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: December 8, 2015

Facilitator: Juan Lumpkin, Provider Outreach and Education (POE), CGS

Attendees:

- John Blumenstock, PHI Air Medical, LLC
- Nancy Horn, Medical Compliance Services, Inc.
- Georgetta Richardson, Norton Healthcare
- Darrell Spear, Kentucky Chiropractic Society
- Darrell Spear, Highland Chiropractic
- Renee Stamp, Paradigm Management
- Stephanie Woods, Greater Louisville Medical Society
- Jenny Berkshire, Wright State Physicians
- Elayne Biddlestone, AMCNO
- Connie Brown, Reid Physician Associates
- Dave Dillahunt, KY and OH Hematology Oncology Society
- Jennifer Hayhurst, OSMA
- Debra Farley, BillPro Management Systems
- Chris Foster, Ambulance
- Jeff Fox, Riverside Radiology & Interventional Associates
- Jennifer Jones, DayStar Billing Services, LLC
- Tracey Lego, Michael Kalus, MD
- Cindy Mack Alexander, Compunet Clinical Laboratories
- Jimelle Rumberg, OHFAMA
- Regina Shorts, Metrohealth Medical Center
- Michelle Skinner, OAMTA
- Bob Swinehart, Mid-American Rehabilitation Network
- Cari Phillips, CGS
- Patricia Schwenk, CGS
- Susan Schwenk, CGS
- Vanessa Williams, CGS

AGENDA ITEMS

CGS Departmental Updates

Medical Review/CERT

- National Data for the November 2015 CERT Reporting Period:
  - Approximately 49,600 claims were sampled during the FY 2015 report period.
  - Medicare **FFS gross improper payment** estimate for **FY 2015 is 12.09 percent** or **$43.33 billion**.
  - The **FY 2015 net improper payment** estimate is **11.39 percent** or **$40.81 billion**.
  - The actual overpayments identified by the CERT program during the FY 2015 report period were **$39,710,413.13**.
  - The identified overpayments are recovered by the MACs via standard payment recovery methods. As of the report publication date, MACs reported collecting **$30,684,727.80** or **77.27 percent** of the actual overpayment dollars identified in the report.
- National Error Rates by Error Description
  - Insufficient Documentation: 68.6%
  - Medical Necessity 17.3%
  - Administrative or Process Errors Made by Other Party 14.1%, due to incorrect coding errors

- Changes in education and enforcement strategies.
  - Beginning on October 1, 2015, the Quality Improvement Organizations (QIOs) assumed responsibility to conduct initial patient status review of providers to determine the appropriateness of Part A payment for short stay inpatient hospital claims. From October 1, 2015 through December 31, 2015, short stay inpatient hospital reviews conducted by the QIOs will be based on Medicare's current payment policies.
  - Beginning on January 1, 2016, QIOs and Recovery Audit Contractors (RACs) will conduct patient status reviews in accordance with policy changes finalized in the Hospital Outpatient Prospective Payment System rule (CMS-1613-P) and effective in calendar year 2016. Effective January 1, 2016, RA's may conduct patient status reviews only for those providers that have been referred by the QIO as exhibiting persistent noncompliance with Medicare payment policies.
  - HHS expanded the use of prior authorization in the Medicare FFS program. Prior authorization reviews are being performed timely and feedback from the industry and beneficiaries has been largely positive. HHS leveraged this success by expanding the demonstration to an additional 12 states
- Improvements to the CERT Program
  - Ongoing education to inform providers and suppliers about the importance of submitting thorough and complete documentation. This education involves national training sessions, individual meetings with providers or suppliers with high improper payment rates, presentations at industry association meetings, and the dissemination of educational materials.
  - Medical record request letters are revised, as needed, to clarify the components of the medical record required for CERT review.

    > http://www.hhs.gov/afr/fy-2015-hhs-agency-financial-report.pdf

Provider Enrollment – Susan Schwenk

- Development/Requests for information:
  - When a paper application is received and additional information is needed, CGS now sends these development requests via e-mail when we have a valid e-mail address on file.
  - **Reminder** - any development requests for a complete application or an original signature must be mailed as hardcopy to our office at the address identified in the letter. These cannot be e-mailed.
  - **Reminder** - All listed contacts on the application are to provide a valid, legible e-mail address for the contact person.
- Top reasons why we develop for additional information.
  - **Copy of Voided Check** – when submitting the CMS-588 EFT; a copy of a voided check or other written confirmation of your bank account must be submitted. Starter checks are not accepted.
  - **Entire 855I** – verify whether the practitioner has an active PECOS enrollment prior to submitting an 855R reassignment application. If the individual does not have an active enrollment record, the CMS-855I must be submitted with the 855R application.

- **Entire 855R** – If an 855I is submitted and the individual is reassigning their benefits to an eligible organization / group, the CMS-855R reassignment application must be completed and sent with the 855I.
- **Adverse Legal History** – When an 855I, 855B, or 855O is submitted, please be sure to review the requirements for Adverse Legal History and complete that section of the application.
  - > Any adverse legal actions occurring within 10 years of the submission of the application must be reported.
  - > We cannot accept a statement in that section that states to see an attachment. The specific action must be listed on the application within the adverse legal action section.
  - > Even though a legal action has been resolved, such as a license suspension, the action (suspension) must still be reported and the resolution listed in the section of the application.
  - > Refer to the explanation on the application of the types of legal actions that must be reported.
- **Section 1A of the 855I** – the individual's NPI is required to be entered in Section 1 of the application. We cannot pull the NPI or make an assumption even if it's located somewhere else with the submission.
- **IRS Document** – If submitting an application for a Sole Owner, Sole Proprietor or Group/Organization; whether initially enrolling, reactivating your billing privileges or revalidating, please ensure that a pre-printed IRS document is submitted with the submission of the application.
- **Legal Business Name submitted on an 855R** – Please be sure the application shows the group's Legal Business Name as it is reported to the IRS.
- If any Medicare contractor identifies a change to a Legal Business Name and updates PECOS, that update will now roll to all enrollments under the same tax ID number.
  - > Contractors are now running reports out of PECOS that identifies any changes made to Legal Business Names and we are required to develop for an updated EFT if one has not been previously received.
  - > If you submit an application that includes Legal Business Name change, and you receive EFTs, please be sure to submit an EFT COI with the application. CMS is requiring that if a change to a Legal Business Name has been identified, contractors are to ensure that we have an EFT on file that reflects the new Legal Business Name.
  - > If we send out a development letter for the EFT COI and do not receive one, the enrollment could be deactivated until we do receive one.

- J15.Provider.Enrollment@cgsadmin.com
  - This e-mail address should only be used to submit additional information or corrections to a pending/in process application after receiving a development letter.
  - It should not be used for provider claim and coverage inquiries, please call the Provider Contact Center.
- Part D Drug Prescribers and Medicare Enrollment
  - In order to have Medicare beneficiaries prescriptions to be covered under Medicare Part D, all providers eligible to order and refer services for Medicare beneficiaries must be enrolled in Medicare in an approved status.

- CMS reissued the MLN Article SE1434 announcing the delayed enforcement of the rule until June 1, 2016. After this date, covered prescriptions will not be covered if the referring provider is not enrolled.
- As a reminder, the provider can enroll via an 855O to order and refer only, an 855I if wanting to bill for Medicare services, or via an Opt-Out affidavit which can identify a provider to also be eligible to order and refer.
- This also applies to dental professions.

New Business

CY 2016 POE AG Membership Drive

- On November 23, 2015, e-mail notifications were submitted to all POE AG members requesting if members wanted to remain a POE AG member for 2016 for KY and OH.
- If you are interested in continuing your membership please reply to the e-mail notification submitted from our J15_PartB_Education@cgsadmin.com e-mail address. We ask that you acknowledge your continuance for 2016 for our records.
- Open Membership will also be available to anyone registered on the CGS Part B E-mail notification.

2016 Physician Quality Report System (PQRS) Payment Adjustment Letter

- In 2014, if an individual eligible professional (EP) or group practice did not satisfactorily report PQRS quality measures, a 2% negative payment adjustment will apply in 2016
- Number of payment adjustment letters mailed:

For PQRS Individual and Group Practices:	For Critical Care Access Hospitals:
28,050 letters • KY 8,286 • OH 19,764	• KY CAH – 328 letters • OH CAH – 655 • WV CAH - 6 • IL CAH - 12

- CMS has extended the informal Review end date to December 16, 2015 at 11:59 p.m. EST

New and Revised Place of Service (POS) Codes for Outpatient Hospital

- Change Request (CR) 9231,updates the “Medicare Claims Processing Manual” by:
  - Revising the current Place of Service (POS) code set by adding new POS code 19 for “Off Campus-Outpatient Hospital” and revising POS code 22 from “Outpatient Hospital” to **“On Campus-Outpatient Hospital;”**
    - The official instruction, CR9231, issued regarding this change is available on the CMS website at:
      - https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3315CP.pdf
      - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9231.pdf

Announcements and Reminders

Therapy Cap Values for CY 2016

- Physical therapy and speech-language pathology combined, the 2016 therapy cap will be $1,960

- For occupational therapy, the cap for 2016 will be $1,960.

Payment Reduction for CT Diagnostic Imaging Services

- Beginning January 1, 2016, a payment reduction of 5 percent applies to the technical component (and the technical component of the global fee) for CT services furnished using equipment that is inconsistent with the CT equipment standard and for which payment is made under the physician fee schedule. This payment reduction becomes 15 percent for 2017 and succeeding years. CT services identified by the following CPT codes:

70450-70498	72125-72133	73200-73206	74150-74178	75571-75574
71250-71275	72191-72194	73700-73706	74261-74263	

  - To implement this provision, CMS will create HCPCS modifier "CT." Beginning in 2016, claims for CT scans described by above-listed CPT codes (and by successor codes) that are furnished on non-NEMA Standard XR-29-2013-compliant CT scans must include HCPCS modifier "CT," which will result in the applicable payment reduction.
  - Reference Change Request 9250 and MLN MM9250
    - > https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3402CP.pdf
    - > https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9250.pdf

2016 Amount in Controversy for Administrative Law Judge (ALJ) Hearing and Federal District Court Review

- In accordance with section 1869(b)(1)(E)(iii) of the Act, the adjusted threshold amounts are rounded to the nearest multiple of $10.
- The CY 2016 AIC threshold amount for ALJ hearings is $150.00
- The AIC threshold amount for judicial review changes to $1,501.25 based on the 50.125 percent increase over the initial threshold amount of $1,000. This amount was rounded to the nearest multiple of $10, resulting in the CY 2016 AIC threshold amount of $1,500.00 for judicial review.

MLN Publications

- **Latest Products:** http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications.html

POE Autumn Handout Update

- New articles added to the Update
  - Improper Payments identified Federal Programs
  - Recovery Auditors quarterly update
  - Post ICD-10 resources
  - LCDs missing ICD-10 codes should be forwarded to CMD.Inquiry@cgsadmin.com
  - Open Payments data for 2014 is available
  - Part B Deductible and coinsurance for 2016
  - Final Rule on 2016 Updates
  - Payment Reduction for CT Diagnostic Imaging Services

- Top 10 reasons for Denials, Return To Providers and Inquiries
- Par Process and MedPard
- Opt Out contract no longer required every 2 years.
- MLN – Web training course available for free to all providers and their staff
- POS 19 update
- Part D Prescriber Enrollment
- MolDX process and Palmetto GBA named the MolDX contractor for Jurisdiction 15

Education upon request

Send request to J15_PartB_Education@cgsadmin.com

Member Roundtable/Questions

- **Question:** Is CGS able to define off-campus for the POS 19?
  Answer: Effective for claims processed on or after January 1, 2016, contractors shall recognize the revised description for place of service (POS) code 22 from "Outpatient Hospital" to "On Campus-Outpatient Hospital" described in Pub. 100-04, chapter 26, section 10.5.
  - See Title 42 CFR 413.65(a)(2) for a definition of "campus" (http://www.ecfr.gov/cgi-bin/text-idx?rgn=div5&node=42:2.0.1.2.13&wb48617274=3834D3C7#se42.2.413_165)
- **Question:** For the payment reduction for CT Diagnostic Imaging, who will keep track to make sure providers are using the modifier?
  Answer: As of right now it is based on good faith of the provider to submit the modifier
- **Question:** On what date will the online Evaluation and Management Documentation training for physicians be available again?
  Answer: We have recently started updating our online courses. Once completed, an e-mail notification will be sent.
- **Question:** Is the Medicare Advantage Fraud Waste and Abuse training course on the CMS website current?
  Answer: Since this is a Medicare Advantage plan requirement you have to work with the advantage plan or private entity.

Invitation for Compliance Officers

If you know of anyone associated with Hospital Compliance who would like to participate in the quarterly CGS Compliance meetings please submit name and contact information to J15_PartB_Education@cgsadmin.com

POE Advisory Group Meeting Schedule: Proposed

Kentucky	Ohio
• March 15, 2016 • June 21, 2016 • September 20,2016 • December 6, 2016 (joint meeting)	• March 8, 2016 • June 14, 2016 • September 13, 2016 • December 6, 2016 (joint meeting)

Adjourn

Meeting was adjourned at 3:05 p.m.