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: September 16, 2016
Facilitator: Annie Scriven, Senior Provider Relations Representative
Attendees:
- Mary Alexander
- Jane Arnold
- Charles Cataline
- Heather Clark
- Janet Creason
- Karen Giacomo
- Denise Gibson
- Jann Gravina
- Regina Jackson
- Robert Kaliszewski
- Janet Lazich
- Laura Martucci
- Julie McTeague
- Kathy Nolan
- Melody Rice
- Cindy Rose
- Dean Shipman
- Rob Sikorski
- Shawn Stack
- Katie Stevens
- Kyung-Hee Swihart
- Rita Tarvin
- Dave Walchanowicz
- Jean Wendland Porter

CGS Staff:
- Julene Mull
- LJ Smith
- Judy Thomas

AGENDA ITEMS

Welcome

Attendance/Roll Call

Purpose and Goals
The primary function of the Advisory Group is to assist the contractor in the creation, implementation, and review of provider education strategies and efforts. The Advisory Group provides input and feedback on training topics, provider education materials, and dates and locations of provider education workshops and events. The group also identifies salient provider education issues, and recommends effective means of information dissemination to all appropriate providers and their staff, including the use of the PCC to disseminate information to providers. The Advisory Group shall be used as a provider education consultant resource, and not as an approval or sanctioning authority.

Old Business

Medicare Secondary Payer (MSP) Claims in Direct Data Entry (DDE) – Annie Scriven
Effective January 1, 2016, MSP claims may be submitted, corrected and/or adjusted via DDE when the required Claim Adjustment Segment (CAS) codes from the primary payer’s remittance are reported on the claim.


We have received several inquiries about the following scenario: The primary insurance is a liability insurer that has not made payment, a claim for conditional payment from Medicare is submitted, but returned for missing CAS codes. Which codes are appropriate to report since there is no remittance from the primary insurer?

- Since CAS code reporting has been required on electronic claim submissions for several years, we suggested contacting a clearinghouse/vendor to obtain the codes reported
for this situation in the past. Mary Alexander volunteered to share this information with the group.

- Heather Clark suggested that CAS codes should not be required when remark code DA (120 days have passed since the primary payer was billed) is reported. She also mentioned a previous issue with tertiary claims that were being returned for the CAS codes and/or the primary remittance was requested. Claim examples are needed to determine if this is a claim submission or processing issue.

Office of Inspector General (OIG) Policy Statement on Self-Administered Drugs (SADs) – LJ Smith

A copy of the document was shared with the group and reviewed as requested. We clarified that it is appropriate to report SADs received at no/reduced cost with revenue code 0637 and non-covered charges since payment is not being requested from Medicare or the beneficiary, but CMS will be able to utilize the information to determine future payment rates for situations in which payment may be requested.

Melody Rice submitted a similar agenda item related to issues with reporting chemotherapy drugs provided at no/reduced cost for off-label use. Jane Arnold stated her facility has been successful in reporting these and offered to share the information with the group.

New Business

Comprehensive Error Rate Testing (CERT) Findings/Updates – Julene Mull

Our J15 Medical Review/CERT Coordinator provided the following summary of the most recent CERT documentation errors:

- The main driver of the Part A CERT error rate continues to be related to documentation errors for inpatient hospital stays that result in changes to the DRG payment. For example, if the CERT contractor determines that the documentation submitted is not sufficient to support a particular diagnosis and/or procedure code, we are instructed to adjust the claim accordingly. As a reminder, you may appeal this decision and include any additional documentation available.

- Examples of Inpatient Rehabilitation Facility (IRF) errors:
  - The IRF admission is not reasonable and necessary because the beneficiary did not receive the required amount of therapy minutes. In addition, she was not seen by the rehab physician at the required frequency, and the individualized plan of care was inadequate.
  - The billed services are not reasonable and necessary because the beneficiary should not have been expected to fully participate in the activities of an IRF due to his dementia. He was described as confused throughout his stay. In addition, there was no supervision by a rehab physician, or one with specialized training and experience in inpatient rehab.

- Missing signed physician orders and documentation of medical necessity for lab tests – Must have both and signatures must be legible. Please remember to submit signature logs and/or attestation statements. Please also reference the article we published related to late signatures: [http://www.cgsmedicare.com/articles/cope33012.html](http://www.cgsmedicare.com/articles/cope33012.html)

- As a reminder, the CERT Claim Identifier Tool is available on our website to track the outcome of claims reviewed by the CERT contractor: [http://www.cgsmedicare.com/medicare_dynamic/cid_tool/index.asp](http://www.cgsmedicare.com/medicare_dynamic/cid_tool/index.asp)

We recently experienced an issue with this tool that has been corrected, but if you encounter any problems, please contact Julene Mull at 1.615.782.4591 or J15.certerrorrate@bcbssc.com.

QIC Transition Effective September 1, 2016 – Annie Scriven

CMS recently awarded the QIC Part A West contract (which includes Kentucky and Ohio) to MAXIMUS Federal Services, Inc. (MAXIMUS). MAXIMUS will be responsible for processing
reconsideration requests received on and after September 1, 2016. The complete article, including contact information, is available at: http://www.cgsmedicare.com/parta/pubs/news/2016/08/cope360.html

DDE/PPTN User ID Annual Recertification Process – Annie Scriven

Beginning on September 21, 2016, CGS will email DDE/PPTN recertification notices to all active Part A, Part B and HHH DDE and PPTN ID recipients or contact person. Instructions for responding and contact information is available at: http://www.cgsmedicare.com/articles/cope481.html

Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) – Annie Scriven

Requested agenda item: Reporting risk management activities to CMS under the MMSEA (e.g., requirements as it pertains to risk management write-offs to Medicare beneficiaries).

CMS and the Benefits Coordination and Recovery Contractor (BCRC) are responsible for this particular scope of work. Detailed information about Section 111, including reporting requirements, training materials, contact information, etc., can be found on the Mandatory Insurer Reporting for Non-Group Health Plans (NGHPs) page on the CMS website at: https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Non-Group-Health-Plans/Overview.html

Website Enhancements – LJ Smith

myCGS

- Future enhancements:
  - Increase the document size to greater than 40 MB for any document submitted via myCGS.
  - Implement “green mail”, in which any type of correspondence that is currently mailed as paper can be accessed via myCGS.

- Education initiative:
  - Thanks to the group’s assistance in disseminating information, we were able to attain our goal of increasing overall usage of the myCGS Web portal.
  - Our next focus is to increase the submission of cost reports via myCGS.

- Feedback:
  - Some account recertification emails only include the company name. Therefore, organizations with multiple IDs assigned to the same company name are unable to determine the specific user ID that needs to be recertified, nor is the EDI Help Desk.
  - Some facilities choose not to submit credit balance and cost reports via myCGS because the login requirement (every 60 days) is more frequent than the report requirements.

Website Feedback vs. ForeSee Survey

The ForeSee survey is a CMS requirement, is used to measure our website satisfaction score and is one of several components considered in awarding Medicare contracts. Therefore, this feedback is very important. However, if you have a specific comment or suggestion related to our website and do not wish to take the time to complete the entire survey, please consider completing the Website Feedback form located in the footer of each page on the website.

Search Feature

As a reminder, when utilizing the search feature, the results default to J15 HHH. Use the search refinement tabs at the top of the page to narrow your search to a specific website category. For example, select J15 Part A to only view the list of results on the Part A site related to your search term.
We are also in the process of improving the search results received by analyzing some of the most common search terms, defining specific links for those topics and eliminating outdated information.

**Calendar of Events and Training Needs – Judy Thomas**

Reviewed the following list of upcoming events at the time of the meeting:

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
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<tbody>
<tr>
<td>September 20, 2016</td>
<td>“Advance Beneficiary Notice of Noncoverage (ABN)” Webinar</td>
</tr>
<tr>
<td>September 27, 2016</td>
<td>“Partners in Compliance” Webinar*</td>
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<tr>
<td>September 29, 2016</td>
<td>Ask-the-Contractor Teleconference (ACT)</td>
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*Note: The “Partners in Compliance” webinar was canceled due to unforeseen circumstances, but has been rescheduled for October 18, 2016 at 10 a.m. ET. The registration link is available on the Calendar of Events page at: [http://www.cgsmedicare.com/medicare_dynamic/wrkshp/pr/parta_report.asp](http://www.cgsmedicare.com/medicare_dynamic/wrkshp/pr/parta_report.asp). However, if you registered on September 27, 2016, you do not need to re-register.

- Topic Suggestions: MSP in DDE, Skilled Nursing Facility (SNF) no-pay bills, SNF ABN, Hospital-Issued Notices of Noncoverage (HINNs)
- Pre-Submitted Questions: We would like to address several recent complaints about responses to questions during our events. As a reminder, we encourage participants to submit questions related to the event topic prior to the event. This allows time for research and a better opportunity to provide thorough responses during the event. Questions may be submitted to: J15_PartA_Education@cgsadmin.com.

**OPEN DISCUSSION**

- The termination date for the DDE eligibility inquiry functions (ELGA, HIQA) is still unknown.
- A webinar related to clinical trials was requested during a previous meeting. We hope to have this coordinated with our Medical Policy area and scheduled before the end of the year.

**NEXT MEETING**

Friday, December 16, 2016 at 12:00 p.m. ET

**ADJOURN**