MLN Connects®
Provider eNews

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"Medicare Enrollment Guidelines for Ordering/Referring Providers" Fact Sheet — Reminder
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Medicare Learning Network® Product Available In Electronic Publication Format

MLN Connects® National Provider Calls

National Partnership to Improve Dementia Care in Nursing Homes and QAPI — Last Chance to Register

Tuesday, March 10; 1:30-3pm ET

To Register: Visit MLN Connects® Upcoming Calls. Space may be limited, register early.

During this MLN Connects® National Provider Call, CMS subject matter experts will provide National Partnership updates and an overview of Quality Assurance and Performance Improvement (QAPI), as well as a presentation on Adverse Events in nursing homes. Additionally, Advancing Excellence will discuss their campaign for quality in America's nursing homes. A question and answer session will follow the presentations.

The National Partnership to Improve Dementia Care in Nursing Homes and QAPI are partnering on MLN Connects Calls to broaden discussions related to quality of life, quality of care, and safety issues. The National Partnership was developed to improve dementia care in nursing homes through the use of individualized, comprehensive care approaches to reduce the use of unnecessary antipsychotic medications. QAPI standards expand the level and scope of quality activities to make sure that facilities continuously identify and correct quality deficiencies and sustain performance improvement.

Agenda:

- National Partnership updates
- QAPI overview
- Adverse Events in nursing homes
- Advancing Excellence – Campaign for quality

Target Audience: Consumer and advocacy groups, nursing home providers, surveyor community, prescribers, professional associations, 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.

Physician Quality Reporting Programs: Reporting Once in 2015 — Register Now

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

To Register: Visit MLN Connects® Upcoming Calls. Space may be limited, register early.

This MLN Connects® National Provider Call provides an overview of how to report once across various 2015 Medicare Quality Reporting Programs, including the Physician Quality Reporting System (PQRS), Medicare Electronic Health Record (EHR) Incentive Program, Value-Based Modifier (VM), and Medicare Shared Savings Program.

This presentation will help guide providers wishing to report quality measures one time during the 2015 program year and maximize their participation in the various Medicare quality reporting programs. Satisfactory reporters will avoid the 2017 PQRS negative payment adjustment, satisfy the Clinical Quality Measure (CQM) component of the Medicare EHR Incentive Program, and satisfy requirements for the VM, avoiding the VM payment adjustment. Eligible professionals (EPs) participating in these programs are strongly encouraged to participate in this call. A question and answer session will follow the presentation.

Agenda:
How to report once for 2015 Medicare Quality Reporting Programs for:

- Individual EPs
- PQRS group practices
- Medicare Shared Savings Program Accountable Care Organizations (ACOs)
- Pioneer ACOs

Target Audience: Physicians, Medicare EPs, 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.

New MLN Connects® National Provider Call Audio Recording and Transcript

An audio recording and transcript are now available for the February 18 call — *Payment of Chronic Care Management Services Under CY 2015 Medicare PFS*. More information is available on the call detail web page. During this call, subject matter experts review the requirements for physicians and other practitioners to bill the new Current Procedure Terminology (CPT) code to the Physician Fee Schedule (PFS).

Providers and Suppliers — Browse the MLN Connects® Call Program Collection of Resources

The CMS MLN Connects® National Provider Call Program has hosted many educational conference calls for the health care community on a variety of topics, including ICD-10, PQRS, chronic care management, Open Payments (the Sunshine Act), 2-Midnight Rule, Medicare Shared Saving Program, ESRD QIP, and dementia care in nursing homes — just to name a few. Check out our Calls and Events web page for links to slide presentations, audio recordings, written transcripts, and a list of upcoming calls, or view one of our videos on the Medicare Learning Network® Playlist on the CMS YouTube Channel. Become more informed about the Medicare Program by reading, listening, or viewing these information packed programs at your convenience. Visit www.cms.gov/npc for more information on the MLN Connects National Provider Call Program.

CMS Events

Special Open Door Forum: Home Health Electronic Clinical Template and Home Health Paper Clinical Template

Wednesday, March 11; 1-2pm ET

To assist physicians/practitioners in thoroughly documenting patient eligibility for the Medicare home health benefit, CMS is considering the development of a voluntary home health *paper* clinical template. A voluntary home health *electronic* clinical template has been in the development process for the past year. CMS believes the use of clinical templates may reduce burden on the physicians and practitioners who order home health services. CMS will be hosting a series of Special Open Door Forum calls to provide an opportunity for physicians/practitioners, home health agencies and/or all other interested parties to provide feedback on both a paper clinical template and the electronic clinical template for home health services. See the call announcement for additional information.

Announcements

Help Your Medicare Patients "Bite into a Healthy Lifestyle" During National Nutrition Month® and Beyond

CMS reminds health care professionals that March is National Nutrition Month® — a time to "Bite into a Healthy Lifestyle" with informed food choices now and throughout the year. This year's theme encourages consumers to adopt a healthy lifestyle that is focused on consuming fewer calories, making informed food choices, and getting daily exercise in order to achieve and maintain a healthy weight, reduce the risk of chronic disease, and promote overall health.

Nutrition related health conditions are prevalent within the Medicare population. Twenty-eight percent of Medicare beneficiaries have diabetes and fifteen percent have chronic kidney disease. More than one-third of American men and women are obese, and adult obesity is associated with a number of serious health conditions, including heart disease, hypertension, diabetes, and some cancers. Read more to learn about nutrition-related health services covered by Medicare.

Physician Groups that Demonstrate High Quality Care Receive Increases to Their Medicare Payments

CMS posted results from the implementation of the first year of the Value-based Payment Modifier (Value Modifier), part of the Affordable Care Act. The Value Modifier rewards physicians and groups of physicians who provide high quality and cost-effective care, while encouraging improvement for those who do not report quality measures or who don't meet the mark. Based on their 2013 performance on quality and cost measures, nearly 7,000 physicians in 14 group practices across the country are receiving an increase in their Medicare payments in 2015.

While groups that exceeded the program's benchmarks in quality and cost efficiency receive an increase in physician payments under the Medicare Physician Fee Schedule, those who do not perform well or failed to meet quality reporting requirements are seeing a decrease to their Medicare payments in 2015. Most physician groups nationwide met the quality reporting requirements and their Medicare payments remain unchanged.

The Value Modifier is being phased in gradually. In 2015, the Value Modifier is being applied to groups with 100 or more eligible professionals. In 2015, these groups were also given the option of electing "quality-tiering," which was voluntary for the first year of the Value Modifier. Physician groups and physicians can find information about their quality and cost performance in their Quality Resource and Use Reports that were made available last fall.

Beginning in 2016, quality-tiering will automatically apply to all groups subject to the Value Modifier, which includes groups with at least 10 or more eligible professionals. In 2017, the Value Modifier will apply to all groups and to solo practitioners who are physicians. Although the Value Modifier currently only applies to physician payments, beginning in 2018, CMS will begin applying it to non-physician eligible professionals as well.

Full text of this excerpted CMS blog (posted February 27).

CMS Announces Release of 2015 Impact Assessment of Quality Measures Report

On March 2, CMS released the 2015 National Impact Assessment of Quality Measures Report. The report demonstrates that the nation has made clear progress in improving the healthcare delivery system to achieve the three aims of better care, smarter spending, and healthier people.

This report is a comprehensive assessment of quality measures used by CMS. The report summarizes key findings from CMS quality measurement efforts and recommended next steps to improve on these efforts. Quality measurement is a key lever that CMS uses to drive the transformation of the health care system in partnership with hospitals, clinicians, and patients.

Full text of this excerpted CMS blog (posted March 2).

Register for the Health Care Payment Learning and Action Network

Working Together to Move Payment toward Value and Quality in the U.S. Health System

The Health Care Payment Learning and Action Network (Network) is being established to provide a forum for public-private partnerships to help the U.S. health care payment system meet or exceed recently established Medicare goals for value-based payments and alternative payment models. The Network will serve as a forum where payers, providers, employers, purchasers, state partners, consumer groups, individual consumers, and others can discuss how to transition towards alternative payment models that emphasize value. The Network will be supported by an independent contractor that will act as a convener and facilitator.

Visit the Network website to register. See the Fact Sheet for more information.

New EHR Attestation Deadline for Medicare Eligible Professionals: March 20

Eligible professionals now have until 11:59pm ET on March 20, 2015**,** to attest to meaningful use for the Medicare Electronic Health Record (EHR) Incentive Program 2014 reporting year. CMS extended the deadline to allow providers extra time to submit their meaningful use data. To attest, submit your data to the Registration and Attestation System, which includes 2014 Certified EHR Technology (CEHRT) Flexibility Rule options.

Medicare eligible professionals must attest to meaningful use every year to receive an incentive and avoid a payment adjustment. Providers who successfully attest for the 2014 program year will:

- Receive an incentive payment
- Avoid the Medicare payment adjustment, which will be applied January 1, 2016

This extension also gives eligible professionals, who have not already used their one “switch”, to switch programs (from Medicare to Medicaid, or vice versa) for the 2014 payment year until March 20. After that time, eligible professionals will no longer be able to switch programs. *Note: The Medicare extension does not affect deadlines for the Medicaid EHR Incentive Program.*

To learn more, see Educational Resources. For help, call the EHR Information Center at 888-734-6433 (TTY 888-734-6563), Monday through Friday from 8:30am to 7:30pm ET.

Submission Extension for EPs Participating in PQRS via EHR and QCDR: March 20

CMS announced that the submission deadlines for some Physician Quality Reporting System (PQRS) reporting methods have been extended to March 20, 2015 at 8pm ET:

- Electronic Health Record (EHR) Direct or Data Submission Vendor that is certified EHR technology (CEHRT)
- Qualified Clinical Data Registries (QCDRs) (using QRDA III format) reporting for PQRS and the clinical quality measure component of meaningful use for the Medicare EHR Incentive Program

All other submission timeframes for other PQRS reporting methods remain the same. An Individuals Authorized Access to CMS Computer Services (IACS) account with the "PQRS Submitter Role" is required for these PQRS data submission methods. Please see the IACS Quick Reference Guides for specifics.

PQRS provides an incentive payment to individual eligible professionals (EPs) and group practices that satisfactorily participate or satisfactorily report data on quality measures for covered Medicare Physician Fee Schedule (PFS) services. Additionally, those who do not meet the 2014 PQRS reporting requirements will be subject to a negative payment adjustment on all Medicare Part B PFS services rendered in 2016.

For questions, please contact the QualityNet Help Desk at 866-288-8912 or via email at Qnetsupport@hcqis.org from 7am to 7pm CT. Complete information about PQRS is available on the PQRS website.

Hospital VBP FY 2017 Baseline Measures Report Now Available

CMS has announced the release of the Hospital Value-Based Purchasing (VBP) Program FY 2017 Baseline Measures Report. The report allows providers to monitor their baseline period performance for all domains and measures required for the Hospital VBP Program and can be accessed by providers in the hospital through the QualityNet Secure Portal.

See How to Read Your Report for more information. For further assistance regarding the Hospital VBP Program, please contact us through the QualityNet Support web page or by calling 844-472-4477 or 866-800-8765 weekdays from 8am to 8pm ET. More information.

HHAs: Get Started with HHCAHPS Participation

Home Health Agencies (HHAs): it is never too late to begin participation in the Home Health Care Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) survey. Agencies should go to the HHCAHPS website for registration and approved survey vendor authorization. CMS cannot endorse any particular HHCAHPS survey vendor, so shop around for the HHCAHPS survey vendor that best meets your needs.

CMS requires *both* HHCAHPS and Outcome and Assessment Information Set (OASIS) in the federally mandated Home Health Quality Reporting Program for the full Annual Payment Update (APU). If agencies do not participate in either HHCAHPS or OASIS then they receive 98% of the APU. The next APU for HHCAHPS participation is from April 2015 to March 2016, and it counts for the CY 2017 APU.

HHCAHPS participation is beneficial
HHCAHPS participation will benefit your agency and the families that you serve in your community:

- Hospital discharge planners use both the HHCAHPS and OASIS data on Home Health Compare to evaluate HHAs in their geographic locales
- Patients and their families also use Home Health Compare to learn about HHAs, including data on patients' experiences of care, which comes from HHCAHPS

For further information

Please email any questions about HHCAHPS to hhcahps@rti.org or to homehealthcahps@cms.hhs.gov. If you would like us to speak with you about HHCAHPS, please email us your telephone number and the best times to reach you.

Request for Comments on ESRD Conditions for Coverage

The Clinical Standards Group (CSG) in the CMS Center for Clinical Standards and Quality is responsible for developing, updating, and overseeing the CMS regulations on the Conditions for Coverage (CfCs) for End-Stage Renal Disease (ESRD) facilities. These regulations were last revised in 2008; CSG is asking the ESRD community to review the current CfCs and provide suggestions for additions/changes/ deletions that may be useful in any future updates. Please email ESRDCSG@cms.hhs.gov by April 1with your suggestions.

Physicians and Teaching Hospitals: Register in Open Payments System

Physicians and teaching hospitals can now register in the Open Payments system. The review and dispute period for the 2014 program year is anticipated to start in April.

- Physicians and teaching hospitals that registered last year are not required to register again
- Registering is voluntary, but if you do not register, you will not have the opportunity to review and dispute data submitted by applicable manufacturers and Group Purchasing Organizations (GPOs) prior to public posting on June 30, 2015

CMS plans to publish the 2014 payment data and make any applicable updates to the 2013 data in June 2015. More information is available on the Open Payments website. Submit your questions to the Help Desk at openpayments@cms.hhs.gov or 855-326-8366, Monday through Friday, from 7:30am to 6:30pm CT, excluding Federal holidays.

PQRS Payment Adjustments and Providers Who Rendered Services at IDTFs

During Physician Quality Reporting System (PQRS) program years 2013 and 2014, CMS issued guidance that Eligible Professionals (EPs) who rendered services at Independent Diagnostic Testing Facilities (IDTFs) would be eligible, but not able, to participate in PQRS due to their billing methodology. However, based on recent analysis, CMS has identified that services provided at or on behalf of an IDTF align with the billing methodology used for PQRS; therefore, these EPs *are* eligible and able to participate in PQRS. More information.

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.

Claims, Pricers, and Codes

Special CBSA Codes for Home Health Claims

Medicare pays for home health services furnished in 2015 using a transitional wage index. Due to the wage index transition, Home Health Agencies (HHAs) may serve beneficiaries in areas where there is more than one unique Core-Based Statistical Area (CBSA). In these cases, HHAs should use special CBSA codes in the range 50xxx on their claims. See MLN Matters® Article MM8969 for more details.

Some HHAs are not using these special CBSA codes, causing the claim to be paid incorrectly with 2014 wage index values. Soon, 2015 claims with invalid CBSA codes will be returned to the provider. HHAs should adjust any claims previously paid incorrectly.

FQHC Prospective Payment System File Update

The Federally Qualified Health Centers (FQHC) Prospective Payment System (PPS)Pricer web page has been updated with the Pricer cobol code text files for October 2014 and January 2015, which may be downloaded.

Medicare Learning Network® Educational Products

"Physician Feedback, Quality and Resource Use Reports (QRURs) and Value-Based Modifier Program – Overview & Implementation" MLN Matters® Article — Released

MLN Matters® Special Edition Article #SE1507, "Physician Feedback, Quality and Resource Use Reports (QRURs) and Value-Based Modifier Program – Overview & Implementation" has been released and is now available in downloadable format. This article is designed to provide education on the Physician Feedback/Value-Based Payment Modifier Program that will provide comparative performance information to individual physicians and groups, as part of Medicare's efforts to improve the quality and efficiency of medical care.

"Diagnosis Coding: Using the ICD-10-CM" Web-Based Training Course — Released

The "Diagnosis Coding: Using the ICD-10-CM" Web-Based Training Course (WBT) was released and is now available. This WBT is designed to provide education on the International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS). It includes ICD-10-CM/PCS

implementation guidance, information on the new ICD-10-CM classification system, and coding examples. Continuing education credits are available to learners who successfully complete this course. See course description for more information.

To access the WBT, go to Medicare Learning Network® Products, scroll to "Related Links" at the bottom of the web page, and click on "Web-Based Training Courses."

"Medicare Physician Fee Schedule" Fact Sheet — Revised

The "Medicare Physician Fee Schedule" Fact Sheet (ICN 006814) was revised and is now available in downloadable format. This fact sheet is designed to provide education on the Medicare Physician Fee Schedule (PFS). It includes the following information: physician services, Medicare PFS payment rates, and resources.

"Medicare Enrollment Guidelines for Ordering/Referring Providers" Fact Sheet — Reminder

The "Medicare Enrollment Guidelines for Ordering/Referring Providers" Fact Sheet (ICN 906223) is available in downloadable format. This fact sheet is designed to provide education on the Medicare enrollment requirements for eligible ordering/referring providers. It includes information on the three basic requirements for ordering and referring, and who may order and refer for Medicare Part A Home Health Agency, Part B, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) beneficiary services.

"Medicare Fraud & Abuse: Prevention, Detection, and Reporting" Fact Sheet — Reminder

The "Medicare Fraud & Abuse: Prevention, Detection, and Reporting" Fact Sheet (ICN 006827) is available in downloadable format. This fact sheet is designed to provide education on preventing, detecting, and reporting Medicare fraud and abuse. It includes fraud and abuse definitions, as well as an overview of the laws used to fight fraud and abuse; descriptions of the government partnerships engaged in preventing, detecting, and fighting fraud and abuse; and resources on how providers can report suspected fraud and abuse.

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® Product Available In Electronic Publication Format

The following product is now available as an electronic publication (EPUB) and through a QR code. Instructions for downloading EPUBs and how to scan a QR code are available at "How To Download a Medicare Learning Network® Electronic Publication."

The "Telehealth Services" Fact Sheet (ICN 901705) 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.

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