Table of Contents for Thursday, April 4, 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 — Register Now
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

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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.

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National Provider Call: ESRD Low-Volume Payment Adjustment — Registration Now Open
Wednesday, April 24; 1:30-3pm ET

Does your dialysis facility qualify for Medicare's low-volume payment adjustment (LVPA) available under the End-Stage Renal Disease (ESRD) Prospective Payment System? Please join us for this important call.

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) required CMS to implement a LVPA for services furnished on or after January 1, 2011 to increase the payment rate for facilities that provide a low volume of dialysis treatments. The payment adjustment was intended to offset the higher costs of care that these facilities incur when furnishing dialysis services. In addition, MIPPA also required that the United States Government Accountability Office (GAO) review Medicare claims and report on payment accuracy.

On March 1, the GAO published a report, "CMS Should Improve Design and Strengthen Monitoring of Low-Volume Adjustment." During this National Provider Call, CMS subject matter experts will discuss the GAO report and Medicare's LVPA payment policies, including eligibility requirements and reporting responsibilities. A question and answer session will follow the presentation.

Target Audience: ESRD facilities and interested stakeholders

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: Transcript and Audio File from March 19 2013 PQRS and eRx Claims-based Reporting Made Simple Call Now Available

The written transcript and MP3 audio file from the March 19 National Provider Call (NPC), "2013 PQRS and eRx Claims-based Reporting Made Simple" are available on the March 19 call web page.

For information from other calls, visit the FFS National Provider Calls web page for content from past and upcoming NPCs on a variety of topics.

Medicare Provides Coverage to Reduce Alcohol Misuse

April is Alcohol Awareness Month – Sponsored by the National Council on Alcoholism and Drug Dependence, Inc. (NCADD), this national health observance serves to increase public awareness and understanding, reduce stigma and encourage local communities to focus on alcoholism and alcohol-related issues. Alcohol is the most commonly used addictive substance in the United States. While alcohol abuse impacts people of all ages, ethnicities, genders, geographic regions, and socioeconomic levels, there are special considerations facing seniors who drink, including:

- *Increased sensitivity to alcohol* – Aging can lower the body's tolerance for alcohol. Older adults generally experience the effects of alcohol more quickly than when they were younger. This puts them at higher risk for falls, car crashes, and other unintentional injuries that may result from drinking.
- *Increased health problems* – Certain health problems such as diabetes, high blood pressure, cardiovascular disease, osteoporosis, memory problems, and mood disorders are common among older adults and alcohol abuse can make these problems worst.

- *Bad Interactions with Medications* – Many prescription and over-the-counter medications, as well as herbal remedies can be dangerous or even deadly when mixed with alcohol.

Medicare Coverage
Medicare provides coverage for *Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse* for eligible beneficiaries. Medicare covers annual alcohol screening for all beneficiaries, and for those that screen positive, Medicare covers up to four brief, face-to-face, behavioral counseling interventions per year, including pregnant women, who are competent and alert at the time that counseling is provided; and, whose counseling is furnished by qualified primary care physician or other primary care practitioner, in a primary care setting.

The Medicare coinsurance and Part B deductible are waived for this preventive service.

For More Information:
- National Coverage Determination (NCD) for Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse
- MLN Preventive Services Educational Products for Health Professionals
- CMS Prevention Website
- Substance (Other Than Tobacco) Abuse Structured Assessment and Brief Intervention (SBIRT) Services Fact Sheet
- National Institute on Alcohol Abuse and Alcoholism
- NCADD – founder and sponsor of Alcohol Awareness Month

CMS Releases 2011 PQRS and eRx Incentive Program Experience Report — Data Shows Gains in Participation

CMS released the 2011 Physician Quality Reporting System (PQRS) and Electronic Prescribing (eRx) Incentive Program Experience Report on March 29, 2013. This report summarizes the reporting experience of eligible professionals in these programs in 2011, historical trends, and preliminary results for the 2012 program year. Each year growth in participation across all reporting options has increased. Overall, 280,229 eligible professionals participated individually in the 2011 PQRS. A total of $261,733,236 in PQRS incentive payments was paid by CMS for the 2011 program year. In addition, 282,382 eligible professionals participated in the 2011 eRx Incentive Program, which was a 116 percent increase from total participants in 2010. A total of $285,049,103 in eRx incentive payments was paid for the 2011 program year. In addition, 135,931 eligible professionals were subject to the 2012 eRx payment adjustment because they either did not qualify for an exemption, meet exclusion criteria for the adjustment, or did not meet eRx reporting requirements in the first half of 2011. The full report can be viewed on the PQRS website.

New and Updated EHR FAQs Recently Added to CMS FAQ Database

To keep you updated with information on the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, CMS has recently added two new FAQs and an updated FAQ to the CMS FAQ Database.

New FAQs:
- Can attestation information submitted for the EHR Incentive Programs be updated, changed, cancelled or withdrawn after successful submission in the EHR Registration and Attestation System? Read the answer here.

- Can eligible professionals (EPs) or eligible hospitals round their patient volume percentage when calculating patient volume in the Medicaid EHR Incentive Program? Read the answer here.

Updated FAQ:
How can an EP that is new to a practice meet the patient volume/practice predominantly criteria to be eligible for the Medicaid EHR Incentive Program? 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.

CMS Posts 2014 Eligible Hospital Clinical Quality Measure Update

The updated 2014 clinical quality measures (CQMs) for eligible hospitals are now available, as well as corresponding specifications for electronic reporting and access to the related data elements and value sets. CMS updates the specifications annually in order to ensure that specifications maintain alignment with current clinical guidelines, and remain relevant and actionable within the clinical care setting.

Beginning in 2014, the CQM specifications will be used for multiple programs to align the EHR Incentive Programs and reduce the burden on providers to report quality measures. CMS strongly encourages the implementation and use of the updated 2014 CQMs for eligible hospitals since they include new codes, logic corrections, and clarifications. However, CMS will accept all versions of the CQMs for meaningful use, beginning with those finalized in the December 4, 2012 CMS-ONC Interim Final Rule, until the next phase of the EHR Incentive Programs.

Updated 2014 CQM Resources for Eligible Hospitals
To help providers navigate the updated CQMs, several resources are available on the new eCQM library:

- Table of 2014 Eligible Hospital Measure Versions
- 2014 eCQM Specifications for Eligible Hospitals Release April 2013
- Technical Release Notes 2014 eCQM for Eligible Hospitals v1.3 April 2013
- 2014 eCQM Measure Logic Guidance v1.3 April 2013
- Guide to Reading EP and Hospital eCQMs April 2013
- Value Set Authority Center [National Library of Medicine]
- eSpec Navigator 2014 eCQMs Release April 2013

Note: The annual update for eligible professional specifications will be released in June 2013.

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.

Hold for IPPS Claims with Technology Add-on Payments

CMS has identified an issue with the remittance advice associated with inpatient prospective payment (IPPS) system claims with new technology add-on payments and a date of discharge on or after April 1, 2013. CMS expects to resolve the issue by April 14, 2013, and, therefore, we will hold affected claims until the correction is complete. Held claims will be released for processing on April 15, 2013. The claim hold should have minimal impact on provider cash flow because, under current law, clean electronic claims are not paid sooner than 14 calendar days (29 for paper claims) after the date of receipt.

Do Not Include Middle Names and Suffixes of Ordering/Referring Providers on Claims

Effective May 1, 2013, CMS will turn on the edits to deny Part B, Durable Medical Equipment (DME), and Part A Home Health Agency (HHA) claims that fail the ordering/referring provider edits. Physicians and others who are eligible to order and refer items or services need to establish their Medicare enrollment record with a valid NPI and must be of a specialty that is eligible to order and refer. If the ordering/referring provider is listed on the claim, the edits will verify that the provider is enrolled in Medicare. The edits will compare the first letter of the first name and the first four letters of the last name. When submitting the CMS-1500, please only include the first and last name as it appears on the ordering and referring file found on CMS.gov. *Middle names (initials) and suffixes (such as MD, RPNA etc.) should not be listed in the ordering/referring fields. Including middle name/initial and/or suffix will cause the claim to be denied once the edits are turned on.*

Effect of Ordering and Referring Denial Edits on the Technical and Professional Component of Imaging Services

Consistent with the Affordable Care Act and 42 CFR § 424.507, suppliers submitting claims for imaging services must identify the ordering or referring physician or practitioner. Imaging suppliers covered by this requirement include the following: independent diagnostic testing facilities (IDTFs), mammography centers, portable x-ray facilities and radiation therapy centers. The rule applies to the technical component of imaging services, and the professional component will be excluded from the edits, which are scheduled to begin May 1, 2013. However, if billing globally, both components will be impacted by the edits and the entire claim will deny if it doesn't meet the ordering and referring requirements. It is recommended that providers and suppliers bill the global claims separately to prevent a denial for the professional component.

"Physician Delegation of Tasks in Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs)" MLN Matters® Article — Released

MLN Matters® Special Edition Article #SE1308, "Physician Delegation of Tasks in Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs)," was released and is now available in downloadable format. This article is designed to provide education on Section 3108 of the Affordable Care Act, related to physician delegation of certain tasks in SNFs and NFs to NPPs (formerly "physician extenders"), physician assistants (PAs), or clinical nurse specialists (CNSs). It includes information and specific requirements about which tasks may be delegated in a SNF or NF setting.

From the MLN: "The Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program: Traveling Beneficiary" Fact Sheet — Revised

"The Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program: Traveling Beneficiary" Fact Sheet (ICN 904484) was revised and is now available in downloadable format. This fact sheet is designed to provide education on DMEPOS suppliers that provide items to Medicare beneficiaries who reside in or travel to areas impacted by the DMEPOS Competitive Bidding Program. It includes information on how to determine whether a beneficiary is in a traveling status, how to properly bill Medicare for the item, and how Medicare will determine the payment amount.

From the MLN: "The DMEPOS Competitive Bidding Program Mail Order Diabetic Supplies" Fact Sheet — Revised

"The DMEPOS Competitive Bidding Program Mail Order Diabetic Supplies" Fact Sheet (ICN 900924) was revised and is now available in downloadable format. This fact sheet is designed to educate on requirements related to providing mail order diabetic supplies to beneficiaries who reside in a competitive bidding area. It also includes information on options for purchasing diabetic supplies on a non-mail order basis.

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.