

Thursday, May 5, 2016

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Claims, Pricers, and Codes

Reprocessing of Selected Dialysis Claims

MLN Connects[®] Events

MACRA Listening Session: Quality Payment Program Proposed Rule — Register Now

Tuesday, May 10 from 2 to 3:30 pm ET

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

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) changes the way Medicare rewards clinicians for providing quality care by streamlining multiple quality programs into a new Quality Payment Program tied to Part B Fee-For-Service payments. With the implementation of MACRA and the replacement of the Sustainable Growth Rate, we will pay clinicians participating in the Merit-based Incentive Payment System or Advanced Alternative Payment Models of the Quality Payment Program beginning in 2019.

This listening session is an opportunity for stakeholders to learn about the proposed policy for the Quality Payment Program. We encourage participants to review the proposed rule ([CMS-5517-P](#)) prior to the listening session.

If time allows, we will open the lines for feedback. We will not consider feedback during the call as 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 June 27, 2016.

Target Audience: Part B Fee-For-Service clinicians; state and national associations that represent health care providers; and other stakeholders.

Continuing education credit may be awarded for participation in certain MLN Connects Calls. Visit the [Continuing Education Credit Information](#) webpage to learn more.

2015 Mid-Year QRURs Webcast — Register Now

Thursday, May 19 from 1:30 to 3 pm ET

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

This event gives an overview of the 2015 Mid-Year Quality and Resource Use Reports (MYQRURs) and explains how to interpret and use the information. A question and answer session will follow the presentation.

The 2015 MYQRURs were recently released to groups and solo practitioners nationwide. These reports are for informational purposes only and contain interim information on a subset of the quality and cost measures used to calculate the 2017 Value Modifier (VM).

- Learn more on the [2015 QRUR and 2017 VM](#) webpage
- Visit the [How to Obtain a QRUR](#) webpage and access your report prior to the event, so you can follow along.

CMS will use webcast technology for this event with audio streamed through your computer. Please note: if you are unable to stream audio through your computer, phone lines are available.

Target Audience: Physicians, practitioners, medical group practices, practice managers, medical and specialty societies, payers, and insurers.

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

New Audio Recordings and Transcripts Available

Audio recordings and transcripts are available for the following events:

- April 19 — [Medicare Shared Savings Program ACO Application Process](#) Call: [audio recording](#) and [transcript](#). CMS subject matter experts cover helpful tips to complete a successful application for the Medicare Shared Savings Program Accountable Care Organization (ACO).
- April 21 — [2016 PQRS Reporting: Avoiding 2018 Negative Payment Adjustments](#) Call: [audio recording](#) and [transcript](#). The presentation covers guidance and instructions on how individual eligible professionals and Physician Quality Reporting System (PQRS) group practices can get

started, satisfactorily report/participate, and avoid the 2018 PQRS negative payment adjustment.

Medicare Learning Network® Publications and Multimedia

Medicare Coverage of Substance Abuse Services MLN Matters® Article — New

An MLN Matters Special Edition Article on [Medicare Coverage of Substance Abuse Services](#) is available. Learn about:

- Services for substance abuse disorders available under Medicare
- Medicare information about substance abuse disorders available online

Medicare Policy Clarified for Prolonged Drug and Biological Infusions Started Incident to a Physician's Service Using an External Pump MLN Matters Article — New

An MLN Matters Special Edition Article on [Medicare Policy Clarified for Prolonged Drug and Biological Infusions Started Incident to a Physician's Service Using an External Pump](#) is available. Learn about payment for prolonged drug and biological infusions.

Announcements

CMS Releases NPRM on the Medicare Access and CHIP Reauthorization Act of 2015

On April 27, CMS released a Notice of Proposed Rulemaking ([NPRM](#)) for the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Supported by a bipartisan majority and stakeholders, such as patient and medical associations, the MACRA legislation ended more than a decade of last-minute fixes and potential payment cliffs for Medicare doctors and clinicians. It also made numerous improvements to America's health care system.

Proposed MACRA Requirements:

Currently, Medicare measures the value and quality that physicians and other clinicians provide through a patchwork of programs. In the MACRA legislation, Congress streamlined these programs into a single framework to help clinicians transition to payments based on value from payments based on volume. The proposed rule would implement changes through this unified framework known as the Quality Payment Program, which includes two paths:

The Merit-based Incentive Payment System (MIPS): Most Medicare clinicians will initially participate in the Quality Payment Program through MIPS. MIPS allows Medicare clinicians to be paid for providing high value care through success in four performance categories:

- Quality (50 percent of total score in year 1)
- Advancing Care Information (25 percent of total score in year 1)
- Clinical Practice Improvement Activities (15 percent of total score in year 1)
- Resource Use (10 percent of total score in year 1)

Advanced Alternative Payment Models (APMs): Clinicians who take a further step toward care transformation would be exempt from MIPS reporting requirements and qualify for financial bonuses. These models include:

- Comprehensive ESRD Care Model (Large Dialysis Organization arrangement)

- Comprehensive Primary Care Plus (CPC+)
- Medicare Shared Savings Program – Track 2
- Medicare Shared Savings Program – Track 3
- Next Generation Accountable Care Organization Model
- Oncology Care Model Two-Sided Risk Arrangement (available in 2018)

You can submit comments using one of the four methods in the [rule](#) until June 27.

For More Information:

- [HHS press release](#)
- [Quality Payment Program Fact Sheet](#)
- [Advancing Care Information](#)

DMEPOS Competitive Bidding: Round 2 Recompete/ National Mail-Order Recompete Contract Suppliers Announced

On April 28, CMS announced the Round 2 Recompete and national mail-order recompete contract suppliers for Medicare’s Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. These contracts will begin on July 1. View the CMS [fact sheet](#) for additional information.

CMS Adds New Quality Measures to Nursing Home Compare

Largest addition of quality measures to Nursing Home Compare since 2003

On April 27, CMS added six new quality measures to the [Nursing Home Compare](#) website:

- Percentage of short-stay residents who were successfully discharged to the community (claims-based)
- Percentage of short-stay residents who have had an outpatient emergency department visit (claims-based)
- Percentage of short-stay residents who were re-hospitalized after a nursing home admission (claims-based)
- Percentage of short-stay residents who made improvements in function (MDS-based)
- Percentage of long-stay residents whose ability to move independently worsened (MDS-based)
- Percentage of long-stay residents who received an antianxiety or hypnotic medication (MDS-based)

CMS is nearly doubling the number of short-stay measures on Nursing Home Compare, which reflect care provided to residents who are in the nursing home for 100 days or less. CMS is also providing information about key short-stay outcomes, including the percentage of residents who are successfully discharged and the rate of activities of daily life improvement among short-stay residents. Beginning in July 2016, CMS will incorporate all of these measures, except for the antianxiety/hypnotic medication measure, into the calculation of the Nursing Home Five-Star Quality Ratings. CMS now reports information on 24 quality measures for 15,655 nursing home providers on Nursing Home Compare. For more information, see the [fact sheet](#).

See the full text of this excerpted [CMS press release](#) (issued April 27).

CMS Publishes Final Rule on Fire Safety Requirements for Certain Health Care Facilities

CMS announced a [final rule](#) to update health care facilities' fire protection guidelines to improve protections for all Medicare beneficiaries in facilities from fire. The new guidelines apply to hospitals; Long-Term Care (LTC) facilities; critical access hospitals; inpatient hospice facilities; programs for all inclusive care for the elderly; religious non-medical healthcare institutions; Ambulatory Surgical Centers (ASCs); and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID). This rule adopts updated provisions of the National Fire Protection Association's (NFPA) 2012 edition of the Life Safety Code, as well as provisions of the NFPA's 2012 edition of the Health Care Facilities Code.

The provisions in this final rule cover construction, protection, and operational features designed to provide safety for Medicare beneficiaries from fire, smoke, and panic. Some of the main requirements include:

- Health care facilities located in buildings that are taller than 75 feet are required to install automatic sprinkler systems within 12 years after the rule's effective date
- Health care facilities are required to have a fire watch or building evacuation if their sprinkler systems is out of service for more than ten hours
- The provisions offer LTC facilities greater flexibility in what they can place in corridors
- Fireplaces will be permitted in smoke compartments without a one hour fire wall rating
- Cooking facilities now may have an opening to the hallway corridor
- For ASCs, all doors to hazardous areas must be self-closing or must close automatically
- Expanded sprinkler requirements for ICF-IIDs

Health care providers affected by this rule must comply with all regulations within 60 days of the May 4 publication date, unless otherwise specified in the final rule.

See the full text of this excerpted [CMS press release](#) (issued May 3).

CMS Finalizes its Quality Measure Development Plan

On May 2, CMS posted the final [Quality Measure Development Plan: Supporting the Transition to the Merit-based Incentive Payment System \(MIPS\) and Alternative Payment Models \(APMs\)](#). CMS aims to drive improvement in our national health care system through the use of quality measures and periodic assessment of the impact of such measurement. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) established payment incentives for physicians and other clinicians based on quality, rather than quantity, of care. Successful implementation of the [Quality Payment Program](#) established by MACRA requires a partnership with patients, their families, frontline clinicians, and professional organizations to develop measures that are meaningful, applicable, and useful across payers and health care settings.

See the full text of this excerpted [CMS blog](#) (issued May 2).

2017 Medicare Shared Savings Program: Notice of Intent to Apply Period Closes May 31

The Medicare Shared Savings Program [Notice of Intent to Apply](#) (NOIA) period is open for the January 1, 2017, program start date. The NOIA is available for:

- Accountable Care Organizations (ACOs) not currently participating in the program (initial applicants)

- Currently participating ACOs with a 2014 start date intending to renew their agreement (renewing applicants)
- Currently participating ACOs in or applying to the program under Track 3 (two-sided risk model) that intend to apply for the Skilled Nursing Facility (SNF) 3-Day Waiver

The NOIA period closes at 5 pm ET on May 31. If you intend to apply to the Medicare Shared Savings Program and/or the SNF 3-Day Waiver for 2017, you must submit an NOIA. An NOIA submission does not bind your organization to submit an application.

Plan to apply?

Submit form CMS-20037 (Application for Access to CMS Computer Systems) to obtain your CMS User ID as soon as possible using the link and instructions provided in your NOIA confirmation email. The final deadline is Friday, June 3. Mail your completed form to CMS via tracked mail (FedEx, UPS, etc.) to: Attention: HPMS Access, Centers for Medicare & Medicaid Services, 7500 Security Blvd, Mailstop C4-18-13, Baltimore, MD 21244.

For information on the NOIA submission and application process, visit the [How to Apply](#) webpage and see Step 1.

New PEPPERs Available for Hospices, SNFs, IRFs, IPFs, CAHs, LTCHs

Fourth quarter FY 2015 Program for Evaluating Payment Patterns Electronic Reports (PEPPERs) are available for hospices, Skilled Nursing Facilities (SNFs), Inpatient Rehabilitation Facilities (IRFs), Inpatient Psychiatric Facilities (IPFs), Critical Access Hospitals (CAHs), and Long-Term Care Hospitals (LTCHs). PEPPERs are distributed by TMF® Health Quality Institute under contract with CMS. These reports summarize provider-specific data statistics for Medicare services that may be at risk for improper payments. Providers can use the data to support internal auditing and monitoring activities.

Hospices, LTCHs and free-standing SNFs and IRFs: For instructions on obtaining your PEPPER, see the [Secure PEPPER Access Guide](#). CAHs, IPFs, and SNF and IRF units of hospitals: PEPPER was distributed via the QualityNet secure portal.

For more information, including guides, 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](#).

CMS to Release a CBR on Podiatry: Nail Debridement and E/M Services in May

CMS will issue a national provider Comparative Billing Report (CBR) on Podiatry: Nail Debridement and Evaluation and Management (E/M) Services in May 2016. The CBR, produced by CMS contractor eGlobalTech, focuses on providers with a specialty of podiatry who bill for nail debridement and E/M services rendered in an office setting. 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.

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 by mail. For more information, visit the [CBR](#) website.

Focusing on Women's Health

National Women's Health Week begins on Mother's Day, May 8, and National Women's Check-up Day is May 9. The goal of these observances is to empower women to make their health a priority. Help your Medicare patients understand the steps they can take to improve their health and recommend appropriate preventive services.

For More Information:

- [Medicare Preventive Services](#) Educational Tool
- [National Women's Health Week](#) webpage
- [Centers for Disease Control and Prevention Women's Health](#) website

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

Claims, Pricers, and Codes

Reprocessing of Selected Dialysis Claims

Dialysis claims with dates of service prior to October 1, 2015, which include screening for sexually transmitted infections, are being denied in full instead of at the line level. Medicare Administrative Contractors are updating their systems to correct this problem and will reprocess denied claims (72X type of bill; HCPCS code 86631, 86632, 87110, 87270, 87320, 87490, 87491, 87800, 87810, 87590, 87591, 87850, 86592, 86593, 86780, 87340, or 87341; diagnosis code V74.5 or V73.89).

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