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Official CMS news from the Medicare Learning Network®

Thursday, August 22, 2019

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Overall Hospital Quality Star Ratings: Upcoming Enhancement

CMS plans to update the quality measurement methodology of the Overall Hospital Quality Star Ratings located on CMS' popular Hospital Compare website in 2021. In the interim, CMS will refresh the Star Ratings using the current methodology in early 2020, ensuring patients have timely access to the most up-to-date hospital quality information while a new methodology is being finalized.

On August 19, CMS posted a summary of comments received on potential technical changes received during a public comment period that ended March 29. This public feedback is a critical part of ongoing efforts, along with comments submitted during future rulemaking that will help shape improvements to the Star Ratings targeted for early 2021. CMS plans more public outreach to shape potential changes including a public listening session in Baltimore on September 19 that will include a call-in option.

See the full text of this excerpted CMS Press Release (issued August 19).

Pneumococcal Vaccine Eligibility Data Issue

Medicare covers pneumococcal conjugate vaccine (PCV13) and pneumococcal polysaccharide vaccine (PPSV23). Original (Fee-For-Service (FFS)) Medicare gives beneficiary eligibility information on those services in various ways, including through vendors and clearinghouses. There is a data issue with FFS beneficiary eligibility information for both Pneumococcal Vaccines (PVs):

- When a provider administers only one vaccine, in some cases the FFS beneficiary eligibility response reflects both vaccines have been administered
- When FFS beneficiary eligibility data indicates your patient got both vaccines, please talk with your patient about prior vaccination status (Medicare Benefit Policy Manual, Chapter 15, Section 50.4.4.2.A.2) until we resolve this issue in early 2020
- The eligibility issue does not affect FFS claims processing for PV

When the FFS beneficiary eligibility response indicates the beneficiary is enrolled in a Medicare Advantage Plan (Part C), check with the plan for beneficiary eligibility information. The FFS beneficiary eligibility transactions give you plan names and contact information so you can get Medicare Advantage Plan benefit information, including PV services your patient received under plan coverage.

Venipuncture: Comparative Billing Report in August

In late August, CMS will issue a Comparative Billing Report (CBR) on venipuncture, focusing on providers who submit Medicare Part B claims. These reports contain data-driven tables with an explanation of findings that compare your billing and payment patterns to those of your peers in your state and across the nation.

CBRs are not publicly available. Look for an email from cbrpepper.noreply@religroupinc.com with your report. Update your contact email address in the National Plan and Provider Enumeration System to ensure accurate delivery. Visit the CBR website for more information.

SNF Provider Preview Reports: Review Your Data by September 16

Skilled Nursing Facility (SNF) Provider Preview Reports are available. Review your performance data by September 16, prior to public display on Nursing Home Compare in October. Corrections to the underlying data are not permitted during this time; request a CMS review if you believe your data is inaccurate.

For More Information:

- SNF Quality Public Reporting webpage
- Access Instructions

SNF PPS Patient Driven Payment Model: Get Ready for Implementation on October 1

On October 1, the new Patient Driven Payment Model (PDPM) is replacing the Resource Utilization Group, Version IV (RUG-IV) for the Skilled Nursing Facility (SNF) Prospective Payment System (PPS). PDPM improves the accuracy and appropriateness of payments by classifying patients into payment groups based on specific, data-driven patient characteristics, while simultaneously reducing administrative burden.

Changes to the Assessment:
Both RUG-IV and PDPM use the Minimum Data Set (MDS) 3.0 as the basis for patient assessment and classification, but the assessment schedule under PDPM is more streamlined and less burdensome on providers. See the presentation (starting on slide 52) to find out how your assessments will change.

Billing for Services:
Use the Health Insurance Prospective Payment System (HIPPS) code generated from assessments with an assessment reference date on or after October 1, 2019, to bill under the PDPM.

Changes to Payment:
Under the PDPM, clinically relevant factors and patient characteristics are used to assign patients into case-mix groups across the payment components to derive payment. Additionally, the PDPM adjusts per diem payments to reflect varying costs throughout the stay.

CMS has resources to help you prepare:

- PDPM webpage, including fact sheets, FAQs, presentation, and coding crosswalks/classification logic
- Videos: PDPM: What Is Changing (and What Is Not) and Integrated Coding & PDPM Case Study
- Materials from the Medicare Learning Network call in December
- Implementation of the SNF PDPM MLN Matters Article
- New Medicare Webpage on PDPM MLN Matters Article

Promoting Interoperability: 2019 Program Requirements for Hospitals

In 2019, CMS continued its overhaul of the Medicare Promoting Interoperability Program to continue the advancement of certified electronic health record technology utilization, focusing on burden reduction and improving interoperability and patient access to health information. Learn about detailed requirements for eligible hospitals, dual-eligible hospitals, and critical access hospitals to ensure a successful reporting period:

- Promoting Interoperability Programs
- 2019 Medicare Promoting Interoperability Program Requirements
- 2019 Medicare Hospital Specification Sheets
- FY 2019 IPPS and Medicare Promoting Interoperability Program Overview Fact Sheet
- 2019 Security Risk Analysis Fact Sheet

Quality Payment Program Exception Applications

The 2019 Quality Payment Program (QPP) Exception Applications for the Promoting Interoperability (PI) performance category and Extreme and Uncontrollable Circumstances for the Merit-based Incentive Payment System (MIPS) are available on the QPP website.

Promoting Interoperability Hardship Exceptions: If you are participating in MIPS during the 2019 performance year as an individual, group, or virtual group – or participating in a MIPS Alternative Payment Model (APM) – you can submit a QPP Hardship Exception Application for the PI performance category. You must submit an application by December 31 for CMS to reweight the PI performance category to 0 percent.

Extreme and Uncontrollable Circumstances: MIPS eligible clinicians impacted by extreme and uncontrollable circumstances may submit a request for reweighting the Quality, Cost, and Improvement Activities performance categories. Submit the application by December 31 for the 2019 MIPS performance year.

For More Information:

- QPP website
- QPP Resource Library webpage
- QPP Webinar Library webpage
- For questions, contact your local technical assistance organization, QPP@cms.hhs.gov, or 1-866-288-8292 (TTY: 1-877-715-6222).

Hospice Compare Refresh

The August 2019 Hospice Compare refresh is available. Visit Hospice Compare to view the data. This refresh includes performance scores for the Hospice Visits when Death is Imminent three-day measure. CMS decided not to publish Measure 2, the seven-day measure, and will conduct further testing.

For More Information:

- Hospice Quality Public Reporting webpage
- Visits when Death is Imminent Fact Sheet and Q & A

Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier

Medicare pays Medicare Diabetes Prevention Program (MDPP) suppliers to furnish group-based intervention to at-risk Medicare beneficiaries:

- Centers for Disease Control and Prevention (CDC)-approved National Diabetes Prevention Program curriculum
- Up to 2 years of sessions delivered to groups of eligible beneficiaries

Find out how to become a Medicare enrolled MDPP supplier:

- Obtain CDC preliminary or full recognition: Takes at least 12 months to obtain preliminary recognition and up to 24 additional months to achieve full recognition; see the Supplier Fact Sheet and CDC website for more information
- Prepare for Medicare enrollment; see the Enrollment Fact Sheet and Checklist
- Apply to become a Medicare enrolled MDPP supplier (existing Medicare providers must re-enroll), See the Enrollment Webinar Recording and Enrollment Tutorial Video
- Furnish MDPP services; see the Session Journey Map
- Submit claims to Medicare; view the Billing and Claims Webinar Recording; see the Billing and Claims Fact Sheet and Billing and Payment Quick Reference Guide

For More Information:

- MDPP Expanded Model Booklet
- Materials from Medicare Learning Network call on June 20
- MDPP webpage
- CDC - CMS Roles Fact Sheet
- Contact the MDPP Help Desk at mdpp@cms.hhs.gov

CBRs: We Want Your Feedback

CMS releases Comparative Billing Reports (CBRs) which reflect the billing patterns of one provider compared to peers' for the same services in the state or specialty, and nationwide. Goals:

- Educate
- Enhance accurate billing practices
- Support your compliance activities

Visit the CBR website to access the CBR portal and resources regarding the July CBR on Breast Re-excision and previous CBR topics including Office Visits, New/Established, Family Practice; Subsequent Hospital Care; Air Ambulance Transfers; and Emergency Department Services. CBRs are only accessible to the providers

who receive them and are not publicly available. When you have a CBR available, you will receive an email from The CBR Team cbrpepper.noreply@religroupinc.com. Update your email address in the National Plan and Provider Enumeration System and the Provider Enrollment, Chain, and Ownership System to ensure accurate delivery.

Provide feedback.

Compliance

Ambulance Fee Schedule and Medicare Transports

In a recent report, the Office of Inspector General (OIG) determined that Medicare made Part B payments to ambulance suppliers for transportation services that were also included in Medicare Part A payments to skilled nursing facilities as part of consolidated billing requirements. CMS developed the Ambulance Fee Schedule and Medicare Transports Booklet to help you bill correctly. Additional resources:

- Ambulance Fee Schedule webpage
- Sections 1861(e)(1) or 1861(j)(1) of the Social Security Act
- Medicare Benefit Policy Manual, Chapter 10, Section 10.3.3
- Medicare Claims Processing Manual, Chapter 15
- Medicare Claims Processing Manual, Chapter 30, Section 50
- Medicare Paid Twice for Ambulance Services Subject to Skilled Nursing Facility Consolidated Billing Requirements OIG Report

Claims, Pricers & Codes

MACRA Patient Relationship Categories and Codes: Reporting HCPCS Level II Modifiers

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 requires the establishment and use of Patient Relationship Categories (PRCs) and codes. When tested, the PRCs will be incorporated into the claims-based cost measures, which assess the beneficiary's total cost of care during the year, or during a hospital stay, and/or during eight episodes of care. Read MLN Matters Article MM11259, and learn how to report HCPCS Level II modifiers.

Events

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.

Dementia Care: Supporting Comfort and Resident Preferences Call — September 10

National Partnership to Improve Dementia Care and Quality Assurance Performance Improvement

Tuesday, September 10 from 1:30 to 3 pm ET

Register for Medicare Learning Network events.

During this call, gain insight on approaches to care for residents living with dementia that focus on resident preferences, maintaining comfort, and assisting with unmet needs. Additionally, CMS provides updates on the progress of the National Partnership to Improve Dementia Care in Nursing Homes. A question and answer session follows the presentations.

Speakers:

- Ann Wyatt, CaringKind
- Michele Laughman, CMS

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

MLN Matters® Articles

New Medicare Beneficiary Identifier (MBI) Get It, Use It — Reissued

A reissued MLN Matters Article SE18006 on New Medicare Beneficiary Identifier (MBI) Get It, Use It is available. Learn the latest information about the MBI including why to use it and how to handle special situations.

Medicare Coverable Services for Integrative and Non-pharmacological Chronic Pain Management

A new MLN Matters Article SE19008 on Medicare Coverable Services for Integrative and Non-pharmacological Chronic Pain Management is available. Learn about National and Local Coverage Determinations and Chronic Care Management services for patients with chronic pain.

Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) – October 2019 Update

A new MLN Matters Article MM11402 on Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) – October 2019 Update is available. Learn about updated payment files.

Manual Update to Sections 1.2 and 10.2.1 in Chapter 18 of the Medicare Claims Processing Manual

A new MLN Matters Article MM11403 on Manual Update to Sections 1.2 and 10.2.1 in Chapter 18 of the Medicare Claims Processing Manual is available. Learn about current influenza codes and payment rates.

Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes - October 2019 Update

A new MLN Matters Article MM11422 on Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes - October 2019 Update is available. Learn about 44 new HCPCS codes, effective for claims with dates of service on or after October 1, 2019.

Inpatient Rehabilitation Facility (IRF) Annual Update: Prospective Payment System (PPS) Pricer Changes for FY 2020 — Revised

A revised MLN Matters Article MM11345 on Inpatient Rehabilitation Facility (IRF) Annual Update: Prospective Payment System (PPS) Pricer Changes for FY 2020 is available. Learn about the new pricer software package.

Publications

MLN Catalog September 2019 Edition

The September 2019 Edition of the MLN Catalog is available. Learn about:

- Products and services you can download for free
- Web-based training courses; some offer continuing education credits
- Helpful links, tools, and tips

Ambulance Fee Schedule and Medicare Transports

A new Ambulance Fee Schedule and Medicare Transports Booklet is available. Learn about coverage, billing, and payment for ground and air ambulance transport benefits.

QPP: New Resources

CMS posted new resources to the Quality Payment Program (QPP) Resource Library webpage:

- 2018 Targeted Review User Guide: How to ask CMS to review your 2020 Merit-based Incentive Payment System (MIPS) payment adjustment
- MIPS Data Validation and Audit Overview: Overview of the process that will be conducted in 2019 for the 2017 and 2018 performance years
- MIPS Data Validation File Upload Instructions Video: Walks through the process to securely upload and submit a MIPS Data Validation File to CMS
- Complex Patient Bonus Fact Sheet: Overview, eligibility requirements, and how the bonus is determined and calculated
- 2019 QPP Clinician Role Demo Video: Demonstrates the steps to add the QPP clinician role, which allows you to view your MIPS eligibility details, performance feedback, and payment adjustment

For More Information:

- 2018 Targeted Review FAQs
- 2017 MIPS Data Validation Criteria and 2018 MIPS Data Validation Criteria: Criteria used to audit and validate data submitted in each performance category
- QPP Access User Guide: Add the QPP clinician role or access the QPP portal
- QPP Resource Library webpage
- QPP website
- For questions, contact your local technical assistance organization, QPP@cms.hhs.gov or 866-288-8292 (TTY: 877-715-6222)

Getting Started with Hospice CASPER Review and Correct Reports

Read Getting Started Review and Correct Reports for an overview of the Hospice Certification and Survey Provider Enhancement Reports (CASPER) Review and Correct Reports for Hospice Item Set data. Learn about the reports and how to use them. For more information visit the Hospice Quality Reporting Program Requirements and Best Practices webpage.

Behavioral Health Integration — Revised

A revised Behavioral Health Integration Medicare Learning Network Booklet is available. Learn about:

- Who can bill for services
- CPT codes
- Primary care services
- Psychiatric Collaborative Care Model

Critical Access Hospital — Revised

A revised Critical Access Hospital Medicare Learning Network Booklet is available. Learn about:

- Critical Access Hospital designation
- Payments
- Grants to states under the Medicare Rural Hospital Flexibility Program

Swing Bed Services — Revised

A revised Swing Bed Services Medicare Learning Network Fact Sheet is available. Learn about:

- Requirements that apply to hospitals and Critical Access Hospitals
- Payments

Screening Pap Tests and Pelvic Examinations Booklet — Revised

A revised Screening Pap Tests and Pelvic Examinations Booklet is available. Learn about:

- Coverage
- Documentation and coding
- Billing and payment

Hospices: CASPER QM Fact Sheet — Updated

CMS updated the Certification and Survey Provider Enhanced Reporting (CASPER) Quality Measure (QM) Reports Fact Sheet. It states that we added the Hospice When Death Is Imminent Measure Pair to both the Hospice-Level and Patient Stay-Level CASPER QM Reports. For more information, see the Hospice Quality Reporting Program Requirements and Best Practices webpage.

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