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Official CMS news from the Medicare Learning Network®

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# News

## New Medicare Card: Transition Period Ends in Less Than 4 Months

Starting January 1, 2020, you must use Medicare Beneficiary Identifiers (MBIs):

- We will reject claims you submit with Health Insurance Claim Numbers (HICNs) with a few exceptions
- We will reject all eligibility transactions you submit with HICNs

Many providers are using the MBI for Medicare transactions. For the week ending August 30, providers submitted 79% of fee-for-service claims with the MBI. Protect your patients' identities by using MBIs now for all Medicare transactions. Don't have 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.

## New Enforcement Authorities to Reduce Criminal Behavior in Medicare, Medicaid, and CHIP

CMS issued a final rule, effective November 4, 2019, that strengthens the agency's ability to stop fraud before it happens by keeping unscrupulous providers out of our federal health insurance programs. This first-of-its-kind action – stopping fraudsters before they get paid – marks a critical step forward in our longstanding fight to end "pay and chase" in federal health care fraud efforts and replace it with smart, effective, and proactive measures.

The final rule creates several new revocation and denial authorities to bolster our efforts to stop waste, fraud, and abuse. A new authority in the rule allows CMS to identify individuals and organizations that pose an undue risk based on their relationships with other previously sanctioned entities.

The rule also includes other authorities that will effectively improve our fraud-fighting capabilities. Similar to the affiliations component, these authorities provide a basis for administrative action to revoke or deny, as applicable, Medicare enrollment if a provider or supplier:

- Circumvents program rules by coming back into the program, or attempting to come back in, under a different name
- Bills for services/items from non-compliant locations
- Exhibits a pattern or practice of abusive ordering or certifying of Medicare Part A or Part B items, services, or drugs
- Has an outstanding debt to CMS from an overpayment that was referred to the Treasury Department

The new rule also gives CMS the ability to prevent applicants from enrolling in the program for up to 3 years if a provider or supplier is found to have submitted false or misleading information in its initial enrollment application. Furthermore, the new rule expands the reenrollment bar that prevents fraudulent or otherwise problematic providers from re-entering the Medicare program. CMS can now block providers and suppliers who are revoked from re-entering the Medicare program for up to 10 years. Additionally, if a provider or supplier is revoked from Medicare for a second time, CMS can now block that provider or supplier from re-entering the program for up to 20 years.

To learn more, visit the Center for Program Integrity Spotlight webpage. See the full text of this excerpted CMS Press Release (issued September 5).

## Different-Day Upper and Lower Endoscopy: Comparative Billing Report in September

In late September, CMS will issue a Comparative Billing Report (CBR) on Different-Day Upper and Lower Endoscopy, focusing on providers who submit Medicare Part B claims. These reports contain data-driven tables with an explanation of findings that compare your billing and payment patterns to those of your peers in your state and across the nation.

CBRs are not publicly available. Look for an email from cbrpepper.noreply@religroupinc.com with your report. Update your contact email address in the National Plan and Provider Enumeration System to ensure accurate delivery. Visit the CBR website for more information.

## Hospices: Call for Panel on Assessment Instrument and Quality Measures — Nominations due September 30

Nominations are due September 30 for a Technical Expert Panel (TEP) to provide input on a hospice assessment instrument and corresponding set of quality measures in support of the Hospice Quality Reporting Program. For more information, visit the TEP webpage.

## Local Coverage Determination Meetings

CMS created a new Local Coverage Determination (LCD) webpage with upcoming Medicare Administrative Contractor (MAC) meetings. The process-related meetings include the Contractor Advisory Committee and Open Meetings. Learn about upcoming meetings across the MACs in one location. We will update this webpage weekly with information one to three weeks prior to each meeting.

## Pain Management: CDC Conversation Starters for Patients and Their Doctors

The Centers for Disease Control and Prevention (CDC) released four new fact sheets that encourage patients and doctors to discuss pain management options and the potential risks of opioid medication. Information includes:

- What patients can expect if they are taking opioids
- Guidance on safer use
- Prompts for a doctor-patient discussion of treatment goals and plans
- Non-pharmacologic and non-opioid medication options for pain management.

The fact sheets cover the important questions and information you should cover when you talk to your patients about:

- Acute pain
- Chronic pain
- Prescription opioids
- Reducing risk of opioid addiction

## Healthy Aging® Month: Discuss Preventive Services with your Patients

Healthy Aging Month focuses national attention on all aspects of growing older. Talk with your patients about adopting a healthy lifestyle, including use of appropriate Medicare-covered preventive services; care coordination for chronic conditions; behavioral health integration; and cognitive assessment and care planning.

For More Information:

- Medicare Preventive Services Educational Tool
- Chronic Care Management Services Booklet
- Connected Care: The Chronic Care Management Resource webpage

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

## Compliance

### Bill Correctly for Device Replacement Procedures

In a September 2017 report, the Office of the Inspector General (OIG) determined that Medicare paid for many device replacement procedures incorrectly. Hospitals are required to use condition codes 49 or 50 on claims for device replacement procedures resulting from a recall or premature failure (whether the device is provided at no cost or with a credit).

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

- Shortcomings of Device Claims Data Complicate and Potentially Increase Medicare Costs for Recalled and Prematurely Failed Devices OIG Report
- Medicare Claims Processing Manual, Chapter 3, Section 100.8
- Medicare Claims Processing Manual, Chapter 4, Section 61.3.5 and 61.3.6

## Claims, Pricers & Codes

### Average Sales Price Files: October 2019

CMS posted the October 2019 Average Sales Price (ASP) and Not Otherwise Classified (NOC) pricing files and crosswalks on the 2019 ASP Drug Pricing Files webpage.

## Events

### Opioids: What's an "Outlier Prescriber"? Listening Session — September 17

Tuesday, September 17 from 4:30 to 6 pm ET

Register for Medicare Learning Network events.

Are you a physician, nurse practitioner, other advanced practice nurse, or physician assistant who prescribes opioids? CMS wants your input on how best to implement Section 6065 of the SUPPORT Act.

Signed into law in October 2018, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) outlines national strategies to help address opioid misuse. As part of Section 6065 of the SUPPORT Act, CMS is required to notify opioid prescribers with prescription patterns identified as "outliers" compared to their peers and encourage them to reference established opioid prescribing guidelines.

The purpose of this listening session is to get feedback on the following topics:

- Methodology to establish outlier prescriber thresholds
- Tone and content of feedback reports to clinicians
- How to best identify a "medical specialty" from the National Provider Identifier framework
- How to define geographic areas for analysis
- Recommendations on opioid prescribing guidelines to include with the notification

You are encouraged to review the following materials before the call:

- SUPPORT Act
- Centers for Disease Control and Prevention (CDC) Guideline 2016
- CDC Advisory
- Food and Drug Administration Safety Alert

Target Audience: All prescribing clinicians.

**Different-Day Upper and Lower Endoscopy: Comparative Billing Report Webinar — September 24**
Tuesday September 24 from 3 to 4 pm ET

Register for this webinar.

Join us for a discussion of the Comparative Billing Report (CBR) on Different-Day Upper and Lower Endoscopy, an educational tool for providers who submit Medicare Part B claims. Visit the CBR website for more information.

## MLN Matters® Articles

**Hurricane Dorian and Medicare Disaster Related State of North Carolina Claims**

The HHS Secretary declared a Public Health Emergency in the State of North Carolina, which allows for CMS programmatic waivers based on Section 1135 of the Social Security Act. An MLN Matters Special Edition Article SE19020 on Hurricane Dorian and Medicare Disaster Related State of North Carolina Claims is available. Learn about blanket waivers issued by CMS. These waivers prevent gaps in access to care for beneficiaries impacted by the emergency.

**Additional Instructions to Hospitals on the Election of a Medicare-Supplemental Security Income (SSI) Component of the Disproportionate Share (DSH) Payment Adjustment for Cost Reports that Involve SSI Ratios for Fiscal Year (FY) 2004 and Earlier, or SSI Ratios for Hospital Cost-Reporting Periods for Patient Discharges Occurring Before October 1, 2004**

A new MLN Matters Article MM10484 on Additional Instructions to Hospitals on the Election of a Medicare-Supplemental Security Income (SSI) Component of the Disproportionate Share (DSH) Payment Adjustment for Cost Reports that Involve SSI Ratios for Fiscal Year (FY) 2004 and Earlier, or SSI Ratios for Hospital Cost-Reporting Periods for Patient Discharges Occurring Before October 1, 2004 is available. Learn about making an election for a particular fiscal period covered by Ruling 1498-R.

**October 2019 Update of the Ambulatory Surgical Center (ACS) Payment System**

A new MLN Matters Article MM11457 on October 2019 Update of the Ambulatory Surgical Center (ACS) Payment System is available. Learn about billing instructions and HCPCS updates.

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

A revised MLN Matters Article SE19007 on Activation of Systematic Validation Edits for OPPS Providers with Multiple Service Locations - Update is available. Learn about the delay of full implementation until April 2020.

**Medicare Part B Clinical Laboratory Fee Schedule: Revised Information for Laboratories on Collecting and Reporting Data for the Private Payor Rate-Based Payment System — Revised**

A revised MLN Matters Article SE19006 on Medicare Part B Clinical Laboratory Fee Schedule: Revised Information for Laboratories on Collecting and Reporting Data for the Private Payor Rate-Based Payment System is available. Learn about the condensed data reporting option.

### 2020 Annual Update for the Health Professional Shortage Area (HPSA) Bonus Payments — Revised

A revised MLN Matters Article MM11437 on 2020 Annual Update for the Health Professional Shortage Area (HPSA) Bonus Payments is available. Learn when Medicare Administrative Contractors will accept the AQ modifier.

## Publications

### Medicare Part A Cost Report Electronic Filing

A new Medicare Part A Cost Report Electronic Filing Medicare Learning Network Booklet is available. Learn:

- Who can submit reports
- Steps
- Benefits

### Quality Payment Program: 2019 MIPS Resources

CMS posted new 2019 Merit-based Incentive Payment System (MIPS) resources on the Quality Payment Program (QPP) Resource Library webpage:

- User Guides: Highlights information on participation, data submission, and scoring for the following topics: 101, Scoring, Alternative Payment Models (APMs), Promoting Interoperability, and Improvement Activities
- Specialty Guides: Highlights measures and activities that may apply to the following specialists: cardiologists, chiropractors, dentists, emergency medicine clinicians, nurse practitioners, ophthalmologists, optometrists, orthopedists, pathologists, physician assistants, podiatrists, and radiologists
- CMS Web Interface Sampling Methodology: Describes the sampling methodology for the 10 clinical quality measures, quality measure reporting, and sample size requirements
- Scores for Improvement Activities in MIPS APMs Fact Sheet: Details the improvement activities required by each APM and the scores that each will receive for the Improvement Activities performance category
- MIPS Exceptions FAQs: Lists questions and answers on extreme and uncontrollable circumstances, as well as hardship exceptions for the Promoting Interoperability performance category
- Patient Facing Encounter Codes: Lists determinants used to assess the non-patient facing status of MIPS eligible clinicians

For More Information:

- QPP website
- Direct questions to your local technical assistance organization, QPP@cms.hhs.gov, or 866-288-8292 (TTY: 877-715-6222)

### Advance Care Planning — Revised

A revised Advance Care Planning Medicare Learning Network Fact Sheet is available. Learn:

- Provider and patient eligibility information
- How to code and bill services

### Medicare Billing: CMS Form CMS-1500 and the 837 Professional — Revised

A revised Medicare Billing: CMS Form CMS-1500 and the 837 Professional Medicare Learning Network Booklet is available. Learn:

- When Medicare will accept a hard copy claim form
- Filing requirements

- How to submit and code claims

### Medicare Secondary Payer— Revised

A revised Medicare Secondary Payer Medicare Learning Network Booklet is available. Learn:

- When Medicare pays first
- How to gather accurate data from the beneficiary
- What happens if you fail to file correct and accurate claims

### Roadmap to Behavioral Health — Updated

CMS and the Substance Abuse and Mental Health Services Administration updated the Roadmap to Behavioral Health. This guide includes information about mental health and substance use disorder services, finding a behavioral health provider, defining behavioral health terms, receiving services, and following up on care. To learn more, visit the From Coverage to Care webpage or email CoverageToCare@cms.hhs.gov.

## Multimedia

### Home Health Call: Audio Recording and Transcript

An audio recording, transcript, revised presentation, and clarification are available for the August 21 Medicare Learning Network call on the Home Health Patient-Driven Groupings Model (PDGM): Operational Issues. Learn information to help your agency prepare to implement billing changes for the PDGM on January 1, 2020.

### Radiation Oncology Listening Session: Audio Recording and Transcript

An audio recording, transcript, and clarification are available for the August 22 Medicare Learning Network listening session on the Radiation Oncology Model. CMS experts briefly cover the major provisions from the proposed rule and address your clarifying questions to help you formulate your written comments for formal submission.

### SNF Value-Based Purchasing Call: Audio Recording and Transcript

An audio recording and transcript are available for the August 27 Medicare Learning Network call on Understanding Your Skilled Nursing Facility (SNF) Value-Based Purchasing Program Performance Score Report. CMS experts present a high level summary of the program and highlight payment year one results.

### Medicare Secondary Payer Provisions Web-Based Training Course — Revised

With Continuing Education Credit

A revised Medicare Secondary Payer Provisions Web-Based Training (WBT) course is available through the Medicare Learning Network Learning Management System. Learn about:

- Identifying provisions
- Recognizing when Medicare is primary and secondary
- Filing accurate claims

### Quality Payment Program for Merit-based Incentive Payment System (MIPS) APMs in 2019 Web-Based Training Course — Revised

With Continuing Education Credit

A revised Quality Payment Program for Merit-based Incentive Payment System (MIPS) APMs in 2019 Web-Based Training (WBT) course is available through the Medicare Learning Network Learning Management System. Learn:

- How to recognize if you are a part of a MIPS Alternative Payment Model (APM)
- Benefits of the special APM scoring standard
- Criteria for reporting on performance

## SNF PPS: Patient Driven Payment Model Videos

On October 1, the new Patient Driven Payment Model (PDPM) is replacing the Resource Utilization Group, Version IV (RUG-IV) for the Skilled Nursing Facility (SNF) Prospective Payment System (PPS). CMS has videos to help you prepare:

- PDPM: What Is Changing (and What Is Not) – Run time: 72 mins
- Integrated Coding & PDPM Case Study – Run time: 58 mins

For more information, visit the PDPM webpage.

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