Table of Contents for Thursday, April 18, 2013

- "How to Use the Medicare National Correct Coding Initiative (NCCI) Tools" Booklet — Revised
- "Medicare Quarterly Provider Compliance Newsletter [Volume 3, Issue 3]" Educational Tool — Released

National Provider Calls: Medicare Shared Savings Program Application Process: Tips on Completing a Successful Application — Last Chance to Register
Tuesday, April 23; 1:30-3pm ET

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 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: ESRD Low-Volume Payment Adjustment — Last Chance to Register
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.

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.

CMS and ONC Meeting About EHRs, Coding, and Billing
Friday, May 3; 9am-2pm ET
CMS Auditorium, 7500 Security Boulevard, Baltimore, Maryland 21244

Please join CMS and the Office of the National Coordinator for Health Information Technology (ONC) for a meeting to discuss Electronic Health Records (EHR) systems, the increase in code levels billed for some Medicare services, and appropriate coding in an increasingly electronic environment. Speakers will discuss the effect of EHRs on clinical care, provider efficiency, and coding, as well as the challenges and opportunities hospitals and clinicians face when implementing code systems. Anyone interested is invited to attend, including providers, Health Information Technology (HIT) vendors, and press. The event will be held May 3 from 9am to 2pm ET at the CMS auditorium in Baltimore. The meeting will also be webcast.

Tentative speakers, include:

- Jonathan Blum, CMS
- David Muntz, MD, ONC
- Benjamin K. Chu, MD, American Hospital Association, Kaiser Foundation Health Plan and Hospitals
- Bruce Siegel, MD, MPH, National Association of Public Hospitals and Health Systems
- Steven J. Stack, MD, American Medical Association
- Sue Bowman, MJ, RHIA, CCS, FAHIMA, American Health Information Management Association
- Mickey McGlynn, Siemens Medical Solutions, Electronic Health Records Association

Location: CMS Auditorium, 7500 Security Boulevard, Baltimore, Maryland 21244

Registration
Attendance is limited, so please register early. *Note: The webcast allows for unlimited remote attendance. More information on how to access the webcast coming soon.*

Special Accommodations
Please contact Kirsten Knutson at 410-786-5886, or kirsten.knutson@cms.hhs.gov, to request special accommodations.

Prepare to Help Your Patients Navigate the New Health Insurance Marketplace on October 1

Starting in October, 2013, individuals, families, and small-business owners in every state will be able to shop in the new Health Insurance Marketplace (also known as the Exchanges) for private insurance coverage that begins January 1, 2014. A recent article in JAMA (The Journal of the American Medical Association), " Connecting to Health Insurance Coverage " by HHS Assistant Secretary for Health Dr. Howard Koh and CMS Acting Administrator Marilyn Tavenner provides key information about the new healthcare landscape. For many patients to fully benefit in this new environment, they will need the guidance of their most trusted health sources. Prepare now to connect people to coverage and make a lasting difference in the health of our nation.

New OPEN PAYMENTS Resources Now Available Online: Updated Website and Continuing Medical Education Activity

The National Physician Payment Transparency Program: OPEN PAYMENTS (The Physician Payments Sunshine Provision of the Affordable Care Act) recently launched a new website to provide enhanced informational resources about OPEN PAYMENTS. OPEN PAYMENTS creates greater transparency around the financial relationships of manufacturers, physicians, and teaching hospitals. For more information about the program and how it works, access the newly updated website.

While the site continues to be a work in progress, new program Fact Sheets, Frequently Asked Questions and Definitions have already been posted. These documents contain details specific to audiences affected by OPEN PAYMENTS: physicians, applicable manufacturers, teaching hospitals, and applicable group purchasing organizations. Remember to check the website frequently for more updated tools and resources, plus announcements of future webinars, calls, and meetings.

Continuing Medical Education Activity Available
Also available for physicians to learn more about OPEN PAYMENTS is a continuing medical education (CME) activity, "Are You Ready for the National Physician Payment Transparency Program?" Accessible via MedScape, and accredited by the Accreditation Council for Continuing Medical Education, physicians can receive a maximum of 1.00 American Medical Association's (AMA) Physician Recognition Award (PRA) Category 1 Credit™ by participating in the activity and receiving a minimum score of 70% on the post-test. Through the activity, participants will learn more about OPEN PAYMENTS, the steps involved in collecting and reporting physician data, key dates for implementation, and actions they can take to verify physician information in advance of website publication.

Questions
For any questions relating to OPEN PAYMENTS, contact the Help Desk at OpenPayments@cms.hhs.gov.

HQRP 2013 Deadlines Have Passed: Next HQRP Data Submission will be April 1, 2014

There were two deadlines for the two required measures for the Hospice Quality Reporting Program (HQRP) Payment Year 2014 cycle: the structural measure deadline was January 31, 2013; the NQF #0209 deadline was April 1, 2013. In order to receive the full market basket increase for FY 2014, the requirement is that both measures be submitted, each by their specified deadline.

Reconsideration Process For Providers That Missed Payment Year 2014 HQRP Deadline(s)
For providers that missed either deadline(s) for the Payment Year 2014 cycle, there will be a reconsideration process. This process will be available to all providers who, on initial determination,

have been found to be out of compliance and wish to provide evidence that supports their compliance. CMS plans to make information about the reconsideration process available on the Hospice Quality Reporting section of the CMS website in mid-May of 2013.

The next data submission for the Payment Year 2015 cycle of the HQRP will be April 1, 2014. Providers will submit their CY 2013 NQF #0209 and structural measure data. *There will not be quarterly submissions of 2013 data*; *all CY 2013 data will be submitted on April 1, 2014.*

Mandated Sequestration Payment Reductions Beginning for Medicare EHR Incentive Program

Incentive payments made through the Medicare Electronic Health Record (EHR) Incentive Program are subject to the mandatory reductions in federal spending known as sequestration, required by the Budget Control Act of 2011.

Incentive Payment Reduction
The American Taxpayer Relief Act of 2012 postponed sequestration for two months. As required by law, President Obama issued a sequestration order on March 1, 2013. Under these mandatory reductions, Medicare EHR incentive payments made to eligible professionals and eligible hospitals will be reduced by 2%.

Reduction Timing
This 2% reduction will be applied to any Medicare EHR incentive payment for a reporting period that ends on or after April 1, 2013. If the final day of the reporting period occurs before April 1, 2013, those incentive payments will not be subject to the reduction. *Please note:* This reduction does not apply to Medicaid EHR incentive payments, which are exempt from the mandatory reductions.

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.

April 2013 Claim Hold Lifted

CMS has directed its Medicare claims administration contractors to release all claims into processing that they have been holding as a result of technical issues associated with the April 2013 quarterly systems release. The claim types being released on Wednesday, April 17, 2013, are (1) Home Health final claims, (2) outpatient Critical Access Hospital and Rural Health Clinic claims where dollars have been applied to the beneficiary deductible, (3) Inpatient Prospective Payment System (IPPS) claims with new technology add-on payments, (4) IPPS claims with outlier payments, (5) outpatient claims with outlier payments, (6) End-Stage Renal Disease claims with outlier payments, and (7) psychiatric hospital claims with outlier payments and no other payment. In summary, at this time all Medicare FFS claims are being processed under normal procedures.

As a reminder, the Medicare claims administration contractors released the Medicare Advantage IPPS with indirect medical education claims as well as the assistant-at-surgery services and Ambulatory Surgical Center claims into processing on Monday, April 15, 2013.

Interim Process for Hospitals to Bill Part B Services Following Denial of an Inpatient Admission as not Reasonable and Necessary

On March 13, 2013 CMS issued Ruling 1455-R which establishes an interim process for hospitals to bill Medicare for Part B services following a denial of a claim for an inpatient admission as not reasonable and necessary. Affected providers shall follow temporary instructions for both the Part B Types of Bills (TOB), TOB 12x and TOB 13x.

Outpatient Therapy Services Functional Reporting Testing Period — Now in Effect

As required by section 3005(g) of the Middle Class Tax Relief and Jobs Creation Act (MCTRJCA) of 2012, CMS implemented a new claims-based data collection system for outpatient therapy services by requiring reporting of 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.

For functional reporting, a testing period is now in effect until 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, a new Remittance Advice message alerts providers about missing information on select therapy claims. Please note: institutional claims will not receive alert messages.

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"

Temporary Bypass of Common Working File Qualifying Stay Edit C7123 for All SNF and SB Claims

CMS is aware of an issue concerning Skilled Nursing Facility (SNF) and Swing Bed (SB) claims incorrectly rejecting for Common Working File (CWF) qualifying stay edit C7123. Therefore, CMS instructed contractors to bypass edit C7123 for all SNF and SB claims until CWF logic is updated to correctly identify prior qualifying hospital stays. Once contractors implement the bypass they will release any affected SNF and SB claims currently suspending in their systems. In addition, providers may adjust those claims that incorrectly rejected with C7123 or bring these affected claims to the attention of your contractor so they can be adjusted.

CMS is currently drafting a transmittal to implement the appropriate qualifying stay bypass criteria for edit C7123 in order to prevent incorrect system rejections. Contractors will continue to bypass edit C7123 until this transmittal is implemented.

Quarterly Provider Specific Files for the Prospective Payment System are Now Available

The April 2013 Provider Specific Files (PSF) are now available for download from the CMS website in SAS and Text format. The files contain information about the facts specific to the provider that affect computations for the Prospective Payment System. The SAS data files are available on the Provider Specific Data for Public Use In SAS Format web page, and the Text data files are available on the Provider Specific Data for Public Use in Text Format web page. The Text data files are available 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.

CY 2013 Outpatient PPS Pricer and Provider File Update

The Outpatient Prospective Payment System (OPPS) Pricer webpage was recently updated to include the April 2013 new payment files and outpatient provider data. These files are ready for download from the "2nd Quarter 2013 Files" section of the OPPS Pricer Code web page.

Modifications to the HCPCS Code Set Posted

The scheduled release of modifications to the Healthcare Common Procedure Coding System (HCPCS) code set are now posted on the HCPCS Quarterly Update web page. Changes are effective on the date indicated on the update.

IPF PPS PC Pricer Updated with January 2013 Provider Data

The Inpatient Psychiatric Facility (IPF) Prospective Payment System (PPS) PC Pricer has been updated with January 2013 provider data for claims dates from October 1, 2012 to September 30, 2013. The latest versions of the IPF PPS RY2013 PC Pricers are now posted on the IPF PPS PC Pricer web page in the "Downloads" section.

Updated PC Pricer Download Instructions

The PC Pricer website has been updated to include revised PC Pricer download instructions for installing the following PC Pricers: HHA, IPPS, IPF, IRF and SNF. This document is available in the "Downloads" section of the Guidelines for Downloading and Executing PPS PC Pricers web page. PC Pricers will be posted as they become available.

"Claims Processing Instructions for Inlier Bills and Cost Outlier Bills with Benefits Exhausted" MLN Matters® Article — Released

MLN Matters® Special Edition Article #SE1310, "Claims Processing Instructions for Inlier Bills and Cost Outlier Bills with Benefits Exhausted" has been released and is now available in downloadable format. This article is designed to provide education on selecting the best method to determine the dollar amount of the cost outlier threshold. It also provides outlier examples to clarify and help providers understand the current policy.

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.

From the MLN: "DMEPOS Competitive Bidding Program: Grandfathering Requirements for Non-Contract Suppliers Fact Sheet"—Revised

The "DMEPOS Competitive Bidding Program: Grandfathering Requirements for Non-Contract Suppliers" Fact Sheet (ICN 900923) was revised and is now available in downloadable format. This fact sheet is designed to provide education on grandfathering requirements under the DMEPOS competitive bidding program. It includes a definition of grandfathered suppliers, notification requirements, and rules and policies related to grandfathering.

From the MLN: "How to Use the Medicare National Correct Coding Initiative (NCCI) Tools" Booklet — Revised

The "How to Use the National Correct Coding Initiative (NCCI) Tools" Booklet (ICN 901346) was revised and is now available in downloadable format. This booklet is designed to provide education on how to navigate the CMS NCCI web pages. It includes information on how to look up Medicare code pair edits and Medically Unlikely Edits (MUEs), as well as an explanation of how the NCCI tools can help providers avoid coding and billing errors and subsequent payment denials.

From the MLN: "Medicare Quarterly Provider Compliance Newsletter [Volume 3, Issue 3]" Educational Tool — Released

The "Medicare Quarterly Provider Compliance Newsletter [Volume 3, Issue 3]" Educational Tool (ICN 908625) was released and is now available in downloadable format. This educational tool is designed to provide education on how to avoid common billing errors and other erroneous activities when dealing with the Medicare Program. It includes information on corrective actions that health care professionals can use to address and avoid the top issues of the particular Quarter.

An index of Recovery Audit and Comprehensive Error Rate Testing (CERT) findings from current and previous newsletters is available. This index is customized by provider type to identify those findings that impact specific providers. Visit the Medicare Quarterly Provider Compliance Newsletter Archive page to download the index and view an archive of previous newsletters.