CGS Administrators, LLC
Provider Outreach and Education
Advisory Group
March 21, 2013 Meeting Minutes

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 21, 2013

Facilitator: Melissa Kress, Provider Relations Specialist, J15 MAC

Attendees
Stephanie Woods – Greater Louisville Medical Society
Stephanie Barnett – Procura Health Solutions
Pat Padgent – Kentucky Medical Association
Sherry Thomas - PHIA
Matt Waldie – Ashland Area Health Alliance
Darrell Spear – Kentucky Chiropractic Society

Jennifer J. Brown – Provider Outreach and Education
Deanna Cruser – Provider Outreach and Education
Juan Lumpkin – Provider Outreach and Education
Patsy Schwenk – Provider Outreach and Education
Vanessa Williams – Provider Outreach and Education

Agenda Items

Topic #1: CGS Departmental Updates

- Provider Enrollment: The institutional fee for a Medicare application is $532. If the fee was paid in 2012, and the application was not processed until 2013, the 2012 payment will be adjusted and we will request the 2013 difference. This institutional fee offsets some of the costs that are required to enroll in the Medicare program (i.e., Site visits for certain providers). This fee is just for facilities and does not affect individual Medicare providers at this time.

- Revalidation Reminders - The Provider Enrollment area has noticed an increase in missing information when processing revalidations, causing the need to develop for information. Provider Outreach and Education developed a handout for members to share with their provider's credentialing staff, identifying the most common errors seen on Revalidation requests. Details are available on our website at http://www.cgsmedicare.com/kyb/enrollment/Revalidation.html

Question: Can we be proactive by completing the CMS-855 application instead of waiting to be notified by you?
Answer: Unfortunately, no, you cannot. CMS randomly selects providers and notifies us when they are required to revalidate. Therefore, providers are required to wait for our notification. This does not affect normal changes that may occur within your organizations (e.g., address changes, retirements). Requests to convert a change of information request into a Revalidation will be made on a case-by-case basis.

Question: Is there a published listing of providers who have been sent a request?
Answer: Yes, CMS maintains a listing on its website. The listing is located at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Revalidations.html

Question: Who do we contact if we are not satisfied with the process?
Answer: If you need assistance with the application, please call customer service and select the Provider Enrollment option when prompted. If you need to escalate the issue, feel free to contact someone from POE.

- Medical Review: Medical Review is currently conducting prepay reviews on the following:
  - Herceptin: Preliminary findings have shown that documentation does not support the service billed and there are no signed orders for the drug. Orders must be documented and signed in order to pay claims.
  - Initial and Subsequent Hospital Visits: Preliminary findings for initial hospital visits show some providers are billing the highest level CPT code, but are not meeting the components of the service as dictated by the CPT. Those are being down coded.
  - Nursing home visits are also being reviewed as part of this process.

  Medical Review has a dedicated section on the website. This website covers all Medical Review information, including the medical review process, articles related to MR topics, and the Progressive Corrective Action (PCA), which will have the results of recent reviews that have being conducted. http://www.cgsmedicare.com/kyb/coverage/mr/index.html

Question: What is the problem with the highest level CPT code for inpatient admissions?
Answer: The documentation submitted does not support the service based on the CPT description and E/M guidelines. Medical Review is also having a difficult time establishing medical necessity. As a result, the service is down coded.

Question: Specifically, what is CGS looking for?
Answer: If the level of service is determined based on counseling and coordination of care, the amount of time spent on those activities must be documented. If not, the three key components must be documented.

- Comprehensive Error Rate Testing (CERT): The goal for CERT is to promote correct coding of the provider community and make sure that CGS provides the educational tools needed to help providers meet criteria and avoid making errors. CGS has created an internal work group to investigate top CERT errors. As a result, CGS will post the top CERT errors and identify ways to avoid the errors. CGS plans to begin posting CERT errors by the end of March. *NOTE: CGS is still working to provide this data. We will be sure to notify you once this is finalized.*

  CERT is still focusing on the following errors:
  - Signature Requirements: Please remember to include the Signature Attestation Statement when responding to our requests for medical records if the signature is illegible or missing. http://www.cgsmedicare.com/kyb/claims/cert/Attestation_form.pdf
  - Orders: Orders must be signed and included when medical records are being reviewed. Information regarding Orders is available at http://www.cgsmedicare.com/kyb/claims/cert/Articles/025.html.
  - Medical necessity: As a reminder, medical records are designed (and expected) to record significant facts, findings, and observations about an individual's health history, including past and present illnesses, examinations, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient. All of these factors help support medical necessity.

  CGS recently posted a Dual Chamber Pacemaker Fact Sheet: http://www.cgsmedicare.com/pdf/dual_chamber_pacemakers.pdf

Question: We will be posting CERT results?
Answer: Yes, we will be identifying CERT errors and providing solutions/references so that providers can avoid making those same errors in the future. Watch your ListServ for more information. Signatures, orders and medical necessity continue to be a problem. There are a number of article currently posted to address these issues and more. Our dedicated CERT page is located at http://www.cgsmedicare.com/kyb/claims/cert/index.html.

The volume of claims reviewed is still very small – only 200 claims each month. Our goal is to make sure educational materials are created and made available to providers to help reduce the CERT error rate. The error rate is one factor used to determine our future status as a contractor.

Topic #2: New Business

- Phase II Ordering/Referring Provider Edits: CMS announced Phase II of the Ordering/Referring Provider Edits will be effective May 1, 2013. The edits verify 1) that the provider's NPI record is established in PECOS, and 2) that, by law, the referring or ordering physician/practitioner reported on the claim can legally order or refer services for Medicare patients. Today, those services are approved for payment; however, your remittance advice would have reflected a reason code indicating that the referring or ordering provider is not eligible to perform services or not enrolled in PECOS. The message codes are N264 or N265. Beginning May 1, 2013, services failing these edits will be rejected. Additional information is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1305.pdf.

Question: Is there a way to determine if a provider is established in PECOS?
Answer: CMS posts the *Ordering/Referring Provider* report on its website. It identifies providers who are in PECOS and of a specialty that can legally order/refer services for Medicare patients. There is a separate listing that identifies providers who currently have a pending CMS 855 application in process. The files are available to view at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/MedicareOrderingandReferring.html.

- Sequestration and Impact on Providers: Effective April 1, 2013, all Medicare payments will face a 2% reduction. This reduction will be applied AFTER determining co-insurance and deductible and will apply to the final payment. Providers must absorb this reduction; it cannot be passed to the patient. There will be no change in the fee schedule. CMS distributed an FAQ article to communicate this information. They are posted on our website at http://www.cgsmedicare.com/kyb/pubs/news/2013/0313/cope21676.html.

One member shared information she received. Medicare Advantage (MA) plans may also be affected by the payment reduction. The KMA is planning to research this issue.

Question: Are incentive payments affected by sequestration?
Answer: Yes – they will be. At this point, CMS has not communicated how sequestration will affect incentive programs. Please watch our ListServ. Information will be shared as soon as we hear more.

Topic #3 – Old Business

There were no topics to discuss.

Topic #4 – Announcements and Reminders

- PQRS for 2013: 2013 is a critical year for PQRS. If you are not successful with reporting PQRS (even just one measure), providers will be subject to 1.5% reduction in payment of Medicare physician fee schedule services in 2015. Information is on the CMS website at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html?redirect=/pqrs

- eRx for 2013: There are providers who are currently receiving reductions for eRx because they either did not report the G-code during the allotted six-month reporting period, were not successful reporters in CY 2011 or did not qualify for hardship exemptions. In order to avoid a 2% reduction in 2014, providers are reminded to send 10 G-codes before June 30, 2013. Providers, who were successful in 2012, will be automatically exempted. Find other ways to avoid the 2014 eRx adjustment at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive/Downloads/2013SE13_eRx2014PaymentAdjustment_020113.pdf.

CMS is sponsoring teleconferences and webinars on these topics. Please try to attend when possible.

Question: Does CGS have statistics on the percentage of participation among Kentucky providers?
Answer: Unfortunately, that data has not been shared.

Question: Will the QualityNet Help Desk provide details on all 150 providers I manage?
Answer: We suggest contacting the QualityNet Help Desk directly to ask. They can be reached at (866) 288-8912 or by email at Qnetsupport@sdps.org.

- A notice from the Office of Civil Rights was recently released regarding HITECH and privacy breaches. The KMA is putting together information on this topic to share with its members.

Topic #5 – Upcoming Educational Events

- The Calendar of Events was reviewed.
  - J15 Part B Ask-The-Contractor Teleconference Schedule
  - J15 Part B Webinar Schedule
    - New Provider Webinars-
      - March 27, 2013: Remittance Advice (interpret, read, breakdowns)
      - April 24, 2013: Medicare Resources
      - May 29, 2013: Claim Denials and Resolutions
  - J15 Part B Upcoming Small Provider Events
    We are currently planning Small Provider Events around the state. The presentation is currently being updated, and we are starting to reserve locations.

- If you need a speaker for one of your educational events, please fill out a Training Request for Provider Outreach and Education.
  http://www.cgsmedicare.com/kyb/education/TrainingRequest.html
- Watch ListServ for more information about upcoming events.

Topic #6 – POE Advisory Group Meeting Schedule

June 20, 2013 – Louisville
September 19, 2013 – Louisville
December 5, 2013 - Teleconference

Topic #7 – Roundtable / Questions

Question: Can commercial plans pay lesser than the Medicare allowed amount?
Answer: PENDING

Question: Can providers bill less than the approve amount?
Answer: Yes. We will pay the lesser amount.

Question: Can you charge self-pay patients less than other patients?
Answer: PENDING

Question: Is there information posted regarding the Place of Service changes effective April 1, 2013?
Answer: Details of the changes are in an article posted on our website at http://www.cgsmedicare.com/kyb/pubs/news/2013/0313/cope21596.html.

Question: Do you think providers will be prepared for Phase 2 of the ordering/referring edits? Answer: We will send a reminder to providers. *NOTE: An email was sent to our partners on April 2, 2013, which included an article posted on our website at http://www.cgsmedicare.com/kyb/pubs/news/2013/0313/cope21830.html*.

Question: Are there profiles set up for physicians for implementing value based? Answer: For groups with 100+ eligible professionals (EPs), calendar year 2013 is the performance period for the Value Modifier that will be applied to physician payments under the Medicare Physician Fee Schedule starting January 1, 2015. All other EPs will be affected in 2017.

Question: Will the webinar on claim denials be a part of the new provider series? Answer: Yes. This is just one topic in the series. Watch out ListServ for additional topics.

Topic #8 - Adjourn

The meeting was adjourned.