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Official CMS news from the Medicare Learning Network

Thursday, January 3, 2019

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News & Announcements

Medicare Shared Savings Program: Final Rule Creates Pathways to Success

On December 21, CMS issued a final rule that sets a new direction for the Medicare Shared Savings Program (Shared Savings Program). Referred to as “Pathways to Success,” this new direction for the Shared Savings Program redesigns the participation options available under the program to encourage Accountable Care

Organizations (ACOs) to transition to performance based risk more quickly and, for eligible ACOs, incrementally, to increase savings for the Trust Funds.

In connection with the program redesign, we will offer an application cycle for a one-time new agreement period start date of July 1, 2019:

- Avoids an interruption in participation by ACOs with a participation agreement ending on December 31, 2018, that elected to extend their current agreement period for an additional 6-month performance year
- Provides new and currently participating ACOs time to review new policies, make business and investment decisions, and complete and submit an application under the new BASIC or ENHANCED track.

New and existing ACOs interested in applying must complete the non-binding Notice of Intent to Apply, which will be available from January 2 through 18. See the [Application Types & Timeline](#) webpage for eligibility requirements, key timelines, and detailed instructions on the submission process. CMS will resume the usual annual application cycle for agreement periods starting on January 1, 2020, and in subsequent years.

The final rule includes:

- Final policy for extreme and uncontrollable circumstances for performance year 2017
- New BASIC and ENHANCED tracks and 5-year agreement periods
- Updated repayment mechanism requirements for two-sided model ACOs
- Rigorous benchmarking using regional benchmarks for all agreement periods
- Reduced opportunities for gaming to ensure program integrity
- Annual choice of assignment methodology
- Expanded use of telehealth for practitioners in ACOs in performance-based risk arrangements
- Expanded eligibility for Skilled Nursing Facility 3-Day Rule Waiver
- Beneficiary incentive programs
- Beneficiary notification
- Claims-based assignment with beneficiary opt-in

For More Information:

- [Final Rule](#)
- [Press Release](#)
- [Blog](#)

See the full text of this excerpted [CMS Fact Sheet](#) (issued December 21).

Physician Compare Preview Period Extended to January 7

The Physician Compare preview period is extended to January 7 at 8 pm ET. Preview your 2017 Quality Payment Program performance information before it will appear on [Physician Compare](#) profile pages and in the downloadable database. Access the secured preview through the [Quality Payment Program](#) website.

For More Information:

- [Physician Compare Preview Period User Guide](#)
- [Medicare Learning Network Webcast](#)
- [Clinician Performance Information on Physician Compare: Performance Year 2017 Preview Period](#)
- [Group Performance Information on Physician Compare: Performance Year 2017 Preview Period](#)
- For assistance accessing the Quality Payment Program website or obtaining your Enterprise Identity Management (EIDM) user role, contact QPP@cms.hhs.gov
- For questions about Physician Compare, public reporting, or the preview period, contact PhysicianCompare@Westat.com

Hospice Provider Preview Reports: Review Your Data by January 9

Two reports are available in your Certification and Survey Provider Enhanced Reports (CASPER) non-validation reports folder:

- Hospice provider preview report: Review Hospice Item Set (HIS) quality measure results from the second quarter of 2017 to the first quarter of 2018
- Hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey provider preview report: Review facility-level CAHPS survey results from the second quarter of 2016 to the first quarter of 2018

Review your HIS and CAHPS results by January 9. If you believe the denominator or other HIS quality metric is inaccurate or if there are errors in the results from the CAHPS survey data, request a CMS review:

- [HIS Preview Reports and Requests for CMS Review](#) webpage
- [CAHPS Preview Reports and Requests for CMS Review](#) webpage

Access Instructions:

- [Hospice Provider Preview Report](#)
- [Hospice CAHPS Provider Preview Reports](#)

Medicare Shared Savings Program: Submit Notice of Intent to Apply by January 18

Pathways to Success

Notice of Intent to Apply:

CMS is accepting Notices of Intent to Apply (NOIAs) via the [Accountable Care Organization \(ACO\) Management System \(ACO-MS\)](#) for the July 1, 2019, start date for the redesigned [Medicare Shared Savings Program - Pathways to Success](#). You must submit a NOIA if you intend to apply to the new BASIC track or ENHANCED track of the Medicare Shared Savings Program, to apply for a Skilled Nursing Facility (SNF) 3-Day Rule Waiver, and/or to establish and operate a Beneficiary Incentive Program.

NOIA submissions are due no later than January 18 at noon ET. A NOIA submission does not bind an organization to submit an application; however, you must submit a NOIA to be eligible to apply. Each ACO should submit only one NOIA. ACOs will have an opportunity to make changes to their tracks, repayment mechanisms, and other NOIA information during the application submission period.

New for this application cycle – ACOs may submit additional documents with your NOIA submission:

- Sample ACO Participant Agreements
- Sample SNF Affiliate Agreements if applying for a SNF 3-Day Rule Waiver
- Draft repayment mechanism documentation if applicable

Submitting these documents with the NOIA will allow CMS to review and provide feedback so you may resolve any issues with this documentation before the application cycle begins. CMS strongly recommends that your ACO submit its NOIA as soon as possible to take advantage of this opportunity to receive feedback early, as this may save your ACO time and effort during the application submission process.

Application Submission Period:

- Due dates for the application submission period will be coming soon
- Additional resources on the application submission process will be available in mid-January

For More Information:

- [Shared Savings Program](#) website
- [Application Types & Timeline](#) webpage
- [ACO-MS](#)
- [NOIA Guidance](#)
- [ACO Participant List and Participant Agreement Guidance](#)
- [SNF 3-Day Rule Waiver Guidance](#)

- [Repayment Mechanism Arrangements Guidance](#)
- For questions email SSPACO_Applications@cms.hhs.gov

Laboratory Date of Service Exception Policy: Enforcement Discretion Exercised until July 1

CMS will exercise enforcement discretion until July 1, 2019, for the laboratory date of service exception policy for advanced diagnostic laboratory tests and molecular pathology tests excluded from the Medicare hospital outpatient prospective payment system packaging policy. Visit the [Laboratory Date of Service Policy](#) webpage for more information.

Quality Payment Program: 2019 Resources

CMS posted new resources to help you prepare for the 2019 performance year of the Merit-based Incentive Payment System (MIPS):

- [Medicare Part B Claims Measure Specifications and Supporting Documents](#): Descriptions of the claims measures for the Quality performance category
- [Clinical Quality Measure Specifications and Supporting Documents](#): Descriptions of the clinical quality measures for the Quality performance category
- [CMS Web Interface Measure Specifications and Supporting Documents](#): Descriptions of the CMS Web Interface measures for the Quality performance category
- [Cross-Cutting Quality Measures](#): List of cross-cutting Quality measures that are broadly applicable to all clinicians regardless of their specialty
- [Quality Measure Benchmarks](#): Lists and explains benchmarks used to assess performance in the Quality performance category
- [Promoting Interoperability Measure Specifications](#): Overview of the requirements for the Promoting Interoperability performance category objectives and measures
- [Cost Measure Code Lists](#): Details the cost measure code lists for each of the 8 episode-based cost measures that are new for the Cost performance category
- [Cost Measure Information Forms](#): Details the measure methodology for each episode-based measure for the Cost performance category
- [MIPS: Summary of Cost Measures](#): Summary of cost measures
- [Improvement Activities Inventory](#): List of the improvement activities and descriptions
- [Qualified Clinical Data Registries \(QCDRs\)](#) and [Qualified Registries](#) Qualified Postings: List of CMS-approved QCDRs and Qualified Registries and the performance categories and measures they support
- [MIPS Participation and Eligibility Fact Sheet](#): Overview of the eligibility criteria
- [Quality Performance Category Fact Sheet](#): Includes an overview of quality measures and how to collect and submit quality data
- [Cost Performance Category Fact Sheet](#): Includes details on the episode-based measures

For More Information:

- [Resource Library](#) webpage
- [Quality Payment Program](#) website
- Reach out to your local [technical assistance organization](#)
- Contact QPP@cms.hhs.gov or 866-288-8292 (TTY: 877-715-6222)

eCQM Resource: The Collaborative Measure Development Workspace

CMS expanded the Electronic Clinical Quality Improvement Resource Center to include a [Collaborative Measure Development \(CMD\) Workspace](#). The CMD Workspace brings together a set of interconnected resources, tools, and processes to promote clarity, transparency, and better interaction across stakeholder communities that develop, implement, and report Electronic Clinical Quality Measures (eCQMs).

Medicare Enrollment Application Fee for CY 2019

On November 18, CMS issued a notice: Provider Enrollment Application Fee Amount for Calendar Year 2019 [[CMS-6079-N](#)]. Effective January 1, the CY 2019 application fee is \$586 for institutional providers that are:

- Initially enrolling in the Medicare or Medicaid program or the Children's Health Insurance Program (CHIP)
- Revalidating their Medicare, Medicaid, or CHIP enrollment
- Adding a new Medicare practice location

This fee is required with any enrollment application submitted from January 1 through December 31, 2019.

Delivery of Initial Prescriptions of Immunosuppressive Drugs

The Medicare Claims Processing Manual is updated to allow suppliers to deliver the initial prescriptions of a beneficiary's immunosuppressive drugs to an alternate address, such as the inpatient hospital that performed the transplant or alternative location where the beneficiary is temporarily staying, instead of delivering the drugs to the patient's home address. See [Chapter 17](#), section 80.3.3 for details.

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 of the Partnership is the percentage of long-stay nursing home residents who receive antipsychotic medication, excluding residents diagnosed with schizophrenia, Huntington's disease, or Tourette's syndrome. In the fourth quarter of 2011, 23.9 percent of residents received an antipsychotic medication; since then there has been a decrease of 38.9 percent to a national prevalence of 14.6 percent in the second quarter of 2018. Success varies by state and CMS region; some states and regions have a reduction greater than 40 percent. A four-quarter average of this measure is posted on the [Nursing Home Compare](#) website.

For More Information:

- Visit the [Partnership](#) webpage
- Send correspondence to dnh_behavioralhealth@cms.hhs.gov

Get Your Patients Off to a Healthy Start in 2019

Get your patients off to a healthy start this year by performing and recommending the [Initial Preventive Physical Examination](#) (IPPE) and [Annual Wellness Visit](#) (AWV). Medicare covers these preventive services at no cost to your patients.

- IPPE or "Welcome to Medicare" preventive visit is a one-time service for newly-enrolled beneficiaries: Review of medical and social health history and preventive services education
- AWV is a yearly office visit that focuses on preventive health: Develop or update a personalized prevention plan; perform a health risk assessment, cognitive and depression screens, and optional advance care planning

For More Information:

- [Preventive Services](#) Educational Tool
- [AWV, IPPE, and Routine Physical - Know the Differences](#) Educational Tool

Visit the [Preventive Services](#) website to learn more about Medicare-covered services.

Provider Compliance

Coding for Specimen Validity Testing Billed in Combination with Urine Drug Testing — Reminder

In a February 2018 report, the Office of the Inspector General (OIG) determined that Medicare payments to clinical laboratories and providers for specimen validity tests did not comply with Medicare billing requirements. A recent [MLN Matters® Special Edition Article](#) reminds laboratories and other providers about proper billing for specimen validity testing done in conjunction with drug testing; this article contains no policy changes.

Current coding for testing for drugs of abuse relies on a structure of presumptive and definitive testing that identifies the specific drug and quantity in the patient. This article includes descriptors for:

- Presumptive drug testing codes
- Definitive drug testing codes

Use the following resources to bill correctly and avoid overpayment recoveries:

- [Medicare Improperly Paid Providers for Specimen Validity Tests Billed in Combination with Urine Drug Tests](#) OIG Report, February 2018
- [The National Correct Coding Initiative Policy Manual](#)
- [Contact your Medicare Administrative Contractor](#)

Claims, Pricers & Codes

Medicare Diabetes Prevention Program: Valid Claims

For a claim to be valid under the Medicare Diabetes Prevention Program (MDPP), you must have both:

- Centers for Disease Control and Prevention (CDC) preliminary or full recognition; see the [Supplier Fact Sheet](#) and [CDC](#) website for more information
- Separate Medicare enrollment as an MDPP supplier (Specialty D1); see the [Enrollment Fact Sheet](#) and [Checklist](#)

Important:

If you do not have a separate Medicare enrollment as a MDPP supplier and you submit a claim for MDPP services, your claim will be rejected.

Medicare enrolled MDPP suppliers: See the [Quick Reference Guide to Payment and Billing](#) and the [Billing and Claims Fact Sheet](#) for information on valid claims:

- Submit claims when a performance goal is met, and report codes only once per eligible beneficiary (except G9890 and G9891)
- List each HCPCS code with the corresponding session date of service and the coach's National Provider Identifier
- List all HCPCS codes associated with a performance payment (including non-payable codes) on the same claim
- Include Demo code 82 in block 19 to identify MDPP services
- Do not include codes for other, non-MDPP services

For More Information:

- [MDPP Expanded Model](#) Booklet
- [MDPP](#) webpage

Upcoming Events

ESRD Quality Incentive Program: CY 2019 ESRD PPS Final Rule Call — January 15

Tuesday, January 15 from 2 to 3 pm ET

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

During this call, learn about provisions for the End-Stage Renal Disease (ESRD) Quality Incentive Program (QIP) in the CY 2019 ESRD Prospective Payment System (PPS) [final rule](#). Find out how CMS will conduct ESRD QIP for Payment Years 2021 and 2022. Topics include:

- Legislative framework
- Updates to ESRD QIP measures, domain structure, and weights
- Modifications to data submission requirements and the National Healthcare Safety Network Validation Study

Target Audience: Dialysis facilities that participate in the ESRD QIP.

Clinical Diagnostic Laboratories to Collect and Report Private Payor Rates Call —January 22

Tuesday, January 22 from 2 to 3 pm ET

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

Do you need to submit data required by the Clinical Diagnostic Test Payment System [final rule](#)? Laboratories, including physician offices laboratories and hospital outreach laboratories that bill using a 14X TOB are required to report laboratory test HCPCS codes, associated private payor rates, and volume data if they:

- Have more than \$12,500 in Medicare revenues from laboratory services on the Clinical Laboratory Fee Schedule (CLFS), and
- Receive more than 50 percent of their Medicare revenues from CLFS and physician fee schedule services during a data collection period

This call provides a refresher on how to collect and submit required data. CMS will use this data to set Medicare payment rates effective January 1, 2021.

A question and answer session follows the presentation; however, you may email questions in advance to CLFS_Inquiries@cms.hhs.gov with “January 22 Call” in the subject line. These questions may be addressed during the call or used for other materials following the call. For more information, visit the [PAMA Regulations](#) webpage.

Target Audience: Clinical diagnostic laboratories, including physician offices and hospital outreach laboratories.

Home Health Patient-Driven Groupings Model Call — February 12

Tuesday, February 12 from 1:30 to 3 pm ET

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

During this call, learn about the Patient-Driven Groupings Model (PDGM) that will be implemented on January 1, 2020. CMS will use the PDGM to reimburse home health agencies for providing home health services under Medicare fee-for-service. Topics include:

- Overview of PDGM model
- Walkthrough of payment adjustments, including low utilization payment adjustments, partial payment adjustments, and outliers payments

A question and answer session follows the presentation. For more information, visit the [Home Health Prospective Payment System](#) webpage; review the CY 2019 [final rule](#) and [Overview of the PDGM](#).

Target Audience: Home health agencies, administrators, clinicians, and other interested stakeholders.

Medicare Learning Network® Publications & Multimedia

Claim Status Category and Codes Update MLN Matters Article — New

A new MLN Matters Article MM11073 on [Claim Status Category and Claim Status Codes Update](#) is available. Learn about updates for ASC X12 276/277 transactions.

Ensuring Only the Active Billing Hospice Can Submit a Revocation MLN Matters Article — New

A new MLN Matters Article MM11049 on [Ensuring Only the Active Billing Hospice Can Submit a Revocation](#) is available. Learn about the new Common Working File edit in Medicare Systems.

Guidance for MACs Processing BFCC QIO 2MN SSR Determinations MLN Matters Article — New

A new MLN Matters Article MM10600 on [Guidance for Medicare Administrative Contractors \(MACs\) Processing Beneficiary and Family Centered Care \(BFCC\) Quality Improvement Organizations \(QIO\) Two-Midnight \(2MN\) Short Stay Review \(SSR\) Determinations](#) is available. Learn about appeal rights and how MACs will adjust denial decisions as a files and update factors.

I/OCE Version 20.0: January 2019 MLN Matters Article — New

A new MLN Matters Article MM11068 on [January 2019 Integrated Outpatient Code Editor \(I/OCE\) Specifications Version 20.0](#) is available. Learn about software changes.

FISS/DDE: New Search Features MLN Matters Article — New

A new MLN Matters Special Edition Article SE18028 on [New Search Features Added to Fiscal Intermediary Shared System \(FISS\)/Direct Data Entry \(DDE\)](#) is available. Learn about a translator tool and option to search for a claim using FISS.

Quality Payment Program in 2018: Group Participation Web-Based Training — New

With Continuing Education Credit

A new Quality Payment Program in 2018: Group Participation Web-Based Training course is available through the [Learning Management System](#). Learn about:

- Difference between a group and a virtual group
- Different reporting mechanisms
- Reporting requirements for groups for each performance category
- How scoring and payment adjustments work for groups

SNF PPS Call: Audio Recording and Transcript — New

An [audio recording](#) and [transcript](#) are available for the [December 11](#) call on the Skilled Nursing Facility (SNF) Prospective Payment System (PPS). On October 1, 2019, the new Patient Driven Payment Model is replacing Resource Utilization Group, Version IV. Learn about this new case-mix classification system for SNF Part A beneficiaries.

IRF Medical Review Changes MLN Matters Article — Revised

A revised MLN Matters Special Edition Article SE17036 on [Inpatient Rehabilitation Facility \(IRF\) Medical Review Changes](#) is available. Learn how to submit claims for services.

New Physician Specialty Code for Undersea and Hyperbaric Medicine MLN Matters Article — Revised

A revised MLN Matters Article MM10666 on [New Physician Specialty Code for Undersea and Hyperbaric Medicine](#) is available. Learn about the D4 code.

Repetitive, Scheduled Non-emergent Ambulance Prior Authorization Model MLN Matters Article — Revised

A revised MLN Matters Special Edition Article SE1514 on [Overview of the Repetitive, Scheduled Non-emergent Ambulance Prior Authorization Model](#) is available. Learn about documentation requirements and the new extension date for the model.

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