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MLN Connects™

Weekly Provider eNews

Thursday, April 3, 2014

MLN Connects™ National Provider Calls

Medicare Shared Savings Program ACO: Preparing to Apply for 2015 — Last Chance to Register
Tuesday, April 8; 1:30-3pm ET

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

During this MLN Connects™ National Provider Call, CMS subject matter experts provide information on what you can do to prepare for the Medicare Shared Savings Program (Shared Savings Program) application process for the January 1, 2015 start date. This MLN Connects Call includes information on Accountable Care Organizations (ACOs), ACO organizational structure and governance, application key dates, the Notice of Intent to Apply (NOI) submission, and the first steps in submitting an application. A question and answer session will follow the presentation.

The Shared Savings Program Application web page has important information, dates, and materials on the application process. Call participants are encouraged to review the application and other materials found on this web page prior to the call.

Target Audience: Potential 2015 ACO Applicants

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

How to Register for the PQRS Group Practice Reporting Option in 2014 — Last Chance to Register
Thursday, April 10; 2:30-4pm ET

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

This MLN Connects™ National Provider Call gives a walkthrough of the Physician Value (PV) - Physician Quality Reporting System (PQRS) Registration System. The PV-PQRS Registration System is an application that serves the Physician Value Modifier and PQRS programs. The PV-PQRS Registration system will allow physician group practices to select/change their CY 2014 PQRS Group Practice Reporting Option (GPRO) reporting mechanism and if applicable, supplement the groups' reporting mechanism with the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) survey in 2014. GPROs can begin registering via the PV-PQRS Registration System beginning April 1, 2014 through September 30, 2014.

In 2016, physicians in groups with 10 or more Eligible Professionals (EPs) will be subject to the Value Modifier based upon satisfactory participation in PQRS in 2014. To avoid the -2% automatic Value Modifier downward adjustment and the -2% PQRS payment adjustment in 2016, groups with 10 or more EPs will need to register for one of the reporting options available to groups in 2014 and meet the criteria to avoid the PQRS payment adjustment in 2016. Or, ensure that at least 50 percent of the EPs in the group report PQRS individually and meet the criteria to avoid the PQRS payment adjustment in 2016.

Agenda:
- Introduction/Opening Remarks
- PV-PQRS Registration Walkthrough
- Question and Answer Session

Target Audience: Physicians, physician group practices, practice managers, medical and specialty societies, payers, 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 — Register Now
Thursday, April 17; 2:30-4pm ET

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

On March 31, 2014, CMS will begin 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 is using this dry run to test the implementation of SRR reporting and to educate dialysis facilities about the measure.

This MLN Connects™ National Provider Call is the second of two calls that provides stakeholders with information about the measure and the dry run report, as well as provides answers to questions that facilities may have about their results. Dialysis facilities will be able to access their SRR report for the dry run by a secure login, at www.DialysisData.org, starting March 31. Each facility should have received a master account password by now. You are encouraged to access your reports and review your results prior to participating in this national provider call. The dry run comment period will run from March 31 – May 2. Facilities will not be able to access their reports after May 2.

If your facility has not received a master account password, or if the master account holder for your facility has changed, please contact the dry run help desk at 855-764-2885.

Agenda:

- Introductions and Roles
- 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.

National Partnership to Improve Dementia Care in Nursing Homes — Registration Now Open
Tuesday, May 20; 1:30-3:00pm 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™ National Provider Call, a CMS subject matter expert will provide National Partnership updates, discuss efforts to monitor enforcement rates, and track surveyor training completion. Additional speakers will be presenting on the critical role that activity professionals play in the mission to improve dementia care and the reduction of antipsychotic medications through person-centered, nonpharmacologic care approaches. A question and answer session will follow the presentation.

Agenda:

- Partnership updates

- Role of activity professionals
- Nonpharmacologic approaches to care
- 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.

New MLN Connects™ National Provider Call Transcripts and Audio Recordings

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

- March 18 — PQRS: Reporting Across Medicare Quality Reporting Programs in 2014, audio, and transcript
- March 20 — Standardized Readmission Ratio for Dialysis Facilities: National Dry Run, audio and transcript

Announcements

Hospital Outpatient Supervision Level Designations: April 30 Deadline for Comments

Based on the Hospital Outpatient Payment (HOP) Panel's recommendations at its meeting on March 10, 2014, CMS is proposing changes to certain current outpatient supervision level requirements described in the CY 2012 Hospital Outpatient Prospective Payment System /Ambulatory Surgical Center Final Rule. The requirements open to public comment are outlined in CMS' Preliminary Decisions on the Recommendations of the Hospital Outpatient Payment Panel on Supervision Levels for Select Services. Comments may be submitted via email to HOPSupervisionComments@cms.hhs.gov through 5pm ET on April 30, 2014. As indicated in the final rule, CMS will consider any comments and post final decisions that will be effective on July 1, 2014.

Physicians and Teaching Hospitals Do Not Need to Take Action Now in Open Payments

Phase 1 of Open Payments registration and data submission for applicable manufacturers and applicable group purchasing organizations (GPOs) ended on March 31. *No action is needed from affected physicians and teaching hospitals at this time.* CMS will soon issue information about when registration and review/correction will open for covered recipients after Phase 2 of industry registration and data submission has launched (May/June 2014).

Physicians can learn more about Open Payments program requirements by reviewing the Program Overview for Physicians. There is also a brochure that explains the program that you can share with your patients. In addition to these resources, continuing education materials are posted to the Physician web page of the Open Payments website, and the Open Payments Mobile for Physicians app is available to help physicians track payments and other transfers of value they receive from applicable manufacturers and applicable GPOs throughout the year. The app is voluntary for use and is free. It can be downloaded at the Google Play™ app store or iOSApple™ app store; search for "Open Payments."

PV-PQRS Registration System is Now Open

The Physician Value-Physician Quality Reporting System (PV-PQRS) Registration System is open for authorized representatives of group practices to select the groups' PQRS reporting mechanism for CY 2014. Also, if the group practice has 25 or more eligible professionals (EPs), then the group can elect to supplement its PQRS reporting mechanism with the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. However, if the group

practice has 100 or more EPs and has selected the Web Interface reporting mechanism for 2014, then the group is *required* to report the CAHPS survey, and the group can elect to include its performance on the 2014 CAHPS survey in the calculation of the group's 2016 Value-Based Payment Modifier. The PV-PQRS Registration System will close on September 30, 2014, and can be accessed at https://portal.cms.gov, using a valid Individuals Authorized Access to the CMS Computer Services (IACS) User ID and password. For additional information regarding registration and obtaining or modifying an IACS account please see the Quick Reference Guides on the CMS Physician Feedback/Value Based Payment website.

2-Midnight Rule: Provider Resources

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). Information on this final rule, commonly known as the "2-Midnight Rule," is available on the Inpatient Hospital Reviews web page. Additional clarification on the provisions of the final rule regarding the physician order and physician certification of hospital inpatient services is posted on the Hospital Center page.

Submit Your 2014 PQRS Quality Measures through the Registry Reporting Method

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

Registry Reporting Criteria for Individual Eligible Professionals
An eligible professional can earn a 2014 PQRS incentive by meeting one of the following criteria for satisfactory registry reporting:

- Report on at least 9 measures covering 3 National Quality Strategy (NQS) domains for at least 50 percent of the eligible professional's Medicare Part B Fee-For-Service (FFS) patients.
- Report at least 1 measures group on a 20-patient sample, a majority of which (at least 11 out of 20) must be Medicare Part B FFS patients.

Registry Reporting Criteria for Group Practices
Group practices must have registered to report via qualified registry under the Group Practice Reporting Option (GPRO) for the 2014 PQRS program. Registration for 2014 GPRO participation opens April 1 and ends September 30, 2014. A group practice can earn a 2014 PQRS incentive by reporting on at least 9 measures covering 3 NQS domains for at least 50 percent of the group's Medicare Part B FFS patients.

Measure-Applicability Validation (MAV) Process
Eligible professionals and group practices that report on fewer than 9 measures and/or report fewer than 3 NQS domains will be subject to the MAV process to determine whether they are incentive eligible.

Steps for Registry Reporting
Eligible professionals and group practices should take the following steps when ready to get started with 2014 participation:

- Determine eligibility to participate in PQRS
- Choose PQRS qualified registry
- Work directly with registry to submit 2014 PQRS data

Eligible professionals may also consider the following option which is available only to individuals:

- Decide whether to report individual measures or measures groups

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

New Security Risk Assessment Tool Helps Providers Ensure HIPAA Compliance

HHS has released a new Security Risk Assessment (SRA) tool to help health care providers in small-to-medium sized offices conduct risk assessments of their organizations. The SRA Tool is the result of a collaborative effort by the HHS Office of the National Coordinator for Health Information Technology (ONC) and Office for Civil Rights (OCR). The tool is designed to help practices conduct and document a risk assessment to evaluate potential security risks in their organizations under the Health Insurance Portability and Accountability Act (HIPAA) Security Rule. The application, available for downloading at www.HealthIT.gov/security-risk-assessment, also produces a report that can be provided to auditors. The webpage contains a User Guide and Tutorial video to help providers begin using the tool.

Security Risk Assessment for Meaningful Use
Conducting and reviewing a security risk assessment is not only a key requirement of the HIPAA Security Rule, but is also a core objective for providers participating in the Medicare and Medicaid EHR Incentive Programs.

The CMS Security Risk Analysis Tipsheet helps providers understand:

- Steps for conducting a security risk analysis
- How to create an action plan
- Security areas to be considered and their corresponding security measures
- Myths and facts about conducting or reviewing a security risk analysis

Be sure to review the steps and conduct or review the analysis. It is required in both stages of meaningful use to receive an incentive payment.

SRA Tool Feedback
ONC is requesting that users provide feedback on the new SRA Tool. Public comments on the SRA Tool will be accepted until June 2, 2014.

For more information about the requirements for meaningful use, visit the EHR Incentive Programs website.

CMS Posts 2014 Eligible Hospital Electronic Clinical Quality Measure Annual Update

The annual update of the 2014 electronic clinical quality measures (eCQMs) for eligible hospitals and corresponding specifications for electronic reporting are now available. CMS updates the specifications annually to ensure that specifications align with current clinical guidelines, code sets, and remain relevant and actionable within the clinical care setting.The eCQM specifications are used for multiple programs, such as the Hospital Inpatient Quality Reporting program, to align with the Electronic Health Record (EHR) Incentive Programs and reduce the burden on providers to report quality measures.

CMS strongly encourages the implementation and use of the updated 2014 eCQMs for eligible hospitals because they include new codes, logic corrections, and clarifications. However, CMS will accept all versions of the eCQMs for meaningful use, beginning with the December 2012 release, until the next phase of the EHR Incentive Programs.

Updated 2014 CQM Resources
To help eligible hospitals navigate the updated eCQMs, several resources are available on the eCQM Library web page:

- Table of 2014 Eligible Hospital Measure Versions
- 2014 eCQM Specifications for Eligible Hospital Release April2014
- 2014 eCQM Measure Logic Guidance v1.6 April2014
- Guide to Reading Eligible Provider and Hospital eCQMs April2014

Need additional eCQM file formats or access to past versions for side by side comparisons?
Visit the Meaningful Use tab of the United States Health Information Knowledgebase (USHIK).

Need additional information about the EHR Incentive Programs?
Visit the EHR Incentive Programs website for the latest news and updates.

Claims, Pricers, and Codes

Appeals for Cancelled Claims Related to Medicare Beneficiaries Classified as "Unlawfully Present" in the U.S.

In some cases, claims submitted for beneficiaries determined to be unlawfully present in the United States were reprocessed without offering appeal rights on the resulting overpayments. See MLN Matters® Article #MM8009, "New Informational Unsolicited Response (IUR) Process to Identify Previously Paid Claims for Services Furnished to Medicare Beneficiaries Classified as "Unlawfully Present" in the United States." In addition, in some cases where appeal rights were offered on the reprocessed claims, appeals were not processed appropriately.

Providers and suppliers are entitled to file appeals for these reprocessed claims, and appeals should be processed on these claims even if appeal rights were not initially offered. Providers and suppliers are entitled to submit a request for redetermination within 120 calendar days from the later of either (a) the date of receipt of the remittance advice indicating recovery of payment for such services, or (b) April 1, 2014.

In cases where a request for redetermination of such services was refused, providers and suppliers are entitled to resubmit their request within 120 calendar days from the later of either (a) the date of receipt of the letter or notice from their Medicare Administrative Contractor (MAC) refusing to process the appeal, or (b) April 1, 2014.

If the request for redetermination of such services resulted in a dismissal notice from their MAC, providers and suppliers may request that the dismissal be vacated. Requests to vacate the dismissal must be filed with their MAC within six months of the later of (a) the date of receipt of the dismissal notice, or (b) April 1, 2014, provided a request for review of the dismissal was not filed with the Qualified Independent Contractor (QIC). Any requests pending before the QIC will be processed by the QIC.

In cases where a redetermination request for such services was processed by their MAC, providers and suppliers are entitled to request a reopening of the redetermination decision within the later of either (a) one year of the date of receipt of the redetermination notice, or (b) October 1, 2014, if they disagree with the redetermination decision, provided a request for reconsideration has not been filed with the QIC. Any requests pending before the QIC will be processed by the QIC.

For any appeal request, request to reopen an appeal decision, or a request to vacate a dismissal where the original claim was cancelled, providers must submit a paper claim that replicates the original cancelled claim with their appeal or reopening request. Failure to submit a paper claim with the appeal or reopening request will result in delays in effectuating favorable appeal decisions.

Mandatory Payment Reduction of 2% Continues through March 31, 2015, for the Medicare FFS Program — "Sequestration"

For the Medicare Fee-for-Service (FFS) program, claims with dates-of-service or dates-of-discharge on or after April 1, 2013, will continue to incur a 2 percent reduction in Medicare payment through March 31, 2015. Claims for durable medical equipment (DME), prosthetics, orthotics, and supplies, including claims under the DME Competitive Bidding Program, will continue to be reduced by 2 percent based upon whether the date-of-service, or the start date for rental equipment or multi-day supplies, is on or after April 1, 2013. The claims payment adjustment will continue to be applied

to all claims after determining coinsurance, any applicable deductible, and any applicable Medicare Secondary Payment adjustments. Though beneficiary payments for deductibles and coinsurance are not subject to the 2 percent payment reduction, Medicare's payment to beneficiaries for unassigned claims is subject to the 2 percent reduction. CMS encourages Medicare physicians, practitioners, and suppliers who bill claims on an unassigned basis to continue discussions with beneficiaries the impact of sequestration on Medicare's reimbursement. Questions about reimbursement should be directed to your Medicare Administrative Contractor.

Adjustment of Community Mental Health Center Claims for Telehealth Originating Facility Fees

Community Mental Health Center (CMHCs) claims for telehealth originating facility fees (procedure code Q3014) processed from January 7, 2013 through February 23, 2014 were incorrectly reimbursed at 100% of billed charges. These claims will be adjusted in the next 90 days. Claims processed on and after February 24, 2014 are paying correctly. Beneficiary liability for deductible and coinsurance is correct and calculated based on the fee schedule amount. No action is required by CMHCs.

Incorrect Overpayments and Denials for Some New Patient Visit Claims

CMS has identified issues related to processing of claims for new patient visits billed by the same physician or physician group within the past three years. CMS has determined that the edits implemented in October, 2013, generated incorrect overpayments and denials for some claims. CMS will be issuing refunds on any offset or recouped payments and interest in the next 90 days. For background see MLN Matters® Article MM8165.

MLN Educational Products

"Medicare Quarterly Provider Compliance Newsletter [Volume 4, Issue 3]" Educational Tool— Released

The "Medicare Quarterly Provider Compliance Newsletter [Volume 4, Issue 3]" Educational Tool (ICN 909006) was released and is now available in a downloadable format. This educational tool is designed to provide education on how to avoid common billing errors and other erroneous activities when dealing with the Medicare Program. It includes guidance to help health care professionals address and avoid the top issues of the particular Quarter.

"Quick Reference Information: The ABCs of Providing the Initial Preventive Physical Examination" Educational Tool — Revised

The "Quick Reference Information: The ABCs of Providing the Initial Preventive Physical Examination" Educational Tool (ICN 006904) was revised and is now available in downloadable format. This educational tool is designed to provide education on the Initial Preventive Physical Examination (IPPE). It includes a list of elements that must be included in the IPPE, as well as coverage and coding information.

"Quick Reference Information: The ABCs of Providing the Annual Wellness Visit" Educational Tool — Revised

The "Quick Reference Information: The ABCs of Providing the Annual Wellness Visit" Educational Tool (ICN 905706) was revised and is now available in downloadable format. This educational tool is designed to provide education on the Annual Wellness Visit (AWV). It includes a list of the required elements in the initial and subsequent AWVs, as well as coverage and coding information.

"Medicare Coverage of Items and Services Furnished to Beneficiaries in Custody Under a Penal Authority" Fact Sheet — Reminder

The "Medicare Coverage of Items and Services Furnished to Beneficiaries in Custody Under a Penal Authority" Fact Sheet (ICN 908084) is available in downloadable format. This fact sheet is designed to provide education on Medicare's policy to generally not pay for medical items and services furnished to beneficiaries who are incarcerated or in custody at the time the items and services are furnished. It includes the following information: policy background, including the definition of individuals who are in custody (or incarcerated) under a penal statute or rule; determining whether a beneficiary is in custody under a penal statute or rule; Medicare claims processing for items and services for incarcerated beneficiaries; exception to Medicare policy; and Informational Unsolicited Response. It is also the featured Product of the Month for April.

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 health care professionals understand common billing errors and avoid improper payments. Please bookmark this page and check back often as a new fast fact is added each month.

MLN Product Available in Electronic Publication Format

The following booklet is now available as an electronic publication (EPUB) and through a QR code. Instructions for downloading EPUBs and how to scan a QR code are available at "How To Download a Medicare Learning Network® (MLN) Electronic Publication" on the CMS website.

The "Medicare Claim Review Programs: MR, NCCI Edits, MUEs, CERT, and Recovery Audit Program" Booklet (ICN 006973) 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 Contractor, and the Comprehensive Error Rate Testing Program.

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