



MLN Connects™

Weekly Provider eNews

Thursday, May 15, 2014

MLN Connects™ National Provider Calls

Individualized Quality Control Plan for CLIA Laboratory Non-Waived Testing — Last Chance to Register
National Partnership to Improve Dementia Care in Nursing Homes — Last Chance to Register
Review of the New Medicare PPS for Federally Qualified Health Centers — Last Chance to Register
Stage 2 Meaningful Use Requirements, Reporting Options, and Data Submission Processes for Eligible Professionals — Register Now
More ICD-10 Coding Basics — Registration Now Open

CMS Events

Special Open Door Forum: Suggested Electronic Clinical Template for Home Health
Webinar for Comparative Billing Report on Ambulance: Ground Transportation
HART User Tool Training Modules Available for Hospice Quality Reporting Program

Announcements

Reforms of Regulatory Requirements to Save Health Care Providers \$660 Million Annually
New HHS Data Show Quality Improvements Saved 15,000 lives and \$4 Billion in Health Spending
Quality Improvement Organization Program Advisory
Notices of Intent to Apply for the Medicare Shared Savings Program 2015 Program Start Date Due by May 30
New PEPPER Release for SNFs, Hospices, CAHs, LTCHs, IPFs, IRFs and PHPs
CMS to Release a Comparative Billing Report on Ambulance: Ground Transportation in May
Physician Self-Referral Law: Expansion Exception Request

Claims, Pricers, and Codes

Acute Inpatient PPS FY 2014.6 Pricer Software Release Available
Hold and Adjustments to Method II CAH Claims that Include Services for a Surgical Assistant
Mass Adjustments to Inpatient Psychiatric Facility Claims with Teaching Adjustment Amounts Not Displaying Correctly

MLN Educational Products

“Screening and Diagnostic Mammography” Booklet – Revised
“Telehealth Services” Fact Sheet – Revised
“Ambulatory Surgical Center Fee Schedule” Fact Sheet – Revised
MLN Products Available in Electronic Publication Format

MLN Connects™ National Provider Calls

Individualized Quality Control Plan for CLIA Laboratory Non-Waived Testing — Last Chance to Register

Monday, May 19; 2-3:30pm ET

To Register: Visit [MLN Connects™ Upcoming Calls](#). Space may be limited, register early.

How will the new Individualized Quality Control Plan (IQCP) affect my laboratory? This MLN Connects™ National Provider Call will educate laboratories on IQCP, the new quality control option for Clinical Laboratory Improvement Amendments (CLIA) laboratories performing non-waived testing. IQCP will provide laboratories with flexibility in customizing Quality Control (QC) policies and procedures, based on the test systems in use and the unique aspects of each laboratory.

IQCP is voluntary. Laboratories will continue to have the option of achieving compliance by following all CLIA QC regulations as written. The IQCP Education and Transition Period began on January 1, 2014 and will conclude on January 1, 2016. This education and transition period gives laboratories the opportunity to learn about IQCP and implement their chosen QC policies and procedures. Prior to the call, providers are encouraged to review [IQCP: A New QC Option](#) and other IQCP educational materials on the [CLIA](#) website.

Agenda:

- IQCP Presentation
- Resources
- Q&A Session

Target Audience: Laboratories, professional organizations, quality improvement experts and other interested stakeholders.

Continuing education credit may be awarded for participation in certain MLN Connects Calls. Visit the [Continuing Education Credit Information](#) web page to learn more.

National Partnership to Improve Dementia Care in Nursing Homes — Last Chance to Register

Tuesday, May 20; 1:30-3:00pm ET

To Register: Visit [MLN Connects™ Upcoming Calls](#). Space may be limited, register early.

During this MLN Connects™ National Provider Call, speakers will share their success stories on the critical role that activity professionals play in the mission to improve dementia care and the reduction of antipsychotic medications through person-centered, nonpharmacologic care approaches. CMS subject matter experts will provide National Partnership updates, discuss efforts to monitor enforcement rates, and share information about future initiative goals. A question and answer session will follow the presentation.

The CMS National Partnership to Improve Dementia Care in Nursing homes was developed to improve dementia care through the use of individualized, comprehensive care approaches. The partnership promotes a systematic process to evaluate each person and identify approaches that are most likely to benefit that individual. The goal of the partnership is to continue to reduce the use of unnecessary antipsychotic medications, as well as other potentially harmful medications in nursing homes and eventually other care settings as well.

Agenda:

- Partnership updates
- Role of activity professionals
- Nonpharmacologic approaches to care
- Next steps

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

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Review of the New Medicare PPS for Federally Qualified Health Centers — Last Chance to Register

Wednesday, May 21; 12:30-2:00pm ET

To Register: Visit [MLN Connects™ Upcoming Calls](#). Space may be limited, register early.

As required by Section 10501 of the Affordable Care Act, Federally Qualified Health Centers (FQHCs) will transition to a prospective payment system (PPS) beginning on October 1, 2014. This MLN Connects™ National Provider Call will describe the final policies for the new Medicare PPS for FQHCs, including the encounter-based per diem payment rate, adjustments, coinsurance, and the transition to the new payment system.

Agenda:

- Review of the requirements of the Affordable Care Act for a new Medicare PPS for FQHCs
- Proposed policies, comments, and final provisions of the new FQHC PPS
- Resources for more information
- Question & Answer

Target Audience: FQHCs and other interested stakeholders.

Continuing education credit may be awarded for participation in certain MLN Connects Calls. Visit [the Continuing Education Credit Information](#) web page to learn more.

Stage 2 Meaningful Use Requirements, Reporting Options, and Data Submission Processes for Eligible Professionals — Register Now

Thursday, May 29; 1:30-3pm ET

To Register: Visit [MLN Connects™ Upcoming Calls](#). Space may be limited, register early.

As an eligible professional, are you aware of the differences between Stage 1 and Stage 2 criteria? Did you know that you can report quality measures once and meet multiple reporting requirements? Do you understand the processes for submitting your data? Eligible professionals who have completed at least two program years under Stage 1 of Meaningful Use in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs are required to meet Stage 2 criteria starting in 2014, the first year of Stage 2 implementation. On May 29, 2014, CMS will be hosting an “office hours” session for eligible professionals participating in these programs to answer your questions.

During this MLN Connects™ National Provider Call, conducted in an office hours format, CMS experts give a brief introductory presentation, providing a concise overview of Stage 2 requirements, reporting options, and data submission processes. This overview will be followed by answers to questions submitted prior to the call and an opportunity for participants to interact with our subject matter experts during a live question and answer session. You are encouraged to email questions to e-measures@mathematica-mpr.com no later than May 21 to be considered for inclusion in the office hours session, then join the call to learn more about Stage 2 implementation.

Agenda:

- Overview of Stage 2 of Meaningful Use
- Reporting
- Data Submission
- Answers to Submitted Questions
- Live Q&A Session

Target Audience: Eligible professionals participating in Stage 2 of Meaningful Use and their staff as well as EHR vendors supporting data submission for Stage 2 of Meaningful Use.

Continuing education credit may be awarded for participation in certain MLN Connects Calls. Visit the [Continuing Education Credit Information](#) web page to learn more.

More ICD-10 Coding Basics — Registration Now Open

Wednesday, June 4; 1:30-3pm ET

To Register: Visit [MLN Connects™ Upcoming Calls](#). Space may be limited, register early.

HHS expects to release an interim final rule in the near future that will include a new compliance date that would require the use of ICD-10 beginning October 1, 2015. Providers would have an extra year to prepare. During this MLN Connects™ National Provider Call, join us for a keynote presentation on more ICD-10 coding basics by Sue Bowman from the American Health Information Management Association (AHIMA), along with updates from CMS. A question and answer session will follow the presentation.

Agenda:

- CMS updates, including the partial code freeze and 2015 code updates
- Why ICD-9-CM is being replaced with ICD-10-CM
- Benefits of ICD-10-CM
- Similarities and differences from ICD-9-CM
- Coding: Process of assigning a diagnosis code, 7th character, placeholder "x," excludes notes, unspecified codes, external cause of injury codes, type of encounter
- Documentation tips
- How to obtain answers to coding questions
- How to request modifications to ICD-10-CM

Target Audience: Medical coders, physicians, physician office staff, nurses and other non-physician practitioners, provider billing staff, health records staff, vendors, educators, system maintainers, laboratories, and all Medicare providers

Continuing education credit may be awarded for participation in certain MLN Connects Calls. Visit the [Continuing Education Credit Information](#) web page to learn more.

CMS Events

Special Open Door Forum: Suggested Electronic Clinical Template for Home Health

Tuesday, May 20; 2-3pm ET

CMS will host a series of Special Open Door Forum (ODF) calls to allow physicians and other interested parties to give feedback on data elements for the Suggested Electronic Clinical Template for Home Health. In order to enhance physician understanding of medical documentation requirements to support orders for Home Health services, CMS has developed a list of clinical elements within a [Suggested Electronic Clinical Template](#) that would assist physicians when documenting the Home Health (HH) face-to-face encounter for Medicare purposes. While not intended to be a data entry form, the template will describe the clinical elements that CMS believes would be useful in supporting the documentation requirements for coverage of Home Health services. CMS will work in collaboration with the HHS Office of the National Coordinator for Health IT (ONC) and the electronic Determination of Coverage (eDoC) workgroup, which are focused on giving practitioners access to payer approved tools for the electronic submission of medical documentation. Comments on the document can be sent to eclinicaltemplate@cms.hhs.gov.

Special Open Door Participation Instructions:

- Participant Dial-In Number: 800-837-1935; Conference ID: 41816301
- Note: TTY Communications Relay Services are available for the Hearing Impaired. For TTY services dial 7-1-1 or 800-855-2880. A Relay Communications Assistant will help.

A transcript and audio recording of this Special ODF will be posted to the [Special Open Door Forum](#) website.

Webinar for Comparative Billing Report on Ambulance: Ground Transportation

Wednesday, June 4; 3-4pm ET

Join us for an informative discussion of the comparative billing report on Ambulance: Ground Transportation (CBR201405). The presentation will be provided by CMS contractor eGlobalTech and its partner, Palmetto GBA. CBR201405 is an educational tool designed to assist providers billing ambulance ground transportation.

Agenda:

- Opening Remarks
- Overview of Comparative Billing Report (CBR201405)
- Coverage Policy for Ambulance: Ground Transportation
- Methodology Report
- Resources
- Question & Answer Session

Presenter Information:

- Speakers: Cheryl Bolchoz, Melissa Parker, Jonathan Savoy, Mark Scogin, Molly Wesley
- Organizations: eGlobalTech and Palmetto GBA

How to Register

- [Register](#) online

Event Replay

You may [access a recording](#) of the webinar two days following the event.

HART User Tool Training Modules Available for Hospice Quality Reporting Program

The Hospice Abstraction Reporting Tool, or HART, is a free JAVA-based application provided by CMS and made available for Hospice providers for the entry and validation of Hospice Item Set (HIS) records prior to submission to the QIES ASAP system. There are four WebEx training modules available on the [HART](#) website that will demonstrate the use of the HART tool. The four modules cover how to log in to HART, how to create a patient and HIS record within the HART Tool, how to import and export HIS records in HART, and how to run the available reports within HART.

In addition to these videos, a demonstration copy of the HART tool will be available to download from the [HART](#) website in mid-May. This demo version will allow you to enter in test facility, user, patient, and HIS Records, so that you can get comfortable with the tool prior to July 1. Since it is a demonstration version, it will not allow imports or exports and any information that is entered will be considered “test” data.

Please contact the QTSO Help Desk at 877-201-4721 or by email at help@qtso.com if you have any questions regarding the training modules or the demo version of HART.

Announcements

Reforms of Regulatory Requirements to Save Health Care Providers \$660 Million Annually

Reforms to Medicare regulations identified as unnecessary, obsolete, or excessively burdensome on hospitals and other health care providers will save nearly \$660 million annually, and \$3.2 billion over five years, through a rule issued on May 7 by CMS. Together with another rule finalized in 2012, this rule is estimated to save health care providers more than \$8 billion over the next five years. This final rule supports President Obama's unprecedented regulatory retrospective review—or "regulatory lookback"—initiative, where federal agencies are modifying, streamlining or eliminating excessively burdensome and unnecessary regulations on business.

This rule helps health care providers to operate more efficiently by getting rid of regulations that are out of date or no longer needed. Many of the rule's provisions streamline health and safety standards health care providers must meet in order to participate in Medicare and Medicaid. For example, a key provision reduces the burden on very small critical access hospitals, as well as rural health clinics and federally qualified health centers, by eliminating the requirement that a physician be held to a prescriptive schedule for being onsite. The rule will also save hospitals resources by permitting registered dietitians and qualified nutritionists to order patient diets directly, which they are trained to do, without requiring the preapproval of a physician or other practitioner.

Major provisions of the rule are:

- Eliminates unnecessary requirements that ambulatory surgical centers must meet in order to provide radiological services that are an integral part of their surgical procedures, permitting them greater flexibility for physician supervision requirements.
- Permits trained nuclear medicine technicians in hospitals to prepare radiopharmaceuticals for nuclear medicine without the supervising physician or pharmacist constantly being present, which will help speed services to patients, particularly during off hours.
- Eliminates a redundant data submission requirement and an unnecessary survey process for transplant centers while maintaining strong federal oversight.

As part of the President's regulatory lookback initiative, CMS issued a final rule in May, 2012, that also reduces burdensome or unnecessary regulations for hospitals and additional health care providers. Those rules are saving nearly \$1.1 billion across the health care system in the first year and more than \$5 billion over five years. View the [final rule](#).

Full text of this excerpted CMS [press release](#) (issued May 7).

New HHS Data Show Quality Improvements Saved 15,000 lives and \$4 Billion in Health Spending

Hospital readmissions fall by 8 percent among Medicare beneficiaries

On May 7, HHS announced that new preliminary data show an overall nine percent decrease in hospital acquired conditions nationally during 2011 and 2012. National reductions in adverse drug events, falls, infections, and other forms of hospital-induced harm are estimated to have prevented nearly 15,000 deaths in hospitals, avoided 560,000 patient injuries, and approximately \$4 billion in health spending over the same period.

The Affordable Care Act is also helping reduce hospital readmissions. After holding constant at 19 percent from 2007 to 2011 and decreasing to 18.5 percent in 2012, the Medicare all-cause 30-day readmission rate has further decreased to approximately 17.5 percent in 2013. This translates into an 8 percent reduction in the rate and an estimated 150,000 fewer hospital readmissions among Medicare beneficiaries between January 2012 and December 2013.

These improvements reflect policies and an unprecedented public-private collaboration made possible by the Affordable Care Act. The data demonstrates that hospitals and providers across the country are achieving reductions in hospital-induced harm experienced by patients. These major strides in patient safety are a result of strong, diverse public-private partnerships and active engagement by patients and families, including efforts from the federal Partnership for Patients

initiative and Hospital Engagement Networks, Quality Improvement Organizations, CMS, the Agency for Healthcare Research and Quality, the Centers for Disease Control and Prevention, the Administration on Community Living, the Indian Health Services, and many others.

View the [report](#).

Full text of this excerpted HHS [press release](#) (issued May 7).

Quality Improvement Organization Program Advisory

On Friday, May 9, CMS launched the first phase of transforming quality of care by announcing the Quality Improvement Organization (QIO) Program Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) contracts. The provider and practitioner communities should be aware that this first phase is part of a greater transformation effort, which will impact the structure and approach to essential program operations of the QIO program. CMS will designate certain QIOs as having primary responsibility for conducting the case review functions such as complaint reviews, quality of care reviews, discharge appeals, higher weighted diagnostic related groups (DRG) requests and Emergency Medical Treatment and Active Labor Act (EMTALA) reviews. CMS will also designate other QIOs as having a primary focus on facilitating continuous quality improvement activities across the country in support of learning systems aimed at transforming healthcare.

CMS announced that Livanta, LLC, located in Annapolis Junction, Maryland and KePRO, located in Seven Hills Ohio were awarded the contracts for the Beneficiary and Family Centered Care QIOs. They will be responsible for ensuring consistency in the review process with consideration of local factors important to beneficiaries and for conducting case review activities beginning on August 1, 2014. *No immediate action is required as a result of this announcement.* CMS plans to hold an [Open Door Forum](#) (ODF) for providers and practitioners to discuss the recent announcement of awardees and what impact that will have on the provider community. Information about the ODF will be provided soon.

The Quality Innovation Network (QIN) QIO contracts will be awarded in July of 2014. These QIN-QIOs will be responsible for working with providers, practitioners, and the community on multiple data driven quality initiatives to improve patient safety, reduce harm, and improve clinical care at the local, regional, and national levels.

The updated approach to improving care will allow for greater efficiencies across the program, eliminate any perceived conflicts of interest, and will continue to emphasize the need for greater patient-centered care in support of the needs of Medicare beneficiaries. The QIO program changes include:

- Separation of case review from quality improvement,
- Extending the contract period of performance from three (3) to five (5) years,
- Removing requirements to restrict QIO activity to a single entity in each state/territory, and
- Opening contractor consideration to a broad range of entities to perform the work.

View the [Press Release](#). If you have any questions, please direct them to QIOProgram@cms.hhs.gov.

Notices of Intent to Apply for the Medicare Shared Savings Program 2015 Program Start Date Due by May 30

If you are interested in applying for participation in the Medicare Shared Savings Program for the January 1, 2015 program start date, you must submit a Notice of Intent to Apply by Friday, May 30, 2014, 8pm ET. For more information about the application process and to register for upcoming calls, visit the [Shared Savings Program Application](#) web page.

New PEPPER Release for SNFs, Hospices, CAHs, LTCHs, IPFs, IRFs and PHPs

A new release of the Program for Evaluating Payment Patterns Electronic Report (PEPPER) is now available for skilled nursing facilities (SNFs), hospices, critical access hospitals (CAHs), long-term acute care hospitals (LTCHs), inpatient

psychiatric facilities (IPFs), inpatient rehabilitation facilities (IRFs) and partial hospitalization programs (PHPs). CMS has contracted with TMF Health Quality Institute to produce and distribute the PEPPER. The PEPPER is available electronically to some providers through QualityNet and in hard-copy format via mail to providers that do not have access to QualityNet.

The following providers can now access their new PEPPER electronically through the [Secure PEPPER Access](#) portal at [PEPPERresources.org](#):

- LTCHs
- Free-standing IRFs (not a unit of a short-term acute care hospital)
- Hospices
- PHPs not associated with a short-term acute care hospital or with an IPF
- SNFs that are not a swing-bed unit of a short-term acute care hospital

The Chief Executive Officer, President, or Administrator of the provider can obtain their PEPPER. Information on accessing and downloading the PEPPER is available in the [Secure PEPPER Access Guide](#).

The following providers received their PEPPER in mid-April through a My QualityNet secure file exchange:

- CAHs
- IPFs
- IRF distinct part units of a short-term acute care hospital
- PHPs administered by a short-term acute care hospital or an IPF
- SNF swing-bed units of a short-term acute care hospital

About PEPPER

PEPPER summarizes provider-specific data statistics for Medicare services that may be at higher risk for improper Medicare payments. Visit [PEPPERresources.org](#) to access resources for using PEPPER, including PEPPER user's guides and recorded training sessions. Questions or comments about PEPPER may be submitted through the [Help Desk](#). Provide feedback or suggestions regarding PEPPER through the [feedback form](#).

CMS to Release a Comparative Billing Report on Ambulance: Ground Transportation in May

CMS will be issuing a national provider Comparative Billing Report (CBR) on Ambulance: Ground Transportation in May, 2014. The CBR, produced by CMS contractor, eGlobalTech, will contain data-driven tables and graphs with an explanation of findings that compare providers' billing and payment patterns to those of their peers in the state and across the nation. The goal of these reports is to offer a tool that helps providers better understand applicable Medicare billing rules. These reports are only available to the providers who receive them.

Providers are advised to update their fax numbers in the Medicare Provider Enrollment, Chain, and Ownership System (PECOS) because fax is the default method of CBR dissemination. Providers should contact the CBR Support Help Desk at 800-771-4430 or CBRsupport@eglobaltech.com if they prefer to receive CBRs through the U.S. Postal Service. For more information, please contact the CBR Support Help Desk or visit the [CBR](#) website.

Physician Self-Referral Law: Expansion Exception Request

Lake Pointe Medical Center in Rowlett, Texas has requested an exception to the prohibition on expansion of facility capacity under the hospital ownership and rural provider exceptions to the physician self-referral law. Notification of this request was published in the [Federal Register](#) on May 12, 2014. Additional information, including the request, has been posted on the [CMS](#) website.

Claims, Pricers, and Codes

Acute Inpatient PPS FY 2014.6 Pricer Software Release Available

The acute inpatient PPS FY 2014.6 Pricer software release with revised provider data and logic, as well as supporting data files, are now available on the [Acute Inpatient PPS](#) website in the “Downloads” section.

Hold and Adjustments to Method II CAH Claims that Include Services for a Surgical Assistant

Method II Critical Access Hospital (CAH) claims that include services for a surgical assistant will be held until the system is fixed on June 9, 2014. No action is required by providers. Beginning on June 9, claims that were processed incorrectly from April 1 through June 9, 2014, will be adjusted for the following criteria:

- Type of Bill (TOB) = 85x
- CAHs Method II (optional Method = 'J') - Page 10, PROVIDER REIM METH = J
- Revenue Code = 96x, 97x, or 98x, excluding 963 and 964
- Modifier = AS, 80, 81 and/or 82 with covered charges greater than zero
- Healthcare Common Procedure Coding (HCPC) = 10000 - 69999

Mass Adjustments to Inpatient Psychiatric Facility Claims with Teaching Adjustment Amounts Not Displaying Correctly

Due to a software issue in the October 2013 release of the Inpatient Psychiatric Facility (IPF) Pricer, the teaching adjustment amounts on IPF claims have not been displaying in the Value Code 19 field. Please note: This has not impacted the total payment amount on the claims, as teaching adjustment amounts were included. Medicare Administrative Contractors (MACs) will complete mass adjustments to all IPF claims with a teaching adjustment, for discharge dates on or after October 1, 2013, within 90 days of the second release of the October 2013 IPF Pricer that will be installed into production on or after July 7, 2014.

MLN Educational Products

“Screening and Diagnostic Mammography” Booklet – Revised

The “[Screening and Diagnostic Mammography](#)” Booklet (ICN 907790) was revised and is now available in hard copy format. This booklet is designed to provide education on early diagnosis and treatment of breast cancer. It includes information on screening mammography, diagnostic mammography as well as other provider and beneficiary resources.

To access a revised product available for order in a *hard copy* format, go to “[MLN Products](#)” and scroll down to the bottom of the web page to the “Related Links” section and click on the “MLN Product Ordering Page.”

“Telehealth Services” Fact Sheet – Revised

The “[Telehealth Services](#)” Fact Sheet (ICN 901705) was revised and is now available in downloadable format. To assist rural providers who have limited internet access, the fact sheet is also available in [text-only format](#). This fact sheet is designed to provide education on services furnished to eligible Medicare beneficiaries via a telecommunications system. It includes information about originating sites, distant site practitioners, telehealth services, billing and payment for professional services furnished via telehealth, billing and payment for the originating site facility fee, resources, and lists of helpful websites and Regional Office Rural Health Coordinators.

“Ambulatory Surgical Center Fee Schedule” Fact Sheet – Revised

The “[Ambulatory Surgical Center Fee Schedule](#)” Fact Sheet (ICN 006819) was revised and is now available in downloadable format. This fact sheet is designed to provide education on the Ambulatory Surgical Center (ASC) Fee Schedule. It includes the following information: the definition of an ASC, ASC payment, how payment rates are determined, and the Ambulatory Surgical Center Quality Reporting Program.

MLN Products Available in Electronic Publication Format

The following publications are now available as electronic publications (EPUBs) and through QR codes. Instructions for downloading EPUBs and how to scan a QR code are available at “[How To Download a Medicare Learning Network® \(MLN\) Electronic Publication](#)” on the CMS website.

- The “[Hospital Outpatient Prospective Payment System](#)” Fact Sheet (ICN 006820) was revised and is now available in downloadable format. This fact sheet is designed to provide education on the Hospital Outpatient Prospective Payment System. It includes the following information: background, ambulatory payment classifications, how payment rates are set, payment rates, and Hospital Outpatient Quality Reporting Program.
- The “[Clinical Laboratory Fee Schedule](#)” Fact Sheet (ICN 006818) was revised and is now available in downloadable format. This fact sheet is designed to provide education on the Clinical Laboratory Fee Schedule. It includes the following information: background, coverage of clinical laboratory services, and how payment rates are set.
- The “[Hospice Payment System](#)” Fact Sheet (ICN 006817) was revised and is now available in downloadable format. This fact sheet is designed to provide education on the Medicare Hospice Payment System. It includes the following information: background, coverage of Hospice services, certification requirements, election periods and election statements, how payment rates are set, patient coinsurance payments, caps on Hospice payments, Hospice option for Medicare Advantage enrollees, and quality reporting.

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