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MLN Connects™

Weekly Provider eNews

Thursday, May 22, 2014

MLN Connects™ National Provider Calls

Stage 2 Meaningful Use Requirements, Reporting Options, and Data Submission Processes for Eligible Professionals — Last Chance to Register

Thursday, May 29; 1:30-3pm ET

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

As an eligible professional, are you aware of the differences between Stage 1 and Stage 2 criteria? Did you know that you can report quality measures once and meet multiple reporting requirements? Do you understand the processes for submitting your data? Eligible professionals who have completed at least two program years under Stage 1 of Meaningful Use in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs are required to meet Stage 2 criteria starting in 2014, the first year of Stage 2 implementation. On May 29, 2014, CMS will be hosting an "office hours" session for eligible professionals participating in these programs to answer your questions.

During this MLN Connects™ National Provider Call, conducted in an office hours format, CMS experts give a brief introductory presentation, providing a concise overview of Stage 2 requirements, reporting options, and data submission processes. This overview will be followed by answers to questions submitted prior to the call and an opportunity for participants to interact with our subject matter experts during a live question and answer session. You are encouraged to email questions to e-measures@mathematica-mpr.com no later than May 21 to be considered for inclusion in the office hours session, then join the call to learn more about Stage 2 implementation.

Agenda:

- Overview of Stage 2 of Meaningful Use
- Reporting
- Data Submission
- Answers to Submitted Questions
- Live Q&A Session

Target Audience: Eligible professionals participating in Stage 2 of Meaningful Use and their staff as well as EHR vendors supporting data submission for Stage 2 of Meaningful Use.

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

More ICD-10 Coding Basics — Register Now

Wednesday, June 4; 1:30-3pm ET

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

HHS expects to release an interim final rule in the near future that will include a new compliance date that would require the use of ICD-10 beginning October 1, 2015. Providers would have an extra year to prepare. During this MLN Connects™ National Provider Call, join us for a keynote presentation on more ICD-10 coding basics by Sue Bowman from the American Health Information Management Association (AHIMA), along with updates from CMS. A question and answer session will follow the presentation.

Agenda:

- CMS updates, including the partial code freeze and 2015 code updates
- Why ICD-9-CM is being replaced with ICD-10-CM
- Benefits of ICD-10-CM
- Similarities and differences from ICD-9-CM
- Coding: Process of assigning a diagnosis code, 7th character, placeholder "x," excludes notes, unspecified codes, external cause of injury codes, type of encounter
- Documentation tips
- How to obtain answers to coding questions
- How to request modifications to ICD-10-CM

Target Audience: Medical coders, physicians, physician office staff, nurses and other non-physician practitioners, provider billing staff, health records staff, vendors, educators, system maintainers, laboratories, and all Medicare providers

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Medicare Shared Savings Program ACO: Application Review — Registration Now Open
Tuesday, June 10; 2:30 -4PM 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 an overview and update to the Medicare Shared Savings Program application process for the January 1, 2015 start date. 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 materials prior to the call.

Agenda:

- Medicare Shared Savings Program application process
- Differences between previous applications and the 2015 application
- Required templates
- Narratives and uploads
- Lessons learned
- Question & Answer

Target Audience: Potential 2015 Accountable Care Organization (ACO) applicants who submitted a Notice of Intent to Apply

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

Open Payments (the Sunshine Act): Updates for Physicians and Teaching Hospitals — Registration Opening Soon
Thursday, June 12; 1:30pm-3pm ET

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

As a physician or teaching hospital, are you aware of Open Payments (the Sunshine Act)? Do you know the differences between Phase 1 and Phase 2 registration for this first Open Payments reporting year? Did you know that registration in the CMS Enterprise Portal is the required first step to be able to review and dispute any of the data reported about you by industry prior to public posting? Do you understand the process for disputing information with industry that you believe to be inaccurate or incomplete? Are you aware that you have a defined number of days to initiate a dispute with industry?

During this MLN Connects™ National Provider Call, CMS experts will give a brief introductory presentation about Open Payments, providing a concise overview of physician and teaching hospital CMS registration phases and the upcoming review and dispute process. This overview will be followed by answers to questions submitted prior to the call and an opportunity for participants to interact with our subject matter experts during a live question and answer session.

Agenda:

- Open Payments overview

- Overview of physician and teaching hospital CMS registration phases
- Upcoming review and dispute process
- Answers to submitted questions
- Live Q&A session

Target Audience: Physicians, Teaching Hospitals, Professional Organizations, Physician Staff and Other Interested Parties

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

PQRS: 2014 Qualified Clinical Data Registry — Registration Now Open

Tuesday, June 17; 1:30-3pm ET

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

This MLN Connects™ National Provider Call will provide an overview of Qualified Clinical Data Registry (QCDR) Reporting. New for 2014, the QCDR reporting method provides a new method to satisfy Physician Quality Reporting System (PQRS) requirements.

A QCDR is a CMS-approved entity (such as a specialty society, certification board, or regional health collaborative) that collects medical and/or clinical data for the purpose of patient and disease tracking to foster improvement in the quality of care provided to patients. The data submitted to CMS via a QCDR covers quality measures across multiple payers and is not limited to Medicare. This presentation will introduce eligible professionals to this new reporting option and provide steps for successful participation.

Agenda:

- Learn the Difference Between a QCDR and a Qualified Registry
- How to Use A QCDR to Qualify for a 2014 PQRS Incentive Payment
- How to Avoid the 2016 PQRS Payment Adjustment

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.

Announcements

"Mind Your Health" — Recognizing the Importance of Mental Health

May is Mental Health Month. This year's theme, "Mind Your Health" emphasizes the integration of the mind and body in the role of overall health and wellness. Just as we aim to prevent chronic diseases, such as cardiovascular disease and diabetes, we need to prevent mental illness and educate patients in the preventive services that can protect their mental well-being.

Medicare provides payment for select preventive services that you can use to monitor your patients' mental well-being in order to promote the synergy of the mind and body. Read more.

"Generations of Strength" — Preventing Osteoporosis Among Medicare Beneficiaries

May is National Osteoporosis Month, a time to ignite the important conversations needed to bring attention to the disease. About 9 million Americans have the disease and over 40 million have low bone density, increasing their risk.

Age is one risk factor for osteoporosis, which can put Medicare beneficiaries at a greater risk for the disease. Read more.

CMS Rule to Help Providers Make Use of Certified EHR Technology

Rule also proposes to extend Stage 2 of the EHR Incentive Programs through 2016

On May 20, HHS published a new proposed rule that would provide eligible professionals, eligible hospitals, and critical access hospitals more flexibility in how they use certified electronic health record (EHR) technology (CEHRT) to meet meaningful use. The proposed rule, from CMS and the Office of the National Coordinator for Health Information Technology (ONC), would let providers use the 2011 Edition CEHRT or a combination of 2011 and 2014 Edition CEHRT for the EHR reporting period in 2014 for the Medicare and Medicaid EHR Incentive Programs. Beginning in 2015, all eligible hospitals and professionals would still be required to report using 2014 Edition CEHRT. Since the Medicare and Medicaid EHR Incentive Programs began in 2011, more than 370,000 hospitals and professionals nationwide have received an incentive payment.

The proposed rule also includes a provision that would formalize CMS and ONC's previously stated intention to extend Stage 2 through 2016 and begin Stage 3 in 2017. These proposed changes would address concerns raised by stakeholders and will encourage the continued adoption of Certified EHR Technology.

- Proposed rule
- EHR Incentive Programs website
- Information about CEHRT

Full text of this excerpted CMS press release (issued May 20), including proposed changes to the meaningful use timeline.

User ID Reminder for 2015 Medicare Shared Savings Program Applicants

Potential applicants who submitted a Notice of Intent (NOI) to apply to the 2015 Medicare Shared Savings Program (Shared Savings Program) are reminded that form CMS-20037 "Application For Access to CMS Computer Systems" to obtain your CMS User ID is due no later than Monday, June 9, 2014. Please do not wait until the deadline. Submit form CMS-20037 as soon as possible by using the link and instructions provided in your NOI acknowledgement email. Mail your completed form to CMS via tracked mail (FedEx, UPS, etc.) to: Attention: Adam Foltz, Centers for Medicare & Medicaid Services, 7500 Security Blvd, Mailstop C4-18-13, Baltimore, MD 21244. Visit the Shared Savings Program Application web page for deadline dates for the 2015 Application cycle.

Am I Eligible to Order and Refer Medicare Items and Services?

The easiest way to determine if you are eligible to order and refer Medicare items and services is to visit the Ordering & Referring Information web page. The download section contains a file that lists the National Provider Identifiers (NPIs) and the names (last name, first name) of the physicians and non-physician practitioners who have current approved or opt out records in PECOS and are of a type/specialty that is eligible to order and refer Part B (clinical laboratory and imaging), Durable Medical Equipment (DME) and Home Health Agency (HHA) claims. The file is available in CSV format, however, it can be downloaded in different formats (i.e., CSV, PDF, XLS, XLSX or XML) by visiting Data.cms.gov and searching for "Order and Referring." This report is updated twice a week and is the only reliable source for verifying ordering and referring eligibility information. See MLN Matters® Article #SE1305, "Full Implementation of Edits on the Ordering/Referring Providers in Medicare Part B, DME, and Part A Home Health Agency (HHA) Claims (Change Requests 6417, 6421, 6696, and 6856)."

Registration for Hospice User IDs Began May 19

Medicare-certified hospices will be required to complete and submit a Hospice Item Set (HIS) Admission record and a Hospice Item Set (HIS) Discharge record for each patient admitted on or after July 1, 2014. The completed HIS records are submitted to the Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system. Hospice providers required to submit the HIS records must register for two separate user IDs – a CMSNet User ID and a QIES User ID. The online registration applications for the CMSNet User ID and the QIES User ID are now available.

CMSNet User ID
Each provider is allowed two CMSNet User IDs, which allows access to the CMS private network where the QIES systems reside. The CMSNet User ID registration is an online, self-registration process. The Hospice CMSNet Online Registration application link is posted on the CMSNet Information web page. Users must follow the registration instructions. Should you have questions while registering for the CMSNet User ID, contact the CMSNet Help Desk at 888-238-2122 or mdcn.mco@palmettogba.com .

QIES User ID
Once successfully logged into the CMS network, providers will access a Hospice link. The Hospice link will allow users to access the CMS QIES Systems for Providers - Hospice Welcome web page and the Hospice User Registration application link. The Hospice User Registration application is used by the hospice provider to register for the QIES User IDs. Each provider is allowed to register for two QIES User IDs. The QIES User ID registration is an online, self-registration process. The Provider User Registration User's Guide that details the process of registering for a QIES User ID is available in the Hospice User Registration application. Should you have questions while registering for the QIES User ID, contact the QTSO Help Desk by phone at 877-201-4721 or help@qtso.com.

You are encouraged to review the Hospice technical training modules 1 (CMSNet User ID Registration Process) through 3 (QIES User ID Registration Process) *prior* to registering for the CMSNet and QIES User IDs. The recorded training modules are available on the QTSO website.

Medicare GME Affiliation Agreements: July 1 Deadline

In accordance with 42 CFR 413.75(b) and 413.79(f), teaching hospitals that wish to be part of a Medicare Graduate Medical Education (GME) Affiliated Group for the purpose of aggregating Indirect Medical Education (IME) and direct GME full-time equivalent (FTE) resident caps must submit a Medicare GME Affiliation Agreement to CMS by the July 1, 2014 deadline. Hospitals must submit amendments to the July 1, 2013 through June 30, 2014 Medicare GME Affiliation Agreements by June 30, 2014, and hospitals must submit new Medicare GME Affiliation Agreements for the July 1, 2014 through June 30, 2015 academic year by July 1, 2014 at 11:59pm ET.

Please submit amendments or new agreements electronically to Medicare_GME_Affiliation_Agreement@cms.hhs.gov (CMS no longer accepts hard copies) with the subject line "[Insert Your Hospital Name and CCN#] Amendment to July 1, 2013—June 30, 2014 Medicare GME Affiliation Agreement" or "[Insert Your Hospital Name and CCN#] New Medicare GME Affiliation Agreement for July 1, 2014—June 30, 2015." Please also remember to submit a copy of the amendment and/or new affiliation agreement to your Medicare Administrative Contractor (MAC), in accordance with your MAC's instructions by June 30 or July 1.

CMS is Accepting Suggestions for PQRS Measures

CMS is accepting quality measure suggestions for potential inclusion in the proposed set of quality measures in the Physician Quality Reporting System (PQRS) for future rule-making years. Quality measures submitted in this Call for

Measures also will be considered for use in other quality programs for physicians and other eligible professionals (e.g. Value Based Modifier, Physician Compare, Medicare Shared Savings Program, etc.).

Beginning this year, the Call for Measures will be conducted in an ongoing open format. Unlike previous years, where the annual Call for Measures closed after a specified period of time, starting in 2014, the Call for Measures will remain open indefinitely. The month that a measure is submitted for consideration will determine when it can be included on the Measures Under Consideration (MUC) list. Measures submitted from May 1, 2014 to June 30, 2014 may be considered for inclusion on the 2014 MUC list for implementation in PQRS as early as 2016.

Each measure submitted for consideration must include all required supporting documentation. Documentation requirements and the submission timeline are posted on the Measures Management System Call for Measures web page.

When submitting measures for consideration, please ensure that your submission is not duplicative of another existing or proposed measure. Additionally, CMS is *not* accepting claims-based only reporting measures in this process. CMS will give priority to measures that are outcome-based, answer a measure gap and address the most up-to-date clinical guidelines. Measures submitted for consideration will be assessed to ensure that they meet the needs of the PQRS. As time permits, feedback will be provided to measure submitters upon review of their submission.

Note: Suggesting individual measures or measures for a new or existing measures group does not guarantee the measure(s) will be included in the proposed or final sets of measures of any Proposed or Final Rules that address the PQRS. Additionally, measures submitted for consideration are not guaranteed to be put forth on the MUC list for MAP review. CMS will determine which individual measures and measures group(s) to include in the proposed set of quality measures, and after a period of public comment, the agency will make the final determination with regard to the final set of quality measures for the PQRS.

Learn About the Special EHR Reporting Periods for Eligible Professionals in 2014

If you are an eligible professional, make sure you are aware of the special reporting periods for submitting meaningful use measures in 2014 for the Electronic Health Record (EHR) Incentive Programs.

Meaningful Use Reporting for Medicare and Medicaid Eligible Professionals
You only need to demonstrate meaningful use for a three-month, or 90-day, reporting period, regardless if you are demonstrating Stage 1 or Stage 2 of meaningful use. Choose your reporting period based on your program and participation year:

- Medicare beyond first year of meaningful use: Select a three-month reporting period fixed to the quarter of the calendar year.
- Medicare in first year of meaningful use: Select any 90-day reporting period. To avoid the 2015 payment adjustment, begin your reporting period by July 1 and attest by October 1.
- Medicaid: Select any 90-day reporting period that falls within the 2014 calendar year.

For More Information
Visit the EHR Incentive Programs website for the latest news and updates.

Medicare EHR Incentive Program: Review Steps for Submitting Stage 2 Meaningful Use Data

Are you preparing to submit Stage 2 meaningful use data for the Medicare EHR Incentive Program? If so, CMS has recently posted the following step-by-step guides to help navigate the CMS Attestation System:

- Stage 2 Attestation User Guide for Eligible Professionals
- Stage 2 Attestation User Guide for Eligible Hospitals and Critical Access Hospitals (CAHs)

These guides provide instructions and important information that you will need in order to successfully attest, as well as helpful tips and screenshots to walk you through the process. *Note:* While all providers begin their registration through the CMS Registration & Attestation System, Medicaid eligible professionals and Medicaid-only eligible hospitals must attest through their State Medicaid Agency's website. Please visit the Medicaid State Information web page to learn more.

Additional Stage 2 Resources
CMS has additional resources to help ensure your attestation will be successful:

- Stage 2 Attestation Worksheet for Eligible Professionals
- Stage 2 Attestation Worksheet for Eligible Hospitals and CAHs
- 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

For More Information
Visit the Stage 2 web page for more information on how to successfully demonstrate meaningful use.

New Resources Explain How to Report Once for Multiple Medicare Quality Reporting Programs

If you are participating in multiple Medicare quality reporting programs in 2014, there is a new interactive CMS tool that will help you understand how to submit your quality data one time only to earn credit for more than one quality program. The Reporting Once for 2014 Medicare Quality Reporting Programs interactive tool provides reporting guidance based on how you plan to participate in PQRS in 2014:

- As an individual eligible professional
- As part of a group practice
- As part of a Medicare Shared Savings Program Accountable Care Organization (ACO)
- As part of a Pioneer ACO

Using the interactive tool, you will learn whether you will be incentive eligible for PQRS in 2014, avoid the 2016 PQRS payment adjustment, and satisfy the clinical quality measure component of the Medicare Electronic Health Record (EHR) Incentive Program. If you are part of a group practice with 10 or more eligible professionals, the tool will also help you assess the impact of your participation in PQRS on the Value-Based Payment Modifier. These reporting once options are only available if you are beyond your first year of participation in the Medicare EHR Incentive Program, and you are still required to report your core and menu objectives through the CMS Registration & Attestation System.

More Resources
You can also use the How to Report Once for 2014 Medicare Quality Reporting Programs fact sheet for an overview of the quality programs and reporting once in 2014.

PQRS Resources
For step-by step instructions for 2014 PQRS participation, view the How to Get Started web page. If you have additional questions, contact the QualityNet Help Desk at 866-288-8912 (TTY 1-877-715-6222) or via Qnetsupport@hcqis.org. The Help Desk is available Monday through Friday from 7am-7pm CT.

Claims, Pricers, and Codes

2015 ICD-10-CM, ICD-10-PCS, and ICD-9-CM Files Available

The 2015 ICD-10-CM and ICD-10-PCS files are now posted on the 2015 ICD-10-CM and GEMs web page and 2015 ICD-10-PCS and GEMs web page. There are no new, revised, or deleted ICD-10-CM or ICD-10-PCS codes.

The 2015 ICD-9-CM files are now available on the ICD-9-CM Diagnosis and Procedure Codes: Abbreviated and Full Code Titles web page. Since there will be no ICD-9-CM updates, there is no FY 2015 addendum. There are no new, revised, or deleted ICD-9-CM codes.

The 2015 General Equivalence Mappings (GEMs) will be posted later this summer.

Partial Code Freeze for ICD-9-CM and ICD-10 Extended

The ICD-9-CM Coordination and Maintenance Committee implemented a partial freeze of the ICD-9-CM and ICD-10 (ICD-10-CM and ICD-10-PCS) codes prior to the implementation of ICD-10, which would end one year after the implementation of ICD-10. On April 1, 2014, the Protecting Access to Medicare Act of 2014 (PAMA) (Pub. L. No. 113-93) was enacted, which said that the Secretary may not adopt ICD-10 prior to October 1, 2015. Accordingly, HHS expects to release an interim final rule in the near future that will include a new compliance date that would require the use of ICD-10 beginning October 1, 2015. The rule will also require HIPAA covered entities to continue to use ICD-9-CM through September 30, 2015.

The partial code freeze will continue through October 1, 2015, the new planned implementation date. Regular updates to ICD-10 will begin on October 1, 2016, one year after the implementation of ICD-10. See Partial Code Freeze for ICD-9-CM and ICD-10 for more information.

Demonstration Allows Public Input on Requests to Discontinue Level II HCPCS Codes

CMS announced plans to initiate a limited demonstration for a web-based notice and comment mechanism for allowing public input on requests to discontinue Level II Healthcare Common Procedure Coding System (HCPCS) codes. This demonstration will add further transparency to the CMS HCPCS coding process by providing advance notice regarding internal decisions to discontinue HCPCS codes and an opportunity for public input into these decisions. Information on the demonstration is available on the HCPCS - General Information website.

FY 2014 Inpatient PPS PC Pricer: 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.

Revision to the Replacement of Home Oxygen Services in the Event that Supplier Exits the Medicare Oxygen Business

CMS allows for the replacement of oxygen equipment in cases where a supplier exits the Medicare oxygen business and is no longer able to continue furnishing oxygen and oxygen equipment. In these instances, the oxygen equipment will be considered lost and a new 36-month rental period and reasonable useful lifetime will begin for the new supplier furnishing replacement oxygen equipment on the date that the replacement equipment is furnished to the beneficiary. Effective immediately, this replacement oxygen equipment guidance applies regardless of whether the supplier’s exit from the Medicare oxygen business is voluntary or due to the revocation of Medicare billing privileges.

MLN Educational Products

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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