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Official CMS news from the Medicare Learning Network

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News & Announcements

Home Health Agency CoP Final Rule: Effective Date Extended to January 13, 2018

CMS extended the effective date of the Home Health Agency (HHA) Conditions of Participation (CoP) final rule by an additional 6 months from July 13, 2017, to January 13, 2018. This extension does not make any changes to the policies in the HHA CoP final rule. Send questions about the requirements to NewHHACoPs@cms.hhs.gov.

Hospice Quality Reporting Program: Non-Compliance Letters

CMS notified hospice providers that are non-compliant with Hospice Quality Reporting Program (HQRP) requirements for CY 2016. Any hospice determined to be non-compliant may be subject to a two percentage point reduction in their FY 2018 annual payment update. Non-compliance letters were dated July 18, 2017, and

sent by mail and via the Quality Improvement and Evaluation Systems (QIES) - Certification and Survey Provider Enhanced Reporting (CASPER) system.

Check your CASPER folder to determine if your hospice received this letter. If so, you may submit a request for reconsideration to CMS no later than 11:59 pm PST on August 17. See the instructions in your notification letter and on the Hospice Reconsideration Requests webpage. Failure to submit a reconsideration by the deadline means acceptance of your non-compliance with HQRP requirements.

IRF Quality Reporting Program: Non-Compliance Letters

CMS notified facilities that are non-compliant with Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP) requirements for CY 2016, which will affect their FY 2018 annual payment update. CMS mailed non-compliance letters and placed them in the Quality Improvement and Evaluation System (QIES) - Certification and Survey Provider Enhanced Reporting (CASPER) system on July 18.

Facilities that received a letter of non-compliance may submit a request for reconsideration to CMS via email no later than 11:59pm PST, August 17. See the instructions in your notification letter and on the IRF Quality Reporting Reconsideration and Exception & Extension webpage.

LTCH Quality Reporting Program: Non-Compliance Letters

CMS notified Long-Term Care Hospitals (LTCHs) that are non-compliant with LTCH Quality Reporting Program (QRP) requirements for CY 2016, which will affect their FY 2018 annual payment update CMS mailed non-compliance letters and placed them in the Quality Improvement and Evaluation System (QIES) - Certification and Survey Provider Enhanced Reporting (CASPER) system on July 18.

Providers that received a letter of non-compliance may submit a request for reconsideration to CMS via email no later than 11:59pm PST, August 17. See the instructions in your notification letter and on the LTCH Quality Reporting Reconsideration and Exception & Extension webpage.

SNF Quality Reporting Program: Non-Compliance Letters

CMS notified Skilled Nursing Facility (SNFs) that are non-compliant with SNF Quality Reporting Program (QRP) requirements for Quarter 4 of CY 2016, which will affect their FY 2018 annual payment update. CMS mailed non-compliance letters and placed them in the Quality Improvement and Evaluation System (QIES) - Certification and Survey Provider Enhanced Reporting (CASPER) system on July 14.

Providers that received a letter of non-compliance may submit a request for reconsideration to CMS via email no later than 11:59pm PST, August 17. Providers that receive a letter of non-compliance may submit a request for reconsideration to CMS via email no later than 11:59pm PST, August 13. See the instructions in your notification letter and on the SNF Quality Reporting Reconsideration and Exception & Extension webpage.

IRF, LTCH, and SNF Quality Reporting Program Data due August 15

Quality Reporting Program (QRP) data for Inpatient Rehabilitation Facilities (IRFs), Long-Term Care Hospitals (LTCHs), and Skilled Nursing Facilities (SNFs) is due August 15 for the first quarter of 2017:

- IRF-PAI, LTCH CARE Data Set, and SNF Minimum Data Set assessment data
- IRF and LTCH data submitted to CMS via the Center for Disease Control and Prevention's National Healthcare Safety Network for discharges

Run validation/output reports prior to each quarterly reporting deadline to ensure you submitted all required data. For a list of measures required for this submission deadline, visit the QRP websites:

- IRF Quality Reporting Data Submission Deadlines
- LTCH Quality Reporting Data Submission Deadlines
- SNF QRP Measures and Technical Information

New PEPPER Available for Home Health Agencies and Partial Hospitalization Programs

New Program for Evaluating Payment Patterns Electronic Reports (PEPPERs) through CY 2016 are available for Home Health Agencies (HHAs) and Partial Hospitalization Programs (PHPs). 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.

Access your PEPPER files:

- HHAs and free-standing PHPs: PEPPER Resources Portal
- Hospital-based PHPs: QualityNet secure file exchange to hospital QualityNet Administrators and user accounts with the PEPPER recipient role

For More Information:

- Visit the Distribution Schedule - Get Your PEPPER webpage
- Visit PEPPERresources.org to learn about upcoming training sessions and access user's guides, recorded training sessions, frequently asked questions, and examples of how other providers are using PEPPER
- If you have questions or need help obtaining your report, visit the Help Desk
- Send us your feedback or suggestions

Hospitals: 2018 QRDA Category I Implementation Guide

CMS published the 2018 Quality Reporting Document Architecture (QRDA) Category I Hospital Quality Reporting Implementation Guide, Schematron, and sample files. The implementation guide provides instructions for submitting QRDA-I documents for Eligible Hospitals and Critical Access Hospitals for the following programs:

- Hospital Inpatient Quality Reporting Program
- Medicare Electronic Health Record Incentive Program

For More Information:

- eCQI Resource Center
- CMS eCQM Library

For questions related to the QRDA Implementation Guide or Schematrons, visit the ONC QRDA JIRA Issue Tracker.

Health Care Fraud Takedown: Charges Against Individuals Responsible for $1.3 Billion in Fraud

On July 13, the Department of Justice and the Department of Health and Human Services (DHHS) announced the largest ever health care fraud enforcement action by the Medicare Fraud Strike Force, involving 412 charged defendants across 41 federal districts, including 115 doctors, nurses and other licensed medical professionals, for their alleged participation in health care fraud schemes involving approximately $1.3 billion in false billings. Of those charged, over 120 defendants, including doctors, were charged for their roles in prescribing and distributing opioids and other dangerous narcotics.

"The United States is home to the world's best medical professionals, but their ability to provide affordable, high-quality care to their patients is jeopardized every time a criminal commits healthcare fraud." said DHHS Secretary Tom Price, M.D.

See the full text of this excerpted press release (issued July 13)

Provider Compliance

Billing For Stem Cell Transplants

In a February 2016 report, the Office of the Inspector General (OIG) determined that Medicare paid for many stem cell transplants incorrectly. The main finding was that providers billed these procedures as inpatient when they should have been submitted as outpatient services. Use the following resources to bill correctly and avoid overpayment recoveries:

- OIG Report Medicare did not Pay Selected Inpatient Claims for Bone Marrow and Stem Cell Transplant Procedures in Accordance with Medicare Requirements
- CMS Transmittal 1805
- MLN Matters Article

Claims, Pricers & Codes

Clinicians: Medicare Part B Crossover Claims Issue Tied to Error Code H31312

Since July 6, there has been a problem with 837 professional coordination of benefits/Medicare crossover claims in which Medicare is the secondary payer. The issue is specific to the Primary Payer 2320 AMT for claims that were submitted electronically with detail Primary Payer 2430 SVD amounts included. The system is not passing the primary payer's paid amount correctly; therefore, affected claims are receiving error H31312 "The Payer Paid Amount does not equal the line level payment amounts less the adjustment amounts."

Once the system is fixed on August 4, CMS will begin to send repaired claims to your patients' insurers that pay after Medicare. In the interim, physicians and practitioners should direct their vendors not to bill their patients' supplemental insurers for balances remaining on Medicare Secondary Payer claims submitted between July 6 and August 3.

Upcoming Events

Revised Interpretive Guidance for Nursing Homes and New Survey Process Call — July 25

Tuesday, July 25 from 1:30 to 3 pm ET

Register for Medicare Learning Network events.

CMS experts discuss the revised Interpretive Guidance for Nursing Homes and the new Survey Process effective November 28, 2017. Learn about the major components of Phase 2 implementation, changes to the survey process, and training resources available to the public. A question and answer session follows the presentation.

You may email questions in advance of the call to NHSurveyDevelopment@cms.hhs.gov. Questions received in advance of the call may be addressed during the call or used for other materials following the call.

Target Audience: Nursing home providers; surveyor community; prescribers, professional associations; consumer and advocacy groups; and other interested stakeholders

ESRD QIP: Proposed Rule for Payment Year 2021 Listening Session — July 26

Wednesday, July 26 from 2 to 3 pm ET

Register for Medicare Learning Network events.

During this call, learn about provisions in the CY 2018 End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) proposed rule, including plans for the program in Payment Years (PY) 2019, 2020, and 2021. Topics include:

- ESRD QIP legislative framework
- Proposed measures, standards, scoring method, and payment reduction scale for PY 2021
- Proposed modifications to PY 2019 and PY 2020 activities
- Methods for reviewing and commenting on the proposed rule

If time allows, we will open the lines for feedback. Note: 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 August 28.

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

New Proposals for RHCs and FQHCs on Care Management Services and ACO Assignments - Listening Session — August 1

Tuesday, August 1 from 2 to 3:30 pm ET

Register for Medicare Learning Network events.

During this call, CMS experts review proposals for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) in the Physician Fee Schedule proposed rule on requirements and payment for Care Management Services, which includes Chronic Care Management (CCM), General Behavioral Health Integration (BHI), and Psychiatric Collaborative Care Model (CoCM) services. Learn about the CMS CCM Campaign and the proposed new process for using RHC and FQHC claims to assign beneficiaries to Accountable Care Organizations (ACOs) participating in the Medicare Shared Savings Program.

A question and answer session follows the presentation. We will open the lines for feedback. Note: 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 comment period on September 11, 2017.

Visit these CMS websites for more information: RHC Center, FQHC Center, and Connected Care: The Chronic Care Management Resource.

Target Audience: RHCs, FQHCs, and other interested stakeholders

Medicare Diabetes Prevention Program Model Expansion Listening Session — August 16

Wednesday August 16 from 1:30 pm to 3 pm ET

Register for Medicare Learning Network events.

The CY 2018 Medicare Physician Fee Schedule proposed rule makes additional proposals to implement the Medicare Diabetes Prevention Program (MDPP) expanded model starting in 2018, including the payment structure, as well as additional supplier enrollment requirements and supplier compliance standards to ensure program integrity. During this call, CMS experts provide a high-level overview of the proposed policies; participants should review the proposed rule prior to the call. Visit the MDPP webpage for more information.

If time allows, we will open the lines for feedback. Note: 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 comment period on September 11.

Target Audience: Current Centers for Disease Control and Prevention recognized Diabetes Prevention Program organizations; organizations interested in becoming MDPP suppliers, including existing Medicare providers/suppliers, community organizations, not-for-profits; associations, and advocacy groups focused on seniors or diabetes; and other interested stakeholders, including health plans, primary care/internal medicine specialties

IMPACT Act: Drug Regimen Review Measure Overview for the Home Health Quality Reporting Program Call — August 17

Thursday, August 17 from 1:30-3 pm ET

Register for Medicare Learning Network events.

The Improving Medicare Post-Acute Care Transformation of 2014 (IMPACT Act) requires 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) for specified domains. During this call, CMS and measure developers will present the Drug Regimen Review (DRR) quality measure which was adopted to fulfill the medication reconciliation domain requirement of the IMPACT Act. This call will focus on the home health measure. A question and answer session follows the presentation.

Agenda:

- Review the goals of the DRR measure
- Review guidance and walk through scenarios for coding the Outcome and Assessment Information Set (OASIS) items used to calculate the measure

You may email questions in advance of the call to PACQualityInitiative@cms.hhs.gov. Questions received in advance of the call may be addressed during the call or used for other materials following the call.

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

LTCH Quality Reporting Program Refresher Training Webinar — August 22

Tuesday, August 22 from 2 to 4 pm ET

CMS is hosting a webinar for Long-Term Care Hospitals (LTCH) providers. Visit the LTCH Quality Reporting Training webpage for more information and to register.

Medicare Learning Network Publications & Multimedia

Quality Payment Program Listening Session: Audio Recording and Transcript — New

An audio recording, transcript, and clarification are available for the July 5 Quality Payment Program Year 2 Proposed Rule Listening Session. During this call, CMS experts discuss proposed policy for the Quality Payment Program.

Medicare Quarterly Provider Compliance Newsletter [Volume 7, Issue 4] Educational Tool — New

A new Medicare Quarterly Provider Compliance Newsletter [Volume 7, Issue 4] Educational Tool is available. Learn about:

- How to avoid common billing errors and other erroneous activities
- How to address and avoid the top issues of this quarter

Medicare Basics: Parts A and B Claims Overview Video — Reminder

The Medicare Basics: Parts A and B Claims Overview Video is available. Learn about:

- Medicare Parts A and B claims
- What you need to know before filing a claim
- How to submit a claim

Chronic Care Management Services Fact Sheet — Reminder

The 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

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