



MLN Connects™ Provider eNews

Part of the Medicare Learning Network®

Thursday, August 29, 2013

MLN Connects™ National Provider Calls

Program Year 2012 Quality and Resource Use Reports — Mapping a Route to Success for the 2015 Value-Based Payment Modifier — Registration Now Open

Did You Miss These MLN Connects Calls?

MLN Connects™ Videos

ICD-10: Implementation for Physicians, Partial Code Freeze, and MS-DRG Conversion Project

MLN Educational Products Update

“Open Payments: An Overview for Physicians and Teaching Hospitals” MLN Matters® Article — Released

“Transitional Care Management Services” Fact Sheet — Released

“Medicare Dependent Hospital” Fact Sheet — Now Available in Electronic Publication Format

“General Equivalence Mappings Frequently Asked Questions” Booklet — Revised

Announcements, Events, and Reminders

Healthy Aging – It’s a Lifestyle Approach

New Data Show Antipsychotic Drug Use is Down in Nursing Homes Nationwide

Program Year 2012 QRURs for Group Practices Are Coming

PV-PQRS Registration is Still Open

Submit Suggestions for Advanced Diagnostic Imaging Program

Opportunity for Provider Input on the IRF Quality Reporting Program

Learn how to Participate in the 2013 PQRS-Medicare EHR Incentive Pilot

LTCH FY 2015 Payment Update Determination: Data Submission Deadlines

Claims, Pricer, and Code Updates

FISS DDE Will Not be Available on Saturday, August 31

Updated Reason Codes for Medicare Conditional Payment Policy and Billing Procedures for Liability, No-Fault, and Workers’ Compensation Medicare Secondary Payer Claims

MLN Connects™ National Provider Calls

Program Year 2012 Quality and Resource Use Reports — Mapping a Route to Success for the 2015 Value-Based Payment Modifier — Registration Now Open

Tuesday, September 24; 3-4:30pm ET

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

Target Audience: Groups with 25 or more eligible professionals.

On September 16, 2013, CMS will make available the 2012 Quality Resource Use Reports (QRURs) to group practices with 25 or more eligible professionals (EPs). These reports show how a group would fare under the policies CMS has finalized for the Physician Value-Based Payment Modifier. This MLN Connects™ National Provider Call will provide an overview of the QRUR and how to interpret and use the data in the report.

Authorized representatives of groups can access the QRURs at <https://portal.cms.gov> using an Individuals Authorized Access to the CMS Computer Services (IACS) account with one of the following group-specific Physician Value-Physician Quality Reporting System (PV-PQRS) Registration System roles:

- Primary PV-PQRS Group Security Official
- Backup PV-PQRS Group Security Official
- PV-PQRS Group Representative

If a group has already registered and selected its 2013 PQRS group reporting mechanism in the PV-PQRS Registration System, then that same person who registered the group can access the group's QRUR using their IACS User ID and password. If a group does not yet have an authorized representative with an IACS account, then one person representing the group must sign up for an IACS account with the primary Group Security Official role. If a group has a representative with an existing IACS account, but not one of the three group-specific Registration System roles listed above, then ensure that the account is still active and then add a group-specific Registration System role to that person's existing IACS account.

We *strongly encourage* representatives of groups to sign up for a new IACS account or modify an existing account at <https://applications.cms.hhs.gov> as soon as possible in order to be able to access the QRURs prior to the call. Quick Reference Guides that provide step-by-step instructions for requesting each PV-PQRS Registration System role for a new or existing IACS account are available in the “Downloads section” of the [Self Nomination/Registration](#) web page.

The call will be more meaningful if you have your QRUR in front of you to follow along. A Quick Reference Guide that provides instructions on how to obtain your 2012 QRUR will be available soon in the “Downloads” section of the [QRUR Templates and Methodologies](#) web page.

Agenda:

- Opening Remarks
- How to Understand and Use the 2012 QRUR
- Question & Answer Session
- Closing

Continuing education credit may be awarded for participation in certain MLN Connects Calls. Visit the [Continuing Education Credit Information](#) web page to learn more.

Did You Miss These MLN Connects Calls?

Call materials for MLN Connects™ Calls are located on the [Calls and Events](#) web page. New materials are now available for the following calls:

- August 14 — ESRD Quality Incentive Program Notice of Proposed Rulemaking: Payment Year 2016, [audio](#) and [transcript](#)
- August 15 — Payment Adjustments and Hardship Exceptions for the Medicare EHR Incentive Program, [audio](#) and [transcript](#)

MLN Connects™ Videos

ICD-10: Implementation for Physicians, Partial Code Freeze, and MS-DRG Conversion Project

Are you ready to transition to ICD-10 on October 1, 2014? In this MLN Connects™ video on the [CMS YouTube Channel](#), Pat Brooks and Dr. Daniel Duval from the Hospital and Ambulatory Policy Group of the Center for Medicare discuss the transition to ICD-10 for medical diagnosis and inpatient procedure coding:

- Hints for a smooth transition to ICD-10 in physician offices
- ICD-10 Implementation and preparation strategies
- Partial freeze prior to ICD-10 implementation
- Medicare Severity Diagnosis Related Grouper (MS-DRG) Conversion Project at CMS

MLN Educational Products Update

“Open Payments: An Overview for Physicians and Teaching Hospitals” MLN Matters® Article — Released

[MLN Matters® Special Edition Article #SE1330](#), “Open Payments: An Overview for Physicians and Teaching Hospitals,” was released and is now available in downloadable format. This article is designed to provide education on the Open Payments program for physicians and teaching hospitals. It includes information on how the program will impact physicians or teaching hospitals and links to important tools and resources.

“Transitional Care Management Services” Fact Sheet — Released

The “[Transitional Care Management Services](#)” Fact Sheet (ICN 908628) was released and is now available in hard copy format. This fact sheet is designed to provide education on Transitional Care Management (TCM) services. It includes the requirements for TCM services, health care professionals who may furnish TCM services, TCM services settings, components included in TCM, billing TCM services, and Frequently Asked Questions. To access a new or revised product available for order in *hard copy* format, go to [MLN Products](#) and click on “MLN Product Ordering Page” under “Related Links” at the bottom of the web page.

“Medicare Dependent Hospital” Fact Sheet — Now Available in Electronic Publication Format

The “[Medicare Dependent Hospital](#)” Fact Sheet (ICN 901683) is now available as an electronic publication (EPUB) and through a QR code. This fact sheet is designed to provide education on Medicare Dependent Hospitals (MDH). It includes the following information: classification criteria and MDH payments.

The EPUB format is available under the “Related Links” section of the publication’s detail page. The QR code is also located on the detail page. Instructions for downloading the EPUB and how to scan a QR code are available at “[How To Download a Medicare Learning Network® \(MLN\) Electronic Publication](#)” on the CMS website.

“General Equivalence Mappings Frequently Asked Questions” Booklet — Revised

The [General Equivalence Mappings Frequently Asked Questions](#) Booklet (ICN 901743) was revised and is now available in hard copy format. This booklet is designed to provide education on the conversion of International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) codes to International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS) and the conversion of ICD-10-CM/PCS codes back to ICD-9-CM. It includes background information and General Equivalence Mappings Frequently Asked Questions. To access a new or revised product available for order in *hard copy* format, go to [MLN Products](#) and click on “MLN Product Ordering Page” under “Related Links” at the bottom of the web page.

Announcements, Events, and Reminders

Healthy Aging – It’s a Lifestyle Approach

September is Healthy Aging® Month, a national health observance designed to focus on the positive aspects of growing older. The main objective of Healthy Aging® Month is to encourage local level Healthy Aging® events that promote taking personal responsibility for one's health... be it physically, socially, mentally or financially. CMS encourages health care professionals to talk with their patients about steps they can take to adopt a healthy lifestyle, including utilizing appropriate Medicare-covered preventive services. Medicare provides payment for many services that can help maintain your patient’s optimal level of health and also contribute to a higher quality of life.

Some of the preventive services covered under Medicare Part B include:

- Alcohol Misuse Screening and Behavioral Counseling Interventions in Primary Care
- Annual Wellness Visit (Providing Personalized Prevention Plan Services)
- Cardiovascular Disease Screening
- Depression Screening in Adults
- Diabetes Screening
- 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
- Tobacco-Use Cessation Counseling

Please refer to the references listed below for a full listing of preventive services covered by Medicare.

For More Information:

- [MLN Preventive Services Educational Products for Health Professionals](#)
- [CMS Prevention General Information Website](#)
- [Healthy Aging® Month](#) website

New Data Show Antipsychotic Drug Use is Down in Nursing Homes Nationwide

Nursing homes are using antipsychotics less and instead pursuing more patient-centered treatment for dementia and other behavioral health care, according to new data released on Nursing Home Compare in July by CMS.

Unnecessary antipsychotic drug use is a significant challenge in dementia care. CMS data show that in 2010 more than 17 percent of nursing home patients had daily doses exceeding recommended levels. In response to these trends, CMS launched the National Partnership to Improve Dementia Care in 2012.

The Partnership’s goal is to reduce antipsychotic drug usage by 15 percent by the end of 2013. These new data show that the Partnership’s work is making a difference:

- The national prevalence of antipsychotic use in long stay nursing home residents has been reduced by 9.1 percent by the first quarter of 2013, compared to the last quarter of 2011.

- There are approximately 30,000 fewer nursing home residents on these medications now than if the prevalence had remained at the pre-National Partnership level.
- At least 11 states have hit or exceeded a 15 percent target and others are quickly approaching that goal. The states that have met or exceeded the target are: Alabama, Delaware, Georgia, Kentucky, Maine, North Carolina, Oklahoma, Rhode Island, South Carolina, Tennessee, and Vermont.

The Partnership aims to reduce inappropriate use of antipsychotics in several ways – including enhanced training for nursing home providers and state surveyors; increased transparency by making antipsychotic use data available online at [Nursing Home Compare](#); and highlighting alternate strategies to improve dementia care.

For more information on the Partnership’s efforts to reduce use of antipsychotic drugs in nursing homes, please visit the [Advancing Excellence in America’s Nursing Homes](#) website.

Full text of this excerpted [CMS press release](#) (issued August 27).

Program Year 2012 QRURs for Group Practices Are Coming

On September 16, Program Year 2012 Quality and Resource Use Reports (QRURs) will be available for group practices with 25 or more eligible professionals (EPs). Authorized representatives of groups can access the QRURs at: <https://portal.cms.gov> using an Individuals Authorized Access to the CMS Computer Services (IACS) account with one of the following group-specific Physician Value-Physician Quality Reporting System (PV-PQRS) Registration System roles:

- Primary PV-PQRS Group Security Official
- Backup PV-PQRS Group Security Official
- PV-PQRS Group Representative

We strongly encourage representatives of groups to sign up for a new IACS account or modify an existing account at <https://applications.cms.hhs.gov> as soon as possible in order to be able to access the QRURs.

PV-PQRS Registration is Still Open

The Physician Value-Physician Quality Reporting System (PV-PQRS) Registration System is open for representatives of group practices to select their group’s PQRS reporting mechanism for CY 2013, and for groups with 100 or more eligible professionals (EPs), to elect quality tiering to calculate the Value Modifier for CY 2015. Additionally, individual EPs will be able to select the CMS-calculated administrative claims reporting mechanism in CY 2013 in order to avoid the PQRS negative payment adjustment in CY 2015.

The PV-PQRS Registration System will close on October 15, 2013. The PV-PQRS Registration System can be accessed at <https://portal.cms.gov> using a valid IACS User ID and password. For additional information regarding registration and obtaining or modifying an IACS account please see the Quick Reference Guide on the [Self Nomination/Registration](#) web page.

Submit Suggestions for Advanced Diagnostic Imaging Program

CMS is looking at revising the Advanced Diagnostic Imaging (ADI) program to potentially incorporate health and safety standards through Conditions for Coverage. CMS has created a public mailbox to receive suggestions related to potential improvements of the current ADI program. Potential improvement topics could include personnel qualifications, infection control practices, quality improvement programs, image quality, patient safety, evidence-based research, etc. You may send your ideas to ADISuggestions@cms.hhs.gov, and you will receive a response confirming that your message has been received. Please feel free to share the mailbox address with any other interested parties.

Opportunity for Provider Input on the IRF Quality Reporting Program

CMS is seeking input from providers related to the implementation of the new Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP) established in the Patient Protection and Affordable Care Act, also known as The Affordable Care Act, Section 3004. Therefore, Health Care Innovation Services, (HCIS), is seeking the voluntary assistance of providers to participate in a brief interview on behalf of CMS to help us better understand the burdens imposed on providers, how providers ensure accuracy of data, how the QRP has impacted patient services and outcomes, and what CMS can do in the future to improve the program, and processes.

This process and the information gathered will provide valuable information for CMS as we continue to develop this program and will be essential to guiding the development of the QRP. This partnership will continue to facilitate an important process in which provider input is shared with CMS, so that we are able to identify strengths, weaknesses, priorities, and how the program might be improved.

Interviews will be conducted over the telephone, and any reports or supplemental documents submitted to CMS will not link specific answers to any specific individuals/providers. If you are interested in participating, please contact Pat Hanson at phanson@hcareis.com.

Learn how to Participate in the 2013 PQRS-Medicare EHR Incentive Pilot

CMS has released a new [fact sheet](#) on how to participate in the 2013 Physician Quality Reporting System (PQRS) Medicare Electronic Health Record (EHR) Incentive Pilot Program. The PQRS-Medicare EHR Incentive Pilot Program allows eligible professionals to meet the clinical quality measure (CQM) reporting requirements for the Medicare EHR Incentive Program, while also reporting for the PQRS program by submitting their CQM data electronically.

PQRS-Medicare EHR Incentive Pilot Participation

Eligible professionals who wish to participate in the electronic reporting pilot must submit 12 months of CQM data. Participants must submit the data between January 1, 2014 and February 28, 2014. Below are steps to guide you through participation in the pilot.

1. Determine eligibility for participation in [PQRS](#) and the [EHR Incentive Programs](#)
2. Indicate intent to participate in the pilot program through the [EHR Incentive Program Attestation Module](#)
3. Determine which clinical quality measures apply
4. Verify your EHR/data submission vendor is [PQRS-qualified](#) and your [EHR is certified](#)
5. If you are not using a data submission vendor, register for an [IACS account](#) (for direct EHR submission only)
6. Document patient information in EHR system
7. Generate required reporting files
8. Test data submission
9. Submit quality data by February 28, 2014 either
 - o By data submission vendor, or
 - o Directly through your EHR
10. Complete EHR Incentive Program attestation by February 28, 2014

Opting Out

If you signed up for the electronic reporting pilot, but are unable to continue or determine that you no longer wish to participate, you may opt-out and complete your attestation through the EHR Incentive Program Attestation System. If you have questions please contact the QualityNet Help Desk:

- By Phone: 866-288-8912 (available 7am-7pm CT, Monday through Friday, TTY 877-715-6222)
- By e-mail at qnetssupport@sdps.org

Receiving Payment

If you complete the pilot, successfully attesting to meaningful use and submitting your PQRS data properly, you should

receive a payment for your 2013 participation in both PQRS and the Medicare EHR Incentive Program. Payment will not be received prior to 2014, as you must submit 12 months of CQM data (January 1, 2013 - December 31, 2013).

Want more information about the EHR Incentive Programs or PQRS?

Make sure to visit the [EHR Incentive Programs](#) website for the latest news and updates on the EHR Incentive Programs. You can also visit the [PQRS Incentive Program](#) website or contact the [Help Desk](#).

LTCH FY 2015 Payment Update Determination: Data Submission Deadlines

Long-Term Care Hospitals (LTCH) should be *collecting* and *submitting* data for the FY 2015 payment update determination required by the LTCH Quality Reporting (LTCHQR) Program.

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 for FY 2015 Payment Update Determination:

- 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)

The deadlines for final data submission for FY 2015 Payment Update Determination are:

- November 15, 2013: April through June 2013 data
- February 15, 2014: July through September 2013 data
- May 15, 2014: October through December 2013 data

Reminder: The submission deadline -- August 15, 2013 for January through March 2013 data that will affect the FY 2015 Payment Update Determination has passed.

Claims, Pricer, and Code Updates

FISS DDE Will Not be Available on Saturday, August 31

On Saturday August 31, 2013 the FISS Direct Data Entry (DDE) will not be available all day due to system maintenance.

Updated Reason Codes for Medicare Conditional Payment Policy and Billing Procedures for Liability, No-Fault, and Workers' Compensation Medicare Secondary Payer Claims

See [MLN Matters® Article #7355](#) for background on the clarification of Medicare Conditional Payment Policy and Billing Procedures for Liability (L), No-Fault (NF), and Workers' Compensation (WC) Medicare Secondary Payer (MSP) Claims. Medicare Administrative Contractors/Fiscal Intermediaries (MACs/FIs) have been directed to set reason codes 39071, 39072, and 39073 to suspend. In early October, the following system changes will occur:

- Bypass claim level reason codes 39071, 39072, and 39073 for home health raps (322 and 332 types of bills); and ensure these types of bills continue to receive an override of N and a non-pay code of Z.
- Cost avoid claims that receive reason codes 39071, 39072, and 39073 will be reprocessed through the MSP drivers. Claims should cost avoid with the appropriate 34xxx MSP reason code, based on the MSP info in CWF 03 trailer; to prevent looping to CWF.
- Modify the system to ensure condition code 15 applies to those claims meeting the criteria for application.

Providers do not need to take any action.

[Register](#) for an opportunity to rate your Medicare Administrative contractor. [Learn more](#)



Please share this important information with your colleagues and encourage them to [subscribe](#) to the MLN Connects Provider eNews.

Previous issues are available in the [archive](#).

Follow the MLN Connects Provider eNews on  &  #CMSMLN