

Thursday, December 11, 2014

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“Provider Enrollment Requirements for Writing Prescriptions for Medicare Part D Drugs” MLN Matters® Article — Revised

“Skilled Nursing Facility Billing Reference” Fact Sheet — Revised  
The Basics of Internet-based PECOS for DMEPOS Suppliers” Fact Sheet — Reminder  
New Medicare Learning Network<sup>®</sup> Provider Compliance Fast Fact  
Medicare Learning Network<sup>®</sup> Products Available In Electronic Publication Format  
Submit Your Feedback on the Medicare Learning Network<sup>®</sup> Learning Management System and Product  
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## MLN Connects™ National Provider Calls

### **Certifying Patients for the Medicare Home Health Benefit — Last Chance to Register**

*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.

### **ESRD QIP Payment Years 2017 and 2018 Final Rule — Registration Opening Soon**

*Wednesday, January 21; 2-3:30 pm ET*

*To Register:* Visit [MLN Connects Event Registration](#). Registration will be opening soon.

This MLN Connects™ National Provider Call provides an overview of the [final rule](#) (published November 6) that operationalized the End-Stage Renal Disease (ESRD) Quality Incentive Program (QIP) for Payment Year (PY) 2017 and PY 2018. The performance period for PY 2017 will begin on January 1, 2015. The ESRD QIP is a pay-for-performance quality program that ties a facility's performance to a payment reduction over the course of a PY.

#### *Agenda:*

- ESRD QIP legislative framework and how it fits in with CMS strategies to improve quality
- Changes reflected in the final rule based on public comments

- The final measures, standards, scoring methodology, and payment reduction scale that are applied to the PY 2017 and PY 2018 programs
- How the PY 2017 and PY 2018 programs compare to PY 2016
- Where to find additional information about the program
- 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.

## MLN Connects™ Videos

### Coding for ICD-10-CM: More of the Basics

In this MLN Connects™ video on [Coding for ICD-10-CM: More of the Basics](#), Sue Bowman from the American Health Information Management Association (AHIMA) and Nelly Leon-Chisen from the American Hospital Association (AHA) provide a basic introduction to ICD-10-CM coding. The objective of this video is to enhance viewers' understanding of the characteristics and unique features of ICD-10-CM, as well as similarities and differences between ICD-9-CM and ICD-10-CM. Run time: 36 minutes.

- How to assign a diagnosis code using ICD-10-CM
- ICD-10-CM code structure
- Coding process and examples: Combination codes, 7th character, placeholder "x," excludes notes, unspecified codes, external cause codes
- Resources for coders

Links to the slide presentation, audio recording, and written transcript are available on the [video](#) detail web page. Visit the [Medicare Fee-For-Service Provider Resources](#) web page for a complete list of MLN Connects videos on ICD-10.

## CMS Events

### Volunteer for ICD-10 End-to-End Testing in April — Registration Opening Soon

*Forms due January 9*

During the week of April 26 through May 1, 2015, a second sample group of providers will have the opportunity to participate in ICD-10 end-to-end testing with Medicare Administrative Contractors (MACs) and the Common Electronic Data Interchange (CEDI) contractor. The goal of end-to-end testing is to demonstrate that:

- Providers and submitters are able to successfully submit claims containing ICD-10 codes to the Medicare Fee-For-Service (FFS) claims systems
- CMS software changes made to support ICD-10 result in appropriately adjudicated claims
- Accurate remittance advices are produced

Approximately 850 volunteer submitters will be selected to participate in the April end-to-end testing. This nationwide sample will yield meaningful results, since CMS intends to select volunteers representing a broad cross-section of provider, claim, and submitter types, including claims clearinghouses that submit claims for

large numbers of providers. *Note:* Testers who are participating in the January testing are able to test again in April and July without re-applying.

*To volunteer as a testing submitter:*

- Volunteer forms will be available no later than close of business December 12 on your [MAC](#) website.
- Completed volunteer forms are due January 9.
- CMS will review applications and select the group of testing submitters.
- By January 30, the MACs and CEDI will notify the volunteers selected to test and provide them with the information needed for the testing.

*If selected, testers must be able to:*

- Submit future-dated claims.
- Provide valid National Provider Identifiers (NPIs), Provider Transaction Access Numbers (PTANs), and beneficiary Health Insurance Claim Numbers (HICNs) that will be used for test claims. This information will be needed by your MAC by February 20, 2015 for set-up purposes; Testers will be dropped if information is not provided by the deadline.

An additional opportunity for end-to-end testing will be available during the week of July 20 through 24, 2015. Any issues identified during testing will be addressed prior to ICD-10 implementation. Educational materials will be developed for providers and submitters based on the testing results.

For more information, see [MLN Matters<sup>®</sup> Special Edition Article #SE1409](#), “Medicare FFS ICD-10 Testing Approach.”

### **QRDA I and III Submissions for Eligible Professionals eHealth Provider Webinar**

*Monday, December 15; 2-3pm ET*

Join CMS and the Lantana Consulting Group for guidance on submitting 2014 quality measures using [Quality Reporting Document Architecture \(QRDA\) Category I and III reports](#). Eligible professionals who participate in the webinar will learn more about:

- Submission of quality measures using QRDA Category I & III reports during the Physician Quality Reporting System (PQRS) submission period of January 2, 2015 to February 28, 2015
- CMS requirements for electronic clinical quality measures (eCQMs)
- Top eCQM submission errors
- Techniques for correcting eCQM submission errors
- A portion of the webinar will be dedicated to Q&A

*Registration Information*

- [Register](#) for the eHealth webinar; Space is limited
- Once your registration is complete, you will receive a follow-up email with step-by-step instructions on how to log-in to the webinar.

*Want more information about CMS eHealth?*

Make sure to visit the [eHealth](#) for the latest news and updates. Previous webinar presentations and recordings can be accessed on the [Events](#) web page.

### **Physician Compare Virtual Office Hour Session**

*Thursday, January 22; 11:30-12:30pm ET*

CMS will be hosting a one hour Virtual Office Hour session for the [Physician Compare](#) website. This session will provide CMS the opportunity to directly address questions you have about Physician Compare and public reporting. The session will be conducted via WebEx. You can register for the session by sending an email to the Physician Compare support team at [PhysicianCompare@Westat.com](mailto:PhysicianCompare@Westat.com). Please use the subject line “Physician Compare Virtual Office Hour” and include your name, organization, telephone number, and email address.

All questions will be solicited in advance. Please include your questions with your registration email or send them separately to the email above when prepared. You may submit up to three questions: one primary question and two secondary questions. All questions must be received *by 5pm ET on Wednesday, January 14*.

For more information about the Physician Compare, visit the [Physician Compare Initiative](#) website.

## Announcements

### **New CMS Rules Enhance Medicare Provider Oversight; Strengthens Beneficiary Protections**

On December 3, CMS Administrator Marilyn Tavenner announced new rules that strengthen oversight of Medicare providers and protect taxpayer dollars from bad actors. These new safeguards are designed to prevent physicians and other providers with unpaid debt from re-entering Medicare, remove providers with patterns or practices of abusive billing, and implement other provisions to help save more than \$327 million annually.

CMS is using new authorities created by the Affordable Care Act to clamp down on Medicare fraud, waste, and abuse. CMS currently has in place temporary enrollment moratoria on new ambulance and home health providers in seven fraud hot spots around the country. The moratoria are allowing CMS to target its resources in those areas, including use of fingerprint-based criminal background checks. These and other successes continue to protect the Medicare Trust Funds. CMS has demonstrated that removing providers from Medicare has a real impact on savings. For example, the Fraud Prevention System, a predictive analytics technology, identified providers and suppliers who were ultimately revoked, and prevented \$81 million from being paid.

New changes announced today allow CMS to:

- Deny enrollment to providers, suppliers and owners affiliated with any entity that has unpaid Medicare debt; this will prevent people and entities that have incurred substantial Medicare debts from exiting the program and then attempting to re-enroll as a new business to avoid repayment of the outstanding Medicare debt.
- Deny or revoke the enrollment of a provider or supplier if a managing employee has been convicted of a felony offense that CMS determines to be detrimental to Medicare beneficiaries. The recently implemented background checks will provide CMS with more information about felony convictions for high risk providers or suppliers.
- Revoke enrollments of providers and suppliers engaging in abuse of billing privileges by demonstrating a pattern or practice of billing for services that do not meet Medicare requirements.

*For more information:*

- [Fact Sheet](#)
- [Final Rule](#)

Full text of this excerpted [CMS press release](#) (issued December 3).

### **New Requirements for Prescribers of Medicare Part D Drugs**

CMS finalized [CMS-4159-F](#), “Medicare Program; Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs” on May 23, 2014. This rule requires physicians and, when applicable, other eligible professionals who write prescriptions for Part D drugs to:

- be enrolled in Medicare in an approved status, or
- have a valid opt-out affidavit on file for their prescriptions to be covered under Part D.

The final regulation stated that the effective date for this requirement would be June 1, 2015. However, CMS is announcing that it will delay enforcement until December 1, 2015 of the requirements in 42 CFR § 423.120(c)(6).

Physicians or eligible professionals who write prescriptions for Part D drugs but are not currently enrolled in Medicare in an approved status or do not have a valid opt-out affidavit on file, must submit a Medicare enrollment application or opt-out affidavit by *June 1, 2015*, or earlier, to ensure sufficient processing times and avoid the denial of patients’ prescription drug claims by their Part D plans beginning December 1, 2015.

For more information on the Part D enrollment requirements and how to enroll online, refer to [MLN Matters® Article SE1434](#), “Provider Enrollment Requirements for Writing Prescriptions for Medicare Part D Drugs.” Questions may be directed to [providerenrollment@cms.hhs.gov](mailto:providerenrollment@cms.hhs.gov).

### **ESRD PPS Low-Volume Payment Adjustment: Act by December 31**

CMS made two clarifications regarding eligibility for the low-volume payment adjustment in the CY 2015 End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) [final rule](#), which was published in the Federal Register on November 6, 2014. ESRD facilities that believe they could be considered a low-volume facility under the ESRD PPS based on these clarifications should contact their [Medicare Administrative Contractor \(MAC\)](#).

For hospital-based ESRD facilities, CMS clarified that MACs can consider other supporting data, such as the individual facility’s total treatment counts, rather than the hospital’s cost report alone, to verify the number of treatments that were furnished by the individual hospital-based facility that is seeking the adjustment. Prior to this clarification, MACs were required to aggregate total treatment counts from all ESRD facilities that were affiliated with a hospital.

The second clarification was regarding ESRD facilities that had a change of ownership that did not result in a new Provider Transaction Access Number (PTAN) but did cause a change in the original FY to that of the new provider, resulting in two non-standard cost reporting periods. CMS clarified that MACs should either combine the two non-standard cost reports that equals 12 consecutive months, or where the two non-standard cost reporting periods in combination exceed 12 consecutive months, prorate the data to equal a full 12 consecutive month period.

ESRD facilities that wish to attest for the low-volume payment adjustment may submit attestations for each applicable year between 2011 and 2015. The timeframe for submission of these attestations was extended until December 31, 2014. ESRD facilities should contact their respective MAC to make sure the attestation was received and that all required information was correctly submitted. MACs are instructed to review the attestations and determine applicability for each previous year submitted by the facility. There will be no extensions.

For more information see [MLN Matters® Article #8898](#), “Clarification of the ESRD PPS Low Volume Adjustment.”

## Eligible Hospitals Must Attest By December 31 to Receive 2014 EHR Incentive

If you are an eligible hospital or Critical Access Hospital (CAH), the last day you can register and attest to demonstrating meaningful use for the Medicare Electronic Health Record (EHR) Incentive Program 2014 reporting year is December 31, 2014. You must successfully *attest by 11:59pm ET on December 31* to receive an incentive payment for your 2014 participation.

CMS extended the deadline for eligible hospitals and CAHs to attest to meaningful use for the Medicare EHR Incentive Program to allow more time for providers 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 also extended 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 electronic CQM (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.

### *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. Please call, 888-734-6433 (primary number) or 888-734-6563 (TTY number) Monday through Friday from 7:30am to 6:30pm CT, except federal holidays. Attestation resources are available on the [Educational Resources](#) web page.

## Financial Incentives and Ability to Exchange Clinical Information Found to be Top Reasons for EHR Adoption

The need to share patient information with other providers and the use of financial incentives are key drivers in why many providers adopt and use health information technology tools like electronic health records (EHRs), according a [data brief](#) released today from the Office of the National Coordinator for Health IT (ONC).

The new data brief details why physicians decided to adopt – or not adopt – EHRs, and it helps to explain how financial incentives drive EHR adoption. The data, from the [2013 National Ambulatory Medical Care Survey](#) also highlights the high level of importance providers put on health information exchange.

The data demonstrates the importance of incentive programs like the Health Information Technology for Economic and Clinical Health (HITECH) Act's Medicare and Medicaid EHR Incentive Programs (meaningful use) and payments for services that include use of certified EHR technology, such as the separately billable Chronic Care Management services finalized under the 2015 Medicare Physician Fee Schedule. ONC today posted a new tool to help clinicians estimate the amount of money they might receive from treating Medicare patients living with chronic conditions, while using their certified health information technology, on the [HealthIT.gov dashboard](#).

The results released today show that since the enactment of HITECH in 2009, 62 percent of physicians who adopted health IT tools identified financial incentives and penalties as a major influence on their decision to adopt, compared with only 23 percent of physicians who adopted before 2009.

The data brief found that the ability to easily share electronic information with other care givers, an important component of chronic care management, is also a major motivation for physicians to adopt EHRs. Among physicians who adopted health IT before incentive funds were available, the ability to electronically exchange clinical information with other health care providers was the greatest motivator for adoption. More than a third of physicians who adopted EHRs after HITECH was enacted cited this capability as a major influence in their decision to adopt, and almost 4 in 10 physicians who were not using an EHR reported that the ability to electronically exchange clinical information would be a major driver in their decision to adopt.

Full text of this excerpted [HHS press release](#) (issued December 5).

### **HHS Awards \$36.3 Million in Affordable Care Act Funding to Reward and Expand Quality Improvement in Health Centers**

On December 9, HHS Secretary Sylvia M. Burwell announced \$36.3 million in Affordable Care Act funding to 1,113 health centers in all 50 states, the District of Columbia, and seven U.S. Territories to recognize health center quality improvement achievements and invest in ongoing quality improvement activities. The health centers receiving awards today are proven leaders in areas such as chronic disease management, preventive care, and the use of Electronic Health Records (EHRs) to report quality data.

Health centers receiving these funds are being recognized for high levels of quality performance in one or more of the following four categories.

- Health center quality leaders received awards if they were among the top 30 percent of all health centers that achieved the best overall clinical outcomes, demonstrating their ability to focus on quality in all aspects of their clinical operations; 361 health centers received funding in this category for approximately \$11.2 million dollars.
- National quality leaders received awards for exceeding national clinical benchmarks (Healthy People 2020 objectives and health center national averages) for chronic disease management, preventive care, and perinatal/prenatal care, demonstrating the critical role that health centers play in promoting higher quality health care nationwide; 57 health centers received funding in this category for approximately \$2.5 million dollars.
- Clinical quality improvers received awards if they demonstrated at least a 10 percent improvement in clinical quality measures between 2012 and 2013, showing a significant improvement in the health of

the patients they serve; 1,058 health centers received funding in this category for approximately \$17.7 million dollars.

- Electronic Health Record reporters received funding if they used EHRs to report clinical quality measure data on all of their patients, a key transformational step in driving quality improvement for all health center patients across the nation; 332 health centers received funding in this category for approximately \$4.9 million dollars.

Nearly 1,300 Health Resources and Services Administration (HRSA)-supported health centers operate more than 9,200 service delivery sites that provide care to nearly 22 million patients in every state, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and the Pacific Basin.

*For more information:*

- [FY 2015 Quality Improvement Awards recipients](#)
- [The Affordable Care Act and Community Health Centers](#)
- [HRSA's Community Health Center Program](#)
- [Find a health center](#) in your area

Full text of this excerpted [HHS press release](#) (issued December 9).

## See the Big Picture with Open Payments Search Tool Enhancements

CMS previously announced the availability of the Open Payments data [search tool](#) to allow users to search [identified data](#) for physicians, teaching hospitals, or companies making payments by name, city, state, and specialty. Now, a search tool enhancement is available: when you search for physicians, teaching hospitals, or companies making payments, you can view detailed and new summary information about them. This new summary data includes the total U.S. dollar value of all payments or transfers of value and the total number of transactions associated with a particular entity.

## Contractor Assists Hospitals in Reporting Inpatient Quality Data

FMQAI/HSAG is a CMS hospital inpatient value, incentives, and quality reporting contractor that can support your hospital in reporting quality data in a complete and timely fashion. You may reach FMQAI/HSAG through:

- [Inpatient Questions and Answers Tool](#)
- Email: [inpatientsupport@vigrc1.hcqis.org](mailto:inpatientsupport@vigrc1.hcqis.org)
- Phone (toll-free): 866-800-8765 weekdays 8am to 8pm ET
- Secure Fax: 877-789-4443
- [Inpatient Live Chat](#): Click on the "Inpatient" link

Please visit the QualityNet [Hospital Inpatient Quality Reporting Program](#) website for useful tools and resources, including:

- [Hospital Inpatient Quality Reporting \(IQR\) Program Important Dates and Deadlines](#)
- [FY 2016 Reporting Quarters](#)
- [Hospital IQR FY 2016 Changes](#)
- [FY 2016 Healthcare Associated Infection \(HAI\) Validation Templates Quick Reference Guide](#)

In addition, the FMQAI/HSAG [Hospital Inpatient and Outpatient Quality Reporting Outreach and Education Support Programs](#) website has additional resources, such as:

- CY 2014 Quarterly Inpatient/Outpatient Timeline

- IQR Provider Participation Report Quick Start Guide
- IQR [Perinatal \(PC-01\) Data Submission](#) Quick Start Guide

CMS and FMQAI/HSAG conduct monthly webinars for hospitals and vendors. For email announcements of upcoming webcasts and other educational events, please [register for program notifications](#) from the Hospital IQR ListServe.

## Updates to IRIS Software

The Intern and Resident Information System (IRIS) software programs (IRISV3 and IRISEDV3) each have three updated files (medical school codes, residency type codes, and IRISV3 Operating Instructions) for collecting and reporting information on resident training in hospital and non-hospital settings. They are categorized as follows:

August 2014 IRISV3 Operating Instructions and Excerpts from IRISV3 Operating Instructions to Use with IRISEDV3 (mandatory for cost reporting periods beginning before July 1, 2014):

- CMS added nine new IRIS residency type codes to the IRIS Residency Type Code Table
- CMS also added seven new IRIS medical school codes to the IRIS Medical School Code Table
- Providers may begin using the new medical school and residency type codes in the IRIS programs for cost reporting periods ending on or after June 30, 2014

September 2014 IRISV3 Operating Instructions and Excerpts from IRISV3 Operating Instructions to Use with IRISEDV3 (mandatory for cost reporting periods beginning on or after July 1, 2014):

- CMS renumbered IRIS residency type codes in the IRIS Residency Type Code Table; CMS removed obsolete IRIS residency type codes from this table
- CMS removed obsolete IRIS medical school codes from the IRIS Medical School Code Table
- Providers must use the renumbered IRIS residency type codes in the IRIS programs for cost reporting periods beginning on or after July 1, 2014

The IRIS programs are available for downloading via the [IRIS](#) website.

## Access Your 2013 QRUR

On September 30, 2014 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 (EPs) 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. CMS encourages you to share this information with your physicians and other clinicians in your group.

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.

## **2012 Supplemental QRURs Available to Group Practices**

In July 2014, CMS made available confidential 2012 Supplemental Quality and Resource Use Reports (QRURs) to group practices with 100 or more eligible professionals (EPs). The Supplemental reports contain information on how groups performed on episode-based measures during the CY 2012 performance period. The episode-based measures are comprised of Medicare payments for clinically related services provided to Medicare Fee-For-Service (FFS) beneficiaries. These 2012 Supplemental QRURs provide medical group practices with summary level and detailed drill down information on payment-standardized, risk-adjusted clinical episodes of care that are attributed to the medical group, including information about Medicare providers who care for the patient during the episode both inside and outside the medical group. The information contained in the 2012 Supplemental QRURs does not affect Medicare payment and is not part of the value-based payment modifier under the Medicare Physician Fee Schedule.

CMS encourages medical group practices with 100 or more EPs to access their 2012 Supplemental QRURs on the [CMS Enterprise Portal](#) web page using their Individuals Authorized Access to the CMS Computer Services (IACS) User ID and password. A quick reference guide for obtaining an IACS account or modifying an existing account can be found on the [Self Nomination/Registration](#) web page. More information on the 2012 Supplemental QRURs can be found on the [Episode Grouping for Medicare and Supplemental QRURs](#) web page. Visit the [Physician Feedback /Value Modifier](#) website for more information on the program.

## **EHR Incentive Programs: Protect Electronic Health Information Core Objective**

The security risk analysis must be completed prior to attestation; review [FAQ #10754](#). If you are a provider participating in the Electronic Health Record (EHR) Incentive Programs, conducting or reviewing a security risk analysis is required to meet [Stage 1](#) and [Stage 2](#) of meaningful use. This meaningful use objective complements but does not impose new or expanded requirements on the [HIPAA Security Rule](#).

### *How This Objective Improves Care*

Security risk analysis doesn't just help your organization ensure it is compliant with HIPAA's [administrative, physical, and technical safeguards](#); this ongoing process also helps reveal areas where your organization's electronic protected health information (e-PHI) could be at risk. Meeting this objective can help you avoid and address common security gaps that lead to cyber-attack or data loss, which helps protect your practice, information, technology, and the people you serve.

### *New CMS Guidance for When to Complete a Security Risk Analysis*

A security risk analysis needs to be conducted or reviewed during each program year for Stage 1 and Stage 2. These steps may be completed outside *or* during the EHR reporting period timeframe, but must take place no earlier than the start of the EHR reporting year and no later than the date the provider submits their attestation for that EHR reporting period.

### *Resources for Security Risk Analysis*

To help providers understand what's required to meet this core objective, CMS has a [Security Risk Analysis Tipsheet](#) available on the [Educational Resources](#) web page that includes:

- Steps for conducting a security risk analysis
- How to create an action plan
- Security areas to consider and potential courses of action
- Myths and facts about conducting or reviewing a security risk analysis

This information is also available as an intermediate level resource on [eHealth University](#). Providers in small-to-medium sized offices may also use Office of the National Coordinator for Health Information Technology's (ONC's) [Security Risk Assessment tool](#) to conduct risk assessments of their organizations. The tool also produces a report that can be provided to auditors. A [User Guide](#) and [Tutorial video](#) are available to help providers use the tool.

### *Want more information about the EHR Incentive Programs?*

Make sure to visit the [Medicare and Medicaid EHR Incentive Programs](#) website.

## **Get Ready Now for ICD-10**

With less than a year to go before the *October 1, 2015 compliance date*, now is the time to get ready. Whether you're a provider, payer, or other health care entity, it's important to prepare for ICD-10 now. Visit the [ICD-10](#) website to learn how to make a plan that fits your needs. By working together, we can make a successful ICD-10 transition.

### *Benefits of ICD-10*

Foundational to advancing health care, the ICD-10 code set will replace ICD-9 codes for both diagnosis and inpatient procedures. Using ICD-10, doctors can capture much more detail, meaning they can better understand important information about the patient's health. And by enabling more detailed patient history coding, ICD-10 can help to better coordinate a patient's care across providers and over time. Among its benefits, ICD-10:

- Better captures details about chronic illnesses, identifying underlying causes, complications of disease, and conditions that contribute to complexity of a disease
- Serves as a building block that allows for greater specificity and standardized data to better support patient care and improve disease management
- Improves data for peer comparison and utilization benchmarking and better documentation of patient complexity and level of care to support reimbursement for care provided
- Enhances public health surveillance and reporting—as well as quality measurement and reporting—with robust detail for research and data analysis

### *CMS Resources Can Help You Get Ready*

Available on the [Provider Resources](#) web page, these resources provide guidance about the transition to ICD-10 with a focus on small practices:

- CMS recently released two new Medscape videos and an expert column. Continuing Medical Education (CME) and nursing Continuing Education (CE) credits are available to health care professionals who

complete the learning modules. Anyone who completes the modules can receive a certificate of completion.

- The [Road to 10 Tool](#) gives an overview of ICD-10 and answers frequently asked questions. The tool is designed to help small practices jumpstart their transitions. Providers can build an ICD-10 action plan and review tailored clinical scenarios to learn more about how ICD-10 affects their practice.

## Claims, Pricers, and Codes

### January 2015 Average Sales Price Files Now Available

CMS has posted the January 2015 Average Sales Price (ASP) and Not Otherwise Classified (NOC) pricing files and crosswalks. All are available for download on the [2015 ASP Drug Pricing Files](#) web page.

## Medicare Learning Network<sup>®</sup> Educational Products

### “Medicare Fee-For-Service (FFS) International Classification of Diseases, 10th Edition (ICD-10) Testing Approach” MLN Matters<sup>®</sup> Article — Revised

[MLN Matters<sup>®</sup> Special Edition Article #SE1409](#), “Medicare Fee-For-Service (FFS) International Classification of Diseases, 10th Edition (ICD-10) Testing Approach” was revised and is now available in downloadable format. This article is designed to provide education on the testing approach that CMS is taking for ICD-10 implementation. It includes information about the comprehensive four-pronged approach to preparedness and testing. The article was revised to include the dates and some additional details for the three end-to-end testing periods.

### “Provider Enrollment Requirements for Writing Prescriptions for Medicare Part D Drugs” MLN Matters<sup>®</sup> Article — Revised

[MLN Matters<sup>®</sup> Special Edition Article #SE1434](#), “Provider Enrollment Requirements for Writing Prescriptions for Medicare Part D Drugs” was revised and is now available in a downloadable format. This article is designed to provide education on writing prescriptions for Medicare beneficiaries for Medicare Part D drugs. It includes background information and examples. The article was revised to emphasize that form CMS-855O is appropriate for use by prescribers.

### “Skilled Nursing Facility Billing Reference” Fact Sheet — Revised

“[Skilled Nursing Facility \(SNF\) Billing Reference](#)” Fact Sheet (ICN 006846) was revised and is now available in downloadable format. This fact sheet is designed to provide education on Medicare Part A which covers skilled nursing and rehabilitation care in a SNF under certain conditions for a limited time. It includes information for SNF providers about SNF coverage, SNF payment, and SNF billing.

### “The Basics of Internet-based PECOS for DMEPOS Suppliers” Fact Sheet — Reminder

“[The Basics of Internet-based PECOS for DMEPOS Suppliers](#)” Fact Sheet (ICN 904283) is available in downloadable format. This fact sheet is designed to provide education on how Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers should enroll in the Medicare Program and maintain

their enrollment information on Internet-based Provider Enrollment, Chain, and Ownership System (PECOS). It includes information on how to complete an enrollment application using Internet-based PECOS and a list of frequently asked questions and resources.

### **New Medicare Learning Network® Provider Compliance Fast Fact**

A new fast fact is now available on the [Medicare Learning Network® 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® Products Available In Electronic Publication Format**

The following products are 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.](#)”

- The “[Skilled Nursing Facility Prospective Payment System](#)” Fact Sheet (ICN 006821) is designed to provide education on the Skilled Nursing Facility Prospective Payment System (SNF PPS). It includes information on the background and elements of the SNF PPS.
- The “[Inpatient Rehabilitation Facility Prospective Payment System](#)” Fact Sheet (ICN 006847) is designed to provide education on the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS). It includes the following information: background, elements of the IRF PPS, payment updates, and IRF Quality Reporting Program.

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

Your feedback is important to us as we use your suggestions to improve your experience using the Medicare Learning Network® Learning Management System and Product Ordering System to take web-based training courses and order Medicare Learning Network educational products. We encourage you to [submit your feedback online](#). Your participation is strictly anonymous and greatly appreciated.

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