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National Provider Call: Stage 1 of the Medicare & Medicaid EHR Incentive Programs for Eligible Professionals: First in a Series — Last Chance to Register
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.

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

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

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 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: Getting Started with PQRS Reporting: Implications for the Value-based Payment Modifier — Register Now
Wednesday, June 5; 1:30-2:30pm ET

This National Provider Call will cover how to obtain an Individuals Authorized Access to the CMS Computer Services (IACS) account in order for (1) physician group practices to select their CY 2013 Physician Quality Reporting System (PQRS) Group Reporting Mechanism, and if applicable, elect quality

tiering to calculate their CY 2015 Value-based Payment Modifier; and (2) individual eligible professionals to select the Administrative Claims reporting mechanism for CY 2013. A question and answer session will follow the presentation.

Please note that while this call is scheduled for 60 minutes. CMS experts will be available to stay on the line for an additional 30 minutes to take outstanding questions, should they exist, at the end of the scheduled call time. Participants can remain on the line until the conclusion of the call or refer to the call transcript and audio recording (to be posted 7-10 business days after the call) if they are unable to participate beyond the 60 minute scheduled duration.

Agenda:

- Introductions and opening remarks
- IACS registration walkthrough
- Question and answer session

Target Audience: Physicians, physician group practices, practitioners, therapists, practice managers, medical and specialty societies, payers, insurers.

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 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.

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National Provider Call: PQRS and eRx Incentive Program Payment Adjustment — Registration Now Open

Tuesday, June 18; 1:30-3pm ET

This National Provider Call provides a general overview on the Physician Quality Reporting System (PQRS) payment adjustment and the Electronic Prescribing (eRx) Incentive Program payment adjustment, as well as specifics on the 2015 PQRS and 2014 eRx adjustments, including eligibility, how to avoid future payment adjustments, key points, and tips for successful participation. This presentation also provides a list of resources and who to contact for help. A question and answer session follows the presentation.

Agenda:

- Announcements
- Presentation on PQRS and eRx Incentive Program payment adjustment
- Question and answer session

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

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 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 Calls: Medicare Shared Savings Program Application Process — Register Now
Thursday, June 20; 1:30-3pm ET— **Application Review**
Thursday, July 18; 1-2:30pm ET— **Application Question and Answer Session**

On October 20, 2011, CMS issued a final rule under the Affordable Care Act to establish the Medicare Shared Savings Program (Shared Savings Program). This initiative will help providers participate in Accountable Care Organizations (ACOs) to improve quality of care for Medicare patients. CMS will host two National Provider Calls on the Shared Savings Program application process.

On Thursday, June 20, CMS subject matter experts will provide an overview and updates to the Shared Savings Program application process for the January 1, 2014 start date. A question and answer session will follow the presentations.

On Thursday, July 18, CMS subject matter experts will be available to answer questions about the Shared Savings Program and application process for the January 1, 2014 start date.

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.

Target Audience: Medicare FFS providers

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 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.

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National Provider Call: Medicare and Medicaid EHR Incentive Programs National Provider Call Series — Save the Dates

The Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs paid out over $13.7 billion in incentives through March of this year. Don't be left out. CMS will be holding a series of National Provider Calls (NPCs) about different aspects of the EHR incentive programs. Don't miss these opportunities to learn from the experts.

Register for the Stage 1 call for Medicare and Medicaid Eligible Professionals on May 30.

Mark your calendars for these upcoming NPCs. Registration will be announced:

Medicare and Medicaid Eligible Professionals, Eligible Hospitals, and Critical Access Hospitals:

- June 27; 2:30-3:45 — Certification
- July 23; 1:30-3 —Clinical Quality Measures
- July 24; 1:30-3 —Stage 2

Medicare Eligible Professionals, Eligible Hospitals, and Critical Access Hospitals

- August 13; 1:30-3 —Hardship Exceptions
- August 15; 1:30-3 —Payment Adjustments

Special Open Door Forum: Suggested Electronic Clinical Template for Lower Limb Prostheses
Tuesday, May 28; 2-3pm ET
Conference Call Only

CMS will host a series of Special Open Door Forum (ODF) calls to allow physicians, prosthetists, and other interested parties to give feedback on the Suggested Electronic Clinical Template for Lower Limb Prostheses for possible nationwide use for Medicare.

In order to enhance physician understanding of medical documentation requirements to support orders for Lower Limb Prostheses, CMS is exploring the development of an electronic clinical template that will assist providers with data collection and medical documentation. These templates may also facilitate the electronic submission of medical documentation. While not intended to be a data entry form per se, the template will describe the data elements that CMS believes would be useful in supporting the documentation requirements for coverage of Lower Limb Prostheses. CMS will work in collaboration with the HHS Office of the National Coordinator for Health IT (ONC) as part of our process. Comments on the proposed document can be sent to eclinicaltemplate@cms.hhs.gov .

Special Open Door Participation Instructions:

- Operator Assisted Toll-Free Dial-In Number: 800-837-1935; Conference ID # 75391152
- Note: TTY Communications Relay Services are available for the Hearing Impaired. For TTY services dial 7-1-1 or 800-855-2880. A Relay Communications Assistant will help.

A transcript and audio recording of this Special ODF will be posted to the Special Open Door Forum website and will be accessible for downloading. For automatic emails of Open Door Forum schedule updates (E-Mailing list subscriptions) and to view Frequently Asked Questions please visit the Open Door Forums website

New DMEPOS Educational Slideshow Presentation for non-Contract Suppliers

An educational slideshow presentation about the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) competitive bidding program for non-contract suppliers is now available. The target audience is non-contract suppliers for Round 2 and the national mail-order program. Topics include a general overview of the programs, grandfathering and other exemptions, and program policies. For your convenience, this webcast is available 24 hours a day, 7 days a week. If you have any questions, please call the Competitive Bidding Implementation Contractor customer service center at 877-577-5331 between 9am and 5:30pm ET, Monday through Friday. You may also e-mail questions to cbic.admin@PalmettoGBA.com.

Data.Medicare.Gov Get Started Webinar

View the webinar hosted by CMS on "Data.Medicare.Gov: Get Started" The training session is appropriate for both technical and non-technical users of Compare website data, for example, researchers, health care administrators and quality improvement professionals.

New Medscape Modules Now Available

The following Medscape modules were recently posted on the Medscape website. These modules may be of interest to providers and their staff.

- "What the Healthcare Marketplace Means for Practices and Patients" — Physicians CME/Nurses CE credits are available
- "The National Quality Strategy and You: How CMS Quality Measures Affect Policy and Practice" — Physicians CME credits are available
- "Are You Ready for the National Physician Payment Transparency Program?" — Physicians CME credits are available

Eligible Medicare Beneficiaries May Receive Coverage for Bone Mass Measurements

May is National Osteoporosis Awareness Month. Osteoporosis is a preventable and treatable disease, yet approximately 10 million Americans have the disease and about 34 million more are at risk. Osteoporosis is often a silent disorder until it causes a fracture. Early diagnosis and treatment are key to reducing and preventing bone loss and fractures. Bone mass measurement or bone density study can aid in the early detection of osteoporosis before fractures happen, provide a precursor to future fractures, and determine the rate of bone loss.

Medicare provides coverage of bone mass measurements for eligible beneficiaries when all coverage criteria are met. For a summary of the eligibility and coverage criteria for this service, refer to the Medicare Learning Network® (MLN) brochure, "Bone Mass Measurements." This service is covered under the beneficiary's Medicare Part B insurance. The deductible and copayment/coinsurance are waived for this service as a result of the Affordable Care Act.

For More Information:

- MLN Preventive Services Educational Products for Health Professionals
- CMS Prevention website
- CMS Immunizations website
- MLN National Provider Calls and Events website

Application Deadlines for the Medicare Shared Savings Program January 1 Program Start Date
Notice of Intent to Apply Due by May 31

If you are interested in applying for participation for the January 1, 2014 program start date of the Medicare Shared Savings Program, you must submit a Notice of Intent to Apply (NOI) *by May 31, 2013*. For more information, visit the Shared Savings Program Application web page.

Once you submit an NOI, you must submit your "Application for Access to CMS Computer Systems,"

Form CMS-20037, no later than *June 10, 2013*:

- Use the link and instructions provided in your NOI acknowledgement email.
- Submit Form CMS-20037 as soon as possible. Do not wait until the June 10 deadline.
- Submit via tracked mail (Federal Express, United Parcel Service, etc.).
- If you have already submitted this form, please disregard this notice.

To learn more about the application process, register to attend upcoming National Provider Calls on June 20 and July 18.

Join a Community Portal Dedicated to Nursing Home Quality

The National Partnership to Improve Dementia Care in Nursing Homes supports Healthcare Communities Portal, a web-based knowledge management system that provides multiple means for the healthcare quality improvement community to share knowledge and contribute to each other's quality improvement work. By joining the portal, you will have the opportunity to:

- Join a listserv
- Participate in forums to exchange ideas and views on a particular issue
- Access free resources and tools

CMS is Accepting Suggestions for Potential PQRS and/or Measures Groups

CMS is currently 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. The Measures Submitted for Consideration Excel Form is posted on the Measures Management System Call for Measures web page. *Only those measures submitted in the provided format will be accepted for consideration*. Please note that full specifications are not requested at this time. When the Call for Measures closes, CMS will review all of the submitted measures to determine those that will move forward. For selected measures, measure stewards will be asked to provide full specifications.

Questions about this Call for Measures or the required documentation may be submitted to PHYSICIAN_REPORTING_TEMP@cms.hhs.gov.

Suggested measures must address the CMS measure selection core criteria listed on the Measures Management System Call for Measures web page to be considered for inclusion in the PQRS. Measure submissions omitting the required core criteria will be disqualified from consideration.

This Call for Measures runs from May 1 through July 1, 2013. *All required documentation* must be completed for each measure submitted for consideration. Completed documentation must be

submitted electronically to PHYSICIAN_REPORTING_TEMP@cms.hhs.gov 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 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 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)

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

- August 15, 2013: January through March 2013 data
- 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 for October through December 2012 data that will affect the FY 2014 Payment Update Determination has passed.

Resource Available for CAH II Physicians Eligible to Participate in the Medicare EHR Incentive Program

Physicians who assign their reimbursement and billing to a Critical Access Hospital (CAH) under Method II (CAH IIs) may participate in the Medicare EHR Incentive Program as eligible professionals. CAH II physicians can begin participating in the Medicare EHR Incentive Program during the 2013 calendar year and are eligible to earn a maximum of $39,000 during the course of the program. Due to CMS system changes, CAH II physicians who participate this year will need to submit attestations in January 2014.

CAH II Resource Available
The CAH Method II Physician Participation fact sheet is available to CAH Method II physicians for more information on how to participate, including additional payment information and guidance on reassigning their billing to the CAH. Additional resources to help CAH Method II physicians navigate the Medicare EHR Incentive Program can be found on the Educational Resources web page of the EHR website.

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.

Several New and Updated FAQs on EHR Incentive Programs Now Available on CMS Website

To keep you updated with information on the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, CMS has recently added three new FAQs and an updated FAQ to the CMS FAQ system. We encourage you to stay informed by taking a few minutes to review the new information below.

New FAQs:

- While the denominator for measures used to calculate meaningful use in the Medicare and Medicaid EHR Incentive Programs is restricted to patients seen during the EHR reporting period, is the numerator also restricted to activity during the EHR reporting period or can actions for certain meaningful use measures be counted in the numerator if they took place after the EHR reporting period has ended? Read the answer here.
- When providing the clinical summary as part of an office visit to meet the measure "Clinical summaries provided to patients or patient-authorized representatives within 1 business day for more than 50 percent of office visits" (§ 495.6(j)(11)(ii)), can a provider determine whether to include information that was not changed or addressed during the visit? Read the answer here.
- When creating a clinical summary as part of an office visit to meet the measure "Clinical summaries provided to patients or patient-authorized representatives within 1 business day for more than 50 percent of office visits" (§ 495.6(j)(11)(ii)), do all of the information elements specified by CMS for a clinical summary need to be individually listed? Read the answer here.

Updated FAQ:
What are the EHR reporting periods for eligible hospitals participating in both the Medicare and Medicaid EHR Incentive Programs, as well as the requirements for receiving an EHR incentive payment? Read the answer here.

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.

Assignment Violations on Claims for DMEPOS

Suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) are reminded that it is a violation of Medicare's assignment rules and, if applicable, your Medicare Participating Physician or Supplier Agreement (Form CMS-460) to collect more than the applicable Medicare deductible and coinsurance amounts from a beneficiary. It has come to the attention of CMS that some billers are not adhering to that rule and, in some cases, are collecting from the beneficiary the entire allowed amount even when the entire allowed amount is not needed to satisfy the beneficiary's coinsurance and applicable deductible.

Such action can not only result in an improper payment amount, but also constitutes an assignment violation because, on an assigned claim, a supplier may not collect more than the coinsurance and any applicable deductible from the beneficiary. Violations of Medicare's assignment rules and/or Participation Agreement may result in revocation of the supplier's right to receive assigned benefits, exclusion from Medicare, and/or civil monetary penalties. In addition, suppliers may be required to refund monies improperly collected from beneficiaries.

Contact your local Medicare administrative contractor if you have questions about assignment violations

and how you may avoid them.

Change to Payment Liability for Therapy Cap Denials

Section 603(c) of the American Taxpayer Relief Act of 2012 (ATRA) changed the payment liability for denials resulting from the outpatient therapy caps from beneficiaries to providers effective January 1, 2013. Medicare systems were not updated in time to accurately represent this change on provider remittance advices (RAs). Medicare contractors may have already processed therapy cap denials for services provided in 2013. These denials incorrectly report on RAs beneficiary liability (Group Code "PR") when liability legally rests with the provider (Group Code "CO").

Due to differing claims processing system constraints, this inaccurate RA reporting will be corrected beginning on different dates for different claim formats. For institutional claims, the correct liability will be reported beginning on June 24, 2013. For professional claims, the correct liability will be reported beginning on January 1, 2014.

Since Medicare's payment amount for these claims is correct, Medicare Administrative Contractors will not adjust claims processed before these dates to correct the Group Code. To do so could create disruptions for providers' accounts receivable. Instead, therapy providers should review any therapy cap denials for dates of service on or after January 1, 2013, to determine whether any payments have been collected from beneficiaries. Providers should refund any beneficiary payments they find for these services. Additionally, providers should cease to collect payments for therapy cap denials unless the beneficiary was appropriately notified via an Advanced Beneficiary Notice of Noncoverage (ABN).

TOB 85X Medically Unlikely Edit Claims Adjudication Change

At this time, CAH Method II providers who received some MUE claim denials for a claim line with a revenue code for professional services 96X, 97X and 98X do not have to take any action. CMS will instruct the contractors to re-process the claims when a system's modification is implemented July 2013. Your A/B Medicare Administrative Contractor will advise you via their website when these adjustments have been completed.

CY 2013 Home Health PPS and FY 2013 Inpatient PPS PC Pricers — Updated

The CY 2013 Home Health (HH) Prospective Payment System (PPS) PC Pricer and the FY 2013 Inpatient PPS PC Pricer have been updated with newer provider data and are now available on the HH PPS PC Pricer and Inpatient PPS PC Pricer web pages in the "Downloads" section.

"Information on the National Physician Payment Transparency Program: OPEN PAYMENTS" MLN Matters® Article — Released

MLN Matters® Special Edition Article #SE1303, "Information on the National Physician Payment Transparency Program: OPEN PAYMENTS" was released and is now available in downloadable format. This article is designed to provide education on the implementation of the National Physician Payment Transparency Program (OPEN PAYMENTS) in accordance with Section 6002 of the Affordable Care Act. It includes a summary of the final rule that was published on Friday, February 8, 2013, in addition to implementation timelines and requirements.

From the MLN: "Medicare-Covered Services Furnished Outside the United States" Fact Sheet — Released

The "Medicare-Covered Services Furnished Outside the United States" Fact Sheet (ICN 908605) was released and is now available in downloadable format. It includes information about Medicare-covered services furnished in the United States (U.S.), Medicare-covered services furnished outside the U.S., and billing and payment.

From the MLN: "ICD-10-CM/PCS The Next Generation of Coding" Fact Sheet — Revised

The "ICD-10-CM/PCS The Next Generation of Coding" Fact sheet (ICN 901044) was revised and is now available in downloadable format. This fact sheet is designed to provide education on the International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS). It includes the following information: ICD-10-CM/PCS compliance date; ICD-10-CM/PCS – an improved classification system; ICD-10-CM/PCS examples; structural differences between International Classification of Diseases, 9th Edition, Clinical Modification and ICD-10-CM/PCS; continued use of Current Procedural Terminology codes; and use of external cause and unspecified codes in ICD-10-CM.

Submit Your Feedback on the MLN Learning Management System and Product Ordering System

Your feedback is important to us as we use your suggestions to improve your experience using the Medicare Learning Network® (MLN) Learning Management System and Product Ordering System to take web-based training courses and order MLN educational products. To submit your feedback, visit the MLN Opinion Page. Scroll down to the "Related Links" section, and click on the "MLN Evaluations" link. You will be directed to the Product Evaluations page. From that page, click on "MLN Learning Management System and Product Ordering System Feedback" at the top of the list. After you have completed the evaluation, click on "Submit."

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 health care professionals 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.

New MLN Educational Web Guides Fast Fact

A new fast fact is now available on the MLN Educational Web Guides web page. This web page provides information on Evaluation and Management services; Guided Pathways that contain resources and topics of interest; lists of health care management products; and easy-to-understand billing and coding educational products. It is designed to provide educational and informational resources related to certain Medicare FFS initiatives. Please bookmark this page and check back often as a new fast fact is added each month.

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