CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

# mlnconnects

Official CMS news from the Medicare Learning Network

**Thursday, July 5, 2018**



## News & Announcements

### New Medicare Card: MBI Changes

There are times when a Medicare Beneficiary Identifier (MBI) may change. People with Medicare or their authorized representatives can request an MBI change. CMS can also initiate a change to an MBI (for example, if the MBI is compromised). There are different scenarios for using the old or new MBIs:

Fee-For Service (FFS) claims submissions with:

- Dates of service before the MBI change date – use the old or new MBI
- Span-date claims with a “From Date” before the MBI change date – use the old or new MBI
- Dates of service that are entirely on or after the effective date of the MBI change – use the new MBI

FFS eligibility transactions when the inquiry:

- Uses new MBI – we will return all eligibility data

- Uses the old MBI and request date or date range overlap the active period for the old MBI – we will return all eligibility data and the old MBI termination date
- Uses the old MBI and request date or date range are entirely on or after the effective date of the new MBI – we will return an error code (AAA 72) of "invalid member ID"

When the MBI changes, we ask people with Medicare to share the new MBI with you. You can also get the MBI from your Medicare Administrative Contractor's secure MBI lookup tool.

Remember:
To ensure people with Medicare continue to get health care services, you can continue to use the Health Insurance Claim Number through December 31, 2019, or until your patient brings in their new card with the new number.

We finished mailing most cards to people with Medicare who live in Wave 1 states: Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, and West Virginia. If someone with Medicare says they did not get a card:

- Print and give them the "Still Waiting for Your New Card?" handout (in English or Spanish).
- Or tell them to call 1-800-Medicare (1-800-633-4227). There might be something that needs to be corrected, such as updating their mailing address.

## MIPS Payment Adjustment Targeted Review: Request by September 30

If you participated in the Merit-based Incentive Payment System (MIPS) in 2017, your MIPS final score and performance feedback is available for review on the Quality Payment Program website. If you believe an error has been made in your 2019 MIPS payment adjustment calculation, you can request a targeted review until September 30.

For More Information:

- Performance Feedback Fact Sheet
- Targeted Review Fact Sheet
- Targeted Review User Guide
- If you have questions about your performance feedback or MIPS final score, contact the Quality Payment Program at 866-288-8292 (TTY: 877-715-6222) or QPP@cms.hhs.gov

## Open Payments Program 2017 Financial Data

CMS published Open Payments Program Year 2017 data, along with newly submitted and updated payment records for previous program years on the Open Payments Data website. In Program Year 2017, applicable manufacturers and Group Purchasing Organizations (GPOs) reported $8.4 billion in payments and ownership and investment interests to physicians and teaching hospitals. This amount is comprised of 11.54 million total records attributable to 628,214 physicians and 1,158 teaching hospitals. Payments are reported in three payment categories for Program Year 2017:

- $2.82 billion in general payments
- $4.66 billion in research payments
- $927 million of ownership or investment interests held by physicians or their immediate family members

CMS is scheduled to refresh the Open Payments data in early 2019 to reflect updates to the data made since this publication. Visit the Open Payments website for more information.

## Laboratory Date of Service Exception

CMS will exercise enforcement discretion until January 2, 2019, for the laboratory date of service exception policy for advanced diagnostic laboratory tests and molecular pathology tests excluded from the Medicare

hospital outpatient prospective payment system packaging policy. Visit the Laboratory Date of Service Policy webpage for more information.

### Qualified Medicare Beneficiary Information on RAs and MSNs

Medicare providers may not bill beneficiaries enrolled in the Qualified Medicare Beneficiary (QMB) program for Medicare Parts A and B deductibles, coinsurance, or copays, but state Medicaid programs may pay for those costs. To make it easier to identify the QMB status of your patients, CMS reintroduced QMB information in provider Remittance Advices (RAs) and Medicare Summary Notices (MSNs) for claims processed on or after July 2, 2018. You can also verify QMB enrollment by using Medicare eligibility information returned by the CMS Health Insurance Portability and Accountability Act (HIPAA) Eligibility Transaction System (HETS) 270/271 application.

For More Information:

- Reinstating the QMB Indicator MLN Matters Article
- Prohibition on Billing Dually Eligible Individuals Enrolled in the QMB Program MLN Matters Article
- QMB Program webpage
- Materials from June 6 Medicare Learning Network call, including presentation and FAQs

## Provider Compliance

### Hospice Election Statements Lack Required Information or Have Other Vulnerabilities — Reminder

After a stratified random sample review of hospice election statements and certifications of terminal illness, the Office of the Inspector General (OIG) reports that more than one-third of hospice General Inpatient (GIP) stays lack required information or had other vulnerabilities.

- Hospice election statements did not always mention – as required – that the beneficiary was waiving coverage of certain Medicare services by electing hospice care or that hospice care is palliative rather than curative
- In 14 percent of GIP stays, the physician did not meet requirements when certifying that the beneficiary was terminally ill and appeared to have limited involvement in determining that the beneficiary's condition was appropriate for hospice care

Hospices should improve their election statements and ensure that physicians meet requirements when certifying beneficiaries for hospice care. Resources:

- Hospices Should Improve Their Election Statements and Certifications of Illness OIG Report, September 2016.
- Hospice Payment System Booklet: Includes a section on the hospice election statement
- Documentation Requirements for the Hospice Physician Certification/Recertification MLN Matters® Article
- Sample Hospice Election Statement MLN Matters Special Edition Article

## Claims, Pricers & Codes

### Rejected Claims for Medicare Diabetes Prevention Program Services

Medicare Administrative Contractors are rejecting claims for Medicare Diabetes Prevention Program (MDPP) services submitted by organizations and existing Medicare providers that are not enrolled separately as MDPP suppliers. Valid claims for MDPP services must be submitted by enrolled MDPP suppliers. Before submitting claims for these services, make sure your organization:

- Meets all MDPP supplier requirements and standards, including preliminary or full Centers for Disease Control and Prevention recognition

- Has a separate Medicare enrollment as an MDPP supplier

Visit the MDPP webpage for information on supplier enrollment.

### ESRD Claims Error: Transitional Drug Adjustment Add-On Payment Adjustment

End Stage Renal Disease (ESRD) claims are incorrectly reimbursed if they:
- Are eligible for Transitional Drug Adjustment Add-On Payment Adjustment and
- Contain non-covered charges

After we fix the system on January 1, 2019, your Medicare Administrative Contractor will mass adjust claims that were paid incorrectly. You do not need to take any action.

## Upcoming Events

### CMS Data Element Library Webinar — July 11

Wednesday, July 11 from 1 to 2 pm ET

Register for this webinar.

Receive an overview and demonstration of the CMS Data Element Library (DEL). A resource for providers, vendors, researchers, and other stakeholders that use CMS assessments. The DEL supports interoperability and the exchange and reuse of data across post-acute care and other providers by using common assessment standards and definitions to facilitate coordinated care and improved health outcomes.

For More Information:
- Press Release
- Fact Sheet

### Public Reporting on Physician Compare Webinar — July 24 or 26

Tuesday, July 24 from 11 am to 12 pm ET
Thursday, July 26 from 3 to 4 pm ET

Register for July 24 or July 26; both webinars will present the same information.

Learn about public reporting on Physician Compare and information in the pipeline for potential inclusion on Physician Compare in late 2018, including Year 1 Quality Payment Program performance information. Topics:
- Overview of public reporting
- Merit-based Incentive Payment System and Alternative Payment Models
- Upcoming 30-day Preview Period

For more information, visit the Physician Compare Initiative webpage.

## Medicare Learning Network® Publications & Multimedia

### NCCI PTP Edits, Version 24.3: Quarterly Update MLN Matters Article — New

A new MLN Matters Article on Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Edits, Version 24.3 Effective October 1, 2018 is available. Learn about updates to the NCCI PTP edits, Chapter 23, Section 20.9 of the Medicare Claims Processing Manual.

## Medicare Diabetes Prevention Program Call: Audio Recording and Transcript — New

An audio recording and transcript are available for the June 20 call on the Medicare Diabetes Prevention Program (MDPP). Find out about the processes organizations and health care providers must go through to enroll as MDPP suppliers and how to bill for services.

## IMPACT Act Call: Audio Recording and Transcript — New

An audio recording and transcript are available for the June 21 call on the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act). CMS answers your frequently asked questions on quality measures, standardized data elements, the CMS data element library, and future directions of the IMPACT Act.

## Prohibition Billing Dually Eligible Individuals Enrolled in the QMB Program MLN Matters Article — Revised

A revised MLN Matters Article on Prohibition Billing Dually Eligible Individuals Enrolled in the Qualified Medicare Beneficiary (QMB) Program is available. Starting July 2018 the Medicare Summary Notice is another way for providers to verify the QMB status of beneficiaries.

## Global Surgical Days for CAH Method II MLN Matters Article — Revised

A revised MLN Matters Article on Global Surgical Days for Critical Access Hospital (CAH) Method II is available. Learn about the implementation of existing Medicare payment policies.

## HCPCS Drug/Biological Code Changes: July 2018 Quarterly Update MLN Matters Article — Revised

A revised MLN Matters Article on Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes – July 2018 Update is available. Learn about six new HCPCS codes effective for claims with dates of service on or after July 1, 2018.

## Comprehensive ESRD Care Model Telehealth: Implementation MLN Matters Article — Revised

A revised MLN Matters Article on Comprehensive ESRD Care (CEC) Model Telehealth - Implementation is available. Learn about the telehealth waiver.

## ASC Payment System: July 2018 Update MLN Matters Article — Revised

A revised MLN Matters Article on July 2018 Update of the Ambulatory Surgical Center (ASC) Payment System is available. Learn about changes to and billing instructions for various payment policies implemented in the July 2018 ASC payment system update.

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