MLN Connects™ Provider eNews

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Thursday, January 15, 2015



## MLN Connects™ National Provider Calls

### ESRD QIP Payment Year 2017 and 2018 Final Rule — Last Chance to Register

*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 began 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.

## CMS Events

### Volunteer for ICD-10 End-to-End Testing in April — Forms Due 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"
- MLN Matters® Special Edition Article #SE1501, "FAQs – ICD-10 Acknowledgement Testing and End-to-End Testing"

### Webinar for Comparative Billing Report on Modifier 59: Dermatology

*Wednesday, February 4; 3-4pm ET*

Join CMS for an informative discussion of the comparative billing report on Modifier 59: Dermatology (CBR201501). The presentation will be provided by CMS contractor eGlobalTech and its partner, Palmetto GBA. CBR201501 is an educational tool designed to assist physicians specializing in dermatology who submitted claims for lesion biopsy and destruction services appended with Modifier 59, a distinct procedural service.

*Agenda:*

- Opening remarks
- Overview of Comparative Billing Report (CBR201501)
- Coverage policy for Modifier 59
- Methods and results
- Resources
- Question & Answer Session

*Presenter Information:*

- Speakers: Craig DeFelice, Cyndi Wellborn, Molly Wesley
- Organizations: eGlobalTech and Palmetto GBA

*How to Register and Event Replay:*

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

### Open Payments Program Overview Video Tutorial Now Available

The 2014 Open Payments Program Overview and Enhancements – Video Tutorial is now available on the Resources web page. This video provides an overview of the 2014 Open Payments program year, along with general guidance on navigating the Open Payments system. During this 20 minute video, viewers can reacquaint themselves with the reporting process and timeline, get an overview of system enhancements, and learn where to access resources and information.

## Announcements

### Help Protect the Vision of Your Medicare Patients — Recommend Annual Glaucoma Screening

January is Glaucoma Awareness Month. Did you know 2.7 million Americans have glaucoma and only half of them know it? Did you know African Americans are at higher risk for glaucoma? Did you know glaucoma runs in families? Glaucoma often presents no early warning signs or symptoms and left untreated, glaucoma can lead to permanent vision loss or blindness. Early detection and treatment is the best way to control the disease. Help protect the vision of your at-risk Medicare patients by recommending an annual glaucoma screening covered by Medicare.

*Medicare Coverage*
Medicare provides coverage of an annual glaucoma screening for beneficiaries in at least one of the following high risk groups:

- Individuals with diabetes mellitus
- Individuals with a family history of glaucoma
- African-Americans age 50 and older
- Hispanic-Americans age 65 and older

A Medicare-covered glaucoma screening includes:

- a dilated eye examination with an intraocular pressure measurement, and
- a direct ophthalmoscopy examination or a slit-lamp biomicroscopic examination.

The copay/coinsurance and deductible apply.

*For More Information*

- Medicare Learning Network® "Quick Reference Information: Preventive Services" 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: The ABCs of Providing the Annual Wellness Visit" Educational Tool
- Medicare Learning Network "Medicare Vision Services" Fact Sheet
- National Eye Health Education Program (NEHEP) – Glaucoma Website

## Hospice Providers: Continue to Collect and Submit HIS Data in 2015

December 31, 2014 marked the close of the FY 2016 data collection cycle for the Hospice Item Set (HIS). For the FY 2016 data collection cycle, hospices were required to report HIS data, including a HIS-Admission and HIS-Discharge record for each patient admission to their hospice from July 1, 2014 through December 31, 2014. HIS data submission for patient admissions occurring between July 1 and December 31, 2014 will be used by CMS to determine compliance and Hospice Quality Reporting Program (HQRP) requirements for the FY 2016 Annual Payment Update (APU) determination. Hospice providers should continue to complete and submit HIS records for patient admissions occurring after December 31, 2014. Patient admissions occurring from January 1, 2015 through December 31, 2015 will impact the FY 2017 APU determination.

For more information on HIS requirements, please visit the HIS web page or contact the Quality HelpDesk at HospiceQualityQuestions@cms.hhs.gov.

## Open Payments System Unavailable through Late January

The Open Payments system remains unavailable until late January. CMS is currently working on system enhancements and preparing for the 2014 program year. Read more about the system enhancements on the Open Payments website.

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 by calling 855-326-8366, Monday through Friday, from 7:30am to 6:30pm CT, excluding Federal holidays.

## Claims, Pricers, and Codes

### Adjustment of Some Home Health Claims: Update

Certain Home Health claims for episodes beginning October 1, 2013 and after, which are subject to the payment shift between the Part A and Part B trust funds, have not been paid correctly. No payment is going to the provider and the entire payment is being reported under Value Code 17. The system correction done in August 2014 was unsuccessful. An additional correction was made on December 8, 2014. Affected claims will be adjusted by April 1, 2015. No provider action is needed.

## Medicare Learning Network® Educational Products

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

MLN Matters® Special Edition Article #SE1501, "FAQs – International Classification of Diseases, 10th Edition (ICD-10) Acknowledgement Testing and 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 testing. It includes FAQs regarding acknowledgement testing and end-to-end testing.

### "Ambulance Fee Schedule" Fact Sheet — Revised

The "Ambulance Fee Schedule" Fact Sheet (ICN 006835) was revised and is now available in downloadable format. This fact sheet is designed to provide education on the Ambulance Fee Schedule. It includes the following information: background, the Medicare ambulance transport benefit, ambulance providers and suppliers, Advance Beneficiary Notice of Noncoverage, payments, how payment rates are set, and updates to the fee schedule.

### "Medicare Secondary Payer for Providers, Physicians, Other Suppliers, and Billing Staff" Fact Sheet — Revised

The "Medicare Secondary Payer for Providers, Physicians, Other Suppliers, and Billing Staff" Fact Sheet (ICN 006903) was revised and is now available in a downloadable format. This fact sheet is designed to provide education on the Medicare Secondary Payer (MSP) provisions. It includes information on MSP basics, common situations when Medicare may pay first or second, Medicare conditional payments, the Coordination of Benefits rules, and role the Benefits Coordination & Recovery Center.

### "Avoiding Medicare Fraud and Abuse: A Roadmap for Physicians" Web-Based Training Course — Revised

The "Avoiding Medicare Fraud and Abuse: A Roadmap for Physicians" Web-Based Training Course (WBT) was revised and is now available. This WBT is designed to provide education on the federal laws that combat

fraud and abuse. It includes the identification of "red flags" that could lead to potential legal liability, compliance recommendations for physicians, real-life fraud and abuse case examples, and helpful online resources about fraud and abuse. Continuing education credits are available to learners who successfully complete this course. See course description for more information.

To access the WBT, go to MLN Products, scroll to the bottom of the web page and under “Related Links” click on “Web-Based Training Courses.”

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