

Thursday, April 23, 2015

## **MLN Connects<sup>®</sup> National Provider Calls**

Medicare Acute Care Quality and Reporting Programs — Registration Now Open  
New MLN Connects<sup>®</sup> National Provider Call Audio Recording and Transcript

## **CMS Events**

Special Open Door Forum: Home Health Electronic and Paper Clinical Templates

## **Announcements**

Proposed FY 2016 Skilled Nursing Facility Payment and Policy Changes  
Proposed FY 2016 Inpatient and Long-Term Care Hospital Payment and Policy Changes  
DMEPOS Competitive Bidding Round 1 2017 Announced  
National Minority Health Month  
CMS Releases Hospital Compare Star Ratings  
New Hospice Reports Available in CASPER  
CMS to Release Transthoracic Echocardiography Comparative Billing Report in May  
CMS to Award Special Innovation Projects for Partnership-Driven Quality Improvement Projects  
CMS is Accepting Suggestions for Potential PQRS Measures

## **Claims, Pricers, and Codes**

Coordination of Benefits Issue Impacting Outpatient Hospital Claims  
Updated: Correcting the Display Issue for OPPS Claims Where Value Code “FD” Is Present

## **Medicare Learning Network<sup>®</sup> Educational Products**

“Independent Diagnostic Testing Facilities” Podcast — Released  
“Vaccine and Vaccine Administration Payments under Medicare Part D” Fact Sheet — Revised  
“Home Health Prospective Payment System” Fact Sheet — Revised  
“Medicare Fraud and Abuse: Prevention, Detection, and Reporting” Web-Based Training Course — Revised  
New Medicare Learning Network<sup>®</sup> Educational Web Guides Fast Fact

## **MLN Connects<sup>®</sup> National Provider Calls**

**Medicare Acute Care Quality and Reporting Programs — Registration Now Open**

*Tuesday, May 12; 1:30-3pm ET*

*To Register:* Visit [MLN Connects<sup>®</sup> Upcoming Calls](#). Space may be limited, register early.

Quality health care for people with Medicare is a high priority for the President, HHS, and CMS. HHS and CMS began launching Quality Initiatives in 2001 to assure quality health care for all Americans through accountability and public disclosure. The various Quality Initiatives touch every aspect of the health care system. This call will provide an overview of all Hospital Inpatient Quality Reporting and Value-Based Purchasing Programs.

*Agenda:*

- Hospital Inpatient Quality Reporting (IQR) Program
- Hospital Value-Based Purchasing (HVBP) Program
- Hospital Acquired Condition Reduction Program (HACRP)
- Hospital Readmission Reduction Program (HRRP)
- Electronic Health Records (EHR) Incentive Program
- Program alignment, goals, and conclusion

*Target Audience:* Hospital administrators, executive-level leaders, quality professionals, and staff new to quality reporting programs.

This MLN Connects Call is being evaluated by CMS for CME and CEU continuing education credit (CE). Refer to the [call detail page](#) for more information.

## **New MLN Connects<sup>®</sup> National Provider Call Audio Recording and Transcript**

The [audio recording](#), [transcript](#), and [post-call clarification](#) are now available for the April 7 call — *Medicare Shared Savings Program ACO: Preparing to Apply for 2016*. More information is available on the [call detail](#) web page. During this call, CMS subject matter experts provided information on what you can do to prepare for the Medicare Shared Savings Program application process for the January 1, 2016, start date.

## **CMS Events**

### **Special Open Door Forum: Home Health Electronic and Paper Clinical Templates**

*Tuesday, April 28; 1:30-2:30 pm ET*

To assist physicians/practitioners in documenting patient eligibility for the Medicare home health benefit, CMS is considering the development of a voluntary electronic clinical template and a voluntary home health paper clinical template. More information and participation instructions are available in the [announcement](#).

## **Announcements**

### **Proposed FY 2016 Skilled Nursing Facility Payment and Policy Changes**

On April 15, CMS issued a proposed rule ([CMS-1622-P](#)) outlining proposed FY 2016 Medicare payment rates for the Skilled Nursing Facility (SNF) Prospective Payment System (PPS). Based on proposed changes contained within this rule, CMS projects that aggregate payments to SNFs will increase by \$500 million, or 1.4 percent, from payments in FY 2015. This estimated increase is attributable to a 2.6 percent market basket increase, reduced by a 0.6 percentage point forecast error adjustment and further reduced by 0.6 percentage point, in accordance with the multifactor productivity adjustment required by law.

The proposed rule also includes:

- Implementation of SNF Quality Reporting Program
- Implementation of SNF Value-Based Purchasing Program
- Changes to staffing data collection

For further information, see the [SNF PPS](#) website. Public comments on the proposal will be accepted until June 15, 2015.

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

### **Proposed FY 2016 Inpatient and Long-Term Care Hospital Payment and Policy Changes**

On April 17, CMS issued a proposed rule ([CMS-1632-P](#)) to update FY 2016 Medicare payment policies and rates under the Inpatient Prospective Payment System (IPPS) and the Long-Term Care Hospital (LTCH) Prospective Payment System (PPS). The proposed rule, which would apply to approximately 3,400 acute care hospitals and approximately 435 LTCHs, would affect discharges occurring on or after October 1, 2015.

The proposed increase in operating payment rates for general acute care hospitals paid under the IPPS that successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program and are meaningful Electronic Health Record (EHR) users is 1.1 percent. This reflects the projected hospital market basket update of 2.7 percent adjusted by -0.6 percentage point for multi-factor productivity and an additional adjustment of -0.2 percentage point in accordance with the Affordable Care Act. Like last year, the rate is further decreased by a proposed 0.8 percent for a documentation and coding recoupment adjustment required by the American Taxpayer Relief Act of 2012. Hospitals that do not successfully participate in the Hospital IQR Program and do not submit the required quality data will be subject to a one-fourth reduction of the market basket update. Also, the law requires that the update for any hospital that is not a meaningful EHR user will be reduced by one-half of the market basket update in FY 2016.

CMS projects that the rate increase, together with other proposed changes to IPPS payment policies, will increase IPPS operating payments by approximately 0.3 percent. CMS projects that total Medicare spending on inpatient hospital services will increase by about \$120 million in FY 2016. Other payment adjustments will include continued penalties for readmissions, a continued -1% penalty for hospitals in the worst performing quartile under the Hospital Acquired Condition (HAC) Reduction Program, and continued bonuses and penalties for hospital Valued-Based Purchasing (VBP).

The proposed rule also includes changes to:

- Bundled Payments for Care Improvement Initiative
- Documentation and coding
- Long-Term Care Hospital Prospective Payment System
- Medicare Disproportionate Share Hospital Payments
- EHR Incentive Programs and Quality Reporting
- Hospital IQR Program
- Hospital VBP Program
- HAC Reduction Program
- Hospital Readmissions Reduction Program
- LTCH Quality Reporting Program
- PPS-Exempt Cancer Hospital Quality Reporting Program
- Two Midnight Rule

CMS will accept comments on the proposed rule until June 16, 2015, and will respond to all comments in a final rule to be issued by August 1, 2015.

Full text of this excerpted [CMS fact sheet](#) (issued April 17).

## **DMEPOS Competitive Bidding Round 1 2017 Announced**

On April 21, CMS announced plans to recomplete the supplier contracts awarded in Round 1 Recompete of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. The Round 1 Recompete contract period for all product categories expires on December 31, 2016.

CMS is conducting Round 1 2017 in the same metropolitan statistical areas that were included in Round 1. See the [Latest News and Announcements](#) to learn about Round 1 2017's timeline, product categories, and zip codes. If you are a supplier interested in bidding, prepare now – don't wait.

## **National Minority Health Month**

April is National Minority Health Month – a time to raise public awareness about health and health care disparities that continue to affect racial and ethnic minorities and efforts to advance health equity. This year's theme: *30 Years of Advancing Health Equity* | [The Heckler Report: A Force for Ending Health Disparities in America](#) commemorates federal efforts towards eliminating health disparities among racial and ethnic minorities.

While our country has made progress towards ending health disparities, racial and ethnic minorities continue to face significant health disparities. Medicare offers an array of preventive services; many of which, as a result of the Affordable Care Act, can be received without any out-of-pocket cost to the beneficiary (no copay, coinsurance, or deductible). However, for many racial and ethnic minorities, preventive health services are underutilized. We need your help to ensure that all people with Medicare take full advantage of the covered preventive services they are eligible for. We urge you to talk with your Medicare patients about the importance of preventive care, encourage utilization, and make recommendations for appropriate covered preventive services that can help identify health issues and improve the health and well-being of your patients. [Continue reading](#) for more information.

## **CMS Releases Hospital Compare Star Ratings**

On April 16, CMS introduced star ratings on [Hospital Compare](#), the agency's public information website, to make it easier for consumers to choose a hospital and understand the quality of care they deliver. The announcement builds on a larger effort across HHS to build a health care system that delivers better care, spends health care dollars more wisely, and results in healthier people.

The Hospital Compare star ratings relate to patients' experience of care at almost 3,500 Medicare-certified acute care hospitals. The ratings are based on data from the Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS) measures that are included in Hospital Compare. HCAHPS has been in use since 2006 to measure patients' perspectives of hospital care.

Consumers will now see 12 HCAHPS Star Ratings on Hospital Compare, one for each of the 11 publicly reported HCAHPS measures, plus a summary star rating that combines or rolls up all the HCAHPS Star Ratings. These star ratings will be updated each quarter.

*For more information:*

- [Fact Sheet](#)
- [HCAHPS](#) website

Full text of this excerpted [CMS press release](#) (issued April 16).

### **New Hospice Reports Available in CASPER**

Three new hospice provider reports are now available in the Certification and Survey Provider Enhanced Reports (CASPER) reporting application:

- HIS Record Error Detail by Provider
- HIS Record Error by Field by Provider
- HIS Records With Error Number

Additional information on the reports is available on the [Spotlights & Announcements](#) web page for the Hospice Quality Reporting Program, including an [informational and instructional document](#). For questions about access to CASPER or the new provider reports, please contact the QTSO Help Desk at [help@qtso.com](mailto:help@qtso.com) or 888-477-7886.

### **CMS to Release Transthoracic Echocardiography Comparative Billing Report in May**

CMS will be issuing a national provider Comparative Billing Report (CBR) on Transthoracic Echocardiography (TTE) in May 2015. The CBR, produced by CMS contractor eGlobalTech, will contain data-driven tables and graphs with an explanation of findings that compare providers' billing and payment patterns to those of their peers in their state and across the nation. The goal of these reports is to offer a tool that helps providers better understand applicable Medicare billing rules. These reports are only accessible to the providers who receive them; they are not publicly available.

Providers are advised to update their fax numbers in the Medicare Provider Enrollment, Chain, and Ownership System (PECOS) because faxing is the default method for disseminating CBRs. Providers should contact the CBR Support Help Desk at 800-771-4430 or [CBRsupport@eglobaltech.com](mailto:CBRsupport@eglobaltech.com) if they prefer to receive CBRs through the U.S. Postal Service. For more information, please contact the CBR Support Help Desk or visit the [CBR](#) website.

### **CMS to Award Special Innovation Projects for Partnership-Driven Quality Improvement Projects**

On April 21, CMS announced that it will award two Special Innovation Projects (SIPs) with combined maximum funding of \$10 million to regional Quality Innovation Network-Quality Improvement Organizations (QIN-QIOs) from the CMS [QIO Program](#) in FY 2015. The SIPs are two-year quality improvement projects that align with the goals of the [CMS Quality Strategy](#) and emphasize the power of partnerships.

The first type of SIP, "Innovations that Advance Local Efforts for Better Care at Lower Cost", addresses health care quality issues that occur within specific QIN-QIO regions. Collaboration with health care, community and/or national partners is an important aspect of the work in terms of brainstorming ideas, identifying potential areas of focus, and developing interventions. The innovations can be either new or pre-existing.

The second type of SIP, "Interventions that are Ripe for Spread and Scalability", is focused on expanding the scope and national impact of a quality improvement project that has had proven success on a more limited level. The expectation would be that similar benefits would be seen on a large scale. CMS is specifically interested in

projects that will result in reduced mortality, harm, health care disparities, and costs, and that will result in a high return on investment, link value to quality, and result in the utilization of alternative payment models by providers.

QIN-QIOs are allowed – though not required – to submit proposals for one or both SIPs, and they are eligible for a maximum of two awards. For more information:

- [QIO Program](#)
- [Complete list of QIN-QIOs](#)

### **CMS is Accepting Suggestions for Potential PQRS Measures**

*Measures submitted prior to June 15 may be considered for inclusion on the 2015 MUC list*

CMS is 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. Quality measures submitted in this Call for Measures may also be considered for use in other quality programs for physicians and other eligible professionals (e.g. Value-based Modifier, Physician Compare, Medicare Shared Savings Program, etc.).

As the PQRS Call for Measures is conducted in an ongoing open format, the month that a measure is submitted for consideration will determine when it may be included on the Measures Under Consideration (MUC) list. Measures submitted prior to June 15, 2015, at 5pm ET may be considered for inclusion on the 2015 MUC list for implementation in PQRS as early as 2017.

CMS will give priority to measures that are outcome-based, answer a measure gap, and address the most up-to-date clinical guidelines. Measures submitted for consideration will be assessed to ensure that they meet the needs of the PQRS. As time permits, feedback will be provided to measure submitters upon review of their submission. When submitting measures for consideration, please ensure that your submission is not duplicative of another existing or proposed measure. Additionally, CMS is not accepting claims-based only reporting measures in this process. Note that measures already included in previous PQRS MUC lists may only be resubmitted for consideration if the measure has undergone substantive changes. Resubmission of measures with no significant changes made from the last submission will be automatically eliminated from the review process.

Each measure submitted for consideration *must* include all required supporting documentation. Documentation requirements and the submission timeline are posted on the [Measures Management System Call for Measures](#) web page. Questions about this Call for Measures or the required documentation may be submitted to [C4M@wvmi.org](mailto:C4M@wvmi.org).

## **Claims, Pricers, and Codes**

### **Coordination of Benefits Issue Impacting Outpatient Hospital Claims**

An issue with the Fiscal Intermediary Shared System negatively impacted 837 institutional crossover claims, starting around April 9, 2015. Institutional Coordination of Benefits (COB) claims were missing a required composite element: 2300 HI01-2 (industry diagnosis code included to explain the patient reason for visit). Consequently, the Benefits Coordination and Recovery Center began to reject these claims with error code H10614—“Missing Mandatory HI0102.”

The systems issue has been corrected as of April 15, 2015, and our Medicare Administrative Contractors are in the process of repairing claims that would have been rejected. Please wait until after April 30 to bill your patients' supplemental insurance companies for balances remaining after Medicare.

### **Updated: Correcting the Display Issue for OPSS Claims Where Value Code "FD" Is Present**

CMS is correcting a display issue for Outpatient Prospective Payment System (OPSS) claims with value code "FD," which was caused by the implementation of payer-only value code "QD." The following claims are affected:

- Type of Bill 12x, 13x
- Processed on or after January 1, 2014 and prior to the July 2015 OPSS Pricer quarterly release
- Value code "FD" is present

Medicare Administrative Contractors will be mass adjusting any processed claims not reflecting a difference that met the above criteria within 60 days after successful implementation of the payer-only value code "QD" into production on or about July 6, 2015. No action is required by providers.

## **Medicare Learning Network<sup>®</sup> Educational Products**

### **"Independent Diagnostic Testing Facilities" Podcast — Released**

The "[Independent Diagnostic Testing Facilities](#)" Podcast (ICN 909204) was released and is now available. This podcast is designed to provide valuable education for Independent Diagnostic Testing Facilities (IDTFs) about enrollment in the Medicare program. It includes information, such as the various requirements for different physicians; performance standards, including the 16 different requirements for an IDTF; billing issues, including the anti-mark-up payment limitation; ordering of tests; and place of service issues.

### **"Vaccine and Vaccine Administration Payments under Medicare Part D" Fact Sheet — Revised**

The "[Vaccine and Vaccine Administration Payments under Medicare Part D](#)" Fact Sheet (ICN 908764) was revised and is now available in downloadable format. This fact sheet is designed to provide education on vaccine payments under Medicare Part D. It includes information on the difference between Part B and Part D vaccine coverage, what Part D covers, and additional information on vaccine coverage under Part D plans.

### **"Home Health Prospective Payment System" Fact Sheet — Revised**

The "[Home Health Prospective Payment System](#)" Fact Sheet (ICN 006816) was revised and is now available in downloadable format. This fact sheet is designed to provide education on the Home Health Prospective Payment System (HH PPS). It includes the following information: background, consolidated billing requirements, criteria that must be met to qualify for home health services, therapy services, elements of the HH PPS, updates to the HH PPS, billing and payment for home health services, and Home Health Quality Reporting Program.

### **"Medicare Fraud and Abuse: Prevention, Detection, and Reporting" Web-Based Training Course — Revised**

The “Medicare Fraud and Abuse: Prevention, Detection, and Reporting” Web-Based Training Course (WBT) was revised and is now available. This WBT is designed to provide education on how to identify Medicare fraud and abuse and understand the related laws and penalties. It includes information on what entities and safeguards protect against fraud and abuse, as well as how you can help prevent and report it. Continuing education credits are available to learners who successfully complete this course. See course description for more information.

To access the WBT, go to [MLN Products](#), scroll to the bottom of the web page and under “Related Links” click on “Web-Based Training Courses.”

### **New Medicare Learning Network® Educational Web Guides Fast Fact**

A new fast fact is now available on the [Medicare Learning Network® 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 CMS initiatives. Please bookmark this page and check back often as a new fast fact is added each month.

**[Like the eNews? Have suggestions? Please let us know!](#)**

**[Subscribe](#) to the *eNews*. Previous issues are available in the [archive](#).**

**Follow the MLN on [Twitter](#) #CMSMLN, and visit us on [YouTube](#).**