

Wednesday, November 26, 2014

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## **MLN Connects™ National Provider Calls**

**2015 Physician Fee Schedule Final Rule: Changes to Physician Quality Reporting Programs — Last Chance to Register**

*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.

## **CMS Events**

### **"Home Health Change of Care Notice and Advance Beneficiary Notice of Noncoverage” Webinar — Reminder**

*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](mailto:CMSCE@cms.hhs.gov)

## Announcements

### In Observance of World AIDS Day — Remember HIV Screenings

December 1st is World AIDS Day, a day observed each year to raise awareness of the global impact of HIV/AIDS, show support for people living with the disease, and remember those who have died. A growing number of older people now have HIV/AIDS. Almost one-fifth of all people with HIV/AIDS in this country are age 55 and older. Some key points regarding older populations and HIV/AIDS risk are:

- Many widowed and divorced people are dating again, and they may be less knowledgeable about HIV than younger people and less likely to protect themselves.
- Older people are less likely than younger people to discuss past sexual activity or drug use with their doctors.
- Doctors are less likely to ask older patients about their sex lives or drug use or discuss activities that might expose their older patients to HIV/AIDS risks.
- Stigma is a particular concern among older Americans because they may already face isolation due to illness or loss of family and friends. Stigma negatively affects people's quality of life, self-image, and behaviors and may prevent them from seeking HIV care and disclosing their HIV status.

CMS encourages healthcare providers to have a conversation with their Medicare patients about the importance of HIV prevention and screening. [Read more.](#)

### CMS Creates New Chief Data Officer Post

On November 19, CMS announced the formation of the Office of Enterprise Data and Analytics (OEDA) which will be led by Niall Brennan, the agency's first Chief Data Officer (CDO), and tasked with overseeing improvements in data collection and dissemination, as the agency strives to be more transparent. OEDA will help CMS better harness its vast data resources to guide decision-making and develop frameworks promoting appropriate external access to and use of data to drive higher quality, patient-centered care at a lower cost.

CMS collects a wealth of data that is critical to decision making for the agency and other stakeholders in the nation's health care system. CMS generates data administering the Medicare, Medicaid, and Children's Health Insurance Program (CHIP) programs. In addition, new responsibilities, including stewardship of the Electronic Health Record (EHR) Incentive Programs, more expansive quality measurement programs, and the establishment of the Health Insurance Marketplaces, have expanded the scope of data that CMS collects. As CMS works to shift the focus from volume of services to better health outcomes for patients, coordinating care, and spending dollars more wisely, the need for CMS to analyze data across its multiple programs and provide greater access to this data, whether in granular or aggregate form, will only intensify.

The creation of this new post and the data and analytics office builds on the steps CMS has taken in recent years to better harness its data resources both internally and externally. CMS is now routinely analyzing claims data in real time and applying predictive analytics to proactively identify fraud and abuse and track key metrics, such as hospital readmissions. Accountable Care Organizations and State Medicaid agencies receive monthly near real-time feeds of Medicare data to support care coordination. CMS has launched the Virtual Research Data Center to facilitate lower cost access to CMS data for researchers and federal grantees. CMS has also released

numerous public use datasets; the most notable releases to date include the release of data on hospital charges and physician utilization in 2013 and 2014.

Full text of this excerpted [CMS press release](#) (issued November 19).

## **Get Ready for DMEPOS Competitive Bidding**

The Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program Round 2 Recompete and the national mail-order recompete competitions are coming soon. Detailed information is available on the [CMS](#) website.

*If you are a supplier interested in bidding, prepare now – don't wait.*

If you haven't already, please do the following:

- Review and update your enrollment records
- Get licensed
- Get accredited

The Competitive Bidding Implementation Contractor (CBIC) is the official information source for bidders and bidder education. CMS cautions bidding suppliers about potential inaccurate information concerning the Competitive Bidding Program posted on non-government websites. Suppliers that rely on this information in the preparation or submission of their bids could be at risk of submitting a non-compliant bid. Visit the [CBIC](#) website to:

- Find a listing of the product categories, competitive bidding areas, timeline, and other bidding information
- View a schedule of educational events
- Register to receive email updates

If you have any questions or need assistance, please contact the CBIC customer service center at 877-577-5331 between 9am and 5:30pm ET, Monday through Friday.

## **EHR Incentive Programs: Hardship Exception Applications due November 30**

CMS reopened the submission period for hardship exception applications for eligible professionals and eligible hospitals to avoid the [2015 Medicare payment adjustments](#) for not demonstrating meaningful use of Certified Electronic Health Record Technology (CEHRT) for the Electronic Health Record (EHR) Incentive Programs. The deadline is *11:59pm ET November 30, 2014*.

Eligible professionals and eligible hospitals that have never met meaningful use before may apply during this reopened [hardship exception application](#) submission period if they meet both of the following:

- The provider was unable to attest by July 1, 2014 (for eligible hospitals) or October 1, 2014 (for eligible professionals); *and*
- The provider has been unable to fully implement 2014 Edition CEHRT by the dates above due to delays in 2014 Edition CEHRT availability.

These are the only circumstances that will be considered for this reopened hardship exception application submission period.

### *Applications Details*

Providers who would like to submit an application should review the following guidance:

- The application is available on the [Payment Adjustments and Hardship Exceptions](#) web page.
- The completed application must be attached to an email and sent to [ehrhardsip@provider-resources.com](mailto:ehrhardsip@provider-resources.com).
- For eligible professionals without Internet connectivity, submit this application and all supporting documentation via fax to 814-464-0147.

## New EHR Attestation Deadline for Eligible Hospitals: December 31

CMS is extending the deadline for eligible hospitals and Critical Access Hospitals (CAHs) to attest to meaningful use for the Medicare Electronic Health Record (EHR) Incentive Program 2014 reporting year from 11:59pm ET on November 30, 2014 to 11:59pm ET on December 31, 2014. This extension will allow more time for hospitals to submit their meaningful use data and receive an incentive payment for the 2014 program year, as well as avoid the 2016 Medicare payment adjustment. CMS is also extending the deadline for eligible hospitals and CAHs that are electronically submitting clinical quality measures (CQMs) to meet that requirement of meaningful use and the Hospital Inpatient Quality Reporting (IQR) program. Hospitals now have until December 31, 2014 to submit their eCQM data via [Quality Net](#). *Note:* This extension does not impact the deadlines for the Medicaid EHR Incentive Program.

### *How to attest?*

Medicare eligible hospitals and CAHs will use the [Registration and Attestation System](#) to submit their attestation for meaningful use for the 2014 reporting year. The [system](#) is open and fully operational, and includes the [2014 Certified EHR Technology \(CEHRT\) Flexibility Rule](#) options. Medicare eligible hospitals and CAHs can attest any time to 2014 data until 11:59pm ET on December 31, 2014 to meet the new 2014 program deadline.

### *Attestation Tips*

Here are some steps to help make the attestation process easier:

- Consider logging on to use the attestation system during non-peak hours, such as evenings and weekends
- Log on to the registration and attestation system now and ensure that your information is up to date and begin entering your 2014 data
- If you experience attestation problems, call the EHR Incentive Program Help Desk and report the problem
- *Reminder:* Medicare eligible hospitals must attest to demonstrating meaningful use *every year* to receive an incentive and avoid a payment adjustment.

### *2016 Payment Adjustments*

Payment adjustments will be applied at the beginning of FY 2016 (October 1, 2015) for Medicare eligible hospitals that have not successfully demonstrated meaningful use in 2014. Read the eligible hospital [payment adjustment tipsheet](#) to learn more. *Note:* CAHs have a different payment adjustment schedule than Medicare eligible hospitals. Review the [CAH payment adjustment and hardship exception tipsheet](#).

### *Resources*

The EHR Information Center is open to assist you with all of your registration and attestation system inquiries at 888-734-6433 or TTY: 888-734-6563, Monday through Friday from 7:30am through 6:30pm CT, except federal holidays. Attestation resources are available on the [Educational Resources](#) web page.

## Claims, Pricers, and Codes

## Hospice Notices Returned to Provider

The FY 2015 Hospice Final Rule and hospice manual update provided new instructions regarding filing hospice Notices of Termination / Revocation (NOTRs), effective October 1, 2014. If a hospice beneficiary is discharged alive or if a hospice beneficiary revokes the election of hospice care, the hospice will file a timely NOTR, using type of bill 8xB, unless it has already filed a final claim. A timely-filed NOTR is a NOTR that is submitted to and accepted by the Medicare Administrative Contractor within 5 calendar days after the effective date of discharge or revocation.

Currently, Medicare systems require that the discharge or revocation date on a NOTR falls within a posted hospice benefit period. Benefit periods are only posted in response to a Notice of Election or to subsequent claims, not in response to the NOTR. In some cases, the discharge or revocation date would fall in a new benefit period but no claims have caused the new benefit period to be posted. In these cases, Medicare systems return the NOTR to the provider with Common Working File (CWF) error codes U5109 or U5114. Medicare is assessing how to correct this system limitation.

In the interim, Medicare considers hospices to have met the filing requirement of a timely-filed NOTR if the NOTRs that they submit are returned for the reason described above. Hospices should file the claim that establishes the current benefit period as soon as possible. The final claim reporting the discharge or revocation can be submitted as soon as the benefit period is posted to CWF. If the final claim is delayed, the NOTR should be resubmitted.

For more information, see [MLN Matters® Article MM8877](#), “Hospice Manual Update for Diagnosis Reporting and Filing Hospice Notice of Election (NOE) and Termination or Revocation of Election.”

## MA Claims Issue for FQHCs that Bill Under the AIR System

CMS is aware of a system issue with Medicare Advantage (MA) claims submitted by Federally Qualified Health Centers (FQHCs) that bill under the All-Inclusive Rate (AIR) system. These claims are editing incorrectly and are currently being held by your Medicare Administrative Contractor (MAC).

A system fix is scheduled for December 5, 2014 to correct this issue. Once implemented, your MAC will release all affected claims to complete the processing. This system issue does not affect MA claims submitted by FQHCs that are authorized to bill under the FQHC Prospective Payment System. Please contact your [MAC](#) with any questions.

## Medicare Learning Network® Educational Products

### “Hospice Related Services – Part B” Podcast — Revised

The “[Hospice Related Services - Part B](#)” Podcast was revised and is now available. This podcast 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.

### New Medicare Learning Network® Educational Web Guides Fast Fact

A new fast fact is now available on the [Medicare Learning Network® 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.

### **Submit Your Feedback on the Medicare Learning Network<sup>®</sup> Learning Management System and Product Ordering System**

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### **Medicare Learning Network<sup>®</sup> Product Available in Electronic 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<sup>®</sup> Electronic Publication](#).”

The “[HIPAA Privacy and Security Basics for Providers](#)” Fact Sheet (ICN 909001) is designed to provide education on basic HIPAA privacy and basic HIPAA security information for providers. It includes information on covered entities, business associates, and the disposal of private health information.

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