

Thursday, November 19, 2015

## MLN Connects<sup>®</sup> Events

National Partnership to Improve Dementia Care and QAPI Call — Register Now  
Medicare Quality Reporting Programs: 2016 Physician Fee Schedule Call — Register Now  
ESRD QIP: Access PY 2016 Performance Score Report and Certificates Call — Register Now

## Announcements

Registration for DMEPOS Competitive Bidding Round 1 2017 Closes November 20  
CMS Awards Partnership-Driven Special Innovation Projects to QIN-QIOs  
Reducing Improper Payment: A Collaborative Effort  
Comprehensive Care for Joint Replacement Model  
Revised 2014 Annual QRURs Available  
2016 Value Modifier Informal Review Deadline Ends November 23  
2016 PQRS Payment Adjustment: Informal Review Deadline Ends November 23  
Comments on Discharge to Community Quality Measure due November 23  
Considering Opting Out of Medicare to Meet the Prescriber Enrollment Requirements? — Updated  
EHR Incentive Programs: New Public Health Reporting FAQs  
Recognizing Lung Cancer Awareness Month and the Great American Smokeout

## Claims, Pricers, and Codes

ICD-10 Transition: Clarifications about NCDs and LCDs  
CY 2013 Referring Provider DMEPOS Data — Updated

## Medicare Learning Network<sup>®</sup> Publications

Complying with Documentation Requirements for Laboratory Services Fact Sheet — New  
Skilled Nursing Facility Prospective Payment System Booklet — Revised  
Product Available in an Electronic Publication Format

## MLN Connects<sup>®</sup> Events

### **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 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](#) webpage to learn more.

**Medicare Quality Reporting Programs: 2016 Physician Fee Schedule Call — Register Now**

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

To Register: Visit [MLN Connects Event Registration](#). Space may be limited, register early.

During this 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](#) webpage for more information.

## **ESRD QIP: Access PY 2016 Performance Score Report and Certificates Call — Register Now**

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 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](#) webpage to learn more.

## **Announcements**

### **Registration for DMEPOS Competitive Bidding Round 1 2017 Closes November 20**

Suppliers interested in participating in Round 1 2017 of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program: Registration will close this Friday, November 20, 2015, at 9pm prevailing ET. No Authorized Officials (AOs), Backup Authorized Officials (BAOs), or End Users (EUs) can register after this time. In order to submit a bid, you are required to obtain a user ID and password to access the online DMEPOS Bidding System, DBidS.

For more information or to register, see the [announcement](#).

### **CMS Awards Partnership-Driven Special Innovation Projects to QIN-QIOs**

CMS awarded 16 two-year Special Innovation Projects (SIPs) to 10 regional Quality Innovation Network-Quality Improvement Organizations (QIN-QIOs). The SIPs address health care quality issues, such as early detection and management of sepsis, advance care planning, colorectal cancer screening, and disease management in rural settings. See the list of [2015 SIPs](#).

See the full text of this excerpted [CMS blog](#) (issued November 12).

### **Reducing Improper Payment: A Collaborative Effort**

On November 16, HHS released the annual [Agency Financial Report](#), which includes an update on the improper payment rate for a variety of programs. The Medicare Fee-For-Service improper payment rate decreased from 12.7 percent in 2014 to 12.1 percent in 2015. The Two Midnight rule and corresponding educational efforts led to a reduction in improper inpatient hospital claims, reducing the improper payment rate from 9.2 percent in 2014 to 6.2 percent in 2015. The improper payment rate for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) also decreased from 73.8 percent in 2010 to 40.1 percent as of September 2015. Corrective actions implemented over a six-year period, including the DMEPOS Accreditation Program, contractor visits to large supplier sites, competitive bidding, and a demonstration testing prior authorization of power mobility devices, contributed to the reduction in the improper payment rate for these items and supplies.

See the full text of this excerpted [CMS blog](#) (issued November 16).

## **Comprehensive Care for Joint Replacement Model**

Hip and knee replacements are the most common inpatient surgery for Medicare beneficiaries and can require lengthy recovery and rehabilitation periods. The [Comprehensive Care for Joint Replacement \(CJR\) Model](#) addresses low quality and high costs that come from fragmentation by promoting coordinated, patient-centered care.

How the CJR Model works:

- The hospital in which the hip or knee replacement and/or other major leg procedure takes place will be accountable for the costs and quality of related care from the time of the surgery through 90 days after hospital discharge
- Depending on the hospital's quality and cost performance during the episode, the hospital will either earn a financial reward or, beginning with the second performance year, be required to repay Medicare for a portion of the spending above an established target
- By "bundling" payments for an episode of care, hospitals, physicians, and other providers have an incentive to work together to deliver more effective and efficient care
- This model is being tested in 67 geographic areas throughout the country, and nearly all hospitals in those geographic areas are required to participate

See the full text of this excerpted [CMS fact sheet](#) (issued November 16).

## **Revised 2014 Annual QRURs Available**

CMS identified issues that impacted the 2014 Annual Quality and Resource Use Reports (QRURs) released on September 8, 2015, including data submitted via Electronic Health Record (EHR) and Qualified Clinical Data Registry (QCDR), as well as a technical issue with the claims used to calculate claims-based measures. CMS corrected these issues and produced revised 2014 Annual QRURs, which are available via the [CMS Enterprise Portal](#). For a small percentage of groups, this correction resulted in a change to their Value-Based Payment Modifier calculation; these groups will receive a separate notification.

For More Information:

- [How to Obtain a QRUR](#)
- [2014 QRUR](#) website, including information on the informal review period open through November 23

- Contact the QRUR Help Desk at [pvhelpdesk@cms.hhs.gov](mailto:pvhelpdesk@cms.hhs.gov) or 888-734-6433 (select option 3)

### **2016 Value Modifier Informal Review Deadline Ends November 23**

The informal review period for the 2016 Value Modifier ends Monday. 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](mailto:pvhelpdesk@cms.hhs.gov) or 888-734-6433 (select option 3).

### **2016 PQRS Payment Adjustment: Informal Review Deadline Ends 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](mailto:qnetsupport@hcqis.org) from 7am to 7pm CT Monday through Friday.

### **Comments on Discharge to Community Quality Measure due November 23**

CMS is developing a discharge to community quality measure for skilled nursing facilities, inpatient rehabilitation facilities, long-term care hospitals, and home health agencies. As part of the measure development process, CMS is [seeking public comments](#) through November 23, 2015. For more information on the measure, see the [draft specifications](#). Email all comments to [discharge\\_to\\_community@rti.org](mailto:discharge_to_community@rti.org).

### **Considering Opting Out of Medicare to Meet the Prescriber Enrollment Requirements? — Updated**

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:

- You cannot be paid for Part A or B benefits offered by a Medicare Advantage plan, including supplementary benefits (other than emergency or urgently needed services)
- Opt out periods last for two years and cannot be terminated early unless you are opting out for the very first time and you terminate your opt out no later than 90 days after the effective date of your first opt out period

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](#) webpage.

## EHR Incentive Programs: New Public Health Reporting FAQs

On October 6, CMS released the [final rule](#) for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs. To support provider participation in 2015, CMS released two additional FAQs in response to inquiries about the public health reporting objective in 2015:

- For 2015, how should a provider report on the public health reporting objective if they had planned to be in Stage 1 meaningful use, which required sending a test message and continued submission if successful but did not require registration of intent? See [FAQ 13409](#).
- Does integration of the Prescription Drug Monitoring Program into an EHR count as a specialized registry? See [FAQ 13413](#).

## Recognizing Lung Cancer Awareness Month and the Great American Smokeout

November is Lung Cancer Awareness Month and November 19 is the Great American Smokeout®. Many smokers want to quit but have difficulty succeeding, and tobacco use is the leading cause of preventable illness and death in the United States.

November is a great time to talk to your patients about quitting and recommend appropriate Medicare-covered preventative services, including Tobacco Use Cessation Counseling and Annual Screening for Lung Cancer with Low Dose Computed Tomography for eligible beneficiaries.

For More Information:

- Medicare [Preventive Services](#) Educational Tool
- [The Great American Smokeout](#) website

## Claims, Pricers, and Codes

### ICD-10 Transition: Clarifications about NCDs and LCDs

All Medicare national and local coverage policies are translated for ICD-10, and to receive payment, providers must bill using ICD-10 codes for services rendered on or after October 1, 2015. Check the National Coverage Determination (NCD) and Local Coverage Determination (LCD) policies in the [Medicare Coverage Database](#) to find out which ICD-10 codes support medical necessity.

NCDs

CMS received stakeholder feedback on certain NCDs and provided additional clarification. See [MLN Matters® Article MM9252](#). Interim solutions are currently in place to permit appropriate claims payment. In most cases, claims were automatically reprocessed, and no action is required. A permanent systems update will be in place by January 4, 2016. Information about specific claim types and the reprocessing of claims is available on your [Medicare Administrative Contractor \(MAC\)](#) website.

#### LCDs

After implementation, some MACs identified LCDs that needed further refinements for ICD-10 diagnosis codes. Claims affected by these edits were temporarily suspended and automatically reprocessed. No action is required. Questions about specific LCDs should be directed to the appropriate [MAC](#).

See the [announcement](#) for more information.

### **CY 2013 Referring Provider DMEPOS Data — Updated**

Updated CY 2013 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) data is available on the [Medicare Provider Utilization and Payment Data: Referring DMEPOS](#) webpage:

- Referring Provider DMEPOS Public Use File (PUF) and the national/state DMEPOS HCPCS aggregate tables are updated to include the number of beneficiaries associated with supplier DMEPOS claims
- Referring Provider DMEPOS National Provider Identifier (NPI) aggregate table now includes the overall number of beneficiaries associated with supplier DMEPOS claims, as well as the number of beneficiaries within each of the sub-groups

## **Medicare Learning Network® Publications**

### **Complying with Documentation Requirements for Laboratory Services Fact Sheet — New**

A new [Complying with Documentation Requirements for Laboratory Services](#) Fact Sheet is available. Learn how to avoid improper payment for laboratory services due to insufficient documentation, as identified by the Comprehensive Error Rate Testing (CERT) Program, including:

- Examples of missing information
- Ordering/referring services
- Tips to remember to help avoid errors

### **Skilled Nursing Facility Prospective Payment System Booklet — Revised**

A revised [Skilled Nursing Facility Prospective Payment System](#) Booklet is available. Learn how facilities are paid for Skilled Nursing Facility (SNF) services, including:

- Elements of the SNF Prospective Payment System
- SNF Quality Reporting Program
- SNF Value-Based Purchasing Program

### **Product Available in an Electronic Publication Format**

A Medicare Learning Network product is available as an Electronic Publication (EPUB) and through a QR code: [DMEPOS Information for Pharmacies](#) Fact Sheet. See [instructions](#) for using these electronic formats.

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