MLN Connects™
Provider eNews

Medicare Learning Network®
Official Information Health Care Professionals Can Trust

Thursday, January 8, 2015

MLN Connects™ National Provider Calls

MLN Connects™ Videos

CMS Events

Announcements

Claims, Pricers, and Codes

Medicare Learning Network® Educational Products

"Modifications to Medicare Part B Coverage of Pneumococcal Vaccinations" MLN Matters® Article — Released
"The 2013 Physician Quality Reporting System (PQRS)" Booklet — Released
"FAQs – International Classification of Diseases, 10th Edition (ICD-10) End-to-End Testing" MLN Matters® Article — Revised
"Inpatient Psychiatric Facility Prospective Payment System" Fact Sheet — Revised
"Discharge Planning" Booklet — Revised
"The Basics of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Accreditation" Fact Sheet — Reminder
"The Basics of Internet-based PECOS for Physicians and Non-Physician Practitioners" Fact Sheet — Reminder
Medicare Learning Network® Products Available In Electronic Publication Format

MLN Connects™ National Provider Calls

Medicare Quality Reporting Programs: Data Submission Process — Last Chance to Register
Tuesday, January 13; 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 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.

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.

IRF PPS: New IRF-PAI Items Effective October 1, 2015 — Last Chance to Register
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 — Register Now

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 Audio Recordings and Transcripts

Audio recordings and transcripts are now available for the following calls:

- December 9 — *National Partnership to Improve Dementia Care in Nursing Homes:* audio recording and transcript. More information is available on the call detail web page. During this call, speakers discussed 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.
- December 16 — *Certifying Patients for the Medicare Home Health Benefit:* audio recording and transcript. More information is available on the call detail web page. During this call, CMS subject matter experts discussed the changes to the Medicare home health benefit.

Continuing Education for Participation in MLN Connects™ National Provider Calls

Many professional organizations, associations, and licensing and certifying bodies award continuing education credit for participation in MLN Connects™ National Provider Calls, including:

- American Academy of Professional Coders (AAPC)
- American Association of Healthcare Administrative Management (AAHAM)
- American Board for Certification in Orthotics, Prosthetics and Pedorthics, Inc. (ABC)
- American College of Medical Practice Executives (ACMPE)
- American Health Information Management Association (AHIMA)
- American Medical Billing Association (AMBA)
- Association of Professional Medical Billers & Administrators (APMBA)
- Association of Registered Health Care Professionals (ARHCP)
- Board of Certification/Accreditation (BOC)
- The Commission on Dietetic Registration, the Credentialing Agency for the Academy of Nutrition and Dietetics,
- Commission on Paraoptometric Certification (CPC)
- Medical Association of Billers (MAB)
- Medical Management Institute (MMI)
- National Center for Competency Testing (NCCT)
- National Council of Certified Dementia Practitioners (NCCDP)
- Professional Association of Health Care Office Management (PAHCOM)

For more information about continuing education credit for participation in MLN Connects Calls, please visit the MLN Connects National Provider Call Program Continuing Education Credit Information web page. If your organization is not on the list, contact them to see if they will award credit for participation in MLN Connects Calls. If they would like to have their information included on our web page, an officer or official representative should email us at MLNConnectsCalls@cms.hhs.gov.

MLN Connects™ Videos

Monthly Spotlight: The 2-Midnight Benchmark Rule

Want to learn more about the 2-Midnight Benchmark Rule? The CMS MLN Connects™ National Provider Call Program has developed a variety of videos, many from previous national provider calls that can help you become more informed about the Medicare Program. Check out the following featured MLN Connects video slideshow presentations to learn more.

- 2-Midnight Benchmark for Inpatient Hospital Admissions MLN Connects National Provider Call, 1/14/14: CMS subject matter experts provide an overview of the inpatient hospital admission and medical review criteria (also known as the 2-Midnight Rule) that was released on August 2, 2013 in the FY 2014 Inpatient Prospective Payment System/Long-Term Care Hospital final rule (CMS-1599-F).

CMS presents case scenarios on the application of the rule to sample medical records. A question and answer session followed the presentation. *Run time:* 121 minutes. The slide presentation, written transcript, and audio recordings are available on the call detail web page.

- 2-Midnight Benchmark for Inpatient Hospital Admissions MLN Connects National Provider Call, 2/27/14: CMS subject matter experts provide an overview of the inpatient hospital admission and medical review criteria that were released on August 2, 2013, including, order and certification guidance case examples, and transfers. A question and answer session followed the presentation. *Run time:* 120 minutes. The slide presentation, written transcript, and audio recordings are available on the call detail web page.

Target Audience: Hospitals, physicians and non-physician practitioners, case managers, medical and specialty societies, and other healthcare professionals.

Important Disclaimer: Physician certification requirements have been modified to apply in fewer inpatient cases. Please see the CY 2015 Outpatient Prospective Payment System final rule (79 FR 66997-66999) for more details.

For More Information:

- Visit the Inpatient Hospital Review web page for the latest information on the 2-Midnight Benchmark Rule.
- For additional MLN Connects resources, check out the MLN Connects Calls and Events web page where you will find slide presentations, audio recordings, and written transcripts from previous MLN Connects Calls, as well as a list of upcoming MLN Connects Calls.
- For a list of other available MLN Connects videos, visit the Medicare Learning Network® Playlist on the CMS YouTube Channel.

CMS Events

Volunteer for ICD-10 End-to-End Testing in April — Deadline Extended to January 21

During the week of April 26 through May1, 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 21.
- CMS will review applications and select the group of testing submitters.
- By February 13, 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"

Open Payments Question & Answer Session

Thursday, January 15; 11:30am-12:30pm ET

Join the Open Payments team for another informal Question & Answer session. The Open Payments team will be available to respond to your questions about the data refresh and the upcoming 2014 Open Payments program year. Information on how to participate is available on the Events web page.

If time runs out before all questions are addressed, you can either send your question to the Help Desk at openpayments@cms.hhs.gov, or save your question for an upcoming Question & Answer Session. CMS plans on conducting these sessions regularly each month, and will announce upcoming calls at least a week in advance.

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. 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.

ICD-10 Clinical Documentation Improvement Webinar Recording Available

CMS recently collaborated with the American Health Information Management Association (AHIMA) to present a webinar on clinical documentation improvement. Watch the recording to learn about:

- Why detailed clinical documentation is important for the ICD-10 transition

- Steps for training your staff
- Additional resources and information

To access the recording, please register for the webinar. The webinar presentation and ICD-10 FAQs are also available on the AHIMA website. *Disclaimer:* The content of this presentation does not supersede published CMS policy. CMS does not explicitly endorse the accuracy of all answers provided by the presenters and/or other participants.

Keep Up to Date on ICD-10
Visit the ICD-10 website for the latest news and resources to help you prepare.

Announcements

Get Your Patients Off to a Healthy Start in 2015 with the AWV and the IPPE

The Medicare Annual Wellness Visit
Under the Affordable Care Act, Medicare beneficiaries now receive coverage for an Annual Wellness Visit (AWV), which is a yearly office visit that focuses on preventive health. During the AWV, you will review a patient's history and risk factors for diseases, ensure that the patient's medication list is up to date, and provide personalized health advice and counseling. The AWV also allows you to establish or update a written personalized prevention plan. This benefit will provide an ongoing focus on prevention that can be adapted as a beneficiary's health needs change over time. Help keep your patients as healthy as possible in 2015 by encouraging them to schedule their AWV.

For Patients Newly Enrolled In Medicare
Medicare also provides coverage for the Initial Preventive Physical Examination (IPPE), commonly known as the "Welcome to Medicare" Preventive Visit, a one-time service to newly-enrolled beneficiaries. The IPPE is an introduction to Medicare and covered benefits, with a focus on health promotion and disease detection. The IPPE must be performed within the first 12 months after the beneficiary's effective date of their Medicare Part B coverage. Help ensure that your newly enrolled Medicare patients get a good start in 2015 by encouraging them to schedule their one-time IPPE. *Note:* Medicare patients do not need to have this visit to be covered for the AWV.

Important Note: Medicare provides coverage of the AWV and the IPPE as Medicare Part B benefits. The beneficiary will pay nothing for the AWV and the IPPE (there is no coinsurance, copayment or Medicare Part B deductible for these benefits).

For More Information
- Medicare Learning Network® "Quick Reference Information: The ABCs of Providing the Annual Wellness Visit" Educational Tool.
- Medicare Learning Network "Quick Reference Information: The ABCs of Providing the Initial Preventive Physical Examination" Educational Tool.
- Medicare Learning Network "Quick Reference Information: Preventive Services" Educational Tool.
- Initial Preventive Physical Exam and Annual Wellness Visit National Provider Call Video Slideshow.
- Medicare.gov Website – Information that you can share with your Medicare patients.

Public Reporting of 2013 Quality Measures on the Physician Compare and Hospital Compare Websites

Public reporting of 2013 quality measures on the Physician Compare website

On December 18, CMS posted the publicly reported 2013 Physician Quality Reporting System (PQRS) Group Practice Reporting Option (GPRO) measures for 139 group practices and 214 Shared Savings Program Accountable Care Organizations (ACOs) and 23 Pioneer ACOs. The specific measures being reported are listed in the fact sheet. Looking ahead, CMS plans to significantly expand the number of quality measures available for public reporting on Physician Compare. In late 2015, CMS will post quality measures for groups of all sizes and a subset of quality measures for individual physicians.

Hospital Compare
Hospital Compare provides information on hospital performance on a wide variety of quality measures, including how often the hospital provides recommended care, certain measures of healthcare infections, and how recently discharged patients responded to a national survey about their hospital experience. Public reporting of hospital performance information empowers consumers by providing information they can use to make more informed health care decisions, encourages providers to improve quality, and drives overall health system improvement. Hospital Compare currently provides information on over 4,000 hospitals, updated on a quarterly basis. This includes measures from the CMS Hospital Inpatient and Outpatient Quality Reporting Programs and Hospital Value-Based Purchasing Program. The measures being reported for the first time, along with new measures that will be reported as part of the Medicare hospital pay-for-performance programs are listed in the fact sheet.

For more information:

- For a list of all of the group practices that currently have quality data, please view the Physician Compare Downloadable Database.
- Physician Care Initiative website
- Hospital Compare

Full text of this excerpted CMS fact sheet (issued December 18).

FY 2015 Results for the HAC Reduction Program and Hospital VBP Program

Hospital-Acquired Condition Reduction Program
The Hospital-Acquired Condition (HAC) Reduction Program is the newest effort under the Affordable Care Act that builds on the progress of reducing hospital acquired conditions achieved through the existing HAC program established under the Deficit Reduction Act (DRA) of 2005.The DRA HAC program currently saves the Medicare program approximately $30 million annually. These savings are the result of not providing additional Medicare payment for treatment of certain reasonably preventable conditions when those conditions are acquired after the beneficiary has been admitted to the hospital. The HAC Reduction Program uses public reporting and financial incentives to encourage Inpatient Prospective Payment System (IPPS) hospitals to reduce HACs and improve patient safety. Hospital specific HAC Reduction Program scores are being posted on the Hospital Compare website. In FY 2015, approximately 724 hospitals will have their payments reduced by one percent under the HAC Reduction Program. Payments for hospital discharges occurring on or after October, 1, 2014, are seeing a reduction.

Hospital Value-Based Purchasing Program
The Hospital Value-Based Purchasing (VBP) Program, which is authorized by the Affordable Care Act, adjusts payments to hospitals under the IPPS based on the quality of care they furnish to patients. The Hospital VBP Program provides a useful snapshot of how hospitals are performing on important quality indicators of patient care, quality, efficiency, and well-being. CMS has posted Hospital VBP incentive payment adjustment factors for FY 2015 on the CMS website. The number of hospitals that will experience a positive change in their base operating diagnosis-related group (DRG) payments in FY 2015 is slightly higher than the number of hospitals

that will experience a negative change. In FY 2015, about half of the hospitals see a small change in their base operating DRG payments (between -0.3 and 0.3 percent) – a reversal from last year.

For more information:

- Visit Quality Net for additional information about the HAC Reduction Program
- Visit the Hospital Value-Based Purchasing website for the FY 2015 value-based incentive payment adjustment factors

Full text of this excerpted CMS fact sheet (issued December 18).

ACOs Moving Ahead: New Participants in Medicare Shared Savings Program

On December 22, CMS announced that 89 new Accountable Care Organizations (ACOs) will be joining the Medicare Shared Savings Program (Shared Savings Program). With today's announcement, CMS will have a total of 405 ACOs participating in the Shared Savings Program next year, serving more than 7.2 million beneficiaries. When combined with the Innovation Center's 19 Pioneer ACOs, CMS will have a total of 424 ACOs serving over 7.8 million beneficiaries.

ACOs are one part of this Administration's vision for improving the coordination and integration of care received by Medicare beneficiaries. ACOs are groups of doctors, hospitals, and other health care providers that work together to give Medicare beneficiaries in Original Fee-For-Service Medicare high quality, coordinated care. ACOs can share in any savings they generate for Medicare, if they meet specified quality targets.

Since ACOs first began participating in the program in early 2012, thousands of health care providers have signed on to participate in the program, working together to provide better care to Medicare's seniors and people with disabilities. In 2014 alone, existing Shared Savings Program ACOs added almost 17,000 healthcare providers, and the 89 new ACOs will bring approximately 23,000 additional physicians and other providers into the ACO program starting January 1.

Full text of this excerpted CMS blog (issued December 22).

CMS Updates Open Payments Data

On December 19, CMS added approximately 68,000 payment records—valued at more than $200 million—to the Open Payments dataset. With this new data, Open Payments now reports information on $3.7 billion in payments and transfers of value made to up to 546,000 individual physicians and up to 1,360 teaching hospitals in the last five months of CY 2013.

Every year, CMS will update the Open Payments data at least once after its initial publication. The refreshed data will include updates to data disputes and other data corrections made since the initial publication of these data documenting payments or transfers of value to physicians and teaching hospitals, and physician ownership and investment interests. This financial data was submitted by applicable manufacturers and applicable Group Purchasing Organizations (GPOs).

The approximately 68,000 records added to the Open Payments dataset were not published in the initial release on September 30 for one of the following reasons:

- The record was still under dispute at the end of the physician and teaching hospital review period (September 11, 2014); or,

- Records attested to on the last day of the data submission period for the 2013 program year (July 7, 2014) were inadvertently excluded from publication (however, they were still included in the full 45-day review and dispute process).

CMS will publish the full CY 2014 financial data by June 30, 2015. In addition, CMS plans to include and publish the missing identification of the de-identified data from CY 2013 by June 30, 2015. *Note:* Due to the ongoing actions taken by applicable manufacturers and applicable GPOs, such as deletions, additions, and corrections within the Open Payments system, the data shared here are subject to change. Information shared is reflective of Open Payments data as of December 19, 2014.

If you have any questions, you can submit an email to the Help Desk at openpayments@cms.hhs.gov. Live Help Desk support is available at 855-326-8366, Monday through Friday from 7:30am to 6:30pm CT, excluding Federal holidays.

Open Payments System Unavailable in January

To improve functionality and build on lessons learned, registration, data submission, and review and dispute functions in the Open Payments system will be unavailable beginning on January 1 through late January 2015, due to system enhancements and preparations for the 2014 program year. However, stakeholders will continue to be able to view Open Payments data and use the data search tool on the CMS website. The CMS Enterprise Identity Management (EIDM) Portal registration will continue to be available throughout this period for reporting entities, physicians, and teaching hospitals. For assistance in completing EIDM registration, visit the Resources web page.

When the system becomes available, a number of enhancements will be operational:

- For applicable manufacturers and applicable Group Purchasing Organizations (GPOs): Records that are not successfully matched to a physician or teaching hospital will be identified as records in error that need to be corrected and re-submitted prior to final submission and attestation. This change removes the record status of “Unmatched,” along with the option for attesters to override records that are unmatched. In addition, new matching logic will be implemented that will prompt records previously in an “on hold" status to be moved through the final submission process.
- For physicians: The status of “conditionally approved” will no longer exist. Physician profiles that do not successfully pass vetting will now return errors that the physician must correct before proceeding in the Open Payments system.

CMS will provide detailed guidance on these and other enhancements to the Open Payments system in upcoming documentation and Q&A sessions beginning in January 2015. CMS anticipates that the Open Payments system will re-open for 2014 registration and data submission shortly after these system preparations are completed.

If you have any questions, you can submit an email to the Help Desk at openpayments@cms.hhs.gov. Live Help Desk support is available at 855-326-8366, Monday through Friday from 7:30am to 6:30pm CT, excluding Federal holidays.

January Quarterly Provider Update Available

The Quarterly Provider Update is a comprehensive resource published by CMS on the first business day of each quarter. It is a listing of all non-regulatory changes to Medicare including Program Memoranda, manual

changes, and any other instructions that could affect providers. Regulations and instructions published in the previous quarter are also included in the Update. The purpose of the Quarterly Provider Update is to:

- Inform providers about new developments in the Medicare program;
- Assist providers in understanding CMS programs and complying with Medicare regulations and instructions;
- Ensure that providers have time to react and prepare for new requirements;
- Announce new or changing Medicare requirements on a predictable schedule; and
- Communicate the specific days that CMS business will be published in the Federal Register.

Teaching Hospitals Receiving FTE Resident Caps Under Section 5506 of the Affordable Care Act

On December 31, 2014, CMS released the results of its decisions regarding which teaching hospitals are receiving increases to their Direct Graduate Medical Education (DGME) and Indirect Medical Education (IME) full-time equivalent (FTE) resident caps under Round 7 of section 5506 of the Affordable Care Act. Section 5506 directed CMS to develop a process to permanently preserve and redistribute the Medicare funded residency slots from teaching hospitals that close. Priority is given to hospitals located in the same or contiguous Core Based Statistical Areas (CBSAs) as the closed hospital, and that met other criteria.

Round 7 of section 5506 redistributes the residency slots of Long Beach Medical Center in Long Beach, NY. A list of hospitals reviewed under Round 7 of section 5506 is available on the Direct Graduate Medical Education web page.

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.

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

Hold on Certain CAH Method II Claims for Anesthesiologist and CRNA Services

Critical Access Hospital (CAH) Method II claims for anesthesiologist and certified registered nurse anesthetist (CRNA) services outside of the normal anesthesia code range (00100 – 01999) and billed with revenue code 0964 are being held due to inaccurate payments. Claims will be held until a system correction is implemented on January 5, 2015. No action is required by providers.

Hospice Claims Returned in Error for Edit U5181

Some hospice claims are being returned in error for edit U5181 when the timely certification date falls within a reported provider liability period for a late notice of election (NOE) filing. Until the system is corrected, hospices receiving this edit in error should change the occurrence code 27 date to the date following the occurrence span code 77 period. This instruction applies only to cases of a timely certification or recertification falling within a late NOE where an exception has not been requested.

Part A Claims Hold for Select Preventive and Screening Services

Intensive Behavioral Therapy for Obesity, Screening Digital Tomosynthesis Mammography, and Anesthesia with Screening Colonoscopy

Part A Claims will be held for the following reason codes: 31784, 31785, 31842, 31843, 31838, 31840, 31841, 31844, and 31839. The computer fix will be installed into production on February 9, 2015. No action needed by providers.

Medicare Learning Network® Educational Products

"Certifying Patients for the Medicare Home Health Benefit" MLN Matters® Article — Released

MLN Matters® Article #SE1436, "Certifying Patients for the Medicare Home Health Benefit" was released and is now available in downloadable format. This article is designed to provide education on the Medicare home health services benefit, including patient eligibility requirements and certification/recertification requirements of covered Medicare home health services. It includes an overview of the Medicare home health services benefits and a list of eligibility and certification requirements.

"Modifications to Medicare Part B Coverage of Pneumococcal Vaccinations" MLN Matters® Article — Released

MLN Matters® Article #MM9051, "Modifications to Medicare Part B Coverage of Pneumococcal Vaccinations" was released and is now available in downloadable format. This article is designed to provide education on updates to the Medicare pneumococcal vaccine coverage requirements, as outlined in Change Request 9051. It includes information on new Advisory Committee on Immunization Practices (ACIP) recommendations for administering two different pneumococcal vaccinations.

"The 2013 Physician Quality Reporting System (PQRS)" Booklet — Released

"The 2013 Physician Quality Reporting System (PQRS)" Booklet (ICN 909056) was released and is now available in downloadable format. This booklet is designed to provide in-depth education on PQRS. It includes information on the following: important changes for the 2013 PQRS, 2015 payment adjustment, and much more.

"FAQs – International Classification of Diseases, 10th Edition (ICD-10) End-to-End Testing" MLN Matters® Article — Revised

MLN Matters® Article #SE1435, "FAQs – International Classification of Diseases, 10th Edition (ICD-10) End-to-End Testing" was revised 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. The article was revised to add additional FAQs.

"Inpatient Psychiatric Facility Prospective Payment System" Fact Sheet — Revised

The "Inpatient Psychiatric Facility Prospective Payment System" Fact Sheet (ICN 006839) was revised and is now available in downloadable format. This fact sheet is designed to provide education on the Inpatient Psychiatric Facility (IRF) Prospective Payment System (PPS). It includes the following information: background, coverage requirements, how payment rates are set, FY 2015 update to the IPF PPS, and the IPF Quality Reporting Program.

"Discharge Planning" Booklet — Revised

The "Discharge Planning" Booklet (ICN 908184) was revised and is now available in downloadable format. This booklet is designed to provide education on Medicare discharge planning. It includes discharge planning information for Acute Care Hospitals, Inpatient Rehabilitation Facilities, and Long Term Care Hospitals; Home Health Agencies; Hospices; Inpatient Psychiatric Facilities; Long Term Care Facilities; and Swing Beds.

"The Basics of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Accreditation" Fact Sheet — Reminder

"The Basics of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Accreditation" Fact Sheet (ICN 905710) is available in downloadable format. This fact sheet is designed to provide education on DMEPOS. It includes information so suppliers can meet DMEPOS quality standards established by CMS and become accredited by a CMS-approved independent national Accreditation Organization (AO). There is also information on the types of providers who are exempt.

"The Basics of Internet-based PECOS for Physicians and Non-Physician Practitioners" Fact Sheet — Reminder

"The Basics of Internet-based PECOS for Physicians and Non-Physician Practitioners" Fact Sheet (ICN 903764) is available in a downloadable format. This fact sheet is designed to provide education on how physician and non-physician practitioners should enroll in the Medicare program and maintain their enrollment information using 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.

Medicare Learning Network® Products Available In Electronic Publication Format

The following products are now available as an electronic publication (EPUB) 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® (MLN) Electronic Publication".

- The "Medicaid Program Integrity: Understanding Provider Medical Identity Theft" Booklet (ICN 908264) is designed to provide education on the scope and definition of medical identity theft. It includes information on cases involving stolen provider medical identities and strategies that Medicare and Medicaid providers can use to protect themselves against medical identity theft.
- The "Medicaid Program Integrity: Preventing Provider Medical Identity Theft" Fact Sheet (ICN 908265) is designed to provide education on how to prevent provider medical identity theft. It includes information on actions Medicare and Medicaid providers can take to mitigate potential risks to their medical identity.
- The "Medicaid Program Integrity: Safeguarding Your Medical Identity Using Continuing Medical Education (CME)" Educational Tool (ICN 908266) is designed to provide education to help health care professionals protect their identity. It includes a list of websites and other resources related to Medicare and Medicaid medical identity theft.

Is the *eNews* meeting your needs? Give us your feedback!

Subscribe to the *eNews.* Previous issues are available in the archive.

Follow the MLN on Twitter #CMSMLN, and visit us on YouTube.