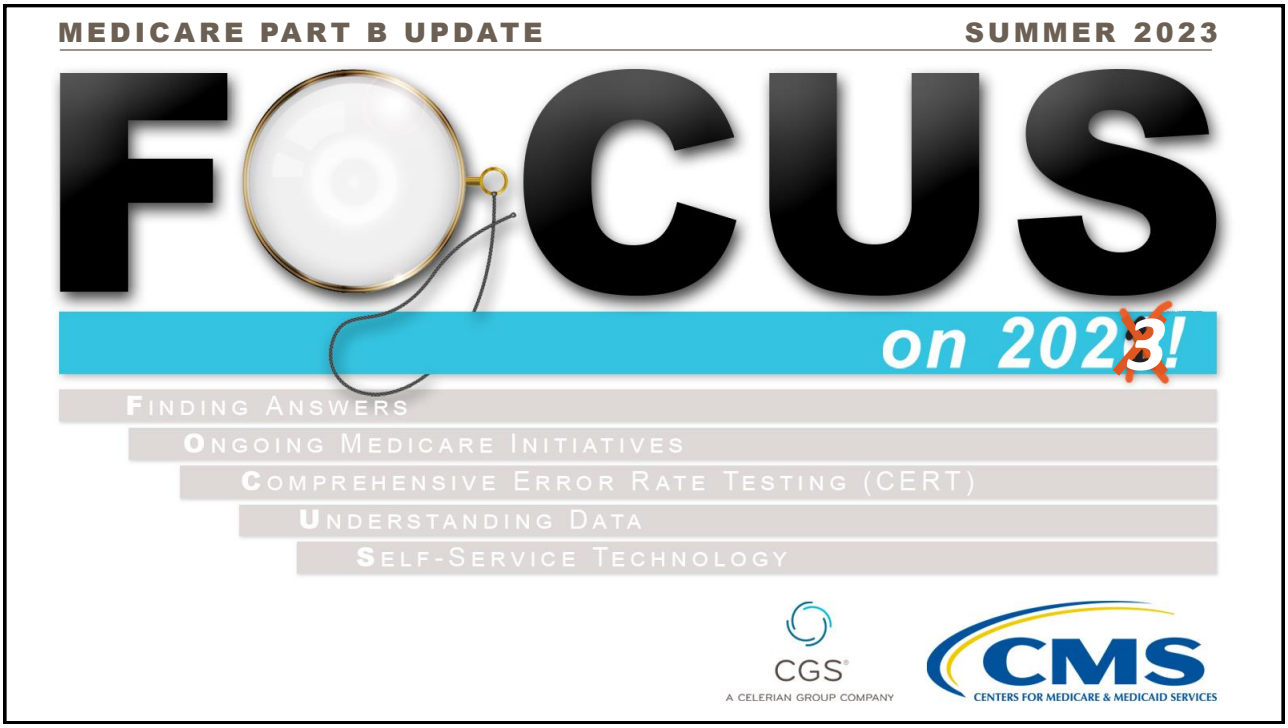

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FOCUS on 2023!

Disclaimer

This presentation was current at the time it was published or uploaded onto the CGS website. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

This presentation was prepared as a tool to assist providers and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services.

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This publication is a general summary that explains certain aspects of the Medicare Program but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings.

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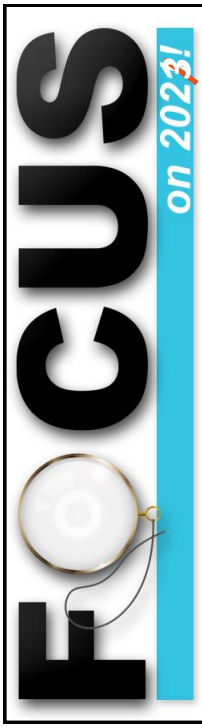
2

Objectives

- Discuss new and updated Medicare initiatives
- Provide information regarding medical record review contractors
- Provide CGS operational reminders
- Introduce resources and self-service technology options

3

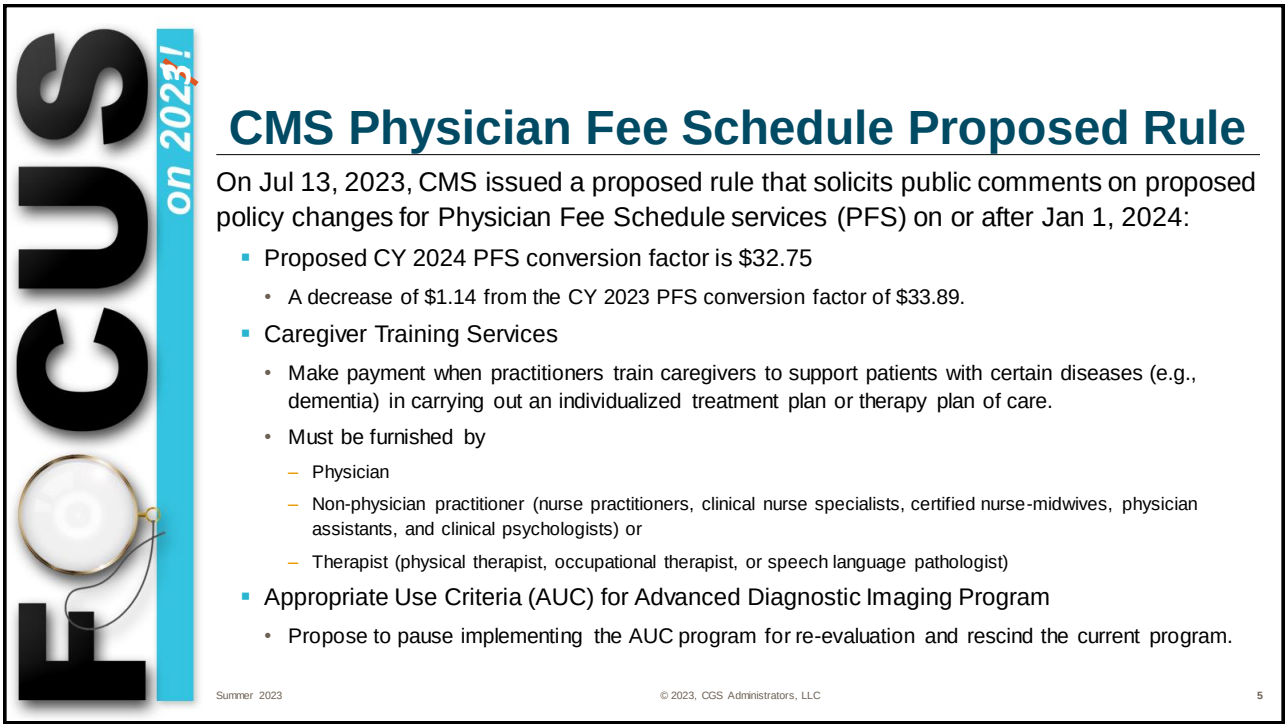


New and ongoing initiatives include:

- *CY 2024 Physician Fee Schedule Proposed Rule*
- *Post-COVID-19 PHE Updates*
- *Discarded Amounts of Single-Dose Drugs*
- *Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging*
- *Data Collection for Global Packages*
- *Prior Authorization Programs*
- *Preventive Services*
- *ABN Form Renewal*
- *MIPS Resources*

Medicare Initiatives

4



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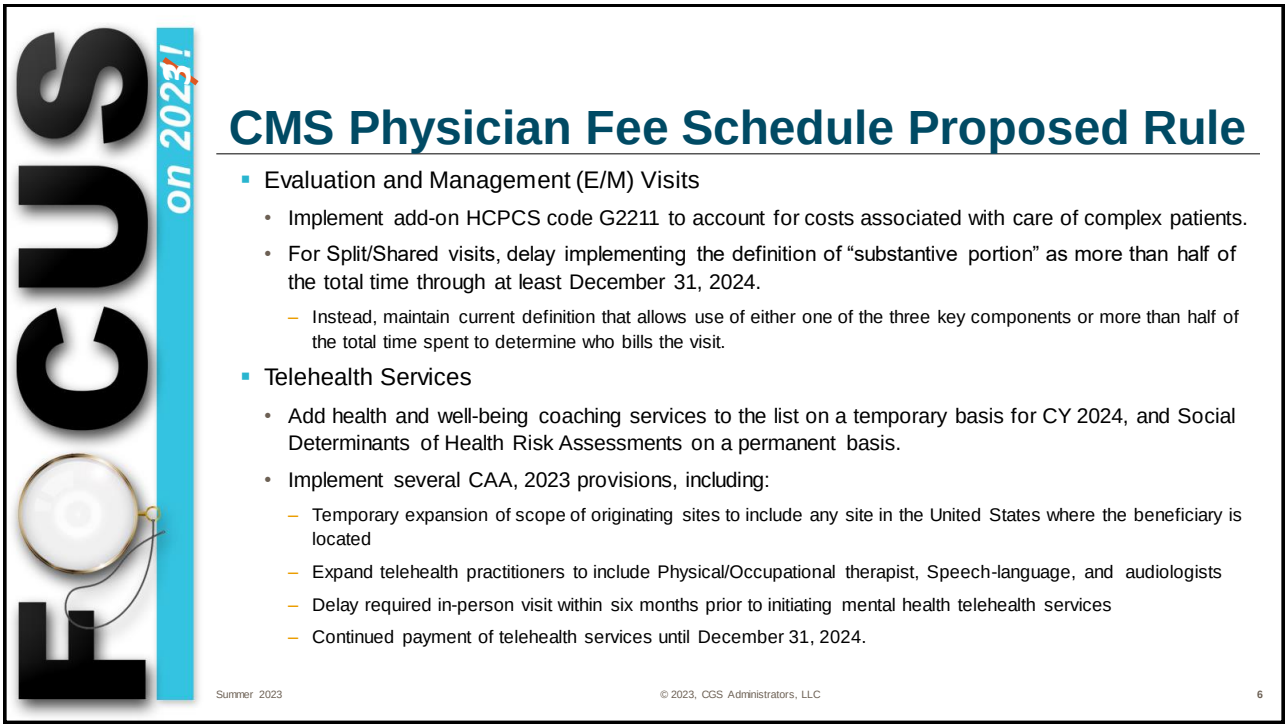
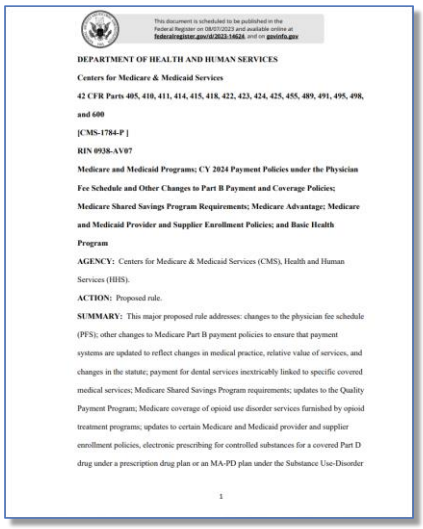


6

CMS Physician Fee Schedule Proposed Rule

- Payment for Dental Services prior to Certain Cancer Treatments
  - Proposing payment for certain dental services prior to and during several different cancer treatments, including, but not limited to, chemotherapy.
- Refer to the CMS fact sheet at Calendar Year (CY) 2024 Medicare Physician Fee Schedule Proposed Rule | CMS
- View the entire proposed rule at 2023-14624.pdf (federalregister.gov)
- Submit comments no later than 5 p.m. on Sep 11, 2023



This document is scheduled to be published in the Federal Register on 08/07/2023 and available online at federalregister.gov/d/2023-14624, and on govinfo.gov

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 405, 410, 411, 414, 415, 418, 422, 423, 424, 425, 455, 489, 491, 495, 498, and 600

[CMS-1784-P]

RIN 0938-AV07

Medicare and Medicaid Programs; CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program

AGENCY: Centers for Medicare & Medicaid Services (CMS), Health and Human Services (HHS).

ACTION: Proposed rule.

SUMMARY: This major proposed rule addresses: changes to the physician fee schedule (PFS); other changes to Medicare Part B payment policies to ensure that payment systems are updated to reflect changes in medical practice, relative value of services, and changes in the statute; payment for dental services inextricably linked to specific covered medical services; Medicare Shared Savings Program requirements; updates to the Quality Payment Program; Medicare coverage of opioid use disorder services furnished by opioid treatment programs; updates to certain Medicare and Medicaid provider and supplier enrollment policies, electronic prescribing for controlled substances for a covered Part D drug under a prescription drug plan or an MA-PD plan under the Substance Use-Disorder

1

Post-COVID-19 PHE Updates

CMS Flexibilities

Centers for Medicare & Medicaid Services (CMS) issued emergency waivers

- At beginning of COVID-19 Public Health Emergency (PHE)
- To enable flexibilities for quick response to COVID-19
- Some still in place; others expired
  - Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19
  - Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs): CMS Flexibilities to Fight COVID-19

CMS

Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19

At the beginning of the COVID-19 Public Health Emergency (PHE), CMS used emergency waiver authorities and various regulatory authorities to enable flexibilities so providers could rapidly respond to people impacted by COVID-19. CMS developed a cross-cutting initiative to use a comprehensive, streamlined approach to reestablish certain he... other financial and program requirements at the eventual end o... emergency.

This CMS cross-cutting initiative focused on evaluating CMS-issu... to prepare the health care system for operation after the PHE. T... concurrent phases:

1. CMS assessed the need for continuing certain waivers based... PHE. Since the beginning of the PHE, CMS has both added an... waivers as needed. In doing so, CMS considered the impacts ... underserved communities — and the potential barriers and o... flexibilities may address.
2. CMS assessed which flexibilities would be most useful in a fu... man-made disasters and other emergencies, to ensure a rapi... emergencies, both locally and nationally, or to address the u... that may experience barriers to accessing health care.
3. CMS is continuing to collaborate with federal partners and th... ensure that the health care system is holistically prepared for... emergencies.

As CMS identified barriers and opportunities for improvement, t... community served were considered and assessed with a health ... analysis, stakeholder engagement, and policy decisions account f... members of underserved communities and health care professi... these communities.

Please note: This fact sheet focuses on Medicare and Medicaid fl...

COVID-19 Vaccines

On October 28, 2020, CMS released an Interim Final Rule with co... announcing that Medicare Part B would establish coding and pay... vaccines and their administration as preventive vaccines, witho...

CMS

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs): CMS Flexibilities to Fight COVID-19

At the beginning of the COVID-19 Public Health Emergency (PHE), CMS used emergency waiver authorities and various regulatory authorities to enable flexibilities so providers could rapidly respond to people impacted by COVID-19. CMS has developed a cross-cutting initiative to use a comprehensive, streamlined approach to reestablish certain health and safety standards and other financial and program requirements at the eventual end of the COVID-19 public health emergency.

This CMS cross-cutting initiative aims to evaluate CMS-issued PHE waivers and flexibilities to prepare the health care system for operation after the PHE. This review is being done in three concurrent phases:

1. CMS is assessing the need for continuing certain waivers based on the current phase of the PHE. Since the beginning of the PHE, CMS has both added and terminated flexibilities and waivers as needed. In doing so, CMS considered the impacts on communities — including underserved communities — and the potential barriers and opportunities that the flexibilities may address.
2. CMS is assessing which flexibilities would be most useful in a future PHE, such as natural and man-made disasters and other emergencies, to ensure a rapid response to future emergencies, both locally and nationally, or to address the unique needs of communities that may experience barriers to accessing health care.
3. CMS is continuing to collaborate with federal partners and the health care industry to ensure that the health care system is holistically prepared for addressing future emergencies.

As CMS identifies barriers and opportunities for improvement, the needs of each person and community served will be considered and assessed with a health equity lens to ensure our analysis, stakeholder engagement, and policy decisions account for health equity impacts on members of underserved communities and health care professionals disproportionately serving these communities.

COVID-19 Vaccines

On October 28, 2020, CMS released an Interim Final Rule with comment period (IFC) announcing that Medicare Part B would establish coding and payment rates for COVID-19 vaccines and their administration as preventive vaccines, without cost-sharing, as soon as the Food and Drug Administration (FDA) authorized or approved the product through an Emergency Use Authorization (EUA) or Biologics License Application (BLA). The IFC also implemented provisions of the CARES Act to ensure swift coverage of COVID-19 vaccines by

05/10/2023 1

Post-COVID-19 PHE Updates

Telehealth Services

CMS [updated Telehealth list]

- Clarifies services available through end of CY 2023, and
- Addressed in CY 2024 Physician Fee Schedule proposed and final rules
- Review for periodic changes

LIST OF MEDICARE TELEHEALTH SERVICES effective January 1, 2023 - updated May 9, 2023

Code	Short Descriptor	Can Audio-only Interaction Meet the Requirement	Medicare Payment Limitations
0362T	Bhv id suprt assmt ea 15 min		
0373T	Adapt bhv tx ea 15 min		
77427	Radiation tx management x5		
90785	Psytx complex interactive	Yes	
90791	Psych diagnostic evaluation	Yes	
90792	Psych diag eval w/med srvcs	Yes	
90832	Psytx w pt 30 minutes	Yes	
90833	Psytx w pt w e/m 30 min	Yes	
90834	Psytx w pt 45 minutes	Yes	
90836	Psytx w pt w e/m 45 min	Yes	
90837	Psytx w pt 60 minutes	Yes	
90838	Psytx w pt w e/m 60 min	Yes	
90839	Psytx crisis initial 60 min	Yes	
90840	Psytx crisis ea addl 30 min	Yes	
90845	Psychoanalysis	Yes	
90846	Family psytx w/o pt 50 min	Yes	
90847	Family psytx w/pt 50 min	Yes	
90853	Group psychotherapy	Yes	
90875	Psychophysiological therapy		Non-covered service
90901	Biofeedback train any meth		
90951	Esrd serv 4 visits p mo <2yr		
90952	Esrd serv 2-3 vsts p mo <2yr		
90953	Esrd serv 1 visit p mo <2yrs		
90954	Esrd serv 4 vsts p mo 2-11		
90955	Esrd srv 2-3 vsts p mo 2-11		

Post-COVID-19 PHE Updates

Telehealth Update

[Chart shows the status] of telehealth-related policies post-PHE

- Be sure to [check link to CMS Fact Sheet] for most up-to-date information!

COVID POLICY	PERMANENT[1]	ENDS WITH PHE	ACTIVE THROUGH 2023[2]	EXPIRES 12/31/24[3]	FACT SHEET PAGE
FACT SHEET: PHYSICIAN & OTHER CLINICIANS					
Allowing all eligible Medicare providers to provide services via telehealth.				X	5
Temporarily continue to allow the use of audio-only to provide certain services.				X	5, 8
Temporarily waive site requirements such as patient needing to be in a rural area or in a specified health care site when receiving services via telehealth.				X	5
Temporarily suspend in-person visit requirement for delivery of mental health services via telehealth when patient is not located in a geographically and/or site eligible location.				X	5

Post-COVID-19 PHE Updates

Compliance Programs Post-PHE

During the PHE, flexibilities were applied across claim types. CMS announced medical review plans after PHE ends:

- CMS plans to primarily focus reviews on claims with dates of service outside of the PHE.
  - May still review DME items and services rendered during the PHE, if needed to address aberrant billing behaviors or potential fraud.
  - The Office of the Inspector General may perform reviews as well.
  - All claims will be reviewed using the applicable rules in place at the time for the claim dates of service.
- Refer to Medicare Fee-for-Service Compliance Programs for more details.

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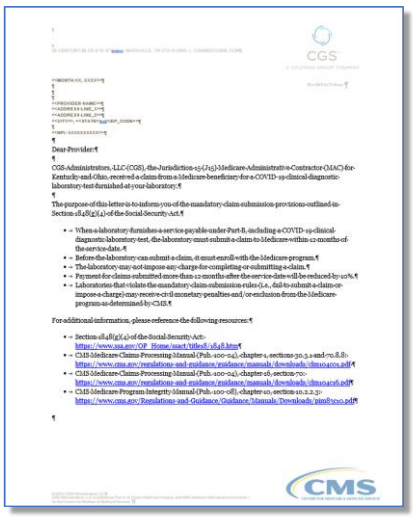
Post-COVID-19 PHE Updates

Payment for COVID-19 Diagnostic Laboratory Tests

Reminder: All lab services must be submitted for consideration by the lab or provider, not by the Medicare beneficiary.

- If claim received by the beneficiary, labs will be reminded of mandatory claim submission provisions
- Quarterly fee schedules are located at CLFS Files | CMS



Dear Provider:

CGS Administrators, LLC (CGS), the Jurisdiction 15 (J15) Medicare Administrative Contractor (MAC) for Kentucky and Ohio, received a claim from a Medicare beneficiary for a COVID-19 clinical diagnostic laboratory test furnished at your laboratory.

The purpose of this letter is to inform you of the mandatory claim submission provisions outlined in Section 1834(g)(4) of the Social Security Act.

- When a laboratory furnishes a service payable under Part B, including a COVID-19 clinical diagnostic laboratory test, the laboratory must submit a claim to Medicare within 12 months of the service date.
- Before the laboratory can submit a claim, it must enroll with the Medicare program.
- The laboratory may not impose any charge for completing or submitting a claim.
- Payment for claims submitted more than 12 months after the service date will be reduced by 10%.
- Laboratories that violate the mandatory claim submission rules (i.e., fail to submit a claim or impose a charge) may receive civil monetary penalties and/or exclusion from the Medicare program as determined by CMS.

For additional information, please reference the following resources:

- Section 1834(g)(4) of the Social Security Act: https://www.ssa.gov/OP_Home/ssact/title18/1834.htm
- CMS Medicare Claims Processing Manual (Pub. 100-04), chapter 1, sections 30.2.1 and 70.8.1: https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c01.pdf
- CMS Medicare Claims Processing Manual (Pub. 100-04), chapter 26, section 70: https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c26.pdf
- CMS Medicare Program Integrity Manual (Pub. 100-08), chapter 10, section 10.2.2.3: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c10.pdf

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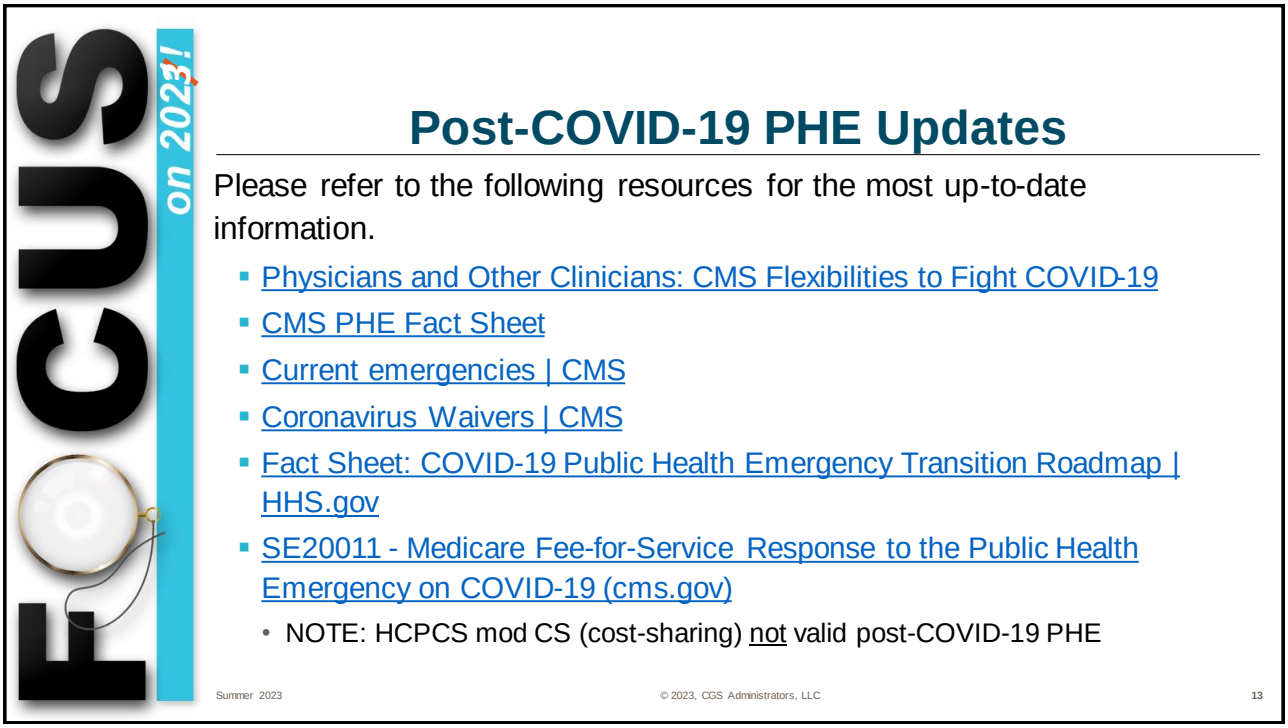
FOCUS on 2023!
Post-COVID-19 PHE Updates
Please refer to the following resources for the most up-to-date information.
Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19
CMS PHE Fact Sheet
Current emergencies | CMS
Coronavirus Waivers | CMS
Fact Sheet: COVID-19 Public Health Emergency Transition Roadmap | HHS.gov
SE20011 - Medicare Fee-for-Service Response to the Public Health Emergency on COVID-19 (cms.gov)
NOTE: HCPCS mod CS (cost-sharing) not valid post-COVID-19 PHE
Summer 2023
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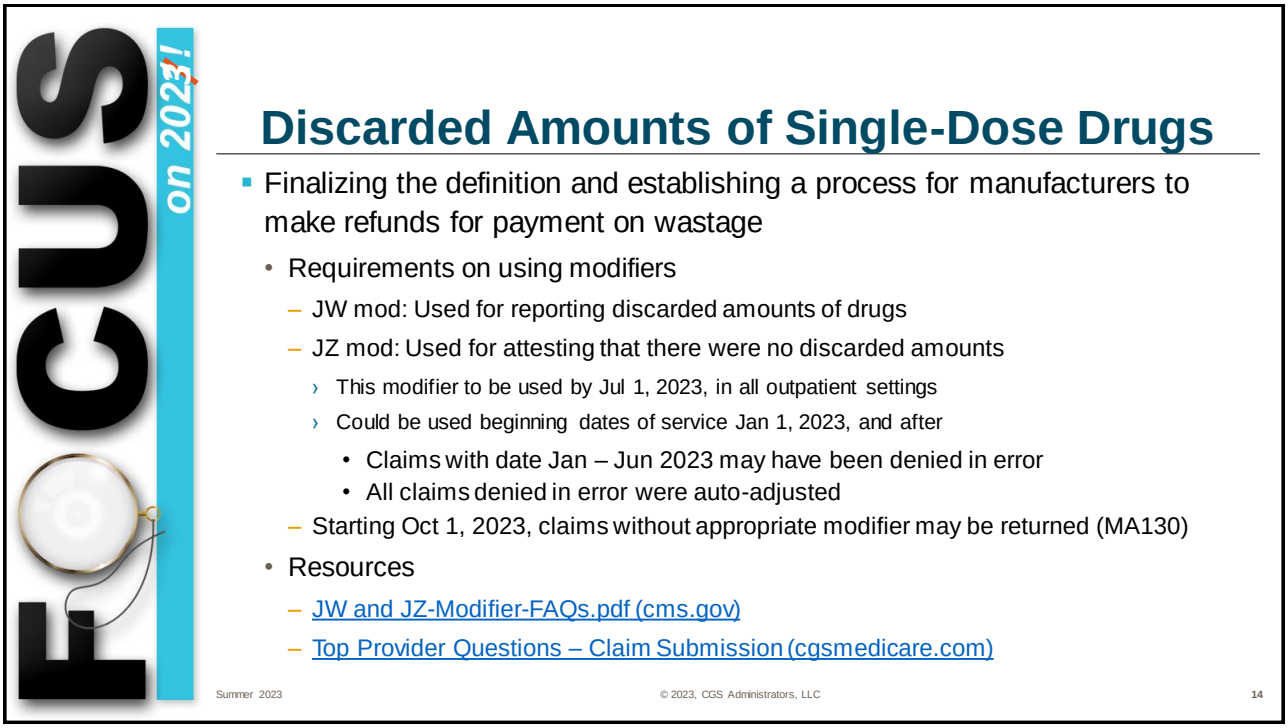
FOCUS on 2023!
Discarded Amounts of Single-Dose Drugs
Finalizing the definition and establishing a process for manufacturers to make refunds for payment on wastage
Requirements on using modifiers
JW mod: Used for reporting discarded amounts of drugs
JZ mod: Used for attesting that there were no discarded amounts
This modifier to be used by Jul 1, 2023, in all outpatient settings
Could be used beginning dates of service Jan 1, 2023, and after
Claims with date Jan – Jun 2023 may have been denied in error
All claims denied in error were auto-adjusted
Starting Oct 1, 2023, claims without appropriate modifier may be returned (MA130)
Resources
JW and JZ-Modifier-FAQs.pdf (cms.gov)
Top Provider Questions – Claim Submission (cgsmedicare.com)
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Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging

Program to increase the rate of appropriate advanced diagnostic imaging services

Type of Imaging Service:	Furnished in the following settings:
Computed tomography (CT)	Physician offices
Positron emission tomography PET)	Hospital outpatient departments (including ER departments)
Nuclear medicine	Ambulatory Surgical Centers (ASCs)
Magnetic resonance imaging (MRI)	Independent diagnostic testing facilities

Ordering provider must check a qualified Clinical Decision Support Mechanism (CDSM)

- CDSM: an interactive tool that communicates AUC information to the user
  - Assists with treatment decision for clinical conditions
  - Confirms whether order adheres to AUC or not (if applicable)
- Furnishing provider must include CDSM findings (G-codes and modifiers) on claim
  - Education and testing period continues; no current payment penalties in place.
  - Refer to Appropriate Use Criteria Program | CMS for program updates

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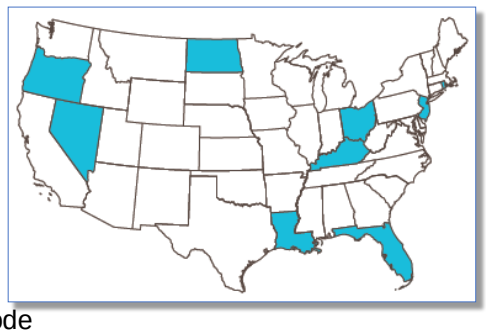
Data Collection for Global Packages

Mandated by The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)



- Data collection strategy is still in effect
- Goal is to revalue global surgical services
- Report visits during post-op period for surgical procedures
  - Those in groups with 10+ practitioners
  - Smaller groups not required but encouraged
- Post-op visits reported using non-payable code
  - CPT code 99024
- View the current listing of codes and reports of findings thus far

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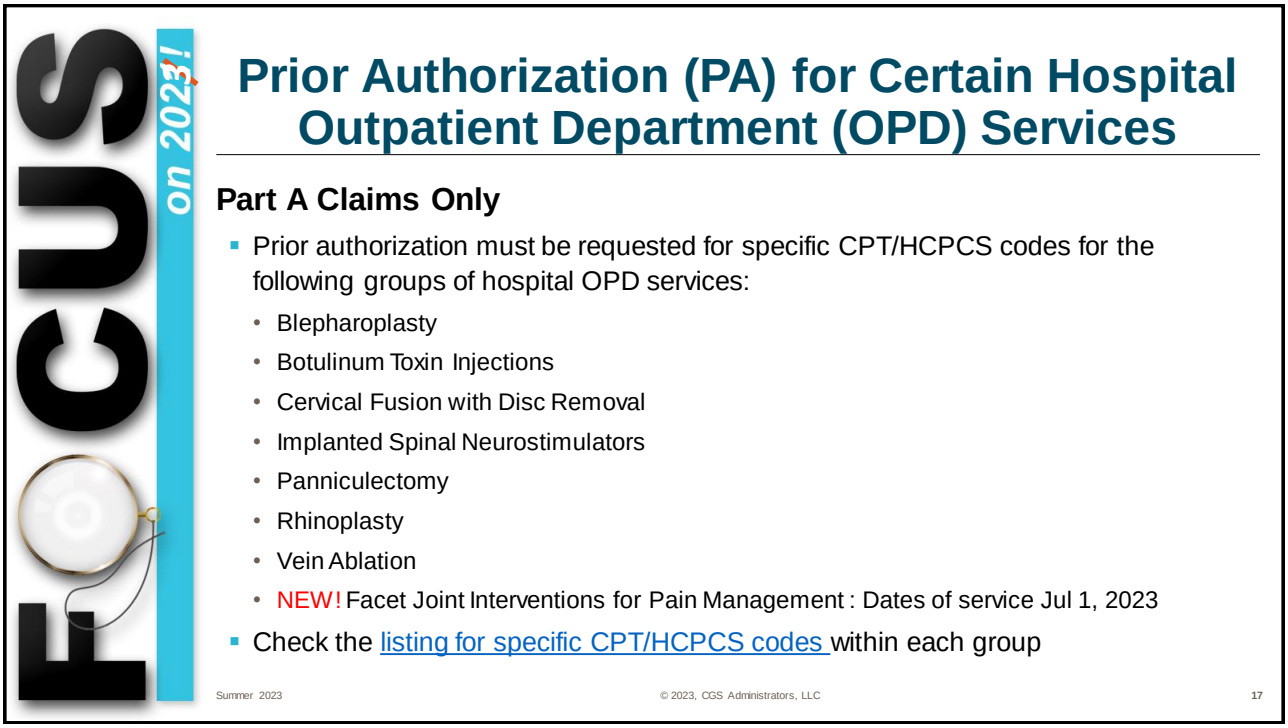

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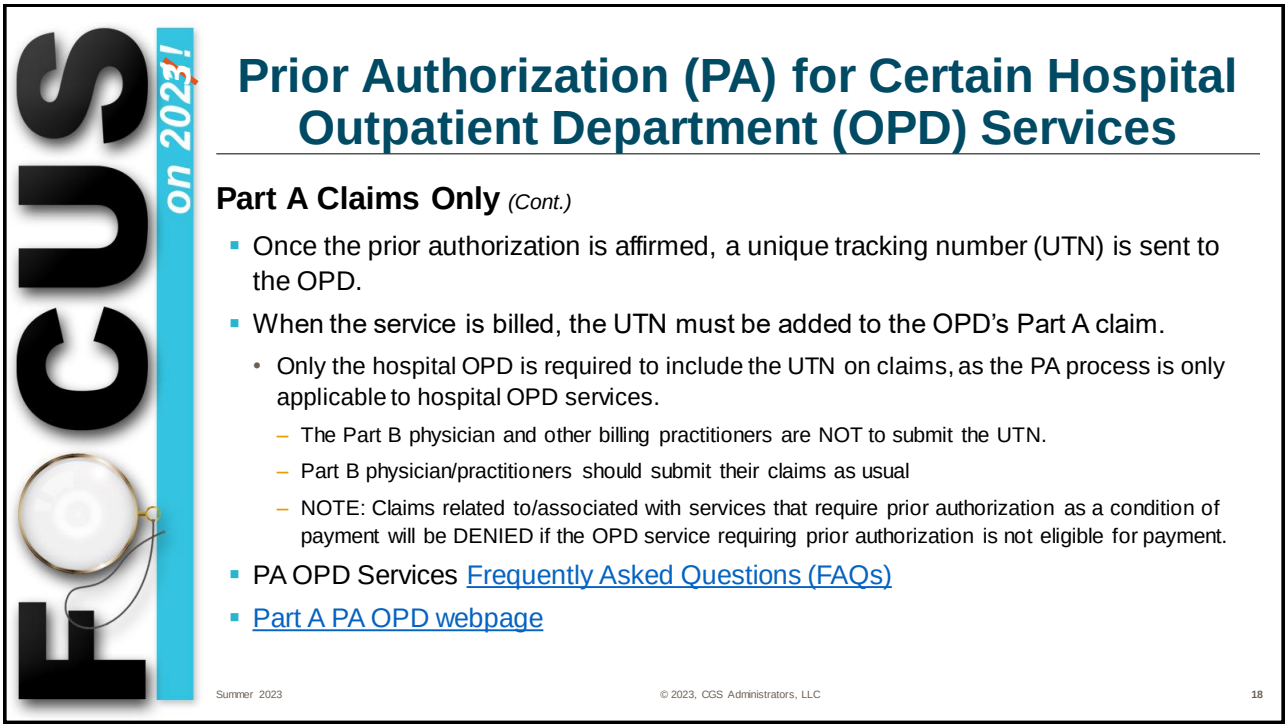

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FOCUS on 2023!

Prior Authorization (PA) for Repetitive, Scheduled, Non-Emergency Ambulance Trips (RSNAT)

For services on and after Aug 1, 2022

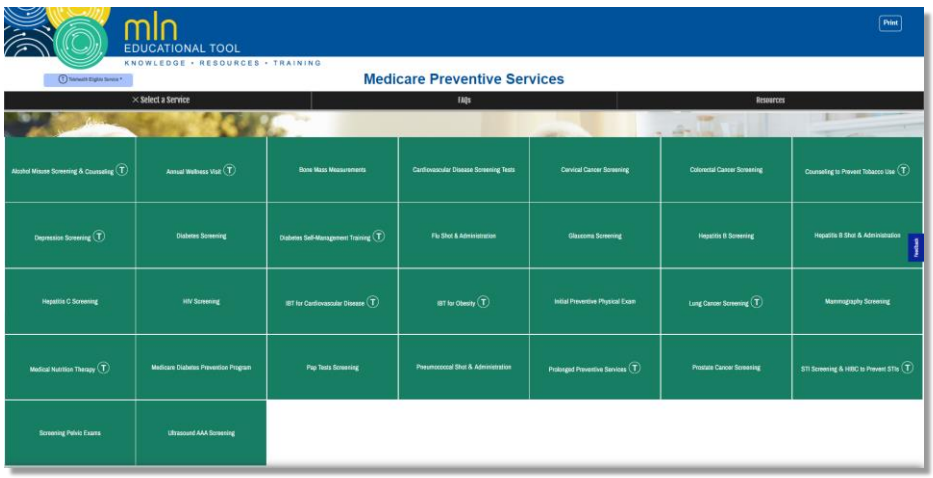
- Helps ambulance suppliers ensure services comply with Medicare coverage, coding, and billing requirements under Part B.
- Applies to Advance and Basic Life Support non-emergency transports
- Documentation requirements remain unchanged
  - **NOTE**: Only Physicians (MDs/DOs) can sign the Physician Certification Statement (PCS) for non-emergency, scheduled, repetitive ambulance services.
    - 42 CFR Ch. IV (10–1–02 Edition) (cms.gov)
- Refer to the Part B PA RSNAT webpage for details

FOCUS on 2023!

Preventive Services

Medicare Learning Network go.cms.gov/mln

Keep our seniors healthy! Offer the Medicare-approved Preventive Services!



FOCUS on 2023!

Annual Wellness Visits Campaign!

Download the 3 Steps to Efficient, Effective, and Reimbursed Medicare Wellness Visits flyer!

Refer to the Medicare Wellness Visits Educational Tool for details!

View Medicare Wellness Visits video!

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FOCUS on 2023!

Cognitive Assessment & Care Plan Services

Medicare covers Cognitive Assessment & Care Plan Services as a separate visit to more thoroughly assess your patient's cognitive function and develop a care plan.

- Medicare increased payment for these services when provided in an office setting
- Added these services to the definition of primary care services
- Permanently covered these services via telehealth
  - Use CPT code 99483 to bill for both in-person and telehealth services
- Learn more on CPT code 99483
  - How Do I Get Started?
  - Who Can Offer a Cognitive Assessment?
  - Where Can I Perform the Cognitive Assessment?
  - What's Included in a Cognitive Assessment?
  - What Care Plan Services Result from the Assessment?
  - Resources (including a link to a video on coverage, eligibility, and billing)
- CMS also has a video tutorial with guidance application and interview strategies for the cognitive assessment known as the Brief Interview for Mental Status (BIMS).

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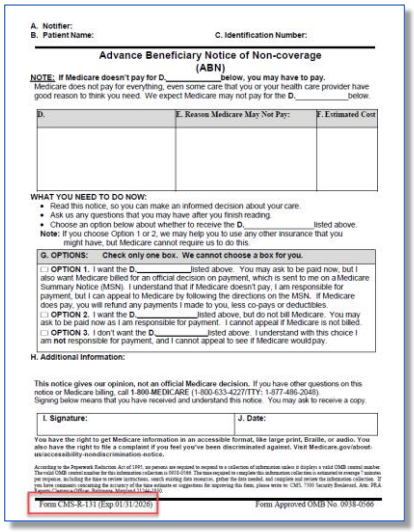
Advance Beneficiary Notice of Non-Coverage (ABN)

Form CMS-R-131 Renewal

- The ABN, Form CMS-R-131, and form instructions have been approved by the Office of Management and Budget (OMB) for renewal.
- Use the renewed form with the expiration date of Jan 31, 2026.
- Updated form **mandatory on Jun 30, 2023**.
- Instructions remain the same.
  - Used for medical necessity situations.
  - May also be used as a reminder Medicare will not pay for statutorily excluded services.
- ABN Forms (English/Spanish and Large Print)
- ABN Form Instructions
- ABN Interactive Tutorial


A. Notifier:
B. Patient Name: C. Identification Number:

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for D._____below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D._____below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:
- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D._____listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ OPTION 1. I want the D._____listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
☐ OPTION 2. I want the D._____listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.
☐ OPTION 3. I don't want the D._____listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048). Signing below means that you have received and understand this notice. You may ask to receive a copy.

I. Signature: J. Date:

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice.

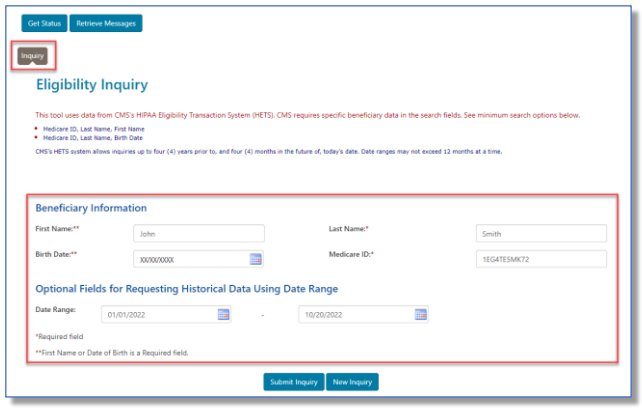
According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average [illegible] minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Office, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (Exp 01/31/2026) Form Approved OMB No. 0938-0566

Your Patient's Medicare Beneficiary Identifier (MBI) May Change

CMS reported a recent data breach

- Included patient's name, SS#, date of birth, MBI, medical history, and much more
- Estimate approx 612,000* beneficiaries impacted
- Ask your patient for their new Medicare card if you get "invalid member ID" when checking Medicare eligibility
- Use myCGS for all eligibility inquiries


Get Status | Retrieve Messages

Inquiry

Eligibility Inquiry

This tool uses data from CMS's HIPAA Eligibility Transaction System (HETS). CMS requires specific beneficiary data in the search fields. See minimum search options below.

- Medicare ID, Last Name, First Name
- Medicare ID, Last Name, Birth Date

CMS's HETS system allows inquiries up to four (4) years prior to, and four (4) months in the future of, today's date. Date ranges may not exceed 12 months at a time.

Beneficiary Information

First Name:** John | Last Name:* Smith

Birth Date:** XX/XX/XXXX | Medicare ID:* 1EG4TE5MK72

Optional Fields for Requesting Historical Data Using Date Range

Date Range: 01/01/2022 - 10/20/2022

*Required field

**First Name or Date of Birth is a Required field.

Submit Inquiry | New Inquiry

*Number subject to change

Quality Payment Program in 2024 Physician Fee Schedule Proposed Rule

CMS issued its proposed policies for the Quality Payment Program (QPP) with proposals applicable to the 2024 performance year.

Highlights of proposed policies continue the development of MIPS Value Pathways (MVPs), which include:

- Introduce 5 new MVPs for the 2024 performance year, and revisions to the MVPs already finalized
- Keep the data completeness threshold to 75% for the 2024 and 2025 performance years with incremental increases
- Update MIPS quality measures and the improvement activities inventory
- Increase performance period for "Promoting Interoperability" to a min. of 180 continuous days within the calendar year
- Remove the numerical 75% threshold for certified EHR technology (CEHRT) for Advanced APMs
  - Instead, have the Advanced APM require the use of CEHRT for QP performance periods starting in 2024.

For more info refer to the CMS fact sheet. The 2024 MVP Guide is also available for review.

Comments must be submitted by Sep 11, 2023.

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2022 MIPS Final Score Preview Now Available

The Final Score Preview period allows you to preview final score prior to the release of payment adjustment information.

- Your 2022 final score is what will determine your 2024 MIPS payment adjustment
- Issues raised during this time are not part of targeted review.
  - The targeted review process allows a review of MIPS payment adjustment calculation
  - This is available after MIPS payment adjustment information is released
- Sign in to the Quality Payment Program website and click "Preview Final Score"
- Contact the QPP Service Center if you find errors
  - 1-866-288-8292 (TRS: 711)
  - e-mail at: QPP@cms.hhs.gov
- Resources
  - 2022 Merit-based Incentive Payment System (MIPS) Final Score Preview
  - 2022 MIPS Final Score Preview Demo - YouTube

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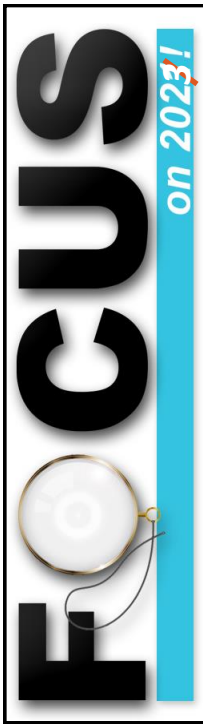

2023 MIPS Resources

CMS posted 2023 MIPS resources

- 2023 MIPS Quality Measures List
- 2023 Medicare Part B Claims Measure Specifications and Supporting Documents
- 2023 Clinical Quality Measure Specifications and Supporting Documents
- 2023 Qualified Clinical Data Registry (QCDR) Measure Specifications
- 2023 Cross Cutting Quality Measures
- 2023 MVP Quality Measure Specifications for Quality IDs 110 and 111
- 2023 Electronic Clinical Quality Measure Specifications

QPP Webinar Library (cms.gov)

- 2023 QPP Final Rule Webinar provide overview of finalized QPP policies for 2023.

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2023 MIPS Resources

Promoting Interoperability

- 2023 Promoting Interoperability Measure Specifications

Improvement Activities

- 2023 Improvement Activities

Cost

- 2023 Cost Measure Codes
- 2023 Cost Measure Information Forms

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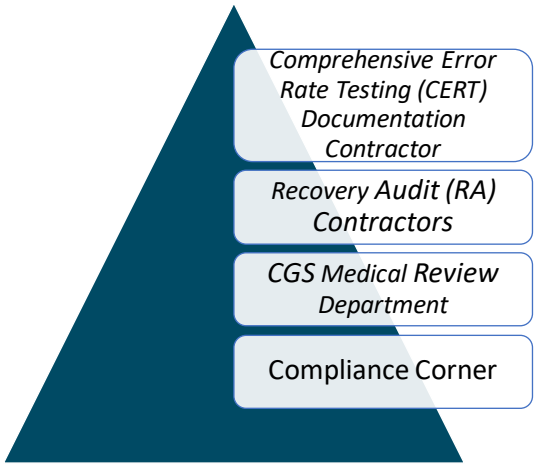
You may receive requests for medical records.



Medicare Record Review Programs

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FY 2022 CERT Improper Payment Rate

CERT improper payment rate is 7.46 percent, representing (projected amount) $31.46 billion in improper payments. (Compared to 6.26% and $25.03 billion in FY 2021)

Claim Type	Improper Payment Rate	Improper Payment Amount
Part A Providers (excluding Hospital IPPS)	8.86%	$17.13 B
Part B Providers	8.21%	$8.75 B
Part A Providers (Inpatient Hospital)	2.99%	$4.12 B
DMEPOS	25.24%	$2.19 B

The reporting period for this improper payment rate is Jul 1, 2020 through Jun 30, 2021.

NOTE: CERT Review Contractor changed name from *NCI Information Systems, Inc.* to *Empower AI, Inc.*

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CERT Error Categories

Insufficient Documentation	Submitted medical records are inadequate to determine if billed services were provided, provided at the level billed, and/or were medically necessary; or when specific documentation required as a condition of payment is missing.
Medically Unnecessary	Submitted medical records contain adequate documentation to make an informed decision that services billed were not medically necessary based upon Medicare coverage and payment policies.
Incorrect Coding	Submitted medical records support a different code than what was billed; the service was performed by someone other than the billing provider/supplier; the billed service was unbundled; or patient was discharged to a site other than the one coded on claim.
No Documentation	Provider/supplier fails to respond to repeated requests for medical records or responds that they do not have the requested documentation.
Other	Errors do not fit into the previous categories (e.g., duplicate payment in error, non-covered or unallowable service, ineligible Medicare beneficiary, etc.)

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CERT Errors: Insufficient Documentation

- Be sure documentation describes the service billed
- Include copies of signed orders
- Verify signatures are valid and/or present
  - Submit Signature Attestation Statement when necessary
- Practitioner Offices and Billing Services must also comply with requests
- Attention Clinical Labs!

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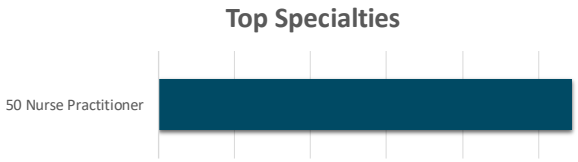
CERT Errors: Medically Unnecessary



- Always check for Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs) to verify medical necessity is met
- Include all relevant medical records
- Identify the reasons surgeries and/or diagnostic tests are performed
- Lab Services/Orders Decision Tree

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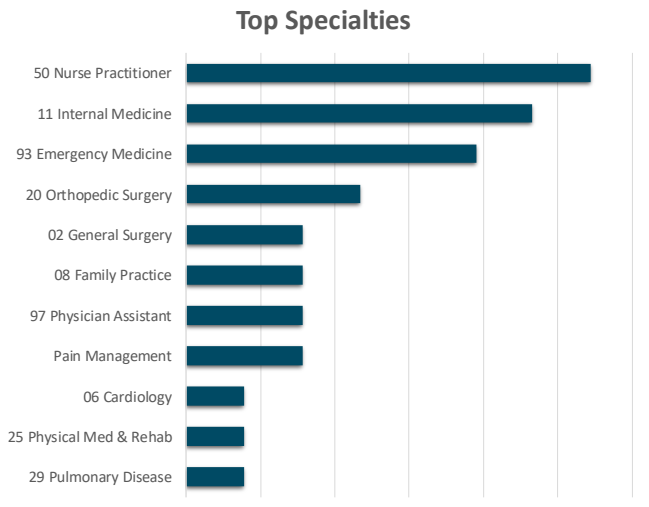
CERT Errors: Incorrect Coding

- Code billed must be fully supported in the medical record
- Be aware of the E/M Documentation Guidelines
  - Key elements of E/M level billed must be met
  - Document time when level of service is based on time spent counseling/coordinating care
  - Always follow the new patient guidelines



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CERT Errors: No Documentation Received / Not Relevant

- The barcoded cover sheet should be the first page of each submission
- Respond promptly to all CERT request
  - Providers/suppliers have 45 days from the initial record request letter
- Respond via postal mail, fax, esMD, encrypted CD
- Suggestions on the types of documentation that may be submitted are available on the CERT Document Request Listing Web page

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CERT: Other Lines of Business (LOBs)

Avoid Part B Errors – Home Health

- Do you certify/recertify patients for Home Health?
- Provider compliance tips for Home Health
- Home Health Recertification Statement
- Home Health Referrals

Avoid Part B Errors – Hospice

- Hospice Services
- Care Plan Oversight Education Series
- Billing Hospice Physician, Nurse Practitioner (NP) and Physician Assistant (PA) Services
- Hospital-Based Hospice compliance tips

Avoid Part B Errors - DMEPOS

- CGS Part B partners with CGS DME to educate Part B providers on various documentation issues observed with ordering DMEPOS that generate CERT errors
- Education articles, videos, and recorded webinars posted on the following:
  - Therapeutic Shoes
  - Nebulizers and Inhalation Medication
  - Glucose Monitors and Supplies
  - Oxygen
  - Positive Airway Pressure (PAP) Devices
  - External Breast Prosthesis and Related Supplies
  - Your Medical Records and Ordering DMEPOS
  - Lower Limb Orthoses

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Welcome to the CERT C3HUB!

Designed to provide Medicare providers, suppliers, and contractors with information about the CERT program and to facilitate coordination, collaboration, and communications between all stakeholders.

Check the C3HUB site for the following resources:

- About CERT
- Submit Records to CERT
- Letter and Contact Information
- Claim Status Search
- Attestation Letters
- Sample Request Letters
- Documentation Request Listings
- Psychotherapy Notes
- FAQs
- CMS Links

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CERT A/B MAC Outreach & Education Task Force

Designed to assist in reducing the CERT error rate through consistent, accurate provider outreach and education.

- Documentation requirements for Outpatient Rehab Therapy Services
- Job aid for chiropractic services
- Documentation requirements for lab services
- Documenting therapy and rehab services
- Avoid insufficient documentation errors

CERT Videos

- Provider Minute: Utilizing Your MAC - YouTube
- Provider Minute: The Importance of Proper Documentation

Check here for more information

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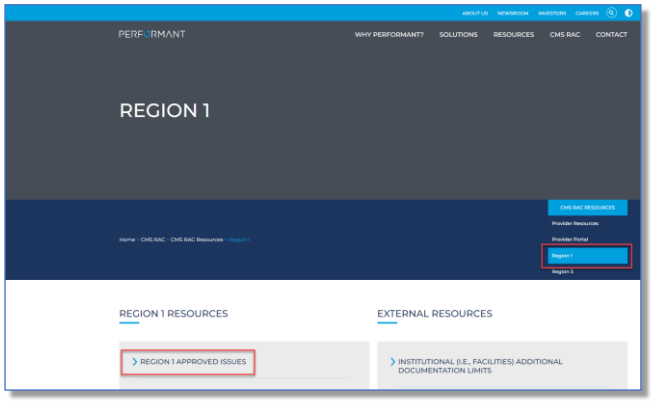
Recovery Audit (RA) Program

The Recovery Audit program was created to detect and correct past improper overpayments and underpayments made to providers.

- Performant Recovery, Inc.
- View Region 1 Resources
- Approved Issues MUST be posted
- Sample documents



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RA Program
Highest Improper Payments

2nd Quarter 2023

CPT/HCPCS Codes	Issue	Rationale
52224, 52234	Ambulatory Payment Classification Coding Validation	APC coding requires that procedural information, as coded and reported by the hospital on its claim, match both the attending physician description and the beneficiary's medical record. Reviewers will validate the APC by reviewing services affecting the APC assignment.
64590	Sacral Neurostimulation: Medical Necessity and Documentation Requirements	Claims for sacral nerve stimulation for urinary or fecal incontinence not deemed to be medically necessary will be denied.
63685	Spinal Cord Stimulation: Medical Necessity and Documentation Requirements	Spinal cord neurostimulators (SCS) may be covered as therapies for the relief of chronic intractable pain, and medical records will be reviewed to determine if the implantation of SCS meets Medicare coverage criteria and documentation requirements.
J9145, J7170, J2796, Q5118	Drugs and Biologicals: Incorrect Units Billed	Claims billed with excessive or insufficient units will be reviewed to determine the actual amount administered, wastage (JW mod), and the correct number of billable/payable units.
Q4210	Bioengineered Skin Substitutes: Excessive or Insufficient Units Billed	Claims for skin substitute products billed with excessive or insufficient units will be reviewed to determine the actual amount administered and the correct number of billable/payable units.
99285	Critical Care Billed on the Same Day as Emergency Room Services: Unbundling	Hospital ER services are not payable for the same calendar date as critical care services when billed for the same beneficiary, on the same date of service and by the same service provider

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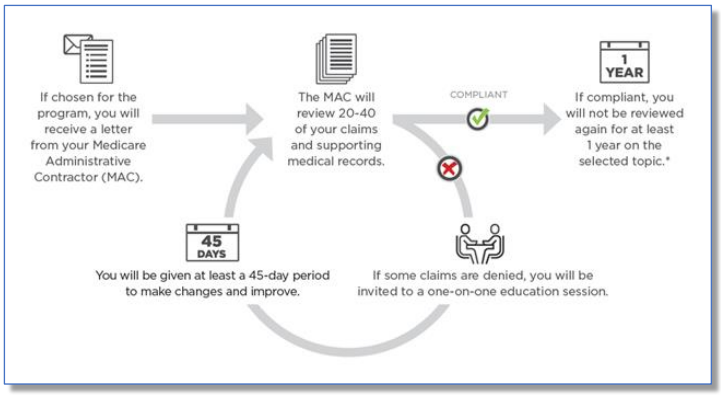
Medical Review

Reminder: Targeted Probe and Educate (TPE)

Based on data analysis of claims payment, CGS identifies areas with the greatest risk of inappropriate program payment.



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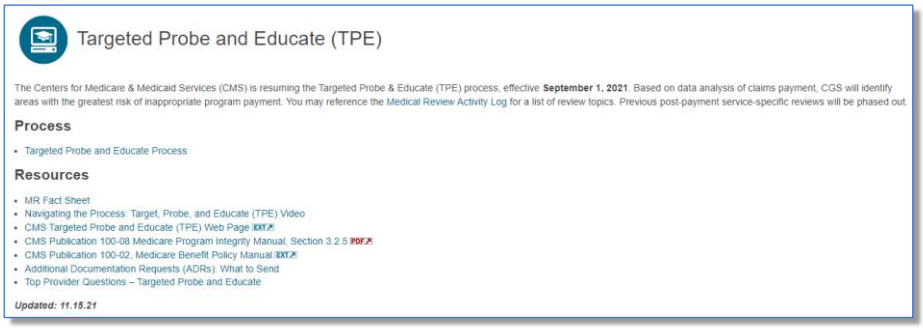
Medical Review

Reminder: Targeted Probe and Educate (TPE)

Refer to the TPE webpage for details on the process and resources. Also, don't forget how to respond to requests for additional documentation!

***NOTE**: Do not resubmit claims under a TPE review.*



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Check LCD Articles for Billing Information

Avoid denial of services by checking the LCD and billing article first!

LCD ID	Top 10 Services Denied due to Non-Covered ICD-10 Codes – 2nd QTR 2023
Multi LCDs	Molecular Diagnostic Tests
L39038	MolDX: Molecular Syndromic Panels for Infectious Disease Pathogen Identification Testing
L33996	Vitamin D Assay Testing
L34045	Non-Invasive Vascular Studies
L34200	Removal of Benign Skin Lesions
L35891	Intravenous Immune Globulin
L33943	B-type Natriuretic Peptide (BNP) Testing
L36029	Controlled Substance Monitoring and Drugs of Abuse Testing
L37578	Micro-Invasive Glaucoma Surgery (MIGS)
L39015	Epidural Steroid Injections for Pain Management

Compliance Corner:
Documentation: Don't Forget Your Partners!

Share your documentation

CGS or other Medicare contractors may request medical records

- To support the medical necessity for services based on Local Coverage Determination (LCD) requirements
- To determine the correct payment

When two separate providers collaborate to provide quality, patient care the obligation of providing, obtaining, and maintaining documentation is not the exclusive responsibility of one or the other provider.

- The treating physician should provide other providers, practitioners and facilities with documentation supporting medical necessity prior to or at the time the service is rendered.

Reference: Section 4317 of the Balanced Budget Act (BBA: SEC.4317, REQUIREMENT TO FURNISH DIAGNOSTIC INFORMATION)

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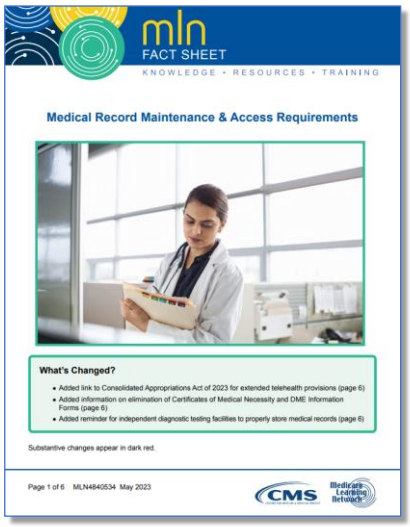
Compliance Corner:
Medical Record Maintenance



This fact sheet gives information on updated documentation maintenance and access requirements for billing services to Medicare patients.

- It also tells you how long to keep the documentation and who is responsible for providing access.
- Includes examples and links to additional resources!

Medical Record Maintenance & Access Requirements

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CGS Operational Reminders

Provider Enrollment	Claims	Appeals	Reopenings	Provider Contact Center

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Provider Enrollment

Provider Enrollment Application Fee Amount for Calendar Year 2023

- Effective Jan 1, 2023, the application fee is $688 for institutional providers that are:
  - Initially enrolling in the Medicare program
  - Revalidating their Medicare enrollment; or
  - Adding a new Medicare practice location.
- This fee is required with any enrollment application submitted from Jan 1 – Dec 31, 2023
  - NOTE: This fee does not apply to physicians, non-physician practitioners and their groups. Only to providers/suppliers that submit the following types of Medicare enrollment applications:
    - CMS-855A
    - CMS-855B (except physician and non-physician practitioner organizations)
    - CMS-855S, or
    - CMS-20134
- Refer to the Medicare Provider Enrollment MLN Education Tool for additional information.

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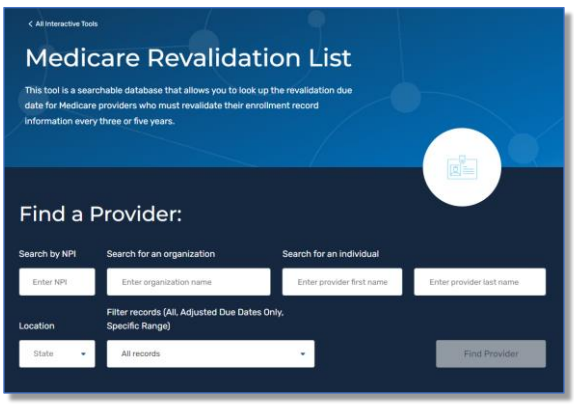
Provider Enrollment

Provider Enrollment Revalidation

- Must revalidate Medicare enrollment every five years
- Revalidation date always the same throughout subsequent cycles
  - Always the last day of the month (e.g., Jul 30th, Aug 31st, Sep 30th)
- Check the Medicare Revalidation List for "due date"
- Watch for changes to PECOS in Summer 2023
  - Watch this 2-minute video
- Avoid errors when completing apps!



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Provider Enrollment

Consolidated CMS-855I and CMS-855R

- The CMS-855R will no longer be used to report reassignment information
- All data is now captured on the CMS-855I
- The revised version of the CMS-855I (05/23) will be accepted **beginning Sep 1st**
  - The 12/21 version of the CMS-855I and the 01/20 version of the CMS-855R will be accepted through Oct 31st
  - Older versions will be returned after Nov 1st
- Refer to Enrollment Applications | CMS for the revised form
- **NOTE**: There is NO change in how reassignments are reported using PECOS
  - Step-by-step enrollment tutorials available at Welcome to the Medicare Provider Enrollment, Chain, and Ownership System (PECOS) (hhs.gov)

Claims

Avoid Misrouted Documentation and Incomplete Fax Cover Sheets

- CGS will accept documentation for electronic claims through the PWK (paperwork) Segment process via fax or mail.
  - You must identify the documentation using the PWK Segment at the claim level (Loop 2300) or line level (Loop 2400) of the electronic claim
    - Check with your software vendor if you need help identifying these fields within your billing system.
    - Refer to this article for details
- Documentation received is imaged and matched to the correct pended claim
- Tips to ensure correct processing:
  - Verify the fax is for a claim submitted to CGS electronically, and not to a different payer (e.g., MA plan)
  - Complete the fax cover sheet accurately and, in its entirety.
    - The fax cover sheet is located here.
  - A separate fax cover sheet is required for EACH individual claim

Claims

Sending a Corrected Claim – Avoid DUPLICATE Denials!

- When resubmitting services initially rejected (message code MA130), DO NOT include services from the claim that were allowed.
- For example:
  - A claim is submitted with three line items.
  - Two of the lines are paid; one is rejected because the CPT code was invalid.
  - When resubmitting a new claim with the corrected CPT code, do not include the two services previously paid, as they will deny as duplicate.

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Claims

Medicare Secondary Payer (MSP) Claims

- As a Part B provider (i.e., physicians and suppliers), you should:
  - Follow the proper claim rules to obtain MSP information such as group health coverage through employment or non-group health coverage resulting from an injury or illness;
  - Inquire with the beneficiary at the time of the visit if he/she is taking legal action in conjunction with the services performed; and
  - Submit an Explanation of Benefits (EOB) form with all appropriate MSP information.
    - If submitting an electronic claim, provide the necessary fields, loops, and segments needed to process an MSP claim.
- Resources
  - Coordination of Benefits & Recovery Overview | CMS
  - Provider Services | CMS
  - Medicare Secondary Payer Information and Filing Claims: Getting It Right the First Time (cgsmedicare.com)
  - myCGS User Manual - Eligibility (cgsmedicare.com)

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Appeals

Submitting Redeterminations to Appeal Other CMS Programs

- Recovery Audit Contractor (RAC)
- Comprehensive Error Rate Testing (CERT)
- Office of Inspector General (OIG)
- Supplemental Medical Review Contractor (SMRC)

Submit request for Redetermination (1st level) if you disagree with outcome

- Please wait until you receive demand letter from CGS before sending Redetermination
  - Use myCGS to send Redeterminations
- If you disagree with decision, submit request for Reconsideration (2nd level)

Date of Service on Professional Claims

- Submit correct date of service on claims that are billed separately with TC and 26 modifiers.
- Refer to Guidance on Coding and Billing Date of Service on Professional Claims (cms.gov)

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Reopenings

A *Reopening* may be requested to correct a minor error or omission to a previously processed Part B claim

- Rejected claims must be corrected and resubmitted as NEW claims
- myCGS and Telephone Reopenings are also accepted!
- Time limit denials due to CGS errors or CWF updates/changes may be reopened
  - See *Good Cause* section of the IOM
- Medicare Secondary Payer (MSP) reopenings may be processed
  - Primary payer recoups payment due to an update in their files showing they should be secondary
  - A copy of recoupment letter or EOB must be sent within 6 months in order for claim to be reopened

Reminder: Submit correct MSP Insurance Type on electronic claims!

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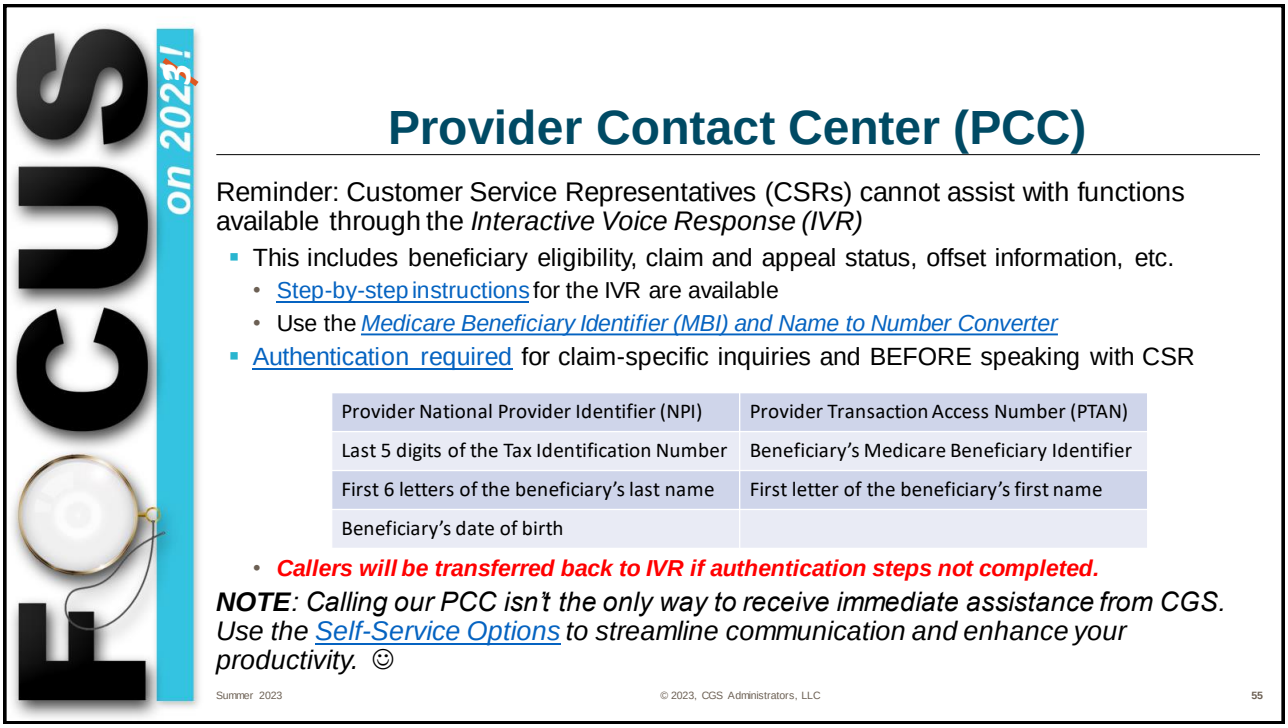

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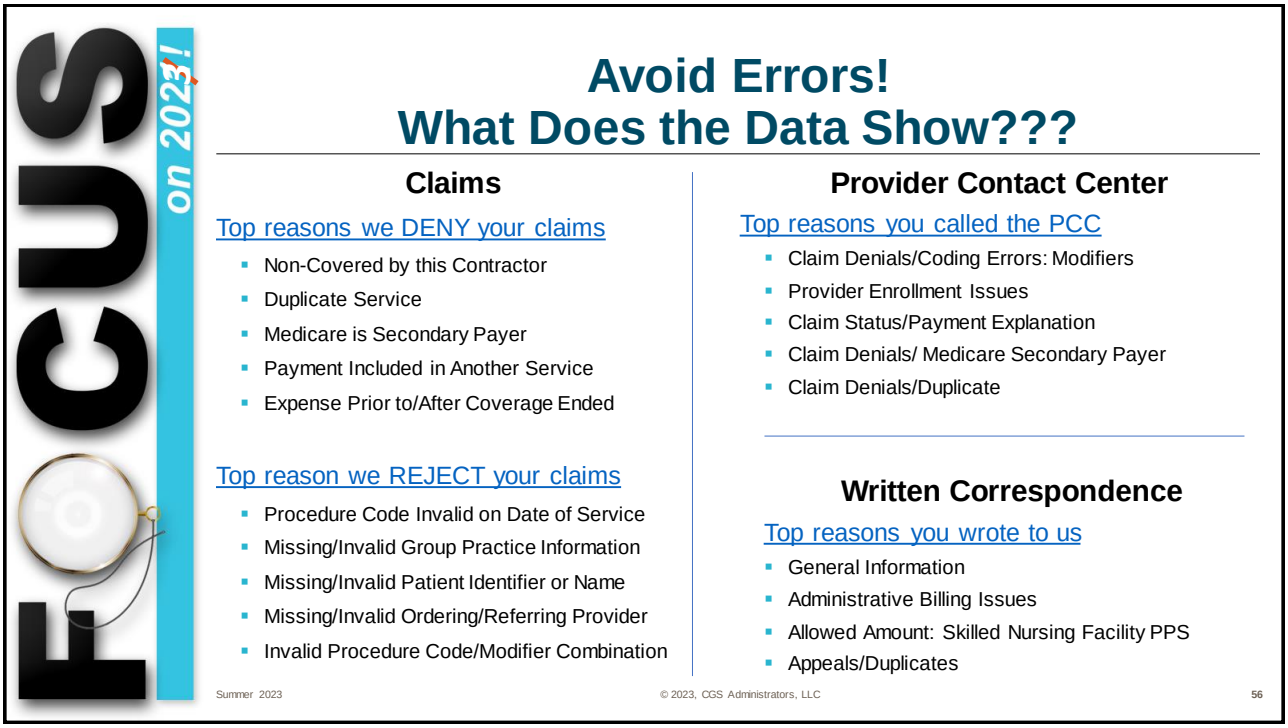

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Pre-Submitted Questions

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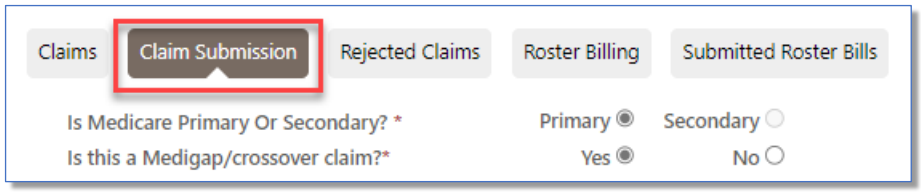
Q&As

Q How do I bill claims using myCGS?

A The claim form in myCGS will allow you to submit claims to us electronically for FREE! Step-by-step instructions are available at myCGS User Manual - Claims (cgsmedicare.com).



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Q&As

- Q How do I use CPT mod 25 correctly?
- A This modifier is for a significant, separately identifiable E/M service by the same physician on the same day as a procedure
  - Used when a minor procedure is performed on the same day
  - Not to be used on New Patient E/M codes
  - Be sure documentation support the use of this modifier
  - E.g., Mr. B goes to his doctor for a diabetes follow up. During the visit he complains of an infected skin tag. The doctor excises the skin tag (minor procedure). Use the 25-modifier to indicate the visit was for a different reason and should be separately paid.
- Q Where can I find information about FQHCs and RHC?
- A Please refer to Part A – Browse by Facility (cgsmedicare.com). There is also a recorded webinar that may be viewed on demand at CGS J15 Part A, Part B, and HHH Education (cvent.com).

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Q&As

- Q How does CGS pay multiple surgical procedures that are performed on the same date of service?
- A Procedures are ranked by fee schedule amount
  - Highest valued procedure paid at 100% of fee schedule amount
  - Second through fifth highest valued procedures are paid at 50% of the fee schedule amount
  - Refer to the Physician Fee Schedule Look-Up Tool | CMS

HCPCS Code	Modifier	Short Description	Proc Stat	PCTC	Global	MULT SURG	BILT SURG	AS SU
66984		Xcapsl ctrc rmvl w/o ecp	A	0	090	2	1	1

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Q&As

- Q: What modifier is used to unbundle services that should be separately paid?
- A: Only under certain circumstances is it necessary to indicate that a procedure or service was distinct from other non-E/M services performed on the same day.
  - Use CPT mod 59 when no other modifier would accurately describe the exception
  - HCPCS modifiers may be used for reporting specificity
  - Refer to MLN1783722 - Proper Use of Modifiers 59, XE, XP, XS, and XU
  - Be sure documentation supports the use of any modifier
- Q: Where can I find information about the Medicare Part B program?
- A: Please refer to MLN908764 – Medicare Part D Vaccines

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CMS Resources You Can Use!

CGS is your first contact as your MAC. Check here for help with other issues.

- CMS Office of Program Operations and Local Engagement

Medicare Home Page

- Acronyms
- Change Requests (CRs) and Transmittals
- The CMS Innovation Center
- Coordination of Benefits
- Health Plans – General Information
- Internet-Only Manuals (IOM)
- Physician Fee Schedule Look-Up Tool | CMS

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CMS Resources You Can Use!

The Medicare Learning Network®

- Free educational materials for providers on CMS programs, policies, and initiatives

Publications & Multimedia

- Publications
- MLN Matters® Articles
- Multimedia

Training

- Calls & Webcasts
- Web-Based Training

News & Updates

- MLN Connects® Newsletter
- Electronic Mailing Lists

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myCGS A/B/HHH MAC JURISDICTION 15

CLAIMS

Submit Part B Medicare claims through myCGS! Also check the status, view remark codes, and perform additional functions.

MR DASHBOARD

View and respond to ALL your MR ADRs on one page. Includes Post-Pay ADRs!

REMITTANCE

View and print remittance advices (RAs).

ELIGIBILITY

Check eligibility, MSP status, MA plan enrollment, inpatient stays, and MORE!

MBI LOOK-UP TOOL

Use myCGS to obtain the patient's Medicare Beneficiary Identifier (MBI).

FINANCIAL TOOLS

Check the number of claims approved-to-pay and the last three checks issued.

MESSAGES

Read secure messages and alerts regarding system access and functions performed in the portal.

FORMS

Submit Redeterminations, Reopenings, eOffset requests and MORE!

ADMIN

Used by Provider Administrator to grant access to other users and unlock user accounts.

MY ACCOUNT

Manage functions of your account including passwords, Multi-Factor Authentication (MFA), and add providers.

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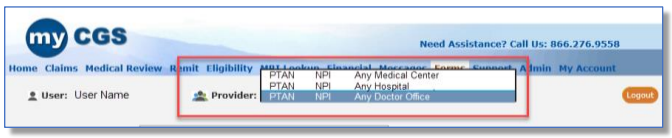
myCGS A/B/HHH MAC JURISDICTION 15

Choose YOUR myCGS Super ID!

Combine multiple User IDs under one master (Super) ID!

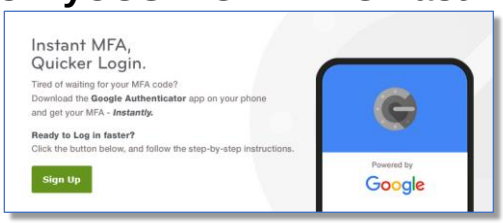


Refer to *My Account* section of the myCGS User Manual tab for more information.

Access myCGS LIGHTNING Fast!!!

Use Google Authenticator to obtain your Multi-Factor Authentication (MFA) code!

- Download from the App Store (Apple) and Android Play Store (Android).



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Self-Service Options!

Additional Documentation Request (ADR) Timeliness Calculator
Determine the date documentation must be received

CMS-1500 Claim Form Instructions Tool
Identifies items of a claim form (and ANSI electronic claim)

Fee Schedule Search Tool
Access to various types of fee schedules

Online EDI Application Status Check Tool
Enter Reference Number for app status: Received, Pending, Approved, Rejected, or No Record

Medically Unlikely Edits (MUEs)
Search for the MUE assigned to CPT/HCPCS codes

Prior Authorization Decision Tree
Identifies the services that require prior authorization

Consolidated Billing
Determine correct billing for a service when the beneficiary is in a covered Part A SNF stay.

MBI and Name-to-Number Converter
Converts the beneficiary's first initial of first name, first six letters of last name, and the alpha/numeric MBI to the numbers necessary to enter on your telephone keypad.

Medicare Secondary Payer (MSP) Tool
Used to determine claim payment calculations when Medicare is the secondary payer

Reason/Remark Code Search and Resolution
Enter the ANSI Reason or Remark Code for the denial and the possible causes and resolution.

Medicare Deductible/Coinsurance Look-Up Tool
Access deductible and coinsurance amounts for a Calendar Year.

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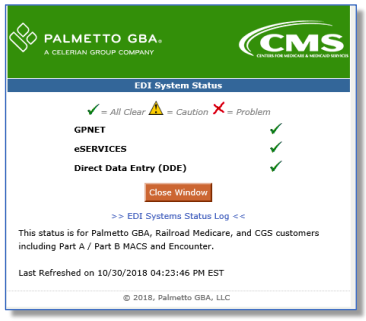
Self-Service Options!

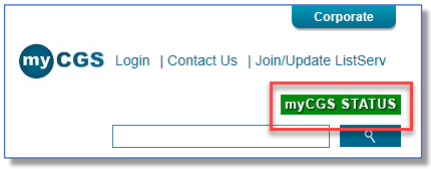
EDI System Status Log

- Easy way to check for any reported system issues
  - From EDI tab or Quick Links section



myCGS Status

- Located upper-right of web site
- At-a-glance notification to let you know the status of myCGS
  - GREEN means myCGS no issues
  - YELLOW means an issue was reported
  - RED means myCGS is not functioning



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Navigating the CGS Website!

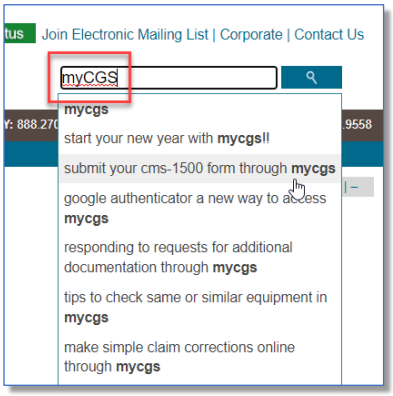
Website Search

CGS continually works to improve your experience when you visit the CGS J15 Medicare website. Functions and tips on using the search engine to find the answers you need:

- Auto-complete: A language prediction tool provides suggestions as you type and changes with each keystroke to provide accurate predictions.
- Search engine makes suggestions on misspelled words
- Use quotation marks to search for a phrase

Check here for additional tips!

- CGS Website Search Feature Enhancements
- Ways to Improve Search Results



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CGS Medicare App

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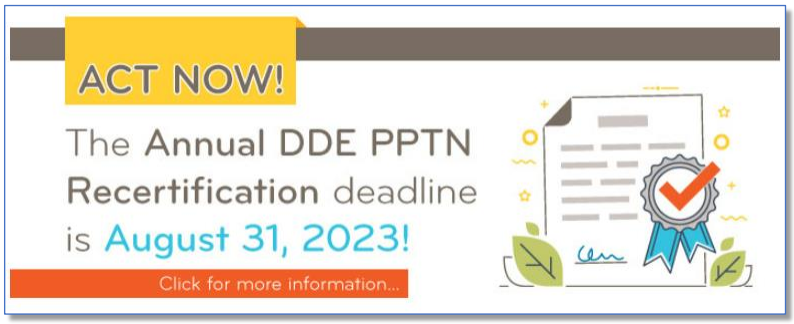
FOCUS on 2023!

2023 PPTN Recertification

Action Required!

If you use the PPTN application for immediate access to claims processing and beneficiary eligibility information, it is time for the annual recertification.



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FOCUS on 2023!

Part B Provider Education

We are here for you, J15!

If you have a specific Medicare Part B education request, you can schedule an appointment with the Part B POE staff at J15_PartB_Education@cgsadmin.com

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FOCUS on 2023!

Your Feedback Matters!

Whether it's your interaction with the website, myCGS or the Provider Contact Center, your feedback matters!

When you see the pop-up, please take a few minutes to complete the survey and share your thoughts to help CGS improve your experience.

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STAY CONNECTED

CHECK OUT OUR WEBSITE:
https://www.cgsmedicare.com

GET EVEN MORE RESOURCES:

- CMS MLN Web page: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo. This includes the MLN Connects, MLN articles, and more.
- Electronic Mailing List page at: https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Electronic-Mailing-Lists
- CMS e-mail updates at: https://public.govdelivery.com/accounts/USCMS/subscriber/new?pop=t&topic_id=USCMS_7819

Follow Us on LinkedIn: @cgs-administrators-llc

Follow Us on YouTube: @cgsmedicare

Visit the myCGS Web Portal:
https://www.cgsmedicare.com/mycgs

SIGN UP FOR EMAIL NOTIFICATIONS:
By clicking on, "Join Electronic Mailing" list in the top right corner of https://www.cgsmedicare.com

Download the CGS Medicare℠ App:

Download on the App Store GET IT ON Google Play

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FOCUS on 2023!

Register for Cvent to Attend Events!

We have a NEW webinar platform!

Either scan the QR code or go to Personal Information - CGS J15 Part A, Part B, and HHH Education (cvent.com) to view events and add them to your personal schedule.

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MEDICARE PART B UPDATE SUMMER 2023

FOCUS on 2023!

Thank you for joining us!

QUESTIONS???

CGS A CELERIAN GROUP COMPANY

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

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