN Education Products Update

OIG Recovery Audit Findings MLN Matters® Articles – Released

The following MLN Matters® Special Edition articles were released and are now available in downloadable format. These articles are designed to provide education on OIG findings related to Recovery Audit issues. They include information about the issues and guidance health care professionals can use to avoid these issues in the future. For the latest MLN educational resources and MLN Matters® articles designed to help health care professionals understand common billing errors and avoid improper payments, visit the MLN Provider Compliance web page.

- SE1312: "Billing for Visits to Patients in Swing Bed Facilities"
- SE1313: "Place of Service Coding for Physician Services in an Outpatient Setting"
- SE1314: "Duplicate Claims—Outpatient"
- SE1315: "Pulmonary Procedures and Evaluation & Management (E/M) Services"
- SE1316: "Incorrect Number of Units Billed for Rituximab (HCPCS J9310) and Bevacizumab (HCPCS C9257 and J9035) – Dose versus Units Billed"
- SE1317: "Post-Acute Care Transfer – Underpayments"
- SE1318: "Guidance To Reduce Mohs Surgery Reimbursement Issues"
- SE1319: "Cataract Removal, Part B"
- SE1320: "Add-on HCPCS/CPT Codes Without Primary Codes"
- SE1321: "Hospice Related Services - Part B"
- SE1322: "Co-Surgery Not Billed with Modifier 62"
- SE1323: "Additional/Subsequent Procedures Performed During the 90 Day Global Period for Major Surgeries"
- SE1324: "Pre-Admission Diagnostic Testing Review"
- SE1326: "Overutilization of Nebulizer Medications"
- SE1327: "Infusion Pump Denied/Accessories & Drug Codes Should Be Denied"

"Health Care Professional Frequently Used Web Pages" Educational Tool — Released

The "Health Care Professional Frequently Used Web Pages" Educational Tool (ICN 908466) was released and is now available in downloadable format. This educational tool is designed to provide education on the most frequently used web pages on the CMS website. It includes information on coverage, billing and payment, and Medicare contracting.

"Detailed Written Orders and Face-to-Face Encounters" MLN Matters® Article — Revised

MLN Matters® Article #MM8304, "Detailed Written Orders and Face-to-Face Encounters" was revised and is now available in downloadable format. This article is designed to provide education on the requirements for detailed written orders for face-to-face encounters that Durable Medical Equipment (DME) Medicare Administrative Contractors (MACs) must implement by Monday, July 1, 2013, as outlined in Change Request 8304 and Section 6407 of the Affordable Care Act. It includes background information and detailed information that must be included in the written order for DME face-to-face encounters. The article was revised to clarify information and add additional references to relevant sections of the "Medicare Program Integrity Manual."

"Payment Related to Prior Authorization for Power Mobility Devices (PMD)" MLN Matters® Article — Revised

MLN Matters® Article #MM8056, "Payment Related to Prior Authorization for Power Mobility Devices (PMD)" was revised and is now available in downloadable format. This article is designed to provide education on the requirements for the PMD demonstration prior authorization initiative, as outlined in Change Request 8056. It includes background information about this initiative and guidance that physicians and certain other health care professionals should follow when submitting a prior authorization request for PMDs. The article was revised to reflect a recent revision to CR 8056. All other information remains the same.

"Medicare Physician Fee Schedule" Fact Sheet — Revised

The "Medicare Physician Fee Schedule" Fact Sheet (ICN 006814) was revised and is now available in downloadable format. This fact sheet is designed to provide education on the Medicare Physician Fee Schedule (PFS). It includes the following information: physician services, Medicare PFS payment rates, and Medicare PFS payment rates formula.

"DMEPOS Competitive Bidding Program: Physicians and Other Treating Practitioners Who Are Enrolled as Medicare DMEPOS Suppliers" Fact Sheet — Revised

The "DMEPOS Competitive Bidding Program: Physicians and Other Treating Practitioners Who Are Enrolled as Medicare DMEPOS Suppliers" Fact Sheet (ICN 900926) was revised and is now available in downloadable format. This fact sheet is designed to provide education on an exception to regular Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) competitive bidding program rules for walkers provided by physicians and other treating practitioners who are enrolled DMEPOS suppliers. It includes information on who can be considered under this exemption.

"DMEPOS Competitive Bidding Program: Hospitals That Are Not Contract Suppliers" Fact Sheet — Revised

The "DMEPOS Competitive Bidding Program: Hospitals That Are Not Contract Suppliers" Fact Sheet (ICN 905463) was revised and is now available in downloadable format. This fact sheet is designed to provide education on an

exception to regular Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) competitive bidding program rules for walkers provided by hospitals that are not contract suppliers. It includes payment rules under this exception.

"The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Physicians and Non-Physician Practitioners" Fact Sheet — Revised

"The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Physicians and Non-Physician Practitioners" Fact Sheet (ICN 903764) was revised and is now available in downloadable format. This fact sheet is designed to provide education on how physician and non-physician practitioners should enroll in the Medicare Program and maintain their enrollment information using Internet-based PECOS. It includes information on how to complete an enrollment application using Internet-based PECOS and a list of frequently asked questions and resources.

Do you refer Medicare beneficiaries for DMEPOS? Learn how DMEPOS Competitive Bidding affects you.
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