

Thursday, March 19, 2015

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March 2015 Version of The Medicare Learning Network[®] Catalog — Released

MLN Connects[®] National Provider Calls

Medicare Shared Savings Program ACO: Preparing to Apply for 2016 — Register Now

Tuesday, April 7; 1:30-3pm ET

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

During this MLN Connects National Provider Call, CMS subject matter experts provide information on what you can do to prepare for the Medicare Shared Savings Program (Shared Savings Program) application process for the January 1, 2016, start date. This MLN Connects Call includes information on Accountable Care Organizations (ACOs), ACO organizational structure and governance, application key dates, the Notice of Intent to Apply (NOI) submission, and the first steps in submitting an application. A question and answer session will follow the presentation.

The [Shared Savings Program Application](#) web page has important information, dates, and materials on the application process. Call participants are encouraged to review the application and materials prior to the call.

Agenda:

- Introduction to the Shared Savings Program
- What is an ACO?
- Organizational structure and governance
- Antitrust and ACOs
- Application process for January 2016 starters

Target Audience: Potential 2016 Shared Savings Program applicants.

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

Open Payments (Sunshine Act) 2015: Prepare to Review Reported Data — Registration Opening Soon

Wednesday, April 15; 2-3:30pm

To Register: Visit [MLN Connects® Upcoming Calls](#). Registration is opening soon.

During this MLN Connects National Provider Call, CMS will provide a brief overview of the Open Payments national transparency program and highlight the parts of the program timeline when it is most critical for physicians and teaching hospitals to be aware and get involved. The call aligns with the beginning of the program phase when physicians and teaching hospitals are able to enter the Open Payments system and review the accuracy of data submitted about them, prior to the publication of this data on the CMS website.

The [Open Payments](#) website has important information about the program, including educational materials. CMS encourages all physicians and teaching hospitals, plus physician office staff members to visit this resource and become familiar with the Open Payments program.

Target Audience: Physicians, teaching hospitals, and physician office staff.

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.

Medicare Shared Savings Program ACO: Application Process — Register Now

Tuesday, April 21; 1:30-3pm, ET

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

During this MLN Connects National Provider Call, CMS subject matter experts cover helpful tips to complete a successful application for the Medicare Shared Savings Program, including information on how to submit an acceptable Accountable Care Organization (ACO) participant list, sample ACO participant agreement, executed ACO participant agreements, and governing body template. A question and answer session will follow the presentation.

The [Shared Savings Program Application](#) web page has important information, dates, and materials on the application process. Call participants are encouraged to review the application and materials prior to the call.

Agenda:

- ACO participant agreements
- ACO participant list
- Beneficiary assignment

Target Audience: Potential 2016 Shared Savings Program applicants.

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

CMS Events

Volunteer for ICD-10 End-to-End Testing in July — Forms Due April 17

During the week of July 20 through 24, 2015, a third sample group of providers will have the opportunity to participate in ICD-10 end-to-end testing with Medicare Administrative Contractors (MACs) and the Common Electronic Data Interchange (CEDI) contractor. Approximately 850 volunteer submitters will be selected to participate in the July end-to-end testing. This nationwide sample will yield meaningful results, since CMS intends to select volunteers representing a broad cross-section of provider, claim, and submitter types, including claims clearinghouses that submit claims for large numbers of providers. *Note:* Testers who are participating in the January and April end-to-end testing weeks are able to test again in July without re-applying.

To volunteer as a testing submitter:

- Volunteer forms are available on your [MAC](#) website
- Completed volunteer forms are due April 17
- CMS will review applications and select the group of testing submitters
- By May 8, the MACs and CEDI will notify the volunteers selected to test and provide them with the information needed for the testing

If selected, testers must be able to:

- Submit future-dated claims.
- Provide valid National Provider Identifiers (NPIs), Provider Transaction Access Numbers (PTANs), and beneficiary Health Insurance Claim Numbers (HICNs) that will be used for test claims. This information will be needed by your MAC by May 29 for set-up purposes; Testers will be dropped if information is not provided by the deadline.

Any issues identified during testing will be addressed prior to ICD-10 implementation. Educational materials will be developed for providers and submitters based on the testing results.

For more information:

- [MLN Matters® Article #MM8867](#), “ICD-10 Limited End-to-End Testing with Submitters for 2015

- [MLN Matters Special Edition Article #SE1435](#), “FAQs – ICD-10 End-to-End Testing”
- [MLN Matters Special Edition Article #SE1409](#), “Medicare FFS ICD-10 Testing Approach”

eHealth Webinar: eCQM 101 on Quality Reporting Programs

Wednesday, March 25; 12-1:30pm ET

Join CMS, the Office of the National Coordinator for Health Information Technology (ONC), and industry representatives for an eHealth webinar on “Getting Started with Electronic Quality Measures (eCQMs 101) for Quality Reporting Programs.” This webinar will provide useful background information and context for those involved in the collection and reporting of eCQMs, including practice administrators, quality leadership, clinicians, physician assistants, and other professionals.

Agenda

The webinar will include a presentation on eCQMs, how they can be used, and the process for submitting prospective measures for implementation in the quality reporting programs. There will also be a live Q&A session. Please email any questions you would like the presenters to address during the webinar to Peri Saunders at psaunders@hcmsllc.com.

Registration

To [register](#). Registration is limited, but a recording and transcript of the webinar will be available on the [eHealth](#) website after the event.

More information about eCQMs is available on the [Resource Center](#).

Medicare Basics for New Providers Webinar — Registration Now Open

Tuesday, March 31; 2-4pm ET

New to the Medicare Program or interested in becoming a Medicare Provider or Supplier? Need a refresher on the basics of Medicare? Then, register now for our upcoming “Medicare Basics for New Providers” webinar. This multi-media webinar will review the history and parts of the Medicare Program (A, B, C, and D). You will also get an overview of the process for becoming a Medicare provider, including enrollment requirements and systems.

Registration:

- To [register](#)
- This webinar will offer both continuing education units (CEU) and continuing medical education (CME) credit.

Announcements

Prepare for a Successful Transition to ICD-10 with Medicare Testing Resources

Take advantage of upcoming ICD-10 testing opportunities with Medicare Fee-For-Service (FFS), including an acknowledgement testing week June 1 through 5, 2015, and a final end-to-end testing week July 20 through 24, 2015. Registration is not required for acknowledgement testing; volunteer forms for the July end-to-end testing are due April 17 - see [article](#) in the CMS Events section for complete details.

The [Medicare FFS Provider Resources](#) web page has testing resources to help you prepare, along with results from previous testing weeks:

- [MLN Matters® Special Edition Article SE1409](#), “Medicare FFS ICD-10 Testing Approach”
- [MLN Matters Article MM8858](#), “ICD-10 Testing - Acknowledgement Testing with Providers”
- [MLN Matters Article MM8867](#), “ICD-10 Limited End-to-End Testing with Submitters for 2015”
- [MLN Matters Special Edition Article SE1501](#), “FAQs – ICD-10 Acknowledgement Testing and End-to-End Testing”
- [MLN Matters Special Edition Article SE1435](#), “FAQs – ICD-10 End-to-End Testing”
- [Results from March 2014 ICD-10 Acknowledgement Testing Week](#)
- [Results from November 2014 ICD-10 Acknowledgement Testing Week](#)
- [Results from January 2015 ICD-10 End-to-End Testing Week](#)

RAs from January 2015 ICD-10 End-to-End Testing

During January 2015 ICD-10 end-to-end testing, Remittance Advices (RAs) were generated and sent for the vast majority of test claims. Due to set-up issues in the Medicare Administrative Contractors (MACs) testing environments that were unrelated to ICD-10, RAs could not be generated for approximately 6 percent of the test claims. Testers will have an opportunity to resubmit any January test claims that did not produce an RA during the April and July end-to-end testing weeks.

This new level of testing, conducted for the first time in January, is an unprecedented step taken by CMS for providers, suppliers, billing companies, and clearinghouses. The MACs are supporting an extensive manual process to adequately set up the test environments to be able to accept and process provider test claims; much of this manual activity must be repeated with each test period. It is expected that these test set-up issues will be resolved for future end-to-end testing weeks.

Bidding for Round 2 Recompete/National Mail-Order Recompete of the DMEPOS Competitive Bidding Program Closes March 25

CMS is currently accepting bids for Round 2 Recompete and the national mail-order recompete of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. All bids must be submitted in DBidS, the online bidding system, before 9pm prevailing ET on Wednesday, March 25, 2015. Your Authorized Official (AO) or Backup Authorized Official (BAO) must approve Form A and certify Form B before the close of bidding. All required hardcopy documents that must be included as part of the bid package must be *received* by the Competitive Bidding Implementation Contractor (CBIC) on or before March 25, 2015. Don't forget to ensure your CMS-855S enrollment application(s), licensure, and accreditation are up to date. [More information.](#)

March is National Colorectal Cancer Awareness Month—Encourage Your Patients to Get Screened

Colorectal cancer is the fourth most common cancer in the United States and the second leading cause of death from cancer. Colorectal cancer affects all racial and ethnic groups and is most often found in people ages 50 and older, and the risk increases with age. There are often no signs or symptoms, which makes screening and early detection so vital.

CMS reminds health care providers that Medicare provides coverage for certain colorectal cancer screening services under Medicare Part B. Colorectal cancer is preventable, treatable, and beatable. Encourage your

patients to get screened. Your recommendation can help save lives. [Read more](#) to learn about colorectal cancer screening services covered by Medicare.

March is Save Your Vision Month

Medicare provides payment for some vision-related services provided to patients with Medicare, subject to certain eligibility criteria. CMS has developed the following resources to help health care professionals understand coverage, coding, and payment guidelines for these services:

- Medicare Learning Network® “[Medicare Vision Services](#)” Fact Sheet
- Medicare Learning Network “[Quick Reference Information: Preventive Services](#)” Educational Tool
- Medicare Learning Network “[Ophthalmology Resource Information Center](#)” web page

Flu on the Decline but Still Active

The Centers for Disease Control and Prevention (CDC) reports that flu activity may continue in parts of the country for a few more weeks, however, flu activity is on a downward curve in most states and has peaked nationally. Flu activity so far this season continues to be most similar to the 2012-2013 season, the last season when H3N2 viruses predominated. More hospitalizations and deaths are typical of H3N2 seasons, which tend to hit young children and older people harder. More than two-thirds of the H3N2 viruses circulating this season are different or "drifted" from the H3N2 vaccine virus, but most B viruses are like the vaccine viruses. The predominance of drifted H3N2 viruses is probably responsible for the reduced protection offered by this season's vaccine. The reduced protection offered by flu vaccine this season makes the appropriate use of influenza antiviral (or "anti-flu") medications more important than usual. [Read more](#).

EHR Incentive Program: Eligible Professionals Attest for 2014 Participation by March 20

Eligible professionals now have until 11:59 pm ET on March 20, 2015, to attest to meaningful use for the Medicare Electronic Health Record (EHR) Incentive Program 2014 reporting year. CMS extended the deadline to allow providers extra time to submit their meaningful use data. CMS continues to urge providers to begin attesting for 2014 as soon as they can. Medicare eligible professionals must attest to meaningful use every year to receive an incentive and avoid a payment adjustment. Providers who successfully attest for the 2014 program year will:

- Receive an incentive payment
- [Avoid the Medicare payment adjustment](#), which will be applied January 1, 2016

Note: The Medicare extension does not affect deadlines for the Medicaid EHR Incentive Program. Additionally, the EHR reporting option for Physician Quality Reporting System (PQRS) has been extended until March 20, 2015.

How to Attest

Submit your data to the [Registration and Attestation System](#), which includes [2014 Certified EHR Technology \(CEHRT\) Flexibility Rule](#) options. To learn more, see [EHR Educational Resources](#). For help, call the EHR Information Center at 888-734-6433 (TTY 888-734-6563), Monday through Friday from 8:30 am to 7:30 pm ET.

CMS Extends Letter of Intent Deadlines for the Oncology Care Model

The Oncology Care Model (OCM) is a new payment model that encourages participating practices to improve care and lower costs through episode-based, performance-based payments that financially incentivize high-quality, coordinated care. Physician group practices and solo practitioners that provide chemotherapy for cancer and are currently enrolled in Medicare may apply to participate. Other payers, including commercial insurers, Medicare Advantage plans, state programs, and Medicaid managed care plans, are also encouraged to apply.

The Center for Medicare and Medicaid Innovation is extending the deadlines for payers and physician practices to submit letters of intent (LOI) to participate in the Oncology Care Model. The new deadlines are listed below.

- To be considered, interested payers must submit a letter of intent through the Oncology Care Model inbox at OncologyCareModel@cms.hhs.gov by 5pm ET on April 9, 2015.
- Interested practices must submit letters of intent through the Oncology Care Model inbox at OncologyCareModel@cms.hhs.gov by 5pm ET on May 7, 2015.
- Payers and practices that submit a timely letter of intent will be sent an authenticated web link and password with which to submit an electronic application. Applications must be submitted by 5pm ET on June 18, 2015.

More information is available on the [OCM](#) website.

Obtaining Your Quality and Resource Use Report: Updated Information Available

CMS has updated the [How to Obtain a QRUR](#) web page to explain how to access a Quality and Resource Use Report (QRUR) on behalf of a group or solo practitioner.

For technical questions about obtaining your QRUR, please contact the QualityNet Help Desk Monday through Friday from 8am to 7pm ET.

- Phone: 866-288-8912 (TTY 877-715-6222)
- Fax: 888-329-7377
- Email: qnetsupport@hcqis.org

For questions about the contents of the QRUR, please contact the Physician Value Help Desk Monday through Friday from 8am to 8pm ET.

- Phone: 888-734-6433, press option 3; (TTY 888-734-6563)
- Fax: 469-372-8023

CMS to Release Ophthalmology Comparative Billing Report in April

CMS will be issuing a national provider Comparative Billing Report (CBR) on ophthalmology in April 2015. The CBR, produced by CMS contractor eGlobalTech, will focus on providers with a specialty of ophthalmology and will contain data-driven tables and graphs 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. Providers should contact the CBR Support Help Desk at 800-771-4430 or CBRsupport@eglobaltech.com if they 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.

Physician-owned Hospital Initial Annual Ownership/Investment Report: Extension of Filing Deadline

CMS has closely examined the data collected in the Initial Annual Ownership/Investment Report required of physician-owned hospitals (POHs) seeking to avail themselves of the hospital ownership or rural provider exceptions. CMS is concerned about the accuracy of these data. Accordingly, we are extending the deadline for the POH Initial Annual Ownership/Investment Report. CMS will provide additional information, when available, regarding the revised deadline, specific instructions for submitting the report, and the timeframe during which the report can be submitted.

Hospitals that did not file the required information by the earlier deadline of March 3, 2014 may have refrained from filing claims after that date to avoid violating the physician self-referral law's claim submission prohibition. Because of the deadline extension, submission of those claims may be permissible. Please refer to 42 CFR §424.44 for timely filing guidelines regarding such claims.

Please stay tuned to the [Physician Self-Referral](#) website, as well as the normal CMS communication channels for notifications related to this issue.

Claims, Pricers, and Codes

Mandatory Payment Adjustment Percentage of 2% Extended for Medicare FFS Claims (Sequestration)

For the Medicare Fee-For-Service (FFS) program, claims with dates-of-service or dates-of-discharge on or after April 1, 2013, will continue to incur a 2 percent reduction in Medicare payment through March 31, 2016. Claims for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), including claims under the DMEPOS Competitive Bidding Program, will continue to be reduced by 2 percent based upon whether the date-of-service, or the start date for rental equipment or multi-day supplies, is on or after April 1, 2013. The claims payment adjustment will continue to be applied to all claims after determining coinsurance, any applicable deductible, and any applicable Medicare Secondary Payment adjustments.

Although beneficiary payments for deductibles and coinsurance are not subject to the 2 percent payment reduction, Medicare's payment to beneficiaries for unassigned claims is subject to the 2 percent reduction. CMS encourages Medicare physicians, practitioners, and suppliers who bill claims on an unassigned basis to continue discussions with beneficiaries on the impact of sequestration on Medicare's reimbursement. Questions about reimbursement should be directed to your [Medicare Administrative Contractor](#).

Correcting the Display Issue for OPPS Claims Where Value Code "FD" Is Present

CMS is correcting a display issue for Outpatient Prospective Payment System (OPPS) claims with value code "FD," which was caused by the implementation of payer-only value code "QD." The following claims are affected:

- Type of Bill 13x (outpatient diagnostic testing services)
- Processed on or after January 1, 2014 and prior to the July 2015 OPPS Pricer quarterly release
- Value code "FD" is present but does not represent the device credit capped amount used for pricing the claim.

Medicare Administrative Contractors will be mass adjusting any processed claims not reflecting a difference that met the above criteria within 60 days after successful implementation of the payer-only value code "QD" into production on or about July 6, 2015. No action is required by providers.

Mass Adjustment of Claims Containing Codes G0473 and 77063

Due to a systems error, coinsurance and deductible are not being waived on claims containing codes G0473 (intensive behavioral therapy for obesity) and 77063 (screening digital breast tomosynthesis, bilateral). The problem will be corrected on April 6, 2015. For claims with dates of service of January 1, 2015 through March 31, 2015, Medicare Administrative Contractors will be mass adjusting these claims and issuing corrected payments for all impacted claims. Providers must reimburse beneficiaries for any overpayment caused by this error.

Medicare Learning Network[®] Educational Products

March 2015 Version of The Medicare Learning Network[®] Catalog — Released

The Medicare Learning Network[®] [March 2015 Catalog](#) is now available. In this latest edition, you will find all the products and services now available through the Medicare Learning Network. The catalog is a free, interactive, downloadable document that links you to online versions of Medicare Learning Network products, services, and the product ordering page for hardcopy materials. Once you have opened the catalog, you may either click on the title of an individual product or on “Formats Available” to quickly access the material you have selected.

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