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Official CMS news from the Medicare Learning Network®

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News

New Medicare Card: Do You Refer Patients?

When you write an order or refer a patient for a service or treatment, use your discretion and share the Medicare Beneficiary Identifier (MBI) with:

- Lab or diagnostic facilities, especially when they do not see the patient
- Skilled nursing facilities for transfers between facilities
- Ambulance transport providers when arranging patient transport

Starting January 1, 2020, all providers must use the MBI 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

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.

Opioid Treatment Programs: Get Ready to Participate in the New Benefit

Starting January 1, 2020, under the CY 2020 Physician Fee Schedule proposed rule, CMS plans to pay Opioid Treatment Programs (OTPs) through bundled payments for opioid use disorder treatment services for people with Medicare Part B, including medication-assisted treatment medications, toxicology testing, and counseling.

Get ready to participate in the new benefit:

- Obtain full OTP certification from the Substance Abuse and Mental Health Services Administration (SAMHSA)
- Enroll in Medicare starting in early November
- Subscribe to MLN Connects for the latest news and updates

For More Information:

- Fact Sheet
- OTP webpage

Home Health Preview Reports for January 2020 Refresh

Download home health preview reports from your Certification and Survey Provider Enhanced Reports (CASPER) folder. These reports preview data that will be displayed on Home Health Compare in January 2020. Save your reports for reference:

- Home Health Compare Provider Preview Reports: Available for 60 days
- Quality of Patient Care Star Ratings Provider Preview Reports: Available for 90 days

For More Information:

- Home Health Quality Reporting Data Submission Deadlines webpage
- Home Health Star Ratings webpage

LTCH Provider Preview Reports: Review Your Data by October 11

Long-Term Care Hospital (LTCH) Provider Preview Reports are now available with second quarter 2018 to first quarter 2019 data. Review your performance data on quality measures by October 11, prior to public display on LTCH Compare in December 2019. Corrections to the underlying data are not permitted during this time; request a CMS review if you believe that your data is inaccurate.

Access your report by logging into the Internet Quality Improvement and Evaluation System (iQIES). At the main screen, select "Reports;" then "My Reports." For more information, visit the LTCH Quality Public Reporting webpage.

IRF Provider Preview Reports: Review Your Data by October 11

Inpatient Rehabilitation Facility (IRF) Provider Preview Reports are now available with second quarter 2018 to first quarter 2019 data. Review your performance data on quality measures by October 11, prior to public display on IRF Compare in December 2019. Corrections to the underlying data are not permitted during this time; request a CMS review if you believe that your data is inaccurate.

For More Information:

- IRF Quality Public Reporting webpage
- Preview Report Access Instructions

Hospice Provider Preview Reports: Review Your Data by October 11

Two reports are available in your Certification and Survey Provider Enhanced Reports (CASPER) non-validation reports folder:

- Hospice provider preview report: Review Hospice Item Set (HIS) quality measure results from the first quarter of 2018 to the fourth quarter of 2018
- Hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS®) provider preview report: Review facility-level CAHPS survey results from the first quarter of 2017 to the fourth quarter of 2018

Review your HIS and CAHPS results by October 11. If you believe the denominator or other HIS quality metric is inaccurate or if there are errors in the results from the CAHPS survey data, request a CMS review:

- HIS Preview Reports and Requests for CMS Review webpage
- CAHPS Preview Reports and Requests for CMS Review webpage

Access Instructions:

- Hospice Provider Preview Report
- Hospice CAHPS Provider Preview Report

CLFS CY 2020 Preliminary Payment Determinations: Comment by October 27

The Clinical Laboratory Fee Schedule (CLFS) CY 2020 Preliminary Payment Determinations are available in the Payment Determinations section of the CMS CLFS Annual Public Meeting website. Submit comments by October 27 to CLFS_Annual_Public_Meeting@cms.hhs.gov. Find more information on the determination process on the CMS CLFS Annual Public Meeting website.

MIPS: Virtual Group Election Period Open Through December 31

To form a virtual group for the 2020 Merit-based Incentive Payment System (MIPS) performance year, you must follow an election process and submit your election to CMS via email by December 31.

For More Information:

- 2020 Virtual Groups Toolkit
- Contact QPP@cms.hhs.gov or 866-288-829 (TTY: 877-715-6222)

LTCH Compare Refresh

The September 2019 quarterly Long-term Care Hospital (LTCH) Compare refresh is available, including updated quality measure results, as well as an annual update to the LTCH claims-based quality measures. Visit LTCH Compare to view the data. For more information, visit the LTCH Quality Public Reporting webpage.

IRF Compare Refresh

The September 2019 quarterly Inpatient Rehabilitation Facility (IRF) Compare refresh is available, including updated quality measure results, as well as an annual update to the IRF claims-based quality measures. Visit IRF Compare to view the data. For more information, visit the IRF Quality Public Reporting webpage.

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

Ostomies are Life-Savers

October 5 is Ostomy Awareness Day, increasing awareness of bowel and urinary diversion surgery and proper care for patients. Review the Provider Compliance Tips for Ostomy Supplies Medicare Learning Network Fact Sheet and learn about:

- Coverage requirements
- Billing
- Guidelines for refills

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

Outpatient Services Payment: Beneficiaries Who Are Inpatients of Other Facilities

In a recent report, the Office of the Inspector General (OIG) determined that Medicare inappropriately paid acute-care hospitals for outpatient services provided to beneficiaries who were inpatients of other facilities, including long term care hospitals, inpatient rehabilitation facilities, inpatient psychiatric facilities, and critical access hospitals. As a result, beneficiaries were unnecessarily charged outpatient deductibles and coinsurance payments.

All items and non-physician services provided during a Medicare Part A inpatient stay must be provided directly by the inpatient hospital or under arrangements with the inpatient hospital and another provider.

Use the following resources to bill correctly:

- Medicare Does Not Pay Acute-Care Hospitals for Outpatient Services They Provide to Beneficiaries in a Covered Part A Inpatient Stay at Other Facilities MLN Matters Special Edition Article
- Provider Compliance Tips for Ordering Hospital Outpatient Services Fact Sheet
- Acute Care Hospital Inpatient Prospective Payment System Fact Sheet; see payment information on page 3
- Items and Services Not Covered Under Medicare Booklet, Page 12
- Medicare Claims Processing Manual, Chapter 3, Section 10.4
- Medicare Inappropriately Paid Acute-Care Hospitals for Outpatient Services They Provided To Beneficiaries Who Were Inpatients of Other Facilities OIG Report

MLN Matters® Articles

Changes to the Laboratory National Coverage Determination (NCD) Edit Software for January 2020

A new MLN Matters Article MM11485 on Changes to the Laboratory National Coverage Determination (NCD) Edit Software for January 2020 is available. Learn about changes to the edit module for clinical diagnostic laboratory services.

January 2020 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

A new MLN Matters Article MM11495 on January 2020 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files is available. Learn about new and revised files available starting December 16.

International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs) - January 2020 Update — Revised

A revised MLN Matters Article MM11392 on International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs) – January 2020 Update is available. Learn about new and revised codes for NCDs.

Publications

Quality Payment Program: 2019 APM Incentive Payment Fact Sheet

Starting in September, clinicians who were qualifying Alternative Payment Model (APM) participants based on their 2017 performance will begin receiving 5% APM incentive payments. CMS posted a new 2019 APM Incentive Payment Fact Sheet to explain:

- Who is eligible to receive an APM incentive payment in 2019
- How CMS determines your payment
- Answers to frequently asked questions

For More Information:

- APMs webpage
- Contact the Quality Payment Program at 866-288-8292 (TTY 877-715-6222) or QPP@cms.hhs.gov

Billing Information for Rural Providers and Suppliers — Revised

A revised Billing Information for Rural Providers and Suppliers Medicare Learning Network Booklet is available. Learn about:

- Critical access hospitals, federally qualified health centers, home health agencies, rural health clinics, skilled nursing facilities, and swing beds
- Regional Office Rural Health Coordinators

Multimedia

Reducing Opioid Misuse Listening Session: Audio Recording and Transcript

An audio recording and transcript are available for the September 17 Medicare Learning Network listening session on Opioids: What's an "Outlier Prescriber"? 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.

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.

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

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