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Health Information Compliance Alert

Medicare Beneficiary Identifiers: Expect HICNs to Reject Starting Jan. 1

Review your MAC's MBI advice now before it's too late.

The countdown is on! In less than a month, the feds will reject Medicare claims that use beneficiaries' old Health Insurance Claims Numbers (HICNs). That means its crunch time, and you should be utilizing your patients' Medicare Beneficiary Identifiers (MBIs) to circumvent issues before the transition ends.

Reminder: Starting on Jan. 1 - no matter the date of service - the **Centers for Medicare & Medicaid Services** (CMS) will reject claims with the old HICNs, with a few exceptions. The transition ends on Dec. 31, and providers should be using beneficiaries' new MBIs on their claims submissions as soon as possible.

Remember, CMS initiated the change to move away from Social Security numbers on Medicare beneficiaries' cards starting in April 2018. The move to replace the old cards with MBIs was made to protect patients from identity theft and fraud.

Don't forget that the new MBIs do not contain "Os," but instead utilize zeros, reminds CMS in guidance. Each unique MBI consists of 11 randomly-generated alphanumeric characters. CMS uses the numbers 0-9 and uppercase letters from A-Z in the MBIs.

Important: An exception to this rule is that the letters S, L, O, I, B, and Z are not included. CMS excluded these letters to avoid confusion.

The most recent statistics show that 87 percent of providers are using the new numbers in their claims submissions, notes a Dec. 10 special edition of MLN Connects.

According to guidance from Part B Medicare Administrative Contractor (MAC) **CGS Medicare**, you can expect these notices on Jan. 1:

- **Electronic claims:** Providers will receive these reject codes if they use HICNs: "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)," CGS notes in its December Bulletin.
- **Paper claims:** According to the Part B MAC, you'll receive these codes on your paper claims for HICN usage: "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.'"

Review the Exceptions

FFS exceptions: For fee-for-service (FFS) claims, there are five exceptions to the MBI rule. You can still submit claims with an HICN for the following reasons:

- Appeals;
- Audits;
- Claims status query for claims before Jan. 1, 2020;
- Claims for "11X-Inpatient Hospitals, 32X-Home Health (home health claims & Request for Anticipated Payments (RAPs)), and 41X-Religious Nonmedical Health Care Institutions" that start during the transition but run past its deadline of Dec. 31; or
- Incoming premium payments for beneficiaries who don't get Social Security or Railroad Retirement benefits.

Medicare plans: According to CMS, there are a few exceptions for Medicare plans, too. It's acceptable to use HICNs for

plan appeals. You can also use them for "Drug Data Processing, Risk Adjustment Processing, and Encounter Data" adjustments, advises the agency.

Currently, CMS intends to use HICNs for incoming and outgoing reports on things like Provider Statistical reports, Accountable Care Organization (ACO) reports, and others "until further notice," guidance indicates. Plans can also use HICNs for older contract years as well.

See more details and advice on helping patients get their MBIs at www.cms.gov/Medicare/New-Medicare-Card/index.