Medicare Learning Network®
Official Information Health Care Professionals Can Trust

MLN Connects™

Weekly Provider eNews

Wednesday, November 27, 2013

Due to the holiday, your *e-News* is arriving a day earlier this week. Happy Thanksgiving.

MLN Connects™ National Provider Calls

CMS Finalized Policies for the Physician Value-Based Payment Modifier under the Medicare Physician Fee Schedule 2014 Final Rule — CE Credit Available

Tuesday, December 3; 1:30-3pm ET

To Register: Visit MLN Connects™ Upcoming Calls. Space may be limited, register early. This MLN Connects Call has been approved by CMS for CME and CEU continuing education credit (CE). Review CE Activity Information and Instructions for specific details.

Target Audience: Physicians, physician group practices, practice managers, medical and specialty societies, payers, insurers.

This MLN Connects Call provides an overview of the finalized policies for the value-based payment modifier (VM) under the 2014 Physician Fee Schedule (PFS) Final Rule. This presentation will discuss how CMS plans to continue to phase in and expand application of the VM in 2016 based on performance in 2014. The presentation will also describe how the VM is aligned with the reporting requirements under the Physician Quality Reporting System (PQRS). A question and answer session will follow the presentation.

Agenda:

- Introduction
- Review of the finalized Value-Based Payment Modifier policies under the 2014 PFS Final Rule
- Question and answer session

2014 Physician Fee Schedule Final Rule: Quality Reporting in 2014 — Register Now

Tuesday, December 17; 1:30-3pm

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

Target Audience: Physicians, physician group practices, practice managers, medical and specialty societies, payers, insurers, and other healthcare professionals.

The December 17 MLN Connects Call provides an overview of the 2014 Physician Fee Schedule (PFS) Final Rule. This presentation covers program updates to the Physician Quality Reporting System (PQRS). In particular, this call includes details on how an eligible professional (EP) or group practice can meet the criteria for satisfactory reporting for the 2014 PQRS incentive and 2016 PQRS payment adjustment. In lieu of satisfactory reporting, the call also covers how to meet the criteria for satisfactory participation under the new qualified clinical data registry option, which will be implemented in 2014 as a result of the American Taxpayer Relief Act of 2012. In addition to the PQRS, this presentation contains additional program updates to the Electronic Health Record (EHR) Incentive Program and Physician Compare. A question and answer session follows the presentation.

Agenda:

- Program updates for PQRS
- How an EP or Group Practice can meet the criteria for satisfactory reporting for the 2014 PQRS incentive and 2016 PQRS payment adjustment
- Criteria for satisfactory participation under the new qualified clinical data registry option
- Program updates for EHR Incentive Program and Physician Compare
- 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.

CMS Events

Provider Webinar on 2014 CMS eHealth Program Milestones for EPs

Thursday, December 5; 12-1:30pm ET

Eligible Professionals (EPs) are encouraged to join the next CMS eHealth webinar on milestones for 2014 eHealth programs. The webinar will help you prepare for major eHealth deadlines, transition milestones , and benchmarks in 2014. CMS experts will present on eHealth programs including the EHR Incentive Programs, ICD-10, and the Physician Quality Reporting System (PQRS).

Key eHealth program milestones in 2014 include:

- January 1, 2014:
  - Effective date of Administrative Simplification operating rules for electronic funds transfers (EFT) and remittance advice.
  - Start of Stage 2 for EPs beginning their third or fourth year of participation in the Medicare and Medicaid EHR Incentive Programs.
- February 28, 2014:
  - Deadline for EPs to submit 2013 PQRS data through some reporting methods for the 2013 program year.
  - Last day for Medicare EPs participating in the Electronic Reporting Pilot to submit quality data to satisfy both the PQRS and the Clinical Quality Measure (CQM) requirement of the EHR Incentive Program.
- October 1, 2014:
  - Transition date from ICD-9 to ICD-10 codes for diagnoses and inpatient procedures. Step-by-step CMS resources can help you make sure you're prepared for the transition.
  - Last day for new meaningful users to attest to 2014 data and avoid the 2015 payment adjustment.

Registration Information

Space is limited. Register now to secure your spot for this eHealth Provider Webinar. Once registration is complete, you will receive a follow-up email with step-by-step instructions on how to log-in to the webinar. Past webinar presentations and recordings can be accessed on the Resources page of the CMS eHealth website.

Want more information about CMS eHealth?

Make sure to visit the CMS eHealth website for the latest news and updates. For additional information about important eHealth milestones, please review the CMS eHealth Interactive Timeline.

Announcements

November is National Home Care and Hospice Month

The Medicare Learning Network® has developed the following publications to educate Medicare providers on coverage and payment for hospice and home health services.

- The "Hospice Payment System" Fact Sheet (ICN 006817) is designed to provide education on the Medicare Hospice Payment System. It includes the following information: background, coverage of Hospice services, certification requirements, election periods, how payment rates are set, patient coinsurance payments, caps on Hospice payments, Hospice option for Medicare Advantage enrollees, and quality reporting.
- The "Home Health Prospective Payment System" Fact Sheet (ICN 006816) is designed to provide education on the Home Health Prospective Payment System (HH PPS). It includes the following information: background, consolidated billing requirements, criteria that must be met to qualify for Home Health services, coverage of Home Health services, elements of the HH PPS, updates to the HH PPS, and health care quality.
- The "Quick Reference Information: Home Health Services" (ICN 908504) is designed to provide education on Home Health services. It includes the following information: qualifying for Home Health services, patient admission to a Home Health Agency, and payment and billing for Home Health services.

In Observance of World AIDS Day — Remember HIV Screenings

December 1 is World AIDS Day, a day observed each year to raise awareness of the global impact of HIV/AIDS, show support for people living with the disease, and remember people who have died. A growing number of older people now have HIV/AIDS. Almost one-fourth of all people with HIV/AIDS in this country are age 50 and older.

The number of HIV/AIDS cases among older people is growing every year in part because:

- Healthcare workers and educators often do not talk with middle-aged and older people about HIV/AIDS prevention.
- Older people are less likely than younger people are to talk about their sex lives or drug use with their doctors.
- Doctors may not ask older patients about their sex lives or drug use or talk with them about risky behaviors.

CMS encourages healthcare providers to have a conversation with their Medicare patients about the importance of HIV prevention and screening.

Medicare Coverage
Medicare provides coverage, under Part B, of both standard and Food and Drug Administration approved rapid HIV screening tests for Medicare beneficiaries that meet certain requirements, including:

- A maximum of one, annual voluntary HIV screening of Medicare beneficiaries at increased risk for HIV infection (11 full months must elapse following the month the previous test was performed in order for the subsequent test to be covered).
- A maximum of three, voluntary HIV screenings of pregnant Medicare beneficiaries:
    - When the diagnosis of pregnancy is known,
    - During the third trimester, and
    - At labor, if ordered by the woman's physician.

Medicare beneficiaries with any known diagnosis of a HIV-related illness are not eligible for this screening test. Medicare provides coverage for HIV screening as a Medicare Part B benefit. There is no coinsurance or copayment or Medicare part B deductible for this benefit.

For More Information

- MLN Human Immunodeficiency Virus Screening brochure.
- MLN Preventive Services Quick Reference Information chart.
- MLN Preventive Services web page.
- NIH National Institute on Aging – HIV, AIDS and Older People.
- AIDS.gov.
- World AIDS Campaign - World AIDS Day web page.

Access Your 2012 eRx Incentive Program Feedback Report Today

Eligible professionals (EPs) and group practices who submitted data for the 2012 Electronic Prescribing (eRx) Incentive Program can now access their 2012 eRx Incentive Program Feedback Reports.

Accessing the reports
If you are an individual EP or part of a group practice, and you submitted 2012 eRx data, you can retrieve your 2012 eRx Feedback Reports using one of the following options:

1. Taxpayer Identification Number (TIN)-level reports are available for download on the Physician and Other Health Care Professionals Quality Reporting Portal (Portal) via QualityNet.
    - TIN-level reports on the Portal require an Individuals Authorized Access to CMS Computer Services (IACS) account. IACS Quick Reference Guides are available on the Portal and these guides provide step-by-step instructions on how to request an IACS account and access the Portal.
2. National Provider Identifier (NPI)-level reports can be requested through the Communication Support Page by creating a NPI-level feedback report request. The report will be sent electronically within 2-4 weeks to the email address you provide in your request.

Distribution of eRx incentive payments to EPs and group practices who successfully participated in the program in 2012 is scheduled to begin in the fall of 2013.

Request an Informal Review
EPs and group practices can request to have an informal review of your 2012 eRx reporting performance. Informal review requests will be accepted beginning *November 1, 2013 through February 28, 2014.* For more information about how to request an informal review, please read the 2012 eRx Incentive Program Informal Review Made Simple fact sheet.

Questions?
For all other questions related to the eRx Incentive Program, 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.

eRx Incentive Program Resources
For more information about participating in the eRx Incentive Program, visit the eRx website. You can also learn about other eHealth initiatives at CMS by visiting the CMS eHealth website.

Learn How to Avoid the 2015 PQRS Payment Adjustment

Providers considered eligible and able to participate in the Physician Quality Reporting System (PQRS) may be subject to payment adjustments beginning in 2015. Eligible professionals (EPs) and group practices that fail to satisfactorily report data on quality measures during the 2013 program year will be subject to a 1.5% payment adjustment of their Physician Fee Schedule (PFS) charges beginning in 2015. Individuals and group practices participating in PQRS must meet one of the following criteria to avoid payment adjustments in 2015.

Criteria for Individual EPs
EPs can avoid the 2015 payment adjustment if *one* of the following criteria is met during the 2013 PQRS program year:

- Meet the requirements outlined in the 2013 PQRS measure specifications (this will enable the EP to earn a 2013 PQRS incentive payment of 0.5% of their covered Medicare Part B charges)
- Report at least:
    - One valid measure via claims, participating registry, or through a qualified Electronic Health Record (EHR) *or*
    - One valid measures group via claims or participating registry
- Elected to participate in the administrative claims-based reporting mechanism October 18, 2013

Criteria for Registered Groups (ACO/PQRS GPRO)
Group practices participating in the Group Practice Reporting Option (GPRO) can avoid 2015 payment adjustments if *one* of the following criteria is met during the 2013 PQRS program year:

- Group meets the following requirements, outlined in the 2013 PQRS GPRO Fact Sheet
    - Report specific Accountable Care Organization (ACO)/GPRO measures through the Web Interface *or*
    - Report at least 3 registry measures (for 80% of the group's eligible patients for each measure) for the GPRO outlined in the 2013 PQRS Measure Specification for Claims/Registry Reporting of Individual Measures
- Report at least one valid measure through the Web Interface *or* participating registry
- Elected to participate as a GPRO in the administrative claims-based reporting mechanism by October 18, 2013
  Note: Administrative claims-based reporting is not available to ACO GPROs

Resources
View the PQRS Payment Adjustments Tip Sheet for more information on how to avoid the 2015 payment adjustment. For more information or support on the PQRS program, please visit the PQRS Incentive Program website or the Help Desk.

Hospitals: Attest by November 30 to Receive EHR Incentive Payment for 2013 Participation

The last day that eligible hospitals and critical access hospitals (CAHs) can register and submit attestation in FY 2013 for the Medicare Electronic Health Record (EHR) Incentive Program is November 30, 2013. Eligible hospitals and CAHs must successfully attest to demonstrating meaningful use *by 11:59 p.m. ET on November 30* to receive a 2013 incentive payment. Hospitals must attest to demonstrating meaningful use *every year* to receive an incentive and avoid a payment adjustment.

Medicaid Eligible Hospitals
Hospitals participating in the Medicaid EHR Incentive Program need to refer to their state deadlines for attestation.

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.

Common Questions and Answers about Clinical Quality Measures (CQMs) and Attestation

- *Question:* I have fewer than the case number threshold that qualifies for the case threshold exemption but do not wish to invoke the exemption. The attestation system requires that I select the case threshold exemption if I have fewer than 20 or fewer per year or 5 or fewer per quarter (or 90-day period). What should I select?
  Answer: If you would like to submit your CQM results via attestation, please select the option for more than 20 cases per year or more than 5 cases per quarter (or 90-day period) so that the system allows you to enter your CQM results.
- *Question:* Where do I input my aggregate population number on the attestation screens for each CQM if I am attesting in 2013.
  Answer: If you are attesting your CQM results, you would only need to select the option that states that you have 20 or fewer cases per year, or 5 or fewer cases per quarter (or 90-day period) to indicate that you have qualified for the exemption. Specific aggregate population numbers would not need to be submitted in 2013 but may be requested if the hospital is audited.
- *Question:* What if my Emergency Department (ED) data is in an uncertified module that feeds into a certified module for purposes of reporting the ED CQMs?
  Answer: Other IT systems that act as data sources and are not intended to perform required capabilities in accordance with adopted certification criteria do not need to be certified simply because they supply data to a complete EHR or EHR Module. See ONC FAQ 09-10-010-2 for more information. Beginning in 2014, certified EHR technology (CEHRT) must include certified modules that can capture each data element for each and every CQM that will be reported to CQMs. Those data elements can be found in the Data Elements Catalog.

Resources

- Meaningful Use Attestation Calculator
- Attestation Worksheet for Eligible Hospitals and CAHs
- Attestation Guide for Eligible Hospitals
- 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.

Learn More about Health Information Exchange in Stage 2 with New EHR Tipsheet for Eligible Professionals

If you are an eligible professional preparing for Stage 2 of the EHR Incentive Programs, check out our new CMS tipsheet on Stage 2 health information exchange requirements.

Three Data Sharing Measures in Stage 2
The tipsheet outlines the required data elements and provides additional guidance for the following three Stage 2 objectives that call for data sharing:

- Summary of Care
- Clinical Summary
- Patient Electronic Access

While some of the data elements are common between the three measures, other data elements are individual to each measure.

When does Stage 2 Begin for Eligible Professionals?
If you are an eligible professional who has completed at least two years of Stage 1 of meaningful use, you will begin Stage 2 in 2014. CMS has additional resources available to help you participate in the next stage, including:

- Stage 2 Beginner's Guide
- Stage 2 PowerPoint and webinar recording, including an overview of audits and payment adjustments
- Specification sheets for Stage 2 criteria
- My Participation Timeline widget to help you determine the year you start each stage of meaningful use
- Stage 2 Exchange Requirements for Eligible Professionals Presentation

If you are just beginning meaningful use, or have only completed one year, you must complete two full years of Stage 1 before moving to Stage 2.

Stage 2 Resources
For more resources to help you prepare for Stage 2, visit the Stage 2 web page on the EHR Incentive Programs website.

Stay Informed: New and Updated FAQs for the EHR Incentive Programs

To keep you updated with information on the Medicare and Medicaid EHR Incentive Programs, CMS has recently added nine new and three 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. If an eligible hospital or critical access hospital (CAH) does not have any reportable lab results during the EHR reporting period (for example, the eligible hospital or CAH outsources all lab testing to a commercial lab or does not perform any lab tests for conditions that are reportable in their jurisdiction) can they be excluded from the requirement in the EHR Incentive programs to submit reportable lab results to a public health agency? Read the answer.
2. If a hospital operates in a jurisdiction where a public health agency has the ability to accept certain reportable laboratory results electronically and in the required standards, but the hospital does not generate those particular reportable laboratory results, how must the hospital attest to the core measure for Electronic Reportable Laboratory Results? Read the answer.
3. Am I permitted to count a patient in the numerator of the "record demographics" objective and measure if the preferred language I record for the patient is outside of the minimum required by the standard for Certified EHR Technology? Read the answer.
4. If an eligible provider fails to meet meaningful use during a participation year in the Medicare EHR Incentive Program, can he/she continue to participate and earn incentives? Read the answer.
5. What is the deadline for EPs to submit attestations to meaningful use for 2013 in the EHR Incentive Programs? Read the answer.
6. What is the deadline for eligible hospitals and CAHs to submit attestations to meaningful use for 2013 in the EHR Incentive Programs? Read the answer.
7. What is the CMS EHR Meaningful Use Audit Team? Read the answer.
8. When maintaining an up-to-date problem list as part of achieving meaningful use in the Medicare and Medicaid EHR Incentive Programs, can both SNOMED CT as well as non-SNOMED CT (for example ICD-9 or ICD-10) elements be included to meet the measure? Read the answer.
9. Can a hospital receive credit for any of the Inpatient Quality Reporting (IQR) Program requirements by electronically submitting the Clinical Quality Measures (CQMs) for the EHR Incentive Program? Read the answer.

Updated FAQs:

1. For the Stage 2 meaningful use objective of the Medicare and Medicaid EHR Incentive Programs that requires the successful electronic exchange of a summary of care document with either a different EHR technology or the CMS designated test EHR, if multiple EPs are using the same certified EHR technology across several physical locations, can a single test meet the measure? Read the answer.
2. What is the maximum EHR incentive an EP can earn under Medicare? Read the answer.
3. Will the CMS conduct audits as part of the Medicare and Medicaid EHR Incentive Programs? Read the answer. Read the answer.

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.

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:

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

Reminder: The submission deadlines — August 15, 2013 for January through March 2013 data and November 15, 2013 for April through June 2013 data — that will affect the FY 2015 Payment Update Determination has passed.

MLN Educational Products

"Vaccine Payments Under Medicare Part D" Fact Sheet — Released

The "Vaccine Payments Under Medicare Part D" Fact Sheet (ICN 908764) was released and is now available in a downloadable format. This fact sheet is designed to provide education on Vaccine Payments under Medicare Part D. It includes information on the difference between Part B and Part D vaccine coverage, what Part D covers, and additional information on vaccine coverage under Part D plans.

MLN Products Available in Electronic Publication Format

The following items are now available as electronic publications (EPUBs) and through QR codes. 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.

- "Contractor Entities At A Glance: Who May Contact You About Specific Centers for Medicare & Medicaid Services (CMS) Activities" Educational Tool (ICN 906983) is designed to provide education on the definitions and responsibilities of entities who are involved with claims adjudication activities. It includes a chart that outlines each entity by type, definitions, responsibilities, and reasons for contacting providers, especially Fee-For-Service providers.

- "Misinformation on Chiropractic Services" Fact Sheet (ICN 006953) is designed to provide education on Chiropractic Services. It includes information on the documentation needed to support a claim submitted to Medicare for medical services.
- "Chiropractic Services" Booklet (ICN 906143) is designed to provide education on Chiropractic Services. It includes information on the documentation needed to support a claim submitted to Medicare for medical services.

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.

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 You Tube & Twitter #CMSMLN