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News

Is Your Vendor/Clearinghouse Submitting Your Claims with the MBI?

If you send the Medicare Beneficiary Identifier (MBI) to your vendor/clearinghouse on your Medicare claim for payment, but you see both the Health Insurance Claim Number (HICN) and the MBI on your remittance advice, your vendor/clearinghouse is not using the MBI to submit your claims. Contact your vendor/clearinghouse today and ask about their process to submit Medicare claims.

Starting January 1, 2020, Medicare will reject claims with the HICN, with a few exceptions. Make sure your vendor/clearinghouse is submitting your claims with the MBI, or they will be rejected.

For more information, see the MLN Matters Article.

DMEPOS Competitive Bidding: Round 2021 Bid Window is Open

The bid window is now open for all suppliers interested in participating in Round 2021 of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program.

In order to bid in Round 2021, you must have a user account in the CMS Enterprise Portal and have access added to the DMEPOS Bidding System, DBidS, and Connexion, the program's secure portal. Instructions on registering and bidding, including the Registration Reference Guide and DBidS User Guide, are available on the Competitive Bidding Implementation Contractor (CBIC) website. Registration to request access to DBidS closes on August 16, 2019. However, registration to add access to Connexion is always open.

Note: On July 1, 2019, CMS removed the following HCPCS codes from the standard power mobility devices product category as they are only applicable to the standard manual wheelchairs product category:

- E0992: Manual Wheelchair Accessory, Solid Seat Insert
- K0056: Seat Height Less Than 17" Or Equal To Or Greater Than 21" For A High Strength, Lightweight, Or Ultralightweight Wheelchair

The CBIC is the official information source for bidders and bidder education. CMS cautions bidders about potential inaccurate information concerning the DMEPOS Competitive Bidding Program posted on websites other than the CBIC website. Bidders that rely on this information in the preparation or submission of their bids could be at risk of submitting a non-compliant bid. Visit the CBIC website for resources, tools, and to subscribe to email updates.

If you have any questions or need assistance, call the CBIC customer service center at 877-577-5331 between 9 am and 5:30 pm ET, Monday through Friday.

Nursing Homes: Updating Requirements for Arbitration Agreements and New Regulations

On July 16, CMS announced two Medicare and Medicaid rules – one proposed and one final – that emphasize the agency's commitment to ensuring safety and quality in nursing homes. In addition to protecting patients and reducing burdens, the rule helps nursing homes focus their resources on their residents by saving them $616 million in administrative costs annually that can be reinvested in patient care.

The proposed rule allows long-term care facility providers to devote more of their time and resources to their residents – instead of unnecessary paperwork – by eliminating obsolete or excessively burdensome regulations. The proposed rule would eliminate prescriptive requirements and allow commonsense flexibilities.

"The Trump administration is helping nursing homes provide high-quality care by allowing them to focus their time and resources on residents – not unnecessary process and outdated regulations," said CMS Administrator Seema Verma. "We know our regulations work best when they are smart, targeted, and patient-

focused, so we have taken a close look at our rules with patients and burden in mind. We've identified opportunities for reducing provider burden while maintaining high quality resident care."

In addition, CMS proposes revisions to certain requirements included in the third phase of our comprehensive 2016 regulatory overhaul, which are scheduled to be implemented in November 2019. To avoid confusion and promote transparency, CMS proposes to allow one year following the effective date of the final rule for implementation.

In a related effort to protect nursing home residents' right to make informed choices, CMS issued a final rule updating the requirements nursing homes must meet to use binding arbitration agreements. The CMS proposal supports patients and their caregivers by removing the ban on binding arbitration agreements while requiring nursing homes to ensure residents have the ability to choose the method of dispute resolution they want. CMS is allowing binding arbitration agreements, but will prohibit nursing homes from requiring residents to sign binding arbitration agreements as a condition for receiving care, and will require nursing homes to inform residents or their representatives that they are not required to sign a binding arbitration agreement. Finally, CMS is prohibiting nursing home arbitration agreements from including language preventing residents or anyone else from communication with federal, state, or local officials.

For More Information:

- Arbitration Agreements: final rule and fact sheet
- Regulatory Provisions: proposed rule and fact sheet

See the full text of this excerpted CMS Press Release (issued July 16).

CMS Proposes to Cover Acupuncture for Chronic Low Back Pain for Medicare Beneficiaries Enrolled in Approved Studies

On July 15, CMS proposed to cover acupuncture for Medicare patients with chronic low back pain who are enrolled participants either in clinical trials sponsored by the National Institutes of Health or in CMS-approved studies. Currently, acupuncture is non-covered by Medicare. CMS conducted evidence reviews to inform this proposal, and the agency recognizes that the evidence base for acupuncture has grown in recent years, but questions remain.

"Today's proposal represents the Trump Administration's commitment to providing Americans with access to a wide array of options to support their health," said HHS Secretary Alex Azar. "Defeating our country's epidemic of opioid addiction requires identifying all possible ways to treat the very real problem of chronic pain, and this proposal would provide patients with new options while expanding our scientific understanding of alternative approaches to pain."

Read the proposed decision. See the full text of this excerpted CMS Press Release (issued July 15).

Quality Payment Program: 2018 MIPS Performance Feedback and Final Score

If you submitted 2018 Merit-based Incentive Payment System (MIPS) data, view your performance feedback and final score on the Quality Payment Program website. Performance feedback is also available for eligible clinicians participating in MIPS alternative payment model entities.

Targeted Review:
The MIPS payment adjustment you will receive in 2020 is based on your final score. If you believe there is an error in your payment adjustment factor calculation, request a targeted review by September 30.

For More Information:

- Access User Guide
- Performance Feedback and 2020 Payment Adjustment FAQs
- Targeted Review: Fact Sheet and FAQs

- For questions about performance feedback or MIPS final score, contact the Quality Payment Program at 866-288-8292 (TTY: 877-715-6222) or QPP@cms.hhs.gov

Quality Payment Program Participation: Preliminary Data on 2018

CMS published a blog and released an infographic to share preliminary participation data for the Quality Payment Program during 2018. Key findings include:

- Overall, Merit-based Incentive Payment System (MIPS) participation rates increased between 2017 and 2018 from 95 percent to 98 percent
- Small practice participation increased from 81% in 2017 to almost 90% in 2018
- 97.63% of the 916,058 total tax identification numbers/national provider identifiers were above the performance threshold; 0.42 percent were at the performance threshold; and 1.95 percent were below the performance threshold
- The number of Qualifying Advanced Payment Model Participants nearly doubled, from 99,076 clinicians in 2017 to 183,306 in 2018

For More Information:

- Resource Library webpage
- Performance Feedback FAQs
- Targeted Review Fact Sheet
- Questions? Contact QPP@cms.hhs.gov or 866-288-8292 (TTY: 877-715-6222)

Physician Compare: 2017 Quality Payment Program Performance Information

2017 Quality Payment Program performance information on Physician Compare profile pages for Merit-based Incentive Payment System (MIPS) eligible clinicians and groups includes:

- 12 MIPS quality measures reported by groups and displayed as measure-level star ratings on group profile pages
- 8 Consumer Assessment for Healthcare Provider and Systems (CAHPS) for MIPS summary survey measures displayed as top-box percent performance scores on group profile pages
- 6 Qualified Clinical Data Registry (QCDR) quality measures reported by groups and displayed as percent performance scores on group profile pages
- 11 QCDR quality measures reported by individual clinicians and displayed as percent performance scores on individual clinician profile pages

For More Information:

- Quality Payment Program and Physician Compare: What You Need to Know Fact Sheet
- Physician Compare Initiative website
- Group Performance Information Document
- Clinician Performance Information Document
- Accountable Care Organization Performance Information Document
- Benchmark and Star Ratings Fact Sheet
- Group Star Rating Cutoffs Document
- For questions, contact PhysicianCompare@Westat.com

PEPPERs for HHAs, PHPs

Fourth quarter CY 2018 Program for Evaluating Payment Patterns Electronic Reports (PEPPERs) are available for Home Health Agencies (HHAs) and Partial Hospitalization Programs (PHPs). These reports summarize provider-specific data statistics for Medicare services that may be at risk for improper payments. Use your data to support internal auditing and monitoring activities.

- HHAs and free-standing PHPs: For instructions on obtaining your PEPPER, see the Secure PEPPER Access Guide

- PHP units of hospitals or inpatient psychiatric facilities or inpatient rehabilitation facilities: PEPPER was distributed via the QualityNet secure portal

For More Information:
- Visit the PEPPER Resources website for user's guides, recorded training sessions, QualityNet account information, FAQs, and examples of how other providers are using the report
- Visit the Help Desk if you have questions or need help obtaining your report
- Send us your feedback or suggestions

2017 Physician and Other Supplier PUF

The Physician and Other Supplier Public Use File (PUF) includes summarized information on Part B services and procedures furnished to Medicare beneficiaries by physicians and other health care professionals. The data includes information on:
- Utilization, payment, and submitted charges organized by National Provider Identifier, HCPCS code, and place of service
- More than 1 million distinct health care providers who collectively received $98.4 billion in Medicare payments

2017 Referring Provider DMEPOS PUF

The Referring Provider Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Public Use File (PUF) contains summarized information on physicians and other health care professionals who referred DMEPOS products and services to Medicare beneficiaries. The data includes information on:
- Utilization, payment, and submitted charges organized by National Provider Identifier, HCPCS code, and supplier rental indicator
- More than 380,000 distinct health care providers who collectively referred DMEPOS products and services in the amount of $7.2 billion in Medicare payments

Qualified Medicare Beneficiary Billing Requirements

Are you in compliance with Qualified Medicare Beneficiary (QMB) billing requirements? People with Medicare who are in the QMB program are also enrolled in Medicaid and get help with their Medicare premiums and cost-sharing. Medicare providers may not bill people in the QMB program for Medicare deductibles, coinsurance, or copays, but state Medicaid programs may pay for those costs. Providers who inappropriately bill individuals enrolled in QMB are subject to sanctions.

Establish processes to routinely identify the QMB status of Medicare beneficiaries prior to billing for items and services:
- Use Medicare 270/271 HIPAA Eligibility Transaction System (HETS) data; see MLN Matters® Article SE1128
- Check your Medicare Remittance Advices (RAs); see MLN Matters Article MM10433
- Check state automated Medicaid eligibility-verification systems

States require providers to enroll in their Medicaid systems for claim review, adjudication, processing, and issuance of Medicaid RAs for payment of Medicare cost-sharing. Check with the states where your beneficiaries reside to determine the enrollment requirements.

Correct billing problems that occur. If you erroneously bill individuals enrolled in the QMB program, recall the charges (including referrals to collection agencies) and refund the invalid charges they paid.

For More Information:
- QMB Program webpage
- Prohibition on Billing Dually Eligible Individuals Enrolled in the QMB Program MLN Matters Article

- QMB Program Billing Requirements FAQs
- Materials from 2018 Medicare Learning Network call
- Dual Eligible Beneficiaries under the Medicare and Medicaid Programs Booklet

Mass Casualty Triage White Paper and June Express

The Office of the Assistant Secretary for Preparedness and Response (ASPR) Technical Resources, Assistance Center, and Information Exchange (TRACIE) released Mass Casualty Trauma Triage Paradigms and Pitfalls, which highlights the differences between "conventional" mass casualty incidents and mass violence incidents. This white paper includes key differences between these events when:

- The scene is dynamic
- The number of patients far exceeds usual resources
- Usual triage and treatment paradigms may fail

The June issue of The Express includes:

- Medical Surge and the Role of Home Health and Hospice Agencies
- Pediatric Surge Annex Template
- Pediatric Topic Collection
- Upcoming events

For More Information:

- ASPR TRACIE Fact Sheet
- ASPR TRACIE website

Looking for Educational Materials?

Visit the Medicare Learning Network and see how we can support your educational needs. Learn about publications; calls and webcasts; continuing education credits; web-based training; newsletters; and other resources.

Compliance

Cardiac Device Credits: Medicare Billing

A 2018 Office of the Inspector General (OIG) Report noted that payments reviewed for recalled cardiac medical devices did not comply with Medicare requirements for reporting manufacturer credits. Medicare incorrectly paid hospitals $7.7 million for cardiac device replacement claims, resulting in potential overpayments of $4.4 million. Manufacturers issued reportable credits to hospitals for recalled cardiac medical devices, but the hospitals did not adjust the claims with the proper condition codes, value codes, or modifiers to reduce payment as required.

CMS developed the Medicare Billing for Cardiac Device Credits Fact Sheet to ensure that hospitals properly report manufacturer credits for cardiac devices and avoid overpayment recoveries. Additional resources:

- Medicare Quarterly Provider Compliance Newsletter Volume 5, Issue 2, January 2015
- Medicare Claims Processing Manual, Chapter 3, Section 100.8: Replaced Devices Offered Without Cost or With a Credit
- Medicare Claims Processing Manual, Chapter 4, Section 61.3.5: Reporting and Charging Requirements When a Device is Furnished Without Cost to the Hospital or When the Hospital Receives a Full or Partial Credit for the Replacement Device Beginning January 1, 2014
- Hospitals Did Not Comply With Medicare Requirements For Reporting Certain Cardiac Device Credits OIG Report, March 2018

Events

DMEPOS Competitive Bidding: Round 2021 Webcast Series

Register for the last webcast in the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program series:

- Registering and Submitting a Bid - Part 2 on July 23 from 3-4 pm ET
- You can submit questions during the webcast; however, to increase the likelihood of your question being answered, submit it in advance to cbic.admin@palmettogba.com with “Webcast Question” in the subject line

On-demand sessions for previous webcasts are available through the registration link:

- Bid Surety Bond and Lead Item Pricing on May 14
- Preparing and Submitting Financial Documents on May 21
- Registering and Submitting a Bid - Part 1 on June 11

Resources such as slides and other handouts will be available during both the live and on-demand sessions. CMS also published responses to frequently asked questions from the first three webcasts.

Enrollment: Multi–Factor Authentication for I&A System Webcast — July 30

Tuesday, July 30 from 2 to 3 pm ET

Register for Medicare Learning Network events.

During this webcast, learn about the new Multi-factor Authentication (MFA) requirement for the Identity and Access (I&A) system. Starting in September, when you login to I&A, you will enter your user ID and password, and then, use a second factor authentication to obtain a verification code:

- The I&A system will guide existing users to set up their MFA device via a simple setup process or defer set up for a grace period
- New users will setup up MFA when creating I&A accounts

In December, the MFA requirement will also extend to the National Plan and Provider Enumeration System (NPPES).

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: Providers and I&A and NPPES users.

IRF Appeals Settlement Initiative Call — August 13

Tuesday, August 13 from 1:30 to 3 pm ET

Register for Medicare Learning Network events.

CMS is accepting Expressions of Interest (EOI) for a settlement option for Inpatient Rehabilitation Facility (IRF) appeals pending at the Medicare Administrative Contractor (MAC), the Qualified Independent Contractor (QIC), the Office of Medicare Hearings and Appeals (OMHA), and/or Medicare Appeals Council (Council) levels of review. Topics:

- Appellant eligibility
- EOI period and settlement process
- Frequently asked questions

A question and answer session follows the presentation; however attendees may email questions in advance to MedicareAppealsSettlement@cms.hhs.gov with “Aug 13 MLN Call” in the subject line. These questions may be addressed during the call or used for other materials following the call.

Target Audience: IRF appellants that filed appeals at the MAC for redetermination no later than August 31, 2018, that are currently pending or are eligible for further appeal at the MAC, QIC, OMHA, or Council.

MLN Matters® Articles

Tropical Storm Barry and Medicare Disaster Related Louisiana Claims

The HHS Secretary declared a Public Health Emergency in the state of Louisiana, which allows for CMS programmatic waivers based on Section 1135 of the Social Security Act. An MLN Matters Special Edition Article on Tropical Storm Barry and Medicare Disaster Related Louisiana Claims is available. Learn about blanket waivers issued by CMS. These waivers prevent gaps in access to care for beneficiaries impacted by the emergency.

Reduce Risk of Opioid Overdose Deaths by Avoiding and Reducing Co-Prescribing Benzodiazepines

A new MLN Matters Article SE19011 on Reduce Risk of Opioid Overdose Deaths by Avoiding and Reducing Co-Prescribing Benzodiazepines is available. Learn about the risk, key issues, and practices to reduce co-prescribing.

Pre-Diabetes Services: Referring Patients to the Medicare Diabetes Prevention Program

A new MLN Matters Article SE19001 on Pre-Diabetes Services: Referring Patients to the Medicare Diabetes Prevention Program is available. Learn about this new Medicare-covered service, benefits for your patients, and the referral process.

Emergency Medical Treatment and Labor Act (EMTALA) and the Born-Alive Infant Protection Act

A new MLN Matters Article SE19012 on Emergency Medical Treatment and Labor Act (EMTALA) and the Born-Alive Infant Protection Act is available. Learn about requirements for Medicare participating hospitals, including critical access hospitals.

Changes to the Laboratory National Coverage Determination (NCD) Edit Software for October 2019

A new MLN Matters Article MM11344 on Changes to the Laboratory National Coverage Determination (NCD) Edit Software for October 2019 is available. Learn about changes to the edit module for clinical diagnostic laboratory services.

Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Edits, Version 25.3 Effective October 1, 2019

A new MLN Matters Article MM11357 on Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Edits, Version 25.3 Effective October 1, 2019 is available. Learn about updates related to Chapter 23, Section 20.9 of the Medicare Claims Processing Manual.

Quarterly Update for the Temporary Gap Period of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP) - October 2019

A new MLN Matters Article MM11336 on Quarterly Update for the Temporary Gap Period of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP) - October 2019 is available. Learn about changes to the HCPCS, ZIP code, and supplier files.

Update to Coverage of Intravenous Immune Globulin for Treatment of Primary Immune Deficiency Diseases in the Home

A new MLN Matters Article MM11295 on Update to Coverage of Intravenous Immune Globulin for Treatment of Primary Immune Deficiency Diseases in the Home is available. Learn about ICD-10-CM codes for the coverage of this treatment.

July 2019 Update of the Ambulatory Surgical Center (ASC) Payment System

A new MLN Matters Article MM11328 on July 2019 Update of the Ambulatory Surgical Center (ASC) Payment System is available. Learn about payment rates for separately payable procedures/services, drugs, and biologicals.

Activation of Systematic Validation Edits for OPPS Providers with Multiple Service Locations — Revised

A revised MLN Matters Article SE19007 on Activation of Systematic Validation Edits for OPPS Providers with Multiple Service Locations is available. Learn about updates to Round 3 testing and delay of full implementation until October 2019.

Publications

Provider Compliance Tips for Respiratory Assistive Devices — Revised

A revised Provider Compliance Tips for Respiratory Assistive Devices Fact Sheet is available. Learn:

- Reasons for claim denials
- How to prevent denials
- Requirements for orders

Provider Compliance Tips for Enteral Nutrition — Revised

A revised Provider Compliance Tips for Enteral Nutrition Fact Sheet is available. Learn:

- Reasons for denials
- How to prevent denials
- Coverage and billing requirements for therapy

Multimedia

Post-Acute Care Call: Audio Recording and Transcript

An audio recording and transcript are available for the June 5 Medicare Learning Network call on the post-acute care quality reporting programs. Learn about reporting requirements and resources for inpatient rehabilitation facilities, long-term care hospitals, and skilled nursing facilities.

Like the newsletter? Have suggestions? Please let us know!

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