mlnconnects
Official CMS news from the Medicare Learning Network®

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News

Quality Payment Program: 2018 Performance Data

CMS released the final 2018 performance data for the Quality Payment Program. Additional data elements show significant success and participation in both the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Model (APM) paths. Performance highlights:

- 98% of eligible clinicians participated in MIPS in 2018 — up from 95% in 2017
- 98% of eligible clinicians exceeded the performance threshold score of 15 points to receive a positive payment adjustment — up from 93% in 2017
- 356,353 clinicians participated in MIPS through APMs — up from 341,220 in 2017

For More Information:

- Blog
- Infographic
- Quality Payment Program website
- Find no-cost technical assistance for Small, Underserved, and Rural Practices
- Contact qpp@cms.hhs.gov or 866-288-8292 (Customers who are hearing impaired can dial 711 to be connected to a TRS communications assistant)

Quality Payment Program APM Incentive Payment: Verify Banking Information

If you are a qualified Alternative Payment Model (APM) participant based on your 2017 performance, you are eligible for a 5% incentive payment for 2019. CMS is unable to pay the incentive to a number of clinicians because we cannot verify their banking information. If you are on our list, contact us so we can send your 2019 payment.

For More Information:

- 2019 Qualifying APM Participants Notice for APM Incentive Payment
- Contact qpp@cms.hhs.gov or 866-288-8292 (Customers who are hearing impaired can dial 711 to be connected to a TRS communications assistant)

Quality Payment Program: Participation Status Tool Includes Third Snapshot of Data

CMS updated the Quality Payment Program Participation Status Lookup Tool based on the third snapshot of data from Alternative Payment Model (APM) entities. The third snapshot includes data from Medicare Part B claims with dates of service between January 1 and August 31, 2019. The tool includes 2019 Qualifying APM Participant (QP) and Merit-based Incentive Payment System APM participation status.

For More Information:

- 2019 QP Methodology Resources
- APM Overview webpage.
- Contact qpp@cms.hhs.gov or 866-288-8292 (Customers who are hearing impaired can dial 711 to be connected to a TRS communications assistant)

Quality Payment Program: Recheck Your Final 2019 MIPS Eligibility

After releasing final 2019 Merit-based Incentive Payment System (MIPS) eligibility data in December, CMS discovered and corrected inconsistencies. Use the Quality Payment Program Participation Status Tool to re-check and confirm your final 2019 MIPS eligibility.

For More Information:

- MIPS Participation webpage
- Participation Infographic
- Participation and Eligibility Fact Sheet and User Guide
- Opt-In and Voluntary Reporting Fact Sheet and Election Toolkit
- Contact qpp@cms.hhs.gov or 866-288-8292 (Customers who are hearing impaired can dial 711 to be connected to a TRS communications assistant)

Quality Payment Program: Check Your Initial 2020 MIPS Eligibility

Use the Quality Payment Program Participation Status Tool to check on your initial 2020 eligibility for the Merit-based Incentive Payment System (MIPS). Just enter your national provider identifier to find out whether you need to participate.

For More Information:

- How MIPS Eligibility is Determined webpage
- Final Rule Overview Fact Sheet
- Contact qpp@cms.hhs.gov or 866-288-8292 (Customers who are hearing impaired can dial 711 to be connected to a TRS communications assistant)

Quality Payment Program: Qualified Registries and QCDRs for CY 2020

CMS posted the CY 2020 approved Qualified Registries and Qualified Clinical Data Registries (QCDRs) qualified postings. These entities collect clinical data from individual Merit-based Incentive Payment System (MIPS)-eligible clinicians, groups, and/or virtual groups and submit data to CMS.

- Qualified Registries Qualified Posting
- QCDRs Qualified Posting

For More Information:

- Resource Library webpage
- Contact qpp@cms.hhs.gov or 866-288-8292 (Customers who are hearing impaired can dial 711 to be connected to a TRS communications assistant)

Hospice Provider Preview Reports: Review Your Data by January 15

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 2018 to the first quarter of 2019
- Hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS®) provider preview report: Review facility-level CAHPS survey results from the second quarter of 2017 to the first quarter of 2019

Review your results by January 15. 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.

For More Information:

- HIS Preview Reports and Requests for CMS Review webpage
- CAHPS Preview Reports and Requests for CMS Review webpage

Feedback on Scope of Practice: Send Recommendations by January 17

CMS is seeking additional input and recommendations regarding elimination of specific Medicare regulations that require more stringent supervision than existing state scope of practice laws, or that limit health professionals from practicing at the top of their license.

We are seeking additional feedback in response to part of the President's Executive Order (EO) #13890 on Protecting and Improving Medicare for Our Nation's Seniors. The EO specifically directs HHS to propose a number of reforms to the Medicare program, including ones that eliminate supervision and licensure requirements of the Medicare program that are more stringent than other applicable federal or state laws. These burdensome requirements ultimately limit healthcare professionals, including Physician Assistants (PAs) and Advanced Practice Registered Nurses (APRNs), from practicing at the top of their professional license.

In response to suggestions we have already received regarding supervision, scope of practice, and licensure requirements, CMS has made a number of regulatory changes in several payment rules, including the CY 2020 Physician Fee Schedule, Home Health, and Outpatient Prospective Payment System final rules. These changes include, but are not limited to: redefining physician supervision for services furnished by PAs, allowing therapist assistants to perform maintenance therapy under the Medicare home health benefit and reducing the minimum level of physician supervision required for all hospital outpatient therapeutic services.

We are proud of the work accomplished, and now we need your help in identifying additional Medicare regulations which contain more restrictive supervision requirements than existing state scope of practice laws, or which limit health professionals from practicing at the top of their license. If you submitted comments on these topics to our 2019 Request for Information on Reducing Administrative Burden to Put Patients over Paperwork, thank you! We are reviewing those submissions.

We welcome any additional recommendations. Please send your recommendations to PatientsOverPaperwork@cms.hhs.gov with the phrase "Scope of Practice" in the subject line by January 17, 2020.

We also continue to welcome your input on ways in which we can reduce unnecessary burden, increase efficiencies and improve the beneficiary experience, and request that input on such topics only be sent to this email address with the phrase "Scope of Practice" in the subject line if they relate to the specific areas in regulation which restrict non-physician providers from practicing to the full extent of their education and training.

Promoting Interoperability Programs: Deadline to Submit 2019 Data is March 2

The deadline to submit your 2019 registration and attestation information for the Medicare Promoting Interoperability Program is March 2:

- Medicare eligible hospitals and Critical Access Hospitals (CAHs): Attest through the QualityNet Secure Portal
- Medicaid eligible professionals, eligible hospitals, and CAHs: Follow the requirements of your State Medicaid agency
- Dual-eligible hospitals and CAHs: Attest through the QualityNet Secure Portal (not your State Medicaid agency)

For More Information:

- Eligible Hospital Information webpage
- Registration and Attestation webpage
- QualityNet Secure Portal Enrollment and Login User Guide
- Contact the QualityNet help desk at 866-288-8912 or qnetsupport@hcqis.org

Quality Payment Program: MIPS 2019 Data Submission Period Open through March 31

The data submission period is open for Merit-based Incentive Payment System (MIPS) eligible clinicians who participated in the 2019 performance period of the Quality Payment Program. Submit and update your data until 8 pm ET on March 31. Note: The data submission period for accountable care organizations and pre-registered groups and virtual groups also closes on March 31.

For More Information:

- Resource Library webpage
- Introduction and Overview of 2019 Data Submission Video
- File Upload and Quality Scoring Video
- Manual Attestation of Improvement Activities Video
- Support for Small, Underserved, and Rural Practices webpage
- Contact qpp@cms.hhs.gov or 866-288-8292 (Customers who are hearing impaired can dial 711 to be connected to a TRS communications assistant)

Hospitals: New Beneficiary Notices (IM, DND, and MOON) Required April 1

The Office of Management and Budget renewed the following notices:

- Important Message from Medicare (IM) (CMS-10065): Revised; new CMS form number (formerly CMS-R-193)
- Detailed Notice of Discharge (DND) (CMS-10066): Revised
- Medicare Outpatient Observation Notice (MOON) (CMS-10611): Unchanged; only the expiration date is different

English and Spanish versions are included in each zip file. Hospitals are required to use the new notices beginning April 1. Both the previous and new versions of the notices are acceptable for use through March 31.

For More Information:

- Hospital Discharge Appeal Notices webpage for information on IM and DND
- MOON webpage

Hospital Outpatient Departments: Prior Authorization Process Begins July 1

For dates of service beginning July 1, you must request prior authorization for the following outpatient department services. Medical necessity documentation requirements remain the same.

- Blepharoplasty
- Botulinum toxin injections
- Panniculectomy
- Rhinoplasty
- Vein ablation

For More Information:

- Hospital Outpatient Prospective Payment System Final Rule: See section XIX, beginning on page 61446 and the full list of HCPCS codes on page 61464
- We will provide additional details before July 1

Home Health Compare: Preview Reports for April Refresh

Certification and Survey Provider Enhanced Reports (CASPER) reports preview data that will be displayed on the Home Health Compare website in April:

- Provider Preview Report

- Quality of Patient Care Star Rating Preview Report

For More Information:
- Home Health Quality Reporting Data Submission Deadlines webpage
- Home Health Star Ratings webpage

Clinical Laboratory Data Reporting Delayed

For Clinical Diagnostic Laboratory Tests (CDLTs) that are not Advanced Diagnostic Laboratory Tests (ADLTs), private payor data reporting is delayed by one year. CDLT data that was supposed to be reported between January 1, 2020, and March 31, 2020, must now be reported between January 1, 2021, and March 31, 2021. Labs must report data from the original data collection period of January 1, 2019, through June 30, 2019. Data reporting for these tests will resume on a three-year cycle, beginning in 2024. (Section 105(a)(1) of the Further Consolidated Appropriations Act of 2020 (FCAA)).

In addition, the statutory phase-in provisions are updated. For 2020, the rates for CDLTs that are not ADLTs or new CLDTs may not be reduced by more than 10% of the rates for 2019. There will be a 15% reduction cap for each of 2021, 2022, and 2023. (Section 105(a)(2) of FCAA). The reduction cap for CDLT rates:
- 2020: 10% based on the January 1, 2017 – May 30, 2017 reporting period
- 2011: 15% based on the January 1, 2017 – May 30, 2017 reporting period
- 2022: 15% based on the January 1, 2021 – March 31, 2021 reporting period
- 2023: 15% based on the January 1, 2021 – March 31, 2021 reporting period

For more information, see the PAMA Regulations webpage. Disregard any messaging, such as remittance advice messages or prior MLN Connects messages, indicating the previous reporting end date of March 31, 2020.

ICD-10-CM Browser Tool

Use the new National Center for Health Statistics ICD-10-CM Browser Tool to:
- Search for ICD-10-CM codes
- Understand how to use the codes
- Access multiple fiscal year version sets with comprehensive results

Provider Enrollment Application Fee Amount for CY 2020

On November 12, CMS issued a notice: Provider Enrollment Application Fee Amount for Calendar Year 2020 [CMS–6089–N]. Effective January 1, 2020, the application fee is $595 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, 2020.

Nursing Home Quality Initiative: Draft 2020 MDS Item Sets

Draft 2020 Minimum Data Set (MDS) item sets (v1.18.0) are available and scheduled to become effective October 1, 2020. For more information, visit the MDS 3.0 Technical Information webpage.

Hospice Quality Reporting Program News

View the December Hospice Quality Reporting Program (HQRP) outreach email for information on:

- Reporting for CY 2020
- Quarterly update for the third quarter of 2019
- November Hospice Compare refresh
- Hospice Outcomes & Patient Evaluation (HOPE) tool

For more information, visit the HQRP Requirements and Best Practices webpage.

Qualified Medicare Beneficiary Billing Requirements

Are you in compliance with Qualified Medicare Beneficiary (QMB) billing requirements? People with Medicare who are in the QMB program are also enrolled in Medicaid and get help with their Medicare premiums and cost-sharing. Medicare providers may not bill people in the QMB program for Medicare deductibles, coinsurance, or copays, but state Medicaid programs may pay for those costs. Providers who inappropriately bill individuals enrolled in QMB are subject to sanctions.

Establish processes to routinely identify the QMB status of Medicare beneficiaries prior to billing for items and services:

- Use Medicare 270/271 HIPAA Eligibility Transaction System (HETS) data; see MLN Matters Article SE1128
- Check your Medicare Remittance Advices (RAs); see MLN Matters Article MM10433
- Check state automated Medicaid eligibility-verification systems

States require providers to enroll in their Medicaid systems for claim review, adjudication, processing, and issuance of Medicaid RAs for payment of Medicare cost-sharing. Check with the states where your beneficiaries reside to determine the enrollment requirements.

Correct billing problems that occur. If you erroneously bill individuals enrolled in the QMB program, recall the charges (including referrals to collection agencies), and refund the invalid charges they paid.

For More Information:

- QMB Program webpage
- Prohibition on Billing Dually Eligible Individuals Enrolled in the QMB Program MLN Matters Article
- QMB Program Billing Requirements FAQs
- Materials from 2018 Medicare Learning Network call
- Dual Eligible Beneficiaries under the Medicare and Medicaid Programs Booklet

Get Your Patients Off to a Healthy Start in 2020

Get your patients off to a healthy start this year by 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 the “Welcome to Medicare” preventive visit is a one-time service for newly-enrolled beneficiaries: Review medical and social health history and discuss preventive services
- AWV is a yearly office visit that focuses on preventive health: Develop or update a personalized prevention plan and perform a health risk assessment

For More Information:

- Medicare 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.

Looking for Educational Materials?

Visit the Medicare Learning Network and see how we can support your educational needs. Learn about publications; calls and webcasts; continuing education credits; Web-Based Training; newsletters; and other resources.

Compliance

Chiropractic Services: Comply with Medicare Billing Requirements

In a recent report, the Office of Inspector General (OIG) determined that payments for chiropractic services did not comply with Medicare billing requirements. Overall, medical record documentation did not support medical necessity or corrective treatment. CMS developed the Medicare Documentation Job Aid for Doctors of Chiropractic Educational Tool to help you bill correctly.

Additional resources:

- Medicare Coverage for Chiropractic Services – Medical Record Documentation Requirements for Initial and Subsequent Visits MLN Matters Article
- Use of the AT modifier for Chiropractic Billing (New Information Along with Information in MM3449) MLN Matters Article
- Educational Resources to Assist Chiropractors with Medicare Billing MLN Matters Article
- Medicare Needs Better Controls to Prevent Fraud, Waste, and Abuse Related to Chiropractic Services OIG Report
- Medicare Benefit Policy Manual, Chapter 15, Sections 30.5 and 240
- Medicare Claims Processing Manual, Chapter 12, Section 220

Events

Quality Payment Program: QCDR Measures Webinar — January 13

Monday, January 13 from 1:30 to 3 pm ET

Register for this webinar.

Learn about the 2020 Qualified Clinical Data Registry (QCDR) measures for the Merit-based Incentive Payment System. CMS experts discuss:

- Requirements, structures, and principles
- Advanced concepts
- Development process
- Review process and expectations
- Resources and support

ESRD Quality Incentive Program: CY 2020 ESRD PPS Final Rule Call — January 14

Tuesday, January 14 from 2 to 3 pm ET

Register for Medicare Learning Network events.

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

- ESRD QIP legislative framework
- Overview of the final rule

A question and answer session follows the presentation.

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

Listening Sessions on MAC Opportunities to Enhance Provider Experience — January 15, 22, or 29

Wednesday, January 15, 22, or 29 from 2 to 3 pm ET

Register for one of these Medicare Learning Network events.

As part of our 2020 priorities, we are holding a series of listening sessions to gather feedback and improve your experience with the Medicare Fee-For-Service (FFS) program. Through competitive cost-plus award-fee contract procurements, CMS encourages Medicare Administrative Contractors (MACs) to innovate and respond to provider, practitioner, and supplier expectations in their jurisdictions.

We invite you to participate in one of three MAC listening sessions. CMS wants to hear your feedback to improve processes and enhance interactions with your MAC related to operations, technology, and business functions. We are particularly interested in hearing provider, practitioner, and supplier ideas about actions we could take to improve the overall beneficiary quality of care and customer service experience they may have with the MACs.

You can email comments or questions in advance of the listening session to CMSListens@cms.hhs.gov with "MAC Provider Experience" in the subject line. We may address them during the listening session or use them to develop other resources following the session.

Target Audience: Medicare FFS providers, practitioners, suppliers, their representative associations, and any interested stakeholders.

MLN Matters® Articles

Internet Only Manual Update to Pub 100-04, Chapter 16, Section 40.8 – Laboratory Date of Service Policy

A new MLN Matters Article (MM11574) on Internet Only Manual Update to Pub 100-04, Chapter 16, Section 40.8 – Laboratory Date of Service Policy is available. Learn about excluding blood banks or centers from the exception.

IVIG Demonstration: Payment Update for 2020

A new MLN Matters Article (MM11372) on IVIG Demonstration: Payment Update for 2020 is available. Learn about the payment rate for Intravenous Immune Globulin (IVIG) demonstration services.

January 2020 Update of the Ambulatory Surgical Center (ASC) Payment System

A new MLN Matters Article (MM11607) on January 2020 Update of the Ambulatory Surgical Center (ASC) Payment System is available. Learn about policy changes and billing instructions, including updates to HCPCS codes.

Manual Update to Publication (Pub.) 100-04, Chapter 20, to Revise the Subsection 10 - Where to Bill Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) and Parenteral and Enteral Nutrition (PEN) Items and Services

A new MLN Matters Article (MM11554) on Manual Update to Publication (Pub.) 100-04, Chapter 20, to Revise the Subsection 10 - Where to Bill Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

and Parenteral and Enteral Nutrition (PEN) Items and Services is available. Learn about billing and HCPCS codes.

Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Medicare Benefit Policy Manual Chapter 13 Update

A new MLN Matters Article (MM11575) on Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Medicare Benefit Policy Manual Chapter 13 Update is available. Learn about clarifications to payment and policy.

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

A reissued MLN Matters Special Edition Article (SE18006) on New Medicare Beneficiary Identifier (MBI) Get It, Use It is available. Learn about full implementation of the MBI.

Home Health Patient-Driven Groupings Model (PDGM) -Split Implementation — Revised

A revised MLN Matters Article (MM11081) on Home Health Patient-Driven Groupings Model (PDGM) -Split Implementation is available Learn about the revised the CR release date.

Publications

MLN Catalog – January 2020 Edition

The January 2020 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

Quality Payment Program and MIPS Resources

Quality Payment Program — Access User Guide (updated): Process of obtaining a user ID and password; connecting to an organization; and managing your access to view, submit, and update your data

Merit-based Incentive Payment System (MIPS) 2020 Performance Period:

- Quality Measures List: Includes descriptions, collection types, and applicable specialty measure sets
- Medicare Part B Claims Measure Specifications and Supporting Documents: Descriptions of the measures for the Quality performance category
- Clinical Quality Measure Specifications and Supporting Documents: Descriptions of the measures for the Quality performance category
- CMS Web Interface Measure Specifications and Supporting Documents: Descriptions of the measures for the Quality performance category
- Qualified Clinical Data Registry Measure Specifications: Measures and corresponding calculations
- Improvement Activities Inventory: Descriptions of activities for the performance category
- Promoting Interoperability Measure Specifications: Requirements for the performance category objectives and measures
- Cost Measure Information Forms: Measure methodology for each of the episode-based cost measures
- Cost Measure Code Lists: Lists for each of the episode-based cost measures
- Summary of Cost Measures

MIPS 2019 Performance Period:

- Automatic Extreme and Uncontrollable Circumstances Policy Fact Sheet: Explains how the policy works and answers frequently asked questions
- 2019 CMS Web Interface Materials: Excel Template, Excel Template with Sample Data, Data Dictionary, FAQs, and User Guide
- Data Validation Execution Report Template

MIPS 2018 Performance Period — Performance Feedback FAQs (updated): Includes information on comparative data for similar practices

For More Information:
- Resource Library webpage
- Contact qpp@cms.hhs.gov or 866-288-8292 (Customers who are hearing impaired can dial 711 to be connected to a TRS communications assistant)

Diabetes Resources

Tailoring diabetes treatment options and resources to meet individual needs can help improve outcomes. CMS released two new resources for health care providers and patient advocates:
- Diabetes Medication Management: Directory of Provider Resources: For primary care teams, particularly providers working with Medicare beneficiaries and vulnerable populations
- Culturally and Linguistically Tailored Type 2 Diabetes Resources Inventory: Catalog of prevention resources tailored to various audiences, including racial and ethnic minorities, LGBTQ communities, people with disabilities, and people with limited English proficiency

For More Information:
- Connected Care: Chronic Care Management Resources
- CMS Office of Minority Health website
- Email OMH@cms.hhs.gov

Hospice Payment System — Revised

A revised Hospice Payment System Medicare Learning Network Booklet is available. Learn about:
- Coverage and certification requirements
- Election periods and statements
- Caps on payments

Medicare Diabetes Prevention and Diabetes Self-Management Training — Revised

A revised Medicare Diabetes Prevention and Diabetes Self-Management Training Medicare Learning Network Fact Sheet is available. Learn how to become a Medicare Diabetes Prevention Program supplier and an accredited Diabetes Self-Management Training provider.

Provider Compliance Tips for Hospital Based Hospice — Revised

A revised Provider Compliance Tips for Hospital Based Hospice Medicare Learning Network Fact Sheet is available. Learn about:
- Certification requirements for billing
- Face to face encounters
- How to avoid claim denials

Multimedia

eCQM: CMS Measure Collaboration Workspace

The Measure Collaboration 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).The workspace has four modules:

- eCQM Concepts: Search existing measure inventories and submit new measure concepts for consideration
- New eCQM Clinical Workflow: Review sample clinical workflows associated with new eCQMs and an opportunity to provide feedback on anticipated challenges
- eCQM Data Element Repository: Data definitions to aid in measure implementation and data mapping
- eCQM Test Results: Transparency into how measures are tested and allow users to express interest in participating in eCQM testing activities

For More Information:

- FAQs
- ecqi-resource-center@hhs.gov.

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