CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

mlnconnects

Official CMS news from the Medicare Learning Network®

Thursday, December 3, 2020

News

Comprehensive Strategy to Enhance Hospital Capacity Amid COVID-19 Surge

On November 25, CMS outlined unprecedented comprehensive steps to increase the capacity of the American health care system to provide care to patients outside a traditional hospital setting amid a rising number of COVID-19 hospitalizations across the country. These flexibilities include allowances for safe hospital care for eligible patients in their homes and updated staffing flexibility designed to allow ambulatory surgical centers to provide greater inpatient care when needed. Building on CMS's previous actions to expand the availability of telehealth across the nation, these actions are aimed at allowing health care services to be provided outside a hospital setting, while maintaining capacity to continue critical non-COVID-19 care, allowing hospitals to focus on the increased need for care stemming from the public health emergency.

Full press release.

CMS Updates Coverage Policies for Artificial Hearts and Ventricular Assist Devices

Updated policy provides enhanced patient-centered access for Medicare beneficiaries

On December 1, CMS finalized updates to Medicare coverage policies for artificial hearts and Ventricular Assist Devices (VADs), both of which are used to treat patients with life-threatening advanced heart failure.

While Medicare generally does not cover experimental or investigational items and services, the program has historically allowed for coverage of certain interventions when they are provided in the context of an approved clinical study or with the collection of additional clinical data. This process can allow for earlier beneficiary access to innovative treatments and technology while additional data is collected.

Prior to December 1, Medicare covered artificial hearts under this "coverage with evidence development" standard. The updated coverage policy CMS is announcing will end this requirement for artificial hearts and instead allow for the more standard coverage determination process where coverage decisions are made by local Medicare Administrative Contractors (MACs). We believe this final decision is in the best interest of Medicare beneficiaries since careful patient selection is important, and the MACs are structured to take into account a beneficiary's particular clinical circumstances to determine which patients will benefit from receiving an artificial heart. Although a small number of Medicare beneficiaries receive artificial hearts, the technology can save the lives of certain end-stage heart failure patients awaiting heart transplantation.

"CMS is dedicated to improving cardiovascular health in the Medicare population," said CMS Administrator Seema Verma. "As part of President Trump's steadfast dedication to strengthening Medicare for our nation's seniors, CMS is continually updating our policies to ensure that Medicare beneficiaries have access to the latest technology and appropriate evidence-based health care. These coverage changes will give beneficiaries and providers more options as they choose the potentially life-saving treatments most likely to produce good health outcomes."

The final national coverage determination (NCD), which is effective December 1, also provides updated coverage criteria for VADs that better aligns with current medical practice and that we believe will expand coverage to a greater number of candidates who are likely to benefit from this technology. Specifically, the updated patient criteria in the NCD aligns with the inclusion criteria derived from recent large randomized controlled trials, which demonstrated improved patient outcomes.

Read the final decision.

PEPPERs for Short-term Acute Care Hospitals: Download December 4 through 14

Third quarter fiscal year 2020 Program for Evaluating Payment Patterns Electronic Reports (PEPPERs) will be available December 4 for short-term acute care hospitals. These reports summarize provider-specific data statistics for Medicare services that may be at risk for improper payments. Use your data to support internal auditing and monitoring activities. Download your report from QualityNet by December 14 before they decommission their file transfer service.

For More Information:

- Visit the PEPPER Resources website for the user's guide, recorded training sessions, QualityNet account information, FAQs, and examples of how other hospitals are using the report
- Visit the Help Desk if you have questions or need help obtaining your report
- Send us your feedback or suggestions

Provider Enrollment Application Fee Amount for CY 2021

On November 23, CMS issued a notice: Provider Enrollment Application Fee Amount for Calendar Year 2021. Effective January 1, the application fee is $599 for institutional providers (as that term is defined in 42 CFR § 424.502) that are:

- Initially enrolling in the Medicare or Medicaid program or the Children's Health Insurance Program (CHIP);

- Revalidating their Medicare, Medicaid, or CHIP enrollment; or
- Adding a new Medicare practice location.

This fee is required with any of these enrollment applications submitted from January 1 through December 31, 2021.

Compliance

Hospices: Create an Effective Plan of Care

An Office of Inspector General (OIG) report found that most hospices have at least one deficiency in their quality of care. Review the Creating an Effective Hospice Plan of Care fact sheet to learn about principles of care planning, care coordination, and common deficiencies. Additional resources:

- Hospice Conditions of Participation final rule
- Medicare Fee-for-Service Response to the Public Health Emergency on COVID-19 MLN Matters Article
- Quality, Certification and Oversight Reports database
- Quality, Safety & Education Portal
- State Operations Manual Appendix M – Guidance to Surveyors: Hospice

Events

Hospital Price Transparency Webcast — December 8

Tuesday, December 8 from 2 to 3 pm ET

Register for this Medicare Learning Network event.

Is your institution prepared to comply with the requirements of the Hospital Price Transparency Final Rule? Effective January 1, each hospital operating in the United States is required to provide clear, accessible pricing information online about the items and services they provide in 2 ways:

- Comprehensive machine-readable file with all items and services
- Display of shoppable services in a consumer-friendly format

During this webcast, learn about resources to help you prepare for compliance and join in a Q&A session that follows the presentation.

You can call in if you can't stream audio through your computer.

Target Audience: All hospitals operating in the United States and other stakeholders.

Interoperability and Patient Access Final Rule Call — December 9

Wednesday, December 9 from 1:30 to 3 pm ET

Register for this Medicare Learning Network event.

On May 1, CMS released the Interoperability and Patient Access final rule, listing ways to give patients better access to their health information. Using data exchange through secure Application Programming Interfaces (APIs), we took a first step in making health information more available to patients and moving toward greater interoperability across the health care system. This approach to data exchange will allow patients to make informed decisions and reduce burden on payers and providers.

During this call, we'll answer your questions about implementing these policies:

- Public reporting and information blocking – targeting late 2020/early 2021
- Provider digital contact information in the National Plan and Provider Enumeration System – targeting March , 2021

- Revisions to the Conditions of Participation (CoPs) of for hospitals and critical access hospitals – effective April 30, 2021
- Patient Access API – enforced after July 1, 2021
- Provider Directory API – enforced after July 1, 2021
- Payer-to-payer data exchange – effective January 1, 2022
- Improving the dual eligible experience – effective April 1, 2022

Visit the Interoperability webpage for more information about the final rule and to find resources.

Target Audience: All Medicare Fee-for-Service providers, payers, and industry-wide stakeholders.

Physician Fee Schedule Final Rule: Understanding 4 Key Topics Call — December 10

Thursday, December 10 from 1:30 to 3 pm ET

Register for this Medicare Learning Network event.

The calendar year 2021 Physician Fee Schedule final rule provisions reduce burden, recognize clinicians for the time they spend taking care of patients, remove unnecessary quality measures, and make it easier for clinicians move toward value-based care:

- Extending telehealth and licensing flexibilities beyond the public health emergency
- Updating Evaluation and Management (E/M) coding guidance
- Updating the Quality Payment Program and Merit-based Incentive Payment System Value Pathways
- Updating opioid use disorder and substance use disorder provisions

During this call, CMS experts briefly cover provisions from the final rule and address your questions. We encourage you to review the final rule prior to the call.

Target Audience: Medicare Part B Fee-for-Service clinicians; office managers and administrators; state and national associations that represent health care providers; and other stakeholders.

MLN Matters® Articles

Implementation of Changes in the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Payment for Dialysis Furnished for Acute Kidney Injury (AKI) in ESRD Facilities for Calendar Year (CY) 2021 — Revised

CMS revised MLN Matters Article MM12011 on Implementation of Changes in the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Payment for Dialysis Furnished for Acute Kidney Injury (AKI) in ESRD Facilities for Calendar Year (CY) 2021 to change the dialysis payment rate for renal dialysis services.

Publications

Major Joint Replacement (Hip or Knee) — Revised

CMS revised the Medicare Learning Network booklet, Major Joint Replacement (Hip or Knee). Learn about:

- Documentation
- Coverage requirements
- Coding

Provider Compliance Tips for Tracheostomy Supplies — Revised

CMS revised the Medicare Learning Network fact sheet, Provider Compliance Tips for Tracheostomy Supplies. Learn about:

- Coverage criteria
- Refill requirements
- How to prevent denials

Multimedia

Diagnosis Coding: Using the ICD-10-CM Web-Based Training Course — Revised

A revised Diagnosis Coding: Using the ICD-10-CM Web-Based Training (WBT) course is available through the Medicare Learning Network Learning Management System. Learn how to:

- Recognize features
- Find correct codes
- Identify structure and format

Procedure Coding: Using the ICD-10-PCS Web-Based Training Course — Revised

A revised Procedure Coding: Using the ICD-10-PCS Web-Based Training (WBT) course is available through the Medicare Learning Network Learning Management System. Learn how to:

- Recognize features
- Find correct codes
- Identify structure and format

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