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 13, 2017

Facilitator: Vanessa Williams, Provider Outreach and Education (POE), CGS

Attendees:

Kelly Martinelli – Healthcare Compliance Assoc.
Debra Farley – BillPro Management
Jennifer Jones – DayStar Billing
Jennifer Hayhurst – Ohio State Medical Assoc.
Connie Brown – Reid Physician Associates
Todd Baker - Ohio Ophthalmological Society
Jenny Berkshire - Wright State Physicians
Mick Polo – NCDS Medical Billing
Chris Foster – Ohio Ambulance
Jimelle Rumberg – Ohio Foot and Ankle Medical Association
Regina Shorts – MetroHealth
Frances Voll – Advanced Billing Concepts Inc.
Jennifer Kelly - OSU Physicians
Robert LaFollette - OSU Havener Eye Institute

CGS Staff
Juan Lumpkin – POE
Patsy Schwenk - POE
Karen Hughes – Provider Enrollment
Julene Mull – Medical Review

AGENDA ITEMS

Opening Remarks

Vanessa welcomed everyone to the meeting.

CGS Departmental Updates

CERT Update - Julene Mull, CGS CERT Coordinator

Julene provided an update on the following CERT related topics:

Complying with Documentation Requirements for Lab Services

- The majority of improper payments for lab services identified by CERT Program
    - Documentation to support intent to order, such as a signed progress note, signed office visit note, or signed physician order
    - Documentation to support the medical necessity of ordered services
- Documentation Requirements
    - TREATING physician MUST order all diagnostic X-ray tests, diagnostic lab tests and other diagnostic tests
        - Tests not ordered by the treating physician are not reasonable and necessary
    - Progress/Office notes should clearly indicate all tests to be performed
        - Run labs or check blood by itself does not support intent to order
    - Clearly document the medical necessity for ordering the service
    - Submit the following in response to request for medical records
        - SIGNED treating providers Progress/office notes
        - SIGNED treating providers order/intent to order

- Lab results
- Attestation/signature log for illegible signatures

- Signature Requirements for Lab Services
  - Unsigned orders or requisitions alone do not support physicians intent to order
  - Physicians should SIGN all orders for diagnostic services
  - Attestation or signature logs should be used for physician notes that are not signed or illegibly signed
  - Attestation statements are NOT acceptable for unsigned orders/requisitions
- Ordering/Referring Services
  - If you bill lab services – YOU MUST obtain the following:
    - Treating physician's signed order/intent to order
    - Documentation to support medical necessity
    - These records may not be housed in your office/facility HOWEVER it is your responsibility as the billing provider to obtain copies to submit with your documentation
- Reference:
    - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ProviderComplianceLabServices-Fact-Sheet-N909221.pdf

SIGNATURES Overall:

- Requirements for Valid signatures:
  - Services that are provided or ordered must be authenticated by the ordering practitioner
  - Signatures are handwritten, electronic, or stamped (stamped signatures are only permitted in the case of an author with a physical disability who can provide proof to a CMS contractor of inability to sign due to a disability)
  - Signatures are legible
- Missing Signature
  - You may not add late signatures to medical records (beyond the short delay that occurs during the transcription process).
  - Medicare does not accept retroactive orders.
  - If the practitioner's signature is missing from the medical record, submit an attestation statement from the author of the medical record.
  - If an order for tests is unsigned, you may submit progress notes showing intent to order the tests.
  - The progress notes must specify what tests you ordered. A note stating "Ordering Lab" is not sufficient.
  - If the orders and the progress notes are unsigned, your facility or practice will be assessed an error, which may involve recoupment of an overpayment.
- Illegible Signatures
  - You may submit a signature log or attestation statement to support the identity of

the illegible signature.

- A signature log is a typed listing of the provider(s) identifying their name with a corresponding handwritten signature.
- This may be an individual log or a group log. A signature log may be used to establish signature identity as needed throughout the medical record documentation.
- If the original record contains a printed signature below the illegible signature, this may be accepted.
- Reference:
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Signature_Requirements_Fact_Sheet_ICN905364.pdf
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Signature_Requirements_Fact_Sheet_ICN905364.pdf

Julene also reminded the members of two email addresses created specifically for provider inquiries:

- CMD.Inquiry@cgsadmin.com – This email address is used to ask questions regarding our local coverage determinations (LCDs), documentation requirements and medical records. Please send inquiries to this email address instead of the medical directors directly, as they often travel and cannot respond timely.
- J15IDE@cgsadmin.com – This email address is used to submit information to CGS regarding approved clinical trials. Additional information on this is available at http://cgsmedicare.com/partb/pubs/news/2013/1213/cope24209B.html.
- IDE submission tips are available at http://cgsmedicare.com/partb/pubs/news/2017/02/cope2020.html.

Contact information for Julene and the CERT contractor are available at http://cgsmedicare.com/partb/cert/contact.html.

Provider Contact Center (PCC) – Vanessa Williams

Vanessa provided an update on the upcoming IVR changes that will allow providers to initiate their own adjustments for the following clerical Reopenings by dialing into the IVR:

- Modifiers (Add, Change, Delete)
- Date of Service but not Year (Add, Change, Delete)
- Diagnosis Codes (Add, Change, Delete)

Once testing is complete an Email notification will be released with instructions on how to complete adjustments through the IVR.

Provider Enrollment – Karen Huges

Members were reminded to check the CMS Provider Enrollment Cycle II database at http://go.cms.gov/MedicareRevalidation for the provider/suppliers due for revalidation;

- If the provider/supplier has a due date listed, CMS encourages you to submit your revalidation within six months of your due date or when you receive notification from your

MAC to revalidate. When either of these occur:

- Submit a revalidation application through Internet-based PECOS located at https://pecos.cms.hhs.gov/pecos/login.do, the fastest and most efficient way to submit your revalidation information. Electronically sign the revalidation application and upload your supporting documentation or sign the paper certification statement and mail it along with your supporting documentation to your MAC; or
- Complete the appropriate CMS-855 application available at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html;
- Reminder; If applicable, pay your fee by going to https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do; and
- Respond to all development requests from your MAC timely to avoid a hold on your Medicare payments and possible deactivation of your Medicare billing privileges.

New Business

Partnering with CGS- Vanessa Williams

POE will be working to increase partnerships throughout Ohio; this will give CGS the opportunity to address a wide range of Medicare education for Ohio. Please continue to invite POE to your events to.

myCGS Update- Vanessa Williams

Self-Service Functions– As we continue to work to enhance the functions available to you through myCGS. CGS will be hosting a webinar on Thursday, June 15, 2017 at 10:00 am ET, for Medicare Part B myCGS users.

- During this webinar you will be provided step by step myCGS instructions on how to submit myCGS Reopenings for;
- Adding/Removing Modifier
- Claim Cancellation
- Changing the Date of Service
- Changing the amount billed for a detail line item
- Register for this webinar at: https://attendee.gotowebinar.com/register/574756892118517251

Multi-Factor Authorization (MFA) Update

- Reminder on the Multi-Factor Authorization (MFA) requirement - MFA is an extra layer of security that will help ensure myCGS accounts and patient's Medicare information is protected. Each time providers access myCGS, they will receive an eight-digit verification code via the option selected (text or email). Once the verification code is entered, providers will gain access to the myCGS website portal.
  - Important Timelines – myCGS users may sign up for MFA for each active user ID.
- May 1, 2017 to June 30, 2017: myCGS Users will be required to sign up for MFA at enrollment, password reset and account update.
- July 1, 2017: myCGS users NOT signed up for MFA will automatically be set to MFA with the email address associated with the user ID.
- Green Mail Update

myCGS Administrators and Users: Opt In to Green Mail

Recently myCGS users were notified of the expansion of our Green Mail process that allows myCGS users IMMEDIATE access to correspondence sent from CGS.

This includes:

- Additional Documentation Request (ADR) for medical records and other documentation (pre- and post-pay)
- Requests for information to complete processing of pending claims
- Unfavorable and partially-favorable decisions on Redeterminations
- Reopening Correction Letter
- Claim dismissal letters
- Letters identifying changes to beneficiary records
- And MANY more!

Notification is delivered to the myCGS "Messages" tab of the Users and Administrators registered under a specific PTAN/NPI combination. To ensure you receive the notification, Users and Administrators will also be sent an email to the registered email address informing them notification has been delivered to the myCGS inbox. In order to continue the Green Mail process, myCGS administrators will need to show "OPT IN" in will need to follow the instructions below after logging into myCGS: https://cgsmedicare.com/articles/cope2974.html

Spring 2017 Medicare Update- Juan Lumpkin

Highlighted changes from the Spring 2017 quarterly update included the following topics:

New Reopenings Forms

- Part B Reopenings Modifier Adjustment Request Form
- Part B Reopenings Billed Amount/Procedure Code/Combined Adjustment Request Form
- Part B Reopenings Date of Service Adjustment Request Form

Data Collection to Accurately Value Global Packages

- CMS finalized a data collection strategy to gather information needed to value global surgical services.
- Beginning July 1, 2017, practitioners in Florida, Kentucky, Louisiana, Nevada, New Jersey, North Dakota, Ohio, Oregon and Rhode Island will be required to report claims showing that a visit occurred during the post-operative period for select global services.
- Practitioners who only practice in settings of fewer than 10 practitioners are not required to report, but are encouraged to do so voluntarily.
- Will apply only to specified high-volume/high-cost services. Such visits will be reported using CPT code 99024.
- In addition, a survey of practitioners will be conducted to gather data on services furnished in the post-operative period. For additional information and listing of the required codes please visit the CMS website at https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched/global-surgery-data-collection-.html

Quality Payment Program (QPP)

- The Quality Payment Program improves Medicare by helping you focus on care quality

and the one thing that matters most — making patients healthier. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate formula, which threatened clinicians participating in Medicare with potential payment cliffs for 13 years.

- If you participate in Medicare Part B, you are part of the dedicated team of clinicians who serve more than 55 million of the country's most vulnerable Americans, and the Quality Payment Program will provide new tools and resources to help you give your patients the best possible care. You can choose how you want to participate based on your practice size, specialty, location, or patient population.
- The Quality Payment Program has two tracks you can choose:
    - Advanced Alternative Payment Models (APMs) or
    - The Merit-based Incentive Payment System (MIPS)
- If you decide to participate in an Advanced APM, through Medicare Part B you may earn an incentive payment for participating in an innovative payment model.
- If you decide to participate in MIPS, you will earn a performance-based payment adjustment.

Recovery Audit (RA) Program

- The Recovery Audit program was created to detect and correct past improper overpayments and underpayments made to providers
    - New RAs announced October 2016
    - Performant Recovery, Inc., is new Region 1 RA Contractor
    - View Provider Portal https://www.performantrac.com/ContentPages.aspx?Page=ProviderPortal for
    - Approved Issues
    - Sample documents
    - Check status of reviews
    - To contact Performant with questions
- FY 2016 CERT Improper Payment Rates
    - Top Service Types with Highest Improper Payments (Part B)
    - Lab Tests – $1.298B
    - Established Office Visits – $1.294B
    - Subsequent Hospital Visits - $990M
    - Initial Hospital Visits – $869M
- Improper Payment Rates by Provider Type and Type of Error
    - Chiropractic – 46.0%
    - Clinical Lab – 31.6%
    - Clinical Psychologist – 30.3%
    - Physical Therapists in PP – 25.5%
    - Occupational Therapists – 25.5%

CERT A/B MAC Outreach & Education Task Force

- Designed to assist in reducing the CERT error rate through consistent, accurate provider outreach and education.
- Refer to the CMS Web site at https://www.cms.gov/Medicare/Medicare-Contracting/FFSProvCustSvcGen/CERT-A-B-MAC-Outreach-Education-Task-Force-.html for upcoming education resources.
- NEW RESOURCE - Complying with Documentation Requirements for Laboratory Services at
    - o https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ProviderComplianceLabServices-Fact-Sheet-ICN909221.pdf

Self Service Technology

- CGS Application Status Check Tool https://www.cgsmedicare.com/medicare_dynamic/pe/login.asp
    - o Check the status of Medicare provider enrollment applications online
    - o CGS acknowledgement letter (sent within 15 days) includes a reference number for tracking
- CERT Claim Identifier (CID) Tool https://cgsmedicare.com/articles/cope25239.html?wb48617274=6FBE3BF5
    - o Allows you to search for details of a CERT review, including comments
- Fee Schedule Search Tool https://www.cgsmedicare.com/partb/fees/index.html?wb48617274=13771417
    - o Allows access to various types of fee schedules
- 277CA Edit Look-up Tool https://www.cgsmedicare.com/articles/cope31721.html?wb48617274=13771417
    - o Easy-to-read descriptions of error codes received on the 5010 277CA report
- Provider Enrollment Interactive Help Tool https://www.cgsmedicare.com/partb/pubs/news/2017/02/cope2244.html
    - o Helps you determine the CORRECT application and documentation to complete

Medicare Social Security Number Removal (SSNRI) - Patsy Schwenk

- The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires us to remove Social Security Numbers (SSNs) from all Medicare cards.
- The SSNRI is being implemented to better protect private health care and financial information. By April 2018, people with Medicare will receive Medicare cards with a new Medicare Beneficiary Identifier (MBI) replacing the social security number / Health Insurance Claim (HIC) number
    - o 11-characters
    - o Consisting of numbers and upper-case letters
- During established transition period both the HIC or new MBI will be accepted
    - o Transition period will be April 1, 2018 – December 31, 2019
- Check the CMS provider resources page for updates
    - o https://www.cms.gov/Medicare/SSNRI/Providers/Providers.html

Old Business – Vanessa

- Reminder Medicare Consultation Guidelines - Effective January 1, 2010, the consultation codes are no longer recognized for Medicare Part B payment. Physicians shall code patient evaluation and management visits with E/M codes that represent where the visit occurs and that identify the complexity of the visit performed. The principal physician of record is identified in Medicare as the physician who oversees the patient's care from other physicians who may be furnishing specialty care. The principal physician of record shall append modifier "-AI" (Principal Physician of Record), in addition to the E/M code.
    - Reference 100-04 Chapter 12 section 30.6.10 - Consultation Services https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf

Announcements and Reminders

PCC training topics

- No topics were shared. Members are welcome to email ideas anytime throughout the upcoming year.

Upcoming Educational Events

- Review the Calendar of Events on our Web site at http://cgsmedicare.com/medicare_dynamic/wrkshp/pr/partb_report.asp.
- Education upon request: Email requests to J15_PartB_Education@cgsadmin.com

POE Advisory Group Meeting Schedule

- September 12, 2017
- December 12, 2017 (teleconference only)

Roundtable/ Questions

- Two members asked if we could provide education on Local Coverage Determinations, Skilled nursing facility billing for nurse practitioner and physicians and risk adjustment/ HCC
- Member asked if the global data collection applied to providers in bordering states who did the surgery in a state not required to participate but rendered a post-op visit in a state that is.
- CMS has a Q&A that addresses this question - If a surgical procedure is furnished in a state that is not included in the sample, but the post-operative visits are furnished in a state that is included in the sample, or vice versa, is reporting required?
    - Answer: Reporting is required by eligible practitioners in the nine states who furnish services that are part of the global periods, regardless of whether or not all of the post-operative visits are furnished in one of the nine states.
    - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Global-Surgery-FAQs.pdf.

Adjourn

- Meeting was adjourned at 2:23 pm