

Thursday, June 25, 2015

**Editor's Note:**

The October 1, 2015, compliance date for ICD-10 will be here in less than 100 days. Starting this week, your eNews has a new "Countdown to ICD-10" section, which groups all related information in one place to help you prepare.

**Countdown to ICD-10**

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- Claims that Span the ICD-10 Implementation Date
- ICD-10 FAQs: CMNs, Prescriptions, and Orders
- Coding for ICD-10-CM: Continue to Report CPT/HCPCS Modifiers for Laterality
- Transition to ICD-10 for Home Health

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- ESRD QIP: Reviewing Your Facility's PY 2016 Performance Data — Register Now
- 2016 PFS Proposed Rule: Medicare Quality Reporting Programs — Register Now
- ESRD QIP: Proposed Rule for Payment Year 2019 — Register Now

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- IQCP for CLIA Laboratory Nonwaived Testing: Workbook Tool — Webcast

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- Changes to the Medicare Opt-Out Law for Physicians and Practitioners
- Corrections to eCQM Measures for 2016 Reporting

**Claims, Pricers, and Codes**

- July 2015 Outpatient Prospective Payment System Pricer File Update
- CY 2015 Home Health PPS Mainframe Pricer Software Available

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## Countdown to ICD-10

### ICD-10 Deadline: October 1, 2015

Get ready now with the new [Quick Start Guide](#). While ICD-10 is almost here, you still have time to get ready. Visit [cms.gov/ICD10](http://cms.gov/ICD10) for free resources, including the [Road to 10](#) tool, designed especially for small and rural practices but useful for all health care professionals.

### ICD-10 Training Series for Small and Rural Practices

*Joint Effort with AHIMA, AAPC, and PAHCOM*

CMS is offering a series of in-person ICD-10 trainings to help providers in small and rural practices prepare for the October 1, 2015, transition. Working in conjunction with the American Health Information Management Association (AHIMA), the American Academy of Professional Coders (AAPC), and the Professional Association of Health Care Office Management (PAHCOM), CMS has conducted dozens of trainings across the United States to help providers get ready. The latest trainings are scheduled for Nebraska and Alaska. Space is limited, so register today.

Nebraska, Metro Omaha Medical Society

- [June 30; 8-10am CT](#)
- [June 30; 2-4pm CT](#)

Alaska, Providence Seward Mountain Haven

- [July 13; 12-1pm AKDT](#)
- [July 13; 12-2:30pm AKDT](#)

Alaska, Providence Alaska Medical Center, Anchorage

- [July 14; 7-8am AKDT](#)
- [July 14; 12-1pm AKDT](#)
- [July 14; 5:30-6:30pm AKDT](#)
- [July 15; 8-9am AKDT](#)
- [July 15; 12-1pm AKDT](#)

Alaska, Providence Valdez Medical Center

- [July 16; 10:30-11:30 am AKDT](#)
- [July 16; 1-2pm AKDT](#)

Alaska, Providence Kodiak Island Medical Center

- [July 17; 7:30 -8:30am AKDT](#)
- [July 17; 9-10am AKDT](#)

[Sign up for trainings](#) in your area. Visit the [ICD-10](#) website for the latest news and resources to help you prepare.

### Claims that Span the ICD-10 Implementation Date

Do you have claims that will span the ICD-10 implementation date of October 1, 2015? CMS has guidance for providers:

- [MLN Matters® Special Edition Article SE1408](#), “Medicare FFS Claims Processing Guidance for Implementing ICD-10 – A Re-Issue of MM7492”
- [MLN Matters Special Edition Article SE1325](#), “Institutional Services Split Claims Billing Instructions for Medicare FFS Claims that Span the ICD-10 Implementation Date”
- [MLN Matters Special Edition Article SE1410](#), “Special Instructions for ICD-10 Coding on Home Health Episodes that Span October 1, 2015”

Visit the [ICD-10 Medicare Fee-For-Service Provider Resources](#) web page for a complete list of Medicare Learning Network® educational materials.

## ICD-10 FAQs: CMNs, Prescriptions, and Orders

### *CMNs*

- Question: I have Certificates of Medical Necessity (CMNs) for patients that contain ICD-9 diagnosis codes. Do I need to submit new CMNs with ICD-10 codes for claims submitted after the transition to ICD-10?
- Answer: CMS is not requiring suppliers to submit updated CMNs for claims submitted on or after the ICD-10 implementation date of October 1, 2015; however, these claims must contain a valid ICD-10 diagnosis code. CMNs created after the transition to ICD-10 must use ICD-10 codes. Suppliers should ensure that the diagnosis code(s) billed on the claim are supported by documentation in the medical record.

### *Prescriptions*

- Question: After ICD-10 implementation, how should pharmacies handle prescriptions with ICD-9 codes that were written prior to the implementation date?
- Answer: When filling prescriptions that were written prior to the ICD-10 implementation date of October 1, 2015, pharmacies have the option to use the reimbursement mappings posted on the [2015 ICD-10-CM and GEMs](#) and [2015 ICD-10 PCS and GEMs](#) web pages to translate ICD-9 codes into ICD-10. New prescriptions written after the transition to ICD-10 must use ICD-10 codes.

### *Physician or qualified non-physician practitioner orders*

- Question: If patients have recurring appointments for physical therapy, occupational therapy, or speech-language pathology services that will continue after ICD-10 implementation, will new orders with ICD-10 codes be required?
- Answer: In cases where physician or qualified non-physician practitioner orders are applicable to rehabilitation services furnished under CMS programs, CMS is not requiring updated orders to continue rehabilitation services after ICD-10 implementation on October 1, 2015; however, these claims must contain a valid ICD-10 diagnosis code. Physicians will need to provide the appropriate ICD-10 code to the therapist for these claims. Orders created after the transition to ICD-10 must use ICD-10 codes.

## 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.

## Transition to ICD-10 for Home Health

Medicare requires the use of ICD-10 codes on home health (HH) claims and Requests for Anticipated Payment (RAPs) with a “Through” date on or after October 1, 2015. Since HH claims are submitted for a 60-day payment episode, there may be cases where an episode spans October 1. In these cases, the RAP for an episode will be submitted using ICD-9 codes and the corresponding claim will be submitted using ICD-10 codes. For more information, see [MLN Matters® Article SE1410](#).

Medicare does not require ICD-10 coding of these episodes in advance of the ICD-10 implementation date. Home Health Agencies should determine whether identifying the ICD-10 codes in advance will benefit them.

## MLN Connects® National Provider Calls

### ESRD QIP System Training — Registration Now Open

*Wednesday, July 8; 1:30-3pm ET*

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

CMS will host an MLN Connects National Provider Call to train the dialysis community on a new user system, ESRD QIP 1.0.0, for the End-Stage Renal Disease (ESRD) Quality Incentive Program (QIP) and related programs. CMS will use data to evaluate your performance for the Payment Year (PY) 2016 program. Learn how to participate in the annual Preview Period and review your data in ESRD QIP 1.0.0, which will provide a portal for dialysis-facility staff to access public-reporting documents. A question and answer session will follow the presentation.

ESRD QIP 1.0.0 replaces the DialysisReports.org ESRD QIP interface that was discontinued earlier this year. Users will have accounts automatically established in the new system on their behalf.

#### *Agenda:*

- How to establish accounts and appropriate permissions for using the system
- How to access and review your facility's PY 2016 Preview Performance Score Report (PSR)
- When and where to ask questions regarding Preview PSR, including how to submit *one* formal inquiry
- Where to access help and additional information

*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.

### ESRD QIP: Reviewing Your Facility's PY 2016 Performance Data — Register Now

*Thursday, July 9; 2-3pm ET*

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

CMS will host an MLN Connects National Provider Call on the End-Stage Renal Disease (ESRD) Quality Incentive Program (QIP), a pay-for-performance initiative that ties a facility's quality scores to a payment percentage reduction over the course of a Payment Year (PY). On July 15, a preliminary PY 2016 Performance Score Report (PSR) will be available for ESRD facilities. Find out how to access, review, and submit a formal inquiry about your report by the August 15 deadline. A question and answer session will follow the presentation.

*Agenda:*

- How to access and review your facility PSR
- How CMS calculated ESRD QIP performance scores using quality data
- What the performance scores means for PY 2016 payment rates
- When and where to ask questions regarding PSR, including how to submit *one* formal inquiry
- Duty and responsibility to make ESRD QIP performance data transparent to patients
- Where to access help and additional information

*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.

### **2016 PFS Proposed Rule: Medicare Quality Reporting Programs — Register Now**

*Thursday, July 16; 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 2016 Medicare Physician Fee Schedule (PFS) Proposed Rule. This presentation will cover proposed updates to the Physician Quality Reporting System (PQRS), Value-Based Payment Modifier (Value Modifier), Electronic Health Record (EHR) Incentive Program, and Comprehensive Primary Care (CPC) Initiative. A question and answer session will follow the presentation.

*Agenda:*

- Proposed changes to PQRS reporting mechanisms, individual measures, and measures groups for inclusion in 2016
- Proposed PQRS reporting criteria for Payment Year 2016
- Criteria for satisfactorily reporting to avoid a PQRS negative payment adjustment and an automatic Value Modifier downward payment adjustment in 2018
- Certification requirements for reporting electronic clinical quality measures in the Medicare EHR Incentive Program, PQRS, and the CPC Initiative
- A move towards the Merit-based Incentive Payment System and Alternative Payment Models, based on the amendment of the Medicare Access and CHIP Reauthorization Act of 2015

*Target Audience:* Physicians, Medicare eligible professionals, 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.

## **ESRD QIP: Proposed Rule for Payment Year 2019 — Register Now**

*Wednesday, July 29; 2-3:30pm ET*

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

CMS will host an MLN Connects National Provider Call on the End-Stage Renal Disease (ESRD) Quality Incentive Program (QIP), a pay-for-performance quality initiative that ties a facility's quality scores to a payment percentage reduction over the course of a Payment Year (PY). This call will focus on the upcoming ESRD Prospective Payment System (PPS) proposed rule, which would operationalize the ESRD QIP in PY 2019. A question and answer session will follow the presentation.

### *Agenda:*

- ESRD QIP legislative framework
- Proposed measures, standards, scoring methodology, and payment reduction scale for PY 2019
- Methods for reviewing and commenting on the proposed rule.

*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.

## **MLN Connects® Events**

### **IQCP for CLIA Laboratory Nonwaived Testing: Workbook Tool — Webcast**

*Wednesday, July 15; 1:30-3:30pm ET*

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

Individual Quality Control Plan (IQCP) is a Quality Control (QC) option for Clinical Laboratory Improvement Amendments ([CLIA](#)) laboratories performing non-waived testing. IQCP will provide laboratories with flexibility in customizing QC policies and procedures. The IQCP Education and Transition Period will conclude on December 31, 2015.

Learn how to customize an IQCP for your laboratory. This MLN Connects Event will introduce participants to “Developing an IQCP, a Step-by-Step Guide,” a new workbook developed by CMS and the Centers for Disease Control and Prevention (CDC). A question and answer session will follow the presentation.

CMS will use webcast technology for this event with audio streamed through your computer. Please note, if you are unable to stream audio through your computer, phone lines are available.

### *Agenda:*

- IQCP Workbook
- Example scenario and forms for performing a Risk Assessment
- Creating a QC Plan
- Identifying Quality Assessment monitors

Target Audience: Laboratorians, professional organizations, quality improvement experts, and other interested stakeholders.

This MLN Connects Event is being evaluated by CMS for CME and CEU continuing education credit (CE). Refer to the [call detail page](#) for more information.

## Announcements

### Are You Providing an Annual Wellness Visit to Your Medicare Patients?

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 by encouraging them to have an AWV.

Don't forget. Medicare also provides coverage for the Initial Preventive Physical Examination (IPPE), commonly known as the "Welcome to Medicare" 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.

*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® [The ABCs of the Annual Wellness Visit \(AWV\)](#) Educational Tool.
- Medicare Learning Network [The ABCs of the Initial Preventive Physical Examination \(IPPE\)](#) 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.

### Affordable Care Act Payment Model Saves More than \$25 Million in First Performance Year

*Independence at Home practices succeed in improving care, lowering costs*

On June 18, CMS announced positive and promising results from the first performance year of the Independence at Home Demonstration, including both higher quality care and lower Medicare expenditures. The Independence at Home Demonstration provides chronically ill Medicare beneficiaries with primary care services in the home setting. In the first performance year, 17 participating practices served over 8,400 Medicare beneficiaries.

The CMS analysis found that Independence at Home participants saved over \$25 million in the demonstration's first performance year – an average of \$3,070 per participating beneficiary – while delivering high quality patient care in the home. CMS will award incentive payments of \$11.7 million

to nine participating practices that succeeded in reducing Medicare expenditures and met designated quality goals for the first year of the demonstration.

Learn more about the [Independence at Home](#) Demonstration, including individual practice results.

Full text of this excerpted [CMS press release](#) (issued June 18).

### **National Medicare Fraud Takedown Results in Charges against 243 Individuals for Approximately \$712 Million in False Billing**

*Most defendants charged and largest alleged loss amount in Strike Force history*

On June 18, HHS Secretary Sylvia M. Burwell and Attorney General Loretta E. Lynch announced a nationwide sweep led by the Medicare Fraud Strike Force in 17 districts, resulting in charges against 243 individuals, including 46 doctors, nurses, and other licensed medical professionals, for their alleged participation in Medicare fraud schemes involving approximately \$712 million in false billings. In addition, CMS also suspended a number of providers using its suspension authority as provided in the Affordable Care Act. This coordinated takedown is the largest in Strike Force history, both in terms of the number of defendants charged and loss amount.

Full text of this excerpted [HHS press release](#) (issued June 18).

### **Changes to the Medicare Opt-Out Law for Physicians and Practitioners**

Prior to enactment of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), physician/practitioner opt-out affidavits were only effective for 2 years. As a result of changes made by MACRA, valid opt-out affidavits signed *on or after June 16, 2015*, will automatically renew every 2 years. If physicians and practitioners that file affidavits effective on or after June 16, 2015, do not want their opt-out to automatically renew at the end of a two year opt-out period, they may cancel the renewal by notifying all Medicare Administrative Contractors (MACs) with which they filed an affidavit in writing at least 30 days prior to the start of the next opt-out period. Valid opt-out affidavits signed *before June 16, 2015* will expire 2 years after the effective date of the opt out. If physicians and practitioners that filed affidavits effective before June 16, 2015, want to extend their opt out, they must submit a renewal affidavit within 30 days after the current opt-out period expires to all MACs with which they would have filed claims absent the opt-out.

### **Corrections to eCQM Measures for 2016 Reporting**

CMS has updated select Electronic Clinical Quality Measures (eCQMs) that eligible professionals and eligible hospitals will electronically report in 2016. The original versions of the measures were posted on the CMS website on May 1, 2015, for the annual update of the 2014 measure set. Errors were found in the XML renderings of 12 eligible professional eCQMs and 4 eligible hospital eCQMs. Corrections for these measures should affect only those who are electronically consuming the Healthcare Quality Measures Format (HQMF). CMS has posted the revised measures, technical release notes, and measure logic document on the [eCQI Resource Center](#) and the [eCQM Library](#).

## **Claims, Pricers, and Codes**

## July 2015 Outpatient Prospective Payment System Pricer File Update

The Outpatient Prospective Payment System (OPPS) Pricer web page has been updated with a Pricer file for July 2015. This file is available for use and may be downloaded from the [OPPS Pricer](#) web page under “3<sup>rd</sup> Quarter 2015 Files.”

## CY 2015 Home Health PPS Mainframe Pricer Software Available

The CY 2015 Home Health (HH) Prospective Payment System (PPS) Mainframe Pricer software was revised and is now available for download on the [HH PPS PC Pricer](#) web page.

## Medicare Learning Network® Educational Products

### Medicare Learning Network® Products Available In Electronic Publication Format

The following products are now available as electronic publications (EPUBs) 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® Electronic Publication”](#).

- The [“ICD-9-CM, ICD-10-CM, ICD-10-PCS, CPT, and HCPCS Code Sets”](#) Educational Tool (ICN 900943) is designed to provide education on the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9-CM); International Classification of Diseases, Tenth Edition, Clinical Modification (ICD-10-CM); International Classification of Diseases, Tenth Edition, Procedure Coding System (ICD-10-PCS); Current Procedural Terminology (CPT); and Healthcare Common Procedure Coding System (HCPCS) code sets. It includes a definition and payment information for each code set.
- The [“Items and Services That Are Not Covered Under the Medicare Program”](#) Booklet (ICN 906765) is designed to provide education on the four categories of items and services that are not covered under the Medicare Program and applicable exceptions (items and services that may be covered) and Beneficiary Notices of Noncoverage. It includes information on services and supplies that are not medically reasonable and necessary; non-covered items and services; services and supplies denied as bundled or included in the basic allowance of another service; and items and services reimbursable by other organizations or furnished without charge.

### New Medicare Learning Network® Educational Web Guides Fast Fact

A new fast fact is now available on the [Medicare Learning Network® Educational Web Guides](#) web page. This web page provides information on Evaluation and Management services; Guided Pathways that contain resources and topics of interest; lists of health care management products; and easy-to-understand billing and coding educational products. It is designed to provide educational and informational resources related to certain CMS initiatives. Please bookmark this page and check back often as a new fast fact is added each month.

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