MLN Connects®
Provider eNews

Medicare Learning Network®
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Thursday, November 5, 2015

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MLN Connects® National Provider Calls and Events

Clinical Diagnostic Laboratory Test Payment System Proposed Rule Call — Last Chance to Register

Tuesday, November 10 from 2-3pm ET

To Register: Visit MLN Connects Event Registration. Space may be limited, register early.

During this MLN Connects National Provider Call, CMS subject matter experts will discuss proposed policy changes in the Clinical Diagnostic Laboratory Test Payment System proposed rule (CMS-1621-P). The proposed rule would significantly revise the Medicare payment system for clinical diagnostic laboratory tests and implement a related data collection system. This call will not include a question and answer session.

You can submit comments on the proposed rule until November 24, 2015.

Target Audience: Clinical diagnostic laboratory industry.

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 and QAPI Call — Register Now

Tuesday, December 1 from 1:30-3pm ET

To Register: Visit MLN Connects Event Registration. Space may be limited, register early.

This MLN Connects National Provider Call will focus on nursing home providers, as well as transitions of care between acute and long-term settings. A physician will share approaches to effectively manage high-risk medications, and a pharmacist will discuss the importance of drug regimen reviews and medication reconciliation. Additionally, CMS subject matter experts will update you on the progress of the National Partnership and Quality Assurance and Performance Improvement (QAPI). A question and answer session will follow the presentations.

The National Partnership to Improve Dementia Care in Nursing Homes and QAPI are partnering on MLN Connects Calls to broaden discussions related to quality of life, quality of care, and safety issues. The National Partnership was developed to improve dementia care in nursing homes through the use of individualized, comprehensive care approaches to reduce the use of unnecessary antipsychotic medications. QAPI standards expand the level and scope of quality activities to ensure that facilities continuously identify and correct quality deficiencies and sustain performance improvement.

Discussion Topics:

- Discussion from Washington Post (Popular blood thinner causing deaths, injuries in nursing homes)
- Medication Management
- Drug Regimen Review & Medication Reconciliation
- QAPI
- National Partnership

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.

Medicare Quality Reporting Programs: 2016 Physician Fee Schedule Call — Registration Now Open

Tuesday, December 8 from 1:30-3pm ET

To Register: Visit MLN Connects Event Registration. Space may be limited, register early.
During this MLN Connects National Provider Call, find out how the 2016 Medicare Physician Fee Schedule final rule impacts Medicare Quality Reporting Programs. A question and answer session will follow the presentation.

Agenda:

- Program changes to the Physician Quality Reporting System (PQRS), Electronic Health Record Incentive Program, Comprehensive Primary Care initiative, Value-Based Payment Modifier (Value Modifier), Medicare Shared Savings Program (Shared Savings Program) and Physician Compare
- Final changes to PQRS and Value Modifier reporting criteria for 2016
- Criteria for satisfactorily reporting to avoid a PQRS negative payment adjustment and an automatic Value Modifier downward payment adjustment in 2018
- Moving toward the Merit-based Incentive Payment System and Alternative Payment Models, based on the amendment of the Medicare Access and CHIP Reauthorization Act of 2015

Target Audience: Physicians, Accountable Care Organizations, Medicare eligible professionals, therapists, medical group practices, practice managers, medical and specialty societies, payers, and insurers.

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

ESRD QIP: Access PY 2016 Performance Score Report and Certificates Call — Registration Now Open

Wednesday, December 9 from 2:30-3:30pm ET

To Register: Visit MLN Connects Event Registration. Space may be limited, register early.

Do you participate in the End-Stage Renal Disease (ESRD) Quality Incentive Program (QIP)? During this MLN Connects National Provider Call, learn how to access a final Payment Year (PY) 2016 Performance Score Report (PSR) and Performance Score Certificates (PSCs). A question and answer session will follow the presentation. Visit the ESRD QIP website for more information.

Agenda:

- How to access and review your final PSR and PSCs starting in December
- What the performance score means to your PY 2016 payment rates
- Where to access ESRD QIP resources and information on facility responsibilities

Target Audience: Dialysis clinics and organizations, nephrologists, hospitals with dialysis units, billers/coders, and quality improvement experts.

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

New MLN Connects National Provider Call Audio Recording and Transcript

An audio recording, transcript, post-call clarification, and updated slide presentation are available from the October 21 call — Improving Medicare Post-Acute Care Transformation Act. See the call detail web page for more information. During this call, CMS subject matter experts discussed the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014.

Announcements

Physician Fee Schedule: Policy and Payment Changes for CY 2016

On October 30, CMS issued a final rule updating payment policies, payment rates, and quality provisions for services furnished under the Medicare Physician Fee Schedule (PFS) on or after January 1, 2016. The rule also finalizes changes to several of the quality reporting initiatives that are associated with PFS payments, including the Physician Quality Reporting System (PQRS), the Physician Value-Based Payment Modifier, and the Medicare Electronic Health Record Incentive Program, as well as changes to the Physician Compare website on Medicare.gov.

Payments are based on the relative resources typically used to furnish the service. Relative Value Units (RVUs) are applied to each service for physician work, practice expense, and malpractice. These RVUs become payment rates through the application of a conversion factor, which is calculated using the formula set forth in statute.

The final rule also includes:

- Medicare Shared Savings Program
- Advance care planning
- Part B Drugs/payment for biosimilar biological products
  Misvalued code target
- Misvalued code changes for radiation therapy
- Implementation of the statutory phase-in of significant RVU reductions
- Misvalued code changes for lower GI endoscopy services
  “Incident to” policy
- Physician self-referral updates
- Changes to Medicare physician and practitioner opt-out
- Appropriate use criteria for advanced diagnostic imaging services

For More Information:

- Final Rule

See full text of this excerpted CMS fact sheet (issued October 30).

Hospital Outpatient and ASC: Policy and Payment Changes for CY 2016

On October 30, CMS released the CY 2016 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) payment system policy changes, quality provisions, and payment rates final rule with comment period. The final rule also includes important changes to the Two Midnight Rule beginning in CY 2016.

CMS is updating OPPS rates based on the projected hospital market basket increase of 2.4 percent minus both a 0.5 percentage point adjustment for multi-factor productivity and a 0.2 percentage point adjustment required by law. There is an additional finalized 2.0 percentage point adjustment to the payment update to redress inflation in the OPPS payment rates, resulting from excess packaged payment for laboratory tests that continue to be paid separately outside of the OPPS. The final rate update will be -0.3 percent. After all other policy changes finalized under the OPPS, including estimated spending for pass-through payments, CMS estimates a -0.4 percent change in spending for hospitals paid under the OPPS in CY 2016. Beneficiary co-insurance for OPPS services is projected to decrease from 19.9 percent in CY 2015 to 19.3 percent in CY 2016.

ASC payments are annually updated for inflation by the percentage increase in the Consumer Price Index for all urban consumers (CPI-U). The Medicare statute specifies a Multifactor Productivity (MFP) adjustment to the ASC annual update. For CY 2016, the CPI-U update is 0.8 percent. The MFP adjustment is 0.5 percent, resulting in an MFP-adjusted CPI-U update factor of 0.3 percent.

The final rule also includes:

- OPPS spending for laboratory services
- Chronic care management services
- Restructuring of ambulatory payment classifications
- Comprehensive ambulatory payment classifications
- Packaged services
- Change in OPPS device pass-through process
- Skin substitutes
- Payment for biosimilar biological products under the OPPS
- New P codes for pathogen-reduced blood products
- Removing certain codes from the list of ASC covered ancillary services
- Update of the Partial Hospitalization Program per diem amounts in outpatient hospital departments and community mental health centers
- Payment transition for former Medicare dependent, small rural hospitals under the Hospital Inpatient Prospective Payment System
- Appropriate claims in provider cost reports; appeals by providers and judicial review
- Hospital Outpatient Quality Reporting Program: Changes for 2017 and 2018 payment determinations
- Ambulatory Surgical Center Quality Reporting Program

For More Information:

- Final Rule
- Fact Sheet: Two-Midnight Rule

See full text of this excerpted CMS fact sheet (issued October 30).

ESRD Facilities: Policies and Payment Rates for CY 2016

On October 29, CMS issued a final rule to update payment policies and rates under the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) for renal dialysis services furnished to

beneficiaries on or after January 1, 2016. This final rule also includes changes to the ESRD Quality Incentive Program for payment years 2017 through 2019 under which payment incentives are made to dialysis facilities to improve the quality of dialysis care.

The finalized CY 2016 ESRD PPS base rate is $230.39. This amount reflects a reduced market basket increase as required by section 1881(b)(14)(F)(i)(I) of the Act, as amended by section 217(b)(2)(A)(ii) of the Protecting Access to Medicare Act of 2014 (PAMA) (0.15 percent), application of the wage index budget-neutrality adjustment factor (1.000495), and a refinement budget-neutrality adjustment factor (0.960319), so that total projected PPS payments in CY 2016 are equal to what the payments would have been in CY 2016 had the refinements not been implemented. The CY 2016 ESRD PPS base rate is a reduction of $9.04 from the CY 2015 base rate of $239.43 ($239.43 x 1.0015 x 1.000495 x 0.960319 = $230.39).

The final rule also includes:

- ESRD PPS refinement
- Drug designation process
- Annual update to the wage index and wage index floor
- Update to the outlier policy
- Impact analysis
- Low-volume payment adjustment
- Payment for oral-only drugs

For More Information:

- Final Rule

See full text of this excerpted CMS fact sheet (issued October 29).

HHAs: Payment Changes for CY 2016

On October 29, CMS announced changes to the Medicare Home Health (HH) Prospective Payment System (PPS) for CY 2016 that will foster greater efficiency, payment accuracy, and improved quality of care. CMS is also finalizing a new initiative, the Home Health Value-Based Purchasing Model, designed to support greater quality and efficiency of care among Medicare-certified Home Health Agencies (HHAs) across the nation.

CMS projects that Medicare payments to HHAs in CY 2016 will be reduced by 1.4 percent, or $260 million. This decrease reflects the effects of the 1.9 percent home health payment update percentage ($345 million increase); a 0.9 percent decrease in payments due to the 0.97 percent payment reduction to the national, standardized 60-day episode payment rate to account for nominal case-mix growth from 2012 through 2014 ($165 million decrease); and a 2.4 percent decrease in payments due to the third year of the four-year phase-in of the rebasing adjustments to the national, standardized 60-day episode payment rate, the national per-visit payment rates, and the non-routine medical supplies conversion factor ($440 million decrease). Compared to the proposed rule, the maximum payment reduction in the first year of the value-based purchasing program was reduced from 5 percent to 3 percent.

The final rule also includes:

- Rebasing the HH PPS payment rates
- Recalibration of the HH PPS case-mix weights
- Reduction to the 60-day episode rate to account for nominal case-mix growth
- Home Health Quality Reporting Program update

For More Information:

- Final Rule
- HH PPS website

See full text of this excerpted CMS fact sheet (issued October 29).

Discharge Planning Proposed Rule Focuses on Patient Preferences

On October 29, CMS proposed to revise the discharge planning requirements that hospitals, including long-term care hospitals and inpatient rehabilitation facilities, critical access hospitals, and home health agencies, must meet in order to participate in the Medicare and Medicaid programs. The proposed changes would modernize the discharge planning requirements by:

- Bringing them into closer alignment with current practice
- Helping to improve patient quality of care and outcomes
- Reducing avoidable complications, adverse events, and readmissions

The proposed rule would also implement the discharge planning requirements of the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act), which will improve consumer transparency and beneficiary experience during the discharge planning process. There is a 60 day comment period on the proposed rule.

See full text of this excerpted CMS press release (issued October 29).

Final Waivers in Connection with the Shared Savings Program

On October 29, HHS published the Medicare Program; Final Waivers in Connection with the Shared Savings Program final rule (80 FR 66726), which finalized waivers of the Federal anti-kickback statute, the civil monetary penalties law related to beneficiary inducements, and the physician self-referral law for specified arrangements involving Accountable Care Organizations (ACOs) participating in the Medicare Shared Savings Program (Shared Savings Program). The waivers have been in effect since November 2, 2011; conduct protected under the waivers issued in 2011 remains permitted under the final rule. This final rule will provide certainty to ACOs participating in the Shared Savings Program to foster innovation in furtherance of better care, smarter spending, and healthier people. For more information on the waivers in this final rule, visit the Fraud and Abuse Waivers web page.

DMEPOS Competitive Bidding Round 1 2017: Covered Document Review Date November 16

If you are a supplier bidding in Round 1 2017 of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program, the Competitive Bidding Implementation Contractor (CBIC) must receive your hardcopy financial documents on or before November 16, 2015, in order for the documents to be eligible for the covered document review and for you to be notified of any missing financial documents. Don't wait – send your hardcopy financial documents to the CBIC today. See the announcement for more information.

Physician Compare Preview Period Extended to November 16

The Physician Compare preview period has been extended to November 16, 2015, to allow more time for individuals and group practices to preview their measures. You can access the secured measures preview site through the PQRS portal. To learn more about which measures will be publicly reported and how to preview your measures, visit the Quality Data and Physician Compare web page. If you have any questions about Physician Compare, public reporting, or the 2014 quality measure preview period, contact PhysicianCompare@Westat.com.

2016 Value Modifier: Informal Review Deadline Extended to November 23

The informal review period for the 2016 Value Modifier has been extended. All requests must be submitted by 11:59pm ET on November 23, 2015. The informal review process allows groups, as identified by their taxpayer identification number, that have 10 or more eligible professionals and are subject to the 2016 Value Modifier to request a correction of a perceived error in their Value Modifier calculations. Visit the 2014 QRUR website for additional information or contact the QRUR Help Desk at pvhelpdesk@cms.hhs.gov or 888-734-6433 (select option 3).

2016 PQRS Payment Adjustment: Informal Review Deadline Extended to November 23

In 2016, CMS will apply a negative payment adjustment to individual eligible professionals, Comprehensive Primary Care practice sites, and group practices participating in the Physician Quality Reporting System (PQRS) group practice reporting option, including Accountable Care Organizations that did not satisfactorily report PQRS in 2014. Individuals and groups that receive the 2016 negative payment adjustment will not receive a 2014 PQRS incentive payment.
If you believe you have been incorrectly assessed for the 2016 PQRS negative payment adjustment, you can submit an informal review through November 23, 2015:

- Requests must be submitted electronically via the Communication Support Page under the Related Links section of the Physician and Other Health Care Professionals Quality Reporting Portal
- See the fact sheet and Analysis and Payment web page for more information

Additional Resources:

- Payment Adjustment Information web page
- Payment Adjustment Toolkit
- Fact Sheet

For additional questions, contact the QualityNet Help Desk at 866-288-8912 (TTY 1-877-715-6222) or via qnetsupport@hcqis.org from 7am to 7pm CT Monday through Friday.

Part D Prescribers Must Enroll in Medicare: Submit Your Application by January 1

CMS can help

Prescribers of Part D drugs must enroll in Medicare by June 1, 2016. Submit your application by January 1, so your application can be approved by the deadline. Be sure your patients' drugs are covered by enrolling now.

Two free ways to enroll in Medicare, so you can prescribe Part D drugs:

1. Use the PECOS website. Download instructions or watch the video tutorial

2. Submit a paper application to your Medicare Administrative Contractor (MAC)**.** MACs process Medicare claims, enroll health care providers in the Medicare program, and educate providers on certain Medicare requirements.

Did you already enroll? Check the list of enrolled providers

For More Information:

- MLN Matters® Special Edition Article #SE1434
- Part D Prescriber Enrollment website
- Contact your local MAC

Considering Opting Out of Medicare to Meet the Prescriber Enrollment Requirements?

Beginning June 1, 2016, prescribers who write prescriptions for Part D drugs must be enrolled in an approved status or have a valid opt-out affidavit on file with Medicare in order for their prescriptions to be covered under Medicare Part D. Before opting out of Medicare, you should consider the following impacts:

- You will not be able to participate in a Medicare Advantage plan, and
- Your opt-out status lasts for two years and cannot be terminated unless within 90 days of your opt out designation

To learn more about the options available to you, refer to the decision chart. For more information on the prescriber enrollment requirements refer to the Part D Prescriber Enrollment web page.

CMS to Release a Comparative Billing Report on Physical Therapy in November

CMS will issue a national provider Comparative Billing Report (CBR) on Physical Therapy in November 2015. The CBR, produced by CMS contractor eGlobalTech, will focus on providers with a specialty of physical therapy and will contain data-driven tables with an explanation of findings that compare these 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 if they prefer to receive CBRs through the U.S. Postal Service. For more information, contact the CBR Support Help Desk, or visit the CBR website.

November is Home Care and Hospice Month

November is Home Care and Hospice Month. Hospice care empowers people with life-limiting illnesses to remain at home, surrounded and supported by family and loved ones at end-of-life. For patients that are considered "confined to the home," Medicare covers a wide range of health care services that can be provided in the home to treat an illness or injury. Home health care is usually less expensive and just as effective as care you get in a hospital or skilled nursing facility. Use this opportunity to talk to your Medicare patients about appropriate hospice and home health services.
For More Information:

- Preventive Services Educational Tool
- Hospice Payment System Fact Sheet
- Home Health Prospective Payment System Fact Sheet
- Medicare Home Care Benefit Fact Sheet
- National Association for Home Care & Hospice website

Each Office Visit is an Opportunity to Recommend Influenza Vaccination

People 65 years and older are at greater risk of serious complications from seasonal influenza. The Centers for Disease Control and Prevention encourages you to use each office visit as an opportunity and recommend seasonal influenza vaccination – to protect your patients, your staff, and yourself. Medicare Part B covers one influenza vaccination and its administration each influenza season for Medicare beneficiaries. If medically necessary, Medicare may cover additional seasonal influenza vaccinations.

For More Information:

- Preventive Services Educational Tool
- Influenza Vaccine Payment Allowances MLN Matters Article
- Influenza Resources for Health Care Professionals MLN Matters Article
- CDC Influenza website
- Use HealthMap Vaccine Finder to help your patients locate the influenza vaccine in their community

Find Information on Medicare-Covered Preventive Services

Medicare covers many preventive services at no cost to your patients. Find out more on the redesigned Preventive Services website. Encourage patients to take advantage of appropriate preventive services to prevent and find diseases early, when treatment works best.

- Use the Preventive Services Tool for coverage, coding, and billing information for each service
- Learn more about the services through Provider Resources
- Keep up to date with the latest Announcements
- Get answers to your Frequently Asked Questions

Claims, Pricers, and Codes

Colorectal Cancer Screening Claims Processing Issue

Due to an increase in inappropriate denials, CMS has expedited an update to National Coverage Determination (NCD) 210.3, Colorectal Cancer Screening Tests. CMS is taking action to correct inappropriate denials of HCPCS code G0105 with ICD-10 code Z86.010 where they exist, and appropriate payment will be made for these procedures within 45 days. No action is needed by providers.

FY 2015 Inpatient PPS PC Pricer Update Available

The FY 2015.4 Inpatient Prospective Payment System (PPS) PC Pricer has been updated and is now available with October 2015 provider data on the Inpatient PPS PC Pricer web page in the "Downloads" section.

FY 2015 HH PPS PC Pricer Update Available

The FY 2015.2 Home Health (HH) Prospective Payment System (PPS) PC Pricer has been updated and is now available with October 2015 provider data on the HH PPS PC Pricer web page in the "Downloads" section.

Medicare Learning Network® Educational Products

Medicare Learning Network Catalog: November 2015 Version Available

The Medicare Learning Network November 2015 Catalog is now available. The catalog is a free, interactive, and downloadable document that links you to online versions of products and services and also to the product ordering page for available hardcopy materials. Once you have opened the catalog, you may either click on the title of an individual product, or click on "Formats Available" to quickly access the material you have selected.

"ICD-10-CM Diagnosis Codes for Bone Mass Measurement" MLN Matters Article — Released

MLN Matters Article #SE1525, "ICD-10-CM Diagnosis Codes for Bone Mass Measurement" was released and is now available in a downloadable format. This article is designed to provide education on the coding and coverage of osteopenia for bone mass measurement under National Coverage Determination (NCD) 150.3. It includes background information.

"Medicare FFS Claims Processing Guidance for Implementing ICD-10" MLN Matters Article — Revised

MLN Matters Article #SE1408, "Medicare Fee-For-Service (FFS) Claims Processing Guidance for Implementing International Classification of Diseases, 10th Edition (ICD-10) – A Re-Issue of MM7492" was revised and is now available in downloadable format. This article is designed to provide education on the required use of the ICD-10 code sets for dates of service on and after October 1, 2015. It includes tables for providers on claims that span the periods where ICD-9 and ICD-10 codes may both be applicable. This article was revised to add language to Table A on Page 3 on the Inpatient Psychiatric Facility and Long Term Care Hospital Prospective Payment System.

Medicare Learning Network Products Available in Electronic Publication Format

The following products 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 Electronic Publication."

- The "Medicare Enrollment and Claim Submission Guidelines" Booklet (ICN 906764) is designed to provide education on applying for enrollment and submitting claims to Medicare. It includes the following information: enrolling in the Medicare Program; private contracts with

Medicare beneficiaries; Medicare claims; deductibles, coinsurance, and copayments; Beneficiary Notices of Noncoverage; and billing requirements.

- "Medicare Enrollment for Physicians and Other Part B Suppliers" Fact Sheet (ICN 903768) is designed to provide education on Medicare enrollment information and how to ensure physicians and other Part B suppliers are qualified and eligible to enroll in the Medicare Program. It includes information on how to enroll in the Medicare Program, how to report changes, and a list of resources.
- "PECOS Technical Assistance Contact Information" Fact Sheet (ICN 903766) is designed to provide Provider Enrollment, Chain and Ownership System (PECOS) technical assistance contact information. It includes a list of contacts and other resources.

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