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Official CMS news from the Medicare Learning Network®

Thursday, October 24, 2019

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News

New Medicare Card: Claim Reject Codes After January 1

Starting January 1, 2020, you must use Medicare Beneficiary Identifiers (MBIs) when billing Medicare regardless of the date of service:
- We will reject claims submitted with Health Insurance Claim Numbers (HICNs) with a few exceptions
- We will reject all eligibility transactions submitted with HICNs

If you do not use MBIs on claims after January 1, you will get:
- Electronic claims reject codes: Claims Status Category Code of A7 (acknowledgment rejected for invalid information), a Claims Status Code of 164 (entity's contract/member number), and an Entity Code of IL (subscriber)
- Paper claims notices: Claim Adjustment Reason Code (CARC) 16 "Claim/service lacks information or has submission/billing error(s)" and Remittance Advice Remark Code (RARC) N382 "Missing/incomplete/invalid patient identifier"

Do not wait. Protect your patients' identities by using MBIs now for all Medicare transactions. Need an MBI?
- Ask your patients for their cards. If they did not get a new card, give them the Get Your New Medicare Card flyer in English or Spanish.
- Use your Medicare Administrative Contractor's look-up tool. Sign up for the Portal to use the tool.
- Check the remittance advice. We return the MBI on the remittance advice for every claim with a valid and active HICN.

For more information, see the MLN Matters Article.

Take Medicare Fraud, Waste and Abuse Fighting Further, Through Innovation

CMS is looking for innovative program integrity solutions to meet the challenges of the new Medicare landscape. We live in a more complex world today than we did when the Medicare program was created. As the Medicare program has evolved, so have our efforts to combat fraud, waste and abuse to ensure we "pay it right." What new solutions can we implement? What does the future of program integrity look like? You tell us.

On October 21, we announced two Requests for Information (RFIs), open until November 20:

- Future of Program Integrity RFI seeks information on how we can better align our initiatives with the changing health care environment. How can we modernize program integrity strategies for value-based programs, improve prior authorization for Medicare fee-for-service, and improve provider education with innovative solutions?
- Advanced Technology in Program Integrity RFI asks: How can we use the latest technology such as artificial intelligence to ensure proper claims payment, reduce provider burden, and maximize efficiency? We want to hear your ideas on technology that could be applied to provider enrollment, electronic health records, and data and analytics systems.

Hear from Administrator Seema Verma on why we are asking for your help.

Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier

Medicare pays Medicare Diabetes Prevention Program (MDPP) suppliers to furnish group-based intervention to at-risk Medicare beneficiaries:

- Centers for Disease Control and Prevention (CDC)-approved National Diabetes Prevention Program curriculum
- Up to 2 years of sessions delivered to groups of eligible beneficiaries

Find out how to become a Medicare enrolled MDPP supplier:

- Obtain CDC preliminary or full recognition: Takes at least 12 months to obtain preliminary recognition and up to 24 additional months to achieve full recognition; see the Supplier Fact Sheet and CDC website for more information
- Prepare for Medicare enrollment; see the Enrollment Fact Sheet and Checklist
- Apply to become a Medicare enrolled MDPP supplier (existing Medicare providers must re-enroll), See the Enrollment Webinar Recording and Enrollment Tutorial Video
- Furnish MDPP services; see the Session Journey Map
- Submit claims to Medicare; view the Billing and Claims Webinar Recording; see the Billing and Claims Fact Sheet and Billing and Payment Quick Reference Guide

For More Information:

- MDPP Expanded Model Booklet
- Materials from Medicare Learning Network call on June 20, 2018
- MDPP webpage
- CDC - CMS Roles Fact Sheet
- Contact the MDPP Help Desk at mdpp@cms.hhs.gov

Compliance

Proper Coding for Specimen Validity Testing Billed in Combination with Urine Drug Testing

In a February 2018 report, the Office of the Inspector General (OIG) determined that Medicare payments to clinical laboratories and providers for specimen validity tests did not comply with Medicare billing requirements.

A recent MLN Matters Special Edition Article reminds laboratories and other providers about proper billing for specimen validity testing done in conjunction with drug testing; this article contains no policy changes.

Current coding for testing for drugs of abuse relies on a structure of presumptive and definitive testing that identifies the specific drug and quantity in the patient. This article includes descriptors for:

- Presumptive drug testing codes
- Definitive drug testing codes

Use the following resources to bill correctly and avoid overpayment recoveries:

- National Correct Coding Initiative Policy Manual
- Contact your Medicare Administrative Contractor
- Medicare Improperly Paid Providers for Specimen Validity Tests Billed in Combination with Urine Drug Tests OIG Report

Claims, Pricers & Codes

ICD-10 Vaping Coding Guidance

A supplement to the ICD-10-CM Official Coding Guidelines is available for encounters related to e-cigarette, or vaping, product use. Visit the 2020 ICD-10-CM webpage for more information.

Events

Submitting Your Medicare Part A Cost Report Electronically Webcast — November 5

Tuesday, November 5 from 1 to 2:30 pm ET

Register for Medicare Learning Network events.

Medicare Part A providers: Learn how to use the new Medicare Cost Report e-Filing (MCReF) system. Use MCReF to submit cost reports with fiscal years ending on or after December 31, 2017. You have the option to electronically transmit your cost report through MCReF or mail or hand deliver it to your Medicare Administrative Contractor. You must use MCReF if you choose electronic submission of your cost report. Note: This content was presented in prior webcasts on May 1 and October 15, 2018 and March 28, 2019.

Topics:

- How to access the system
- Detailed overview
- Frequently asked questions

A question and answer session follows the presentation; however, attendees may email questions in advance to OFMDPAOQuestions@cms.hhs.gov with “Medicare Cost Report e-Filing System Webcast” in the subject line. These questions may be addressed during the webcast or used for other materials following the webcast. For more information, see the MCReF Medicare Learning Network Booklet, MCReF MLN Matters Article, and MCReF webpage.

CMS will use webcast technology for this event with audio streamed through your computer. If you are unable to stream audio, phone lines are available.

Target Audience: Medicare Part A providers and entities that file cost reports for providers.

Clinical Diagnostic Laboratory Test Payment System: Data Reporting Call — November 14

Thursday, November 14 from 2 to 3 pm ET

Register for Medicare Learning Network events.

During this call, learn how to report data required by the Clinical Diagnostic Test Payment System final rule. CMS demonstrates how to register in the system and submit then certify data. Laboratories, including physician offices laboratories and hospital outreach laboratories that bill using a 14X TOB are required to report laboratory test HCPCS codes, associated private payor rates, and volume data if they:

- Have more than $12,500 in Medicare revenues from laboratory services on the Clinical Laboratory Fee Schedule (CLFS), and
- Receive more than 50 percent of their Medicare revenues from CLFS and physician fee schedule services during a data collection period

CMS will use this data to set Medicare payment rates effective January 1, 2021. For more information, visit the PAMA Regulations webpage.

A question and answer session follows the presentation; however, you may email questions in advance to CLFS_Inquiries@cms.hhs.gov with "November 14 Call" in the subject line. These questions may be addressed during the call or used for other materials following the call.

Target Audience: Clinical diagnostic laboratories, including physician offices and hospital outreach laboratories.

MLN Matters® Articles

Updating Calendar Year (CY) 2020 Medicare Diabetes Prevention Program (MDPP) Payment Rates

A new MLN Matters Article MM11455 on Updating Calendar Year (CY) 2020 Medicare Diabetes Prevention Program (MDPP) Payment Rates is available. Learn about HCPCS G-codes and payment amounts for 2020.

Multimedia

CDC Opioids Training Module for Nurses

The Centers for Disease Control and Prevention (CDC) released a new module, A Nurse's Call to Action for Safer Opioid Prescribing Practices in the interactive online training series, Applying CDC's Guideline for Prescribing Opioids. In this module, nurses learn how they can support the implementation of the CDC Guideline to address the opioid overdose epidemic.

Each module offers free continuing education and includes clinical scenarios, knowledge feedback prompts, and a resource library to enhance learning.

Quality Payment Program: APMs Web-Based Training

CMS posted five Continuing Medical Education (CME) modules on Alternative Payment Models (APMs). Access them by logging into the Medicare Learning Network Learning Management System. Modules include:

- Quality Payment Program 2019 Overview: Information on the origin and objectives of the program, the Merit-based Incentive Payment System (MIPS), and Advanced APMs
- Transitioning to an Advanced APM: 2019 Update: Benefits and features of Advanced APM participation, how to prepare to join an Advanced APM, and resources to help with the transition
- Quality Payment Program for MIPS APMs in 2019: Overview, benefits of participation, and reporting criteria
- Quality Payment Program for Advanced APMs in 2019: Identifies the different Advanced APMs, participation and reporting requirements, and information on achieving Qualifying APM Participant (QP) status
- Quality Payment Program: All-Payer Combination Option in 2019: Explains the option, criteria for Other Payer Advanced APM participation, and QP determinations

For More Information:

- Resource Library webpage
- Contact QPP@cms.hhs.gov or 866-288-8292 (TTY: 877-715-6222)

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