Medicare Learning Network®
Official Information Health Care Professionals Can Trust

MLN Connects™

Weekly Provider eNews

Thursday, April 10, 2014

MLN Connects™ National Provider Calls

Standardized Readmission Ratio for Dialysis Facilities: National Dry Run — Last Chance to Register

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.

Medicare Shared Savings Program ACO Application Process — Registration Now Open

Tuesday, April 22; 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 cover helpful tips on completing a successful application, including information on how to submit an acceptable Accountable Care Organization (ACO) Participant List, Sample ACO Participant Agreement, Executed ACO Participant Agreements, and Governing Body Template for the Medicare Shared Savings Program 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.

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

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

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Announcements

Medicare Coverage Includes Screening and Counseling for Alcohol Misuse

April is Alcohol Awareness Month. This national health observance serves to increase public awareness and understanding, reduce stigma, and encourage local communities to focus on alcoholism and alcohol-related issues.

Alcohol addiction and excessive alcohol misuse affects people of all ages, gender and ethnicities. Seniors and others covered by Medicare can be screened for alcohol misuse under the Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse benefit. Read more.

Historic Release of Data Gives Consumers Unprecedented Transparency on the Medical Services Physicians Provide and How Much They are Paid

On April 9, as part of the Obama administration's work to make our health care system more transparent, affordable, and accountable, HHS Secretary Kathleen Sebelius announced the release of new, privacy-protected data on services and procedures provided to Medicare beneficiaries by physicians and other health care professionals. The new data also show payment and submitted charges, or bills, for those services and procedures by provider.

The new data set has information for over 880,000 distinct health care providers who collectively received $77 billion in Medicare payments in 2012, under the Medicare Part B Fee-For-Service program. With this data, it will be possible to conduct a wide range of analyses that compare 6,000 different types of services and procedures provided, as well as payments received by individual health care providers.

The information also allows comparisons by physician, specialty, location, the types of medical service and procedures delivered, Medicare payment, and submitted charges. Physicians and other health care professionals determine what they will charge for services and procedures provided to patients and these "charges" are the amount the physician or health care professional generally bills for the service or procedure.

Last May, CMS released hospital charge data allowing consumers to compare what hospitals charge for common inpatient and outpatient services across the country.

Full text of this excerpted CMS press release (issued April 9).

Participation Rises in Medicare PQRS and eRx Incentive Program

On April 3, CMS released the 2012 Physician Quality Reporting System (PQRS) and Electronic Prescribing (eRx) Experience Report, showing a significant increase in participation in two key programs that allow eligible professionals to earn incentive payments through voluntary participation. PQRS has been using incentive payments, and will begin to use payment adjustments in 2015, to encourage eligible health care professionals to report on designated quality measures. The eRx Incentive Program used a combination of incentive payments and payment adjustments to encourage electronic prescribing by eligible professionals.

Increased participation in 2012
The 2012 report found that there was increased participation in both PQRS and the eRx Program, marking progress in CMS's efforts to improve quality measurement, as well as to build a national electronic health information infrastructure in the United States. Report highlights include:

- Participation in the PQRS program increased by 36 percent from 2011.
- PQRS participation is highest among eligible professionals who see the most Medicare patients.
- Participation in the eRx program is up by 22 percent from 2011.

The report demonstrates that one significant factor in the increased participation in these programs is CMS's efforts to align quality measurement across programs in order to minimize the burden on eligible professionals participating in multiple programs. Next years' experience report will include the results of the final eRx program year, and CMS looks forward to reporting even stronger participation results.

More information about the PQRS, including how eligible professionals can participate and the criteria for reporting to qualify for an incentive payment, is available on the PQRS website. More information about the eRx Incentive Program can be found on the eRx website.

Full text of this excerpted CMS press release (issued April 3).

Probe and Educate Clarifications: Timeframes for Additional Documentation Requests and Education

Under the final rule CMS-1599-F or "2-Midnight" rule, Medicare Administrative Contractors (MACs) have been performing prepayment patient status probe reviews on a sample of 10 claims for most hospitals (25 claims for large hospitals) with dates of admission on or after October 1, 2013. These "probe and educate" reviews are being conducted to assess provider understanding and compliance with CMS policy on inpatient hospital and critical access hospital (CAH) admissions. Based on the results of the initial reviews, the MACs will conduct individualized educational efforts and repeat the process where necessary. MACs are beginning the education portion of the process and have been instructed to allow providers 45 days before requesting additional documentation. This 45 day timeframe will give hospitals additional time to implement strategies aimed at increased compliance with the rule. CMS has instructed the MACs that any providers with incomplete probe and educate samples (i.e. less than 10 or 25 claims selected and/or received for review) will automatically be offered education and undergo a second probe review, regardless of the results of the first probe review.

EHR Incentive Programs: New Meaningful Use Calculator Helps Providers Attest to Stage 2

Are you a provider participating in Stage 2 of meaningful use for the Electronic Health Record (EHR) Incentive Programs? If so, use the new CMS Stage 2 Meaningful Use Attestation Calculator to determine if you will successfully meet Stage 2 requirements. Like the Stage 1 calculator, eligible professionals, eligible hospitals, and critical access hospitals (CAHs) can enter and review their data for each measure. The tool then calculates whether or not you will successfully demonstrate Stage 2 of meaningful use. A results page explains why you may or may not receive an incentive payment by displaying a pass/fail summary for each measure.

Get Started
Take four easy steps to get started:

- Select your provider type: eligible professional or eligible hospital/CAH
- Answer questions on your meaningful use core objectives
- Answer questions on your meaningful use menu objectives
- Receive your results

Be sure to answer each measure you intend to meet by either filling in the numerator and denominator values or marking down an exclusion (for those that apply).

Please note: The attestation calculator is not actual attestation and does not guarantee that you will meet the program's qualifications. It is only a guide of whether or not you would meet the program's Stage 2 meaningful use requirements.

Resources
Providers who have completed at least two years of Stage 1 of meaningful use will demonstrate Stage 2 in 2014. Additional Stage 2 resources:

- Stage 2 Guide
- Stage 2 Meaningful Use Specification Sheet Table of Contents for Eligible Professionals
- Stage 2 Meaningful Use Specification Sheet Table of Contents for Eligible Hospitals and CAHs
- Stage 2 Data Sharing Tipsheet for Eligible Professionals

Want more information?
Visit the Registration and Attestation and Stage 2 pages for useful resources to help you successfully demonstrate meaningful use.

Review New and Updated FAQs for the EHR Incentive Programs

To keep you updated with information on the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, CMS has recently added three new FAQs and five updated FAQs 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 Eligible Professionals (EP) in the Medicaid EHR Incentive Program using the group proxy method of calculating patient volume, how should the EPs calculate patient volume using the "12 months preceding the EP's attestation" approach, as not all of the EPs in the group practice may use the same 90-day period. Read the answer.
- Can a hospital count a patient toward the measures of the "Patient Electronic Access" objective in the Medicare and Medicaid EHR Incentive Programs if the patient accessed his/her information before they were discharged? Read the answer.
- When demonstrating Stage 2 meaningful use in the EHR Incentive programs, would an EP be required to report on the "Electronic Notes" objective even if he or she did not see patients during their reporting period? Read the answer.

Updated FAQs:

- Do States need to verify the "installation" or "a signed contract" for adopt, implement, or upgrade (AIU) in the Medicaid EHR Incentive Program? Read the answer.

- For Stage 1 and 2 meaningful use objectives of the Medicare and Medicaid EHR Incentive Programs that require submission of data to public health agencies, if multiple EPs are using the same certified EHR technology across several physical locations, can a single test or onboarding effort serve to meet the measures of these objectives? Read the answer.
- For the Stage 2 meaningful use objective of the Medicare and Medicaid EHR Incentive Programs that requires the successful electronic exchange of a summary of care document with either a different EHR technology or the CMS designated test EHR, if multiple EPs are using the same certified EHR technology across several physical locations, can a single test meet the measure? 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 EHR Incentive Program, which transitions would count toward the numerator of the measures? 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.

Claims, Pricers, and Codes

CMS Releases Modifications to HCPCS Code Set

The scheduled release of modifications to the Healthcare Common Procedure Coding System (HCPCS) code set are posted on the HCPCS Quarterly Update web page. Changes are effective on the dates indicated on the update.

SNFs and Changes in Part B Payment Methodology for Certain DME

Beginning April 1, 2014, Medicare reclassified certain Durable Medical Equipment (DME) Healthcare Common Procedure Coding System (HCPCS) codes from the inexpensive and routinely purchased payment category to the capped rental payment category. Skilled Nursing Facilities (SNFs) should be aware of this change in Part B payment methodology that affects certain DME codes, including speech generating devices and complex rehabilitative manual wheelchairs. For more information on this change, including clarification on how it interacts with the SNF's bundled Part A payment for a resident's Medicare-covered stay, please see MLN Matters® Article MM8566 .

MLN Educational Products

"Updating Beneficiary Information with the Benefits Coordination & Recovery Center (formerly known as the Coordination of Benefits Contractor)" MLN Matters® Article — Released

MLN Matters® Special Edition Article #SE1416, "Updating Beneficiary Information with the Benefits Coordination & Recovery Center (formerly known as the Coordination of Benefits Contractor)" was released and is now available in downloadable format. This article is designed to provide education on the initiatives adopted to maintain the most up-to-date and accurate beneficiary Medicare Secondary Payer (MSP) information. It includes updated information regarding the BCRC. This article reissues MLN Matters® Special Edition Article #SE1205.

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

The following guide 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 "Basic Medicare Information for Providers and Suppliers" Guide (ICN 005933) 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.

"Mental Health Services" Booklet — Revised

The "Mental Health Services" Booklet (ICN 903195) was revised and is now available in hard copy format. This booklet is designed to provide education on mental health services. It includes the following information: covered and non-covered mental health services, eligible professionals, outpatient and inpatient psychiatric hospital services, same day billing guidelines, and National Correct Coding Initiative.

To access a new or revised product available for order in a *hard copy* format, go to MLN Products and scroll down to the bottom of the web page to the "Related Links" section and click on the "MLN Product Ordering 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.

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