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Official CMS news from the Medicare Learning Network

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First Breakthrough-Designated Test to Detect Extensive Number of Cancer Biomarkers

On November 30, the U.S. Food and Drug Administration (FDA) approved the FoundationOne CDx (F1CDx), the first breakthrough-designated, Next Generation Sequencing (NGS)-based In Vitro Diagnostic (IVD) test that can detect genetic mutations in 324 genes and two genomic signatures in any solid tumor type. CMS at the same time proposed coverage of the F1CDx. The test is the second IVD to be approved and covered after overlapping review by the FDA and CMS under the Parallel Review Program, which facilitates earlier access to innovative medical technologies for Medicare beneficiaries.

Compared to other companion diagnostics previously approved by the FDA that match one test to one drug, the F1CDx is a more extensive test that provides information on a number of different genetic mutations that may help in the clinical management of patients with cancer. Additionally, based on individual test results, the new diagnostic can identify which patients with any of five tumor types may benefit from 15 different FDA-approved targeted treatment options. Its results provide patients and health care professionals access to all of this information in one test report, avoiding duplicative biopsies.

CMS issued a proposed national coverage determination of the F1CDx and other similar NGS IVDs for Medicare beneficiaries with advanced cancer, who have not been previously tested using the same NGS technology and continue to seek further cancer therapy. The proposed national coverage determination provides coverage of NGS IVD tests to assist patients and their treating physicians in making informed cancer treatment decisions that improve health outcomes. Use of a test as a diagnostic also includes the ability to help patients and their treating physicians determine candidacy for cancer clinical trials.

See the full text of this excerpted CMS Press Release (issued November 30).

CMS Finalizes Comprehensive Care for Joint Replacement Model Changes, Cancels Episode Payment Models & Cardiac Rehabilitation Incentive Payment Model

On November 30, CMS finalized the cancellation of the mandatory hip fracture and cardiac bundled payment models that were to be operated by the CMS Innovation Center and implemented changes to the Comprehensive Care for Joint Replacement (CJR) Model. These changes will offer greater flexibility and choice for hospitals in providing care to Medicare patients.

"While CMS continues to believe that bundled payment models offer opportunities to improve quality and care coordination while lowering spending, we believe that focusing on developing different bundled payment models and engaging more providers is the best way to drive health system change while minimizing burden and maintaining access to care. We anticipate announcing new voluntary payment bundles soon," said CMS Administrator Seema Verma.

In the final rule, CMS is reducing the number of mandatory geographic areas participating in CJR from 67 areas to 34 areas. As part of the agency's ongoing commitment to addressing the unique needs of rural providers, CMS is also making participation voluntary for all low volume and rural hospitals participating in the model in all 67 geographic areas. This regulation also includes an Interim Final Rule with Comment Period, in which CMS is establishing and seeking comment on a final policy to provide flexibility in determining episode costs for participant hospitals located in areas impacted by extreme and uncontrollable circumstances, such as the major hurricanes of 2017.

For More Information:

- Fact Sheet
- CJR Model webpage
- Final Rule and Interim Final Rule with Comment

See the full text of this excerpted CMS Press Release (issued November 30).

Updated Medicare Part D Opioid Drug Mapping Tool

On November 29, CMS released an updated version of the Medicare Part D Opioid Prescribing Mapping Tool, an interactive, web-based resource that presents geographic comparisons of Medicare Part D opioid prescribing rates:

- Includes extended-release opioid prescribing rates and county-level hot spots and outliers, which may identify areas that warrant attention

- Presents Medicare Part D opioid prescribing rates for 2015 as well as the change in opioid prescribing rates from 2013 to 2015

The mapping tool offers local communities greater transparency into opioid prescribing in the Medicare Part D program. Communities can use this resource to understand how this critical issue affects their area, examine regional variation, and make informed decisions about how to allocate resources. The underlying data that feeds this tool is also used by CMS to monitor and manage high risk use of opioids in the Part D program.

Prescription opioids can be prescribed by doctors to treat moderate to severe pain, however, they also can have serious risks including addiction and overdose. The majority of drug overdose deaths involve opioids, and since 1999, the number of overdose deaths involving prescription opioids has quadrupled. In 2015, more than 15,000 people died from overdoses involving prescription opioids.

See the full text of this excerpted Press Release (issued November 29).

Quality and Cost Measures under Consideration: CMS Releases List for 2018 Pre-rulemaking

CMS posted the Measures under Consideration List on the Pre-Rule Making webpage. Each year, CMS publishes a list of quality and cost measures that are under consideration for Medicare quality reporting and value-based purchasing programs and collaborates with the National Quality Forum (NQF) to get critical input from multiple stakeholders on the measures that are best suited for these programs. CMS is taking a new approach to coordinated implementation of meaningful quality measures focused on the most critical, highly impactful areas for improvement while reducing the burden of quality reporting on all providers so they can spend more time with their patients. For more information on public stakeholder review, visit the NQF website.

See the full text of this excerpted CMS Blog (issued November 30).

Hospice Provider Preview Reports: Review by December 30

Two reports are available in your Certification and Survey Provider Enhanced Reports (CASPER) folder: Hospice Provider Preview Report and Hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Provider Preview Report. Review your reports by December 30:

- Hospice Item Set (HIS) quality measure results from second quarter 2016 to first quarter 2017
- Facility-level CAHPS survey results from second quarter 2015 to first quarter 2017

You can request a CMS review if you think that the denominator or other HIS quality metric is inaccurate or if there are errors within the results from the CAHPS survey data. For information on the review process, see the Hospice Quality Public Reporting and CAHPS Preview Reports webpages.

Access Instructions:

- Hospice Provider Preview Report
- Hospice CAHPS Provider Preview Report

Quality Payment Program Hardship Exception Application Deadline: December 31

The deadline to submit a Quality Payment Program Hardship Exception Application for the 2017 transition year is December 31. Merit-based Incentive Payment System eligible clinicians and groups may submit a hardship exception application for one of the following reasons:

- Insufficient internet connectivity
- Extreme and uncontrollable circumstances
- Lack of control over the availability of Certified Electronic Health Record Technology

For More Information:

- About Hardship Exceptions webpage
- Quality Payment Program website
- For questions, contact the Quality Payment Program Service Center at QPP@cms.hhs.gov or 866-288-8292 (TTY: 877-715-6222)

IRF and LTCH Provider Preview Reports: Review by January 3

Inpatient Rehabilitation Facility (IRF) and Long-term Care Hospital (LTCH) Quality Reporting Program Provider Preview Reports are available through January 3. Review your performance data on each quality measure, based on second quarter 2016 to first quarter 2017 data, prior to public display on IRF Compare and LTCH Compare. Corrections to the underlying data are not be permitted during this preview period; however, you can request a CMS review if you believe your data is inaccurate.

For More Information:

- IRF Quality Public Reporting webpage and Preview Report Access Instructions
- LTCH Quality Public Reporting webpage and Preview Report Access Instructions

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New PEPPER Available for Short-term Acute Care Hospitals

Third quarter FY 2017 Program for Evaluating Payment Patterns Electronic Reports (PEPPERs) are available for short-term acute care hospitals. 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. The PEPPER files were recently distributed through a QualityNet secure file exchange to hospital QualityNet Administrators and user accounts with the PEPPER recipient role.

Visit PEPPERresources.org for more information, including guides, recorded training sessions, information about QualityNet accounts, frequently asked questions, and examples of how other hospitals are using PEPPER. If you have questions or need help obtaining your report, visit the Help Desk. Send us your feedback or suggestions.

Quality Payment Program Resources

CMS posted new Merit-based Incentive Payment System (MIPS) resources on Quality Payment Program Resource Library webpage:

- CMS Web Interface: Excel template for uploading sample beneficiary data with corresponding user guide and instructional video
- Extreme and Uncontrollable Circumstances Fact Sheet: Overview of the policy established in the interim final rule with comment period to support clinicians affected by the California wildfires and Hurricanes Harvey, Irma, and Maria
- MIPS 101 Guide: Overview of MIPS, including who is eligible to participate, three ways to participate in 2017, and reporting requirements for the four performance categories
- MIPS Optometry Specialty Guide: Sample of measures and activities for the Quality, Improvement Activities, and Advancing Care Information performance categories that may apply to optometry in 2017
- MIPS Participation Infographic: Three ways eligible clinicians can participate in MIPS in 2017
- Quality Payment Program FAQs: Answers to nearly 40 questions about the Quality Payment Program in 2017

Other Resources:

- MIPS Scoring 101 Guide
- Specialty guides for radiologists and podiatrists
- Virtual Groups Toolkit

For More Information:

- Visit the Quality Payment Program website to check your participation status, explore measures, and review guidance
- Quality Payment Program Resource Library webpage
- For questions, contact the Quality Payment Program Service Center at QPP@cms.hhs.gov or 866-288-8292 (TTY: 877-715-6222)

Extreme and Uncontrollable Circumstances Policy for MIPS Clinicians in 2017

Many clinicians are affected by the Northern California wildfires and Hurricanes Harvey, Irma, and Maria—all of which happened in 2017, the transition year for the Merit-based Incentive Payment System (MIPS). As part of the Quality Payment Program Year 2 final rule, CMS issued an interim final rule with comment period, which includes the Extreme and Uncontrollable Circumstances policy for the transition year of MIPS.

For More Information:

- Fact Sheet
- For questions, contact the Quality Payment Program Service Center at QPP@cms.hhs.gov or 866-288-8292 (TTY: 877-715-6222)

Targeted Probe and Educate Limits MAC Medical Record Reviews

Targeted Probe and Educate (TPE) is a new initiative at Medicare Administrative Contractors (MACs) to:

- Limit the number of medical records requested for review
- Emphasize education and assistance in correcting claims errors

TPE involves the review of 20 to 40 claims per provider/supplier, per item or service, followed by personalized education. MACs repeat this process of review and education up to three times:

- Providers who follow Medicare's rules before the end of the three rounds will be removed from review for that topic
- Providers who do not will be referred to CMS for stronger corrective action

This new process reduces burden if you quickly become compliant with Medicare rules. Find out more on the TPE webpage.

Medical Record Documentation: Helpful Clinical Templates and Data Elements

Clinical templates and suggested Clinical Data Elements (CDEs) are available to assist you with data collection and medical record documentation:

- IT vendors: Integrate the CDEs into Electronic Health Record (EHR) systems to remind providers what they need to document
- Providers: If you are not using an EHR, you can print a template, fill it out, and file it in the patient's medical record

Find Clinical Template and CDEs for:

- Home health
- Glucose monitors
- Oxygen
- Lower limb prosthesis
- Power mobility devices

Qualified Medicare Beneficiary: HETS and Remittance Advice

Look for new information and messages in the CMS HIPAA Eligibility Transaction System (HETS) to identify patients' Qualified Medicare Beneficiary (QMB) status and exemption from cost-sharing prior to billing. See the MLN Matters® Special Edition Article to learn about QMB billing requirements and steps you can take to promote compliance.

On October 2, provider Remittance Advices (RAs) and Medicare Summary Notices (MSNs) began identifying the QMB status of beneficiaries and reflecting their zero cost-sharing liability. However, beginning December 8, CMS will temporarily suspend the system changes due to unforeseen issues affecting the processing of QMB cost-sharing claims by states and other payers secondary to Medicare. We are working to remediate these issues, with the goal of reintroducing QMB information to RAs and MSNs in 2018. Visit the QMB Program webpage for more information.

Can I change the QMB status information in HETS if I think it is incorrect?
No, states submit QMB information to CMS at least monthly but as often as daily. If you think the data is incorrect, check the applicable state Medicaid eligibility system and compare it to the information received via HETS 270/271. If there is a discrepancy between the two systems, default to the state Medicaid system eligibility response status.

National Influenza Vaccination Week: December 3 through 9

National Influenza Vaccination Week is a national observance that highlights the importance of continuing influenza vaccination through the holiday season and beyond. The Centers for Disease Control and Prevention (CDC) recommends that everyone 6 months of age and older receive an influenza vaccine every year. Now is a great time to vaccinate – 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

National Handwashing Awareness Week: December 3 through 9

Practicing hand hygiene is a simple yet effective way to prevent infections. Cleaning your hands can prevent the spread of germs, including those that are resistant to antibiotics. Create a safe environment for your patients and staff.

Medicare Learning Network resources:

- Infection Control: Hand Hygiene Video — Learn when to wash your hands and techniques to wash visibly and non-visibly dirty hands — run time 1:58 minutes
- Infection Control: Hand Hygiene Web-Based Training Course — Learn about hand hygiene in patient care zones and nearby administrative areas; appropriate methods for maintaining good hand hygiene; and how to recognize opportunities for hand hygiene in a health care setting — with continuing education credit

Provider Compliance

Hospital Discharge Day Management Services CMS Provider Minute Video — Reminder

Avoid delays. Bill it right the first time. The CMS Provider Minute: Hospital Discharge Day Management Services video includes helpful pointers to properly bill for these services. Learn about:

- Appropriate Healthcare Common Procedure Coding System (HCPCS) codes
- Who can submit a bill

This video is part of a series to help providers of all types improve in areas identified with a high degree of noncompliance.

Claims, Pricers & Codes

January 2018 Average Sales Price Files Available

CMS posted the January 2018 Average Sales Price (ASP) and Not Otherwise Classified (NOC) pricing files and crosswalks on the 2018 ASP Drug Pricing Files webpage.

Upcoming Events

Medicare Diabetes Prevention Program Model Expansion Orientation Webinar — December 13

Wednesday, December 13 from 1 to 2:30 pm ET

Register for this webinar.

This webinar provides key information that enables interested Medicare Diabetes Prevention Program (MDPP) suppliers to prepare for Medicare enrollment:

- Overview of Medicare and MDPP services
- How to enroll as an MDPP supplier
- MDPP supplier support needs, requirements, and resources

A question and answer session follows the presentation.

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.

Home Health QRP: Proposed Removal of Influenza Vaccination Measure from Home Health Quality of Patient Care Star Rating Webinar — December 14

Thursday, December 14 from 2 to 3 pm ET

Register for this webinar.

Following the October 10 Medicare Learning Network call on the Quality of Patient Care Star Rating Algorithm, CMS is finalizing the proposal to remove the Influenza Vaccination Measure. During this webinar, CMS presents the rationale, comments received, timing, and impact of this change. For more information, visit the Home Health Quality Reporting Program (QRP) Training webpage.

Medicare Learning Network Publications & Multimedia

DMEPOS Quality Standards Educational Tool – Revised

A revised DMEPOS Quality Standards Educational Tool is available. Learn about:

- Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) quality standards for suppliers
- Accreditation organizations
- Business service requirements
- Product-specific service requirements.

Advance Beneficiary Notice of Noncoverage Interactive Tutorial Educational Tool — Revised

A revised Advance Beneficiary Notice of Noncoverage Interactive Tutorial Educational Tool is available. Learn about: completing the Advance Beneficiary Notice of Noncoverage (ABN) which allows beneficiaries to make informed decisions about items or services that may not be covered by Medicare.

Medicare Advance Written Notices of Noncoverage Booklet — Revised

A revised Medicare Advance Written Notices of Noncoverage Booklet is available. Learn about:

- Issuing and completing advance written notices of noncoverage
- Prohibitions and frequency limits
- Collecting payment from the beneficiary
- Financial liability
- Claim reporting modifiers
- When you should not use the notice.

How to Use the Searchable Medicare Physician Fee Schedule Booklet — Revised

A revised How to Use the Searchable Medicare Physician Fee Schedule Booklet is available. Learn about:

- Navigating the Medicare Physician Fee Schedule
- Searching for payment information, pricing, and relative value units
- Payment policies

Long-Term Care Hospital Prospective Payment System Booklet — Revised

A revised Long-Term Care Hospital Prospective Payment System Booklet is available. Learn about:

- Certification

- Medicare Severity Long-Term Care Diagnosis-Related Groups patient classification
- Site neutral payment rate, payment policy adjustments, and payment updates
- Quality Reporting Program

Power Mobility Devices Booklet — Revised

A revised Power Mobility Devices Booklet is available. Learn about:

- General coverage criteria
- Provider and supplier requirements
- Programs that may affect reimbursement

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