



MLN Connects™

Weekly Provider eNews

Thursday, January 9, 2014

We would like to thank everyone who has provided their [feedback](#) on the eNews.

Some readers indicated that they have difficulty copying and pasting articles with imbedded hyperlinks from the email edition of the eNews. As a reminder, a PDF version of every issue is also available in the [archive](#).

MLN Connects™ National Provider Calls

2-Midnight Benchmark for Inpatient Hospital Admissions — Register Now

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

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National Partnership to Improve Dementia Care in Nursing Homes — Register Now

Did You Miss This MLN Connects Call?

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“Systematic Validation of Payment Group Codes for Prospective Payment Systems (PPS) Based on Patient Assessments” MLN Matters® Article — Released

“Further Information on Mandatory Reporting of an 8-Digit Clinical Trial Number on Claims” MLN Matters® Article — Released

“Point of Origin for Admission or Visit Code (Formerly Source of Admission Code) for Inpatient Psychiatric Facilities (IPFs)” MLN Matters® Article — Released

“Medicare Quarterly Provider Compliance Newsletter [Volume 4, Issue 2]” Educational Tool — Released

“Information on the National Physician Payment Transparency Program: Open Payments” Podcast — Released

“Hospice Related Services – Part B” Podcast — Released

“Discharge Planning” Booklet — Revised

“The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Physicians and Non-Physician Practitioners” Fact Sheet — Reminder

New MLN Provider Compliance Fast Fact

MLN Products Available in Electronic Publication Format

MLN Connects™ National Provider Calls

2-Midnight Benchmark for Inpatient Hospital Admissions — Register Now

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.

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

2012 Quality and Resource Use Reports Overview and December Addendum — CE Credit Available

Thursday, January 16; 2:30-4pm 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.

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.

National Partnership to Improve Dementia Care in Nursing Homes — Register Now

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 17 — 2014 Physician Fee Schedule Final Rule: Quality Reporting in 2014, [audio](#) and [transcript](#)

Transcript and Audio Now Available for December 19 Call on “Program Manual Updates to Clarify SNF, IRF, HH, and OPT Coverage Pursuant to *Jimmo v. Sebelius*”

The [transcript](#) and [audio](#) for the MLN Connects Call on “Program Manual Updates to Clarify SNF, IRF, HH, and OPT Coverage Pursuant to *Jimmo v. Sebelius*” are now available on the [December 19](#) call web page. The transcript was prepared and is being distributed as a result of the settlement agreement in the case of *Jimmo v. Sebelius*.

CMS Events

Join the Next eHealth Provider Webinar to Learn How You Can Prepare for Stage 2

Tuesday, January 14; 12-1:30pm ET

Are you participating in the EHR Incentive Programs? Have you completed two or more years of Stage 1? If so, it's time to start preparing for Stage 2 and earn an incentive for 2014 participation. Join CMS for the next eHealth provider webinar to get ready for Stage 2.

What will you learn?

Find out about requirements for Stage 2 and ask CMS experts your questions about the programs. Webinar topics will include:

- Stage 2 and 2014 Clinical Quality Measures
- 2014 certification of EHR systems
- Payment adjustments
- Audits
- Q&A

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. If you'd like to view past webinars, they can be accessed on the [Resources](#) page of the eHealth website.

Want more information about CMS eHealth?

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

Hospice Item Set Data Collection Training — Registration Now Available

February 4 and 5; 12:30-4:30pm ET

[Registration](#) for Hospice Item Set (HIS) Data Collection Training will be open until 11:59pm ET on Monday, January 27. The training will be held at the CMS Central Office in Baltimore, MD, on February 4 and 5 from 12:30-4:30 pm each day. Participants will need to attend both afternoons; the February 5 session is not a repeat of February 4, but includes unique material. The number of participants on-site will be limited and the number of in-person participants per hospice will be limited to one. Early registration is recommended.

To ensure access to the training for all hospices, the training will be live-streamed, and will also be recorded and posted on the CMS website for on-demand viewing. Instructions for live video-streaming access will be provided on the [HIS](#) web page. No registration is required for video-streaming. If you are unable to live-stream the HIS Data Collection Training, videos of the trainings will be posted on the same web page shortly after the training is complete.

The HIS Data Collection Training will closely follow along with the HIS Manual, which will be available on the [HIS](#) web page website in late January. A PDF version of the PowerPoint slide presentation will also be posted on the [HIS](#) web page prior to the training. In-person training participants are encouraged to print out a copy of the manual and the slide presentation before the training, as printed materials will not be provided at the training.

This training will cover the data collection portion of the HIS only. Detailed training on the technical submission processes and data submission software will be provided in May. Additional information about that training and the associated registration will be announced at a later date.

Register for ICD-10 Testing Week: March 3-7

On October 1, 2014, the ICD-9 code sets used to report medical diagnoses and inpatient procedures will be replaced by ICD-10 code sets. To help you prepare for this transition, CMS announces a national testing week for current direct submitters (providers and clearinghouses) from March 3 through 7, 2014.

This testing week will give trading partners access to the Medicare Administrative Contractor's (MACs) and Common Electronic Data Interchange (CEDI) for testing with real-time help desk support. The event will be conducted virtually. Registration is required.

What you can expect during testing:

- Test claims with ICD-10 codes must be submitted with current dates of service (i.e. October 1, 2013 through March 3, 2014), since testing does not support future dated claims.
- Test claims will receive the 277CA or 999 acknowledgement as appropriate, to confirm that the claim was accepted or rejected in the system.
- Testing will not confirm claim payment or produce remittance advice.
- MACs and CEDI will be staffed to handle increased call volume during this week.

More information is available in [MLN Matters® Article MM8465](#), "ICD-10 Testing with Providers through the Common Edits and Enhancements Module (CEM) and Common Electronic Data Interchange (CEDI)"

Registration Information:

Registration information will be posted soon on your [MAC](#) website.

Announcements

January is National Glaucoma Awareness Month

Glaucoma is a leading cause of blindness and visual impairment for Americans, affecting as many as 2.2 million people nationwide. Studies show that at least half of all persons with glaucoma do not know that they have this potential sight-stealing condition.

Medicare Coverage

Medicare provides coverage of an annual glaucoma screening for beneficiaries in at least one of the following high risk groups:

- Individuals with diabetes mellitus
- Individuals with a family history of glaucoma
- African-Americans age 50 and older
- Hispanic-Americans age 65 and older

A Medicare-covered glaucoma screening includes:

- a dilated eye examination with an intraocular pressure measurement, and
- a direct ophthalmoscopy examination or a slit-lamp biomicroscopic examination.

The copay/coinsurance and deductible apply.

Early detection and treatment of glaucoma is the best way to control glaucoma before it causes major vision loss. Eligible Medicare beneficiaries should be encouraged to utilize this benefit, which can help save their vision.

For more information on coverage, coding, and billing of the Medicare glaucoma screening benefit and National Glaucoma Awareness Month, please visit:

- [Medicare Learning Network® Glaucoma Screening Brochure](#)
- [Medicare Learning Network® Quick Reference Information: Preventive Services](#)
- [Medicare Learning Network® Preventive Services Educational Products](#)
- [The National Eye Institute – National Eye Health Education Program](#)

Continue Seasonal Flu Vaccination through January and Beyond

Seasonal influenza activity is increasing in parts of the United States and is expected to continue to increase across the country in the coming weeks. As long as flu viruses are circulating, flu vaccine can still offer protection. The Centers for Disease Control and Prevention (CDC) urges individuals not yet vaccinated to get their flu vaccine now. With each office visit, health care professionals should continue to assess patient vaccination status. For patients who haven't received the seasonal flu vaccine, encourage vaccine usage by discussing the benefits and importance of flu vaccination, offer to vaccinate, or refer to a vaccine provider when appropriate.

As a reminder, generally, Medicare Part B covers one influenza vaccination and its administration each 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.

More Partnerships between Doctors and Hospitals Strengthen Coordinated Care for Medicare Beneficiaries

123 New Accountable Care Organizations Join Program to Improve Care for Medicare beneficiaries

Doctors, hospitals and other health care providers have formed [123 new Accountable Care Organizations](#) (ACOs) in Medicare, providing approximately 1.5 million more Medicare beneficiaries with access to high-quality coordinated care across the United States, Health and Human Services Secretary Kathleen Sebelius announced December 23.

Doctors, hospitals and health care providers establish ACOs in order to work together to provide higher-quality coordinated care to their patients, while helping to slow health care cost growth. Since passage of the Affordable Care Act, more than 360 ACOs have been established, serving over 5.3 million Americans with Medicare. Beneficiaries seeing health care providers in ACOs always have the freedom to choose doctors inside or outside of the ACO. ACOs share with Medicare any savings generated from lowering the growth in health care costs when they meet standards for high quality care.

The ACOs must meet quality standards to ensure that savings are achieved through improving care coordination and providing care that is appropriate, safe, and timely. CMS evaluates ACO quality performance using 33 quality measures on patient and caregiver experience of care, care coordination and patient safety, appropriate use of preventive health services, and improved care for at-risk populations.

The new ACOs include a diverse cross-section of health care providers across the country, including providers delivering care in underserved areas. More than half of ACOs are physician-led organizations that serve fewer than 10,000 beneficiaries. Approximately 1 in 5 ACOs include community health centers, rural health clinics, and critical access hospitals that serve low-income and rural communities.

Affordable Care Act provisions have a substantial effect on reducing the growth rate of Medicare spending. Growth in Medicare spending per beneficiary hit historic lows during the 2010-2012 period, and this trend has continued into 2013. Projections by both

the Office of the Actuary at CMS and the Congressional Budget Office estimate that Medicare spending per beneficiary will grow at approximately the rate of growth of the economy for the next decade, breaking a decades-old pattern of spending growth outstripping economic growth.

The next application period for organizations interested in participating in the Shared Savings Program beginning January 2015 will be in summer 2014. More information about the Shared Savings Program, including previously announced ACOs, is available on the [Shared Savings Program](#) website.

Full text of this excerpted [CMS press release](#) (issued December 23).

Exception to the Physician Self-Referral Law for the Donation of Electronic Health Records Items and Services

On December 23, CMS issued a [final rule](#) that revises the exception to the physician self-referral law (section 1877 of the Social Security Act) that permits certain arrangements involving the donation of electronic health records items and services.

Extension of Expiration Date

Under current regulations, the exception expires on December 31, 2013. The final rule extends the expiration date of the exception for an additional eight years to December 31, 2021.

Interoperability

The final rule updates the provision under which electronic health records software is deemed interoperable. Additionally, in the rule, CMS clarifies the requirement prohibiting any action that limits or restricts the use, compatibility, or interoperability of donated items and services. The revised regulation states that software is deemed to be interoperable if it is certified to an edition of the electronic health record certification criteria identified in the then-applicable version of 45 CFR part 170. In addition, the regulation is revised to identify the National Coordinator for Health Information Technology as the office that authorizes certifying bodies for purposes of certifying electronic health records software.

Covered Entities

Under this final rule any entity furnishing designated health services other than a laboratory company is permitted to donate electronic health records items and services. CMS is finalizing the exclusion of laboratory companies from the types of entities that may donate electronic health records items and services. The final rule does not prohibit donations by any other type of entity. Any arrangements for ongoing or continued donations between laboratory companies and referring physicians must be terminated before the effective date of the final rule.

Electronic Prescribing

Previous regulations required that donated electronic health records items and services must have the capability for electronic prescribing. In response to public comment, CMS is removing that requirement. Software donated prior to the effective date of the regulatory modifications set forth in the final rule must satisfy all of the requirements of the existing exception at 42 CFR § 411.357(w), including the requirement in § 411.357(w)(11).

Additional information is available in the [fact sheet](#).

Emergency Preparedness Standards for Medicare and Medicaid Participating Providers and Suppliers

CMS issued a [proposed rule](#) (CMS-3178-P) to establish consistent emergency preparedness requirements for health care providers participating in Medicare and Medicaid, increase patient safety during emergencies, and establish a more coordinated response to natural and man-made disasters. This notice of proposed rulemaking would establish national emergency preparedness requirements to ensure that health care facilities adequately plan for disasters and coordinate with Federal, state, tribal, regional, and local emergency preparedness systems to make sure that providers and suppliers are adequately prepared to meet the needs of patients during disasters and emergency situations.

Proposed Requirements

Upon review of the current Medicare emergency preparedness requirements for both providers and suppliers, CMS found that regulatory requirements were not comprehensive enough to address the complexities of emergency preparedness. For example, the requirements did not address the need for: communication to coordinate with other systems of care within cities or states; contingency planning; and training of personnel. In consultation with experts in emergency response and health care facilities, CMS

has identified four specific areas that are central to an effective system. The proposed rule would require participating providers and suppliers to meet these four standards:

- Emergency plan: Based on a risk assessment, develop an emergency plan using an all-hazards approach focusing on capacities and capabilities.
- Policies and procedures: Develop and implement policies and procedures based on the plan and risk assessment.
- Communication plan: Develop and maintain a communication plan that complies with both Federal and State law. Patient care must be well-coordinated within the facility, across health care providers, and with State and local public health departments and emergency systems.
- Training and testing program: Develop and maintain training and testing programs, including initial and annual trainings, conducting drills and exercises or participate in an actual incident that tests the plan.

The proposed requirements are adjusted to reflect the characteristics of each type of provider and supplier. CMS is seeking comment on whether additional modifications are required for each type of provider. Additional information is available in the [fact sheet](#).

Hospice Quality Reporting Program Data Entry and Submission Site Now Available for FY 2015 Reporting Cycle

The [Hospice Quality Reporting Program Data Entry and Submission Site](#) is now available for FY 2015 reporting cycle data submission, including user account registration, data entry, and submission of 2013 measure data. Click on “Register” at the top of the page to establish a User Account.

This site will be used to enter and submit the 2013 Structural measure and the 2013 NQF #0209 Pain measure data to CMS for the FY 2015 payment determination. Data for each measure must be submitted to CMS by 11:59pm ET on April 1, 2014 for payment determination. The [Technical User’s Guide](#), posted on the [Data Submission](#) web page is the primary reference for the Hospice Quality Reporting Program Data Entry and Submission Site for the FY2015 reporting cycle.

Please Note: User accounts that were established during the January 1, 2013 through April 1, 2013 submission period are no longer valid. Each individual submitting measure data during the January 1, 2014 through April 1, 2014 submission period must register for a new account.

Password Reset in the I&A System

In response to provider concerns, CMS recently made a temporary change to the expiration date of passwords. To help ease the transition to the new system we have extended the password expiration to 150 days. This means that Identity & Access Management (I&A) System passwords will now expire 150 days from October 7, 2013. Please note that this is only a temporary change and at the end of the 150 day extension, passwords will resume their usual 60 date expiration. *Reminder:* An expired password simply means that you cannot log in to the I&A, Electronic Health Record (EHR) Incentive Programs or the Provider Enrollment Chain and Ownership System (PECOS) until you reset your password. An expired password will not affect your NPI, Medicare enrollment, claims payments, or EHR incentive payments; and will not remove the ability for any Surrogates to attest or work on behalf of their providers if they had previously been authorized in the system. It will only prevent logging in to those systems until the password is reset.

Learn About 2014 Physician Fee Schedule Rule Changes Affecting eHealth Programs Next Year

CMS recently issued a final rule that updates the payment policies and payment rates for services furnished under the Medicare Physician Fee Schedule (PFS) on or after January 1, 2014. The changes affect programs such as the Physician Quality Reporting System (PQRS), the Electronic Health Record (HER) Incentive Programs, and the Value-Based Payment Modifier (Value Modifier) payment model. Many of these changes make participating in multiple eHealth programs easier. Here are some helpful highlights:

PQRS

Providers can no longer avoid the 2016 [payment adjustment](#) by selecting the administrative claims-based reporting mechanism next year. Instead, providers must report using the program set of clinical quality measures. There are also several new PQRS reporting options for 2014, including:

- Certified survey vendor reporting (CAHPS) mechanism and EHR reporting for groups
- Qualified clinical quality registry (QCDR) for individual eligible professionals

Value-Based Payment Modifier

The group size threshold for the value modifier has been lowered. Starting in 2016, groups of physicians with 10 or more eligible professionals are subject to the value-based payment modifier.

EHR Incentive Program

Next year, Medicare eligible professionals can submit clinical quality measurement (CQM) information using QCDRs (as defined for PQRS) to meet the CQM reporting component of meaningful use. Of note: Medicare eligible professionals will have to use 2014 certified EHR technology (CEHRT) and report on 2014 CQMs.

Comprehensive Primary Care Initiative (CPCI)

Beginning in CY 2014, eligible professionals in a CPCI practice that successfully submit at least 9 CQMs covering 3 domains can choose a group reporting option for the Medicare EHR Incentive Program. Eligible professionals in a CPCI practice site will satisfy the CQM reporting component of meaningful use if the practice site successfully submits and meets the reporting requirements of the CPCI.

Accountable Care Organizations

To align with PQRS next year, Medicare Shared Savings ACOs will report the ACO group practice reporting option (GPRO) measures through a CMS web interface on behalf of eligible professionals. ACOs must also meet the criteria for the 2014 PQRS incentive to satisfactorily report and avoid the 2016 PQRS payment adjustment.

Learn More

Read the CMS [press release](#) and [fact sheet](#) to learn more about the 2014 PFS rule. To learn more about eHealth, visit www.cms.gov/ehealth.

Additional Guidance: How the Proposed New Timeline for the EHR Incentive Programs Affects You

Last week, CMS and the Office of the National Coordinator for Health Information Technology (ONC) [announced](#) the intent to change the Stage 3 timeline and extend Stage 2 of meaningful use through 2016.

Important to note about the proposed timeline

- It does not delay the start of Stage 2 of meaningful use.
- It does not affect the current reporting periods and deadlines for 2014 participation.

What this Means for You

- If you begin participation with your *first year of Stage 1* for the Medicare EHR Incentive Program in 2014:
 - You must begin your 90 days of Stage 1 of meaningful use no later than July 1, 2014 and submit attestation by October 1, 2014 in order to avoid the 2015 payment adjustment.
- If you have completed *1 year of Stage 1* of meaningful use:
 - You will demonstrate a second year of Stage 1 of meaningful use in 2014 for a three-month reporting period fixed to the quarter for Medicare or any 90 days for Medicaid.
 - You will demonstrate Stage 2 of meaningful use for two years (2015 and 2016).
 - You will begin Stage 3 of meaningful use in 2017.
- If you have completed *two or more years of Stage 1* of meaningful use:
 - You will still demonstrate Stage 2 of meaningful use in 2014 for a three-month reporting period fixed to the quarter for Medicare or any 90 days for Medicaid.
 - You will demonstrate Stage 2 of meaningful use for three years (2014, 2015 and 2016).
 - You will begin Stage 3 of meaningful use in 2017.

Please be sure to look for additional guidance in the Federal Register for rulemaking on this proposal.

For More Information

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

New Interactive Tool from CMS Helps You Determine Eligibility for eHealth Programs

Not sure which CMS eHealth programs you can participate in? Well now there's an easy tool to help you find out. Determine your eligibility in a few simple steps with the new interactive [eHealth Eligibility Assessment Tool](#). It will help you determine if you are an "eligible professional" for the following eHealth programs:

- [Medicaid and Medicare EHR Incentive Program](#)
- [Physician Feedback/Value-Based Payment Modifier Program](#)
- [Physician Quality Reporting System \(PQRS\)](#)
- [Maintenance of Certification Program Incentive](#)

Answer a few questions about your provider type, whether you bill Medicare and/or Medicaid, and your chosen CMS reporting methods to find out which eHealth programs you may qualify for. Your results will include helpful information and resources to get you started. Find this tool, along with other helpful information, on the [Resources](#) section of the CMS [eHealth](#) website.

Want to find out more about eHealth?

Visit the CMS [eHealth](#) website for the latest news and updates on CMS eHealth initiatives. Sign up for [CMS eHealth Listserv](#) and [follow us](#) on Twitter.

Review Your 2013 PQRS Interim Claims Feedback Data

Individual eligible professionals (EPs) who reported at least one Physician Quality Reporting System (PQRS) quality measure this year via claims-based reporting can now view first and second quarter data (January 2013 through June 2013) regarding their submissions using the 2013 PQRS Interim Feedback Dashboard. The Dashboard will analyze data for those EPs who reported individual measures or measures group(s) and can be viewed as a Taxpayer Identification Number (TIN) summary or as individual National Provider Identifier (NPI) detail. The Dashboard data allows EPs and group practices to monitor the status of their claims-based measures and measures group reporting, to see where they are in meeting the PQRS reporting requirements. The Dashboard is available through the [Physician and Other Health Care Professionals Quality Reporting Portal](#), with Individual Authorized Access to the CMS Computer System (IACS) sign-in.

Dashboard Resources

The following CMS resources are available to help EPs and group practices access and interpret their 2013 PQRS interim feedback data:

- The [User Guide: 2013 Interim Feedback Dashboard](#) provides detailed information about accessing and interpreting the data provided in the feedback report.
- [IACS Quick Reference Guides](#) provide step-by-step instructions on how to request an IACS account in order to access the Portal, if you do not already have one.

Note: The Dashboard does *not* provide the final data analysis for full-year reporting or indicate 2013 PQRS incentive eligibility or subjectivity to the 2015 PQRS payment adjustment or the Value-based Payment Modifier to be implemented in 2015. The Dashboard will *only* provide claims-based data for 2013 interim feedback. Data from other CMS programs will *not* be included for purposes of the 2013 Dashboard data feedback. Data submitted for 2013 PQRS reporting via methods other than claims will be available for review in the fall of 2014 through the final PQRS feedback report or the Quality and Resource Use Report (QRUR) for 2013 PQRS GPROs.

For More Information about PQRS

For more information about participating in PQRS, visit the [PQRS](#) website. For additional support or questions, contact the [QualityNet Help Desk](#).

Didn't Participate in eRx in 2012 or 2013?

If you were not a successful electronic prescriber under the 2012 or 2013 Electronic Prescribing (eRx) Incentive Program:

- You will be subject to a payment adjustment in 2014.
- The final 2.0% [eRx payment adjustment](#) will be applied during the 2014 calendar year.

That means you will only receive 98% of your Medicare Part B PFS amount for covered professional service in 2014. CMS will notify you if you are subject to the 2014 eRx payment adjustment.

Medicare EHR Payment Adjustments

If you are eligible to participate in the Medicare EHR Incentive Program:

- If you have not successfully demonstrated meaningful use, payment adjustments will be applied beginning January 1, 2015.
- The adjustment is determined by the reporting period in a prior year.

Additional eRx Impact for Medicare EHR providers with a 2015 Payment Adjustment

- If you *were not* subject to the 2014 eRx payment adjustment, your 2015 EHR payment adjustment will be 1%.
- If you *were* subject to the eRx adjustment, your 2015 EHR payment adjustment will be 2%.

To Avoid Medicare Payment Adjustments

If you successfully participated in the Medicaid or Medicare EHR Incentive Program and demonstrate meaningful use before 2015 or if you are eligible for a hardship exemption, you may be able to avoid the payment adjustment. *Note:* 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. Learn more by reviewing the [Payment Adjustments & Hardship Exceptions Tipsheet for Eligible Professionals](#).

Request an eRx Informal Review

You can request an informal review if you were notified that you will be subject to the 2014 eRx payment adjustment. Informal review requests can be submitted to eRxInformalReview@cms.hhs.gov through February 28, 2014.

For More Information

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

Claims, Pricers, and Codes

CAH Method II Overpayments Related to the Annual Wellness Visit

In July 2013, Medicare Administrative Contractors (MACs) began to recover overpayments on Annual Wellness Visit (AWV) claims with dates of service on and after January 1, 2011 that were processed by Medicare on and after April 4, 2011 through March 31, 2013 (see [MLN Matters® Article # 8153](#)). It was subsequently determined that both the professional and technical components of Method II critical access hospital (CAH) claims had been identified as overpayments and recouped in error. Method II CAHs are entitled to payment for the professional components of these claims.

In September, a system update prevented the problem going forward. Another systems update is planned for February that will allow MACs to refund the professional components of these claims that were recouped in error. Method II CAHs should not resubmit claims unless directed to do so by their MAC.

Changes to Payment Dispute Process between Non-Contracted Providers, MAOs, and Other Payers after January 31

Currently, CMS provides the services of an independent contractor, C2C Solutions, Inc., to adjudicate payment disputes between non-contracted providers, Medicare Advantage Organizations (MAOs), and other payers. After January 31, 2014, CMS will no longer be able to offer these services due to budgetary constraints. However, C2C will continue to adjudicate all payment disputes received by January 31, 2014 that meet the filing requirements. After January 31, 2014, C2C will return any payment disputes to providers with instructions to contact the MAO or other payer directly to dispute the payment.

Provider Types Affected

This information applies to all non-contracted provider types that perform services for beneficiaries enrolled in MAOs, including private Fee-For-Service plans, Program of All-Inclusive Care for the Elderly (PACE) organizations, Section 1876 cost-based contractors, and health care prepayment plans.

Provider Action Needed

Providers and billing staff should not send any requests for a payment dispute to C2C after January 31, 2014. C2C will return all payment disputes requests received after that date to the provider with instructions to contact the plan to resolve the dispute or take other action the provider deems appropriate. Providers that have exhausted the plan's internal dispute process and who still maintain they have not been reimbursed fairly may file a complaint through 1-800-Medicare in addition to taking other action the provider deems appropriate. CMS does not offer advice to providers on their potential rights in a payment dispute.

CMS is committed to ensuring that MAOs and other payers follow regulations at 42 CFR §§422.214, 417.559 and 422.520 when reimbursing non-contracted providers for services provided to Medicare beneficiaries. Non-contracted providers are required to accept as payment, in full, the amounts that the provider could collect if the beneficiary were enrolled in original Medicare.

MLN Educational Products

“Updated Mobile Applications (Apps) for Open Payments” MLN Matters® Article — Released

[MLN Matters® Special Edition Article #SE1402](#), “Updated Mobile Applications (Apps) for Open Payments” was released and is now available in a downloadable format. This article is designed to provide education on updates to the mobile applications (apps), Open Payments Mobile for Industry and Open Payments Mobile for Physicians, implemented as a result of user feedback to CMS. It includes detailed information on recent enhancements to the apps and provides additional resources for technical support.

“Systematic Validation of Payment Group Codes for Prospective Payment Systems (PPS) Based on Patient Assessments” MLN Matters® Article — Released

[MLN Matters® Special Edition Article #SE1342](#), “Systematic Validation of Payment Group Codes for Prospective Payment Systems (PPS) Based on Patient Assessments” was released and is now available in a downloadable format. This article is designed to provide education on editing requirements within the Fiscal Intermediary Shared System (FISS) system, for Inpatient Rehabilitation Facility Prospective Payment System (IRF PSS) claims and the matching process with the IRF-Patient Assessment Instrument (PAI). It includes information to remind IRFs that they must completely submit and process an IRF-PAI at the CMS National Assessment Collection Database before submitting an IRF claim to FISS.

“Further Information on Mandatory Reporting of an 8-Digit Clinical Trial Number on Claims” MLN Matters® Article — Released

[MLN Matters® Special Edition Article #SE1344](#), “Further Information on Mandatory Reporting of an 8-Digit Clinical Trial Number on Claims” was released and is now available in a downloadable format. This article is designed to provide education on mandatory reporting of a clinical trial identifier number on claims for items and services provided in clinical trials that are qualified for coverage, as specified in Change Request (CR) 8401 and the “Medicare National Coverage Determination (NCD) Manual”. It includes information that health care professionals can use to properly report an 8-digit, generic number of 99999999 using instructions in CR8401.

“Point of Origin for Admission or Visit Code (Formerly Source of Admission Code) for Inpatient Psychiatric Facilities (IPFs)” MLN Matters® Article — Released

[MLN Matters® Special Edition Article #SE1401](#), “Point of Origin for Admission or Visit Code (Formerly Source of Admission Code) for Inpatient Psychiatric Facilities (IPFs)” was released and is now available in a downloadable format. This article is designed to provide education on how to apply the point of origin for admission or visit code for IPFs claims. It includes information and case studies that support Recovery Auditor findings of overpayments for inpatient psychiatric services directly following an acute care stay within the same facility.

“Medicare Quarterly Provider Compliance Newsletter [Volume 4, Issue 2]” Educational Tool — Released

The “[Medicare Quarterly Provider Compliance Newsletter \[Volume 4, Issue 2\]](#)” Educational Tool (ICN 908894) was released and is now available in a downloadable format. This fact sheet 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.

“Information on the National Physician Payment Transparency Program: Open Payments” Podcast — Released

The "[Information on the National Physician Payment Transparency Program: Open Payments](#)" podcast has been released. This podcast is designed to provide education on Section 6002 of the Affordable Care Act. It includes information on increasing public awareness of financial relationships among manufacturers, providers and organizations who participate in the Medicare Program.

"Hospice Related Services – Part B" Podcast — Released

The "[Hospice Related Services – Part B](#)" Podcast has been released. This podcast is designed to provide education on the hospice benefit covered by the Medicare Program. It includes information on election, coverage, revoking the election of hospice and correct use of the modifier on claims.

"Discharge Planning" Booklet — Revised

The "[Discharge Planning](#)" Booklet (ICN 908184) was revised and is now available in downloadable format. This booklet is designed to provide education on Medicare discharge planning. It includes discharge planning information for Acute Care Hospitals, Inpatient Rehabilitation Facilities, and Long Term Care Hospitals; Home Health Agencies; Hospices; Inpatient Psychiatric Facilities; Long Term Care Facilities; and Swing Beds.

"The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Physicians and Non-Physician Practitioners" Fact Sheet — Reminder

"[The Basics of Internet-based Provider Enrollment, Chain and Ownership System \(PECOS\) for Physicians and Non-Physician Practitioners](#)" Fact Sheet (ICN 903764) is available in a downloadable format. This fact sheet is designed to provide education on how physician and non-physician practitioners should enroll in the Medicare Program and maintain their enrollment information using Internet-based PECOS. It includes information on how to complete an enrollment application using Internet-based PECOS and a list of frequently asked questions and resources.

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.

MLN Products Available in Electronic Publication Format

The following booklet is now available as an electronic publication (EPUB) and through a QR code. 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.

The "[Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse](#)" Booklet (ICN 907798) is designed to provide education on screening and behavioral counseling interventions in primary care to reduce alcohol abuse. It includes information about risky/hazardous and harmful drinking.

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