

# The Face Sheet

## MBI and the Face Sheet

Medicare Beneficiary Identifier

Per CMS, all individuals new to Medicare as of April 1, 2018 and after will receive the new Medicare cards. All current Medicare individuals will begin receiving replacement cards at some point after that. The current schedule shows NYS in group #4 which will be after June 2018. We urge you to keep watch on the CMS website for updates.

With the 2017.1 release of our software, the Edit Insurance function has a field for the new MBI number. It is located to the right of the old number (HICN).

Insurance Information  
SCREEN # 1 EDIT INSURANCE

Soc. Sec. Number . . . . 123-45  Not Available Primary Payor

Medicare (HICN) 1234 A New MBI 1CE4F MVP HEALTH PLAN

Medicare Effective Dates (If same date for both blank if not available)

Parts A 01/02/1990 B 01/02/1990 D Skilled Care? Y Hospice? N

As you begin receiving the new NBI information, place it into this new field. **DO NOT remove the old information.** During the transition period, claims and remittance information will be utilizing both numbers. If you admit a person who is new to Medicare and only has the new number, leave the HICN field blank and put the Medicare number into the new MBI field.

To clarify

Old Medicare number = HICN = field on the left

New Medicare number = MBI = field on the right

The Face Sheet has been updated to reflect both sets of numbers. The old Medicare number is on the left and the new MBI is on the right.

SS: \_\_\_\_\_

Medicare: 1234 A / 1CE4F

Part A: 01/02/1990 B: 01/02/1990

Part D: \_\_\_\_\_

Medicaid: 0

County #: \_\_\_\_\_ County: \_\_\_\_\_

\* HMO-MVP HEALTH PLAN # CSJ65

# \_\_\_\_\_

# \_\_\_\_\_

Reminder – the primary payer at the time the Face Sheet is printed will have an asterisk \* in front of the name. In the example above, the primary payer is HMO-MVP Health Plan.

## Admission Dates

We have updated the Face Sheet to show dates as they relate to the current episode of care. These are located in the upper left corner of the single page Face Sheet.

- First Admission to Facility – the date the resident was first admitted to your facility. This is the first admission without regard to types of discharges or length of time between admissions.
- Admission for this stay – this is the date the resident was admitted for this episode of care. It may be the same as the First Admission if this is the first time they have been with you. If the resident was discharged without expectation of return or was gone for more than 30 days, then the re-entry would trigger a new stay. This would be the date of that readmission. An example would be a resident who first admitted in 2012 for hip replacement rehab, was discharged home, and then came back in 2018 for a knee replacement. The first admission would be the hip (2012), the admission for this stay would be the knee (2018).
- The Most Recent Admission Date – if a resident goes in and out to the hospital within a single episode of care, this is the date of the most recent re-entry.
- Admitted From – this is the location where the resident is coming from. It may be the hospital/facility associated with the First Admission if this is the only episode of care. If there have been subsequent episodes, then it is the one associated with the most recent Admission for this Stay.

An example of how these dates change over time –

Resident came to the facility **5/22/2002** following a hip replacement at Lakewood Hospital. This is the *First Admission*. A facesheet printed at this time would show the First Admission and the Admission for this Stay as 5/22/2002. The *Admitted From* would have been Lakewood Hospital.

The resident was then discharged without expectation of return to home 6/30/2002. This ends this episode of care.

First Admission to Facility: <b>05/22/2002</b>
Admission for this stay: <b>05/22/2002</b>
Most Recent Admission Date: _____
Admitted From: <b>ABC HOSPITAL</b>

Resident was readmitted **2/6/2010** from **Big Hospital**. The readmission follows a discharge without expectation of return (and there is a lapse of more than 30 days) so this is considered a new episode of care. The date of the *First Admission* does not change. It will always remain the same. The new date for this episode of care shows as the *Admission for this Stay*. The *Admitting From* now shows as Big Hospital.

First Admission to Facility: <b>05/22/2002</b>
Admission for this stay: <b>02/06/2010</b>
Most Recent Admission Date: _____
Admitted From: <b>BIG HOSPITAL</b>

Resident then discharges with expectation of return on 1/30/2011, admitted, gone more than 24 hours. She is sent to Gentle Care Hospital. Resident is returned on **2/1/2011**. This is a brief discharge within the same episode of care. This is the *Most Recent Admission for this Stay*. The top two dates and the hospital do not change since we are still within the same episode of care.

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First Admission to Facility: <u>05/22/2002</u>
Admission for this stay: <u>02/06/2010</u>
Most Recent Admission Date: <u>02/01/2011</u>
Admitted From: <u>BIG HOSPITAL</u>