MLN Connects™
Provider eNews

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Thursday, December 4, 2014

MLN Connects™ National Provider Calls

National Partnership to Improve Dementia Care in Nursing Homes — Last Chance to Register

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.

MLN Connects™ Videos

Monthly Spotlight: Physician Feedback Program/Value-based Payment Modifier

Want to learn more about the Physician Feedback Program/Value-based Payment Modifier? Watch The CMS Value-Based Payment Modifier: What Medicare Eligible Professionals Need to Know in 2014, 6/6/14 video. This MLN Connects™ video presentation provides an overview of the value-based payment modifier and how it relates to the Physician Quality Reporting System (PQRS), so Medicare physicians will understand how the value modifier can affect Medicare reimbursement starting in 2015. This presentation educates healthcare professionals on a variety of topics that are essential to the value-based payment modifier. It also provides a walkthrough of a very detailed decision tree that has been created to help providers ask the necessary questions to determine how the value modifier in 2016 will be affected by their PQRS participation this year. Run time: Approximately 50 minutes.

Continuing education credit is available for viewing this video. Refer to the video detail web page for more information.

Be sure to visit the Physician Feedback Program/Value-Based Payment Modifier website for the most up-to-date program information. For a list of other available MLN Connects videos, visit the Medicare Learning Network® Playlist on the CMS YouTube Channel. MLN Connects videos are a part of the Medicare Learning Network.

CMS Events

Webinar for Comparative Billing Report on Modifier 25: Family Practice

Wednesday, December 10; 3-4:30pm ET

Join us for an informative discussion of the comparative billing report on Modifier 25: Family Practice (CBR201409). The presentation will be provided by CMS contractor eGlobalTech and its partner, Palmetto GBA. CBR201409 is an educational tool designed to assist family practice physicians who submitted claims for evaluation and management (E/M) services appended with Modifier 25.

Agenda:

- Opening Remarks
- Overview of Comparative Billing Report (CBR201409)
- Coverage Policy for Modifier 25
- Methods and Results
- Resources
- Question & Answer Session

Presenter Information:

- Speakers: Cheryl Bolchoz, Cyndi Wellborn, Molly Wesley
- Organizations: eGlobalTech and Palmetto GBA

How to Register and Event Replay:

- Register online
- You may access a recording of the webinar five days following the event

Announcements

National Influenza Vaccination Week – December 7-13

National Influenza Vaccination Week (NIVW) is December 7-13. This national health observance was established by the Centers for Disease Control and Prevention (CDC) to highlight the importance of continuing influenza vaccination through the holiday season and beyond. Historically, seasonal flu vaccination drops significantly after the end of November. Influenza activity usually peaks between December and February and can last as late as May. As long as influenza viruses are circulating and causing illness, vaccination can provide protection against the flu and should continue to be encouraged. While patients are engaged in holiday mode, they may need to be reminded that if they haven't gotten their seasonal flu shot that now is a great time for almost everyone (6 months and older) to get a flu vaccine to protect themselves and their loved ones from flu.

Another goal of NIVW is to communicate the importance of flu vaccination for people at high risk for developing flu-related complications like pneumonia, or worsening of existing health conditions that can lead to hospitalization or death. Young children; pregnant women; people with certain chronic health conditions, such as asthma, diabetes, or heart and lung disease; and people age 65 years and older, are all considered high risk. Refer to CDC's "People at High Risk of Developing Flu-Related Complications" for more information. Read more.

CMS Releases New Proposal to Improve Accountable Care Organizations

Shared Savings Program Proposed Rule reflects focus on primary care and improved incentives for participation, quality, and efficiency

On December 1, CMS released a proposal to strengthen the Shared Savings Program (SSP) for Accountable Care Organizations (ACOs) through a greater emphasis on primary care services and promoting transitions to performance-based risk arrangements. The proposed rule reflects input from program participants, experts, consumer groups, and the stakeholder community at large. CMS is seeking to continue this important dialogue to ensure that the Medicare SSP ACOs are successful in providing seniors and people with disabilities with better care at lower costs.

Through the Affordable Care Act, ACOs encourage doctors, hospitals and other health care providers to work together to better coordinate care when people are sick and keep people healthy, which helps to reduce growth in health care costs and improve outcomes. ACOs become eligible to share savings with Medicare when they deliver that care more efficiently, while meeting or exceeding performance benchmarks for quality of care. The SSP now includes more than 330 ACOs in 47 states, providing care to more than 4.9 million beneficiaries in Medicare Fee-For-Service.

CMS is seeking comment on a number of adjustments to improve the Medicare SSP, including:

- Providing more flexibility for ACOs seeking to renew their participation in the program
- Encouraging ACOs to take on greater performance-based risk and reward
- Emphasis on primary care
- Alternative methodologies for benchmarks
- Streamlining data sharing and reducing administrative burden

For more information:

- Fact Sheet
- Proposed Rule
- Comments may be submitted at http://www.regulations.gov/

Full text of this excerpted CMS press release (issued December 1).

Efforts to Improve Patient Safety Result in 1.3 Million Fewer Patient Harms, 50,000 Lives Saved and $12 Billion in Health Spending Avoided

Hospital-acquired conditions decline by 17 percent over a three-year period

A report released by HHS on December 2 shows an estimated 50,000 fewer patients died in hospitals and approximately $12 billion in health care costs were saved as a result of a reduction in hospital-acquired conditions from 2010 to 2013. This progress toward a safer health care system occurred during a period of concerted attention by hospitals throughout the country to reduce adverse events. The efforts were due in part to provisions of the Affordable Care Act, such as Medicare payment incentives to improve the quality of care and the HHS Partnership for Patients initiative. Preliminary estimates show that in total, hospital patients experienced 1.3 million fewer hospital-acquired conditions from 2010 to 2013. This translates to a 17 percent decline in hospital-acquired conditions over the three-year period.

This data represent demonstrable progress over a three-year period to improve patient safety in the hospital setting, with the most significant gains occurring in 2012 and 2013. According to preliminary estimates, in 2013 alone, almost 35,000 fewer patients died in hospitals, and approximately 800,000 fewer incidents of harm occurred, saving approximately $8 billion.

Hospital-acquired conditions include adverse drug events, catheter-associated urinary tract infections, central line associated bloodstream infections, pressure ulcers, and surgical site infections, among others. The HHS Agency for Healthcare Research and Quality (AHRQ) analyzed the incidence of a number of avoidable hospital-acquired conditions compared to 2010 rates and used as a baseline estimate of deaths and excess health care costs that were developed when the Partnership for Patients was launched. The results update the data showing improvement for 2012 that were released in May.

AHRQ has produced a variety of tools and resources to help hospitals and other providers prevent hospital-acquired conditions, such as reducing infections, pressure ulcers, and falls. The tools and resources include the Comprehensive Unit-based Safety Program, the Re-Engineered Discharge Toolkit, TeamSTEPPS®, and more. HHS will continue working with partners to capitalize on these promising results and continue on the path of improving patient safety and reducing health care costs, while providing the best, safest possible care to patients.

Additional Information:

- Interim Update on 2013 Annual Hospital-Acquired Condition Rate and Estimates of Cost Savings and Deaths Averted from 2010 to 2013
- May 2014 patient safety results report
- Partnership for Patients Preliminary Evaluation Report

Full text of this excerpted HHS press release (issued December 2).

Provider Enrollment Application Fee Amount for CY 2015

On December 2, CMS issued a notice: Provider Enrollment Application Fee Amount for Calendar Year 2015 (CMS-6056-N, effective January 1, 2015.This notice announces a $553.00 CY 2015 application fee for institutional providers that are initially enrolling in the Medicare or Medicaid program or the Children's Health Insurance Program (CHIP); revalidating their Medicare, Medicaid, or CHIP enrollment; or adding a new

Medicare practice location.This fee is required with any enrollment application submitted on or after January 1, 2015 and on or before December 31, 2015

CMS is Accepting Suggestions for Potential 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 may also 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.).

The PQRS Call for Measures is now conducted in an ongoing open format, remaining open indefinitely. The month that a measure is submitted for consideration will determine when it may be included on the Measures Under Consideration (MUC) list. Measures submitted prior to June 15, 2015 may be considered for inclusion on the 2015 MUC list for implementation in PQRS as early as 2017.

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. 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. Note that measures already included in previous PQRS MUC lists may only be re-submitted for consideration if the measure has undergone substantive changes.

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 Questions about this Call for Measures or the required documentation may be submitted to C4M@wvmi.org.

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 Measures Application Partnership (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.

Claims, Pricers, and Codes

ICD-10 MS-DRGs v32 Software Now Available

ICD-10 Medicare Severity - Diagnosis Related Groups (MS-DRGs) v32 Grouper and Medicare Code Editor (MCE) software for mainframe and PC is now available from the National Technical Information Service. Ordering information is posted on the MS-DRG Conversion Project web page in the “Related Links” section. The MS-DRG v32 Definitions Manual and MCE files in text and HTML formats are also posted on this web page.

These files and software represents the ICD-10 version of the MS-DRGs v32, which are based on ICD-9-CM codes. The ICD-10 MS-DRGs v33, which will be implemented on October 1, 2015, will be subject to formal rulemaking as part of the Inpatient Prospective Payment System proposed rule.

Inpatient PPS FY 2014.8 PC Pricer Updated

The FY 2014 Inpatient Prospective Payment System (PPS) PC Pricer has been updated. The latest version is now available on the Inpatient PPS PC Pricer web page in the "Downloads" section.

Clarification of Specialty Care Transport Payment Policy for Ambulance Transportation Services

Specialty Care Transport (SCT) under the Fee Schedule for Ambulance Services is defined in 42 CFR §414.605 as an interfacility transportation of a critically injured or ill beneficiary by a ground ambulance vehicle, including medically necessary supplies and services, at a level of service beyond the scope of the Emergency Medical Technician (EMT)–Paramedic. SCT is necessary when a beneficiary's condition requires ongoing care that must be furnished by one or more health professionals in an appropriate specialty area, for example, nursing, emergency medicine, respiratory care, cardiovascular care, or a paramedic with additional training. In the December 1, 2006 Final Rule (71 FR 69716), CMS expanded the definition of "interfacility" to include both hospitals and skilled nursing facilities (SNFs). CMS considers a "facility" to include only a SNF or a hospital that participates in the Medicare program, or a hospital-based facility that meets our requirements for provider-based status as specified at 42 CFR §413.65. Medicare hospitals include, but are not limited to, rehabilitation hospitals, cancer hospitals, children's hospitals, psychiatric hospitals, Critical Access Hospitals (CAHs), inpatient acute care hospitals, and Sole Community Hospitals (SCHs).

Medicare Learning Network® Educational Products

"Affordable Care Act Provider Compliance Programs: Getting Started" Web-Based Training Course — Released

The "Affordable Care Act Provider Compliance Programs: Getting Started" Web-Based Training (WBT) Course was released and is now available. This WBT course will assist providers developing compliance programs as required under the Affordable Care Act. Subject matter experts explain policies and procedures, including internal auditing and enforcement stipulated in the Affordable Care Act. In addition, a health care professional operating a successful program offers information on best practices. Continuing education credits are available to learners who successfully complete this course. See course description for more information.

To access the WBTs, go to MLN Products and click on "Web-Based Training Courses" under "Related Links" at the bottom of the web page.

"Complying With Medical Record Documentation Requirements" Fact Sheet — Released

The "Complying With Medical Record Documentation Requirements" Fact Sheet (ICN 909160) was released and is now available in downloadable format. This fact sheet is designed to provide education on proper medical record documentation requirements. It includes information and resources to help Medicare providers understand how to provide accurate and supportive medical record documentation. This Medicare Learning Network® publication was developed in conjunction with the Comprehensive Error Rate Testing (CERT) Part A and Part B and Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Outreach & Education Task Forces in an effort to provide nationally-consistent education on topics of interest to health care professionals.

"Hospital Reclassifications" Fact Sheet — Revised

The "Hospital Reclassifications" Fact Sheet (ICN 907243) was revised and is now available in downloadable format. This fact sheet is designed to provide education on hospital reclassifications. It includes the following information: urban to rural reclassification, geographic reclassification, Rural Referral Center status, Sole Community Hospital status, and Critical Access Hospital status.

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® Electronic Publication."

"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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