



# MLN Connects™

## Weekly Provider eNews

Thursday, December 19, 2013

Two important notes for you this week:

Please take a moment to [give us your feedback](#) about the eNews.

Due to the holidays, the next regular edition of the eNews will be released Thursday, January 9.

Happy Holidays and Happy New Year!

### MLN Connects™ National Provider Calls

- 2-Midnight Benchmark for Inpatient Hospital Admissions — Registration Now Open
- End-Stage Renal Disease Quality Incentive Program Payment Year 2016 Final Rule — Register Now
- 2012 Quality and Resource Use Reports Overview and December Addendum — Registration Now Open
- National Partnership to Improve Dementia Care in Nursing Homes — Registration Now Open
- Did You Miss This MLN Connects Call?

### Announcements

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- DMEPOS Competitive Bidding Program: January 1, 2014 Round 1 Recompete Implementation — Resources
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- HHS Announces Affordable Care Act Mental Health Services Funding
- More Than 25 Million Original Medicare Beneficiaries Received Free Preventive Services through November 2013
- LTCH FY 2015 Payment Update Determination: Data Submission Deadlines
- Upcoming Deadline for EPs in EHR Incentive Programs; Prepare for Attestation
- Request an Informal Review of 2014 eRx Payment Adjustment

### Claims, Pricers, and Codes

- CMS Furnishes Final List of Off-The-Shelf Orthotic HCPCS Codes

### MLN Educational Products

- “Mental Health Services” Booklet — Revised
- “Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Information for Pharmacies” Fact Sheet — Reminder

### MLN Connects™ National Provider Calls

## **2-Midnight Benchmark for Inpatient Hospital Admissions — Registration Now Open**

*Tuesday, January 14; 1:30-3pm ET*

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

This MLN Connects Call provides an overview of the inpatient hospital admission and medical review criteria (also known as the 2-Midnight Rule) that was released on August 2, 2013 in the FY 2014 Inpatient Prospective Payment System/Long-Term Care Hospital final rule ([CMS-1599-F](#)). CMS will present case scenarios on the application of the rule to sample medical records. Following the presentation, CMS will address frequently asked questions received from providers.

### *Agenda:*

- Summary of the 2-Midnight Rule
- Case example presentation
- Question and answer session

*Target Audience:* Hospitals, physicians and non-physician practitioners, case managers, medical and specialty societies, and other healthcare professionals.

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

## **End-Stage Renal Disease Quality Incentive Program Payment Year 2016 Final Rule — Register Now**

*Wednesday, January 15; 2-3:30pm ET*

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

On January 15, CMS, Center for Clinical Standards and Quality (CCSQ) 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 program that ties a facility's performance to a payment reduction over the course of a payment year (PY). This MLN Connects Call will focus on the [final rule](#) for operationalizing the ESRD QIP in PY 2016, which was put on display on November 22, 2013.

The performance period for PY 2016 will begin on January 1, 2014. Facilities and other stakeholders should take steps to understand the contours of the program. After the presentation, participants will have an opportunity to ask questions.

### *Agenda:*

- ESRD QIP legislative framework and how it fits in with CMS strategies to improve quality
- Changes reflected in the final rule based on public comments
- The final measures, standards, scoring methodology, and payment reduction scale that are applied to the PY 2016 program
- How the PY 2016 program compares to PY 2015
- Where to find additional information about the program
- Question and answer session

*Target Audience:* Dialysis clinics and organizations, nephrologists, hospitals with dialysis units, billers/coders and quality improvement experts, and other interested stakeholders.

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## **2012 Quality and Resource Use Reports Overview and December Addendum — Registration Now Open**

*Thursday, January 16; 2:30-4pm ET*

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

This MLN Connects Call will provide an overview of the 2012 Quality and Resource Use Reports (QRURs), including a review of the December addendum and how to interpret and use the data in the report.

On September 16, CMS released the 2012 QRURs to group practices with 25 or more eligible professionals (EPs). The QRUR previews each group's performance on quality and cost measures that could be used to calculate the group's Value-Based Payment Modifier in 2015. On December 23, CMS released an addendum to the 2012 QRURs to include individual eligible professional (EP) PQRS performance data. The addendum will be available for all group practices with 25 or more EPs for which at least one EP reported PQRS measures as an individual in 2012 and was found to be incentive eligible.

*Agenda:*

- How to understand and use the QRURs
- Individual EP PQRS performance data addendum
- Question and answer session

*Target Audience:* Groups with 25 or more eligible professionals.

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

*Wednesday, February 26; 2-3:30pm ET*

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

The CMS National Partnership to Improve Dementia Care in Nursing homes was developed to improve dementia care through the use of individualized, comprehensive care approaches. The partnership promotes a systematic process to evaluate each person and identify approaches that are most likely to benefit that individual. The goal of the partnership is to continue to reduce the use of unnecessary antipsychotic medications, as well as other potentially harmful medications in nursing homes and eventually other care settings as well.

During this MLN Connects Call, a CMS subject matter expert will discuss the critical role of both state and federal surveyors in the implementation of the partnership. Additional speakers will be presenting on the importance of leadership, as well as the strong correlation that exists between proper pain assessment and antipsychotic medication use. A question and answer session will follow the presentation.

*Agenda:*

- Role of surveyors
- Importance of leadership
- Proper pain assessment
- Next steps

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

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

## Did You Miss This MLN Connects Call?

Call materials for MLN Connects™ Calls are located on the [Calls and Events](#) web page. New materials are now available for the following call:

- December 3 — CMS Finalized Policies for the Physician Value-Based Payment Modifier under the Medicare Physician Fee Schedule 2014 Final Rule, [audio](#) and [transcript](#)

## Announcements

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### Remember To Ask, Have You Gotten Your Flu Shot?

Increases in influenza activity across the U.S. are expected in the coming weeks. The Centers for Disease Control and Prevention (CDC) recommends a yearly flu vaccination as the first and most important step in protecting against flu and its potentially serious complications. The CDC recommends that you assess vaccination status with each patient visit, encourage seasonal influenza vaccination, and vaccinate or refer to a vaccine provider when appropriate. Health care providers should also get vaccinated and continue offering and encouraging flu vaccination among staff, colleagues, and patients.

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 is *not* a Part D-covered drug.

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

- [MLN Matters® Article #MM8433](#), “Influenza Vaccine Payment Allowances - Annual Update for 2013-2014 Season.”
- [MLN Matters® Article #SE1336](#), “2013-2014 Influenza (Flu) Resources for Health Care Professionals.”
- While some providers may offer flu vaccines, those that don’t can help their patients locate flu vaccines within their local community. The [HealthMap Vaccine Finder](#) is a free, online service where users can search for locations offering flu and other adult vaccines.
- [Free Resources](#) can be downloaded from the CDC website including [prescription-style tear-pads](#) that will allow you to give a customized flu shot reminder to patients at high-risk for complications from the flu.

### DMEPOS Competitive Bidding Program: January 1, 2014 Round 1 Recompete Implementation — Resources

#### *Educational Resources Reminder*

CMS is required by law to recompetete contracts under the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program at least once every three years. The Round 1 Rebid contracts will expire on December 31, 2013, and the Round 1 Recompete contracts and prices are scheduled to go into effect on January 1, 2014.

When a round of the Program becomes effective in a competitive bidding area (CBA), beneficiaries with Original Medicare who obtain competitively bid items in that CBA must obtain these items from a contract supplier for that round in order for Medicare to pay, unless an exception applies. Educational resources are available on the [CMS](#) website. [Materials](#) to assist you with beneficiary inquiries about the program are also available.

#### *CBIC Liaison Reminder*

Competitive Bidding Implementation Contractor (CBIC) liaisons are available to assist suppliers, referral agents, and other key stakeholders with questions and concerns about the Medicare DMEPOS Competitive Bidding Program. The liaisons can provide assistance with issues such as:

- the quality of services or items,
- suspected fraud or abuse,
- guidelines on particular policies,

- information on regulations,
- general information about the program, and
- educational materials.

There is a dedicated CBIC liaison assigned in each of several regional geographic territories. For more information and to see a listing of the CBIC liaisons, visit the [DMEPOS Competitive Bidding](#) website.

### Step-by-Step Instructions for Using the I&A System to Access PECOS, EHR, and NPPES

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) Registration and Attestation System, and the National Plan and Provider Enumeration System (NPPES). CMS has developed the following tools to make it easy for you to use the Identity and Access management (I&A) System used to access PECOS, EHR and NPPES.

- [Quick Reference Guide](#): Overview of features and tools to manage your account
- Videos:
  - [How to Create an Account](#): How to create an account if you are an individual provider, an Authorized or Delegated Official for your organization or to work on behalf of providers
  - [How to register as an Authorized Official for your Organization](#): How to register with CMS as an Authorized or Delegated Official
  - [Setting Up Staff](#): How to add credentialing staff to your healthcare organization or 3rd party organization
  - [Connections](#): How a healthcare or 3rd party organization can request to work on behalf of a provider as a surrogate

#### Questions?

[Frequently Asked Questions](#): Answers to common questions about registration, who should register, and how to manage your account.

### HHS Announces Affordable Care Act Mental Health Services Funding

On December 10, HHS announced that it plans to issue a \$50 million funding opportunity announcement to help Community Health Centers establish or expand behavioral health services for people living with mental illness, and drug and alcohol problems. Community Health Centers will be able to use these new funds, made available through the Affordable Care Act, for efforts such as hiring new mental health and substance use disorder professionals, adding mental health and substance use disorder services, and employing team-based models of care. It is estimated these awards will support behavioral health expansion in approximately 200 existing health centers nationwide.

Full text of this excerpted [HHS press release](#) (issued December 10).

### More Than 25 Million Original Medicare Beneficiaries Received Free Preventive Services through November 2013

According to new data released by CMS on December 17, more than 25.4 million people covered by Original Medicare received at least one preventive service at no cost to them during the first eleven months of 2013 because of the Affordable Care Act. This announcement exceeds the comparable figure from last November, when an estimated 24.7 million people with Original Medicare received one or more preventive benefits at no out of pocket costs by this point in time during 2012. When factoring in Medicare Advantage utilization rates and a full year of experience, an estimated 34.1 million people with Medicare took advantage of at least one preventive service in 2012. Moreover, in the first eleven months of 2013, more than 3.5 million beneficiaries with Original Medicare took advantage of the Annual Wellness Visit established by the health care law – a significant increase from the 2.8 million who used this service by this point in the year in 2012.

Full text of this excerpted [CMS press release](#) (issued December 17).

## 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 have passed.

## Upcoming Deadline for EPs in EHR Incentive Programs; Prepare for Attestation

December 31, 2013, is an important deadline for eligible professionals (EPs) participating in the EHR Incentive Programs. It marks the end of the calendar year and the last day of the 2013 meaningful use program year.

### *Attestation Deadline*

If you are an EP participating in the Medicare EHR Incentive Program, you have until February 28, 2014, to attest to demonstrating meaningful use of the data collected during the reporting period for the 2013 calendar year. You must *attest by 11:59pm ET on February 28* to demonstrate meaningful use. If you are participating in the Medicaid EHR Incentive Program, please refer to your [state's deadlines](#) for attestation information. You 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 January 1, 2015, if you have not successfully demonstrated meaningful use. The adjustment is determined by the reporting period in a prior year. For more information, visit the [payment adjustment tipsheet](#). 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.

### *EPs in 2014*

January 1, 2014 marks many important milestones for EPs participating in the EHR Incentive Programs, including:

- The start of [Stage 2](#) for EPs who have already completed at least two years of Stage 1.
- The last year that Medicare EPs can begin participation and earn an incentive.
- A 3-month reporting period in 2014, regardless of the stage of meaningful use, to allow time to upgrade to 2014 certified EHR technology.
  - Medicare EPs beyond their first year of meaningful use must select a three-month reporting period fixed to the quarter of the calendar year.
  - Medicare EPs in their first year of meaningful use may select any 90-day reporting period that falls within the 2014 calendar year.
  - Medicaid EPs can select any 90-day reporting period that falls within the 2014 calendar year.

## Resources

- [Meaningful Use Attestation Calculator](#)
- [Attestation Worksheet for EPs](#)
- [Attestation Guide for Medicare EPs](#)
- [Stage 2 Payment Adjustment Tipsheet for EPs](#)

## Plan Ahead

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

## Request an Informal Review of 2014 eRx Payment Adjustment

Eligible professionals and group practices (who self-nominated for the 2012 and/or 2013 Electronic Prescribing (eRx) group practice reporting option) who were not successful electronic prescribers under the 2012 or 2013 eRx Incentive Program will be subject to a payment adjustment in 2014. CMS will notify those eligible professionals and group practices who will be subject to the 2014 eRx payment adjustment. The 2014 eRx payment adjustment will result in an eligible professional or group practice receiving 98.0% of his or her Medicare Part B physician fee schedule (PFS) allowed charges amount that would otherwise apply to such services for all charges with dates of service from January 1 through December 31, 2014.

### *Request an Informal Review*

CMS has implemented an informal review process for the 2014 eRx payment adjustment. An informal review may be requested if the eligible professional or group practice receives notification from CMS confirming they will be subject to the 2014 eRx payment adjustment or they did not meet the requirements to avoid the 2014 eRx payment adjustment. Informal review requests will be accepted *through February 28, 2014*. Eligible professionals and group practices should submit their eRx informal review request via email to the informal review mailbox at [eRxInformalReview@cms.hhs.gov](mailto:ERXInformalReview@cms.hhs.gov). Complete instructions on how to request an informal review are available in the [2014 eRx Payment Adjustment Informal Review Made Simple](#) educational document.

### *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 [qnetssupport@sdps.org](mailto:qnetssupport@sdps.org). They are available Monday through Friday from 7am-7pm CT.

## Claims, Pricers, and Codes

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### CMS Furnishes Final List of Off-The-Shelf Orthotic HCPCS Codes

On August 12, 2013, CMS issued guidance identifying specific Healthcare Common Procedure Coding System (HCPCS) codes that are considered Off-The-Shelf (OTS) orthotics. This posting on the [OTS Orthotics](#) web page provides the final OTS HCPCS codes approved by the HCPCS Alpha Numeric Workgroup effective January 1, 2014.

Section 1847(a)(2) of the Social Security Act (the Act) defines OTS orthotics as those orthotics described in section 1861(s)(9) of the Act for which payment would otherwise be made under section 1834(h) of the Act, which require minimal self-adjustment for appropriate use and do not require expertise in trimming, bending, molding, assembling, or customizing to fit to the individual. Orthotics that are currently paid under section 1834(h) of the Act and are described in section 1861(s)(9) of the Act are leg, arm, back and neck braces. The Medicare Benefit Policy Manual (Publication 100-02), Chapter 15, Section 130 provides the longstanding Medicare definition of “braces.” Braces are defined in this section as “rigid or semi-rigid devices which are used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body.”

Suppliers of any orthotic other than an OTS orthotic must be in compliance with Appendix C of the DMEPOS quality standards, which specifies that suppliers must possess specialized education, training, and experience in fitting and certification and/or licensing.

Please note that in some cases there are two codes in the HCPCS that may both describe a particular prefabricated orthotic product, one code for when the device is furnished OTS, and a second code for when the device is furnished with custom fitting. In these cases, and in the case of any code for a prefabricated orthotic that requires more than minimal self-adjustment and requires expertise in fitting or customizing, the code that describes a custom fitted orthotic cannot be used unless the custom fitting services have been performed and the supplier is in compliance with Appendix C of the DMEPOS quality standards.

CMS regulations at 42 CFR 414.402 also define the term “minimal self-adjustment” to mean an adjustment that the beneficiary, caretaker for the beneficiary, or supplier of the device can perform and that does not require the services of a certified orthotist (that is, an individual who is certified by the American Board for Certification in Orthotics and Prosthetics, Inc., or by the Board for Orthotist/Prosthetist Certification) or an individual who has specialized training.

To view the final list of 2014 OTS orthotic HCPCS codes, please visit the CMS [DMEPOS Fee Schedule](#) website and click on “[OTS Orthotics](#).”

## MLN Educational Products

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### “Mental Health Services” Booklet — Revised

The “[Mental Health Services](#)” Booklet (ICN 903195) was revised and is now available in downloadable format. This booklet is designed to provide education on mental health services. It includes the following information: covered and non-covered mental health services, eligible professionals, outpatient and inpatient psychiatric hospital services, same day billing guidelines, and National Correct Coding Initiative.

### “Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Information for Pharmacies” Fact Sheet — Reminder

The “[Durable Medical Equipment, Prosthetics, Orthotics, and Supplies \(DMEPOS\) Information for Pharmacies](#)” Fact Sheet (ICN 905711) is available in a downloadable format. This fact sheet is designed to provide education for pharmacies on DMEPOS. It includes information on accreditation by CMS-approved independent national Accreditation Organization (AO) as well as information if a pharmacy wants to be considered for an exemption from the accreditation requirements.

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