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Official CMS news from the Medicare Learning Network

Wednesday, November 22, 2017

News & Announcements

Medicare Clinical Laboratory Fee Schedule: Final CY 2018 Payment Rates

On November 17, CMS published final payment rates with the supporting data files as part of the implementation of Section 216 of the Protecting Access to Medicare Act of 2014. This section requires clinical laboratories to report how much private insurers pay for lab tests. CMS also published final CY 2018 Clinical Lab Fee Schedule (CLFS) determinations on gapfilling and/or crosswalking methodologies for new laboratory tests and laboratory tests with no reported private payor rate information. The new private payor rate-based CLFS will go into effect on January 1, 2018.

The data reported to CMS captures over 96% of laboratory tests on the CLFS, representing over 96% of Medicare's spending on tests in CY 2016. Laboratories from every state, the District of Columbia, and Puerto Rico reported data.

For More Information:

- CY 2018 CLFS - Final Payment Rates and Crosswalking/Gapfilling Determinations

- Applicable Information Raw Data File
- Annual Laboratory Public Meetings

National Rural Health Day

On November 16, CMS celebrated National Rural Health Day by commemorating our partners who provide quality care to the nearly one in five Americans who reside in rural communities. CMS took action to improve access and quality for healthcare providers serving rural patients, including:

- Released new Medicare telehealth payment codes so more services can be accessed in rural areas
- Placed a two-year moratorium on the direct supervision requirement for outpatient therapeutic services at Critical Access Hospitals(CAHs) and small rural hospitals
- Announced that CAHs should no longer expect to receive medical record reviews related to the 96-hour certification requirement
- Provide free technical assistance through our Service Center, Regional Offices, and the Quality Payment Program webpage
- Finalized policies to reduce burdens and help clinicians in small practices successfully participate in the Quality Payment Program
- Developed resources for rural providers and other stakeholders and centralized resources into a Rural Health website

See the full text of this excerpted blog (issued November 16).

2017 Medicare FFS Improper Payment Rate Below 10 Percent for First Time Since 2013

CMS's new leadership is re-examining existing corrective actions and exploring new and innovative approaches to reducing improper payments, while minimizing burden for its partners. Due to the successes of actions we put into place to reduce improper payments, the Medicare Fee-For-Service (FFS) improper payment rate decreased from 11.0 percent in 2016 to 9.5 percent in 2017, representing a $4.9 billion decrease in estimated improper payments. The 2017 Medicare FFS estimated improper payment rate represents claims incorrectly paid between July 1, 2015, and June 30, 2016. This is the first time since 2013 that the Medicare FFS improper payment rate is below the 10 percent threshold for compliance established in the Improper Payments Elimination and Recovery Act of 2010.

See the full text of this excerpted CMS Blog (issued November 15).

CMS Measures Inventory Tool

CMS is working to improve quality in healthcare without additional burden to those providers on the frontlines.The new CMS Measures Inventory Tool (CMIT), an interactive web-based application, provides a comprehensive list of measures under development, implemented for use, and removed from a CMS quality program or initiative. User-friendly functions allow you to find measures quickly and compile and refine sets of related measures. The tool increases transparency and can be used to identify measures across the continuum of care and will help coordinate measurement efforts across all conditions, settings, and populations. The CMIT lists each measure by program; dates of measure consideration and implementation; and measure specifications. Visit the CMS Measures Inventory webpage or more information.

See the full text of this excerpted CMS Blog (issued November 20).

2016 PQRS Feedback Reports and Annual QRURs: Informal Review Period Ends December 1

The 2016 Physician Quality Reporting System (PQRS) Feedback Reports and 2016 Annual Quality and Resource Use Reports (QRURs) are available. If you believe that your payment adjustment status was made in error, you may request an informal review by December 1 at 8 pm ET:

- 2016 PQRS: 2018 Downward Payment Adjustment - Informal Review Made Simple Guide
- 2018 Value Modifier Informal Review Request Quick Reference Guide

For More Information on Your PQRS Feedback Report:

- Quick Reference Guide for Accessing 2016 PQRS Feedback Reports
- 2016 PQRS Feedback Report User Guide
- Analysis and Payment webpage
- Review materials from September 26 call

For More Information on Your Annual QRUR:

- How to Obtain a QRUR webpage
- 2016 QRUR and 2018 Value Modifier webpage
- Review materials from October 19 webcast

Questions:

- For assistance with Enterprise Identity Management or PQRS Feedback Reports, contact the QualityNet Help Desk at 866-288-8912 (TTY 877-715- 6222) or qnetsupport@hcqis.org
- For assistance with the QRURs or Value Modifier, contact the Physician Value Help Desk at pvhelpdesk@cms.hhs.gov or 888-734-6433 (select option 3)

Hospice Compare: Guidance on Updating Demographic Data

The demographic data displayed on Hospice Compare is generated from the information stored in the Automated Survey Processing Environment (ASPEN) system. View guidance on how to update your demographic information, including address, telephone number, and ownership with your state ASPEN coordinator, as well as the cutoff dates for changes.

Hospice Compare Refresh Delayed

The Hospice Compare Refresh scheduled for November 21 is delayed. CMS will inform the provider community when the new refresh date is determined. This refresh delay will not impact the Hospice Item Set (HIS) freeze date of November 15 and HIS Provider Preview Reports that will be available on December 1.

Submit Suggestions for Precedential Medicare Appeals Council Decisions

The HHS Departmental Appeals Board (DAB) is accepting suggestions for precedential Medicare Appeals Council (Council) decisions from stakeholders, appellants, and the general public. The Council reviews appeals from decisions issued by Administrative Law Judges at the Office of Medicare Hearings and Appeals and is the final level of administrative review in the Medicare appeals process. If you believe that a certain Council decision should be designated as precedential, think there is an issue that should be addressed by precedent, or have any other suggestions regarding precedential decisions, email the suggestion to DABStakeholders@hhs.gov. The DAB will review all suggestions but is unable to respond to each individual submission. For more information, see the DAB's chair announcement.

IPPS Hospitals: Review FY 2014 and FY 2015 Worksheet S-10 Cost Report Data

Form CMS-2552-10 modified the application of the cost to charge ratio for hospital uncompensated and indigent care amounts reported on Worksheet S-10. The modification is applied to all FY 2014 and 2015 cost reports, both amended and not amended, for Inpatient Prospective Payment System (IPPS) hospitals eligible

for a Disproportionate Share (DSH) payment adjustment. To benefit from the modified calculations, review Worksheet S-10 data to ensure your cost reports pass all edits. Amend your cost report if an edit is flagged; amendments must be received on or before January 2, 2018. Approximately 300 DSH eligible IPPS providers need to amend their cost reports to correct these edits.

Worksheet S-10 edits ensure:

- Medicare allowable bad debts do not exceed total facility bad debts
- Charity care charges do not exceed total facility charges
- Charges for patient days beyond the indigent care program's length of stay limit (line 20, column 2) are greater than or equal to charges for patient days beyond the indigent care program's length of stay limit (line 25)

For More Information:

- Transmittal 11
- MLN Matters® Article SE17031

Recommend Influenza Vaccination: Each Office Visit is an Opportunity

People 65 years and older are at greater risk for serious influenza-related complications. The Centers for Disease Control and Prevention (CDC) recommends that everyone 6 months of age and older receive an influenza vaccine every year. Research shows that your recommendation for influenza vaccination and taking action to get yourself vaccinated is vital – to protect your patients, your staff, and yourself.

Medicare Part B covers one influenza vaccination and its administration each influenza season for Medicare beneficiaries. Medicare may cover additional seasonal influenza vaccinations if medically necessary.

For More Information:

- Preventive Services Educational Tool
- Influenza Resources for Health Care Professionals MLN Matters Article
- Influenza Vaccine Payment Allowances MLN Matters Article
- CDC Influenza website
- CDC Influenza Information for Health Professionals webpage
- CDC Make a Strong Flu Vaccine Recommendation webpage

Provider Compliance

OIG Video: Reporting Fraud to the Office of the Inspector General — Reminder

Do you suspect someone is submitting fraudulent claims to Medicare? Watch a brief video on How to Report Fraud to the OIG and learn how you can report these activities anonymously to The Office of the Inspector General (OIG). Help protect the Medicare Program and your patients.

This video is part of the OIG Health Care Fraud Prevention and Enforcement Action Team (HEAT) Provider Compliance Training initiative to prevent fraud, waste, and abuse. The video originally aired in 2011, but the information is current.

Upcoming Events

Revisions to DMEPOS Quality Standards for Therapeutic Shoe Inserts Special Open Door Forum — November 28

Tuesday, November 28 from 2 to 3 pm ET

This Special Open Door Forum allows podiatrists; orthotic and prosthetic providers; and other interested parties to ask questions on the proposed revisions to the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Quality Standards released in draft form on November 2. See the announcement for more information.

Quality Payment Program Year 2 Final Rule Call — November 30
Thursday, November 30 from 1:30 to 3 pm ET

Register for Medicare Learning Network events.

The Quality Payment Program, established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), is a quality payment incentive program for physicians and other eligible clinicians, which rewards value and outcomes in one of two ways:

- The Merit-based Incentive Payment System
- Alternative Payment Models

The Quality Payment Program allows clinicians to choose the best way to deliver quality care and participate based on their practice size, specialty, location, or patient population. During this call, learn about the Quality Payment Program Year 2 provisions in the final rule with comment and interim final rule with comment; participants should review the final rules prior to the call. A question and answer session follows the presentation.

Target Audience: Medicare Part B Fee-For-Service clinicians; office managers and administrators; state and national associations that represent healthcare providers; and other stakeholders.

Medicare Diabetes Prevention Program Model Expansion Call — December 5
Tuesday, December 5 from 1:30 to 3 pm ET

Register for Medicare Learning Network events.

The CY 2018 Medicare Physician Fee Schedule final rule includes the expansion of the Medicare Diabetes Prevention Program (MDPP) Model starting in 2018. During this call, CMS experts provide a high-level overview of the finalized policies. A question and answer session follows the presentation.

The MDPP expanded model is a structured intervention with the goal of preventing progression to type 2 diabetes in individuals with an indication of pre-diabetes. Participants should review the final rule prior to the call.

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, non-for-profits; associations, and advocacy groups focused on seniors or diabetes; and other interested stakeholders, including health plans, primary care/internal medicine specialties.

SNF QRP: Assessment-Based Measures Confidential Feedback Report Webinar — December 6
Wednesday, December 6 from 2 to 3 pm ET

Register for this webinar.

CMS experts provide information on the Confidential Feedback Reports for the assessment-based measures adopted for the Skilled Nursing Facility (SNF) Quality Reporting Program (QRP). These reports will be available in your Certification and Survey Provider Enhanced Reporting (CASPER) folder in late November. For more information, visit the SNF QRP Training webpage.

LTCH Quality Reporting Program In-Person Training — December 6 and 7

Wednesday, December 6 through Thursday, December 7 in Dallas, TX

Register for this training.

CMS is hosting a 2-day Long Term Care Hospital (LTCH) Quality Reporting Program Train the Trainer event. See the LTCH Quality Reporting Training webpage for details.

IMPACT Act Special Open Door Forum — December 12

Tuesday, December 12 from 2 to 3 pm ET

This Special Open Door Forum (SODF) provides information and solicits feedback on the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act):

- Update on RAND's national field test launch
- Planned stakeholder engagement activities for 2018
- Ways to remain engaged and informed during the upcoming year

View the announcement for more information.

National Partnership to Improve Dementia Care and QAPI Call — December 14

Thursday, December 14 from 1:30 to 3 pm ET

Register for Medicare Learning Network events.

During this call, learn how to work with physicians to ensure compliance with the new psychotropic medication prescribing requirements for long-term care facilities. Also, find out how nursing homes are putting the new Quality Assurance Performance Improvement (QAPI) requirements into practice. Additionally, CMS experts share updates on the progress of the National Partnership to Improve Dementia Care in Nursing Homes and QAPI. A question and answer session follows the presentations.

Speakers:

- Dr. Arif Nazir, Signature Healthcare
- Deb Fournier, Maine Veterans' Homes
- Sarah Schumann, Brookside Inn (Colorado)
- Michele Laughman and Debbie Lyons, CMS

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

Medicare Learning Network Publications & Multimedia

Medicare Fraud & Abuse Poster — New

A new Medicare Fraud & Abuse Poster is available. Learn about actions that are considered fraud or abuse, and find out about Medicare Learning Network materials on this topic.

Medicare Fraud & Abuse: Prevention, Detection, and Reporting Booklet — Revised

A revised Medicare Fraud & Abuse: Prevention, Detection, and Reporting Booklet is available. Learn about:

- Fraud and abuse in healthcare

- Laws governing fraud and abuse activities
- Government partnerships fighting fraud and abuse
- Where to report suspected fraud and abuse

Medicare Disproportionate Share Hospital Fact Sheet — Revised

A revised Medicare Disproportionate Share Hospital Fact Sheet is available. Learn about:

- Methods to qualify for the Medicare Disproportionate Share Hospital (DSH) adjustment
- Medicare Prescription Drug, Improvement, and Modernization Act and Affordable Care Act provisions that impact Medicare DSHs
- Counting the number of beds and patient days in hospital
- Payment adjustment formulas

ABCs of the Initial Preventive Physical Examination Educational Tool — Reminder

The revised ABCs of the Initial Preventive Physical Examination Educational Tool is available. Learn about:

- Components
- Coding, diagnosis, and billing
- Frequently Asked Questions

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