



**mlnconnects**

Official CMS news from the Medicare Learning Network®

**Thursday, December 12, 2019**

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## News

### Open Payments: Review and Dispute Data by December 31

On June 28, CMS published program year 2018 Open Payments data along with updated and newly submitted data from previous program years (2013-2017). This data is available for review and dispute through December 31.

Physicians and teaching hospitals: Review of the data is voluntary but strongly encouraged. Use the [Open Payments Search Tool](#) to review publically available data. If you believe any records attributed to you are inaccurate, you may initiate a dispute and work with the reporting entity to reach a resolution. Note: CMS does not mediate disputes.

For More Information

- [Review and Dispute for Physicians and Teaching Hospitals](#) webpage
- [Resources](#) webpage
- Submit questions to [openpayments@cms.hhs.gov](mailto:openpayments@cms.hhs.gov) or call 855-326-8366 (TTY: 844-649-2766)

### **LTCH Provider Preview Reports: Review Your Data by January 9**

Long-Term Care Hospital (LTCH) Provider Preview Reports are now available with third quarter 2018 to second quarter 2019 data. Review your performance data on quality measures by January 9, prior to public display on [LTCH Compare](#) in March 2020. Corrections to the underlying data are not permitted during this time; request a CMS review if you believe that your data is inaccurate.

Access your report by logging into the [Internet Quality Improvement and Evaluation System](#) (iQIES). At the main screen, select “Reports;” then “My Reports.” For more information, visit the [LTCH Quality Public Reporting](#) webpage.

### **IRF Provider Preview Reports: Review Your Data by January 9**

Inpatient Rehabilitation Facility (IRF) Provider Preview Reports are now available with third quarter 2018 to second quarter 2019 data. Review your performance data on quality measures by January 9, prior to public display on [IRF Compare](#) in March 2020. Corrections to the underlying data are not permitted during this time; request a CMS review if you believe that your data is inaccurate.

Access your report by logging into the [Internet Quality Improvement and Evaluation System](#) (iQIES). At the main screen, select “Reports;” then “My Reports.” For more information, visit the [IRF Quality Public Reporting](#) webpage.

### **Quality Payment Program: Check Your Final 2019 MIPS Eligibility Status**

Your eligibility status may have changed for the Merit-based Incentive Payment System (MIPS). Check the Quality Payment Program [Participation Status Tool](#) to view your final 2019 eligibility status:

- Your initial eligibility status was based on review of Medicare Part B claims and Provider Enrollment, Chain and Ownership System (PECOS) data from October 1, 2017, to September 30, 2018
- We updated your status based on a second review of Medicare Part B claims and PECOS data from October 1, 2018, to September 30, 2019

For More Information:

- [MIPS Participation](#) webpage
- [Participation Infographic](#)
- [Participation and Eligibility Fact Sheet](#)
- [Participation and Eligibility User Guide](#)
- Contact [QPP@cms.hhs.gov](mailto:QPP@cms.hhs.gov) or 866-288-8292 (TTY: 877-715-6222)

### **Quality Payment Program: MIPS Low-Volume Threshold Criteria for 2019**

CMS added a third low-volume threshold criterion for determining Merit-based Incentive Payment System (MIPS) eligibility for 2019. Clinicians and groups are excluded from MIPS if they:

- Billed \$90,000 or less in Medicare Part B allowed charges for covered professional services during either of the two determination periods (October 1, 2017 – September 30, 2018, or October 1, 2018 – September 30, 2019)
- Provided care to 200 or fewer Part B-enrolled patients during either of the two determination periods
- New for 2019 – Provided 200 or fewer covered professional services under the Physician Fee Schedule during either of the two determination periods

In order to be eligible for MIPS, a clinician or group must exceed all three criteria listed above. Check the Quality Payment Program [Participation Status Tool](#) to view your final 2019 eligibility status for MIPS.

Clinicians and groups who are not eligible for MIPS can still choose to report data to MIPS through the opt-in or voluntary reporting options.

For More Information:

- [Reporting Options Overview Webpage](#)
- [2019 MIPS Opt-In Reporting and Election Process Toolkit](#)
- Contact [QPP@cms.hhs.gov](mailto:QPP@cms.hhs.gov) or 866-288-8292 (TTY: 877-715-6222)

### Home Health Agencies: OASIS Considerations for PDGM Transition

Home health agencies: Find [transition guidance](#) on the Outcome and Assessment Information Set (OASIS) for the Patient-Driven Groupings Model (PDGM). This includes how to get Health Insurance Prospective Payment System codes for PDGM payment periods that begin January 1 or later. Visit the [OASIS User Manuals](#) webpage for more information.

## Compliance

### Bill Correctly for Device Replacement Procedures

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:

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

## Claims, Pricers & Codes

### Payment for Outpatient Clinic Visit Services at Excepted Off-Campus Provider-Based Departments

The American Hospital Association challenged CMS's use of its authority under Subsection (t)(2)(F) of the Medicare statute to pay for certain outpatient clinic visit services provided at excepted off-campus Provider-Based Departments (PBDs) at the same rate that CMS uses to pay non-excepted off-campus PBDs for those services under the separate Physician Fee Schedule as finalized with Final Rule, Medicare Program: Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting, 83 Fed. Reg. 58,818 (Nov. 21, 2018) (Rule).

The United States District Court for the District of Columbia issued instructions for CMS to immediately cease the clinic visit provided at excepted off-campus PBDs payment reduction for CY 2019 implemented with final

Rule, Medicare Program: Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting, 83 Fed. Reg. 58,818 (Nov. 21, 2018) (Rule).

CMS installed a revised Hospital Outpatient Prospective Payment System Pricer to update the rates being applied to claim lines. The revised Pricer went into production on November 4, 2019, and applies to claims with a line item date of service of January 1, 2019, and after. Starting January 1, 2020, and over the next few months, the Medicare Administrative Contactors will automatically reprocess claims paid at the reduced rate; no provider action needed.

## Events

### **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.

## MLN Matters® Articles

### **Medicare Part B Home Infusion Therapy Services with the Use of Durable Medical Equipment**

A new MLN Matters Article SE19029 on [Medicare Part B Home Infusion Therapy Services with the Use of Durable Medical Equipment](#) is available. Learn about the accreditation process to become a qualified supplier.

### **CY 2020 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule**

A new MLN Matters Article MM11570 on [CY 2020 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies \(DMEPOS\) Fee Schedule](#) is available. Learn about new codes, data files, and update factors.

### **Summary of Policies in the Calendar Year (CY) 2020 Medicare Physician Fee Schedule (MPFS) Final Rule, Telehealth Originating Site Facility Fee Payment Amount and Telehealth Services List, CT Modifier Reduction List, and Preventive Services List**

A new MLN Matters Article MM11560 on [Summary of Policies in the Calendar Year \(CY\) 2020 Medicare Physician Fee Schedule \(MPFS\) Final Rule, Telehealth Originating Site Facility Fee Payment Amount and Telehealth Services List, CT Modifier Reduction List, and Preventive Services List](#) is available. Learn about changes to Medicare Part B payment for services furnished in CY 2020.

### **Update to Medicare Claims Processing Manual, Chapters 1, 23 and 35**

A new MLN Matters Article MM10882 on [Update to Medicare Claims Processing Manual, Chapters 1, 23 and 35](#) is available. Learn about new sections on global billing and separate technical component and professional component billing instructions.

### **Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging – Educational and Operations Testing Period - Claims Processing Requirements — Revised**

A revised MLN Matters Article MM11268 on [Appropriate Use Criteria \(AUC\) for Advanced Diagnostic Imaging – Educational and Operations Testing Period - Claims Processing Requirements](#) is available. Learn about the removal of codes that are not available for 2020.

### **Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year (CY) 2020 — Revised**

A revised MLN Matters Article MM11536 on [Home Health Prospective Payment System \(HH PPS\) Rate Update for Calendar Year \(CY\) 2020](#) is available. Learn about corrected low-utilization payment adjustment add-on factors.

### **Looking for an MLN Matters Article?**

The URLs for some MLN Matters Articles have changed. If you get an error when you click on a bookmarked link, go to the [MLN Matters Articles](#) webpage, and search for the article by number.

## **Publications**

### **Opioid Treatment Programs (OTPs) Medicare Billing & Payment**

A new [Opioid Treatment Programs \(OTPs\) Medicare Billing & Payment](#) Medicare Learning Network Fact Sheet is available. Learn about:

- Covered opioid use disorder treatment services
- Coding and submitting claims for OTP services
- Payment and remittance advice

### **Hospice Comprehensive Assessment Measure**

CMS posted an [infographic](#) with key information about the Hospice Comprehensive Assessment Measure. See how the seven Hospice Item Set measures contribute to the Comprehensive Assessment Measure and how to stay on target by completing all measures for each patient. Visit the [Current Measures](#) webpage for more information.

## **Multimedia**

### **Hospital Price Transparency Call: Audio Recording and Transcript**

An [audio recording](#) and [transcript](#) are available for the [December 3](#) Medicare Learning Network call on the Hospital Price Transparency Final Rule. Learn about provisions effective January 1, 2021.

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