

Thursday, December 18, 2014

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Medicare Learning Network® Educational Products

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MLN Connects™ National Provider Calls

Medicare Quality Reporting Programs: Data Submission Process — Registration Opening Soon

Tuesday, January 13; 1:30-3pm ET

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

This MLN Connects™ National Provider Call provides an overview of the 2014 submission process for Medicare Quality Reporting Programs, including the Physician Quality Reporting System (PQRS), Value-

Based Payment Modifier, and the Electronic Health Record (EHR) Incentive Program. The presentation will provide information for eligible professionals (EPs) and group practices submitting 2014 data. This session will provide guidance on how EPs and PQRS group practices can earn the 2014 PQRS incentive and avoid the 2016 negative PQRS payment adjustment through these reporting mechanisms. A question and answer session will follow the presentation.

Agenda:

- CMS updates and announcements
- 2014 PQRS information
- Submission information, including Qualified Registry, EHR-based Reporting Data Submission Vendor, Direct EHR, Qualified Clinical Data Registry, Accountable Care Organization /Group Practice Reporting Option Web Interface, Maintenance of Certification Program
- Resources and who to call for help
- Question and answer session

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

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

IRF PPS: New IRF-PAI Items Effective October 1, 2015 — Registration Now Open

Thursday, January 15; 1:30-3pm ET

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

In the FY 2015 Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) [final rule](#), CMS finalized two new items on the IRF- Patient Assessment Instrument (PAI): an arthritis attestation item and the therapy information section. This MLN Connects™ National Provider Call will focus on training providers on how to code and complete these new items on the IRF-PAI, which will become effective for IRF discharges occurring on or after October 1, 2015. Additionally, CMS subject matter experts will clarify the signature page requirements.

Prior to the call, participants are encouraged to review the updated IRF-PAI training manual in the “Downloads” section of the [IRF-PAI](#) web page. A question and answer session will follow the presentation.

Agenda:

- Arthritis attestation: Item 24A
- Therapy information section: Items O0401 and O0402
- Signature page clarification: Item Z0400A

Target Audience: IRF providers, industry stakeholders, and other interested parties.

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 Year 2017 and 2018 Final Rule — Registration Now Open

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

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

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.

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

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

- November 5 — *Transitioning to ICD-10*: [video slideshow](#). Links to the audio recording and transcript from this call can be found on the [call detail](#) web page. During this call, CMS subject matter experts discussed ICD-10 implementation issues, opportunities for testing, and resources.
- December 2 — *2015 Physician Fee Schedule Final Rule: Changes to Physician Quality Reporting Programs*: [audio recording](#) and [transcript](#). More information is available on the [call detail](#) web page. This call provided an overview of changes to the Physician Quality Reporting Programs in the 2015 Physician Fee Schedule final rule, including the Physician Quality Reporting System, Value-based Payment Modifier, Physician Compare, Electronic Health Record Incentive Program, Comprehensive Primary Care Initiative, and Medicare Shared Savings Program.

CMS Events

Volunteer for ICD-10 End-to-End Testing in April — 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 are available 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:

- [MLN Matters® Special Edition Article #SE1409](#), “Medicare FFS ICD-10 Testing Approach”
- [MLN Matters® Special Edition Article #SE1435](#), “FAQs – ICD-10 End-to-End Testing”

Announcements

CDC Continues to Recommend a Flu Vaccine as the Best Way to Protect Against the Flu

On December 3, 2014 the Centers for Disease Control and Prevention (CDC) issued a [Health Advisory](#) announcing that H3N2 viruses are predominant so far this season, some of which are different from the vaccine virus and reminding clinicians about CDC’s vaccine and treatment recommendations. The information about which viruses are circulating this season is noteworthy for two reasons. 1.) Seasons during which influenza A H3N2 viruses predominate are sometimes associated with more hospitalizations and deaths than during H1N1 or influenza B-predominant seasons; and, 2.) The vaccine may not work as well against the H3N2 viruses that are different from what is in the vaccine.

Influenza viruses are constantly changing – they can change from one season to the next or they can even change within the course of the same season. While vaccine effectiveness against drifted H3N2 viruses may be reduced this season, influenza vaccination still offers the best protection we have against seasonal flu.

Even when drifted viruses are circulating, CDC continues to recommend influenza vaccination for people age 6 months and older. [Read more.](#)

Revisions to Certain Patient’s Rights Conditions of Participation and Conditions for Coverage Overview

On December 12, CMS issued a [proposed rule](#) to revise selected conditions of participation (CoPs) for providers, conditions for coverage (CfCs) for suppliers, and requirements for long-term care facilities, to ensure that certain requirements are consistent with the Supreme Court decision in *United States v. Windsor*, 570 U.S. 12, 133 S.Ct. 2675 (2013) and HHS policy.

For all Medicare and Medicaid provider and supplier types, CMS conducted a review of the Code of Federal Regulations (CFR) for instances in which our regulations defer to state law for purposes of defining “representative,” “spouse,” and similar terms in which reference to a spousal relationship is explicit or implied. We have identified several provisions that we believe should be revised in light of the Windsor decision. These provisions have been interpreted to support the denial of federal rights and privileges to a same-sex spouse if their state of residence does not recognize same-sex marriages.

This proposed rule would revise these regulations governing Medicare and Medicaid participating providers and suppliers by proposing to clarify that where state law or facility policy provides or allows certain rights or privileges to a patient’s opposite-sex spouse under certain provisions, a patient’s same-sex spouse must be afforded equal treatment if the marriage is valid in the jurisdiction in which it was celebrated. These revisions would promote equality and ensure the recognition of the validity of same-sex marriages when administering the patient rights and services at issue.

Full text of this excerpted [CMS fact sheet](#) (issued December 11).

HIS Data Collection for FY 2016 Annual Payment Update Ends December 31

All Medicare-certified hospice providers with at least one patient admission since July 1, 2014 are required to submit Hospice Item Set (HIS) records for each patient admission during the period from July 1, 2014 through December 31, 2014 to avoid a 2 percentage point reduction in their Annual Payment Update (APU) for FY 2016. Providers will continue to collect and submit HIS data on patient admissions on or after January 1, 2015; however patient admissions occurring from January 1, 2015 through December 31, 2015 will be part of the FY 2017 payment determination. If you have questions about HIS data collection requirements, please visit the [HIS](#) web page or contact the Quality HelpDesk at HospiceQualityQuestions@cms.hhs.gov.

If you have not yet created a Quality Improvement Evaluation System (QIES) Account to submit HIS data, you should do so immediately. Providers must have two User IDs to submit HIS data to the QIES Assessment Submission and Processing (ASAP) system: the CMS Net User ID and the QIES User ID. If you need assistance obtaining your User IDs, please visit the [HIS Technical Information](#) web page or contact the QTSO Technical HelpDesk at 877-201-4721 or help@qtso.com.

For more information on Hospital Quality Reporting Program (HQRP) requirements, please visit the [HQRP](#) website.

IRF-PAI Training Manual Updated with Information on New Items Effective October 1, 2015

An updated Inpatient Rehabilitation Facility (IRF) – Patient Assessment Instrument (PAI) training manual is now available in the “Downloads” section of the [IRF-PAI](#) web page. It includes information on two new items on the IRF-PAI, an arthritis attestation item and the therapy information section, which will become effective for IRF discharges occurring on or after October 1, 2015. CMS finalized these new items in the FY 2015 IRF Prospective Payment System [final rule](#).

[Register](#) for the January 15 MLN Connects™ National Provider Call, which will focus on training providers on how to code and complete these new items on the IRF-PAI. Additionally, CMS subject matter experts will clarify the signature page requirements.

Frequently Asked Questions on DMEPOS 2015 Medicare Payment Final Rule

[Frequently Asked Questions and Answers](#) are available on the methodology for adjusting Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule payment amounts using information from the Medicare DMEPOS Competitive Bidding Programs (CBPs). Also, frequently asked questions and answers are available on the payment rules for standard power wheelchairs and Continuous Positive Airway Pressure (CPAP) devices under certain Medicare DMEPOS CBPs. CMS finalized [CMS-1614-F](#), “Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)” on November 6, 2014.

Open Payments: Final Rule Changes Related to Continuing Education Events

On October 31, CMS published four revisions as a final rule in the Federal Register as part of the 2015 Medicare Physician Fee Schedule publication. The [Law and Policy](#) web page includes details about the four revisions made to the Open Payments final rule. The most significant change affects the Open Payments reporting requirements for payments or other transfers of value provided at continuing education events; these requirements will change starting for data collected in 2016. This policy change was made in response to public comments, to create a more consistent reporting requirement and provide more consistency for consumers who will ultimately have access to the reported data. For detailed examples of how this will be applied, visit the [Law and Policy](#) web page.

Learn more about the final rule changes, review:

- [Fact sheet](#) for the Medicare Physician Fee Schedule
- CY 2015 Medicare Physician Fee Schedule [final rule](#)
- [Sections](#) of the CY 2015 Medicare Physician Fee Schedule final rule that pertain to Open Payments
- [Frequently Asked Questions](#)

Comparative Billing Report on Modifier 59: Dermatology

CMS will issue a national provider Comparative Billing Report (CBR) on dermatology providers’ use of Modifier 59 in January 2015. The CBR, produced by CMS contractor eGlobalTech, will focus on dermatology providers and will contain data-driven tables and graphs with an explanation of findings comparing these providers’ billing and payment patterns to those of their peers in their state and across the nation. The goal of these reports is to offer a tool that helps providers better understand applicable Medicare billing rules. These reports are only accessible to the providers who receive them; they are not publicly available.

Providers should update their fax numbers in the Medicare Provider Enrollment, Chain, and Ownership System (PECOS) because faxing is the default method for disseminating CBRs. Providers should contact the CBR Support Help Desk at 800-771-4430 or CBRsupport@eglobaltech.com if they prefer to receive CBRs through the U.S. Postal Service. For more information, please contact the CBR Support Help Desk, or visit the [CBR](#) website.

Claims, Pricers, and Codes

Reprocessing of IPPS Claims Assigned to DRG 410, 573 or 907

CMS was recently made aware of a discrepancy in the relative weight assigned to Diagnosis Related Groups (DRGs) 410, 573, and 907 in the Inpatient Prospective Payment System (IPPS) Pricer. The relative weight for these DRGs is scheduled to be corrected in January, 2015. Once corrected, your Medicare Administrative Contractor will reprocess affected claims to correct reimbursement.

Medicare Learning Network[®] Educational Products

“FAQs – International Classification of Diseases, 10th Edition (ICD-10) End-to-End Testing” MLN Matters[®] Article — Released

[MLN Matters[®] Special Edition Article #SE1435](#), “FAQs – International Classification of Diseases, 10th Edition (ICD-10) End-to-End Testing” has been released and is now available in downloadable format. This article is designed to provide education on the guidelines and requirements for successful ICD-10 end-to-end testing. It includes FAQs regarding what to know prior to testing and what to know during testing.

“Medical Privacy of Protected Health Information” Fact Sheet — Revised

The “[Medical Privacy of Protected Health Information](#)” Fact Sheet (ICN 006942) was revised and is now available in a downloadable format with a print ready feature. This fact sheet is designed to provide education on resources and information regarding the HIPAA Privacy Rule and how this rule applies to customary health care practices. It includes information on accessing the HHS HIPAA web page resources.

Medicare Learning Network Products[®] Available In Electronic Publication Format

The following fact sheets are now available as electronic publications (EPUBs) and through QR codes. Instructions for downloading EPUBs and how to scan a QR code are available at “[How To Download a Medicare Learning Network[®] Electronic Publication](#)” on the CMS website.

- The “[Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians](#)” Fact Sheet (ICN 905645) is designed to provide education for physicians on understanding how to comply with Federal laws that combat fraud and abuse and ensure appropriate quality medical care. It includes information on identifying "red flags" that could lead to potential liability in law enforcement and administrative actions.
- The “[Medicare Appeals Process](#)” Fact Sheet (ICN 006562) is designed to provide education on the five levels of claim appeals in Original Medicare (Medicare Part A and Part B). It includes details explaining how the Medicare appeals process applies to providers, participating physicians, and participating suppliers in addition to including more information on available appeals-related resources.

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