CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-14 Medicare End Stage Renal Disease (ESRD) Network Organizations	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 10	**Date: May 17, 2019**
	Change Request 11284

SUBJECT: Update to Publication (Pub.) 100-14 to Provide Language-Only Changes for the New Medicare Card Project

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update Pub. 100-14 with the New Medicare Card Project-related language. There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

EFFECTIVE DATE: June 18, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: June 18, 2019
Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	4/80/80.3/CMS-Directed Changes (Notifications) to the Network Patient Database
R	4/110/110.1/Processing Form CMS-2728-U3
R	4/140/CMS ESRD Forms Data Discrepancies and Data Corrections
R	4/170/Coordination of Additional Renal Related Information
R	9/90/Additional Considerations
R	Acronyms/Medicare ESRD Network Organizations List of Commonly Used Acronyms

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-14	Transmittal: 10	Date: May 17, 2019	Change Request: 11284

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EFFECTIVE DATE: June 18, 2019
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IMPLEMENTATION DATE: June 18, 2019

I. GENERAL INFORMATION

A. Background: The CMS is implementing changes to remove the Social Security Number (SSN) from the Medicare card. A new number, called the Medicare Beneficiary Identifier (MBI), will be assigned to all Medicare beneficiaries. This CR contains language-only changes for updating the New Medicare Card Project language related to the MBI in Pub. 100-14.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires removal of the SSN-based Health Insurance Claim Number (HICN) from Medicare cards within four years of enactment. There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

B. Policy: MACRA of 2015.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11284.1	MACs shall be aware of the updated language for the New Medicare Card Project in Pub. 100-14. Effective April 1, 2008, contractors shall be aware of clarification to the Medicare ESRD Network Organizations Manual (CMS Pub. 100-14) regarding the Network Organizations' responsibilities, as articulated in Chapter 10 ("Sanctions and Referrals") of this manual.	X	X	X	X					ESRD Network Organizations

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility

		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Kim Davis, 410-786-4721 or kimberly.davis@cms.hhs.gov , Tracey Mackey, 410-786-5736 or Tracey.Mackey@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare ESRD Network Organizations Manual
Chapter 4 - Information Management

80.3 - CMS-Directed Changes (Notifications) to the Network Patient Database
(Rev.10, Issued: 05-17-19, Effective: Effective: 06-18-19, Implementation: 06-18-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

ENO 440.3

The CMS may have additional or more current information on important patient data. The CMS will notify the Networks about important data element discrepancies in *the* patient database. The Networks review discrepancies and determine whether appropriate action is necessary. The Networks should update *the patient* database with accepted changes (e.g., beneficiary name, date of birth, and *Medicare beneficiary identifier*) contained in the PMMIS, and Provider Certification databases. The CMS will provide these changes to the Networks electronically through *REMIS/CROWNWeb*. Advise CMS of any outstanding discrepancies related to these notifications.

110.1 - Processing Form CMS-2728-U3
(Rev.10, Issued: 05-17-19, Effective: Effective: 06-18-19, Implementation: 06-18-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

ENO 455.1

Upon receipt of hardcopy or electronic forms in the Network Office, the Network reviews the forms for completeness, and returns them for correction or completion to the provider/facility if necessary. Each form must provide the key data elements as established by CMS. Refer to the SIMS Web site for key data element listings located at:- **www.simsproject.com/downloads_manualsinstructions.asp**
Networks are to replicate validated forms to the Central Repository nightly. CMS will access the data from the Central Repository.

- If the patient has had a transplant, check the REMIS database to see if the Organ Procurement and Transplantation Network/United Network for Organ Sharing (OPTN/UNOS) has assigned a "dummy" number. This number will usually have "9FN" in the first 3 positions. If so, use this number for the social security number in SIMS.

- If a patient does not have a *Medicare beneficiary identifier*, or a social security number, AND is not applying for Medicare benefits, and has not received a transplant, issue a "dummy" social security number using the following formula:

  Position 1 = X
  Positions 2-7 = Provider number of provider completing form
  Positions 8-9 = Sequential numbering

- Use of this "dummy" number should be a rare occurrence and only used, for example, in the case of foreign nationals or illegal aliens who generally do not have social security numbers.

Facilities must submit the Medical Evidence Report within 45 days after either a transplant or the start of a regular course of dialysis (whichever occurs first).

NOTE: The start of a regular course of dialysis is defined as the date of the first dialysis treatment after the physician has determined that the patient has ESRD and has written a prescription for a "regular course of dialysis," regardless of the dialysis setting and regardless of any acute treatments received prior to the implementation of the prescription.

If the data described in the SIMS Web site are not present, the Network returns the form to the provider, within one week of receipt, for completion of these data. Prior to returning the form, the Network may key and hold this form in SIMS until all mandatory data have been entered.

The Network enters the data from the form into SIMS and replicates daily all the “queued validated ready” information from the CMS-2728 forms to the Central Repository.

The Network maintains a file of all CMS ESRD hard copy forms that are entered at the Network. The hard copy forms are retained for two years after the date of completion and until electronic reporting through VISION is mandatory. If forms are necessary to document ongoing educational, quality assurance, or disciplinary actions beyond the retention period, the Network retains these forms for two years following the completion of that activity. Following the retention period, any forms that are patient-specific and are not maintained for the Network's use, or as documentation of actions specified above are shredded, incinerated, or otherwise completely destroyed, for patient privacy purposes.

140 - CMS ESRD Forms Data Discrepancies and Data Corrections

(Rev.10, Issued: 05-17-19, Effective: Effective: 06-18-19, Implementation: 06-18-19)

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ENO 470

When the Network makes changes to any of the SIMS patient data, it should replicate the information as soon as possible to the Central Repository. When the REMIS system reacts to the presence of modified data, the information will be automatically assumed into REMIS. Discrepancies in patient identification will appear as SIMS notifications from REMIS.

A. Notifications from REMIS to SIMS

The SIMS Notifications feature notifies users of differences in data between REMIS and SIMS. When the REMIS system senses a difference, it provides daily notification updates to a centralized staging table on the SIMS Central Repository.
Notifications are created when CMS patient data differ from the SIMS patient data. The Elements are:

- SSN

- *Medicare beneficiary identifier*

- SURNAME
- FIRSTNAME
- SEX
- DOB
- DOD
- Most recent TX (transplant) date
- Most recent TX fail date
- Most recent setting date

The Network staff is expected to access these data through SIMS by selecting:

CROWN>CMS Data Updates – Four dropdown fields will be available (Record Type, Filter by Column, Value, and Action). The user will then select "Notifications" from the Record Type dropdown field. Using the Filter By Column and then filtering through by Value, Provider Number, Source, and Action fields, the user will be shown notifications that are in the Notification Table.

Networks are expected to search and view the data that have not been processed as well as items that have already been previously marked "under investigation" and update the status of each notification as it is reviewed.

- Network users have the option of Accepting, Rejecting or marking any notification as "Under Investigation". New notifications will be available to Networks on a daily basis.

  ACCEPT – This will update SIMS data with the CMS indicated changes.

  REJECT – This will not update SIMS data and will set the status of the notification to Reject.

  UNDER INVESTIGATION – This will not update SIMS data and will set the status of the notification to Under Investigation.
- If a user chooses to reject a notification, the user can double click on the record to enter a comment on why the user does not want to process this notification. All comments are stored in the database for future analysis.

- See the SIMS Notification Functional Specification (on the SIMS Web site) and the SIMS User Manual for more details on the use of the SIMS utilities.

B. Processing Expectations:

Notifications should be processed within 60 days of receipt.

Notifications should not have an “under investigation” status for more than 60 days. Periodically, CMS will compare the number of records rejected and “under investigation” by each Network to the national average of all 18 Networks; CMS will also compare the amount of time records remain in the “unprocessed” and “under investigation” categories. Statistical outliers will be asked to explain the differences between their data and performance practice and those of the other Networks.

C. Determining the Correct *Medicare Beneficiary Identifier*

If the patient is deceased and was an ESRD patient, the correct *Medicare beneficiary identifier* is still required. In cases where the patient died shortly after the onset of renal failure, it is possible that Medicare entitlement was never established. If this is the case, the Network should report the patient as "non-Medicare" on the appropriate SIMS screen and assure that the related data is replicated to the Central Repository. In some of these cases, the patient may have been previously enrolled in Medicare due to old age or disability. The CMS needs to know whether a person was actually an ESRD patient as opposed to an acute renal failure patient [i.e., a patient who was placed on dialysis but who was expected to recover function from his/her native kidney (not a transplanted kidney)]. If the person is definitely an ESRD patient, the Network should obtain a Medical Evidence Report, enter it into SIMS, and assure that the related data is replicated to the Central Repository.

One way of determining a correct name/number is to ask the facility/provider where the patient was, or is, being treated and to contact the billing office to obtain the correct *Medicare beneficiary identifier*, name, or information concerning the patient. The Network may also request a copy of the patient's Medicare card from the facility/provider. In the event that the patient is found to be non-Medicare, enter this fact on the appropriate SIMS screen.

D. Other Incorrect Data Elements

In addition to the *Medicare beneficiary identifier*, one of several other data elements could be incorrect. All of these data elements are used to match a master record:

- Spelling of the surname;
- Date of birth;
- Sex;
- First initial; and
- SSN.

If any of these elements are different from the ones the facility/provider reports, the Network should enter the correction into SIMS and assure that the related data are replicated to the Central Repository.

170 - Coordination of Additional Renal Related Information

(Rev.10, Issued: 05-17-19, Effective: Effective: 06-18-19, Implementation: 06-18-19)

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ENO 485

A. Veterans Health Administration (VHA)

The Network processes CMS ESRD forms on VHA patients from all VHA facilities. The submission of data to the Network by VHA facilities on their ESRD patients is mandatory. The VHA released VHA Directive 2001-024 on April 23, 2001, to its dialysis and transplant units. This Directive provides instructions for participation in the United States Renal Data System through the completion of ESRD forms.

The Network supplies the VHA units with the Medical Evidence Report and Death Notification forms. CMS ensures that the Network is supplied with adequate forms to meet the requests from VHA units. Each VHA facility must fill out the ESRD Facility Survey. Follow the instructions below when receiving data on VHA patients:

1. Completion of VHA Forms

Completion of CMS ESRD forms on VHA patients is mandatory on the part of the VHA. VHA facilities may but are not required to participate in Network activities (e.g., meetings, quality improvement projects, committee or Board members).

2. Submission of VHA Forms to CMS

The Network submits VHA patient data with the other CMS forms that are submitted on a monthly basis. If the forms do not pass the critical edits, the Network returns the unaccepted form(s) to the VHA facility, explains the problem, and requests the VHA unit to resubmit the form with the necessary corrections to it. The Network is not required to validate the information supplied by the VHA unit; however, the Network is required to track the VHA unit's compliance with forms submission, resubmission, completion, or accuracy.

VHA units must submit forms on VHA patients using their CMS provider number, which is an "F" number. VHA units should forward to the Network all copies of the ESRD forms that they complete (after they retain one copy for their files). The Network keeps one copy of each form for its files and destroys all other copies, to protect patient privacy.

If the VHA patient has a *Medicare beneficiary identifier*, the Network submits this information with the monthly CMS forms it is submitting.

The Network may share information with other Networks if it is discovered that VHA patients who received transplants in other network areas are now located in a new network area. Since information on VHA patients may not be otherwise available, information on the VHA transplant recipient may be the only source for the other Network.

B. Inquiries From Medicare+Choice (M+C) Organizations

The Network responds to permissible inquiries from its area M+C organizations regarding the ESRD status of Medicare beneficiaries who are members of the M+C organizations. Permissible inquiries are for those patients who have been on dialysis for at least 4 months and whose records are not retrievable through other CMS-provided electronic data sources. CMS provides the Network with a list of the M+C organizations in its network area. M+C organizations receive a higher rate of payment for Medicare enrollees with ESRD. It is important that M+C organizations are correctly paid for their members with ESRD.

NOTE: With the current demonstration project, M+C organizations have access to a CMS-supplied database that provides entitlement status. It is anticipated that this service will be extended to all M+C organizations, thereby replacing the labor-intensive case-by-case look-up and reporting by Networks.

1. Information to be Provided to M+C Organizations

The Network provides the following types of information to M+C organizations upon written request:

- The patient's current dialysis/transplant functional status;

- The first date of dialysis or date of transplant; and
- The date Form CMS-2728 data was submitted to CMS

The Network uses its local database or PMMIS database to provide the above information to the M+C organizations.

2. Information Not Required to be Provided to M+C Organizations

The Network is not required to answer any questions regarding the date of death or the status of a current or pending Medicare entitlement, application, or payment. The M+C organizations have been advised to refer entitlement and/or application questions to the SSA servicing office and to refer payment questions to the CMS ROs. In addition, the Network should not routinely provide M+C organizations with copies of Form CMS-2728. M+C organizations should obtain this information from the servicing dialysis facility.

If the Network suspects that either the M+C organization or its agents are abusing these privileges, report these matters along with any proof the Network may have to Janice Bailey, CMS, CBC, and DEPO, at E-mail address jbailey1@cms.hhs.gov or Marla Kilbourne, CMS, CBC, and DEPO, at E-mail address mkilbourne@cms.hhs.gov .

The Network reports to its PO in the Quarterly Progress and Status Report, the number of inquiries received from M+C organizations during the quarter.

Medicare ESRD Network Organizations Manual
Chapter 9 - Information Collection

90 - Additional Considerations
(Rev.10, Issued: 05-17-19, Effective: Effective: 06-18-19, Implementation: 06-18-19)

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ENO 980

The Network **must** include the following items in its information collection activity:

A. Beneficiary Notification Letter

Before contacting a beneficiary to participate in a survey (either by mail or by phone), notify the beneficiary in writing of the possibility of his/her being contacted. The letter, which must go out over the Regional Administrator's signature, must:

- Identify the Network (e.g., the State's quality improvement organization for Medicare's ESRD program);
- Describe the nature of the survey (e.g., whether it is a mail or phone survey, the purpose of the survey, etc.);
- Inform the beneficiary that he/she is under no obligation to respond to the survey;
- Assure the beneficiary that the decision to respond or not to respond will not affect the beneficiary's Medicare (or Medicaid, where applicable) benefits; and
- Assure the beneficiary that his/her identity and the responses provided by him or her are confidential and that all information provided is protected by the Privacy Act.

The letter must be dated and must include a toll-free or collect phone number with the name of a contact person at the Network that the beneficiary can call if he/she has additional questions about the survey or prefers not to participate in the survey. Beneficiary Notification Letters must be received by the beneficiary at least fifteen (15) calendar days prior to the implementation of the survey.

The project officer must review and approve the content and format of the Beneficiary Notification Letter prior to its being mailed to the beneficiaries. The Network work with its Network project officer to secure the proper CMS authorization and signature for the letter. The letter must be written on CMS letterhead and may be mailed in an envelope using the Network's return address. The Network is encouraged to model its Beneficiary Notification Letter after previously approved letters, to expedite the review and clearance processes. Consider the time required for this review and clearance when planning its information collection activity.

The RO review of the Beneficiary Notification Letter may occur simultaneously with the RCO's review of the Network’s Request.

B. Beneficiary No-Contact List

During the course of its work, the Network may encounter beneficiaries who indicate that they prefer not to participate in surveys that the Network conducts. The Network must maintain a list (including name, *Medicare beneficiary identifier*, address, and date of birth) of these beneficiaries and **must not** contact any of these beneficiaries to participate in a survey. Before sending a Beneficiary Notification Letter, the Network consults its Beneficiary No-Contact List to determine whether any of the beneficiaries that the Network intends to contact are on that list, and remove those beneficiaries from the survey sample. At such time that CMS may request it, the Network must provide to CMS the name, *Medicare beneficiary identifier*, address, and date of birth of all beneficiaries on its Beneficiary No-Contact List.

Medicare ESRD Network Organizations
List of Commonly Used Acronyms

(Rev.10, Issued: 05-17-19, Effective: Effective: 06-18-19, Implementation: 06-18-19)

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AAKP -- American Association of Kidney Patients

AHRQ -- Agency for Healthcare Research and Quality

AKF -- American Kidney Fund

ANNA -- American Nephrology Nurses Association

BOD -- Board of Directors

BUN -- Blood Urea Nitrogen

CMS -- Centers for Medicare & Medicaid Services

CMSDC -- CMS Data Center

CO -- Central Office (CMS)

CPM -- Clinical Performance Measure

CQI -- Continuous Quality Improvement

CROWN -- Consolidated Renal Operations in a Web-Enabled Network

EC -- Executive Committee of the Network

EDEES -- ESRD Data Entry and Editing System (CMS)

EPO -- Erythropoietin

ESRD -- End Stage Renal Disease

FPR -- Final Project Report

HCQIP -- Health Care Quality Improvement Program

HCT -- Hematocrit

HD -- Hemodialysis

Mbi -- *Medicare beneficiary identifier*

IMRP -- Instruction Manual for Renal Providers

MRB -- Medical Review Board

NC -- Network Council

NCC -- Network Coordinating Council

NIDDK -- National Institute of Diabetes, and Digestive and Kidney Diseases

NIH -- National Institutes of Health

NIP -- National Improvement Project

NKF -- National Kidney Foundation

NPP -- Narrative Project Plan

NRAA -- National Renal Administrators Association

OCSQ -- Office of Clinical Standards and Quality

ODIE -- Online Data Input and Edit

OGC -- Office of General Counsel (CMS)

OIC -- Opportunity to Improve Care

OIG -- Office of the Inspector General (CMS)

OPO -- Organ Procurement Organization

OPTN -- Organ Procurement and Transplantation Network

OSCAR -- Online Survey Certification and Reporting

PD -- Peritoneal Dialysis

PID -- Project Idea Document

PIP -- Performance Improvement Plan

PMMIS -- Program Management and Medical Information System

PO -- Project Officer

QA -- Quality Assurance

QI -- Quality Improvement

QIO -- Quality Improvement Organization

QIP -- Quality Improvement Project

REBUS -- Renal Beneficiary and Utilization System

REMIS -- Renal Management Information System

RO -- Regional Office (CMS)

ROPO -- Regional Office Project Officer

RPA -- Renal Physicians Association

SA -- State Agency/State Survey Agency

SIMS -- Standard Information Management System

SOW -- Statement of Work

SSA -- Social Security Administration

SSN -- Social Security Number

TQE -- Total Quality Environment

UNOS -- United Network for Organ Sharing

USRDS -- United States Renal Data System

VHA -- Veterans Health Administration

VISION -- Vital Information System to Improve Outcomes in Nephrology