



MLN Connects™

Weekly Provider eNews

Thursday, February 6, 2014

MLN Connects™ National Provider Calls

National Partnership to Improve Dementia Care in Nursing Homes — Register Now
2-Midnight Benchmark: Discussion of the Hospital Inpatient Admission Order and Certification — Registration Opening Soon

CMS Events

eHealth Summit: Road to ICD-10
Physician Compare Town Hall Meeting
Webinar for Comparative Billing Report on Upper Limb Orthotics

Announcements

Medicare Heart Healthy Preventive Services
Flu Activity is Widespread — Continue to Recommend and Offer Flu Vaccination
Medicare's Delivery System Reform Initiatives Achieve Significant Savings and Quality Improvements — Off to a Strong Start
HHS Strengthens Patients' Right to Access Lab Test Reports
NPPES Modernization — We Need Your Feedback
New Feature: Simple Online Reset of User IDs and Passwords for PECOS, NPPES, and EHR
2013 was Final Program Year for Medicare eRx Incentive Program
CMS to Release a Comparative Billing Report on Upper Limb Orthotics in February
Submit Quality Data for 2013 PQRS-Medicare EHR Incentive Pilot by February 28
Learn What's New in 2014 for PQRS Participation
New EHR Data Brief Takes a Closer Look at EHR Participation
EHR Incentive Program: Important Payment Adjustment Information for Medicare EPs

Claims, Pricers, and Codes

Notification Regarding the New Benefits Coordination & Recovery Center
Claims Hold for ESRD Facilities that Waived Full PPS Payment
HIPAA 837 Institutional COB Claims Not Crossing Over Due to Error H24391

MLN Educational Products

"Psychiatry and Psychotherapy Services" MLN Matters® Article — Released
"Guidance on Hospital Inpatient Admission Decisions" Podcast — Released
"Post-Acute Care Transfer—Underpayments" Podcast — Released
The "Diagnosis Coding: Using the ICD-9-CM" Web-Based Training Course — Revised
"Medicare Claim Review Programs: MR, NCCI Edits, MUEs, CERT, and Recovery Audit Program" Booklet — Revised
Updated MLN Matters® Search Indices
MLN Product Available in Electronic Publication Format
New MLN Educational Web Guides Fast Fact

MLN Connects™ National Provider Calls

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.

2-Midnight Benchmark: Discussion of the Hospital Inpatient Admission Order and Certification — Registration Opening Soon

Thursday, February 27; 2:30-4pm ET

To Register: Visit [MLN Connects™ Upcoming Calls](#). Registration will be opening soon.

On August 2, 2013, CMS issued a final rule, [CMS-1599-F](#), updating FY 2014 Medicare payment policies and rates under the Inpatient Prospective Payment System (IPPS) and the Long-Term Care Hospital Prospective Payment System (LTCH PPS). The final rule, commonly known as the “2-Midnight Rule,” modifies and clarifies the longstanding policy on Medicare Administrative Contractor review of inpatient hospital and critical access hospital (CAH) admissions for payment purposes. Under this final rule, surgical procedures, diagnostic tests and other treatments (in addition to services designated as inpatient-only), are generally appropriate for inpatient hospital admission and payment under Medicare Part A when the physician expects the beneficiary to require a stay that crosses at least two midnights and admits the beneficiary to the hospital based upon that expectation. This policy responds to both hospital calls for more guidance about when a beneficiary is appropriately treated—and paid by Medicare—as an inpatient and beneficiaries’ concerns about increasingly long stays as outpatients due to hospital uncertainties about payment. This MLN Connects National Provider Call will provide an overview of the inpatient hospital admission and medical review criteria that were released on August 2, 2013. We will address frequently asked questions received to date and answer questions from the public.

CMS has released [additional clarification](#) on the provisions of the final rule regarding the physician order and physician certification of hospital inpatient services. Additional information on the 2-Midnight Rule can be found on the [Inpatient Hospital Reviews](#) web page.

Agenda:

- Order and certification guidance
- Case examples
- Transfers
- 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.

CMS Events

eHealth Summit: Road to ICD-10

Friday, February 14; 9am-3:30pm ET

CMS invites you to view the live webcast sessions during the CMS eHealth Summit on ICD-10. At this meeting, representatives from various health care sectors will share their perspectives on preparing for the October 1, 2014, ICD-10 compliance date. Panels will include health care providers, payers and vendors, who will discuss best practices and available resources.

Webcast Registration

[Register](#) to attend the meeting via webcast. A confirmation email will be sent to you prior to the summit with a link to view the live webcast sessions. For detailed information on session times and discussion topics, please review the [summit agenda](#). We hope you can join CMS for this webcast to learn more about ICD-10.

Keep Up to Date on ICD-10

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

Physician Compare Town Hall Meeting

Monday, February 24; 1-5pm ET

Main Auditorium of CMS Headquarters, 7500 Security Blvd, Baltimore, MD 21244

CMS is hosting a Town Hall meeting to solicit input on the future of the [Physician Compare](#) website. The Town Hall will give stakeholders the opportunity to provide feedback and suggestions regarding the future of public reporting on Physician Compare.

Registration

Register for the Town Hall by sending an e-mail to PhysicianCompare@Westat.com. Please use the subject line "Physician Compare Town Hall Registration" and include your name, address, telephone number, and email address. Please indicate if you wish to make a statement and whether you plan to participate in person or via telephone. The meeting is open to the public; however, space is limited for those who want to attend in person. *All participants must register by 5pm ET on Monday, February 17*

For more information about the Town Hall meeting, please visit the [Federal Register Call to Meeting](#) or the [Physician Compare Initiative](#) website. For more information about the PQRS program, please visit the [PQRS](#) website or the [Help Desk](#).

Webinar for Comparative Billing Report on Upper Limb Orthotics

Wednesday, February 26; 3-4pm ET

Join us for an informative discussion of the comparative billing report on upper limb orthotics (CBR201402). The presentation will be provided by CMS contractor eGlobalTech and its partner, Palmetto GBA. CBR201402 is an educational tool designed to assist suppliers of Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) billing upper limb orthotics.

- [Register online](#) and join the live event
- Test your connection: This event is being streamed. Please test your connection prior to joining at the [CBR Connection Test Link](#).

Agenda:

- Opening Remarks
- Overview of Comparative Billing Report (CBR201402)
- Coverage Policy for Upper Limb Orthotics
- Methodology Report
- Resources
- Question & Answer Session

Presenter Information:

- Speakers: Melissa Parker, Jonathan Savoy, and Molly Wesley
- Organizations: eGlobal Tech and Palmetto GBA

Event Replay: You may [access a recording](#) of the webinar two days following the event.

Announcements

Medicare Heart Healthy Preventive Services

February is American Heart Month. Heart disease is the leading cause of death for both men and women in the US. Making lifestyle changes to lower risk, prevent, and manage disease is not easy. Medicare provides coverage for a variety of preventive services that can help screen for risk factors and can provide information and tools that can assist your Medicare patients in making informed decisions about heart-healthy lifestyle choices.

Medicare-covered preventive services include the following, subject to certain eligibility criteria:

- Initial Preventive Physical Exam (IPPE, also known as the “Welcome to Medicare” Preventive Visit)
- Annual Wellness Visit providing Personalized Prevention Plan Services
- Cardiovascular Disease Screening Blood Tests (total cholesterol, high-density lipoproteins, and triglycerides tests)
- Diabetes Screening
- Intensive Behavioral Therapy for Cardiovascular Disease
- Intensive Behavioral Therapy for Obesity
- Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse
- Tobacco-use Cessation Counseling Services

For More Information

- [The ABCs of Providing the Initial Preventive Physical Examination](#) quick reference chart
- [The ABCs of Providing the Annual Wellness Visit](#) quick reference chart
- [Medicare Preventive Services](#) quick reference chart
- [Medicare Learning Network® \(MLN\) Medicare Fee-for-Service Preventive Services Education Products](#) for providers
- [Million Hearts®](#) – initiative to help prevent 1 million heart attacks and strokes by 2017
- [National Wear Red Day](#) – February 7 – campaign to call attention to women’s heart health
- [Healthfinder.gov](#) – February Health Observance Toolkit

Flu Activity is Widespread — Continue to Recommend and Offer Flu Vaccination

As we move further into the influenza season, many people continue to experience severe flu illness, flu-related complications (like pneumonia), hospitalization, and, unfortunately, even death. The Centers for Disease Control and Prevention (CDC) urges people who still have not gotten vaccinated to do so now. The CDC recommends that everyone 6 months and older get an influenza vaccine each season. The predominant virus so far this season is H1N1. This is the H1N1 virus that emerged in 2009 to cause a pandemic. All flu vaccines this season are designed to protect against the H1N1 virus. This virus disproportionately affects young and middle-aged adults, especially those with medical conditions that put them at high risk for flu complications, as well as pregnant women and those who are morbidly obese.

Influenza vaccination is especially important for people at high risk for serious flu complications, including:

- People with chronic medical conditions such as asthma, diabetes, heart disease, or neurological conditions
- Pregnant women
- Those younger than 5 years or older than 65 years of age

A full list of high risk factors is available on the [CDC](#) website.

Influenza can be a serious illness for anyone, including previously healthy adults. If you have patients who haven’t yet been vaccinated, discuss the benefits and importance of flu vaccination. Offer to vaccinate or refer them to a vaccine provider. The [Healthmap Vaccine Finder](#) can assist in locating available flu vaccine, 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. On the CDC order form, under “Programs”, select “Immunizations and Vaccines (Influenza/Flu)” for a list of flu related resources.

Medicare’s Delivery System Reform Initiatives Achieve Significant Savings and Quality Improvements — Off to a Strong Start

On January 30, CMS released findings on a number of its initiatives to reform the health care delivery system. These include interim financial results for select Medicare Accountable Care Organization (ACO) initiatives, an in-depth savings analysis for Pioneer ACOs, results from the Physician Group Practice demonstration, and expanded participation in the Bundled Payments for Care Improvement Initiative. Savings from both the Medicare ACOs and Pioneer ACOs exceed \$380 million.

While ACOs are designed to achieve savings over several years, not always on an annual basis, the interim financial results released today for the Medicare Shared Savings Program ACOs show that, in their first 12 months, nearly half (54 out of 114) of the ACOs that started program operations in 2012 already had lower expenditures than projected. Of the 54 ACOs that exceeded their benchmarks in the first 12 months, 29 generated shared savings totaling more than \$126 million – a strong start this early in the program. In addition, these ACOs generated a total of \$128 million in net savings for the Medicare Trust Funds. ACOs share with Medicare any savings generated from lowering the growth in health care costs while meeting standards for high quality care. Final performance year-one results will be released later this year. While evaluation of the program’s overall impact is ongoing, the interim results are currently within the range originally projected for the program’s first year. A great majority of the program’s overall net impact was projected to phase-in over the program’s ensuing performance years. Moreover, through regular webinars; tools for sharing information and best practices; opportunities for ACOs to connect with one another; and other activities, ACOs are being provided the infrastructure and resources to learn from one another and to then diffuse what’s working and what is not.

An independent preliminary evaluation of the Pioneer ACO Model - the ACO model designed for more experienced organizations prepared to take on greater financial risk –also released today shows Pioneer ACOs generated gross savings of \$147 million in their first year while continuing to deliver high quality care. Results showed that of the 23 Pioneer ACOs, nine had significantly lower spending growth relative to Medicare fee for service while exceeding quality reporting requirements. These savings far exceed findings from a previous analysis conducted by CMS, which used a different methodology.

CMS also released results today for the Physician Group Practice Demonstration initiatives, which offered incentive payments for delivering high-quality, coordinated health care that generates Medicare savings. The Physician Group Practice Demonstration evaluation report confirmed overall savings over the 5 year experience with 7 out of 10 physician group practices earning shared savings payments for improving the quality and cost efficiency totaling \$108 million over the course of the Demonstration. The participating organizations consistently demonstrated high quality of care on a broad range of chronic disease and preventive care measures.

The above models represent just a few initiatives CMS is testing to improve the quality of care delivery, while lowering costs. Today, CMS announced that 232 acute care hospitals, skilled nursing homes, physician group practices, long-term care hospitals, and home health agencies have entered into agreements to participate in the Bundled Payments for Care Improvement initiative. Bundling payment for services that patients receive across a single episode of care, such as heart bypass surgery or a hip replacement, is one way to encourage doctors, hospitals and other health care providers to work together to better coordinate care for patients, both when they are in the hospital and after they are discharged.

This is the largest and most ambitious test ever of a bundled payment model in Medicare or any other payer in the U.S. Through this initiative, made possible by the Affordable Care Act, CMS will test how bundled payments for clinical episodes can result in more coordinated care for beneficiaries and lower costs for Medicare.

To learn more about the ways HHS is working to reform the health care delivery system:

- [Fact sheet](#)
- [Bundled Payments](#) website
- [Medicare Shared Savings Program](#) website
- [Pioneer ACO Model](#) website.
- [Medicare Physician Group Practice Demonstration](#) website

Full text of this excerpted [CMS press release](#) (issued January 30).

HHS Strengthens Patients’ Right to Access Lab Test Reports

As part of an ongoing effort to empower patients to be informed partners with their health care providers, HHS has taken action to give patients or a person designated by the patient a means of direct access to the patient's completed laboratory test reports.

The [final rule](#) announced on February 3 amends the Clinical Laboratory Improvement Amendments of 1988 (CLIA) regulations to allow laboratories to give a patient, or a person designated by the patient, his or her "personal representative," access to the patient's completed test reports on the patient's or patient's personal representative's request. At the same time, the final rule eliminates the exception under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule to an individual's right to access his or her protected health information when it is held by a CLIA-certified or CLIA-exempt laboratory. While patients can continue to get access to their laboratory test reports from their doctors, these changes give patients a new option to obtain their test reports directly from the laboratory while maintaining strong protections for patients' privacy.

The final rule is issued jointly by three agencies within HHS: CMS, which is generally responsible for laboratory regulation under CLIA, the Centers for Disease Control and Prevention (CDC), which provides scientific and technical advice to CMS related to CLIA, and the Office for Civil Rights (OCR), which is responsible for enforcing the HIPAA Privacy Rule.

Under the HIPAA Privacy Rule, patients, patient's designees and patient's personal representatives can see or be given a copy of the patient's protected health information, including an electronic copy, with limited exceptions. In doing so, the patient or the personal representative may have to put their request in writing and pay for the cost of copying, mailing, or electronic media on which the information is provided, such as a CD or flash drive. In most cases, copies must be given to the patient within 30 days of his or her request.

Full text of this excerpted [CMS press release](#) (issued February 3).

NPPES Modernization — We Need Your Feedback

CMS is continuously working to improve all aspects of the systems associated with Medicare Enrollment and would like your feedback through the [NPPES Modernization Forum](#).

In recent years the importance of the National Plan and Provider Enumeration System (NPPES) in the health care community ecosystem has grown by leaps and bounds. Tens of thousands of individuals and organizations access this information each month to either maintain or verify National Provider Identifier (NPI) information. To better support this growing demand, the Center for Program Integrity has recently launched the [NPPES Modernization](#) project, which is a partnership between CMS and the [HHS Entrepreneur](#) program. This effort is focused on improving the NPPES website engagement, usability, and access to the NPI information for use by the health care community.

We know the key to success for this project is getting information from the real users of this system and data. To support this we have setup a [public forum](#) where *you* can post thoughts on the current system, how you use it in your daily operations, and suggestions about what you would like to see in the future. In the coming months there will also be more requests for information and feedback as the prototype takes shape. We hope you will be able spare a few minutes from your very busy schedules to give feedback that will help make NPPES a better tool for the community.

New Feature: Simple Online Reset of User IDs and Passwords for PECOS, NPPES, and EHR

In response to provider concerns, and EUS Helpdesk call volume, CMS recently updated the process for retrieving forgotten user IDs and passwords for the Identity & Access Management (I&A) System, which controls access to the Provider Enrollment, Chain and Ownership System (PECOS), the National Plan and Provider Enumeration System (NPPES), and EHR (Electronic Health Record Incentive Programs). Forgotten user IDs and passwords can now be retrieved or reset online in seconds, without calling the EUS Helpdesk. When resetting your passwords, you will now have the option to answer 3 of your security questions *or* enter personal information. If you need to retrieve a forgotten

user ID, you can either enter your email address on file and have it sent to you immediately, *or* you can enter personal information and have it displayed on screen.

2013 was Final Program Year for Medicare eRx Incentive Program

Did you know that 2013 was the final program year for participating and reporting in the Medicare Electronic Prescribing (eRx) Incentive Program? The 6-month 2014 eRx payment adjustment reporting period, which began on January 1, 2013 and ended on June 30, 2013, was the final reporting period to avoid the 2014 eRx payment adjustment. You do *not* need to report G-codes (G8553) for 2014 eRx events.

- 2013 was the last year to earn an eRx incentive payment
- 2014 is the last year to incur an eRx payment adjustment

Content will remain available on the [eRx Incentive Program](#) website so participants have an opportunity to access reference materials associated with the eRx incentive payment, payment adjustment, and feedback reports.

Electronic Prescribing Continues with EHR Incentive Programs

It is important to note that eRx via certified Electronic Health Record (EHR) technology is still a requirement for eligible professionals (EPs) in order to achieve meaningful use under the [Medicare and Medicaid EHR Incentive Programs](#):

- Stage 1: EPs need to send more than [40 percent](#) of all prescriptions electronically
- Stage 2: EPs need to send more than [50 percent](#) of all prescriptions electronically
- *Exclusions for these core measures may apply*

Want more information about the EHR Incentive Programs?

Learn more about the requirements for the eRx core measure for the EHR Incentive Programs on the [EHR Incentive Programs](#) website.

CMS to Release a Comparative Billing Report on Upper Limb Orthotics in February

CMS will be issuing a national supplier Comparative Billing Report (CBR) on Upper Limb Orthotics in February, 2014. The CBR, produced by eGlobalTech, will contain data-driven tables and graphs with an explanation of findings that compare suppliers' billing and payment patterns to those of their peers in the state and across the nation. The goal of these reports is to offer a tool that helps providers better understand applicable Medicare billing rules. These reports are only available to the suppliers who receive them.

Providers are advised to update their fax numbers in the Medicare Provider Enrollment, Chain, and Ownership System (PECOS) due to fax being the default method of CBR dissemination. Suppliers should contact the CBR Support Help Desk at 1-800-771-4430 or CBRsupport@eglobaltech.com if they prefer to receive CBRs through the U.S. Postal Service. For more information, please contact the CBR Support Help Desk or visit the [CBR](#) website.

Submit Quality Data for 2013 PQRS-Medicare EHR Incentive Pilot by February 28

The Physician Quality Reporting System (PQRS) Medicare Electronic Health Record (EHR) Incentive Pilot allows eligible professionals to meet the [clinical quality measure](#) (CQM) reporting requirement for the Medicare EHR Incentive Program through electronic submission while also reporting for the PQRS program.

Are you an [eligible professional](#) (EP) who is participating or wishes to participate in the [2013 PQRS-Medicare EHR Incentive Pilot](#)? You can now submit your 2013 quality data. If you would like to participate in the pilot you must submit 12 months of CQM data by *February 28, 2014 at 11:59pm ET*.

Steps to Successfully Participate

To successfully participate in the pilot, you must do the following by February 28, 2014:

1. Register for an Individuals Authorized Access to the CMS Computer Services (IACS) account (for EHR submission only)
2. Indicate intent to report CQMs using pilot in EHR Registration & Attestation System
3. Generate required reporting files
4. Test data submission
5. Submit quality data

If you cannot submit your CQM data for 12 months electronically through PQRS, you must return to the EHR Attestation System and deselect the electronic reporting option. *Please note:* if you do not submit your 2013 quality data or deselect the electronic reporting option in the EHR Attestation System, you will not receive an EHR incentive payment.

For More Information

For further guidance on the 2013 PQRS-Medicare EHR Incentive Pilot, please read the [Participation Guide](#) and [Quick-Reference Guide](#). If you have additional questions, please contact QualityNet Help Desk at 1-866-288-8912 (TTY 1-877-715-6222) or via qnetsupport@sdps.org. The Help Desk is available Monday through Friday from 7am through 7pm CT.

Learn What's New in 2014 for PQRS Participation

Are you an eligible professional (EP) or group practice participating in the Physician Quality Reporting System (PQRS) for the 2014 reporting year? CMS has released a new [fact sheet](#) to highlight program changes for the 2014 reporting year. Here are some highlights to help you get started with 2014 participation:

2014 Program Changes

- An EP or group practice participating in the group practice reporting option (GPRO) must satisfactorily report 2014 PQRS quality measures to avoid a 2% payment adjustment in 2016.
- CMS has added 37 new individual quality measures for the 2014 program year and retired 45 measures from 2013. Participants should use the most current version of the 2014 PQRS [measure specifications](#).
- Professionals who reassign benefits to a Critical Access Hospital (CAH) that bills professional services at a facility level, such as CAH Method II billing, can [now participate](#) in PQRS (in all reporting methods except for claims-based).
 - To do so, the CAH must include the individual provider National Provider Identifier (NPI) on their Institutional claims.

2014 Reporting Changes

- EPs must report on 9 measures across 3 National Quality Strategy (NQS) domains via claims, qualified registry, and Electronic Health Record (EHR)-based reporting methods.
- EHR-based reporting is [now available](#) for groups participating in GPRO.
 - The Medicare EHR Incentive Program requires that an EP or group practice submit clinical quality measures using a [2014 certified EHR](#).
- Measure groups can only be reported through the qualified registry.
- EPs can now participate in the [qualified clinical data registry \(QCDR\)](#).
 - A list of CMS-designated QCDRs will be available on the CMS PQRS website in May 2014.
- Group practices of 25 or more eligible professionals now have the option to report PQRS data through the [certified survey vendor reporting method \(CAHPS\)](#).
- EPs and group practices can no longer use the administrative claims-based reporting method to avoid a 2016 payment adjustment.
- The [Measure-Applicability Validation \(MAV\) process](#) has expanded from claims-based reporting to also include qualified registry reporting.

For More Information

Review the [What's New in 2014](#) fact sheet for an overview of 2014 changes to the PQRS program. For more information or support for PQRS, please visit the [PQRS](#) website or the [Help Desk](#).

New EHR Data Brief Takes a Closer Look at EHR Participation

CMS released a [new data brief](#) outlining how providers are progressing with participation in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs. [Read the full blog.](#)

Registration

Since the inception of the programs in 2011, more than 436,000 eligible professionals (EPs), eligible hospitals, and critical access hospitals are actively registered in the Medicare and Medicaid EHR Incentive Programs:

- Approximately 93% of all eligible hospitals have registered to participate in the EHR Incentive Programs.
- Approximately 82% of all eligible professionals have registered to participate in the EHR Incentive Programs.

Meaningful Use

The data show that providers aren't just registering for the EHR Incentive Programs, they are meeting, and often far exceeding, the requirements for meaningful use. For the objectives requiring that providers perform [medication reconciliation](#), maintain an [active medication list](#), and maintain an [active allergy list](#), EPs are surpassing threshold (minimum result of numerator over denominator) requirements.

Payments

More than 334,000 providers have received payment for participating in the Medicare and Medicaid EHR Incentive Programs. Thousands of providers were paid for their successful participation since 2011:

- More than 107,000 Medicaid EPs received an EHR incentive payment.
- More than 221,000 Medicare EPs received an EHR incentive payment.

Of the more than 215,288 Medicare eligible professionals that had attested at the time of analysis in 2013, 215,075 were successful— a 99.9% success rate.

EHR Incentive Program: Important Payment Adjustment Information for Medicare EPs

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

If you began in 2011 or 2012

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

If you began in 2013

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

If you plan to begin in 2014

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

Avoiding Payment Adjustments in the Future

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

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

Helpful Resources

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

Want more information about the EHR Incentive Programs?

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

Claims, Pricers, and Codes

Notification Regarding the New Benefits Coordination & Recovery Center

CMS has restructured its Coordination of Benefits (COB) and Medicare Secondary Payer (MSP) recovery activities. COB activities for both group health plans and non-group health plans (that is, liability insurance (including self-insurance), no-fault insurance, and workers' compensation laws or plans) and recovery activities for non-group health plans have been transitioned from the COB contractor and the MSP Recovery Contractor effective February 1, 2014. The new Benefits Coordination & Recovery Center (BCRC) will assume these activities. It is important to note that there will be no change to any of the COB & MSP Recovery (COB&R) processes.

The changes that will impact providers include a new, consolidated customer service phone number and a new Post Office (P.O.) Box for correspondence. BCRC Customer Service Representatives are available Monday through Friday, from 8am to 8pm ET, except holidays, at toll-free lines: 1-855-798-2627 (TTY/TDD: 1-855-797-2627). The new P.O. Box is:

Medicare - MSP General Correspondence
P.O. Box 138897
Oklahoma City, OK 73113-8897

To ensure you have the most current information regarding COB&R activities, you can [sign-up](#) for updates. More information is available on the [COB&R Overview](#) website. COB&R information specific to provider services may be found on the [Provider Services](#) website.

Claims Hold for ESRD Facilities that Waived Full PPS Payment

A problem has been discovered with calculating line item outlier amounts for some 2014 claims for End-Stage Renal Disease (ESRD) facilities that chose to waive full Prospective Payment System (PPS) payment. Affected claims will be held until a computer fix scheduled for February 24, 2014 is implemented. At that time, the claims will be processed. No action is required by ESRD facilities. Claims effected are TOB 72x, dates of service on or after January 1, 2014, and a return code of 06, 07, 09, 16-19, 23, 24, 28-30 or 33-35.

HIPAA 837 Institutional COB Claims Not Crossing Over Due to Error H24391

CMS is alerting all institutional providers that an error condition, which was introduced into the January 2014 Medicare quarterly systems release, has negatively affected Medicare's ability to cross over 837 institutional claims to insurers that pay after Medicare. Specifically, the error condition contributed to the creation of a malformed 2310E (Service Facility location) loop on outbound 837 institutional COB claims, as evidenced by a missing "required" NM103 segment.

- A systems fix was implemented on January 27 to correct the 2310E loop issue. CMS has verified that the fix works as intended.
- CMS has learned that the earliest a claims repair for affected claims can be implemented is March 10. Therefore, CMS has opted not to implement a claims repair process.

- Providers that have received letters from their Medicare Administrative Contractor (MAC) that contain error code H24391 will need to coordinate directly with their patients' supplemental insurer for balances remaining after Medicare.

MLN Educational Products

"Psychiatry and Psychotherapy Services" MLN Matters® Article — Released

[MLN Matters® Special Edition Article #SE1407](#), "Psychiatry and Psychotherapy Services" was released and is now available in a downloadable format. This article is designed to provide education on billing for psychiatry and psychotherapy services with Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes. It includes information about improper payments for psychiatry and psychotherapy services that were identified through Comprehensive Error Rate Testing (CERT) review of Medicare Part B claims.

"Guidance on Hospital Inpatient Admission Decisions" Podcast — Released

The "[Guidance on Hospital Inpatient Admission Decisions](#)" Podcast was released. This podcast is designed to provide education on Hospital Inpatient Admission Decisions covered by the Medicare Program. It includes information on screening tools to assist in medical review, medical necessity determination, and CMS policy guidance based on the Program Integrity Manual and the Medicare Benefit Policy Manual.

"Post-Acute Care Transfer—Underpayments" Podcast — Released

The "[Post-Acute Care Transfer—Underpayments](#)" Podcast was released. This podcast is designed to provide education on Medicare claims underpayments in post-acute care transfer. It includes information on the importance of coding claims as transfers only if the beneficiary is discharged to another facility.

The "Diagnosis Coding: Using the ICD-9-CM" Web-Based Training Course — Revised

The "Diagnosis Coding: Using the ICD-9-CM" Web-Based Training Course (WBT) was revised and is now available. This WBT is designed to provide education on how to select accurate diagnosis codes from the ICD-9-CM volumes. It also includes information on how to use the ICD-9-CM diagnosis codes correctly on Medicare claims.

To access the WBT, go to [MLN Products](#) and click on "Web-Based Training Courses" under "Related Links" at the bottom of the web page.

"Medicare Claim Review Programs: MR, NCCI Edits, MUEs, CERT, and Recovery Audit Program" Booklet — Revised

The "[Medicare Claim Review Programs: MR, NCCI Edits, MUEs, CERT, and Recovery Audit Program](#)" Booklet (ICN 006973) was revised and is now available in a downloadable format. This booklet is designed to provide education on the different CMS claim review programs and assist providers in reducing payment errors; in particular, coverage and coding errors. It includes frequently asked questions, resources, and an overview of the various programs, including Medical Review, Recovery Audit Program, and the Comprehensive Error Rate Testing Program.

Updated MLN Matters® Search Indices

The MLN Matters® Articles Search indices were updated and are now available. Each index is organized by year and provides the ability to search by specific keywords and topics. Most indices link directly to the related article(s). For more information and a list of available indices, visit the [MLN Matters® Articles](#) web page and scroll down to the “Downloads” section.

The Medicare Learning Network® offers other ways to search and quickly find articles of interest to you:

- MLN Matters® Dynamic Lists: an archive of previous and current articles organized by year with the ability to search by keyword, transmittal number, subject, article number, and release date. To view and search articles, select the desired year from the left column on the [MLN Matters® Articles](#) web page.
- MLN Matters® Electronic Mailing List: a free, electronic notification service that sends an email message when new and revised MLN Matters® articles are released. For more information, including how to subscribe to the service, download [How to Sign Up for MLN Matters®](#). You can also view and search an [archive](#) of previous messages.

MLN Product Available in Electronic Publication Format

The following MLN product 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 “[Vaccine Payments Under Medicare Part D](#)” Fact Sheet (ICN 908764) 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.

New MLN Educational Web Guides Fast Fact

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

[Is the eNews Meeting Your Needs? Give Us Your Feedback!](#)



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