MEDICARE UPDATE | Summer 2025

FOCUS

August 5, 2025

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

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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.

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.

The Centers for Medicare & Medicaid Services (CMS) employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this guide.

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.

Objectives

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

CMS Proposed Rule for CY 2026

CMS issued the proposed rule for the Physician Fee Schedule (PFS) on July 14, 2025. Providers have until September 12, 2025, to submit comments to CMS. Some proposals include:

CY 2026 PFS Conversion Factor

- Proposes two separate conversion factors: one for clinicians participating in Advanced Alternative Payment Models (APMs) and another for those who are not
  - The qualifying APM conversion factor increase by $1.24 (3.83%) to $33.59
  - The non-qualifying APM conversion factor increase by $1.17 (3.62%) to $33.42
  - $32.35 is the current conversion factor

Telehealth Services

- Streamline the addition of services to the Medicare telehealth services list and permanently remove certain frequency limits

CMS Proposed Rule for CY 2026

Cont'd…

Skin Substitutes

- Pay for skin substitute products as incident-to supplies when they are used as part of a covered application procedure paid under the PFS in the non-facility setting or under the OPPS in the hospital outpatient department setting

Reference:

Calendar Year (CY) 2026 Medicare Physician Fee Schedule (PFS) Proposed Rule (CMS-1832-P)

Note:

- CMS also proposed policies for the Quality Payment Program (QPP)
- Refer to the Medicare QPP Proposed Rule for CY 2026

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Medicare Fraud Fax/Phishing Alert!

Protect Your Information!

CMS has identified a fraud scheme targeting Medicare providers and suppliers. Scammers are impersonating CMS and sending phishing fax requests for medical records and documentation, falsely claiming to be part of a Medicare audit

- CMS doesn't initiate audits by requesting medical records via fax
- **If you receive a suspicious request, don't respond**
- If you think you got a fraudulent or questionable request, work with your Medical Review Contractor website to confirm if it's real

Reference: Attention: Phishing Fax Requests

Telehealth Update

- Medicare patients can receive telehealth services for non-behavioral/mental health care in their home through September 30, 2025
- There are no geographic restrictions for originating site for Medicare non-behavioral/mental telehealth services through September 30, 2025
- Non-behavioral/mental telehealth services in Medicare can be delivered using audio-only communication platforms through September 30, 2025
  - Starting October 1, 2025, the statutory limitations that were in place for Medicare telehealth services before the COVID-19 PHE will retake effect for most telehealth services. These include:
    - Geographic restrictions
    - Location restrictions on where you can provide services
    - Limitations on the scope of practitioners who can provide telehealth services

Reference: CMS Telehealth & Remote Patient Monitoring & Telehealth FAQs

Therapy Caps

2025 Therapy Caps

The therapy caps (aka KX modifier thresholds) increased for CY 2025. There is one amount for Physical Therapy (PT) and Speech-Language Pathology (SLP) services combined and a separate amount for Occupational Therapy (OT) services. The KX modifier threshold amounts are:

- **$2,410** for PT and SLP services combined
- **$2,410** for OT services
- Claims from suppliers or providers for therapy services above these amounts without the KX modifier are denied
    - Medicare Claims Processing Manual Chapter 5 - Part B Outpatient Rehabilitation and CORF/OPT Services (Section 10.3.3 - Use of the KX Modifier)

Advanced Primary Care Management Services

Advanced Primary Care Management (APCM) Services

APCM services incorporate elements of several existing care management and communication technology-based services into a bundle of services that reflects the essential elements of the delivery of advanced primary care, including Principal Care Management, Transitional Care Management, and Chronic Care Management

Starting January 1, 2025, you can bill for APCM services if:

- You're a physician or non-physician practitioner (NPP), including a nurse practitioner (NP), physician assistant (PA), or clinical nurse specialist (CNS)
- You're responsible for all your patient's primary care services
- You're the focal point for all your patient's needed health care services
- You've gotten either written or verbal consent from your patient

APCM service codes are primarily for primary care specialties, (i.e., general internal medicine, family medicine, geriatric medicine, or pediatrics)

Prior Authorization Review Timeframe Change

Effective January 1, 2025, Centers for Medicare & Medicaid Services (CMS) will reduce the timeframe for Medicare Administrative Contractors (MACs) to review Medicare Fee-for-Service standard prior authorization requests to no more than **7 calendar days**

More Information:

- Prior Authorization for Certain Hospital Outpatient Department Services
- Prior Authorization Process for Certain DMEPOS Items
- Prior Authorization of Repetitive, Scheduled Non-Emergent Ambulance Transport

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

Part A Claims Only Once the PA 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 (services will be rejected if UTN is listed on the claim)**
    - Part B physician/practitioners should submit their claims as usual. However, physician's claims submitted before Part A receives the hospital claim, may cause a rejection
    - **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] for listing of procedures

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

Effective January 9, 2025:

- RSNAT medical record review will be completed and communicated with a written decision to the ambulance supplier and to the beneficiary within **7 calendar days**
  - **Note:** Weekends and federal/contractor holidays are included in the 7 calendar-day period (CR 13711)

Reference: Part B PA RSNAT webpage for details

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

RSNAT PA helps ambulance suppliers ensure services comply with Medicare coverage, coding, and billing requirements under Part B, before services are rendered and submitted for payment. The following ambulance HCPCS codes are subject to prior authorization:

- ***A0426*** *(Ambulance service, Advanced Life Support (ALS), non-emergency transport, Level 1)*
- ***A0428*** *(Ambulance service, Basic Life Support (BLS), non-emergency transport)*
- Prior authorization does not create new clinical documentation requirements
    - Documentation requirements remain unchanged. Only Physicians (MDs/DOs) can sign the Physician Certification Statement (PCS) for non-emergency, scheduled, repetitive ambulance services
- RSNAT PA is voluntary, but claims are subject to prepayment medical review after the first three round trips are submitted for payment

Medicare Covered Vaccines

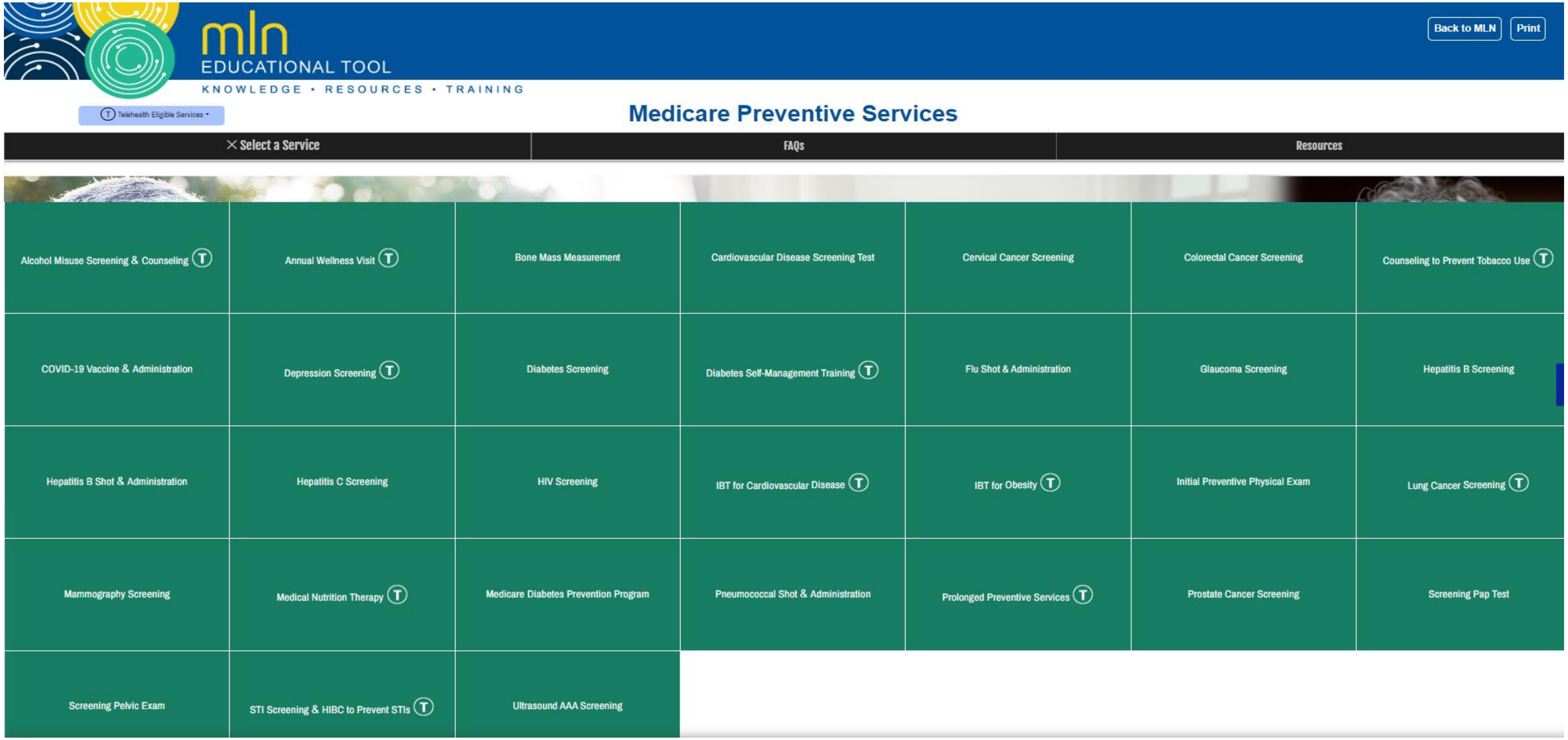
Medicare Part B pays for certain preventive vaccines such as Influenza, COVID-19, Pneumococcal, and Hepatitis B

Refer to the CMS Vaccine Pricing webpage for the most current vaccine fee schedules

- Annual flu vaccine season is August 1st - July 31st
- Medicare allows one seasonal flu vaccine
- Administration codes fee schedule is effective from Jan 1st – Dec 31st
  - 2025 Administration Codes – Influenza, Pneumococcal, and Hepatitis B

Preventive Services

Keep our seniors healthy! [Medicare Approved Preventive Services]



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

Review the coding and requirements (PDF):

- Use HCPCS codes G0402, G0438, and G0439 for billing initial preventive physical examination (IPPE) and annual wellness visit (AWV) services
  - **Do not 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
  - Advance Beneficiary Notice of Noncoverage (ABN) Form CMS-R-131

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)

Note: CMS has a video tutorial with guidance application and interview strategies for the cognitive assessment known as the Brief Interview for Mental Status (BIMS)

Medicare Diabetes Prevention Program (MDPP)

Medicare Diabetes Prevention Program (MDPP) 2025 Changes

The MDPP Expanded Model is intended to prevent Medicare beneficiaries with an indication of prediabetes from developing diabetes

- Prevention of diabetes among this high-risk group of Medicare beneficiaries is expected to result in significant cost savings to the Medicare program

Effective January 1, 2025, CMS has removed the MDPP bridge payment (HCPCS code G9890) from the 2025 fee schedule and updated the payment rates

- Claims will be denied for HCPCS code G9890 for dates of service on or after January 1, 2025

Reference: MLN34893002 – Medicare Diabetes Prevention Program Expanded Model

MDPP Resources

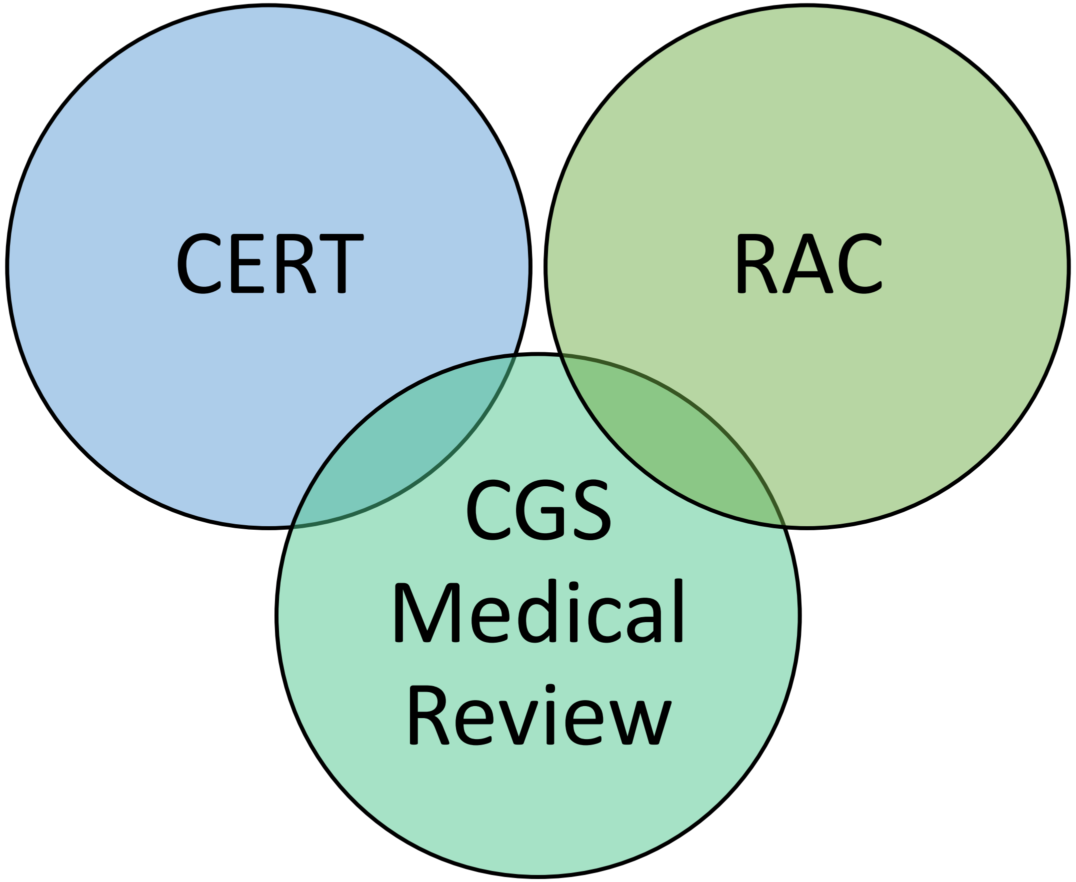
- CDC Recognition and Enrollment in Medicare
- Fingerprinting FAQs
- Billing and Claims
- MDPP Set of Services and Beneficiary Eligibility
- Coach Requirements and Supplier Standards
- Medicare Advantage (MA)
- Crosswalk File Submission
- MDPP PHE Flexibilities
- Additional Resources
- Help Desk Support

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
- 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

You May Receive Requests for Medical Records



Medicare Record Review Programs

FY 2024 CERT Improper Payment Rate

CERT improper payment rate is 7.66 percent, representing $31.70 billion in improper payments (Compared to 7.38% and $31.23 billion in FY 2023).

Claim Type	Improper Payment Rate	Improper Payment Amount
Part A Providers (excluding Hospital IPPS)	7.56%	$14.19 B
Part B Providers	10.35%	$11.45 B
Part A Providers (Inpatient Hospital)	3.89%	$5.17 B
DMEPOS	21.41%	$1.92 B

The reporting period for this improper payment rate is July 1, 2023, through June 30, 2024.
Comprehensive Error Rate Testing (CERT) | CMS

National 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

National 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

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
    - Lab Services/Orders Decision Tree
- Non-Response
- Signature
- Transitional Care
- 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

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
- Physical Therapy
  - Plan of Care
  - Certification/Recertification

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
  - Dates not matching on certification to care being given. Down code of UOS for missing dates
- 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

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
- Submitting Records to CERT
- Letter and Contact Information
- Completion Status Chart
- Claim Status Search
- Attestation Letters
- Sample Request Letters
- Documentation Request Listings
- Psychotherapy Notes
- FAQs
- CMS Links
- Contacting CERT Contractors

CERT Medical Records Requests: Respond Timely

Medicare providers are required to respond in a timely manner to Comprehensive Error Rate Testing (CERT) requests for medical records

- Without a response, your MAC may adjust your CERT sampled claim and recoup the payment
- To review the Initial Request Schedule, visit the CERT C3HUB and select Letters and Contact Information
- If your CERT requests need to go to an address other than what's in the PECOS "Correspondence Address" field, contact the CERT C3HUB to discuss your options
    - You can also contact them for copies of documentation

CERT Medical Record Requests: Respond Timely

If you get a CERT error for non-response to a documentation request, find your [MAC's website]

More Information:

- Complying with Medical Record Documentation Requirements
- Medical Record Maintenance & Access Requirements
- Medicare Provider Enrollment
- Section 12.10, Medicare Program Integrity Manual, Chapter 12
- Section 1862(a)(1)(A), Social Security Act

CERT Outreach & Education Articles

Please refer to the following CERT articles:

- Reference Guide to Avoid Duplicate Documentation for a CERT ADR
- 2025 CERT Documentation Deadline
- Steps to Take if You Get a CERT Documentation Request
- Verify Your Medical Records Correspondence Address
- We Appreciate Your Efforts

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

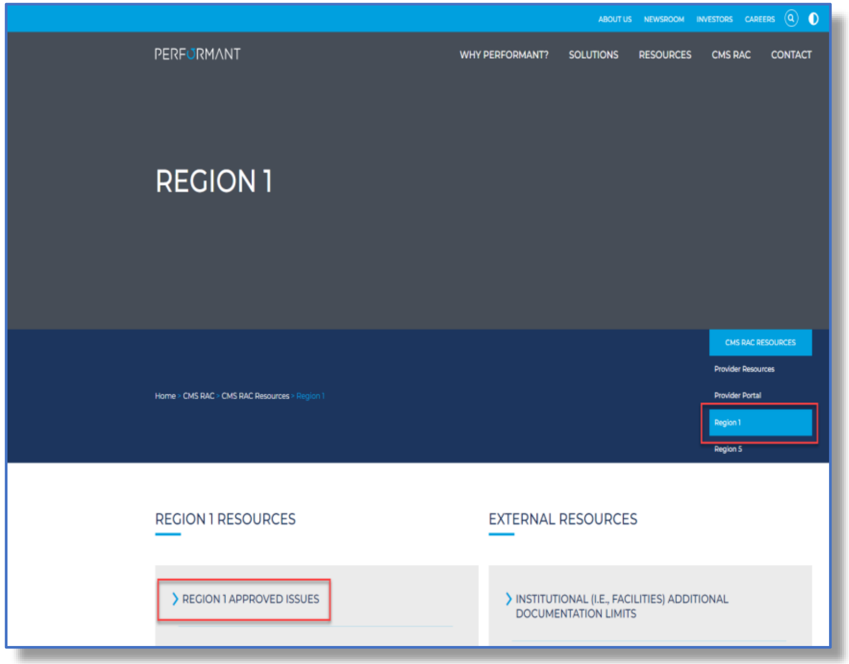
Comprehensive Error Rate Testing Medical Record Requests: Respond Timely

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



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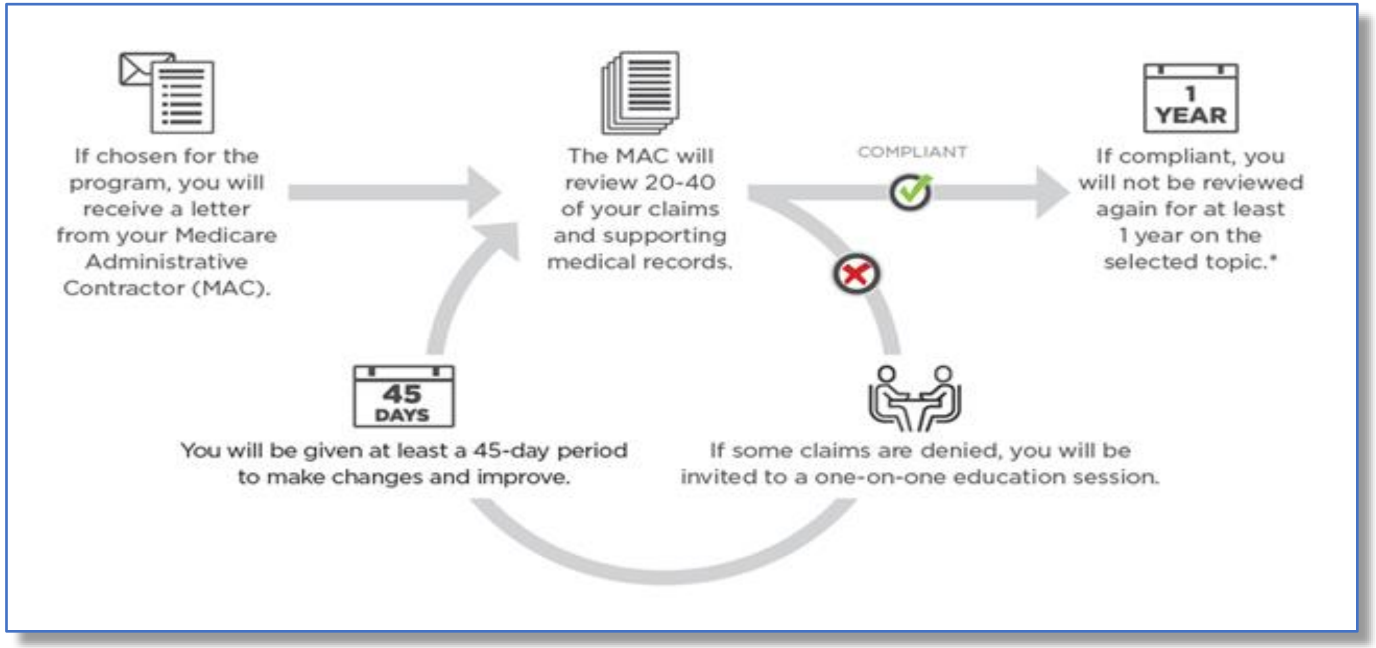
RA Program Highest Improper Payments (2025)

CPT/HCPCS Codes	Issue	Rationale
99309/99308	Nursing Facility Services	Excessive Units
99306	Evaluation and Management Services in Skilled Nursing Facilities/ Nursing Facility Services	Incorrect Coding/Excessive Units
99239	Visits to Patients in Swing Beds	Incorrect Coding
99233	Skilled Nursing Facility Consolidated Billing	Incorrect Coding
99232	Visits to Patients in Swing Beds/Duplicate Payments	Incorrect Coding/Professional Services
19303	Physician/Non-Physician Practitioner	Coding Validation
J9034	Drugs and Biologicals in Multi-Dose Vials	Billed with JW Modifier
J0775	Drugs and Biologicals	Incorrect Units Billed

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

- Claim Resubmission/Rebilling
- 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
- When You Don't Respond to Additional Documentation Requests (ADRs): Quick Reference Guide PDF

Updated: 04.22.2025

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

MR Activities

Updated: 05.21.2025

Review Topic	Codes Involved	Review Type	Status	Resources
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 • Dear Clinician – Diagnostic Imaging Resources PDF
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
Evaluation and Management Services	99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215	Targeted Probe and Educate Prepayment Review	Active	• Targeted Probe and Educate to Focus on E/M services • E/M Documentation Checklist Tool PDF • E/M 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 – 1st Qtr 2025
Multi LCDs	Molecular Diagnostic Tests
L36029	Controlled Substance Monitoring and Drugs of Abuse Testing
L33996	Vitamin D Assay Testing
L35891	Intravenous Immune Globulin
L39506	Cosmetic and Reconstructive Surgery
L34200	Removal of Benign Skin Lesions
L34045	Non-Invasive Vascular Studies
L39038	MolDX: Molecular Syndromic Panels for Infectious Disease Pathogen Identification Testing
L34032	Debridement Services
L33943	B-Type Natriuretic Peptide (BNP) Testing

Compliance Corner: Share Your Documentation!

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

Don't forget your partners!

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

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

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 2025

- **Effective Jan 1, 2025, the application fee is $730 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, 2025
  - 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

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

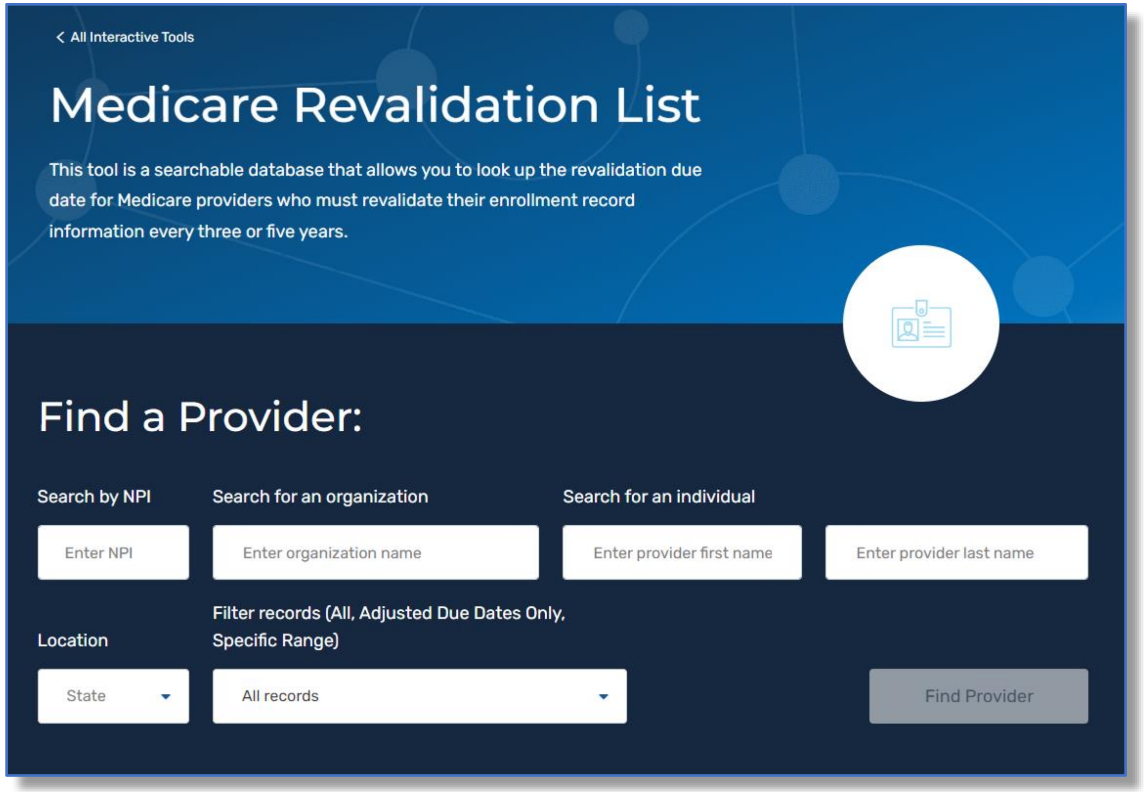
You must report all other changes within 90 days

- If you applied online, keep your information up to date in PECOS
- If you applied using a paper application, 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!



J15 Provider Enrollment Webpage

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 - Submitting Documentation (PWK)

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 required CMS 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 - Reminder!

Submitting your claims correctly the first time is the KEY to successful billing:

- Avoid duplicate denials - when resubmitting services initially rejected (ANSI code MA130), DO NOT include services from the claim that were allowed
- Avoid common billing errors (i.e., invalid procedure codes, invalid group practice information, invalid or mismatch patient name/identifier, missing or invalid modifier, provider not certified or eligible)
- Submit correct MSP Insurance Type on electronic claims
- Submit correct date of service on claims that are billed separately with TC and 26 modifiers
  - Refer to Billing the Professional and Technical Components

Claims – Overpayment Reminder!

When submitting the Overpayment Request Form to CGS, we encourage our providers to use the myCGS portal to submit your forms

We are receiving large number of requests from provider groups, via fax

- myCGS is the preferred safe and secured method to submit your requests
- If you are a myCGS user and do not have access to the Overpayment Request Form, talk with your provider administrator

Billing Not Otherwise Classified (NOC) HCPCS Code

CGS will not correctly code a billed NOC code when a valid code is available.

Items billed with any HCPCS/CPT code with a narrative description that indicates miscellaneous, NOC, unlisted, or non-specified, must also include:

- Narrative in the NTE 2400 (line note) or NTE 2300 (claim note) segments of the American National Standard Institute (ANSI X12) format
- Narrative may also be added in Item 19 of the CMS-1500 claim form
- Enter as much information as possible to ensure prompt processing of the claim

Note: Medicare will deny services reported with not otherwise classified (NOC) codes if valid codes are available for item.

Refer to our Part B article for complete information

Billing Instructions for Concurrent Care – E&M Service: Similar Services from Multiple Physicians & NPPs Within the Same Group

Providers can have claims considered for payment upon submission and avoid unnecessary appeals for concurrent care evaluation and management (E&M) services by taking the following actions:

- Electronic claims: Include the rendering physician's sub-specialty designation, if applicable (both the numeric AND narrative sub-specialty description are required) in either NTE 2300 Loop or Line NTE 2400 Loop
- Electronic claims: Include the NPP specialty they're representing (both the numeric AND narrative specialty description are required) in either NTE 2300 Loop or Line NTE 2400 Loop
- Paper claims: Include the rendering physician's sub-specialty designation or the NPP specialty they're representing in Item 19
- The claim line diagnoses listed should be specific to the reason for the billed visits

[Billing Instructions for Concurrent Care – E&M Service: Similar Services from Multiple Physicians & NPPs Within the Same Group]

CR 13705 Update – HCPCS Code G2211

Starting January 1, 2025, add-on code G2211 is payable even if you report the base code with modifier 25, only when the service or other procedure requiring the reporting of modifier 25 is an allowed Part B service. These services include:

- Part B Preventive Services
- Immunization Administrations
- Annual Wellness Visit

May 1, 2025, CMS updated [CR 13705](), for the list of allowed preventive services provided on the same day

Incorrect SNF POS

Place of Service (POS) Codes identify where a patient gets a service. Enter the correct 2-digit code on Medicare claims to ensure proper payment for physician services provided to patients in inpatient facilities like skilled nursing facilities (SNFs) and hospitals. Frequently used POS codes include:

- Inpatient hospital: 21
- **SNF (with Part A coverage): 31**
- **Nursing facility (or SNF with no Part A coverage): 32**

For example, if a patient is seen in a physician's office but is also:

- An inpatient of a hospital, use POS code 21 for inpatient hospital
    - **A patient of a SNF (with Part A), use POS code 31 for SNF**
- A patient of a nursing facility or SNF without Part A, use POS code 32 for nursing facility

The POS code reflects a different setting than the address and ZIP Code of the practice location

Claims - Medicare Secondary Payer

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 MSP Contractor (aka Benefits Coordination & Recovery Center) 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

Reminder: Avoid unnecessary claim rejections! Submit correct MSP Insurance Type on electronic claims!

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)

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) reopening 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 for claim to be reopened

Reopening Submission Errors

We are receiving an increased number of incorrect reopening requests.

Errors such as:

- Duplicate reopening for claims previously corrected for the same request
- Written reopening requests to correct a cancelled claim/service, once a paid claim or service is adjusted for a cancellation, this will create an overpayment (**cannot submit a reopening for ANY TYPE of overpayment**)
  - Providers will receive a demand letter from Overpayment Recovery
  - If you disagree with an overpayment, you have 120 days from the date of the demand letter to submit a redetermination request
- ***If you are past the time limit to submit an appeal, you cannot submit a reopening request to supersede timely filing guidelines for the appeal***

Appeals Submission Errors

We are receiving an increased number of incorrect redetermination requests. Errors such as:

- Submitting a redetermination for services that denied for the SNF Consolidated Billing
- Be sure check patient eligibility information in myCGS, under the Eligibility Tab
- Part A covered SNF periods, along with the facility's NPI, is located under the Inpatient Sub-Tab
- When a patient is in a covered Part A SNF stay, Part B only covers professional fees and certain ambulance transports, drugs and biologicals (all other services are billed to the SNF)
- Providers are required to submit a claim with the corrected information (i.e., 26 modifier) for Medicare consideration

Reference: Part B Consolidated Billing Tool

Provider Contact Center (PCC)

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

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

Reference: *MLN3171902 – Checking Medicare Claim Status*

J15 Part B Customer Service Guide for CTI

When calling Customer Service, providers will reach the Computer Telephony Integration (CTI) system, which is an automated phone system that:

- Requires the caller to respond to prompts by keying information on their telephone keypad
- Validates each keyed response before the caller reaches a customer service representative (CSR)

CTI is used to:

- Authenticate Medicare providers
- Verify Medicare beneficiaries
- Only disclose personally identifiable information (PII) or protected health information (PHI) about beneficiaries (living or deceased) to authenticated Medicare providers
- Reference: [J15 Part B Customer Service Guide]

Disable Beneficiary Eligibility Information from Medicare Administrative Contractor (MAC) Interactive Voice Response (IVR) Systems

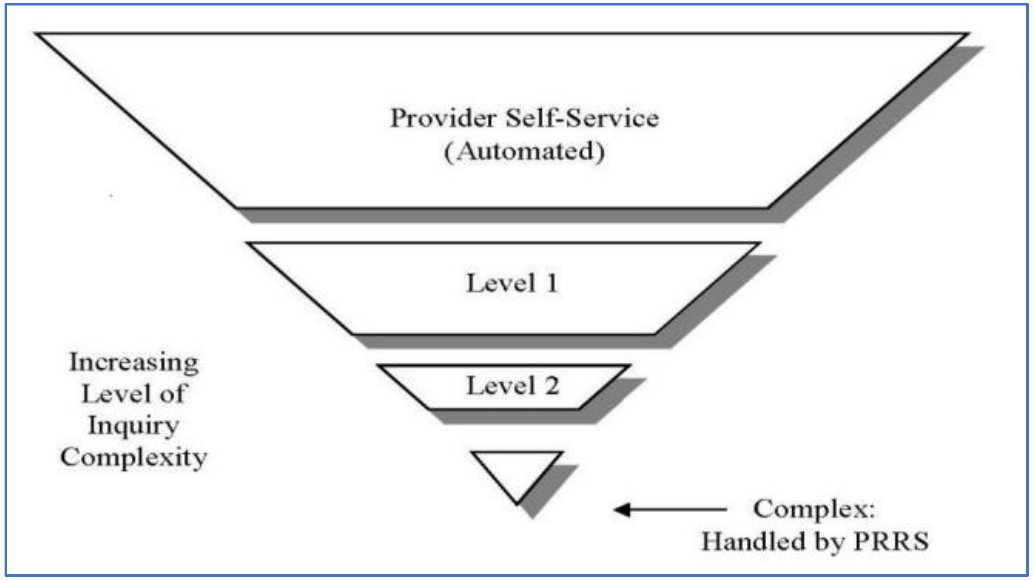
As of March 1, 2025, the CGS IVR no longer provides beneficiary eligibility information

- This information may now be obtained through the following channels:
  - myCGS portal
  - Billing agencies, clearinghouses or software vendors
  - Health Insurance Portability and Accountability Act (HIPAA) Eligibility Transaction System (HETS)
  - **D**irect **D**ata **E**ntry (Part A & HHH)
  - **P**rofessional **P**rovider **T**elecommunications **N**etwork (Part B)
    - CMS MLN8816413 – Checking Medicare Eligibility
    - CR13754: https://www.cms.gov/files/document/r12858otn.pdf

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 - Data Analysis

Provider Contact Center - **Top reasons providers called the PCC**

- Incomplete Information Provided
- Misrouted Calls & General Information
- Claim Denials/Billing Errors
- Provider Enrollment Eligibility/Requirements
- Claim Denials/Frequency
- Claim Denials/ Provider Number
- Claim Denials/Coding & Modifiers

Provider Contact Center - Data Analysis

Written Correspondence - **Top reasons providers wrote the PCC**

- Incomplete Information Provided
- Appeal Status/Duplicate
- Claim Denials/Unprocessable Claims
- Duplicate Denials
- Medicare Secondary Payer Denials
- Coding Errors & Modifiers


CMS Webpages
Stay Connected!
myCGS
Resources
CGS Medicare App
CGS Web site
Self-Service Options

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

CMS Medicare Resources

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

CMS Resources You Can Use!

The Medicare Learning Network®

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

Resources & Training

Learn about CMS policies and programs at your own pace

- Publications & Multimedia
- Web-Based Training
- MLN Matters® Articles

News

Get weekly Medicare Fee-for-Service email updates

- MLN Connects® Newsletter

Compliance

Learn about issues and avoid common billing errors

- Provider Compliance
- CERT Outreach & Education Task Force

FOCUS

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

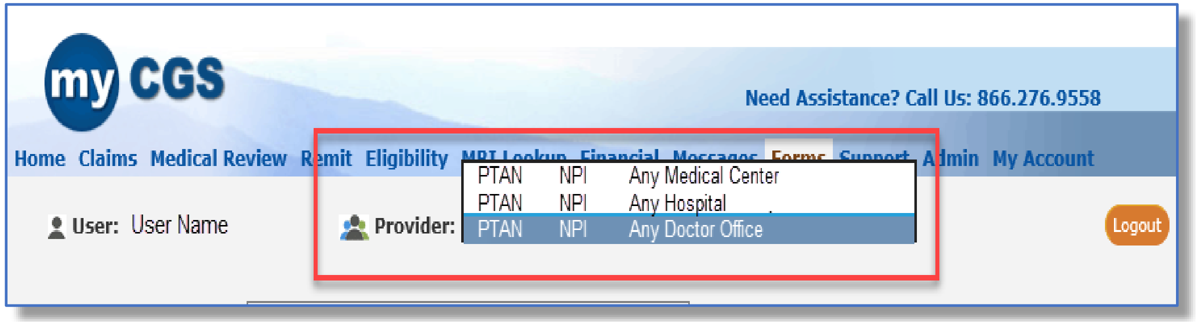
MY ACCOUNT

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

[myCGS (cgsmedicare.com)](https://www.cgsmedicare.com)

Choose YOUR myCGS Super ID!

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

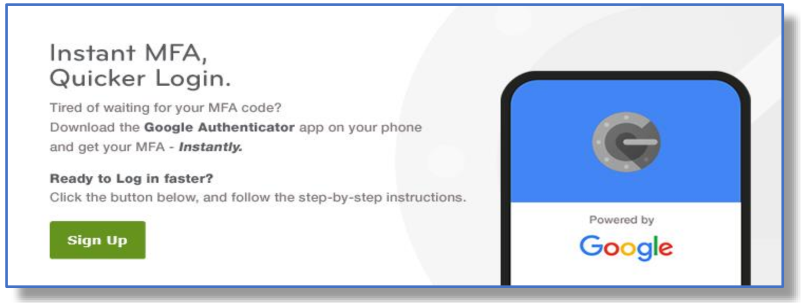


Refer to [My Account section of the myCGS User Manual tab](#) for more information

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)



FOCUS

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

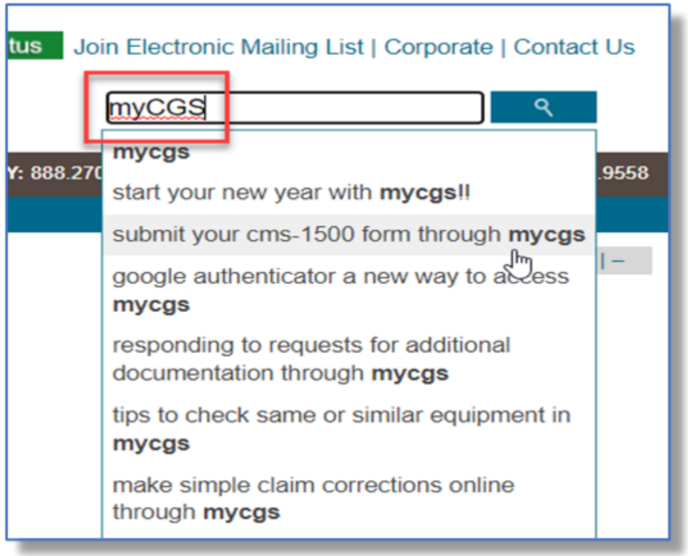
Medicare Deductible/Coinsurance Look-Up Tool

Access deductible and coinsurance amounts for a Calendar Year

Navigating the CGS Website!

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



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 smart device!

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

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

Please visit the video tutorial for help with registering and webinar tips

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 with our [CGS Satisfaction Surveys!](#)

Satisfaction surveys of CGS services.

Part B Provider Education

We are here for you, J15!

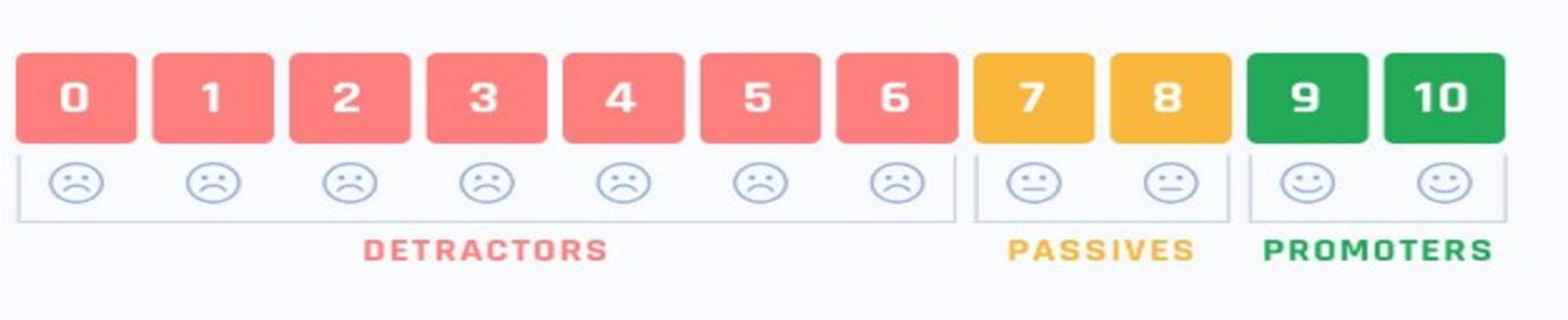
If you have a specific Medicare Part B education request, you can schedule an appointment with the Part B POE staff at:

J15_PartB_Education@cgsadmin.com

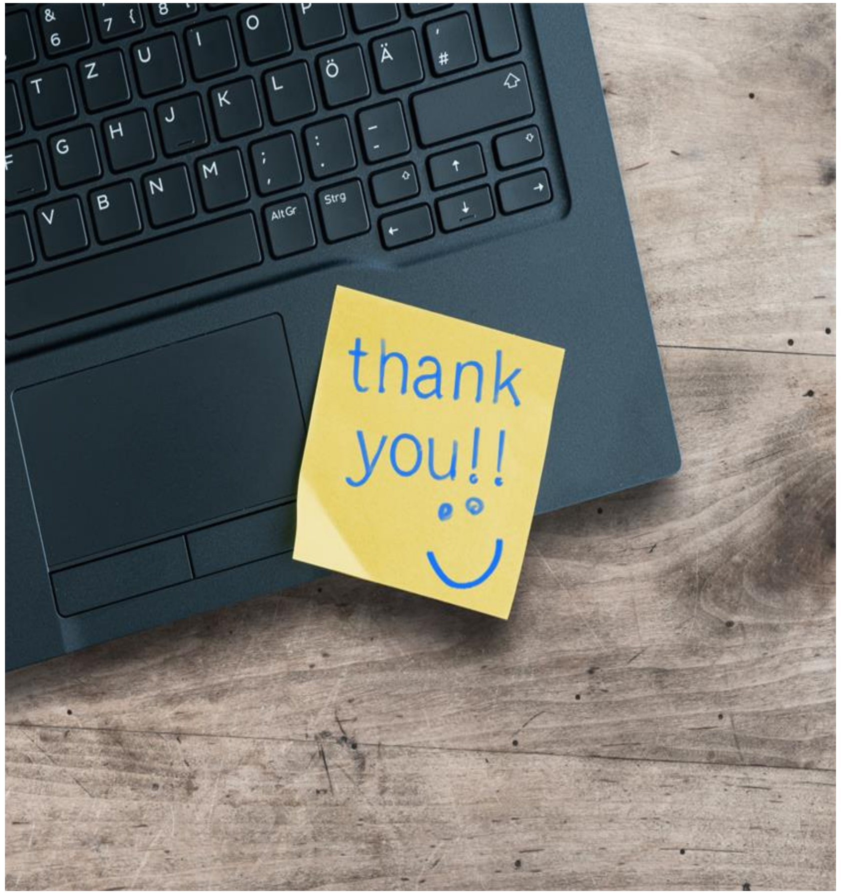
We Want Your Feedback!

Survey asks: How likely are you to recommend our education to a colleague or peer?

(If you score in the detractor range, please leave a comment and contact information)



Thank you!



Share this information with your colleagues!!

Don't forget to click on the survey link or scan the QR Code and let us know how much you enjoyed this session!

https://qr-creator.com/d/807492493