Thursday, January 28, 2016

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MLN Connects® Events
IMPACT Act: Connecting Post-Acute Care across the Care Continuum Call — Last Chance to Register
Thursday, February 4 from 1:30 to 3 pm ET

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

The Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 requires the reporting of standardized patient assessment data by Post-Acute Care (PAC) providers, including skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and long-term care hospitals. It specifies that data elements must be standardized and interoperable to allow for the exchange and use of data among these PAC and other providers, including common standards and definitions to facilitate coordinated care and improved beneficiary outcomes. During this call, CMS subject matter experts and the Office of the National Coordinator for Health IT discuss the implications of the IMPACT Act for health information exchange across the care continuum.

For an overview of the IMPACT Act, watch the new MLN Connects video.

Agenda:
- Requirements to standardize and make interoperable post-acute care assessment data elements
- Using and exchanging clinically relevant assessment data for multiple purposes
- Health Information Technology Standards - A Primer
- CMS Data Element Library
- Electronic health information exchange

Target Audience: Providers across the care continuum, including long-term/post-acute care and home and community-based service providers, acute and primary care providers, integrated delivery systems and representatives from other payment models, health IT vendors, 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.

Other CMS Events

Special Open Door Forum: Understanding the IMPACT Act
Tuesday, February 2 from 2 to 3 pm ET

This Special Open Door Forum will provide information and solicit feedback on the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act), including measure alignment and IMPACT outcomes. See the announcement for more information.

LTCH Quality Reporting Program Webinar
Wednesday, February 3 from 1:30 pm to 4:30 pm ET

Register for the Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP) webinar to learn more about Sections GG, M, and O of the LTCH Continuity Assessment Record and Evaluation (CARE) Data Set V 3.0. Providers should review the training materials from the November 2015 LTCH QRP training prior to this webinar.
Physician Compare Public Reporting Information Sessions

Interested in learning more about the future of public reporting on Physician Compare and how it will affect you? CMS will host public reporting information sessions about recent updates to the Physician Compare website and future plans for public reporting, including a publicly reported benchmark and star ratings (80 FR 71128-71129). Each one-hour webinar will offer stakeholders an opportunity to ask questions about public reporting and quality measures on Physician Compare. All sessions will present the same information. Register for a session:

- Tuesday, February 23 at 12 pm ET
- Wednesday, February 24 at 4 pm ET
- Thursday, February 25 at 11 am ET

Medicare Learning Network® Publications and Multimedia

CMS Provider Minute: Duplicate Professional Claims Video — New

This video includes helpful pointers to avoid duplicate professional claims. This is the second in a series of Medicare Compliance Videos.

Medicare Advance Beneficiary Notices Booklet — Revised

A revised Medicare Advance Beneficiary Notices Booklet is available. Learn about:

- Types of Advance Beneficiary Notices (ABNs)
- Prohibitions and frequency limits
- Completing the ABN
- Collecting payment from the beneficiary
- Financial liability and the ABN
- Claim reporting modifiers

Skilled Nursing Facility Billing Reference Fact Sheet — Revised

A revised Skilled Nursing Facility (SNF) Billing Reference Fact Sheet is available. Learn about SNF:

- Coverage
- Payment
- Billing requirements

Suite of Products & Resources for Billers & Coders Educational Tool — Revised

A revised Suite of Products & Resources for Billers & Coders Educational Tool is available. Learn about:

- Claims submission
- Federal initiatives and incentive program
Suite of Products & Resources for Compliance Officers Educational Tool — Revised

A revised Suite of Products & Resources for Compliance Officers Educational Tool is available. Learn about:

- General compliance guidelines
- The claims submission process
- Initiatives and incentives

Suite of Products & Resources for Educators & Students Educational Tool — Revised

A revised Suite of Products & Resources for Educators & Students Educational Tool is available. Learn about:

- Federal health care programs and how they work
- Medicare program resources

Suite of Products & Resources for Inpatient Hospitals Educational Tool — Revised

A revised Suite of Products & Resources for Inpatient Hospitals Educational Tool is available. Learn about:

- The claims process submission process
- Payment systems and fee schedules

Updated MLN Matters® Search Indices

Updated MLN Matters Articles search indices are available in the “Downloads” section of the MLN Matters Articles webpage. Search the lists by specific keywords and topics. You can also search the MLN Matters archive by year on the left side of the webpage. Subscribe to the electronic mailing list to find out when new and revised MLN Matters articles are released.

New Educational Web Guides Fast Fact

A new fast fact is available on the Educational Web Guides webpage. Learn about:

- Evaluation and Management services
- Guided Pathways resource booklets
- Health care management, billing, and coding products

Announcements

CMS Releases Guide to Preventing Readmissions among Racially and Ethnically Diverse Medicare Beneficiaries

On January 26, the CMS Office of Minority Health released a new Guide to Preventing Readmissions among Racially and Ethnically Diverse Medicare Beneficiaries, as part of the CMS Equity Plan for Improving Quality in Medicare. The guide is designed to assist hospital leaders and stakeholders focused on quality, safety, and care redesign in identifying root causes and solutions for preventing avoidable readmissions among racially and ethnically diverse Medicare beneficiaries.
Racial and ethnic minority populations are more likely than their white counterparts to be readmitted within 30 days of discharge for certain chronic conditions, such as heart failure, heart attack, and pneumonia, among others. Social, cultural, and linguistic barriers contribute to these higher readmission rates. The Guide provides:

- New, action-oriented guidance for addressing avoidable readmissions in this population by providing an overview of the issues related to readmissions for diverse Medicare beneficiaries
- A set of seven key recommendations that hospital leaders can take to prevent avoidable readmissions in this population
- Concrete examples of initiatives and strategies that may be applied to reduce readmissions in diverse populations

See the full text of this excerpted CMS press release (issued January 26).

**PQRS: Submission Timeframes for 2015 Data**

Eligible Professionals who do not satisfactorily report quality measure data to meet the 2015 Physician Quality Reporting System (PQRS) requirements will be subject to a negative PQRS payment adjustment on all Medicare Part B physician fee schedule services for 2017. Submissions end at 8 pm ET:

- Electronic Health Record direct or data submission vendor (QRDA I or III) – January 1 through February 29, 2016
- Qualified clinical data registries (QCDRs) (QRDA III) – January 1 through February 29, 2016
- Group practice reporting option web interface – January 18 through March 11, 2016
- Qualified registries (Registry XML) – January 1 through March 31, 2016
- QCDRs (QCDR XML) – January 1 through March 31, 2016

An Enterprise Identity Management (EIDM) account with the Submitter Role is required for these PQRS data submission methods. See the EIDM System Toolkit for additional information. For questions, contact the QualityNet Help Desk at 866-288-8912 or Qnetsupport@hcqis.org from 7am to 7 pm CT. Complete information is available on the PQRS website.

**Comment Period for IMPACT Act Measures Extended to January 29**

The public comment period for “Medicare Spending Per Beneficiary – Post-Acute Care (MSPB-PAC) Resource Use Measures” has been extended to January 29. CMS encourages interested parties to submit comments on these draft measures mandated by the Improving Post-Acute Care Medicare Transformation Act of 2014 (IMPACT Act). We ask that stakeholders provide comments regarding the overall episode construction methodology, exclusions, and the risk adjustment approach. We are also interested in stakeholders’ comments on the treatment of episodes with hospice. Information on this measure is available on the public comment website. Send your comments to mspb-pac-measures-support@acumenllc.com by 11:59pm ET on Friday, January 29, 2016.

**PQRS: Self-Nomination for 2016 Qualified Registries and QCDRs Open through January 31**

Entities interested in becoming a Physician Quality Reporting System (PQRS) qualified registry or Qualified Clinical Data Registry (QCDR) for 2016 must submit a self-nomination to CMS using a self-nomination form prior to 5 pm ET on January 31, 2016.
CMS to Release a Comparative Billing Report on Modifier 25: Internal Medicine in February

CMS will issue a national provider Comparative Billing Report (CBR) in February 2016 on internal medicine physicians’ use of modifier 25. The CBR, produced by CMS contractor eGlobalTech, will focus on internal medicine physicians who submitted claims for established patient Evaluation and Management (E/M) services appended with modifier 25. The CBR will contain data-driven tables 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.

CBRs are only accessible to the providers who receive them; they are not publicly available. Providers should update their fax numbers in the Medicare Provider Enrollment, Chain, and Ownership System (PECOS) because faxing is the default method for disseminating the reports. Contact the CBR Support Help Desk at 800-771-4430 or CBRsupport@eglobaltech.com with questions or to receive CBRs through the U.S. Postal Service. For more information, visit the CBR website.

CMS Seeks Public Comments on Draft Quality Measure Development Plan by March 1

CMS is soliciting comments on the Draft Quality Measure Development Plan (MDP) through March 1, 2016. The MDP, as mandated by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), builds on our efforts to shift Medicare payments from volume to value. After taking all public comments, CMS will post the Final MDP on the CMS website by May 1, 2016.

For More Information:
- Blog: CMS Quality Measure Development Plan Supporting the Transition to the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs)
- MIPS and APMs webpage

Prior Authorization for Certain DMEPOS Items: FAQs on the Final Rule

On December 29, CMS issued a final rule that establishes a prior authorization process for certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) items that are frequently subject to unnecessary utilization. This process assures that all Medicare coverage, coding, and clinical documentation requirements are met before the item is furnished to the beneficiary and before the claim is submitted for payment. See the new Frequently Asked Questions and the CMS Fact Sheet (issued December 29) for more information.
Have you accessed your Program for Evaluating Payment Patterns Electronic Report (PEPPER)? PEPPERs are available for Skilled Nursing Facilities (SNFs), Home Health Agencies (HHAs), hospices, Critical Access Hospitals (CAHs), Long-Term Care Hospitals (LTCHs), Inpatient Psychiatric Facilities (IPFs), Inpatient Rehabilitation Facilities (IRFs), and Partial Hospitalization Programs (PHPs). CMS contracts with TMF to produce and distribute these comparative billing reports that summarize Medicare claims data to help providers identify and prevent improper Medicare payments.

The following providers can access their PEPPER electronically through the PEPPER Resources Portal:
- LTCHs
- Free-standing IRFs (not a unit of a short-term acute care hospital)
- Hospices
- PHPs not associated with a short-term acute care hospital or with an IPF
- SNFs that are not a swing-bed unit of a short-term acute care hospital
- HHAs

Other providers received their PEPPER in April 2015 through a QualityNet secure file exchange to users with the PEPPER recipient role:
- CAHs
- IPFs
- IRF distinct part units of a short-term acute care hospital
- PHPs administered by a short-term acute care hospital or an IPF
- SNF swing-bed units of a short-term acute care hospital

For more information and to access resources, including the user’s guide, recorded training sessions, information about QualityNet accounts, frequently asked questions, and examples of how other hospitals are using PEPPER, visit PEPPERresources.org. If you have questions or need help obtaining your report, visit the Help Desk. Send us your feedback or suggestions.

Payment for Group 3 Power Wheelchair Cushions and Accessories

Under Section 2 of the Patient Access and Medicare Protection Act (PAMPA), 2016 Medicare fee schedule amounts for Group 3 power wheelchair accessories and cushions cannot be adjusted based on information from competitive bidding programs. Although this change was effective January 1, 2016, Medicare claims processing systems cannot be updated any sooner than July 1, 2016. More information on this change is available on the Durable Medical Equipment Center webpage.

Changes to the Medicare EHR Incentive Program Hardship Exception Process

CMS posted new, streamlined hardship applications on the Payment Adjustments and Hardship Information webpage, reducing the amount of information that eligible professionals, eligible hospitals, and Critical Access Hospitals (CAHs) must submit to apply for an exception from the 2017 payment adjustment. Application timeline:
- Eligible Professionals: March 15, 2016
- Eligible Hospitals and CAHs: April 1, 2016
Groups of providers may apply for a hardship exception on a single application. Under the group application, multiple providers and provider types may apply together using a single submission. The hardship exception categories are the same as those applicable for the individual provider application.

**Testing QRDA I Release 2 and QRDA III Release 1 Files**

The Submission Engine Validation Tool (SEVT) located on the [Physician and Other Health Care Professionals Quality Reporting Portal](https://physicianportal.cms.gov) is updated and includes changes to the Quality Reporting Document Architecture (QRDA) Category I, Release 2 and Electronic Health Record (EHR) QRDA Category 3, Release 1 requirements for 2015 submission. CMS encourages you to retest your files prior to the submission period.

**Resources:**


**Claims, Pricers, and Codes**

**New Drug Testing Laboratory Codes Editing Incorrectly**

CMS discovered systems errors affecting claims with new drug testing laboratory codes (HCPCS codes G0477 through G0483) with dates of service on or after January 1, 2016. Your Medicare Administrative Contractor (MAC) will be holding these claims until April 4, 2016. No provider action is required. However, should you wish to avoid your claims from being held, you can remove codes G0477 through G0483 and submit the rest of the services on the claim. When the system is updated in April, you can submit an adjustment claim to add these HCPCS codes. Your MAC will correct any claims previously returned to you in error with these codes and reason code W7006 after the system is updated.

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