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Today's edition of the *e-News* includes recommendations from the CDC for controlling carbapenem-resistant Enterobacteriaceae transmission in hospitals, long-term acute care facilities, nursing homes, and health departments in "CDC and CMS Sound Alarm on "Nightmare" Bacteria." Please act now to address what may be one of the most pressing patient safety threats of our time.

National Provider Call: 2013 PQRS and eRx Claims-Based Reporting Made Simple — Registration Now Open

Tuesday, March 19; 1:30-3pm ET

This National Provider Call provides an overview of how to report for PQRS and eRx through claims, including how to start reporting, key points, scenarios, and tips for satisfactorily reporting. The presentation also includes information about the claims-reporting process, 2013 reporting periods and frequency, coding/measure specification, review of CMS-1500 form, and other helpful hints. A question and answer session follows the presentation.

Agenda:

- Welcome and program announcements
- 2013 PQRS and eRx claims-based reporting made simple
- Question & 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 prior to the call on the FFS National Provider Calls web page. In addition, a link to the slide presentation will be emailed to all registrants on the day of the call.

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

National Provider Call: Implementation of Edits on the Ordering/Referring Providers in Medicare Part B, DMEPOS, and Part A Home Health Agency Claims — Registration Now Open
Wednesday, March 20; 3-4pm ET — Note time change

CMS will hold a national provider call on March 20 from 3-4pm ET on the "Implementation of Edits on the Ordering/Referring Providers in Medicare Part B, DMEPOS, and Part A Home Health Agency Claims." Please note this call will be one hour in length.

Effective May 1, 2013, CMS will instruct contractors to turn on Phase 2 denial edits on the following claims to check for a valid individual National Provider Identifier (NPI) and to deny the claim when this information is missing:

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

Agenda:

- Provider Types Eligible to Order/Refer
- Action Steps for Billing Providers
- Action Steps for Providers Who Order/Refer
- Resources

Target Audience: Part B providers which order, refer and /or bill for these services; HHAs

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.

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National Provider Call: Video Slideshow Presentation from January 31 Call on the CMS National Partnership to Improve Dementia Care in Nursing Homes Now Available

CMS has released a YouTube video slideshow presentation from the January 31 National Provider Call on the CMS National Partnership to Improve Dementia Care in Nursing Homes. The call presentation is now available on the CMS YouTube Channel as a video slideshow that includes the call audio. Visit the January 31 call web page for access to all of the related call materials, including the slide presentation, complete audio recording, and written transcript.

Colorectal Cancer is Preventable and Treatable – Your Recommendation Can Help Save Lives

March is National Colorectal Cancer Awareness Month – a time to encourage everyone over the age of 50 to get screened regularly for colorectal cancer. The risk of getting colorectal cancer increases with age. More than 90 percent of cases occur in people who are 50 years old or older. Colorectal cancer often can be prevented. Regular screening can find precancerous polyps so they can be removed before they turn into cancer and screening can find colorectal cancer early, when treatment can be effective.

Medicare Coverage
Medicare defines high risk of developing colorectal cancer as someone who has one or more of the following risk factors:

- Close relative (sibling, parent, or child) who has had colorectal cancer or an adenomatous polyp,
- Family history of familial adenomatous polyposis,
- Family history of hereditary nonpolyposis colorectal cancer,
- Personal history of adenomatous polyps,
- Personal history of colorectal cancer, or
- Personal history of inflammatory bowel disease, including Crohn's Disease and ulcerative colitis.

All Medicare beneficiaries age 50 and older, who are *not* at high risk for colorectal cancer, and meet certain eligibility requirements are covered for the following screening services:

- Screening Fecal Occult Blood Test (FOBT) every year,
- Screening Flexible Sigmoidoscopy once every 4 years (unless a screening colonoscopy has been performed and then Medicare may cover a screening sigmoidoscopy after at least 119 months) ,
- Screening Colonoscopy every 10 years (unless a screening flexible sigmoidoscopy has been performed and then Medicare may cover a screening colonoscopy only after at least 47 months), and
- Screening Barium Enema (as an alternative to a covered screening flexible sigmoidoscopy).

All Medicare beneficiaries age 50 and older, who are at high risk for colorectal cancer, and meet certain eligibility requirements are covered for the following screening services:

- Screening FOBT every year,
- Screening Flexible Sigmoidoscopy once every 4 years,
- Screening Colonoscopy every 2 years (unless a screening flexible sigmoidoscopy has been performed and then Medicare may cover a screening colonoscopy only after at least 47 months), and
- Screening Barium Enema (as an alternative to a covered screening colonoscopy).

What Can You Do?
Screening and early detection saves lives. Your help is needed to increase awareness of colorectal cancer and ensure that more people with Medicare take advantage of colorectal cancer screening services, as appropriate.

- Talk with your patients about colorectal cancer and the importance of getting screened for colorectal cancer and other ways to reduce the risk of the disease, such as not smoking, maintaining a healthy weight, exercising, eating less red meat, and consuming alcohol in moderation or not at all.
- Inform your patients about their risk factors and the role screening plays in early detection and prevention.
- Remind your patients when they are due for a colorectal cancer screening.
- Encourage your patients to take full advantage of the colorectal cancer screenings covered by Medicare.

For More Information

- MLN Preventive Services Educational Products for Health Professionals
- CMS Prevention Web Site
- United States Preventive Services Task Force (USPSTF)
- National Cancer Institute at National Institutes of Health

Are you ready for DMEPOS Competitive Bidding?

Are you a Medicare enrolled provider, physician, treating practitioner, discharge planner, social worker, pharmacist, or other health professional who may prescribe or refer beneficiaries for DMEPOS items in a competitive bidding area? Round 2 of the DMEPOS Competitive Bidding Program is targeted to go into effect in 91 Metropolitan Statistical Areas on July 1, 2013. Medicare also will implement a national mail-order program for diabetic testing supplies on July 1, 2013. When the program becomes effective in a competitive bidding area, beneficiaries with Original Medicare who obtain competitively bid items in the area must obtain these items from a contract supplier in order for Medicare to pay, unless an exception applies. Are you ready to help beneficiaries when the program starts?

Where are the Round 2 areas? What if a beneficiary travels? What do you need to know before prescribing a DMEPOS item or referring the beneficiary to a DMEPOS supplier? Want more information on the national mail-order program for diabetic testing supplies?

For answers to these questions and more, sign up for the CMS DME Referral Agent Electronic Mailing List.

CDC and CMS Sound Alarm on "Nightmare" Bacteria

The Centers for Disease Control and Prevention (CDC) and CMS are asking your assistance in tackling what may be one of the most pressing patient safety threats of our time—carbapenem-resistant Enterobacteriaceae (CRE). CDC recently released a report on the presence of CRE in U.S. inpatient medical facilities, demonstrating that action is needed now to halt the spread of these deadly bacteria. We are asking for rapid action from healthcare leaders to ensure that infection prevention measures are aggressively implemented in your facilities and those around you.

Enterobacteriaceae are a family of more than 70 bacteria, including *Klebsiella pneumoniae* and *E. coli*, that normally live in the digestive system. Over time, some of these bacteria have become resistant to a group of antibiotics known as carbapenems, often referred to as last-resort antibiotics. During the last decade, CDC has tracked one type of CRE from a single healthcare facility to facilities in at least 42 states. In some healthcare facilities, these bacteria already pose a routine threat to patients.

CDC has released a concise, practical CRE prevention toolkit with recommendations for controlling CRE transmission in hospitals, long-term acute care facilities, nursing homes, and health departments. Key recommendations follow CDC's "Detect and Protect" strategy, including:

- Enforcing use of infection control precautions (standard and contact precautions).
- Grouping patients with CRE together.
- Dedicating rooms, staff, and equipment to the care of patients with CRE whenever possible.
- Having facilities alert each other when patients with CRE transfer back and forth.
- Asking patients whether they have recently received care somewhere else (including another country).
- Using antibiotics wisely.

When fully implemented, CDC recommendations have been proven to work. Medical facilities in several states have reduced CRE infection rates by following CDC's prevention guidelines.

The United States is at a critical point in our ability to stop the spread of CRE. If we do not act quickly, we will miss our window of opportunity and CRE could become widespread across the country.

HHS Announces 2013 Agenda to Bring Down Costs and Improve Quality of Care Through Implementation of Health Information Technology

On March 6, CMS Acting Administrator Marilyn Tavenner and the National Coordinator for Health Information Technology Farzad Mostashari, M.D. announced HHS's plan to accelerate health information exchange (HIE) and build a seamless and secure flow of information essential to transforming the health care system.

This year, HHS will:

- Set aggressive goals for 2013: HHS is setting the goal of 50 percent of physician offices using electronic health records (EHR) and 80 percent of eligible hospitals receiving meaningful use incentive payments by the end of 2013.
- Increase the emphasis on interoperability: HHS will increase its emphasis on ensuring electronic exchange across providers. It will start that effort by issuing today a request for information (RFI) seeking public input about a variety of policies that will strengthen the business case for electronic exchange across providers to ensure patients' health information will follow them seamlessly and securely wherever they access care.
- Enhance the effective use of electronic health records through initiatives like the Blue Button initiative. Medicare beneficiaries can access their full Medicare records online today. HHS is working with the Veterans Administration and more than 450 different organizations to make

health care information available to patients and health plan members. HHS is also encouraging Medicare Advantage plans to expand the use of Blue Button to provide beneficiaries with one-click secure access to their health information.

- Implement Meaningful Use Stage 2: HHS is implementing rules that define what data must be able to be exchanged between Health IT systems, including how data will be structured and coded so that providers will have one uniform way to format and securely send data.
- Underscoring program integrity: HHS is taking new steps to ensure the integrity of the program is sound and technology is not being used to game the system. For example, it is conducting extensive medical reviews and issuing Comparative Billing reports that identify providers.

The goals build on the significant progress HHS and its partners have already made on expanding health information technology use. EHR adoption has tripled since 2010, increasing to 44 percent in 2012 and computerized physician order entry has more than doubled (increased 168 percent) since 2008.

In addition to seeking public input, the RFI also discusses several potential new policies and ideas to accelerate interoperability and exchange of a patient's health information across care settings so that they can deliver better and more affordable care to their patients. The deadline for comments on the RFI is April 21, 2013.

Full text of this excerpted HHS press release (issued March 6).

Notice Issued on Extension of the Low-Volume Hospital Payment Adjustment and the Medicare – Dependent Hospital Program

On March 7, CMS issued a Federal Register Notice (CMS-1588-N) on the extension of the payment adjustment for low-volume hospitals and the Medicare-dependent hospital (MDH) program under the hospital Inpatient Prospective Payment Systems (IPPS) for acute care hospitals for FY 2013, providing information on how these two IPPS provisions are to be implemented. The notice outlines which providers will be affected and includes instructions for providers on any action(s) they must take in order to receive the low-volume hospital adjustment and/or be reinstated under the MDH program during FY 2013.

As detailed in this notice, hospitals that meet the eligibility criteria for the low-volume hospital adjustment must send a written request to their Medicare contractor *no later than March 22, 2013* in order for the adjustment to apply retroactively to discharges occurring on or after October 1, 2012. Each provider affected by the MDH program extension will receive a notice from their Medicare contractor, detailing their status in light of the MDH program extension. Additional background information is available in the Federal Register Notice, which is also posted on the Acute Inpatient PPS website.

Recovery Auditors Shall Not Issue Any "Failure to Respond" Denials to esMD Providers

The Electronic Submission of Medical Documentation (esMD) system has recently experienced exponential growth. Unfortunately, this increased volume has led to the frequent gateway outages.

Some providers have expressed concern that because the esMD gateway is down when they try to submit, they will receive denials from Recovery Audit Contractors (RACs) due to "failure to respond timely." Effective immediately, the Recovery Auditors shall look to the date a provider submits documentation to their Health Information Handler (HIH) to determine whether a provider has

submitted timely. The RACs will not issue any "failure to respond" denials to esMD providers who were timely in submitting the documentation to their HIH. This change will be in effect until May 1, 2013.

Hospice Quality Reporting Program: NQF #0209 Deadline April 1
Deadline quickly approaching to avoid 2 percentage point reduction to APU for FY 2014

To comply with the Payment Year 2014 Hospice Quality Reporting Program (HQRP) requirements, providers should currently be entering their NQF #0209 data on the data entry and submission website. Providers that have not already created a data entry account should do so now.

The deadline for reporting NQF #0209 data for Payment Year 2014 is April 1, 2013. In order to avoid a 2 percentage point reduction in their Annual Payment Update (APU), providers must have submitted their structural measure data by January 31, 2013 and must submit their NQF #0209 data by April 1. Providers that may have missed the structural measure deadline can still visit the data entry website, create an account, and enter their NQF #0209 data. The link to the data entry site, along with a Technical User Guide giving step-by-step instructions on the data entry process, can be found on the Data Submission portion of the CMS HQRP website.

User Account Deactivation Requests for the HQRP
If you anticipate needing a deactivation request for your HQRP user account, please submit the user account deactivation request to the Technical Help Desk via fax at 888-477-7871 or email at help@QTSO.com *prior to March 25, 2013.* Any deactivation requests received on or after March 25 puts a hospice organization at risk for missing the NQF #0209 deadline, which is April 1. *Please note: all data submitted by a user who is deactivated is permanently deleted.*

CMS Continues Efforts to Improve Quality of Care for People with Medicare
20 Sites Named in Initiative to Improve Transitions from the Hospital to Home or Other Care Settings

On March 7, CMS announced 20 additional organizations selected to participate in the Community-based Care Transitions Program (CCTP). These new participants will join 82 existing sites, where community-based organizations are already working with local hospitals and other health care and social service providers. These groups are supporting Medicare beneficiaries who are at increased risk of being readmitted to the hospital while transitioning from hospital stays to their homes, a nursing home, or other care settings.

The CCTP was created by the Affordable Care Act and will help community-based organizations and hospitals form partnerships to prevent readmissions after beneficiaries leave the hospital. These new participating sites will work with CMS to provide support for beneficiaries as they move from the hospital to other care settings. Already these efforts are paying off, with an estimated 70,000 readmissions prevented last year as a result of declining rates of readmission.

The additional 20 CCTP participants will bring the total to 102 participants providing care transition services to over 700,000 beneficiaries in 40 states. Each participant enters into a two-year agreement with the CMS Innovation Center and will be paid a flat fee per beneficiary for care transition services.

Under the Affordable Care Act, the program may spend up to $500 million over five years. Nearly one in five Medicare patients discharged from a hospital—approximately 2.6 million seniors—is readmitted within 30 days, at a cost of over $26 billion every year. Any future opportunities to apply will be posted on the Community-based Care Transitions Program website.

Several New and Updated EHR FAQs Added to CMS Database

CMS has recently added three new and three updated FAQs related to the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs. We encourage you to stay informed by taking a few minutes to review the new information. To search and access more FAQs related to the EHR Incentive Programs, please use the CMS FAQ System.

New FAQs:

1. If an eligible professional (EP) practices at an outpatient location, a location other than an inpatient (place of service 21) or emergency department (place of service 23), and that location is only equipped with Certified EHR Technology to the criteria applicable to an inpatient setting, must the EP include that location in their meaningful use calculations? Read the answer here.
2. If an EP practices at an outpatient location that has not implemented all the functionalities necessary to meet meaningful use, is that location considered equipped with Certified EHR Technology? Must that location be included in the EP's meaningful use calculations? Does it matter if the location possesses ambulatory Certified EHR Technology covering the relevant meaningful use objectives, but does not implement them? Read the answer here.
3. When combining meaningful use data from multiple locations equipped with Certified EHR Technology, is it required to have a full meaningful use report from each location or is it acceptable to only collect denominator information from one or more locations? Read the answer here.

Updated FAQs:

1. How and when will incentive payments for the Medicare EHR Incentive Programs be made? Read the answer here.
2. If multiple EPs or eligible hospitals contribute information to a shared portal or to a patient's online personal health record (PHR), how is it counted for meaningful use when the patient accesses the information on the portal or PHR? Read the answer here.
3. If I participated in the Medicaid EHR Incentive Program last year, am I required to participate in the following year? Read the answer here.

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

From the MLN: "Screening, Brief Intervention, and Referral to Treatment (SBIRT) Services" Fact Sheet — Revised

The "Screening, Brief Intervention, and Referral to Treatment (SBIRT) Services" Fact Sheet (ICN 904084) was revised and is now available in downloadable format. This fact sheet includes an early intervention approach that targets those with nondependent substance use to provide effective strategies for intervention prior to the need for more extensive or specialized treatment.

From the MLN: "Power Mobility Devices (PMDs) Fact Sheet — Revised

The "Power Mobility Devices (PMDs)" Fact Sheet (ICN 905063) was revised and is now available in downloadable format. The fact sheet is designed to provide education on basic coverage criteria and

documentation requirements, as well as detailed coverage guidelines for the specific type of PMD provided.

CMS asks that you share this important information with interested colleagues and recommends they subscribe to receive the *e-News* directly.

Previous issues are available in the archive.