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August 6, 2024

Finding Answers
Ongoing Medicare Initiatives
Comprehensive Error Rate Testing (CERT)
Understanding Data
Self-Service Technology

CGS®
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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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.

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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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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

Prior Authorization (PA) for Certain Hospital Outpatient Department (OPD) Services

Part A Claims Only

- Prior authorization must be requested for specific CPT/HCPCS codes for the following groups of hospital OPD services:
  - Blepharoplasty
  - Botulinum Toxin Injections
  - Cervical Fusion with Disc Removal
  - Implanted Spinal Neurostimulators
  - Panniculectomy
  - Rhinoplasty
  - Vein Ablation
  - Facet Joint Interventions for Pain Management
- Check the listing for specific CPT/HCPCS codes within each group

Prior Authorization (PA) for Certain Hospital Outpatient Department (OPD) Services

Part A Claims Only *(Cont.)*

- Once the prior authorization is affirmed, a unique tracking number (UTN) is sent to the OPD.
- When the service is billed, the UTN must be added to the OPD's Part A claim.
  - Only the hospital OPD is required to include the UTN on claims, as the PA process is only applicable to hospital OPD services.
    - The Part B physician and other billing practitioners are NOT to submit the UTN.
    - Part B physician/practitioners should submit their claims as usual
    - NOTE: Claims related to/associated with services that require prior authorization as a condition of payment will be DENIED if the OPD service requiring prior authorization is not eligible for payment.
- PA OPD Services Frequently Asked Questions (FAQs)
- Part A PA OPD webpage

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

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

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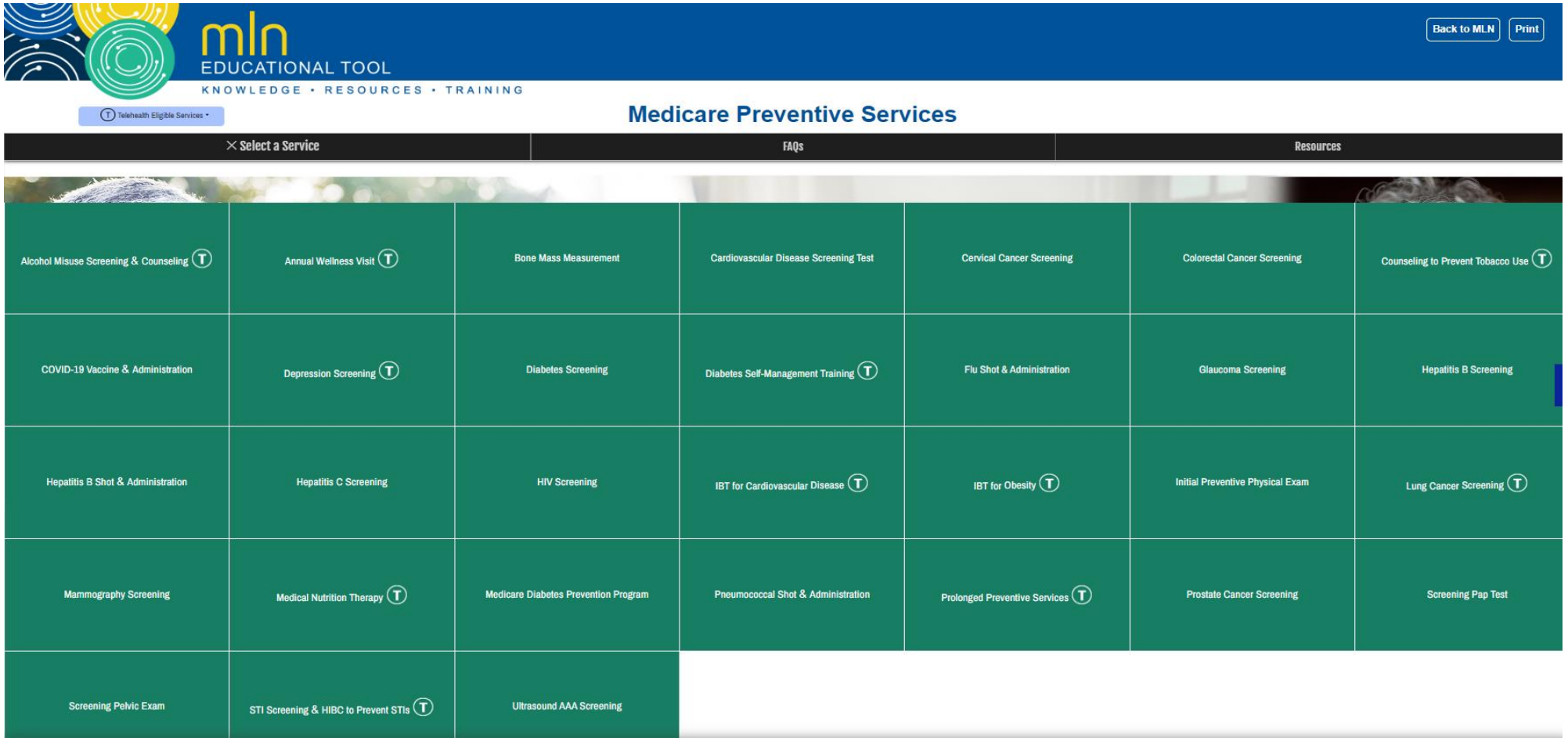
Preventive Services

Keep our seniors healthy! Medicare-approved Preventive Services



HCPCS Billing Codes & Advance Beneficiary Notice of Non-coverage Requirements

Learn about coding and requirements (PDF):

- Use HCPCS codes G0402, G0438, and G0439 for billing initial preventive physical examination (IPPE) and annual wellness visit (AWV) services
- **Don't bill CPT codes 99381–99397 for IPPE or AWV services**
  - Give your patients an Advance Beneficiary Notice of Non-coverage for certain preventive services like services in the CPT code range 99381-99397

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).

Understanding Coverage on Behavioral Health Integration

The Consolidated Appropriations Act, 2023 requires CMS to conduct outreach to physicians and appropriate non-physician practitioners on these three services:

- Behavioral Health Integration (BHI) Services
- Psychotherapy for Crisis
- Opioid Use Disorder (OUD) Screening & Treatment

Coverage/guidelines available :

- MLN909432 Behavioral Health Integration Services Booklet (cms.gov)
- Psychotherapy for Crisis | CMS
- Opioid Use Disorder Screening & Treatment | CMS

Guiding an Improved Dementia Experience Model

Learn about this 8-year voluntary national model (PDF) starting on July 1, 2024, including:

- What are the goals?
- Who can apply, and what's the target participation?
- How does CMS pay participants?
- How do participants submit claims?
  - The GUIDE payments won't include non-physician practitioner's payment reduction.
  - CMS is waiving patient coinsurance and deductible payments on DCMP and respite services under the model and Medicare will pay 100% of the DCMP amount.
  - Unless **noted,** GUIDE claims are subject to all other adjustments, like sequestration, and policies applicable to other FFS claims.
  - MACs will verify patient attribution and provider eligibility for the GUIDE DCMP code eligibility.

Medicare Dental Coverage

- In most cases, Medicare **doesn't** cover dental services like routine cleanings, fillings, tooth extractions, or items like dentures.
- Medicare **may** cover:
  - Certain dental services may be considered when a beneficiary is admitted as a hospital inpatient for a dental procedure, either because of an underlying medical condition or the severity of the procedure
  - Specific inpatient or outpatient dental services directly related to certain covered medical treatments.
- In these cases, the beneficiary must get the dental service because it's linked to the success of the medical treatment they need, like:
  - An oral exam and dental treatment before receiving a heart valve replacement or a bone marrow, organ, or kidney transplant
  - A procedure (like a tooth extraction) to treat a mouth infection before receiving cancer treatment services like chemotherapy
  - Treatment for a complication they may experience while getting head and neck cancer treatment services

Beneficiary Costs in Original Medicare

- Beneficiary - pays 100% for non-covered services, including most dental services.
- For Part A-covered inpatient hospital stays, beneficiary will pay this for each benefit period:
  - **Days 1-60**: $1,632 deductible
  - **Days 61–90**: $408 each day
  - **Days 91 and beyond**: $816 each day while using your 60 lifetime reserve days
  - **Each day after they will use all their lifetime reserve days:** All costs
- For Part B-covered dental services, you pay 20% of the Medicare-approved amount after you meet the Part B deductible. If you get the covered service in an outpatient hospital or other facility setting, you'll also pay a copayment to the facility

Testing for Medicare Dental (837D Format) Claims

Beginning on May 31, 2024, providers, clearinghouses, and vendors may:

- Enroll to submit the 837D transaction.
- Send test 837D transactions.
  - Refer to the Standard Companion Guide – Health Care Claim: Dental (837D)

NOTE: Since this is a new transaction, 837D submitters must submit a minimum of 5 claims for testing before production status is approved

- CGS will return 999 and 277CA transactions to testing providers. Refer to Dental Claim Edits for 5010A2 837D Files for details
- The myCGS portal and Interactive Voice Response (IVR) system do not currently support inquiries related to 837D dental claim status
- Until a self-service option is available, our customer service representatives (CSRs) may provide claim status information for 837D claims **only**
- For other claim status inquiries, you must continue to use myCGS or the IVR
- Please review the information available on the CMS Medicare Dental Coverage page to determine if you should begin testing

Medicare Prescription Drug Coverage

- Starting in 2025 the Medicare Prescription Payment Plan aims to ensure that people with Medicare prescription drug coverage, especially those most likely to benefit, are aware of the payment option
- The Medicare Prescription Payment Plan provides the option to people with Medicare prescription drug coverage to spread the costs of their prescription drugs over the calendar year rather than paying in full at the pharmacy counter each time they fill a prescription
- People with Medicare must opt into the Medicare Prescription Payment Plan to utilize the new benefit
  - Notably, this payment option launches at the same time that all individuals with Medicare prescription drug coverage will begin to have their annual out-of-pocket prescription drug costs capped at $2,000, providing needed financial relief for high prescription drug costs

- More Information:
  - Full press release
  - Fact sheet (PDF)
  - Updated implementation timeline (PDF)

Reminder - 2025 ICD-10-CM

- The ICD-10-CM diagnosis codes are effective from October to September per Calendar Year (CY)
- 2025 ICD-10-CM diagnosis codes will be effective October 1, 2024, through September 30, 2025

- Reference
  - https://www.cms.gov/medicare/coding-billing/icd-10-codes/2025-icd-10-cm

MIPS Resources

CMS posted MIPS resources

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

QPP Webinar Library (cms.gov)

- QPP Final Rule Webinar provide overview of finalized QPP policies
- https://qpp.cms.gov/apms/advanced-apms

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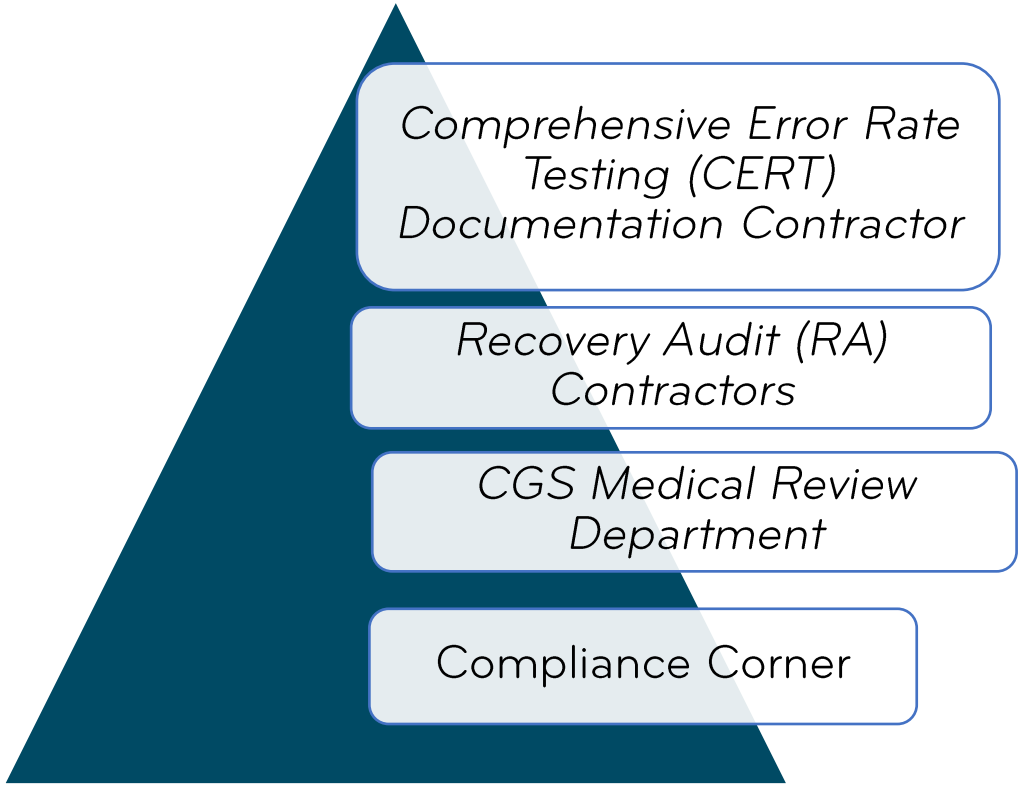
You may receive requests for medical records.



Medicare Record Review Programs

FY 2023 CERT Improper Payment Rate

CERT improper payment rate is 7.38 percent, representing (projected amount) $31.23 billion in improper payments. (Compared to 7.46% and $31.46 billion in FY 2022)

Claim Type	Improper Payment Rate	Improper Payment Amount
Part A Providers (excluding Hospital IPPS)	7.75%	$14.22 B
Part B Providers	10.03%	10.99 B
Part A Providers (Inpatient Hospital)	3.36%	$4.08 B
DMEPOS	22.51%	$1.95 B

The reporting period for this improper payment rate is Jul 1, 2021, through Jun 30, 2022

- Comprehensive Error Rate Testing (CERT) | CMS
- 2022 Medicare Fee-for-Service (FFS) Supplemental Improper Payment Data

Common CGS J15 Errors - Home Health

Signature

- Missing
- Signed after claim was submitted

Certification

- Missing/Illegible
- Signed after the claim was submitted
- Inadequate-documentation did not show the patient still needed this level of care

Service Intensity Add on

- No notes documenting visits to support

Common CGS J15 Errors - Hospice

Certification

- Missing
- Inadequate
- Signed after the claim was submitted
- Physical Therapy certification missing for the therapy that was being given

Service intensity Add on

- Notes not submitted

Beneficiary Election statement

- MISSING: Documentation to support that the Hospice Election Statement Addendum, "Patient Notification of Hospice Non-Covered Items, Services, and Drugs " was provided to the beneficiary and /or representative as requested

Common CGS J15 Errors - Part B

Lab Orders

- Missing treating providers order or intent to order lab
- Clinical documentation to support medical necessity
- Missing risk assessment or documentation of the individual's risk of abusing opioids

Non-Response

Physical Therapy

- Missing providers certification
- Plan of care

Evaluation and Management Codes

- Down coding due to documentation not supporting the level of medical decision making

CMS Key Actions to Address Payment Integrity Risks – Automation

Automated Edits:

- Due to the high volume of Medicare claims processed by HHS daily and the significant cost associated with conducting medical reviews of an individual claim, HHS relies on automated edits to identify inappropriate claims.
- HHS designed its systems to detect anomalies and prevent payment for many erroneous claims through these efforts. HHS also uses the National Correct Coding Initiative to prevent improper payments of Medicare Part B claims and Medicaid claims.
- HHS will report FY 2023 savings from these edits in the forthcoming Annual Report to Congress on the Medicare and Medicaid Integrity Programs.

CMS Key Actions to Address Payment Integrity Risks – Hospital Outpatient Prior Authorization

- HHS included Facet Joint Interventions in the nationwide prior authorization process for hospital outpatient department services in November 2022 for services provided on or after July 1, 2023.
- Facet Joint Interventions were added to the existing list of services requiring prior authorization, which includes Blepharoplasty, Botulinum Toxin Injections, Panniculectomy, Rhinoplasty, Vein Ablation, Implanted Spinal Neurostimulators, and Cervical Fusion with Disc Removal. HHS has provisionally affirmed 152,990 through this process.

CMS Key Actions to Address Payment Integrity Risks – Ambulance Transport Prior Authorization

- In FY 2023, HHS continued nationwide prior authorization for the Repetitive, Scheduled Non-Emergent Ambulance Transport Prior Authorization Model
  - HHS provisionally affirmed 22,760 ambulance prior authorization requests with this process.
    - *A single prior authorization decision may affirm up to 40 round trips for up to a 60-day period. Beneficiaries with a chronic medical condition are eligible to receive an extended affirmation period. For these beneficiaries, a single prior authorization decision may affirm up to 120 round trips for up to a 180-day period*

CMS Key Actions to Address Payment Integrity Risks – Medical Review Strategies

- HHS and its contractors use improper payment data to develop medical review strategies to target the areas of highest risk and exposure.
- HHS requires its Medicare review contractors to identify and prevent improper payments due to documentation errors in error -prone claim types like SNF, hospital outpatient claims, IRF, hospice, and home health.

CMS Key Actions to Address Payment Integrity Risks – Medical Review Accuracy Award Fee Metric

HHS incorporates the Medical Review Accuracy Award Fee Metric into the Award Fee Plan for Medicare Administrative Contractors (MACs) handling Part A, Part B, and DME claims.

- This metric evaluates the accuracy of the MACs complex medical review decisions.
  - This helps promote consistency in medical review decisions across MACs, ensuring consistent provider education on all improper payments, including those related to medical necessity and insufficient documentation errors.
- Additionally, this projects goals aims to identify and simplify unclear or burdensome policy requirements to reduce unnecessary denials.

CMS Key Actions to Address Payment Integrity Risks – Provider Billing Review Evaluation

HHS released 10 Comparative Billing Reports for 9 unique topics that include:

- Initial Nursing Facility Evaluation and Management Services,
- Bronchodilator Nebulizer Medications,
- Chiropractic Manipulative Treatment of the Spine,
- Immunosuppressive Drugs,
- Laboratory Testing:
  - Urinalysis,
  - Blood Counts
- Hospice,
- End-Stage Renal Disease Related Services,
- Lower Endoscopy, and
- Subsequent Annual Wellness Visits.

CMS Key Actions to Address Payment Integrity Risks – Audits: Supplemental Medical Review Contractor (SMRC) Reviews

SMRC conducted post payment Medicare FFS reviews for hospital outpatient, IRF, SNF, hospice, and DMEPOS claims.

- After the SMERC completes their reviews, they shares the results with the MACs for claim adjustments.
- Providers receive detailed SMRC review result letters and MAC demand letters for overpayment recovery, including educational information regarding what was incorrect in the original billing of the claim

SMRC conducted post-payment reviews for 7,936 hospital outpatient claims, 4,588 SNF claims, 7,184 IRF claims, 38,604 hospice claims, 5,897 DME claims, and other areas.

CMS Key Actions to Address Payment Integrity Risks – Audits: Recovery Audit Contractor (RAC) Reviews

- Medicare FFS RACs identified and collected improper payments related to IRF, SNF, professional services, home health, and DMEPOS claims.
  - The majority of Medicare FFS RAC recoveries, 30 percent, came from hospital outpatient overpayments, with an additional 5 percent originating from SNF overpayments.

CMS Key Actions to Address Payment Integrity Risks - Predictive Analytics: Fraud Prevention System Models

The Fraud Prevention System employs advanced algorithms to focus investigative efforts;

- Detect suspect claims or providers/suppliers
- Aid investigations in cases of severe or unusual activity.
- They provided information for 1,994 existing and 1,137 new leads or investigations opened by program integrity contractors. 30 Contractors initiated actions against 1,095 providers as a result.

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!

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

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
  - Review the CGS Medical Review "Activity List"

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

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

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

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
A/B MAC OUTREACH & EDUCATION
Task Force for Error-Free Medicare Claims

CERT Videos

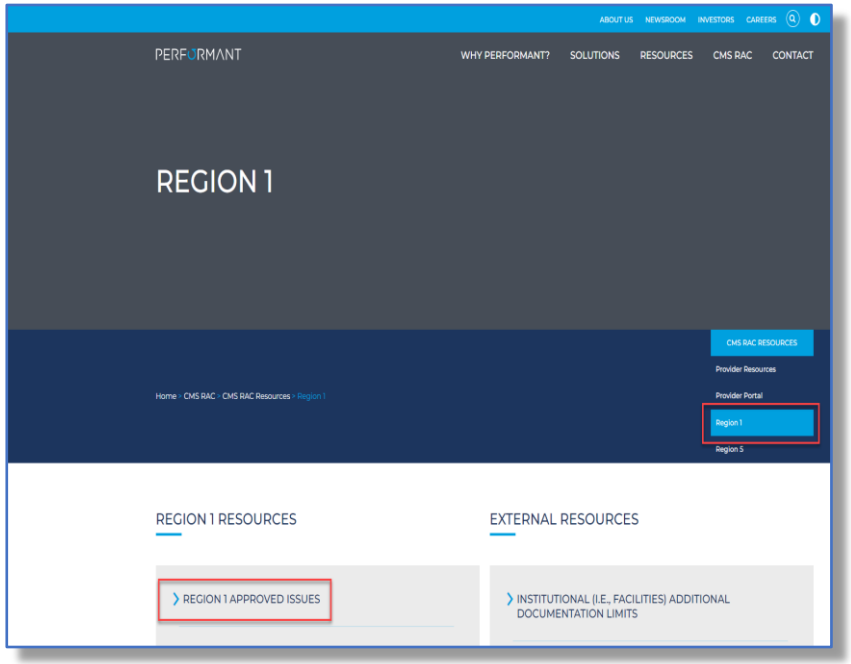
- Provider Minute: Utilizing Your MAC - YouTube
- Provider Minute: The Importance of Proper Documentation

Check here for more information

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



RA Program
Highest Improper Payments

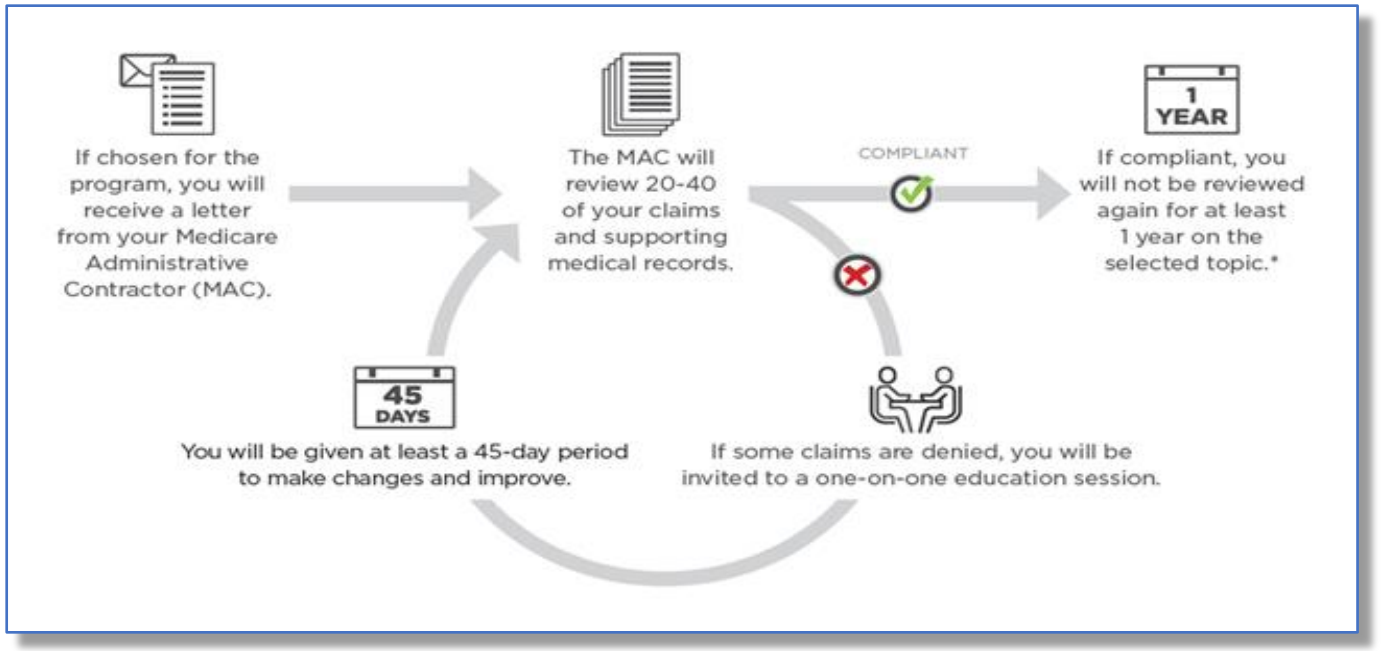
Last Quarter Report

CPT/HCPCS Codes	Issue	Rationale
64582	Hypoglossal Nerve Stimulation for Obstructive Sleep Apnea	Medical Necessity and Documentation Requirements
27279	Minimally Invasive Surgical (MIS) Fusion of the Sacroiliac Joint	Medical Necessity and Documentation Requirements
63047	Physician/Non-physician practitioner	Coding Validation
22513/22514	Vertebroplasty or Kyphoplasty	Medical Necessity and Documentation Requirements
33249	Implantable Automatic Defibrillator-Outpatient Procedure	Medical Necessity and Documentation Requirements
64581/64590	Sacral Neurostimulation	Medical Necessity and Documentation Requirements
52235/52240	Urethra and Bladder Transurethral Surgical Procedure	Ambulatory Payment Classification Coding Validation

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.

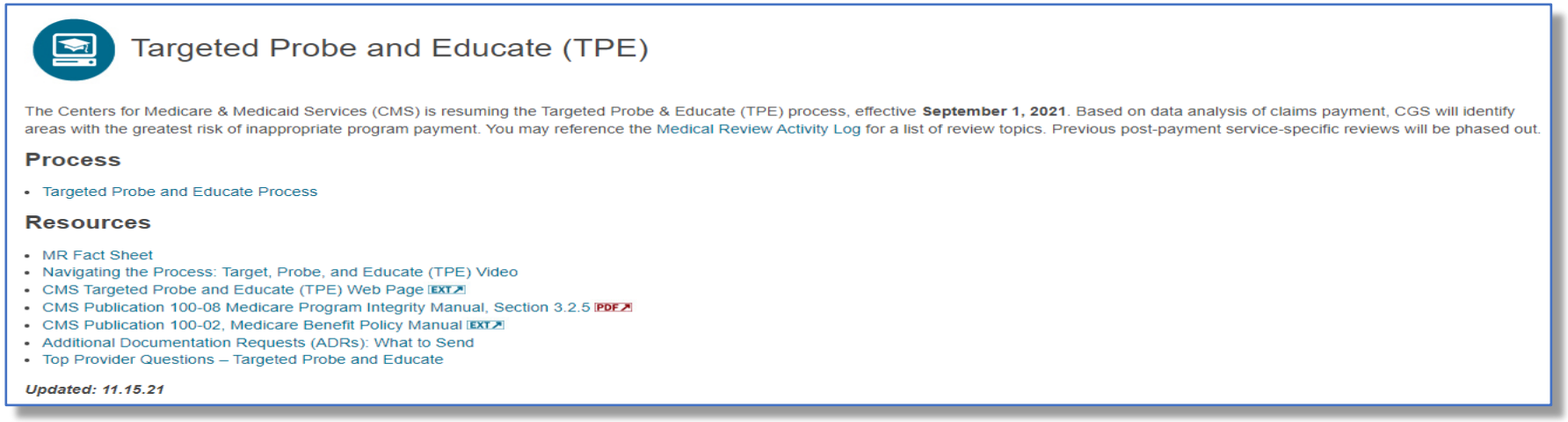


Medical Review

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.



Targeted Probe and Educate (TPE)

The Centers for Medicare & Medicaid Services (CMS) is resuming the Targeted Probe & Educate (TPE) process, effective **September 1, 2021**. Based on data analysis of claims payment, CGS will identify areas with the greatest risk of inappropriate program payment. You may reference the Medical Review Activity Log for a list of review topics. Previous post-payment service-specific reviews will be phased out.

Process

- Targeted Probe and Educate Process

Resources

- MR Fact Sheet
- Navigating the Process: Target, Probe, and Educate (TPE) Video
- CMS Targeted Probe and Educate (TPE) Web Page EXT
- CMS Publication 100-08 Medicare Program Integrity Manual, Section 3.2.5 PDF
- CMS Publication 100-02, Medicare Benefit Policy Manual EXT
- Additional Documentation Requests (ADRs): What to Send
- Top Provider Questions – Targeted Probe and Educate

Updated: 11.15.21

Medical Review [Medical Review Activity Log (cgsmedicare.com)]

MR Activities

Updated: 03.04.24

Review Topic	Codes Involved	Review Type	Status	Resources
Ambulance	A0425, A0429	Targeted Probe and Educate Prepayment Review	Active	• Targeted Probe and Education Program to Focus on Ambulance Claims • Ambulance Fact Sheet PDF • Ambulance Decision Tree • Ambulance Documentation Checklist Tool PDF
Annual Wellness Visit	G0438 and G0439	Targeted Probe and Educate Prepayment Review	Active	• Targeted Probe and Educate Program to Focus on Annual Wellness Visits • Annual Wellness Visits (AWV) Fact Sheet PDF • Annual Wellness Visits (AWV) Documentation Checklist Tool PDF • Annual Wellness Visits (AWV) Decision Tree
Diagnostic Imaging	74174, 74176, 74177, 71046, 71260, 71250	Targeted Probe and Educate Prepayment Review	Active	• CT of Abdomen and Chest Fact Sheet PDF • CT of Abdomen and Chest Documentation Checklist Tool PDF • CT of Abdomen and Chest Decision Tree
Drugs/Biologicals	J0129, J0178, J0717, J2778, J0897, J0585, J1602, J7326	Targeted Probe and Educate Prepayment Review	Active	• Billing and Coding: JW and JZ Modifier Guidelines • HCPCS J0129 PDF • HCPCS J0178 PDF • HCPCS J0585 PDF • HCPCS J2778 PDF • Drugs & Biologicals Decision Tree • Drugs and Biological Services Documentation Checklist Tool PDF • IOM 100-4, Processing Manual, Chapter 17 – Drugs and Biologicals PDF • Targeted Probe and Education Program to Focus on Drugs and Biological Claims
Cataract Removal	66821, 66982, 66984	Targeted Probe and Educate Prepayment Review	Active	• Targeted Probe and Education Program to Focus on Cataract Removal Claims • Cataract Documentation Checklist PDF • Cataract Services Decision Tree • Cataract Surgery Fact Sheet PDF

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 – 4th QTR 2023
Multi LCDs	Molecular Diagnostic Tests
L39038	MolDX: Molecular Syndromic Panels for Infectious Disease Pathogen Identification Testing
L33996	Vitamin D Assay Testing
L34200	Removal of Benign Skin Lesions
L34045	Non-Invasive Vascular Studies
L33943	B-type Natriuretic Peptide (BNP) Testing
L36029	Controlled Substance monitoring and Drugs of Abuse
L37578	Micro-Invasive Glaucoma Surgery (MIGS)
L38773	Facet Joint Interventions for Pain Management
L35891	Intravenous Immune Globulin

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

Share your documentation

CGS or other Medicare contractors may request medical records

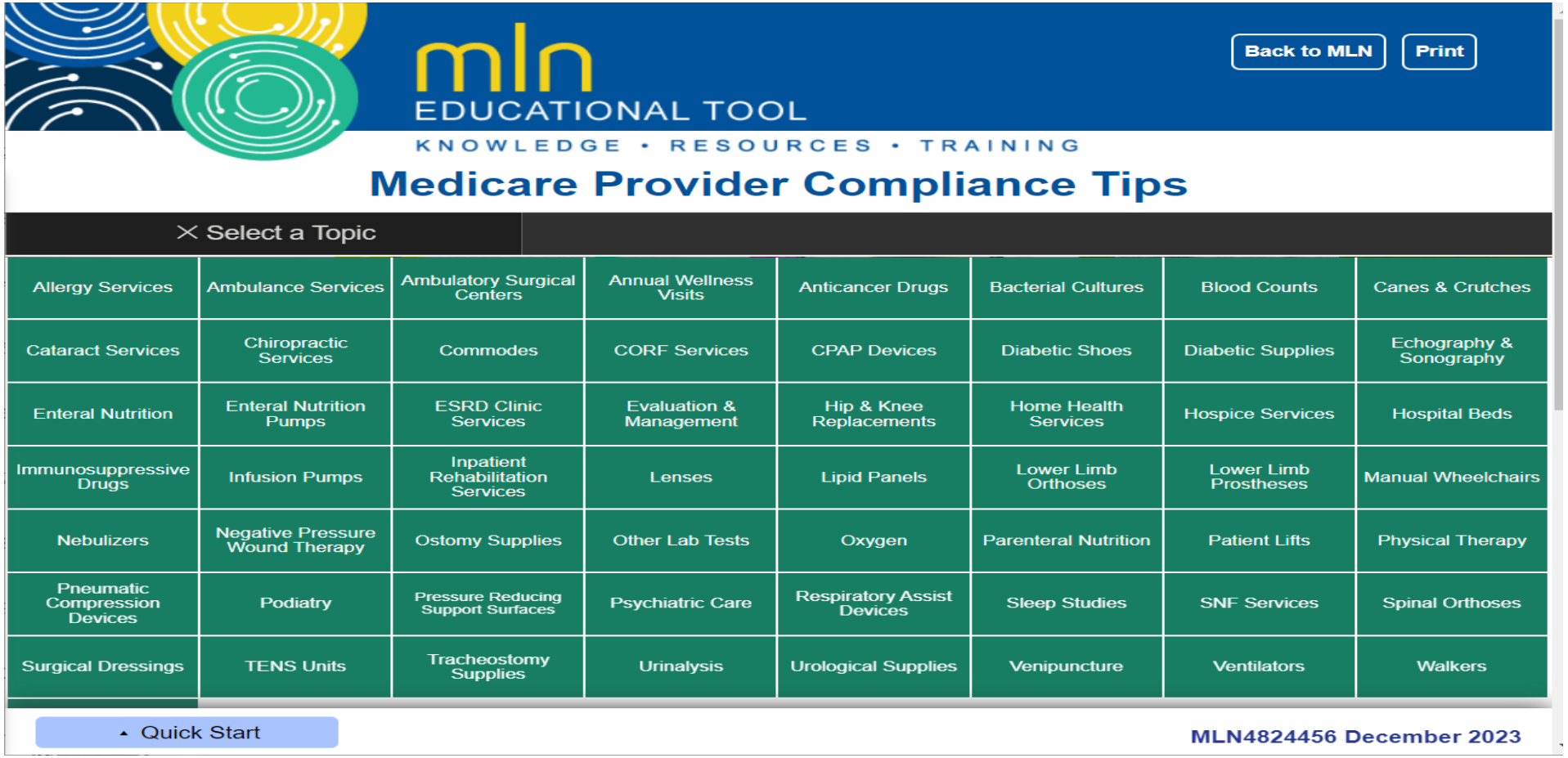
- To support the medical necessity for services based on Local Coverage Determination (LCD) requirements
- To determine the correct payment

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.

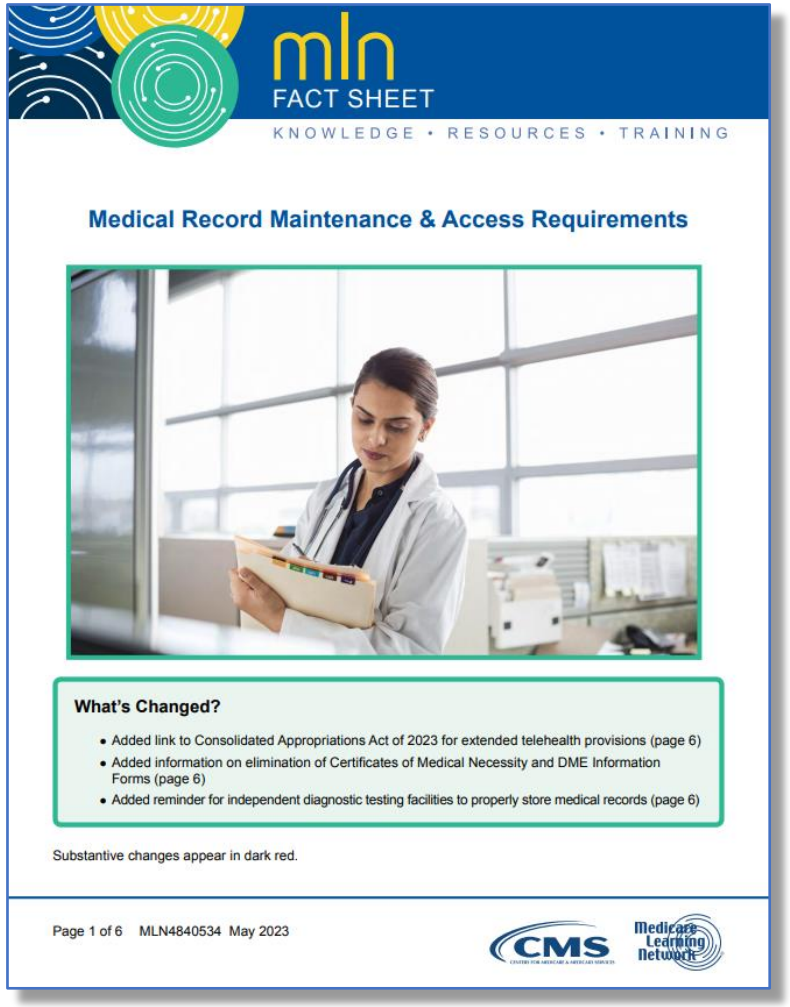
Reference: Section 4317 of the Balanced Budget Act (BBA: SEC.4317, REQUIREMENT TO FURNISH DIAGNOSTIC INFORMATION)

Compliance Corner: Compliance Tips Specific to Various Services



https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/medicare-provider-compliance-tips/medicare-provider-compliance-tips.html

Compliance Corner: Medical Record Maintenance


mln
FACT SHEET
KNOWLEDGE • RESOURCES • TRAINING

Medical Record Maintenance & Access Requirements

What's Changed?

- Added link to Consolidated Appropriations Act of 2023 for extended telehealth provisions (page 6)
- Added information on elimination of Certificates of Medical Necessity and DME Information Forms (page 6)
- Added reminder for independent diagnostic testing facilities to properly store medical records (page 6)

Substantive changes appear in dark red.

Page 1 of 6 MLN4840534 May 2023

CMS

Medicare Learning Network

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

Provider Enrollment

Provider Enrollment Application Fee Amount for Calendar Year 2024

- Effective Jan 1, 2024, the application fee is $709 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, 2024
  - 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.

FOCUS

Keep Your Enrollment Information Current

It's important to keep your enrollment information up to date. To avoid having your Medicare billing privileges revoked, be sure to report the following changes within 30 days:

- a change in ownership
- an adverse legal action
- a change in practice location

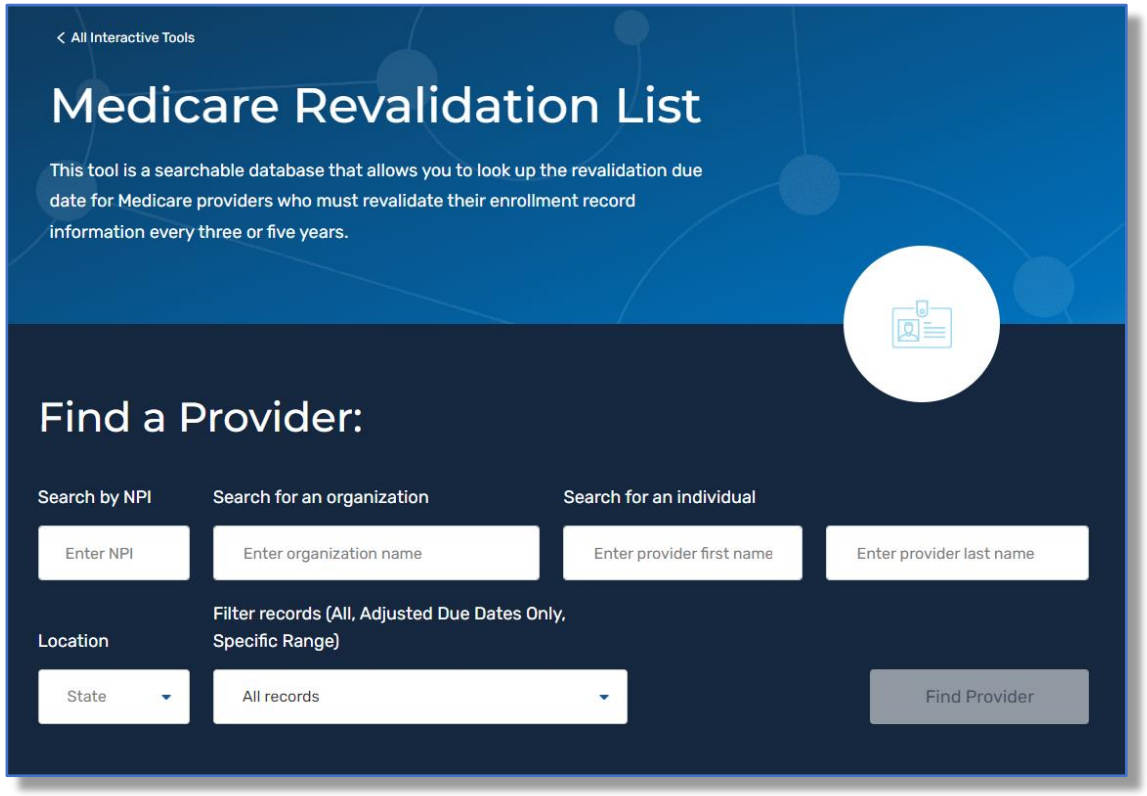
You must report all other changes within 90 days. If you applied online, you can keep your information up to date in PECOS.

If you applied using a paper application, you'll need to resubmit your form to update information.

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 this 2min video on PECOS updates
- Avoid errors found in data analysis to get apps processed correctly the FIRST time!



Marriage and Family Therapists & Mental Health Counselors: Enroll NOW!

CMS has implemented 2 new provider types effective January 1, 2024:

- Marriage and family therapist
- Mental health counselor

You must enroll in Medicare to submit claims and get paid for covered items or services. Find out how to become a Medicare provider, and take these steps to enroll:

- Review the application: electronic version in PECOS or paper CMS-855I
- Gather your supporting documents
- Sign up to get our weekly MLN Connects newsletter

Your effective enrollment date won't be earlier than January 1st.

More Information:

- Physician Fee Schedule final rule
- Medicare Enrollment for Providers & Suppliers webpage
- FAQs (PDF)

Provider Enrollment

https://www.cgsmedicare.com/partb/enrollment/index.html

Application and Forms

Contact Us

PECOS

Provider Enrollment Processes

Most Common Reasons for Delays in Application Processing

Revalidation

OPT OUT Status

Tools, Tracking, & Resources

FAQs

Medicare Participating Physicians/Suppliers Database (MEDPARD)

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.

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.
- NOTE: The Benefits Coordination & Recovery Center (BCRC) will no longer accept calls from providers/suppliers to create or update MSP records.
- 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)
  - Non-Group Health Plan (NGHP) Medicare Secondary Payer (MSP) Beneficiary Reference Guide

Claims: Data Analysis

Avoid common errors to get claims paid the FIRST time!

- Top reasons we DENY your claims
  - Non-Covered by this Contractor
  - Duplicate Service
  - Medicare is Secondary Payer
  - Payment Included in Another Service
  - Expense Prior to/After Coverage Ended

Top reason we REJECT your claims

- Procedure Code Invalid on Date of Service
- Missing/Invalid Group Practice Information
- Missing/Invalid Patient Identifier or Name
- Missing/Invalid Ordering/Referring Provider
- Invalid Procedure Code/Modifier Combination

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)

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 is PREFERRED method; 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!

Provider Contact Center (PCC)

Reminder: Staff cannot assist with functions available through the *Interactive Voice Response (IVR)*

- This includes beneficiary eligibility, claim and appeal status, offset information, etc.
  - Step-by-step instructions for the IVR are available
  - Use the *Medicare Beneficiary Identifier (MBI) and Name to Number Converter*
- Authentication required for claim-specific phone AND written inquiries!

Provider National Provider Identifier (NPI)	Provider Transaction Access Number (PTAN)
Last 5 digits of the Tax Identification Number	Beneficiary's Medicare Beneficiary Identifier
First 6 letters of the beneficiary's last name	First letter of the beneficiary's first name
Beneficiary's date of birth	

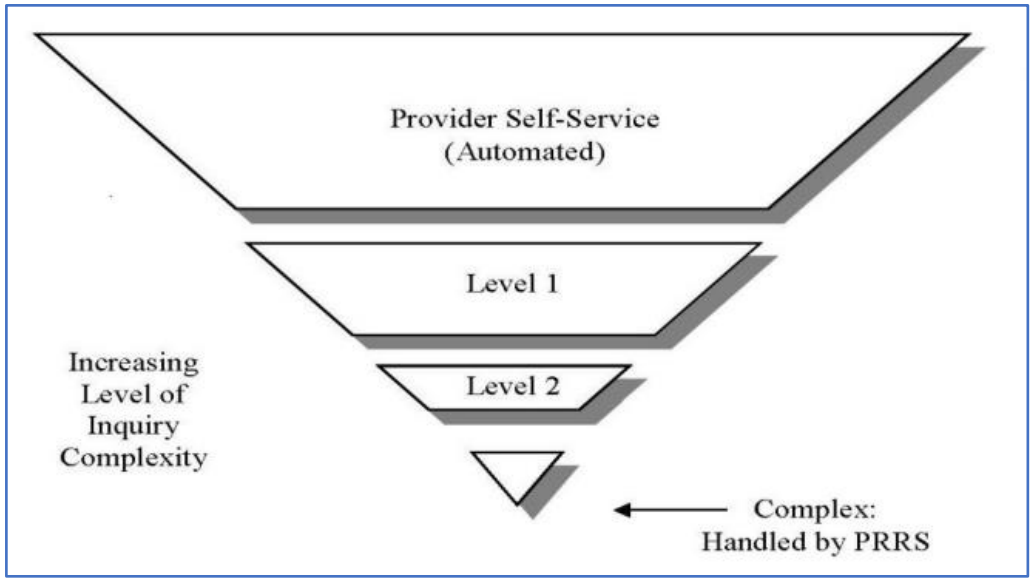
Callers will be transferred back to CTI/IVR if authentication steps not completed.

Utilize the Self-Service Options to enhance your productivity. ☺

Provider Contact Center (PCC)

Inquiry Triage Process

- Provider inquiries may require varying degrees of expertise to answer.
  - CMS requires a triage mechanism to answer and/or route inquiries.
    - 1st Level: CSRs answer wide range of basic questions that cannot be answered the IVR.
    - 2nd Level: CSRs with more experience and expertise to answer more complex questions.
    - 3rd Level: Provider Relations Research Specialists (PRRS) handle most complex issues.



Provider Contact Center (PCC): Data Analysis

Provider Contact Center

Top reasons you called the PCC

- Claim Denials/Coding Errors: Modifiers
- Provider Enrollment Issues
- Claim Status/Payment Explanation
- Claim Denials/ Medicare Secondary Payer
- Claim Denials/Duplicate

Written Correspondence

Top reasons you wrote to us

- General Information
- Administrative Billing Issues
- Allowed Amount: Skilled Nursing Facility PPS
- Appeals/Duplicates

FOCUS

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

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

FOCUS

myCGS A/B/HHH MAC JURISDICTION 15

myCGS (cgsmedicare.com)

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 various types of workload electronically!

ADMIN

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

MY ACCOUNT

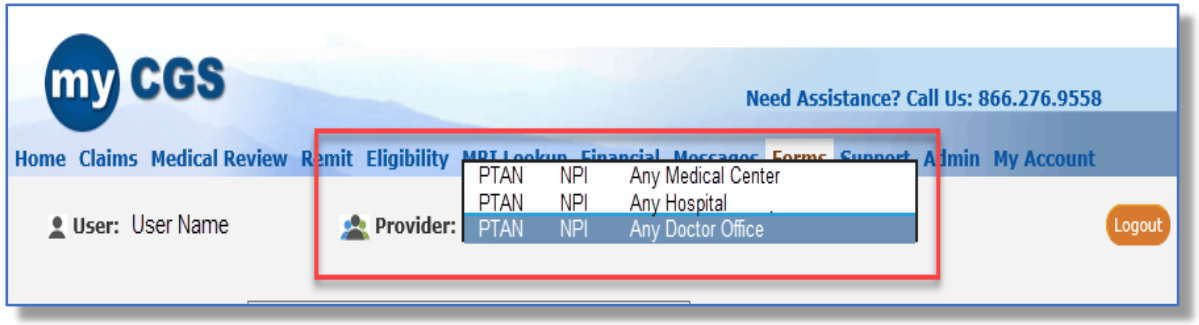
Manage functions of your account including passwords, Multi-Factor Authentication (MFA), and add providers.

FOCUS

myCGS A/B/HHH MAC JURISDICTION 15

Choose YOUR myCGS Super ID!

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

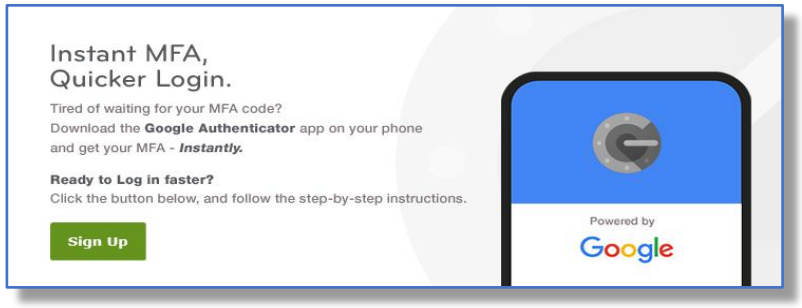


Refer to *My Account* section of the myCGS User Manual tab for more information.

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).



Self-Service Options!

Self-Service Options (cgsmedicare.com)

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.

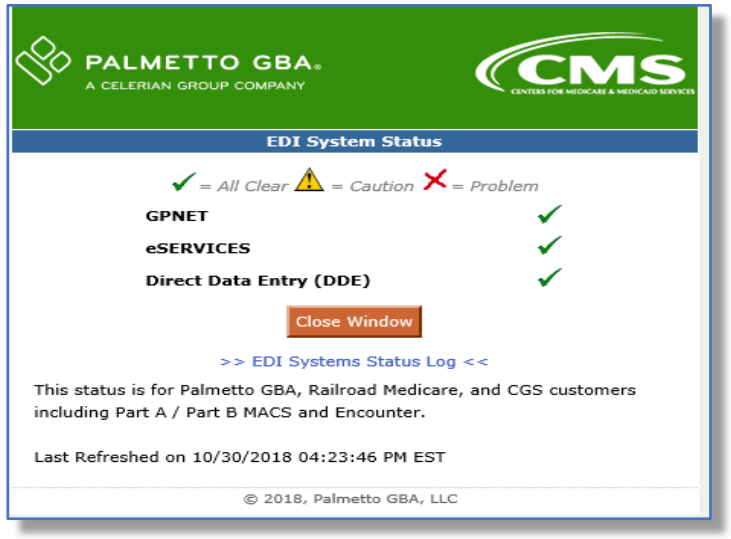
Medicare Deductible/Coinsurance Look-Up Tool

Access deductible and coinsurance amounts for a Calendar Year.

Self-Service Options!

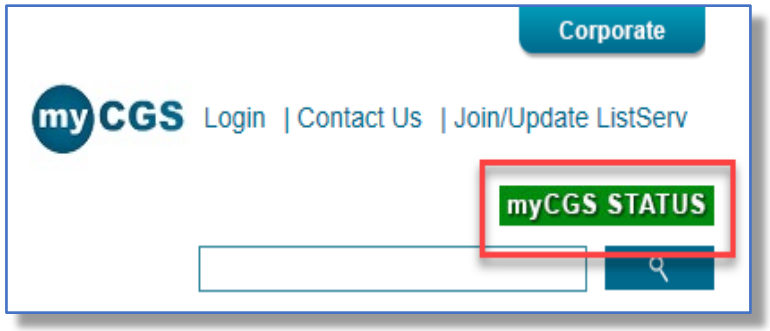
EDI System Status Log

- 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



Navigating the CGS Website!

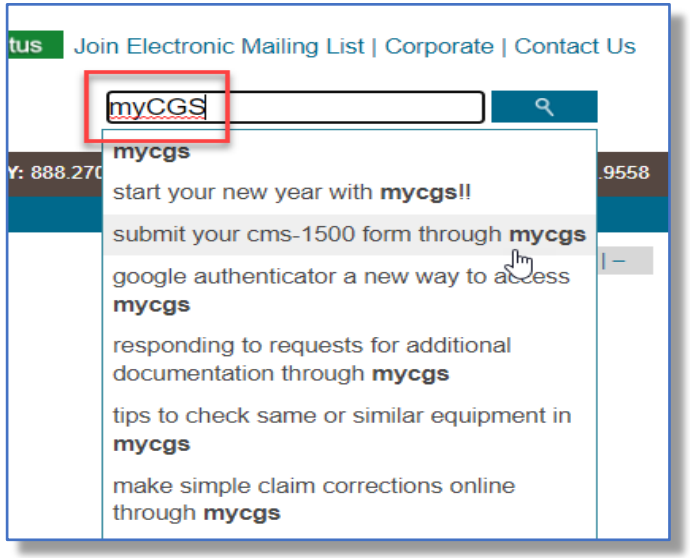
Website Search

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



CGS Medicare App

The CGS Medicare app allows you to read Physician Letters, use the MBI Name to Number Converter, access disaster resources, and more.

Access key information from your smartphone!

Search "CGS Medicare" in the App Store or Google Play store and download the app today!
To download CGS Medicare:
Visit the App Store **Visit the Google Play Store**

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.
- 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

Register for Cvent to Attend Events!

CGS J15 - 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.

CGS Customer Experience

We believe healthcare administration should be *easy, consistent, and transparent*. We simplify the system and deliver valuable solutions that IMPACT lives.

Help improve our website, portal and other services by providing your valuable feedback in our various satisfaction surveys: at https://www.cgsmedicare.com/hhh/pubs/reviews.html

Satisfaction surveys of CGS services

This survey link will appear randomly on our website or myCGS portal. It allows you to rate and provide feedback about your experience.

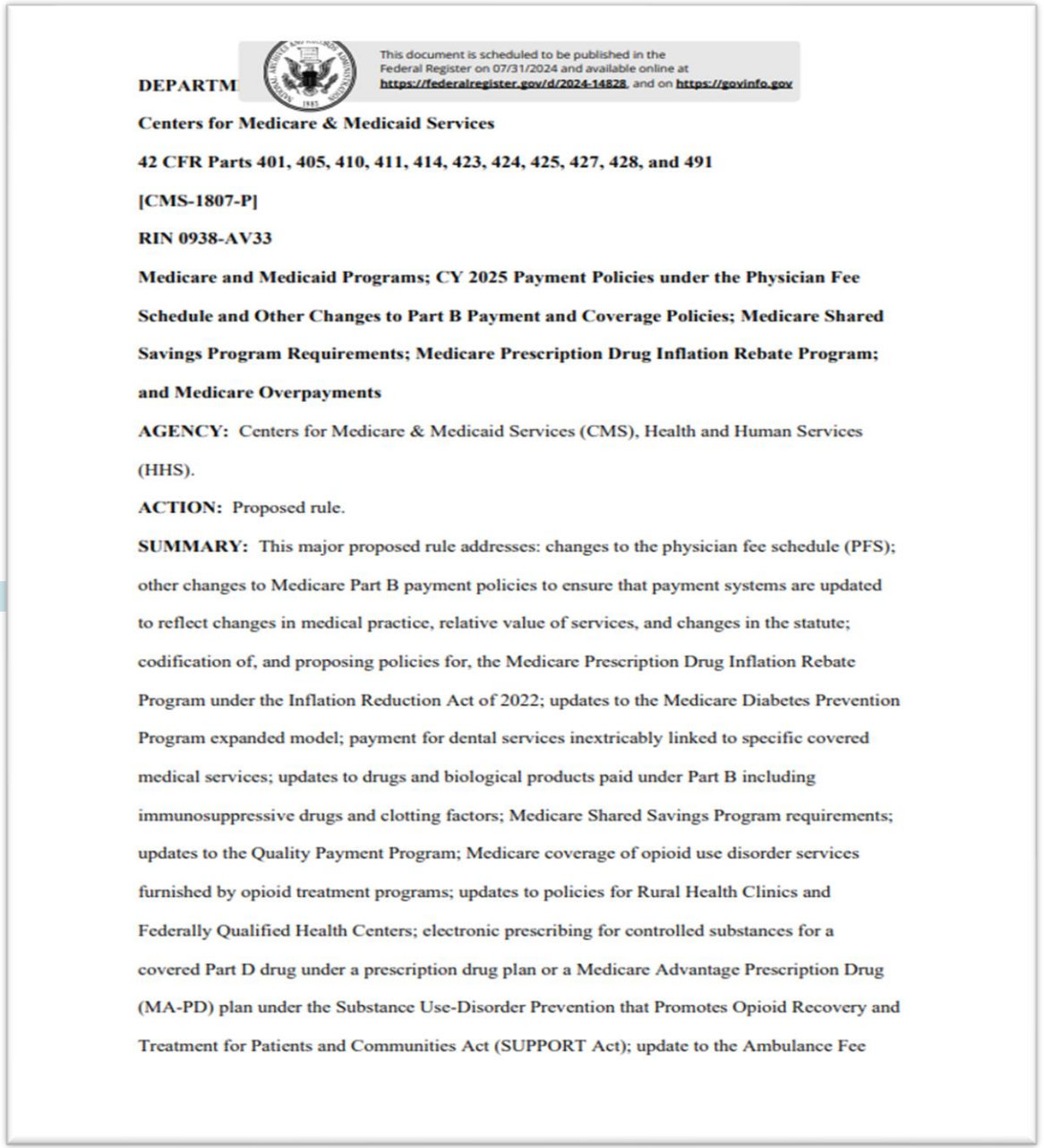
Part B Provider Education

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

CMS 2025 Proposed Rule

Review 2025 proposal at:
https://www.federalregister.gov/public-inspection/2024-14828/medicare-and-medicaid-programs-calendar-year-2025-payment-policies-under-the-physician-fee-schedule



This document is scheduled to be published in the Federal Register on 07/31/2024 and available online at https://federalregister.gov/d/2024-14828, and on https://govinfo.gov

DEPARTM

Centers for Medicare & Medicaid Services

42 CFR Parts 401, 405, 410, 411, 414, 423, 424, 425, 427, 428, and 491

[CMS-1807-P]

RIN 0938-AV33

Medicare and Medicaid Programs; CY 2025 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments

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; codification of, and proposing policies for, the Medicare Prescription Drug Inflation Rebate Program under the Inflation Reduction Act of 2022; updates to the Medicare Diabetes Prevention Program expanded model; payment for dental services inextricably linked to specific covered medical services; updates to drugs and biological products paid under Part B including immunosuppressive drugs and clotting factors; 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 policies for Rural Health Clinics and Federally Qualified Health Centers; electronic prescribing for controlled substances for a covered Part D drug under a prescription drug plan or a Medicare Advantage Prescription Drug (MA-PD) plan under the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act); update to the Ambulance Fee

CMS Physician Fee Schedule Proposed Rule

CY 2025 PFS Rate Setting and Conversion Factor

- By factors specified in law, average payment rates under the PFS are proposed to be reduced by 2.93% in CY 2025 compared to the average amount these services are being paid for most of CY 2024.
  - The change to the PFS conversion factor incorporates the 0.00 percent overall update required by statute, the expiration of the 2.93% increase in payment for CY 2024 required by statute, and a relatively small estimated 0.05% adjustment necessary to account for changes in work relative value units (RVUs) for some services.
- This amounts to a proposed estimated **CY 2025 PFS conversion factor of $32.36, a decrease of $0.93 (or 2.80%) from the current CY 2024 conversion factor of $33.29.**

2025 CMS Proposed Rule

- Caregiver Training Services (CTS)
- Services Addressing Health-Related Social Needs (Community Health Integration Services, Social Determinants of Health Risk Assessment, and Principal Illness Navigation Services)
- Advanced Primary Care Management Services (APCM)
- Cardiovascular Risk Assessment and Management
- Strategies for Improving Global Surgery Payment Accuracy
- Behavioral Health Services
- Opioid Treatment Programs (OTPs)
- Hospital Inpatient or Observation (I/O) Evaluation and Management (E/M) Add-on for Infectious Diseases
- Telehealth Services under the PFS
- Supervision Policy for Physical Therapists (PTs) and Occupational Therapists (OTs) in Private Practice
- Certification of Therapy Plans of Treatment with a Physician or NPP Order
- Dental and Oral Health Services
- Drugs and Biological Products Paid Under Medicare Part B
  - Requiring Manufacturers of Certain Single-dose Container or Single-use Package Drugs to Provide Refunds with Respect to Discarded Amounts
  - Approach to Payment Limit Calculations when Negative or Zero ASP Data is Reported to CMS

Review full proposal at: https://www.federalregister.gov/public-inspection/2024-14828/medicare-and-medicaid-programs-calendar-year-2025-payment-policies-under-the-physician-fee-schedule

Submitting Comments for the Proposed Rule

- Electronically.
  - You may submit electronic comments on this regulation to: https://www.regulations.gov.
- By regular mail
  - You may mail written comments to the following address ONLY:

    Centers for Medicare & Medicaid Services, Department of Health and Human Services,
    Attention: CMS-1807-P, P.O. Box 8016,
    Baltimore, MD 21244-8016.
- By express or overnight mail
  - You may send written comments to the following address ONLY:

    Centers for Medicare & Medicaid Services, Department of Health and Human Services,
    Attention: CMS-1807-P,
    Mail Stop C4-26-05,
    7500 Security Boulevard, Baltimore, MD 21244-1850.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on September 9, 2024

Thank You!

Thank you for joining us! Questions?

Don't forget to complete the survey!