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National Provider Call: PQRS and eRx Incentive Program —Register Now [↑]
Tuesday, December 18; 1:30-3pm ET

This National Provider Call will provide an overview of the Program Year 2012 data submission for the Physician Quality Reporting System (PQRS) and Electronic Prescribing (eRx) Incentive Program Pilot and Program Year 2013 self-nomination process for group practice reporting options (GPROs), registries, maintenance of certification, and electronic health record (EHR) data submission vendors.

Target Audience: Eligible Professionals, medical coders, physician office staff, provider billing staff, health records staff, vendors and all other interested Medicare FFS health care professionals

Agenda:

- Announcements
- Program Year 2012 Data Submission for the PQRS-EHR Incentive Program Pilot
- Program Year 2013 Self-Nomination Process for GPROs, Registries, Maintenance of Certification & EHR Data Submission Vendors
- Resources & Who to Contact for Help
- Question and Answer Session

Registration Information: In order to receive call-in information, you must register for the call on the CMS Upcoming National Provider Calls registration website. Registration will close at 12pm on the day of the call or when available space has been filled; no exceptions will be made, so please register early.

Presentation: The presentation for this call will be posted prior to the call on the FFS National Provider Calls web page. In addition, a link to the slide presentation will be emailed to all registrants on the day of the call.

Continuing education credit may be awarded for participation in certain CMS National Provider Calls. Visit the Continuing Education Credit Notification web page to learn more.

National Provider Call: Implementation of Section 3133 of the Affordable Care Act: Improvement to Medicare DSH Payments — Registration Opening Soon [↑]
Tuesday, January 8; 1:30-3:30pm ET

CMS will host a National Provider Call on "Implementation of Section 3133 of the Affordable Care Act: Improvement to Medicare Disproportionate Share Hospital (DSH) Payments." This presentation will cover a review of Medicare DSH payment methodology under Section 3133 of the Affordable Care Act, which is effective in fiscal year 2014. CMS commissioned Dobson DaVanzo & Associates, LLC and KNG Health Consulting, LLC to provide technical assistance. They will present findings of their analyses identifying possible data sources and definitions for measuring the change in uninsured and uncompensated care. Participants will also have an opportunity to provide comments.

Agenda:

- Review of Section 3133
- Analytic Methods
- Uninsured Definitions and Data Sources
- Uncompensated Care Definitions and Data Sources
- Conclusions
- Next Steps
- Discussion: Public Comments

Registration Information: In order to receive call-in information, you must register for the call on the

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National Provider Call: Meaningful Use: Stage 1 and Stage 2 — Save the Date [↑]
Wednesday, January 16; 2-3:30pm ET

CMS will host a National Provider Call on the first 2 stages of Meaningful Use under the Medicare and Medicaid EHR Incentive Programs On January 16. The agenda and registration information will be available soon on the CMS Upcoming National Provider Calls registration website.

CMS Distributes Free Hand in Hand Toolkit to Every Nursing Home in the Nation [↑]

Nursing Homes, CMS Regional Offices, and State Survey Agencies will receive a *free* toolkit from CMS by January 31, 2013. Hand in Hand is a high quality training series for nursing homes that emphasizes person-centered care for persons with dementia, as well as the prevention of abuse. These tool kits are being mailed *free* to every nursing home in the country by IPC Systems, a CMS contractor.

Section 6121 of the Affordable Care Act requires CMS to ensure that nurse aides receive regular training on caring for residents with dementia and on preventing abuse. Hand in Hand addresses the annual requirement for nurse aide training on these important topics. While annual training for nurse aides on dementia care and abuse prevention is required in current nursing home regulations, CMS does not require nursing homes to use the Hand in Hand training specifically. Other tools and resources are also available.

More information is available on the Hand in Hand website. If you have questions or comments regarding these materials, please contact cms_training_support@icpsystems.com.

CMS to Release a Comparative Billing Report on Home Health Services — Target Release January 23 [↑]

On January 23, 2013, CMS will release a national provider Comparative Billing Report (CBR) addressing Home Health Services.

CBRs produced by SafeGuard Services under contract with CMS, contain actual data-driven tables and graphs with an explanation of findings that compare provider's billing and payment patterns to those of their peers located in the state and across the nation.

These reports are not available to anyone except the providers who receive them. To ensure privacy, CMS presents only summary billing information. No patient or case-specific data is included. These reports are an example of a tool that helps providers better understand applicable Medicare billing rules and improve the level of care they furnish to their Medicare patients. CMS has received feedback from a number of providers that this kind of data is very helpful to them and encouraged us to produce more CBRs and make them available to providers.

For more information and to review a sample of the Home Health Services CBR, please visit the CBR Services website or call the SafeGuard Services' Provider Help Desk, CBR Support Team at 530-896-7080.

Hospice Quality Reporting Program Data Submission WebEx is Available [↑]

A WebEx training about the web-based data submission for hospices is available on the QTSO website.

For the first year of reporting affecting the FY 2014 payment determination, hospices are submitting two measures: The Structural/Quality Assessment and Performance Improvement (QAPI) measure and the National Quality Forum (NQF) #0209 measure. The data collection period is October 1 through December 31, 2012. The structural measure must be reported by January 31, 2013 and the NQF #0209 by April 1, 2013. Additional information and materials about the hospice quality reporting program are available on the Hospice Quality Reporting Spotlight & Announcements web page.

Future Hospice Data Collection — Public Comments Accepted Through January 31 [↑]

CMS is seeking public comments on possible additional data collection on hospice claims and has an update on revisions to hospice cost reports. Please see the description of the potential data collection and the sample claim, which are posted in the Spotlight section of the Hospice Center web page. CMS asks for your feedback on the suggested data collection by January 31, 2013. Please send comments to HospiceData@cms.hhs.gov.

Review the Changes to the EHR Incentive Programs for Hospitals Included in New Interim Final Rule with Comment [↑]

CMS and ONC have released an Interim Final Rule with Comment (IFC) that makes several changes to the Medicare and Medicaid EHR Incentive Programs and 2014 Edition EHR Certification Criteria that will affect hospitals. The rule also provides notice of CMS's intention to issue technical corrections to the electronic specifications for clinical quality measures (CQMs) released on October 25, 2012.
The IFC's major changes include:

- Revising the regulation text for the hospital measures for the objective of making patient information available online. The measure will now base the denominator not on all patients, but all unique patients.
- Expanding the denominator options for the objective of sending electronic lab results to ambulatory providers. It now allows hospitals to choose between a denominator of all lab orders received from ambulatory providers or all lab orders received electronically from ambulatory providers.
- Moving the CQM minimum denominator threshold effective date from 2014 to 2013, so hospitals can begin taking advantage of this flexibility right away.

More information about the comment period will be included in an upcoming listserv.

Want more information about the EHR Incentive Programs?
Make sure to visit the EHR Incentive Programs website for the latest news and updates on the EHR Incentive Programs.

Get Paid for 2012: Stay Informed of Key Program Deadlines for the EHR Incentive Programs [↑]

December 31 deadline
The reporting year ends on *December 31, 2012* for eligible professionals (EPs) participating in the Medicare and Medicaid EHR Incentive Programs in 2012. For participating EPs, this means they must have completed their 90 or 365-day reporting period (within the calendar year) by the end of 2012 in order to receive an incentive payment.

When do I attest?
Medicare EPs must complete attestation for the 2012 program year by *February 28, 2013*, but can attest as soon as their reporting period is complete. CMS encourages EPs to register and attest sooner rather than later to resolve any potential issues that may delay their payment.

Medicaid EPs should check with their State for their attestation deadline.

Resources from CMS
CMS has several resources located on the EHR Incentive Programs website to help EPs properly meet meaningful use and attest, including:

- A Registration & Attestation web page on the CMS EHR Incentive Programs website that houses information on registration and attestation, and includes links to additional resources.
- The Meaningful Use Attestation Calculator allows EPs and eligible hospitals to determine if they have met the Stage 1 meaningful use guidelines before they attest in the system. The calculator prints a copy of each EP's or eligible hospital's specific measure summary.
- The Attestation User Guide for Medicare Eligible Professionals provides step-by-step guidance for EPs participating in the Medicare EHR Incentive Program on navigating the attestation system.
- The Attestation Worksheet for EPs allows users to enter their meaningful use measure values, creating a quick reference tool to use while attesting.

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Make sure to visit the EHR Incentive Programs website for the latest news and updates on the EHR Incentive Programs.

Where to Find ICD-10 Information [↑]

On October 1, 2014, you and your practice will be required to switch from the familiar ICD-9 code set to more detailed ICD-10 codes. While ICD-10 contains many more codes, your practice will continue to use only codes that are relevant to the patients you treat.

Think about your office today – you have been using the same ICD-9 codes for years and have probably memorized the ones you work with most frequently. To prepare for the new code set:

- Identify the diagnoses you most frequently code.
- Use an ICD-10 code book or software tool to look up these diagnoses and review the potential new codes for the best match.
- Understand how your clinicians communicate with your coding/billing colleagues: What words do they use to describe their routine protocols to coders/billers?
- Identify how your practice will enter key words, medical notes, and content in medical records so the protocols are clearly communicated.
- Discuss changes that may occur in clinical documentation to support ICD-10 code selection.
- As you begin testing ICD-10 in the coming year, share your ICD-10 code interpretation and selections with your colleagues to minimize the learning curve and avoid miscommunications.

You may notice multiple ICD-10 codes for a given ICD-9 code. The ICD-10 code structure accommodates more information than the ICD-9 structure, for added detail. The result is a more complete picture of

complex medical conditions that your clinical documentation will need to capture.
To take advantage of the power of ICD-10, your practice will need to:

- Look at how ICD-10 codes differ from ICD-9 codes for your most common diagnoses.
- Identify what additional documentation or descriptive language clinicians might need to include to ensure selection of the correct ICD-10 code.

Keep Up to Date on ICD-10
Visit the CMS ICD-10 website for the latest news and resources to help you prepare. For practical transition tips:

- Read recent ICD-10 email update messages
- Access the ICD-10 continuing medical education modules developed by CMS in partnership with Medscape

January 2013 Average Sales Price Files Now Available [↑]

CMS has posted the January 2013 Average Sales Price (ASP) and Not Otherwise Classified (NOC) pricing files and crosswalks. All are available for download on the2013 ASP Drug Pricing Files web page.

"HIPAA Eligibility Transaction System (HETS) to Replace Common Working File (CWF) Medicare Beneficiary Health Insurance Eligibility Queries" MLN Matters® Article — Released [↑]

MLN Matters® Special Edition Article #SE1249, "HIPAA Eligibility Transaction System (HETS) to Replace Common Working File (CWF) Medicare Beneficiary Health Insurance Eligibility Queries" was released and is now available in downloadable format. This article is designed to provide education on the transition of CWF Medicare beneficiary eligibility queries to HIPAA HETS. It includes important information and frequently asked questions providers can use to prepare for the transition.

"Important Reminder for Providers and Suppliers Who Provide Services and Items Ordered or Referred by Other Providers and Suppliers" MLN Matters® Article — Revised [↑]

MLN Matters® Special Edition Article #SE1201, "Important Reminder for Providers and Suppliers Who Provide Services and Items Ordered or Referred by Other Providers and Suppliers" was revised and is now available in downloadable format. This article is designed to provide education on the requirements for billing for ordered and referred services. It includes information about what providers and suppliers who provide services and items ordered or referred by other providers and suppliers should know before submitting a claim to Medicare. The article was revised to remove a reference that states portable X-Ray services may only be ordered by a Doctor of Medicine or Doctor of Osteopathy. All other information remains the same.

"Phase 2 of Ordering/Referring Requirement" MLN Matters® Article — Revised [↑]

MLN Matters® Special Edition Article #SE1221, "Phase 2 of Ordering/Referring Requirement" was revised and is now available in downloadable format. This article is designed to provide education on phase 2 of the requirement by which CMS will deny Part B, Durable Medical Equipment (DME), and Part A Home Health Agency (HHA) claims that fail ordering/referring provider edits, as outlined in final rule CMS-6010-F, which CMS published on April 24, 2012. It includes additional resources and information about phases 1 and 2 of the requirement and which types of providers are eligible to order or refer items or services to Medicare beneficiaries. The article was revised to remove a reference that states portable X-Ray services may only be ordered by a Doctor of Medicine or Doctor of Osteopathy. All other

information remains the same.

From the MLN: "NPI: Guidance for Organization Health Care Providers Who Apply for National Provider Identifiers (NPIs) for Their Health Care Provider Employees" Fact Sheet — Revised [↑]

The "NPI : Guidance for Organization Health Care Providers Who Apply for National Provider Identifiers (NPIs) for Their Health Care Provider Employees" Fact Sheet (ICN 902604) was revised and is now available in downloadable format. This fact sheet is designed to provide education on National provider Identifiers (NPIs) for health care providers who apply for their health care employees. It includes the steps a health care provider should take when applying for an employee's NPI on an individual record-by-record basis.

From the MLN: "The National Provider Identifier (NPI): What You Need to Know" Booklet — Revised [↑]

"The National Provider Identifier (NPI): What You Need to Know " Booklet (ICN 902603) was revised and is now available in downloadable format. This booklet is designed to provide education on the National Provider Identifier (NPI). It includes information on NPI basics, the National Plan and Provider Enumeration System, health care provider categories, and how to apply for an NPI.

From the MLN: "Mass Immunizers and Roster Billing" Fact Sheet — Revised [↑]

The "Mass Immunizers and Roster Billing" Fact Sheet (ICN 907275) was revised and is now available in downloadable format. This fact sheet is designed to provide education on mass immunizers and roster billing. It includes information on simplified billing procedures for the influenza and pneumococcal vaccinations.