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Official CMS news from the Medicare Learning Network®

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SNF: FY 2020 Payment and Policy Changes

On July 30, CMS issued a final rule for FY 2020 Medicare payment rates and quality programs for Skilled Nursing Facilities (SNFs). CMS projects aggregate payments to SNFs will increase by $851 million, or 2.4 percent, for FY 2020 compared to FY 2019. This estimated increase is attributable to a 2.8 percent market basket increase factor with a 0.4 percentage point reduction for the multifactor productivity adjustment.

The final rule also includes:

- Payment policy
- Sub-regulatory process for ICD-10 code revisions
- Align group therapy definitions with other post-acute care settings
- SNF Value-Based Purchasing (VBP) Program policy changes
- SNF Quality Reporting Program (QRP)

For More Information:

- Final Rule
- SNF PPS website
- SNF QRP Measures and Technical Information webpage
- SNF VBP Program website

See the full text of this excerpted CMS Fact Sheet (Issued July 30).

IPF: FY 2020 Payment and Quality Reporting Updates

On July 30, CMS finalized a rule that further advances our continuing efforts to strengthen the Medicare program by better aligning payments for Inpatient Psychiatric Facilities (IPFs) with the costs of providing care. The final rule will update Medicare payment policies and rates for the IPF Prospective Payment System (PPS) and the IPF Quality Reporting Program for FY 2020.

CMS estimates total IPF payments to increase by 1.5 percent or $65 million in FY 2020. The IPF market basket increase, which is used to update IPF payment rates, is 2.9 percent. This is further adjusted by two reductions required by law (the productivity adjustment of 0.4 percentage point and a 0.75 percentage point reduction), resulting in an IPF payment rate update of 1.75 percent. Additionally, total estimated payments to IPFs are estimated to decrease 0.23 percentage point due to updating the threshold amount used in calculating outlier payments.

Major provisions of the final rule:

- Rebased and revised the IPF market basket
- Removed the one-year lag of the IPF PPS wage index
- IPF Quality Reporting Program: Adopted a new claims-based measure beginning with the FY 2021 payment determination and subsequent years

See the full text of this excerpted CMS Fact Sheet (issued July 30).

Protect Your Patients' Identities: Use the MBI Now

Protect your patients' identities by using the Medicare Beneficiary Identifier (MBI) now. Don't have an MBI?

- Ask your patients for their card. If they did not get a new card, give them the Get Your New Medicare Card flyer in English or Spanish.
- Use your Medicare Administrative Contractor's look up tool. Sign up for the Portal to use the tool.
- Check the remittance advice. We return the MBI on the remittance advice for every claim with a valid and active HICN.

Will your claims be paid in 2020? Starting January 1, you must use the MBI. We will reject claims you submit with the Health Insurance Claim Number (HICN), with a few exceptions, and reject all eligibility transactions.

CMS Advances MyHealthEData with New Pilot to Support Clinicians

On July 30, CMS announced changes that further protect and strengthen Medicare by unleashing the power of data and placing it firmly where it belongs, in the hands of patients and the clinicians who treat them. CMS is accelerating the transformation of the nation's health care system to one that is based on value by increasing patient and provider access to the data needed through a new pilot program for clinicians called Data at the Point of Care (DPC). DPC is based on an industry-standard application programming interface and is part of the MyHealthEData Administration-wide initiative.

The DPC pilot program will leverage Medicare's Blue Button data to provide clinicians with access to claims data. The claims data will fill in information gaps for clinicians, giving them a more structured and complete patient history with information like previous diagnoses, past procedures, and medication lists. Clinicians will be able to access the DPC pilot data directly within their workflow, without needing to log into another application. This will reduce burden in the exam room and give clinicians more time to deliver high quality care for their patients.

DPC is one of many critical steps CMS is taking to build on our actions to make a truly interoperable health care system. If you are interested in participating in the DPC pilot program, sign up by visiting the Data at the Point of Care website. Beneficiaries who wish to opt out of data sharing can do so by calling 1-800-Medicare.

See the full text of this excerpted CMS Press Release (Issued July 30).

Reducing Administrative Burden: Comment by August 12

In June, CMS issued a Request for Information (RFI) seeking your ideas on how to continue the progress of the Patients over Paperwork initiative. Since launching in fall 2017, Patients over Paperwork has streamlined regulations to significantly cut the "red tape" that weighs down our health care system and takes clinicians away from their primary mission—caring for patients. As of January, CMS estimates that through regulatory reform alone, the health care system will save an estimated 40 million hours and $5.7 billion through 2021. These estimated savings come from both final and proposed rules.

The RFI provides an opportunity for you to recommend further changes to rules, policies, and procedures that would shift more of your time and our health care system's resources from needless paperwork to high-quality care that improves patient health. We seek ways to improve:

- Reporting and documentation requirements
- Coding and documentation requirements for Medicare or Medicaid payment
- Prior authorization procedures
- Policies and requirements for rural providers, clinicians, and beneficiaries
- Policies and requirements for dually enrolled (i.e., Medicare and Medicaid) beneficiaries
- Beneficiary enrollment and eligibility determination
- CMS processes for issuing regulations and policies

For more information, including how to submit comments, read the RFI. Submit comments by August 12.

Medicare Coverage for Treatment Services Furnished by Opioid Treatment Programs

CMS proposed policies to implement Section 2005 of the Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act), which established a new Medicare Part B benefit for opioid use disorder treatment services, including medications for medication-assisted treatment, furnished by Opioid Treatment Programs (OTPs). Comments on the proposed OTP policies are due via the official comment submission process by September 27.

For More Information:

- Proposed Rule see section II.G
- OTP webpage

Open Payments Program Expansion

The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) impacts Open Payments by expanding the definition of a covered recipient to include five additional provider types: Physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, and certified nurse midwives. For more information, visit the Open Payments website.

Improve Accessibility of Care for People with Disabilities: New Resources

In recognition of the anniversary of the Americans with Disabilities Act, CMS offers new resources for people with disabilities and their care providers to improve access to high quality health care and support independent living. Adults with disabilities are almost twice as likely as other adults to report unmet health care needs due to problems accessing a doctor's office or clinic.

- Getting the Care You Need: A Guide for Individuals with Disabilities
- Modernizing Health Care to Improve Physical Accessibility: Resources Inventory
- How Does Disability Affect Access to Health Care for Dual Eligible Beneficiaries?

Learn about the experiences of people that use wheelchairs and how you can be a better advocate; watch the Navigating Health Care with a Disability videos:

- Our Stories, a Focus on People with Disabilities
- Our Stories, a Focus on the Provider

For more information visit the CMS Office of Minority Health website.

Part A Providers: Formal Telephone Discussion Demonstration

CMS expanded the Qualified Independent Contractor Formal Telephone Discussion Demonstration to include Part A appeals on May 1. If you submit Part A claims to the following Medicare Administrative Contractors you are eligible to participate:

- All Part A appeals: JH, JJ, JK, JL, JM, and JN
- Home health and hospice (HHH) appeals in J6 and J15

Participation in the Demonstration remains voluntary. All Part A claim types are eligible, except:

- Reconsiderations for service termination
- Hospital discharge reviews
- Claims or providers that are already involved in another CMS initiative (e.g., the Settlement Conference Facilitation)

Benefits of participating in a telephone discussion:

- Direct interaction with the reconsideration decision maker
- Ability to discuss the facts of the case and provide verbal testimony
- Opportunity to receive education regarding applicable CMS policies
- Improvement of future claim submissions

Current Demonstration activities conducted within DME MAC Jurisdictions will continue. Visit the Original Medicare Appeals webpage for more information.

July – September Quarterly Provider Update

The July – September Quarterly Provider Update is available, including issuances and regulations. Find out about:

- Regulations and major policies currently under development during this quarter
- Regulations and major policies completed or cancelled
- New or revised manual instructions

Disaster Preparedness Resources

The Office of the Assistant Secretary for Preparedness and Response (ASPR) Technical Resources, Assistance Center, and Information Exchange (TRACIE) released several new resources:

- Health Care Coalition Surge Estimator Tool and Data Collection Form
- Topic Collection updates: Mental Health/Behavioral Health, Responder Safety and Health, and Viral Hemorrhagic Fever/Ebola
- Federal Recovery Programs for Health Care Organizations Fact Sheet
- Medical Surge and the Role of Accountable Care Organizations

For More Information:

- ASPR TRACIE Fact Sheet
- ASPR TRACIE website

Vaccines Are Not Just for Kids

National Immunization Awareness Month (NIAM) is an annual observance to highlight the importance of vaccinations. Protect your Medicare patients:

- Assess their vaccination status
- Educate and counsel on recommended vaccines
- Vaccinate at the same visit or refer the patient to a vaccinating provider
- Document receipt of the vaccine

For More Information:

- Medicare Preventive Services Educational Tool
- Medicare Part B Immunization Billing: Seasonal Influenza Virus, Pneumococcal, and Hepatitis B Educational Tool
- Mass Immunizers and Roster Billing: Simplified Billing for Influenza Virus and Pneumococcal Vaccinations Booklet
- Medicare Part D Vaccines and Vaccine Administration Fact Sheet
- NIAM website, Centers for Disease Control and Prevention (CDC)
- Adult Vaccination Information webpage, CDC

Visit the Preventive Services website to learn more about Medicare-covered services.

Compliance

DMEPOS: Bill Correctly for Items Provided During Inpatient Stays

In a recent report, the Office of Inspector General (OIG) determined that Medicare improperly paid suppliers for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) items provided during inpatient stays. Medicare should not pay a supplier for items furnished to a beneficiary when the beneficiary is still an inpatient.

CMS developed the Medicare DMEPOS Improper Inpatient Payments Fact Sheet to help you bill correctly. Additional resources:

- Medicare Quarterly Provider Compliance Newsletter, Volume 9, Issue 2
- Medicare Claims Processing Manual, Chapter 20, Section 10
- Medicare Claims Processing Manual, Chapter 30, Section 130.1
- Medicare Improperly Paid Suppliers for DMEPOS Provided to Beneficiaries During Inpatient Stays OIG Report
- Medicare Inappropriately Paid Acute-Care Hospitals for Outpatient Services They Provided to Beneficiaries Who Were Inpatients of Other Facilities OIG Report
- Medicare Paid New England Providers Twice for Nonphysician Outpatient Services Provided Shortly Before or During Inpatient Stays OIG Report
- Medicare Continues To Pay Twice for Nonphysician Outpatient Services Provided Shortly Before or During an Inpatient Stay OIG Report

Events

Emergency Triage, Treat, and Transport Model Application Tutorial Webinar — August 8
Thursday, August 8 from 12 to 1:30 pm ET

Register for this webinar.

Join us for an Emergency Triage, Treat, and Transport (ET3) Model application portal tutorial webinar. CMS reviews key functionality and provides tips and best practices for submitting a complete application. A question and answer session follows the presentation.

Physician Fee Schedule Proposed Rule: Understanding 3 Key Topics Listening Session — August 12
Monday, August 12 from 1-2:30 pm ET

Register for Medicare Learning Network events.

Proposed changes to the CY 2020 Physician Fee Schedule are aimed at reducing burden, recognizing clinicians for the time they spend taking care of patients, removing unnecessary measures, and making it easier for clinicians to be on the path towards value-based care. During this listening session, CMS experts briefly cover three provisions from the proposed rule and address your clarifying questions to help you formulate your written comments for formal submission:

- Increasing value of Evaluation and Management (E/M) payments
- Continuing to improve the Quality Payment Program by streamlining the program's requirement's in order to reduce clinician burden
- Creating the new Opioid Treatment Program benefit in response to the opioid epidemic

We encourage you to review the following materials prior to the call:

- Proposed rule
- Press release
- Physician Fee Schedule proposed rule fact sheet
- Quality Payment Program proposed rule fact sheet

Note: feedback received during this listening session is not a substitute for your formal comments on the rule. See the proposed rule for information on submitting these comments by September 27.

Target Audience: Medicare Part B fee-for-service clinicians; office managers and administrators; state and national associations that represent health care providers; and other stakeholders.

IRF Appeals Settlement Initiative Call — August 13
Tuesday, August 13 from 1:30 to 3 pm ET

Register for Medicare Learning Network events.

CMS is accepting Expressions of Interest (EOI) for a settlement option for Inpatient Rehabilitation Facility (IRF) appeals pending at the Medicare Administrative Contractor (MAC), the Qualified Independent Contractor (QIC), the Office of Medicare Hearings and Appeals (OMHA), and/or Medicare Appeals Council (Council) levels of review. Topics:

- Appellant eligibility
- EOI period and settlement process
- Frequently asked questions

A question and answer session follows the presentation; however attendees may email questions in advance to MedicareAppealsSettlement@cms.hhs.gov with "Aug 13 MLN Call" in the subject line. These questions may be addressed during the call or used for other materials following the call.

Target Audience: IRF appellants that filed appeals at the MAC for redetermination no later than August 31, 2018, that are currently pending or are eligible for further appeal at the MAC, QIC, OMHA, or Council.

OPPS and ASC Proposed Rule Listening Session — August 14
Wednesday, August 14 from 2:30 to 4 pm ET

Register for Medicare Learning Network events.

CMS proposed updates and policy changes under the Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) payment systems, including price and quality transparency that lay the foundation for a patient-driven health care system. During this listening session, CMS experts briefly cover provisions from the proposed rule and address your clarifying questions to help you formulate your written comments for formal submission. Topics include:

- Price transparency: Requirements for all United States hospitals to make their standard charges public
- Increasing choices and encouraging site neutrality, including payments for clinic visits

We encourage you to review the proposed rule, press release, and fact sheet prior to the call. Note: Feedback received during this listening session is not a substitute for your formal comments on the rule. See the proposed rule for information on submitting these comments by September 27.

Target Audience: All hospitals operating in the United States and other stakeholders.

ESRD Quality Incentive Program: CY 2020 ESRD PPS Proposed Rule Call — August 20
Tuesday, August 20 from 2 to 3 pm ET

Register for Medicare Learning Network events.

During this call, learn about proposals for the End Stage Renal Disease (ESRD) Quality Incentive Program (QIP) in the CY 2020 ESRD Prospective Payment System (PPS) proposed rule. Topics include:

- ESRD QIP legislative framework
- Overview of the proposed rule
- Methods for reviewing and commenting on the proposed rule

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

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

Home Health Patient-Driven Groupings Model: Operational Issues Call — August 21

Wednesday, August 21 from 1:30 to 3 pm ET

Register for Medicare Learning Network events.

During this call, learn information to help your agency prepare to implement billing changes for the Patient-Driven Groupings Model (PDGM) 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:

- Billing and claims processing overview
- How Outcome and Assessment Information Set (OASIS) data will be used in the claims system
- Reporting new occurrence codes
- Period timing and admission source scenarios
- Transition scenarios

A question and answer session follows the presentation. For more information, visit the Home Health Prospective Payment System website, and review MLN Matters Articles MM11081 and MM11272.

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

Understanding Your SNF VBP Program Performance Score Report Call — August 27

Tuesday, August 27 from 1:30 to 3 pm ET

Register for Medicare Learning Network events.

During this call, learn about your Skilled Nursing Facility (SNF) Value-Based Purchasing (VBP) Program Performance Score Report. CMS experts present a high level summary of the program and highlight the payment year 1 results (FY 2019 program year).

A question and answer session follows the presentation; however attendees may email questions in advance to SNFVBP@rti.org with "SNF VBP Aug 27 NPC" 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 SNF VBP website.

Target Audience: SNFs, clinicians, industry associations, and health care researchers.

MLN Matters® Articles

Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging – Educational and Operations Testing Period – Claims Processing Requirements

A new MLN Matters Article MM11268 on Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging – Educational and Operations Testing Period – Claims Processing Requirements is available. Learn about the AUC program and related HCPCS procedure codes, modifiers, and G codes.

New Waived Tests

A new MLN Matters Article MM11354 on New Waived Tests is available. Learn about new Clinical Laboratory Improvement Amendments of 1988 waived tests approved by the Food and Drug Administration.

Documentation of Medical Necessity of the Home Visit; and Physician Management Associated with Superficial Radiation Treatment — Revised

A revised MLN Matters Article MM11273 on Documentation of Medical Necessity of the Home Visit; and Physician Management Associated with Superficial Radiation Treatment is available. Learn about removal of a requirement and how to bill codes with modifier 25.

Publications

Skilled Nursing Facility 3-Day Rule Billing

A new Skilled Nursing Facility 3-Day Rule Billing Medicare Learning Network Fact Sheet is available. Learn about:

- Communication of coverage
- Claims processing edits
- Financial responsibility

Provider Compliance Tips for Glucose Monitors and Diabetic Accessories/Supplies — Revised

A revised Provider Compliance Tips for Glucose Monitors and Diabetic Accessories/Supplies Fact Sheet is available. Learn:

- Reasons for claim denials
- How to prevent denials

Multimedia

Quality Payment Program Merit-based Incentive Payment System (MIPS): Cost Performance Category in 2019 Web-Based Training Course — Revised

With Continuing Education Credit

A revised Quality Payment Program Merit-based Incentive Payment System (MIPS): Cost Performance Category in 2019 Web-Based Training course is available through the Medicare Learning Network Learning Management System. Learn about:

- Data sources used to calculate scores
- Cost score calculation methods
- Beneficiary attribution

Quality Payment Program 2019 Overview Web-Based Training Course — Revised

With Continuing Education Credit

A revised Quality Payment Program 2019 Overview Web-Based Training course is available through the Medicare Learning Network Learning Management System. Learn about:

- Origin and objectives
- Four performance categories within the Merit-based Incentive Payment System
- Three criteria to be considered an Advanced Alternative Payment Model
- Resources

Quality Payment Program Merit-based Incentive Payment System (MIPS): Quality Performance Category in 2019 Web-Based Training Course — Revised

With Continuing Medical Education Credit

A revised Quality Payment Program Merit-based Incentive Payment System (MIPS): Quality Performance Category in 2019 Web-Based Training course is available through the Medicare Learning Network Learning Management System. Learn about:

- Reporting requirements

- Identifying data submission and collection types
- Scoring and benchmark methodology
- Resources

Quality Payment Program Merit-based Incentive Payment System (MIPS): Improvement Activities in 2019 Web-Based Training Course — Revised

With Continuing Education Credit

A revised Quality Payment Program Merit-based Incentive Payment System (MIPS): Improvement Activities in 2019 Web-Based Training Course is available through the Medicare Learning Network Learning Management System. Learn about:

- Requirements
- Steps to report data
- Basics of scoring

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