The minutes below are a summary of the Advisory group meeting topics group discussion actions and outcomes as a result of this meeting.

MEETING DETAILS

Date: June 19, 2019

Facilitator: Curtis McFadden, Senior Provider Relations Representative

Attendees:

- Shawn Stack
- Stephanie Meinze
- Jann Gravina
- Yakiesha Stiggers
- Crystal Wilborn
- Jane Arnold
- Gloria Beazley
- Diane Burns
- Janet Creason
- Karen Downing
- Sue Fager
- Regina Jackson
- Wayne Johnson
- Laura Martucci
- Kristen McDonald
- Jean Wendland Porter
- Rena Aleshire
- Jann Gravina

CGS Staff:

- Annie Scriven
- Judy Thomas
- Cindy Baird

AGENDA ITEMS

Welcome /Purpose and Goals – Curtis McFadden

The primary function of the Advisory Group is to assist us in the creation, implementation, and review of provider education strategies and efforts. Members provide input and feedback on training topics, provider education materials, and dates and locations of provider education workshops and events. The group also identifies widespread provider education needs and assists us in developing solutions and sharing information.

Targeted Probe and Educate (TPE) Update – Cindy Baird

Any questions related to the TPE process may be submitted to: j15aprobeandeducation@cgsadmin.com. Please include your facility's name and PTAN. Any providers selected for a TPE review are strongly encouraged to provide contact information for the person(s) responsible for responding to Additional Documentation Request (ADR) letters and/or to receive education.

New Business – Curtis McFadden

Provider-Based Billing Edits Reminders

- Reason codes 34977 and 34978 are scheduled to be activated on July 1, 2019.
- We encourage you to utilize the resources below and continue to coordinate with your credentialing staff and vendors/clearinghouses to ensure the address reported on your claim is an **exact** match to the information in PECOS and that modifiers PN, PO or ER are reported appropriately.
  - CMS MLN Matters article SE19007: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE19007.pdf
  - "Provider-Based Billing" recorded webinars: https://www.cgsmedicare.com/parta/education/recorded_webinars.html
  - "Provider-Based Billing" Ask the Contractor Teleconference (ACT) Q&As: https://www.cgsmedicare.com/parta/education/educational_materials.html
  - A Direct Data Entry (DDE) inquiry screen that allows you to view your practice location addresses as entered in PECOS was implemented in April 2019.
  - The Part A Claims Practice Addresses screen in the myCGS portal was implemented on June 1, 2019.

- The third round of testing is scheduled this week. CGS will analyze data to conduct targeted education and determine if additional widespread education is needed. In addition, all Medicare Administrative Contractors (MACs) will be required to report results to CMS to determine if the edits will be activated as scheduled or postponed again.

New Medicare Card Update

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE18006.pdf

The New Medicare Card mailing is complete. We are now encouraging all providers to obtain the new Medicare Beneficiary Identifier (MBI) from all of your patients and use them for all of your Medicare transactions to ensure you are prepared for the implementation date on January 1, 2020. CMS has also instructed all MACs to begin targeted education for any states/facility types with an MBI submission percentage that is lower than the national average (currently 75%). Both OH and KY are above the national average (Part A OH: approximately 85%; Part A KY: approximately 80%). The MBI must be used starting January 1, 2020 except for limited exceptions (span claims, appeals, certain reportings).

Patient-Driven Payment Model

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE18026.pdf

As a reminder, CMS published MLN Matters article SE18026, which introduces Skilled Nursing Facility (SNF) providers to the PDPM Web page and the various resources available to prepare for implementation on October 1, 2019. Please review and share this information with your staff/members. CGS will be conducting education on this upcoming change. Registration will be available via our Calendar of Events and electronic mailing list.

A question was asked, “What is the impact for hospitals?” All details concerning the patient’s care and stay should be reported correctly in the patient’s discharge paperwork and medical records. It is vital that hospitals provide information to the SNF correctly and timely.

Documentation Requests

When medical records are requested from any medical review contractor, please ensure you submit the following: all documentation listed in the Additional Documentation Request (ADR) letter, review any coverage policies (i.e., Internet-Only Manuals (IOMs), Local/National Coverage Determinations (LCDs/ NCDs), etc.) related to the service(s) and ensure all coverage requirements are properly documented, as well as any other documentation that supports medical necessity of the service(s). It is also a good idea to review the information available on the CMS Provider Compliance Web page and the TPE results articles on the CGS website to determine common reasons and how to prevent claim denials.

Effective June 8, 2019, the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) territories have changed to align with the CMS Regional Offices. KEPRO will remain the BFCC-QIO for Kentucky; the BFCC-QIO for Ohio is Livanta, LLC: https://livantaqio.com/en.

Survey Changes

Currently, Foresee and the Medicare Satisfaction Indicator (MSI) are the surveys available for you to provide feedback related to the CGS website and services. In the near future, CMS will implement changes to these surveys, but the purpose will remain the same. Additional information will be provided as it becomes available.

DDE Recertification

https://www.cgsmedicare.com/forms/annual_dde_pptn_recert_formRE.pdf

Each year, Medicare providers are required to recertify their Fiscal Intermediary Standard System (FISS) Direct Data Entry (DDE) user access. You must verify all user IDs, sign, and date the Annual DDE PPTN Recertification Form at the bottom. Notification for DDE recertification is distributed via our electronic mailing list. Part A DDE Recertification is scheduled to begin in August.

Medicare Providers Working Together (Part B Discussion) – Patsy Schwenk

CGS plans to include this topic as a standing agenda item for each Advisory Group meeting in the future. The purpose is to allow Part A providers an opportunity to discuss issues/concerns related to Part B providers and the Part B Provider Relations Representatives will share that information with the Part B provider community. A Part A POE representative will also attend, and extend the same opportunity, during the Part B POE AG meetings. For example, Part B ambulance providers often state that PCS forms are not completed or do not include sufficient details. Members did not share any specific issues/concerns, but were encouraged to be prepared to discuss this topic at the next meeting.

Website Enhancements – Curtis McFadden

Medicare Beneficiary Identifier (MBI) and Name to Number Convertor Tool

https://www.cgsmedicare.com/medicare_dynamic/j15/ivr_mbi_converters.asp

Based on recent feedback, this tool was created to simplify the process of entering the beneficiary information required to access the IVR/CTI. Before calling, access the convertor tool, enter the MBI and/or beneficiary's name, and select "Convert". The corresponding numbers to enter on your telephone key pad will be provided for entry.

Medicare Secondary Payer (MSP) Billing & Adjustments Online Tool

https://www.cgsmedicare.com/parta/claims/msp_tool.html

During the last meeting, we discussed the changes and resources added to our MSP page. In addition, an enhancement was made to the MSP Billing & Adjustments Online Tool. An interactive working aged billing example was added to replace the long document that was previously referenced. Please review and provide feedback so we can determine if additional examples should be added in the same or a different format. MSP Billing Example: https://www.cgsmedicare.com/parta/claims/working_aged.html

Reason Code Search and Resolution Tool

https://www.cgsmedicare.com/medicare_dynamic/j15/j15a_reasoncodes.asp

As a reminder, this feature allows users to access certain reason code descriptions and steps to resolve/prevent the edit. A complete listing of every possible reason code is not available. Initially, reason codes identified in website searches, top claim submission errors, and phone inquiries were included. We will continue to monitor such data to identify reason codes to be added in the future. Members are also welcome to submit any additional suggestions.

Calendar of Events – Curtis McFadden

https://www.cgsmedicare.com/medicare_dynamic/wrkshp/pr/parta_report.asp

Curtis demonstrated the new Calendar of Events format. A list of all scheduled events is now accessible on one page. Select the + button to the left of the Event Title to view the intended audience, description, and the link to register. Events are generally added at least one to two months in advance to allow attendees the opportunity to schedule accordingly.

OPEN DISCUSSION

Incorrect discharge status code is consistently among the top Comprehensive Error Rate Testing (CERT) errors. Members were asked to discuss the following topics to assist POE with the creation of widespread education material. POE will develop and share a draft document with the group for feedback and additional suggestions.

- **Describe any processes/best practices you have in place to determine/verify the discharge status of your patients prior to submitting your claim.**

  Responses:

  - Billers call the home health agency to verify if the patient received services prior to submitting the claim.

- A vendor sends a quarterly report and the provider calls CGS to confirm.
- Discharge planners document the discharge status code; coders enter the code and follow up.

- **Describe any challenges you encounter to determine/verify the discharge status of your patients prior to submitting your claim.**

  Response: The general consensus is that the verification process is very time consuming and many providers encounter staffing concerns and/or are responsible for multiple facilities.

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