HEALTHCARE BUSINESS MANAGEMENT ASSOCIATION

Washington Report – April, 2018
(Covers activity between 4/1/18 and 4/30/18)
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CMS Mails First Phase of New Medicare Cards

The Centers for Medicare and Medicaid Services (CMS) has begun sending out new Medicare cards to beneficiaries in select states. These cards replace the Social Security Number (SSN)-based Health Insurance Claim Number (HICN) with a new alpha-numeric Medicare Beneficiary Identifier (MBI) number.

Providers can use either the HICN or the MBI on claims during a transition period that begins in April, 2018 and runs through 2019. Beginning in 2020, claims must use the MBI.

To help providers with the transition, CMS has developed an online MBI look-up tool that is available through each Medicare Administrative Contractor (MAC). CMS is also providing information on the MBI in the remittance advice on claims.

CMS is publicizing a number of resources to help practices prepare for the new Medicare cards. These include:

- Learn how you and your office staff can get ready for and use the new MBIs.
- Read a Medicare Learning Network fact sheet.
- See a timeline.
- Find Open Door Forum recaps.
- Review outreach materials for your Medicare patients.
- Contact the new Medicare card provider Ombudsman.

CMS is aware that criminals are posing as CMS to scam patients into providing personal information to receive their card. CMS is asking providers to help educate patients about these scams. Beneficiaries do not need to provide any information to receive their new card. CMS will automatically mail the cards to each beneficiary.

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Administration Issues Final Rule Giving States Increased Flexibility in Implementing ACA

On April 9th, the Centers for Medicare and Medicaid Services issued a Final Rule that establishes regulations that health plans must meet in order to be offered to consumers through the federal and state health insurance exchanges created under the Affordable Care Act (ACA) for the 2019 plan year.

This Final Rule provides states with greater authority to regulate their individual and small group health insurance markets by allowing states greater flexibility for establishing essential health benefits and network adequacy, among other things, for plans sold in the state's exchange.

With regard to essential health benefits (EHB), CMS is providing states with greater authority to determine the EHBs that plans in their state must offer. At a minimum, states are still required to offer a plan that includes the 10 broad EHB categories required by the ACA statute. Examples of these benefits are prescription drugs, mental health and maternity care. Under these new regulations, states would have more flexibility to determine the benefit structure for the EHBs such as which specific services are covered under each category.

Each state sets a benchmark plan that determines the EHBs for the rest of the plans sold in that market. States design their benchmark plan based on other plans sold in recent years in the small or large group market in the state. The Final Rule is providing states with three new options for how to select the benchmark plan starting in plan year 2020:

- **Option 1:** Selecting the EHB-benchmark plan that another State used for the 2017 plan year.

- **Option 2:** Replacing one or more categories of EHBs under its EHB-benchmark plan used for the 2017 plan year with the same category or categories of EHB from the EHB-benchmark plan that another State used for the 2017 plan year.
- **Option 3:** Otherwise selecting its own set of benefits that would become the State's EHB-benchmark plan. Under this option, the new EHB-benchmark plan cannot exceed the generosity of the most generous among a set of comparison plans such as the State's EHB benchmark plan used for the 2017 plan year.

States that plan to use one of these new options beginning with the 2020 plan year have until July 2, 2018 to submit their documentation to CMS on how they would change their EHB benchmark plan.

CMS is also providing states with greater network adequacy oversight authority. CMS will allow states to conduct network adequacy reviews on their own assuming that the state has a sufficient network adequacy review process (determined by CMS). States that do not have an adequate review process would be able to have an HHS-recognized accrediting entity perform the network adequacy reviews. The federal government has traditionally performed this oversight.

The Final Rule significantly reforms the Small Business Health Options Program (SHOP) that small businesses use to offer coverage to their employees. Beginning with the 2018 plan year, states will be allowed to eliminate the online SHOP exchanges. States will also be able to allow employers to work directly with a registered insurance agent or directly with the health insurer to provide insurance for their employees. This is similar to how the current large-group health insurance market functions.

According to CMS, as of January 1, 2017 only 7,600 employer groups, covering 39,000 lives, were enrolled in the federal SHOP Exchange.

The final rule also raises the threshold for premium increases that will require a review from a state regulator. For the 2019 plan year, a premium increase of 15 percent will require a review from a state regulator. That amount was 10 percent in previous years.

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CMS Creates Hardship Exemption from ACA Coverage

In addition to the Final Rule for the 2019 plan year, CMS issued guidance that provides a hardship exemption from the requirement to have health insurance to consumers who have no plan issuers or only one plan issuer in their county. The guidance also allows CMS to consider a broad range of circumstances that result in consumers needing hardship exemptions.

CMS will exempt consumers from the requirement to maintain health insurance who:

1. Live in a county, borough, or parish in which no qualified health plan (QHP) is offered through the exchange;
2. Live in a county, borough, or parish in which there is only one issuer offering coverage through the exchange and can show that the resulting lack of choice has precluded them from obtaining coverage under a QHP;
3. Have a hardship obtaining coverage because all affordable plans offered through the FFE in the person's county, borough, or parish provide coverage of abortion, contrary to one's beliefs, and the absence of any affordable plan without such coverage causes a hardship in obtaining health insurance; or
4. Experience personal circumstances that create a hardship in obtaining health insurance coverage under a QHP, such as when a person needs specialty care by a specialist physician but the affordable plans offered through the FFE in the person's county, borough, or parish do not provide access to such specialty care.

Congress eliminated the ACA Individual Mandate penalty beginning with the 2019 plan year in the tax reform bill that became law earlier this year. Despite the absence of a penalty for not having insurance, CMS is adding this hardship exemption because some consumers will need this exemption to qualify for other types of coverage such as catastrophic health insurance.

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2018 MIPS Eligibility Tool Now Available on QPP Website

The Centers for Medicare and Medicaid Services (CMS) has added an updated eligibility look-up tool for eligible clinicians to check their participation status for the Merit-based Incentive Payment System (MIPS) 2018 reporting year. This tool is available on the Quality Payment Program (QPP) website.

ECs can use this tool to enter their National Provider Identifier (NPI) to see if they are exempt from MIPS reporting and payment adjustments because they qualify for the low-volume provider exemption.

ECs are excluded from MIPS reporting and payment adjustments if they:

- Billed $90,000 or less in Medicare Part B allowed charges for covered professional services under the Physician Fee Schedule (PFS), or
- Furnished covered professional services under the PFS to 200 or fewer Medicare Part B - enrolled beneficiaries.

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Trump Administration Outlines Proactive Approach to Health IT

April has been a busy month for the Trump Administration's health IT policy agenda. The Administration has continued to build upon previously announced initiatives such as the MyHealthEData initiative while also announcing new initiatives such as a rebranding and redesigning of its health IT reporting programs.

The Administration used the Health Datapalooza conference, a major health IT conference held annually in Washington, D.C., to make some of these announcements and state the Administration's position on how it will approach Health IT policy in general. Administration officials including Centers for Medicare and Medicaid Services (CMS) Administrator Seema Verma and Department of Health and Human Services (HHS) Deputy Secretary Eric Hargan addressed the conference.

Specifically, HHS and CMS intend to take a proactive approach for two key health IT policy goals: promoting EHR interoperability and giving patients greater access to their health data. With regard to interoperability, there has been an ongoing debate among the government and industry over the government's role in the process. Should the government play an active role in setting interoperability standards or should industry be allowed to work this out on its own? In his remarks to the conference, Deputy Secretary Hargan stated that HHS will take a more active role in promoting interoperability to the degree where some stakeholders will feel "uncomfortable."

In her remarks at the conference, Administrator Verma described how the MyHealthEData initiative is beginning to take shape. Under this initiative, CMS will rely on application programming interfaces (API) to improve how data is shared. Rather than setting standards for EHRs to transmit data, APIs allow private companies to develop applications that can serve as a translator for transmitting this information between systems.

Standards might also be considered in the future but those can take many years to develop. Many of the Health Insurance Portability and Accountability Act (HIPAA) electronic transaction standards that yet to be developed over the 21 years since HIPAA was enacted.

CMS is also going to increase the amount of CMS data that is available to researchers and other industry partners. CMS announced that it will make 2015 Medicare Advantage (MA) encounter data available to approved researchers and related entities. This encounter data provides detailed information about services to beneficiaries enrolled in a Medicare Advantage managed care plan in calendar year 2015. Researchers already have access to Medicare claims data for the fee-for-service program, and this release of MA data will provide a fuller picture of care provided to Medicare beneficiaries.

CMS also announced that it plans to release data from Medicaid and the Children's Health Insurance Program (CHIP) next year.

Lastly, and perhaps most important, CMS included a proposal to redesign the Medicare EHR reporting program for hospitals and physician practices in the 2019 Hospital Inpatient Prospective Payment System (IPPS) proposed rule that was issued earlier this month.

CMS will rename the Advancing Care Information (ACI) category of the Merit-based Incentive Payment System (MIPS) the "Promoting Interoperability" category. It will also refocus this reporting category on EHR interoperability and providing patients with electronic access to their health data. CMS is reducing the number of health IT measures hospitals would have to report. This could indicate that CMS will also reduce the number of health IT measures that eligible clinicians will have to report under MIPS.

CMS is also considering adding a hospital's ability to share health information electronically with other hospitals, community providers and patients to the Medicare Conditions of Participation (CoP) list. This would be an incredibly powerful incentive for improving information sharing. This moves beyond a payment reduction and/or bonus as the primary incentive for meeting health IT standards. The CoP dictates a hospital's ability to participate in the Medicare program.

It is unclear if CMS is seriously considering adding interoperability to the hospital CoP or if this is a "shot across the bow" to warn industry that CMS is going to be generally more aggressive with regard to interoperability.

Although physician practices do not have a similar CoP requirement, perhaps this provision of the IPPS implies that CMS will make a comparably drastic proposal in the 2019 Medicare Physician Fee Schedule (PFS) proposed rule.

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CMS Interested in Requiring Hospitals to Post Prices Online

In the 2019 Medicare Hospital Inpatient Prospective Payment System (IPPS) proposed rule (page 1,464), the Centers for Medicare and Medicaid Services (CMS) included a proposal that would require hospitals to list their prices for IPPS services, including diagnosis related groups (DRG), in a readable format. This can be the hospital's chargemaster or a format of the hospital's choice. Hospitals would be required to update this information on an annual basis.

The proposal aims to create a more consumer friendly pricing model, with increased transparency. CMS Administrator Verma acknowledged that in emergency or other acute situations, it could be difficult to know the price of a service in advance. However, CMS believes patients should know what it will cost to receive planned service.

CMS included a Request for Information (RFI) from stakeholders in conjunction with this proposal. CMS wants to hear recommendations from industry stakeholders on how to best implement this proposal should it be finalized.

CMS is requesting information on:

- How to define a "standard charge" that a hospital must list.
- What type of information would be most useful to patients?
- How can third parties create patient-friendly interfaces with these data?
- Should health care providers be required to inform patients how much their out-of-pocket costs for a service will be?
- Should health care providers provide patients with information on what Medicare pays for a particular service performed by a health care provider?
- How should CMS enforce its price transparency requirements?

While the proposal seems to be focused on hospitals and hospital pricing, some of the items for which CMS is requesting information specifically mention "health care providers" instead of hospitals. This could mean that CMS intends to expand this type of price transparency requirement to physician services as well. The 2019 Medicare Physician Fee Schedule (PFS) is expected to be released by early July.

The HBMA Government Relations Committee will be monitoring CMS' proposed rules for any price transparency provision that would apply to PFS services.

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CMS Considering Testing Direct Contracting Model

The Centers for Medicare and Medicaid Services (CMS) is requesting feedback from stakeholders on how CMS could design a direct contracting payment model for healthcare. Under this type of arrangement, patients would pay providers (not insurance companies) a flat monthly rate that would cover a predetermined set of medical services. Patients would be able to contract with primary care or multispecialty physician practices to pay a fixed amount per beneficiary every month. Providers would be accountable for cost and quality of care.

This proposal is very similar to how an Accountable Care Organization (ACO) is structured. Beneficiaries would have to opt into being in this payment model and providers in the model would be able to earn bonuses based on cost and quality performance.

This model is not yet a formal proposal. CMS is issuing a request for information (RFI) on how to implement such a model. The RFI itself did not include many specific details about the direct contracting proposal. CMS did not include details of what reporting metrics it would use or how the program would quantify its results. It was instead seeking broader feedback from stakeholders surrounding the idea of a program like this being implemented.

CMS is accepting feedback from interested stakeholders until May 25th.

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House E&C Health Subcommittee Approves 57 Bills to Address Opioid Crisis

On April 25th, the House Energy and Commerce Committee's Health Subcommittee held a markup of dozens of individual bills that would address the opioid crisis. By the end of the session, the subcommittee had approved 57 bills, mostly with bipartisan support. The Subcommittee hopes that these bills will be passed by the full House of Representatives before June. It is unclear if the Senate has an interest in considering this package should it reach the Chamber.

Addressing the opioid crisis has received bipartisan support in Congress as well as strong support from the Trump Administration. The FY 2018 Omnibus Appropriations bill that funds the federal government through September 30th included hundreds of millions of dollars to help states address the opioid crisis. This package of bills would supplement action that has already been taken by Congress.

Many of the bills that were approved by the subcommittee would affect Federal Agencies such as the Food and Drug Administration (FDA) and the National Institutes of Health (NIH). However, a number of the bills would impact how healthcare professionals interact with their patients. Below is a summary of several of the bills that affect how healthcare professionals provide care to patients.

- **CMS Action Plan**
  Requires the Secretary of HHS to provide an "Action Plan" on recommendations for changes under Medicare and Medicaid to prevent opioid addictions and enhance access to medication-assisted treatments. The plan will highlight recommendations regarding opioid addiction, as well as payment and service delivery models, data collection, provider education, and expanding care to rural or medically underserved areas.
- **Welcome to Medicare**
  Requires a review of current opioid prescriptions for chronic pain. Also requires a screening for opioid use disorder to be included in the initial Medicare preventative exam.
- **Post-Surgical Injections as an Opioid Alternative**
  Provides modifications in payment for certain outpatient surgical services. This freezes payments for certain targeted tests or procedures to an individual in an ambulatory surgical center to the 2016 price.
- **Use of Telehealth to Treat Opioid Use Disorder**
  Provides the Secretary of HHS the authority to waive Medicare telehealth requirements in the case of an opioid use disorder or co-occurring mental health disorder. They are eligible to waive requirements such as originating site, geographic limitations, and any limitation on store-and-forward information.
- **Incentivizing Non-Opioid Drugs**
  Encourages the use of non-opioid analgesics for post-surgical pain management under Medicare. Changes bundled cost conflict under Medicare to allow for patients to seek

alternative options. Works to change prescribing practices to rely less on opioids, and encourage more R&D pertaining to non-opioid pain management options.

- **Prescriber Notification**
  Requires the Secretary of HHS to provide notifications to the outlier prescribers of opioids.
- **Prescriber Education**
  Establishes grants for eligible entities to provide technical assistance to outlier prescribers of opioids. They will teach the outlier prescribers: the best prescribing practices, alternative treatments, and how to reduce the amount of opioid prescriptions.

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CMS Considering Updates to the HIPAA Administrative Simplification Complaint Form

The Centers for Medicare and Medicaid Services (CMS) has announced in the *Federal Register* that it is considering issuing a formal Request for Information (RFI) from stakeholders on how to revise certain elements of CMS Form 10148. This form is used for submitting a HIPAA Administrative Simplification complaint to CMS.

CMS is specifically seeking comments on if it should issue an RFI on how to update Form 10148 and how its proposed information request can be improved. CMS will then decide if and when it will publish the actual RFI on how to update CMS Form 10148 based on these comments.

The Form requires contact information for both parties and allows the complainant to describe the violation. The description section allows complainants to categorize the complaint as related to transactions, standards, code sets, unique identifiers, and/or operating rules.

CMS is considering adding an option for filing complaints under Unique Identifier and Operating Rules. CMS is also considering adding an area on the complaint form to list the email address for filed against entities, if available.

Comments to CMS on how to improve this proposed information request on updates to CMS Form 10148 must be submitted to CMS by May 29, 2018. Comments can be submitted electronically via www.regulations.gov.

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OIG Estimates $3.7 Million in Improper Medicare Telehealth Payments

In a recently published report, the Department of Health and Human Services (HHS) Office of the Inspector General (OIG) has estimated that Medicare has made $3.7 million in improper telehealth payments in 2014 and 2015.

A telehealth claim must meet certain criteria in order to be reimbursable through Medicare Part B. For example, the originating site of the telehealth visit must be a practitioner's office or a medical facility, and the beneficiary must be located in a qualified area.

According to the report, there were over 190,000 telehealth claims filed in the 2014-2015 time period. OIG selected a random sample of 100 claims to test the validity of the claims. Of those selected claims, OIG found that 30 should not have been paid for a variety of reasons. Twenty-four of the beneficiaries did not originate from a qualified area, and the other six had issues with the status of the office administering the care.

OIG extrapolated that sample to all of the claims filed, to arrive at its estimate of $3.7 million in improper payments. These findings will likely be an increased level of scrutiny on providers when filing a claim for telehealth services.

CMS recently added new codes to the list of covered telehealth services for 2018. It would be safe to assume that OIG will continue to focus on telehealth billing compliance.

OIG highlighted the Health Resources and Services Administration (HRSA) Medicare Telehealth Payment Eligibility Analyzer to help providers accurately bill for telehealth services. The analyzer is a government run website that will instantly inform a provider if their practice location is eligible for Medicare telehealth reimbursement.

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CBO Analysis Indicates Medicare Will Significantly Contribute to Federal Deficit

In its annual analysis of the federal deficit and its effect on the economy, the Congressional Budget Office (CBO) indicated that federal deficits will be larger than historical standards but that annual Gross Domestic Product (GDP) will continue to grow at a strong pace.

The CBO is a non-partisan agency of Congress that provides general economic analysis and analyzes the effect legislation will have on the federal deficit and the economy as a whole.

According to CBO, two bills passed into law by this Congress will increase the federal deficit in the short-term. The recently passed tax reform bill that will reduce federal revenues by upwards of $1 trillion over ten years (not factoring potential economic growth) and the recent FY 2018 government spending bill spends another $1 trillion. According to the CBO, the federal deficit will stabilize in relation to the economy after 2023.

Despite the rising federal deficit, the CBO projects that real GDP (GDP adjusted for inflation) will increase by 3.3 percent this year and by 2.4 percent in 2019. CBO attributes most of this growth to consumer spending, business investment and federal spending.

In its deeper analysis of federal spending, the CBO believes that Medicare and Medicaid spending will increase over the next decade. The finding that Medicare spending growth will accelerate is consistent with reports and analysis conducted by other federal agencies and non-government interest groups.

Spending on major federal health programs such as Medicare and Medicaid is projected to grow by 1.3 percent over the next decade. This is predominantly due to the aging population which will create an influx of newly eligible Medicare beneficiaries.

Over the 2019–2028 period, Medicare spending is projected to increase by an average of seven percent per-year largely due to projected rising per-beneficiary costs of medical care. By 2028, CBO believes that the federal government will be spending $1.2 trillion in annual Medicare spending. For comparison, current annual Medicare spending is about $660 billion per year.

The Medicare Hospital Insurance (HI) Trust Fund, which funds Medicare Part A benefits, is projected to grow at an annual rate of five percent. However, HI Trust Fund spending is projected to increase at an annual rate of seven percent. According to CBO, this will result in HI Trust Fund being exhausted in 2026.

The Medicare Supplementary Medical Insurance (SMI) Trust Fund, which funds Medicare Parts B and D, is projected to remain healthy and stable over the next decade.

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Health Care Fraud and Abuse Control Program 2017 Annual Report

The Health Care Fraud and Abuse Control Program (HCFAC) is a joint Department of Justice (DOJ) and Department of Health and Human Services (HHS) program created to combine the efforts of the two agencies to reduce fraud in healthcare. The program was founded in 1996 and coordinates federal, state, and local law enforcement in regards to healthcare fraud and abuse. In April, the HCFAC released its annual performance report for 2017.

In 2017, the program won or negotiated $2.4 billion in healthcare fraud judgements and settlements. In total, $2.6 billion was returned to the Federal Government or private parties. Of those $2.6 billion, $1.4 billion went to Medicare trust funds, with $406.7 million being transferred back to the Medicaid program.

In FY 2017 there was a total of 967 new criminal healthcare fraud investigations opened. Of those 967, federal prosecutors filed criminal charges in 439 cases. Their expected 'return on investment' over the last three years has been $4.20 for every dollar spent.

As a part of the program, there have been multiple initiatives implemented at CMS to prevent and reduce fraud, such as the National Correct Coding Initiative (NCCI). The NCCI is a set of

automated edits designed to reduce fraud in Medicare Part B. The two components of this are Procedure-to-Procedure (PTP) edits, and Medically Unlikely Edits (MUE). PTP edits prevent payment for billing code pairs that should not be reported together, and MUEs prevent payment for an inappropriate quantity of the same service on the same day. According to the report, PTPs and MUEs saved Medicare $186.9 million and $359.8 million, respectively.

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CMS Transmittals

The following transmittals were issued by CMS in April.

Transmittal Number	Subject	Effective Date
2075OTN	Medicare Cost Report E-Filing (MCReF)	2018-06-12
R2062OTN	Updates to Peritoneal Dialysis Claims Processing, Provider Statistical and Reimbursement Report (PSR) and Payment for Ultrafiltration for Beneficiaries with Acute Kidney Injury (AKI)	2018-10-01
R2063OTN	Processing Instructions to Update the Identification Code Qualifier Being Used in the NM108 Data Element at the 2100 Loop, NM1- Patient Name Segment in the 835 Guide	2018-10-01
R2055OTN	Update to the Hospital Transfer Policy for Early Discharges to Hospice Care	2018-10-01
R2056OTN	User CR: Develop Enhanced Claims Search Reporting in Fiscal Intermediary Shared System (FISS) - Phase 1	2019-04-01
R2057OTN	Common Working File (CWF) to Increase Next Eligible Date Occurrences to 99 for Preventative Services	2018-10-01
R4027CP	Inexpensive or Routinely Purchased Durable Medical Equipment (DME) Payment Classification for Speech Generating Devices (SGD) and Accessories	2018-10-01
R4026CP	Revisions to the Telehealth Billing Requirements for Distant Site Services	2018-10-01
R2069OTN	Shared System Enhancement 2014: Implementation of Fiscal Intermediary Shared System (FISS) Obsolete On-Request Jobs - Phase 3	2018-10-01
R4035CP	Enhancements to Processing of Hospice Routine Home Care Payments	2018-10-01
R791PI	Restoring Section 3.2.3 B. and Section 3.2.3 C. to Chapter 3 of Publication (Pub.) 100-08 in the Internet Only Manual (IOM)	2018-05-29

R2071OTN	Phase 4 - Updating the Fiscal Intermediary Shared System (FISS) to Make Payment for Drugs and Biologicals Services for Outpatient Prospective Payment System (OPPS) Providers	2018-10-01
R196DEMO	Comprehensive ESRD Care (CEC) Model Telehealth - Implementation	2018-10-01
R2070OTN	Shared System Enhancement 2015: Identify Inactive Medicare Demonstration Projects within the Fiscal Intermediary Shared System - (Removing/Archiving Demonstration Codes 51 and 56)	2018-10-01
R2067OTN	Shared System Enhancement 2014: Implementation of Fiscal Intermediary Shared System (FISS) Obsolete On-Request Jobs - Phase 2	2018-10-01
R2066OTN	Enhancement for Undeliverable Pay Medicare Summary Notices (MSNs) for Multi-Carrier System (MCS) Users	N/A
R4039CP	New Physician Specialty Code for Medical Genetics and Genomics	2018-10-01
R304FM	New Physician Specialty Code for Medical Genetics and Genomics	2018-10-01
R2072OTN	Implementation of Business Requirements to Increase Claim Counter Maximum and Create Auto-Deletion Utility	2018-10-01
R4038CP	Modifying FISS Part B Claims Overlap Edits	2018-10-01
R2073OTN	Use the VMAP/4D States Table in all VMS Address Processing	N/A
R4040CP		2018-10-01
R2074OTN	Modifying FISS Part B Claims Overlap Edits	2018-10-01
R4037CP	Removal of KH Modifier from Capped Rental Claims	2018-10-01
R4036CP	Quarterly Update for the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program (CBP) - July 2018	2018-07-02
R2064OTN	Part B Detail Line Expansion - Fiscal Intermediary Shared System (FISS)	2018-10-01
R2065OTN	Part B Detail Line Expansion - Multi-Carrier System (MCS) Phase 9	2019-04-01
R4025CP	Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes - July 2018 Update	2018-07-01
R4024CP	Conversions Related to the Spanish Translation of the Healthcare Common Procedure Coding System (HCPCS) Descriptions	2018-07-02
R4023CP	Update of Internet Only Manual (IOM), Medicare Claims Processing Manual, Publication 100-04, Chapter 37 -	2018-07-20

	Department of Veterans Affairs (VA) Claims Adjudication Services Project	
R786PI	Reimbursing Providers and Health Information Handlers (HIHs) for Additional Documentation	2018-05-14
R3P243	Medicare Provider Reimbursement Manual - Part 2, Provider Cost Reporting Forms and Instructions, Chapter 43, Form CMS-1984-14	2018-04-13
R178SOMA	Revisions to State Operations Manual (SOM) Appendix J, Part I – Survey Protocol for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)	2018-04-13
R2054OTN	Change in Type of Service (TOS) for Current Procedural Terminology (CPT) Code 77067	2018-07-02
R4021CP	Ambulance Transportation for a Skilled Nursing Facility (SNF) Resident in a Stay Not Covered by Part A - Medicare Benefit Policy Manual, Chapter 10 and Medicare Claims Processing Manual, Chapter 15	2018-07-16
R243BP	Ambulance Transportation for a Skilled Nursing Facility (SNF) Resident in a Stay Not Covered by Part A - Medicare Benefit Policy Manual, Chapter 10 and Medicare Claims Processing Manual, Chapter 15	2018-07-16
R4022CP	Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Edits, Version 24.2 Effective July 1, 2018	2018-07-02
R195DEMO	Update to CR9341 Oncology Care Model (OCM) Restricted Care Management Code List	2018-07-02
R303FM	Notice of New Interest Rate for Medicare Overpayments and Underpayments -3rd Qtr Notification for FY 2018	2018-04-17
R785PI		2018-05-07
R4017CP	Increased Ambulance Payment Reduction for Non-Emergency Basic Life Support (BLS) Transports to and from Renal Dialysis Facilities	2018-10-01
R4018CP	New Waived Tests	2018-07-02
R2051OTN	Claims Processing Actions to Implement Certain Provisions of the Bipartisan Budget Act of 2018	2018-04-02
R2050OTN	Modifications to the Implementation of the Paperwork (PWK) Segment of the Electronic Submission of Medical Documentation (esMD) System	2018-07-02
R206NCD	Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD)	N/A
R4016CP	Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD)	N/A

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