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Official CMS news from the Medicare Learning Network®

Thursday, October 31, 2019

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News

Protect Your Patients' Identities: Use the MBI Now

Protect your patients' identities by using the Medicare Beneficiary Identifier (MBI) now. 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 Health Insurance Claim Number (HICN).

Will your claims be paid in 2020? Starting January 1, you must use MBIs when billing Medicare regardless of the date of service:

- We will reject claims submitted with HICNs with a few [exceptions](#)
- We will reject all eligibility transactions submitted with HICNs

For more information, see the [MLN Matters Article](#).

Hospital Value-Based Purchasing Program Results for FY 2020

The Hospital Value-Based Purchasing (VBP) Program works by adjusting what Medicare pays hospitals under the Inpatient Prospective Payment System based on the quality and cost of inpatient care the hospitals provide to patients. In FY 2020, more hospitals will receive positive payment adjustments than will receive negative payment adjustments. In total, more than 1,500 hospitals (over 55 percent) will receive higher Medicare payments.

For FY 2020, the law requires that 2 percent of the payments for all participating hospitals be withheld and redistributed to the hospitals based on their performance on a previously announced set of quality and cost measures. We estimate that the total amount available for value-based incentive payments in FY 2020 will be approximately \$1.9 billion.

The Total Performance Score for each hospital is based upon hospital performance scores in each of four measurement domains. Each domain contributes 25 percent to the total score. The measurement domains for FY 2020 are:

- Clinical Outcomes
- Safety
- Person and Community Engagement
- Efficiency and Cost Reduction

We posted the Hospital VBP Program incentive payment adjustment factors for each participating hospital for FY 2020 in [Table 16B](#). Hospitals' payments will depend on the following:

- How they performed—compared to their peers—on important health care quality and cost measures during a performance period
- How much they have improved the quality of care provided to patients over time

For FY 2020, almost 60 percent of hospitals will see a small change (between -0.5 and 0.5 percent) in their Medicare payments. The average net payment adjustment is 0.16 percent. The average net increase in payment adjustments is 0.60 percent, and the average net decrease in payment adjustments is -0.39 percent. Due to the Hospital VBP Program, the highest performing hospital in FY 2020 will receive a net increase in payments of 2.93 percent, and the lowest performing hospital will incur a net decrease in payments of -1.72 percent.

For More Information:

- [Hospital VBP Program](#) webpage
- [QualityNet](#) website

See the full text of this excerpted [CMS Fact Sheet](#) (issued October 29), including information on computing the Hospital VBP score.

IRF/LTCH/SNF Quality Reporting Program Submission Deadline: November 15

The submission deadline for the Inpatient Rehabilitation Facility (IRF), Long-Term Care Hospital (LTCH), and Skilled Nursing Facility (SNF) Quality Reporting Programs is November 15 for second 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 is submitted.

Nursing Home Compare Refresh

The October 2019 Nursing Home Compare refresh is available, including quality measure results based on Skilled Nursing Facility (SNF) Quality Reporting Program data. Visit the [Nursing Home Compare](#) website to view the data.

For More Information:

- [SNF Quality Public Reporting](#) webpage
- Discharge to Community measure [Fact Sheet](#) and [FAQ](#)
- Potentially Preventable Readmission measure [Fact Sheet](#) and [FAQ](#)

Influenza Vaccination: Protect Your Patients this Season

The Centers for Disease Control and Prevention (CDC) recommends annual influenza vaccination for everyone 6 months and older. Influenza is a serious health threat, especially to vulnerable populations like people 65 and older, who are at high risk for hospitalization and developing serious complications. Vaccinate by the end of October – to help protect your patients, your staff, and yourself.

Medicare Part B covers:

- Influenza virus vaccine once per influenza season
- Additional influenza vaccines if medically necessary

For More Information:

- [Medicare Preventive Services](#) Educational Tool
- [Influenza Resources for Health Care Professionals](#) MLN Matters Article
- [Influenza Vaccine Payment Allowances](#) MLN Matters Article
- [CDC Influenza](#) website
- [CDC Information for Health Professionals](#) webpage
- [CDC Fight Flu Toolkit](#) webpage
- [CDC Make a Strong Flu Vaccine Recommendation](#) webpage

Compliance

DMEPOS: Bill Correctly for Items Provided During Inpatient Stays

In a recent [report](#), the Office of Inspector General (OIG) determined that Medicare improperly paid suppliers for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) items provided during inpatient stays. Medicare should not pay a supplier for items furnished to a beneficiary when the beneficiary is still an inpatient.

CMS developed the [Medicare DMEPOS Improper Inpatient Payments](#) Fact Sheet to help you bill correctly.

Additional resources:

- [Medicare Quarterly Provider Compliance Newsletter](#), Volume 9, Issue 2
- [Medicare Claims Processing Manual, Chapter 20](#), Section 10
- [Medicare Claims Processing Manual, Chapter 30](#), Section 130.1
- [Medicare Improperly Paid Suppliers for DMEPOS Provided to Beneficiaries During Inpatient Stays](#) OIG Report
- [Medicare Inappropriately Paid Acute-Care Hospitals for Outpatient Services They Provided to Beneficiaries Who Were Inpatients of Other Facilities](#) OIG Report

- [Medicare Paid New England Providers Twice for Nonphysician Outpatient Services Provided Shortly Before or During Inpatient Stays](#) OIG Report
- [Medicare Continues To Pay Twice for Nonphysician Outpatient Services Provided Shortly Before or During an Inpatient Stay](#) OIG Report

Claims, Pricers & Codes

Liver Transplant Claims: Possible Overpayment

Inpatient Part A claims for liver transplants processed after January 1, 2017, and before November 18, 2019, may be overpaid because Medicare Administrative Contractors (MACs) did not request medical records due to a system error. MACs will adjust these claims and request medical records.

Hospitals: It is important to provide the records. If records are not received, the claim will be considered overpaid, and the overpayment will be recovered.

Events

Submitting Your Medicare Part A Cost Report Electronically Webcast — November 5

Tuesday, November 5 from 1 to 2:30 pm ET

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

Medicare Part A providers: Learn how to use the new Medicare Cost Report e-Filing (MCR eF) system. Use MCR eF to submit cost reports with fiscal years ending on or after December 31, 2017. You have the option to electronically transmit your cost report through MCR eF or mail or hand deliver it to your Medicare Administrative Contractor. You must use MCR eF if you choose electronic submission of your cost report. Note: This content was presented in prior webcasts on May 1 and October 15, 2018 and March 28, 2019.

Topics:

- How to access the system
- Detailed overview
- Frequently asked questions

A question and answer session follows the presentation; however, attendees may email questions in advance to OFMDPAOQuestions@cms.hhs.gov with “Medicare Cost Report e-Filing System Webcast” in the subject line. These questions may be addressed during the webcast or used for other materials following the webcast. For more information, see the [MCR eF](#) Medicare Learning Network Booklet, [MCR eF](#) MLN Matters Article, and [MCR eF](#) webpage.

CMS will use webcast technology for this event with audio streamed through your computer. If you are unable to stream audio, phone lines are available.

Target Audience: Medicare Part A providers and entities that file cost reports for providers.

Clinical Diagnostic Laboratory Test Payment System: Data Reporting Call — November 14

Thursday, November 14 from 2 to 3 pm ET

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

During this call, learn how to report data required by the Clinical Diagnostic Test Payment System [final rule](#). CMS demonstrates how to register in the system and submit then certify data. Laboratories, including physician offices laboratories and hospital outreach laboratories that bill using a 14X TOB are required to report laboratory test HCPCS codes, associated private payor rates, and volume data if they:

- Have more than \$12,500 in Medicare revenues from laboratory services on the Clinical Laboratory Fee Schedule (CLFS), and
- Receive more than 50 percent of their Medicare revenues from CLFS and physician fee schedule services during a data collection period

CMS will use this data to set Medicare payment rates effective January 1, 2021. For more information, visit the [PAMA Regulations](#) webpage.

A question and answer session follows the presentation; however, you may email questions in advance to CLFS_Inquiries@cms.hhs.gov with “November 14 Call” in the subject line. These questions may be addressed during the call or used for other materials following the call.

Target Audience: Clinical diagnostic laboratories, including physician offices and hospital outreach laboratories.

Success with the Hospice Quality Reporting Program Webinar — November 14

Thursday, November 14 from 2 to 3 pm ET

[Register](#) for this webinar.

Find out how to put the pieces together to meet compliance. CMS experts provide an overview of Hospice Quality Reporting Program (HQRP) requirements. Topics:

- Hospice Item Set (HIS) reporting requirements
- HQRP compliance cycle
- How to achieve hospice compliance
- Consumer Assessment of Healthcare Providers & Systems (CAHPS) survey requirements
- How to switch CAHPS survey research vendors

Target Audience: Medicare-certified hospice providers.

MLN Matters® Articles

Billing Instructions for Beneficiaries Enrolled in Medicare Advantage (MA) Plans for Services Covered by Decision Memo CAG-00451N

A new MLN Matters Article SE19024 on [Billing Instructions for Beneficiaries Enrolled in Medicare Advantage \(MA\) Plans for Services Covered by Decision Memo CAG-00451N](#) is available. Learn about coverage of Chimeric Antigen Receptor (CAR) T-cell therapy for cancer.

Overview of the Repetitive, Scheduled Non-emergent Ambulance Prior Authorization Model — Revised

A revised MLN Matters Article SE1514 on [Overview of the Repetitive, Scheduled Non-emergent Ambulance Prior Authorization Model](#) is available. Learn about extension of the model for an additional year.

What New Home Health Agencies (HHAs) Need to Know About Being Placed in a Provisional Period of Enhanced Oversight — Revised

A revised MLN Matters Article SE19005 on [What New Home Health Agencies \(HHAs\) Need to Know About Being Placed in a Provisional Period of Enhanced Oversight](#) is available. Learn who will be affected and when CMS started to place new HHAs into a provisional period.

Multimedia

Medicare Fraud & Abuse: Prevent, Detect, and Report Web-Based Training Course

With Continuing Education Credit

A new Medicare Fraud & Abuse: Prevent, Detect, and Report Web-Based Training (WBT) Course is available through the Medicare Learning Network [Learning Management System](#). Learn about:

- Provisions and penalties
- Prevention methods
- How to report

Quality Payment Program: MIPS 2019 Web-Based Training Courses

CMS posted six Continuing Medical Education (CME) modules on the Merit-based Incentive Payment System (MIPS). Access them by logging into the Medicare Learning Network [Learning Management System](#). Modules include:

- Quality Payment Program 2019 Overview: Information on the origin and objectives of the program, MIPS, and Advanced Alternative Payment Models
- Quality Payment Program Merit-based Incentive Payment System (MIPS): Participation in 2019: Eligibility, participation options, and reporting
- Quality Payment Program Merit-based Incentive Payment System (MIPS): Quality Performance Category in 2019: Requirements, data submission and collection types, and scoring
- Quality Payment Program Merit-based Incentive Payment System (MIPS): Promoting Interoperability Performance Category in 2019: Reporting requirements, measures, and reweighting
- Quality Payment Program Merit-based Incentive Payment System (MIPS): Improvement Activities in 2019: Requirements, reporting steps, and scoring
- Quality Payment Program Merit-based Incentive Payment System (MIPS): Cost Performance Category in 2019: New measures, attribution, and scoring

For More Information:

- [Web-Based Training](#) webpage
- [Resource Library](#) webpage
- Contact QPP@cms.hhs.gov or 866-288-8292 (TTY: 877-715-6222)

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