

Thursday, November 20, 2014

MLN Connects™ National Provider Calls

2015 Physician Fee Schedule Final Rule: Changes to Physician Quality Reporting Programs — Register Now

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

Certifying Patients for the Medicare Home Health Benefit — Register Now

New MLN Connects™ National Provider Call Audio Recording and Transcript

CMS Events

"Home Health Change of Care Notice and Advance Beneficiary Notice of Noncoverage" Webinar — Registration Open

Announcements

National Home Care and Hospice Month

Seasonal Influenza and Diabetes Awareness

Affordable Care Act and Health Care Coverage: CME Articles on Medscape

Prior Authorization Process for Repetitive, Scheduled, Non-Emergent Ambulance Transport

2013 QRURs Available

PEPPER Still Available for SNFs, Hospices, CAHs, LTCHs, IPFs, IRFs and PHPs

Distribution of 2012 PQRS Supplemental Incentive Payments

EHR Incentive Program: How to Report Once in 2014 for Medicare Quality Reporting Programs

EHR Incentive Programs: Summary of Care Meaningful Use Requirements in Stage 2

Medicare Learning Network® Educational Products

The Medicare Learning Network® Autumn 2014 Catalog — Released

"Revised Centers for Medicare & Medicaid Services (CMS) 855R Application – Reassignment of Medicare Benefits" MLN Matters® Article — Released

"Medicare Billing: 837I and Form CMS-1450" Fact Sheet — Revised

"Medicare Billing: 837P and Form CMS-1500" Fact Sheet — Revised

"Evaluation and Management Services Guide" Educational Tool — Revised

New Medicare Learning Network® Provider Compliance Fast Fact

Medicare Learning Network® Product Available in Electronic Publication Format

MLN Connects™ National Provider Calls

2015 Physician Fee Schedule Final Rule: Changes to Physician Quality Reporting Programs — Register Now

Tuesday, December 2; 1:30-3pm ET

To Register: Visit [MLN Connects Event Registration](#). Space may be limited, register early.

This MLN Connects™ National Provider Call provides an overview of changes to the Physician Quality Reporting Programs in the 2015 Physician Fee Schedule (PFS) [final rule](#), including the Physician Quality Reporting System (PQRS), Value-based Payment Modifier, Physician Compare, Electronic Health Record (EHR) Incentive Program, Comprehensive Primary Care Initiative (CPC), and Medicare Shared Savings Program. A question and answer session will follow the presentations.

PQRS: Topics covered include changes to reporting mechanisms, individual measures and measures groups for inclusion in 2015, criteria for satisfactory reporting under claims-based reporting, qualified registry-based reporting, and EHR-based reporting options. Additionally, this presentation will cover satisfactory participation under the qualified clinical data registry option to avoid future payment adjustments and requirements for eligible professionals wanting to report one time across several Medicare quality reporting programs.

Value-based Payment Modifier: Learn how CMS continues to phase in and expand the application of the Value-based Payment Modifier in 2017, based on performance in 2015. CMS will also describe how the Value-based Payment Modifier aligns with the reporting requirements under the PQRS.

Agenda:

- Final rule changes to PQRS individual reporting requirements and PQRS Group Practice Reporting Option
- Final Rule Updates to Physician Compare, the EHR Incentive Program, and Value-based Payment Modifier policies
- Where to call for help
- Question and Answer Session

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

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

Tuesday, December 9; 1:30-3pm ET

To Register: Visit [MLN Connects Event Registration](#). Space may be limited, register early.

During this MLN Connects™ National Provider Call, speakers will discuss innovative efforts from State-based Alzheimer's Association Chapters related to train-the-trainer programs, as well as the implementation of the Comfort First Approach in nursing homes. CMS subject matter experts will provide National Partnership updates and discuss next steps for the initiative. A question and answer session will follow the presentations.

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.

Agenda:

- Partnership updates
- Innovation through the Alzheimer's Association - Train the Trainer, Habilitation Therapy, and the Comfort First Approach
- 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.

Certifying Patients for the Medicare Home Health Benefit — Register Now

Tuesday, December 16; 1:30-3pm ET

To Register: Visit [MLN Connects Event Registration](#). Space may be limited, register early.

The CY 2015 Home Health Prospective Payment System [final rule](#) finalized a new patient certification requirement for home health agencies beginning January 1, 2015. During this MLN Connects™ National Provider Call, CMS subject matter experts will discuss the changes to the Medicare home health benefit, followed by a question and answer session.

Agenda:

- Benefit overview
- Patient eligibility
- Certification requirements, including the required face-to-face encounter
- Recertification requirements
- Resources
- Q&A session

Target Audience: Physicians who certify patients for the Medicare home health benefit, hospital/Skilled Nursing Facility discharge planners, non-physician practitioners who are allowed to perform Medicare home health face-to-face encounters, and home health agencies.

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 Audio Recording and Transcript

An audio recording and transcript are now available for the following call:

- November 5 — Transitioning to ICD-10, [audio](#) and [transcript](#). More information is available on the [call detail](#) web page.

CMS Events

"Home Health Change of Care Notice and Advance Beneficiary Notice of Noncoverage" Webinar — Registration Open

Monday, December 1; 2-4pm ET

This webinar is designed to provide information on use of the Home Health Change of Care Notice (HHCCN) and Advance Beneficiary Notice of Noncoverage (ABN) by home health care providers. Participants will learn how to:

- Recognize the legal basis for HHCCN and ABN issuance;
- Identify home health care situations that require notice issuance; and
- Recognize when to issue the HHCCN and ABN per CMS guidelines.

Registration Information:

- [To register](#)
- Continuing education credits will be available to learners who successfully complete this webinar
- For questions, please contact: CMSCE@cms.hhs.gov

Announcements

National Home Care and Hospice Month

November is National Home Care and Hospice Month. The Medicare Learning Network® offers the following publications to educate Medicare providers on coverage and payment for hospice and home health services:

- The “[Hospice Payment System](#)” Fact Sheet, (ICN 006817) is designed to provide education on the Medicare Hospice Payment System. It includes the following information: background, coverage of hospice services, certification requirements, election periods and election statements, how payment rates are set, patient coinsurance payments, caps on hospice payments, hospice option for Medicare Advantage enrollees, and quality reporting.
- The “[Hospice Related Services – Part B](#)” Podcast, (ICN 908995) is designed to provide education on the hospice benefit covered by the Medicare Program. It includes information on election, coverage, revoking the election of hospice, and correct use of the modifier on claims. Runtime: Approximately 6 minutes.
- The “[Home Health Prospective Payment System](#)” Fact Sheet, (ICN 006816) is designed to provide education on the Home Health Prospective Payment System (HH PPS). It includes the following information: background, consolidated billing requirements, criteria that must be met to qualify for home health services, coverage of home health services, elements of the HH PPS, updates to the HH PPS, and health care quality.
- The “[Quick Reference Information: Home Health Services](#)” Educational Tool, (ICN 908504) is designed to provide education on home health services. It includes the following information: qualifying for home health services, patient admission to a Home Health Agency, and payment and billing for home health services.

For more information on Home Care and Hospice Month, please visit the [National Association for Home Care & Hospice](#) website.

Seasonal Influenza and Diabetes Awareness

November is National Diabetes Month and also a time when flu activity usually increases. Even if diabetes is well managed, flu illness can cause serious complications for someone with diabetes. The Centers for Disease Control and Prevention (CDC) advises that now is an opportune time to take action to combat the flu. Health care providers are encouraged to get a flu vaccine to help protect themselves from the influenza and to keep from spreading it to their family, co-workers, and patients. In addition, now is the perfect time for providers to vaccinate Medicare beneficiaries, as it can take 2 weeks after vaccination to develop antibodies that protect

against seasonal influenza. Influenza vaccination is especially important for Medicare beneficiaries who suffer from diabetes, due to a weakened immune system and increased susceptibility to respiratory infections such as influenza and pneumonia.

As a health care provider, you play an important role in setting an example by getting yourself vaccinated, and recommending and promoting influenza vaccination. The CDC recommends that you assess vaccination status with each patient visit, encourage seasonal influenza vaccination, and vaccinate or refer to a vaccine provider when appropriate.

Generally, Medicare Part B covers one influenza vaccination and its administration per influenza season for Medicare beneficiaries without co-pay or deductible. *Note:* The influenza vaccine is not a Part D-covered drug.

For more information on coverage and billing of the influenza vaccine and its administration, visit:

- [MLN Matters® Article #MM8890](#), “Influenza Vaccine Payment Allowances - Annual Update for 2014-2015 Season.”
- [MLN Matters® Article #SE1431](#), “2014-2015 Influenza (Flu) Resources for Health Care Professionals.”
- CDC [Influenza \(Flu\)](#) web page for the latest information on flu including the CDC 2014-2015 recommendations for the prevention and control of influenza.
- While some providers may offer flu vaccines, those that don’t can help their patients locate flu vaccines within their local community. The [HealthMap Vaccine Finder](#) is a free online service where users can search for locations offering flu and other adult vaccines. If you provide vaccination services and would like to be included in the HealthMap Vaccine Finder database, [register](#) for an account to submit your information in the database.

Affordable Care Act and Health Care Coverage: CME Articles on Medscape

Gain credits from CME articles that focus on how the Affordable Care Act has impacted health care coverage—especially with the availability of the Health Insurance Marketplace. All articles are available on [Medscape.edu](#). CMEs are also Nursing accredited. To view the articles, you must be a registered Medscape user. There is no cost to join. Links to the articles are also available through the CMS [Earn Credit](#) web page.

- [Talking with patients about the Affordable Care Act: why insurance matters](#): Summarizes the importance of insurance and gives providers answers for patients enquiring about insurance and the Marketplace.
- [Talking with patients about the Affordable Care Act: preventive services for the family](#): Summarizes the importance of preventive health care for provider conversations. Diabetes screening, depression screening, and women’s preventive care are highlighted.
- [Talking with patients about the Affordable Care Act: protecting access to care for serious illness](#): Summarizes protections that can help your patients, such as lifetime and yearly limits, equal coverage for pre-existing conditions, and clinical trial participation coverage.
- [Talking with patients about the Affordable Care Act: coverage to care](#): Helps prepare providers for interacting with the newly insured, who might not have had insurance previously. Focus areas are the consumer interaction points and helpful topics to discuss with new patients. Also includes a patient checklist of common screenings and preventive services.
- [Talking with patients about the Affordable Care Act: immunization coverage](#): Shares immunization coverage under the Affordable Care Act, vaccine coverage programs, and frequently asked questions that providers could encounter on vaccines and immunizations. Also includes immunization schedules for children, teens, and adults.
- [Talking with patients about the Affordable Care Act: making the most of the Marketplace](#): Helps providers answer questions they might get from patients on the Marketplace. This article is a good resource for talking with patients who struggle with health care costs to remove that barrier to care. Also

includes a patient handout to help them apply for Children's Health Insurance Program (CHIP) or Medicaid through the Marketplace.

- [Your patients & you: test your knowledge on the Affordable Care Act](#): A great resource for providers looking for one CME to learn more about the Affordable Care Act and its impact. The CME covers the Marketplace, Small Business Health Options Program (SHOP), individual impact and tax credits, consumer protections, Essential Health Benefits (EHBs), covered preventive services, insurance market reforms, clinical trial coverage, and the impact on Medicare or Medicaid.

Prior Authorization Process for Repetitive, Scheduled, Non-Emergent Ambulance Transport

On November 13, CMS announced the start date of the [prior authorization process](#) for repetitive, scheduled, non-emergent ambulance transport. CMS seeks to use this process to address growing concerns about beneficiaries receiving non-medically necessary repetitive scheduled non-emergent ambulance transport services. New Jersey, Pennsylvania, and South Carolina were selected for initial implementation of this process because of their high utilization and improper payment rates for these services.

2013 QRURs Available

On September 30, CMS made 2013 Quality and Resource Use Reports (QRURs) available to group practices and physician solo practitioners nationwide. The 2013 QRURs contain quality and cost performance data for CY 2013, which is the performance period for the Value-Based Payment Modifier (VM) that will be applied to physician payments for items and services furnished under the Medicare Physician Fee Schedule for groups of 100 or more eligible professionals in 2015. The 2013 QRURs are intended to provide clinically meaningful and actionable information that can be used to plan for improving the quality and efficiency of care provided to Medicare beneficiaries and also to understand and improve performance on quality and cost measures for the 2016 VM. The 2013 QRURs include data assessing a group practice or solo practitioner's performance on cost measures, information about the services and procedures contributing most to beneficiaries' costs, as well as performance on quality measures including performance on three outcome measures.

Authorized representatives of groups and solo practitioners can access the QRURs at <https://portal.cms.gov>, using a valid Individuals Authorized Access to the CMS Computer Services (IACS) User ID and password. An authorized representative of a group must obtain an IACS account with one of the following group-specific Physician Value-Physician Quality Reporting System (PV-PQRS) system roles:

- PV-PQRS Group Security Official (primary or back-up)
- PV-PQRS Group Representative

A solo practitioner or an authorized representative of a solo practitioner must obtain an IACS account with one of the following individual-specific PV-PQRS System roles:

- PV-PQRS Individual Practitioner
- PV-PQRS Individual Practitioner Representative

Quick reference guides that provide step-by-step instructions for requesting each PV-PQRS system role for a new or existing IACS account are available in the "Downloads" section on the [Self Nomination/Registration](#) web page. Visit the [2013 QRUR](#) and the [How to Obtain the 2013 QRUR](#) web pages for more information on the 2013 QRURs.

PEPPER Still Available for SNFs, Hospices, CAHs, LTCHs, IPFs, IRFs and PHPs

In April and May of 2014 TMF Health Quality Institute completed the most recent Program for Evaluating Payment Patterns Electronic Report (PEPPER) release (version Q4FY13) for Skilled Nursing Facilities (SNFs), hospices, Critical Access Hospitals (CAHs), Long-Term Acute Care Hospitals (LTCHs), Inpatient Psychiatric Facilities (IPFs), Inpatient Rehabilitation Facilities (IRFs), and Partial Hospitalization Programs (PHPs). The following providers can continue to access their PEPPER electronically through the [Secure PEPPER Access](#) web page at [PEPPERresources.org](#):

- LTCHs
- Free-standing IRFs (not a unit of a short-term acute care hospital)
- Hospices
- PHPs not associated with a short-term acute care hospital or with an IPF
- SNFs that are not a swing-bed unit of a short-term acute care hospital

The following providers received their PEPPER in mid-April through a My QualityNet secure file exchange to QualityNet Administrators and user accounts with the PEPPER recipient role:

- CAHs
- IPFs
- IRF distinct part units of a short-term acute care hospital
- PHPs administered by a short-term acute care hospital or an IPF
- SNF swing-bed units of a short-term acute care hospital

TMF is contracted with CMS to produce and distribute the PEPPER. Visit [PEPPERresources.org](#) for more information on obtaining PEPPER and to access resources for using PEPPER, including PEPPER user guides and recorded training sessions. Questions about PEPPER or requests for assistance may be submitted through the [Help Desk](#).

Distribution of 2012 PQRS Supplemental Incentive Payments

The 2012 Physician Quality Reporting System (PQRS) Supplemental Incentives have begun to be distributed to eligible professionals who submitted data for the reporting period of January 1, 2012 through December 31, 2012 and met criteria for satisfactory reporting. 2012 PQRS Supplemental Incentives will be provided to those eligible professionals who submitted a PQRS informal review request that was approved by CMS. The incentive is 0.5% of total estimated 2012 Medicare Part B Physician Fee Schedule allowed charges for covered professional services furnished during reporting period.

- Paid as lump sum to the Taxpayer Identification Number (TIN) under which the eligible professional's claims were submitted.
- PQRS incentive payments will also include an additional 0.5% for the Maintenance of Certification Program Incentive, if applicable.

If needed, please contact the QualityNet Help Desk for assistance at 866-288-8912 (TTY 877-715-6222) or via qnet-support@hcqis.org from 7am to 7pm CT Monday through Friday.

EHR Incentive Program: How to Report Once in 2014 for Medicare Quality Reporting Programs

Providers participating in the 2014 Physician Quality Reporting System (PQRS) program may be eligible to report their quality data one time only to earn credit for multiple Medicare quality reporting programs. Individual eligible professionals and group practices will be able to report once on a single set of clinical quality measures (CQMs) and satisfy some of the various requirements of several of the following programs, depending on eligibility:

- PQRS
- Value-Based Payment Modifier (VM)

- Medicare Electronic Health Record (EHR) Incentive Program
- Medicare Shared Savings Program Accountable Care Organization (ACO)
- Pioneer ACO
- Comprehensive Primary Care Initiative (CPCI)

CMS aligned some of the reporting requirements for these programs starting in 2014 to reduce the burden of data collection. Those eligible professionals who choose to report once will reap several benefits:

- Earn the 2014 PQRS incentive and avoid the 2016 PQRS payment adjustment.
- Satisfy the CQM requirements of the Medicare EHR Incentive Program.
- Satisfy requirements for the 2016 VM, ACO, and/or CPCI, if eligible.

Note: aligned reporting options are only available to eligible professionals beyond their first year of participation in the Medicare EHR Incentive Program.

How to Report Once

Individual eligible professionals and group practices must submit a full year (January 1 through December 31, 2014) of data to receive credit for the various programs. The following resources will help explain how providers can report their quality data one time for 2014 participation in applicable quality programs:

- [Reporting Once Interactive Tool](#): Provides reporting guidance based on how the eligible professional plans to participate in PQRS in 2014.
- [eHealth University Reporting Once Module](#): Explains how to report quality measures one time during the 2014 program year and satisfy quality reporting requirements PQRS, the Medicare EHR Incentive Program, the VM, and ACOs.
- [2014 CQM Electronic Reporting Guide](#): Provides an overview of 2014 CQMs and options for reporting them to CMS.

2014 QRDA III SEVT Testing Available

The Submission Engine Validation Tool (SEVT) for 2014 Quality Reporting Document Architecture (QRDA) III submission is available on the [QualityNet Portal](#). CMS recommends QRDA submitters and certified EHR technology vendors use this tool for 2014 submission testing. For more information about CQMs visit the [CQM Basics](#) web page.

EHR Incentive Programs: Summary of Care Meaningful Use Requirements in Stage 2

If you are an eligible provider participating in the Electronic Health Record (EHR) Incentive Programs, you will have the option of reporting the Summary of Care menu objective in [Stage 1](#), but will be required to meet the core objective in [Stage 2](#).

Guidance for Meeting Measure #2

For Measure #2 of the Stage 2 Summary of Care objective, an eligible professional, eligible hospital, or Critical Access Hospital (CAH) may count a transition of care or referral in its numerator for the measure if they electronically create and send a summary of care document when a third party organization is involved so long as:

- The summary of care document is created using Certified EHR Technology (CEHRT);
- The summary of care document electronically transmitted by the eligible professional, eligible hospital, or CAH to the third party organization is done so using either: Their CEHRT's transport standard capability; or an exchange facilitated by an organization that is an eHealth Exchange participant.
- The third party organization can confirm for the sending provider that the summary of care document was ultimately received by the next provider of care.

In instances where a "third party organization that plays a role in determining the next provider of care and ultimately delivers the summary of care document" is involved, the service the third party provides does not

have to be certified for the transmission to be counted in the numerator for Measure #2. Nor are there any specific requirements around the technical standards or methods by which the third party delivers the summary of care document to the receiving provider.

For More Information

For more information, read the [updated FAQ](#). For additional Stage 2 resources, visit the [Stage 2](#) web page.

Medicare Learning Network[®] Educational Products

The Medicare Learning Network[®] Autumn 2014 Catalog — Released

The Medicare Learning Network[®] [Autumn 2014 Catalog](#) is now available. In this latest edition, you will find all the products and services now available through the Medicare Learning Network. The Catalog is a free, interactive, downloadable document that links you to online versions of Medicare Learning Network products, services, and 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” to quickly access the material you have selected.

“Revised Centers for Medicare & Medicaid Services (CMS) 855R Application – Reassignment of Medicare Benefits” MLN Matters[®] Article — Released

[MLN Matters[®] Article #SE1432](#), “Revised Centers for Medicare & Medicaid Services (CMS) 855R Application – Reassignment of Medicare Benefits” was released and is now available in downloadable format. This article is designed to provide education on the revised CMS 855R application, which physicians, non-physician practitioners, providers, and suppliers must begin using on June 1, 2015. It includes information on how the form has changed and when it will be available for use on the CMS website.

“Medicare Billing: 837I and Form CMS-1450” Fact Sheet — Revised

The “[Medicare Billing: 837I and Form CMS-1450](#)” Fact Sheet (ICN 006926) was revised and is now available in downloadable format. This fact sheet is designed to provide education on electronic and paper claims for institutional providers as well as other health care professionals and suppliers. It includes information about Medicare claims submissions, coding, submitting accurate claims, when Medicare will accept a hard copy claim form, and timely filing.

“Medicare Billing: 837P and Form CMS-1500” Fact Sheet — Revised

The “[Medicare Billing: 837P and Form CMS-1500](#)” Fact Sheet (ICN 006976) was revised and is now available in downloadable format. This fact sheet is designed to provide education on electronic and paper claims for health care professionals and suppliers. It includes information about Medicare claims submissions, coding, submitting accurate claims, when Medicare will accept a hard copy claim form, timely filing, and where to submit Fee-For-Service (FFS) claims.

“Evaluation and Management Services Guide” Educational Tool — Revised

The “[Evaluation and Management Services Guide](#)” Educational Tool (ICN 006764) was revised and is now available in downloadable format. This guide is designed to provide education on evaluation and management services. It includes the following information: medical record documentation, evaluation and management billing and coding considerations, the “1995 Documentation Guidelines for Evaluation and Management Services,” and the “1997 Documentation Guidelines for Evaluation and Management Services.”

New Medicare Learning Network[®] Provider Compliance Fast Fact

A new Fast Fact is now available on the [MLN Provider Compliance](#) web page. This web page provides the latest [Medicare Learning Network[®] 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.

Medicare Learning Network[®] Product Available in Electronic Publication Format

The following product 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.](#)”

The “[Medicare Disproportionate Share Hospital](#)” Fact Sheet (ICN 006741) is designed to provide education on Medicare Disproportionate Share Hospitals (DSHs). It includes the following information: background; methods to qualify for the Medicare DSH adjustment; Affordable Care Act provision that impacts Medicare DSHs; Medicare Prescription Drug, Improvement, and Modernization Act provisions that impact Medicare DSHs; number of beds in hospital determination; Medicare DSH payment adjustment formulas; resources; and lists of helpful websites and Regional Office Rural Health Coordinators.

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