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MLN Connects™

Weekly Provider eNews

Thursday, February 27, 2014

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MLN Connects™ National Provider Calls

PQRS: Reporting Across Medicare Quality Reporting Programs in 2014 — Registration Opening Soon
Tuesday, March 18; 1:30-3pm ET

To Register: Visit MLN Connects Upcoming Calls. Registration will be opening soon.

This MLN Connects™ National Provider Call provides an overview of how to report across various 2014 Medicare Quality Reporting Programs – including the Physician Quality Reporting System (PQRS), Electronic Health Record (EHR) Incentive Program, Value-Based Modifier (VBM), and Accountable Care Organizations (ACO). CMS subject matter experts will guide individual eligible professionals, group practices, Medicare Shared Savings Program ACOs, and Pioneer ACOs wishing to report quality measures one time during the 2014 program year to maximize their participation in the various Medicare reporting programs.

Agenda:
- Become incentive eligible for 2014 PQRS
- Avoid the 2016 PQRS payment adjustment
- Satisfy the clinical quality measure (CQM) component of the EHR Incentive Program
- Satisfy requirements regarding the 2016 VBM adjustment, if applicable

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

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

Standardized Readmission Ratio for Dialysis Facilities: National Dry Run — Registration Opening Soon
Thursday, March 20; 2:30-4pm ET

To Register: Visit MLN Connects Upcoming Calls. Registration will be opening soon.

In 2014, CMS is conducting a national dry run of the Standardized Readmission Ratio (SRR) for dialysis facilities. The CMS Center for Clinical Standards and Quality has contracted with the University of Michigan Kidney Epidemiology and Cost Center to develop and implement the dry run. CMS will use this dry run to test the implementation of SRR reporting and to educate dialysis facilities about the measure. This MLN Connects™ National Provider Call focuses on providing stakeholders with information about the SRR, the dry run report, and how the reports can be accessed. After the presentation, participants will have an opportunity to ask questions. For more information about the SRR measure specifications and the dry run process for dialysis facilities, visit the Dialysisdata.org website.

Agenda:
- Introductions and Roles
- Motivation
- Dry Run Overview
- Measure Details
- Report Details
- Resources
- Q&A 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.

CMS Events

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:

- MLN Matters® Article MM8465, "ICD-10 Testing with Providers through the Common Edits and Enhancements Module (CEM) and Common Electronic Data Interchange (CEDI)"
- MLN Matters® Special Edition Article #SE1409 — Revised, "Medicare Fee-For-Service (FFS) ICD-10 Testing Approach"

Registration Information:
Registration information is available on your MAC website.

ICD-10 Coordination and Maintenance Committee Meeting

March 19-20; 9-5pm ET

The ICD-10 Coordination and Maintenance Committee Meeting provides a public forum to discuss proposed changes to ICD-10. There are three options available to participate in the March meeting:

- Participate via webcast. Registration is not required.
- Participate by phone: 877-267-1577; Meeting ID: 998-975-524. Registration is not required.
- Attend in person at the CMS auditorium in Baltimore. Registration is now open.

Meeting Materials:

- Agenda for procedure topics on March 19
- Agenda for diagnosis topics on March 20

More information on the ICD-10 Coordination and Maintenance Committee Meeting is available on the CMS website and the Centers for Disease Control and Prevention website.

Webinar for Comparative Billing Report on Nebulizer Drugs

Wednesday, March 19; 3-4pm ET

Join us for an informative discussion of the comparative billing report on nebulizer drugs (CBR201403). The presentation will be provided by CMS contractor eGlobalTech and its partner, Palmetto GBA. CBR201403 is an educational tool designed to assist providers prescribing and billing nebulizer drugs.

Agenda:

- Opening Remarks
- Overview of Comparative Billing Report (CBR201403)
- Coverage Policy for Nebulizer Drugs
- Methodology Report
- Resources
- Question & Answer Session

Presenter Information:

- Speakers: Cheryl Bolchoz, Melissa Parker, Jonathan Savoy, Mark Scogin, Molly Wesley
- Organizations: eGlobalTech and Palmetto GBA

How to Register:

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

Event Replay:
You may access a recording of the webinar two days following the event.

Announcements

Quality Data Added to Physician Compare Website

On February 21, CMS announced that for the first time, quality measures have been added to Physician Compare, a website that helps consumers search for information about hundreds of thousands of physicians and other health care professionals. The site helps consumers make informed choices about their care.

In the first year, 66 group practices and 141 Accountable Care Organizations (ACO) now have quality data publicly reported on Physician Compare. The data are reported at the group practice and ACO level. The quality measures added include:

- Controlling blood sugar levels in patients with diabetes.
- Controlling blood pressure in patients with diabetes.
- Prescribing aspirin to patients with diabetes and heart disease.
- Patients with diabetes who do not use tobacco.
- Prescribing medicine to improve the pumping action of the heart in patients who have both heart disease and certain other conditions.

Physician Compare, created by the Affordable Care Act, already includes information about specialties offered by doctors and group practices; board certification; and affiliation with hospitals and other health care professionals.

Full text of this excerpted CMS press release (issued February 21).

Next Edition of Electronic Health Record Technology Certification Criteria Issued

Progress by HHS increases interoperability and supports clinical and delivery reforms

On February 21, the HHS Office of the National Coordinator for Health Information Technology (ONC) issued proposals for the next edition (the “2015 Edition”) of electronic health record (EHR) technology certification criteria.

This proposed rule marks the first time ONC has proposed an edition of certification criteria separate from the CMS "meaningful use" regulations. The proposals represent ONC's new regulatory approach that includes more incremental and frequent rulemaking. This approach allows ONC to update certification criteria more often to reference improved standards, continually improve regulatory clarity, and solicit comments on potential proposals as a way to signal ONC's interest in a particular topic area.

Compliance with the 2015 Edition would be voluntary – EHR developers that have certified EHR technology to the 2014 Edition would not need to recertify to the 2015 Edition for customers to participate in the Medicare and Medicaid EHR Incentive Programs. Similarly, health care providers eligible to participate in the Medicare and Medicaid EHR Incentive Programs would not need to "upgrade" to EHR technology certified to 2015 Edition to have EHR technology that meets the Certified EHR Technology definition.

The proposed rule will be published in the Federal Register on February 26. ONC will accept comments on the proposed rule through April 28, 2014. The final rule is expected to be issued in summer 2014.

Full text of this excerpted HSS press release (issued February 21).

Adult Immunization: Are You Meeting the Standards for Patient Care?

A Message from the CDC

Vaccination is a critical preventive health measure. Making sure your patients are up-to-date on vaccines recommended by the Centers for Disease Control and Prevention (CDC) gives them the best protection available from several serious diseases. The National Vaccine Advisory Committee (NVAC) recently revised and updated the Standards for Adult Immunization Practice to reflect the important role that *all* healthcare professionals play in ensuring that adults are getting the vaccines they need.

These new standards were drafted by the National Adult Immunization and Influenza Summit (NAIIS) of over 200 partners, including federal agencies, medical associations, state and local health departments, pharmacists associations, and other immunization stakeholders. What makes adult immunization a priority for leaders in medicine and public health? First and foremost, adult vaccination rates are very low (National Health Interview Survey, 2012). For example, rates for Tdap and zoster vaccination are 20% or less for adults who are recommended to get them. Even high risk groups are not getting the vaccines they need—only 20% of adults younger than 65 years old who are high risk for complications from pneumococcal disease are vaccinated.

Each year, tens of thousands of adults needlessly suffer, are hospitalized, and even die as a result of diseases that could be prevented by vaccines. However, a recent national survey showed that most US adults are not even aware that they need vaccines throughout their lives to protect against diseases like shingles, pertussis, and hepatitis.

Adults trust their healthcare professionals to advise them about important preventive measures. Most health insurance plans provide coverage for recommended adult vaccines. And, research indicates that most patients are willing to get vaccinated if recommended by their doctor. However, most patients report their healthcare providers are not talking with them about vaccines, missing opportunities to immunize. Incorporating vaccine assessments into routine clinical care is key to improving vaccination rates.

CDC is calling on *all* healthcare professionals to make adult immunization a standard of patient care in their practice by integrating four key steps:

1. Assess immunization status of all your patients in every clinical encounter. This involves staying informed about the latest CDC recommendations for immunization of adults and implementing protocols to ensure that patients' vaccination needs are routinely reviewed.
2. Share a strong recommendation with your patients for vaccines that they need. Key components of this include tailoring the recommendation for the patient, explaining the benefits of vaccination and potential costs of

getting the diseases they protect against, and addressing patient questions and concerns in clear and understandable language.

3. Administer needed vaccines or refer your patients to a provider who can immunize them. It may not be possible to stock all vaccines in your office, so refer your patients to other immunization providers in the area to ensure that they get the vaccines they need to protect their health.
4. Document vaccines received by your patients. Help your office, your patient, and your patients' other providers know which vaccines they have had by participating in your states' immunization registry. And for the vaccines you don't stock, follow up to confirm that patients received recommended vaccines.

For more information and resources to improve adult immunization practice, visit the CDC Adult Vaccination Information for Healthcare and Public Health Professionals website.

Note: CMS reminds all health care professionals that certain vaccines are covered by Medicare. For more information on Medicare-covered vaccines, please refer to the following CMS Medicare Learning Network® provider publications:

- Preventive Immunizations Booklet
- Quick Reference Information: Medicare Immunization Billing Quick Reference Chart
- Vaccine Payments under Medicare Part D Fact Sheet
- Mass Immunizers and Roster Billing Fact Sheet

Open Payments: Additional Phase 1 Registration and Data Submission Resources Now Available

No provider action required at this time

CMS has posted a number of new resources to the Open Payments website, in an effort to educate industry stakeholders about the two-phased approach to Open Payments registration and data submission that began on February 18. *No action is needed from affected physicians and teaching hospitals at this time.* CMS will soon issue more specific information regarding the dates for Phase 2 registration and data submission, as well as when registration and review/correction will open for covered recipients, which will be no later than August 1, 2014. This phased approach to Open Payments registration and data submission is for the 2013 program year *only* (data collected between August 1, 2013 and December 31, 2013).

Read more about newly available registration and data submission resources for Industry:

- Step-by-step instructions for completing new user registration with the CMS Enterprise Portal,
- A sample template to be used for Phase 1 aggregate data submission, and
- New frequently asked questions (FAQs) added to the CMS FAQ website to address some of the most common questions about the phased approach to Open Payments registration and data submission (including user role details and an explanation of how consolidated reports are not accepted in Phase 1).

More Information

For more information about Open Payments, please visit the Open Payments website. To sign up for the Open Payments listserv, enter your email address on the main page, in the "Email Updates" box, or on the "Contact Us" page. Please submit any questions to the Help Desk at openpayments@cms.hhs.gov.

Important Information about Upcoming HQRP Reporting Cycle Deadlines

As part of the Hospice Quality Reporting Program (HQRP), hospices should currently be preparing to submit FY 2015 Reporting Cycle data and preparing to implement the Hospice Item Set (HIS), which will be required for the FY 2016 Reporting Cycle. CMS will provide information about reporting requirements, provider resources, and important dates for both the FY 2015 and FY 2016 Reporting Cycles of the HQRP on the March 5 Home Health, Hospice & Durable Medical Equipment Open Door Forum (ODF). Additional information about the ODF, including the agenda, call-in information and conference ID, will be posted on the Home Health, Hospice & Durable Medical Equipment ODF web page.

The FY 2015 Reporting Cycle consists of reporting on two measures: the structural measure and the National Quality Forum (NQF) #0209 pain measure collected during Calendar Year 2013. The HQRP Data Entry and Submission Site is now available for data submission. Data for each measure must be submitted to CMS by 11:59pm ET on April 1, 2014 for FY 2015 payment determination. The Technical User's Guide, posted on the Data Submission web page is the primary reference for the HQRP Data Entry and Submission Site for the FY 2015 Reporting Cycle.

As part of the FY 2016 Reporting Cycle, Medicare-certified hospices will implement the HIS for all patient admissions on or after July 1, 2014. The HIS is a set of patient-level data items that can be used to calculate 6 NQF-endorsed measures and one modified NQF measure.

Deadline for Physician-owned Hospitals to Report Ownership and Investment Information Extended to March 1

Reminder: The deadline for physician-owned hospitals to report ownership and investment information pursuant to Section 6001 of the Affordable Care Act is March 1, 2014. Physician-owned hospitals that submitted the information on or after December 1, 2012, consistent with the process specified in MLN Matters® Article #SE1332, will be considered to have met the March 1, 2014 deadline. Generally, when a due dates falls on a Saturday, Sunday, or federal legal holiday, it is delayed until the next business day, which will be Monday, March 3.

Submit Suggestions for Advanced Diagnostic Imaging Program

CMS is requesting suggestions regarding the future development of regulations to improve the safety and quality of services furnished by Advanced Diagnostic Imaging (ADI) suppliers and would greatly appreciate any insights that you could share with us. CMS has created a public mailbox to receive suggestions related to potential improvements, which could include personnel qualifications, infection control practices, quality improvement programs, image and equipment quality, patient safety, evidence-based research, etc. All suggestions may be sent to ADISuggestions@cms.hhs.gov. You will receive a response confirming that your message has been received. Please feel free to share the mailbox address with any other interested parties. CMS will be accepting submissions to the mailbox until March 31, 2014.

2013 Final Program Year for the 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. 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 electronic prescribing via certified Electronic Health Record (EHR) technology is still a requirement for eligible professionals in order to achieve meaningful use under the Medicare and Medicaid EHR Incentive Programs:

Want to find out more about eHealth?
Visit the CMS eHealth website for the latest news and updates on eHealth initiatives. Sign up for eHealth Listserv and follow us on Twitter.

Prepare for Upcoming eHealth Milestones with New eHealth Interactive Timeline

If you are a health care professional participating in the eHealth programs, you know that 2014 will be a busy year with many important milestones approaching. To help you prepare and navigate program deadlines, CMS has released a new eHealth Interactive Timeline Tool. The interactive timeline will help you identify key program dates for 2014-2017 and corresponding resources for the following eHealth initiatives:

- Medicaid and Medicare EHR Incentive Program
- Quality Measurement
    - Hospital Inpatient Quality Reporting Program (IQR)
    - Physician Quality Reporting System (PQRS)
    - Maintenance of Certification Program Incentive
- Administrative Simplification Operating Rules
    - Health Plan Identifier (HPID)
    - Electronic Funds Transfer (EFT) and Remittance Advice (ERA)
    - ICD-10
- Patient Outcomes and Payment Reform
    - Comprehensive Primary Care (CPC) Initiative
    - Physician Feedback/Value-Based Payment Modifier Program

Filter by the eHealth initiatives you are interested in, and the timeline will provide you with important month-by-month dates and deadlines, as well as helpful resources. You can 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 eHealth website for the latest news and updates on CMS eHealth initiatives. Sign up for CMS eHealth Listserv and follow us on Twitter.

New and Updated FAQs for the EHR Incentive Programs Now Available

To keep you updated with information on the Medicare and Medicaid Electronic Health Record (HER) Incentive Programs, CMS has recently added four new FAQs and an updated FAQ to the CMS FAQ system. We encourage you to stay informed by taking a few minutes to review the new information below.

New FAQs:

- For some of the eligible professional (EP) clinical quality measures (CQMs), there are look back periods or look forward periods for which data was not available. How are these CQMs calculated for the reporting period? Read the answer.
- Why does the result of the clinical quality measure for CMS140v2 not accurately reflect an accurate performance rate upon calculation according to the measure logic in the specification? Read the answer.
- In calculating the meaningful use objectives requiring patient action, if a patient sends a message or accesses his/her health information made available by their EP, can the other EPs in the practice get credit for the patient's action in meeting the objectives? Read the answer.
- When reporting on the Summary of Care objective in the Electronic Health Records (EHR) Incentive Program, how is a transition of care defined and which transitions would count toward the numerator of the measures? Read the answer.

Updated FAQ:
A number of measures for Meaningful Use objectives for eligible hospitals and critical access hospitals (CAHs) include patients admitted to the Emergency Department (ED). Which ED patients should be included in the denominators of these measures for the Medicare and Medicaid EHR Incentive Programs? Read the answer.

Want more information about the EHR Incentive Programs?
Make sure to visit the Medicare and Medicaid EHR Incentive Programs website for the latest news and updates on the

EHR Incentive Programs.

Claims, Pricers, and Codes

FY 2014 Inpatient PPS PC Pricer Updated with New Provider Data

The FY 2014 Inpatient Prospective Payment System (PPS) PC Pricer is now available on the Inpatient PPS PC Pricer web page in the "Downloads" section with the latest provider data.

MLN Educational Products

"Special Instructions for ICD-10 Coding on Home Health Episodes that Span October 1, 2014" MLN Matters® Article — Released

MLN Matters® Special Edition Article #SE1410, "Special Instructions for ICD-10 Coding on Home Health Episodes that Span October 1, 2014" has been released and is now available in downloadable format. This article is designed to provide education on further details regarding home health claims for episodes that span the October 1 date. It includes a summary table of scenarios.

"Basic Medicare Information for Providers and Suppliers" Guide — Revised

The "Basic Medicare Information for Providers and Suppliers" Guide (ICN 005933) was revised and is now available in downloadable format. This guide is designed to provide education on the Medicare Program. It includes the following information: an introduction to the Medicare Program, becoming a Medicare provider or supplier, Medicare reimbursement, Medicare services, protecting the Medicare Trust Fund, Medicare overpayments and Fee-For-Service appeals, and provider outreach and education.

"Medicare Disproportionate Share Hospital" Fact Sheet — Revised

The "Medicare Disproportionate Share Hospital" Fact Sheet (ICN 006741) was revised and is now available in downloadable format. This fact sheet is designed to provide education on Medicare Disproportionate Share Hospitals (DSH). It includes the following information: background; methods to qualify for the Medicare DSH adjustment; Affordable Care Act provision that impacts Medicare DSHs; Medicare Prescription Drug, Improvement, and Modernization Act provisions that impact Medicare DSHs; number of beds in hospital determination; Medicare DSH payment adjustment formulas; resources; and lists of helpful websites and Regional Office Rural Health Coordinators.

"Acute Care and the IPPS" Web-Based Training Course — Revised

The Acute Care and the Inpatient Prospective Payment System (IPPS) Web-Based Training Course was revised and is now available. This WBT is designed to provide an overview of acute care hospital coverage and payment under the IPPS. It includes a basic explanation of inpatient hospital coverage, billing, and payment for beneficiaries enrolled in Original Medicare. Continuing Education Credits are available to learners who successfully complete this course. See course description for more information.

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.

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 Medicare Fee-For-Service initiatives. Please bookmark this page and check back often as a new fast fact is added each month.

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.

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CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

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