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MLN Connects™

Weekly Provider eNews

Thursday, April 17, 2014

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MLN Connects™ National Provider Calls

Medicare Shared Savings Program ACO Application Process — Last Chance to Register

Tuesday, April 22; 1:30-3pm ET

To Register: Visit MLN Connects™ Upcoming Calls. Space may be limited, register early.

During this MLN Connects™ National Provider Call, CMS subject matter experts cover helpful tips on completing a successful application, including information on how to submit an acceptable Accountable Care Organization (ACO) Participant List, Sample ACO Participant Agreement, Executed ACO Participant Agreements, and Governing Body Template for the Medicare 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 other materials found on this web page prior to the call.

Target Audience: Potential 2015 ACO Applicants

Continuing education credit may be awarded for participation in certain MLN Connects Calls. Visit the Continuing Education Credit Information web page to learn more.

Individualized Quality Control Plan for CLIA Laboratory Non-Waived Testing — Registration Now Open

Monday, May 19; 2-3:30pm ET

To Register: Visit MLN Connects™ Upcoming Calls. Space may be limited, register early.

How will the new Individualized Quality Control Plan (IQCP) affect my laboratory? This MLN Connects™ National Provider Call will educate laboratories on IQCP, the new quality control option for Clinical Laboratory Improvement Amendments (CLIA) laboratories performing non-waived testing. IQCP will provide laboratories with flexibility in customizing Quality Control (QC) policies and procedures, based on the test systems in use and the unique aspects of each laboratory.

IQCP is voluntary. Laboratories will continue to have the option of achieving compliance by following all CLIA QC regulations as written. The IQCP Education and Transition Period began on January 1, 2014 and will conclude on January 1, 2016. This education and transition period gives laboratories the opportunity to learn about IQCP and implement their chosen QC policies and procedures. Prior to the call, providers are encouraged to review IQCP: A New QC Option and other IQCP educational materials on the CLIA website.

Agenda:

- IQCP Presentation
- Resources
- Q&A Session

Target Audience: Laboratories, professional organizations, quality improvement experts and other interested stakeholders.

Continuing education credit may be awarded for participation in certain MLN Connects Calls. Visit the Continuing Education Credit Information web page to learn more.

National Partnership to Improve Dementia Care in Nursing Homes — Register Now
Tuesday, May 20; 1:30-3:00pm ET

To Register: Visit MLN Connects™ Upcoming Calls. Space may be limited, register early.

The CMS National Partnership to Improve Dementia Care in Nursing homes was developed to improve dementia care through the use of individualized, comprehensive care approaches. The partnership promotes a systematic process to evaluate each person and identify approaches that are most likely to benefit that individual. The goal of the partnership is to continue to reduce the use of unnecessary antipsychotic medications, as well as other potentially harmful medications in nursing homes and eventually other care settings as well.

During this MLN Connects™ National Provider Call, a CMS subject matter expert will provide National Partnership updates, discuss efforts to monitor enforcement rates, and track surveyor training completion. Additional speakers will be presenting on the critical role that activity professionals play in the mission to improve dementia care and the reduction of antipsychotic medications through person-centered, nonpharmacologic care approaches. A question and answer session will follow the presentation.

Agenda:
- Partnership updates
- Role of activity professionals
- Nonpharmacologic approaches to care
- Next steps

Target Audience: Consumer and advocacy groups, nursing home providers, surveyor community, prescribers, professional associations, and other interested stakeholders

Continuing education credit may be awarded for participation in certain MLN Connects Calls. Visit the Continuing Education Credit Information web page to learn more.

CMS Events

Special Open Door Forum: Suggested Electronic Clinical Template for Home Health
Tuesday, April 22; 3-4pm ET
Conference Call Only

CMS will host a series of Special Open Door Forum (ODF) calls to allow physicians and other interested parties to give feedback on data elements for the Suggested Electronic Clinical Template for Home Health.

In order to enhance physician understanding of medical documentation requirements to support orders for Home Health services, CMS has developed a list of clinical elements within a Suggested Electronic Clinical Template that would assist physicians when documenting the Home Health (HH) face-to-face encounter for Medicare purposes. While not intended to be a data entry form, the template will describe the clinical elements that CMS believes would be useful in supporting the documentation requirements for coverage of Home Health services. CMS will work in collaboration with the DHHS Office of the National Coordinator for Health IT (ONC) and the electronic Determination of Coverage (eDoC) workgroup which are focused on giving practitioners access to payer approved tools for the electronic submission of medical documentation. Comments on the document can be sent to eclinicaltemplate@cms.hhs.gov. Additional information is available on the HH Electronic Clinical Template web page.

Special Open Door Participation Instructions:
- Participant Dial-In Number: 800-837-1935; Conference ID # 20361722
- Note: TTY Communications Relay Services are available for the Hearing Impaired. For TTY services dial 7-1-1 or 1-800-855-2880. A Relay Communications Assistant will help.

- A transcript and audio recording of this Special ODF will be posted on the Special Open Door Forum website

Announcements

Prevention is Power: Taking Action for Health Equity

April is National Minority Health Month – a time to raise awareness about the health disparities that disproportionately impact racial and ethnic minorities. This year's theme: *Prevention is Power: Taking Action for Health Equity* emphasizes prevention as a key strategy for achieving health equity.

Although the overall health of Americans has improved, racial, ethnic, and underserved groups, including people with disabilities and those living in rural areas, often encounter barriers that prevent them from getting the preventive care they need to ward off chronic disease. Every American should have the opportunity to live a healthier, more prosperous, and more productive life, regardless of who they are and where they live.

CMS reminds you that Medicare provides coverage for many preventive services that can help seniors and others with Medicare stay healthy, live longer, and delay or prevent many serious health issues. Read more.

CMS Proposes Adoption of Updated Life Safety Code

On April 14, CMS announced a proposed rule on the adoption of an updated life safety code (LSC) that CMS would use in its ongoing work to ensure the health and safety of all patients, family and staff in every provider and supplier setting. The updated code contains new provisions that are vital to the health and safety of all patients and staff.

A key priority of CMS is to ensure that patients and staff continue to experience the highest degree of safety possible, including fire safety. CMS intends to adopt the National Fire Protection Association's (NFPA) 2012 editions of the (LSC) and the Health Care Facilities Code (HCFC). This would reduce burden on health care providers, as the 2012 edition of the LSC also is aligned with the international building codes and would make compliance across codes much simpler for Medicare and Medicaid-participating facilities.

The Health Care Facilities Code contains more detailed provisions specific to health care and ambulatory care facilities. Adoption of this code would provide minimum requirements for the installation, inspection, testing, maintenance, performance, and safe practices of health care facility materials, equipment and appliances.

The new edition of the LSC applies to: hospitals, long term care facilities (LTC), critical access hospitals (CAHs), Programs for All Inclusive Care for the Elderly (PACE), religious non-medical healthcare institutions (RNHCIs), hospice inpatient facilities, ambulatory surgical centers (ASCs), and intermediate care facilities for individuals with intellectual disabilities (ICF-IIDs).

The proposed rule was published in the April 16, 2014 Federal Register. The deadline to submit comments is June, 16, 2014.

Full text of this excerpted CMS fact sheet (issued April 14).

Comprehensive ESRD Care Model

In 2013, CMS announced that the CMS Innovation Center will test a new Comprehensive End-Stage Renal Disease (ESRD) Care model. Through this new initiative, CMS will partner with groups of health care providers and suppliers – ESRD Seamless Care Organizations (ESCOs) – to test and evaluate a new model of payment and care delivery specific to Medicare beneficiaries with ESRD. The goals of the model are to improve beneficiary health outcomes and reduce per

capita Medicare expenditures. After receiving stakeholder feedback on the model, on April 15, 2014, the CMS Innovation Center released a revised Request for Applications (RFA) for the Comprehensive ESRD Care model.

Participating organizations will consist of groups of health care providers led by care professionals experienced in providing care to beneficiaries with ESRD. The organizations must include representation from dialysis facilities, nephrologists, and other Medicare providers and suppliers.

Application Process
Organizations interested in participating in the testing of the model are required to submit both a letter of intent and an application to CMS. Letters of intent are nonbinding, but are a required prerequisite to submitting an application to CMS. In the revised RFA, CMS has two different application periods for ESCOs:

- ESCOs that include at least one dialysis facility owned by a large-dialysis organization (LDO) must submit both a letter of intent and an application to CMS by June 23, 2014.
- ESCOs with participating non-LDOs must submit both a letter of intent and an application to CMS by September 15, 2014.

Information about how to apply is available on the Innovation Center website.

Full text of this excerpted CMS fact sheet (issued April 15).

HQRP Announces Call for Technical Expert Panel

CMS is seeking nominations for the Hospice Quality Reporting Program (HQRP) Technical Expert Panel (TEP). The purpose of this TEP is to review and provide input on findings from an environmental scan that is currently being conducted by RTI International. Input from this TEP will be used to support the development of additional quality measures for future implementation in the HQRP. Nominations are due April 30, 2014. The Call for TEP and Nomination Form are available on the TEP web page.

HQRP: Final Hospice Item Set Version and Data Specifications Available

The final version of the Hospice Item Set (HIS) is now available on the HIS web page in the "Downloads" section, and the data specifications are available on the HIS Technical web page.

- On April 8, 2014, the Office of Management and Budget (OMB) approved the HIS Paperwork Reduction Act package. No changes were made as a result of the OMB review. Providers should refer to the final OMB approved versions of the HIS as they prepare for HIS implementation.
- The data specifications detail the requirements for the submission of HIS records. Please disregard any previous versions.

All Medicare-certified hospices will be required to submit a HIS-Admission record and a HIS-Discharge record for each patient admission on or after July 1, 2014.

Review Your 2013 PQRS Interim Claims Feedback Data

Do you want to check your progress towards meeting the 2013 Physician Quality Reporting System (PQRS) reporting requirements? Now you can. The2013 PQRS Interim Feedback Dashboard is available through the Physician and Other Health Care Professionals Quality Reporting Portal, with Individuals Authorized Access to the CMS Computer Services (IACS) sign-in.

- If you are an individual eligible professional who reported at least one PQRS quality measure in 2013 via claims-based reporting, you can now view the entire calendar year (first through fourth quarter) of data using the dashboard.

- If you reported individual measures or measures group(s), the dashboard will display your summary data by Taxpayer Identification Number (TIN) or individual detail by your National Provider Identifier (NPI).
- The dashboard data allows you to monitor the status of your claims-based measures and measures group reporting to see where you are in meeting the PQRS reporting requirements.

Dashboard Resources
The following CMS resources are available to help you access and interpret your 2013 PQRS interim feedback data:
- The User Guide: 2013 Interim Feedback Dashboard provides detailed information about accessing and interpreting the data provided in the feedback report.
- IACS Quick Reference Guides provide step-by-step instructions on how to request an IACS account in order to access the Portal, if you do not already have one.

For more information about participating in PQRS, visit the PQRS website. For additional support or questions, contact the QualityNet Help Desk.

Eligible Professionals Must Start Medicare EHR Participation in 2014 to Earn Incentives
Important Medicare Deadline Approaching for Eligible Professionals

If you are an eligible professional for the Medicare Electronic Health Record (EHR) Incentive Program, 2014 is the last year you can start participation in the Medicare EHR Incentive Program in order to receive incentive payments. Eligible professionals who begin participation in the Medicare EHR Incentive Program after 2014 will *not* be able to earn an incentive payment for that year or any subsequent year of participation. If you choose to participate in the Medicare EHR Incentive Program for the first time in 2014, you should begin your 90-day reporting period no later than July 1, 2014 and submit attestation by October 1, 2014 in order to avoid the payment adjustment in 2015.

Note: October 1 is the attestation deadline for eligible professionals in their first year of participation to avoid the payment adjustment. However, eligible professionals who miss this deadline can still demonstrate meaningful use during the last 90-day reporting period of the year (October through December 2014) and earn an incentive payment for 2014.

Providers Who First Begin Participation in 2014 must:
- Demonstrate Stage 1 of meaningful use
- Meet 2014 EHR certification criteria
- Select any 90-day reporting period to demonstrate meaningful use, but must start no later than July 1, in order to avoid the adjustment

To Earn Your Maximum Medicare Incentive
- Demonstrate 90 days of Stage 1 of meaningful use in 2014 to earn up to $11,760.
- Demonstrate a full year of Stage 1 of meaningful use in 2015 to earn up to $7,840.
- Demonstrate a full year of Stage 2 of meaningful use in 2016 to earn up to $3,920.

If you successfully demonstrate meaningful use each year beginning in 2014, your total payment amount could be as much as $23,520.

Additional Resources
The EHR Incentive Program website offers several helpful tools and resources so you can successfully begin participation:
- An Introduction to the Medicare EHR Incentive Program for Eligible Professionals
- Interactive Eligibility Assessment Tool
- The Stage 1 Meaningful Use Attestation Calculator
- My EHR Participation Timeline
- Payment Adjustments & Hardship Exceptions Tipsheet for Eligible Professionals

Eligible Hospitals: Review Changes in Stage 1 Meaningful Use Criteria for EHR Incentive Program

Is your Medicare eligible hospital or critical access hospital (CAH) participating or planning to participate in Stage 1 of the Medicare or Medicaid Electronic Health Record (EHR) Incentive Program this year? The Stage 2 rule for meaningful use included changes to Stage 1 requirements that took effect at the start of the 2014 fiscal year on October 1, 2013. These changes include:

Record and Chart Changes in Vital Signs

- Change: The age limit increased for recording blood pressure in patients, from age 2 to age 3; there is no age limit for height and weight.
- 2014 Measure: For more than 50 percent of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period, blood pressure (for patients age 3 and over only) and height and weight (for all ages) should be recorded as structured data.

Patient Electronic Access

- Change: Core objective "Electronic copy of health information" and core objective "Electronic copy of discharge instructions" are combined to become the new "View online, download, and transmit" core objective.
- 2014 Measure: More than 50 percent of all unique patients discharged from the inpatient or emergency departments of the eligible hospital or CAH (POS 21 or 23) during the EHR reporting period have access to their information online within 36 hours of discharge.

Clinical Quality Measure (CQM) Reporting

- Change: Reporting CQMs is still required, but it has been removed as a separate objective.

Stage 1 Resources

Resources to help you understand changes to Stage 1 of meaningful use are available on the EHR Incentive Programs website, including:

- Stage 1 Changes Tipsheet
- 2014 Stage 1 Changes Tipsheet

For More Information

Visit the Medicare and Medicaid EHR Incentive Programs website for the latest news and updates on the EHR Incentive Programs.

EHR Incentive Programs: Learn More about the Batch Reporting Option for 2014

Are you part of a group practice with multiple eligible professionals or part of a system of eligible hospitals participating in the Medicare Electronic Health Record (EHR) Incentive Program? If so, you now have the option to submit your attestations through the batch reporting method. The batch reporting method – or attestation batch upload – is a new reporting method for 2014 that allows you to upload and submit attestations for multiple eligible professionals or eligible hospitals. You can submit your attestation with other members of your medical group or hospital system in a single file through the CMS Registration and Attestation System, while still tracking each eligible professional's and eligible hospital's individual meaningful use data. Providers in Stage 1 or Stage 2 of meaningful use can submit their attestation through batch reporting with 2014 certified EHR technology.

Please note: While batch reporting provides groups with the ability to submit attestations together, incentive payments are distributed to each eligible professional or eligible hospital. Providers participating in the Medicaid EHR Incentive Program should check with their state to determine if batch reporting is available.

What measures can you submit with batch reporting?

You can submit the following measure combinations through batch reporting:

- Core measures and menu measures
- Core measures, menu measures, and clinical quality measures
- Clinical quality measures only

Helpful resources
For more information on submitting your groups' attestations using the batch reporting method, review the new Batch Reporting User Guide. You may also visit the Attestation Batch Upload Page to view the batch templates and sample batch attestations.

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.

New EHR Incentive Programs Tipsheet for Eligible Professionals Practicing in Multiple Locations

Are you an eligible professional practicing in multiple locations? Review the new Multiple Locations Tipsheet for information on how to successfully demonstrate meaningful use in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs. The tipsheet includes guidance on determining if a location is equipped with certified EHR technology, calculating patient encounters, and what to do when different menu objectives and clinical quality measures (CQMs) are chosen across locations.

Guidance for Multiple Locations
Here are some key points to keep in mind if you are practicing in multiple locations:

- To demonstrate meaningful use, 50 percent of patient encounters must take place at locations with certified EHR technology during the reporting period.
- A location is equipped with certified EHR technology if you have access to the certified EHR at the beginning of the EHR reporting period.
- You can add numerators and denominators from each certified EHR system for an accurate total.
- You should report on menu objectives and CQMs from the location with the most patient encounters if different locations chose different measures.

For More Information
Visit the CMS EHR Incentive Programs website for more resources to help you successfully participate.

Learn More About eHealth with New Resources from CMS eHealth University

Looking for more information about CMS eHealth programs? CMS has added two new intermediate-level materials to eHealth University, a CMS resource launched at the HIMSS14 Annual Conference. The new materials are designed to help you understand and implement changes to eHealth programs in 2014:

- Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs: 2014 Stage 1 Changes Tipsheet- provides an overview of changes to Stage 1 of meaningful use for the 2014 reporting year, including new and updated objectives, measures, and exclusions for eligible professionals and eligible hospitals.
- Physician Quality Reporting System (PQRS): 2014 Group Practice Reporting Option (GPRO) Requirements- provides an overview of requirements for group practices participating in GPRO for the 2014 reporting year, including information about group size, registration, and reporting method requirements.

CMS will continue to add to eHealth University as new resources become available.

About eHealth University
eHealth University is a tool to help providers find information and materials on each of the eHealth programs in one location. Watch the new introductory video to learn more about eHealth and eHealth University.

Want to learn more?
Visit the CMS eHealth website and follow us on Twitter for the latest news and updates on CMS eHealth initiatives.

Claims, Pricers, and Codes

PC Print Version 4.3.0 Incompatible with Microsoft XP

PC Print software allows Medicare Part A providers to print the electronic remittance advices in a human readable format. Version 4.3.0 of PC Print, released in April 2014, is not compatible with Windows XP. Windows XP end of life was April 8, 2014. Part A providers using Windows XP should continue to use version 4.2.6 of PC Print until they are able to upgrade to a newer version of Windows. PC Print version 4.3.0 displays the English descriptions for the claim adjustment reason codes (CARCs), remittance advice remark codes (RARCs) and Group codes at the claim and line levels, as well as indicating the appropriate Council for Affordable Quality Healthcare Committee on Operating Rules for Information Exchange (CAQH CORE) business scenario. PC Print version 4.2.6 displays the CARC, RARC and group codes, but the English descriptors and CAQH CORE business scenarios for these codes will not be displayed. Part A providers that have Windows XP will still need to refer to the Washington Publishing Company website to get the English descriptors for these codes and the CAQH CORE website to get the CORE Code Combination business scenarios. For background, see MLN Matters® Article # MM8479, "MREP and PC Print Updates for Operating Rules Phase III 360 Rule Compliance."

SNF Consolidated Billing: Exclusion of HCPCS Code G0463 for Certain Outpatient Hospital Clinic Visits

Effective January 1, 2014, CMS recognized Healthcare Common Procedure Coding System (HCPCS) code G0463 (Hospital outpatient clinic visit for assessment and management of a patient) for payment under the Outpatient Prospective Payment System (OPPS) for outpatient hospital clinic visits. Effective January 1, 2014, Current Procedural Terminology (CPT) codes 99201-99205 and 99211-99215 are no longer recognized for payment under the OPPS.

For Skilled Nursing Facility (SNF) consolidated billing (CB) purposes, these CPT code ranges represent a hospital's facility charge for clinic services of a hospital-based physician and are excluded from SNF CB. Therefore, HCPCS code G0463 is also excluded from SNF CB for outpatient clinic visits effective January 1, 2014. Medicare Administrative Contractors (MACs) were recently instructed to bypass this code when billed on outpatient hospital claims. If you previously received a SNF CB rejection for HCPCS G0463, you should contact your MAC to verify if you can adjust or resubmit your previously processed claim.

CMS is currently updating the claims processing internet-only manual, Chapter 6 "Inpatient Part A Billing and SNF Consolidated Billing," section 20.1.1.2, "Hospital's 'Facility Charge' in Connection with Clinic Services of a Physician" to include HCPCS code G0463.

Hold on CAH Claims for Non-Patient Specimen Analysis

Critical Access Hospital (CAH) claims for Type of Bill 14X with Date of Service on or after April 1, 2013 and Reason Code 39910 will be held starting April 1, 2014 until May 12, 2014. A fix will be applied on May 12, 2014 and held claims will be processed as normal. No action is required by the CAHs.

Hold on Some Part B Claims Following April Inpatient Payment Policy Update

CMS implemented Part B inpatient payment policies in April, 2014. See MLN Matters® Article MM8445. After implementation of the April 2014 Quarterly Release on April 7, 2014, issues were identified, and claims with the following Reason Codes will be held until the system is fixed on April 28, 2014.

- Reason Code 34910 assigns incorrectly for Type of Bill (TOB) 13X

- Reason Codes 31795 and 31797 assign incorrectly for TOB 13X with a Statement To date on or after 10/01/13 and the Receipt date is on or after 04/01/14 with A/B Rebilling in the first treatment authorization field without a W2 Condition Code.
- Reason Code 31796 assigns incorrectly for claims with the Receipt date on or after 04/01/14 with an Admit date greater than or equal to 10/01/13 and A/B Rebilling is in the first treatment authorization field with a W2 Condition Code.
- Reason Code 39015 assigns incorrectly for TOB 12X, Admit date prior to 10/01/13 with a Receipt date on or after 04/01/14 or TOB 13X with statement To date prior to 10/01/13 and Receipt date is on or after 04/01/14.
- Reason Codes 39011 and 39012 will assign incorrectly for TOB 12X when the Admit date is equal to 10/01/13 or greater and the Receipt date is greater than one year from the 10/01/13 date.
- Reason Code 31818 will assign incorrectly for TOB 13X when non-covered Part B services are identified on the Part B Rebilled 12X TOB for Claims when the Admit date is on or after 10/01/13 and Receipt date on or after 04/01/14.

Once the fix is installed, these claims will be released. No action is required by providers.

MLN Educational Products

"Certifying Physicians and the Phase 2 Ordering and Referring Denial Edits for Home Health Agencies (HHAs)" MLN Matters® Article — Released

MLN Matters® Special Edition Article #SE1413, "Certifying Physicians and the Phase 2 Ordering and Referring Denial Edits for Home Health Agencies (HHAs)" has been released and is now available in downloadable format. This article is designed to provide education on the requirement to report the National Provider Identifier (NPI) of the certifying physician along with the attending physician effective July 1, 2014. It includes background and ordering/referring edits information.

"Implementation of Fingerprint-Based Background Checks" MLN Matters® Article — Released

MLN Matters® Special Edition Article #SE1417, "Implementation of Fingerprint-Based Background Checks" has been released and is now available in a downloadable format. This article is designed to provide education on the Centers for Medicare & Medicaid Services (CMS) implementation of fingerprint-based background checks to enhance the enrollment screening provisions contained in the Affordable Care Act. It includes detailed background information.

"Medicaid Program Integrity: What Is a Prescriber's Role in Preventing the Diversion of Prescription Drugs?" Fact Sheet — Released

The "Medicaid Program Integrity: What Is a Prescriber's Role in Preventing the Diversion of Prescription Drugs?" Fact Sheet (ICN 901010) was released and is now available in a downloadable format. This fact sheet is designed to provide education on the prescriber's role in preventing the diversion of prescription drugs. It includes information regarding practices to prevent, the impact of, and the penalties for drug diversion.

"CMS Website Wheel" Educational Tool — Revised

The "CMS Website Wheel" Educational Tool (ICN 006212) was revised and is now available in a hard copy format. This educational tool is designed to easily lead people to CMS related websites where they can find more information on a variety of health care-related topics.

To access a revised product available for order in *hard copy* format, go to MLN Products and scroll down to the bottom of the web page to the "Related Links" section and click on the "MLN Product Ordering Page."

MLN Products Available in Electronic Publication Format

The following publications are now available as electronic publications (EPUBs) and through a QR code. Instructions for downloading EPUBs and how to scan a QR code are available at "How To Download a Medicare Learning Network® (MLN) Electronic Publication" on the CMS website:

- The "Sole Community Hospital" Fact Sheet (ICN 006399) is designed to provide education on Sole Community Hospitals (SCH). It includes the following information: SCH classification criteria, SCH payments, urban to rural hospital reclassifications, resources, and lists of helpful websites and Regional Office Rural Health Coordinators.
- The "Medicare Quarterly Provider Compliance Newsletter [Volume 4, Issue 3]" Educational Tool (ICN 909006) is designed to provide education on how to avoid common billing errors and other erroneous activities when dealing with the Medicare Program. It includes guidance to help health care professionals address and avoid the top issues of the particular Quarter.
- The "Inpatient Rehabilitation Facility Prospective Payment System" Fact Sheet (ICN 006847) is designed to provide education on the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS). It includes the following information: background, elements of the IRF PPS, and quality reporting.
- The "Discharge Planning" Booklet (ICN 908184) is designed to provide education on Medicare discharge planning. It includes discharge planning information for Acute Care Hospitals, Inpatient Rehabilitation Facilities, and Long Term Care Hospitals; Home Health Agencies; Hospices; Inpatient Psychiatric Facilities; Long Term Care Facilities; and Swing Beds.
- The "Quick Reference Information: Home Health Services" Educational Tool (ICN 908504) is designed to provide education on Home Health services. It includes the following information: qualifying for Home Health services, patient admission to a Home Health Agency, and payment and billing for Home Health services.
- The "Items and Services That Are Not Covered Under the Medicare Program" Booklet (ICN 906765) is designed to provide education on non-covered items and services. It includes information about the four categories of items and services that are not covered under the Medicare Program and applicable exceptions (items and services that may be covered) and Beneficiary Notices of Noncoverage.
- The "Medicare Enrollment Guidelines for Ordering/Referring Providers" Fact Sheet (ICN 906223) is designed to provide education on the Medicare enrollment requirements for eligible ordering/referring providers. It includes information on the three basic requirements for ordering and referring and who may order and refer for Medicare Part A Home Health Agency, Part B, and DMEPOS beneficiary services.

Pilot Testers Needed

Are you interested in volunteering your time and expertise to review Medicare Learning Network® publications and web-based trainings (WBTs)? There are no specific qualifications and we appreciate volunteers from all Medicare-related backgrounds and fields. If you would like to participate, please send your name and e-mail address to CMSCE@cms.hhs.gov.

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