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MLN Connects™

Weekly Provider eNews

Thursday, March 13, 2014

MLN Connects™ National Provider Calls

PQRS: Reporting Across Medicare Quality Reporting Programs in 2014 — Last Chance to Register
Tuesday, March 18; 1:30-3pm ET

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

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:
Individual eligible professionals, group practices and ACOs will learn how to:

- 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 — Last Chance to Register
Thursday, March 20; 2:30-4pm ET

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

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
- SRR Measure Description
- 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.

Did You Miss These MLN Connects™ Calls?

Call materials for MLN Connects™ Calls are located on the Calls and Events web page. New materials are now available for the following calls:

- February 26 — National Partnership to Improve Dementia Care in Nursing Homes, Helpful Resources: Nonpharmacologic Approaches to Care and Effective Pain Assessment & Management, audio, and transcript
- February 27 — 2-Midnight Benchmark: Discussion of the Hospital Inpatient Admission Order and Certification, audio and transcript

CMS Events

Road to 10: ICD-10 Training Webinar Series

As the October 1, 2014, ICD-10 compliance date approaches, CMS continues to work in collaboration with providers and other industry stakeholders to help prepare for the transition. CMS is hosting a series of ICD-10 Training Webinars that will focus on ICD-10 basics, key preparation steps for a successful transition, billing, and clinical documentation concepts.

ICD-10 Overview: Basics and Transition Tips

- March 13; 12-1pm ET
- Register for this webinar
- This training reviews ICD-10 basics, key preparation steps for a successful transition, billing, and clinical documentation concepts.

ICD-10 Clinical Documentation

- March 18; 12-1pm ET
- Register for this webinar
- This training will discuss why good clinical documentation and coding practices are important; the effect ICD-10 will have on clinician and coder relationships; and identifying documentation essentials for specialties, clinical areas, and patient conditions

Keep Up to Date on ICD-10

Visit the CMS ICD-10 website for the latest news and resources to help you prepare for the *October 1, 2014*, compliance date. Sign up for CMS ICD-10 Industry Email Updates and follow us on Twitter.

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.

Volunteers Sought for ICD-10 End-to-End Testing: July 21-25

Deadline to submit volunteer forms is March 24

During the week of July 21 through 25, a sample group of providers will have the opportunity to participate in end-to-end testing with Medicare Administrative Contractors (MACs) and the Common Electronic Data Interchange (CEDI) contractor to demonstrate that CMS and provider systems are ready for ICD-10 implementation on October 1, 2014. The goal of this testing is to demonstrate that:

- Providers and submitters are able to successfully submit claims containing ICD-10 codes to the Medicare Fee-For Service (FFS) claims systems
- CMS software changes made to support ICD-10 result in appropriately adjudicated claims
- Accurate Remittance Advices are produced using 2014 payment rates

Over 500 volunteer submitters will be selected to participate in end-to-end testing. This statistically meaningful, nationwide sample will represent a broad cross-section of provider, claim, and submitter types, including claims clearinghouses, which represent large numbers of providers.

To volunteer as a testing submitter:

- Volunteer forms are available on your MAC website
- Completed volunteer forms are due March 24
- CMS will review applications and select the group of testing submitters
- By April 14, the MACs and CEDI will notify the volunteers selected to test and provide them with the information needed for the testing

Any issues identified during end-to-end testing will be addressed prior to ICD-10 implementation. Additional educational materials will be developed for providers and submitters based on the testing results.

For more information:

- MLN Matters® Article MM8602, "ICD-10 Limited End-to-End Testing with Submitters"
- MLN Matters® Special Edition Article #SE1409, "Medicare FFS ICD-10 Testing Approach"

Announcements

Medicare Provides Coverage for Certain Colorectal Cancer Screenings

March is Colorectal Cancer Awareness Month – a time to increase awareness of colorectal cancer and the important role that regular colorectal cancer screenings can play in the prevention and early detection of disease. Colorectal cancer affects all racial and ethnic groups, is most often found in people age 50 or older, and the risk for developing the cancer increases with age. CMS reminds all health care professionals that Medicare provides coverage for certain colorectal cancer screening services. All Medicare beneficiaries age 50 and older are covered; however, when an individual is at high risk, there is no minimum age required to receive a screening colonoscopy or a barium enema (rendered in place of the screening colonoscopy). CMS ask that you to talk with your patients 50 and older about the importance of getting screened.

Medicare Coverage

Medicare defines high risk of developing colorectal cancer as someone who has one or more of the following risk factors:

- Close relative (sibling, parent, or child) who has had colorectal cancer or an adenomatous polyp,

- Family history of familial adenomatous polyposis,
- Family history of hereditary nonpolyposis colorectal cancer,
- Personal history of adenomatous polyps,
- Personal history of colorectal cancer, or
- Personal history of inflammatory bowel disease, including Crohn's Disease and ulcerative colitis.

All Medicare beneficiaries age 50 and older, who are *not* at high risk for colorectal cancer, and meet certain eligibility requirements are covered for the following screening services:

- Screening Fecal Occult Blood Test (FOBT) every year,
- Screening Flexible Sigmoidoscopy once every 4 years (unless a screening colonoscopy has been performed and then Medicare may cover a screening sigmoidoscopy after at least 119 months) ,
- Screening Colonoscopy every 10 years (unless a screening flexible sigmoidoscopy has been performed and then Medicare may cover a screening colonoscopy only after at least 47 months), and
- Screening Barium Enema (as an alternative to a covered screening flexible sigmoidoscopy).

All Medicare beneficiaries age 50 and older, who are at high risk for colorectal cancer, and meet certain eligibility requirements are covered for the following screening services:

- Screening FOBT every year,
- Screening Flexible Sigmoidoscopy once every 4 years,
- Screening Colonoscopy every 2 years (unless a screening flexible sigmoidoscopy has been performed and then Medicare may cover a screening colonoscopy only after at least 47 months), and
- Screening Barium Enema (as an alternative to a covered screening colonoscopy).

The copayment/coinsurance and deductible are waived for the screening FOBT, screening flexible sigmoidoscopy, and screening colonoscopy. For the screening barium enema, the copayment/coinsurance applies but the deductible is waived.

For More Information

- MLN Preventive Services Educational Products for Health Professionals
- United States Preventive Services Task Force (USPSTF)
- National Cancer Institute at National Institutes of Health

Part D Payment for Drugs for Beneficiaries Enrolled in Hospice: Final 2014 Guidance

CMS has issued a final memorandum, "Part D Payment for Drugs for Beneficiaries Enrolled in Hospice—Final 2014 Guidance." This memorandum provides final guidance for Part D sponsors and hospices as it relates to payment for drugs for hospice beneficiaries in 2014. The effective date of this policy clarification will be *May 1, 2014.*

HQRP FY 2015 Reporting Cycle Data: Deadline April 1

Hospice providers must submit data by 11:59pm ET on April 1, 2014 in order to avoid 2 percentage point reduction in their FY 2015 Annual Payment Update.

As part of the Hospice Quality Reporting Program (HQRP), hospices should currently be submitting FY 2015 Reporting Cycle data. 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 CY 2013.

Providers should visit the HQRP Data Entry and Submission Site now to create an account and submit their data. 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. Please also refer to the Data Collection User Guide for information on data collection and how providers will aggregate the NQF #0209 data.

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.

EHR Incentive Programs: Medicare EPs Must Attest by March 31 to Receive 2013 Incentive

*Due to the large volume of providers attesting, please submit your data as soon as possible and during non-peak hours to avoid system delays.*If you are an eligible professional (EP), the last day you can register and attest to demonstrating meaningful use for the 2013 Medicare Electronic Health Record (EHR) Incentive Program is March 31, 2014. You must successfully *attest by 11:59pm ET on March 31*, to receive an incentive payment for your 2013 participation.

CMS extended the deadline for EPs to attest to meaningful use for the Medicare EHR Incentive Program to allow more time for providers to submit their meaningful use data and receive an incentive payment for the 2013 program year.

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

Eligible Hospitals
If you are an eligible hospital, you may contact CMS for assistance submitting your attestation retroactively. You must contact CMS by 11:59pm on March 15, 2014 in order to participate for the 2013 program year.

Payment Adjustments
Payment adjustments for EPs will be applied beginning January 1, 2015, to Medicare participants that have not successfully demonstrated meaningful use. For more information, visit the payment adjustment tipsheet for eligible professionals.

- You must attest to demonstrating meaningful use *every year* to receive an incentive and avoid a payment adjustment .
- If you are only eligible to participate in the Medicaid EHR Incentive Program, you are not subject to payment adjustments.

Resources

- Meaningful Use Attestation Calculator
- Attestation Worksheet for Eligible Professionals
- Attestation Guide for Medicare Eligible Professionals
- Stage 2 Payment Adjustment Tipsheet for Eligible Professionals

Plan Ahead
Review important dates for the EHR Incentive Programs and all CMS eHealth program using this Interactive Timeline.

Eligible Hospitals: Take Action by April 1 to Avoid 2015 EHR Incentive Program Payment Adjustment

Payment adjustments for eligible hospitals that have not successfully participated in the Medicare Electronic Health Record (EHR) Incentive Program will begin on *October 1, 2014*. Hospitals can avoid the payment adjustment by taking action by April 1. Hospitals that have never participated in the Medicare EHR Incentive Program can:

- Submit a hardship exception application for experiencing circumstances that posted a significant barrier to achieving meaningful use
- Begin 90 days of meaningful use for the 2014 reporting year by April 1 and attest by July 1

Hospitals that participated in 2011 or 2012, but did not successfully participate in 2013 due to circumstances that created barriers can also submit a hardship exception.

About Hardship Exceptions

The hardship exception application for Medicare eligible hospitals is available on the EHR Incentive Programs website and outlines the specific types of circumstances that CMS considers to be barriers to achieving meaningful use. Supporting documentation must also be provided. CMS will review applications to determine whether or not a hardship exception should be granted. As a reminder, the application must be submitted electronically or postmarked no later than *11:59pm ET on April 1, 2014* to be considered. If approved, the exception is valid for one year.

Demonstrate Meaningful Use

CMS has developed resources for hospitals that demonstrate meaningful use of certified EHR technology, including:

- Stage 1 meaningful use spec sheets
- Attestation worksheet
- Meaningful use attestation calculator

Dually eligible hospitals can avoid the Medicare payment adjustment by successfully meeting meaningful use under the Medicaid EHR Incentive Program.

Want more information about the EHR Incentive Programs?

Be sure to visit the Medicare and Medicaid EHR Incentive Programs website for the latest news and updates on the EHR Incentive Programs.

Learn About Upcoming PQRS Milestones this March

If you are an eligible professional (EP) or group practice participating in the Physician Quality Reporting System (PQRS), CMS wants to make sure you are prepared for this month's important program milestones. Some important dates to remember for this month with helpful resources are listed below.

March 21

- Last day for groups to submit 2013 data through the GPRO Web Interface

March 31

- Last day to submit 2013 PQRS data through the registry reporting method
  - 2013 PQRS: Registry Reporting Made Simple
  - Registry Reporting web page
- Last day for Maintenance of Certification (MOC) Program Incentive entities to submit 2013 quality data
  - MOC Program Incentive web page
- Last day for Qualified Clinical Data Registries (QCDRs) to submit measure information for 2014 participation
  - QCDR web page
  - 2014 PQRS: Qualified Clinical Data Registry Data Submission Criteria

Additional Resources

To help you navigate these program deadlines, CMS released a PQRS interactive timeline that will help you identify key program dates for PQRS between 2014 and 2016, and direct you to related resources.

You can find the interactive timeline, along with other helpful information, on the Educational Resources web page of the PQRS website.

Submit Your PQRS Quality Measures through the EHR Reporting Method

Are you interested in submitting your Physician Quality Reporting System (PQRS) quality measures using the EHR Reporting method? Resources for 2014 participation are now available for individual eligible professionals (EPs) and group practices that wish to report using this option.

EHR Reporting Methods
If using electronic health records (EHRs) for PQRS participation, EPs must ensure they are using 2014 certified EHR technology (CEHRT), in accordance with the Medicare and Medicaid EHR Incentive Programs Certified Health IT Product List. Individual EPs and group practices have the following EHR-based reporting options:

- Submit PQRS quality measure data directly from the CEHRT. To submit quality measure data directly from their own EHR, EPs and groups need to verify that their EHR vendor's product meets 2014 certification criteria.
- Submit PQRS quality measure data extracted from their CEHRT to a qualified Data Submission Vendor. Data Submission Vendors are responsible for submitting PQRS measures data from an EP or group practice's CEHRT to CMS via CMS specified format(s) on behalf of the EP or the group practice for the program year.

PQRS and the EHR Incentive Program
EPs who are also eligible for the Medicare EHR Incentive Programs can submit their clinical quality measures (CQMs) through the PQRS EHR reporting options to fulfill the CQMs requirements for both PQRS and the Medicare EHR Incentive Program. EPs would still need to meet the additional reporting requirements of the EHR Incentive Programs. PQRS EHR reporters must use the June 2013 eCQM measures specifications from the EHR Incentive Program's eCQM library if choosing this alignment option. There is an exception for CMS140, which is to be reported using the December 2012 version (CMS140v1).To view more information about CQMs, click on this direct link to the EHR Incentive Programs' eCQM Library.

For More Information
Review the 2014: PQRS EHR Reporting Made Simple fact sheet for an overview of the EHR reporting method for PQRS in 2014. For more information or support for PQRS, please visit the PQRS website or the Help Desk.

Claims, Pricers, and Codes

Home Health Claims Incorrectly Paid with Reason Code V8030

Some home health claims with dates of service on or after October 1, 2013 that contain reason code V8030 have been paid and/or reported incorrectly. Therefore, Medicare Administrative Contactors (MACs) will hold home health claims that meet all of these criteria:

- Reason Code equals V8030
- Date of Service greater than or equal to October 1, 2013
- Value Code equals 64
- Value Code equals 17

Once a systems fix has been implemented, these claims will be processed. No action is required by home health providers.

Updates to IRIS Software

The Intern and Resident Information System (IRIS) software programs (IRISV3 and IRISEDV3) have three updated files (medical school codes, residency type codes, and IRISV3 Operating Instructions as of February 2014) for collecting and reporting information on resident training in hospital and non-hospital settings:

- 30 new IRIS residency type codes added to the IRIS Residency Code Table.
- 7 new IRIS medical school codes added to the IRIS Medical School Code Table.

Providers may begin using the new medical school and residency type codes in the IRIS programs for cost reporting periods ending on or after Thursday, October 31, 2013. The IRIS programs are available for downloading on the IRIS website.

MLN Educational Products

"International Classification of Diseases, Tenth Revision (ICD-10) Limited End-to-End Testing with Submitters" MLN Matters® Article — Released

MLN Matters® Article #MM8602, "International Classification of Diseases, Tenth Revision (ICD-10) Limited End-to-End Testing with Submitters" has been released and is now available in downloadable format. This article is designed to provide education on how to volunteer for ICD-10 end-to-end testing with Medicare in July 2014 and the requirement to complete the volunteer form on the Medicare Administrative Contractor (MAC) website by March 24, 2014. It includes background information.

"Update to 2014 Hospital Outpatient Clinical Diagnostic Laboratory Test Payment and Billing" MLN Matters® Article — Released

MLN Matters® Special Edition Article #SE1412, "Update to 2014 Hospital Outpatient Clinical Diagnostic Laboratory Test Payment and Billing" has been released and is now available in downloadable format. This article is designed to provide education on the operational mechanism OPPS hospital should use to bill Medicare on or after July 1, 2014, for outpatient clinical diagnostic laboratory tests furnished in CY 2014. It includes the billing scenarios for the new modifier.

"Advance Beneficiary Notice of Noncoverage" Booklet — Revised

The "Advance Beneficiary Notice of Noncoverage" Fact Sheet (ICN 006266) was revised and is now available in downloadable format. This booklet is designed to provide education on the Advanced Beneficiary Notice (ABN). It includes information on when an ABN should be used and how it should be completed.

"Hospital Outpatient Prospective Payment System" Fact Sheet — Revised

The "Hospital Outpatient Prospective Payment System" Fact Sheet (ICN 006820) was revised and is now available in downloadable format. This fact sheet is designed to provide education on the Hospital Outpatient Prospective Payment System. It includes the following information: background, ambulatory payment classifications, how payment rates are set, payment rates, and Hospital Outpatient Quality Reporting Program.

"Clinical Laboratory Fee Schedule" Fact Sheet — Revised

The "Clinical Laboratory Fee Schedule" Fact Sheet (ICN 006818) was revised and is now available in downloadable format. This fact sheet is designed to provide education on the Clinical Laboratory Fee Schedule. It includes the following information: background, coverage of clinical laboratory services, and how payment rates are set.

"Resources for Medicare Beneficiaries" Fact Sheet — Reminder

The "Resources for Medicare Beneficiaries" Fact Sheet (ICN 905183) is available in a downloadable format. This fact sheet is designed to provide education on the variety of beneficiary-related publications available to assist providers in answering patients' questions. It includes a list of products with information you can print out and provide to your Medicare beneficiaries.

"Complying With Medicare Signature Requirements" — Electronic Publication

"Complying With Medicare Signature Requirements" (ICN 905364) is now available as an electronic publication (EPUB®) and through a QR code. This fact sheet is designed to provide education on common Comprehensive Error Rate Testing (CERT) Program errors related to signature requirements .It includes information on the documentation needed to support a claim submitted to Medicare for medical services.

The EPUB format and QR code are available on the publication's detail page. Instructions for downloading the EPUB and how to scan a QR code are available at "How To Download a Medicare Learning Network® (MLN) Electronic Publication" on the CMS website.

Submit Feedback on MLN Educational Products

The Medicare Learning Network® (MLN) is interested in what you have to say. Visit the MLN Opinion web page to submit an anonymous evaluation about MLN educational products. Your feedback is important and helps us develop high-quality MLN products that meet your educational needs.

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