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News & Announcements

CMS Finalizes New Medicare and Medicaid Home Health Care Rules and Beneficiary Protections

On January 9, CMS finalized rules governing Home Health Agencies (HHAs) that will improve the quality of health care services and strengthen patients’ rights. These conditions of participation are the minimum health and safety standards HHAs must meet to participate in the Medicare and Medicaid programs. The final rule includes:

- Comprehensive patient rights condition of participation that clearly enumerates the rights of patients and the steps that must be taken to assure those rights
- Expanded comprehensive patient assessment requirement that focuses on all aspects of patient wellbeing
- Requirement that assures that patients and caregivers have written information about upcoming visits, medication instructions, treatments administered, instructions for care, and contact information for an HHA clinical manager
- Requirement for an integrated communication system that ensures patient needs are identified and addressed, care is coordinated among all disciplines, and active communication between the HHA and the patient’s physician(s)
- Requirement for a data-driven, agency-wide quality assessment and performance improvement program that continually evaluates and improves agency care for all patients at all times
- New infection prevention and control requirement that focuses on the use of standard infection control practices and patient/caregiver education and teaching
- Streamlined skilled professional services requirement that focuses on appropriate patient care activities and supervision across all disciplines
- Expanded patient care coordination requirement that makes a licensed clinician responsible for all patient care services
- Revisions to simplify the organizational structure of HHAs while continuing to allow parent agencies and their branches
- New personnel qualifications for HHA administrators and clinical managers

See the full text of this excerpted CMS Press Release (issued January 9).

**Addressing the Opioid Epidemic: Keeping Medicare and Medicaid Beneficiaries Healthy**

Many Medicare and Medicaid beneficiaries and their families have been affected by opioid misuse and opioid use disorder, commonly referred to as addiction. Given the growing body of evidence on the risks of misuse and the Administration’s commitment to combatting the opioid epidemic, we outlined our strategy and actions to address the national opioid misuse epidemic.

For More Information:
- Centers for Disease Control and Prevention (CDC) [Guideline for Prescribing Opioids for Chronic Pain](https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6324a1.htm)
- CDC [Opioid Guideline Mobile App](https://www.cdc.gov/drugoverdose/prescribing-guideline/mobile-app.html)

See the full text of this excerpted CMS Blog (issued January 5).

**Post-Acute Care TOH Quality Measures Pilot Study: Respond by January 17**

CMS contracted with RTI International and Abt Associates to develop and implement two Transfer of Health Information and Care Preferences (TOH) quality measures for skilled nursing facility, inpatient rehabilitation facility, long-term care hospital, and home health agency settings. The TOH measures meet requirements under the Improving Medicare Post-Acute Care Transformation Act (IMPACT Act) of 2014. As part of the measure development process, we are pilot testing the TOH measures to investigate data collection methods, time to complete the items, feasibility of implementing, and properties.

Agencies and facilities that have been Medicare-certified for at least one year are eligible to participate in the pilot study. View the Transfer of Health Pilot zip file on the IMPACT Act Downloads and Videos webpage for more information, including the Recruitment Letter and Interest Form, and respond by January 17.

**Clinical Laboratories: Prepare Now to Report Lab Data through March 31**

If you are an applicable lab required to report pricing data:
- Identify who will submit and certify your Clinical Lab Fee Schedule (CLFS) data. These two individuals must register in the Enterprise Identity Management (EIDM) system and request a CLFS submitter or certifier role in the Fee-For-Service Data Collection System.
- The CLFS submitter must be certified in the Provider Enrollment, Chain and Ownership System (PECOS) as a User or Authorized User on the PECOS Medicare Enrollment forms (CLFS submitters must have their name appear within one of the following 855 application forms: A,B,C,I,R).

The updated PAMA webpage includes the following:
- MLN Matters® Special Edition Articles SE1619 and SE17002
- CLFS Data Collection System User Guide
- Materials from the November 2 MLN Connects Call on data reporting
- Frequently Asked Questions: Section 2 deals with applicable laboratories

**Chronic Care Management Services Changes for 2017**

CMS recently approved a number of changes to the payment rules for Chronic Care Management (CCM) services under Medicare Part B for CY 2017 to reduce administrative burden and improve payment accuracy. See the CCM Services Changes for 2017 fact sheet, FAQs, and the Care Management webpage for more information.

**eCQI Resource Center Integrated with USHIK**

CMS, the Agency for Healthcare Research and Quality, and the Office of the National Coordinator for Health Information Technology integrated the eCQI Resource Center with the U.S. Health Information Knowledgebase (USHIK). This integration allows you to compare different versions and metadata of electronic Clinical Quality Measures (eCQMs) and download measure version details in several file formats. See the measures tables on the Eligible Hospitals and Eligible Professionals webpages.

**eCQM Value Sets for 2017 Performance Period: Addendum Available**

CMS and the National Library of Medicine published an addendum to the 2016 Electronic Clinical Quality Measure (eCQM) specifications. This addendum updates relevant ICD-10-CM and ICD-10-PCS value sets for the 2017 performance year. These changes affect electronic reporting of eCQMs for the following programs:
- Hospital Inpatient Quality Reporting Program
- Medicare Electronic Health Record Incentive Program for eligible hospitals and critical access hospitals
- Merit-based Incentive Payment System for eligible clinicians.

Updated measure information is available on the eCQM library and eCQI Resource Center websites. Visit the ICD-10-CM/PCS Frequently Asked Questions webpage for more information on implementing and mapping of ICD-10 codes. Questions about the addendum, eCQM value sets, appropriateness of mapping, and non-ICD-10 code system updates should be reported to the ONC CQM Issue Tracker.

**Medicare Quality Programs: ICD-10 Code Updates and Impact to 4th Quarter 2016**

CMS determined that the ICD-10 code updates will impact our ability to process data reported on certain quality measures for the 4th quarter of CY 2016. We will not apply the 2017 or 2018 Physician Quality Reporting System (PQRS) downward payment adjustments, as applicable, to any individual eligible professional or group practice that fails to satisfactorily report for CY 2016 solely as a result of the impact of ICD-10 code updates on quality data reported for the 4th quarter of CY 2016.

For More Information:
- ICD-10 Code Updates Message from December 15
- PQRS ICD-10 webpage
- ICD-10 FAQs
January is Cervical Health Awareness Month

Cervical cancer can often be prevented with regular screening tests and follow-up care. Talk to your patients about cervical health and encourage them to take advantage of Medicare-covered preventive services, including the screening Pap test and screening pelvic examination.

For More Information:
- [Screening for Cervical Cancer with Human Papillomavirus Tests](#)
- [Preventive Services Educational Tool](#)
- [Centers for Disease Control and Prevention Cervical Cancer webpage](#)

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

Provider Compliance

CMS Provider Minute: CT Scans Video

Insufficient documentation continues to be a leading cause of Medicare noncompliance for providers who bill for CT Scans. The [CMS Provider Minute: CT Scans](#) video includes pointers to help you properly submit claims with sufficient documentation. This is the fourth in a [series](#) of Medicare compliance videos to educate on areas identified with a high degree of noncompliance.

Upcoming Events

**ESRD QIP: Payment Year 2020 Final Rule Call — January 17**

Tuesday, January 17 from 1:30 to 3 pm ET

To register or for more information, visit [MLN Connects Event Registration](#).

Do you participate in the End-Stage Renal Disease (ESRD) Quality Incentive Program (QIP)? During this call, CMS experts discuss the [final rule](#) that operationalizes the ESRD QIP for Payment Year (PY) 2020. The performance period for PY 2020 will begin on January 1, 2018. Take steps now to understand the changes to the program.

**Agenda:**
- Legislative framework and how it fits in with CMS strategies to improve quality
- Changes reflected in the final rule based on public comments
- Final measures, standards, scoring methodology, and payment reduction scale
- How the PY 2020 program compares to PY 2019
- Where to find additional information about the program

**Target Audience:** Dialysis clinics and organizations; nephrologists; hospitals with dialysis units; billers/coders; and quality improvement experts.

**Home Health Groupings Model Technical Report Call — January 18**

Wednesday, January 18 from 1:30 to 3 pm ET

To register or for more information, visit [MLN Connects Event Registration](#).
In December 2016, CMS published the Medicare Home Health (HH) Prospective Payment System (PPS): Case-Mix Methodology Refinements technical report, including an overview of the Home Health Groupings Model (HHGM). This technical report describes efforts to reassess the current HH PPS and develop large-scale payment methodology changes. During this call, CMS experts introduce the HHGM model. A question and answer session follows the presentation.

Prior to the call, participants are encouraged to review the technical report.

Target Audience: Home Health Agencies and other interested stakeholders.

**Home Health Quality of Patient Care Star Rating Call — January 19**
Thursday, January 19 from 1:30 to 3 pm ET

To register or for more information, visit [MLN Connects Event Registration](#).

Learn about proposed changes to the Home Health Quality of Patient Care star rating on Home Health Compare based on stakeholder and technical expert panel feedback, overview of the current calculation algorithm, proposed changes, and potential roll-out plans. A question and answer session follows the presentation.

Agenda:
- Introduction and purpose
- Overview of current Star Rating methodology
- Proposed changes and supporting analyses
- Next steps and potential timeline
- Questions and comments

Target Audience: Home health providers.

**Medicare Quality Programs: Transitioning from PQRS to MIPS Call — January 24**
Tuesday, January 24 from 2 to 3:30 pm ET

To register or for more information, visit [MLN Connects Event Registration](#).

During this call, find out how to complete the final reporting period for the legacy Medicare quality reporting programs and transition to the Merit-based Incentive Payment System (MIPS). A question and answer session follows the presentation.

Agenda:
- Wrapping Up the 2016 Program Year for the Physician Quality Reporting System (PQRS), Medicare Electronic Health Record (EHR) Incentive Program, and Value-Based Payment Modifier (VM)
- Transitioning to MIPS
- Timeline for PQRS, EHR, VM, and MIPS programs with submission timeframes and other key milestones
- Resources

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 page](#) for more information.
**Additional Guidance for Clinical Laboratories as Data Reporting Begins MLN Matters Article — New**

An MLN Matters Special Edition Article on Additional Guidance for Clinical Laboratories as Data Reporting Begins is available. Learn about the new requirements under Section 1834A of the Social Security Act for the Medicare Part B Clinical Laboratory Fee Schedule. The data reporting period opened on January 1, 2017.

**Revised CMS 855S Application: DMEPOS Suppliers MLN Matters Article — New**

An MLN Matters Special Edition Article on Revised CMS 855S Application – Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers is available. Learn how to use the revised application.

**Chronic Care Management Services Changes for 2017 Fact Sheet — New**

A new Chronic Care Management Services Changes for 2017 Fact Sheet is available. Learn about:
- 2017 coding changes
- Included services
- Key improvements reducing requirements associated with initiating care

**How to Use the Medicare Coverage Database Booklet — Revised**

A revised How to Use the Medicare Coverage Database Booklet is available. Learn about:
- Navigating the database
- Searching indexes and reports
- Download features

**SNF Prospective Payment System Booklet — Revised**

A revised Skilled Nursing Facility Prospective Payment System Booklet is available. Learn about:
- Elements of the Skilled Nursing Facility (SNF) Prospective Payment System
- SNF Quality Reporting Program
- SNF Value-Based Purchasing Program

**Acute Care Hospital Inpatient Prospective Payment System Booklet — Revised**

A revised Acute Care Hospital Inpatient Prospective Payment System Booklet is available. Learn about:
- Basis for Inpatient Prospective Payment System payment, payment rates, how payment rates are set, and payment updates
- Hospital Inpatient Quality Reporting and Electronic Health Record Meaningful User Incentive Programs

**HH Prospective Payment System Booklet — Revised**

A revised Home Health Prospective Payment System Booklet is available. Learn about:
- Elements of the Home Health (HH) Prospective Payment System and updates
- Consolidated billing requirements, physician billing, and payment
- Criteria for HH services
- Therapy services
HH Quality Reporting Program

IRF Prospective Payment System Fact Sheet — Revised

A revised Inpatient Rehabilitation Facility Prospective Payment System Fact Sheet is available. Learn about:
- Elements of the Inpatient Rehabilitation Facility (IRF) Prospective Payment System
- Payment updates
- IRF Quality Reporting Program

Chronic Care Management Services Fact Sheet — Revised

A revised Chronic Care Management Services Fact Sheet is available. Learn about:
- Separately payable services for patients with multiple chronic conditions
- Codes and Physician Fee Schedule billing requirements
- Practitioner and patient eligibility
- Service elements

Medicare Vision Services Fact Sheet — Revised

A revised Medicare Vision Services Fact Sheet is available. Learn about:
- Billing for cataract removal of intraocular lenses
- Glaucoma screening
- Other eye-related Medicare-covered services

Swing Bed Services Fact Sheet — Revised

A revised Swing Bed Services Fact Sheet is available. Learn about:
- Requirements that apply to hospitals and critical access hospitals
- Payments

Mass Immunizers and Roster Billing Fact Sheet — Revised

A revised Mass Immunizers and Roster Billing Fact Sheet is available. Learn about:
- Requirements for mass immunizers
- Roster billing
- Centralized billing

Like the newsletter? Have suggestions? Please let us know!

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