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Official CMS news from the Medicare Learning Network®

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New Medicare Card: Questions about Using the MBI?

Remember: The Medicare Beneficiary Identifier (MBI) uses numbers 0-9 and all uppercase letters except for S, L, O, I, B, and Z. We exclude these letters to avoid confusion when differentiating some letters and numbers (e.g., between “0” and “O”). Read MLN Matters Article New MBI: Get It, Use It for other helpful information, such as how to get the MBI, and what to do if an MBI changes.

Protect your patients’ identities, and use the MBI now. We will reject claims you submit with the Health Insurance Claim Number (HICN), with a few exceptions and reject all eligibility transactions starting January 1, 2020.

Don't have an MBI?

- Ask your patients for their card. 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.

2020 QRDA III Implementation Guide, Schematron, and Sample Files

CMS released the 2020 Quality Reporting Document Architecture (QRDA) III I Implementation Guide along with the Schematron and Sample Files. The Implementation Guide outlines requirements for eligible clinicians and eligible professionals to report CY 2020 performance period electronic clinical quality measures, improvement activities, and promoting interoperability measures for these programs:

- Quality Payment Program: Merit-based Incentive Payment System and Advanced Alternative Payment Models
- Comprehensive Primary Care Plus
- Medicaid Promoting Interoperability

For More Information:

- QRDA webpage
- For questions, visit the Office of the National Coordinator QRDA Project Tracking System

Antipsychotic Drug Use in Nursing Homes: Trend Update

CMS is tracking the progress of the National Partnership to Improve Dementia Care in Nursing Homes by reviewing publicly reported measures. The official measure of the Partnership is the percentage of long-stay nursing home residents who receive antipsychotic medication, excluding residents diagnosed with schizophrenia, Huntington's disease, or Tourette's syndrome. In the fourth quarter of 2011, 23.9 percent of residents received an antipsychotic medication; since then there has been a decrease of 39 percent to a national prevalence of 14.6 percent in the fourth quarter of 2018:

- Success varies by state and CMS region; some states and regions have a reduction greater than 45 percent.
- A four-quarter average of this measure is posted on the Nursing Home Compare website

For More Information:

- Visit the Partnership webpage
- Register for the September 10 Medicare Learning Network call
- Send correspondence to dnh_behavioralhealth@cms.hhs.gov

Clinical Diagnostic Laboratories: Resources about the Private Payor Rate-Based CLFS

The Protecting Access to Medicare Act of 2014 (PAMA) required significant changes to how Medicare pays for clinical diagnostic laboratory tests under the Clinical Laboratory Fee Schedule (CLFS). Effective January 1, 2018, the payment amount for most tests equals the weighted median of private payor rates. Payment rates under the private payor rate-based CLFS are updated every three years.

If you are a laboratory, including an independent laboratory, a physician office laboratory, or hospital outreach laboratory that meets the definition of an applicable laboratory, you are required to report information, including laboratory test HCPCS codes, associated private payor rates, and volume data.
Learn more by reading:

- Summary: Overview of key terms and concepts and how to determine whether your laboratory is an applicable laboratory
- MLN Matters Article: Detailed information and examples to help you determine if you need to report

- Frequently Asked Questions: Responses to questions regarding the changes effective January 1

If you meet the applicable laboratory criteria, act now using this schedule:
- January – June, 2019: Collect data
- July – December, 2019: Analyze data
- January – March, 2020: Report data

For more information, review the materials from the January 22 Medicare Learning Network call and the PAMA Regulations webpage.

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

Separate NPI for MDPP Enrollment:
We strongly encourage you to obtain a separate National Provider Identifier (NPI) for MDPP enrollment; claim rejections and denials may occur if multiple enrollments are associated with a single NPI. If you are a currently enrolled MDPP supplier that elects to obtain a separate NPI, update your enrollment in the Provider Enrollment, Chain and Ownership System (PECOS) with the new NPI. Contact your Medicare Administrative Contractor for assistance if:
- Your organization is unable to obtain a separate NPI
- You continue to encounter claims submission and processing issues after you update your enrollment with the new NPI

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

World Hepatitis Day: Medicare Coverage for Viral Hepatitis

World Hepatitis Day is July 28. “Baby boomers” are 5 times more likely to have hepatitis C than other adults, and most people with chronic hepatitis virus do not know they are infected. Symptoms usually do not appear until the later stages of the infection, so screening is critical. Medicare covers viral hepatitis immunization and screening services, including:
- Hepatitis B virus screening
- Hepatitis B virus vaccine and administration
- Hepatitis C virus screening

- Screening for Sexually Transmitted Infections (STIs) and high-intensity behavioral counseling to prevent STIs

For More Information:
- Medicare Preventive Services Educational Tool
- Medicare Part B Immunization Billing Educational Tool
- Viral Hepatitis and World Hepatitis Day websites, Centers for Disease Control and Prevention
- World Hepatitis Day website

Visit the Preventive Services website to learn more about Medicare-covered services.

Compliance

Importance of Proper Documentation: Provider Minute Video

Why is proper documentation important to you and your patients? Find out how it affects items/services, claim payment, and medical review in the Provider Minute: The Importance of Proper Documentation video.

Learn about:
- Top five documentation errors
- How to submit documentation for a Comprehensive Error Rate Testing review
- How your Medicare Administrative Contractor can help

Claims, Pricers & Codes

Medicare Diabetes Prevention Program: Valid Claims

For a claim to be valid under the Medicare Diabetes Prevention Program (MDPP), you must have both:
- Centers for Disease Control and Prevention (CDC) preliminary or full recognition; see the Supplier Fact Sheet and CDC website for more information
- Separate Medicare enrollment as an MDPP supplier (Specialty D1); see the Enrollment Fact Sheet and Checklist

Important:
If you do not have a separate Medicare enrollment as an MDPP supplier and you submit a claim for MDPP services, your claim will be rejected.

Medicare enrolled MDPP suppliers: See the Quick Reference Guide to Payment and Billing and the Billing and Claims Fact Sheet for information on valid claims:
- MDPP Medicare beneficiary eligibility data is returned via the HIPAA Eligibility Transaction System (HETS) on the 271 response; use this data to determine if a beneficiary meets the criteria to receive MDPP services
- Submit claims when a performance goal is met, and report codes only once per eligible beneficiary (except G9890 and G9891)
- List each HCPCS code with the corresponding session date of service and the coach's National Provider Identifier (NPI)
- List all HCPCS codes associated with a performance payment (including non-payable codes) on the same claim
- Include Demo code 82 in block 19 (Loop 2300 segment REF01 (P4) and segment REF02 (82)) to identify MDPP services
- Do not include codes for other, non-MDPP services on the same claim

Trouble with MDPP billing and claims:
- Some MDPP claims are being denied as a result of a systems issue

- Medicare Administrative Contractors (MACs) are manually processing these claims through October 2019 until the fix is implemented
- Contact your MAC with questions

For More Information:
- MDPP Expanded Model Booklet
- MDPP webpage

Events

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.

Diagnosing and Treating Dementia: Current Best Practices Webinar — July 30
Tuesday July 30 from 11:30 am to 1 pm ET

Register for this webinar.

This webinar describes best practices and guidelines for diagnosing and assessing dementia among older adults who are dually eligible and provides an overview of current evidence-based treatments. Continuing Medical Education (CME) and Continuing Education (CE) credits may be available.

Quality Payment Program Performance Information on Physician Compare Webinar — July 30/Aug 1
Tuesday, July 30 from 11 am to noon ET
Thursday, August 1 from 3 to 4 pm ET

Register for July 30 or August 1:
- Both webinars present the same information
- Registration closes on July 29

During this webinar, learn about Physician Compare and the 2017 performance information recently added to profile pages for Merit-based Incentive Payment System eligible clinicians and groups and accountable care organizations. A question and answer session follows the presentation.

For questions, visit the Physician Compare Initiative website, or contact PhysicianCompare@Westat.com.

Disability-Competent Care Conversation on Access Webinar — July 31

Wednesday July 31 from 2 to 3 pm ET

Register for this webinar.

This event, in collaboration with the ADA National Network, provides a platform for questions on how to best improve accessibility for participants with disabilities to meet their care needs. It focuses on health care facility accessibility, including physical and communication barriers.

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.

Home Health Patient-Driven Groupings Model: Operational Issues Call — August 21

Wednesday, August 21 from 1:30 to 3 pm ET

Register for Medicare Learning Network events.

During this call, learn information to help your agency prepare to implement billing changes for the Patient-Driven Groupings Model (PDGM) on January 1, 2020. CMS will use the PDGM to reimburse home health agencies for providing home health services under Medicare fee-for-service. Topics include:

- Billing and claims processing overview
- How Outcome and Assessment Information Set (OASIS) data will be used in the claims system
- Reporting new occurrence codes
- Period timing and admission source scenarios
- Transition scenarios

A question and answer session follows the presentation. For more information, visit the Home Health Prospective Payment System website, and review MLN Matters Articles MM11081 and MM11272.

Target Audience: Home health agencies, administrators, billers, coders, and other interested stakeholders.

MLN Matters® Articles

Medicare Plans to Modernize Payment Grouping and Code Editor Software

An MLN Matters Article SE19013 on Medicare Plans to Modernize Payment Grouping and Code Editor Software is available. Learn about the proposed schedule to convert this software to Java.

Publications

Medicare DMEPOS Improper Inpatient Payments

A new Medicare DMEPOS Improper Inpatient Payments Medicare Learning Network Fact Sheet is available. Learn about:

- Federal regulations and guidance
- Deliveries before discharge

Medicare Part D Vaccines — Revised

A revised Medicare Part D Vaccines Medicare Learning Network Fact Sheet is available. Learn about:

- Administration coverage
- Reimbursement in a prescriber's office
- Patient access

Provider Compliance Tips for Enteral Nutrition Pumps — Revised

A revised Provider Compliance Tips for Enteral Nutrition Pumps Medicare Learning Network Fact Sheet is available. Learn:

- Reasons for denials
- How to prevent denials

Multimedia

Hospital Listening Session: Audio Recording and Transcript

An audio recording and transcript are available for the June 20 Medicare Learning Network listening session on ligature risk in hospitals. CMS is seeking your input on compliance with the Conditions of Participation and ligature risk extension request process.

Hospice Quality Reporting Program Web-Based Courses

Need an overview of the Hospice Quality Reporting Program (HQRP)? Visit the Training and Education Library webpage to take the following courses:

- Introduction to the HQRP
- HQRP Data Submission Requirements and Reports

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