FOCUS

August 11, 2026

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

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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Objectives

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

CY 2027 Medicare PFS Proposed Rule

CMS issued the Medicare Physician Fee Schedule (PFS) Proposed Rule for CY 2027 on July 14, 2026. The proposed rules includes:

- 2027 conversion factors
  - $33.17 for Qualifying APM Participants ($0.40 decrease from CY 2026)
  - $32.84 for Non-Qualifying APM Participants ($0.56 decrease from CY 2026)
    - The overall reduction from the 2026 rates stems from the expiration of the temporary 2.5% statutory increase provided for CY 2026, under Public Law 119-21 (the Working Families Tax Cut)
- Reduce payment when a separately identifiable office/outpatient evaluation and management (E/M) visit is furnished by the same physician (or a physician in the same practice) on the same day as a 0-, 10-, or 90-day global procedure
  - Most expensive service (either surgical or E/M visit) would be paid at 100% and all other surgical procedure(s) or E/M visit(s) furnished on the same day would be paid at 50%

CY 2027 Medicare PFS Proposed Rule (cont'd)

- Transition HCPCS code G2211 to a modifier for the associated E/M code
  - The modifier would increase the payment of the associated E/M code by 16%
- Reforming the Practice Expense methodology used to calculate the Medicare PFS payment rates
- Create two new HCPCS codes for advance care planning (ACP) services furnished by clinical staff under the direct supervision of the billing physician or other practitioner

Comment period ends on September 14, 2026

Reference: MLN Connects Newsletter for July 16, 2026

Telehealth Update

CMS has extended the telehealth provisions to December 31, 2027:

- Through December 31, 2027, beneficiaries can continue to receive Medicare telehealth services anywhere in the United States and U.S. territories
  - Starting January 1, 2028, except for behavioral health services, beneficiaries will generally need to be in a medical facility and in a rural area to receive Medicare telehealth services.
  - Through December 31, 2027, an extended range of practitioners may bill for Medicare telehealth services - Starting January 1, 2028, physical therapists, occupational therapists, speech-language pathologists, and audiologists can no longer furnish Medicare Telehealth services
- Beneficiaries may continue to receive audio-only telehealth services in their homes through December 31, 2027

Reference: CMS Telehealth FAQs and Telehealth & Remote Patient Monitoring

CY 2026 Therapy Caps

2026 Therapy Caps

The therapy caps (aka KX modifier thresholds) increased for CY 2026. 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:

- **$2480** for PT and SLP services combined
- **$2480** for OT services
  - 2026 Annual Update of Per-Beneficiary Threshold Amounts
- 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)

CMS Prior Authorization Programs

CMS runs a variety of prior authorization and pre-claim review initiatives to help ensure compliance with Medicare rules. Current initiatives that impact CGS Jurisdiction 15 providers include:

- Prior Authorization for Certain Hospital Outpatient Department (OPD) Services
- Prior Authorization of Repetitive, Scheduled Non-Emergent Ambulance Transport (RSNAT)
- Wasteful and Inappropriate Service Reduction (WISeR) Model
- Prior Authorization Demonstration for Certain Ambulatory Surgical Center (ASC) Services

Prior Authorization 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 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 complete information

Prior Authorization 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, non-emergency transport)
- A0428 (Ambulance service, Basic Life Support, 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

Reference: Part B PA RSNAT webpage for details

WISeR Model

WISER:

- Prior Authorization and Medical Review Processes
- Leverages enhanced technologies with human clinical review
  - Artificial Intelligence (AI)
  - Machine Learning (ML)
- Ensure timely and appropriate Medicare payment for a select set of items and services
  - Vulnerable to fraud, waste, and abuse
- Applicable state for this MAC: **Ohio**
  - Hospital Outpatient Departments
  - Ambulatory Surgical Centers
  - Physician office or home setting

Model Participant

Participants:

- A model participant technology company is assigned to each participating state to:
  - Process prior authorization requests and issue affirmed or denial decisions
  - Perform prepay medical review for model service claims submitted without prior authorization
- The model participant for Ohio is **Innovaccer, Inc.**
  - **Innovaccer Website**: https://innovaccer.com/resources/cms-wiser/oh
  - **Innovaccer WISeR Provider Portal**: https://wiser.innovaccer.us/login
  - **Innovaccer WISeR Provider Portal User Guide**: https://content.innovaccer.app/hubfs/WISeR%20Provider%20Portal%20Guide_v2.0.pdf

Categories of Service

Service categories include:

- Skin and Tissue Substitutes
  - Application of Bioengineered Skin Substitutes to Lower Extremity Chronic Non-Healing Wounds
  - Wound Application of Cellular and/or Tissue Based Products (CTPs), Lower Extremities
- Incontinence Control Devices
- Epidural Steroid Injections for Pain Management
- For a complete listing of service categories included with this review, refer to the **WISeR Model Provider and Supplier Operational Guide:**
  - **Appendix A** – WISeR Select Items and Services (https://www.cms.gov/files/document/wiser-provider-supplier-guide.pdf)

WISeR Model

Process:

Beginning on January 5, 2026, you may submit prior authorization requests for dates of service on or after January 15, 2026.

- myCGS Portal (Select the PA WISeR Form)
- Fax: 615.660.5300
- Mail

  CGS Administrators, LLC

  J15 Part B Correspondence

  PO Box 20018

  Nashville, TN 37202
- CGS will forward information to the model participant (**Innovaccer**)

WISeR Model

Process (cont'd)

Submit prior authorization requests directly to Innovaccer

- Electronic Submission of Medical Documentation (esMD)
- Innovaccer WISeR Portal
- Fax: 419.965.6730
- Participant will send a decision with UTN
- UTNs are valid for 120 calendar days from decision date

WISeR Model

Model service claims submitted without prior authorization:

- CGS will suspend claim and forward to model participant
- Model participant will send an ADR letter
- Send documentation to the model participant
- CGS will process claim based on the model participant's medical review decision

Reference: CGS Medicare WISeR webpage for complete information

Prior Authorization for ASC Services

The prior authorization demonstration for **Ohio** ambulatory surgery center (ASC) services was implemented on February 16, 2026.

- Ohio providers can submit prior authorization requests for dates of service on or after February 16, 2026
- Prior authorization for the ASC demonstration is voluntary; however, if a provider elects to bypass prior authorization, applicable ASC claims will be subject to a prepayment medical review
- Currently, five service categories are included in the ASC PA Demonstration
- Does not create new documentation requirements
  - The same documentation ASCs are regularly required to maintain
  - Refer to the CGS ASC PA Webpage for complete information & January

Prior Authorization for ASC Services (Cont'd)

The service categories targeted by the demonstration are:

- Blepharoplasty
- Botulinum toxin injections
- Panniculectomy
- Rhinoplasty
- Vein ablation

Click here for the full list of codes ASC prior authorization

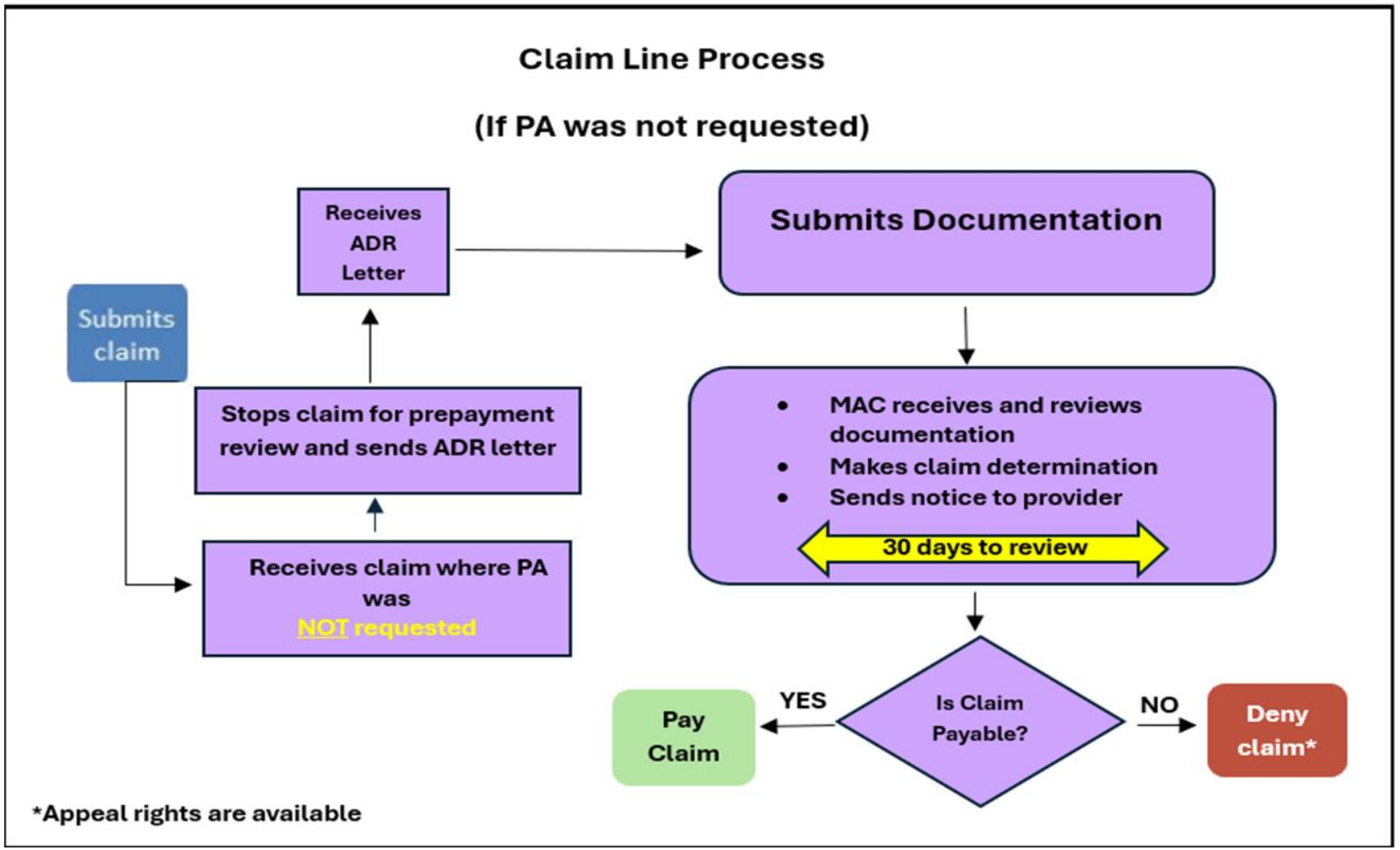
- Except for expedited requests, a prior authorization request is reviewed in 7 calendar days, the ASC provider will receive a decision letter along with a unique tracking number (UTN)
- The beneficiary will also receive a decision letter

Prior Authorization for ASC Services (Cont'd)

Once the PA is affirmed, a unique tracking number (UTN) is sent to the ASC

- When the service is billed, the UTN must be added to the ASC's Part B claim
  - **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
  - **NOTE:** Claims related to/associated with services that require prior authorization as a condition of payment will be DENIED if the service requiring prior authorization is not eligible for payment
- Part B PA ASC webpage for complete information

CGS Prepayment Review Process for PA Services



Medicare Covered Vaccines

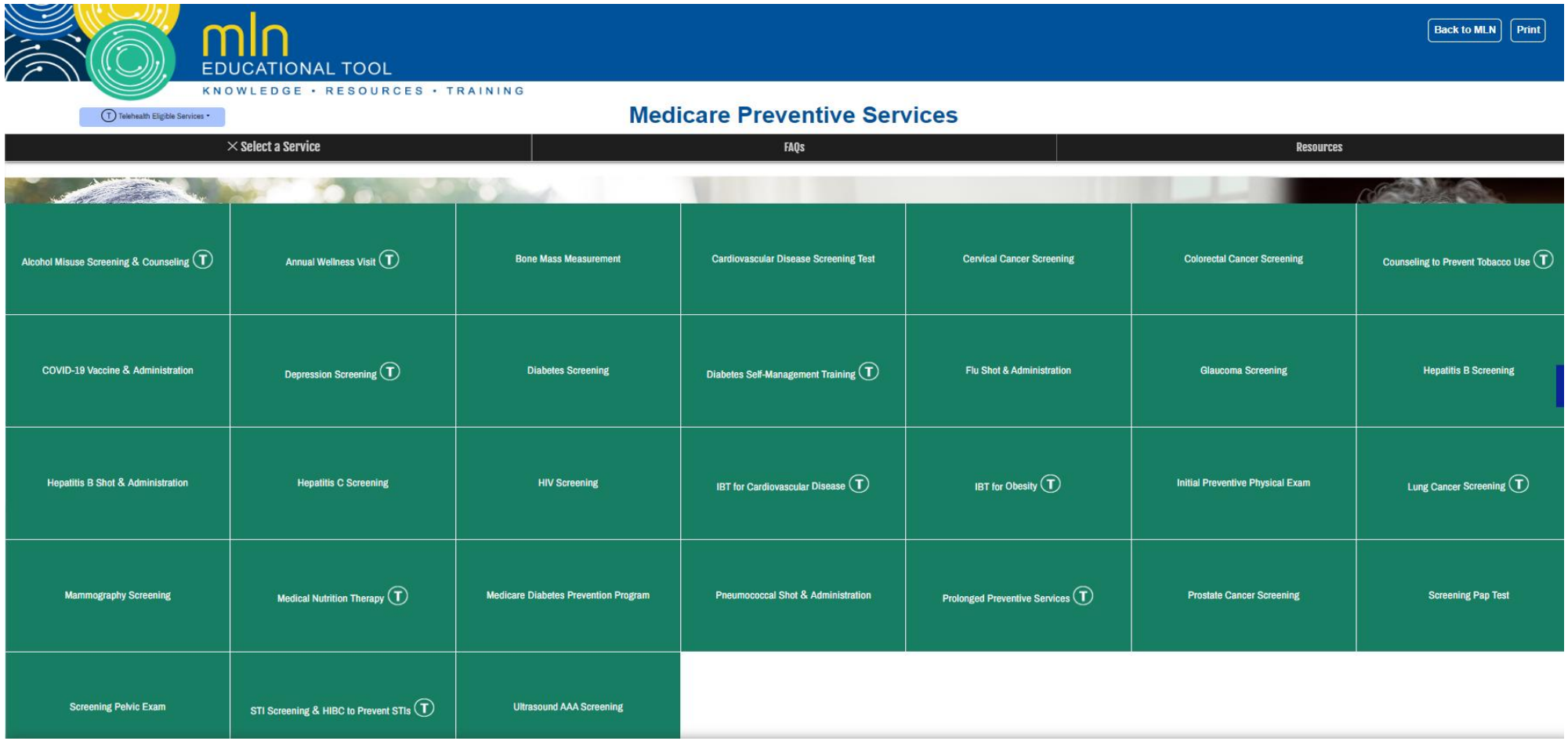
Medicare Part B pays for certain preventive vaccines such as Influenza, COVID-19, Pneumococcal, and Hepatitis B

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
  - 2026 Fees for 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

Chronic Care Management Services

Medicare covers chronic care management (CCM), which is managing a patient's multiple (2 or more) chronic conditions expected to last at least 12 months, or until their death. Examples of chronic conditions include but aren't limited to:

- Alzheimer's disease and related dementia
- Cancer
- Chronic obstructive pulmonary disease (COPD)
- HIV and AIDS

- Before CCM services can start, Medicare requires an initiating visit for new patients or patients who haven't been seen within the previous 1 year
- Conduct the initiating visit during the comprehensive face-to-face evaluation and management (E/M) visit, annual wellness visit (AWV), or initial preventive physical exam (IPPE)

Chronic Care Management Services (cont'd)

- Chronic care management codes are based on time per calendar month (Medicare will allow only one CCM service per month)

References:

CCM Services Booklet

CCM FAQs

Care Management Webpage

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Advanced Primary Care Management Services

Advanced Primary Care Management (ACPM) services combine elements of several existing care management and communication technology-based services. The payment bundle reflects the essential elements of advanced primary care, including:

- Principal care management (PCM)
- Transitional care management (TCM)
- Chronic care management (CCM)

Communication technology-based services include virtual check-ins, remote evaluations of pre-recorded patient information, and interprofessional consultations.

Medicare Diabetes Prevention Program

The Medicare Diabetes Prevention Program (MDPP) Expanded Model is an evidence-based behavior change intervention to delay or prevent the onset of type 2 diabetes among people with Medicare.

- This voluntary model was certified for expansion in 2016 and is covered under Medicare Part B as a preventive service.

References:

Medicare Diabetes Prevention Program Expanded Model

Medicare Diabetes Prevention Program (MDPP) - Frequently Asked Questions

Medicare Diabetes Prevention Program (MDPP) Expanded Model: Supplier Resources

GUIDE Model

The Guiding an Improved Dementia Experience (GUIDE) Model is a voluntary nationwide model test that aims to support people with dementia and their unpaid caregivers. The model began on July 1, 2024, and will run for eight years. Refer to the CMS webpage to learn:

- What are the goals?
- Who can apply, and what's the target participation?
- How does CMS pay participants?
- How do participants submit claims?

ACCESS Model

Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) Model – Beginning July 5, 2026, the ACCESS Model is a 10-year voluntary Innovation Center model that tests whether an alternative payment methodology, Outcome-Aligned Payments (OAPs), for technology-enabled chronic care reduces expenditures while enhancing quality of care for Medicare patients.

- ACCESS Model OAP is billed monthly with the appropriate HCPCS G-Code
- Claims are processed as zero-paid claims by the MAC
- Payments are issued by CMS

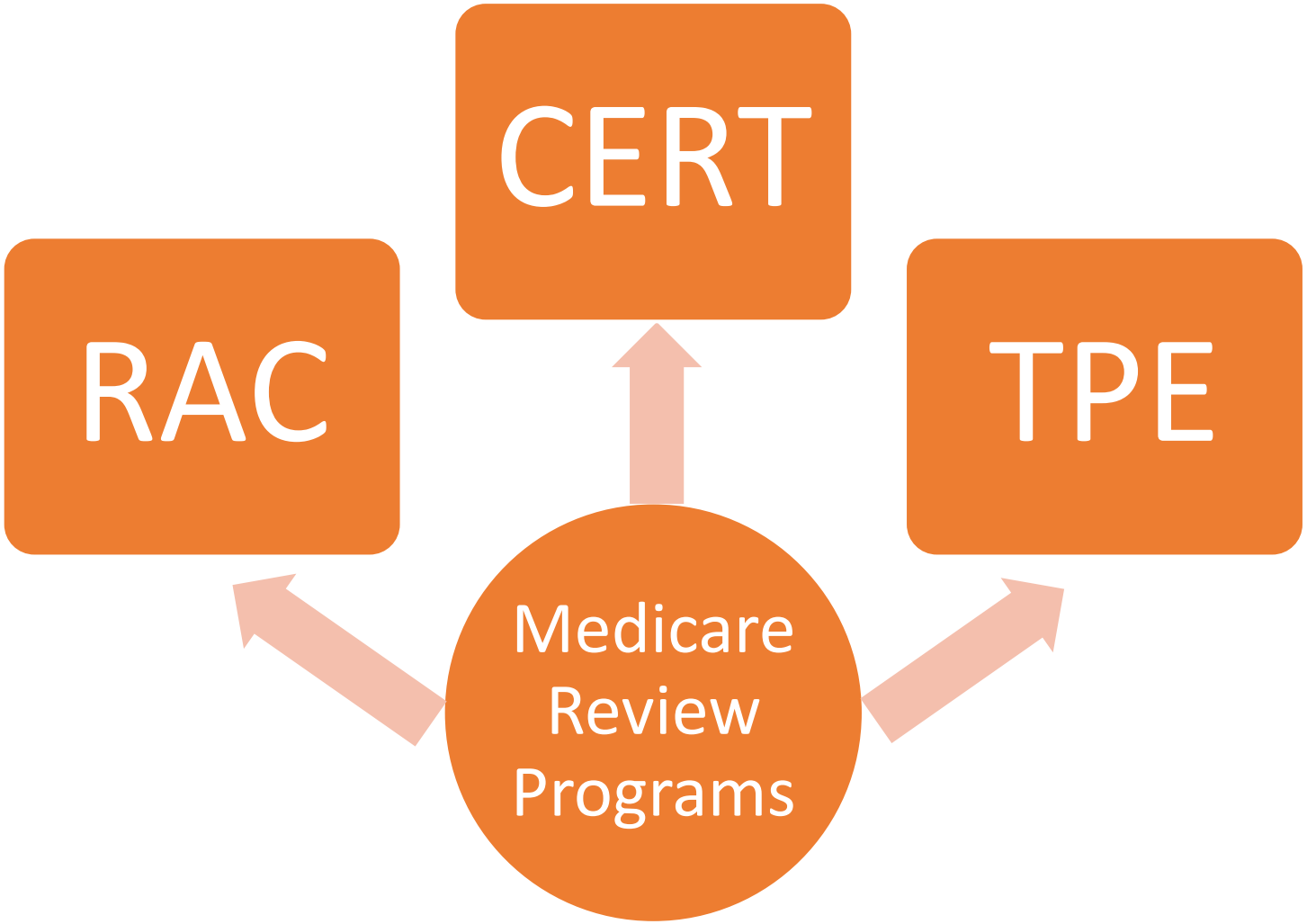
General questions about this model, refer to the ACCESS Model Helpdesk at ACCESSModelTeam@cms.hhs.gov

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

Requests for Medical Records



What is CERT

CMS developed the Comprehensive Error Rate Testing (CERT) program to measure the error rate of improper FFS payments. The CERT program calculates improper payment rates based on the results of the reviews conducted.

- These rates include an overall national Medicare FFS improper payment rate; and
- Improper payment rates for each claim type

CMS uses the CERT program to perform special studies and supplemental measurements to determine the improper payment rates of particular claim types. This program is also capable of producing other statistical measurements, such as error-prone provider rates.

Note: The improper payment rate is not a "fraud rate," but is a measurement of payments that did not meet Medicare requirements.

FY 2025 CERT Improper Payment Rate

Medicare FFS properly paid an estimated 93.45 percent of total overall or $411.8 billion. CERT improper payment rate is 6.55 percent, representing $28.83 billion in improper payments (Compared to 7.66% and $31.70 billion in FY 2024).

Claim Type	Improper Payment Rate	Improper Payment Amount
Part A Providers (excluding Hospital IPPS)	6.67%	$13.2B
Part B Providers	8.4%	$9.62 B
Part A Providers (Inpatient Hospital)	3.15%	$4.61B
DMEPOS	24.1%	$1.9B

Common CGS J15 Errors

- Non-Response
- Signature Issues
  - Missing from Documentation
    - Documentation not Signed/Dated
    - Certification/Recertifications
    - Laboratory/Radiology reports
  - Illegible-if signature of the provider is hard to read, please send signature log or attestation
  - Check page breaks to make sure signature is not cut off

Common CGS J15 Errors

- Insufficient Documentation (Please send all documentation pertaining to the service given on date in question for the claim)
  - Evaluation and Management (E&M)
    - Your documentation must support the level of care being billed
    - Order for observation is included in documentation
    - Split/share Visits-each provider should document their care for the patient and both should be in the patients record
    - Make sure modifier FS is on the claim line for split shared visits (technical error)
  - Certification/Recertification is included and signed
    - If delayed a statement explaining why is needed in the documentation
  - Plan of care-included in documentation to support treatment determined for the patient's treatment and gone over with the patient/caregiver
  - Make sure all coverage requirements for NCD are meet.
    - Ex. TAVR requires the patient (preoperatively and postoperatively) is under the care of a heart team: a cohesive, multi-disciplinary, team of medical professionals and includes a heart surgeon and interventional cardiologist.

Common CGS J15 Errors

- Laboratory/Radiology
  - Intent to order missing
  - Clinical documentation is sometimes needed to support and may be requested from lab/radiology center or CERT review contractor
  - PET scans for oncology choose the appropriate modifier PI or PS modifier both should not be submitted on the same line (technical error)
  - Drug Tests-risk assessment and plan of the assessment included in documentation
- Drugs/Biologicals
  - Documentation should support why the drug was given
  - Discarded Amounts-included in documentation how much was discarded and why
  - Infusion-start and stop time should be included

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 Contractor

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, to our CERT webpage for contact information.

More Information:

- Complying with Medical Record Documentation Requirements
- Medical Record Maintenance & Access Requirements
- Medicare Provider Enrollment
- Reference Guide to Avoid Duplicate Documentation for a CERT ADR
- 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

The goal of the A/B MAC Outreach & Education Task Force is to ensure consistent communication and education to reduce the Medicare Part A and Part B error rates.

CERT Videos:

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

Education Resources:

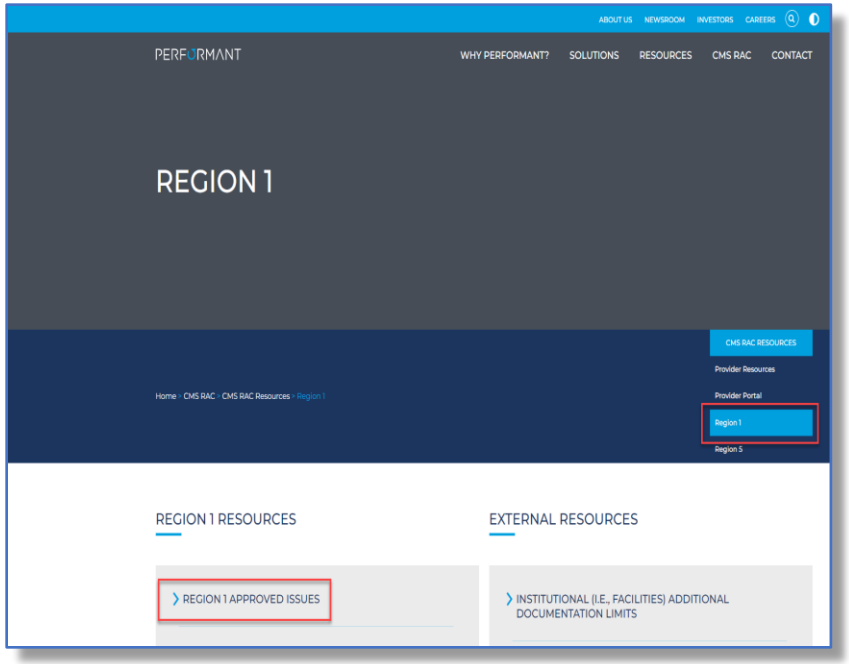
- Check here for more information

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

Recovery Audit (RA) Program

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

- Performant – Recovery Audit Contractor
- View Region 1 Resources
- CMS Approved Issues must be posted
- Sample documents



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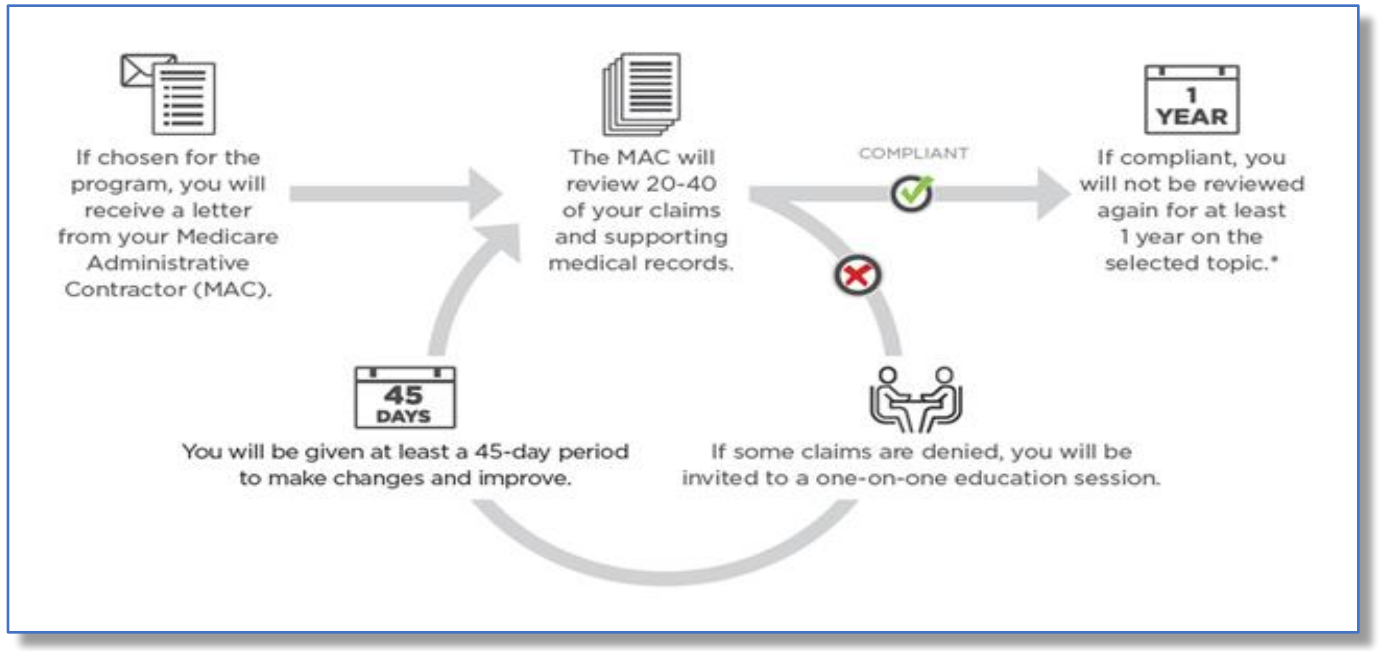
RA Program Highest Improper Payments (2nd Qtr 2026)

CPT/HCPCS Codes	Issue	Rationale
99213	Evaluation and Management Services for Office or Other Outpatient Visit Billed for Hospital Inpatients	Incorrect Coding
99214	Evaluation and Management Services for Office or Other Outpatient Visit Billed for Hospital Inpatients	Incorrect Coding
99232	Visits to Patients in Swing Beds	Incorrect Coding
22514	Vertebroplasty or Kyphoplasty	Medical Necessity and Documentation Requirements
22845	Physician/Non-physician practitioner	Coding Validation
27279	Minimally-Invasive Surgical (MIS) Fusion of the Sacroiliac Joint	Medical Necessity and Documentation Requirements
64582	Hypoglossal Nerve Stimulation for Obstructive Sleep Apnea	Medical Necessity and Documentation Requirements
64590	Sacral Neurostimulation	Medical Necessity and Documentation Requirements
66984	Cataract Removal/Ambulatory Surgical Center	Medical Necessity and Documentation Requirements/Services Billed during a Covered Part A Skilled Nursing Facility Stay- Unbundling

Medical Review

Reminder: Targeted Probe and Educate (TPE)

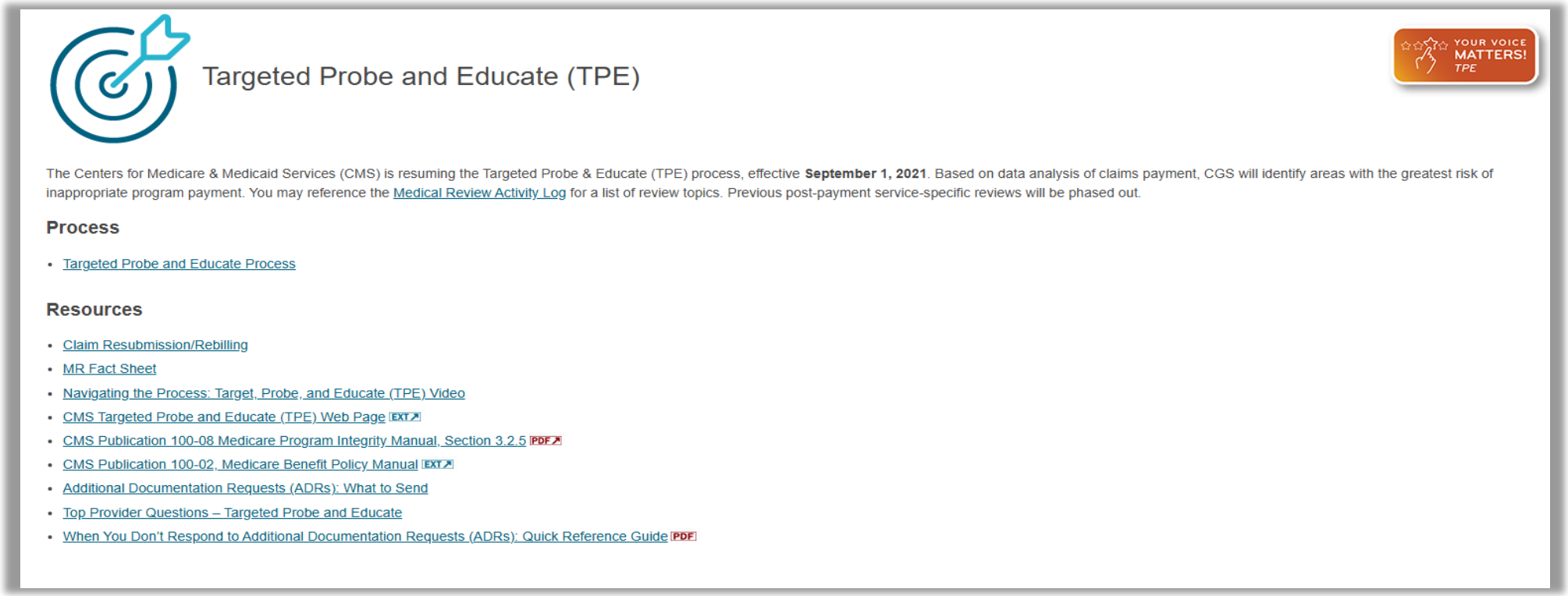
Based on data analysis of claims payment, CGS identifies areas with the greatest risk of inappropriate program payment:



Medical Review – Targeted Probe & Educate

Reminder: 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)

YOUR VOICE MATTERS! 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

Medical Review Activities

Part B MR Activities Log

MR Activities

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 • Documentation for Diagnostic Services
Drugs/Biologicals	J0129, J0178, J0717, J2778, J0897, 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 2026
Multi LCDs	Molecular Diagnostic Tests
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
L39857	Botulinum Toxin Injections

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)

Medicare Fraud Fax/Phishing Alert!

Protect Your Information!

In 2025, 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

CGS Operational Reminders

Provider Enrollment	Claims	Appeals	Reopenings	Provider Contact Center

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

Reference: Medicare Provider Enrollment

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”
- **Currently, the CMS revalidation is only for organizations or groups**
- The only time an individual may be impacted is when it is a sole owner – and that request will come as the group
- If a provider needs to update their enrollment, and a revalidation is not due, submit the application as a *Change of Information*, not a revalidation
  - If submitted as revalidation, and a revalidation is not due, it will be returned as unsolicited

Provider Enrollment

Provider Enrollment Application Fee Amount for Calendar Year 2025

- **Effective Jan 1, 2026, the application fee is $750 for institutional providers** that are:
  - Initially enrolling in the Medicare program
  - Revalidating their Medicare enrollment
  - Adding a new Medicare practice location
- This fee applies to Medicare enrollment applications submitted on or after January 1st through December 31st
- **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,
  - Refer to the Medicare Provider Enrollment MLN Education Tool for additional information

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)

Advanced Beneficiary Notice: CMS-R-131

- CMS Advanced Beneficiary Notice of Noncoverage (ABN) has been updated.
- Check the [CMS website](#) for the new ABN.
- The current ABN expires March 31, 2029.

Form CMS-R-131 (Exp. 03/31/2029)

Patient name:
Identification number: *(optional)*

Notifier name
Notifier address
Notifier phone (including TTY)

Advance Beneficiary Notice of Non-coverage (ABN)

Medicare doesn't pay for everything, even some care you or your health care provider think you need. **We expect Medicare may not pay for the item, test, service or care listed below.** If Medicare doesn't pay, you may have to pay.

Item, test, service or care	Reason Medicare may not pay	Estimated cost

What to do now
- Read this notice to make an informed decision about your care.
- Ask any questions you have.
- Choose one option below to let us know if you still want to get the item, test, service or care.

Choose ONE option below. We can't choose for you.
If you choose Option 1 or 2, we may help you use any other insurance you might have, but Medicare can't require us to do this.

○ **Option 1: I want the item, test, service or care listed above, and I want Medicare to be billed for an official decision on payment, which I'll get on a Medicare Summary Notice (MSN).** You can ask to be paid now. I understand that if Medicare doesn't pay, I'm responsible to pay, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you'll refund any payments I made to you, minus co-pays or deductibles.

○ **Option 2: I want the item, test, service or care listed above, but don't bill Medicare.** You can ask to be paid now and I'm responsible to pay. I understand that I can't appeal, since Medicare isn't billed.

○ **Option 3: I don't want the item, test, service or care listed above.** I understand I'm not responsible for payment and I can't appeal to see if Medicare would pay.

Additional information:

This notice gives our opinion, not an official Medicare decision. For other questions about this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. Signing below means you received and understand this notice. You can ask to get a copy.

Signature	Date (mm/dd/yyyy)

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

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. This information collection is for providers, suppliers, Hospice and Religious Non-medical HealthCare Institutes and Home Health Agencies to notify original Medicare beneficiaries of their potential financial liability under specific conditions. The time required to complete this information collection is estimated to average less than 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, to review and complete the information collection. This information collection is mandatory under Section 1879 of the Social Security Act, 42 CFR 411.404(b) and (c) and 411.408(d)(2) and (f). If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (Exp. 03/31/2029) Form Approved OMB No. 0938-0566

Claim Payment Alerts – Reminder!

Claim payment alerts are posted on this webpage for information about confirmed, system-related issues before you contact Customer Service. Click on the description to view details.

Date Reported	Description of Issue
04.10.2026	This is an addendum to the 04/08/2026 CPIL regarding E & M codes denying in error. Services were denied as payment made for same/similar procedure within set time frame. We've identified QPP Mass Adjustments are also impacted.
04.08.2026	Evaluation and Management codes denying in error indicating service denied because payment already made for same/similar procedure within set time frame.
03.10.2026	Quality Payment Program: Claim Adjustments to Correct Conversion Factor EXT - Starting in CY 2026, the update to the qualifying alternative payment model (APM) conversion factor is +0.75%, while the update to the nonqualifying APM conversion factor is +0.25%.
02.11.2026	Denials for vaccine codes when billed by pharmacies (specialty A5 type 50) in KY
01.13.2026	E & M SERVICES CONCURRENT CARE

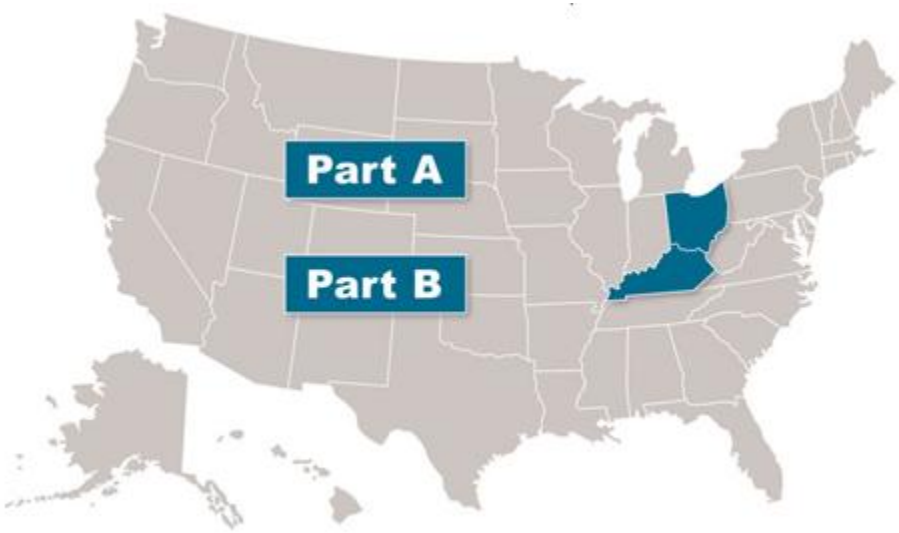
Claims - Submitting Documentation (PWK)

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

Claims - Submitting Documentation (PWK)

- 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 (Be sure to review the correct MAC information)
  - A separate fax cover sheet is required for EACH individual claim



Use the PWK Process for CGS J15 Part B

Billing Professional & Technical Components

Submit the correct date of service on claims that are billed separately with TC and 26 modifiers

- The technical component (TC) is billed on the date test was performed. When billing global service, the provider can submit the date of service of the professional component with a date of service as the date of the review and interpretation or the date the technical component was performed
- **If the provider <u>did not</u> perform a global service and instead performed only one component**:
  - The date of service for the technical component would the date the patient received the service
  - The date of service for the professional component would be the date the review and interpretation is completed
- Refer to Billing the Professional and Technical Components

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 any 1st level appeal decision, submit request for Reconsideration (2nd level appeal) to the QIC

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*

Part B PCC Telephone Reopening Line

Important Information Regarding the Part B Telephone Reopening Line!

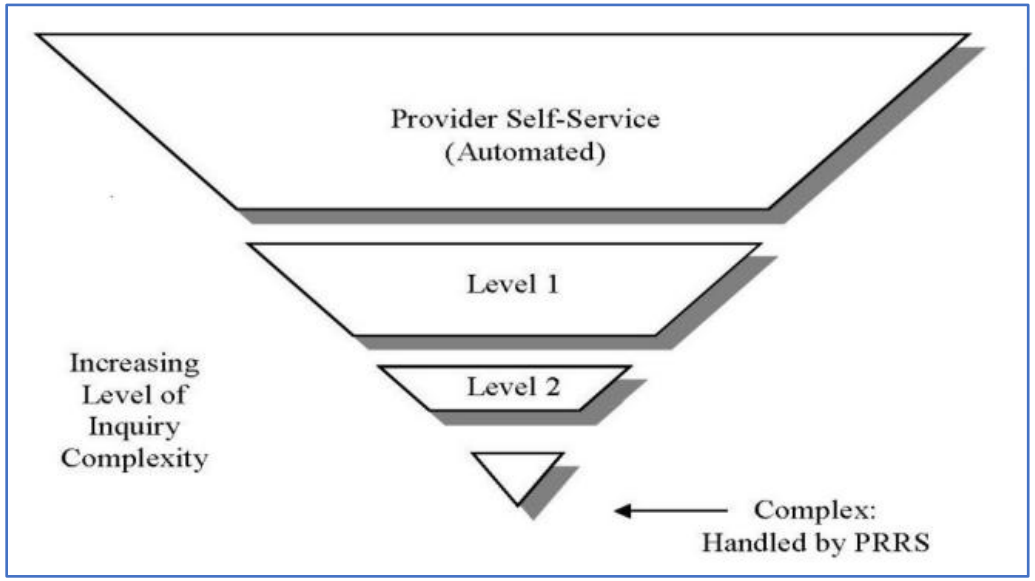
Effective as of August 1st, 2026, CGS Part B providers will no longer be able to utilize the Part B Customer Service Telephone Reopening Line to request a correction for a claim.

Providers can submit their reopening request through one self-service channels, including the CGS Part B IVR, the myCGS portal, and written submissions. This update follows CMS mandated use of self-service technology.

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 and written inquiries



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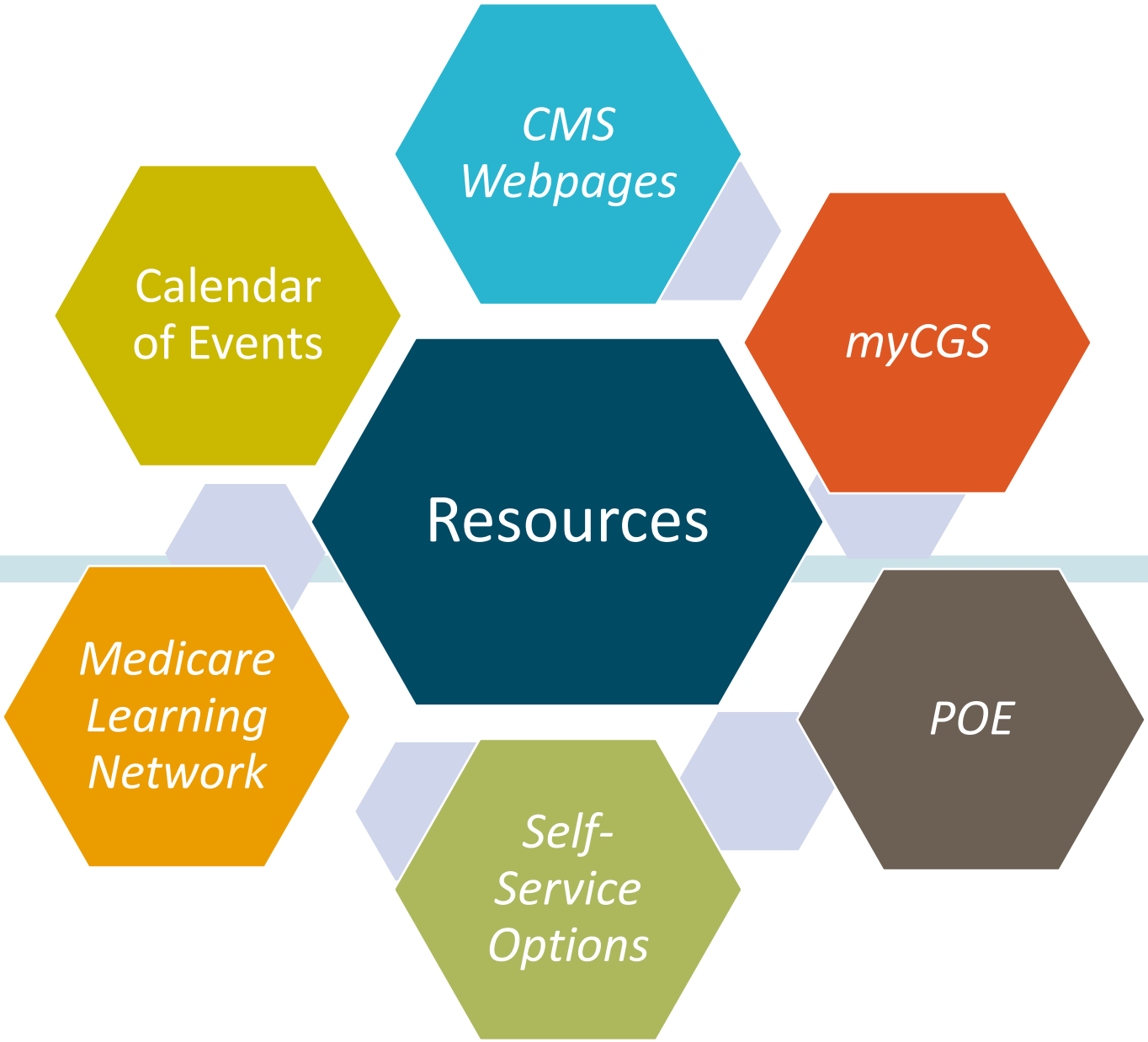


CMS Resources You Can Use!

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

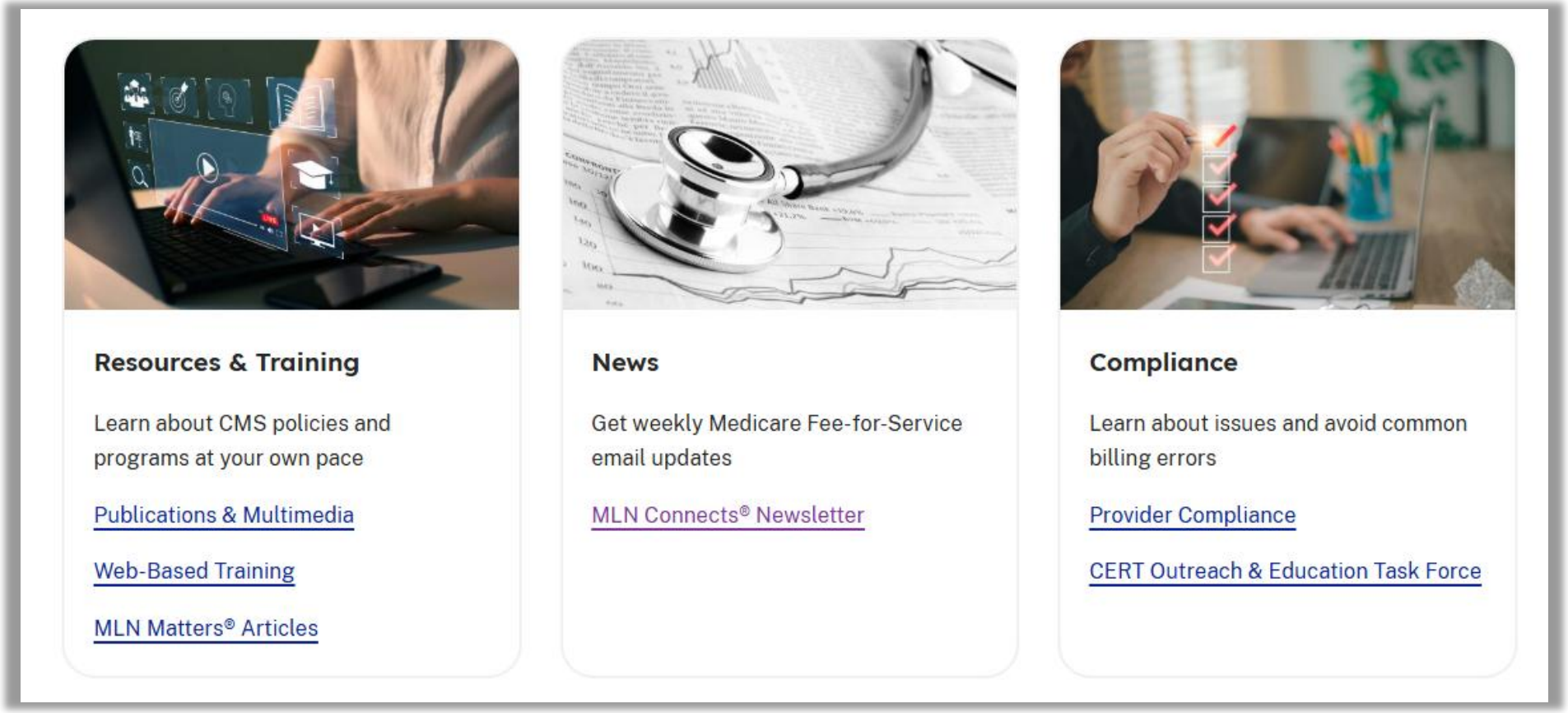
- CMS Office of Program Operations and Local Engagement

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

The Medicare Learning Network®

Click here to get educational materials for health care providers on CMS programs, policies, and initiatives!



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myCGS A/B/HHH MAC JURISDICTION 15

CLAIMS

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

MR DASHBOARD

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

REMITTANCE

View and print remittance advices (RAs)

ELIGIBILITY

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

MBI LOOK-UP TOOL

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

FINANCIAL TOOLS

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

MESSAGES

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

FORMS

Submit 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)

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 Chart

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

Calendar of Events!

Register Today

	Event Title	Jurisdiction	Event Date	Time
⊞	Choosing the Right Call Route: Part A vs. Part B in PCC and IVR	Part A, Part B	8/4/2026	12:00 pm - 1:00 pm ET
⊞	Targeted Probe and Educate (TPE) Overview: Ophthalmic Procedures Level II Review	Part B	8/6/2026	12:00 pm - 1:00 pm ET
⊞	myCGS Lunch and Learn	Part A, Part B, Home Health & Hospice	8/11/2026	1:00 pm - 1:30 pm ET
⊞	Self Service Series: Claim Filing Support	Part B	8/18/2026	11:00 am - 12:00 pm ET
⊞	Medicare 101 - Understanding Medicare Overpayments	Part B	8/19/2026	12:00 pm - 1:00 pm ET
⊞	Navigating Self-Service Tools: Part A vs. Part B	Part A, Part B	9/2/2026	12:00 pm - 1:00 pm ET
⊞	Whats New with myCGS???	Part A, Part B, Home Health & Hospice	9/8/2026	11:00 am - 12:00 pm ET
⊞	Self Service Series: Claim Systems Navigation	Part B	9/15/2026	11:00 am - 12:00 pm ET
⊞	National AB MAC Ambulance Provider/Supplier Quarterly Coalition Meeting	Part A, Part B	9/16/2026	1:00 pm - 3:00 pm ET
⊞	Laboratory Testing - Level II Review	Part B	9/17/2026	1:00 pm - 2:00 pm ET
⊞	Provider Guide to Beneficiary Notices: Part A vs. Part B	Part A, Part B	10/6/2026	12:00 pm - 1:00 pm ET
⊞	Claim Accuracy: Top Errors and How to Correct Them	Part A, Part B	10/27/2026	3:00 pm - 4:00 pm ET
⊞	Understanding Medicare Reviews: Part A vs. Part B	Part A, Part B	11/3/2026	12:00 pm - 1:00 pm ET

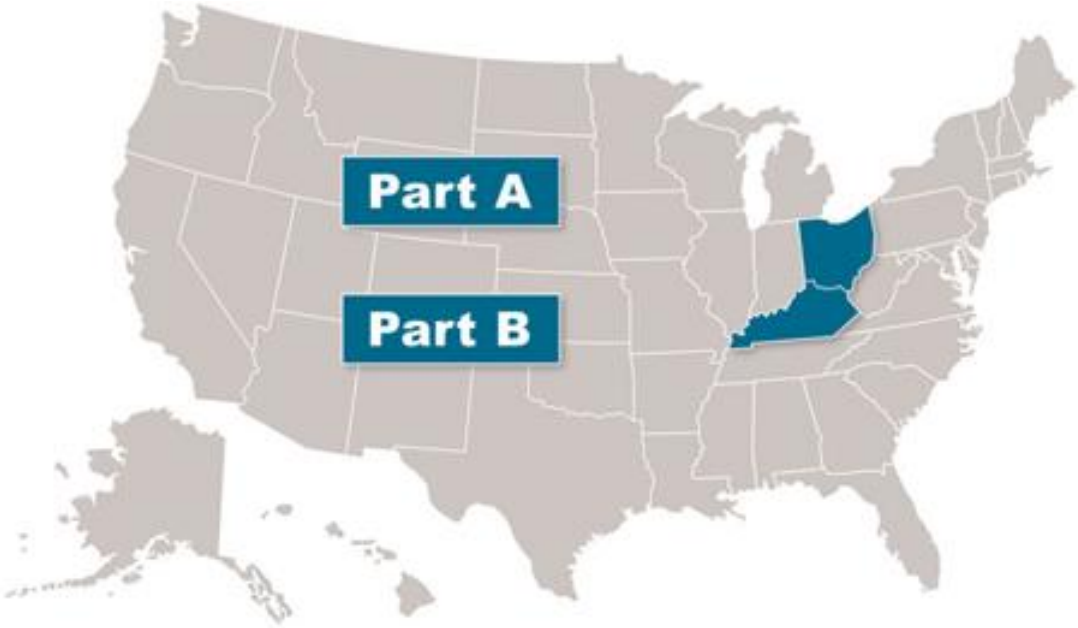
Click on the link for our previous sessions - https://web.cvent.com/attendee-login/login

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

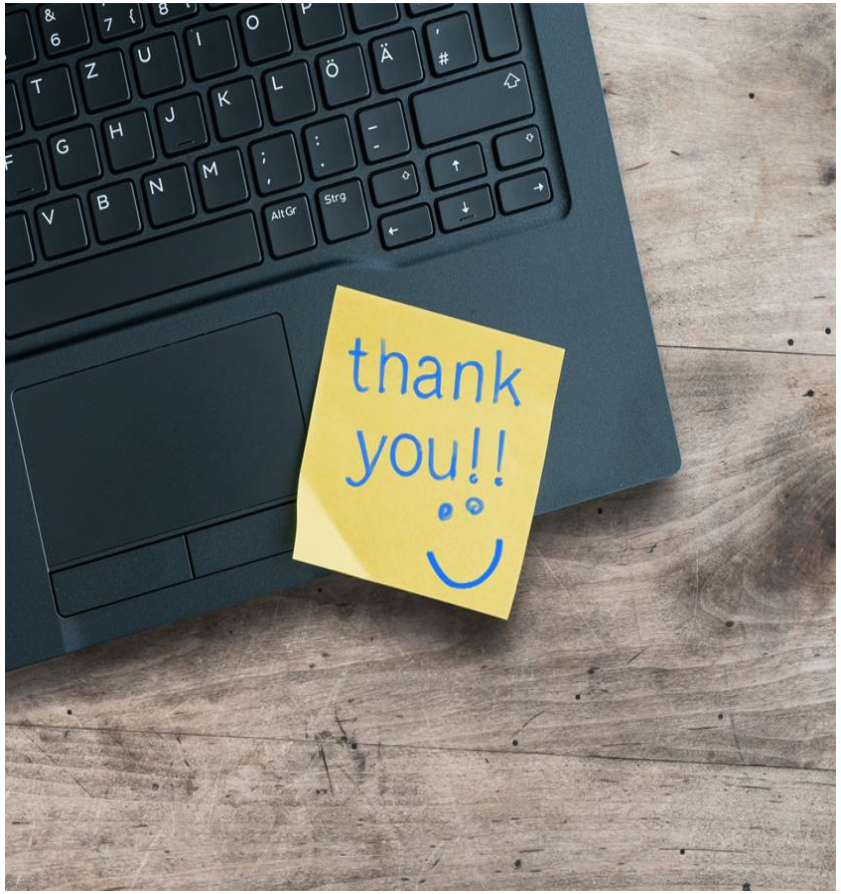


We Want Your Feedback!

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!

Survey Link: https://qr-creator.com/d/808108377