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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

MLN Connects™ Provider eNews

Part of the Medicare Learning Network®

Thursday, September 5, 2013

MLN Connects™ National Provider Calls

Program Year 2012 Quality and Resource Use Reports — Mapping a Route to Success for the 2015 Value-Based Payment Modifier — Register Now

Tuesday, September 24; 3-4:30pm ET

To Register: Visit MLN Connects™ Upcoming Calls. Space may be limited, register early.

Target Audience: Groups with 25 or more eligible professionals.

On September 16, 2013, CMS will make available the 2012 Quality Resource Use Reports (QRURs) to group practices with 25 or more eligible professionals (EPs). These reports show how a group would fare under the policies CMS has finalized for the Physician Value-Based Payment Modifier. This MLN Connects™ National Provider Call will provide an overview of the QRUR and how to interpret and use the data in the report.

Authorized representatives of groups can access the QRURs at https://portal.cms.gov using an Individuals Authorized Access to the CMS Computer Services (IACS) account with one of the following group-specific Physician Value-Physician Quality Reporting System (PV-PQRS) Registration System roles:

- Primary PV-PQRS Group Security Official
- Backup PV-PQRS Group Security Official
- PV-PQRS Group Representative

If a group has already registered and selected its 2013 PQRS group reporting mechanism in the PV-PQRS Registration System, then that same person who registered the group can access the group's QRUR using their IACS User ID and password. If a group does not yet have an authorized representative with an IACS account, then one person representing the group must sign up for an IACS account with the primary Group Security Official role. If a group has a representative with an existing IACS account, but not one of the three group-specific Registration System roles listed above, then ensure that the account is still active and then add a group-specific Registration System role to that person's existing IACs account.

We *strongly encourage* representatives of groups to sign up for a new IACS account or modify an existing account at https://applications.cms.hhs.gov as soon as possible in order to be able to access the QRURs prior to the call. Quick Reference Guides that provide step-by-step instructions for requesting each PV-PQRS Registration System role for a new or existing IACS account are available in the "Downloads section" of the Self Nomination/Registration web page.

The call will be more meaningful if you have your QRUR in front of you to follow along. A Quick Reference Guide that provides instructions on how to obtain your 2012 QRUR will be available soon in the "Downloads" section of the QRUR Templates and Methodologies web page.

Agenda:

- Opening Remarks
- How to Understand and Use the 2012 QRUR
- Question & Answer Session
- Closing

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

MLN Educational Products Update

Fall 2013 Version of "The Medicare Learning Network® Catalog" — Now Available

The Fall 2013 version of the MLN Catalog is now available. The MLN Catalog is part of an ongoing effort to be responsive to the education needs of the health care professional community. The Medicare Learning Network® now includes:

- MLN Educational Publications and Tools
- MLN Matters® Articles
- MLN Web-based Training Courses (Many offer Continuing Education Credits)
- MLN Podcasts and Media
- CMS Continuing Education Program (Administered by the MLN)
- MLN Connects™ National Provider Calls
- MLN Connects™ Provider Association Partnerships
- MLN Connects™ Provider eNews

The MLN Catalog contains brief descriptions of each offering. Downloadable items include clickable links that allow you to view products or get more information as you browse. All MLN products and services are available free of charge.

"ICD-10-CM Classification Enhancements" Fact Sheet — Revised

The "ICD-10-CM Classification Enhancements" Fact Sheet (ICN 903187) was revised and is now available in hard copy format. This fact sheet is designed to provide education on the International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS). It includes the following information: ICD-10-CM/PCS compliance date; benefits of ICD-10-CM; similarities and differences between International Classification of Diseases, 9th Edition, Clinical Modification and ICD-10-CM; new features in ICD-10-CM; additional changes in ICD-10-CM; and use of external cause and unspecified codes in ICD-10-CM. 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.

"Medicare Enrollment and Claim Submission Guidelines" Booklet – Revised

The "Medicare Enrollment and Claim Submission Guidelines" Booklet (ICN 906764) was revised and is now available in downloadable format. This booklet is designed to provide education on applying for enrollment and submitting claims to Medicare. It includes the following information: enrolling in the Medicare Program; private contracts with Medicare beneficiaries; Medicare claims; deductibles, coinsurance, and copayments; Beneficiary Notices of Noncoverage; and billing requirements.

Announcements, Events, and Reminders

CDC Letter to Providers: Recommending Flu Vaccination for the 2013-14 Season

The Centers for Disease Control and Prevention (CDC) has released a Letter to Providers: Recommending Flu Vaccination for the 2013-14 Season. In addition, the CDC website offers health professionals key information about vaccination, infection control, prevention, treatment, and diagnosis of seasonal influenza.

New Materials Available for Hospital Outpatient Prospective Payment System Proposed Rule

CMS has posted corrected addenda, cost statistics files, an impact file, and an impact table for the CY 2014 Hospital Outpatient Prospective Payment System (OPPS) Proposed Rule (CMS-1601-P). These corrected files are available on the Hospital Outpatient PPS website. More information about the proposed rule is available on the Hospital Outpatient Regulations and Notices web page.

Steps to Avoid Negative Payment Adjustments under PQRS and Value Modifier

Physicians and other health care professionals who provide Medicare Part B Physician Fee Schedule (PFS) covered professional services need to be aware of negative payment adjustments being implemented in CY 2015. These payment adjustments include:

1. A negative 1.5% payment adjustment under the Physician Quality Reporting System (PQRS) for individual eligible professionals (EPs) who do not submit data on PQRS quality measures to CMS in 2013.
2. A negative 1% adjustment under the Value-Based Payment Modifier (VM) for physicians in groups of 100 or more EPs who submit claims to Medicare under a single tax identification number who fail to report under PQRS in 2013.

What Do Individual EPs need to do?
Individual eligible professionals (EPs) can submit data through the traditional PQRS methods (claims, registry and EHR) to avoid the 2015 payment adjustment and potentially earn a 2013 incentive payment of 0.5%. Alternatively, to avoid the payment adjustment only, EPs can request that CMS calculate their quality data from administrative claims. EPs must register for the CMS-calculated administrative claims option by October 15, 2013.

To register for the CMS-calculated administrative claims option, EPs should use the instructions and information available in the Quick Reference Guide for Individual EPs.

What Do Group Practices Need To Do?
For purposes of the PQRS and VM payment adjustments, group practices should first to identify how many EPs they have billing Medicare under their tax identification number. If the number of EPs in the group is under 100, the group is not subject to the value modifier for 2015. Groups with 2-99 EPs can still register to report under the PQRS Group Practice Reporting Option (GPRO) to avoid the 2015 PQRS payment adjustment and potentially earn a 2013 PQRS incentive payment of 0.5%, however it is not required. Groups with 100 or more EPs are required to register for purposes of avoiding a negative VM payment adjustment. Reporting options for group practices include the web-interface GPRO and registry. The reporting option available to the group will depend on the group size. Alternatively, to avoid payment adjustments only, groups can request that CMS calculate their quality data from administrative claims. Group practices must register and select their reporting method by October 15, 2013.

To register as a group practice and select a reporting method, group practices should use the instructions and information available in the Quick Reference Guide for Group Practices.

Resources
Additional information and resources are available on the PQRS website and the Physician Feedback/VM Self Nomination/Registration website. If you have questions, please contact the QualityNet Help Desk at 866-288-8912 (TTY 1-877-715-6222) or via qnetsupport@sdps.org. They are available Monday through Friday from 7am-7pm CT.

Opportunity for Provider Input on the Hospice Quality Reporting Program

CMS is seeking input from providers related to the implementation of the Hospice Quality Reporting Program (HQRP) established in Section 3004 of the Patient Protection and Affordable Care Act, also known as The Affordable Care Act. On behalf of CMS, Health Care Innovation Services (HCIS) is looking for providers who will voluntarily participate in a brief interview. The interview is intended to help CMS better understand the strengths, weaknesses, priorities, and burdens associated with the HQRP, how providers ensure the accuracy of submitted data, how the HQRP has impacted patient services and outcomes, and what CMS can do to improve the program and processes in the future. The information gathered through this collaborative process will be valuable to CMS in the development of the quality reporting program.

Interviews will be conducted over the telephone. Information provided in any reports or summaries will not be linked to a particular provider. If you are interested in participating, please contact Pat Hanson at phanson@hcareis.com.

Learn More About Submitting Quality Data for the EHR Incentive Programs for 2013

Providers must report clinical quality measures (CQMs) to CMS to demonstrate meaningful use under the EHR Incentive Programs. For the 2013 reporting year, there are two options for reporting CQMs for the Medicare EHR Incentive Program: through the CMS Attestation System *or* through electronic reporting pilots.

Attestation
When you are ready to submit CQM data through the Attestation System, you should:

1. Log in to the CMS Registration and Attestation system
2. Enter your data for the meaningful use core and menu objectives
3. Report your CQM data directly from your certified EHR technology into the Attestation System:
    - Eligible professionals must report a total of six CQMs
        - Three core or alternate core measures (only report an alternate core measure if one of the core denominators is zero)

        - Three additional measures from a list of 38
    - Eligible hospitals must report a total of 15 CQMs
        - Two measures that target emergency department throughput processes
        - Seven measures that address the care of patients with stroke
        - Six measures that address the care of patients with venous thromboembolism
    - If you are attesting to CQM data for the EHR Incentive Programs you may submit a zero result for a CQM if the zero is the accurate calculation from your EHR

Electronic Reporting Pilots
Eligible professionals and eligible hospitals also have the option to submit CQMs through electronic reporting, or eReporting, pilots:

- For eligible professionals: Through the PQRS-Medicare EHR Incentive Pilot
- For eligible hospitals: Through the QualityNet portal

Providers participating in the Medicaid EHR Incentive Program will need to attest through their state's internet-based portal.

Exclusions
Some CQMs cannot be met during the reporting period chosen by the provider and so exclusions are available for those CQMs. For example, many CQMs for EPs require a minimum of two visits for a patient to meet the denominator criteria. Exclusions do not count against a provider's attestation requirements.

2014 CQM Reporting Changes
Beginning in 2014, all providers must report CQMs based on new requirements outlined in the Stage 2 final rule, regardless of what stage they are in. For more information on these requirements, such as the number of CQMs and how to select which ones to report, visit the 2014 CQMs web page.

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.

New and Updated FAQs for the EHR Incentive Programs Now Available

To keep you updated with information on the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, CMS has recently added four new and five updated FAQs 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. When meeting the meaningful use measure for computerized provider order entry (CPOE) in the EHR Incentive Programs, does an individual need to have the job title of medical assistant in order to use the CPOE function of certified EHR technology for the entry to count toward the measure, or can they have other titles as long as their job functions are those of medical assistants? Read the answer here.
2. For the Medicare and Medicaid EHR Incentive Programs, how should an eligible professional (EP), eligible hospital, or critical access hospital attest if the certified EHR vendor uses 2011 edition certified EHR technology for the first part of 2013 and 2014 edition certified EHR technology for the remainder of 2013? Read the answer here.
3. The specifications for Denominator 2 for measure CMS64v2 do not produce an accurate calculation according to the measure's intent. When will a correction to this clinical quality measure (CQM) be published? Read the answer here.
4. For the meaningful use Stage 2's transitions of care and referrals objective, in what ways can the second measure be met that requires more than 10% of the summary care records provided for transitions of care and referrals to be electronically transmitted in the EHR Incentive programs? Read the answer here.

Updated FAQs:

1. 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 health information exchange? Read the answer here.
2. If an EP sees a patient in a setting that does not have certified EHR technology but enters all of the patient's information into certified EHR technology at another practice location, can the patient be counted in the numerators and denominators of meaningful use measures for the Medicare and Medicaid EHR Incentive Programs? Read the answer here.
3. When new versions of CQM specifications are released by CMS, do developers of EHR technology need to seek retesting/recertification of their certified complete EHR or certified EHR module in order to keep its certification valid? Read the answer here.
4. If EHR technology "Product A" is already certified to the December 2012 CQM specifications, can it be updated to include CMS updated June 2013 specifications without seeking retesting/recertification? Read the answer here.
5. If EHR technology is not yet certified to CQM criteria (45 CFR 170.314(c)(1) through (3)), can the EHR technology be tested and certified to only the newest available version of the CQM specifications or must it be tested and certified to the December 2012 specifications (first or as well)? 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.

Claims, Pricer, and Code Updates

October 2013 Average Sales Price Files Now Available

CMS has posted the October 2013 Average Sales Price (ASP) and Not Otherwise Classified (NOC) pricing files and crosswalks. All are available for download on the 2013 ASP Drug Pricing Files web page.

Register for an opportunity to rate your Medicare Administrative contractor. Learn more

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