Table of Contents for Thursday, March 28, 2013

National Provider Calls: Medicare Shared Savings Program Application Process — Register Now
Tuesday, April 9; 2:30-4pm ET— **Preparing to Apply**
Tuesday, April 23; 1:30-3pm ET— **Tips on Completing a Successful Application**

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 in April on the Shared Savings Program application process.

On Tuesday, April 9, CMS subject matter experts will provide information on what you can do now to prepare for the Shared Savings Program application process for the January 1, 2014 start date. This National Provider Call will include information on 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.

On Tuesday, April 23, CMS subject matter experts will cover tips on completing a successful application, including information on how to submit an acceptable ACO Participant List, Participation Agreement Sample, Executed Participant Agreement pages, and Governing Body Template for the Shared Savings Program 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.

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.

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: PQRS Group Practice Reporting Option and Registry Reporting — Registration Now Open
Tuesday, April 16; 1:30-3pm ET

Register now for the upcoming CMS National Provider Call (NPC) on the 2013 Physician Quality Reporting System (PQRS) and Electronic Prescribing (eRx) claims-based reporting. This NPC will provide an overview to eligible professionals on reporting requirements and criteria for satisfactorily reporting for Group Practice Reporting Option (GPRO) and Registry Reporting. The presentation will include how to participate, how to report through a registry, tips for successful participation, and information about the 2013 PQRS group option for reporting data through registries for purposes of earning the 2013 PQRS incentive payment and avoiding the 2015 PQRS payment adjustment. A question and answer session will

follow the presentation.

Agenda:

- Announcements
- Overview on the 2013 PQRS GPRO and Registry Reporting
- 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 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: Begin Transitioning to ICD-10 in 2013 — Register Now
Thursday, April 18; 1:30-3pm ET

On September 5, 2012, CMS published a final rule that delays the ICD-10 compliance date from October 1, 2013 to October 1, 2014. Are you ready to transition to ICD-10? Now is the time to prepare. Join us to learn how to prepare in 2013 for the transition.

CMS Subject matter experts will review basic information on the transition to ICD-10 and discuss implementation planning and preparation strategies. A question and answer session will follow the presentations.

Agenda:

- Planning for transition to ICD-10
- Claims processing
- National implementation issues
- National Coverage Decisions
- Outreach

Target Audience: Medical coders, physicians, physician office staff, nurses and other non-physician practitioners, provider billing staff, health records staff, vendors, educators, system maintainers, laboratories, and all 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.

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.

Physician Compare Redesign Open Door Forum Registration

In 2012, CMS initiated a full redesign of the Physician Compare website based on feedback from site users, physicians and other healthcare professionals, and other stakeholders. The goal of the redesign was to improve the accuracy and currency of the information available on the website as well as improve the usability and functionality for all users. Two primary enhancements of the redesign include an overhaul of the underlying database and the addition of a new Intelligent Search functionality.

The redesigned Physician Compare website will be launched soon. You are invited to participate in an Open Door Forum where CMS will unveil the redesign. The Open Door Forum will be conducted via webinar. If you are interesting in participating, please send an email with your name, affiliation, and email address to the Physician Compare team at PhysicianCompare@Westat.com. Please put "ODF" in the subject line. The Physician Compare team will email logistical details and instructions for the webinar to everyone who registers the week of the ODF.

Mandatory Payment Reductions in the Medicare FFS Program — "Sequestration"

As required by law, President Obama issued a sequestration order on March 1, 2013 requiring across-the-board reductions in Federal spending.

In general, Medicare FFS claims with dates-of-service or dates-of-discharge on or after April 1, 2013, will incur a 2 percent reduction in Medicare payments. Therefore, to prevent making overpayments, interim and pass-through payments related to the Medicare cost report will be reduced by 2 percent. Beginning April 1, 2013 the 2 percent reduction will be applied to Periodic Interim Payments (PIP), Critical Access Hospital (CAH) and Cancer Hospital interim payments, and pass-through payments for Graduate Medical Education, Organ Acquisition, and Medicare Bad Debts.

Questions about reimbursement should be directed to your Medicare Administrative Contractor.

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

In May, CMS will begin accepting quality measure suggestions for potential inclusion in the proposed set of quality measures in the Physician Quality Reporting System (PQRS) for future rule-making years. CMS is seeking a quality set of measures that are outcome-based and fall into one of the National Quality Strategy (NQS) Priorities domains where there are known measure and performance gaps. The measure gaps that CMS most wishes to fill include clinical outcomes, patient-reported outcomes, care coordination, safety, appropriateness, efficiency, and patient experience and engagement.

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

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

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

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

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

Frequently Asked Questions About Billing Medicare for Transitional Care Management Services Available

CMS has posted to the Physician Fee Schedule web page Frequently Asked Questions about Billing Medicare for Transitional Care Management Services. Effective January 1, 2013, Medicare pays for two Current Procedural Terminology (CPT) codes (99495 and 99496) that are used to report physician or qualifying nonphysician practitioner care management services for a patient following a discharge from a hospital, Skilled Nursing Facility (SNF), or Community Mental Health Center (CMHC) stay, outpatient observation, or partial hospitalization. This policy is discussed in the CY 2013 Physician Fee Schedule final rule published on November 16, 2012.

Have You Tried the CMS Medicare Physician Fee Schedule Search Tool?

Did you know the CMS website has a searchable look-up tool that provides Medicare Physician Fee Schedule (MPFS) payment information for physician and non-physician practitioner services?

The easy to use MPFS Search Tool allows you to:

- Search payment amounts, relative value units (RVUs), various payment policy indicators, and geographic practice cost indexes (GPCIs) for a single procedure code, a range of procedure codes, or a list of procedure codes.
- Find the national payment amount, the payment amount for a specific Carrier/Medicare

Administrative Contractor (MAC), or the payment amount in a specific locality.

Updated at least quarterly, the look-up tool currently provides information on more than 10,000 physician and non-physician practitioner services. The information available includes payment rates, RVUs, and various payment policy indicators (i.e., covered, bundled, multiple procedure payment reduction percentage, payment of assistant-at-surgery, diagnostic procedure supervision, etc.).

To start your search, go to the Medicare Physician Fee Schedule Search Tool. To learn more about the MPFS Search Tool, read the MLN® booklet, "How to Use the Searchable Medicare Physician Fee Schedule."

New Release of PEPPER for LTCHs, CAHs, IPFs, IRFs, Hospices and PHPs

The Q4FY12 release of the Program for Evaluating Payment Patterns Electronic Report (PEPPER) with statistics through September 2012 will soon be available for long-term acute care hospitals (LTCHs), critical access hospitals (CAHs), inpatient psychiatric facilities (IPFs), inpatient rehabilitation facilities (IRFs), hospices, and partial hospitalization programs (PHPs) nationwide.

In late March, the PEPPERs will be distributed electronically to CAHs, IPF, and IRF distinct part units of short-term acute care hospitals and PHPs administered by short-term acute care hospitals through a My QualityNet secure file exchange to hospital QualityNet Administrators and user accounts with the PEPPER recipient role. LTCHs, hospices, free-standing IPFs and IRFs, and PHPs not administered by a short-term acute care hospital will receive their PEPPER in hard copy format via FedEx addressed to the Chief Executive Officer, with FedEx delivery beginning in mid-April 2013.

New for this release in the LT PEPPERs is a new target area report ("Short Stays for Respiratory System Diagnoses"). New for this release in the CAH PEPPERs is a new target area report ("Single CC/MCC") and the discontinuation of one target area report ("One-day Stays for Chest Pain/Atherosclerosis"). In this release of the PHP PEPPERs, three target areas have been revised (Days of Service with 4 Units, Group Therapy, and 60+ Days of Service); there have also been modifications in the way PHP episodes of care are reported. In this release of the Hospice PEPPERs there have been modifications in the way hospice claims are evaluated. For more information, visit the applicable "Training and Resources" section of PEPPERresources.org.

About PEPPER
PEPPER summarizes provider-specific data statistics for Medicare services that may be at risk for improper payments. Providers can use the data to support internal auditing and monitoring activities. Visit PEPPERresources.org to access updated resources for using PEPPER, including recorded web-based training sessions, sample PEPPERs, and PEPPER User's Guides, which are available on the applicable "Training and Resources" pages. The website also provides information about QualityNet accounts and frequently asked questions. Questions and requests for assistance may be submitted through the Help Desk. PEPPER is distributed by TMF® Health Quality Institute under contract with CMS.

CMS encourages hospitals to provide feedback on PEPPER through a feedback form so that the reports can be continually improved.

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

Hospice providers must enter and attest to their NQF #0209 data on the data entry website no later than 11:59pm ET on April 1, 2013 in order to comply with Payment Year 2014 NQF #0209 requirements. Providers that have not already begun entering their NQF #0209 data for the Hospice Quality Reporting Program (HQRP) Payment Year 2014 cycle should begin doing so immediately. In order to avoid a 2 percentage point reduction in Annual Payment Update (APU) for FY 2014, providers must have submitted data for both the structural measure and the NQF #0209 measure by the specified deadlines: January 31, 2013 for the structural measure and April 1, 2013 for the NQF #0209 measure. 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.

It is highly recommend that hospice providers confirm attestation and submission of their NQF #0209 data, as compliance with NQF #0209 reporting requirements for FY 2014 is based on the attestation and submission step. Providers are encouraged to print for their records the "NQF #0209 Pain Measure Submitted" page that displays immediately following submission of data. This page confirms the successful submission of data to CMS. Providers may also verify attestation and submission of their NQF #0209 data by logging into the data entry website and viewing the "Measure Data Entry Links and Submission Status" page. If you have submitted and attested to your NQF #0209 data, the NQF #0209 Pain Measure Submission Status will show: "Data Attested and Submitted," along with the date and time-stamp of attestation. Providers may wish to print or save a copy of the "Measure Data Entry Links and Submission Status Page" for their records.

EHR Incentive Programs: New Interactive Resource on Stage 2 and the 2014 CQMs

CMS recently posted a new resource to help eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) prepare for Stage 2 of the Electronic Health Record (EHR) Incentive Programs. Available on the Educational Resources page of the EHR Incentive Programs website, the interactive Stage 2 Toolkit includes materials on Stage 2 and the 2014 clinical quality measure (CQM) requirements.

The toolkit is divided into three main sections:

- Basics
- Resources for EPs
- Resources for eligible hospitals and CAHs

Providers who use the toolkit will find the following information:

- An overview of Stage 2
- Stage 2 FAQs
- How the Stage 2 provisions affect Stage 1 requirements
- Comparison tables of Stage 1 and Stage 2 criteria
- Details about payment adjustment and hardship exemptions
- 2014 CQMs, including descriptions, technical release notes, and the recommended core sets for EPs and eligible hospitals

Reminder: The earliest that the criteria for Stage 2 will be effective is the first day of fiscal year 2014 (October 1, 2013) for eligible hospitals and CAHs, or calendar year 2014 (January 1, 2014) for EPs. All providers must achieve meaningful use under the Stage 1 criteria before moving to Stage 2.

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.

Manual Medical Review of Outpatient Therapy Claims Will Begin April 1

On January 2, 2013, President Barack Obama signed the American Taxpayer Relief Act of 2012. Section 603 of this Act, contains a number of Medicare provisions which directly impacts claims submitted for outpatient therapy services. Revisions of the Financial Limitation for Outpatient Therapy Services – Section 3005 of the Middle Class Tax Relief and Job Creation Act of 2012 requires Original Medicare to temporarily apply therapy caps (and related provisions) to therapy services furnished in outpatient hospital settings between the dates of January 1 through December 31, 2013.

What you need to know
Effective April 1, 2013, Recovery Auditors will begin the process of reviewing all therapy claims, which have exceeded the $3,700 threshold cap for the year. Importantly, there are two separate thresholds triggering manual medical reviews (MMRs) and build upon the separate therapy caps as follows: one for occupational therapy (OT) services, and; one for physical therapy (PT) and speech language pathology (SLP) services combined. Although PT and SLP services are combined for triggering the threshold, the medical review will be conducted separately by discipline. Additional conditions include the requirement that all suppliers and providers who report on the beneficiary's claims for therapy services provide the National Provider Identifier (NPI) of the physician (or non-physician practitioner where applicable) who is responsible for reviewing the therapy plan of care.

Recovery Auditors will complete two types of review:

- Prepayment Review:
  - Eleven states will be participating in the Recovery Audit Prepayment Review Demonstration. All therapy claims that have exceeded the $3,700 therapy cap threshold for the year will be reviewed and compared to the medical record before the claim is processed for payment. The demonstration will occur in the following 11 states (FL, CA, MI, TX, NY, LA, IL, PA, OH, NC, and MO).
  - If the Recovery Auditors determine an improper claim has been submitted, a review results letter will be sent to the provider, which clearly documents the rationale for the determination. The letter provides vital information to the provider regarding the Recovery Auditors findings and detailed description of the Medicare policy or rule that was violated.
  - Typical Additional Documentation Requests (ADR) limits will not apply. All therapy claims at or above the $3,700 threshold cap will trigger the MMR process and will need to be reviewed by the Recovery Auditors.
  - The Recovery Auditors will conduct prepayment review within 10 business days of receiving the medical record.
  - The ADR will be sent to the provider by the Medicare Administrative Contractor (MAC) with instructions to send the records to the Recovery Auditor.
- Post Payment Review:
  - In the remaining states, the Recovery Auditors shall conduct immediate post-pay reviews.
  - All therapy claims that have exceeded the $3,700 therapy cap threshold for the year will be reviewed and compared to the medical record after the claim has been processed for payment.
  - If the Recovery Auditors determine an improper payment has resulted, a demand letter will be sent to the provider, which clearly documents the rationale for the determination. The letter provides vital information to the provider regarding the Recovery Auditors findings and detailed description of the Medicare policy or rule that was violated.
  - Typical ADR limits will not apply. All therapy claims at or above the $3,700 threshold cap will

trigger the manual medical review process and will need to be reviewed by the Recovery Auditors.
    - The ADR will be sent to the provider immediately after the claim is paid. The ADR will be sent by the MAC to the provider with instructions to send the records to the Recovery Auditor.

The threshold cap will accrue for claims with dates of service from January 1 through December 31, 2013. The therapy cap applies to all Part B outpatient therapy settings and providers including:

- Private Practices
- Part B Skilled Nursing Facilities
- Home Health Agencies (TOB 34X)
- Outpatient Rehabilitation Facilities (ORFs)
- Rehabilitation Agencies (Comprehensive Outpatient Rehabilitation Facilities)
- Outpatient Hospitals

Questions
Additional guidance on the MMR process for Therapy claims above the $3,700 threshold, as well as helpful medical review guidelines can be found on the Therapy Cap web page. For all additional questions, please contact the appropriate Recovery Audit Contractor (RAC) and/or A/B MAC in your region at their toll-free number, which may be found on the Provider Compliance Group Interactive Map.

New Remittance Advice Message for Therapy Claims

As required by section 3005(g) of the Middle Class Tax Relief and Jobs Creation Act of 2012, CMS implemented a new claims-based data collection system for outpatient therapy services by requiring reporting functional limitations with 42 new nonpayable G-codes and 7 new modifiers on specified claims for physical therapy (PT), occupational therapy (OT) and speech-language pathology (SLP) services. The claims-based data collection system is effective for outpatient therapy services with dates of service on and after January 1, 2013. A testing period is currently in effect from January 1 through June 30, 2013. During the testing period, claims without the required G-codes and severity/complexity modifiers will continue to be processed and adjudicated by your carrier or Part B Medicare Administrative Contractor. However, beginning April 1, 2013, a new Remittance Advice message will alert providers about missing information on select therapy claims. Please note, institutional claims will not receive alert messages.

Effective April 1 through June 30, 2013, for therapy claims with dates of service on and after January 1, 2013, contractors will use Remittance Advice messages to alert providers, who submit claims containing:

- Functional G-codes without severity/complexity modifiers that functional G-codes require severity/complexity modifiers; and
- Evaluation/re-evaluation therapy codes without functional reporting that these codes require functional G-codes and appropriate modifiers.

Please read the following MLN Matters® articles for more information:

- MM8166 – "Outpatient Therapy Functional Reporting Non-Compliance Alerts"
- MM8005 – "Implementing the Claims-Based Data Collection Requirement for Outpatient Therapy Services — Section 3005(g) of the Middle Class Tax Relief and Jobs Creation Act (MCTRJCA) of 2012"

Quarterly Provider Specific Files for the Prospective Payment System Updated

The January 2013 Inpatient Provider Specific File (PSF) has been updated with corrected rural core based statistical area (CBSA) values and more default values and is now available for download from the CMS website in text format. The file contains information about the facts specific to the inpatient provider that affect computations for the Prospective Payment System. The text data file is available on the Provider Specific Data for Public Use in Text Format web page in two versions. One version contains the provider records that were submitted to CMS. The other version also includes name and address information for providers at the end of the records.

From the MLN: "DMEPOS Competitive Bidding Program Hospitals That Are Not Contract Suppliers" Fact Sheet — Revised

"DMEPOS Competitive Bidding Program Hospitals That Are Not Contract Suppliers" Fact Sheet (ICN 905463) was revised and is now available in downloadable format. This fact sheet is designed to provide education on an exception to regular DMEPOS competitive bidding program rules for walkers provided by hospitals that are not contract suppliers. It also includes payment rules under this exception.

From the MLN: "DMEPOS Competitive Bidding Program Physicians and Other Treating Practitioners Who Are Enrolled as Medicare DMEPOS Suppliers" Fact Sheet — Revised

"DMEPOS Competitive Bidding Program Physicians and Other Treating Practitioners Who Are Enrolled as Medicare DMEPOS Suppliers" Fact Sheet (ICN 900926) was revised and is now available in downloadable format. This fact sheet is designed to provide education on an exception to regular DMEPOS competitive bidding program rules for walkers provided by physicians and other treating practitioners who are enrolled DMEPOS suppliers. It also includes information on who can be considered under this exemption.

From the MLN: "The Medicare Appeals Process" Fact Sheet — Revised

"The Medicare Appeals Process" Fact Sheet (ICN 006562) was revised and is now available in downloadable format. This fact sheet is designed to provide education on Section 1869 of the Social Security Act and 42 C.F.R. Part 405 Subpart I, which contains the procedures for conducting appeals of claims in Original Medicare (Medicare Part A and Part B). It includes details on where to obtain more information about the appeals process.

From the MLN: "The Basics of Medicare Enrollment for Physicians and Other Part B Suppliers" Fact Sheet — Revised

"The Basics of Medicare Enrollment for Physicians and Other Part B Suppliers" Fact Sheet (ICN 903768) has been revised and is now available in downloadable format. This fact sheet is designed to provide education on basic Medicare enrollment information and how to ensure physicians and other Part B suppliers are qualified and eligible to enroll in the Medicare Program. It includes information on how to enroll in the Medicare Program, how to report changes, and a list of resources.

"Clarification for Billing Part B versus Part D for the Anti-emetic Aprepitant (Emend®)" MLN Matters®

Article — Reminder

MLN Matters® Special Edition Article #SE0910, "Clarification for Billing Part B versus Part D for the Anti-emetic Aprepitant (Emend®)" is available in downloadable format. This article is designed to provide education on billing Part B for the Anti-emetic Aprepitant (Emend) when it is part of a three-drug combination regimen. It provides information to clarify and help providers understand how to properly bill for Emend coverage under the Medicare Part B Program.

Medicare Learning Network®
Official CMS Information for Medicare Fee-For-Service Providers

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.