



mlnconnects

Official CMS news from the Medicare Learning Network

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News & Announcements

MyHealthEData Initiative Puts Patients at the Center of the US Health Care System

On March 6, CMS Administrator Seema Verma announced a new Trump Administration initiative – MyHealthEData – to empower patients by giving them control of their health care data and allowing it to follow them through their health care journey. MyHealthEData will help to break down the barriers that prevent patients from having electronic access and true control of their own health records. Patients will be able to choose the provider that best meets their needs and then give that provider secure access to their data, leading to greater competition and reducing costs.

In an address at the Healthcare Information and Management Systems Society (HIMSS) Annual Conference in Las Vegas, Administrator Verma also announced the launch of Medicare’s Blue Button 2.0 – a new and secure way for Medicare beneficiaries to access and share their personal health data in a universal digital format. This enables patients who participate in the traditional Medicare program to connect their claims data to the secure applications, providers, services, and research programs they trust.

Additionally, CMS intends to overhaul the Electronic Health Record Incentive Programs to refocus the programs on interoperability and reduce the time and cost required of providers to comply with the programs’ requirements.

The Administrator also highlighted other CMS plans to empower patients with data:

- Require providers to update their systems to ensure data sharing
- Require that a patient’s data follow them after they are discharged from the hospital
- Streamline documentation and billing requirements for providers to allow doctors to spend more time with their patients
- Reduce the incidence of unnecessary and duplicative testing which occurs as a result of providers not sharing data

For More Information:

- Fact Sheet: [Trump Administration Announces MyHealthEData Initiative at HIMSS18](#)
- Speech: [Remarks by CMS Administrator Seema Verma at the HIMSS18 Conference](#)

See the full text of this excerpted [CMS Press Release](#) (issued March 6).

New Medicare Card Transition Begins In Less Than a Month

CMS will begin mailing new Medicare cards with the [Medicare Beneficiary Identifier](#) (MBI) on April 1. Start using the MBI as soon as your patients get their new cards. The MBI on the new card is effective immediately unless the patient is new to Medicare, in which case refer to the “coverage starts” date on the card. People new to Medicare will only have a Medicare card with an MBI.

How can I get the MBI?

- From your patient’s new Medicare card: From April 2018 through December 31, 2019, if you submit a HICN on the 270 eligibility transaction request, we will tell you in the message field of the 271 response when we mailed a new Medicare card to each individual with Fee-For-Service Medicare. ([Mailing schedule](#))
- From your Medicare Administrative Contractor’s (MAC) portal if your patient can’t provide the card: Starting in June 2018, use the look-up tool on your MAC’s portal. If you don’t have access, [sign up](#).
- From the Remittance Advice (RA): From October 2018 through December 31, 2019, we will include the MBI on the RA if you submit a HICN on the claim. ([Examples](#))

People with Medicare enrolled in Medicare Advantage and/or Part D plans will continue to use the cards from those plans when they get health care and/or prescriptions.

Questions? Attend the next Open Door Forum devoted to answering provider questions. . Details will be provided in a future MLN Connects.

For More Information:

- [Fact Sheet](#)
- [Overview](#) webpage
- [Provider](#) webpage

MACRA Funding Opportunity: Measure Development for the Quality Payment Program

On March 2, CMS announced a new funding opportunity for the development, improvement, updating, and expansion of quality measures for use in the Quality Payment Program. CMS will be partnering directly with clinicians, patients, and other stakeholders to provide up to \$30 million of funding and technical assistance in development of quality measures over three years.

Through these cooperative agreements, CMS aims to provide the necessary support to help external entities expand the Quality Payment Program quality measure portfolio with a focus on clinical and patient perspectives and minimizing burden for clinicians. Focusing on patient perspectives will ensure measures focus on what is important to patients and drive the improvement of patient outcomes. To accomplish this, the cooperative agreements prioritize the development of:

- Outcome measures, including patient reported outcome and functional status measures
- Patient experience measures
- Care coordination measures
- Measures of appropriate use of services, including measures of overuse

For more information, view the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) Funding Opportunity: Measure Development for the Quality Payment Program on [Grants.gov](#), or visit the [MACRA](#) webpage.

See the full text of this excerpted [CMS Blog](#) (issued March 2).

IRF and LTCH Compare Refresh

The March 2018 quarterly Inpatient Rehabilitation Facility (IRF) and Long-term Care Hospital (LTCH) Compare refresh is available, including quality measure results based on data submitted to CMS between the second quarter of 2016 and the first quarter of 2017. Visit [IRF Compare](#) and [LTCH Compare](#) to view the data. For more information, visit the [IRF Quality Public Reporting](#) and [LTCH Quality Public Reporting](#) webpages.

Quality Payment Program: Submit 2017 Participation Data through March 31

If you are an eligible clinician participating in the Quality Payment Program, you can submit your 2017 performance data using the new feature on the [Quality Payment Program](#) website. The 2017 data submission period runs through March 31 with two exceptions:

- Individual eligible clinicians submitting quality data via claims should have already submitted their claims for processing
- For groups using the CMS Web Interface, your submission period ends on March 16 at 8 pm ET

For More Information:

- Data submission [fact sheet](#) and [video](#)
- Contact the Quality Payment Program at gpp@cms.hhs.gov or 866-288-8292

EHR Incentive Program: Hospitals Submit Proposals for New Measures until June 29

Eligible hospitals and critical access hospitals: Submit a measure proposal for the Medicare Electronic Health Record (EHR) Incentive Program Annual Call for Measures until June 29. Measures will be considered for inclusion in rulemaking in CY 2019. CMS is interested in adding measures that:

- Build on the advanced use of certified EHR technology using 2015 Edition Standards and Certification Criteria
- Increase health information exchange and interoperability
- Continue improving program efficiency, effectiveness, and flexibility
- Measure patient outcomes
- Emphasize patient safety

For More Information:

- [2018 Call For Measures](#) webpage
- [Fact Sheet](#)
- [Submission Form](#); send to CMSCallforMeasuresEHR@Ketchum.com

PEPPER for Short-term Acute Care Hospitals

Fourth quarter FY 2017 Program for Evaluating Payment Patterns Electronic Reports (PEPPERS) are available for short-term acute care hospitals. PEPPERS are distributed by TMF® Health Quality Institute under contract with CMS. These reports summarize provider-specific data statistics for Medicare services that may be at risk for improper payments. Providers can use the data to support internal auditing and monitoring activities. The PEPPER files were recently distributed through a QualityNet secure file exchange to hospital QualityNet Administrators and user accounts with the PEPPER recipient role.

Visit PEPPERresources.org for more information, including [guides](#), [recorded training sessions](#), information about QualityNet accounts, [FAQs](#), and examples of how other hospitals are using PEPPER. If you have questions or need help obtaining your report, visit the [Help Desk](#). Send us your [feedback or suggestions](#).

DME Supplier Feedback on Telephone Discussion and Reopening Process Demonstration

CMS implemented the [Telephone Discussion and Reopening Demonstration](#) in January 2016. Over the coming months, the evaluation contractor, IMPAQ International LLC, will select a random sample of Durable Medical Equipment (DME) suppliers who participated in the Demonstration. These suppliers will receive an electronic invitation from DME-Discussions@impaqint.com for a brief online survey, a 30-minute telephone interview, or both. The feedback collected will help CMS and the Demonstration Qualified Independent Contractor (QIC) better educate DME suppliers through the Demonstration, resulting in better billing practices and fewer disputed claims. Supplier participation is voluntary, and CMS will not know which DME suppliers are selected, which participated, or the specific responses provided.

For More Information:

- [QIC DME: Formal Telephone Discussion Demonstration](#) webpage
- [DME Suppliers Survey](#)
- Submit questions to DME-Discussions@impaqint.com

EHR Incentive Programs FAQs

Visit the Electronic Health Record (EHR) Incentive Programs [FAQ](#) webpage to search by topic or FAQ number. For more information, contact the EHR Information Center at 888-734-6433 (press option 1) or TTY 888-734-6563.

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 residents received an antipsychotic medication; since then there has been a decrease of 35.4 percent to a national prevalence of 15.4 percent in the third quarter of 2017. Success varies by state and CMS region; some states and regions have a reduction greater than 35 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
- [Register](#) for the Medicare Learning Network call on March 20

Help Your Patients Go Further With Food

March is National Nutrition Month® - "Go Further with Food" and discuss the numerous benefits of healthy eating habits. Talk to your patients about making informed food choices to help prevent or reduce nutrition-related health conditions, including diabetes, chronic kidney disease, and obesity. Encourage your patients to take advantage of appropriate [Medicare-covered preventive services](#):

- Medical Nutrition Therapy
- Diabetes Screening
- Diabetes Self-Management Training
- Intensive Behavioral Therapy for Obesity
- Intensive Behavioral Therapy for Cardiovascular Disease
- Annual Wellness Visit

For More Information:

- [Medicare Preventive Services](#) Educational Tool
- [National Nutrition Month](#) webpage
- [National Diabetes Education Program](#) website
- [National Kidney Disease Education Program](#) website
- [Million Hearts®](#) website
- [Find a Registered Dietitian/Nutritional Professional](#)

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

Provider Compliance

Bill Correctly for Device Replacement Procedures — Reminder

In a September 2017 report, the Office of the Inspector General (OIG) determined that Medicare paid for many device replacement procedures incorrectly. Hospitals are required to use condition codes 49 or 50 on claims for device replacement procedures resulting from a recall or premature failure (whether the device is provided at no cost or with a credit).

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

- OIG Report: [Shortcomings of Device Claims Data Complicate And Potentially Increase Medicare Costs for Recalled and Prematurely Failed Devices](#)
- [Medicare Claims Processing Manual, Chapter 3](#), section 100.8
- [Medicare Claims Processing Manual, Chapter 4](#), section 61.3.5 and 61.3.6

Claims, Pricers & Codes

April 2018 Average Sales Price Files

CMS posted the April 2018 Average Sales Price (ASP) and Not Otherwise Classified (NOC) pricing files and crosswalks on the [2018 ASP Drug Pricing Files](#) webpage.

Upcoming Events

Low Volume Appeals Settlement Option Update Call — March 13

Tuesday, March 13 from 1:30 to 3 pm ET

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

As part of the broader HHS commitment to improving the Medicare appeals process, CMS made available the Low Volume Appeals (LVA) settlement option on February 5, 2018. LVA is for providers and suppliers (appellants) with fewer than 500 appeals pending at the Office of Medicare Hearings and Appeals (OMHA) and the Medicare Appeals Council (the Council) at the Departmental Appeals Board.

During this call, learn more about LVA, the current status, and how the settlement process works. CMS speakers discuss how to identify whether you are eligible, which of your pending appeals may be settled, and upcoming submission timeframes. Visit the [Low Volume Appeals Initiative](#) webpage for more information.

A question and answer session follows the presentation; however attendees may email questions in advance to MedicareSettlementFAQs@cms.hhs.gov with “Low Volume Appeals Settlement March 13 Call” in the subject line. These questions may be addressed during the call or used for other materials following the call.

Target Audience: Medicare fee-for-service providers, physicians, and other suppliers with fewer than 500 appeals pending at OMHA and the Council.

National Patient Safety Week Panel Discussion — March 13

Thursday, March 13 from 1:30 to 3 pm ET

[Participate](#) in a live streamed panel discussion.

This year's theme is “United in Mission to Ensure Patient Safety.” During the panel discussion, learn how the Health Resources & Services Administration and HHS are addressing patient safety in the ambulatory care setting. Participants will be able to ask questions.

Open Payments: The Program and Your Role Call — March 14

Wednesday, March 14 from 2 to 3 pm ET

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

Industry is currently submitting data to the Open Payments System on payments or transfers of value made to physicians and teaching hospitals during 2017. Beginning in April, physicians and teaching hospitals have 45 days to review and dispute records attributed to them. During this call, find out how to access the Open Payments system to review the accuracy of the data submitted about you before it is published on the CMS website. A question and answer session follows the presentation.

See the [Open Payments Registration](#) webpage for more information. CMS will publish the 2017 payment data and updates to the 2013 through 2016 data on June 30, 2018.

Topics

- Overview of the Open Payments national transparency program
- Program timeline
- Registration process
- Critical deadlines for physicians and teaching hospitals to review and dispute data

Target Audience: Physicians, teaching hospitals and physician office staff.

QRDA Category I Implementation Guide for CY 2018 Hospital Quality Reporting Webinar — March 19

Monday, March 19 from 2 to 3 pm ET

[Register](#) for this webinar.

This presentation provides an overview of the 2018 CMS Quality Reporting Document Architecture (QRDA) Category I Implementation Guide for Hospital Quality Reporting, including changes made from CY 2017 to CY 2018. It will also provide a high-level overview of updates to the Health Level Seven base standard and a review of available resources.

Dementia Care: Person-Centered Care Planning and Practice Recommendations Call — March 20

National Partnership to Improve Dementia Care and Quality Assurance Performance Improvement
Tuesday, March 20 from 1:30 to 3 pm ET

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

During this call, gain insight on the phase two changes for person-centered care planning and discharge planning. Also, learn about the new Alzheimer's Association Dementia Care Practice Recommendations. Additionally, CMS shares updates on the progress of the [National Partnership to Improve Dementia Care in Nursing Homes](#). A question and answer session follows the presentations.

Speakers:

- Debra Lyons, CMS
- Douglas Pace, Alzheimer's Association
- Michele Laughman, CMS

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

E/M Services: Documentation Guidelines and Burden Reduction Listening Session — March 21

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

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

CMS is looking for physicians and non-physician practitioners to provide feedback on Evaluation and Management (E/M) services. CMS seeks comments from stakeholders on potential updates to the E/M guidelines to reduce burden and better align coding and documentation with the current practice of medicine. This listening session follows CY 2018 Medicare Physician Fee Schedule rulemaking and is part of an ongoing effort to seek input from stakeholders on these topics.

Target Audience: Individual physicians and non-physician practitioners who perform and bill E/M services; state and national associations that represent health care providers; and other interested stakeholders.

Medicare Learning Network® Publications & Multimedia

Provider Compliance Tips for Glucose Monitors Fact Sheet — New

A new [Provider Compliance Tips for Glucose Monitors](#) Fact Sheet is available. Learn about:

- Improper payment rates for glucose monitors
- How to prevent claim denials
- Type of order needed to submit a claim

Provider Compliance Tips for Manual Wheelchairs Fact Sheet — New

A new [Provider Compliance Tips for Manual Wheelchairs](#) Fact Sheet is available. Learn about:

- Reasons for denials
- How to prevent claim denials
- Coverage requirements

Provider Compliance Tips for Ordering Lower Limb Prostheses Fact Sheet — New

A new [Provider Compliance Tips for Ordering Lower Limb Prostheses](#) Fact Sheet is available. Learn about:

- Reasons for denial
- How to prevent claim denials
- Medical necessity determinations

Provider Compliance Tips for Laboratory Tests – Bacterial Cultures Fact Sheet — New

A new [Provider Compliance Tips for Laboratory Tests – Bacterial Cultures](#) Fact Sheet is available. Learn about

- Reasons for denials
- How to prevent claim denials
- Acceptable methods to communicate and order

Provider Compliance Tips for Wheelchair Options/Accessories Fact Sheet — New

A new [Provider Compliance Tip for Wheelchair Options/Accessories](#) Fact Sheet is available. Learn about:

- Reasons for denials
- How to prevent claim denials
- Types of options/accessories

Provider Compliance Tips for Ostomy Supplies Fact Sheet — New

A new [Provider Compliance Tip for Ostomy Supplies](#) Fact Sheet is available. Learn about:

- Reasons for denials
- How to prevent claim denials
- Coverage requirements

Provider Compliance Tips for Ordering Oxygen Supplies and Equipment Fact Sheet — New

A new [Provider Compliance Tips for Ordering Oxygen Supplies and Equipment](#) Fact Sheet is available. Learn about:

- Reasons for denials

- How to prevent claim denials
- Documentation requirements
- Qualifying criteria for oxygen saturation results

Provider Compliance Tips for Negative Pressure Wound Therapy Fact Sheet — New

A new [Provider Compliance Tips for Negative Pressure Wound Therapy](#) Fact Sheet is available. Learn about:

- Reasons for denials
- How to prevent claim denials
- Documentation requirements

Provider Compliance Tips for Surgical Dressings Fact Sheet — New

A new [Provider Compliance Tips for Surgical Dressings](#) Fact Sheet is available. Learn about:

- Reasons for denials
- How to prevent claim denials
- Documentation requirements
- Code specific requirements

Provider Compliance Tips for Urological Supplies Fact Sheet — New

A new [Provider Compliance Tips for Urological Supplies](#) Fact Sheet is available. Learn about:

- Reasons for denials
- How to prevent claim denials
- Documentation requirements
- Specific criteria that must be met to quality for payment

Low Volume Appeals Settlement Call: Video Presentation — New

A [video presentation](#) is available for the [February 13](#) call on the Low Volume Appeals Settlement Option. Learn how the settlement process works, how to identify whether you are eligible and which of your pending appeals may be settled.

ESRD QIP Call: Audio Recording and Transcript — New

An [audio recording](#) and [transcript](#) are available for the [February 22](#) call on the End-Stage Renal Disease (ESRD) Quality Incentive Program (QIP). Learn about provisions in the CY 2018 ESRD Prospective Payment System final rule, including plans for the ESRD QIP in Payment Years 2019 through 2021.

Rural Health Clinic Fact Sheet — Revised

A revised [Rural Health Clinic](#) Fact Sheet is available. Learn about:

- Medicare certification
- Visits
- Payments
- Cost reports
- Annual reconciliation

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