MLN Connects®
Provider eNews

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News & Announcements

Updates to Dialysis Facility Compare: Patient Experience Ratings Available

On October 28, CMS announced changes to the Dialysis Facility Compare website, which provides quality information about thousands of Medicare-certified dialysis facilities across the country. In response to consumer feedback, CMS made changes to the website to make it easier to find information and make complex quality information easier to understand.

For the first time, visitors will be able to view information about patients' experiences with dialysis facilities. CMS collects patient experience data though the In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH-CAHPS) Survey, which measures patients' perspectives on the care they received at dialysis centers. This patient experience information will be displayed, along with the quality star ratings and detailed clinical quality information, for each dialysis facility.

CMS is also adding two additional quality measures to Dialysis Facility Compare, the standardized infection ratio and the pediatric peritoneal dialysis Kt/V measure. Other major changes to the website include modifications to the methodology for calculating dialysis facility star ratings based on recommendations from a 2015 Technical Expert Panel.

For More Information:

- Fact Sheet
- Blog

Hospital Value-Based Purchasing Program Results for FY 2017

The Hospital Value-Based Purchasing (VBP) Program adjusts what Medicare pays hospitals under the Inpatient Prospective Payment System based on the quality of care they provide to patients. For FY 2017, the law requires that the applicable percent reduction, the portion of Medicare payments available to fund the program's value-based incentive payments, increase from 1.75 to 2 percent of the base operating Medicare Severity Diagnosis-Related Group (MS-DRG) payment amounts for all participating hospitals. CMS estimates that the total amount available for value-based incentive payments for FY 2017 discharges will be approximately $1.8 billion.

The Hospital VBP incentive payment adjustment factors for FY 2017 are posted in Table 16B on the FY 2017 Final Rule and Correction Notice Tables webpage. For FY 2017, more hospitals will have an increase in their base operating MS-DRG payments than will have a decrease. In total, over 1,600 hospitals will have a positive payment adjustment.

For More Information:

- Hospital VBP Program webpage
- QualityNet website

See the full text of this excerpted CMS fact sheet (issued November 1).

DMEPOS Competitive Bidding Program: CMS Awards Contracts for Round 1 2017

On November 1, CMS announced the Round 1 2017 contract suppliers for the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. View the fact sheet for additional information.

2017 PQRS Results: Submit an Informal Review by November 30

In 2017, CMS will apply a downward payment adjustment to those who did not satisfactorily report for the Physician Quality Reporting System (PQRS) in 2015 including:

- Individual eligible professionals

- Comprehensive Primary Care practice sites
- PQRS group practices
- Accountable Care Organizations

If you believe you have been incorrectly assessed the 2017 PQRS payment adjustment, submit an informal review through November 30:

- See 2015 PQRS: 2017 PQRS Negative Payment Adjustment - Informal Review Made Simple
- All informal review requestors will be notified via email of a final decision by CMS within 90 days of the original request for an informal review
- The Quality Reporting Communication Support Page will be unavailable during the following Maintenance Weekend: November 18 through 20

2015 PQRS feedback reports are available:

- Quick Reference Guide for Accessing 2015 PQRS Feedback Reports
- 2015 PQRS Feedback Report User Guide

For more information, visit the Analysis and Payment webpage. For questions about the informal review process, contact the QualityNet Help Desk at 866-288-8912 (TTY 877-715-6222) or Qnetsupport@hcqis.org.

IRF and LTCH Quality Reporting Program: NHSN Rebaseline Guidance

As noted in the Rebaseline Timeline posted in the June 2016 National Healthcare Safety Network (NHSN) Newsletter, the Centers for Disease Control and Prevention (CDC) submitted Standardized Infection Ratios (SIRs) to CMS using the new 2015 baseline starting with 2016 Q1 data. The Inpatient Rehabilitation Facility (IRF) and Long-term Care Hospital (LTCH) Quality Reporting Program (QRP) Preview Reports that CMS provided on September 1, 2016, contained CY 2015 Healthcare-Associated Infection (HAI) SIRs in accordance with the new NHSN baselines, based on nationally collected data from 2015. However, providers were unable to use NHSN to verify the accuracy of the HAI data contained within their Preview Reports for the Compare websites during the 30-day preview period established for this purpose.

Consequently, CMS will begin publically displaying the NHSN data on the Compare websites for IRFs and LTCHs in the next quarterly refresh in spring 2017, instead of in fall 2016. Providers will have the chance to appropriately review their HAI data and inquire about data they believe to be discrepant. IRFs and LTCHs will receive Preview Reports in December 2016 for the data that will be displayed in spring 2017.

For information on use of the rebaselined data and how to monitor your data:

- Guidance for IRFs on the IRF QRP webpage
- Guidance for LTCHs on the LTCH QRP webpage
- Register for a webinar on November 16

Recovery Audit Contractor Awards

On October 31, CMS announced the awards for the Medicare Fee-for-Service (FFS) Recovery Audit Contractor (RAC) contracts.

- Region 1: Performant Recovery, Inc.
- Region 2: Cotiviti, LLC

- Region 3: Cotiviti, LLC
- Region 4: HMS Federal Solutions
- Region 5: Performant Recovery, Inc.

The RACs in Regions 1 through 4 will perform postpayment review to identify and correct Medicare claims that contain improper payments (overpayments or underpayments) that were made under Part A and Part B, for all provider types other than Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) and Home Health/Hospice. The Region 5 RAC will be dedicated to the postpayment review of DMEPOS and Home Health/Hospice claims nationally.

For More Information:
- Map of Regions 1 through 4
- Map of Region 5
- Medicare FFS Recovery Audit Program website

Antipsychotic Drug use in Nursing Homes: Trend Update

CMS is tracking the progress of the National Partnership to Improve Dementia Care in Nursing Homes by reviewing publicly reported measures. The official measure is the percentage of long-stay nursing home residents who receive an antipsychotic medication, excluding residents diagnosed with schizophrenia, Huntington's disease, or Tourette's syndrome. In the fourth quarter of 2011, 23.9 percent of long-stay nursing home residents received an antipsychotic medication; since then there has been a decrease of 31.8 percent to a national prevalence of 16.3 percent in second quarter of 2016. Success varies by state and CMS region; some states and regions have seen a reduction greater than 30 percent. A four-quarter average of this measure is posted on the Nursing Home Compare website.

For More Information:
- Visit the National Partnership webpage
- Send correspondence to dnh_behavioralhealth@cms.hhs.gov
- Register for the December 6 call

November is Home Care and Hospice Month

Did you know that Medicare covers a wide range of health care services that can be provided in the home to treat an illness or injury for homebound beneficiaries who require skilled services? In addition, hospice care empowers people with life-limiting illnesses to remain at home, surrounded and supported by family and loved ones. Talk to your Medicare patients about appropriate home care and hospice services.

For More Information:
- Home Health Prospective Payment System Fact Sheet
- Medicare Home Care Benefit Fact Sheet
- Hospice Payment System Fact Sheet

Provider Compliance

Chiropractic Services: High Part B Improper Payment Rate

The Office of Inspector General (OIG) recently released a 2016 Final Report on Medicare payments for chiropractic services. There were approximately $389 million in improper payments for chiropractic services during the 2013 reporting period; most payments did not comply with Medicare requirements. The OIG attributed the improper payments to services that were medically unnecessary, incorrectly coded, insufficiently documented, or not documented to support the billed services.

Understand Medicare requirements for chiropractic services, especially documentation and medical necessity. Resources:

- Hundreds of Millions in Medicare Payments for Chiropractic Services Did Not Comply with Medicare Requirements OIG Report October 2016
- Chiropractic Education webpage
- Improving the Documentation of Chiropractic Services Video: Learn about medical necessity and proper documentation
- April 2013 Medicare Quarterly Provider Compliance Newsletter: Article on chiropractic claims

MLN Matters® Articles:

- Overview of Medicare Policy Regarding Chiropractic Services
- Medicare Coverage for Chiropractic Services: Medical Record Documentation Requirements for Initial and Subsequent Visits
- Use of the AT Modifier for Chiropractic Billing
- Educational Resources to Assist Chiropractors with Medicare Billing

Claims, Pricers & Codes

Billing for Influenza: New CPT Code 90674

The American Medical Association issued a new Current Procedural Terminology (CPT) code for influenza vaccineFlucelvax, CPT 90674, effective August 1, 2016, for Medicare claims. However, Medicare claims processing systems will not be able to accept the new code until January 1, 2017. Until this time, you may hold claims containing CPT 90674. Finally, if you bill institutional claims, note that code CPT 90674 will be implemented on February 20, 2017.

Upcoming Events

Quality Payment Program Final Rule Call — November 15

Tuesday, November 15 from 1:30 to 3 pm ET

To register or for more information, visit MLN Connects® Event Registration. Space may be limited, register early.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ends the sustainable growth rate and moves Medicare closer to a system that pays physicians based on the outcomes that matter to patients. The Quality Payment Program allows clinicians to choose the best way to deliver quality care and to participate based on their practice size, specialty, location, or patient population. During this call, learn about the provisions in the recently released final rule; participants should review the rule prior to the call. A question and answer session will follow the presentation.

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

2016 Hospital Appeals Settlement Call — November 16

Wednesday, November 16 from 1:30 to 3 pm ET

To register or for more information, visit MLN Connects Event Registration. Space may be limited, register early.

On September 28, 2016, CMS announced that we will once again allow eligible providers to settle their inpatient status claims currently under appeal using the Hospital Appeals Settlement process. This call will give an overview of the process. A question and answer session will follow the presentation.

In early November, details on the settlement process will be posted on the Hospital Appeals Settlement Process 2016 webpage.

Target Audience: Acute care hospitals, including those paid via the prospective payment system, periodic interim payments, and the Maryland waiver; and critical access hospitals.

IRF and LTCH: Transition to NHSN Rebaseline Webinar — November 16

Wednesday, November 16 from 1 to 2 pm ET

The Centers for Disease Control and Prevention (CDC) is implementing a new national baseline for Healthcare-Associated Infection (HAIs) that are reported to the National Healthcare Safety Network (NHSN). Starting December 10, NHSN users can run standardized infection ratios for 2015 and 2016 under both the old and new baselines. Data for 2017 will only be available under the new baseline.

During this webinar, the CDC explains the new HAI models, as they relate to Long-Term Care Hospitals (LTCHs) and Inpatient Rehabilitation Facilities (IRFs), and the reason HAI data in IRF and LTCH Preview Reports may not align with the data in the NHSN for the same target period.

Register for this webinar. For more information, visit the IRF Quality Public Reporting and LTCH Quality Public Reporting webpages.

IRF and LTCH Quality Measure Report Call — December 1

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

To register or for more information, visit MLN Connects Event Registration. Space may be limited, register early.

During this call, CMS experts present on the recently released Certification and Survey Provider Enhanced Reports (CASPER) Quality Measure (QM) reports for the Inpatient Rehabilitation Facility (IRF) and Long-Term Care Hospital (LTCH) Quality Reporting Programs. Find out how to get aggregate performance for the current quarter or past three quarters, find reporting errors that may affect your performance, and interpret the information.

Agenda:

- Quality measures for public reporting in 2016
- Reports associated with public reporting
- Content of the CASPER QM reports by data source
- How to interpret facility and patient level results
- Accessing reports in CASPER
- Resources for providers

Target Audience: IRF and LTCH providers, healthcare industry professionals, clinicians, researchers, health IT vendors, and other interested stakeholders.

National Partnership to Improve Dementia Care and QAPI Call — December 6

Tuesday, December 6 from 1:30 to 3 pm ET

To register or for more information, visit MLN Connects Event Registration. Space may be limited, register early.

During this call, learn about the reform of requirements for long-term care facilities, highlighting the Behavioral Health Services & Pharmacy Services sections. A Tennessee nursing home will also discuss innovative approaches that they implemented to dramatically reduce the use of antipsychotic medications. Additionally, CMS subject matter experts share updates on the progress of the National Partnership to Improve Dementia Care in Nursing Homes and Quality Assurance and Performance Improvement (QAPI). A question and answer session will follow the presentations.

Speakers:

- Diane Corning, CMS
- Douglas Ford, National HealthCare Corporation, Fort Sanders
- Michele Laughman and Debbie Lyons, CMS

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

CMS 2016 Quality Conference — December 13-15

Aligning for Innovation and Outcomes

For more information and to register, visit the CMS Quality Conference webpage.

Join more than nearly 2,000 thought leaders in American health care quality improvement in Baltimore, MD. This conference will explore how patients, advocates, providers, researchers, and the many leaders in health care quality improvement can develop and spread solutions to some of America's most pervasive health system challenges.

Medicare Learning Network® Publications & Multimedia

Provider Compliance Fact Sheets — New

New Provider Compliance Fact Sheets are available with tips for:

- Hyperbaric Oxygen Therapy
- Ambulance Services: Emergent and non-emergent

- Ordering Hospital Outpatient Services
- Home Health Services: Part A non DRG

QRUR Call: Audio Recording and Transcript — New

An audio recording and transcript are available for the October 20 call on the 2015 Supplemental Quality and Resource Use Reports (QRURs), confidential feedback reports for medical group practices and solo practices on resource use for Fee-For-Service episodes of care.

Hospital-Acquired Conditions and Present on Admission Indicator Reporting Provision Fact Sheet — Revised

A revised Hospital-Acquired Conditions and Present on Admission Indicator Reporting Provision Fact Sheet is available. Learn about:

- Exempt hospitals
- Resources

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