Implementation of the Phase 2 ordering and referring denial edits is being delayed. Additional information is available in "Temporary Delay in Implementing Ordering and Referring Denial Edits."

Table of Contents for Thursday, April 25, 2013

National Provider Call: Stage 1 of the Medicare & Medicaid EHR Incentive Programs for Eligible

Professionals: First in a Series — Save the Date
Thursday May 30; 1:30-3 PM ET

This session will inform individual practitioners on the basics of Stage 1 of the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs. Learn if you are eligible, and if so, what you need to do to earn an incentive. This is the first in a series of 6 National Provider Calls on the Medicare and Medicaid EHR Incentive Programs. Other topics include: Stage 2, clinical quality measures, hardship exceptions, payment adjustments, and a discussion on certification by the Office of the National Coordinator for Health Information Technology.

Target Audience: Professionals eligible for the Medicare and/or Medicaid EHR Incentive Programs. For more details: Eligibility Requirements for Professionals.

Agenda:

- Are you eligible?
- How much are the incentives and how are they calculated?
- How do you get started?
- What are major milestones regarding participation and payment?
- How do you report on meaningful use?
- Where can you find helpful resources?
- Question and Answer Session

Registration information will be available soon on the CMS Upcoming National Provider Calls registration website.

National Provider Call: Audio Recording and Written Transcript from April 9 "Medicare Shared Savings Program Application Process: Preparing to Apply" Call Now Available

The audio recording and written transcript from the April 9 "Medicare Shared Savings Program Application Process: Preparing to Apply" call are now available on the April 9 call web page in the "Call Materials" section.

Advancing Health Equality for All

April is National Minority Health Month - This year's theme, *Advance Health Equity Now: Uniting Our Communities to Bring Health Care Coverage to All* is a call to action, a charge for all of us to unite towards a common goal of improving the health of our communities and increasing access to quality, affordable health care for everyone. Everyone in America should have a chance to realize their optimal health, regardless of race or ethnicity. All people covered by Medicare now have available to them a wide array of preventive services that can prevent and detect disease early when outcomes are best and can help them maintain and enjoy a healthy lifestyle.

Medicare Covered Preventive Services
Medicare provides payment for the following preventive services and screenings, subject to certain beneficiary eligibility criteria:

- Abdominal Aortic Aneurysm Screening
- Alcohol Misuses Screening and Behavioral Counseling Interventions in Primary Care
- Annual Wellness Visit Providing Personalized Prevention Plan Services
- Bone Mass Measurements

- Cancer Screenings
    - Breast Cancer (mammograms and clinical breast exam)
    - Cervical and Vaginal Cancer (pap test and pelvic exam (includes the clinical breast exam))
    - Colorectal Cancer
        - Fecal Occult Blood Test
        - Flexible Sigmoidoscopy
        - Colonoscopy
        - Barium Enema
- Cardiovascular Disease Screening
- Diabetes Screening
- Diabetes Self-Management Training
- Glaucoma Screening
- Human Immunodeficiency Virus (HIV) Screening
- Immunizations (Seasonal Influenza, Pneumococcal, and Hepatitis B)
- Initial Preventive Physical Examination (IPPE) also commonly referred to as the "Welcome to Medicare" Preventive Visit
- Intensive Behavioral Therapy for Cardiovascular Disease
- Intensive Behavioral Therapy for Obesity
- Medical Nutrition Therapy (for beneficiaries with diabetes or renal disease)
- Prostate (PSA blood test and Digital Rectal Exam)
- Screening for Depression in Adults
- Screening for Sexually Transmitted Infections (STIs) and High-Intensity Behavioral Counseling to prevent STIs
- Tobacco-Use Cessation Counseling

For More Information:

- MLN Preventive Services Educational Products for Health Professionals
- CMS Prevention Website
- MLN National Provider Calls and Events
- The HHS Office of Minority Health
- CDC Minority Health

Temporary Delay in Implementing Ordering and Referring Denial Edits

Due to technical issues, implementation of the Phase 2 ordering and referring denial edits is being delayed. These edits would have checked the following claims for an approved or validly opted-out physician or non-physician who is an eligible specialty type with a valid individual National Provider Identifier (NPI). If either of these were missing or incorrect, claims would deny.

- Medicare Part B claims from laboratories, imaging centers and Durable Medical Equipment, Orthotics, and Supplies (DMEPOS) that have an ordering or referring physician/non-physician provider; and
- Part A Home Health Agency (HHA) claims that require an attending physician provider.

CMS will advise you of the new implementation date in the near future. In the interim, informational edits will continue to be sent for those claims that would have been denied had the edits been in place.

Major Improvements to the Internet-based PECOS System

Over the last year, CMS has listened to your feedback about Internet-based Provider Enrollment, Chain and Ownership System (PECOS). CMS made improvements to increase access to more information. PECOS is easier to use than ever with the following upgrades that are now available:

- Email notifications sent from PECOS now include the provider/supplier's National Provider Identifier (NPI) and Provider Transaction Access Number (PTAN).
- Individuals reassigning all benefits to a group now need to complete fewer topics, making the application process faster and more efficient.
- The Medicare Participating Provider or Supplier Agreement (CMS-460 form) hyperlink is now displayed in the PAR (participation agreement) Status topic instead of at the end of the application process. Additionally, CMS has improved the list of supporting documents required to be submitted with the application, including a matrix with definitions of each document to help the provider/supplier understand exactly what is required to be submitted with their application.
- We've clarified the language for performing a change of information on the Application Questionnaire page. PECOS now displays two options and specifies details regarding each, to ensure the provider/supplier is selecting the appropriate scenario to accurately update their enrollment application.
- A new status of "Approval Pending Regional Office Review" has been added which alerts the Part A certified provider/supplier that the Medicare Administrative Contractor (MAC) has completed processing their portion of the enrollment application and it has been submitted to the CMS Regional Office for a final determination.
- Formatting restrictions have been removed from the Social Security Number (SSN), Individual Taxpayer Identification Number (ITIN), Employer Identification Number (EIN) and Phone Number fields. Providers/suppliers are no longer required to enter spaces, apostrophes or dashes

To access internet-based PECOS, go to the PECOS website.

Internet –Based PECOS Tutorials and Resources

Are you taking advantage of the internet-based Provider Enrollment, Chain and Ownership System (PECOS)? View the tutorials below to learn how you can easily accomplish common actions using this system. Links to these tutorials can also be found by scrolling down on the PECOS log in page. The PECOS log in page also provides links to many helpful resources which allow you to see if you have been sent a revalidation request, the status of enrollment applications submitted in the last 90 days and more. Bookmark the PECOS log in page for easy reference.
The 6 tutorials cover:

- Initial Enrollment: Step-by-step demonstration of an initial enrollment application in PECOS.
  Individual Provider or Organization/Supplier
- Change of Information: Step-by-step demonstration of how to update or change information for an existing enrollment already on file with CMS.
  Individual Provider or Organization/Supplier
- Revalidation: Step-by-step demonstration on how to submit your revalidation application using PECOS.
  Individual Provider or Organization/Supplier
- Voluntary Withdraw: Example of how to deactivate an existing enrollment record.
  Individual Provider
- Reactivation: Step-by-step demonstration of how to re-enroll based on enrollment information that already exists in PECOS.

Organization/Supplier

- Adding a Practice Location (DMEPOS Only): Demonstration of how to add a new practice location for DMEPOS supplier who is already enrolled with CMS.
  DME Supplier

CMS to Begin Accepting Suggestions for Potential PQRS Measures and Measures Groups in May

In May, CMS will begin 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. CMS is seeking a quality set of measures that are outcome-based and fall into one of the National Quality Strategy (NQS) Priorities domains where there are known measure and performance gaps. The measure gaps that CMS most wishes to fill include clinical outcomes, patient-reported outcomes, care coordination, safety, appropriateness, efficiency, and patient experience and engagement.

Measures submitted for consideration will be assessed to ensure that they meet the needs of the Physician Quality Reporting Program. In addition, CMS encourages eligible providers to submit measures that do not have an adequate representation within the program for participation. When submitting measures for consideration, please ensure that your submission is not duplicative of another existing or proposed measure. Each measure submitted for consideration must include all required supporting documentation. Documentation requirements will be posted on the Measures Management System Call for Measures web page on or around May 1, 2013. Only those measures submitted in the provided format will be accepted for consideration.

Suggested measures must address the CMS measure selection core criteria to be considered for inclusion in the PQRS. Measure submissions omitting the required core criteria will be disqualified from consideration.

- Measure addresses an important condition/topic with a performance gap and has a strong scientific evidence base to demonstrate that the measure, when implemented, can lead to the desired outcomes and/or more appropriate costs (i.e., the National Quality Forum's Importance criteria)
- Measure addresses one or more of the six NQS Priorities:
  - Patient Safety
  - Person and Caregiver-Centered Experience and Outcomes
  - Communication and Care Coordination
  - Effective Clinical Care
  - Community/Population Health
  - Efficiency and Cost Reduction
- Promotes alignment with specific program attributes and across CMS and HHS programs
- Program measure set includes consideration for health care disparities
- Measure reporting is feasible

This Call for Measures will run from May 1 through July 1, 2013. All required documentation must be completed for each measure submitted for consideration no later than 5pm ET July 1, 2013.

Note: Suggesting individual measures or measures for a new or existing measures group does not guarantee the measure(s) will be included in the proposed or final sets of measures of any Proposed or Final Rules that address the PQRS. CMS will determine which individual measures and measures group(s) to include in the proposed set of quality measures, and after a period of public comment, the agency will make the final determination with regard to the final set of quality measures for the PQRS.

LTCH FY 2014 Data Submission Due May 15

Long-Term Care Hospital (LTCH) providers should currently be engaging in two activities for the LTCH Quality Reporting (LTCHQR) Program: data *submission* for the FY 2014 payment update determination and data *collection* and *submission* for the FY 2015 payment update determination.

FY 2014 Payment Update Determination—Deadline for Data Submission: May 15, 2013

In the FY 2012 IPPS/LTCH PPS Final Rule (76 FR 51743 through 51756, and 51780 through 51781), three measures were adopted for data collection and reporting for October 1 through December 31, 2012 for the FY 2014 Payment Update Determination:

- Percent of Residents with Pressure Ulcers That Are New or Worsened (NQF #0678)
- Urinary Catheter-Associated Urinary Tract Infection (CAUTI) (NQF #0138)
- Central Line Catheter-Associated Bloodstream Infection (CLABSI) (NQF #0139)

To avoid a 2-percentage-point reduction in their Annual Payment Update, providers must submit data for all three measures *by the May 15, 2013 deadline*. Current definitions for the three LTCH quality measures are available in the LTCHQR Program Manual in the "Downloads" section of the LTCHQR Program website.

The Percent of Residents with Pressure Ulcers That Are New or Worsened (NQF #0678) measure requires use of the LTCH Continuity Assessment Record and Evaluation (CARE) Data Set Version 1.01, approved on April 24, 2012, by the Office of Management and Budget (OMB) in accordance with the Paperwork Reduction Act (PRA). The OMB Control Number is 0938-1163, Expiration Date April 30, 2013. Please note that while the current PRA approval of the LTCH CARE Data set has an expiration date of April 30, 2013, the subsequent version of the data set is currently in the PRA approval process with the OMB; this acts to extend the PRA deadline of April 30, 2013 until the currently submitted PRA package receives approval. Details on the LTCH CARE Data Set technical submission specifications can be found at LTCHQR Program Technical Information web page.

For the submission of data for CAUTI and CLABSI measures, the deadline for enrollment in Centers for Disease Control and Prevention's (CDC's) National Health Safety Network (NHSN) was December 31, 2012. If you have not registered with the NHSN, please visit the NHSN LTCH web page, and contact the NHSN at NHSN@cdc.gov for additional guidance. Frequently asked questions about the NHSN enrollment process are available on the CDC website.

Fiscal Year 2015 Payment Update Determination

In addition to engaging in data *submission* activities for the FY 2014 Payment Update Determination, LTCHs should be engaging in data *collection* and *submission* activities for the FY 2015 Payment Update Determination. Per the FY 2013 IPPS/LTCH PPS Final Rule (77 FR 53614 through 53637, and 53667 through 53672), data on three measures will be collected from January 1 through December 31, 2013:

- Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (NQF #0678)
- NHSN CAUTI Outcome Measure (NQF #0138)
- NHSN CLABSI Outcome Measure (NQF #0139),

For the four quarters in CY 2013 (i.e., January through March 2013, April through June 2013, July through September 2013, and October through December 2013), the final deadlines for data submission are August 15, 2013, November 15, 2013, February 15, 2014, and May 15, 2014, respectively for FY 2015 Payment Update Determination.

LTCH CARE Data Set Technical Submission Specification Changes Effective April 21, 2013

A change has been made to the LTCH data submission specifications scheduled to take effect on April 21, 2013. An errata document for V1.00.3 of the data submission specifications is posted in the "Downloads" section of the under the Downloads section of the LTCHQR Program Technical Information web page.

Interim Process for Hospitals to Bill Part B Services Following Denial of an Inpatient Admission as Not Reasonable and Necessary — Temporary Instructions Revised

On March 13, 2013 CMS issued Ruling 1455-R which establishes an interim process for hospitals to bill Medicare for Part B services following a denial of a claim for an inpatient admission as not reasonable and necessary. Affected providers shall follow the revised temporary instructions for both the Part B Types of Bills (TOB), TOB 12x and TOB 13x. On April 19, CMS revised its instructions for billing both Part B inpatient and outpatient claims.

Inpatient PPS PC Pricer Update

The FY 2012 Inpatient Prospective Payment System (PPS) PC Pricer has been updated with the latest Provider Data and the FY 2013 Inpatient PPS PC Pricer is now available on the Inpatient PPS PC Pricer web page in the "Downloads" section.

Home Health PPS PC Pricer Update

The CY 2012 Home Health PPS (HH PPS) PC Pricer provider data has been updated with January 2013 provider data and is now available for download and the CY 2013 HH PPS PC Pricer is now available on the HH PPS PC Pricer web page in the "Downloads" section.

Inpatient Psychiatric Facility PPS PC Pricer Update

The FY 2013 Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) PC Pricer has been updated with newer provider data, and is now available on the IPF PPS PC Pricer web page in the "Downloads" section. This Pricer is for claims dated from October 1, 2012 to September 30, 2013.

Inpatient Rehabilitation Facility PPS PC Pricer Update

The Inpatient Rehabilitation Facility (IRF) PPS PC Pricer has been updated with the January 2013 provider data, and is now available on the IRF PPS PC Pricer web page in the "Downloads" section. This Pricer is for claims dated from October 1, 2012 to September 30, 2013.

From the MLN: "Durable Medical Equipment, Prosthetics, Orthotics & Supplies (DMEPOS) Competitive Bidding Program: Non-Contract Supplier" Fact Sheet—Revised

The "Durable Medical Equipment, Prosthetics, Orthotics & Supplies (DMEPOS) Competitive Bidding Program: Non Contract Supplier" Fact Sheet (ICN 900925) was revised and is now available in downloadable format. This fact sheet is designed to provide education on requirements for non-contract suppliers. It includes information on rented DMEPOS, enteral nutrition, mail order diabetes test

strips, Skilled Nursing Facilities (SNFs), and other program requirements for non-contract suppliers.

New MLN Provider Compliance Fast Fact

A new fast fact is now available on the MLN Provider Compliance web page. This web page provides the latest MLN Education Products and MLN Matters® Articles designed to help Medicare FFS providers 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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