CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

mlnconnects
Official CMS news from the Medicare Learning Network

Thursday, August 16, 2018

News & Announcements

Provider Compliance

Upcoming Events

Medicare Learning Network® Publications & Multimedia

News & Announcements

New Medicare Card: Order Handouts for Patients That Did Not Get Their New Cards

Has CMS finished mailing new Medicare cards in your state? Register and order (or print) new Still Waiting for Your New Card? tear-off sheets (Product #12023) and give to your Medicare patients who did not receive their cards.

Other products (order or print) to make your Medicare patients aware that new Medicare cards are coming:

- Poster,11”x17” (Product #12009-P)
- Pad of 50 You’re Getting a New Medicare Card! tear-off sheets, 4”x 5.25” (Product #12006)
- Flyer, 8.5”x11” (Product #12002)

Play the one minute New Medicare Cards are coming! video in your waiting room, so your Medicare patients know when and how they will receive the new card (also available in opened caption and 1080p formats).

Remember:
To ensure people with Medicare continue to get health care services, you can continue to use the Health Insurance Claim Number through December 31, 2019, or until your patient brings in their new card with the new number.

Visit the Provider webpage for the latest information.

Proposed Pathways to Success for the Medicare Shared Savings Program

On August 9, CMS issued a proposed rule that would set a new direction for the Medicare Shared Savings Program (Shared Savings Program). Referred to as "Pathways to Success," this proposed new direction for the Shared Savings Program would redesign the participation options available under the program to:

- Encourage Accountable Care Organizations (ACOs) to transition to two-sided models (in which they may share in savings and are accountable for repaying shared losses)
- Increase savings for the Trust Funds and mitigate losses
- Reduce gaming opportunity and increase program integrity
- Promote regulatory flexibility and free-market principles

This proposed rule would also strengthen beneficiary engagement, ensure rigorous benchmarking, and help improve care for Medicare beneficiaries with an emphasis on combatting opioid addiction and expanding the use of interoperable electronic health record technology among ACO providers/suppliers. The proposed policies also include changes to address the additional tools and flexibilities for ACOs established by the Bipartisan Budget Act of 2018, specifically in the areas of new beneficiary incentives, telehealth services, choice of beneficiary assignment methodology, and voluntary alignment refinements.

The proposed rule also includes:

- New BASIC and ENHANCED tracks and 5 year agreement periods
- Six-month agreement period extension and mid-year 2019 start date allow ACOs to prepare
- Updates to repayment mechanism requirements for two-sided model ACOs

For More Information:

- Proposed Rule: Comment period closes on October 16
- Press Release

See the full text of this excerpted CMS Fact Sheet (issued August 9).

Quality Payment Program: Design Examples for CY 2019 Proposed Rule

The Quality Payment Program created a set of design examples that illustrate key concepts in the CY 2019 proposed rule. See the proposed rule to submit comments by September 10.

Quality Payment Program: Participation Status Tool Includes 2018 Data Snapshot

CMS updated the Quality Payment Program Participation Status Tool to include 2018 Qualifying Alternative Payment Model (APM) Participant (QP) and Merit-Based Incentive Payment System (MIPS) APM status. The tool is updated based on calculations from Medicare Part B claims with dates of service between January 1 and March 31, 2018.

For More Information:

- QP Methodology Fact Sheet
- MIPS Overview
- APMs Overview
- Enterprise Identity Data Management Account Guide
- Contact the Quality Payment Program Service Center at QPP@cms.hhs.gov or 866-288-8292 (TTY: 877-715-6222)

Provider Compliance

Cochlear Devices Replaced Without Cost: Bill Correctly — Reminder

In November 2016, the Office of the Inspector General (OIG) reported that hospitals did not always comply with Medicare requirements for reporting cochlear devices replaced without cost to the hospital or beneficiary. In 116 of 149 claims reviewed, hospitals did not report the appropriate modifiers and charges or a combination of the appropriate value code and condition codes. Medicare Administrative Contractors use this information to adjust payment; incorrect billing led to Medicare overpayments of $2.7 million.

- Services furnished on or after January 1, 2014: outpatient hospitals should report value code “FD” along with condition code 49 or 50
- Services furnished prior to January 1, 2014: outpatient hospitals should report the modifier “FB” on the same line as the procedure code (not the Cochlear Device code)

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

- Hospitals Did Not Always Comply With Medicare Requirements for Reporting Cochlear Devices Replaced Without Cost. OIG Report, November 2016
- List of CMS resources

Upcoming Events

Physician Fee Schedule Proposed Rule: Understanding 3 Key Topics Listening Session — August 22

Wednesday, August 22 from 1:30 to 3 pm

Register for Medicare Learning Network events.

Proposed changes to the CY 2019 Physician Fee Schedule would increase the amount of time doctors and other clinicians spend with their patients by reducing the burden of Medicare paperwork. During this listening session, CMS experts will briefly cover three provisions from the proposed rule and address your clarifying questions to help you formulate your written comments for formal submission:

- Streamlining Evaluation and Management (E/M) payment and reducing clinician burden
- Advancing virtual care
- Continuing to improve the Quality Payment Program to reduce burden and offer flexibilities to help clinicians successfully participate

We encourage you to review the proposed rule prior to the call, as well as the following materials on the provisions to be covered:

- Quality Payment Program Year 3 (2019) Webinar Recording, Transcript, Presentation, and Comparison Fact Sheet
- Presentation on E/M and Advancing Virtual Care
- E/M Coding Reform videos: Introduction, Office Visits and Panel Discussion

Note: feedback received during this listening session will not be considered formal comments on the rule. See the proposed rule for information on submitting these comments by September 10, 2018.

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.

Medicare Learning Network® Publications & Multimedia

Inclusion of PMD Codes in DMEPOS Prior Authorization Program MLN Matters® Article — New

A new MLN Matters Article SE18010 on Inclusion of Power Mobility Device (PMD) Codes in the Prior Authorization Program for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Items is available. Learn about prior authorization for select DMEPOS items to reduce unnecessary usage and aberrant billing.

Medicare Physician Fee Schedule Database: October 2018 Update MLN Matters Article — New

A new MLN Matters Article MM10898 on Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - October 2018 Update is available. Learn about HCPCS and Q codes added to the database.

Hospice Payment Rates, Cap, Wage Index, and Pricer: FY 2019 Update MLN Matters Article — New

A new MLN Matters Article MM10631 on Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index and Hospice Pricer for FY 2019 is available. Learn about the hospice updates.

HCPCS Drug/Biological Code Changes: October 2018 Update MLN Matters Article — New

A new MLN Matters Article MM10834 on Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes – October 2018 Update is available. Learn about the addition of the new HCPCS code Q5108.

2018 DMEPOS Fee Schedule: October Update MLN Matters Article — New

A new MLN Matters Article MM10881 on October Quarterly Update for 2018 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule is available. Learn about the fee schedule amounts for new and existing codes.

Advance Care Planning Fact Sheet — Revised

A revised Advance Care Planning Fact Sheet is available. Learn about:

- Beneficiary eligibility
- Provider and location eligibility
- Diagnosis requirements

PECOS for Physicians and NPPs Booklet — Reminder

The PECOS for Physicians and Non-Physician Practitioners (NPPs) Booklet is available. Learn about:

- Registering in the Provider Enrollment, Chain, and Ownership System (PECOS)
- Obtaining an National Provider Identifier
- Entering information
- Responding to Medicare Administrative Contractor requests

Medicare Enrollment for Institutional Providers Booklet — Reminder

The Medicare Enrollment for Institutional Providers Booklet is available. Learn about:

- Who are institutional providers
- Enrolling in the Medicare program
- Medicare resources

Medicare Part D Vaccines and Vaccine Administration Fact Sheet — Reminder

The Medicare Part D Vaccines and Vaccine Administration Fact Sheet is available. Learn about:

- Differences between Part B and Part D vaccine coverage
- Reimbursement
- Patient access to vaccines

Like the newsletter? Have suggestions? Please let us know!

Subscribe to MLN Connects. Previous issues are available in the archive.
This newsletter is current as of the issue date. View the complete disclaimer.

Follow the MLN on Twitter #CMSMLN, and visit us on YouTube.