REVENUE CYCLE MANAGEMENT

University Physicians' Association, Inc.

November 2019

www.upasolutions.com

Annual CPT Coding Updates

Annual CPT Coding updates are coming soon. There are 394 CPT changes that will be effective 1/1/2020. Ensure your providers and staff are up to date with the new, deleted, and revised codes that may affect your practice.

Highlights Include:

- 23 New EEG codes for long term monitoring services will replace 95950, 95951, 95953, 95956
- New behavior assessment and intervention codes: 96156, 96158, 96164, 96167, 96170 and add-on codes 96159, 96165, 96168, 96171. These codes replace six older codes (96150-96155)
- New Category I reporting codes

New Medicare Cards MBI Deadline Approaching

All Medicare eligible patients should have received new Medicare cards without their social security number. Medicare began issuing new cards with Medicare beneficiary identifiers (MBI) in early 2018. During the new card roll-out period CMS allowed providers a transition period to report either the patient's previous Health Insurance Claim Number (HICN) or the new MBI. The transition period ends on 12/31/19 and CMS will then reject any claims submitted without the MBI. Palmetto GBA has an MBI Look up tool available through their E-Services portal.

Veterans Administration Community Care Network

The VA's new Community Care Network (CCN) contracts for Regions 1, 2, 3 (Tennessee is Region 3) have been awarded to Optum Solutions, Inc. This program takes the place of the Veterans Choice Program (VCP) and allows the U.S. Department of Veterans Affairs to increase veterans' access to healthcare. The CCN will allow the VA to purchase care for veterans from community healthcare providers. TriWest Healthcare Alliance will continue to provide care coordination until the CCN is fully implemented. At this time, there is no target date for the Optum contracts to begin, however the rollout process will continue through 2020. For additional information, the FAQ attached is provided by Optum.

Blue Cross Blue Shield of Tennessee (October Blue Alert)

Practices are reminded to report accurate NDC information on provider administered vaccines. Clinicians, as well as charge entry staff should be documenting and reporting the NDC number directly from the product's vial or syringe for any medication administered, which is the preferred method of most payers. The use of "cheat sheets" for billing NDCs is discouraged, as failure to validate information as medication stock changes could lead to claim denials, and potential lost revenue.

October Blue Alert

Changes Related to NDC and J-Codes

We've required the National Drug Code (NDC) on all institutional and professional claims for provider-administered medications since 2014. As of September 1, 2019, we'll reject claims submitted without a valid NDC. Please be sure to include the full 11-digit NDC code on the claim, including any leading zeroes. You may refer to our **Provider Administration Manuals** for more information.

Blue Cross Blue Shield of Tennessee (November Blue Alert)

Reminder from Bluecare and Tenncare Select that prior authorizations are required for secondary claims, unless the services are considered covered by Medicare as primary.

November Blue Alert

Prior Authorization Required for Secondary Claims

Please remember that prior authorization requirements apply when you submit claims for secondary payment from BlueCare or TennCareSelect. Prior authorization is not necessary if the primary carrier is Medicare and the services provided are covered by Medicare, hospice services where Medicare is primary, or if the primary carrier provided benefits and there are no plans to file a secondary claim. Services not covered by Medicare, or where Medicare benefits are exhausted require prior authorization as outlined in the Provider Administration Manual.

Note: Retrospective review can be requested for members with Medicare when Medicare fails to provide benefits for services typically covered.

Jennifer Bright, CPC, CPB, CPPM
Billing, Coding, and Appeals Manager
9000 Executive Park Drive; C200, Knoxville, TN 37923
office : 865.670.6104 cell: 865.776.6072 fax : 865.670.6181
JTBright@utmck.edu \ upasolutions.com

mln MATTERS®
KNOWLEDGE • RESOURCES • TRAINING

New Medicare Beneficiary Identifier (MBI) Get It, Use It

MLN Matters Number: SE18006 Reissued
Related Change Request (CR) Number: N/A
Article Release Date: August 19, 2019
Effective Date: N/A
Related CR Transmittal Number: N/A
Implementation Date: N/A

Note: We reissued this article on August 19, 2019, to show that all new Medicare cards have been mailed, to encourage providers to use MBIs now to protect patients' identities, to emphasize that providers must use MBIs beginning January 1, 2020, and to explain the rejection codes providers will get if they submit a HICN after January 1, 2020.

PROVIDER TYPE AFFECTED

This Special Edition MLN Matters® Article is for physicians, providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs), including Durable Medical Equipment MACs (DME MACs) and Home Health and Hospice MACs, for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

Use MBIs now for all Medicare transactions. The Centers for Medicare & Medicaid Services (CMS) finished mailing new Medicare cards. The new cards without Social Security Numbers (SSNs) offer better identity protection. Help protect your patients' personal identities by getting their MBIs and using them for Medicare business, including claims submission and eligibility transactions.

Starting January 1, 2020, even for services provided before this date, you must use MBIs. With a few exceptions, Medicare will reject claims you submit with Health Insurance Claim Numbers (HICNs.) Medicare will reject all eligibility transactions you submit with HICNs.

There are 3 ways you and your office staff can get MBIs:

1. Ask your Medicare patients

Ask your Medicare patients for their new Medicare cards when they come for care. If they didn't get a new card, give them the Get Your New Medicare Card flyer in English or Spanish.

2. Use your MAC's secure MBI look-up tool

You can look up MBIs for your Medicare patients when they don't or can't give them. Sign up for the Portal to use the tool. You can use this tool even after the end of the transition period – the

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
Medicare Learning Network®

tool doesn't end on December 31, 2019. Even if your patients are in a Medicare Advantage Plan, you can look up their MBIs to bill for things like indirect medical education.

You must have your patient's SSN for the search and it may differ from the HICN, which uses the SSN of the primary wage earner. If your Medicare patient doesn't want to give the SSN, tell your patient to log into mymedicare.gov to get the MBI.

If the look-up tool returns a last name matching error and the beneficiary's last name includes a suffix, such as Jr. Sr. or III, try searching without and with the suffix as part of the last name.

3. Check the remittance advice

We'll also return the MBI on every remittance advice when you submit claims with valid and active HICNs through December 31, 2019. Get the MBI from the remittance advice and save it in your systems to use with your next Medicare transaction.

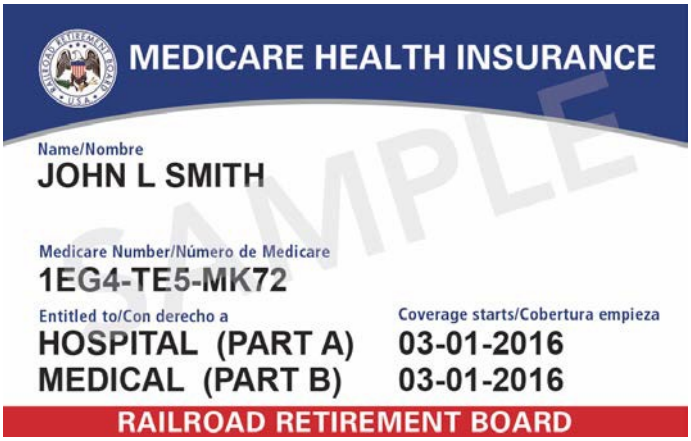
BACKGROUND

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) required CMS to remove SSNs from all Medicare cards by April 2019. CMS replaced the SSN-based HICN with a new, randomly generated MBI. The new MBI is noticeably different than the HICN. **Just like with the HICN, the MBI hyphens on the card are for illustration purposes: don't include the hyphens or spaces on transactions.** The 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 **(for example, between "0" and "O").**

The Railroad Retirement Board (RRB) also mailed new Medicare cards with MBIs. The RRB logo will be in the upper left corner and "Railroad Retirement Board" at the bottom, but you can't tell from looking at the MBI if your patient is eligible for Medicare because they're a railroad retiree. You'll be able to identify them by the RRB logo on their card, and we'll return a "Railroad

Retirement Medicare Beneficiary" message on the Fee-For-Service (FFS) MBI eligibility transaction response.

RRB Issued Medicare Card



Use the MBI the same way you used the HICN. Put the MBI in the same field where you've always put the HICN. This also applies to reporting informational only and no-pay claims. **Don't use hyphens or spaces with the MBI to avoid rejection of your claim.** The MBI replaces the HICN on Medicare transactions including Billing, Eligibility Status, and Claim Status. The effective date of the MBI, like the old HICN, is the date each beneficiary was or is eligible for Medicare. After January 1, 2020, we will reject claims submitted with HICNs, with few exceptions. You will get:

- Electronic claims- Reject codes: Claims Status Category Code of A7 (acknowledgment rejected for invalid information), a Claims Status Code of 164 (entity's contract/member number), and an Entity Code of IL (subscriber)
- Paper claims- paper notice; Claim Adjustment Reason Code (CARC) 16 "Claim/service lacks information or has submission/billing error(s)" and Remittance Advice Remark Code (RARC) N382 "Missing/incomplete/invalid patient identifier"

The beneficiary or their authorized representative can request an MBI change. CMS can also change an MBI. An example is if the MBI is compromised. There are different scenarios for using the old or new MBIs:

FFS claims submissions with:

- Dates of service before the MBI change date – use old or new MBIs.
- Span-date claims with a "From Date" before the MBI change date – use old or new MBIs.
- Dates of service that are entirely on or after the effective date of the MBI change – use new MBIs.

FFS eligibility transactions when the:

- Inquiry uses new MBI – we'll return all eligibility data.
- Inquiry uses the old MBI and request date or date range overlap the active period for the old MBI – we'll return all eligibility data. We'll also return the old MBI termination date.
- Inquiry uses the old MBI and request date or date range are entirely on or after the effective date of the new MBI – we'll return an error code (AAA 72) of "invalid member ID."

When the MBI changes, we ask the beneficiary to share the new MBI with you. You can also get the MBI from your MAC's secure MBI lookup tool.

Exceptions

There are a few exceptions when you can use either the HICN or MBI on or after January 1, 2020:

- Appeals – You can use either HICNs or MBIs for claim appeals and related forms.
- Claim status query – You can use the HICN or MBI to check the status of a claim (276 transactions) if the earliest date of service on the claim is before January 1, 2020. If you are checking the status of a claim with a date of service on or after January 1, 2020, you must use the MBI.
- Span-date claims – You can use HICNs or MBIs for 11X-Inpatient Hospital, 32X-Home Health (home health claims and Request for Anticipated Payments [RAPs]) and 41X-Religious Non-Medical Health Care Institution claims if the "From Date" is before the end of the transition period (December 31, 2019). If a patient starts getting services in an inpatient hospital, home health, or religious non-medical health care institution before December 31, 2019, but stops getting those services after December 31, 2019, you may submit a claim using either the HICN or the MBI, even if you submit it after December 31, 2019. Since you submit home health claims for a 60-day payment episode, you can send in the episode's RAP with either the HICN or the MBI, but after the transition period ends on December 31, 2019, you have to use the MBI when you send in the final claim that goes with it.

The MBI doesn't change Medicare benefits. **Protect the MBI as Personally Identifiable Information (PII); it is confidential like the HICN.**

Medicare Advantage and Prescription Drug plans continue to assign and use their own identifiers on their health insurance cards. For patients in these plans, continue to ask for and use the plans' health insurance cards.

ADDITIONAL INFORMATION

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

To sign up for your MAC's secure portal MBI look-up tool, visit https://www.cms.gov/Medicare/New-Medicare-Card/Providers/MACs-Provider-Portals-by-State.pdf.

The MBI format specifications, which provide more details on the construct of the MBI, are available at https://www.cms.gov/Medicare/New-Medicare-Card/Understanding-the-MBI.pdf.

A fact sheet discussing the transition to the MBI and the new cards is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TransitiontoNewMedicareNumbersandCards-909365.pdf.

DOCUMENT HISTORY

Date of Change	Description
August 19, 2019	We reissued this article to show that all new Medicare cards have been mailed, to encourage providers to use MBIs now to protect patients' identities, to emphasize that providers must use MBIs beginning January 1, 2020, and to explain the rejection codes providers will get if they submit a HICN after January 1, 2020.
March 6, 2019	We revised this article to add language that the MBI look-up tool can be used to obtain an MBI even for patients in a Medicare Advantage Plan. All other information remains the same.
December 10, 2018	The article was revised to update the language regarding when MACs can return an MBI through the MBI look up tool (page 1). All other information remains the same.
July 11, 2018	This article was revised to provide additional information regarding the format of the MBI not using letters S, L, O, I, B, and Z (page 2).
June 25, 2018	This article was revised to provide additional information regarding the ways your staff can get MBIs (page 1).
June 21, 2018	The article was revised to emphasize the need to submit the MBI without hyphens or spaces to avoid rejection of your claim.
May 25, 2018	Initial article released.

VA Community Care Network

Frequently Asked Questions for Providers

Overview

- Community Care Network (CCN) contracts are awarded by the Department of Veterans Affairs (VA) to ensure health care services and resources are available for the diverse population of Veterans who are unable to receive care at a VA medical facility.
- VA CCN contracts provide eligible Veterans access to licensed community health care providers.
- VA awarded VA CCN contracts for Regions 1, 2 and 3 to Optum. VA CCN will roll out in phases. Health care delivery began in Summer 2019 for Region1 and will proceed in Regions 2 and 3 in 2019 and throughout 2020. As the phases roll out, Optum's network of community providers will be delivering expanded services to Veterans.

Region 1		Region 2		Region 3	
Connecticut	New Hampshire	Illinois	Missouri	Alabama	South Carolina
Delaware	New Jersey	Indiana	Nebraska	Arkansas	Tennessee
District of Columbia	New York	Iowa	North Dakota	Florida	U.S. Virgin Islands
Maine	North Carolina	Kansas	Ohio	Georgia	
Maryland	Pennsylvania	Kentucky	South Dakota	Louisiana	
Massachusetts	Rhode Island	Michigan	Wisconsin	Mississippi	
	Vermont	Minnesota		Oklahoma	
	Virginia			Puerto Rico	
	West Virginia				

To become more familiar with VA CCN, please read the following frequently asked questions (FAQs). Please visit vacommunitycare.com to find the VA CCN Provider Manual and other training material.

Eligibility and Benefits

Q. Are all Veterans eligible to receive care from providers participating in VA CCN?

A. VA will determine a Veteran's eligibility to receive community care. To be eligible, a Veteran must be both:

- Enrolled in VA's patient enrollment system
- Have an approved referral from VA for community care

Enrolled Veterans would normally receive care from a VA medical facility or VA provider. When services are not available at a VA medical facility, an appointment is not available at a VA medical facility within a certain timeframe or the Veteran lives too far away from a VA medical facility, VA may issue an approved referral for a Veteran to receive community care. The Veteran's caregivers and family members are not eligible for VA CCN.

Q. How do I confirm that a Veteran is eligible for VA CCN services?

A. VA will contact the VA CCN provider to request acceptance of a referral and supply a referral packet with information to include the type of care the Veteran can receive. To view approved referrals and check eligibility, access vacommunitycare.com > I am a Provider > Medical/Behavioral Provider.

Q. How will I know when VA will begin sending referrals to me under the Optum VA CCN?

A. VA CCN will roll out in phases. Health care delivery began in Summer 2019 for Region1 and will proceed in Regions 2 and 3 throughout 2020. As each VAMC becomes active, you will begin receiving referrals from VA. To view deployment schedules, go to vacommunitycare.com > I am a Provider > Training & Guides.

Referrals

Q. Are referrals required for VA CCN?

A. Yes. Before a Veteran receives care or services from a VA CCN provider, VA must issue an approved referral with a standardized episode of care (SEOC) and a consult order indicating what services the VA provider is requesting. If the VA CCN provider delivers care or services without an approved referral, the VA CCN provider may not be reimbursed for the care or services provided.

- The referral will include a start date and an end date, along with a specified number of visits and/or services related to a plan of care.
- If a Veteran has selected a VA CCN primary care provider (PCP), VA will issue a referral that is valid for up to one year to include unlimited primary care visits to the VA CCN primary care provider.
- All approved services will be listed on the approved referral under the SEOC section. The VA CCN provider will be able to verify the status of an approved referral at vacommunitycare.com or by calling CCN Provider Services at **888-901-7407**.

Q. If I want to perform additional services not included on the approved referral and SEOC, can I perform additional care without a new approved referral?

A. No. When a VA CCN provider identifies a need for care that falls outside of the Veteran's SEOC, or a need to extend the number of authorized visits, the VA CCN provider must send a request for services (RFS) form to VA. You can find the referral instructions and procedures at vacommunitycare.com > I am a Provider > Training & Guides.

Q. Can I perform any medical procedure after confirming that an eligible Veteran has been referred to me?

A. No. All approved referrals will include a SEOC and consult order. Services provided within the SEOC are approved, however, the provider should review the consult order to see which services are being requested from VA and use their clinical judgement to evaluate and treat the Veteran. In many situations, not all services listed on the SEOC will be medically necessary.

Q. Are approved referrals required for VA CCN treatment during a medical emergency?

A. If a VA CCN provider is providing services to a Veteran under an approved referral and determines that the Veteran is experiencing an emergent symptom or condition, follow internal emergent protocols. Once the situation has stabilized, contact the referring VA medical facility listed on the referral to report the incident.

Q. Can I refer a Veteran for care to another provider in the VA CCN network?

A. Yes, for services and procedures on the approved referral and SEOC. However, all referral requests for additional services not on the approved referral and SEOC must be approved by VA. The VA CCN provider must send a RFS to VA. You can find the referral instructions and procedures at vacommunitycare.com > I am a Provider > Training & Guides.

Q. Can I refer a Veteran for care to a provider in another region?

A. No. A Veteran's eligibility for community care is specific to the region where VA issues the referral. Even if a VA CCN provider has an additional clinic or office that is outside of the region from the approved referral, the Veteran can't be treated there without a new referral.

Q. Can I refer a Veteran to a hospital for admission?

A. Referral requests for hospitalization must be approved by VA, just the same as any other services beyond what is specified in the approved referral and SEOC. You can find the referral instructions and procedures at vacommunitycare.com > I am a Provider > Training & Guides.

Claims and Provider Reimbursement

Q. How do I file a claim?

A. The VA CCN provider will find instructions for filing electronic and paper CCN claims for medical care, behavioral health, dental, and pharmacy services at vacommunitycare.com. All claims must have an approved referral number. Medical documentation must be sent directly to VA and not submitted with the claim.

Q. What is the VA CCN reimbursement rate for approved services?

A. For claims submitted with a valid approved referral number, services will be reimbursed according to the following payment order:

- Covered services will be reimbursed at 100 percent of the Centers for Medicare & Medicaid Services (CMS) Fee Schedule amount.

- Covered services that are not covered by the Medicare program or for which the Medicare program does not have local pricing, will be reimbursed according to the VA Fee Schedule.
- If the VA Fee Schedule does not include a rate for the covered service provided, reimbursement will be made at 100 percent of customary charges, as defined in the provider's VA CCN Payment Appendix.

The VA Fee Schedule is available at vacommunitycare.com > I am a Provider > Documents & Links

Q. Are there exceptions to the reimbursement rates noted above?

A. Yes.

- For home infusion providers, if not covered by CMS Fee Schedule and the VA Fee Schedule does not include a rate for the covered services provided, reimbursement will be made at 85 percent of customary charges, as defined in the provider's VA CCN Payment Appendix.
- All providers will be paid $20.50 for the administration of influenza (flu) vaccine.
- All dental providers will be reimbursed according to the fee schedule in their Dental Payment Appendix.

Q. Can I bill the Veteran for services denied by VA?

A. No. VA CCN providers cannot bill Veterans for any services denied by VA or for services not included on approved referral issued by VA.

Additional VA Resources

Q. Where can community providers find additional information on VA CCN?

A. VA information on CCN, including upcoming training, is available at va.gov/communitycare.