



MLN Connects™ Provider eNews

Part of the Medicare Learning Network®

Thursday, October 31, 2013

MLN Connects™ National Provider Calls

[Streamlined Access to PECOS, EHR, and NPPES — Register Now](#)

[National Partnership to Improve Dementia Care in Nursing Homes — Registration Now Open](#)

Announcements

[National Breast Cancer Awareness Month](#)

[Payment Rules Notice](#)

[Proposed Quality Measures for EHR Incentive Program — Public Comments Due November 25](#)

[MEDCAC — Request for Nomination of Members](#)

[Therapy Services Functional Reporting FAQ Document Updated](#)

[Program Year 2012 QRURs for Group Practices Are Here](#)

[LTCH FY 2015 Payment Update Determination: Data Submission Deadlines](#)

[EHR Incentive Programs: Important Payment Adjustment Information for Medicare EPs](#)

[EHR Incentive Programs: Stage 1 Meaningful Use Calculator Includes Updated Measure Requirements](#)

[Learn How Your Eligible Hospital's EHR Participation Affects Upcoming Payment Adjustments](#)

[Create an ICD-10 Project Plan](#)

Claims, Pricers, and Codes

[ICD-10 MS-DRGs v31 Now Available](#)

[Release of 2014 PC Pricers](#)

[October 2013 Outpatient Prospective Payment System Pricer File Update](#)

MLN Educational Products

[“Post-Acute Transfer Processing Of CWF A/B Crossover Edit 7272 Update” MLN Matters® Article — Released](#)

[“2013-2014 Influenza \(Flu\) Resources for Health Care Professionals” MLN Matters® Article — Released](#)

[“September 2013 ICD-10-CM/PCS Billing and Payment Frequently Asked Questions” Fact Sheet — Released](#)

[New MLN Provider Compliance Fast Fact](#)

[MLN Products Available In Electronic Formats](#)

[“Temporary Instructions for Implementation of Final Rule 1599-F for Part A to Part B Billing of Denied Hospital Inpatient Claims” MLN Matters® Article — Revised](#)

MLN Connects™ National Provider Calls

Streamlined Access to PECOS, EHR, and NPPES — Register Now

Friday, November 15; 2-3:30 ET

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

Target Audience: All Medicare Fee-For-Service providers, as well as [Professionals](#) and [Hospitals](#) eligible for the Medicaid Electronic Health Record (EHR) Incentive Program.

Changes have been 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, available since October 7, 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). This MLN Connects Call will provide detailed instructions on these changes.

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 use your established user ID and password to access the systems.

Agenda:

- Opening remarks
- Access Changes for PECOS, EHR, NPPES
- 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.

National Partnership to Improve Dementia Care in Nursing Homes — Registration Now Open

Monday, November 25; 2-3:30pm ET

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

Target Audience: Consumer and advocacy groups, nursing home providers, surveyor community, prescribers, professional associations, and other interested stakeholders

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 provide a brief overview of the progress that has been made so far during the implementation of this national partnership. Additional speakers will be presenting on the CMS Hand in Hand training series. A question and answer session will follow the presentation.

Agenda:

- National partnership overview
- Using Hand in Hand to improve dementia care
- Closing and next steps
- Question and answer session

Announcements

National Breast Cancer Awareness Month

October is National Breast Cancer Awareness Month. During this national health observance, CMS reminds health professionals that Medicare provides coverage of screening mammography for the early detection of breast cancer for women with no signs or symptoms of disease. Medicare does not require a physician's prescription or referral for screening mammography. The screening mammography is a Medicare Part B benefit with no co-pay/co-insurance or deductible. Medicare does not cover screening mammography for men. However, Medicare does provide coverage for diagnostic mammography for men and women who meet certain coverage criteria.

A clinical breast exam is also covered under Medicare Part B as part of the screening pelvic examination for beneficiaries who meet coverage criteria. There is no co-pay/co-insurance or deductible for this screening benefit.

For More Information:

- [The MLN Screening and Diagnostic Mammography Booklet](#)
- [The MLN Screening Pelvic Examinations Booklet](#)
- [MLN Preventative Services Products for Health Professionals](#)
- [CMS General Prevention Website](#)
- [National Breast Cancer Awareness Month Website](#)

Payment Rules Notice

Although CMS is still assessing the impact of the partial government shutdown on completion of the CY 2014 Medicare Fee-For-Service payment regulations, CMS intends to issue the final rules on or before November 27, 2013, generally to be effective on January 1, 2014. The impacted regulations include:

- Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (CMS-1526-F)
- CY 2014 Changes to the Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System (CMS-1601-FC)
- CY 2014 Home Health Prospective Payment System Final Rule (CMS-1450-F)
- Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2014 Final Rule with Comment Period (CMS-1600-FC)

Proposed Quality Measures for EHR Incentive Program — Public Comments Due November 25

CMS has contracted with Mathematica Policy Research to develop new measures for potential use by eligible professionals (EPs) in future stages of the Electronic Health Records (EHR) Incentive Program. CMS is requesting that

stakeholders review these measures and provide feedback on them. All comments are welcome, but we are particularly interested in feedback in the following areas:

- Relevance of the measures to the mission of public reporting under the EHR Incentive Program for EPs
- Usefulness of the measures to improve quality of care for patients
- Feasibility of data collection via EHRs for public reporting under the EHR Incentive Program for EPs

A list of the proposed measures and directions to submit comments are available on the [Measure Management System Public Comment](#) web page. The comment period ends at 5pm ET on November 25, 2013.

MEDCAC — Request for Nomination of Members

CMS has posted a [request for nomination of members](#) to the Medicare Evidence Development & Coverage Advisory Committee (MEDCAC). The MEDCAC was established to provide independent guidance and expert advice to CMS on specific clinical topics. The MEDCAC is used to supplement CMS internal expertise and to allow an unbiased and current deliberation of “state of the art” technology and science. The MEDCAC reviews and evaluates medical literature, technology assessments, and examines data and information on the effectiveness and appropriateness of medical items and services that are covered under Medicare or that may be eligible for coverage under Medicare. The MEDCAC judges the strength of the available evidence and makes recommendations to CMS based on that evidence. Further background information is available on the [Medicare Evidence Development & Coverage Advisory Committee](#) web page.

Therapy Services Functional Reporting FAQ Document Updated

To keep you current on information about CMS coverage of therapy services, the [Functional Reporting: PT, OT, and SLP Services Frequently Asked Questions](#) document has recently been updated. We encourage you to stay informed by reviewing the new information below.

Updated FAQ item — Question 14:

- Question: How do I report an evaluative procedure when it is for a different functional limitation than I am currently reporting?
- Answer: You should report the evaluative procedure furnished for a second/different functional limitation other than the primary functional limitation for which ongoing reporting is occurring as a one-time visit (i.e., report all three G-codes in the code set for the functional limitation that most closely matches that for which the evaluative procedure was furnished). The ongoing reporting of a primary functional limitation is not affected when all three G-codes in a code set are reported for the evaluative procedure furnished for a second functional limitation. Note: The reporting of all three G-codes for the evaluative procedure for a second functional limitation *and* the ongoing reporting of a primary functional limitation *can* both occur on the same date of service.

Want more information about CMS’ Coverage of Therapy Services?

Make sure to visit the CMS [Therapy Services](#) website for the latest news and updates.

Program Year 2012 QRURs for Group Practices Are Here

Program Year 2012 Quality and Resource Use Reports (QRURs) are available for group practices with 25 or more eligible professionals (EPs). 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

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. A [Quick Reference Guide](#) that provides instructions on how to obtain your 2012 QRUR is available in the “Downloads” section of the [How to Obtain the 2012 QRUR](#) 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.

EHR Incentive Programs: Important Payment Adjustment Information for Medicare EPs

Eligible professionals (EPs) participating in the Medicare EHR Incentive Program may be subject to payment adjustments beginning on *January 1, 2015*. CMS will determine the payment adjustment based on meaningful use data submitted prior to the 2015 calendar year. EPs must demonstrate meaningful use prior to 2015 to avoid payment adjustments. Determine how your EHR Incentive Program participation start year will affect the 2015 payment adjustments:

If you began in 2011 or 2012

If you first demonstrated meaningful use in 2011 or 2012, you must demonstrate meaningful use for a full year in 2013 to avoid the payment adjustment in 2015.

If you began in 2013

If you first demonstrate meaningful use in 2013, you must demonstrate meaningful use for a 90-day reporting period in 2013 to avoid the payment adjustment in 2015.

If you plan to begin in 2014

If you first demonstrate meaningful use in 2014, you must demonstrate meaningful use for a 90-day reporting period in 2014 to avoid the payment adjustment in 2015. This reporting period must occur in the first 9 months of calendar year 2014, and EPs must attest to meaningful use no later than October 1, 2014, to avoid the payment adjustment.

Avoiding Payment Adjustments in the Future

You must continue to demonstrate meaningful use every year to avoid payment adjustments in subsequent years. If you are eligible to participate in both the Medicare and Medicaid EHR Incentive Programs, you *must* demonstrate meaningful use to avoid the payment adjustments. You may demonstrate meaningful use under either Medicare or Medicaid.

If you are only eligible to participate in the Medicaid EHR Incentive Program, you are not subject to these payment adjustments.

Helpful Resources

For more information on EP payment adjustments, view the [Payment Adjustments and Hardship Exceptions Tipsheet](#) for EPs.

Want more information about the EHR Incentive Programs?

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

EHR Incentive Programs: Stage 1 Meaningful Use Calculator Includes Updated Measure Requirements

The [Stage 1 Meaningful Use Attestation Calculator](#) can help you prepare to enter your meaningful use information into the CMS attestation system. Enter your meaningful use data into the calculator to learn if you have met all of the objectives and the associated measures prior to completing attestation for Stage 1 of the EHR Incentive Programs.

Calculator Updates

The updated calculator reflects the latest requirements for participation in Stage 1 of meaningful use. Changes include:

- Removal of core measures no longer required for Stage 1
- Updates to measure requirements in accordance with the Stage 2 rule

You can find the Stage 1 Meaningful Use Attestation Calculator and more information about the attestation process on the [Registration and Attestation](#) page of the EHR Incentive Programs website. In order to better understand the meaningful use criteria, you can also review the Stage 1 Meaningful Use Specification Sheets for [eligible professionals](#) or for [eligible hospitals and Critical Access Hospitals](#). These specification sheets contain detailed information on each core and menu meaningful use measure.

Want more information about the EHR Incentive Programs?

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

Learn How Your Eligible Hospital's EHR Participation Affects Upcoming Payment Adjustments

Subsection (d) hospitals that are eligible to participate in the Medicare EHR Incentive Program must meet meaningful use requirements to avoid the federally-mandated payment adjustments that begin in FY 2015. The adjustment is determined by the hospital's reporting period in a prior year. Find out how your hospital's participation start year will affect its 2015 payment adjustments:

For Hospitals that Began Participation in 2011 or 2012:

Eligible hospitals that first demonstrated meaningful use in FY 2011 or 2012 must demonstrate meaningful use for a full year in FY 2013 to avoid payment adjustments in 2015. This data must be submitted via attestation by November 30, 2013.

For Hospitals that Begin Participation in 2013:

Eligible hospitals that first demonstrate meaningful use in FY 2013 must demonstrate meaningful use for a 90-day reporting period in 2013 to avoid payment adjustments in 2015. This data must be submitted via attestation by November 30, 2013.

For Hospitals that will Begin Participation in 2014:

Eligible hospitals that first demonstrate meaningful use in FY 2014 must demonstrate meaningful use for a 90-day reporting period in 2014 to avoid payment adjustments in 2015. This reporting period must occur in the first nine

months of FY 2014 (i.e. they must begin the 90-day reporting period by April 1), and hospitals must attest to meaningful use no later than July 1, 2014, in order to avoid the payment adjustments.

Avoiding Payment Adjustments in the Future

Once hospitals begin participation in the Medicare EHR Incentive Program, they must continue to demonstrate meaningful use every year to avoid payment adjustments in subsequent years.

For more information on timing and how to avoid payment adjustments, view the [Payment Adjustment and Hardship Exemptions Tipsheet for Eligible Hospitals and Critical Access Hospitals](#).

Want more information about the EHR Incentive Programs?

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

Create an ICD-10 Project Plan

With less than a year to go, you should be getting ready now for the October 1, 2014 transition to ICD-10. You can help guide your practice through a smooth transition with a project plan that maps out your practice's ICD-10 prep from start to finish.

Your project plan should identify each task to be completed, when tasks should begin and end, and who should be responsible for each task. At a minimum, your organization should consider the following activities:

- Ensure senior leadership understands the breadth and significance of the ICD-10 change. Download free ICD-10 fact sheets and background information from the [CMS](#) website and share trade publication articles on the transition.
- Assign overall responsibility and decision-making authority for managing the transition. This can be one person or a committee depending on the size of the organization.
- Plan a comprehensive and realistic budget. This should include costs such as software upgrades and training needs.
- Ensure involvement and commitment of all internal and external stakeholders. Contact vendors, physicians, affiliated hospitals, clearinghouses, and others to determine their plans for ICD-10 transition.
- Take advantage of free webinars and implementation materials.
- Share best practices with peers.
- Schedule software/hardware testing.
- Review internal policies to support the transition.
- Adhere to a well-defined timeline.

Here are some tasks that should be included in the project plan.

- Identify commonly used ICD-9 codes and begin to explore related ICD-10 codes.
- Identify and update paper and electronic forms to accommodate the ICD-10 code structure.
- Schedule ICD-10 training for clinicians, office managers, billers, coders, and other key staff.

For more information, check out the resources on [implementation planning on the Provider Resources](#) web page of the ICD-10 website.

Want more information about ICD-10?

Visit the [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.

Claims, Pricers, and Codes

ICD-10 MS-DRGs v31 Now Available

The ICD-10 Medicare Severity Diagnosis Related Groupers (MS-DRGs) v31 is now available on the [ICD-10 MS-DRG Conversion Project](#) web page. This is the ICD-10 version of the currently used FY 2014 MS-DRGs v31, which are based on ICD-9-CM codes. ICD-10 will be implemented on October 1, 2014, and the final ICD-10 MS-DRGs v32 will be subject to formal rulemaking.

The ICD-10 MS-DRGs v31 Definitions Manual, Medicare Code Editor, and ICD-10 MS-DRGs v30 and v31 Comparison File are now available on the [ICD-10 MS-DRG Conversion Project](#) web page.

- An HTML version of the Definitions Manual will be posted soon in the “Related Links” section.
- PC and mainframe versions will also be available soon from the [National Technical Information Service](#) (NTIS)

Release of 2014 PC Pricers

The release of the 2014 PC Pricers may occur within 60 days *after* the start of the quarter to which the update applies. This applies to all PC Pricers, including End-Stage Renal Disease (ESRD) Facility, Home Health Agency (HHA), Inpatient Prospective Payment System (IPPS) Facility, Inpatient Psychiatric Facility (IPF), Inpatient Rehabilitation Facility (IRF), Long Term Care Hospital (LTCH), and Skilled Nursing Facility (SNF) PC Pricers.

October 2013 Outpatient Prospective Payment System Pricer File Update

The [Outpatient Prospective Payment System \(OPPS\) Pricer](#) web page has been updated with Pricer file and outpatient provider data for October 2013. The “4th Quarter 2013 Files” are available in the “Downloads” section.

MLN Educational Products

“Post-Acute Transfer Processing Of CWF A/B Crossover Edit 7272 Update” MLN Matters® Article — Released

[MLN Matters® Special Edition Article #SE1335](#), “Post-Acute Transfer Processing Of CWF A/B Crossover Edit 7272 Update,” was released and is now available in a downloadable format. This article is designed to provide education on the updated editing requirements within the Common Working File (CWF) system. It includes information on modifications made to correct CWF A/B Crossover Edit 7272 for an Inpatient Prospective Payment System (IPPS) hospital claim.

“2013-2014 Influenza (Flu) Resources for Health Care Professionals” MLN Matters® Article — Released

[MLN Matters® Special Edition Article #SE1336](#), “2013-2014 Influenza (Flu) Resources for Health Care Professionals,” was released and is now available in a downloadable format. This article is designed to provide education on available resources designed to educate health care professionals on how to order, refer, or administer flu vaccinations to Medicare beneficiaries. It includes a list of relevant Medicare Learning Network® educational products and other helpful websites and resources.

“September 2013 ICD-10-CM/PCS Billing and Payment Frequently Asked Questions” Fact Sheet — Released

The [“September 2013 ICD-10-CM/PCS Billing and Payment Frequently Asked Questions”](#) Fact Sheet (ICN 908974) was released and is now available in downloadable 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 and billing and payment Frequently Asked Questions.

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 Education 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.

MLN Products Available In Electronic Formats

The "[Expanded Coverage Under the Affordable Care Act: Information for Health Care Professionals](#)" fact sheet (ICN 908826) was released and is now available as an electronic publication (EPUB®) and through a QR code. This fact sheet provides education on the Health Insurance Marketplace under the Affordable Care Act. It includes information health care professionals need to know about the Marketplace, an explanation of how the Affordable Care Act expands access to health coverage, an explanation of the Marketplace, how it affects health care professionals and their patients, and resources.

The "[Screening for Depression](#)" booklet (ICN 907799) was released and is now available as an EPUB® and through a QR code. This booklet is designed to provide education on screening for depression. It includes coverage, coding, billing, and payment information.

The "[Medicare Quarterly Provider Compliance Newsletter \[Volume 4, Issue 1\]](#)" Educational Tool (ICN 908950) was released and is now available as an EPUB® and through a QR code. This educational tool is designed to provide education on how to avoid common billing errors and other erroneous activities when dealing with the Medicare Program. It includes guidance to help health care professionals address and avoid the top issues of the particular Quarter.

Instructions for downloading EPUBs and how to scan a QR code are available at "[How To Download a Medicare Learning Network® \(MLN\) Electronic Publication](#)" on the CMS website.

"Temporary Instructions for Implementation of Final Rule 1599-F for Part A to Part B Billing of Denied Hospital Inpatient Claims" MLN Matters® Article — Revised

[MLN Matters® Special Edition Article #SE1333](#), "Temporary Instructions for Implementation of Final Rule 1599-F for Part A to Part B Billing of Denied Hospital Inpatient Claims," was revised and is now available in a downloadable format. This article is designed to provide education on temporary instructions used to implement billing for Medicare Part B services provided during a hospital inpatient stay not covered by Medicare, as required under CMS-1599-F. It includes information about appeals, billing, and a list of revenue codes not covered under inpatient Part B medical necessity denials. The article was revised to adjust the table on page 5 that lists revenue codes not covered under inpatient Part B medical necessity denials. All other information remains the same.



Official Information Health Care
Professionals Can Trust

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