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Official CMS news from the Medicare Learning Network

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News & Announcements

SNF FY 2019 Payment and Policy Changes

On July 31, CMS issued a [final rule](#) outlining Fiscal Year (FY) 2019 Medicare payment updates and quality program changes for skilled nursing facilities (SNFs). Three major provisions of the rule:

- Changes to the case-mix classification system used under the SNF Prospective Payment System (PPS)
- SNF Value-Based Purchasing Program (VBP)
- SNF Quality Reporting Program (QRP)

The final rule includes policies that continue a commitment to shift Medicare payments from volume to value, with continued implementation of the SNF VBP and SNF QRP.

Effective October 1, 2019, we will use a new case-mix model, the Patient-Driven Payment Model, which focuses on the patient's condition and resulting care needs rather than on the amount of care provided in order to determine Medicare payment. The final rule also modernizes Medicare through innovation in SNF, meaningful quality measure reporting, reduced paperwork, and reduced administrative costs.

Based on changes contained within this final rule, we estimate that the FY 2019 aggregate impact will be an increase of \$820 million in Medicare payments to SNFs, resulting from the FY 2019 SNF market basket update required to be 2.4 percent by the Bipartisan Budget Act of 2018. Absent the application of this statutory requirement, the FY 2019 market basket update factor would have been 2.0 percent which reflects the SNF FY 2019 market basket index of 2.8 percent, reduced by the multifactor productivity adjustment of 0.8 percent. This 2.0 percent update would have resulted in an estimated aggregate increase of \$670 million in Medicare payments to SNFs.

Find more information in the [Fact Sheet](#).

IRF FY 2019 Prospective Payment System Final Rule

On July 31, CMS issued a [final rule](#) outlining changes to how Medicare pays inpatient rehabilitation facilities (IRFs) to support the Patients over Paperwork Initiative, and to facilitate the use of electronic health records. It finalizes updates to Medicare payment policies and rates under the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS).

The updates in the IRF PPS final rule further the agency's priority of creating a patient-driven healthcare system by achieving greater price transparency, interoperability, and significant burden reduction, while ensuring a focus on quality, safety, and program integrity.

In the FY 2018 IRF PPS proposed rule, CMS released a Request for Information (RFI) that solicited ideas to provide greater flexibilities and efficiencies in the IRF PPS. CMS received numerous ideas in response to the Request for Information on how to improve the IRF PPS from beneficiaries, clinicians, advocacy groups, and other stakeholders. The policies in the final rule are responsive to this feedback.

Provisions of the final rule include:

- Burden Reduction / Patients over Paperwork
- Meaningful Measures
- Advancing My HealthEData: Request for Information

For FY 2019, CMS is updating IRF PPS payments to reflect an estimated 1.35 percent increase factor (reflecting an IRF market basket update of 2.9 percent, reduced by a 0.8 percentage point multifactor productivity adjustment and a 0.75 percentage point reduction required by law). An additional approximate 0.1 percent decrease to aggregate payments due to updating the outlier threshold to maintain estimated outlier payments at 3.0 percent of total payments results in an overall estimated update for FY 2019 of approximately 1.3 percent (or \$105 million), relative to payments in FY 2018.

Read the full text of this excerpted [Fact Sheet](#) (issued July 31).

IPF FY 2019 Final Medicare Payment and Quality Reporting Updates

On July 31, CMS issued a [rule](#) finalizing fiscal year (FY) 2019 updates to Medicare payment policies and rates for the Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) and to the IPF Quality Reporting (IPFQR) Program.

We estimate IPF payments will increase by 1.10 percent or \$50 million in FY 2019. This amount reflects a 2.9 percent IPF market basket update less the productivity adjustment of 0.80 percentage point and less the 0.75 percentage point reduction required by law, for a net market basket update of 1.35 percent. Additionally, estimated payments to IPFs are reduced by 0.24 percentage point due to updating the outlier fixed-dollar loss threshold amount.

We are finalizing removal of 5 IPFQR Program measures beginning with the FY 2020 payment determination and subsequent years. Three other measures that were originally proposed for removal (Physical Restraint

Use, Seclusion Use, and Tobacco Use Treatment at Discharge) are being retained in the program as a result of overwhelming public comment that emphasized their importance for patient safety and health issues specific to the patient population.

In addition, we are finalizing our proposal to no longer require facilities to submit sample size counts for measures for which sampling is performed beginning with the FY 2020 payment determination.

Read the full text of this excerpted [Fact Sheet](#) (issued July 31).

Qualified Medicare Beneficiary Program Billing Requirements FAQs

During the June 6 Medicare Learning Network call, CMS experts discussed Qualified Medicare Beneficiary (QMB) billing requirements and their implications. Updated [FAQ](#) are available, including new FAQs on Advance Beneficiary Notices and statutorily excluded services and revised information for Medicare Advantage providers.

For More Information:

- [Materials from June 6 call](#)
- [Prohibition on Billing Dually Eligible Individuals Enrolled in the QMB Program](#) MLN Matters Article
- [QMB Program](#) webpage

Data Element Library Webinar: Video Recording

A [video](#) is available of the July 11 webinar about the [Data Element Library](#); a public resource about CMS assessments. This video includes a review of the Improving Medicare Post-Acute Care Transformation Act of 2014, standardization and interoperability, and an overview and demonstration of the Data Element Library.

CMS Administrator Address on Strengthening Medicare

On July 25, CMS Administrator Seema Verma delivered a speech focused on Strengthening Medicare at the Commonwealth Club of California.

Learn more in the [prepared remarks](#) and [video](#).

2018 QRDA III Implementation Guide for Eligible Professionals — Updated

CMS updated the [2018 CMS Quality Reporting Document Architecture Category III \(QRDA III\) Implementation Guide \(IG\) for Eligible Clinicians and Eligible Professionals](#).

More Information:

- [What changed](#)
- [Electronic Clinical Quality Improvement Resource Center](#) - QRDA related resources, current and past IGs
- Questions about QRDA IGs and Schematrons - [ONC QRDA JIRA Issue Tracker](#)
- Questions on Quality Payment Program/Merit-Based Incentive Payment System data submissions - Quality Payment Program website; call 1-866-288-8292 (TTY: 1-877-715-6222) or email QPP@cms.hhs.gov

LTCH Provider Preview Reports Reissued

Your June 2018 Provider Preview Report for the Discharge to Community (DTC) - Post-Acute Care (PAC) Long-Term Care Hospital Quality Reporting Program (L018.01) measure contained an error; your risk-standardized rate and performance category was based only on 7 of the 8 required quarters of data. Data from October through December 2016 (Q1 FY 2017) were inadvertently omitted.

Corrected Preview Reports containing the DTC measure data are available via your Certification and Survey Provider Enhanced Reports (CASPER) system folders. We redistributed this report for the 30-day preview period in advance of public reporting for the September 2018 LTCH Compare Refresh. You can preview the corrected DTC data through August 31. Submit inquiries to LTCHPRquestions@cms.hhs.gov no later than 11:59:59 pm ET August 31.

For More Information:

- [LTCH Provider Preview Report Access Instructions](#)

Provider Compliance

Ophthalmology Services: Questionable Billing and Improper Payments — Reminder

The Office of the Inspector General (OIG) reports that Medicare is vulnerable to fraud, waste, and abuse for wet Age-related Macular Degeneration (wet AMD) and cataracts:

- Administration of Lucentis injections for wet AMD more than once every 28 days (based on local coverage determinations)
- Billing for a second cataract surgery on the same eye
- Submitting disproportionately more claims for complex than standard cataract surgery

Review the following resources for proper claims coding, billing, and payment:

- [Questionable Billing for Medicare Ophthalmology Services](#) OIG Report, September 2015
- [Medicare Paid \\$22 Million in 2012 for Potentially Inappropriate Ophthalmology Claims](#) OIG Report, December 2014
- [Cataract Removal, Part B](#) MLN Matters® Special Edition Article
- [Implementation of CMS Ruling Regarding Presbyopia-Correcting Intraocular Lenses for Medicare Beneficiaries](#) MLN Matters Article
- [Multiple Procedure Payment Reduction on the Technical Component of Diagnostic Cardiovascular and Ophthalmology Procedures](#) MLN Matters Article
- [Medicare Vision Services](#) Fact Sheet
- [NCCI Policy Manual for Medicare Services, Chapter 8](#): Section D: Ophthalmology
- [Medicare National Coverage Determinations Manual, Part 1](#): Section 10.1: Use of Visual Tests Prior to and General Anesthesia During Cataract Surgery
- [Medicare Benefit Policy Manual, Chapter 15](#): Section 120: Prosthetic Devices and Section 260.2: Ambulatory Surgical Center Services

Upcoming Events

MIPS Quality Performance Category for Year 2 (2018) Overview Webinar — August 6

Monday, August 6 from 1-2 pm

[Register](#) for this webinar.

CMS will cover topics including category requirements, scoring details, and data submission mechanisms.

ESRD Quality Incentive Program: CY 2019 ESRD PPS Proposed Rule Call — August 14

Tuesday, August 14 from 2 to 3 pm ET

[Register](#) for Medicare Learning Network events.

During this call, learn about proposals for the End Stage Renal Disease Quality Incentive Program (ESRD QIP) in the CY 2019 ESRD Prospective Payment System (PPS) [proposed rule](#). Topics include:

- ESRD QIP legislative framework
- Proposed updates to ESRD QIP measures, domain structure, and weights
- Proposed modifications to data submission requirements and the National Healthcare Safety Network Validation Study
- Methods for reviewing and commenting on the proposed rule

Please note: This call will not include a question and answer session.

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

Sharing Federal Strategies to Address the Opioid Epidemic Open Door Forum — August 15

Wednesday, August 15 from 1:30 -3 pm ET

CMS will host a Special Open Door Forum to educate opioid prescribers on federal resources and strategies to combat the opioid epidemic. The misuse of and addiction to opioids—including prescription pain relievers, heroin, and synthetic opioids such as fentanyl—is a serious national crisis that affects public health as well as social and economic welfare.

Hear information from the following federal agencies:

- CMS
- Centers for Disease Control and Prevention
- Food and Drug Administration
- Substance Abuse and Mental Health Services Administration
- Office of Inspector General, U.S. Department of Health & Human Services

Participation Instructions:

- Participant Dial-In Number: 800-857-1738; Conference ID #: 7785347
- TTY Communications Relay Services are available for the Hearing Impaired; dial 7-1-1 or 800-855-2880

A transcript and audio recording will be posted to the [Podcasts and Transcripts](#) webpage.

Physician Fee Schedule Proposed Rule: Understanding 3 Key Topics Listening Session – August 22

Wednesday, August 22 from 1:30 to 3 pm

[Register](#) for Medicare Learning Network events.

Proposed changes to the CY 2019 Physician Fee Schedule would increase the amount of time doctors and other clinicians spend with their patients by reducing the burden of Medicare paperwork. During this listening session, CMS experts will briefly cover three provisions from the proposed rule and address your clarifying questions to help you formulate your written comments for formal submission:

- Streamlining Evaluation and Management (E/M) payment and reducing clinician burden
- Advancing virtual care
- Continuing to improve the Quality Payment Program to reduce clinician burden, focus on outcomes, and promote interoperability

We encourage you to review the [proposed rule](#) prior to the call, as well as the following materials on the provisions to be covered:

- Quality Payment Program Year 3 (2019) [Webinar Recording](#), [Transcript](#), [Presentation](#), and [Comparison Fact Sheet](#)
- [Slide presentation on E/M and Advancing Virtual Care](#)
- E/M Coding Reform videos: [Introduction](#), [Office Visits](#) and [Panel Discussion](#)

Note: feedback received during this listening session will not be considered formal comments on the rule. See the [proposed rule](#) for information on submitting these comments by September 10, 2018.

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 Learning Network® Publications & Multimedia

Provider Minute Video: Physician Orders/Intent to Order Laboratory Services and Other Diagnostic Services - New

Proper physician orders are important to you and your patients. Find out how they affect patient care/services, claim payment, and medical review in the [Provider Minute: Physician Orders/Intent to Order Laboratory Services and Other Diagnostic Services](#). Learn about:

- Importance of legible signed orders
- Signed orders versus Intent to Order Services
- Documentation of Medical Necessity

PECOS Technical Assistance Contact Information Fact Sheet — Reminder

The [PECOS Technical Assistance Contact Information](#) Fact Sheet is available. Learn about:

- Common problems and who to contact
- Provider Enrollment, Chain, and Ownership System (PECOS) resources

Medicare Enrollment Resources Educational Tool — Reminder

The [Medicare Enrollment Resources](#) Educational Tool is available. Learn about:

- How to enroll in the Medicare Program
- What to do if you run into problems
- Where to locate enrollment forms

PECOS for DMEPOS Suppliers Booklet — Reminder

The [PECOS for DMEPOS Suppliers](#) Booklet is available. Learn about:

- Medicare enrollment application submission options in the Provider Enrollment, Chain, and Ownership System (PECOS)
- Individual and organizational Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers

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