



MLN Connects™

Weekly Provider eNews

Thursday, July 3, 2014

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MLN Connects™ National Provider Calls

Dialysis Facility Compare: Rollout of Five Star Rating — Register Now

Thursday, July 10; 2:30-4pm ET

To Register: Visit [MLN Connects™ Upcoming Calls](#). Space may be limited, register early.

This MLN Connects™ National Provider Call will provide stakeholders with the following:

- Information about the implementation of a Five Star Rating on Dialysis Facility Compare (DFC) in October, 2014
- The methodology used to calculate the rating
- Directions on how to access and preview the rating in the July, 2014 DFC Preview Period reports

Background:

CMS is adopting Five Star Ratings across all Medicare.gov Compare websites to help consumers understand the information and make more informed decisions about where to get healthcare. The CMS Center for Clinical Standards and Quality has contracted with the University of Michigan Kidney Epidemiology and Cost Center to develop and implement a Five Star Rating program for dialysis facilities. In October, 2014, CMS will introduce a Five Star Rating on DFC that reflects the overall quality of each dialysis facility. Providers will be able to see their facility's Five Star Rating during the July, 2014 DFC Preview Period.

Agenda:

- Introduction and roles
- Importance of Five Star Compare Systems
- Description of rating methodology
- Report details
- Maintenance and updates of Five Star Ratings
- Resources
- Q&A Session

Target Audience: Dialysis clinics and organizations, nephrologists, End-Stage Renal Disease (ESRD) Networks, hospitals with dialysis units, billers/coders, 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.

ESRD Quality Incentive Program: Reviewing Your Facility's PY 2015 Performance Data — Register Now

Wednesday, July 16; 2-3pm ET

To Register: Visit [MLN Connects™ Upcoming Calls](#). Space may be limited, register early.

During this MLN Connects™ National Provider Call, CMS experts will give a presentation on the End-Stage Renal Disease (ESRD) Quality Incentive Program (QIP). The ESRD QIP is a pay-for-performance initiative that ties a facility's quality scores to a payment percentage reduction over the course of a payment year (PY). On July 15, 2014, each dialysis facility will have access to a preliminary PY 2015 Performance Score Report (PSR) that “previews” how well it scored on the quality measures that CMS will use for determining any payment reductions.

This MLN Connects Call will focus on the steps dialysis facilities need to take to review the data CMS will use to evaluate performance as part of the PY 2015 program. After the presentation, participants will have an opportunity to ask questions of subject matter experts.

Agenda:

- How to access and review a dialysis facility PSR
- How CMS calculates facility ESRD QIP performance score using quality data
- What a performance score means to a facility PY 2015 payment rates

- When and where to ask questions regarding PSR, including how to submit one formal inquiry
- Duty and responsibility to make ESRD QIP performance data transparent to patients
- Where to access help and additional information

Target Audience: Dialysis clinics and organizations, nephrologists, hospitals with dialysis units, billers/coders, and quality improvement experts.

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Open Payments (the Sunshine Act): Registration, Review, and Dispute — Registration Opening Soon

Tuesday, July 22; 2:30-4pm 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)? Now that you have completed Phase 1 of registration in the CMS Enterprise Portal, are you ready for Phase 2? Do you know that Phase 2 allows you to register in the Open Payments system, and then review and (if needed) dispute any of the data reported about you by the industry prior to public posting of the data?

During the time specified by CMS in Phase 2, physicians and teaching hospitals can voluntarily register with CMS to review information about payments or other transfers of value given to them by industry prior to public posting of the data. Physicians and teaching hospitals that choose to participate will initially need to register in the CMS Enterprise Portal (Phase 1 registration) in order to register in the Open Payments system to access and review the information submitted about them by industry and potentially dispute information with industry that they believe to be inaccurate or incomplete.

During this MLN Connects™ National Provider Call, CMS experts will give a brief introductory presentation about Open Payments and provide a step-by-step review of the registration and 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:

- Brief Open Payments overview
- Recap registration process in the CMS Enterprise Portal
- Provide step-by-step instructions on how to register in the Open Payments system and participate in the 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. Additional information is available on the [July 22](#) call web page.

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

ESRD Quality Incentive Program: Notice of Proposed Rulemaking for PY 2017 and 2018 — Register Now

Wednesday, July 23; 2-3:30pm ET

To Register: Visit [MLN Connects™ Upcoming Calls](#). Space may be limited, register early.

During this MLN Connects™ National Provider Call, CMS experts will give a presentation on the End-Stage Renal Disease (ESRD) Quality Incentive Program (QIP). The ESRD QIP is a pay-for-performance quality initiative that ties a facility's performance to a payment reduction over the course of a payment year (PY). This MLN Connects Call will focus on the upcoming ESRD Prospective Payment System (PPS) proposed rule with 30 day comment period, which includes rules for operationalizing the ESRD QIP in PY 2017 and PY 2018. A question and answer session will follow the presentation giving participants an opportunity to ask questions of subject matter experts.

Agenda:

- ESRD QIP legislative framework;
- Proposed measures, standards, scoring methodology, and payment reduction scale for PY 2017 and PY 2018
- Methods for reviewing and commenting on the proposed rule
- Question and answer session

Target Audience: Dialysis clinics and organizations, nephrologists, hospitals with dialysis units, billers/coders, and quality improvement experts.

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

2015 Medicare PFS Proposals for PQRS, Value Modifier, EHR Incentive Program, and the Physician Compare Website— Registration Now Open

Thursday, July 24; 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 the 2015 Physician Fee Schedule (PFS) Proposed Rule. This presentation will cover potential program updates to the Physician Quality Reporting System (PQRS). The topics covered include changes to reporting mechanisms, individual measures, measures groups for inclusion in 2015, criteria for satisfactorily reporting for an incentive, criteria for avoiding future payment adjustments, requirements for Medicare incentive program alignment, and satisfactory participation under the qualified clinical data registry option.

The presentation also provides an overview of the proposals for the value-based payment modifier, including how CMS proposes to continue to phase in and expand application of the value-based payment modifier in 2017 based on performance in 2015. The presentation also describes how the value-based payment modifier is aligned with the reporting requirements under the PQRS. This presentation further provides updates to Physician Compare and the Electronic Health Record (EHR) Incentive Program.

Agenda:

- Proposed changes to PQRS individual reporting requirements and PQRS Group Practice Reporting Option (GPRO)
- Proposed updates to Physician Compare and the EHR Incentive Program
- Review of the proposed value-based payment modifier policies under the 2015 proposed rule
- Plan for the future of the PQRS GPRO
- Where to call for help

Target Audience: Physicians, practitioners, therapists, medical group practices, practice managers, medical and specialty societies, payers, insurers.

This MLN Connects Call is being evaluated by CMS for CME and CEU continuing education credit (CE). Refer to the [call detail page](#) for more information.

New MLN Connects™ National Provider Call Video Slideshow, Transcript, and Audio Recording

A video slideshow, audio recording, and transcript are now available for the following calls:

- January 27 — 2-Midnight Benchmark for Inpatient Hospital Admissions, [video slideshow](#)
- June 17 — PQRS: 2014 Qualified Clinical Data Registry, [audio](#) and [transcript](#)

Call materials for MLN Connects™ Calls are located on the [Calls and Events](#) web page.

CMS Events

Webinar for Comparative Billing Report on Electrodiagnostic Testing

Wednesday, July 9; 3-4pm ET

Join us for an informative discussion of the comparative billing report on Electrodiagnostic Testing (EDX) (CBR201406). The presentation will be provided by CMS contractor eGlobalTech and its partner, Palmetto GBA. CBR201406 is an educational tool designed to assist providers billing electrodiagnostic tests.

Agenda:

- Opening Remarks
- Overview of Comparative Billing Report (CBR201406)
- Coverage Policy for Electrodiagnostic Testing (EDX)
- Methodology Report
- Resources
- Question & Answer Session

Presenter Information:

- Speakers: Cheryl Bolchoz, Becke Turner, Molly Wesley
- Organizations: eGlobalTech and Palmetto GBA

How to Register and Event Replay

Register [online](#). You may access a [recording](#) of the webinar two days following the event.

PERM Cycle 3 Provider Education Webinar/Conference Call Sessions

CMS is hosting Payment Error Rate Measurement (PERM) provider education webinar/conference calls for Medicare providers who also provide Medicaid and Children's Health Insurance Program (CHIP) services. Complete details are available in the [webinar announcement](#).

Presentations will include:

- The PERM process and provider responsibilities during a PERM review
- Frequent mistakes and best practices
- The Electronic Submission of Medical Documentation (esMD) program

To join the meeting:

- Registration is not required, however, space is limited
- All webinars are from 3-4pm ET
- Audio: 877-267-1577
- [Wednesday, July 16](#) or [Wednesday, July 30](#)

Announcements

CMS Proposes Payment Changes for Medicare Home Health Agencies for 2015

On July 1, CMS announced proposed changes to the Medicare home health prospective payment system (HH PPS) for CY 2015 that would foster greater efficiency, flexibility, payment accuracy, and improved quality. Based on the most recent data available, CMS estimates that approximately 3.5 million beneficiaries received home health services from nearly 12,000 home health agencies, costing Medicare approximately \$18 billion in 2013.

In the rule, CMS projects that Medicare payments to home health agencies in CY 2015 will be reduced by 0.30 percent, or -\$58 million based on the proposed policies. The proposed decrease reflects the effects of the 2.2 percent home health payment update percentage (\$427 million increase) and the rebasing adjustments to the national, standardized 60-day episode payment rate, the national per-visit payment rates, and the non-routine medical supplies (NRS) conversion factor (\$485 million decrease).

The proposed rule includes:

- Face-to-face encounter requirements
- Recalibration of the HH PPS case-mix weights
- Rate-setting changes
- Home Health Quality Reporting Program (HH QRP) update
- Conditions of Participation for speech-language pathologists
- Home Health Value-based Purchasing Model

For additional information about the Home Health Prospective Payment System, visit the [Home Health PPS](#) website. View the [proposed rule](#). CMS will accept comments on the proposed rule until September 2, 2014.

Full text of this excerpted CMS [fact sheet](#) (issued July 1).

CMS Fraud Prevention System Identified or Prevented \$210 Million in Improper Medicare Payments in Second Year of Operations

In its second year of operations, CMS' state-of-the-art Fraud Prevention System, that employs advanced predictive analytics, identified or prevented more than \$210 million in improper Medicare Fee-For-Service payments, double the previous year. It also resulted in CMS taking action against 938 providers and suppliers, according to a [report](#) sent to Congress today.

The Fraud Prevention System is a key element of the anti-fraud strategy that has led to a record \$19.2 billion in fraud recoveries over the previous five years. The Fraud Prevention System uses predictive algorithms and other sophisticated analytics to analyze billing patterns against every Medicare Fee-For-Service claim. Building on its expert knowledge for investigators and analysts, CMS is leading the government and healthcare industry in systematically applying advanced analytics on a nationwide scale. The system also uses other data sources including compromised Medicare identification numbers and complaints made through 1-800-MEDICARE. The tool is part of CMS's comprehensive program integrity strategy.

CMS also expects to expand the use of the Fraud Prevention System beyond the initial focus on identifying potential fraud into the areas of waste and abuse, which will increase future savings. The Fraud Prevention System now has the capability to stop payment of certain improper claims, without human intervention, by communicating a denial message to the claims payment system.

CMS also has pilot projects underway evaluating the expansion of the program that provides waste, fraud and abuse leads to Medicare Administrative Contractors for early intervention.

Full text of this excerpted CMS [press release](#) (issued June 25).

Physician and Teaching Hospitals: Complete Phase 1 Registration for Open Payments

As a reminder, Phase 1 of the voluntary Open Payments registration process for physicians and teaching hospitals (registration in the CMS Enterprise Portal) is currently open. Although this is a voluntary process, it is required if physicians or teaching hospitals want to access, review, and dispute any of the data reported about them by the industry prior to public posting of the data.

Registration and data review and dispute for physicians and teaching hospitals will be conducted in two phases for this first Open Payments reporting year:

- *Phase 1* (available now): Includes user registration in the CMS Enterprise Portal.
- *Phase 2* (begins in mid-July and extends for a 45-day initial review period, and then a 15-day correction period): Includes physician and teaching hospital registration in the Open Payments system, and allows them to review and (if needed) dispute data submitted by applicable manufacturers and applicable group purchasing organizations (GPOs) prior to public posting of the data. *Note:* Any data that is disputed, if not corrected by industry, will still be made public but will be marked as disputed. [Learn more about the review and dispute process.](#)

Very soon, CMS will provide additional guidance on the exact date when the Open Payments system will open for Phase 2. CMS will also soon announce extensive educational resources to support physicians and teaching hospitals during Phase 2 registration, and review and dispute process.

Physicians can learn more about Open Payments requirements by reviewing the [Program Overview for Physicians](#). Continuing education materials relating to Open Payments are available on the [Physicians](#) page of the [Open Payments](#) website. CMS has also developed a [brochure](#) about the program to be shared with patients. Check the [Open Payments](#) website periodically for more information.

Download Next Generation Mobile Apps for Open Payments

The Open Payments Mobile for Physicians app helps physicians track payments and other transfers of value they receive from applicable manufacturers and applicable GPOs throughout the year. In the past week, updated versions of the Open Payments Mobile for Industry and Open Payments Mobile for Physicians have launched and include the following new features, among others:

- Capability to sort and filter payments or transfers of value (by date, dollar amount, vendor, year, or company),
- Enhanced tablet layout,
- Ability to drill-down to specific payment information in bar and pie charts, and
- Quick scan QR code functionality that allows QR code scans from outside the app (without logging into the app).

If you have already downloaded the apps, you will need to run an update to take advantage of the new app functionality; visit either the Google Play™ app store or iOSApple™ app store, look for your available updates, and select the Open Payments apps to download the updates. Note that you will not lose any data you've entered into the old version of the apps; it will all be transferred into the new version of the app.

If you have not yet downloaded the apps, search for “Open Payments” in the applicable app store and you will be prompted to download the newly updated versions. For help with the apps you can contact the Help Desk at openpayments@cms.hhs.gov. Live Help Desk support is available by calling 855-326-8366, Monday through Friday, from 7:30am to 6:30pm CT, excluding Federal holidays. More information on the apps can be found on the [Open Payments](#) website.

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 date indicated on the update.

ICD-10 Basics: Unspecified Diagnosis Codes, CPT Codes, and Version 5010 Standards

HHS expects to release a 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 new compliance date would give providers an extra year to prepare. Now is a great time to brush up on ICD-10 basics as you get ready for the transition. If you missed the June 4 MLN Connects™ National Provider Call on “More ICD-10 Coding Basics,” a [written transcript and audio recording](#) are now available.

Unspecified Diagnosis Codes

In both ICD-9 and ICD-10, sign/symptom and “unspecified” diagnosis codes have acceptable, even necessary, uses. While specific diagnosis codes should be reported when they are supported by the available medical record documentation and clinical knowledge of the patient’s condition, there are instances when signs/symptoms or unspecified codes are the best choices for accurately reflecting the health care encounter. Each health care encounter should be coded to the level of certainty known for that encounter. If a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for sign(s) and/or symptom(s) in lieu of a definitive diagnosis. When sufficient clinical information isn’t known or available about a particular health condition to assign a more specific code, it is acceptable to report the appropriate “unspecified” code (e.g., a diagnosis of pneumonia has been determined, but not the specific type). In fact, unspecified codes should be reported when they are the codes that most accurately reflect what is known about the patient’s condition at the time of that particular encounter. It would be inappropriate to select a specific code that is not supported by the medical record documentation or to conduct medically unnecessary diagnostic testing in order to determine a more specific code.

CPT Codes

The transition to ICD-10 does not affect Current Procedural Terminology (CPT) coding for outpatient procedures. Like ICD-9 procedure codes, ICD-10 procedure codes (ICD-10-PCS) are for hospital inpatient procedures only.

Version 5010

You must be using [Version 5010 HIPAA standards](#) in order to conduct electronic transactions with ICD-10. The earlier, Version 4010 HIPAA standards cannot accommodate the longer ICD-10 codes. Most organizations began using Version 5010 in 2012, when compliance became mandatory under HIPAA. Any providers or organizations still using Version 4010 for electronic transactions are in violation of HIPAA. If you are not certain whether you are Version 5010-compliant, check with your health IT professional or your clearinghouse or billing service.

Find Out More About the Basics in the Road to 10

To find out more about ICD-10 basics and beyond—including how to build an action plan, update your processes, and test your readiness—check out the [Road to 10](#) resource for small medical practices, available on the [ICD-10](#) website.

Keep Up to Date on ICD-10

Visit the CMS [ICD-10](#) website for the latest news and resources to help you prepare. Sign up for [CMS ICD-10 Industry Email Updates](#) and [follow us](#) on Twitter.

MLN Educational Products

Summer 2014 Version of Medicare Learning Network Products Catalog Now Available

The [Summer 2014 version of the MLN Products Catalog](#) is now available. The Medicare Learning Network (MLN) Products Catalog is a free interactive downloadable document that links you to online versions of MLN products or the product ordering page for hardcopy materials. Once you have opened the catalog, you may either click on the title of an individual product or on “Formats Available.”

“Medically Unlikely Edits (MUE) and Bilateral Procedures” MLN Matters® Article — Released

[MLN Matters® Special Edition Article #SE1422](#), “Medically Unlikely Edits (MUE) and Bilateral Procedures” has been released and is now available in downloadable format. This article is designed to provide education on how to properly file claims for certain bilateral surgical procedures by using a -50 modifier and one unit of service (UOS). It includes background information and examples.

“Medicare Quarterly Provider Compliance Newsletter [Volume 4, Issue 4]” Educational Tool — Released

The “[Medicare Quarterly Provider Compliance Newsletter \[Volume 4, Issue 4\]](#)” Educational Tool (ICN 909012) 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.

“The Basics of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Accreditation” Fact Sheet — Revised

“[The Basics of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies \(DMEPOS\) Accreditation](#)” Fact Sheet, (ICN 905710) was revised and is now available in downloadable format. This fact sheet is designed to provide education on Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS). It includes information so suppliers can meet DMEPOS Quality Standards established by CMS and become accredited by a CMS-approved independent national Accreditation Organization (AO). There is also information on the types of providers who are exempt.

“Complying with Medicare Signature Requirements” Fact Sheet — Reminder

The “[Complying with Medicare Signature Requirements](#)” Fact Sheet (ICN 905364) is available in downloadable format. This fact sheet describes common Comprehensive Error Rate Testing (CERT) Program errors related to signature requirements and provides information on the documentation needed to support a claim submitted to Medicare for medical services and supplies. It also discusses options for dealing with illegible physician signatures.

“Medicare Enrollment Guidelines for Ordering/Referring Providers” Fact Sheet — Reminder

The “[Medicare Enrollment Guidelines for Ordering/Referring Providers](#)” Fact Sheet (ICN 906223) is available in downloadable format. This fact sheet is designed to provide education on the Medicare enrollment requirements for eligible ordering/referring providers. It includes information on the three basic requirements for ordering and referring and who may order and refer for Medicare Part A Home Health Agency, Part B, and Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) beneficiary services.

MLN Products Available in Electronic Publication Format

The following fact sheets are now available as electronic publications (EPUBs) and through QR codes. 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 [“Ambulatory Surgical Center Fee Schedule”](#) Fact Sheet (ICN 006819) is designed to provide education on the Ambulatory Surgical Center (ASC) Fee Schedule. It includes the following information: the definition of an ASC, ASC payment, how payment rates are determined, and Ambulatory Surgical Center Quality Reporting Program.
- The [“Telehealth Services”](#) Fact Sheet (ICN 901705) is designed to provide education on services furnished to eligible Medicare beneficiaries via a telecommunications system. It includes information about originating sites, distant site practitioners, telehealth services, billing and payment for professional services furnished via telehealth, billing and payment for the originating site facility fee, resources, and lists of helpful websites and Regional Office Rural Health Coordinators.

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