CGS Administrators, LLC
Provider Outreach and Education
Advisory Group
March 19, 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 19, 2013

Facilitator: Juan Lumpkin, Provider Relations Specialist, J15 MAC

Attendees

Jeff Fox - Ohio Radiology Business Managers Association
Cindy Wolfe – Ohio State Medical Association
Dave Dillahunt - Ohio Hematology Society
Bob Swinehart – Ohio Physical Therapy Network
Laura Dornsife – Ohio State University Medical Center
Michael Ranney – Ohio Psychological Association
Jon Wills – Ohio Osteopathic Association
Cindy Alexander – CompuNet Clinical Laboratories
Luci Ridolfo - Ohio Podiatic Medical Association
Randy Leffler – Ohio Association of Ambulatory Surgical Centers
Sally Streiber – University Hospitals of Cleveland
Luann Nitz- Midwest Community Health Associates
Elayne Biddlestone- Academy of Medicine of Cleveland and Northern Ohio
Gail Pfeiffer - Cleveland Clinic
Todd Baker- Ohio Ophthalmological Society
Jenny Berkshire – Wright State Physicians

Jennifer J. Brown – Provider Outreach and Education
Deanna Cruser – Provider Outreach and Education
Melissa Kress – Provider Outreach and Education
Julene Mull – Medical Review/CERT
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/ohb/enrollment/Revalidation.html

Question: Will a provider receive an acknowledgement letter after submitting a Medicare enrollment application?
Answer: Yes, you will receive a letter verifying receipt of the application. This will also include a reference number to use in case of questions on the application.

Question: How long does it take to receive the acknowledgement letter?
Answer: 5-10 days from the date of receipt by CGS, either electronically or through paper applications. The letter will be mailed to the contact address as stated on the application.

Question: If additional information is requested from Provider Enrollment, does the provider receive another acknowledgement letter indicating the information was received?
Answer: There will not be an additional letter sent. However, the reference number on the original letter will still be used to track the application's progress.

Question: When submitting a revalidation request and no information is being changed, added or deleted, which is the appropriate box to check?
Answer: If there are no changes on the application, these boxes are not required.

Question: Our provider is receiving multiple acknowledgement letters for multiple applications for the same group. How do we know which provider the reference number is assigned?
Answer: The acknowledgement letter will contain the specific provider's name in addition to a reference number.

Question: What's the average time for a new provider to get the application approved and obtain his Provider Transaction Access Number (PTAN)?
Answer: It will be 45-90 days, depending if the application is correct. Provider Enrollment recommends using online PECOS to ensure the complete information is submitted the first time. Electronic applications are averaging 95% within a 45-day time frame... Paper submissions are averaging 80% within a 60-day time frame.

- 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/ohb/coverage/mr/index.html

- 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/ohb/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/ohb/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: Can we divide CERT errors by specialty?
Answer: We are able to. The plan is to report errors- by specific codes and specialties.

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: Can a provider who opts out of Medicare refer services?
Answer: Yes, even if a provider has opted out of Medicare he/she can refer services. However, the provider will still have to be enrolled through PECOS. There is a specific Medicare Application, the CMS-855O, which is solely for the purposes of enrolling in Medicare to order/refer services for Medicare patients. That form is located at: http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/cms855o.pdf.

- 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 to communicate this information (http://www.cgsmedicare.com/ohb/pubs/news/2013/0313/cope21676.html).

Question: What about providers who are receiving a Meaningful Use incentive?
Answer: CMS has not instructed contractors how to apply the reduction to incentive payments. When those details are released, we will get the information out to our provider community.

Question: How will we know the reduction has processed?
Answer: Claim adjustment reason code 223 will be used on the remittance advice.

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.

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.
  - Ohio State Medical Association Summer Series begins in June

- 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 ListServs for more information about upcoming events.

Topic #6 – POE Advisory Group Meeting Schedule

June 18, 2013- Columbus
September 17, 2013- Columbus
December 3, 2013 - Teleconference

Topic #7 – Roundtable / Questions

Question: When a claim is processed, does the system use the specialty or taxonomy code?
Answer: We use the specialty code. Taxonomy codes are not required. If a provider opts to report taxonomy codes, however, the code must be correct or may result in processing issues.

Question: We are radiologists. Effective April 1, 2013, the place of service should be the same setting as the physicians. Will the information in block 32 (the address of where the actual service was completed) need to reflect the physician's setting?
Answer: No. The physical address would still need to match the actual physical location of the radiologist reading the service. The zip code determines the appropriate contractor the service is to be submitted.

Topic #8 - Adjourn

The meeting was adjourned.