

Thursday, October 6, 2016

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News & Announcements

CMS Finalizes Improvements in Care, Safety, and Consumer Protections for Long-Term Care Facility Residents

On September 28, CMS issued a final rule to make major changes to improve the care and safety of the nearly 1.5 million residents in the more than 15,000 long-term care facilities that participate in the Medicare and Medicaid programs. The policies in this final rule are targeted at reducing unnecessary

hospital readmissions and infections, improving the quality of care, and strengthening safety measures for residents in these facilities.

Changes finalized in this rule include:

- Strengthening the rights of long-term care facility residents, including prohibiting the use of pre-dispute binding arbitration agreements
- Ensuring that long-term care facility staff members are properly trained on caring for residents with dementia and in preventing elder abuse
- Ensuring that long-term care facilities take into consideration the health of residents when making decisions on the kinds and levels of staffing a facility needs to properly take care of its residents
- Ensuring that staff members have the right skill sets and competencies to provide person-centered care to residents
- Improving care planning, including discharge planning for all residents with involvement of the facility's interdisciplinary team and consideration of the caregiver's capacity, giving residents information they need for follow-up after discharge, and ensuring that instructions are transmitted to any receiving facilities or services
- Allowing dietitians and therapy providers the authority to write orders in their areas of expertise when a physician delegates the responsibility and state licensing laws allow
- Updating the long-term care facility's infection prevention and control program, including requiring an infection prevention and control officer and an antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use

For More Information:

- [Final Rule](#)
- [Commitment to Person-Centered Care for Long-Term Care Facility Residents](#) Blog

See the full text of this excerpted [CMS press release](#) (issued September 28).

CMS Awards \$347 Million to Continue Progress toward a Safer Health Care System

CMS awarded \$347 million to 16 national, regional, or state hospital associations, Quality Improvement Organizations, and health system organizations to continue efforts in reducing hospital-acquired conditions and readmissions in the Medicare program. The Hospital Improvement and Innovation Network contracts build upon the collective momentum of the Hospital Engagement Networks and Quality Improvement Organizations to reduce patient harm and readmissions.

Through 2019, these Hospital Improvement and Innovation Networks will work to achieve a 20 percent decrease in overall patient harm and a 12 percent reduction in 30-day hospital readmissions as a population-based measure from the 2014 baseline. Hospital Improvement and Innovation Networks will also work to expand and develop learning collaboratives for hospitals and provide a wide array of initiatives and activities to improve patient safety in the Medicare program.

For more information, see the [fact sheet](#). See the full text of this excerpted [CMS press release](#) (issued September 29), including list of 16 organizations receiving contracts.

HH Quality of Patient Care Star Ratings and HH Compare Preview Reports Available

Preview Reports are available on Home Health (HH) Quality of Patient Care Star Ratings and HH Compare in the Certification and Survey Provider Enhanced Reporting (CASPER) application. These reports contain data that will be publicly reported on the HH Compare website in January 2017. Visit the [HH Quality Initiative](#) webpage for more information.

The deadline to submit a request to have Quality of Patient Care Star Rating data suppressed is October 24, 2016; see directions in your report.

New Electronic Appeals System: MOD E-File Available

The Medicare Operations Division Electronic Filing System (MOD E-File), launched on October 1, 2016, allowing appellants to file electronic requests for review with the Medicare Appeals Council. Appellants, parties, and the public can also use MOD E-File to check the status of appeals. Visit the [MOD E-File](#) website to learn more about MOD E-File and how to use it.

New EHR Contract Guide and Health IT Playbook

HHS Office of the National Coordinator for Health Information Technology (ONC) released two tools to help health care providers get the most out of their health Information Technology (IT), including Electronic Health Records (EHRs):

- [EHR Contracts Untangled: Selecting Wisely, Negotiating Terms, and Understanding the Fine Print](#) explains important concepts and includes example contract language to help you plan and negotiate contract terms with vendors for an EHR system
- [Health IT Playbook](#) is a dynamic, web-based tool with practical information and guidance on specific topics as you research, buy, use, or switch EHRs

EHR Incentive Programs: Learn About Important Changes

CMS recently released two proposed rules and a final rule that will affect the future of the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs:

- FY 2017 Hospital Inpatient Prospective Payment System [final rule](#) includes changes that require providers to report four quarters of data for eight of the 15 hospital inpatient quality reporting clinical quality measures
- Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) [proposed rule](#) would establish the Quality Payment Program, which is set to begin January 1, 2017
- CY 2017 Changes to the Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center [proposed rule](#) recommends changes to the EHR Incentive Programs

To learn more, visit the [EHR Incentive Programs](#) website.

EHR Incentive Programs: 2016 CQM Requirements

To participate successfully in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, Eligible Professionals (EPs), eligible hospitals, and critical access hospitals must submit clinical quality measures (CQMs). The CQM reporting options for EPs and hospitals in 2016 are the same as the options that were available in 2015. Visit the [2016 Program Requirements](#) and [2015 CQM Reporting Options](#) webpages for more information.

October is National Breast Cancer Awareness Month

Other than skin cancer, breast cancer is the most common cancer among women in the United States. Talk to your patients about the importance of breast cancer screening.

Medicare Part B provides coverage for screening mammography. A clinical breast exam is also covered as part of the screening pelvic examination for beneficiaries who meet coverage criteria.

For More Information:

- [Medicare Preventive Services](#) Educational Tool
- [National Breast Cancer Awareness Month](#) website

The screening mammography benefit is promoted on your patient's Medicare Summary Notices. Visit the [Preventive Services](#) website to learn more about Medicare-covered services.

Provider Compliance

Automatic External Defibrillators: Inadequate Medical Record Documentation

Automatic External Defibrillator (AED) providers often submit claims that lack sufficient medical record documentation. Physicians and non-physician practitioners must follow Medicare requirements:

- Before delivery of the AED, examine the beneficiary in-person within six months prior to the date of the written order.
- Document that the beneficiary was evaluated and/or treated for a condition that supports the need for the AED.
- Sign and date the order. As of November 10, 2015, physicians are not required to co-sign face-to-face encounters performed by non-physician practitioners.

Document and bill correctly for AEDs:

- [July 2016 Issue of the Medicare Quarterly Provider Compliance Newsletter, pages 1-3](#)
- [Local Medicare Coverage Policy Articles Effective October 2015 for AEDs](#)
- [Medicare Program Integrity Manual, Chapter 5](#)

Claims, Pricers & Codes

Billing for Influenza: New CPT Code 90674

The American Medical Association issued a new Current Procedural Terminology (CPT) code for influenza vaccine Flucelvax, CPT 90674, effective August 1, 2016 for Medicare claims. However, Medicare claims processing systems will not be able to accept the new code until January 1, 2017. Until this time, you may hold claims containing CPT 90674. Alternatively, Medicare Administrative Contractors (MACs) may direct use of a Not Other Classified (NOC) code to allow billing for the vaccine for dates of service on or after August 1, 2016, and before January 1, 2017. Check with your MAC for this information and other interim billing instructions. Finally, if you bill institutional claims, note that code CPT 90674 will be implemented on February 20, 2017.

Upcoming Events

IMPACT Act: Data Elements and Measure Development Call — October 13

Thursday, October 13 from 1:30 to 3 pm ET

To register or for more information, visit [MLN Connects® Event Registration](#). Space may be limited, register early.

During this call, CMS experts discuss how data elements are used in measure development. Find out how information from assessment instruments is used to calculate quality measures. The Improving Medicare Post-Acute Care Transformation Act of 2014 ([IMPACT Act](#)) requires the reporting of standardized patient assessment data on quality measures, resource use, and other measures by Post-Acute Care (PAC) providers, including skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and long-term care hospitals.

Agenda:

- Overview of National Quality Strategy and CMS Quality Strategy
- Why do we have quality measures?
- How do data elements fit within measure development?
- How is provider data used in the development process?
- Example: pressure ulcer measure
- Question and answer/discussion session

Target Audience: PAC providers, healthcare industry professionals, clinicians, researchers, health IT vendors, and other interested stakeholders.

Physician Compare Public Reporting Information Sessions — October 18 and 19

Tuesday, October 18 from 11 am to 12 pm ET

Wednesday, October 20 from 3 to 4 pm ET

CMS is hosting two webinars about public reporting and the preview period. Learn more about how your 2015 performance scores may be publicly reported on Physician Compare targeted for release in late 2016, and get ready for the 30-day preview period. During each webinar, the Physician Compare Support Team will address your questions during a question and answer session.

[Register](#) for an upcoming webinar:

- Both sessions will present the same information
- Registration ends on Friday, October 14

2015 Supplemental QRUR Physician Feedback Program Call — October 20

Thursday, October 20 from 1:30 to 3 pm ET

To register or for more information, visit [MLN Connects Event Registration](#). Space may be limited, register early.

During this call, find out about the 2015 Supplemental Quality and Resource Use Reports (QRURs), confidential feedback reports for medical group practices and solo practices on resource use for Fee-For-Service episodes of care. The 2015 Supplemental QRURs report on 23 major episode types and

an additional 44 episode subtypes, resulting in 67 total reported episode types. These reports are for informational purposes only and are not used to adjust payments. Learn more about the reports on the [Supplemental QRURs and Episode-Based Payment Measurement](#) webpage. Visit [How to Obtain a QRUR](#) to access your report prior to the call.

Agenda:

- Introduction to the 2015 Supplemental QRURs
- CMS Approach to Episode-Based Measures
- Understanding your report, including a review of the exhibits and drill down tables
- Accessing the reports via the CMS Enterprise Portal

Target Audience: Physicians, physician group practices, practice managers, medical societies, and specialty societies.

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

Long-Term Care Facilities: Reform of Requirements Call — October 27

Thursday, October 27 from 1:30 to 3 pm ET

To register or for more information, visit [MLN Connects Event Registration](#). Space may be limited, register early.

During this call, learn about the [final rule](#) to reform the requirements for long-term care facilities. These requirements are the federal health and safety standards that long-term care facilities must meet in order to participate in the Medicare or Medicaid programs. Find out about the changes included in the final rule; implementation and survey process; and provider training and resources. A question and answer session will follow the presentation.

Target Audience: Consumer and advocacy groups, nursing home providers, surveyor community, prescribers, professional associations, and other interested stakeholders.

How to Report Across 2016 Medicare Quality Programs Call — November 1

Tuesday, November 1 from 1:30 to 3 pm ET

To register or for more information, visit [MLN Connects Event Registration](#). Space may be limited, register early.

Learn how to report quality measures during the 2016 program year to maximize your participation in Medicare quality programs, including the Physician Quality Reporting System (PQRS), Medicare Electronic Health Record (EHR) Incentive Program, Value-Based Payment Modifier (Value Modifier), and the Medicare Shared Savings Program. Satisfactory reporters will avoid the 2018 PQRS negative payment adjustment, satisfy the clinical quality measure component of the EHR Incentive Program, and satisfy requirements for the Value Modifier to avoid the downward payment adjustment. A question and answer session will follow the presentation.

Agenda:

How to Report Across 2016 Medicare Quality Programs for:

- Individual Eligible Professionals (EPs)

- PQRS group practices
- Medicare Shared Savings Program Accountable Care Organizations (ACOs)
- Pioneer and Next Generation ACOs

Target Audience: Physicians, individual EPs, group practices, Comprehensive Primary Care practice sites, Accountable Care Organizations, therapists, 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 page](#) for more information.

Medicare Learning Network® Publications & Multimedia

Medicare Part B Drug Average Sales Price Reporting by Manufacturers – Blending National Drug Codes MLN Matters® Article — New

An MLN Matters Special Edition Article on [Medicare Part B Drug Average Sales Price Reporting by Manufacturers – Blending National Drug Codes](#) is available. Learn about the Average Sales Price reporting requirements drug manufacturers must meet.

Medicare Parts A & B Appeals Process Booklet — Revised

A revised [Medicare Parts A & B Appeals Process](#) Booklet is available. Learn about:

- Original Medicare's (Part A and Part B) five levels of claim appeals
- How the Medicare appeals process applies to providers, participating physicians, and participating suppliers
- The available appeals-related resources

Resources for Medicare Beneficiaries Booklet — Revised

A revised [Resources for Medicare Beneficiaries](#) Booklet is available. To order a hard copy, visit the [Learning Management and Product Ordering System](#). Learn about:

- Resources providers can use to answer beneficiaries' questions on Medicare, Medicare supplements, and other insurance
- Medical expenses and basic needs
- Long-term care
- Informed decisions, rights and protections, notices, and forms
- Fraud, waste, and abuse
- Caregiving

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