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MLN Connects[®] National Provider Calls

Medicare Acute Care Quality and Reporting Programs — Register Now

Tuesday, May 12; 1:30-3pm ET

To Register: Visit [MLN Connects® Upcoming Calls](#). Space may be limited, register early.

Quality health care for people with Medicare is a high priority for the President, HHS, and CMS. HHS and CMS began launching Quality Initiatives in 2001 to assure quality health care for all Americans through accountability and public disclosure. The various Quality Initiatives touch every aspect of the health care system. This call will provide an overview of all Hospital Inpatient Quality Reporting and Value-Based Purchasing Programs.

Agenda:

- Hospital Inpatient Quality Reporting (IQR) Program
- Hospital Value-Based Purchasing (HVBP) Program
- Hospital Acquired Condition Reduction Program (HACRP)
- Hospital Readmission Reduction Program (HRRP)
- Electronic Health Records (EHR) Incentive Program
- Program alignment, goals, and conclusion

Target Audience: Hospital administrators, executive-level leaders, quality professionals, and staff new to quality reporting programs.

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.

2014 Mid-Year QRURs – Save the Date

Wednesday, June 3; 1:30-3pm ET

To Register: Visit [MLN Connects® Upcoming Calls](#). Space may be limited, register early.

CMS has released the 2014 Mid-Year Quality and Resource Use Reports (MYQRURs) to physician solo practitioners and groups of physicians nationwide, including solo practitioners and groups with physicians who participated in the Medicare Shared Savings Program, the Pioneer Accountable Care Organization (ACO) model, or the Comprehensive Primary Care (CPC) initiative in 2014. The 2014 MYQRURs were made available for informational purposes and contain information on a subset of the measures used to calculate the 2016 Value Modifier. This MLN Connects® National Provider Call will provide an overview of the 2014 MYQRUR and explain how to interpret and use the information in the report. Learn more about the reports on the [MYQRUR web page](#).

The call will be more meaningful if you have your MYQRUR in front of you to follow along. Visit the [How to Obtain a QRUR](#) web page and access your report prior to the call.

Agenda:

- Overview of the 2014 MYQRUR
- How to understand and use the 2014 MYQRURs
- Question and answer session

Target Audience: Physicians, practitioners, 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 Video Slideshow, Audio Recordings and Transcripts

A video slideshow presentation, audio recordings, and transcripts are now available for the following calls:

- February 26 — *ICD-10 Implementation and Medicare Testing*: [video slideshow presentation](#). More information is available on the [call detail](#) web page. During this call, CMS subject matter experts discussed opportunities for testing and results from previous testing weeks, along with implementation issues and resources for providers.
- April 15 — *Open Payments (Sunshine Act) 2015: Prepare to Review Reported Data*: [audio recording](#) and [transcript](#). More information is available on the [call detail](#) web page. This call provided a brief overview of the Open Payments national transparency program and highlighted the parts of the program timeline when it is most critical for physicians and teaching hospitals to be aware and get involved.
- April 16 — *How to Register for the PQRS Group Practice Reporting Option in 2015*: [audio recording](#) and [transcript](#). More information is available on the [call detail](#) web page. This call gave a walkthrough of the PV-PQRS Registration System, an application that serves the Value Modifier and Physician Quality Reporting System (PQRS) programs.

CMS Events

Participate in Final ICD-10 Acknowledgement Testing Week: June 1 through 5

To help you prepare for the transition to ICD-10, CMS offers acknowledgement testing for current direct submitters (providers and clearinghouses) to test with the Medicare Administrative Contractors (MACs) and the Durable Medical Equipment (DME) MAC Common Electronic Data Interchange (CEDI) contractor anytime up to the October 1, 2015, implementation date.

CMS previously conducted three successful acknowledgement testing weeks in [March 2014](#), [November 2014](#), and [March 2015](#). These acknowledgement testing weeks give submitters access to real-time help desk support and allow CMS to analyze testing data. Mark your calendar for the final acknowledgement testing week on June 1 through 5, 2015.

Note: [MLN Matters® Special Edition Article SE1501](#) explains the differences between acknowledgement and end-to-end testing with Medicare. For acknowledgement testing, all electronic submitters are encouraged to participate, even if you submit claims through a clearinghouse.

How to participate:

Information is available on your [MAC](#) website or through your clearinghouse (if you use a clearinghouse to submit claims to Medicare). Any provider who submits claims electronically can participate in acknowledgement testing.

What you can expect during testing:

- Test claims will receive the 277CA or 999 acknowledgement as appropriate, to confirm that the claim was accepted or rejected in the system
- Test claims will be subject to all current front-end edits, including edits for valid National Provider Identifiers (NPIs), Provider Transaction Access Numbers (PTANs), and codes, including Healthcare Common Procedure Coding System (HCPCS) and place of service
- Testing will not confirm claim payment or produce a Remittance Advice (RA)

- MACs and CEDI will be staffed to handle increased call volume during this week

Testing tips:

- Make sure test files have the "T" in the ISA15 field to indicate the file is a test file
- Send ICD-10 coded test claims that closely resemble the claims that you currently submit
- Use valid submitter ID, NPI, and PTAN combinations
- Use current dates of service on test claims (i.e. October 1, 2014 through June 1, 2015)
- Do not use future dates of service or your claim will be rejected

For more information:

- [MLN Matters Article MM8858](#), "ICD-10 Testing - Acknowledgement Testing with Providers"
- [MLN Matters Special Edition Article SE1409](#), "Medicare FFS ICD-10 Testing Approach"

Special Open Door Forum: Home Health Patient Survey Star Ratings

Thursday, May 7; 1:30-2:30pm ET

CMS will host a Special Open Door Forum about a new set of Star Ratings for the Home Health Compare website. More information and participation instructions are available in the [announcement](#).

Announcements

Proposed FY 2016 Inpatient Rehabilitation Facility Payment and Policy Changes

On April 23, CMS issued a proposed rule ([CMS-1624-P](#)) outlining proposed FY 2016 Medicare payment policies and rates for the Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) and the IRF Quality Reporting Program (QRP).

CMS is proposing to update the IRF PPS payments for FY 2016 to reflect an estimated 1.9 percent increase factor (reflecting a new IRF-specific market basket estimate of 2.7 percent, reduced by a 0.6 percentage point multi-factor productivity adjustment and a 0.2 percentage point reduction required by law). CMS is proposing that if more recent data are subsequently available, we would use such data to determine the FY 2016 update in the final rule. An additional 0.2 percent decrease to aggregate payments due to updating the outlier threshold results in an overall update of 1.7 percent (or \$130 million), relative to payments in FY 2015.

The proposed rule also includes:

- No changes to the facility-level adjustments
- ICD-10-CM conversion for the IRF PPS
- Changes to the wage index

CMS will accept comments on the proposed rule until June 22, 2015.

Full text of this excerpted [CMS fact sheet](#) (issued April 23).

Proposed FY 2016 Inpatient Psychiatric Facility Payment and Policy Changes

On April 24, CMS issued a proposed rule ([CMS-1627-P](#)) outlining proposed FY 2016 Medicare payment policies and rates for the Inpatient Psychiatric Facility (IPF) Prospective Payment System. The proposed rule also updates the IPF Quality Reporting (IPFQR) Program, which requires participating facilities to report on

quality measures or incur a reduction in their annual payment update. This proposed rule would expand the measure sets in future fiscal years and change certain data reporting requirements for these measures.

CMS is proposing to update the estimated payments to IPFs in FY 2016 relative to estimated payments in FY 2015 by 1.6 percent (or \$80 million). This amount reflects a 2.7 percent IPF-specific market basket estimate less the productivity adjustment of 0.6 percentage point and less the 0.2 percentage point reduction required by law, for a net update of 1.9 percent. Estimated payments to IPFs are reduced by 0.3 percent due to updating the outlier fixed-dollar loss threshold amount.

The proposed rule also includes:

- Stand-alone IPF market basket and labor related share for FY 2016
- Updates to the wage index
- IPFQR measures proposed for adoption for FY 2018 payment determination and subsequent years
- IPFQR measures proposed for removal

CMS will accept comments on the proposed rule until June 23, 2015.

Full text of this excerpted [CMS fact sheet](#) (issued April 24).

Focusing on Women's Health

National Women's Health Week kicks off this year on Mother's Day, May 10, and continues through May 16; Monday, May 11 is the 13th annual National Women's Check-up Day. The goal of these national health observances, led by the [HHS Office on Women's Health](#), is to empower women to make their health a priority. The week also serves as a time to help women understand what steps they can take to improve their health. CMS reminds health care professionals that Medicare provides coverage for an array of preventive services that can help women take steps to meet the challenge to be healthier, many without any out-of-pocket costs to them. [Continue reading](#).

Open Payments Physician and Teaching Hospital Review and Dispute Period Ends May 20

Physicians and teaching hospitals have until May 20, 2015, to voluntarily review data reported by drug and medical device makers about them, and, if necessary, dispute payments before the data is made public on June 30, 2015. To review data, physicians and teaching hospitals must [register in both the CMS Enterprise Portal and the Open Payments system](#). This is the second reporting cycle for Open Payments, and it covers payments made in 2014. Last year, CMS published information about 4.45 million payments valued at \$3.7 billion for the last five months of 2013.

Physicians and teaching hospitals who registered last year do not need to register again in the CMS Enterprise Portal or the Open Payments system. Go to the [CMS Enterprise Portal](#), log in using your user ID and password, and navigate to the Open Payments system home page. Use the [Review and Dispute Process Quick Reference Guide](#) to assist you with reviewing the submitted information and affirming or disputing the reported data before it is published.

The CMS Enterprise Portal locks accounts if there is no activity for 60 days or more and deactivates accounts if there is no activity for 180 days or more. To unlock an account, go to the [CMS Enterprise Portal](#), enter your user ID, and correctly answer all challenge questions; you'll then be prompted to enter a new password. To reinstate an account, contact the [Open Payments Help Desk](#).

Learn more about the review and dispute process by accessing the educational materials available on the [Resources](#) web page.

Notices of Intent to Apply for Medicare Shared Savings Program January 1, 2016, Start Date Due by May 29

If you are interested in applying for participation in the Medicare Shared Savings Program for the January 1, 2016, program start date, you must submit a Notice of Intent to Apply by Friday, May 29, 2015, 8pm ET. For more information about the application process, visit the [Shared Savings Program Application](#) web page.

2015 PV-PQRS GPRO Registration is Open

Groups can register to participate in the 2015 Physician Quality Reporting System (PQRS) Group Practice Reporting Option (GPRO) via the Physician Value - Physician Quality Reporting System (PV-PQRS) Registration System. PQRS GPRO is an option available to groups with 2 or more eligible professionals (EPs). Groups must meet the satisfactory reporting criteria through the PQRS GPRO in order to avoid the -2.0% CY 2017 PQRS payment adjustment. More information is available on the [PQRS Payment Adjustment Information](#) web page.

Physicians in groups of all sizes and physician solo practitioners are subject to the Value Modifier in 2017, based on performance in 2015. Under the Value Modifier, these physicians and groups must meet the criteria to avoid the downward payment adjustment under PQRS in order to avoid an *additional* automatic downward adjustment under the Value Modifier and qualify for adjustments based on their quality performance. Satisfactorily reporting via a PQRS GPRO is one of the ways groups can avoid automatic downward adjustments and qualify for performance-based payment incentives under the Value Modifier. See [What Physicians Need to do in 2015 for the 2017 VM](#) on the [Value Modifier](#) web page for more information.

Groups can participate in the PQRS program for the 2015 performance period by selecting one of the GPRO reporting mechanisms between April 1, 2015, and June 30, 2015, at 11:59pm ET:

- Qualified PQRS Registry.
- Electronic Health Record (EHR) via Direct EHR using certified EHR technology (CEHRT) or CEHRT via Data Submission Vendor.
- Web Interface (for groups with 25 or more EPs only).
- Consumer Assessment of Health Providers and Systems (CAHPS) for PQRS Survey via a CMS-certified Survey Vendor (as a supplement to another GPRO reporting mechanism). See [CAHPS for PQRS Made Simple](#) for complete details.

Physician groups with 2 or more EPs that choose not to register, must ensure that at least 50% of the EPs in the group meet the criteria to avoid the 2017 PQRS payment adjustment as individuals in order for the group to avoid the automatic 2017 Value Modifier downward payment adjustment (-2.0% or -4.0% depending on the group's size).

The [Registration System](#) can be accessed using a valid Individuals Authorized Access to the CMS Computer Services (IACS) account. Instructions for obtaining an IACS account with the correct role are provided on the [PQRS GPRO Registration](#) web page. Instructions for registering to participate in the 2015 PQRS GPRO are provided in the [2015 PQRS GPRO Registration Guide](#).

Participation Continues to Rise in Medicare PQRS and eRx Incentive Program

On April 23, CMS released the [2013 Physician Quality Reporting System \(PQRS\) and Electronic Prescribing \(eRx\) Incentive Program Experience Report](#), which provides data and trends on participation, incentive eligibility, incentive payments, and payment adjustments since the beginning of the programs. The 2013 report found that there was an increase in participation from eligible professionals and in reporting clinical quality information for both PQRS and the eRx Incentive Program, reflecting both increased use of electronic prescribing, as well as increased tracking and reporting of important quality information. The report also indicates progress in CMS efforts to improve quality measurements and to encourage building a national electronic health information infrastructure in the United States.

Report highlights include:

- Participation in the PQRS program increased by 47 percent from 2012 to 2013
- 469,755 eligible professionals were subject to a 2015 PQRS negative payment adjustment
- 2013 participation in the eRx Incentive Program rose by 9 percent from 2012

For more information about PQRS, including the criteria for reporting to avoid the negative payment adjustment, which started in 2015, visit the [PQRS](#) website. For more information about the eRx Incentive Program, which ended in 2014, visit the [eRx](#) website.

Full text of this excerpted [CMS fact sheet](#) (issued April 23).

Antipsychotic Drug use in Nursing Homes: Trend Update

CMS is [tracking the progress](#) of the National Partnership to Improve Dementia Care in Nursing Homes by reviewing publicly reported measures. The National Partnership has a mission to deliver health care that is person-centered, comprehensive, and interdisciplinary with a specific focus on protecting residents from being prescribed antipsychotic medications unless there is a valid, clinical indication and a systematic process to evaluate each individual's need.

The official measure of the National Partnership is the percentage of long-stay nursing home residents who are receiving an antipsychotic medication, excluding those residents diagnosed with schizophrenia, Huntington's Disease, or Tourette's Syndrome. In the fourth quarter of 2011, 23.9% of long-stay nursing home residents were receiving an antipsychotic medication; since then there has been a decrease of 20.1% to a national prevalence of 19.1% in fourth quarter of 2014. Success has varied by state and CMS region, with some states and regions having seen a reduction of greater than 20%.

For more information:

- [Register](#) for the June 16 MLN Connects[®] National Provider Call
- Visit the [National Partnership](#) web page
- Send correspondence to dnh_behavioralhealth@cms.hhs.gov

Five Facts about ICD-10

To help dispel some of the myths surrounding ICD-10, CMS recently talked with providers to identify common misperceptions about the transition to ICD-10. These five facts address some of the common questions and concerns CMS has heard about ICD-10:

- The ICD-10 transition date is October 1, 2015. The government, payers, and large providers alike have made a substantial investment in ICD-10. This cost will rise if the transition is delayed, and further ICD-10 delays will lead to an unnecessary rise in health care costs. Get ready now for ICD-10.
- You don't have to use 68,000 codes. Your practice does not use all 13,000 diagnosis codes available in ICD-9, nor will it be required to use the 68,000 codes that ICD-10 offers. As you do now, your practice will use a very small subset of the codes.
- You will use a similar process to look up ICD-10 codes that you use with ICD-9. Increasing the number of diagnosis codes does not necessarily make ICD-10 harder to use. As with ICD-9, an alphabetic index and electronic tools are available to help you with code selection.
- Outpatient and office procedure codes aren't changing. The transition to ICD-10 for diagnosis coding and inpatient procedure coding does not affect the use of Current Procedural Terminology (CPT) for outpatient and office coding. Your practice will continue to use CPT.
- All Medicare Fee-For-Service providers have the opportunity to conduct testing with CMS before the ICD-10 transition. Your practice or clearinghouse can conduct acknowledgement testing at any time with your Medicare Administrative Contractor (MAC). Testing will ensure that you can submit claims with ICD-10 codes. During a special acknowledgement testing week to be held in June 2015, you will have access to real-time help desk support. Contact your [MAC](#) for details about testing plans and opportunities.

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

2014 Mid-Year QRURs Available

CMS has released the 2014 Mid-Year Quality and Resource Use Reports (MYQRURs) to physician solo practitioners and groups of physicians nationwide, including those who participated in the Shared Savings Program, the Pioneer Accountable Care Organization (ACO) model, or the Comprehensive Primary Care (CPC) initiative in 2014.

The 2014 MYQRURs were made available for *informational purposes only* and contain information on a subset of the measures used to calculate the 2016 Value Modifier. The MYQRUR provides interim information about performance on the six cost and three quality outcomes measures that CMS calculates from Medicare claims. These are some of the measures used in the calculation of the Value Modifier. The information in the MYQRUR is based on care provided from July 1, 2013, through June 30, 2014, a period that precedes the actual calendar year 2014 performance period for the 2016 Value Modifier. More information about the MYQRUR can be found on the [2014 MYQRUR](#) web page.

The 2014 MYQRUR can be accessed on the [CMS Enterprise Portal](#) using a valid Individuals Authorized Access to the CMS Computer Services (IACS) account. More information about obtaining a MYQRUR can be found on the [How to Obtain a QRUR](#) web page. If you have not done so already, we strongly encourage authorized representatives to sign up for a new IACS account or modify an existing account at the [CMS Applications Portal](#) as soon as possible.

Claims, Pricers, and Codes

April 2015 Outpatient Prospective Payment System Pricer File Update

The [Outpatient Prospective Payment System \(OPPS\) Pricer](#) web page has been updated with Pricer file and outpatient provider data for April 2015. The April provider data is available for use and may be downloaded from the OPPS Pricer web page under "2nd Quarter 2015 Files."

Coding for ICD-10-CM: Continue to Report CPT/HCPCS Modifiers for Laterality

On October 1, 2015, ICD-10-CM will replace the ICD-9-CM code set currently used by providers for reporting diagnosis codes. Implementation of ICD-10-CM will not change the reporting of Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes, including CPT/HCPCS modifiers for physician services. While ICD-10-CM codes have expanded detail, including specification of laterality for some conditions, providers will continue to follow CPT and CMS guidance in reporting CPT/HCPCS modifiers for laterality.

Medicare Learning Network[®] Educational Products

“Physicians and Non-Physician Practitioners Reported on Part A Critical Access Hospital (CAH) Claims” MLN Matters[®] Article — Released

[MLN Matters[®] Special Edition Article #SE1505](#), “Physicians and Non-Physician Practitioners Reported on Part A Critical Access Hospital (CAH) Claims” has been released and is now available in downloadable format. This article is designed to provide education on the requirements set for submitting CAH Methods II claims. It also includes background information.

“Accreditation for Ventilators” MLN Matters[®] Article — Released

[MLN Matters[®] Special Edition Article #SE1513](#), “Accreditation for Ventilators” has been released and is now available in downloadable format. This article is designed to provide education on accreditation requirements for ventilators to ensure that frequent and substantial servicing is provided to Medicare beneficiaries. It includes background information and key points.

“The Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program Repairs and Replacements” Fact Sheet — Revised

[“The Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies \(DMEPOS\) Competitive Bidding Program Repairs and Replacements”](#) Fact Sheet (ICN 905283) was revised and is now available in downloadable format. This fact sheet is designed to provide education on repairs and replacements under the Medicare DMEPOS competitive bidding program. It includes information on which items and services can be provided by contract versus non-contract suppliers.

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.

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- [MLN Matters Articles Electronic Mailing List](#): MLN Matters are national articles that educate health care professionals about important changes to CMS programs. Articles explain complex policy information in plain language to help health care professionals reduce the time it takes to incorporate these changes into their CMS-related activities. You will receive email updates when new and revised articles are released.

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