CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-02 Medicare Benefit Policy	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 257	**Date: March 1, 2019**
	Change Request 11170

SUBJECT: Update to Publication 100-02 Provide Language-Only Changes for the New Medicare Card Project

I. SUMMARY OF CHANGES: This Change Request (CR) contains language-only changes for updating the New Medicare Card Project-related language in Publication 100-02. 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: April 1, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 1, 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	5/40.1/Election Format
R	5/40.2.1/Revocation Format
R	11/140.9/Post-transplant Services Provided to Live Donor

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. 100-02	Transmittal: 257	Date: March 1, 2019	Change Request: 11170

SUBJECT: Update to Publication 100-02 Provide Language-Only Changes for the New Medicare Card Project

EFFECTIVE DATE: April 1, 2019
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IMPLEMENTATION DATE: April 1, 2019

I. GENERAL INFORMATION

A. Background: 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 Publication 100-02.

B. Policy: The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires removal of the Social Security Number (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.

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	
11170.1	MACs shall be aware of the updated language for the New Medicare Card Project in Publication 100-02.	X	X	X	X					

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): Tracey Mackey, 410-786-5736 or Tracey.Mackey@cms.hhs.gov, Kim Davis, 410-786-4721 or kimberly.davis@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 Benefit Policy Manual
Chapter 5 - Lifetime Reserve Days

40.1 - Election Format
(Rev. 257, Issued: 03-01-19, Effective: 04- 01-19 Implementation: 04- 01-19)

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.

The following model election language may be used:

Election Not To Use Lifetime Reserve Days

> I do not wish to have Medicare benefits paid on my behalf under the lifetime reserve provisions of section 18l2 (b) of the Social Security Act for services furnished me by (name of hospital) beginning (date).

WHERE THE ELECTION MAY TERMINATE BEFORE THE END OF THE STAY IN ACCORDANCE WITH §40, THE FOLLOWING MAY BE INCLUDED:

> The last day to which this election applies is (date).
>
> I understand that I will be responsible for all of the hospital's charges not reimbursed by Medicare because of this election, except those covered under Medicare Part B. Where Medicare Part B payments may be made for services furnished during the period covered by the election, I will be responsible for the deductible and 20 percent coinsurance amounts.
>
> (Signature) (Date)
> (*Medicare beneficiary identifier*)

40.2.1 - Revocation Format
(Rev. 257, Issued: 03-01-19, Effective: 04- 01-19 Implementation: 04- 01-19)

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.

The revocation of an election not to use reserve days should specify the name of the hospital, the admission date of the stay to which it applies and, if appropriate, the effective date of revocation. The following model language is suggested:

Revocation of Election Not To Use Lifetime Reserve Days

> I wish to revoke the election previously made by me or on my behalf not to use lifetime reserve days to pay for the inpatient hospital services furnished me by (name of hospital) during my stay there beginning (admission date). (If appropriate add: I wish to revoke my election not to use lifetime reserve days for the period from _____to_____.) I understand that my lifetime reserve days will be used for these services (to the extent that I have such days available) but that I will still be

responsible to pay the Medicare coinsurance amounts and any charges for services not covered under the Medicare program.

(Signature) (Date)
(*Medicare beneficiary identifier*)

Medicare Benefit Policy Manual
Chapter 11 - End Stage Renal Disease (ESRD)

140.9 – Post-transplant Services Provided to Live Donor

(Rev. 257, Issued: 03-01-19, Effective: 04- 01-19 Implementation: 04- 01-19)

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.

The donor of an organ for a Medicare transplant beneficiary is covered for an unlimited number of days of care in connection with the organ removal operation. Days of inpatient hospital care used by the donor in connection with the organ removal operation shall not be charged against either party's utilization record. However, the program's assumption of liability is limited to those donor expenses that are incurred directly in connection with the organ donation.

Coverage of organ donor services includes postoperative recovery services directly related to the organ donation. For routine follow-up care the period of postoperative recovery ceases when the donor no longer exhibits symptoms related to the kidney donation. Claims for services rendered more than 3 months after donation surgery will be reviewed. However, follow-up examinations may be covered up to 6 months after the donation to monitor for possible complications. The requirement that additional payment cannot be made for services included in the donor's organ removal charge still applies.

Regarding donor follow-up:

Expenses incurred by the transplant center for routine donor follow-up care are included in the transplant center's organ acquisition cost center.

Follow-up services performed by the operating physician are included in the 90-day global payment for the surgery. Beyond the 90-day global payment period, follow-up services are billed using the recipient's *Medicare beneficiary identifier*.

Follow-up services billed by a physician other than the operating physician for up to 3 months following donation surgery should be billed under the recipient's *Medicare beneficiary identifier*.

Regarding donor complications:

Expenses incurred for complications that arise with respect to the donor are covered only if they are directly attributable to the donation surgery. Complications that arise after the date of the donor's discharge will be billed under the recipient's *Medicare beneficiary identifier*. This is true of both facility cost and physician services. Billings for donor complications will be reviewed.

In all of these situations, the donor is not responsible for co-insurance or deductible.