MLN Connects®
Provider eNews

Medicare Learning Network®
Official Information Health Care Professionals Can Trust

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## ICD-10

### Use ICD-10 Now

On October 1, the United States health care community transitioned to ICD-10. To give providers a quick reference, CMS posted the Use ICD-10 Now infographic.

*Coding Claims: When to Use ICD-10 versus ICD-9:*
Use of ICD-10 versus ICD-9 on claims is based on dates of service; not on dates that claims are submitted.

- For dates of service before October 1, 2015, use ICD-9 codes
- For dates of service on or after October 1, 2015, use ICD-10 codes

For hospital inpatient claims, use date of discharge, rather than date of service to determine whether to code in ICD-10 or ICD-9.

*Physician Orders:*

For orders written with ICD-9 codes before October 1, CMS is *not* requiring the ordering provider to rewrite the original order with the appropriate ICD-10 code for lab, radiology services, or any other services. See FAQ 12625.

*Splitting Claims:*
A Medicare Fee-For-Service claim cannot contain both ICD-9 codes and ICD-10 codes. CMS has issued guidance for providers dealing with claims spanning the compliance date. See FAQ 12609.

*Other Resources:*
- Find the latest resources on the ICD-10 website, including the ICD-10 Coding Resources fact sheet
- Visit Roadto10.org to build a customizable action plan, and to see common codes, documentation tips, and clinical scenarios for your specialty
- Find additional ICD-10 resources at low or no cost through medical and trade associations

### ICD-10 Ombudsman and ICD-10 Coordination Center Support Your Transition Needs

Help is available if you have problems with ICD-10:
- ICD-10 Ombudsman
- ICD-10 Coordination Center

*First-Line ICD-10 Information and Support:*
- For general ICD-10 information, we have many resources on the ICD-10 website and Road to 10 web page.
- Contact your Medicare Administrative Contractor (MAC) for Medicare claims questions. MACs cannot respond to questions about Medicaid or Commercial health plans.
- Contact your State Medicaid Agency for Medicaid claim questions.
- If you have a commercial or private health plan claim question, contact your health plan directly.

### Qualifiers for ICD-10 Diagnosis Codes on Electronic Claims

What qualifier do I use for ICD-10 diagnosis codes on electronic claims?
- For X12 837P 5010A1 claims, the HI01-1 field for the Code List Qualifier Code must contain the code “ABK” to indicate the principal ICD-10 diagnosis code being sent. When sending more than one diagnosis code, use the qualifier code “ABF” for the Code List Qualifier Code to indicate up to 11 additional ICD-10 diagnosis codes that are sent.
- For X12 837I 5010A1 claims, the HI01-1 field for the Principal Diagnosis Code List Qualifier Code must contain the code “ABK” to indicate the principal ICD-10 diagnosis code being sent. When sending more than one diagnosis code, use the qualifier code “ABF” for each Other Diagnosis Code to indicate up to 24 additional ICD-10 diagnosis codes that are sent.
- For NCPDP D.0 claims, in the 492.WE field for the Diagnosis Code Qualifier, use the code “02” to indicate an ICD-10 diagnosis code is being sent.

## MLN Connects® National Provider Calls and Events

### Improving Medicare Post-Acute Care Transformation Act Call — Last Chance to Register

*Wednesday, October 21; 1:30-3pm ET*

*To Register:* Visit MLN Connects Event Registration. Space may be limited, register early.

During this MLN Connects National Provider Call, CMS subject matter experts will discuss the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014. The IMPACT Act, through transformation and the use of standardized data, will improve the long-term outcomes of beneficiaries receiving post-acute services across the nation. This call includes information on opportunities for provider participation and stakeholder engagement. The call will be more meaningful if you read the entire Act, since there are multiple sections that apply to each setting.

*Agenda:*

- Legislative requirements of the IMPACT Act related to the use of standardized data, quality measures, and resource use and other measures for Skilled Nursing Facilities (SNFs), Inpatient Rehabilitation Facilities (IRFs), Long-Term Care Hospitals (LTCHs), and Home Health Agencies (HHAs)
- Participation in the quality measure assessment and development process
- Opportunities for stakeholder engagement and input

*Target Audience:* All SNFs, IRFs, LTCHs, HHAs, 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.

### Stay Informed about Medicare Program Changes

MLN Connects National Provider Calls and Webcasts educate the health care community on a variety of topics, including PQRS, Value-Based Payment Modifier, chronic care management, Open Payments, and long-term care. Check out our Calls and Events web page for upcoming events and links to materials from previous events, or view one of our educational videos. Visit www.cms.gov/npc for more information.

## Other CMS Events

### Long-Term Care Hospital Quality Reporting Program Provider Training

*November 19; 8:45am to 5pm ET and*
*November 20; 9am to 4:30pm ET*

Register for Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP) provider training on the implementation of new LTCH QRP quality measures and LTCH Continuity Assessment Record and Evaluation (CARE) Data Set Version 3.00. This training is open to all LTCH providers, associations, and organizations. Visit the LTCH QRP Spotlight and Announcements web page for additional information.

## Announcements

### CMS Launches New ACO Dialysis Model

*Affordable Care Act model designed to improve care for beneficiaries with kidney failure while reducing costs*

CMS announced the participants for the Comprehensive End-Stage Renal Disease (ESRD) Care (CEC) Model, a new Accountable Care Organization (ACO) model. The CEC Model is designed specifically for beneficiaries with ESRD and builds on experiences from other models and programs with ACOs, including the Pioneer ACO Model and the Medicare Shared Savings Program.

In the CEC Model, dialysis facilities, nephrologists, and other providers have joined together to form ESRD Seamless Care Organizations (ESCOs) to coordinate care for ESRD beneficiaries. ESCOs will be financially accountable for quality outcomes and Medicare Part A and B spending, including all spending for dialysis services, for their ESRD beneficiaries. The CEC Model includes separate financial arrangements for ESCOs with large and small dialysis organizations. For more information, visit the CEC Model web page.

See full text of this excerpted CMS press release (issued October 7), including a list of selected applicants.

## New Medicare Utilization and Payment Data Available for Medical Equipment, Supplies

*Data serves as comprehensive resource for information on durable medical equipment costs and services*

CMS posted a new data set as part of the Provider Utilization and Payment files. The Referring Provider Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Public Use File (PUF) provides information on physicians and other healthcare professionals who referred DMEPOS products and services. It contains information on utilization, payment, and submitted charges organized by National Provider Identifier (NPI), Healthcare Common Procedure Coding System (HCPCS) code, and supplier rental indicator. This PUF was created from CMS administrative claims data for Medicare beneficiaries enrolled in the Fee-For-Service program available from the CMS Chronic Condition Data Warehouse website.

The data in the Referring Provider DMEPOS PUF covers calendar year 2013 and is based on information from Part B non-institutional DMEPOS claims. These new data include information on over 385,000 providers who referred DMEPOS products in 2013. In total, the data represent over 100 million claims and $11 billion in Medicare allowed amounts. See the fact sheet.

See full text of this excerpted CMS press release (issued October 8).

## Primary Care Makes Strides in Improving Quality and Costs

On October 7, CMS announced promising results of the first shared savings performance year for the Comprehensive Primary Care (CPC) initiative. In 2014, CPC practices showed positive quality results, with hospital readmissions lower than national benchmarks and high performance on patient experience measures, particularly on provider communication with patients and timely access to care. CPC practices that demonstrated high quality care and reduced spending above a threshold shared in savings generated for Medicare.

During this first shared savings performance year, the initiative decreased Medicare Part A and Part B spending compared to spending targets while achieving high quality outcomes. The CPC initiative generated a total of $24 million in gross savings overall (excluding the CPC care management fees). These results reflect the work of 483 practices that served approximately 377,000 people with Medicare and more than 2.7 million patients overall.

See full text of this excerpted CMS blog (issued October 7).

### CMS to Release a Comparative Billing Report on Optometry Services in October

CMS will issue a national provider Comparative Billing Report (CBR) on Optometry Services in October 2015. The CBR, produced by CMS contractor eGlobalTech, will focus on educating optometrists about their billing patterns for general ophthalmological services, Evaluation and Management (E/M) services, and/or diagnostic ophthalmic imaging services. The CBR will contain data-driven tables with an explanation of findings that compare these providers' billing and payment patterns to those of their peers in their state and across the nation. 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 are advised to update their fax numbers in the Medicare Provider Enrollment, Chain, and Ownership System (PECOS) because faxing is the default method for disseminating CBRs. Contact the CBR Support Help Desk at 800-771-4430 or CBRsupport@eglobaltech.com if you 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.

### EHR Incentive Program: 2016 Payment Adjustments and Reconsiderations

Providers eligible to participate in the Medicare Electronic Health Record (EHR) Incentive Program must demonstrate meaningful use in either the Medicare EHR Incentive Program or in the Medicaid EHR Incentive Program (or be granted a hardship exception) to avoid a payment adjustment.

*2016 Payment Adjustments:*
Providers receive the Medicare payment adjustment amount that is tied to a specific calendar/fiscal year. An eligible professional or eligible hospital that did not successfully demonstrate meaningful use for an applicable EHR reporting period in 2014 will receive a payment adjustment in calendar/fiscal year 2016. Though the deadlines for 2016 hardship exception applications have passed, more information about the 2017 applications for avoiding the 2017 payment adjustment will be available in early 2016.

*2016 Reconsiderations:*
For the eligible hospitals that received a Medicare payment adjustment letter for 2016, the application submission period for reconsiderations is October 1 through November 30, 2015. The application is now available. For eligible professionals, the submission period for 2016 reconsiderations will be January 1 through February 29, 2016. An announcement will be made when the application is available.

*Resources:*
To learn more, visit the Payment Adjustments & Hardship Information web page. A fact sheet on the 2016 payment adjustments for Medicare eligible hospitals is also available.

## Medicare Learning Network® Educational Products

## "Medicare Quarterly Provider Compliance Newsletter [Volume 6, Issue 1]" Educational Tool —

The "Medicare Quarterly Provider Compliance Newsletter [Volume 6, Issue 1]" educational tool (ICN 909229) was released and is now available in downloadable format. This educational tool 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.

## Medicare Learning Network Products Available in Hard Copy Format

To access a product available for order in a hard copy format, go to Medicare Learning Network Products, scroll down to the bottom of the web page to the "Related Links" section, and click on the "Medicare Learning Network Product Ordering Page."

- The "Dual Eligible Beneficiaries Under the Medicare and Medicaid Programs" Fact Sheet (ICN 006977) is designed to provide education on dual eligible beneficiaries under the Medicare and Medicaid Programs, including assignment and prohibited billing.
- 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, 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.
- The "Medicare Appeals Process Parts A and B" Fact Sheet (ICN 006562) is designed to provide education on the five levels of claim appeals in Original Medicare (Medicare Part A and Part B). It includes details explaining how the Medicare appeals process applies to providers, participating physicians, and participating suppliers in addition to including more information on available appeals-related resources.
- The "Chronic Care Management Services" Fact Sheet (ICN 909188) is designed to provide background on the separately payable Chronic Care Management (CCM) Services for non-face-to-face care coordination services furnished to Medicare beneficiaries with multiple chronic conditions. It includes information on eligible providers and patients; Physician Fee Schedule billing requirements; a table aligning the CCM Scope of Service Elements and billing requirements with the Certified Electronic Health Record or other electronic technology requirements; and a table of CCM resources.

## 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 Medicare Quarterly Provider Compliance Newsletter [Volume 6, Issue 1] 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.

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