FOCUS

Finding Answers

Ongoing Medicare Initiatives

Comprehensive Error Rate Testing (CERT)

Understanding Data

Self-Service Technology

Table of Contents

Our mission is simple, We IMPACT Lives! Every claim processed and every telephone call answered has a direct impact on the health and well-being of a Medicare beneficiary. They rely on us to take good care of the health care providers and medical equipment suppliers who are helping them stay healthy. With over 20 million Medicare beneficiaries and over 85,000 health care professionals depending on us, our impact spans the United States.

CGS® A CELERIAN GROUP COMPANY

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

URLs to Save

CGS: Part B Homepage

http://www.cgsmedicare.com/partb/index.html

- **myCGS**
  http://www.cgsmedicare.com/partb/myCGS/index.html
- **Customer Service**
  http://www.cgsmedicare.com/partb/cs/index.html
- **Appeals**
  http://www.cgsmedicare.com/partb/appeals/index.html
- **Browse by Specialty**
  http://www.cgsmedicare.com/partb/specialty/index.html
- **Browse by Topic**
  http://www.cgsmedicare.com/partb/topic/index.html
- **Education & Events**
  http://www.cgsmedicare.com/partb/education/index.html
- **EDI**
  http://www.cgsmedicare.com/partb/edi/index.html
- **FAQs**
  http://www.cgsmedicare.com/partb/faqs/index.html
- **Fee Schedules & Reimbursement**
  http://www.cgsmedicare.com/partb/fees/index.html
- **Forms**
  http://www.cgsmedicare.com/partb/forms/index.html
- **Medical Policies**
  http://www.cgsmedicare.com/partb/medicalpolicy/index.html
- **Medical Review**
  http://www.cgsmedicare.com/partb/mr/index.html
- **News & Publications**
  http://www.cgsmedicare.com/partb/pubs/index.html
- **Overpayments & Refunds**
  http://www.cgsmedicare.com/partb/overpay/index.html
- **Provider Enrollment**
  http://www.cgsmedicare.com/partb/enrollment/index.html
- **Tools**
  http://www.cgsmedicare.com/partb/tools/index.html

CMS: Medicare Homepage

https://www.cms.gov/Medicare/Medicare.html

- **Beneficiary Notices Initiative (ABNs)**
  https://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html
- **SNF Consolidated Billing**
  https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html
- **Correct Coding Initiative (CCI) and Medically Unlikely Edits (MUEs)**
  https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html
- **Physician Fee Schedule Look-up Tool**
  https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PFSlookup/index.html
- **Preventive Services**
  https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/index.html
- **Provider-Supplier Enrollment**
  https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html
- **MLN Matters® Articles**
  https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html?redirect=/MLNMattersArticles/
- **Medicare Learning Network® (MLN) Web-based Training Courses**
  https://learner.mlnlms.com/Default.aspx
- **Global Surgery**
  https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/GlobalSurgery-ICN907166.pdf

Medscape

http://www.medscape.org/

Recovery Audit Contractor – CGI Federal, Inc.

https://racb.cgi.com/default.aspx

Frequently Asked Questions (FAQs)

Part B Reopenings

A *Reopening* may be requested to correct a minor error or omission to a previously processed claim http://www.cgsmedicare.com/partb/forms/gateways/reopenings.html

- Be sure request is not one that should be sent as a Redetermination http://www.cgsmedicare.com/partb/forms/pdf/reopen_vs_redet_jobaid.pdf
- Claims rejected due to billing errors (Return-to-Provider (RTP)) must be corrected and resubmitted as NEW claims
- Reopenings may also be requested through myCGS and via phone - 1.866.276.9558 (option 4)
- Claims denied due to timely filing may be handled as a Reopening in specific situations
  - > Errors made by CGS
  - > Errors in the Common Working File (CWF), or patient's master records
  - > When the beneficiary's entitlement has changed
  - > When the provider's Medicare enrollment files have been updated/changed
- In cases when a primary insurer requests money be returned upon determining they should have paid as secondary, a Reopening request must be filed within six month of the date of recoupment
  - > Include a copy of a dated recoupment letter or EOB from insurer
- Reopenings cannot be done to increase the payment on services reduced due to the following:
  - > Physician Quality Reporting System (PQRS)
  - > Electronic Health Record (EHR)
  - > Value-Based Modifier (VM)
  - > Sequestration payment reductions
    - Look for **CARC 237** – *Legislated/Regulatory Penalty*
    - **PQRS:** N699 - Payment adjusted based on the Physician Quality Reporting System (PQRS) Incentive Program
    - **EHR:** N700 - Payment adjusted based on the Electronic Health Records (EHR) Incentive Program
    - **VM:** N701 - Payment adjusted based on the Value-based Payment Modifier
- Reopenings submitted through myCGS must follow the same guidelines as hardcopy requests http://www.cgsmedicare.com/partb/pubs/news/2014/0814/cope26668.html
- Telephone reopening requests cannot be accepted if the claim has had a payment adjustment applied due to PQRS, EHR and/or VM
  - > Request a written reopening instead http://www.cgsmedicare.com/partb/pubs/news/2016/05/cope32980.html
- Be sure to include ALL required information, such as claim ICNs
  - > Verify information is correct when submitting requests to avoid errors
- Services requiring the review of medical records CANNOT be handled as a Reopening
  - > This includes services that were reduced during the medical review process based on submitted documentation
  - > Reduced services may be reconsidered by requesting a Redetermination http://www.cgsmedicare.com/partb/pubs/news/2014/0714/cope26233.html
- Reopening requests should not be resubmitted until a decision is made on initial request
- Reopening requests (myCGS and hardcopy) can take up to 60 days to process

Refer to *Reopenings: Tips and Reminders* for additional information http://www.cgsmedicare.com/partb/pubs/news/2015/0115/cope28151.html

Redeterminations

Providers may submit Redetermination (appeal) requests for an initial claim determination when Medicare's decision is to deny or partially deny a claim or when the provider disagrees with the payment. http://www.cgsmedicare.com/partb/appeals/index.html

- Be sure request is not one that should be sent as a Reopening http://www.cgsmedicare.com/partb/forms/pdf/reopen_vs_redet_jobaid.pdf
- To be accepted as a valid request, Redeterminations must be submitted with required information including:
  - > The patient's name and Health Insurance Claim (HIC) number
  - > Identify the date of service and the specific item/service being appealed
  - > Name and signature of the requestor
- Completing the Redeterminations form will help ensure we can accept and process your request http://www.cgsmedicare.com/pdf/partb_redeterminationform.pdf
- All medical records, radiology reports, office notes, etc., submitted must be legible
- The time limit is 120 days from the initial determination of the claim
- Be aware of specific claims processing and payment guidelines
  - > Correct Coding Initiative (CCI) https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html
  - > Medically Unlikely Edits (MUEs) https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html

> Global Surgery https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/GlobalISurgery-ICN907166.pdf

- Submit multiple dates of service under one Internal Claim Number (ICN) on the same request
- Redetermination requests are not accepted via fax
- Use **myCGS** to submit Redeterminations as a huge time saver! http://www.cgsmedicare.com/pdf/partb_mycgs_redetermination_requests.pdf

Provider Contact Center (PCC)

- Providers are reminded the customer service representative in the PCC cannot assist with processes that can be completed through the *Interactive Voice Response (IVR)*. This includes beneficiary eligibility and Medicare Part B claim status.
  > Step-by-step IVR instructions http://www.cgsmedicare.com/partb/cs/ivr.html
  > IVR System User Guide http://www.cgsmedicare.com/partb/cs/partb_ivr_user_guide.pdf
- Customer Service Representatives (CSRs) are required to go through authentication process when addressing claim-specific questions http://www.cgsmedicare.com/partb/pubs/news/2016/04/cope32689.html

Electronic Data Interchange (EDI)

- If your electronic software/vendor does not allow you to submit Medicare Secondary Payer (MSP) claims, submitting them as paper claims is not an option
  > **myCGS** – All Part B claims (including MSP claims) are accepted and processed as electronic claims http://www.cgsmedicare.com/partb/pubs/news/2015/0215/cope28475.html
  > **PC-ACE Pro32** – This software is available for download from the CGS website at http://www.cgsmedicare.com/partb/edi/pro32/index.html

Jurisdiction B DME Contract

- CGS has been awarded the Jurisdiction B (JB) DME MAC workload
- The JB contract will provide support for more than 6.8 million Medicare beneficiaries and 18,000 DME suppliers in Kentucky, Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin
- CGS will begin full operation in July 2016
- Refer to the *DME MAC Jurisdiction B Implementation* Web page http://www.cgsmedicare.com/jb/index.html

Computer Telephony Integration (CTI) System Coming Soon

CGS will soon be implementing a Computer Telephony Integration (CTI) system in our Part A, Part B, and Home Health & Hospice Provider Contact Centers. The CTI will provide a streamline process in which providers will enter authentication information before reaching a Customer Service Representative (CSR). The CSR will access the information you entered and will be ready to assist you with your question. Please watch for more information about the CTI in upcoming ListServ messages, and social media outlets.

Physician Quality Reporting System (PQRS)

- Federally-mandated quality reporting program for specific eligible professionals (EPs) http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/How_To_Get_Started.html
- Utilize the beginner, intermediate and advanced *PQRS Educational Resources* https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/EducationalResources.html
- Program Year (PY) 2016 emphasis on avoiding the Calendar Year (CY) 2018 payment adjustment of -2% https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Payment-Adjustment-Information.html
  - > Choose at least 9 measures across 3 National Quality Strategy (NQS) domains report each measure for at least 50% of the EPs FFS patients via claims or qualified registry reporting
  - > Report at least 1 cross-cutting measure (that is broadly applicable across multiple providers and specialties) if there is at least 1 face-to-face encounter https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html
  - > Specialty-specific measure sets are available
  - > Use the NEW *PQRS Web-Based Measure Search Tool* to find measures for claim and registry reporting https://pqrs.cms.gov/#/home
- Subject to *Measure-Applicability Validation (MAV)* process if the requirements above are not met https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/AnalysisAndPayment.html
- If you did not satisfactorily report or satisfactorily participate in PY 2015, a -2% reduction will be applied in CY 2017
- Contact the *QualityNet Help Desk* at 1.866.288.8912 or Qnetsupport@hcqis.org

Value-Based Payment Modifier (VM)

- The *Affordable Care Act* mandated that, by 2015, CMS begin applying a value modifier under the Medicare Physician Fee Schedule (MPFS) https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html
  - > Upward, downward, or neutral payment adjustment based on PQRS participation
- Physician reimbursement that rewards *value and quality* rather than volume
  - > Affects group of 100+ EPs in CY 2015 (based on PQRS reporting in CY 2013)
  - > Includes groups of 10-99 EPs in CY 2016 (based on PQRS reporting in CY 2014)
  - > Includes solo EPs and groups of 2-9 EPs in CY 2017 (based on PQRS reporting in CY 2015)
  - > Will apply to non-physician EPs in CY 2018
- CMS posted results from the implementation of the second year of value modifier https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2016-VM-Overview-PDF-Memo.pdf
  - > 13,813 physician groups (10+ EPs) subject to the VM
    - 8,395 groups met the VM criteria
    - 5,418 groups to receive an automatic -2% downward VM payment adjustment in CY 2016 because they did not meet the reporting requirements
  - > Groups/EPs subject to an upward or downward payment adjustment began seeing claims and adjustments to previously processed claims after March 14, 2016
- Contact *Physician Value Help Desk* with VM questions at 1.888.734.6433 (option 3)

Electronic Health Record (EHR)

- Promotes Electronic Health Record (EHR) technology for the "meaningful use" of certified electronic health records technology https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html
- Requirements for the 2016 reporting period https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/2016ProgramRequirements.html
  - > All providers are required to attest to a single set of objectives and measures
    - For EPs, there are 10 objectives https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/2016_EPTableOfContents.pdf
  - > All providers must attest using EHR technology certified to the 2014 Edition
    - May also use the 2015 Edition, or a combination of the two (if the 2015 Edition is available)
  - > Full year (January – December 2016) reporting period for all returning participants
    - A continuous 90-day reporting period for EPs who have not demonstrated meaningful use in a prior year
  - > EPs who did not demonstrate meaningful use in CY 2014 are currently receiving a -2% payment adjustment in CY 2016
- Requirements for the 2017 reporting period will be available at https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/2017ProgramRequirements.html
- 2017 Payment Adjustment
  - > EPs who did not demonstrate meaningful use in CY 2015 will receive a -2% payment adjustment in CY 2017
  - > Requests for a hardship exception from 2017 payment adjustment may be submitted by July 1, 2016 https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/PaymentAdj_Hardship.html

  - Insufficient internet connectivity
  - Extreme and uncontrollable circumstances (disaster, financial issues, EHR certification delays, practice closure)
  - Lack of control over availability of EHR technology within the practice
  - Lack of face-to-face encounters
- Contact the *EHR Information Center* with questions at 1.888.734.6433 (option 1) or e-mail at HBOSC_EHRIC@cms.hhs.gov

Provider Enrollment Cycle 2 Revalidation

- Cycle 2 of Revalidation began March 2016
  > DME suppliers revalidate every 3 years; all other providers/ suppliers every five years
- Process is much more streamlined
  > Revalidation due dates will be consistent throughout subsequent cycles
  > A new *Revalidation Look-up Tool* is available https://data.cms.gov/revalidation
    - Revalidation due dates will be posted up to 6 months in advance of the due date
    - If date not assigned, "TBD" is shown
    - Do not submit a revalidation request until a date has been posted
    - Requests received prior to the 6 month timeframe will be considered "unsolicited" and returned
  > CGS will continue to mail the CANARY YELLOW envelope 2-3 months prior to revalidation due date
  > Application must be completed and returned within 60 days to avoid deactivation
    - If PTAN deactivated due to non-response, a new complete enrollment application must be submitted to reactive original PTAN
    - Reactivation date based on date of receipt of new application which may result in gap in reimbursement
- Resources are available to help!
  > CMS website https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Revalidations.html
  > CGS Revalidation Web page http://www.cgsmedicare.com/partb/enrollment/pe_revalidation.html

Social Security Number Removal Initiative (SSNRI)

- The *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA) requires us to remove Social Security Numbers (SSNs) from all Medicare cards
- The *SSNRI* is being implemented to better protect private health care and financial information
- By April 2019, people with Medicare will receive Medicare cards with a new number replacing the social security number
- Processing systems are being updated
- Watch for more information on this initiative

Sequestration

- Affects all services reimbursed under the Medicare Fee-for-Service program
- Claims with dates of service or dates of discharge on or after April 1, 2013, will continue to incur a 2% reduction in Medicare payment until further notice
- Applied to all claims after determining coinsurance, any applicable deductible, and any applicable Medicare Secondary Payment adjustments
- Medicare's payment to beneficiaries for unassigned claims is subject to the 2% reduction
  > Those who submit unassigned claims are encourage to explain this to their patients
- Refer to *Sequestration Frequently Asked Questions (FAQs)* http://www.cgsmedicare.com/partb/faqs/sequestration_faqs.html

HCPCS Modifier JW

- HCPCS modifier JW identifies unused drugs or biologicals that are appropriately discarded
- Current policy allows contractors the discretion to determine whether to require this modifier
- Effective January 1, 2017, the use of HCPCS modifier JW to identify unused drugs or biologicals that are appropriately discarded is required https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9603.pdf
- Also, providers are required to document the discarded drug or biological in the patient's medical record
- Providers are encouraged to administer drugs and biologicals to patients in such a way that they are used most efficiently, in a clinically appropriate manner.

Comparative Billing Report (CBR)

- A Comparative Billing Report (CBR) provides comparative billing data to an individual health care provider http://www.cbrinfo.net/
- CBRs contain an explanation of findings that compare provider's billing and payment patterns to those of their peers on both a national and state level
- CBR study topics are selected because they are prone to improper payments
- CMS has formalized and expanded the CBR program
- Contact the CBR Support Help Desk with questions regarding CBRs Toll-Free 1.800.771.4430 or e-mail cbrsupport@eglobaltech.com

COMPREHENSIVE ERROR RATE TESTING (CERT)

The Centers for Medicare & Medicaid Services (CMS) implemented CERT to measure improper payments in the Medicare fee-for-service (FFS) program. Contractors are charged errors, which are used to identify educational needs of the provider community. http://www.cgsmedicare.com/partb/cert/index.html

FY 2015 CERT Improper Payment Rates

The fiscal year (FY) 2015 Medicare FFS program CERT improper payment rate is **12.1 percent**, representing **$43.3 billion** in improper payments.

Top 20 Service Types with Highest Improper Payments (National: Part B)

Part B Services	Projected Improper Payments	Improper Payment Rate
Lab Tests - other (non-Medicare Fee Schedule)	$1,159,548,803	39.0%
Office visits - established	$1,141,913,178	7.7%
Hospital visit - subsequent	$1,048,419,405	19.1%
Hospital visit - initial	$888,882,432	30.2%
Ambulance	$734,079,079	15.7%
Minor procedure - other (Medicare Fee Schedule)	$593,574,346	20.1%
Office Visit New	$490,841,942	17.8%
Nursing home visit	$362,260,716	19.8%
Specialist - psychiatry	$311,258,894	30.8%
Chiropractic	$299,130,240	51.7%
Emergency Room Visit	$292,397,866	13.6%
Lab tests - other (Medicare Fee Schedule)	$270,988,901	15.2%
Hospital Visit - critical care	$267,748,423	27.8%
Other tests - other	$257,957,552	17.6%
Anesthesia	$241,654,272	11.4%
Other drugs	$225,205,407	3.5%
Major procedure - Other	$158,604,068	9.8%
Dialysis services (Medicare Fee Schedule)	$147,792,301	17.8%
Specialist - other	$136,900,637	19.4%
Advanced imaging - CAT/CT/CTA: other	$129,739,583	12.4%

Improper Payment Rates by Provider Type and Type of Error (Based on November 2015 Reporting Period)

			Type of Error				
Provider Type (Part B)	Improper Payment Rate	Sampled Claims	No Doc	Insufficient Documentation	Medical Necessity	Incorrect Coding	Other
Chiropractic	51.7%	468	0.3%	95.8%	3.3%	0.6%	0.0%
Clinical Lab (billing independently)	37.1%	3667	0.8%	96.6%	2.0%	0.3%	0.3%
Clinical Social Worker	29.8%	108	0.0%	100.0%	0.0%	0.0%	0.0%
Clinical Psychologist	28.9%	111	0.0%	94.9%	5.1%	0.0%	0.0%
Geriatric Medicine	28.9%	38	53.9%	24.7%	0.0%	21.4%	0.0%
Psychiatry	28.8%	265	11.2%	49.9%	0.0%	38.7%	0.3%
Thoracic Surgery	28.5%	48	0.0%	48.2%	0.0%	51.8%	0.0%
Allergy/ Immunology	27.5%	55	0.0%	71.7%	25.5%	2.7%	0.0%
Occupational Therapist in Private Practice	24.8%	36	0.0%	91.8%	0.0%	0.0%	8.2%
Physical Therapist in Private Practice	23.4%	548	0.1%	82.8%	0.0%	1.1%	15.9%
Interventional Pain Management	21.6%	74	2.9%	93.4%	0.2%	3.5%	0.0%
Critical Care (Intensivists)	21.1%	66	5.1%	45.5%	0.0%	49.4%	0.0%
Pulmonary Disease	20.1%	334	0.0%	46.6%	0.0%	52.2%	1.2%
Nephrology	17.7%	364	4.3%	53.4%	0.0%	35.8%	6.5%
Obstetrics/ Gynecology	17.0%	57	4.7%	12.5%	1.3%	60.0%	21.5%
Physical Medicine & Rehabilitation	15.8%	160	4.0%	56.2%	0.0%	39.8%	0.0%
Ambulance Supplier	15.7%	400	5.4%	79.5%	10.7%	2.6%	1.8%
Endocrinology	15.4%	90	0.0%	64.2%	0.0%	35.8%	0.0%
CRNA	15.0%	121	8.1%	91.9%	0.0%	0.0%	0.0%
Internal Medicine	14.8%	2014	3.9%	49.8%	1.1%	43.9%	1.3%
Cardiology	14.5%	899	2.1%	69.2%	0.0%	28.7%	0.0%

COMPREHENSIVE ERROR RATE TESTING (CERT)

CERT A/B MAC Outreach & Education
Task Force for Error-Free Medicare Claims

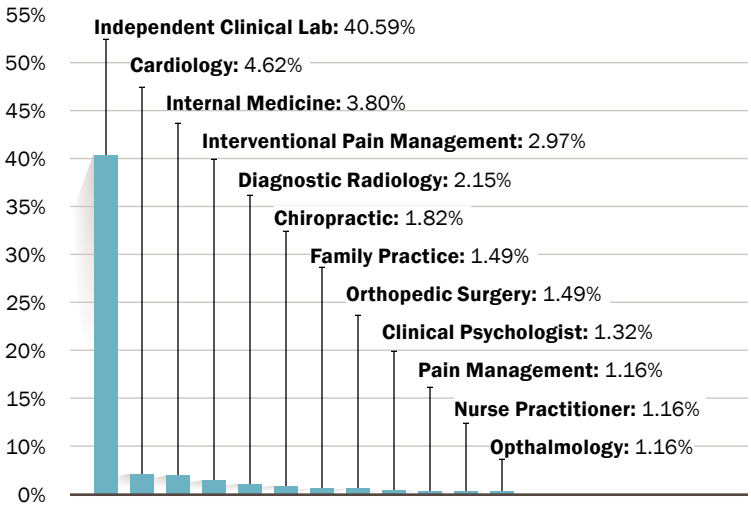
CERT A/B MAC Outreach & Education Task Force

Medicare Administrative Contractors (MACs) introduced the CERT A/B MAC Outreach & Education Task Force as a new collaboration of all Part A and Part B MACs to educate providers on national issues of concern regarding improper payment errors. The goal is to reduce the national payment error rate, as measured by the CERT program. This new partnership affords providers the benefit of a collaborative, consistent voice to reduce costly claim denials as well as the CERT error rate. Check here for more information. http://www.cgsmedicare.com/partb/education/cert_task_force.html

CERT Errors Charged by Specialty

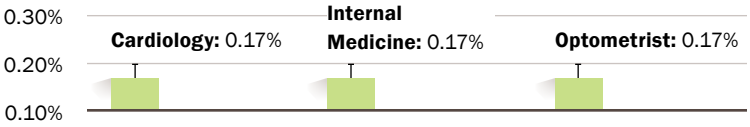
Avoid "Insufficient Documentation" Errors
http://www.cgsmedicare.com/partb/pubs/news/2014/1014/cope27264.html

- Be sure documentation adequately describes the service billed
- Include copies of signed orders (http://www.cgsmedicare.com/partb/pubs/news/2013/0913/cope23292.html)
- Verify signatures are valid, legible and/or present
  - > Submit a Signature Attestation Statement when necessary http://www.cgsmedicare.com/partb/pubs/news/2013/1113/cope23836.html
- Information for Practitioner Offices and Blling Services http://www.cgsmedicare.com/partb/pubs/news/2014/0214/cope24803.html



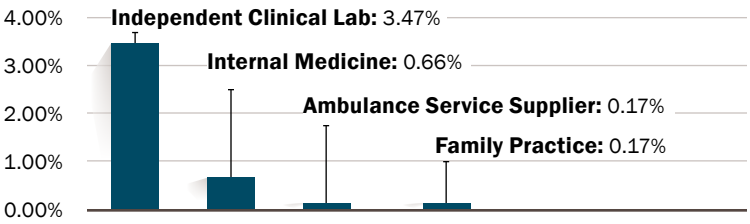
Avoid "No Documentation" Errors
http://www.cgsmedicare.com/partb/cert/review_process.html

- Respond to all requests completely
- Return documentation within 75 days
- Include a copy of the bar-coded page with the request (http://www.cgsmedicare.com/articles/cope26239.html)



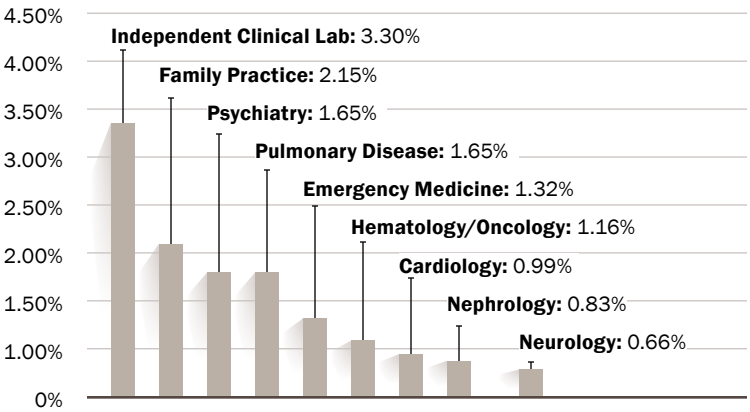
Avoid "Medically Unnecessary" Errors

- Include all relevant medical records
- Identify the reasons surgeries and/or diagnostic tests are performed
- Always check for LCDs and NCDs to verify medical necessity is being met http://www.cms.gov/medicare-coverage-database/

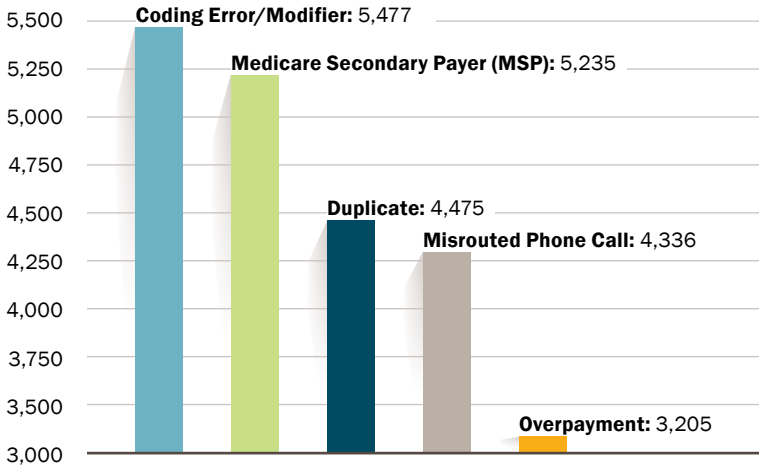


Avoid "Incorrect Coding" Errors

- Be aware of the E/M Documentation Guidelines http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/EMDOC.html
  - > 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 http://www.cgsmedicare.com/partb/pubs/news/2013/1013/cope23465.html



Top Phone Inquiries:
Jan 2016 - May 2016



Coding Errors/Modifiers

- Utilize the *Modifier Finder Tool* for help with correctly selecting and using modifiers https://www.cgsmedicare.com/medicare_dynamic/modifiers_ky/search.asp

Medicare Secondary Payer (MSP)

- When Medicare is secondary, the primary payer must be billed first http://www.cgsmedicare.com/partb/pubs/news/2014/0314/cope24889.html
- Refer to the *MSP Job Aid* to determine how patient's record "should" appear
  - > If changes needed, contact the *Benefits Coordination and Recovery Center (BCRC)*
- Verify patient eligibility
  - > myCGS http://www.cgsmedicare.com/pdf/mycgs/chapter4.pdf
  - > IVR http://www.cgsmedicare.com/partb/cs/partb_ivr_user_guide.pdf

Duplicate Service

- Always check the status of claim BEFORE resubmitting them
  - > Customer Service Representative (CSRs) cannot check the status of claims
    - myCGS http://www.cgsmedicare.com/pdf/mycgs/chapter2_partb.pdf
    - IVR http://www.cgsmedicare.com/partb/cs/partb_ivr_user_guide.pdf
- When responding to Additional Documentation Requests (ADRs), do not resubmit the claim until a decision has been made on the initial claim
  - > ADR claims may take up to 46 days to process

Misrouted Phone Call

- Check the *Customer Service* Web page for options before calling CGS
  - > Provider Contact Center (PCC): 1.866.276.9558
    - **Option 1:** *To speak with a CSR* regarding claim denials; payment calculation; locating resources; understanding claim submission guidelines
    - **Option 2:** To reach the *Electronic Data Interchange (EDI)* Department
    - **Option 3:** For help with *Provider Enrollment*, including credentialing and Revalidation questions
    - **Option 4:** To request a *Telephone Reopening*
    - **Option 5:** For assistance with issues involving *Overpayments and Refunds*
  - > The *Interactive Voice Response (IVR)* is available for claim status, Redetermination status, beneficiary eligibility information, and information on Medicare checks: **1.866.290.4036**

Overpayment

- Requests for repayment of Medicare funds are time sensitive
- Use *myCGS* to request an *eOffset* (immediate offset) of a demanded overpayment http://www.cgsmedicare.com/articles/cope25833.html
- Respond to demand letters immediately and include a copy when refunding via check
- For Voluntary Refunds, use the *Overpayment Refund Form* and complete it in its entirety http://www.cgsmedicare.com/partb/forms/overpayment.html

Top Written Inquires:
Jan 2016 – May 2016

Appeals/Status Explanation Resolution

- You may check the status of Redeterminations submitted through myCGS! http://www.cgsmedicare.com/pdf/mycgs/chapter7_partb.pdf
- The IVR also provides appeal status http://www.cgsmedicare.com/partb/cs/partb_ivr_user_guide.pdf

Contractual Obligation Not Met

- Services denied with a "CO" group code may not be billed to the patient
- Rely on the *CGS Website Search Engine* to locate articles to address a number of issues. http://www.cgsmedicare.com/searchtips.html

Misrouted Written Correspondence

- Refer to the *Part B Contact Information* Web page for current mailing addresses http://www.cgsmedicare.com/partb/cs/contactinfo.html

- Use *myCGS* to submit general inquiries on a variety to topics, including appeals, claims processing, finance, medical review provider enrollment and provider outreach http://www.cgsmedicare.com/partb/pubs/news/2016/01/cope31726.html

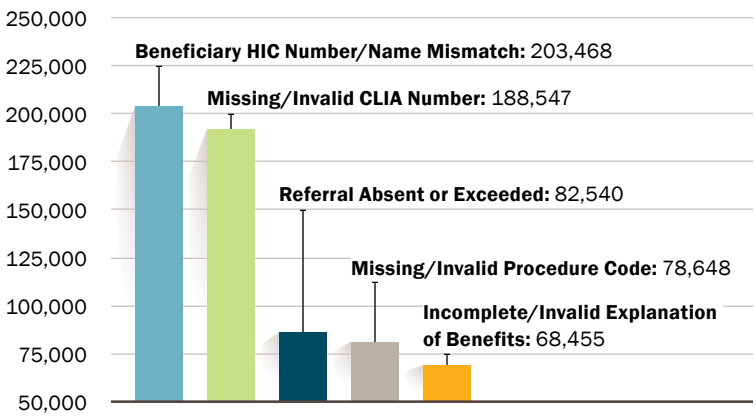
Provider Enrollment/Requirements

- Refer to the CGS *Provider Enrollment* Web page for information on the enrollment process, a link to Internet-Based PECOS, contact information and MORE! http://www.cgsmedicare.com/partb/enrollment/index.html

Policy/Coverage/Benefits/Exclusions

- Utilize the *Medical Policies* Web page for links to policies (local and national), coverage articles, clinical trials and other coverage information http://www.cgsmedicare.com/partb/medicalpolicy/index.html

Top Rejections: Jan 2016 – May 2016



Beneficiary Health Insurance Claim (HIC) Number/Name Mismatch

- Maintain current patient records and copies of Medicare cards
  - > Submit the name as it appears on the card
  - > Patient must contact Social Security to make corrections or changes to their card
- HIPAA regulations do not allow contractors to verify HIC

Missing/Invalid CLIA Number

- Entities that perform clinical lab tests are required to be certified
- The appropriate certificate number must be submitted on the claim
- Information on obtaining a CLIA certificate http://www.cgsmedicare.com/partb/pubs/news/2014/0714/cope26261.html

Referral Absent or Exceeded

- Missing, incomplete or invalid referring provider name or NPI submitted on claim
  - > Name must be submitted as registered in PECOS
- Service submitted requires ordering/referring provider but one is not reported
- Ordering/referring provider reported but he/she not enrolled in PECOS
  - > Also must be of a specialty legally allowed to order/refer services for Medicare patients
- Verify provider's enrollment in PECOS https://Data.cms.gov
  - > Select Ordering and Referring link and use filter to search

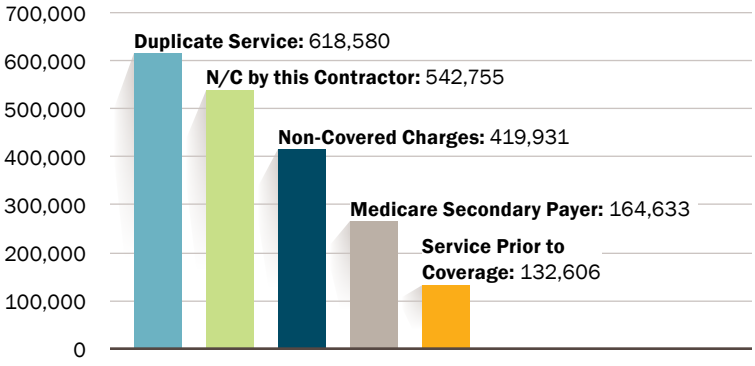
Missing/Invalid Procedure Code

- Code claims using current CPT and HCPCS manuals
  - > Codes are valid January through December each year
  - > HIPAA requires the use of codes valid the year the service is rendered
- Provide staff with resources needed

Incomplete/Invalid Explanation of Benefits (EOB)

- Enter complete primary insurance information in correct electronic fields when submitting MSP claims https://www.cgsmedicare.com/pdf/MSP_JobAid.pdf
  - > myCGS eClaim submitters must use correct fields http://www.cgsmedicare.com/partb/pubs/news/2015/0215/cope28475.html
- Paper submitters – include complete copy of primary insurer EOB
  - > Be sure primary insurer is identified on EOB
    - myCGS http://www.cgsmedicare.com/pdf/mycgs/chapter4.pdf
    - IVR http://www.cgsmedicare.com/partb/cs/partb_ivr_user_guide.pdf

Top Denials: Jan 2016 – May 2016



Duplicate Service

- It is important to avoid submitting duplicate claims
- The Remittance Advice will contain CO-18 Duplicate Service(s) when this denial is appropriate

> Indicates service has already been processed/paid for:
  - The same patient, service, date of service, and provider

- Ways to avoid duplicate denials
  > Consider submitting multiple same services provided on the same date on ONE claim
  > Use appropriate modifiers for unilateral (RT/LT) or bilateral services (50) http://www.cgsmedicare.com/medicare_dynamic/modifiers_ky/search.asp
  > Always check the status of claims
    - myCGS http://www.cgsmedicare.com/pdf/mycgs/chapter2_partb.pdf
    - IVR http://www.cgsmedicare.com/partb/cs/partb_ivr_user_guide.pdf
- When resubmitting rejected services, do not include services previously allowed and/or paid

Non-Covered by this Contractor

- Verify patient coverage PRIOR TO submitting claims
  > Obtain copies of ALL patient insurance cards
  > Check patient eligibility
    - myCGS http://www.cgsmedicare.com/pdf/mycgs/chapter4.pdf
    - IVR http://www.cgsmedicare.com/partb/cs/partb_ivr_user_guide.pdf
  > *Reminder: Open enrollment period if October of each year, affecting coverage for the next calendar year.*
- Check the 2016 Jurisdiction List for *DMEPOS HCPCS Codes* to ensure DME, drugs, supplies and other items are submitted to correct contractor https://www.cgsmedicare.com/jc/pubs/news/2016/0116/cope31625.pdf

Non-Covered Charges

- Primarily includes services submitted to Medicare for reporting purposes only
  > PQRS, Outpatient Therapy Functional Reporting

Medicare Secondary Payer (MSP)

- Always verify if there is a payer primary to Medicare
  > myCGS http://www.cgsmedicare.com/pdf/mycgs/chapter4.pdf
  > IVR http://www.cgsmedicare.com/partb/cs/partb_ivr_user_guide.pdf
- Utilize resources available under *Browse by Topic/MSP* http://www.cgsmedicare.com/partb/topic/index.html

Service Rendered Prior to Coverage

- This denial is charged when our records show patient did not have Part B coverage when service was rendered
  > Check patient eligibility
    - myCGS http://www.cgsmedicare.com/pdf/mycgs/chapter4.pdf
    - IVR http://www.cgsmedicare.com/partb/cs/partb_ivr_user_guide.pdf
  > Refer patient to Social Security if there are problems with eligibility dates

Tool	Function	Resource
myCGS Web Portal (http://www.cgsmedicare.com/partb/myCGS/index.html)**:** Allows you the flexibility to perform a number of Medicare inquiries and actions securely and electronically!	**Claims Tab:** Submit Part B claims (including Medicare Secondary Payer (MSP))securely through myCGS! You can also check the status of claims.	http://www.cgsmedicare.com/pdf/mycgs/chapter2.pdf
	REMITTANCE Tab: View and print remittance advices (RAs).	http://www.cgsmedicare.com/pdf/mycgs/chapter3.pdf
	ELIGIBILITY Tab: Check patient deductible and therapy cap information; preventive services eligibility date; enrollment in Medicare Advantage (MA) plans; payers primary to Medicare; home health episodes and hospice benefit periods; hospital and skilled nursing facility stays.	http://www.cgsmedicare.com/pdf/mycgs/chapter4.pdf
	FINANCIAL TOOLS Tab: Inquire about claims approved-to-pay and the last three checks issued.	http://www.cgsmedicare.com/pdf/mycgs/chapter5.pdf
	MESSAGES Tab: Read secure messages and alerts regarding system access and functions performed in the portal.	http://www.cgsmedicare.com/pdf/mycgs/chapter6.pdf
	FORMS Tab: Submit Redeterminations; eOffsets (immediate offset); Reopenings; Respond to Medical Review (MR) Additional Documentation Requests (ADRs) Also, attach supporting documentation. **NEW! Submit General Inquiries**	http://www.cgsmedicare.com/pdf/myCGS/chapter7_partb.pdf
	ADMIN Tab: Used by Provider Administrator to grant access to other users.	http://www.cgsmedicare.com/pdf/mycgs/chapter8.pdf
	F**UTURE ENHANCEMENTS:** Send correspondence (GreenMail); Make refunds (eCheck); Web Chat; single log-in (being evaluated)	Watch for e-mail notifications!
CGS Application Status Check Tool (http://www.cgsmedicare.com/medicare_dynamic/pe/login.asp)**:** J15 providers who submit provider enrollment application can check the status of the request.	Use the reference number from the acknowledgement letter along with the 5-digit ZIP code of the contact address, to check the status of the application.	http://www.cgsmedicare.com/medicare_dynamic/pe/login.asp 1.866.276.9558 and select Option 3
Modifier Finder Tool (http://www.cgsmedicare.com/medicare_dynamic/modifiers_ky/search.asp)**:** Designed to aid Medicare providers in using modifiers correctly.	Search the database by modifier, keyword or view the entire listing of modifiers, their definitions, and additional billing information.	http://www.cgsmedicare.com/medicare_dynamic/modifiers_ky/search.asp
CERT Claim Identifier Tool (http://www.cgsmedicare.com/medicare_dynamic/cid_tool/index.asp)**:** Allows you to search for the results of CERT reviews.	Use your CERT-assigned CID number or your NPI to search for review results. A password is required to access the tool.	http://www.cgsmedicare.com/medicare_dynamic/cid_tool/index.asp
Interactive Voice Response (IVR) (http://www.cgsmedicare.com/partb/cs/ivr.html)**:** Available to complete various inquiries	The IVR may be used to check claim status, patient eligibility, financial and offset information, and other general information.	http://www.cgsmedicare.com/partb/cs/partb_ivr_user_guide.pdf
	Step-by-step instructions are available to help with navigation.	http://www.cgsmedicare.com/partb/cs/ivr.html
	A tool to convert the patient's name to the corresponding numbers on your telephone key pad.	http://www.cgsmedicare.com/medicare_dynamic/J15/converter.asp
Fee Schedule Search Tool (http://www.cgsmedicare.com/partb/fees/index.html)**:** Access to various types of fee schedules.	Search the Medicare Physician Fee Schedule (MPFS), Ambulatory Surgery Center (ASC) databases, and other fee schedules including Ambulance, NOC drugs, and clinical lab.	http://www.cgsmedicare.com/partb/fees/index.html