MLN Connects®
Provider eNews

Medicare Learning Network®
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Thursday, January 7, 2016

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MLN Connects® Events

ESRD QIP: Payment Year 2019 Final Rule Call — Register Now
Tuesday, January 19 from 2 to 3:30 pm ET

To Register: Visit MLN Connects Event Registration. Space may be limited, register early.

Do you participate in the End-Stage Renal Disease (ESRD) Quality Incentive Program (QIP)? During this call, CMS subject matter experts will discuss the final rule that operationalizes the ESRD QIP for Payment Year (PY) 2019. The performance period for PY 2019 will begin on January 1, 2017. Facilities and other stakeholders should take steps now to understand the changes to the program.

A question and answer session will follow the presentation. Visit the ESRD QIP website for more information.

Agenda:

- ESRD QIP legislative framework and how it fits in with CMS strategies to improve quality
- Changes reflected in the final rule based on public comments
- Final measures, standards, scoring methodology, and payment reduction scale that are applied to the PY 2019 programs
- How the PY 2019 program compares to PY 2018
- Where to find additional information about the program

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

Continuing education credit may be awarded for participation in certain MLN Connects Calls. Visit the Continuing Education Credit Information webpage to learn more.

Collecting Data on Global Surgery as Required by MACRA Listening Session — Register Now
Wednesday, January 20 from 2:30 to 4 pm ET

To Register: Visit MLN Connects Event Registration. Space may be limited, register early.

This listening session provides an opportunity for CMS to learn from stakeholders about how to conduct the data collection required under Section 523 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). CMS is developing a proposal for implementing these new data collection requirements, including the definition of global periods, sampling approach, mechanisms for data collection, and definition of services furnished within the global period.

Refer to the listening session questions and provide your input. Stakeholders are also encouraged to review Section 523 prior to the session.

Agenda:

- Mechanisms for capturing the types of services typically furnished during the global period
- Determining the representative sample for the claims-based data collection
- Determining whether CMS should collect data on all surgical services or which services should be sampled
- Potential for designing data collection elements to interface with existing infrastructure used to track follow-up visits within the global period
- Consideration of use of 5% withhold until required information is furnished

Target Audience: Practitioners who furnish surgical services to Medicare beneficiaries, state and national associations that represent these practitioners, integrated delivery systems representatives, coding professionals, and practice managers.

Continuing education credit may be awarded for participation in certain MLN Connects Calls. Visit the Continuing Education Credit Information webpage to learn more.

IMPACT Act: Connecting Post-Acute Care across the Care Continuum Call — Register Now
Thursday, February 4 from 1:30 to 3 pm ET

To Register: Visit MLN Connects Event Registration. Space may be limited, register early.

The Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 requires the reporting of standardized patient assessment data by Post-Acute Care (PAC) providers, including skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and long-term care hospitals. It specifies that data elements must be standardized and interoperable to allow for the exchange and use of data among these PAC and other providers, including common standards and definitions to facilitate coordinated care and improved beneficiary outcomes. During this call, CMS subject matter experts and the Office of the National Coordinator for Health IT discuss the implications of the IMPACT Act for health information exchange across the care continuum.

Agenda:

- Requirements to standardize and make interoperable post-acute care assessment data elements
- Using and exchanging clinically relevant assessment data for multiple purposes
- Health Information Technology Standards - A Primer
- CMS Data Element Library
- Electronic health information exchange

Target Audience: Providers across the care continuum, including long-term/post-acute care and home and community-based service providers, acute and primary care providers, integrated delivery systems and representatives from other payment models, health IT vendors, and other interested stakeholders.

Continuing education credit may be awarded for participation in certain MLN Connects Calls. Visit the Continuing Education Credit Information webpage to learn more.

New Audio Recordings and Transcripts Available

Audio recordings and transcripts are available for the following calls:

- December 8 — Medicare Quality Reporting Programs: 2016 Physician Fee Schedule Call: audio recording, transcript, updated presentation, and post-call clarification. Find out how the 2016 Medicare Physician Fee Schedule final rule impacts Medicare Quality Reporting Programs.
- December 9 — ESRD QIP: Access PY 2016 Performance Score Report and Certificates Call: audio recording and transcript. Do you participate in the End-Stage Renal Disease (ESRD) Quality Incentive Program (QIP)? Learn how to access a final Payment Year (PY) 2016 Performance Score Report and Performance Score Certificates.

Stay Informed about Medicare Program Changes

MLN Connects National Provider Calls and Webcasts educate the health care community on a variety of topics, including PQRS, Value-Based Payment Modifier, chronic care management, Open Payments, and long-term care. Check out our Calls and Events webpage for upcoming events and links to materials from previous events, or view one of our educational videos. Visit www.cms.gov/npc for more information.

Other CMS Events

Comparative Billing Report on Home E/M Services Webinar

Wednesday, January 20 from 3 to 4 pm ET

Join CMS for an informative discussion of the Comparative Billing Report (CBR) on Home Evaluation and Management (E/M) Services (CBR201512), an educational tool designed to assist providers who bill Current Procedural Terminology codes 99347 through 99350 to report E/M services for patients in their private residences. During the webinar, providers will interact directly with content specialists and submit questions about the report.

Agenda:

- Overview of CBR201512
- Coverage policy
- Methods and results
- References and resources
- Question and answer session

Presenter Information:

- Speakers: Cheryl Bolchoz, Cyndi Wellborn, Molly Wesley
- Organizations: eGlobalTech and Palmetto GBA

How to Participate:

- Register
- Access a recording of the webinar five business days following the event

Questions:
If you have questions about this webinar or CBR201512, visit the CBR website or contact the CBR Support Help Desk at CBRSupport@eglobaltech.com or 800-771-4430.

Medicare Learning Network® Publications and Multimedia

FY 2017 and After Payments to Hospice Agencies That Do Not Submit Required Quality Data MLN Matters® Article — Released

An MLN Matters Article on Fiscal Year 2017 and After Payments to Hospice Agencies That Do Not Submit Required Quality Data – This CR Rescinds and Fully Replaces CR9091 is available. Learn about changes to the payment reduction reconsideration process and general clarifications to the revised Medicare Quality Reporting Incentive Programs Manual, Chapter 3, Section 40.

Remittance Advice Resources and FAQs Fact Sheet — New

A new Remittance Advice Resources and FAQs Fact Sheet is available. Learn about:

- Standard Paper Remittance (SPR) vs Electronic Remittance Advice (ERA)
- Enrolling in ERA
- Free Medicare ERA software
- Commercial ERA software

Medicare Overpayments Fact Sheet — Revised

A revised Medicare Overpayments Fact Sheet is available. Learn about:

- Definition of an overpayment
- An overview of the overpayment collection process
- Timeframes for the debt collection process

Medicare Vision Services Fact Sheet — Revised

A revised Medicare Vision Services Fact Sheet is available. Learn about:

- Coding requirements
- Coverage guidelines and exclusions

Screening, Brief Intervention, and Referral to Treatment Services Fact Sheet — Revised

A revised Screening, Brief Intervention, and Referral to Treatment (SBIRT) Services Fact Sheet is available. Learn about:

- Who may provide SBIRT services
- When will Medicare/Medicaid cover SBIRT services
- How must I document SBIRT services

Medicare Enrollment Guidelines for Ordering/Referring Providers Fact Sheet — Revised

A revised Medicare Enrollment Guidelines for Ordering/Referring Providers Fact Sheet is available. Learn about:

- The three basic requirements for ordering and referring
- How to enroll in Medicare as an ordering/referring provider

Certificate of Medical Necessity Web-Based Training Course — Revised

With Continuing Education Credit

A revised Certificate of Medical Necessity (CMN) Web-Based Training (WBT) course is available through the Learning Management and Product Ordering System. Learn about:

- Items that require a CMN
- Different sections of a CMN
- Documentation required to verify a CMN

New Educational Web Guides Fast Fact

A new fast fact is available on the Educational Web Guides webpage. Visit the webpage for resources on CMS initiatives, including:

- Evaluation and Management services
- Guided Pathways resource booklets
- Health care management, billing, and coding products

Announcements

Medicare FFS Utilization and Payment Data Available for HHAs

Data serves as comprehensive resource for information on home health agencies costs and services

On December 18, CMS released a public data set with information on services provided to Medicare beneficiaries by Home Health Agencies (HHAs). The HHA Utilization and Payment Public Use File contains information on utilization, payments, and submitted charges organized by provider, state, and home health resource group. It was created from CMS administrative claims data for Medicare beneficiaries enrolled in the Fee-For-Service (FFS) program available from the CMS Chronic Condition Data Warehouse. The data covers CY 2013 and is based on HHA Part A institutional claims. These new data include information on 11,062 HHAs, over 6 million claims, and over $18 billion in Medicare payments for 2013.

For More Information:

- The data are posted on the Medicare HHA Transparency Data webpage
- Fact Sheet

See the full text of this excerpted CMS press release (issued December 18).

CMS Finalizes Rule Creating Prior Authorization Process for Certain DMEPOS Items

On December 29, CMS issued a final rule that establishes a prior authorization process for certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) items that are frequently subject to unnecessary utilization. This prior authorization process will help ensure that certain DMEPOS items are provided consistent with Medicare coverage, coding, and payment rules. Under the final rule, the prior authorization process will require the same information necessary to support Medicare payment today, just earlier in the process. The prior authorization process assures that all relevant coverage, coding, and clinical documentation requirements are met before the item is furnished to the beneficiary and before the claim is submitted for payment.

See the full text of this excerpted CMS Fact Sheet (issued December 29).

CMS Quality Measure Development Plan

On December 18, CMS posted the draft Quality Measure Development Plan, a strategic framework for future clinician quality measurement development. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) supports the path to value in health care with the new Merit-based Incentive Payment System (MIPS) and incentives for providers to participate in Alternative Payment Models (APMs).To accelerate the alignment of quality measurement and program policies, MACRA sunsets payment adjustments for three existing clinician reporting and incentive programs:

- Physician Quality Reporting System (PQRS)
- Value-based Payment Modifier (VM)
- Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals, commonly known as Meaningful Use.

The Measure Development Plan outlines how we will draw from our quality measure development experience to build a measure portfolio for MIPS and APMs. It focuses on gaps we identified in the quality measure sets currently in use in PQRS, VM, and the EHR Incentive Program and offers recommendations for filling these gaps.

We encourage you to read the Measure Development Plan and send us your comments, questions or thoughts by March 1, 2016. See the MIPS and APMs webpage for more information.

See the full text of this excerpted CMS blog (issued December 18).

Improving the Submission of Quality Data to CMS Quality Reporting Programs

On December 30, CMS, in partnership with the Office of the National Coordinator for Health Information Technology (ONC), issued a Request for Information (RFI) on Certification Frequency and Requirements for the Reporting of Quality Measures under CMS Programs. The RFI provides CMS and ONC with an opportunity to assess policy options that could improve the effectiveness of the certification of health IT and specifically the certification and testing of Electronic Health Record products used for the reporting of quality measures. The RFI has a 30-day comment period.

See the full text of this excerpted CMS blog (issued December 30).

Pilot Project to Test Improving Patients' Health by Addressing Their Social Needs

$157 million in funding will bridge clinical care with social services

On January 5, HHS announced a new funding opportunity of up to $157 million to test whether screening beneficiaries for health-related social needs and associated referrals to and navigation of community-based services will improve quality and affordability in Medicare and Medicaid. The five-year program, called the Accountable Health Communities Model, is the first CMS Innovation Center model to focus on the health-related social needs of Medicare and Medicaid beneficiaries, including building alignment between clinical and community-based services at the local level. The goal of this model is that beneficiaries struggling with unmet health-related social needs are aware of the community-based services available to them and receive assistance accessing those services.

Thanks to funding provided under the Affordable Care Act, the Accountable Health Communities Model will support up to 44 bridge organizations, which will deploy a common, comprehensive

screening assessment for health-related social needs among all Medicare and Medicaid beneficiaries accessing care at participating clinical delivery sites. Eligible applicants for the model are community-based organizations, hospitals and health systems, institutions of higher education, local government entities, tribal organizations, and for-profit and not-for-profit local and national entities with the capacity to develop and maintain a referral network with clinical delivery sites and community service providers. Applications will be due in early 2016 and CMS anticipates announcing awards in the fall of 2016.

For More Information:

- Accountable Health Communities Model webpage
- Fact Sheet

See the full text of this excerpted HHS press release (issued January 5).

EHR Incentive Programs: 2015 Program Year Attestation Begins January 4

CMS updated the Electronic Health Record (EHR) Incentive Programs Attestation Batch Upload webpage with the specifications for 2015 program year attestation. These specifications include both CSV and XML data mapping options for the batch upload of the attestation information. Attestations for the 2015 program year will be accepted for all Medicare eligible professionals, eligible hospitals, and critical access hospitals from January 4 through February 29, 2016. All Medicaid program participants should refer to their State Medicaid offices for more information on attestation timeframes for the 2015 program year.

PQRS: Submission Timeframes for 2015 Data

Eligible Professionals who do not satisfactorily report quality measure data to meet the 2015 Physician Quality Reporting System (PQRS) requirements will be subject to a negative PQRS payment adjustment on all Medicare Part B physician fee schedule services for 2017. Submissions end at 8 pm ET:

- Electronic Health Record direct or data submission vendor (QRDA I or III) – January 1 through February 29, 2016
- Qualified clinical data registries (QCDRs) (QRDA III) – January 1 through February 29, 2016
- Group practice reporting option web interface – January 18 through March 11, 2016
- Qualified registries (Registry XML) – January 1 through March 31, 2016
- QCDRs (QCDR XML) – January 1 through March 31, 2016

An Enterprise Identity Management (EIDM) account with the Submitter Role is required for these PQRS data submission methods. See the EIDM System Toolkit for additional information. For questions, contact the QualityNet Help Desk at 866-288-8912 or Qnetsupport@hcqis.org from 7am to 7 pm CT. Complete information is available on the PQRS website.

PQRS: Self-Nomination for 2016 Qualified Registries and QCDRs Open through January 31

Entities interested in becoming a Physician Quality Reporting System (PQRS) qualified registry or Qualified Clinical Data Registry (QCDR) for 2016 must submit a self-nomination to CMS using a self-nomination form prior to 5 pm ET on January 31, 2016.

- For information on becoming a 2016 qualified registry, see the 2016 PQRS: Qualified Registry Criteria Toolkit on the Registry Reporting webpage

- For information on becoming a 2016 QCDR, see the 2016 PQRS: QCDR Criteria Toolkit on the QCDR Reporting webpage

For questions, contact the QualityNet Help Desk at 866-288-8912 or Qnetsupport@hcqis.org from 7am to 7 pm CT.

IRF Data Submission Deadline Extended to February 15

The National Healthcare Safety Network (NHSN) data submission deadline for Inpatient Rehabilitation Facility (IRF) providers is extended to February 15, 2016, for CY 2015 first and second quarter FY 2017 payment determination. This extension also applies to the assessment data deadline for the quality reporting program. Facilities should review their first and second quarter data in NHSN and the Quality Improvement Evaluation System (QIES) to add or update data and ensure completeness. See the IRF Quality Reporting Data Submission Deadlines webpage for more information. Contact the helpdesk at IRF.questions@cms.hhs.gov if you have any questions.

LTCH Data Submission Deadline Extended to February 15

The National Healthcare Safety Network (NHSN) data submission deadline for Long-Term Care Hospital (LTCH) providers is extended to February 15, 2016, for CY 2015 first, second, and third quarter FY 2017 payment determination. This extension also applies to the assessment data deadline for the quality reporting program. Facilities should review their first, second, and third quarter data in NHSN and the Quality Improvement Evaluation System (QIES) to add or update data and ensure completeness. See the LTCH Quality Reporting Data Submission Deadlines webpage for more information. Contact the helpdesk at LTCHQualityQuestions@cms.hhs.gov if you have any questions.

LTCH QRP: FAQs and Provider Training Materials Available

The Long-term Care Hospital (LTCH) Quality Reporting Training webpage is updated with new FAQs and training materials from the LTCH Quality Reporting Program (QRP) training, which took place on November 19 through 20, 2015.

- The Frequently Asked Questions document addresses general questions about the LTCH QRP, including information about the quality measures, data submission deadlines, technical specifications, and submitting the LTCH CARE Data Set
- View full presentations from the November LTCH QRP provider training, including answers and scenarios

Hospice Item Set Timeliness Compliance Threshold Fact Sheet Available

A Timeliness Compliance Threshold Fact Sheet is available on the Hospice Item Set (HIS) webpage. This fact sheet outlines the timeliness compliance threshold for HIS submissions, finalized by CMS in the FY 2016 final rule and presents a preliminary algorithm for the timeliness compliance threshold calculation. These policies go into effect for the FY 2018 reporting year, which begins January 1, 2016. Starting January 1, for every patient admission and discharge from your hospice, you must submit at least 70 percent of the corresponding HIS records by the 30-day submission deadline.

Compliance with HIS reporting requirements is determined based on HIS data that is successfully submitted to and processed by the Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system. Hospice providers can verify successful submission and

processing by viewing Final Validation reports. For instructions, see Quick Reference to Hospice File Submission, Submission Status, and Final Validation Reports.

Improving the Documentation of Chiropractic Services Video

The Provider Compliance Group has a new educational and training program video on Improving the Documentation of Chiropractic Services. This video educates chiropractors on documentation requirements to help reduce the improper payment rate for chiropractic services, which have the highest rate of improper payments for Medicare Part B services. In 2014, the improper payment rate for chiropractic services was 54 percent, and many of the errors were attributed to insufficient documentation.

Section 514 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires the development of educational and training programs to improve a chiropractor's ability to document services and increase compliance with Medicare's policies. For more information, visit the Chiropractic Education webpage.

Reporting the Diabetes: Hemoglobin A1c Measure for Program Year 2015

Due to an error found in the logic, CMS has guidance relating to measure CMS122v3 (Diabetes: Hemoglobin A1c Poor Control), which was posted on May 30, 2014. Version CMS122v3, impacts the 2015 program year and 2017 payment year for several programs:

- Physician Quality Reporting System (PQRS): Reporting CMS122v3 will count as one of the nine measures required to satisfactorily report for the PQRS program. For questions, contact the QualityNet Help Desk at Qnetsupport@hcqis.org, 866-288-8912, or TTY 877-715-6222.
- Electronic Health Record (EHR) Incentive Program: Reporting CMS122v3 will count as one of the nine measures required to satisfactorily report for the EHR Incentive Program. For questions, contact the EHR Incentive Program Information Center at 888-734-6433 or TTY 888-734-6563.
- Value-Based Payment Modifier Program: Based on this logic error, CMS will not include CMS122v3 in the calculation of the Quality Composite for the CY 2017 Value Modifier. For questions, contact the Physician Value Help Desk at pvhelpdesk@cms.hhs.gov or 888-734-6433 (press option 3).
- Comprehensive Primary Care (CPC): All practices are required to report 9 measures from the 13 CPC Electronic Clinical Quality Measures (eCQMs). If a practice is unable to report on a different CPC eCQM, then they should report this measure to meet the 9 measure reporting requirement for the CPC program. For 2015 CPC Medicare shared savings, CMS will not include this measure in performance calculations for quality scoring purposes. Practices that report on CMS122v3 will still be eligible to receive any Medicare shared savings based on their other reported eCQMs. For questions, contact Comprehensive Primary Care Support at cpcisupport@telligen.org or 800-381-4724.

A subsequent posting of this measure in 2015 (CMS122v4) resolved this issue for the 2016 program year. For more information, visit the eCQM Library.

CMS to Release a Comparative Billing Report on Domiciliary E/M Services in January

CMS will issue a national provider Comparative Billing Report (CBR) on Domiciliary Evaluation and Management (E/M) Services in January 2016. The CBR, produced by CMS contractor eGlobalTech,

will focus on providers who bill Current Procedural Terminology codes 99334 through 99337 to report E/M services for patients in a shared living situation, such as a group home or assisted living facility. CBRs contain data-driven tables with an explanation of findings that compare providers' billing and payment patterns to those of their peers in their state and across the nation. The goal of these reports is to offer a tool that helps providers better understand applicable Medicare billing rules.

CBRs are only accessible to the providers who receive them; they are not publicly available. Providers should update their fax numbers in the Medicare Provider Enrollment, Chain, and Ownership System (PECOS) because faxing is the default method for disseminating the reports. Contact the CBR Support Help Desk at 800-771-4430 or CBRsupport@eglobaltech.com with questions or to receive CBRs through the U.S. Postal Service. For more information, visit the CBR website.

January Quarterly Provider Update Available

The Quarterly Provider Update is a comprehensive resource published by CMS on the first business day of each quarter. It is a listing of all non-regulatory changes to Medicare including Program Memoranda, manual changes, and any other instructions that could affect providers. Regulations and instructions published in the previous quarter are also included in the Update. The purpose of the Quarterly Provider Update is to:

- Inform providers about new developments in the Medicare program;
- Assist providers in understanding CMS programs and complying with Medicare regulations and instructions;
- Ensure that providers have time to react and prepare for new requirements;
- Announce new or changing Medicare requirements on a predictable schedule; and
- Communicate the specific days that CMS business will be published in the Federal Register.

Get Your Patients Off to a Healthy Start in 2016

In the New Year, get your Medicare patients off to a healthy start by recommending the Initial Preventive Physical Examination (IPPE) or Annual Wellness Visit (AWV). Thanks to the Affordable Care Act, Medicare covers these preventive services at no cost to your patients.

- The IPPE or "Welcome to Medicare" preventive visit is a one-time service for newly-enrolled beneficiaries
- The AWV is a yearly office visit that focuses on preventive health

For More Information:

- Preventive Services Educational Tool
- Initial Preventive Physical Examination Educational Tool
- Annual Wellness Visit Educational Tool
- Frequently Asked Questions

Continue Seasonal Influenza Vaccination through January and Beyond

Influenza activity often peaks in February, but activity can last as late as May. The Centers for Disease Control and Prevention (CDC) recommends an influenza vaccine each year for everyone 6 months of age and older to reduce the risk of illness and hospitalization. It is not too late to get vaccinated – to protect your patients, your staff, and yourself.

People 65 years and older are at greater risk of serious complications from seasonal influenza. Medicare Part B covers one influenza vaccination and its administration each influenza season for Medicare beneficiaries. If medically necessary, Medicare may cover additional seasonal influenza vaccinations.

For More Information:

- Preventive Services Educational Tool
- Influenza Vaccine Payment Allowances MLN Matters Article
- Influenza Resources for Health Care Professionals MLN Matters Article
- CDC Influenza website
- Use HealthMap Vaccine Finder to help your patients locate the influenza vaccine in their community

Claims, Pricers, and Codes

Holding of 2016 Date-of-Service Claims for Services Paid Under the 2016 MPFS

On October 30, 2015, the CY 2016 Medicare Physician Fee Schedule (MPFS) final rule was published in the Federal Register. In order to implement corrections to technical errors discovered after publication of the MPFS rule and process claims correctly, Medicare Administrative Contractors will hold claims containing 2016 services paid under the MPFS for up to 14 calendar days (i.e., Friday January 1, 2016 through Thursday January 14, 2016). The hold should have minimal impact on provider cash flow as, under current law, clean electronic claims are not paid sooner than 14 calendar days (29 days for paper claims) after the date of receipt.

MPFS claims for services rendered on or before Thursday December 31, 2015, are unaffected by the 2016 claims hold and will be processed and paid under normal procedures and time frames.

Provider Enrollment Application Fee Amount for CY 2016

On December 3, CMS issued a notice: Provider Enrollment Application Fee Amount for CY 2016 [CMS–6066–N]. Effective January 1, 2016, the CY 2016 application fee is $554 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, 2016.

Clarification for Coding Relating to Cologuard

CMS recently implemented a National Coverage Determination to cover Cologuard – a multitarget stool DNA test – as a colorectal cancer screening test for asymptomatic, average risk beneficiaries, aged 50 to 85 years. Previously, providers/suppliers used Healthcare Common Procedure Coding System (HCPCS) code G0464 to bill for the Cologuard test. Per the 2016 Clinical Lab Fee Schedule Change Request 9465, effective December 31, 2015, HCPCS code G0464 expires. Beginning

January 1, 2016, providers/suppliers should bill CPT code 81528 for the Cologuard test. Continue to use HCPCS code G0464 for claims with prior dates of service through December 31, 2015.

January 2016 OPPS Pricer File Available

The Outpatient Prospective Payment System (OPPS) Pricer webpage is updated with Pricer file and outpatient provider data for January 2016 under "1st Quarter 2016 Files."

January 2016 FQHC Pricer Files Available

The Federally Qualified Health Center (FQHC) Pricer webpage is updated with Pricer files for January 2016.

Transcatheter Mitral Valve Repair Claims Editing Incorrectly

A system error caused claims related to Transcatheter Mitral Valve Repair (TMVR) with dates of service on or after October 1, 2015, to edit incorrectly. A fix is scheduled to be implemented on January 25, 2016. Your Medicare Administrative Contractor will temporarily hold any affected claims and release them once the system is corrected. No provider action is required.

Pharmacogenomic Testing for Warfarin Responsiveness Claims Editing Incorrectly

A system error caused claims submitted with HCPCS code G9143 for dates of service on or after October 1, 2015, to edit incorrectly. Your Medicare Administrative Contractor will correct all affected claims. No provider action is required.

Adjustments to Correct Home Health Claim Payments

Medicare contractors have identified an incorrect payment calculation affecting home health claims. Claims reporting Health Insurance Prospective Payment System (HIPPS) codes beginning with 5 are not being recoded correctly when fewer than 20 therapy services are provided. These errors affect only home health claims with receipt dates on or after October 1, 2015. Medicare systems were corrected on January 4, 2016. Home health agencies do not need to take any action. Medicare Administrative Contractors will adjust the claims to correct payments.