



# MLN Connects™ Provider eNews

*Part of the Medicare Learning Network®*

Thursday, August 8, 2013

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## **MLN Connects™ National Provider Calls**

**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 an 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](#). Space may be limited, register early.

*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

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### **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

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### 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 23 — Medicare and Medicaid EHR Incentive Programs for Eligible Professionals: In-depth Overview of Clinical Quality Measures for Reporting Beginning in 2014: [audio](#) and [transcript](#)
- June 24 — Stage 1 and Stage 2 of Meaningful Use for the EHR Incentive Programs: [audio](#) and [transcript](#)
- June 25 — CMS Proposals for PQRS and Physician Value-Based Payment Modifier under the Medicare Physician Fee Schedule 2014 Proposed Rule: [audio](#) and [transcript](#)

### Other Calls, Meetings, & Events

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#### Special Open Door Forum: Suggested Electronic Clinical Template for Lower Limb Prostheses

*Wednesday, September 11; 4-5 pm ET  
Conference Call Only*

CMS will host multiple Special Open Door Forum (ODF) calls to allow physicians, prosthetists, and other interested parties to give feedback on clinical elements for the [Suggested Electronic Clinical Template for Lower Limb Prostheses](#) for possible Medicare use nationwide. Comments on the document can be sent to [eclinicaltemplate@cms.hhs.gov](mailto:eclinicaltemplate@cms.hhs.gov).

In order to enhance physician understanding of medical documentation requirements to support orders for Lower Limb Prostheses, CMS is exploring the development of an electronic clinical template that will assist providers with data collection and medical documentation. These templates may also facilitate the electronic submission of medical documentation. While not intended to be a data entry form per se, the template will describe the clinical elements that CMS believes would be useful in supporting the documentation requirements for coverage of Lower Limb Prostheses.

CMS will work in collaboration with the HHS Office of the National Coordinator for Health IT (ONC) and the electronic Determination of Coverage (eDoC) workgroup which is focused on developing the standards necessary for an electronic clinical template.

*Special Open Door Participation Instructions:*

- Operator Assisted Toll-Free Dial-In Number: (800) 603-1774; Conference ID # 21646970
- Note: TTY Communications Relay Services are available for the Hearing Impaired. For TTY services dial 7-1-1 or 800-855-2880. A Relay Communications Assistant will help.

A transcript and audio recording of this Special ODF will be posted to the [Special Open Door Forum](#) website for downloading. For automatic emails of Open Door Forum schedule updates (E-Mailing list subscriptions) and to view Frequently Asked Questions please visit the [Open Door Forum](#) website.

## **Announcements and Reminders**

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### **FY 2014 Payment and Policy Changes for Medicare Inpatient Rehabilitation Facilities**

On July 31, CMS issued a final rule [[CMS-1448-F](#)] updating FY 2014 Medicare payment policies and rates for the Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) and the IRF Quality Reporting Program (QRP).

Changes to IRF Payment Policies and Rates:

- FY 2014 updates to the payment rates under the IRF PPS
- Facility-level adjustment updates
- “60-percent rule” presumptive methodology code list updates

Changes to the IRF Quality Reporting Program:

- Prior-year quality measures
- New quality measures
- Changes to the IRF Patient Assessment Instrument (IRF-PAI).
- New reconsideration and disaster waiver processes for quality reporting

More information is available in the [fact sheet](#).

### **CMS Finalizes Updates to the Wage Index and Payment Rates for the Medicare Hospice Benefit**

On August 2, CMS issued a final rule [[CMS-1449-F](#)] that would update FY 2014 Medicare payment rates and the wage index for hospices serving Medicare beneficiaries. This hospice payment rule reflects the ongoing efforts of CMS to support beneficiary access to hospice. Hospices will see an estimated one percent (\$160 million) increase in their payments for FY 2014. The hospice payment increase is the net result of a hospice payment update percentage of 1.7 percent (a “hospital market basket” increase of 2.5 percent minus 0.8 percentage point for reductions mandated by law), and a 0.7 percent decrease in payments to hospices due to updated wage data and the fifth year of CMS’ seven-year phase-out of its wage index budget neutrality adjustment factor (BNAF). As finalized in this rule, CMS will update the hospice per diem rates for FY 2014 and subsequent years through the annual hospice rule or notice, rather than solely through a Change Request, as has been done in prior years. The FY 2014 hospice payment rates and wage index will be effective on October 1, 2013.

Final Rule Details:

- BNAF phase-out
- Coding clarification
- Hospice quality reporting
- Patient Experience of Care

- Other Affordable Care Act reforms

To read the technical report with details on reform research methods and findings please go to the [Hospice Center](#) website. More information is available in the [fact sheet](#).

### **Streamlined Access to PECOS, EHR, and NPPES — Coming Soon**

Changes are being made to simplify the way Providers and Suppliers access the Provider Enrollment Chain and Ownership System (PECOS), the Electronic Health Records (EHR) Incentive Program, and the National Plan and Provider Enumeration System (NPPES). These updates will improve the user experience when registering as an individual practitioner, authorized or delegated official of an organization, or someone working within PECOS on behalf of a provider or supplier (also known as a surrogate).

The new process will:

- Allow registered users to manage and reset their user ID and password online without calling a CMS Help Desk.
- Provide a simple and secure way for providers and suppliers to authorize individuals or groups of individuals to act on their behalf in PECOS and EHR.
- Allow designated authorized officials already on file with Medicare, to be quickly approved to access PECOS without the need to submit documentation to CMS for verification prior to submitting the application.
- Allow organizations with potentially large numbers of credentialing or support staff to manage staff access to the various functions.
- Increase security to reduce the risk of Provider identity theft and unauthorized access to systems.

*Important Note:* If you already have a user ID and password from NPPES, or currently access PECOS, NPPES, and/or EHR, your accounts will not be affected by this change. You can continue to utilize your established user ID and password to access the systems.

More information will be available in the near future.

### **Seeking Nominations for Physician Compare Quality Measurement Technical Expert Panel — August 22 Deadline**

CMS is seeking nominations for the Physician Compare Quality Measurement Technical Expert Panel (TEP). The TEP will provide expert feedback on physician quality measures that have been proposed for public reporting and make recommendations regarding future quality measures for public reporting on the Physician Compare website. CMS is seeking nominations from individuals with the following areas of expertise and perspectives:

- Public reporting of health care performance data/CMS Compare sites
- Reliability and validity testing
- Risk models and risk adjustment
- Performance measurement
- Quality improvement
- Consumer perspective
- Health care disparities

CMS is also looking for patients or their caregivers to join the TEP to provide feedback on the Physician Compare website. To nominate an individual for the TEP, please submit the following set of materials:

- A completed and signed TEP Nomination/Disclosure/Agreement form
- A letter of interest (not to exceed two pages), highlighting experience/knowledge relevant to the expertise described above and involvement in measure development
- Curriculum vitae and/or list of relevant experience (e.g., publications), a maximum of 10 pages total

More information, including the TEP Nomination/Disclosure/Agreement form, will be available on the [TEP](#) web page soon. If you wish to nominate yourself or other individuals for consideration, please complete the form and email it to [PhysicianCompare@Westat.com](mailto:PhysicianCompare@Westat.com). Nominations are due by *close of business August 22, 2013 ET*.

### **CMS Announces Teaching Hospital Closures and Round 6 of Section 5506 of the Affordable Care Act**

On August 2, 2013, as part of the FY 2014 IPPS/LTCH final rule, CMS announced Round 6 of Section 5506 of the Affordable Care Act. Section 5506 authorizes CMS to redistribute residency cap slots after a hospital that trained residents in an approved medical residency program(s) closes. Under Round 6, the resident cap slots of Cooper Green Mercy Hospital, in Birmingham, AL, and Sacred Heart Hospital, in Chicago, IL, are to be redistributed. First priority in redistributing the slots is given to hospitals located in the same or contiguous Core Based Statistical Areas (CBSAs) as the respective closed hospitals. Hard copy applications from hospitals to receive indirect medical education (IME) and direct graduate medical education (GME) full-time equivalent (FTE) resident slots from these two closed teaching hospitals must be received by CMS Central Office, not postmarked, by 5pm ET on October 31, 2013.

The "[Section 5506 Application Form](#)" and "[Guidelines for Submitting Applications Under Section 5506](#)" are located on the CMS [Direct Graduate Medical Education](#) web page, along with links to other rules that contain policy guidance on submitting section 5506 applications, including the CY 2011 OPPI final rule ([75 FR 72212](#)) and the FY 2013 IPPS/LTCH PPS final rule ([77 FR 53434](#) through 53447).

### **CMS Hospital Quality Activities**

CMS conducts various measure development and testing activities for potential use in quality initiatives. CMS seeks stakeholder feedback and participation to improve measurement efforts, including the following activities related to new measure development and dry runs of new measures for potential quality initiative implementation:

#### *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](mailto:cmsepisodepaymentmeasures@yale.edu). Additional information, such as a Frequently Asked Question sheet and measure information are available on [QualityNet](#).

#### *Dry Run of Stroke and Chronic Obstructive Pulmonary Disease (COPD) 30-day Readmission and Mortality Measures Begins August 12*

CMS is hosting a dry run of new claims-based measures addressing 30-day Stroke and COPD readmissions and mortality. The dry run begins August 12, 2013. Hospital-Specific Reports (HSRs) for these measure will be available for hospitals and QIOs on [My QualityNet](#) from *August 12, 2013 through September 11, 2013*. Additional information, such as Frequently Asked Question sheets and measure information are available on QualityNet. For Stroke readmission and mortality measure information, please visit: [QualityNet - Stroke](#). For COPD readmission and mortality measure information, please visit: [QualityNet - COPD](#).

#### *Public Comment Period for 30-day Risk-Standardized Heart Failure and Pneumonia Payment Measures*

Yale New Haven Health Systems Corporation/Center for Outcomes Research and Evaluation (YNHHSC/CORE), under contract with CMS, is hosting a 30-day comment period for feedback on the development of 30-day Risk-Standardized Heart Failure and Pneumonia Payment measures. Measure specifications found in the Measure Information Forms and the Measure Justification Forms can be accessed on [CMS.gov](#). Please email your comments to [costmeasure@yale.edu](mailto:costmeasure@yale.edu). Comments on the measures must be *received by close of business August 29, 2013*. The comments received will be posted approximately three weeks after the public comment period closes.

Questions about the measure can be submitted to the following measure-specific email addresses:

- Stroke readmission measure: [strokereadmission@yale.edu](mailto:strokereadmission@yale.edu)
- Stroke mortality measure: [strokemortality@yale.edu](mailto:strokemortality@yale.edu)
- COPD readmission measure: [copdreadmission@yale.edu](mailto:copdreadmission@yale.edu)
- COPD mortality measure: [copdmortality@yale.edu](mailto:copdmortality@yale.edu)

## EHR Incentive Programs: Review New FAQs on HIE and Public Health Measure Requirements for Meaningful Use

To keep you updated with information on the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, CMS has recently added five new FAQs and an updated FAQ to the [CMS FAQ system](#). We encourage you to stay informed by taking a few minutes to review the new information below.

### New FAQs:

1. Can a state capture electronic Clinical Quality Measures, or eCQMs, for the Medicaid EHR Incentive Program through a Health Information Exchange (HIE)? [Read the answer here.](#)
2. Can a public health agency use a HIE to interface with providers who are submitting public health data to meet the public health objectives of meaningful use (such as submitting information to an immunization registry, reporting lab results to a public health agency or reporting syndromic surveillance information)? [Read the answer here.](#)
3. If a provider utilizes a health information organization that participates with the eHealth Exchange but is not connected to public health entities in the provider's state, does the provider still need to connect to those entities for purposes of participating in the Medicare and Medicaid EHR Incentive Program? [Read the answer here.](#)
4. How does a provider attest to a meaningful use objective (e.g., the "transitions of care," "view/download patient data," and public health objectives) where the provider electronically transmits data using technical capabilities provided by a HIE? [Read the answer here.](#)
5. If an EP or hospital attesting to meaningful use in the EHR Incentive Program submits a successful test to the immunization registry in year 1 of Stage 1 and engages with the immunization registry in year 2, but does not achieve ongoing submission of data to the immunization registry during their reporting period in year 1 or year 2, should they attest to the measure or the exclusion? [Read the answer here.](#)

### Updated FAQ:

If multiple eligible professionals or eligible hospitals contribute information to a shared portal or to a patient's online personal health record (PHR), how is it counted for meaningful use when the patient accesses the information on the portal or PHR? [Read the answer here.](#)

### Want more information about the EHR Incentive Programs?

Make sure to visit the [Medicare and Medicaid EHR Incentive Programs](#) website for the latest news and updates on the EHR Incentive Programs.

## Have You Checked Your Patient's Immunization Status?

*Please Note: This article was originally released in the August 1 edition of the eNews with incorrect beneficiary cost-sharing information for the hepatitis B vaccination. The article is being re-released with the corrected information. We apologize for any confusion.*

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 when it is administered by qualified providers under Medicare Part B. Neither a Part B deductible nor coinsurance or copayment applies to the vaccines or their administration from qualified providers that agree to accept assignment.

### *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](#)
- [Office of Disease Prevention and Health Promotion NIAM 2013 Toolkit](#)
- [National Public Health Information Coalition NIAM Communications Toolkit](#)

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

## **Claims, Pricer, and Code Updates**

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### **Medicare to Adjust ESRD Home Dialysis Claims to Correct Network Reduction**

In March of 2013, it was discovered that End-Stage Renal Disease (ESRD) Network Reduction amounts were incorrectly calculated. The reduction amount for Continuous Ambulatory Peritoneal Dialysis (CAPD) and Continuous Cycle Peritoneal Dialysis (CCPD) home dialysis treatments is \$1.50 per week, per publication 100-4, chapter 8, section 110, "Reduction in Medicare Program Payment to Fund ESRD Network." This results in a daily network reduction rate of approximately twenty one cents per treatment, rather than the fifty cents per treatment deducted from impacted claims.

Medicare Administrative Contractors will adjust the impacted claims. Providers do not need to take any action or request a reopening or review of their claims. The adjustments will impact ESRD home dialysis claims with process dates from January 1, 2013 through May 6, 2013. All adjustments are to be completed by September 6, 2013.

### **FAQs about Incarcerated Beneficiary Claims Denials Now Available**

CMS has posted Frequently Asked Questions (FAQs) about incarcerated beneficiary claims denials on the [All Fee-For-Service Providers](#) website. These FAQs will be updated as more information becomes available.

### **2014 GEMS Now Available**

The General Equivalence Mappings (GEMs) show the mapping between ICD-9-CM and the appropriate ICD-10 code(s). There are both forward (ICD-9-CM to ICD-10) and backward (ICD-10 to ICD-9-CM) mappings. The 2014 GEMs, based on the 2014 ICD-9-CM and 2014 ICD-10 codes, have been posted on the [2014 ICD-10-CM and GEMs](#) web page (for the diagnosis GEMs) and the [2014 ICD-10 PCS and GEMs](#) web page (for the procedure GEMs).

The 2014 Reimbursement Mappings will be posted in October 2013.

## MLN Educational Products Update

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### **“Incorrect Number of Units Billed for Rituximab (HCPCS J9310) and Bevacizumab (HCPCS C9257 and J9035) – Dose versus Units Billed” MLN Matters® Article — Revised**

[MLN Matters® Special Edition Article #SE1316](#), “Incorrect Number of Units Billed for Rituximab (HCPCS J9310) and Bevacizumab (HCPCS C9257 and J9035) – Dose versus Units Billed” was revised and is now available in downloadable format. This article is designed to educate providers on how to properly compute the units of rituximab and bevacizumab that are billed to Medicare. The article was revised to add the section on “Supplemental Information Related to Reporting Drugs.”

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



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