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Medicare Inpatient Payment Final Rule Indicates Changes Coming to Physician Reimbursements
House Ways and Means Committee Advances Bills on Medicare Smart Cards and LCD Transparency
CDC Survey Shows Decline in Uninsured Rate
House Ways and Means Committee Recommends Regulatory Relief Actions to CMS
HHS Making Progress in Reducing Backlog of Appealed Claims
Senate Passes HHS Spending Bill Setting up Negotiations on Final Version with House
Social Security Number Removal Initiative Update
CMS Publishes 2017 ACO Performance Data
CMS Transmittals

Return to Top

Medicare Inpatient Payment Final Rule Indicates Changes Coming to Physician Reimbursements

- CMS published the 2019 Hospital Inpatient Prospective Payment System (IPPS) Final Rule.
- A number of provisions from the IPPS proposed rule were also included in the 2019 Medicare Physician Fee Schedule (PFS) proposed rule. The IPPS final rule could foreshadow how CMS will finalize these same provisions in the PFS.

The Centers for Medicare and Medicaid Services (CMS) issued its 2019 Medicare Hospital Inpatient Prospective Payment System (IPPS) final rule on August 2nd. This regulation makes changes to Medicare reimbursement policies for hospital inpatient services.

CMS is finalizing a number of provisions that were included in other proposed Medicare payment regulations such as the 2019 Medicare Physician Fee Schedule (PFS) and the 2019 Hospital Outpatient Prospective Payment System (OPPS).

The final rule builds upon CMS' initiatives to reduce administrative burden by eliminating dozens of duplicative or topped out measures from the hospital quality reporting programs. CMS has made similar proposals in the 2019 PFS proposed rule.

The IPPS proposed rule also included two requests for information from the public on price transparency and EHR interoperability.

With regard to price transparency, CMS finalized a proposed requirement that hospitals publish their "standard charges" on a publicly available website which is to be updated at least on an annual basis. Many industry stakeholders opposed this proposal due to the potential for patients to misinterpret this information.

CMS also collected information on how to improve patient access to information about their out-of-pocket charges with the purpose of reducing "surprise" medical bills. CMS is not finalizing any policy regarding this information collection, instead stating that it will analyze the comments it received and consider future action.

The fact that CMS will require hospitals to post their standard charges online indicates that CMS could finalize a similar provision that would apply to physician offices when it issues the 2019 PFS final rule.

CMS is not finalizing its drastic proposal to make EHR interoperability for hospitals a Medicare Condition of Participation (CoP). This would be an enormous policy shift from CMS' current approach to encourage the adoption of interoperable EHR products through payment incentive programs such as the Merit-based Incentive Payment System (MIPS). Making ownership of an interoperable EHR system a condition for being able to submit claims to Medicare would be a massive escalation compared to how programs like MIPS incentivize EHR adoption.

CMS included a similar proposal in the 2019 PFS proposed rule and the 2019 OPPS proposed rule. If CMS did not finalize this proposal in the IPPS final rule, it is unlikely it would finalize this policy in the PFS or OPPS.

The comment period for the 2019 PFS proposed rule concludes on September 10th. We will not know if CMS decides to finalize these proposals until the final PFS rule is published in November.

HBMA's comments to CMS on the PFS proposed rule includes a response to CMS' RFIs for price transparency and EHR interoperability.

Return to Top

House Ways and Means Committee Advances Bills on Medicare Smart Cards and LCD Transparency

- The House Ways and Means Committee approved a bill that requires MACs to be more transparent with how they issue LCDs.
- The Committee also passed a bill that would require CMS to implement a pilot program to test "Smart" Medicare beneficiary cards that require the use of a machine reader and PIN.
- Both bills can now be considered on the House Floor. It is unclear when or if either will get a vote in either the House or Senate.

The House Ways and Means (W&M) Committee considered a handful of Medicare bills and referred those bills for a vote on the House floor. The W&M Committee is one of the main Committees in the House of Representatives with jurisdiction over the Medicare program.

One of those bills, H.R. 3635, the Local Coverage Determination Clarification Act, would require Medicare Administrative Contractors to be more transparent in how they develop and issue Local Coverage Determinations (LCD). It also is intended to give members of the public greater opportunity to provide comments to MACs on proposed LCDs.

The bill would require MACs to publish proposed LCDs and convene public meetings with experts and industry stakeholders to receive their input. The MAC will also be required to provide a public comment period and respond to the comments it received when issuing the final LCD. The bill also requires MACs to be more transparent when going through a LCD reconsideration process.

The W&M Committee also approved H.R.6690, the Fighting Fraud to Protect Care for Seniors Act of 2018**.** This bill would require the Centers for Medicare and Medicaid Services (CMS) to conduct a pilot program to test the use of Medicare "smart" beneficiary cards. Smart cards would require the use of a personal identification number (PIN) similar to a bank debt card. The purpose of smart cards is to prevent fraud.

The bill fully defines "smart cards" as a machine readable, tamper-resistant card that includes an embedded integrated circuit chip with a secure micro-controller that enables the verification and secure, electronic authentication of the identity of a Medicare beneficiary at the point of service through a combination of the smart card and a personal identification number known by or associated with the beneficiary.

Under the pilot program outlined in the bill, CMS would select at least three geographic areas where it would issue smart cards to patients and smart card readers to providers who participate in the demonstration. This pilot program would last for three years.

This pilot program would not impact the Medicare Social Security Number Removal Initiative (SSNRI) which requires CMS to issue all Medicare beneficiaries new beneficiary cards that replaced their Social Security Numbers with a new, unique alpha-numeric identification number.

Both bills have been referred out of Committee for a vote on the House floor. It is not clear when (or if) a vote on these bills will occur. The Senate has introduced its own version of the LCD Clarification Act but there is no related Smart Card bill in the Senate. It is unclear if the Senate will consider either of these measures should they pass the House.

Failure to pass either bill before the end of the calendar year will require each to be reintroduced and reconsidered by the Committee once the new Congress is sworn-in in January.

Return to Top

CDC Survey Shows Decline in Uninsured Rate

- The CDC published its survey on health insurance rates and trends for the first quarter of 2018.
- The uninsured rate improved slightly from last year to 8.8 percent.

The Centers for Disease Control and Prevention (CDC) released preliminary results from its annual survey on the number of Americans with/without health insurance. According to the data, which analyzes data from only the first quarter of the year, the uninsured rate was 28.3 million people, a decrease of about half a million people from last year. This represents an uninsured rate of 8.8 percent.

According to the data, in the first three months of 2018:

- Among adults aged 18–64, 12.5 percent were uninsured at the time of interview, 19.2 percent had public coverage, and 70.0 percent had private health insurance coverage.
- Among children aged 0–17 years, 4.6 percent were uninsured, 41.9 percent had public coverage, and 54.6 percent had private health insurance coverage.
- Among adults aged 18–64, 70.0 percent (138.6 million) were covered by private health insurance plans at the time of interview in the first 3 months of 2018. This includes 4.2 percent (8.3 million) covered by private health insurance plans obtained through the ACA's Health Insurance Marketplace or state-based exchanges.

It is also worth noting that the percentage of Americans under age 65 with private health insurance enrolled in a high-deductible health plan (HDHP) increased, from 43.7 percent in 2017 to 47.0 percent. HDHPs, which are usually linked to health savings accounts (HSA) are being promoted by critics of the Affordable Care Act (ACA) as an alternative to plans offered in the ACA exchanges.

The report points out that despite small gains in reducing the uninsured rate from the previous year, the current number of Americans without health insurance is about 20 million people fewer than the pre-ACA uninsured rate.

Return to Top

House Ways and Means Committee Recommends Regulatory Relief Actions to CMS

- The House Ways and Means Committee has issued a long-awaited list of recommendations for how CMS can reduce regulatory burdens on healthcare providers.
- The Committee has been working on this report for over 18 months.
- In its report, the Committee opposes CMS' proposal in the 2019 Physician Fee Schedule proposed rule to collapse the Evaluation and Management code set to only two levels.

Over one year ago, the House Ways and Means (W&M) Committee began soliciting recommendations from healthcare industry stakeholders on how Congress can help reduce administrative and financial burdens on the healthcare industry. The W&M Committee is one of the main Committees in the House of Representatives with jurisdiction over the Medicare program.

The HBMA Government Relations (GR) Committee provided written recommendations to the Committee and reiterated our recommendations during in-person meetings with the Committee's staff.

After 18 months of hearing from stakeholders, the Committee has finally submitted a full list of recommendations to CMS for how the Agency should reduce regulatory burdens on the healthcare industry. The Committee broke its recommendations into three letters, one for physician offices, one for hospitals and one for post-acute care.

The Committee acknowledges actions already being taken by CMS such as reducing unnecessary and overly burdensome MIPS reporting measures. The letter also urges CMS to use its statutory flexibilities to implement the Medicare Quality Payment Program (QPP) at a "gradual" pace.

Notably, the letter from the W&M Committee cautions CMS' proposal from the 2019 Medicare Physician Fee Schedule proposed rule to collapse the five evaluation and management (E/M) visit levels to only two levels. The Committee specifically asks that CMS "takes a more deliberate approach working with stakeholders, and consider a policy with at least three coding categories, including considerations such as patient risk scores in addition to time spent, to ensure higher levels of accuracy while still reducing burdens."

The W&M Committee also sees prior authorization as an overly burdensome practice but does not put forward specific recommendations for how to reform its utilization. The Committee also opposes CMS' proposal to reduce the potential shared savings for upside-only Accountable Care Organizations (ACO) from 50 percent to 25 percent.

This letter indicates Congress is asking CMS to take action on its own. If CMS fails to take action that pleases the Committee, Congress can always pass legislation requiring CMS to take specific actions.

Return to Top

HHS Making Progress in Reducing Backlog of Appealed Claims

- HHS is making progress in its effort to clear the backlog of appealed claims pending before the Office of Medicare Hearings and Appeals.
- HHS is on track to completely eliminate the backlog by 2022.
- Stakeholders such as the American Hospital Association believe 2022 is too long.

In court documents filed as part of a lawsuit brought by the American Hospital Association (AHA), the Department of Health and Human Services (HHS) has stated that it is making significant progress toward reducing the massive backlog of pending claim appeals. According to HHS, there are currently 444,894 outstanding appealed claims as of the end of July. This is down from over 652,000 pending appeals as of a year ago. During the peak of the backlog, there were over 700,000 pending claims appeals. HHS anticipates completely alleviating the backlog by 2022. The AHA prefers that HHS eliminates the backlog sooner than 2022.

The AHA filed the lawsuit because the backlog was causing HHS to exceed its deadline to adjudicate claims. Most of the appealed claims in the backlog were hospital inpatient claims that were appealed by Medicare program integrity contractors. The backlog has therefore caused significant revenue disruptions for many hospitals. This backlog also causes disruptions for physician offices whose appeals are caught up in the backlog.

There are five levels of claims appeals. Most of the appeals are pending before the third appeal level which is the Office of Medicare Hearings and Appeals (OMHA).

Most of the appealed claims are inpatient determinations that Recovery Audit Contractors (RAC) challenged believing they should have been billed as outpatient claims. RACs are entitled to keep a percentage of what was recovered as a result of a successful claim appeal which gave them an incentive to take an aggressive approach to appeals and audits. As a means to reduce the aggressive audit practices, CMS eventually removed some of the audit authority from RACs, transferring this authority to another contractor program.

CMS also ended the “two-midnight” rule that was used to justify many of the RAC challenges of inpatient claims. HHS also has dedicated increased resources to alleviating the backlog and has taken measures such as allowing appellants to settle low-volume appeals at a set percentage of the Medicare allowable payment for those claims.

These steps have led to a slower influx of new appeals while also providing HHS with additional resources to alleviate the existing backlog. According to the HHS filing, RAC appeals accounted for only 12 percent of new appeals. At one point, RACs accounted for 50 percent of appealed claims. Additionally, OMHA now has the resources to adjudicate over 188,000 claim appeals per year, more than double its capacity from the previous year.

Return to Top

Senate Passes HHS Spending Bill Setting up Negotiations on Final Version with House

- Both the House and Senate are making progress towards funding the government for the 2019 fiscal year ahead of the September 30th expiration of current government funding.
- Each Chamber has passed their own version of a bill to fund the Department of Health and Human Services (HHS). Both Chambers will now negotiate a reconciliation between the two versions that will receive a final vote by each Chamber.

The Senate completed passage of an appropriations bill to provide funding for the Department of Health and Human Services (HHS) and its sub-agencies for the 2019 fiscal year. The HHS appropriations bill also includes funding for the Department of Labor and the Department of Education. The government is currently funded through the remainder of the fiscal year (September 30th).

The Senate's passage of this bill sets up negotiations with the House of Representatives to negotiate the differences between each Chamber's versions of an HHS funding bill using the Conference Committee Process. A Conference Committee includes a handful of members from each Chamber representing both parties to produce a reconciled version of the bill. Each Chamber must vote on the report the conference committee produces.

The HHS appropriations bill provides funding for mandatory spending such as Medicare benefits as well as discretionary spending for many other important programs such as program integrity and program management.

In total, the Labor, Education and HHS appropriations bill allocates $1.045 trillion in both mandatory and discretionary spending. Of this total, about $654.5 billion is allocated for mandatory spending for paying Medicare benefits and grants to states for Medicaid spending.

$12 billion is allocated for the Department of Labor, $70 billion is allocated for the Department of Education and $89 billion is allocated for discretionary HHS spending. All of these spending levels represent an increase from the previous year's funding levels.

Congress must pass all twelve appropriations bills funding the government for FY 2019 by the September 30th deadline. If Congress is not able to pass some or all of the appropriations bills before the end of the fiscal year, Congress can also pass a short-term Continuing Resolution (CR) to extend funding at current levels to provide legislators additional time to pass a permanent appropriations legislation.

Failure to pass either appropriations legislation or a CR will result in a full or partial government shutdown depending on which appropriations bills were passed into law.

Appropriations bills are often accompanied by a bill "Report" that is used to explain congressional intent behind specific provisions of the bill. Bill Reports do not carry the force of law but they are influential with federal agencies.

Notable provisions in the bill Reports accompanying the House and Senate appropriations bills for HHS include:

- Expressing satisfaction with CMS' implementation of the Social Security Number Removal Initiative,
- Asking CMS to clarify the "Usual, Customary & Reasonable" payment rate for emergency services for purposes of determining payments for out-of-network emergency care,
- Expressing support for Recovery Audit Contractors (RAC), and
- Expressing Congress' desire that CMS should more strongly consider testing physician-focused payment models (PFPM). PFPMs are alternative payment models (APM) designed by industry stakeholders such as medical specialty associations.

Return to Top

Social Security Number Removal Initiative Update

- CMS' effort to issue all Medicare beneficiaries with a new Medicare card that contains a new, alpha-numeric beneficiary number is proceeding according to schedule.
- CMS continues to provide technical clarifications to healthcare providers and beneficiaries.

The transition to new Medicare beneficiary cards is proceeding according to schedule. The Centers for Medicare and Medicaid Services (CMS) must issue all Medicare beneficiaries with a new card that replaces the Social Security Number (SSN)-based Health Insurance Claim Number (HICN) with a unique alpha-numeric beneficiary number, called the Medicare Beneficiary Identifier (MBI). All newly enrolled beneficiaries as of April 1st began receiving cards with an MBI instead of a HICN.

Congress required CMS to begin replacing Medicare cards with MBIs. Congress saw the SSN-based HICN as an identity theft and fraud risk. The replacement effort is called the Medicare Social Security Number Removal Initiative.

CMS began issuing new cards on April 1st. New cards are being issued a few states at a time over the course of seven mailing waves. Waves 1, 2 and 3 have recently concluded. Wave 4 is ongoing and Wave 5 recently started. Wave 5 states include Alabama, Florida, Georgia, North Carolina, and South Carolina.

CMS will accept claims that use either a HICN or MBI through December 31, 2019. Beginning on January 1, 2020, CMS will only accept claims with an MBI.

CMS is offering various resources to help beneficiaries and providers transition to the new cards. For example, CMS includes the MBI on claims remittance advice. CMS also allows providers to look up a patient's MBI online via their Medicare Administrative Contractor's (MAC) website.

CMS recently issued a clarification to providers regarding the use of the digit “0” and the letter “O” in MBIs.

The MBI uses numbers 0-9 and all uppercase letters *except* for S, L, O, I, B, and Z. CMS excludes these letters to avoid confusion when differentiating some letters and numbers (e.g., between “0” and “O”).

CMS is facilitating a New Medicare Card Open Door Forum will be held Thursday, September 13th, from 2-3 p.m. eastern time. Share your experiences transitioning to the MBI.

Return to Top

CMS Publishes 2017 ACO Performance Data

- CMS has released 2017 performance data for the Medicare ACO programs.
- Overall, Medicare ACOs are achieving savings and improving quality but perhaps at a slower pace than intended.

The Centers for Medicare and Medicaid Services (CMS) has published the 2017 performance data for the Medicare Accountable Care Organization (ACO) program. ACOs were created under the Affordable Care Act (ACA) with the goal of bringing healthcare providers and healthcare systems together to be accountable for the cost and quality of care for a Medicare patient population. ACOs that perform well on cost and quality measures are allowed to keep some of the money they saved the Medicare program.

ACOs are also supposed to bear some financial risk for the care they provide. However, CMS allows many ACOs to remain in an “upside-only” arrangement in which they bear no risk but are eligible to receive shared savings. CMS has been trying to push ACOs out of the upside-only arrangements towards accepting risk.

Recently, CMS issued a new proposed rule that would reduce the potential shared savings that upside-only ACOs are eligible to earn as a way to push ACOs towards bearing risk. CMS is also proposing to limit the amount of time an ACO can be in an upside-only arrangement.

According to the data release, 472 ACOs participating in the Medicare Shared Savings Program (MSSP), a predominantly upside-only ACO model, saved $1.1 billion to the Medicare program. 162 of those MSSP ACOs earned back about $800 million in shared savings. After paying out the shared savings, CMS was left with a net savings of $313 million from the MSSP ACOs. About 9 million Medicare beneficiaries participated in the MSSP program.

Out of 39 ACOs that accepted risk, 16 ACOs in the risk bearing tracks earned about $57 million in shared savings.

The data indicates that the longer an ACO has existed, the better it tends to perform. ACOs that have been around since 2012 (the first participation year), performed better than ACOs that began participating in the program in 2016.

To put these numbers in perspective, Medicare spends about $650 billion per year on healthcare benefits across all four "parts" of Medicare. The $1.1 billion in savings is well less than one percent of total Medicare spending and that is before CMS pays some of those savings back to ACOs for shared savings payments.

Many ACOs have indicated that they will stop participating in the program if they are required to take on down-side risk.

Return to Top

CMS Transmittals

The following transmittals were issued by CMS in August.

Transmittal Number	Subject	Effective Date
R124MSP	Updates to Chapters 5 and 6 of Publication 100-05 to Further Clarify Medicare Secondary Payer (MSP) Processes that Include Electronic Correspondence Referral System (ECRS) Requests Submissions and Timely Submission of MSP I Records, General Inquiries and Hospital Reviews	2018-10-01
R823PI	Update to Exhibit 16 - Model Payment Suspension Letters in Publication (Pub.) 100-08	2018-10-01
R4124CP	Influenza Vaccine Payment Allowances - Annual Update for 2018-2019 Season	2018-11-01
R4125CP	October 2018 Update of the Ambulatory Surgical Center (ASC) Payment System	2018-10-01
R2135OTN	Medicare Appeals System (MAS) Part B and Durable Medical Equipment (DME) Data Collection Web Services Pilot	2018-10-01
R205DEMO	Next Generation Accountable Care Organization (ACO) Model 2019 Benefit Enhancement	2019-01-07
R2134OTN	Shared System Enhancement 2015: Resolve Operating Report (ORPT) Issues - Development and Implementation	2020-01-06

R180SOMA	Revisions to the State Operations Manual (SOM) Appendix Y, Organ Procurement Organization (OPO) Interpretive Guidance	2018-08-24
R4121CP	2019 Healthcare Common Procedure Coding System (HCPCS) Annual Update Reminder	2019-01-07
R4120CP	Instructions for Downloading the Medicare ZIP Code File for January 2019	2019-01-07
R4118CP	Combined Common Edits/Enhancements Modules (CCEM) Code Set Update	2019-01-07
R4117CP	Implement Operating Rules - Phase III Electronic Remittance Advice (ERA) Electronic Funds Transfer (EFT): Committee on Operating Rules for Information Exchange (CORE) 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) Rule - Update from Council for Affordable Quality Healthcare (CAQH) CORE	2019-01-07
R4116CP	Healthcare Provider Taxonomy Codes (HPTCs) October 2018 Code Set Update	N/A
R4115CP	Claim Status Category and Claim Status Codes Update	2019-01-07
R4122CP	October 2018 Integrated Outpatient Code Editor (I/OCE) Specifications Version 19.3	2018-10-01
R4123CP	October 2018 Update of the Hospital Outpatient Prospective Payment System (OPPS)	2018-10-01
R822PI	Update to Chapter 15 of Publication (Pub.) 100-08, Certification Statement Policies	2018-10-01
R817PI	New Instructions for Home Health Agency Misuse of Requests for Anticipated Payments (RAPs)	2018-09-17
R819PI	Adding a Targeted Probe and Educate (TPE) Sub-Section Into Section 3.2 of Chapter 3 in Publication (Pub.) 100-08	2018-09-17
R123MSP	Updating Language to Clarify for Providers Chapter 3, Section 20 and Chapter 5, Section 70 of the Medicare Secondary Payer Manual	2018-11-20
R122MSP	Electronic Correspondence Referral System (ECRS) Enhanced Functionality	2018-09-17
R2131OTN	Ensuring Home Health Standardized Amounts Are Reflected in the National Claims History	2019-01-07

R2133OTN	Clarification of Policies Related to Reasonable Cost Payment for Nursing and Allied Health Education Programs	2018-11-19
R2132OTN	User CR: MCS - Enhance H9 Screen to Hold Information After Claim Finalizes	2019-01-07
SE18011	Current Medicare Coverage of Diabetes Supplies	
R2130OTN	Enhancement for Undeliverable Pay Medicare Summary Notices (MSNs) for Multi-Carrier System (MCS) Users	2019-01-07
R4109CP	Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - October 2018 Update	2018-10-01
R4111CP	Revisions to Medicare Claims Processing Manual for Foreign, Emergency and Shipboard Claims	2018-09-11
R78QRI	Payments to Home Health Agencies That Do Not Submit Required Quality Data - This CR Rescinds and Fully Replaces CR 9651.	2018-09-11
R2112OTN	User CR: FISS to Add Additional Search Features to Provider Direct Data Entry (DDE) Screen	2019-01-07
R2111OTN	Modifications Within Common Working File (CWF) to Adjustment Claims Exceeding Annual Therapy Threshold	2019-01-07
R2113OTN	Combined Common Edits/Enhancements Module (CCEM) Updates for JAVA (version 6) to JAVA (version 7)	2019-01-07
R203DEMO	Next Generation Accountable Care Organization (ACO) Model 2019 Benefit Enhancement	2019-01-07
R2119OTN	Process Improvement for Recovery Audit Contractor (RAC) Mass Adjustment Input File – Underpayment Adjustment Enhancement	2019-01-07
R2116OTN	Modifications to the National Coordination of Benefits Agreement (COBA) Medicare Crossover Process	2019-01-07
R4108CP	October Quarterly Update for 2018 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule	2018-10-01
R4114CP	Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes - October 2018 Upda	2018-10-01
R2125OTN	Medicare Diabetes Prevention Program (MDPP) Service Period Change from 3 Years to 2 Years	N/A
R2120OTN		2019-01-07

R2126OTN	User CR: FISS to Add Location/Statuses to the 6H File Fix	2019-01-07
R2122OTN	International Code of Diseases, Tenth Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs)	N/A
R4086CP	Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index and Hospice Pricer for FY 2019	2018-10-01
R2115OTN		2019-01-07
SE18010	Inclusion of Power Mobility Device Codes in the Prior Authorization Program for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Items	
R2102OTN	Shared System Enhancement 2014: Implementation of Fiscal Intermediary Shared System (FISS) Obsolete On-Request Jobs - Phase 3	2019-01-07
R2104OTN	Analysis of the Structured Data Elements for Sending Additional Documentation Request (ADR) Decision Letters and Prior Authorization/Pre-Claim Review (PA/PCR) Decision Letters Electronically via the Electronic Submission of Medical Documentation (esMD) System	2018-11-05
R4098CP	Update to the Fiscal Intermediary Shared Systems (FISS) Outpatient Provider Specific File (OPSF) for Outpatient Prospective Payment System (OPPS) Hospitals and OPPS Pricer Interface	2019-01-07
R4096CP	Update to the Medicare Claims Processing Manual, Chapter 24, Section 90	2018-11-05
R4100CP	Quarterly Influenza Virus Vaccine Code Update - January 2019	2019-01-07
R2101OTN	Shared System Enhancement 2014: Implementation of Fiscal Intermediary Shared System (FISS) Obsolete On-Request Jobs - Phase 4	2019-01-07
R4104CP	Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Updates for Fiscal Year (FY) 2019	2018-10-01
R2108OTN	Shared System Enhancement 2015: Identify Inactive Medicare Demonstration Projects within the Fiscal Intermediary Shared System - (Removing /Archiving demonstration codes 44 and 47)	2019-01-07
R245BP	System Changes to Implement Epoetin Alfa Biosimilar, Retacrit for End Stage Renal Disease (ESRD) and Acute Kidney Injury (AKI) Claims	2019-01-07

R4107CP	October 2018 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files	2018-10-01
R4105CP	System Changes to Implement Epoetin Alfa Biosimilar, Retacrit for End Stage Renal Disease (ESRD) and Acute Kidney Injury (AKI) Claims	2019-01-07

Return to Top