



MLN Connects™ Provider eNews

Part of the Medicare Learning Network®

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MLN Connects™ National Provider Calls

Did You Miss These MLN Connects Calls?

Call materials for MLN Connects™ Calls are located on the [Calls and Events](#) web page. New materials are now available for the following calls:

- August 7 — ESRD Quality Incentive Program: Reviewing Your Facility’s Payment Year 2014 Performance Data: [audio](#) and [transcript](#)
- August 8 — OPEN PAYMENTS - Policy Updates on Payments and the Physician Resource Toolkit: [audio](#) and [transcript](#)

MLN Educational Products Update

“Guidance for Correct Claims Submission When Secondary Payers Are Involved” MLN Matters® Article — Reminder

[MLN Matters® Special Edition Article #SE1217](#), “Guidance for Correct Claims Submission When Secondary Payers Are Involved,” is available in downloadable format. This article is designed to provide education on how Medicare health care professionals should correctly submit claims associated with a Medicare Secondary Payer (MSP). It includes guidance to ensure that MSP information is captured at the time of billing and that treatment is not denied by a physician, provider, or other supplier based on an open MSP record.

“Quick Reference Chart: Short & Long Descriptors for Therapy Functional Reporting G-codes” Educational Tool — Released

The “[Quick Reference Chart: Short & Long Descriptors for Therapy Functional Reporting G-codes](#)” Educational Tool (ICN 908924) is now available as an electronic publication (EPUB) and through a QR code. This educational tool is designed to provide short & long descriptors for each of the 42 non-payable functional G-codes. It also includes severity/complexity modifiers which are used to report functional limitation.

The EPUB format is available under the “Related Links” section of the publication’s detail page. The QR code is also located on the detail page. Instructions for downloading the EPUB and how to scan a QR code are available at “[How To Download a Medicare Learning Network® \(MLN\) Electronic Publication](#)” on the CMS website.

New MLN Educational Web Guides Fast Fact

A new fast fact is now available on the [MLN Educational Web Guides](#) web page. This web page provides information on Evaluation and Management services; Guided Pathways that contain resources and topics of interest; lists of health care management products; and easy-to-understand billing and coding educational products. It is designed to provide educational and informational resources related to certain CMS initiatives. Please bookmark this page and check back often as a new fast fact is added each month.

New MLN Provider Compliance Fast Fact

A new fast fact is now available on the [MLN Provider Compliance](#) web page. This web page provides the latest [MLN Educational Products](#) and [MLN Matters® Articles](#) designed to help Medicare FFS providers understand common billing errors and avoid improper payments. Please bookmark this page and check back often as a new fast fact is added each month.

“A Physician’s Guide to Medicare Part D Medication Therapy Management Programs” Podcast — Reminder

The “[A Physician’s Guide to Medicare Part D Medication Therapy Management Programs](#)” Podcast (ICN 903694) is available in downloadable format. This podcast is designed to provide education on the Medicare Part D Medication Therapy Management Programs. It includes information from MLN Matters® Article #SE1229 titled, “A Physician’s Guide to Medicare Part D Medication Therapy Management Programs”.

“Medicare Fraud & Abuse: Prevention, Detection, and Reporting” Podcast — Reminder

The “[Medicare Fraud & Abuse: Prevention, Detection, and Reporting](#)” Podcast (ICN 906509) is available in downloadable format. This podcast is designed to provide education on preventing, detecting and reporting Medicare fraud and abuse. It includes information from the Medicare Learning Network® fact sheet titled, "Medicare Fraud & Abuse: Prevention, Detection, and Reporting," which describes relevant laws, regulations, and partnerships designed to combat fraud and abuse.

“Medicare Parts C and D Fraud, Waste and Abuse Training and Medicare Parts C and D General Compliance Training” Web-Based Training Course — Reminder

The “Medicare Parts C and D Fraud, Waste and Abuse Training and Medicare Parts C and D General Compliance Training” Web-Based Training Course (WBT) is available. This WBT is designed to provide education on fraud, waste, and abuse in the Medicare Parts C and D program and general compliance concepts. It includes two parts and can be used to satisfy general compliance training requirements and fulfill the annual fraud, waste and abuse training requirement for Medicare Parts C and D organizations.

To access the WBT, go to [MLN Products](#) and click on “Web-Based Training Courses” under “Related Links” at the bottom of the web page.

Announcements, Events, and Reminders

CMS Rule 1599-F: Inpatient Hospital Admission and Medical Review Criteria (2-Midnight Provision) and Part B Inpatient Billing in Hospitals

CMS hosted a Special Open Door Forum (ODF) call to allow hospitals, practitioners, and other interested parties to give feedback on the physician order and physician certification, inpatient hospital admission and medical review criteria, and Part B inpatient billing provisions that were released on August 2, 2013 in the FY 2014 Inpatient Prospective Payment System (IPPS) final rule ([CMS-1599-F](#)). This introductory call allowed for initial discussions between stakeholders and CMS. The transcript and MP3 audio file will be posted to the [Special ODF](#) webpage under the "Downloads" section around August 22 and will be available for 30 days. CMS understands that providers or associations may have additional questions or concerns. You are encouraged to submit questions related to the two midnight provision for admission and medical review to the IPPSadmissions@cms.hhs.gov mailbox. Questions on Part B inpatient billing and the clarifications regarding the physician order and certification should be sent to the subject matter staff listed in the final rule. CMS will review stakeholder feedback as quickly as possible and provide responses and clarification as needed.

For more information:

- [FY 2014 IPPS Rule Outreach](#)
- [Final Rule \(CMS-1599-F\)](#)

Transitioning to ICD-10 Video Slideshows Now Available

On June 20, CMS Regional Offices hosted webinars on “Transitioning to ICD-10.” These webinars are now available as video slideshows on the CMS YouTube Channel and cover the background and impact of ICD-10 on industry, CMS ICD-10

implementation, how CMS is working with the states, how CMS is partnering with industry, best practices, frequently asked questions and resources and contact information. The change to ICD-10 is required for everyone covered by the Health Insurance Portability Accountability Act and will take place on October 1, 2014.

- [The Eastern event](#) was held for healthcare professionals, coders and organizations operating within the CMS Regions I, II, III and IV which include the following states: AL, CT, DC, DE, FL, GA, KY, LA, MA, MD, ME, MS, NC, NH, NJ, NY, PA, RI, SC, TN, VA, VT, and WV.
- [The Central event](#) was held for healthcare professionals, coders and organizations operating within the CMS Regions V, VI and VII which include the following states: AR, IA, IL, IN, KS, MI, MN, MO, NE, NM, OH, OK, TX, and WI.
- [The Mountain-Pacific event](#) was held for healthcare professionals, coders and organizations operating within the CMS Regions V, VI and VII which include the following states: AK, AZ, CA, CO, HI, ID, MT, ND, NV, OR, SD, UT, WA, and WY.

OPEN PAYMENTS Website — New Resources Now Available

New resources are now available on the [OPEN PAYMENTS](#) website to keep you informed of the latest developments related to the OPEN PAYMENTS Program (Physician Payments Sunshine Act).

[Additional FAQs Added](#)

These new FAQs are related to a wide variety of OPEN PAYMENTS topics, including loans for covered devices, clarification on when a distributor is considered an applicable manufacturer and how to classify a number of different forms of payments.

Two Continuing Medical Education Activities are Available

Two continuing medical education (CME) activities are also available and accessible via Medscape for physicians to learn more about OPEN PAYMENTS. Both activities are accredited by the Accreditation Council for Continuing Medical Education:

1. [“Are You Ready for the National Physician Payment Transparency Program?”](#) Physicians can receive a maximum of 1.00 AMA PRA Category 1 Credit™ by participating in the activity and receiving a minimum score of 70% on the post-test. Through the activity, participants will learn more about OPEN PAYMENTS, the steps involved in collecting and reporting physician data, key dates for implementation, and actions they can take to verify physician information in advance of website publication.
2. [“The Physician Payment Transparency Program and Your Practice”](#) Physicians can receive a maximum of 0.25 AMA PRA Category 1 Credit™ by participating in the activity and receiving a minimum score of 70% on the post-test. Through this activity, participants will be able to identify opportunities for physicians to review transfers of value attributed to them and differentiate types of transfers of value that will or will not be reported under OPEN PAYMENTS.

Medscape accounts are free and users do not have to be health care professionals to register. Registration can be found on the Medscape website www.medscape.com.

[Data Submission File Specifications \(formerly known as Data Collection Templates\)](#)

The OPEN PAYMENTS program [website](#) includes the data submission file specifications for 2013; physicians, applicable manufacturers and applicable group purchasing organizations (GPOs) should become familiar with the categories used to describe reportable payments or other transfers of value, and ownership or investment interests. These specifications are critical, as they will be needed for data submission in early 2014. The OMB control number is 0938-1173. Note, the first OPEN PAYMENTS program cycle (August 1, 2013 through December 31, 2013) is a partial data collection period of only five months, as compared to future program cycles which will run for the entire year. For this first period, the data collected by applicable manufacturers and GPOs through December 31, 2013 will be submitted to CMS in early 2014. Physicians do not need take any action or submit data to CMS. They will have the opportunity to review the submitted data and work with the applicable manufacturer and applicable GPO to correct their submitted information before CMS makes it public.

CMS Created Mobile Apps to Assist with Payment Tracking

As physicians, applicable manufacturers and applicable GPOs begin tracking financial data, remember that there are new mobile apps available to assist in OPEN PAYMENTS implementation, one for industry use and one that physicians may use. Indeed, the objective for these apps is to make tracking payment information easier and more convenient, and to improve the accuracy of payment information by tracking payments as they occur throughout the year. You can download the mobile apps directly from your app store (iOS Apple™ or GooglePlay™); search for either [OPEN PAYMENTS Mobile for Industry](#) or [OPEN PAYMENTS Mobile for Physicians](#).

Questions

For any questions relating to OPEN PAYMENTS, contact the Help Desk at OpenPayments@cms.hhs.gov.

OPEN PAYMENTS Notice: Public Comments Due September 20

In accordance with the Paperwork Reduction Act (PRA), OPEN PAYMENTS published a notice in the Federal Register requesting public comments for [CMS-10495](#) (Registration, Attestation, Dispute and Resolution, Assumptions Document and Data Retention Requirements for Open Payments). This [PRA package](#) explains the OPEN PAYMENTS registration data to be collected from applicable manufacturers and applicable GPOs, plus the data needed from physicians and investors for them to register for the program and review the data provided by applicable manufacturers and applicable GPOs. The 60-day public comment period on CMS-10495 closes on September 20, 2013.

Looking for Your 2012 PQRS Feedback Reports?

Individual eligible professionals (EPs) who submitted 2012 PQRS data can now access their 2012 Physician Quality Reporting System (PQRS) Feedback Reports through the following methods:

1. National Provider Identifier (NPI)-level reports can be requested through the [Communication Support Page](#) by creating an NPI-level feedback report request. The report will be sent electronically to the email address provided in the request within 2-4 weeks.
2. Taxpayer Identification Number (TIN)-level reports, which contain NPI-level detail, are available for download on the Physician and Other Health Care Professionals Quality Reporting Portal (Portal) available via [QualityNet](#). TIN-level reports on the Portal require an Individuals Authorized Access to CMS Computer Services (IACS) account. The [IACS Quick Reference Guides](#) are available on the Portal and provide step-by-step instructions on how to request an IACS account in order to access the Portal, if you do not already have one.

Groups who participated in 2012 PQRS Group Practice Reporting Option (GPRO) will be able to access PQRS feedback through the 2012 Quality and Resource Use Reports (QRURs) on *September 16, 2013*. The 2012 QRURs will include the group's performance on PQRS quality measures, outcome measures and cost measures that indicate the groups' resource use as well as information on PQRS incentive eligibility. Authorized representatives of practices with 25 or more EPs can access the QRURs at <https://portal.cms.gov> using an IACS account with one of the following group-specific PV-PQRS Registration System roles:

- Primary PV-PQRS Group Security Official
- Backup PV-PQRS Group Security Official
- PV-PQRS Group Representative

Information about QRURs and the required IACS roles is available on the CMS Physician Feedback Program website under the [QRUR Templates and Methodologies](#) web page.

Distribution of the 2012 PQRS incentive payment to EPs and group practices who participated in 2012 PQRS GPRO who met the criteria for satisfactory reporting is scheduled to begin August 2013.

Need to Request an Informal Review?

CMS has implemented an informal review process for the 2012 PQRS. This means that EPs and group practices can request to have their 2012 PQRS reporting performance reviewed. An informal review may be requested if the feedback report reveals that the EP or group practice did not earn the 2012 PQRS incentive payment although they believe that an incentive payment was earned, or if they believe the payment amount is incorrect. Informal review requests will be accepted beginning *November 1, 2013 through February 28, 2014*.

EPs and group practices must submit their 2012 PQRS informal review request through the [Communication Support Page](#) online tool. The Communication Support Page will be available November 1, 2013 through February 28, 2014. From the Communication Support Page the requestor should select the "Create an Informal Review Request" link to begin the informal review request process. Complete the mandatory fields in the online form, including the appropriate justification, in order for the request to be deemed valid. Failure to complete the form in full will result in the inability to have the informal review request analyzed. CMS or the QualityNet Help Desk may contact the requestor for additional information if necessary.

Please note: The informal review will be for all 2012 reporting transmission methods, including claims, qualified registry, qualified EHR, and GPRO Web Interface. The informal review will cover data submitted for dates of service from January 1, 2012 through December 31, 2012.

Need More Information?

The following CMS resources are available to help EPs and group practices access and understand their 2012 PQRS feedback reports and request an informal review:

- The [User Guide: 2012 Physician Quality Reporting System \(PQRS\) Feedback Report](#) provides detailed information about accessing and interpreting the data provided in the feedback report.
- The [2012 PQRS Informal Review Made Simple](#) educational document provides additional information on how to request a 2012 PQRS informal review.

Questions?

For all other questions related to PQRS, please contact the QualityNet Help Desk at 1-866-288-8912 (TTY 1-877-715-6222) or via qnetssupport@sdps.org. They are available Monday through Friday from 7:00 a.m.-7:00 p.m. CST.

2012 eRx Incentive Program Feedback Reports Are Now Available

Eligible professionals (EPs) and group practices (who self-nominated for the 2012 Electronic Prescribing (eRx) group practice reporting option or GPRO) who submitted 2012 [eRx Incentive Program](#) data can now access their 2012 eRx Incentive Program Feedback Reports. Taxpayer Identification Number (TIN)-level reports are available for download on the Physician and Other Health Care Professionals Quality Reporting Portal (Portal) available via [QualityNet](#). TIN-level reports on the Portal require an Individuals Authorized Access to CMS Computer Services (IACS) account. The [IACS Quick Reference Guides](#) are available on the Portal and provide step-by-step instructions on how to request an IACS account in order to access the Portal, if you do not already have one.

Individual EPs can also request their National Provider Identifier (NPI)-level reports through the [Communication Support Page](#) by creating a NPI-level feedback report request. The report will be sent electronically to the email address provided in the request within 2-4 weeks.

Distribution of the 2012 eRx incentive payment to EPs and group practices who participated in 2012 eRx GPRO who met the criteria for successful electronic prescribing is scheduled to begin in the fall of 2013.

Need to Request an Informal Review?

CMS has implemented an informal review process for the 2012 eRx Incentive Program. This means that EPs and eRx GPROs can request to have their 2012 eRx reporting performance reviewed. An informal review may be requested if the feedback report reveals that the EP or eRx GPRO did not earn the 2012 eRx incentive payment although they believe

that an incentive payment was earned or the payment amount was incorrect. Informal review requests will be accepted beginning *November 1, 2013 through February 28, 2014*.

EPs and eRx GPROs should submit their eRx informal review request via email to the informal review mailbox at [eRxInformalReview@cms.hhs.gov](mailto:ERXInformalReview@cms.hhs.gov). Please include your individual rendering NPI, contact information (email, telephone, mailing address), and justification as to why you are requesting an informal review. *Do not provide the TIN via email.* CMS or the QualityNet Help Desk may contact the requestor for additional information if necessary.

Please note: The informal review will be for all 2012 eRx Incentive Program reporting transmission methods, including claims, qualified registry, and qualified EHR. The informal review will cover data submitted for dates of service from January 1, 2012 through December 31, 2012.

Need More Information?

The following CMS resources are available to help EPs and group practices access and understand their 2012 eRx Incentive Program feedback reports and request an informal review:

- The [User Guide: 2012 Electronic Prescribing \(eRx\) Incentive Program Feedback Report](#) provides detailed information about accessing and interpreting the data provided in the feedback report.
- The [2012 eRx Incentive Program Informal Review Made Simple](#) educational document provides additional information on how to request a 2012 eRx Incentive Program informal review.
- The CMS eRx Incentive Program website [payment adjustment page](#) provides complete information about the eRx payment adjustment.

Questions?

For all other questions related to the eRx Incentive Program, please contact the QualityNet Help Desk at 866-288-8912 (TTY 1-877-715-6222) or via gnetsupport@sdps.org. They are available Monday through Friday from 7am-7pm CT.

Opportunity for Provider Input on LTCH Quality Reporting Program

CMS is seeking input from providers related to the implementation of the new LTCH Quality Reporting Program (QRP) established in the Patient Protection and Affordable Care Act, also known as The Affordable Care Act, Section 3004. Therefore, Health Care Innovation Services, (HCIS), is seeking the voluntary assistance of providers to participate in a brief interview on behalf of CMS, to help us better understand the burdens imposed on providers, how providers ensure accuracy of data, how the QRP has impacted patient services and outcomes, and what CMS can do in the future to improve the program, and processes.

This process and the information gathered will provide valuable information for CMS as we continue to develop this program and will be essential to guiding the development of the quality reporting program. This partnership will continue to facilitate an important process in which provider input is shared with CMS, so that we are able to identify strengths, weaknesses, priorities, and how the program might be improved.

Interviews will be conducted over the telephone, and any reports, or supplemental documents, submitted to CMS will not link specific answers to any specific individuals/providers. If you are interested in participating, please contact Pat Hanson at phanson@hcareis.com.

New Materials Available on Hospice Quality Reporting Program Website

FY 2015 Reporting Cycle Training Materials and Final Rule Now Available for Providers

Training materials instructing providers on FY 2015 Reporting Cycle data collection requirements are now available on the [Hospice Quality Reporting Program \(HQRP\)](#) website. To understand FY 2015 Reporting Cycle requirements, providers should review the [HQRP Fiscal Year 2015 Reporting Cycle Requirements Fact Sheet](#), the [User Guide for Hospice Quality Reporting Data Collection](#) and the [HQRP FY 2015 Reporting Cycle HQRP Training Slides](#) available in the “downloads”

section of [HQRP Data Collection](#) web page. The User Guide and Training Slides instruct providers on data collection activities for the 2 required measures for the FY 2015 Reporting Cycle: the structural measure and the NQF #0209 Pain Measure. Providers will be required to submit data for both of these measures by April 1, 2014 in order to avoid a 2 percentage point reduction in their FY 2015 APU (Annual Payment Update).

Also available for provider review is the [FY 2014 Hospice Wage Index and Payment Rate Update; Hospice Quality Reporting Requirements; and Updates on Payment Reform](#) Final Rule. The final rule notifies providers of requirements for future Reporting Cycles of the HQRP.

CMS to Release a Comparative Billing Report on Home Health Services - Target Release August 29

On August 29, 2013, CMS will release a national provider Comparative Billing Report (CBR) addressing Home Health Services.

CBRs produced by SafeGuard Services under contract with CMS, contain actual data-driven tables and graphs with an explanation of findings that compare providers' billing and payment patterns to those of their peers located in the state and across the nation.

These reports are not available to anyone except the providers who receive them. To ensure privacy, CMS presents only summary billing information. No patient or case-specific data is included. These reports are an example of a tool that helps providers better understand applicable Medicare billing rules and improve the level of care they furnish to their Medicare patients. CMS has received feedback from a number of providers that this kind of data is very helpful to them and encouraged us to produce more CBRs and make them available to providers.

For more information and to review a sample of the Home Health Services CBR, please visit the [CBR Services](#) website or call the SafeGuard Services' Provider Help Desk, CBR Support Team at 530-896-7080.

Replacement of Home Oxygen Services in the Event that a Supplier Exits the Medicare Oxygen Business

Effective immediately, CMS will allow for the replacement of oxygen equipment in cases where a supplier exits the Medicare oxygen business and is no longer able to continue furnishing oxygen and oxygen equipment. In these instances, the oxygen equipment will be considered lost and a new 36-month rental period and reasonable useful lifetime will begin for the new supplier furnishing replacement oxygen equipment on the date that the replacement equipment is furnished to the beneficiary.

Suppliers exiting the Medicare oxygen business with patients that they were unable to transfer to new suppliers should be aware that they are in violation of the statutory and regulatory requirements for furnishing oxygen equipment both before and after the payment cap. As such, oxygen suppliers that do not fulfill their oxygen obligations and voluntarily exit the Medicare oxygen business are not in compliance with the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) supplier standards set forth at 42 CFR 424.535(c).

Reminder: LTCH/IRF 1st Quarter Quality Data Due Friday August 23

CMS extended the deadline for Long-Term Care Hospitals (LTCHs) and Inpatient Rehabilitation Facilities (IRFs) submitting first quarter 2013 (January – March) quality data to 11:59:59pm on August 23, 2013. Due to data submission challenges with both CMS reporting and the National Healthcare Safety Network systems, the extension applies to both clinical data and data on healthcare-associated infections.

Seeking Nominations for Physician Compare Quality Measurement Technical Expert Panel — Deadline Extended to September 3

CMS is seeking nominations for the Physician Compare Quality Measurement Technical Expert Panel (TEP). The TEP will provide expert feedback on physician quality measures that have been proposed for public reporting and make recommendations regarding future quality measures for public reporting on the Physician Compare website. CMS is seeking nominations from individuals with the following areas of expertise and perspectives:

- Public reporting of health care performance data/CMS Compare sites
- Reliability and validity testing
- Risk models and risk adjustment
- Performance measurement
- Quality improvement
- Consumer perspective
- Health care disparities

CMS is also looking for patients or their caregivers to join the TEP to provide feedback on the Physician Compare website. To nominate an individual for the TEP, please submit the following set of materials:

- A completed and signed [TEP Nomination/Disclosure/Agreement form](#)
- A letter of interest (not to exceed two pages), highlighting experience/knowledge relevant to the expertise described above and involvement in measure development
- Curriculum vitae and/or list of relevant experience (e.g., publications), a maximum of 10 pages total

More information is available on the [TEP](#) web page. If you wish to nominate yourself or other individuals for consideration, please complete the form and e-mail it to PhysicianCompare@Westat.com. Nominations are due by *September 3, 2013, at 12pm ET*.

CMS Announces Teaching Hospital Closures and Round 6 of Section 5506 of the Affordable Care Act

Note: This announcement was first made in the August 8 eNews and is being reissued to include the link to the FY 2014 Inpatient Prospective Payment System/Long-Term Care Hospital (IPPS/LTCH) final rule.

On August 2, 2013, as part of the [FY 2014 IPPS/LTCH](#) final rule, CMS announced Round 6 of Section 5506 of the Affordable Care Act. Section 5506 authorizes CMS to redistribute residency cap slots after a hospital that trained residents in an approved medical residency program(s) closes. Under Round 6, the resident cap slots of Cooper Green Mercy Hospital, in Birmingham, AL, and Sacred Heart Hospital, in Chicago, IL, are to be redistributed. First priority in redistributing the slots is given to hospitals located in the same or contiguous Core Based Statistical Areas (CBSAs) as the respective closed hospitals. Hard copy applications from hospitals to receive indirect medical education (IME) and direct graduate medical education (GME) full-time equivalent (FTE) resident slots from these two closed teaching hospitals must be received by CMS Central Office, not postmarked, by 5pm ET on October 31, 2013.

The "[Section 5506 Application Form](#)" and "[Guidelines for Submitting Applications Under Section 5506](#)" are located on the CMS [Direct Graduate Medical Education](#) web page, along with links to other rules that contain policy guidance on submitting section 5506 applications, including the CY 2011 OPSS final rule ([75 FR 72212](#)) and the FY 2013 IPPS/LTCH PPS final rule ([77 FR 53434](#) through 53447).

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