CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

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Official CMS news from the Medicare Learning Network®

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New Medicare Card: Will Your Claims Reject?

Protect your patients' identities by using the Medicare Beneficiary Identifier (MBI) now. Starting January 1, 2020, you must use the Medicare Beneficiary Identifier (MBI). We will reject claims you submit with the Health Insurance Claim Number (HICN), with a few exceptions, and reject all eligibility transactions.

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.

Securing Access to Life-Saving Antimicrobial Drugs for American Seniors

Antimicrobial Resistance (AMR) represents an urgent clinical and economic crisis for the American health care system. Each year, more than 2 million Americans are infected by bacteria that are resistant to existing antibiotic drugs, resulting in thousands of deaths annually. CMS is committed to removing regulatory restraints on innovators and modernizing payment systems to secure access to medications for Medicare beneficiaries and all Americans.

As part of the FY 2020 Inpatient Prospective Payment System (IPPS) final rule, CMS has finalized an alternative pathway for the New Technology Add-On Payment (NTAP) for drugs designated by the Food and Drug Administration as Qualified Infectious Disease Products (QIDPs), under which these drugs would not have to meet the substantial clinical improvement criterion. Additionally, CMS is increasing the NTAP for QIDPs from 50% to 75%. Limiting access to the current upper band of NTAP to only QIDP drugs reflects the agency's awareness of the public health imperative for novel antibiotics.

Additionally within IPPS, CMS finalized a change in the severity level designation for 18 ICD-10 codes for antimicrobial drug resistance from 'non-CC' to 'CC' (complications or comorbidities). This change to CC recognizes the added clinical complexity and cost of treating patients with drug resistance, and ensures physicians are appropriately incentivized to use the correct (and sometimes, more expensive) drugs needed to manage patients with AMR. By increasing payments for inpatient cases with drug resistance, we are removing financial disincentives to antibiotic innovation and thus increasing beneficiaries' access to these drugs.

CMS will also seek further feedback about additional changes to the Diagnosis-Related Group system, such as any additional payment adjustments for antimicrobial resistance based on the relative hospital resources used in these cases, allowing us to receive feedback from stakeholders on this topic. This will help inform our thinking beyond IPPS on how to implement additional reforms to the government's current payment methodologies and pave the road for new antimicrobial drug innovations in the long-term.

CMS – based on significant stakeholder feedback from academia, professional societies, non-profits, and innovators – is also exploring implementing Centers for Disease Control and Prevention -recommended guidelines for hospital-based Antibiotic Stewardship Programs into the regulations that govern hospitals' Conditions of Participation in Medicare. This potential policy change will help slow AMR, and improve the safety and quality of inpatient care.

See the full text of this excerpted CMS Blog (Issued August 6).

IRF/LTCH/SNF Quality Reporting Programs: Submission Deadline August 15

The submission deadline for the Inpatient Rehabilitation Facility (IRF), Long-Term Care Hospital (LTCH), and Skilled Nursing Facility (SNF) Quality Reporting Programs is August 15 for first quarter 2019 data:.

- IRF- Patient Assessment Instrument (PAI) and LTCH Continuity Assessment Record and Evaluation (CARE) assessment data and data submitted to CMS via the Center for Disease Control and Prevention National Healthcare Safety Network
- Minimum Data Set (MDS) data

List of Measures:

- IRF Quality Reporting Data Submission Deadlines webpage

- LTCH Quality Reporting Data Submission Deadlines webpage
- SNF Quality Reporting Program Data Submission Deadlines webpage

CMS recommends that you run analysis reports prior to each quarterly reporting deadline to make sure all required data has been submitted.

Hospice Patient Assessment Instrument Focus Groups: Respond by August 26

CMS is recruiting experienced hospice providers and clinicians to participate in focus groups to discuss and provide input as we develop a hospice patient assessment tool:

- Interested participants will be considered based on their hospice role, knowledge, and experience with the Hospice Quality Reporting Program (QRP) or completing patient assessments
- Selection will take into account hospice type and location to ensure a nationally balanced representation of diverse hospices

For More Information:

- Announcement and Application: Deadline August 26
- Hospice QRP Provider Engagement Opportunities webpage

Emergency Triage, Treat, and Transport Model: Apply by September 19

Ambulance providers and suppliers: Apply to participate in the Emergency Triage, Treat, and Transport (ET3) Model. The Request for Applications Online Portal is open, and applications will be accepted through September 19. Visit the ET3 Model webpage for more information.

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
- New Medicare Webpage on PDPM MLN Matters Article
- Implementation of the SNF PDPM MLN Matters Article

2019 QRDA III Implementation Guide: Updated Addendum

CMS released an updated addendum to the 2019 Quality Reporting Document Architecture (QRDA) Category III implementation guide for eligible clinicians and eligible professionals programs. The Implementation Guide supports CY 2019 electronic clinical quality measure, Improvement Activity, and Promoting Interoperability reporting for the following programs:

- Quality Payment Program: Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models
- Comprehensive Primary Care Plus
- MIPS Promoting Interoperability Performance Category

For More Information:

- QRDA webpage
- For questions about the Implementation Guide or Schematrons, visit the QRDA Project Tracking System webpage.
- For questions about Quality Payment Program/MIPS data submissions, visit the Quality Payment Program website, call 866-288-8292, or email QPP@cms.hhs.gov

Quality Payment Program: Reporting Patient Relationship Categories

Merit-based Incentive Payment System (MIPS)-eligible clinicians: CMS released an MLN Matters Article about reporting Patient Relationship Categories and Codes (PRC) on Medicare claims. Note: Reporting these codes will not affect reimbursement or have an impact on beneficiaries.

Voluntary Reporting Period:
As of January 1, 2018, Medicare Part B MIPS-eligible clinicians may report patient relationships on Medicare claims using the PRC codes. While this will be mandatory in the future, it is voluntary during this initial period of implementation:

- Participate to gain familiarity with the categories and experience submitting codes
- CMS will review data on these codes to consider their potential future in cost measure attribution methodology

CMS proposed in the 2020 Quality Payment Program Proposed Rule that voluntary reporting of the codes would count towards the Improvement Activity performance category of MIPS for the 2020 performance year.

Compliance

Skilled Nursing Facility 3-Day Rule Billing

In a recent report, the Office of Inspector General (OIG) determined that Medicare improperly paid for Skilled Nursing Facility (SNF) services when the Medicare 3-Day inpatient hospital stay requirement was not met. CMS developed the Skilled Nursing Facility 3-Day Rule Billing Fact Sheet to help you bill correctly.
Additional resources:

- Reminder of the Required Three-day Hospital Stay for SNF Admissions, MLN Matters Special Edition Article
- SNF Billing Reference Medicare Learning Network Booklet
- Title 42 of the Code of Federal Regulations (CFR) § 411.400
- Medicare Benefit Policy Manual, Chapter 8
- Medicare Claims Billing Manual, Chapter 6
- Medicare Claims Billing Manual, Chapter 30
- Medicare Financial Management Manual, Chapter 3, 70.3(C), 90, 100
- CMS Improperly Paid Millions of Dollars for Skilled Nursing Facility Services When the Medicare 3-Day Inpatient Hospital Stay Requirement Was Not Met OIG Report

Events

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.

Radiation Oncology Model Listening Session — August 22
Thursday, August 22 from 1:30 to 3 pm ET

Register for Medicare Learning Network events.

The proposed Radiation Oncology (RO) Model is an innovative payment model that would improve the quality of care for cancer patients receiving radiotherapy treatment, and reduce provider burden by moving toward a simplified and predictable payment system. During this listening session, CMS experts briefly cover the major provisions from the proposed rule and address your clarifying questions to help you formulate your written comments for formal submission. Proposals to be discussed include:

- Prospective, episode-based payments, based on a patient's cancer diagnosis
- Required participation in selected core-based statistical areas to test the model
- Transition to site-neutral payment
- Episode payments split into two components — professional and technical
- Requirements to qualify as an Advanced Alternative Payment Model (APM) and a Merit-based Incentive Payment System APM under Quality Payment Program

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

- Proposed rule
- RO Model webpage
- RO Model fact sheet
- Report to Congress: Episodic Alternative Payment Model for Radiation Therapy Services

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 16.

Target audience: Hospitals, hospital associations, accreditation organizations, physician group practices, hospital outpatient departments, freestanding radiation therapy centers for radiotherapy, 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

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

A new 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.

Instructions for Use of Informational Remittance Advice Remark Code Alert on Laboratory Service Remittance Advices

A new MLN Matters Article MM11369 on Instructions for Use of Informational Remittance Advice Remark Code Alert on Laboratory Service Remittance Advices is available. Learn about a revised Alert Code, N817, which reminds applicable laboratories to report private payor data to CMS between January 1 and March 31, 2020.

Medicare Shared Savings Program (Shared Savings Program) Skilled Nursing Facility (SNF) Affiliates' Requirement to Include Demonstration Code 77 on SNF 3-Day Rule Waiver Claims

A new MLN Matters Article MM11290 on Medicare Shared Savings Program (Shared Savings Program) Skilled Nursing Facility (SNF) Affiliates' Requirement to Include Demonstration Code 77 on SNF 3-Day Rule Waiver Claims is available. Learn about submitting demonstration code 77 to attest that a claim meets the eligibility requirements for the SNF 3-Day Rule Waiver.

Modification to the National Coordination of Benefits Agreement (COBA) Crossover Process

A new MLN Matters Article MM11307 on Modification to the National Coordination of Benefits Agreement (COBA) Crossover Process is available. Learn about two new return to provider edits for claims submitted via direct data entry or on paper.

October Quarterly Update to 2019 Annual Update of HCPCS Codes Used for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Enforcement

A new MLN Matters Article MM11381 on October Quarterly Update to 2019 Annual Update of HCPCS Codes Used for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Enforcement is available. Learn about updates to HCPCS codes subject to SNF consolidated billing and three incorrectly categorized CPT codes.

Oxygen Policy Update

A new MLN Matters Article MM10837 on Oxygen Policy Update is available. Learn about new oxygen payment classes and HCPCS code for portable liquid oxygen.

Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment

A new MLN Matters Article MM11406 on Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment is available. Learn about new and deleted laboratory codes effective October 1, 2019.

Multimedia

CMS: Beyond the Policy Podcast: Nursing Home Strategy Part 1 – Strengthening Oversight

CMS released the latest episode of our podcast, CMS: Beyond the Policy. This edition focuses on the first of our 5-pronged strategy on strengthening oversight in nursing homes. You can also listen to the podcast on Google Play and iTunes.

CLFS Public Meetings: Videos

Watch videos of two 2019 meetings about the Clinical Laboratory Fee Schedule (CLFS).

CLFS Annual Laboratory Public Meeting, June 24

- Morning Session

- Afternoon Session
- For more information, visit the CLFS Annual Public Meeting website

Medicare Advisory Panel on Clinical Diagnostic Laboratory Tests, July 22-23

- July 22 - Morning Session
- July 22 - Afternoon Session
- July 23 - Morning Session
- July 23 - Afternoon Session
- For more information, visit the Advisory Panel on Clinical Diagnostic Laboratory Tests website

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