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: March 15, 2016

Facilitator: Patricia Schwenk, Provider Outreach and Education (POE), CGS

Attendees:

- Symphony Diagnostic Services No 1 LLC
- John M. Johnstone, MD, FACC, PSC
- St. Elizabeth Physicians
- Norton Healthcare
- Paradigm Management
- Ashland Area Health Alliance

CGS Staff:

- Medical Review
- Provider Enrollment
- Redeterminations
- Reopenings
- Provider Outreach and edcataion

AGENDA ITEMS

Opening Remarks

The Kentucky Part B POE AG membership drive was a huge success. We would like to welcome our new members and those members that have selected to remain on as a POE AG member for Kentucky Part B. We are looking forward in working together to provide education and resources to our Provider Community.

CGS Departmental Updates

Medical Review

- Activity Log
  - On the CGS website at https://www.cgsmedicare.com/partb/mr/activity_log.html
    - > The Activity log will show what the active and pending services our Medical Review area are reviewing and will be reviewing the near future
    - > Providers and their staff are encourage to review the Activity Log and do internal audits to assure they are meeting the requirements for the service they are providing
    - > The Activity Log will be update throughout the year

CERT

- Errors continue with:
  - No documentation
  - Insufficient Documentation
  - Medically Unnecessary
  - Incorrect Coding
- Please remind your members and staff the importance of responding to CERT documentation request
- During a CERT review, you may be asked to provide more information related to a claim you submitted, such as medical records or certificates of medical necessity, so that the CERT review contractor can verify that billing was proper. The CERT

Documentation Contractor sends requests for this additional information via fax and/or postal mail. There are times when the response received might be one of the following:

- Patient was not seen on this date of service
- Patient not seen in this office
- Records are at the hospital, call them

- In many cases, the patients were seen at a different facility. As a Medicare provider **it is your responsibility to obtain additional supporting documentation from a third party (hospital, nursing home, etc.), as necessary** (in accordance with 42 U.S.C. 1320C-5 (a) (3) and 1833 of the Social Security Act). Providing medical records of Medicare patients to the Comprehensive Error Rate Testing (CERT) contractor is within the scope of compliance with the Health Insurance Portability and Accountability Act (HIPAA).
- Please check the date of service and the name of the patient is listed is valid for that date of service is corresponding with the CERT documentation reqeust
- Ensure the records are complete (check front/back of records, if using paper records)
- Do not copy the patient's entire file; only send the relevant portions that are related to the request
- If CERT does not receive the documentation then CERT will have CGS setup a overpayment on the service
- We are seeing wrong date of service
- If you have any questions or concerns regarding the CERT you can contact Julene Lienard at: julene.lienard@cgsadmin.com
- Visit the following websites for CERT
  - https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/CERT-Reports.html
  - http://www.cgsmedicare.com/partb/cert/articles/055.html
- **Signature Requirements** - We are still receiving documentation that is not meeting Signature requirements
  - Make certain your documentation contains a **LEGIBLE IDENTIFIER (signature)** or valid electronic signature (initials are not acceptable) of the person performing the service.
  - For illegible handwritten signatures you may include a signature sample/log when responding to a request for records
  - Failure to submit medical records with a valid signature is one of the top reasons for claim denials and payment delays. This is also one of the most easily preventable denial reasons. All health care providers should be aware of the increased level of scrutiny regarding signatures in medical records and take steps to ensure they have procedures in place to address this critical issue.
  - CGS strongly recommends that, **before you submit a claim or any medical records that have been requested,** you ensure that the medical records for that specific service meet Medicare's guidelines for signatures (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6698.pdf). This applies for record requests from CGS, the Recovery Auditor, Comprehensive Error Rate Testing (CERT) contractor, and the Zone Program Integrity Contractor (ZPIC).

> If the records are not signed or do not meet Medicare's signature guidelines, contact the provider of service and request that he/she complete and sign an attestation (https://www.cgsmedicare.com/partb/forms/index.html#MR).

> If the claim has not been filed yet, ensure that a signature is on the documentation, if not you may file the completed attestation with the patient's medical records.

> If the claim has already been filed:

▪ Submit the signed attestation (https://www.cgsmedicare.com/partb/forms/index.html#MR) with the records.

- **Clinical Trial Reminder** when billing for services that are part of ANY clinical trial (this includes IDE, PMA, HUD, 501k claims must have the following:
  - IDE MUST have CMS approval if FDA approval was prior to January 2015
  - CGS approval is also required so that we can update systems accordingly
  - This link explains the approval process: https://www.cgsmedicare.com/partb/pubs/news/2013/1213/cope24209B.html
  - ANY clinical trial must have CGS approval
  - ALL services that are part of ANY clinical trial being billed to Medicare MUST have the IDE number AND the NCT Registry number in the 2300 Loop
  - CGS article that outlines VERY specifically how to bill these services. https://www.cgsmedicare.com/partb/pubs/news/2015/0815/cope30166.html

    > Resources

    ▪ Clinical trials https://www.cgsmedicare.com/partb/medicalpolicy/clinical_trials.html

    ▪ In addition we have J15IDE@cgsadmin.com e-mail for any questions/issues they are experiencing.
- Questions & Answers
  - **Question:** Member posed a question – how should we handle documentation that is not complete or signed by the rendering provider who unexpectedly passed away prior to the completion of their documentation?
    Answer: CERT will deny this for not having a signature.
  - **Question:** Member asked, should we still submit for payment?
    Answer: Member was asked to submit this question to our CMD Inquiry e-mail at CMD.Inquiry@cgsadmin.com
  - **Question:** Member questioned the use of the modifier 25, if we have a patient seeing an orthopedic for the first time and during that encounter should we use the 25 modifier on a New Patient code, we are being told that the 25 must accompany the new patient code?
    Answer: Providers are required to review the Correct Coding Initiative Edits list at: https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html
  - **Question:** Member would like to know why the Split/Shared Care service is not the same for hospital setting and office setting. Why does Medicare have different requirements when the service is provided in the office from in the hospital?
    Answer: Please remember that for Hospital or SNF - inpatient or outpatient hospital services and services to residents in a Part A covered stay in a SNF the unbundling provision (1862 (a)(14) provides that payment for all services are made to the

hospital or SNF by a Medicare intermediary (except for certain professional services personally performed by physicians and other allied health professionals). **Therefore, incident to services are not separately billable to the carrier or payable under the physician fee schedule when provided in a Hospital Inpatient/Outpatient (On Campus or Off Campus)/Emergency Department Setting.**

> SPLIT/SHARED E/M SERVICE

- Office/Clinic Setting: In the office/clinic setting when the physician performs the E/M service the service must be reported using the physician's UPIN/PIN. When an E/M service is a shared/split encounter between a physician and a non-physician practitioner (NP, PA, CNS or CNM), the service is considered to have been performed "incident to" if the requirements for "incident to" are met and the patient is an established patient. If "incident to" requirements are not met for the shared/split E/M service, the service must be billed under the NPP's UPIN/PIN, and payment will be made at the appropriate physician fee schedule payment.
- Hospital Inpatient/Outpatient (On Campus or Off Campus)/Emergency Department Setting: When a hospital inpatient/hospital outpatient (on campus-outpatient hospital or off campus outpatient hospital) or emergency department E/M is shared between a physician and an NPP from the same group practice and the physician provides any face-to-face portion of the E/M encounter with the patient, the service may be billed under either the physician's or the NPP's UPIN/PIN number. However, if there was no face-to-face encounter between the patient and the physician (e.g., even if the physician participated in the service by only reviewing the patient's medical record) then the service may only be billed under the NPP's UPIN/PIN. Payment will be made at the appropriate physician fee schedule rate based on the UPIN/PIN entered on the claim.
- EXAMPLES OF SHARED VISITS
  - If the NPP sees a hospital inpatient in the morning and the physician follows with a later face-to-face visit with the patient on the same day, the physician or the NPP may report the service.
  - In an office setting the NPP performs a portion of an E/M encounter and the physician completes the E/M service. If the "incident to" requirements are met, the physician reports the service. If the "incident to" requirements are not met, the service must be reported using the NPP's UPIN/PIN.
- References:
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se0441.pdf
  - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf
  - 30.6.1 - Selection of Level of Evaluation and Management Service

- **Question:** Member asked if there is a easier way to find medical necessity from our LCD's, they are speding a lot of time trying to find the appropriate LCD, is there a easier way in finding direction on what to bill and what should not be billedl?
Answer: When you are looking at the LCD, if there are specific ICD-10 you will have to review the complete LCD, this would include going to the end of the LCD to see if additional articles listed based on the procedure being performed.

> **Reminder:** If you find a LCD that is missing a ICD-10 please forward the LCD number and descriptor with the ICD-10 to be added to the CMD.Inquiry@

cgsadmin.com your request will be reveiwed and if the ICD-10 is to be added you will be notified once we have completed the LCD update.

Members were reminded that if they have clincal questions to please contact our CMD Inquiry line at: CMD.Inquiry@cgsadmin.com

Provider Enrollment

- Revalidation
  - CMS Revalidation requires all providers/suppliers to resubmit and recertify the accuracy of their enrollment information
  - DME suppliers are required to revalidate every 3 years; all other providers/suppliers every 5 years
  - All providers/suppliers must be revalidated under the new enrollment screening criteria
    - > Cycle 1 started in 2011 and finished up earlier this year.
  - Cycle 2 will start this month. CGS will start our mailings within the next couple of weeks.
    - > Cycle 2 is a more streamlined process that has several process improvements implemented based on feedback from providers as well as MACs. CMS has tried to standardize the process across all MACS.
      - One of the updates is that CMS has established revalidation due dates that are consistent for everyone. Revalidations will be due the last day of the month. Once this due date is set, it will generally remain the same for subsequent revalidation cycles.
    - > CMS has created a revalidation due date lookup tool on their website. This lookup tool allows providers to see their due dates in advance. There will be up to 6 months of dates posted and will be updated periodically. If a date has not been assigned it will show "TBD." In addition to this due date lookup, there will be a crosswalk to the reassignment information. The website is http://go.cms.gov/MedicareRevalidation.
  - CGS will continue to issue revalidation notices in addition to the posted list. We will be mailing these notices 2-3 months before the established due date. If you are within 2 months of your listed due date and have not received the notice, you are encouraged to submit your revalidation application. If we do not receive the revalidation application, deactivation may occur, just as in cycle 1.
  - Although we do encourage providers to send application by their revalidation due date, we cannot accept unsolicited revalidations. CMS defines unsolicited revalidation applications as one submitted more than 6 months in advance of the due date. If this occurs, we will return the application. If your intention was to make a change, please submit the application as "Change of information" instead of "revalidation."
  - If a PTAN is deactivated for non response to revalidation, you will be required to submit a complete enrollment application to reactivate. You will maintain the original PTAN, but the reactivation date will be based on the receipt date of the new application. This will cause a gap in reimbursement because the services will not be paid during the period of deactivation. Therefore, we are strongly urging providers to check the website - http://go.cms.gov/MedicareRevalidation – to get their revalidation due dat

> **Question:** Member asked when the Revalidation Due Date tool be available on CMS website?
> **Answer:** The CMS Revalidation Due Date tool was active effective March 1, 2016 at http://go.cms.gov/MedicareRevalidation

Redetermination

The redeterminations information is located under the CGS website at: https://www.cgsmedicare.com/partb/appeals/index.html.

Redetermination sections related to the Internet Only Manuals (IOM)- Medicare Claims Processing Manual, Chapter 29- Appeals of Claims Decisions and Medicare Claims Processing Manual Chapter 30- Financial Liability Protections

Total overview of January 2016 Redetermination request

511 which were processed as incomplete redetermination requests.

- The requirements for a valid request are:
- Redetermination request which were processed as incomplete redetermination requests. The requirements for a valid request are:
  - The beneficiary's name,
  - The Medicare health insurance claim number of the beneficiary,
  - The specific service for which the redetermination is being requested and the specific date of service,
  - The name and signature of the person filing the redetermination request
  - Stamped signatures are not acceptable
  - Not a proper party, no Appointment of Representation (AOR), or AOR is not valid,
  - No initial determination on the claim appealed; and
  - Beneficiary is deceased with no remaining party or appointed representative with financial interest.

1,599 which were affirmed

- Examples of request which were affirmed and the reason why:
  - Notes were illegible
  - Excessive MUE's
  - 2 E&M visits same day, same providers billing similar services notes not showing separate services
  - Pricing for multiple surgeries
  - Modifier 53
  - Providers in the same group billing similar services
  - Incorrect diagnosis not covered per LCD-17110-L34200
  - Billing excessive emergency room codes when notes did not show that a comprehensive history and examination or medical decision making of high complexity were performed

57 Requests which were partially affirmed:

- There were multiple cases submitted by different providers, most are related to the excessive billing of MUE.

485 Dismissed request for:

- Multiple providers- past timely filings, cases received after the 120 filing date for a redetermination.

Web portal cases: Kentucky 236 and Ohio 1839 cases

- We would like to see more providers submitting redetermination cases through the Web portal, this would save the appellant's time and postage cost, as well as other factors.

52 faxes were submitted for Redetermination

- CGS currently does not accept faxes. When submitting a redetermination request, these need to be sent via mail or via mycgs Web portal. Access to my CGS is available 24/7 and is free of charge to all CGS providers.

22 cases received that were identified as being related to ICD-10

- These cases were received as a redetermination however simple ICD-10 corrections should be sent to the **Reopening department for handling**

750 Redeterminations received which truly are reopening's and should have been submitted to the Reopening department for handling, as these were simple adjustments based on minor errors and submissions.

- Refer to the CGS website under Reopenings vs. Redeterminations Job Aid (https://www.cgsmedicare.com/partb/forms/pdf/reopen_vs_redet_jobaid.pdf).
- When submitting redetermination requests for multiple dates of service under one Internal Claim Number (ICN), submit each date of service on one redetermination form, each date of service should not be submitted on separate redetermination forms.
- It would be helpful, if the redetermination form that is listed on the CGS website (https://www.cgsmedicare.com/partb/appeals/index.html), although it's not required, the one that is listed on our website is in line with our automation and would help with the processing of the redetermination.
- MUE's- Medically Unlikely edits, some MUE values are confidential and are not published. The MUEs will automatically deny procedures containing units of service billed in excess of the MUE criteria. Providers can access the values for the MUE's at http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html

Reopening

- Negative Payment Reductions (such as PQRS, Legislative, and EHR):
  - CMS has instituted several types of Negative Payment Reductions, a few examples of these are PQRS, Legislative, and EHR. These reductions are controlled by CMS and cannot be overridden by CGS Administrators.
  - Each type of reduction has been taken for a different reason; the specifics of the reductions are available on CMS' website.
  - Once a reduction has been taken, if you disagree, you must apply to CMS for a review. Currently, CGS is receiving both Reopenings and Redetermination requests to increase the payment amounts. These Negative Payment Reductions are not eligible for adjustment or appeal. Regardless of which department a request is filed to, the Reopenings department will return a letter stating that a Negative Payment Reduction was taken and provide information to contact CMS.
  - Just as a sidenote, after January 1st, 2015, the most common reduction are EHR (Electronic Health Record) and PQRS reductions.

- Air Ambulance Rural Rate Payments
  - Previously, there was a system issue with the rural rate payments for Air Ambulance services only. Air Ambulance services did not have the correct Rural Rate payments applied. This issue has been identified and corrected.
    - > If there is a claim which did not correctly apply the rural rate, it is considered a Reopening to correct an error and re-issue the correct payment amount.
    - > Please note, Land Ambulance services were not affected, and did apply the correct Rural rate payments.
- Medicare Secondary Payer claims
  - Medicare Secondary Payer claims are considered Reopenings adjustments, except in the case where money was previously requested to be returned to Medicare. When money has previously been requested back, you must file an Appeal for a review of that recoupment. If there is an issue with an insurance that was primary, but is now secondary or does not cover the beneficiary for the dates of service, a reopening request must be filed within 6 months of the date of the recoupment. In those cases, please provide the letter of recoupment or an EOB showing a recoupement from the other insurance, with a printed date from the other insurance company. We cannot accept any date that has “faxed date” or a date that the document was printed. It must be from the other insurance company. For conditional payment situations, please be sure to file to Medicare to receive the conditional payment or denial, to prevent any issues that may later arise from late filing. Please note that CMS does clearly state that MSP Third Party Payer error is not a good reason to allow any claim billed past time time limit of one year from the original remittance date.
- Timely Filing denials
  - Timely Filing denials are ineligible for an Appeal.
  - Timely Filing denials can be handled as a Reopening, but only in situations which are considered “good cause” by CMS.
  - These include errors on the part of the Medicare contractor, or CWF, for a beneficiary when entitlement has been changed, or for a provider when they have had a legitimate update to their information through Provider Enrollment.
- Claims which are denied “Return Reject” (provider billing errors).
  - Denials should be reviewed prior to filing a Reopening. Claims with return reject denials are currently being submitted to Reopenings and Redetermination departments, and these are ineligible for an adjustment or appeal, when there is a legitimate billing or clerical error.
  - These need to be submitted as new claims to correct these errors.
  - If a claim is submitted timely to Medicare, but denies for return reject rationale (for a billing or clerical error), it is not eligible to be considered when determining timely filing for a Reopening request.
- Web Portal Submission
  - We would like to see more providers submitting Reopenings cases through Web Portal. This would save time, postage, and be an easier way to track a submission, as Web Portal generates e-mails for submitted, transferred, and completed cases.

- Questions & Answers
  - **Question:** Member asked for clarification on claims that have a penalty (payment adjustment) applied to a service, and they have a clerical error to correct can these be handled by a telephone reopening?
    Answer: No, any claim that has a payment adjustment applied, can not be handled by a telephone reopening. These types of services must written reopenings.
  - **Question:** Member asked if they have a clerical error can this be be handled by a phone reopening?
    Anwswer: if the clerical correction is the only thing wrong with the service, no payment ajustments, or additional coverage requirements, then the clerical correction can be done through the telephone reopenings.

NEW BUSINESS

POE Winter Handout Update

- We IMPACT Lives, we continue to provide this type of presentation material so that our providers and their staff are able to return to their offices with this handout to use during their daily work schedule.
  - The Winter update includes the following self-help tools so that you are able to find the information you need to ensure your services are processed correctly and timely;
    - > Compliance Corner
    - > myCGS Web portal
    - > Contacting CGS
    - > Payment Issues
    - > Urgent updates
    - > Reminders and Tip
  - Members were asked if they had anything they would like to have added to the handout
    - > Several members asked if we could add information on our LCD's and medical review process to our handout
- Questions & Answers
  - **Question:** Member asked if we were allowed to share the handout with there providers?
    Answer: Yes please share this with your providers and members
  - **Question:** Member asked for the effective date for the new DME contract, and if they will need to apply for a new PTAN number?
    Answer: Our implementation plans include working closely with NGS to make sure there are no delays in claims processing as a result of the implementation. Billing is dependent on the official contract start date rather than the date of service on the claim. Our first day of business as the new Jurisdiction B contractor will be July 5, 2016. Effective July 5, 2016, CGS will begin "day one" operations; therefore, claims – regardless of date of service – will be sent to CGS for processing.
    - > For additional information on the transition from NGS to CGS please visit the CGS DME website at: https://www.cgsmedicare.com/jb/index.html

- **Question:** What states does CGS cover for the DME contract?
  Answer: Jurisdiction B processes FFS Medicare DME claims for Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio and Wisconsin
  - > Reference:
    - CMS https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Downloads/Award-Background-DME-B-Sept-2015.pdf
    - CGS https://www.cgsmedicare.com/jb/index.html?wb48617274=52028502

Mandatory Payment Reduction of 2%

- The 2% Sequestration will remain in effect until further notice for the Medicare Fee For Service Program
- Old Business
- Suggestions for PCC training topics
  - The POE team will continue to participate in the PCC quarterly training scheduled throughout the CY 2016
    - > Member reqeusted that our PCC's get certified to address their detailed calls

Announcements and Reminders

- myCGS
  - Users that have a large number of individual providers that they work with, will need a login for each provider they have for myCGS
    - > We are working with CMS for approval to use super user ID's
  - For those who receive reqeust for additional documentation request (ADR)from our medical review, you can now submit the documentation through myCGS
  - Questions & Answers:
    - > **Question:** Member asked if there will ever be a time when myCGS will issue more than one user number
      Answer: No, each user has their own user and password. The first person that signs up is the administrator, the administrator will assign what parts of myCGS the staff will have access to. Please remember that if you can to have at least 2 aministrators for your grop or practice.

Upcoming Educational and 2015 POE Calendar of Events

- **J15 Small Provider Forum**
  - If there are any areas members would like for POE to schedule a small provider forum please submit to J15_PartB_Education@cgsadmin.com
- **Calendar of Events**
  - Review calendar on website at https://www.cgsmedicare.com/partb/education/index.html
- **Education upon request**
  - If you would like to sponsor an event for our CMD's to speak or have a Part A and B event
    - > Send request to J15_PartB_Education@cgsadmin.com

ROUNDTABLE/QUESTIONS

- **Question:** A Member asked, why when we setup a offset on their providers CGS is setting it up on the tax id and not the practice group number who rendered the service?
  Answer: All overpayments are setup under the Tax ID, when one is on record. If the provider does not have a Tax ID and only a Social Security number on file then the overpayment would be setup under the Social.
  - Reference IOM**:** https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/fin106c04.pdf
- **Question:** Member asked if we have received any information on if CGS will be taking over the Hospice for Kentucky.
  Answer: CGS has not received any notifications that Kentucky Hospice will be under the CGS Jurisdiction.
- **Question:** Member asked for clarification on when to use the AI modifier for the initial visit during a hospital setting, they been told that consults are no longer recogized by Medicare and that the initial should be billed without the AI modifier .
  Answer: Yes, it should be submitted without the AI modifier.

POE ADVISORY GROUP MEETING SCHEDULE

- June 21, 2016
- September 20, 2016
- December 6, 2016 (Joint Meeting Kentucky and Ohio Teleconfence)

ADJOURN

Meeting was adjourned at 3:05 p.m.