



MLN Connects™ Provider eNews

Part of the Medicare Learning Network®

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Announcements

Registration for MAC Satisfaction Indicator Closing September 30

Have you registered for the Medicare Administrative Contractor (MAC) Satisfaction Indicator (MSI)? If not, your time is running out. MSI registration will close on Monday, September 30.

Why should I register?

- The MSI will provide the best opportunity for you to rate your satisfaction with your MAC
- Your input will help your MAC to improve the services that they offer you
- Your opinion counts

If you are a Medicare Fee-For-Service (FFS) provider or you represent a Medicare FFS provider and are interested in participating, register your contact information by completing the [application](#).

- It will take about 1 minute to complete.
- You'll need your national provider identifier (NPI) and provider transaction access number (PTAN) to sign up. If you work for a medical practice, you can list a group NPI and PTAN.
- MAC services to be rated include, but are not limited to, claims processing, Medicare enrollment, and responsiveness to inquiries
- It's quick and easy - Those selected to participate will be emailed a link to an online survey
- All information collected will be kept confidential and used solely for this survey.

For more information, visit the CMS [MSI](#) website.



Influenza Season is Almost Here

As the 2013-2014 influenza season quickly approaches, now is an opportune time to send reminders and schedule appointments for patients' flu vaccinations. Seniors and people with chronic health conditions—like asthma, diabetes, and heart disease—are at a higher risk for serious complications from the flu. According to the Centers for Disease Control and Prevention, last season overall deaths attributed to flu and pneumonia were the highest in nearly a decade, and people 65 years and older accounted for half of all flu-related hospitalizations. Recommending and offering flu vaccine to Medicare beneficiaries ahead of the flu season is very crucial, as patients are more likely to get vaccinated when flu vaccination is recommended and offered by a health care professional.

Generally, Medicare Part B covers one influenza vaccination and its administration per influenza season for Medicare beneficiaries without co-pay or deductible. *Note:* The influenza vaccine and its administration are covered under Medicare Part B. Influenza vaccine is *not* a Part D-covered drug.

For more information on coverage and billing of the influenza virus vaccine and its administration, please visit:

- [CMS Medicare Learning Network® Preventive Services Educational Products](#) and [CMS Immunizations](#) web pages. (Check back for CMS 2013-2014 influenza season updates — coming soon to these web pages).
- [MLN Matters® Article #MM8433](#), "Influenza Vaccine Payment Allowances - Annual Update for 2013-2014 Season."
- While some providers may offer the flu vaccine, others can help their patients locate a vaccine provider within their local community. [HealthMap Vaccine Finder](#) is a free, online service where users can search for locations offering flu and other adult vaccines.

CMS Proposes a Medicare Prospective Payment System for Federally Qualified Health Centers

Health Centers will Transition to a New Medicare Payment System and Higher Medicare Reimbursements

On September 18, CMS issued a proposed rule that would establish methodology and payment rates for a prospective payment system (PPS) for Federally Qualified Health Center (FQHC) services under Medicare Part B beginning on October 1, 2014, in compliance with the statutory requirements of the Affordable Care Act. CMS is proposing payment to FQHCs based on a single encounter-based per diem rate per Medicare beneficiary. The encounter-based per-diem rate would be calculated based on an average cost per encounter and is estimated to be \$155.90, subject to change in the final rule based on more current data. The rate would be adjusted for geographic differences in the cost of services by adopting the Geographic Practice Cost Indices (GPCI) used to adjust payment under the physician fee schedule (PFS).

In addition, the rate would be adjusted (increased by approximately 33 percent) for greater intensity and resource use when an FQHC furnishes care to a patient that is new to the FQHC or to a beneficiary receiving a comprehensive initial Medicare visit (i.e., an initial preventive physical examination or an initial annual wellness visit). FQHCs would transition into the PPS beginning October 1, 2014, based on their cost reporting periods.

This proposed rule also amends the Clinical Laboratory Improvement Amendments (CLIA) of 1988 to be in alignment with the Taking Essential Steps for Testing (TEST) Act of 2012, proposing the regulatory changes needed to fully implement the TEST Act. This proposed rule outlines the framework for the application of sanctions in proficiency testing (PT) referral cases.

The proposed rule will be published in the September 23 Federal Register. CMS will accept comments on the proposed rule until November 18, 2013, and will respond to them in a final rule to be issued in 2014. Additional information is available in the [CMS press release](#), [fact sheet](#) and [proposed rule](#).

Preventing and Detecting Potential Fraud in the Health Insurance Marketplace

On September 18, Attorney General Eric Holder, U.S. Department of Health and Human Services (HHS) Secretary Kathleen Sebelius, and Federal Trade Commission (FTC) Chairwoman Edith Ramirez met at the White House to kick off a comprehensive interagency initiative to prevent, protect against, and, where necessary, prosecute consumer fraud and privacy violations in the Health Insurance Marketplace. Meeting participants reaffirmed their ongoing commitment to protect consumers from potential threats in this area. Building on a successful infrastructure that exists, the interagency officials highlighted the following new initiatives:

- The dedication of the Marketplace Call Center (1-800-318-2596, TTY 1-855-889-4325) as a resource and referral to FTC for consumer fraud concerns, with trained Call Center staff to effectively refer consumer threats and complaints
- Connecting consumers to FTC's Complaint Assistant through [HealthCare.gov](#)
- Development of a system of routing complaints through the FTC's Consumer Sentinel Network for analysis and referral as appropriate
- Establishment of a rapid response mechanism for addressing privacy or cybersecurity threats, and
- Ramping up public education to empower consumers and assisters to know the facts and avoid scams.

A fact sheet is available with tips for your patients: [Protect Yourself from Fraud in the Health Insurance Marketplace](#). More information is available in the HHS [press release](#).

Steps to the Avoid the 2015 PQRS Negative Payment Adjustments for Individuals and Group Practices with 2-99 EPs

Physicians and other health care professionals who provide Medicare Part B Physician Fee Schedule (PFS) covered professional services need to be aware of 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. The payment adjustment will be implemented in CY 2015.

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 (with 2-99 EPs) Need To Do?

Group practices with 2-99 EPs can 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 that they register under the GPRO if the preference is for each EP to report PQRS as an individual. 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, so group practices should determine how many EPs they have billing Medicare under their tax identification number. 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. *Please note:* Groups with less than 100 EPs are not subject to the value modifier (VM) for 2015. 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 qnetssupport@sdps.org. They are available Monday through Friday from 7am-7pm CT.

Physician Groups of 100 or More: 2 Weeks Left to Register for PV- PQRS to Avoid a -1% Payment Adjustment

The Physician Value-Physician Quality Reporting System (PV-PQRS) Registration System is open for representatives of group practices to select their group's PQRS reporting mechanism for CY 2013, and for groups with 100 or more eligible professionals (EPs), to elect quality tiering to calculate the Value Modifier for CY 2015. Additionally, individual EPs will be able to select the CMS-calculated administrative claims reporting mechanism in CY 2013 in order to avoid the PQRS negative payment adjustment in CY 2015.

The PV-PQRS Registration System will close on October 15, 2013. The PV-PQRS Registration System can be accessed at <https://portal.cms.gov> using a valid IACS User ID and password. For additional information regarding registration and obtaining or modifying an IACS account please see the Quick Reference Guide on the [Self Nomination/Registration](#) web page.

LTCH FY 2015 Payment Update Determination: Data Submission Deadlines

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

Per the [FY 2013 IPPS/LTCH PPS Final Rule](#) (77 FR 53614 through 53637, and 53667 through 53672), data on three measures will be collected from January 1 through December 31, 2013 for FY 2015 Payment Update Determination:

- Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (NQF #0678)
- NHSN CAUTI Outcome Measure (NQF #0138)
- NHSN CLABSI Outcome Measure (NQF #0139)

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

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

Reminder: The submission deadline -- August 15, 2013 for January through March 2013 data that will affect the FY 2015 Payment Update Determination has passed.

New Online ICD-10 Implementation Guide

To help the health care industry prepare for ICD-10, CMS has developed an online [ICD-10 implementation guide](#). This web-based tool, released as part of Health IT Week, includes a basic overview of ICD-10 as well as step-by-step guidance on how to transition to ICD-10 for small/medium practices, large practices, small hospitals, and payers. Users can easily navigate to information that is most relevant to them—wherever they are in the implementation process. The online guide also includes links to CMS ICD-10 resources and other tools to help with the ICD-10 transition.

Keep Up to Date on ICD-10

Visit the CMS [ICD-10](#) website for the latest news and resources to help you prepare for the *October 1, 2014*, deadline. Sign up for [CMS ICD-10 Industry Email Updates](#) and [follow us](#) on Twitter.

EHR Hospital Reporting for 2013 Ends September 30: Begin Preparing for Attestation Today

September 30, 2013 is an important deadline for eligible hospitals and critical access hospitals (CAHs) participating in the EHR Incentive Programs. It marks the end of the FY and the last day of the 2013 meaningful use program year.

Attestation Deadline

Hospitals participating in the Medicare EHR Incentive Program have until November 30, 2013 to attest to demonstrating meaningful use of the data collected during the FY 2013 reporting period. Hospitals participating in the Medicaid EHR Incentive Program need to refer to their [state deadlines](#) for attestation. Hospitals must attest to demonstrating meaningful use *every year* to receive an incentive and avoid a payment adjustment.

Payment Adjustments

Payment adjustments will be applied beginning FY 2015 (October 1, 2014) to Medicare eligible hospitals that have not successfully demonstrated meaningful use. The adjustment is determined by the hospital's reporting period in a prior year. Read the eligible hospital [payment adjustment tipsheet](#) to learn more.

Fiscal Year 2014

October 1, 2013 marks the start of FY 2014 and many important milestones for eligible hospitals, including:

- The start of [Stage 2](#) for eligible hospitals that have completed at least two years of Stage 1.
- A reduced EHR [incentive payment](#) for hospitals that begin participation in 2014 and later.
- A 3-month reporting period in 2014, regardless of the stage of meaningful use to allow more time to upgrade to 2014 certified EHR technology.
 - The reporting period must be fixed to the quarter for Medicare eligible hospitals and CAHs.
 - The reporting period can be any 90 days for Medicaid eligible hospitals and CAHs.

Resources

- [Meaningful Use Attestation Calculator](#)
- [Attestation Worksheet for Eligible Hospitals and CAHs](#)
- [Attestation Guide for Eligible Hospitals](#)
- [Stage 2 Payment Adjustment Tipsheet for Eligible Hospitals](#)

Plan Ahead

Review all of the important dates for the EHR Incentive Programs on the [Health Information Technology Timeline](#).

Stage 2 Guide for the EHR Incentive Programs Now Available

CMS has released a new resource, [An Eligible Professional's Guide to Stage 2 of the EHR Incentive Programs](#), which provides a comprehensive overview of Stage 2 of the EHR Incentive Programs to eligible professionals. The guide outlines criteria for Stage 2 meaningful use, 2014 clinical quality measure reporting, and 2014 EHR certification. The guide's table of contents makes it easy for you to navigate through Stage 2 topics. Interactive tabs included at the bottom of each page allow you to transition between different chapters. Chapters include:

- What is Stage 2 of the EHR Incentive Programs?
- What are the requirements under Stage 2 of Meaningful Use?
- How will clinical quality measures (CQMs) change?
- Resources

The guide can be found on the [Educational Resources](#) page of the [EHR](#) website.

Want more information about the EHR Incentive Programs?

Visit the [EHR Incentive Programs](#) website for the latest news and updates on the EHR Incentive Programs.

New White Paper Reveals 57,000 EPs and 800 Eligible Hospitals Met and Successfully Attested to Stage 1 Meaningful Use in 2011

CMS released a [white paper](#) with data on year one of the [Electronic Health Record \(EHR\) Incentive Programs](#). The report focused on five areas of [Stage 1 of meaningful use](#): Quality, Safety, Efficiency, and Health Disparity Reduction; Patient and Family Engagement; Care Coordination; Population and Public Health Improvement; and Privacy and Security. The meaningful use data is analyzed by state and specialty type for eligible professionals and eligible hospitals who participated in the 2011 Medicare EHR Incentive Program.

Meaningful Use Highlights

In the first year of the EHR Incentive Programs, approximately ten percent of all Medicare eligible professionals and 17 percent of eligible hospitals met and successfully attested to demonstrating meaningful use for Stage 1. No eligible hospitals were unsuccessful in attesting to meaningful use. Both eligible professionals and eligible hospitals performed well above minimum performance thresholds for all measures of Stage 1 of meaningful use, and those providers that have already successfully attested are expected to meet the higher thresholds of the same measures for Stage 2 of meaningful use.

CMS plans to release a white paper on 2012 attestation data shortly. Visit the [Registration and Attestation](#) web page on the EHR website to view the latest registration and attestation information.

Want more information about the EHR Incentive Programs?

CMS encourages any eligible providers who have not yet registered and attested for the EHR Incentive Programs to [get started today](#). Visit the [EHR Incentive Programs](#) website for the latest news and updates on the EHR Incentive Programs.

New Eligibility Fact Sheet Helps Health Care Professionals Determine eHealth Program Participation

On September 23, CMS released a [new resource](#) that will help you as a health care professional determine your eligibility for eHealth programs. The tool outlines eligibility for eHealth programs based on your area of practice.

Eligibility information for the following eHealth programs is included:

- [Medicare and Medicaid Electronic Health Record \(EHR\) Incentive Programs](#)
- [Electronic Prescribing \(eRx\) Incentive Program](#)
- [Physician Quality Reporting System \(PQRS\)](#)

The tool also includes links to information and materials on other eHealth programs:

- [Maintenance of Certification Program](#)
- [Physician Feedback/Value-Based Payment Modifier Program](#)
- [Medicare Shared Savings Program](#)
- [Advance Payment ACO Model](#)
- [Pioneer ACO Model](#)

CMS encourages health care professionals to use this tool to determine the eHealth programs that affect your practice. You can find this resource, along with several other helpful tools and materials, on the [Resources](#) section of the eHealth website.

Want to find out more about eHealth?

Visit the [eHealth](#) website for the latest news and updates on CMS eHealth initiatives.

New eHealth Interactive Tool Helps Determine Potential Upcoming Payment Adjustments

Payment adjustments affect certain eligible professionals who do not satisfy mandatory criteria for one or more of the eHealth programs. You can determine if you will incur a future eHealth program payment adjustment with this easy-to-use, interactive eHealth Payment Adjustment Tool CMS developed. The tool shows what payment adjustments to expect based on your past, current, and expected future participation in eHealth programs.

eHealth Programs with Upcoming Payment Adjustments

Navigate through the tool by answering a series of questions about your participation and eligibility status for the following programs:

- [Electronic Prescribing \(eRx\) Incentive Program](#)
- [Medicare Electronic Health Record \(EHR\) Incentive Program](#)
- [Physician Quality Reporting System \(PQRS\)](#)

Each program has its own interactive decision tree that provides results based on the eligible professional's (EP's) answers. CMS encourages you to use the tool to become more informed about potential payment adjustments.

Resources

To access this new tool, visit the [Resources](#) section of the CMS eHealth website. Additional payment adjustment resources for specific eHealth programs are also available:

- [Medicare EHR Incentive Program Payment Adjustments: What Providers Need to Know](#)
- [Payment Adjustments & Hardship Exceptions Tipsheet for Eligible Professionals](#)
- [2015 PQRS Payment Adjustment Fact Sheet](#)
- [2014 eRx Payment Adjustment Fact Sheet](#)

Want to find out more about eHealth?

Visit the [eHealth](#) website for the latest news and updates on CMS eHealth initiatives.

MLN Educational Products Update

New MLN Educational Web Guides Fast Fact

A new fast fact is now available on the [MLN Educational Web Guides](#) web page. This web page provides information on Evaluation and Management services; Guided Pathways that contain resources and topics of interest; lists of health care management products; and easy-to-understand billing and coding educational products. It is designed to provide educational and informational resources related to certain CMS initiatives. Please bookmark this page and check back often as a new fast fact is added each month.

New MLN Provider Compliance Fast Fact

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

“The Basics of Medicare Enrollment for Physicians and Other Part B Suppliers” Fact Sheet — Reminder

“[The Basics of Medicare Enrollment for Physicians and Other Part B Suppliers](#)” Fact Sheet (ICN 903768) is available in downloadable format. This fact sheet is designed to provide education on basic Medicare enrollment information and how to ensure physicians and other Part B suppliers are qualified and eligible to enroll in the Medicare Program. It includes information on how to enroll in the Medicare Program, how to report changes, and a list of resources.

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



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