

Thursday, March 3, 2016

MLN Connects[®] Events

Medicare Shared Savings Program Listening Session: Proposed Rule on Revised Benchmark Rebasing Methodology— Reminder

Medicare Learning Network[®] Publications and Multimedia

Provider Enrollment Revalidation: Cycle 2 MLN Matters[®] Article — New
CMS Quality Conference 2015: Industry Leaders Discuss IMPACT Act Video — New
CMS Provider Minute: Multiple Same Day Surgeries and Modifier 51 Video — New
Home Health Prospective Payment System Booklet — Revised
Suite of Products & Resources for Rural Health Providers Educational Tool — Revised
DMEPOS Quality Standards Booklet — Reminder

Announcements

Major Commitments from Healthcare Industry to Make Electronic Health Records Work Better
Program Integrity Enhancements to the Provider Enrollment Process
CMS to Release a Comparative Billing Report on Non-invasive Vascular Studies in March
EHR Incentive Program Hardship Application Deadline Extended to July 1
EHR Incentive Programs: FAQs on Public Health Reporting Requirements
ICD-10 Next Steps Toolkit
Antipsychotic Drug use in Nursing Homes: Trend Update
“Savor the Flavor of Eating Right” During National Nutrition Month[®] and Beyond

Claims, Pricers, and Codes

Mandatory Payment Reduction of 2% Continues until Further Notice for the Medicare FFS Program – “Sequestration”

MLN Connects[®] Events

Medicare Shared Savings Program Listening Session: Proposed Rule on Revised Benchmark Rebasing Methodology— Reminder

Thursday, March 3 from 2 to 3:30 pm

To Participate: Visit the [March 3](#) call webpage for instructions.

This listening session is an opportunity for CMS to receive early feedback from stakeholders on proposed policy changes to the Medicare Shared Savings Program. Participants are encouraged to review the proposed rule ([CMS-1644-P](#)) prior to the listening session.

Feedback received during the listening session will not be considered formal comments on the rule. See the proposed rule for information on submitting these comments by the close of the 60-day comment period on March 28, 2016 at 5 pm ET.

Agenda:

- Introduction to the proposed policy changes
- Feedback on proposed revisions to the benchmarking methodology: Proposals for incorporating regional Fee-For-Service (FFS) expenditures into the methodology for resetting the Accountable Care Organization's (ACO's) historical benchmark and proposals for a streamlined approach to adjusting the ACO's benchmark for changes in its composition of ACO participants
- Feedback on other proposed revisions, including an additional option to facilitate ACOs' transition to performance-based risk and administrative finality of financial calculations

Target Audience: Medicare FFS providers; ACOs currently participating in the Medicare Shared Savings Program and organizations considering applying to the program; state and national associations that represent healthcare providers and ACOs; and other stakeholders.

Medicare Learning Network® Publications and Multimedia

Provider Enrollment Revalidation: Cycle 2 MLN Matters® Article — New

An MLN Matters Special Edition Article on [Provider Enrollment Revalidation – Cycle 2](#) is available. Learn about the second round of revalidations required by the Affordable Care Act and 42 CFR §424.515.

CMS Quality Conference 2015: Industry Leaders Discuss IMPACT Act Video — New

This [MLN Connects video](#) features segments from the December 2015 CMS Quality Conference in Baltimore. Industry leaders share their thoughts on the relevance and importance of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act in today's health care delivery system for Post-Acute Care (PAC), including:

- Keynote presentation by Kate Goodrich, MD, Director of the Center for Clinical Standards and Quality
- Achieving Data Standardization across PAC Settings by Tara McMullen, PhD, MPH, Health Analyst for the Division of Chronic and Post-Acute Care
- Interviews with industry leaders

CMS Provider Minute: Multiple Same Day Surgeries and Modifier 51 Video — New

This [video](#) includes helpful pointers to avoid receiving improper payments when modifiers are applied incorrectly. This is the third in a series of Medicare Compliance Videos.

Home Health Prospective Payment System Booklet — Revised

A revised [Home Health Prospective Payment System](#) Booklet is available. Learn about:

- Home Health Prospective Payment System (HH PPS) background

- Consolidated billing requirements
- Criteria that must be met to qualify for home health services
- Therapy services
- Elements of and updates to the HH PPS
- Billing and payment for home health services
- Home Health Quality Reporting Program

Suite of Products & Resources for Rural Health Providers Educational Tool — Revised

A revised [Medicare Learning Network Suite of Products & Resources for Rural Health Providers Educational Tool](#) is available. Learn about publications and resources available for the unique information needs of the rural health community.

DMEPOS Quality Standards Booklet — Reminder

The [DMEPOS Quality Standards](#) Booklet is available. Learn about:

- Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) quality standards for suppliers
- Accreditation organizations
- Business service requirements
- Product-specific service requirements

Announcements

Major Commitments from Healthcare Industry to Make Electronic Health Records Work Better

On February 29, HHS Secretary Sylvia M. Burwell announced that companies that provide 90 percent of electronic health records used by U.S. hospitals, the nation's five largest private healthcare systems, and more than a dozen leading professional associations and stakeholder groups have pledged to implement three core commitments that will improve the flow of health information to consumers and healthcare providers:

- **Consumer Access:** To help consumers easily and securely access their electronic health information, direct it to any desired location, learn how their information can be shared and used, and be assured that this information will be effectively and safely used to benefit their health and that of their community
- **No Information Blocking:** To help providers share individuals' health information for care with other providers and their patients whenever permitted by law and not block electronic health information
- **Standards:** Implement federally recognized, national interoperability standards, policies, guidance, and practices for electronic health information and adopt best practices, including those related to privacy and security

For More Information:

- [Fact Sheet](#)
- [List of individual organizations](#) that have made commitments and their pledges
- [Federal Health IT Strategic Plan 2015-2020](#)
- [Connecting Health and Care for the Nation: A Shared Nationwide Interoperability Roadmap](#)

See the full text of this excerpted [HHS press release](#) (issued February 29).

Program Integrity Enhancements to the Provider Enrollment Process

CMS is [proposing new regulations](#) that implement additional provider enrollment provisions of the Affordable Care Act to help make certain that entities and individuals who pose risks to the Medicare program and beneficiaries are kept out of or removed from Medicare for extended periods. These enhancements, if finalized, would allow CMS to take action to remove or prevent the enrollment of health care providers and suppliers that attempt to circumvent Medicare's enrollment requirements. The proposed provisions will also address other program integrity issues and vulnerabilities.

Major Provisions:

- Disclosure of affiliations
- Different name, numerical identifier, or business identity
- Abusive ordering/certifying
- Increasing Medicare Program re-enrollment bars
- Other public program termination
- Expansion of ordering/certifying requirements

See the full text of this excerpted [CMS fact sheet](#) (issued February 25).

CMS to Release a Comparative Billing Report on Non-invasive Vascular Studies in March

CMS will issue a national provider Comparative Billing Report (CBR) on Non-invasive Vascular Studies in March 2016. The CBR, produced by CMS contractor eGlobalTech, will focus on duplex scans of the extracranial arteries, lower extremity arteries, or extremity veins billed by providers of all specialties, except radiology. CBRs 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.

EHR Incentive Program Hardship Application Deadline Extended to July 1

CMS extended the hardship application deadline for the Medicare Electronic Health Record (EHR) Incentive Program to July 1, 2016. Eligible professionals, eligible hospitals, and critical access hospitals will have time to submit their applications to avoid adjustments to their Medicare payments in 2017. In January, CMS posted new, streamlined hardship exception application forms on the [Payment Adjustments and Hardship Information](#) webpage.

EHR Incentive Programs: FAQs on Public Health Reporting Requirements

CMS has new FAQs about the public health reporting objective for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs:

- Can a provider register their intent after the first 60 days of the reporting period in order to meet the measures if a registry becomes available after that date? See [FAQ #14393](#).
- What should a provider do in 2016 if they did not previously intend to report to a public health reporting measure that was previously a menu measure in Stage 2 and they do not have the necessary software in CEHRT or the interface the registry requires available in their health IT systems? What if the software is potentially available but there is a significant cost to connect to the interface? See [FAQ #14397](#).
- For 2016, what alternate exclusions are available for the public health reporting objective? Is there an alternate exclusion available to accommodate the changes to how the measures are counted? See [FAQ #14401](#).

Updated FAQs:

- What steps does a provider have to take to determine if there is a specialized registry available for them, or if they should instead claim an exclusion? See [FAQ #13657](#).
- What steps do eligible hospitals and Critical Access Hospitals (CAHs) need to take to meet the specialized registry objective? Is it different from eligible professionals? See [FAQ #14117](#).
- What can count as a specialized registry? See [FAQ #13653](#).

For More Information:

- [EHR Incentive Programs](#) website
- [Eligible Professionals: Public Health Reporting in 2015](#) Fact Sheet
- [Eligible Hospitals/CAHs: Public Health Reporting in 2015](#) Fact Sheet
- [EHR Incentive Program FAQs](#)

ICD-10 Next Steps Toolkit

CMS released the [Next Steps Toolkit](#) to help providers track and improve ICD-10 progress with information and resources on how to:

- Assess ICD-10 progress using key performance indicators to identify potential productivity or cash flow issues
- Address opportunities for improvement
- Maintain progress and keep up-to-date on ICD-10

Visit the [ICD-10](#) website and [Roadto10.org](#) for the latest news and official resources, including the [ICD-10 Quick Start Guide](#), and a [contact list for provider Medicare and Medicaid questions](#).

Antipsychotic Drug use in Nursing Homes: Trend Update

CMS is [tracking the progress](#) of the National Partnership to Improve Dementia Care in Nursing Homes by reviewing publicly reported measures. The official measure of the Partnership is the percentage of long-stay nursing home residents who receive an antipsychotic medication, excluding those residents diagnosed with schizophrenia, Huntington's disease or Tourette's syndrome. In the fourth quarter of 2011, 23.9% of long-stay nursing home residents received an antipsychotic medication. Since then, there has been a decrease of 27% to a national prevalence of 17.4% in the

third quarter of 2015. Success varies by state and CMS region, with some states and regions seeing a reduction greater than 25%.

For More Information:

- Register for the April 28 [MLN Connects National Provider Call](#)
- Visit the [National Partnership](#) webpage
- Send correspondence to dnh_behavioralhealth@cms.hhs.gov.

“Savor the Flavor of Eating Right” During National Nutrition Month® and Beyond

March is National Nutrition Month - a time to “Savor the Flavor of Eating Right” with informed food choices now and throughout the year. Nutrition-related health conditions, including diabetes, chronic kidney disease, and obesity affect the Medicare population. Encourage your patients to adopt a healthy lifestyle and take advantage of appropriate Medicare-covered preventive services:

- Medical Nutrition Therapy
- Diabetes Screening
- Diabetes Self-management Training
- Intensive Behavioral Therapy for Obesity
- Intensive Behavioral Therapy for Cardiovascular Disease
- Annual Wellness Visit

For More Information:

- [Medicare Preventive Services](#) Educational Tool
- [National Nutrition Month](#) website
- [National Diabetes Education Program](#) website
- [National Kidney Disease Education Program](#) website
- [Million Hearts®](#) website
- [Find a registered dietitian nutritionist](#)

Visit the [Preventive Services](#) website to learn more about Medicare-covered services.

Claims, Pricers, and Codes

Mandatory Payment Reduction of 2% Continues until Further Notice for the Medicare FFS Program – “Sequestration”

Medicare Fee-For-Service (FFS) claims with dates-of-service or dates-of-discharge on or after April 1, 2013, will continue to incur a 2 percent reduction in Medicare payment until further notice. Claims for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), including claims under the DMEPOS Competitive Bidding Program, will continue to be reduced by 2 percent based upon whether the date-of-service, or the start date for rental equipment or multi-day supplies, is on or after April 1, 2013. The claims payment adjustment will continue to be applied to all claims after determining coinsurance, any applicable deductible, and any applicable Medicare Secondary Payment adjustments. Though beneficiary payments for deductibles and coinsurance are not subject to the 2 percent payment reduction, Medicare’s payment to beneficiaries for unassigned claims is subject to the 2 percent reduction. CMS encourages Medicare physicians, practitioners, and suppliers who bill claims on an unassigned basis to continue discussions with beneficiaries on the impact of sequestration on Medicare’s

reimbursement. Questions about reimbursement should be directed to your [Medicare Administrative Contractor](#).

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