News & Announcements

New Medicare Card: Webpage Updates
IRF Quality Reporting Program: Reconsideration Period Ends August 17
LTCH Quality Reporting Program: Reconsideration Period Ends August 17
Hospice Quality Reporting Program: Reconsideration Period Ends August 17
EHR Incentive Program Hardship Exception Application Due by October 1
Hospitals: Submit Meaningful Use Data to the HQR via the QualityNet Secure Portal in 2018
Chronic Care Management: New Connected Care Videos
Medicare Fee-For-Service Beneficiary Selection of a Primary Clinician
Home Health Quality Reporting Program: OASIS-C2 2018 Guidance Manual Available
Quality Payment Program Hardship Exception Application for 2017 Transition Year Open
Quality Payment Program: Explanation of Special Status Calculation — Correction

Provider Compliance
Home Health Care: Proper Certification Required

Claims, Pricers & Codes
July 2017 OPPS Pricer File
Part B Billing for Certain New Biosimilar Biological Products before the Modifier is Implemented

Upcoming Events
IRF Quality Reporting Program Refresher Training Webinar — August 15
Medicare Diabetes Prevention Program Model Expansion Listening Session — August 16
Quality Payment Program Year 2 NPRM Virtual Office Hours Session — August 16
IMPACT Act: Drug Regimen Review Measure Overview for the Home Health QRP Call — August 17
LTCH Quality Reporting Program Refresher Training Webinar — August 22
Nursing Home Facility Assessment Tool and State Operations Manual Revisions Call — September 7

Medicare Learning Network Publications & Multimedia
August 2017 Catalog Available
Quality Payment Program 2017: MIPS Quality Performance Category Web-Based Training Course — New
Long-Term Care Call: Audio Recording and Transcript — New
ESRD Listening Session: Audio Recording and Transcript — New
Medicare Secondary Payer Web-Based Training Course — Revised
Medicare Secondary Payer Booklet — Revised

News & Announcements

New Medicare Card: Webpage Updates

CMS updates the New Medicare Card pages on a rolling basis. Check the New Medicare Card homepage and Provider webpage frequently for changes. This week, we added a new exception for claim status queries.

IRF Quality Reporting Program: Reconsideration Period Ends August 17
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 11:59 pm 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: Reconsideration Period Ends August 17

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 11:59 pm PST, August 17. See the instructions in your notification letter and on the LTCH Quality Reporting Reconsideration and Exception & Extension webpage.

Hospice Quality Reporting Program: Reconsideration Period Ends August 17

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.

EHR Incentive Program Hardship Exception Application Due by October 1

Eligible professionals (EPs) who are first-time participants in the Medicare Electronic Health Record (EHR) Incentive Program in 2017 are eligible to apply for a one-time hardship exception by October 1, 2017. A first-time EP may apply for this one-time significant hardship to avoid a 2018 payment adjustment if:

- The EP is a first-time participant in the EHR Incentive Program in CY 2017 and intends to participate in the Medicare EHR Incentive Program in CY 2017
- The EP is transitioning to Merit-based Incentive Payment System (MIPS) for the 2017 performance period
- The EP intends to report on measures specified for the Advancing Care Information performance category under the MIPS in 2017

For More Information:
- Hardship Exception Instructions
- EHR Incentive Programs website
- Quality Payment Program Service Center at 866-288-8292 (TTY 877-715-6222) or QPP@cms.hhs.gov
- EHR Information Center at 888-734-6433 (press 1)
Hospitals: Submit Meaningful Use Data to the HQR via the QualityNet Secure Portal in 2018

CMS is continuing efforts to reduce burden by easing reporting requirements and streamlining data submission methods for eligible hospitals and Critical Access Hospitals (CAHs) participating in the Electronic Health Record (EHR) Incentive Programs.

- Medicare Eligible Hospitals: Beginning January 2, 2018, eligible hospitals and CAHs participating in the Medicare EHR Incentive Program will submit their 2017 meaningful use data to the [QualityNet Secure Portal](https://www.qualitynet.org/). The Registration and Attestation System will not be available for Medicare hospitals after December 31, 2017.
- Medicaid Eligible Hospitals: The Registration and Attestation System will still be available for Medicaid eligible hospitals. Medicaid-only hospitals should contact their [state Medicaid agencies](https://www.medicaid.gov) for specific information on how to attest.
- Medicare and Medicaid Eligible Hospitals: Hospitals attesting for both the Medicare and Medicaid EHR Incentive Programs as dually eligible hospitals will register and attest for the Medicare program in the Hospital Quality Reporting System (HQR) system and contact their state Medicaid agencies to submit Medicaid attestations.

For More Information:
- [EHR Incentive Programs website](https://www.cms.gov/Medicare/Billing/EHRIncentiveInnovationInstitute/EHRIncentivePrograms/index.html)
- Contact the EHR Inquiries Mailbox at [EHRinquiries@cms.hhs.gov](mailto:EHRinquiries@cms.hhs.gov).

Chronic Care Management: New Connected Care Videos

The CMS Connected Care campaign has new videos:

- **Physician Testimonial**: A rural physician shares her experience offering Chronic Care Management (CCM) services (2 minutes)
- **Connecting the Dots** ([English](https://www.cms.gov/medicare/medicare-beneficiaries/chronic-care-management.html) and [Spanish](https://www.cms.gov/medicare/medicare-beneficiaries/chronic-care-management.html)): This animated video provides CCM services information for Medicare beneficiaries living with multiple chronic conditions (30 seconds)

You can also download posters and postcards about CCM from the [Connected Care website](https://www.cms.gov/medicare/medicare-beneficiaries/chronic-care-management.html) or request printed copies at no cost from the [CMS Product Ordering website](https://www.cms.gov/medicare/medicare-beneficiaries/chronic-care-management.html):

- **Postcard for Health Care Professionals** (Pub # 909444): An overview of CCM, the four billing codes for payment, and how to learn more about implementation
- **Postcard for Consumers** ([English](https://www.cms.gov/medicare/medicare-beneficiaries/chronic-care-management.html) and [Spanish](https://www.cms.gov/medicare/medicare-beneficiaries/chronic-care-management.html), Pub #909443): Helps you explain CCM and its benefits
- **Poster** ([English](https://www.cms.gov/medicare/medicare-beneficiaries/chronic-care-management.html) and [Spanish](https://www.cms.gov/medicare/medicare-beneficiaries/chronic-care-management.html), Pub #909445): Display in office or waiting room to get your patient’s attention and help start the conversation

For More Information:
- [Connected Care website](https://www.cms.gov/medicare/medicare-beneficiaries/chronic-care-management.html)
- [Connected Care Health Care Professional Toolkit](https://www.cms.gov/medicare/medicare-beneficiaries/chronic-care-management.html)
- [Partner Toolkit](https://www.cms.gov/medicare/medicare-beneficiaries/chronic-care-management.html)
- Email [ccm@cms.hhs.gov](mailto:ccm@cms.hhs.gov)

Medicare Fee-For-Service Beneficiary Selection of a Primary Clinician

Medicare Fee-For-Service beneficiaries are now able to login to [MyMedicare.gov](https://www.medicare.gov) and select their primary clinician, the practitioner the beneficiary believes is responsible for their overall care coordination. Selection of a primary clinician does not affect the beneficiary’s benefits; ability to choose a doctor; or change Medicare Part A or Part B billing and payment policies.

CMS believes that the selection of a primary clinician will strengthen beneficiary engagement in their health care and empower clinicians to better coordinate care. CMS will begin using beneficiary selection in Performance Year 2018 to hold Medicare Shared Savings Program Accountable Care Organization clinicians
Home Health Quality Reporting Program: OASIS-C2 2018 Guidance Manual Available

The 2018 guidance manual for the OASIS-C2 version of the Outcome and Assessment Information Set (OASIS) data set is available. This version corrects errata from the previous version and contains clarifications about the One Clinician Rule. The effective date is January 1, 2018. Visit the OASIS Data Sets and OASIS User Manuals webpages for more information.

Quality Payment Program Hardship Exception Application for 2017 Transition Year Open

The Quality Payment Program Hardship Exception Application for the 2017 transition year is available on the Quality Payment Program website. Merit-based Incentive Payment System (MIPS) eligible clinicians and groups may qualify for a reweighting of their Advancing Care Information performance category score to 0% of the final score and can submit a hardship exception application for one of the following specified reasons:

- Insufficient internet connectivity
- Extreme and uncontrollable circumstances
- Lack of control over the availability of Certified EHR Technology (CEHRT)

There are some MIPS eligible clinicians who are considered Special Status, who will be automatically reweighted (or exempted in the case of MIPS eligible clinicians participating in a MIPS Alternative Payment Model) and do not need to submit a Quality Payment Program Hardship Exception Application.

Quality Payment Program: Explanation of Special Status Calculation — Correction

CMS recently sent a message incorrectly stating that clinicians considered to have “special status” would be exempt from the Quality Payment Program. These circumstances are applicable for rural, non-patient facing and hospital-based clinicians, as well as clinicians in Health Professional Shortage Areas and small practices. Special status affects the number of total measures, activities, or entire categories that an individual clinician or group must report. Individual clinicians or groups with special status are not exempt from the Quality Payment Program because of their special status determination.

Provider Compliance

Home Health Care: Proper Certification Required

Physicians or non-physician practitioners are required to have face-to-face encounters with beneficiaries before they certify eligibility for the home health benefit. One aspect of the certification is for the certifying physician to certify (attest) that the face-to-face encounter occurred and document the date of the encounter. For medical review purposes, Medicare requires documentation in the certifying physician’s medical records and/or the acute/post-acute care facility’s medical records to be used as the basis for certification of patient eligibility. This documentation must include the clinical note or discharge summary for the face-to-face encounter. Avoid home health claims payment denials or improper payment recoveries by understanding Medicare’s requirements.

Resources:

- CY 2015 Home Health Prospective Payment System Final Rule
- Medicare Benefit Policy Manual, Chapter 7, Section 30.5.1
- Certifying Patients for the Medicare Home Health Benefit National Provider Call

MLN Matters® Articles:
Certifying Patients for the Medicare Home Health Benefit

Manual Updates to Clarify Requirements for Physician Certification and Recertification of Patient Eligibility for Home Health Services

Claims, Pricers & Codes

July 2017 OPPS Pricer File

The Outpatient Prospective Payment System (OPPS) Pricer webpage is updated with revised outpatient provider data for July 2017 under “3rd Quarter 2017 Files.” The revised files include new fields for “County code” and “Payment CBSA.”

Part B Billing for Certain New Biosimilar Biological Products before the Modifier is Implemented

Modifiers that identify the manufacturer of a biosimilar biological product are required on Part B claims. CMS updates assignment of modifiers to specific HCPCS codes quarterly. In situations where a HCPCS code is already associated with one or more modifiers and a new biosimilar biological product becomes available before its corresponding manufacturer’s modifier becomes effective, a Not Otherwise Classified (NOC) code without a modifier may be used to bill for the new biosimilar product. For more information, visit the Part B Biosimilar Biological Product Payment and Required Modifiers webpage.

Upcoming Events

IRF Quality Reporting Program Refresher Training Webinar — August 15

Tuesday, August 15 from 2 to 4 pm ET

CMS is hosting a webinar for Inpatient Rehabilitation Facility (IRF) providers. Visit the IRF Quality Reporting Training webpage for more information and to register.

Medicare Diabetes Prevention Program Model Expansion Listening Session — August 16

Wednesday, August 16 from 1:30 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.
Quality Payment Program Year 2 NPRM Virtual Office Hours Session — August 16
Wednesday, August 16 from 12 to 1 pm ET

Register for this session.

Join CMS for a virtual office hours session on the draft provisions included in the Quality Payment Program Year 2 Notice of Proposed Rulemaking (NPRM). CMS provides a brief overview of the Quality Payment Program and addresses questions about the Year 2 NPRM.

CMS is seeking comment on a variety of proposals in the NPRM, as well as alternate proposals that increase program flexibilities. Comments are due by 5 pm ET on August 21.

For More Information:
- Resource Library webpage
- Quality Payment Program Service Center: 866-288-8292 (TTY 877-715-6222) or QPP@cms.hhs.gov.

IMPACT Act: Drug Regimen Review Measure Overview for the Home Health QRP Call — August 17
Thursday, August 17 from 1:30 to 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 for the home health Quality Reporting Program (QRP), which was adopted to fulfill the medication reconciliation domain requirement. 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.

Nursing Home Facility Assessment Tool and State Operations Manual Revisions Call — September 7
Thursday, September 7 from 1:30 to 3 pm ET

Register for Medicare Learning Network events.

During this call, learn about the new Facility Assessment Tool to help identify and develop the specific assessment of your facility. Also, find out about frequently asked questions related to revision of the State
Operations Manual Appendix PP for Phase 2 of the Reform of Requirements for Long-Term Care Facilities final rule. A question and answer session follows the presentation.

Speakers:
- Kelly O’Neill, Stratis Health
- CMS Experts

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

Medicare Learning Network Publications & Multimedia

August 2017 Catalog Available

The August 2017 Catalog is available. Learn about:
- Products and services that can be downloaded for free
- Web-based training courses; some offer continuing education credits
- Helpful links, tools, and tips

Quality Payment Program 2017: MIPS Quality Performance Category Web-Based Training Course — New

A new, online and self-paced overview course on the Quality Payment Program is now available through the Learning Management System. Learners will receive information on the Merit-based Incentive Payment System (MIPS) Quality Performance Category:
- Requirements and how this category fits into the larger Quality Payment Program
- Data submission methods
- Scoring and benchmark methodology

This is the fourth course in an evolving curriculum on the Quality Payment Program. Keep checking the Learning Management System for updates on new courses. This course offers CME credit.

Long-Term Care Call: Audio Recording and Transcript — New

An audio recording and transcript are available for the July 25 call on the Revised Interpretive Guidance for Nursing Homes and 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.

ESRD Listening Session: Audio Recording and Transcript — New

An audio recording and transcript are available for the July 26 listening session on the End-Stage Renal Disease (ESRD) Quality Improvement Program Proposed Rule for Payment Year (PY) 2021. Learn about provisions in the proposed rule, including plans for PY 2019, 2020, and 2021.

Medicare Secondary Payer Web-Based Training Course — Revised
With Continuing Education Credit

A revised Medicare Secondary Payer Web-Based Training (WBT) course is available through the Learning Management System. Learn about:
- Common situations when Medicare may pay first or second
- When Medicare makes conditional payments
Medicare Secondary Payer Booklet — Revised

A revised Medicare Secondary Payer Booklet is available. Learn about:
- Common situations when Medicare may pay first or second
- Medicare conditional payments
- The Coordination of Benefits rules
- The role of the Benefits Coordination & Recovery Center

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