

Thursday, January 29, 2015

MLN Connects™ National Provider Calls

Payment of Chronic Care Management Services Under CY 2015 Medicare PFS — Registration Now Open

ICD-10 Implementation and Medicare Testing — Registration Now Open

New MLN Connects™ National Provider Call Audio Recording and Transcript

CMS Events

Special Open Door Forum: Prior Authorization of Non-Emergent Hyperbaric Oxygen Therapy

Special Open Door Forum: Understanding Dialysis Facility Compare-Driving Informed Decision Making

Special Open Door Forum: Adding Star Ratings to the Home Health Compare Website

Announcements

Influenza Updates from CDC

Pneumococcal Vaccinations Update from CMS

CMS Launches Dialysis Facility Compare Star Ratings

HHS Sets Clear Goals and Timeline for Shifting Medicare Reimbursements from Volume to Value

EHR Incentive Program: Eligible Professional 2014 Attestation Deadline on February 28

EHR Incentive Programs: New Stage 2 Summary of Care FAQ Provides Guidance on Measure #3

Comparative Billing Report on Modifiers 24 & 25: Specialty Surgeons

ICD-10 Resources

Claims, Pricers, and Codes

Payment for HCPCS Code Q0091 as an RHC or FQHC Billable Visit under the All-Inclusive Rate System

Medicare Learning Network® Educational Products

“Continued Use of Modifier 59 after January 1, 2015” MLN Matters® Article — Released

“Telehealth Services” Fact Sheet — Revised

“Medicare Part B Immunization Billing” Educational Tool — Revised

New Medicare Learning Network® Provider Compliance Fast Fact

Medicare Learning Network® Products Available In Electronic Publication Format

MLN Connects™ National Provider Calls

Payment of Chronic Care Management Services Under CY 2015 Medicare PFS — Registration Now Open

Wednesday, February 18; 1:30-3pm ET

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

In CY 2015, CMS will begin making separate payment under the Medicare Physician Fee Schedule (PFS) for Chronic Care Management (CCM) services under Current Procedure Terminology (CPT) code 99490. CCM services are non-face-to-face care management/coordination services for certain Medicare beneficiaries having multiple (two or more) chronic conditions. During this MLN Connects™ National Provider Call, CMS will review the requirements for physicians and other practitioners to bill the new CPT code to the PFS. A question and answer session will follow the presentation.

Call participants are encouraged to review the following rules prior to the call: The 2014 PFS final rule (CMS-1600-FC) pages 74414-74427 and the 2015 PFS final rule (CMS-1612-FC) pages 67715-67730, which are available on the [PFS](#) web page.

Note: CPT codes, descriptions, and other data only are copyright 2014 American Medical Association. All rights reserved.

Agenda:

- Overview
- Eligible population
- Scope of service
- Question and answer session

Target Audience: Practitioners and providers interested in billing chronic care management services to Medicare, as well as coders, practice managers, and other interested stakeholders.

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

ICD-10 Implementation and Medicare Testing — Registration Now Open

Thursday, February 26; 1:30-3pm ET

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

CMS is offering acknowledgement testing and end-to-end testing to help the Medicare Fee-For-Service (FFS) provider community get ready for the October 1, 2015 implementation date. During this MLN Connects™ National Provider Call, CMS subject matter experts will discuss opportunities for testing and results from previous testing weeks, along with implementation issues and resources for providers. A question and answer session will follow the presentations.

Participants are encouraged to review the testing resources on the [Medicare FFS Provider Resources](#) web page prior to the call, including MLN Matters® Articles and testing results.

Agenda:

- Participating in acknowledgement and end-to-end testing
- Results from previous acknowledgement and end-to-end testing weeks
- National implementation update

- Provider resources

Target Audience: Medical coders, physicians, physician office staff, nurses and other non-physician practitioners, provider billing staff, health records staff, vendors, educators, system maintainers, laboratories, and all Medicare providers.

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 Recording and Transcript

An audio recording and transcript are now available for the following call: January 13 — *Medicare Quality Reporting Programs: Data Submission Process*: [audio recording](#) and [transcript](#). More information is available on the [call detail](#) web page. This call provides an overview of the 2014 submission process for Medicare Quality Reporting Programs, including the Physician Quality Reporting System, Value-Based Payment Modifier, and the Electronic Health Record Incentive Program.

CMS Events

Special Open Door Forum: Prior Authorization of Non-Emergent Hyperbaric Oxygen Therapy

Tuesday, February 3; 1:30-2:30pm ET

CMS will host a Special Open Door Forum (ODF) to allow Medicare providers, hospitals, and additional interested parties to learn about the upcoming prior authorization of non-emergent hyperbaric oxygen therapy in the states of Illinois, Michigan, and New Jersey. This Special ODF, the third on this prior authorization model, will include information on the prior authorization process and a question and answer period. Additional information and participation instructions are available on the [announcement](#).

Special Open Door Forum: Understanding Dialysis Facility Compare-Driving Informed Decision Making

Wednesday, February 4; 2-3pm ET

CMS will host a Special Open Door Forum call with patient advocacy groups, dialysis patients, and other interested parties to provide information and to solicit feedback on the introduction of star ratings on Dialysis Facility Compare. Additional information and participation instructions are available on the [announcement](#).

Special Open Door Forum: Adding Star Ratings to the Home Health Compare Website

Thursday, February 5; 1:30-3pm ET

CMS will host a second Special Open Door Forum call to allow consumers, home health agencies, and other interested parties to give additional input and feedback on the planned addition of star ratings to the Medicare.gov Home Health Compare website. Additional information and participation instructions are available on the [announcement](#).

Announcements

Influenza Updates from CDC

From the CDC: Protection from flu vaccination is reduced this season; CDC urges early treatment of severely ill and high-risk patients

Recent Centers for Disease Control and Prevention (CDC) data indicate this season's influenza vaccine offers reduced protection, lessening a person's risk of having to go to the doctor because of flu by 23 percent among people of all ages. The reduced protection offered by flu vaccine this season makes the appropriate use of influenza antiviral (or "anti-flu") medications more important than usual.

CDC is recommending that all hospitalized patients and all outpatients at high risk for serious complications be treated as soon as possible with one of three available influenza antiviral medications if influenza is suspected, regardless of a patient's vaccination status and without waiting for confirmatory testing. Further, health care providers should advise patients at high risk to call promptly if they get symptoms of influenza.

For those who have not yet been vaccinated this season, getting vaccinated is still worthwhile. Even while offering reduced protection, this season's vaccine can prevent some influenza infections and can also lessen serious complications that could result in hospitalization and death.

Note: The influenza vaccine and its administration are covered under Medicare Part B. The Influenza vaccine is not a Part D-covered drug.

For More Information:

- CDC [Influenza \(Flu\)](#) web page for the latest information on flu, including the CDC 2014-2015 recommendations for the prevention and control of influenza, antiviral information, CDC flu mobile app, Q&As, toolkit for long term care employers, and other free resources.
- CDC [Antiviral Drugs](#) website for information about how antiviral medications can be used to prevent or treat influenza when influenza activity is present in your community, and view the updated [Influenza Antiviral Medications: Summary for Clinicians](#).
- A CDC [Health Update](#) reminding clinicians about the importance of flu antiviral medications was distributed via the CDC Health Alert Network on January 9, 2015.
- [MLN Matters® Article #MM8890](#), "Influenza Vaccine Payment Allowances - Annual Update for 2014-2015 Season."
- [MLN Matters Article #SE1431](#), "2014-2015 Influenza (Flu) Resources for Health Care Professionals."

Pneumococcal Vaccinations Update from CMS

Update from CMS: Medicare Part B coverage of pneumococcal vaccinations — Modification

Prior to 2015, pneumococcal vaccine was covered once in a beneficiary's lifetime, with revaccinations covered for those at highest risk if 5 years have passed since the last vaccination or if the beneficiary's vaccination history was unknown. The Advisory Committee on Immunization Practices (ACIP) recently updated its guidelines regarding pneumococcal vaccines. The ACIP recommends administration of two different pneumococcal vaccinations.

CMS updated the Medicare coverage requirements to more closely align with the updated ACIP recommendations. An initial pneumococcal vaccine may be administered to all Medicare beneficiaries who have never received a pneumococcal vaccine under Medicare Part B. A different, second pneumococcal vaccine may be administered 1 year after the first vaccine was administered (i.e., 11 full months have passed following the month in which the last pneumococcal vaccine was administered). Refer to [MLN Matters® Article #MM9051](#) for more information on this coverage change.

Note: The pneumococcal vaccine and its administration are covered under Medicare Part B. The pneumococcal vaccine is not a Part D-covered drug.

CMS Launches Dialysis Facility Compare Star Ratings

On January 22, CMS added star ratings to the Dialysis Facility Compare (DFC) website. These ratings summarize performance data, making it easier for consumers to use the information on the website. These ratings also spotlight excellence in health care quality. In addition to posting the star ratings, CMS updated data on individual DFC quality measures to reflect the most recent data for the existing measures.

DFC joined Nursing Home Compare and Physician Compare in expanding the use of star ratings on CMS websites. The DFC rating gives a one to five-star rating based on information about the quality of care and services that a dialysis facility provides. Currently, nine DFC quality measures are being used collectively to comprise the DFC star ratings. In the future, CMS will add more measures.

CMS also plans to add the Standardized Readmission Ratio (SRR) for dialysis facilities to the publicly reported quality outcome measures available on the Compare website. SRR is a measure of care coordination. SRR is not included in DFC's star rating at this time.

DFC quality measure data is either updated quarterly or annually. CMS plans to update the DFC's star rating on an annual basis beginning in October 2015.

For more information:

- [Fact Sheet](#)
- [Dialysis Facility Compare](#) website

Full text of this excerpted [CMS press release](#) (issued January 22).

HHS Sets Clear Goals and Timeline for Shifting Medicare Reimbursements from Volume to Value *Better, Smarter, Healthier*

On January 26, in a meeting with nearly two dozen leaders representing consumers, insurers, providers, and business leaders, HHS Secretary Sylvia M. Burwell announced measurable goals and a timeline to move the Medicare program, and the health care system at large, toward paying providers based on the quality, rather than the quantity of care they give patients.

HHS has set a goal of tying 30 percent of traditional, or Fee-For-Service, Medicare payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs) or bundled payment arrangements by the end of 2016, and tying 50 percent of payments to these models by the end of 2018. HHS also set a goal of tying 85 percent of all traditional Medicare payments to quality or value by 2016 and 90 percent by 2018 through programs such as the Hospital Value-Based Purchasing and the Hospital Readmissions Reduction Programs. This is the first time in the history of the Medicare program that HHS has set explicit goals for alternative payment models and value-based payments.

To make these goals scalable beyond Medicare, Secretary Burwell also announced the creation of a Health Care Payment Learning and Action Network. Through the Learning and Action Network, HHS will work with private payers, employers, consumers, providers, states and state Medicaid programs, and other partners to expand alternative payment models into their programs. HHS will intensify its work with states and private payers to support adoption of alternative payment models through their own aligned work, sometimes even

exceeding the goals set for Medicare. The Network will hold its first meeting in March 2015, and more details will be announced in the near future.

For more information:

- Article in the New England Journal of Medicine by Secretary Burwell: [Setting Value-Based Payment Goals — HHS Efforts to Improve U.S. Health Care](#)
- Fact Sheet: [Better Care. Smarter Spending. Healthier People: Why It Matters](#)
- Fact Sheet: [Better Care. Smarter Spending. Healthier People: Paying Providers for Value, Not Volume](#)
- Fact Sheet: [Better Care, Smarter Spending, Healthier People: Improving Our Health Care Delivery System](#)

Full text of this excerpted [HHS press release](#) (issued January 26).

EHR Incentive Program: Eligible Professional 2014 Attestation Deadline on February 28

If you are an eligible professional participating in the Medicare Electronic Health Record (EHR) Incentive Program, you have until February 28, 2015 at 11:59pm ET to attest to demonstrating meaningful use of the data collected during your EHR reporting period for the 2014 CY. The [CMS Attestation System](#) is open and operational, and includes the [2014 Certified EHR Technology \(CEHRT\) Flexibility Rule](#) options.

- You must attest to demonstrating meaningful use *every year* to receive an incentive and avoid a Medicare payment adjustment.
- If you are participating in the Medicaid EHR Incentive Program, please refer to your [state's deadlines](#) for attestation information.

Payment Adjustments

Payment adjustments were applied beginning January 1, 2015 for Medicare eligible professionals that did not successfully demonstrate meaningful use in 2013 (or 2014 for first-time participants) and did not receive a 2015 hardship exception. Medicare eligible professionals that did not successfully demonstrate meaningful use in 2014 and do not receive a 2016 hardship exception will have payment adjustments applied beginning January 1, 2016. The application period will open in early January 2015. For more information, please review the [payment adjustment tipsheet](#).

- If you are eligible to participate in both the Medicare and Medicaid EHR Incentive Programs, you *must* demonstrate meaningful use to avoid the payment adjustments. You may demonstrate meaningful use under either Medicare or Medicaid.
- If you are only eligible to participate in the Medicaid EHR Incentive Program, you are not subject to these payment adjustments.

Attestation Resources

- [Stage 1 Eligible Professionals Meaningful Use Table of Contents \(2014 definition\)](#)
- [Stage 2 Eligible Professionals Meaningful Use Table of Contents](#)
- [2014 Stage 1 Attestation User Guide for Eligible Professionals](#)
- [2013 Stage 1 Attestation User Guide for Eligible Professionals](#)
- [Stage 2 Attestation User Guide for Eligible Professionals](#)
- [CEHRT Flexibility Attestation Guide](#)

EHR Incentive Programs: New Stage 2 Summary of Care FAQ Provides Guidance on Measure #3

CMS recently added a new FAQ on the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs Stage 2 Summary of Care objective. Question: When reporting on the Summary of Care objective in

the EHR Incentive Programs, how can eligible professionals, eligible hospitals, and critical access hospitals meet measure 3 if they are unable to complete a test with the CMS Designated Test EHR (NIST EHR-Randomizer Application)? [Read the answer.](#)

Comparative Billing Report on Modifiers 24 & 25: Specialty Surgeons

CMS will issue a national provider Comparative Billing Report (CBR) on specialty surgery providers' use of Modifiers 24 and 25 in February 2015. The CBR, produced by CMS contractor eGlobalTech, will focus on specialty surgeons (excluding general and orthopedic surgeons) who bill Evaluation and Management (E/M) services, 99211-99215, during the global period of a procedure and receive payment by appending Modifier 24 and/or Modifier 25 to the E/M service. The CBR will contain data-driven tables with an explanation of findings comparing these providers' billing and payment patterns to those of their peers within their specialty. 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.

ICD-10 Resources

CMS offers resources to help the health care community prepare for the October 1, 2015, ICD-10 transition — No matter where you are in the process.

ICD-10 Basics

Basic resources are a great place to start if you are looking for the background and benefits of the ICD-10 transition. These resources include overviews tailored by audience, including small and rural practices, payers, and non-covered entities:

- [The ICD-10 Transition: An Introduction](#)
- [ICD-10 Basics for Medical Practices](#)
- [ICD-10 Basics for Small and Rural Practices](#)
- [ICD-10 Basics for Payers](#)
- [The ICD-10 Transition: Focus on Non-Covered Entities](#)

Communicating About ICD-10

Communication between health care providers, software vendors, clearinghouses, and billing services is vital to a successful transition. Learn how to get the conversation started with these resources:

- [Talking to Your Vendors About ICD-10: Tips for Medical Practices](#)
- [Questions to Ask Your Systems Vendors about ICD-10](#)
- [The Role of Clearinghouses in ICD-10](#)
- [Talking to Your Customers About ICD-10: Tips for Software Vendors](#)

Road to 10

The [Road to 10](#) tool is an online resource built with input from providers in small practices. Intended to help small medical practices jumpstart their ICD-10 transition, Road to 10 includes specialty references and the capability to build tailored action plans.

Medscape Education Modules

CMS has two videos and an expert column to help providers prepare for ICD-10 on the [Provider Resources](#) web page. These Medscape education modules offer an overview of ICD-10 for small practices. Continuing medical education (CME) and nursing continuing education (CE) credits are available to providers who complete these resources. Anyone with a free Medscape account can receive a certificate of completion.

Keep Up to Date on ICD-10

Visit the [ICD-10](#) website for the latest news and resources to help you prepare.

Claims, Pricers, and Codes

Payment for HCPCS Code Q0091 as an RHC or FQHC Billable Visit under the All-Inclusive Rate System

CMS determined that screening Papanicolaou smear, Healthcare Common Procedure Coding System (HCPCS) code Q0091, is a billable visit when furnished by a Rural Health Clinic (RHC) or Federally Qualified Health Center (FQHC) practitioner to a RHC or FQHC patient. If other billable visits are furnished on the same day as HCPCS code Q0091, only one visit shall be paid.

To avoid payment delays, RHCs and FQHCs that bill under the All-Inclusive Rate (AIR) system should follow the guidance in the Preventive Services Chart on the [RHC](#) or [FQHC](#) center pages in the first section under Important Links. Submit adjustments for any claims with Q0091, rejected on or after January 1, 2014 to your Medicare Administrative Contractor (MAC), using this billing guidance. For RHCs and FQHCs billing under the AIR system that do not follow this billing guidance, your MAC will hold any claim submitted with Q0091 as a stand-alone service until the system fix is implemented on April 6, 2015.

Medicare Learning Network[®] Educational Products

“Continued Use of Modifier 59 after January 1, 2015” MLN Matters[®] Article — Released

[MLN Matters[®] Article #SE1503](#), “Continued Use of Modifier 59 after January 1, 2015” was released and is now available in downloadable format. This article is designed to provide education on continued use of the new -X {EPSU} modifiers, as outlined in Change Request 8863. It includes information to remind providers that they may continue using the -59 modifier after January 1, 2015, in any instance in which it was correctly used prior to January 1, 2015.

“Telehealth Services” Fact Sheet — Revised

The “[Telehealth Services](#)” Fact Sheet (ICN 901705) was revised and is now available in downloadable format. This fact sheet is designed to provide education on services furnished to eligible Medicare beneficiaries via a telecommunications system. It includes information about originating sites, distant site practitioners, telehealth services, billing and payment for professional services furnished via telehealth, billing and payment for the originating site facility fee, resources, and lists of helpful websites and Regional Office Rural Health Coordinators.

“Medicare Part B Immunization Billing” Educational Tool — Revised

The “[Medicare Part B Immunization Billing](#)” Educational Tool (ICN 006799) has been revised and is now available in downloadable format. This educational tool is designed to provide education on Medicare-covered preventive immunizations. It includes coverage, coding, and billing information on the influenza, pneumococcal, and Hepatitis B vaccines and their administration.

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 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 “[Medicare Quarterly Provider Compliance Newsletter \[Volume 5, Issue 2\]](#)” Educational Tool (ICN 909177) is designed to provide education on how to avoid common billing errors and other erroneous activities when dealing with the Medicare Program. It includes guidance to help health care professionals address and avoid the top issues of the particular Quarter.
- The “[Medicare Billing: 837I and Form CMS-1450](#)” Fact Sheet (ICN 006926) is designed to provide education on electronic and paper claims for institutional providers, as well as other health care professionals and suppliers. It includes information about Medicare claims submissions, coding, submitting accurate claims, when Medicare will accept a hard copy claim form, and timely filing.
- The “[Medicare Billing: 837P and Form CMS-1500](#)” Fact Sheet (ICN 006976) is designed to provide education on electronic and paper claims for health care professionals and suppliers. It includes information about Medicare claims submissions, coding, submitting accurate claims, when Medicare will accept a hard copy claim form, timely filing, and where to submit Fee-For-Service (FFS) claims.

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