HEALTHCARE BUSINESS MANAGEMENT ASSOCIATION

Washington Report – November 2018
(Covers activity between 11/1/18 and 11/30/18)
Bill Finerfrock, Matt Reiter, and Carolyn Bounds

Return to Top

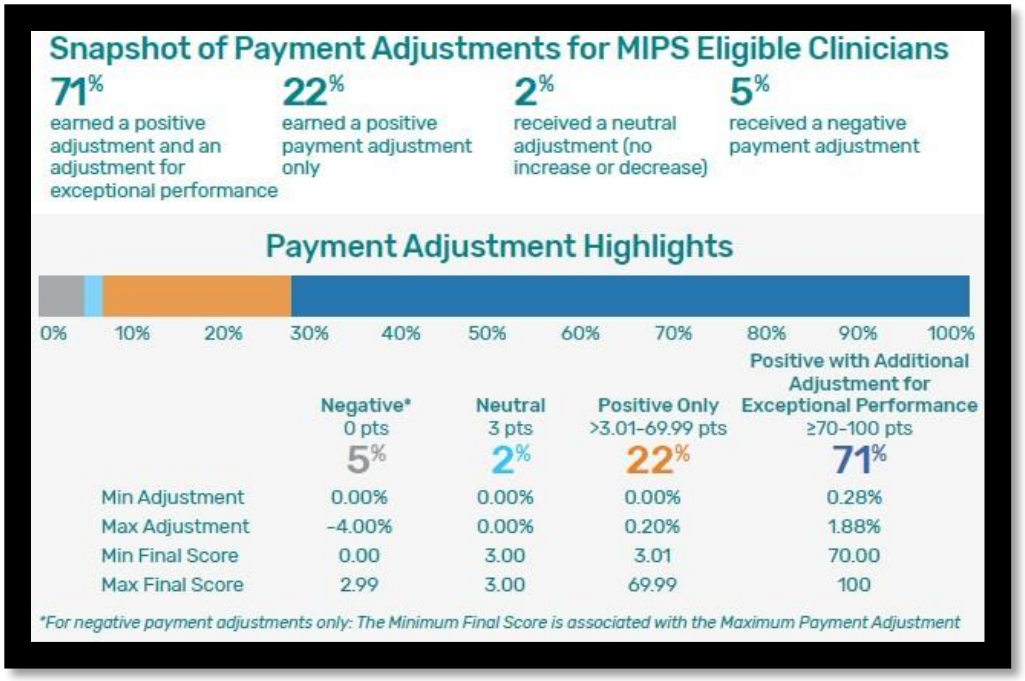
MIPS Performance Results Available Online

- CMS has released information about overall MIPS performance for the 2017 reporting year. This is separate from individual performance feedback that every MIPS-EC received earlier this year.
- As expected, almost every EC avoided a negative payment adjustment in 2017. Only five percent of ECs received a negative payment adjustment.
- The MIPS payment adjustments are budget neutral meaning the five percent of ECs who received a negative adjustment must fund the positive payment adjustments that 93 percent of ECs were eligible for in 2017.

Every eligible clinician (EC) – either individual or group – who participated in the Merit-based Incentive Payment System (MIPS) in 2017 has been able to see their individual/group's performance results and corresponding payment adjustment for the 2019 payment year. This

month, the Centers for Medicare and Medicaid Services (CMS) made more information about the aggregate 2017 MIPS performance results available to the public.

According to CMS, 93 percent of MIPS ECs received a positive payment adjustment for their performance in 2017, and 95 percent avoided a negative payment adjustment. CMS calculated that 1,057,824 MIPS ECs will receive a MIPS payment adjustment, either positive, neutral, or negative. Of that population, 1,006,319 MIPS ECs received a neutral payment adjustment or better. Additionally, under the Advanced APM track, 99,076 eligible clinicians earned Qualifying APM Participant (QP) status.



The small number of ECs who received a four percent negative payment adjustment is a double-edged sword. On the one hand, it is good news that few providers will receive a payment cut in 2019. However, MIPS payment adjustments are budget neutral. The positive payment adjustments are funded by the negative payment adjustments. This means the five percent of ECs who earned a four percent negative payment adjustment are funding the bonuses for the 93 percent of ECs who earned a positive payment adjustment. Therefore, the ECs who earned a positive payment adjustment will receive a very small payment bump because there is very little money to go around.

The national mean (or average) score for MIPS eligible clinicians was 74.01 points and the national median was 88.97 points. To further break down the national mean and median:

- Clinicians participating in MIPS as individuals or groups (and not through an APM) received a mean score of 65.71 points and a median score of 83.04 points
- Clinicians participating in MIPS through an Alternative Payment Model (APM) received a mean score of 87.64 points and a median score of 91.67 points

On average, MIPS eligible clinicians in rural practices earned a mean score of 63.08 points, while clinicians in small practices received a mean score of 43.46 points.

The data on performance scores must be read in context. Many ECs in MIPS participated only to the degree that they could earn enough points to avoid the negative payment adjustment. Others might have decided to use 2017 as a test year in which they did not fully participate for the entire reporting period.

The minimum score necessary to avoid a negative payment adjustment was only three points in 2017. This performance threshold increased to 15 points in 2018 and will increase further to 30 points in 2019.

Return to Top

New Leaders Chosen for Congressional Leadership Positions and Health Policy Committees

- Democrats and Republicans began picking who will serve in key Leadership and Committee positions in each Chamber of Congress once the new Congress is sworn-in in January.
- Former Speaker of the House and Current House Minority Leader Nancy Pelosi (D-CA) is vying to return to the Speakership in January.
- Both parties are also selecting who will serve atop important committees and subcommittees in the new Congress.

Both the House and Senate are making progress towards deciding which legislators will serve in key leadership positions in the 116th Congress. Most of the changes will occur in the House of Representatives which is switching to Democratic control in January. Many key leadership positions atop Congressional Committees are also being decided.

Speaker of the House is the most significant Leadership role that will change come January. Democrats selected current House Minority Leader, Nancy Pelosi (D-CA) as their candidate for Speaker. Pelosi prevailed in an internal, secret election by a vote of 203-32. Pelosi served as Speaker of the House from 2007-2011 and was largely responsible for securing passage of the Affordable Care Act (ACA) in the House of Representatives.

The full House of Representatives will elect the Speaker in January. A simple majority of voting Members is required to be elected Speaker on the House Floor. Pelosi will need some of the Democrats who voted against her in the conference nomination vote to support her during the full House election as no House Republicans are expected to vote for her.

Current House Majority Leader Kevin McCarthy (R-CA) was already elected by his Conference to serve as House Minority Leader in the new Congress. The leadership of both parties in the Senate will remain mostly unchanged with Sen. Mitch McConnell (R-KY) and Sen. Chuck Schumer (D-NY) continuing to lead their respective parties in the Senate.

Three of the four key Congressional Committees with jurisdiction over healthcare policy will have new Chairs in the new Congress. Sen. Grassley (R-IA) will take over as Chair of the Senate Finance Committee for retiring Sen. Orrin Hatch (R-UT). Sen. Grassley previously served as the Chair of the Finance Committee in 2001 and from 2003-2007. He will give up his current Chairmanship of the Senate Judiciary Committee for the Finance gavel. Sen. Lamar Alexander (R-TN) will continue to Chair the Senate Health, Education, Labor and Pensions (HELP) Committee.

Rep. Richard Neal (D-MA) will Chair the House Ways and Means Committee, and Rep. Frank Pallone (D-NJ) will lead the House Energy and Commerce Committee. Nita Lowey (D-NY) is expected to become Chair of the House Appropriations Committee. All three were Ranking Member on their respective Committees during this Congress. The Ways and Means Committee and Energy and Commerce Committee have jurisdiction over most healthcare issues in the House. The Appropriations Committee controls how the government is funded.

The Chairs of the subcommittees within these committees are still being decided. Also, the addition of two Republican Senate seats will likely increase the number of Republicans in relation to Democrats on Senate Committees. This will lead to more reshuffling of Senate committees.

Return to Top

Partial Government Funding Fight on the Horizon

- Congress passed a short-term funding extension for several federal agencies while it negotiates outstanding policy issues.
- Funding for these agencies was set to expire on December 8th. Congress extended funding through December 21st, at which point a further extension of funding must be passed in order to prevent a shutdown of the agencies funded by these bills.

Federal funding for several government agencies was set to expire on Friday, December 7th. However, Congress passed legislation to extend funding until December 21st which staves off a shutdown of those agencies for two weeks while Congress and the President attempt to compromise on a full-fiscal year funding bill.

Every year, Congress must pass 12 appropriations bills that fund the government for the coming fiscal year. Congress completed passage of many of the appropriations bills but not all. Congress passed a short-term funding bill that expires on December 8th for the agencies funded by the bills for which Congress has yet to pass an appropriations bill.

Congress has yet to pass a full fiscal year Interior-Environment, Financial Services, Transportation-Housing and Urban Development (HUD), Agriculture-Food and Drug Administration (FDA), Homeland Security, Commerce-Justice-Science, or State and Foreign Operations appropriations bills.

Congress already passed legislation that funds the Department of Health and Human Services (HHS) and its sub-agencies such as the Centers for Medicare and Medicaid Services (CMS) for the 2019 Fiscal Year.

This funding bill is perhaps the last piece of legislation that will move through both Chambers of Congress before the new Congress is sworn into office in January. Therefore, it is the final opportunity for Congress or the President to attach pet policy provisions, many of which are politically charged. Perhaps the most notable of these provisions is an increase in funding for a wall along our border with Mexico that is being pushed by President Trump.

Congress was gearing up for a fight over these provisions. However, the death of President George H.W. Bush postponed votes for much of the week of December 3rd to allow Congress to honor the passing of our 41st President. The delay of votes meant that Congress did not have time to finish negotiating a solution to these issues before December 8th.

As a result, Congress passed a short-term Continuing Resolution (CR) that extends funding for these agencies until December 21st. Failure to extend funding beyond this day with either a CR or a full-fiscal year spending bill will result in a shutdown of the agencies funded by these bills.

Return to Top

CMS Proposed Rule on Drug Prices Will Affect Part B Drugs

- CMS proposed a rule to provide greater flexibility for Medicare Part C and D drug benefit designs.
- CMS is also proposing to apply step therapy for Part B drugs.

The Centers for Medicare and Medicaid Services issued a proposed rule to reform how prescription drugs, including drugs administered in physician office settings, are covered by Medicare Parts C and D plans.

Among the key provisions of the proposed rule, CMS is proposing requirements for how Medicare Advantage plans can apply "step therapy" for drugs administered in a physician office setting. Step therapy is a policy in which an insurer requires a provider to try a specific, often cheaper, drug/treatment before it will approve coverage for a more expensive drug/treatment.

Under the proposal, step therapy requirements would only apply to new starts of medication. Applications to use step therapy would also be required to be reviewed and approved by the health plan's pharmacy and therapeutics committee.

Within Part D, CMS is proposing changes to the Part D plan coverage requirements for the six "protected class" drug types. Part D plans are required to cover drugs in all six classes which are:

1. Antidepressants;
2. Antipsychotics;

3. Anticonvulsants;
4. Immunosuppressants for treatment of transplant rejection;
5. Antiretrovirals; and
6. Antineoplastics.

The proposal would provide Part D plans with greater flexibility to negotiate discounts for drugs in "protected" therapeutic classes. CMS believes the reduced costs will be passed on to consumers. CMS is proposing to:

1. Implement broader use of prior authorization and step therapy for protected class drugs,
2. Exclude a protected class drug from a formulary if the drug represents only a new formulation of an existing single-source drug or biological product, regardless of whether the older formulation remains on the market; and
3. Exclude a protected class drug from a formulary if the price of the drug increased beyond a certain threshold over a specified look-back period.

CMS is also considering revising how it calculates a Part D drug's "baseline price" that is used to calculate Part D reimbursement and cost-sharing.

The proposed rule also would implement a Congressionally-passed ban on "gag clauses" that prevent pharmacies from informing patients if a drug is cheaper if they pay out of pocket instead of through their insurance.

Return to Top

Online Tool Compares Price of Medicare Outpatient Services

- CMS published a new online tool to show the average cost of Medicare Services performed in hospital outpatient departments and ambulatory surgical centers.
- The tool also estimates beneficiary cost sharing.

The Centers for Medicare and Medicaid Services (CMS) rolled out a new, online Procedure Price Lookup tool that allows beneficiaries to see the average Medicare fee-for-service (FFS) cost for services performed in hospital outpatient departments (HOPD) and ambulatory surgical centers (ASC). The tool also estimates the beneficiary's cost-sharing for the procedure.

CMS was required to create this tool under the 21st Century Cures Act that passed in 2016.

This tool builds on CMS' efforts to improve price transparency for consumers. The 2019 Hospital Inpatient Prospective Payment System (IPPS) final rule requires hospitals to list their standard charge for the services they provide on a publicly available website. CMS also issued a proposed rule that, if finalized, would require drug manufacturers to display a drug's list price in television advertisements.

The new lookup tool does not include the average Medicare FFS cost for physician fee schedule (PFS) services. However, it is not unreasonable to expect CMS price transparency initiatives to extend to physician office settings in the future.

Return to Top

Provider Enrollment Application Fee Updated for 2019

- CMS announced the provider enrollment application fee for 2019 will be $586.
- This fee applies to providers newly enrolling in the Medicare program as well as provider revalidations.

The Centers for Medicare and Medicaid Services (CMS) announced that the provider enrollment application fee for 2019 will be $586. This is a slight increase from the 2018 enrollment fee of $569.

The enrollment application fee applies to "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

An "institutional provider" for purposes of Medicare is defined as "(a)ny provider or supplier that submits a paper Medicare enrollment application using the CMS-855A, CMS-855B (not including physician and non-physician practitioner organizations), CMS-855S, CMS-20134, or associated internet-based PECOS enrollment application."

This fee is required with any enrollment application submitted from January 1 through December 31, 2019.

Return to Top

CMS Report Details Increase in Telehealth Services Utilization

- CMS published a Congressionally-mandated report on the utilization of telehealth services.
- The report highlights the types of services that utilize telehealth services as well as statutory barriers to greater adoption.

The Centers for Medicare and Medicaid Services (CMS) published a report on the utilization of Medicare telehealth services in 2016. The report also describes policy barriers that prevent greater utilization rates. Congress required CMS to issue this report in the 21st Century Cures Act of 2016.

According to the report, about 90,000 Medicare fee-for-service beneficiaries utilized 275,199 telehealth services in 2016, representing one-quarter of a percent (0.25%) of the more than 35 million Medicare FFS beneficiaries included in the analysis. The 2016 utilization figure is a 48 percent increase compared to 2014.

The report shows significant growth in utilization among the oldest population—beneficiaries 85 years and older. A majority of all beneficiaries using telehealth (85.4 percent) had at least one mental health diagnosis, and psychotherapy is among the services most commonly furnished through telehealth. The data also suggests that the use of telehealth services is concentrated in states that have large rural areas. The ten states with the highest utilization of telehealth services are Texas, Iowa, California, Missouri, Michigan, Minnesota, Wisconsin, Georgia, Virginia, and Kentucky.

The report highlights how Medicare's statutory authority for telehealth reimbursement limits telehealth utilization rates. For example, Medicare telehealth reimbursement is limited to services on the list of covered Medicare telehealth services, which includes the services specified in the statute and other services that are added through the annual Physician Fee Schedule notice and comment rulemaking.

Telehealth reimbursement is also limited to real-time encounters. Store-and-forward visits are only covered through small demonstration projects. Telehealth services can only be delivered using the originating/distant site model. There are many statutory limitations to what types of facilities can be a telehealth originating site.

Return to Top

ACA Enrollment Update

- Open enrollment for the 2019 plan year for the federal health insurance exchange (healthcare.gov) established under the Affordable Care Act (ACA) began on November 1st and ends on December 15th.
- As of November 24th, 2.42 million people were enrolled in health plans through the federal exchange.
- As of September 15th, 10.3 million consumers were still enrolled in their 2018 health plan.

Open enrollment for the 2019 plan year for the federal health insurance exchange (healthcare.gov) established under the Affordable Care Act (ACA) began on November 1st and ends on December 15th. As of November 24th, 2.42 million people were enrolled in health plans through the federal exchange. Of this total, 1.83 million are consumers who renewed coverage from last year while 588,131 were new customers.

These enrollment figures do not include consumers who enrolled in a state that facilitates its own health insurance exchange.

The Centers for Medicare and Medicaid Services (CMS) also published updated 2018 plan year enrollment data. As of September 15th, 10.3 million consumers were still enrolled in their 2018 health plan. This represents about a 1.5 million coverage loss over this period compared to the end of the 2018 open enrollment period.

CMS' data also shows that the average monthly premium across all federal exchange plan types for all enrollees over the first six months of 2018 was $595.89. Enrollees received an average of $519.18 in monthly premium tax credits.

2019 is the first plan year for which there will be no individual mandate penalty for failing to maintain qualified insurance coverage. The Trump Administration has also used the regulatory process to expand the availability of non-exchange plans such as association health plans (AHP) and short-term limited duration health insurance plans (STLDI).

Return to Top

CMS Proposes Rule to Give States More Medicaid Managed Care Authorities

- A CMS proposed rule would give states greater authority to set network adequacy requirements for Medicaid managed care plans.
- States would be able to establish their own network adequacy standard rather than be required to use the federal time and distance standard.

A proposed rule issued by the Centers for Medicare and Medicaid Services (CMS) on November 14th would provide states with greater flexibility to set regulations for Medicaid managed care plans.

States are increasingly moving towards managed care models for their Medicaid programs as they seek greater budget certainty and look to get out of the insurance business. According to a Government Accountability Office (GAO) report, federal spending on services paid for under Medicaid managed care was $171 billion in 2017, almost half of the total federal Medicaid expenditures for that year.

Among the notable provisions of the proposed rule is a proposal to allow states more authority to set network adequacy requirements. States are currently required to use a specific time and distance standard for network adequacy regulations. The proposed rule would give states the ability to set their own minimum access standard. The new standard could use a time and distance standard, but states would have the flexibility to use measures such as provider to enrollee ratios or other access-to-care factors instead of (or in addition to) time and distance.

The proposed rule also would expand the ability of managed care plans to cover telehealth services and would increase federal program integrity efforts for managed care payments.

Return to Top

Beneficiaries in Final States Receive New Medicare Cards

- CMS is in the seventh and final mailing wave of new Medicare beneficiary cards.
- The new cards replace the HICN with a new MBI.
- Providers can submit claims with either the HICN or MBI through 2019. Beginning in 2020, CMS will only accept claims with an MBI.

The Centers for Medicare and Medicaid Services (CMS) effort to issue new Medicare cards to all Medicare beneficiaries is nearly complete. The final of seven mailing waves is underway and will soon be complete. The following states and territories make up the final wave: Kentucky, Louisiana, Michigan, Mississippi, Missouri, Ohio, Puerto Rico, Tennessee, Virgin Islands.

Congress required CMS to issue new Medicare cards to all beneficiaries over concerns that the Social Security Number (SSN)-based Health Insurance Claim Number (HICN) posed a fraud and identity theft risk to beneficiaries. Congress required CMS to replace all Medicare cards with a card that has a unique alpha-numeric number called a Medicare Beneficiary Identifier (MBI).

Healthcare providers can submit claims with either the HICN or MBI through 2019. However, beginning on January 1, 2020, CMS will only accept claims with an MBI.

Return to Top

CMS Publishes Four Recommended ACA Waiver Concepts

- CMS published a guide to states to help them understand how to use the ACA's section 1332 waiver process to reform their individual and small group healthcare markets.
- This fact sheet provides examples of the types of reforms states can propose in waiver requests.

The Centers for Medicare and Medicaid Services (CMS) published a fact sheet that outlines four concepts that states can use for requests to waive specific requirements of the Affordable Care Act (ACA).

States can submit section 1332 waivers to seek approval from CMS to implement their own version of ACA requirement. This process is intended to provide states with the ability to design innovative healthcare systems.

Waiver requests are required to meet four statutory guardrails relating to comprehensiveness, affordability, coverage, and federal deficit neutrality.

This fact sheet is intended to provide states with examples of the types of innovations CMS will approve under the section 1332 waiver process. The four waiver concepts are:

1. **Account-Based Subsidies**: Under this waiver concept, a state can direct public subsidies into a defined-contribution, consumer-directed account that an individual uses to pay for health insurance premiums or other health care expenses. The account could be funded with pass-through funding made available by waiving the Premium Tax Credit (PTC) under section 36B of the Internal Revenue Code (IRC) or the small business health care tax credit under section 45R of the IRC. The account could also allow individuals to aggregate funding from additional sources, including individual and employer contributions. An account-based approach could give beneficiaries more choices and require them to take responsibility for

managing their health care spending. This approach could also allow a consumer greater ability to select a plan based on the individual's or their family's needs, including a higher deductible plan with lower premiums.

2. **State-Specific Premium Assistance**: States can use the State-Specific Premium Assistance waiver concept to create a new, state-administered subsidy program. A state may design a subsidy structure that meets the unique needs of its population in order to provide more affordable health care options to a broader range of individuals, attract more young and healthy consumers into their market, or to address structural issues that create perverse incentives, such as the subsidy cliff. States may receive federal pass-through funding by waiving the PTC under section 36B of the IRC to help fund the state subsidy program.

3. **Adjusted Plan Options**: Under this waiver concept, states would be able to provide financial assistance for different types of health insurance plans, including non-Qualified Health Plans, potentially increasing consumer choice and making coverage more affordable for individuals. For example, states could choose to expand the availability of catastrophic plans beyond the current eligibility limitations by waiving the applicable section of the ACA. Used in conjunction with the Account-based Subsidy waiver concept, states could provide subsidies in the form of contributions to accounts, allowing individuals to use the funds to purchase coverage that is right for them and use any remaining funds in the account to offset out-of-pocket health care expenses.

4. **Risk Stabilization Strategies**: To address risk associated with individuals with high health care costs, this waiver concept gives states more flexibility to implement reinsurance programs or high-risk pools. For example, a state can implement a state-operated reinsurance program or high-risk pool by waiving the single risk pool requirement under the ACA. Reinsurance programs have lowered premiums for consumers, improved market stability, and increased consumer choice. To date, States have chosen to use a variety of models to operate their state-based reinsurance programs, using flexibility available under section 1332. These models include a claims cost-based model, a conditions-based model, and a hybrid conditions and claims cost-based model. If the state shows an expected reduction in federal spending on PTC, the state can receive federal pass-through funding to help fund the state's high risk pool/reinsurance program.

Return to Top

House Passes Bill to Codify Healthcare Fraud Prevention Partnership's Authority

- The House of Representatives passed a bill that codifies the Healthcare Fraud Prevention Partnership and better defines its purpose.
- The HFFP already exists as a public-private partnership facilitated by CMS to foster data sharing to combat healthcare fraud.

- Separate from this bill, CMS announced that the Medicare Fee-for-Service (FFS) improper payment rate has improved to the lowest rate since 2010, representing a $4.59 billion decrease in estimated improper payments.

On November 28th the House of Representatives passed H.R. 6753, the Strengthening the Health Care Fraud Prevention Task Force Act by a voice vote. The bill now goes to the Senate where it is pending further action.

H.R. 6753 codifies the Healthcare Fraud Prevention Partnership (HFPP), a voluntary public-private partnership between the federal government, state agencies, law enforcement, private health insurance plans, and healthcare anti-fraud associations that facilitates the sharing of data to identify and prevent healthcare fraud. The HFPP also facilitates fraud prevention education.

The HFPP improves the detection and prevention of healthcare fraud by:

- Exchanging data and information between the public and private sectors.
- Leveraging various analytic tools against data sets provided by HFPP partners.
- Providing a forum for public and private leaders and subject matter experts to share successful anti-fraud practices and effective methodologies for detecting and preventing healthcare fraud.

Although the HFPP already exists as a Centers for Medicare and Medicaid Services (CMS) initiative, this bill codifies and describes the HFPP's authority including the responsibilities of each type of HFPP member.

Separate from this bill, CMS announced that the Medicare Fee-for-Service (FFS) improper payment rate has improved to the lowest rate since 2010, representing a $4.59 billion decrease in estimated improper payments. The 2018 Medicare-FFS improper payment rate decreased from 9.51 percent ($36.2 billion) in 2017 to 8.12 percent ($31 billion) in 2018. According to CMS, this is the second consecutive year the rate has been below 10 percent.

Some of the largest gains came from improved oversight of home health payments. According to the announcement, the home health improper payment rate decreased from 58.95 percent in 2015 to 17.61 percent in 2018. Skilled Nursing Facility (SNF) and Durable Medical Equipment (DME) payments were another source of improvements.

CMS cites prior authorization, enhanced audit programs, and targeting high-risk providers as successful strategies in reducing improper payments.

Return to Top

CMS Transmittals

CMS issued the following transmittals in November.

Transmittal Number	Subject	Effective Date
4171CP	Instructions for Downloading the Medicare ZIP Code Files for April 2019	2019-04-01
R4172CP	Ambulance Inflation Factor for Calendar Year 2019 and Productivity Adjustment	2019-01-07
R210NCD	National Coverage Determination (NCD90.2): Next Generation Sequencing (NGS)	2019-03-08
R4173CP	Revision of Definition of the Physician Supervision of Diagnostic Procedures, Clarification of DSMT Telehealth Services, and Establishing a Modifier for Expanding the Use of Telehealth for Individuals with Stroke	2019-01-02
R4177CP	File Conversions Related to the Spanish Translation of the Healthcare Common Procedure Coding System (HCPCS) Descriptions	2019-01-07
R251BP	Revision of Definition of the Physician Supervision of Diagnostic Procedures, Clarification of DSMT Telehealth Services, and Establishing a Modifier for Expanding the Use of Telehealth for Individuals with Stroke	2019-01-02
R4175CP	Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Edits, Version 25.0 Effective January 1, 2019	2019-01-07
R4176CP	Summary of Policies in the Calendar Year (CY) 2019 Medicare Physician Fee Schedule (MPFS) Final Rule, Telehealth Originating Site Facility Fee Payment Amount and Telehealth Services List, CT Modifier Reduction List, and Preventive Services List	2019-01-07
R2208OTN	Implementing the Insertion of a Sheet of Paper Promoting the Electronic Medicare Summary Notices (eMSNs) into Mailed Medicare Summary Notices (MSNs)	2019-01-07
R4178CP	Annual Update to the Per-Beneficiary Therapy Amounts	2019-01-07
R2207OTN	Targeted Probe and Educate	2018-10-01
R215DEMO	Next Generation Accountable Care Organization (NGACO) Model Post Discharge Home Visit HCPCS	2019-04-01
R2206OTN	Implementation of a Bundled Payment for Multi-Component Durable Medical Equipment (DME)	2019-01-07
R209NCD	National Coverage Determination (NCD) 20.4 Implantable Cardiac Defibrillators (ICDs)	2019-02-26
R185SOMA	Revisions to the State Operations Manual (SOM) Chapter 7	2018-11-16
R4167CP	Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update	2019-04-01

R4168CP	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	2019-04-01
R4170CP	Quarterly Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement	2019-04-01
R211DEMO	IVIG Demonstration: Payment Update for 2019	N/A
R4169CP	New Waived Tests	2019-01-07
R2204OTN	Update to the Long Description for Spanish Records on The Procedure Descriptor Master File for all Adds and Updates That Were Not Loaded with Change Request (CR) 10286	N/A
R250BP	Implementation of Changes in the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Payment for Dialysis Furnished for Acute Kidney Injury (AKI) in ESRD Facilities for Calendar Year (CY) 2019	2019-01-07
R4164CP	Instructions for Retrieving the 2019 Pricing and Healthcare Common Procedure Coding System (HCPCS) Data Files through CMS' Mainframe Telecommunications Systems	2019-01-07
R2195OTN	Analysis to Discuss and Resolve the Challenges Around the Design of (Pre-/Post-Pay) Electronic Medical Documentation Requests (eMDR) via the Electronic Submission of Medical Documentation (esMD) System	2019-04-01
R2196OTN	Analysis to Create a Standard Coded List of Document Types to be used by Review Contractors (RC) for Requesting Documentation in Pre-Pay and Post-Pay Additional Documentation Request (ADR) Letters (and/or Electronic Medical Documentation Requests (eMDR) via the Electronic Submission of Medical Documentation (esMD) System)	2019-04-08
R2197OTN	ViPS Medicare System (VMS) Prepayment Review File	2019-04-01
R2199OTN	Appeon PowerBuilder Upgrade Analysis Only	2019-04-01
R2198OTN	Enhancing the Verification Process of Common Working File (CWF) Part A Provider Inquiries	N/A
R4166CP	Revisions to Medicare Claims Processing Manual Reference to Burn Medicare Severity-Diagnostic Related Groups (MS-DRGs) for Transfer Policy	2018-12-11

R40COM	Medicare Contractor Beneficiary and Provider Communications Manual IOM Pub. 100-09 Chapter 5 Correct Coding Initiative	2018-12-11
R2201OTN	User CR: Fiscal Intermediary Shared System (FISS) - Implementation of the Molecular Diagnostic Services (MolDX)	2019-04-01
R2202OTN	International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs)	2019-04-01
R2203OTN	User CR: FISS to Add Location/Statuses to the 6H File Fix	2019-01-07
R2200OTN	International Classification of Diseases, Tenth Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs)	N/A
R4165CP	Calendar Year (CY) 2019 Participation Enrollment and Medicare Participating Physicians and Suppliers Directory (MEDPARD) Procedures	2018-10-19
R2178OTN	Removal of the Provider Requirement for Reporting on an Institutional Claim a Value Code (VC) 05 - Professional Component-Split Implementation	N/A
R4157CP	Hospital and Critical Access Hospital (CAH) Swing-Bed Manual Revisions and Shared Systems Changes	2019-04-01
R2176OTN	Revision of Skilled Nursing Facility (SNF) Consolidated Billing (CB) Edits for Ambulance Services Rendered to Beneficiaries in a Part A SNF Stay	2019-04-01
R2183OTN	Shared System Enhancement 2018: Move Authorized Reason Code Override Processing to FSSBSTUF	N/A
R2181OTN	User CR: ViPS Medicare System (VMS) Changes to Bypass Claim Edit 0192 on an Adjustment Claim when Payment was Suppressed on the Previous Adjustment	2019-04-01
R4160CP	Modifications to the National Coordination of Benefits Agreement (COBA) Crossover Process	2019-04-01
R2180OTN	FISS Integrated Outpatient Code Editor (IOCE) Claim and Return Buffer Interface Changes Related to new Contractor Line Level Bypass Updates	2019-04-01
R2179OTN	User Change Request (CR): ViPS Medicare System (VMS) Changes to Edit Dispensing and Supply Fee Codes Allowed when Related Drug Codes are Denied in Batch	2019-04-01
R119GI	Update to Medicare Deductible, Coinsurance and Premium Rates for 2019	2018-11-02
R120GI	Internet Only Manual Updates to Pub. 100-01, 100-02 and 100-04 to Correct Errors and Omissions (SNF) (2018 Q4)	2018-12-04

R249BP	Internet Only Manual Updates to Pub. 100-01, 100-02 and 100-04 to Correct Errors and Omissions (SNF) (2018 Q4)	2018-12-04
R2189OTN	User CR: Update FISS Utility to Retain Original Claim Receipt Date	2019-04-01
R2182OTN	User Change Request (CR): Multi-Carrier System (MCS) - Analysis to Enhance the Maximum Claim Counter Process for Edits and Audits	2019-04-01
R2191OTN	Multi-Carrier System (MCS) Prepayment Review File	2019-04-01
R2190OTN	Shared System Enhancement 2018: Improve Organization of the International Code of Diseases, Tenth Revision (ICD-10) File during Creation	2019-04-01
R2186OTN	Shared System Enhancement 2018: Analysis to Minimize Data for Medicare Beneficiary Database (MBD) Extract	2019-04-01
R2185OTN	User Change Request (CR): Multi-Carrier System (MCS) - Enhance System Control Facility (SCF) to Add Fraud Prevention System (FPS) Criteria	2019-04-01
R2187OTN	Shared System Enhancement 2018: Rewrite Fiscal Intermediary Shared System (FISS) module FSSB6001, Common Working File (CWF) Unsolicited Response Function	N/A
R2188OTN	Fiscal Intermediary Standard System (FISS) Prepayment Review Report	2019-04-01
R2192OTN	Implementation of Healthcare Common Procedure Coding System (HCPCS) Code J3591 and Additional Changes for End Stage Renal Disease (ESRD) Claims	2019-01-07
R2194OTN	Medicare Cost Report E-Filing (MCReF)	N/A
R2193OTN	Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Update	2019-01-07

Return to Top