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 8, 2016

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

Attendees:

- Firelands Regional Medical Ctr.
- Ohio Ophthalmological Society
- Wright State Physicians
- Academy of Medicine Cleveland and Northeast Ohio
- Reid Physician Associates
- Ohio State Medical Association
- Cleveland Clinic Senior Director, Coding and Compliance
- Ohio Hematology Oncology Society
- Quest Diagnostics
- BILLPro Management Systems
- Ohio Ambulance
- Renal Physicians Inc
- Ohio State Medical Association
- Carolyn Hedman, Midwest Physician Anethesia Services
- The Christ Hospital Medical Associates
- DayStar Billing Services, LLC
- OSU Physicians
- Compass Community Health
- CompuNet Clinical Laboratories
- Healthcare Compliance Association
- Kettering Physician Network
- Kettering Health Network/Community Connect
- Maxx Medical Inc.
- NCDS Medical Billing
- Ohio Foot and Ankle Medical Association
- Kettering Health Network
- Toledo Clinic
- Metrohelath Medical Center
- Ohio Ambulance Medical Transport Association
- Mid Americal Rehabilitation Network
- Advanced Billing Concepts Inc

CGS Staff

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

AGENDA ITEMS

Opening Remarks

The Ohio Part B POE AG membership drive was a huge success. Provider Outreach and Education Advisory group membership has increased to 41 members. We welcome our new members and those members that have selected to remain on as a POE AG member for Ohio Part B. We are looking forward in working together to provide education and resources to our *Provider Community.*

CGS Departmental Updates

Medical Review

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: http://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. http://www.cgsmedicare.com/partb/pubs/news/2015/0815/cope30166.html
  - Resources
    - > Clinical trials http://www.cgsmedicare.com/partb/medicalpolicy/clinical_trials.html
    - > In addition we have J15IDE@cgsadmin.com email for any questions/issues they are experiencing.

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 (http://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 (http://www.cgsmedicare.com/partb/forms/index.html#MR) with the records.

CERT

- 2015 Improper Payments Report
  - CGS has an error rate of 13.7% for Ohio and 15.9% for Kentucky.
  - Errors continue with:
    - > No documentation
    - > Insufficient Documentation
    - > Medically Unnecessary
    - > Incorrect Coding

- 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

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.
    - > **Question:** Will the revalidation letters be mailed in a specific color envelope as was Cycle 1 revalidation reqeust?
    - > **Answer:** Yes, CGS will continue to mail the revalidation request in a Yellow envelope
  - 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 date.

Redetermination

The redeterminations information is located under the cgswebsite at: http://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 (http://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 (http://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.

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
      - **Question:** A member asked if the Winter handout was available through a link to a PDF, they would like to send this out to their members, however the file size is to large to send out through their electonic list?
      - **Answer:** Our POE Update is not available by a link to a PDF at this time. We are looking to have this available in the future

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
    - > No training topics were offered

ANNOUNCEMENTS AND REMINDERS

MACRA/MIPS – HSAG QIN

- **For Ohio updates contact:** Kim Harris-Salamone, PhD, Vice President
  1.602.801.6960
  ksalamone@hsag.com

myCGS

- Eligibility for Medicare Advantage Plans
- The eligibility information, including the MA Plan section, is pulled from HETS. It is important to note, if the myCGS user is doing a date range in the Eligibility main screen, the date range may be outside of the MA Plan coverage dates. If that is the case it will not pull MA Plan information, because the date range (eligibility query) only shows what is effective at that time.

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 http://www.cgsmedicare.com/partb/education/index.html

Education upon request

Send request to J15_PartB_Education@cgsadmin.com

ROUNDTABLE/QUESTIONS

- A Member asked how should they request a recondsideration to a Local Coverage Determination (LCD)
  - If the request is to consider adding a ICD-10 diagnosis that may have been left off one of the current LCD's, CGS request that you submitt your request to the CGS Inquiry department at www.cgsinquiry@cgsadmin.com
    - > Please remember to list the LCD Title and Number with the ICD-10 diagnosis with the request
- If the request is to have a revision to the current LCD CMS requires that you follow the contractors LCD Reconsideration Process at:
  - http://www.cgsmedicare.com/partb/medicalpolicy/reconsiderationprocess.html
- A member asked if LCD's with the ICD-9 Diagnosis code were still accessible through the CGS website, there are still some dates of service that may need to be submitted prior to the October 1, 2015 cut off date for ICD-9 diagnosis
  - CGS recently made this available at http://www.cgsmedicare.com/articles/cope32324.html
  - A member announced to the POE AG that Medicaid recently mailed out a notification identifying the requirements for specific State of Ohio licensed medical professionals, to submit a CMS-855 application to CGS Provider Enrollment in order to continue submit services to Medicaid, the letter identified some non-phyisican specialities that Medicare does not recognize as a eligible Medicare provider
    - > A copy of the letter was forwarded to the CGS Provider Enrollmennt department, provideer enrollment is aware of the Medicaid mass mailing and recently met with the State of Ohio Medicaid enrollment department to address CMS enrollment regulations and processing guidelines for eligible and non eligible license professionals. Medicaid has made the recommended changes and mailed out a revised notification to their providers.
- Several members provided their assocation upcoming calendar of events:
  - Ohio State Chiropractic Assocation - Understanding the Implications of New Medicare Rules (http://www.oscachiro.org)
  - Ohio State Medical Association – 2016 Annual Education Symposium (https://www.osma.org)
  - The Academy of Medicine of Cleveland & Northern Ohio – Third Party Payer Seminar (http://amcno.org)

  - The Ohio Foot and Ankle Medical Association – Ohio Annual Foot and Ankle Scientific Seminar (http://ohfama.org/aws/OHFAMA/pt/sp/home_page)
  - Ohio Osteopathic Association Annual Meeting – Ohio Osteopathic Symposium (http://ooanet.org/aws/OOSA/pt/sp/home_page)
- Members were reminded that if they had individual issues or questions related to claims processing or individual coverage concerns, that they can request a meeting with the Outreach staff at:
  - J15_PartB_Education@cgsadmin.com

POE ADVISORY GROUP MEETING SCHEDULE

- June 14, 2016
- September 13, 2016
- December 6, 2016

ADJOURN

Meeting was adjourned at 3:15 p.m.