



MLN Connects™ Provider eNews

Part of the Medicare Learning Network®

Thursday, August 1, 2013

MLN Connects™ National Provider Calls

ESRD Quality Incentive Program: Reviewing Your Facility's Payment Year 2014 Performance Data — Register Now
OPEN PAYMENTS: Policy Updates on Payments and the Physician Resource Toolkit — Register Now
ESRD Quality Incentive Program Notice of Proposed Rulemaking: Payment Year 2016 — Register Now
Payment Adjustments and Hardship Exceptions for the Medicare EHR Incentive Program — Register Now
ICD-10 Basics — Register Now
Did You Miss These MLN Connects Calls?

Announcements and Reminders

Have You Checked Your Patient's Immunization Status?
Prescribing Specific Brands under the DMEPOS Competitive Bidding Program
Additional Data Reporting Requirements for Hospice Claims
Medicare Payments to Inpatient Psychiatric Facilities Are Projected to Increase 2.3 percent in FY 2014
Dry Run of 30-day Risk-Standardized Acute Myocardial Infarction Payment Measure Begins August 5

Claims, Pricer, and Code Updates

Claims Hold Related to Part A to Part B Rebilling of Denied Hospital Inpatient Claims
Quarterly Provider Specific Files for the Prospective Payment System are Now Available
July 2013 Outpatient Prospective Payment System Pricer File Update

MLN Educational Products Update

"Medicare-Covered Services Furnished Outside the United States" Fact Sheet — Released
"Outpatient Therapy Functional Reporting Requirements" MLN Matters® Article — Released

MLN Connects™ National Provider Calls

ESRD Quality Incentive Program: Reviewing Your Facility's Payment Year 2014 Performance Data — Register Now
Wednesday, August 7; 3-4pm ET

To Register: Visit [MLN Connects Upcoming Calls](#). Space may be limited, register early.

Target Audience: Dialysis clinics and organizations, nephrologists, hospitals with dialysis units, billers/coders and quality improvement experts.

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 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.

On July 29, 2013, CMS will make available to each facility a preliminary PY 2014 Performance Score Report (PSR) that "previews" how well it scored on the quality measures CMS will use for determining any payment reductions. CMS encourages every dialysis facility to carefully review its PSR before CMS makes the information available publicly at the end of 2013. Facilities will have from July 29 through August 29, 2013 to complete this important review. Also during this period, facilities will have an opportunity to ask questions about how their scores were calculated, and also have the ability to submit *one* formal inquiry if they find or suspect an error in the score calculations.

Agenda:

- How to access and review facility's PSR;
- How CMS calculated a facility's ESRD QIP performance score using quality data;
- What the performance score means to a facility's PY 2014 payment rates;
- When and where to ask questions regarding a PSR, including how to submit *one* formal inquiry;
- Duties and responsibilities to make ESRD QIP performance data transparent to patients;
- Where to access help and get additional information

Continuing education credit may be awarded for participation in certain MLN Connects Calls. Visit the [Continuing Education Credit Information](#) web page to learn more.

OPEN PAYMENTS: Policy Updates on Payments and the Physician Resource Toolkit — Register Now

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

To Register: Visit [MLN Connects Upcoming Calls](#). Space may be limited, register early.

Target Audience: Physicians, teaching hospitals, and other interested stakeholders.

OPEN PAYMENTS (Physician Payment Sunshine Act) requires manufacturers of pharmaceuticals or medical devices to publicly 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. There will be a question and answer session following the presentation. Don't miss this opportunity to learn from the experts.

Agenda:

- Update on program policy, with a focus on Third Party Payments & Indirect Payments
- Physician Resource Toolkit
- Question and answer session

Continuing education credit may be awarded for participation in certain MLN Connects Calls. Visit the [Continuing Education Credit Information](#) web page to learn more.

ESRD Quality Incentive Program Notice of Proposed Rulemaking: Payment Year 2016 — Register Now

Wednesday, August 14; 3-4:30pm ET

To Register: Visit [MLN Connects Upcoming Calls](#). Space may be limited, register early.

Target Audience: Dialysis clinics and organizations, nephrologists, hospitals with dialysis units, billers/coders and quality improvement experts.

CMS will host a MLN Connects Call on the End-Stage Renal Disease (ESRD) Quality Incentive Program (QIP). The ESRD QIP is a pay-for-performance quality initiative that ties a facility's performance to a payment reduction over the course of a payment year (PY).

This call will focus on the [proposed rule](#) for operationalizing the ESRD QIP in PY 2016. This proposed rule was published in the Federal Register on July 8. The public will have until August 30, 2013, to submit their comments about the content of the rule. CMS encourages every dialysis facility and ESRD stakeholder to carefully review the proposed rule and participate in the comment period.

After the presentation, participants will have an opportunity to ask questions.

Agenda:

- ESRD QIP legislative framework
- Proposed measures, standards, scoring methodology, and payment reduction scale for PY 2016
- Methods for reviewing and commenting on the proposed rule
- Question and answer session

Continuing education credit may be awarded for participation in certain MLN Connects Calls. Visit the [Continuing Education Credit Information](#) web page to learn more.

Payment Adjustments and Hardship Exceptions for the Medicare EHR Incentive Program — Register Now

Thursday, August 15; 1:30-3

To Register: Visit [MLN Connects Upcoming Calls](#). Registration will open soon.

Target Audience: [Eligible hospitals](#) and [eligible professionals](#).

Beginning in 2015, Medicare eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) that do not successfully demonstrate meaningful use will be subject to a payment adjustment. The payment adjustments for EPs start at 1% and increase each year up to 5% if the provider does not demonstrate meaningful use of Electronic Health Record (EHR) technology. Join the CMS experts on an MLN Connects Call to learn who will be affected, how to apply for an exception if you are eligible, and how the payment adjustment will be applied. *Note: Providers which are not eligible for the Medicare EHR incentive program, or who successfully attest to the Medicaid EHR incentive program, will not be subject to payment adjustments.*

Agenda:

- Who is subject to payment adjustments
- Who can request an exception
- Adjustments for professionals
- Adjustments for hospitals and CAHs

Continuing education credit may be awarded for participation in certain MLN Connects Calls. Visit the [Continuing Education Credit Information](#) web page to learn more.

ICD-10 Basics — Register Now

Thursday, August 22; 1:30-3pm ET

To Register: Visit [MLN Connects Upcoming Calls](#). Space may be limited, register early.

Target Audience: Medical coders, physicians, physician office staff, nurses and other non-physician practitioners, provider billing staff, health records staff, vendors, educators, system maintainers, laboratories, and all Medicare providers

Are you ready to transition to ICD-10 on October 1, 2014? Join us for a keynote presentation on ICD-10 basics by Sue Bowman from the American Health Information Management Association (AHIMA), along with an implementation update by CMS. A question and answer session will follow the presentation.

Agenda:

- Benefits of ICD-10
- Similarities and differences from ICD-9
- Coding
 - Basics of finding a diagnosis code
 - Placeholder "x"
 - Unspecified codes
 - External cause of injury codes
 - Type of encounter
- Training needs and timelines
- Resources for coding and training
- National implementation issues

Continuing education credit may be awarded for participation in certain MLN Connects Calls. Visit the [Continuing Education Credit Information](#) web page to learn more.

Did You Miss These MLN Connects Calls?

Call materials for MLN Connects calls are available on the [Calls and Events](#) web page. New materials are now available for the following calls:

- June 5 — Getting Started with PQRS: Implications for the Value-based Payment Modifier, [YouTube Video](#) [Slideshow Presentation](#)
- July 10 — CMS National Partnership to Improve Dementia Care in Nursing Homes, [audio](#) and [transcript](#)
- July 18- Medicare Shared Savings Program Application Question and Answer Session, [audio](#) and [transcript](#)

Announcements and Reminders

Have You Checked Your Patient's Immunization Status?

August is National Immunization Awareness Month (NIAM). This annual national health observance provides an opportunity to highlight the need for improving national immunization levels. The Centers for Disease Control and Prevention (CDC) list influenza and pneumococcal as especially serious diseases for adults 65 and older. Accordingly, CMS asks health care professionals to encourage Medicare beneficiaries to stay current on their immunizations; especially seasonal influenza, pneumococcal and hepatitis B for those who are at risk. Medicare Part B covers these immunizations and their administration for qualified beneficiaries.

- Influenza Immunizations: Medicare covers both the costs of the vaccine and its administration by recognized providers. There is no coinsurance or co-payment applied to this benefit, and a beneficiary does not have to meet his or her deductible to receive this benefit.
- Pneumococcal Vaccinations: Medicare provides coverage for one (1) pneumococcal vaccine for all beneficiaries. One vaccine at age 65 generally provides coverage for a lifetime, but for some high risk persons, revaccination may be appropriate. Medicare will also cover a pneumococcal vaccine for persons at the highest risk if 5 years

have passed since the last vaccination. There is no coinsurance or co-payment applied to this benefit, and a beneficiary does not have to meet his or her deductible to receive this benefit.

- Hepatitis B Vaccinations: Persons at high or intermediate risk, such as people with renal disease, hemophilia, and diabetes mellitus, are among those who are eligible to receive coverage for this immunization benefit under Medicare Part B, when administered by qualified providers. The coinsurance or co-payment applies after the yearly deductible has been met.

For More Information:

- [*CMS Immunization Website](#)
- [*MLN Preventive Immunizations Booklet for Health Care Professionals](#)
- [*MLN Quick Reference Medicare Immunization Billing Chart](#)
- [CDC Adult Immunization Schedule](#)
- [National Immunization Awareness Month 2013 Toolkit](#)

*Check back for – CMS 2013-2014 influenza season updates – coming soon.

Prescribing Specific Brands under the DMEPOS Competitive Bidding Program

Do you order or refer Medicare beneficiaries for items included in the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program? If so, we would like to remind you that the requirement for suppliers to furnish items in accordance with the prescription continues to apply under the program. In addition, the program includes a special beneficiary safeguard to ensure that beneficiaries have access to specific brands or modes of delivery of competitively bid items when needed to avoid an adverse medical outcome. This safeguard, which is sometimes called the Physician Authorization Process, allows a physician (including a podiatric physician) or treating practitioner (i.e., a physician assistant, clinical nurse specialist, or nurse practitioner) to prescribe a specific brand or mode of delivery to avoid an adverse medical outcome. The physician or treating practitioner must document in the beneficiary's medical record the reason why the specific brand or mode of delivery is necessary to avoid an adverse medical outcome.

If a physician or treating practitioner prescribes a particular brand or mode of delivery for a beneficiary to avoid an adverse medical outcome, the contract supplier must, as a term of its contract, ensure that the beneficiary receives the needed item. If the contract supplier does not ordinarily furnish the specific brand or mode of delivery and cannot obtain a revised prescription or locate another contract supplier that will furnish the needed item, the contract supplier *must* furnish the item as prescribed. Medicare will pay the single payment amount for covered competitively bid items furnished through the Physician Authorization Process.

For more information about the Physician Authorization Process, please see the [Referral Agents Fact Sheet](#) on the CMS website.

Additional Data Reporting Requirements for Hospice Claims

[MLN Matters® Article MM8358](#), “Additional Data Reporting Requirements for Hospice Claims,” discusses requirements effective for voluntary reporting as of January 1, 2014, and for required reporting as of April 1, 2014. Additional claims data reporting for hospices is required to support the hospice payment form, as authorized by the Affordable Care Act of 2010, section 3132(a).

Medicare Payments to Inpatient Psychiatric Facilities Are Projected to Increase 2.3 percent in FY 2014

On July 29, CMS issued a notice that will update payment rates to 481 freestanding inpatient psychiatric facilities (IPFs), and 1,143 IPF units of acute care hospitals, including a small number of IPF units in critical access hospitals (CAHs) that

are paid under the IPF Prospective Payment System (PPS). The new rates will apply to services furnished to Medicare beneficiaries during FY 2014, beginning with discharges on or after October 1, 2013.

CMS updates the payment rates under the IPF PPS annually, using the Rehabilitation, Psychiatric, and Long-Term Care (RPL) market basket index, which reflects changes in the prices of goods and services in IPFs, Inpatient Rehabilitation Facilities, and Long-Term Care Hospitals. For FY 2014, the RPL market basket estimate is 2.6 percent. The market basket is reduced by a 0.5 percent multifactor productivity (MFP) adjustment and a 0.1 percentage point reduction, both mandated by the Affordable Care Act. The net estimated increase to aggregate payments for FY 2014 is 2.3 percent.

CMS is also decreasing the outlier threshold amount for FY 2014 to \$10,245 from \$11,600 in FY 2013 to maintain outlier payments at 2.0 percent of total payments for FY 2014.

CMS estimates the total impact of the FY 2014 payment rate update to be an increase of approximately \$115 million.

The [notice](#) went on display July 29 at the Office of the Federal Register's Public Inspection Desk and will appear in the Federal Register on August 1. For more information, please see the [Inpatient Psychiatric Facility PPS](#) website.

Dry Run of 30-day Risk-Standardized Acute Myocardial Infarction Payment Measure Begins August 5

CMS is hosting a dry run of a new claims-based 30-Day Risk-Standardized Acute Myocardial Infarction (AMI) Payment measure. The dry run begins August 5, 2013. A Hospital-Specific Report (HSR) for this measure will be available to hospitals and QIOs on [My QualityNet](#) from *August 5, 2013 through September 4, 2013*. Questions about the measure can be submitted to cmsepisodepaymentmeasures@yale.edu. Additional information, such as a Frequently Asked Question sheet and measure information will be available on [QualityNet](#) starting August 5.

Claims, Pricer, and Code Updates

Claims Hold Related to Part A to Part B Rebilling of Denied Hospital Inpatient Claims

In July, CMS directed Medicare Administrative Contractors (MACs) to mass adjust claims related to Part A to Part B rebilling of denied hospital inpatient claims. A systems problem has been identified. MACs have been directed to hold claims with FISS Reason Codes 31182, 31796, and 31797 until a fix is implemented on August 5, at which time these claims will be released for processing. Providers need take no action.

For more background on "CMS Administrator's Ruling: Part A to Part B Rebilling of Denied Hospital Inpatient Claims," see [MLN Matters® Article MM8185](#).

Quarterly Provider Specific Files for the Prospective Payment System are Now Available

The July 2013 Provider Specific Files (PSF) are now available for download from the CMS website in SAS or Text format. The files contain information about the facts specific to the provider that affect computations for the Prospective Payment System. The SAS data files are available on the [Provider Specific Data for Public Use In SAS Format](#) web page, and the Text data files are available on the [Provider Specific Data for Public Use in Text Format](#) web page. The Text data files are available in two versions. One version contains the provider records that were submitted to CMS. The other version also includes name and address information for providers at the end of the records.

July 2013 Outpatient Prospective Payment System Pricer File Update

The Outpatient Prospective Payment System (OPPS) Pricer web page has been updated with outpatient provider data for July 2013. The July provider data is available for use and may be downloaded from the [OPPS Pricer](#) web page under “3rd Quarter 2013 Files.”

MLN Educational Products Update

“Medicare-Covered Services Furnished Outside the United States” Fact Sheet — Released

The “[Medicare-Covered Services Furnished Outside the United States](#)” Fact Sheet (ICN 908605) was released and is now available in hard copy format. This fact sheet is designed to provide education on Medicare-covered services. It includes information about Medicare-covered services furnished in the United States (U.S.), Medicare-covered services furnished outside the U.S., and billing and payment. To access a new or revised product available for order in *hard copy* format, go to [MLN Products](#) and click on “MLN Product Ordering Page” under “Related Links” at the bottom of the web page.

“Outpatient Therapy Functional Reporting Requirements” MLN Matters® Article — Released

[MLN Matters® Special Edition Article #SE1307](#), “Outpatient Therapy Functional Reporting Requirements,” was released and is now available in downloadable format. This article is designed to provide education on the reporting requirements for Functional Reporting using 42 G-codes and seven severity/complexity modifiers. It includes an overview and background information about the requirements, which are effective for therapy services with a date of service on or after January 1, 2013, and required under the Middle Class Tax Relief and Job Creations Act of 2012.

[Register](#) for an opportunity to rate your Medicare Administrative contractor. [Learn more](#)



Please share this important information with your colleagues and encourage them to [subscribe](#) to the MLN Connects Provider eNews.

Previous issues are available in the [archive](#).

Follow the MLN Connects Provider eNews on  &  #CMSMLN