PRISM

Provider Resources, Information, & Self-Service Manual

Opioid Treatment Program Providers Welcome to CGS!

CGS Administrators, LLC

CGS®
A CELERIAN GROUP COMPANY

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Disclaimer

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This publication is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings. Medicare policy changes frequently, and links to the source documents have been provided within the document for your reference.

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Objectives

- Provider overview of Medicare program
- Introduce CGS Administrators, LLC
- Identify coverage criteria for OTP services
- Explain the claim submission process
- Discuss the payment process
- Introduce the appeal process
- Identify the inquiry process
- Provide tips on using the various CGS web tools

Acronyms in this Presentation

ASCA – Administrative Simplification Compliance Act	**MBI** – Medicare Beneficiary Identifier
ASP – Average Sales Price	**MSN** – Medicare Summary Notice
CARC – Claim Adjustment Reason Codes	**NPI** – National Provider Identifier
CMS – Centers for Medicare & Medicaid Services	**NSV** – Network Service Vendor
CY – Calendar Year	**OTP** – Opioid Treatment Program
EDI – Electronic Data Interchange	**OUD** – Opioid Use Disorder
FDA – Food and Drug Administration	**PECOS** – Provider Enrollment Chain and Ownership System
FFS – Fee-For-Service	**PFS** – Physician Fee Schedule
FTE – Full-time Equivalent	**PTAN** – Provider Transaction Access Number
IVR – Interactive Voice Response	**RA** – Remittance Advice
MA – Medicare Advantage	RARC – Remittance Advice Remark Codes
MAC – Medicare Administrative Contractor	**RVU** – Relative Value Unit
MAT – Medication-Assisted Treatment	**SAMHSA** – Substance Abuse and Mental Health Services Admin

Medicare Basics

Four Parts of the Medicare Program

- Part A: Hospital coverage
- Part B: Medical coverage

Traditional Medicare

- Part C: Medicare Advantage Plans
- Part D: Prescription Drug Coverage

66%
are in the Medicare Fee-For-Service (FFS) Program

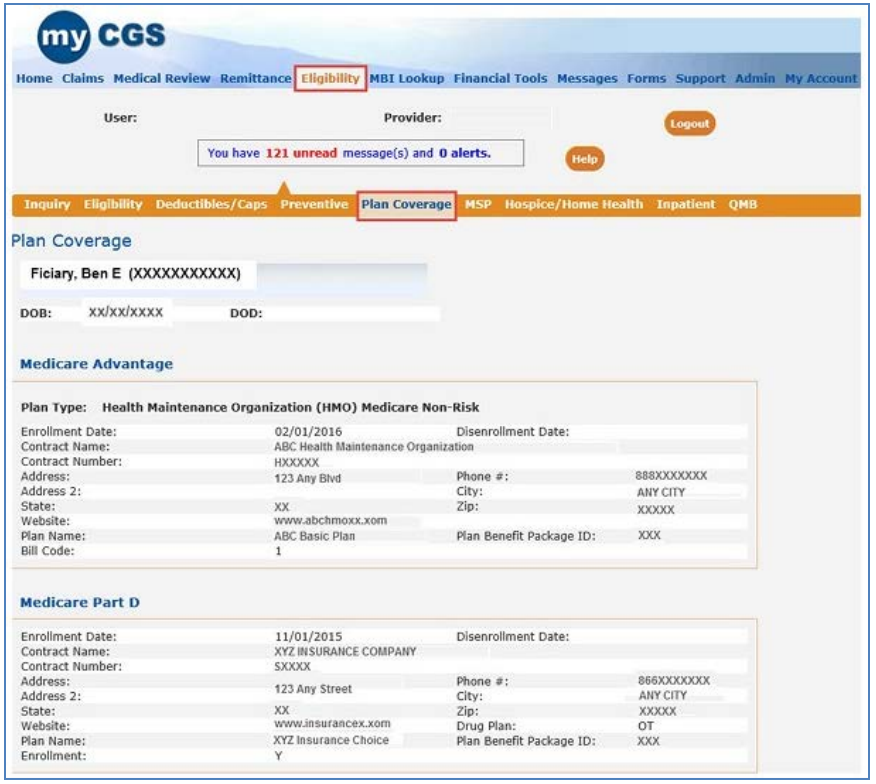
34%
are in the Medicare Advantage (MA) Program

Traditional Medicare vs. Medicare Advantage

- Medical Advantage plans are an alternative to traditional Medicare
  - They are not a supplement; they replace a patient's traditional Medicare coverage.
- **Because they act as a replacement product, traditional Medicare cannot answer claim or coverage-related questions on behalf on a Medicare Advantage plan.**
  - Such inquiries must be directed to the individual Medicare Advantage Plan.
- The myCGS Web portal provides additional information as to whether a patient is enrolled in a Medical Advantage plan

Traditional Medicare vs. Medicare Advantage

- The Eligibility tab in myCGS is used to find out information specific to your patients BEFORE claims are submitted! https://www.cgsmedicare.com/pdf/mycgs/chapter4.pdf
  - Another health plan may pay in place of Medicare
    - Submit claims directly to the Medicare Advantage plan



How does Medicare Coordinate with Other Health Plans?

- Medicare Secondary Payer (MSP)
  - Another health plan may pay **before** Medicare
    - Examples: Working Aged, Liability Insurance, Workers Compensation
    - Medicare processes claim after the primary payer
- Supplemental Plans
  - Additional health insurance coverage may pay **after** Medicare
    - Examples: Medigap plans, Medicaid, complementary crossovers

How does Medicare Coordinate with Other Health Plans?

- The Eligibility tab in myCGS is used to find out information specific to your patients BEFORE claims are submitted! https://www.cgsmedicare.com/pdf/mycgs/chapter4.pdf
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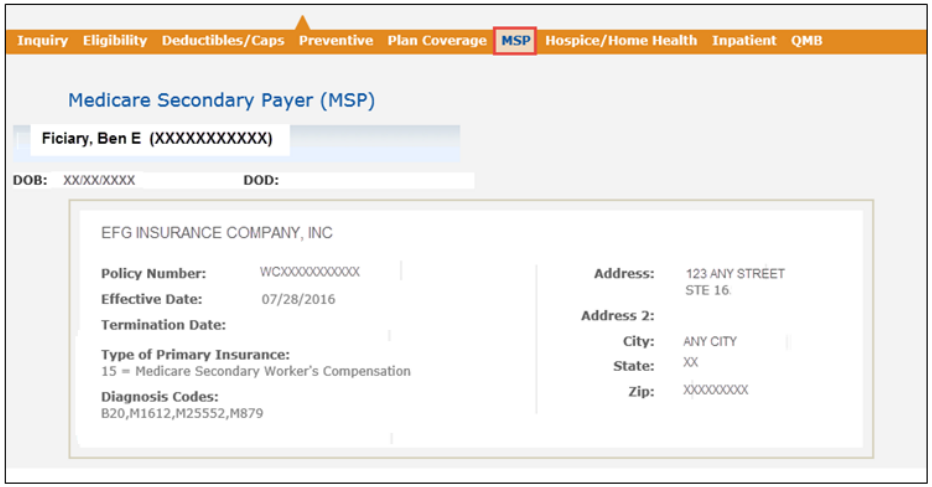
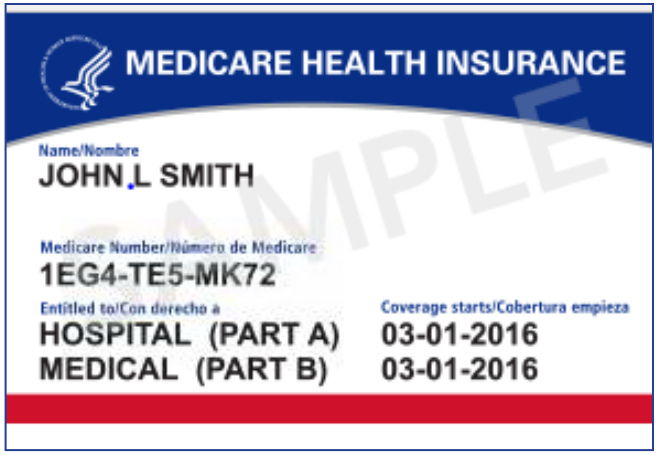


CY 2020 Beneficiary Costs

- Monthly Part B premium
  - Standard premium= $144.60 ($135.50 in 2019)
  - Sliding income-based scale for beneficiaries with higher incomes
- Annual Part B deductible
  - $198 ($185 in 2019)
- Coinsurance
  - 20% for most items and services
- Non-covered items/services
  - Patient pays 100% for non-covered care
- NOTE: For OUD treatment services, deductible will apply; coinsurance will not.

Medicare Identification Card

- Always request a copy of the patient's Medicare card
- It is important to note:
  - Beneficiary name
  - Medicare Beneficiary Identifier (MBI)
  - Entitlement sections and dates
- Only card accepted January 1, 2020
  - The old cards with the Health Insurance Claim Number (HICN) will not be accepted for Medicare transactions
    - https://www.cgsmedicare.com/partb/pubs/news/2019/11/cope14640.html



Medicare Basics Resources

- Medicare Beneficiaries at a Glance
  - https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Beneficiary-Snapshot/Downloads/Bene_Snaphot.pdf
- myCGS User Manual
  - https://www.cgsmedicare.com/mycgs/manual.html
- myCGS Medicare Advantage
  - https://www.cgsmedicare.com/partb/pubs/news/2018/12/cope10258.html
- myCGS Medicare Secondary Payer (MSP) information
  - https://www.cgsmedicare.com/partb/pubs/news/2018/12/cope10260.html
- 2020 Medicare Parts A & B Premiums and Deductibles Fact Sheet
  - https://www.cms.gov/newsroom/fact-sheets/2020-medicare-parts-b-premiums-and-deductibles

Welcome to CGS!

CGS Jurisdiction 15
Who We Are!

- CGS is a leading provider of administrative services for healthcare programs and stakeholders, including Medicare beneficiaries, providers, and medical equipment suppliers.

38	148k	24m
states served across the nation	providers and suppliers	beneficiaries

CGS Current Contracts

Jurisdiction 15 Medicare Part A	Jurisdiction 15 Medicare Part B	Jurisdiction 15 Home Health & Hospice	Jurisdiction B DME MAC	Jurisdiction C DME MAC
• Kentucky • Ohio	• Kentucky • Ohio	• Colorado • Delaware • D.C. • Iowa • Kansas • Maryland • Missouri • Montana • Nebraska • North Dakota • Pennsylvania • South Dakota • Utah • Virginia • West Virginia • Wyoming	• Illinois • Indiana • Kentucky • Michigan • Minnesota • Ohio • Wisconsin	• Alabama • Arkansas • Colorado • Florida • Georgia • Louisiana • Mississippi • New Mexico • North Carolina • Oklahoma • Puerto Rico • South Carolina • Tennessee • Texas • U.S. Virgin Islands • Virginia • West Virginia

Opioid Treatment Program (OTP) Coverage

The SUPPORT for Patients and Communities Act

- Section 2005 of the *Substance Use-Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act*
  - New Medicare Part B benefit for Opioid Use Disorder (OUD) treatment services furnished by OTPs on or after January 1, 2020.
- The statute allows implementation, "through one or more bundles based on
  - the type of medication provided (such as buprenorphine, methadone, naltrexone, or a new innovative drug),
  - the frequency of services,
  - the scope of services furnished,
  - characteristics of the individuals furnished such services, or
  - other factors as the Secretary determine[s] appropriate."

OTP Background

- OTPs provide medication-assisted treatment for people diagnosed with an OUD.
- OTPs must be certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) and accredited by an independent, SAMHSA-approved accrediting body.
  - Approved Certified OTPs https://dpt2.samhsa.gov/treatment/directory.aspx
- For SAMHSA certification, OTPs must comply with all pertinent state laws and regulations and all regulations enforced by the Drug Enforcement Administration.

OTP Background

- Medicare previously covered office-based opioid treatment with buprenorphine and naltrexone
  - Historically, has not covered services furnished in OTPs, which are the only entities authorized to use methadone to treat OUD.
- Beginning January 1, 2020, Medicare coverage of OTPs is a new benefit that we anticipate will expand access to care.
- No other provider or supplier type except for an OTP can bill for OTP services.
  - Physicians and other practitioners in the office setting may bill bundled payment codes and payment rates under the PFS for an episode of OUD treatment.

Definition of an OTP

- Enrolled in Medicare
- Fully certified by SAMHSA
- Accredited by an accrediting body approved by SAMHSA
- Meets such additional conditions as the Secretary may find necessary to ensure:
  - The health and safety of individuals being furnished services under such program
  - The effective and efficient furnishing of such services

OTP Enrollment

- OTP providers should enroll in Medicare **now** to be able to bill Medicare for OTP services beginning January 1, 2020
  - Note: OTPs fully-certified by SAMHSA and accredited by a SAMHSA-approved accrediting body can start enrolling in the Medicare program so they can bill for services starting January 1, 2020
- OTPs Medicare Enrollment Fact Sheet
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/OTP-enrollment-factsheet-MLN6325432.PDF

OTP Services

- OUD treatment services provided by OTPs includes the following:
  - U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medications for the treatment of OUD
  - Dispensing and administering such medications (if applicable)
  - Substance use counseling
  - Individual and group therapy
  - Toxicology testing, including presumptive and definitive testing
  - Intake activities
  - Periodic assessments

OTP Coding and Payment

HCPCS Codes	Short Descriptions
G2067	Medication assisted treatment, methadone
G2068	Medication assisted treatment, buprenorphine (oral)
G2069	Medication assisted treatment, buprenorphine (injectable)
G2070	Medication assisted treatment, buprenorphine (implant insertion)
G2071	Medication assisted treatment, buprenorphine (implant removal)
G2072	Medication assisted treatment, buprenorphine (implant insertion and removal)
G2073	Medication assisted treatment, naltrexone

- Refer to OTPs Medicare Billing and Payment Fact Sheet for full descriptions
  - https://www.cms.gov/files/document/otp-billing-and-payment-fact-sheet
  - Submit G-codes with Place of Service (POS) code 58, which represents a Non-residential Opioid Treatment Facility

OTP Coding and Payment

HCPCS Codes	Short Descriptions
G2074	Medication assisted treatment, weekly bundle not including the drug
G2075	Medication assisted treatment, medication not otherwise specified
G2076	Intake activities
G2077	Periodic assessments
G2078	Take-home supply of methadone
G2079	Take-home supply of buprenorphine (oral)
G2080	Additional counseling furnished

- Refer to OTPs Medicare Billing and Payment Fact Sheet for full descriptions
  - https://www.cms.gov/files/document/otp-billing-and-payment-fact-sheet
  - Submit G-codes with Place of Service (POS) code 58, which represents a Non-residential Opioid Treatment Facility

OTP Coding and Payment

- OTPs can only bill Medicare using the specific codes for OTP services
  - OTPs cannot bill Medicare for non-OTP services
- Coding structure for OUD treatment services includes non-drug services and varies by the medication administered
  - Weekly (a 7-day contiguous period) bundles
    - Only one weekly G-code can be billed in any 7-day contiguous period per beneficiary except in limited clinical circumstances (e.g., guest dosing, transfer of care)
- The codes describing OTP are assigned flat dollar payment amounts
  - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Opioid-Treatment-Program/Downloads/CY2020-OTP-Payment-Rates.pdf

OTP Coding and Payment

Each bundled payment is composed of a:

- Drug component
  - The typical maintenance dose determines the drug costs for each bundle
  - CMS finalized a payment of average sales price (ASP) +0 percent, when ASP data are available.
    - For methadone, CMS will use TRICARE pricing when ASP is not reported.
    - For oral buprenorphine, CMS will use National Average Drug Acquisition Cost pricing when ASP is not reported.
- Non-drug component
  - Includes payment for counseling, therapy, toxicology testing, and drug dispensing and administration
  - Uses the payment rates for similar services paid under Medicare in the non-facility setting

OTP Coding and Payment

- Add-On Adjustments
  - Bundled payment rates adjusted by using add-on codes to account for:
    - Intake activities or periodic assessments
    - Additional counseling or therapy furnished for patient that substantially exceeds the amount specified in the patient's individualized treatment plan
    - Take home dosing for methadone or oral buprenorphine is provided to a patient
- Partial Episodes
  - CMS may consider creating partial episodes in the future

Dually Eligible Beneficiaries

- Starting January 1, 2020, Medicare will be primary payer for OTP services for dually eligible beneficiaries who currently get OTP services through Medicaid.
  - Dually Eligible – Those enrolled in both Medicare and Medicaid
- The SUPPORT Act mandates all states cover OTP in their Medicaid programs effective October 2020.
  - Medicaid must continue paying Medicaid-enrolled OTP providers not yet enrolled in Medicare
  - Medicaid will recoup any payments back to effective date of the OTP provider's Medicare enrollment date

Medicare Advantage Beneficiaries

- Medicare Advantage (MA) plans:
  - Must use only OTP providers that meet the same requirements as those providing services under Medicare Part B
  - May furnish access to the OTP by direct contracting
    - Or allow enrollees access to OTP services on a non-contract basis
  - Must furnish access to the OTP benefit that is as good or better than what is available to beneficiaries in Original Medicare
- CMS will inform MA plans they should create a transition process for individuals in treatment with non-contract OTP providers so they continue to receive treatment until patient transitions to a network provider.

OTP Coverage Resources

- Approved Certified OTPs
  - https://dpt2.samhsa.gov/treatment/directory.aspx
- OTPs Medicare Enrollment Fact Sheet
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/OTP-enrollment-factsheet-MLN6325432.PDF
- HCPCS Descriptor Drug/Non-Drug Payment Rates
  - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Opioid-Treatment-Program/Downloads/CY2020-OTP-Payment-Rates.pdf
- OTPs Medicare Billing and Payment Fact Sheet
  - https://www.cms.gov/files/document/otp-billing-and-payment-fact-sheet

Submitting Part B Claims

ASCA

The Administrative Simplification Compliance Act (ASCA) requires that, as of October 16, 2003, all initial Medicare claims be submitted electronically, except in limited situations which include:

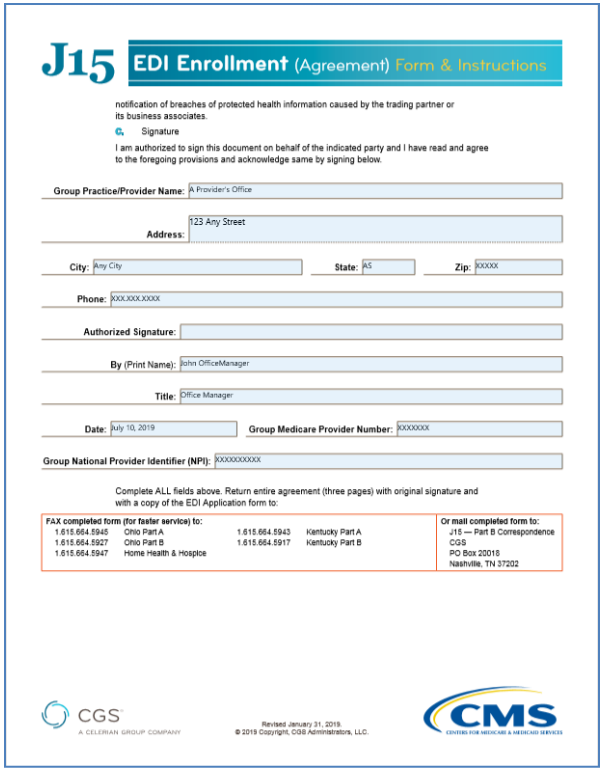
- Small Practices
  - Fewer than 10 (Part B) full-time equivalent employees (FTEs)
- Medicare Secondary Payer claims when there is more than one primary payer
- Claims submitted by Medicare beneficiaries
- Claims for services or supplies furnished outside of the U.S. by non-U.S. providers
- No electricity or communication connection lasting more than two business days.
- Providers that submit fewer than ten claims per month on average (in a calendar year)

Electronic Claims

- Submit claims to CGS electronically
  - Claims are processed according to ANSI 5010 and CMS requirements
  - May be paid as soon as 13 days after submission
    - Versus 29 days after the date of receipt for paper claims
  - Earlier detection of errors
  - Accurate payment since reduced chance of manual entry errors
  - Support personnel available to assist
  - Save money on postage and paper forms

Electronic Claims

- Complete the J15 EDI Enrollment Form
  - https://www.cgsmedicare.com/pdf/J15_EDI_EnrollAgreement2015re.pdf
  - When enrolling for electronic billing
  - When using a third-party
    - Billing service or clearinghouse
    - Network Service Vendor (NSV)
      - » https://www.cgsmedicare.com/partb/edi/nsv_list.html



J15 EDI Enrollment (Agreement) Form & Instructions

notification of breaches of protected health information caused by the trading partner or its business associates.

Signature

I am authorized to sign this document on behalf of the indicated party and I have read and agree to the foregoing provisions and acknowledge same by signing below.

Group Practice/Provider Name: A Provider's Office

Address: 123 Any Street

City: Any City State: AS Zip: XXXXX

Phone: XXX.XXX.XXXX

Authorized Signature:

By (Print Name): John OfficeManager

Title: Office Manager

Date: July 10, 2019 Group Medicare Provider Number: XXXXXXX

Group National Provider Identifier (NPI): XXXXXXXXX

Complete ALL fields above. Return entire agreement (three pages) with original signature and with a copy of the EDI Application form to:

FAX completed form (for faster service) to:
1.615.664.5945 Ohio Part A
1.615.664.5927 Ohio Part B
1.615.664.5947 Home Health & Hospice
1.615.664.5943 Kentucky Part A
1.615.664.5917 Kentucky Part B

Or mail completed form to:
J15 — Part B Correspondence
CGS
PO Box 20018
Nashville, TN 37202

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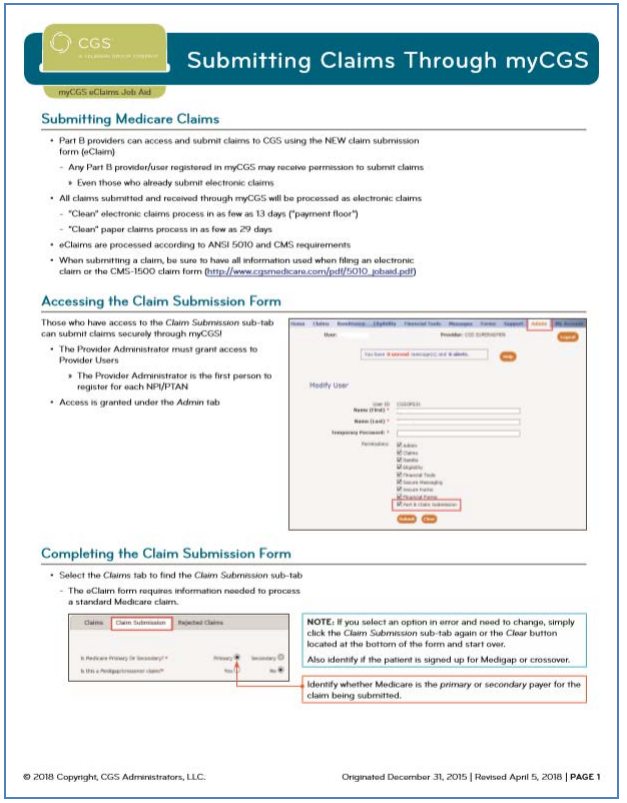
Verify Patient Eligibility

Before sending claims, verify patient is eligible for Medicare Part B

- myCGS Web Portal
  - Identifies whether patient has traditional Medicare (CGS) or one of the Medicare Advantage (MA) plans
    - Also indicates if there is a payer primary to Medicare
    - https://www.cgsmedicare.com/pdf/mycgs/chapter4.pdf
- Part B Interactive Voice Response (IVR)
  - Also provides eligibility information
    - Save time by using the Medicare Beneficiary Identifier (MBI) and Name to Number Converter for help using your telephone keypad! https://www.cgsmedicare.com/medicare_dynamic/j15/ivr_mbi_converters/ivr_mbi_converters.aspx.

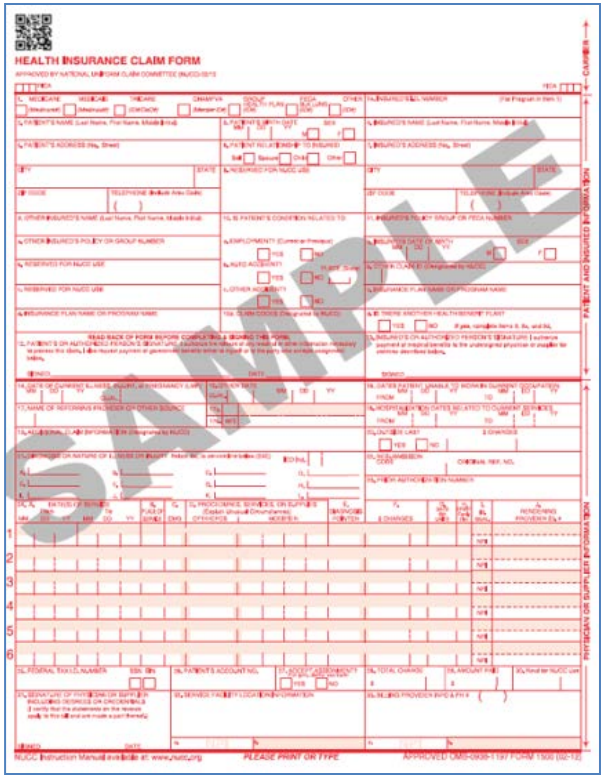
myCGS Electronic Claims

- Submit Part B claims using myCGS
  - Must have a signed Electronic Data Interchange (EDI) Enrollment Agreement on file with us.
  - When submitting a claim, be sure to have all information used when filing an electronic claim or the CMS-1500 claim form
- https://www.cgsmedicare.com/partb/mycgs/mycgs_eclaims_jobaid.pdf



Hardcopy Claims

- CMS-1500 Claim Form
  - May be used by those who are permitted to submit hardcopy claims (Refer to ASCA slide)
    - 29 days to process paper claims
    - Must be typed according to very specific instructions to ensure scanner captures data https://www.cgsmedicare.com/partb/pubs/news/2015/0715/cope29732.html
  - Instructions for completing the form are located at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c26.pdf



Common Claim Submission Mistakes!

- Data analysis completed on the top reasons your claims are not paid
  - Top reasons claims are denied
    - Patient has a Medicare Advantage plan instead of traditional Medicare Part B
    - Expense incurred prior to patient has coverage
    - https://www.cgsmedicare.com/partb/education/claim_denials.html
  - Top reasons claims are rejected
    - Procedure code invalid on the date of service
    - Missing/incorrect group practice information (National Provider Identifier)
    - Patient name/identifier mismatch
    - https://www.cgsmedicare.com/partb/education/cse_data.html

Part B Claim Submission Resources

- EDI Enrollment Agreement
  - https://www.cgsmedicare.com/pdf/J15_EDI_EnrollAgreement2015re.pdf
- Approved Network Service Vendor (NSV) List
  - https://www.cgsmedicare.com/partb/edi/nsv_list.html
- myCGS Resources
  - myCGS Registration Page https://www.onlineproviderservices.com/cgs_ops/initProviderRegistration.do
    - Recorded event: “myCGS Registration Made Easy!” https://register.gotowebinar.com/recording/1067957143645018627
  - myCGS Log-In https://www.cgsmedicare.com/mycgs/index.html
  - myCGS Part B Claim Submission Job Aid https://www.cgsmedicare.com/partb/mycgs/mycgs_eclaims_jobaid.pdf
    - Medicare Secondary Payer (MSP) Claims https://www.cgsmedicare.com/partb/pubs/news/2015/0215/cope28475.html

Processing/Payment Information

Check the Status of Your Claims

Wondering whether your claims are processing or have finalized?

- Access myCGS to check the status of your claims!
  - View detailed information and perform additional functions!
    - https://www.cgsmedicare.com/partb/pubs/news/2018/11/cope9818.html
- The Interactive Voice Response (IVR) is also available!
  - May also be used to check the status of Appeals and check patient eligibility
    - IVR User Guide https://www.cgsmedicare.com/partb/cs/partb_ivr_user_guide.pdf
    - Medicare Beneficiary Identifier (MBI) and Name to Number Converter https://www.cgsmedicare.com/medicare_dynamic/j15/ivr_mbi_converters/ivr_mbi_converters.aspx

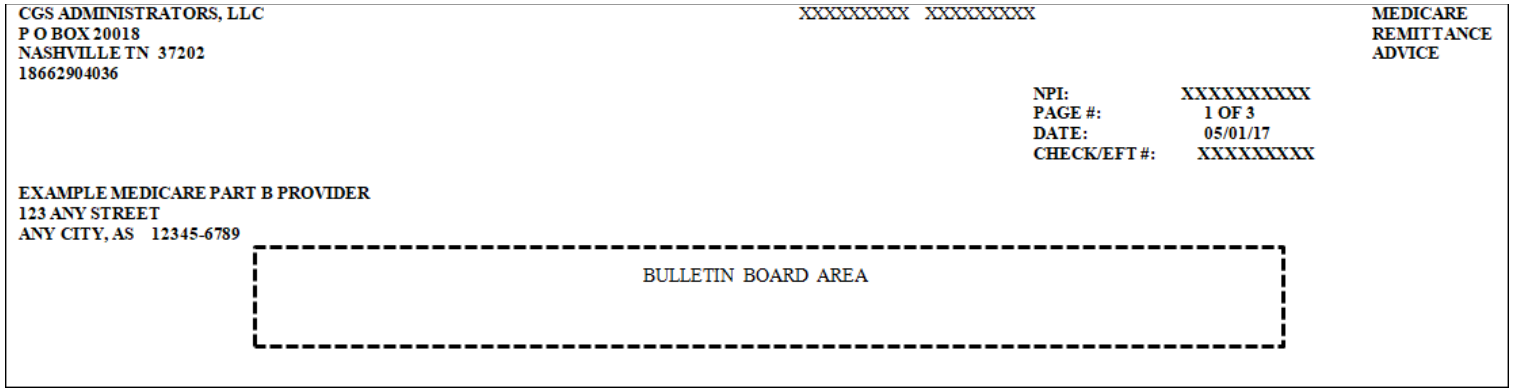
Part B Remittance Advice (RA)

- RAs provide you with claim and payment information
  - Itemized information for each claim and/or service line
  - Explanations and guidance as to whether Medicare made a payment
  - The reason and the value of adjustments
- Main sections of an RA
  - Header information
  - Claims information
  - Glossary

Part B Remittance Advice (RA)

Header Information

- Contains identifying information for the MAC and the provider.
- Bulletin board area used to share news and information related to Medicare.



Part B Remittance Advice (RA)

Claim Information

- Header row identifies information in each of the columns
- Information on each claim filed is listed in alphabetical order by patient's last name.
- Claim-level and service-line-level information for the claim is listed.

PERF PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT		PROV PD
NAME FICIARY, BEN E			MID XXXXXXXXXA MBI XXXXXXXXXXX		ACNT XXXXX-XXXXX		ICN XXXXXXXXXXXXX		ASG Y	MOA MA01 MA18		
XXXXXXXXXX	0501 050119	11	3.0	97110	GPKX	150.00	77.47	0.00	15.49	CO-45 CO-223 CO-59	57.39 1.24 15.14	60.74
XXXXXXXXXX	0501 050119	11	1.0	G8983	GPCH	0.01	0.00	0.00	0.00	CO-246	0.01	0.00
XXXXXXXXXX	0515 051519	11	1.0	97140	GP	50.00	0.00	0.00	0.00	PR-119	50.00	0.00
REM: N365												
PT RESP	65.49			CLAIM TOTALS		200.01	77.47	0.00	15.49		123.78	60.74
CLAIM INFORMATION FORWARDED TO: A SUPPLEMENTAL INSURANCE											NET	60.74

TOTALS:	# OF CLAIMS	BILLED AMT	ALLOWED AMT	DEDUCT AMT	COINS AMT	TOTAL RC-AMT	PROV PD AMT	PROV ADJ AMT	CHECK AMT
	1	200.01	77.47	0.00	15.49	123.78	60.74	23.73	37.01

PROVIDER ADJ DETAILS:	PLB REASON CODE	FCN	AMOUNT	CHECK AMOUNT	HIC NUMBER
	WO	XXXXXXXXXXXXXXX	7.58		XXXXXXXXXA
	WO	XXXXXXXXXXXXXXX	10.89		XXXXXXXXXB
	WO	XXXXXXXXXXXXXXX	5.26		XXXXXXXXXD1

Part B Remittance Advice (RA)

Glossary

- Refer to this section for an explanation of the decisions CGS made on your claims.
  - Contains all Group Codes, Remittance Advice Remark Codes (RARCs), Claim Adjustment Reason Codes (CARCs), and Provider-Level Adjustment Reason Codes that appear on the RA.
    - All of the RARCs and CARCs are available to you at http://www.wpc-edi.com/reference.

GLOSSARY:	Group, Reason, MOA, Remark and Adjustment Codes
CO	Contractual Obligation. Amount for which the provider is financially liable. The patient may not be billed for this amount.
PR	Patient Responsibility. Amount that may be billed to a patient or another payer.
119	Benefit maximum for this time period or occurrence has been reached.
223	Adjustment code for mandated federal, state or local law/regulation that is not already covered by another code and in mandated before a new code can be created.
246	This non-payable code is for required reporting only.
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
59	Processed based on multiple or concurrent procedure rules.
MA01	Alert: If you do not agree with what we approved for these services, you may appeal our decision. In order to be eligible for an appeal, you must write to us within 120 days of the date you received this notice, unless you have a good reason for being late.
MA18	Alert: The claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them.
N365	This procedure code is not payable. It is for reporting/information purposes only.
WO	Overpayment Recovery

RA Message Codes

- Avoid Common Claim Submission Mistakes!
  - If you submit claims to CGS prior to approval or enrolling, you will see the following messages:
    - CARC 185: The rendering provider is not eligible to perform the service billed
      - NOTE: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present
    - RARC N95: The provider type/provider specialty may not bill this service
      - Note: OTPs are defined by Specialty code D5
    - Group Code: CO
  - The beneficiary Medicare Summary Notice (MSN) will show:
    - MSN 26.4: This service is not covered when performed by this provider

ERA Vs. SPR

Electronic Remittance Advice (ERA) or a Standard Paper Remittance (SPR)

- The RA is available in the form of an ERA or an SPR
  - The ERA is the most convenient (PREFERRED)
    - Electronic format that can be manipulated into various reports
      - » Only print the information you need!
    - Easier to post payments and reconcile patient accounts
  - The SPR is a hardcopy document
    - Paper! Paper! Paper!
    - Standardized format that cannot be manipulated
  - Medicare Remit Easy Print (MREP) software available for FREE! https://www.cgsmedicare.com/partb/edi/easy_print.html

Processing/Payment Resources

- Check the status of your claims
  - myCGS: https://www.cgsmedicare.com/partb/pubs/news/2018/11/cope9818.html
  - IVR: https://www.cgsmedicare.com/partb/cs/partb_ivr_user_guide.pdf
    - Medicare Beneficiary Identifier (MBI) and Name to Number Converter https://www.cgsmedicare.com/medicare_dynamic/j15/ivr_mbi_converters/ivr_mbi_converters.aspx
- Remittance Advice Overview
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Remit-Advice-Overview-Fact-Sheet-ICN908325.pdf
- Washington Publishing Company (WPC) codes and descriptors
  - http://www.wpc-edi.com/reference/
- Medicare Remit Easy Print (MREP) software
  - https://www.cgsmedicare.com/partb/edi/easy_print.html

CMS Appeal Process

Appeal Levels

All parties have the right to appeal claim determinations made by CGS

Level	Time Limit	Monetary Threshold
Redetermination	120 days from the date of receipt of the initial determination	None
Reconsideration	180 days from the date of receipt of the Redetermination.	None
Administrative Law Judge (ALJ) Hearing	60 days from the date of receipt of the Reconsideration	CY 2020 Amount in Controversy (AIC) is $170
Departmental Appeals Board (DAB) Review	60 days from the date of receipt of the ALJ hearing decision	None
Federal Court Review	60 days from date of receipt of the Appeals Board decision	CY 2020 Amount in Controversy (AIC) is $1,670

When to File a Redetermination

- When your remittance advice identifies the following messages:
  - CARC 119: Benefit maximum for this time period or occurrence has been reached
  - RARC N640: Exceeds number/frequency approved/allowed within time period
- Group Code: CO
- The beneficiary Medicare Summary Notice (MSN) will show:
  - MSN 15.22: The information provided does not support the need for this many services or items in this period of time so Medicare will not pay for this item or service

How to File a Redetermination

- Submit Redeterminations using myCGS! (PREFERRED)
  - Allows you to upload attachments and send request electronically
    - Link to the Redeterminations form is available on the claim status screen
      - » Details of claim are pre-populated on the form
      - » Step-by-step instructions also available at https://www.cgsmedicare.com/pdf/partb_mycgs_redetermination_requests.pdf.
- Redetermination form is also an option
  - Must be completed online, then printed and mailed
    - https://www.cgsmedicare.com/pdf/partb_redeterminationform.pdf

Redetermination Vs. Reopening

Verify request should not be send as a Reopening

- Omissions or simple corrections needed to original claim
  - Transposed procedure or diagnosis codes
  - Incorrect date of service (month/day)
  - Inaccurate data entry or other minor errors
  - Utilize the Appeal Decision Tree for help determining Redetermination Vs. Reopening https://www.cgsmedicare.com/partb/appeals/decision_tree.html.
- Must be requested within one year from the date of the initial determination
- Reopenings accepted through myCGS (PREFERRED) or paper https://www.cgsmedicare.com/partb/forms/gateways/when_to.html
  - myCGS Reopenings are assessable from the claim status screen, and form is pre-populated with required information.

Inquiry Process

Inquiry Process

Interactive Voice Response (IVR): 1.866.290.4036

Type of Inquiry	
Status of claims and appeals	Part B deductible status
Medicare Secondary Payer information	ESRD, Smoking cessation, and Hepatitis B screening information
Allowable for procedure codes	Claim denial reasons
Outstanding check amounts and Electronic Funds Transfers (EFTs)	Offset information
NPI and PTAN validation	Other claim processing information

Inquiry Process: IVR Tips

- Avoid using cell phones or a speaker phone
- Be sure you have the following:
  - Facility's National Provider Identifier (NPI),
  - Facility's Provider Transaction Access Number (PTAN),
  - Last five digits of your Tax ID number
- If calling on a beneficiary or claim, be sure you also have:
  - Beneficiary name
  - Beneficiary date of birth
  - Medicare Beneficiary Identifier (MBI)
  - Date of service (if applicable)
- Use the *MBI Converter and IVR Beneficiary Name to Number Converter*
  - https://www.cgsmedicare.com/medicare_dynamic/j15/ivr_mbi_converters.asp

Inquiry Process

Part B Provider Contact Center (PCC): 1.866.276.9558

Select:	For questions about:
Option 1: Claims	Claims specific information that requires the CSR to access beneficiary or claim information
Option 2: Electronic Data Interchange (EDI)	EDI enrollment, connectivity, PC-Ace Pro32, MREP, or network service vendors.
Option 3: Provider Enrollment	Provider enrollment application (CMS-855) process, or Revalidation
Option 4: Telephone Reopening (TRO)	Reopening requests submitted over the phone.
Option 5: Overpayment Recovery (OPR)	Offsets, voluntary refunds, demand letters, or extended repayment plans
Option 9: General Inquiries	Non-claim specific information, i.e., coverage and benefit guidelines, finding CGS or CMS website information, address or telephone numbers, or how to read a remittance advice.

Inquiry Process: PCC Tips

- Customer Service Representatives (CSRs) available to help with functions not available on the IVR
- Computer Telephony Integration (CTI) is used for authentication purposes and to save time
  - When choosing Options 1 through 5 you will be prompted to enter:
    - Facility's National Provider Identifier (NPI),
    - Facility's Provider Transaction Access Number (PTAN),
    - Last five digits of your Tax ID number
    - Beneficiary's Medicare Beneficiary Identifier (MBI) (not applicable to Options 2 and 3)
    - First letter of the beneficiary's first name
    - First six letters of the beneficiary's last name
    - Beneficiary's date of birth
  - https://www.cgsmedicare.com/partb/pubs/news/2016/09/cope662.html

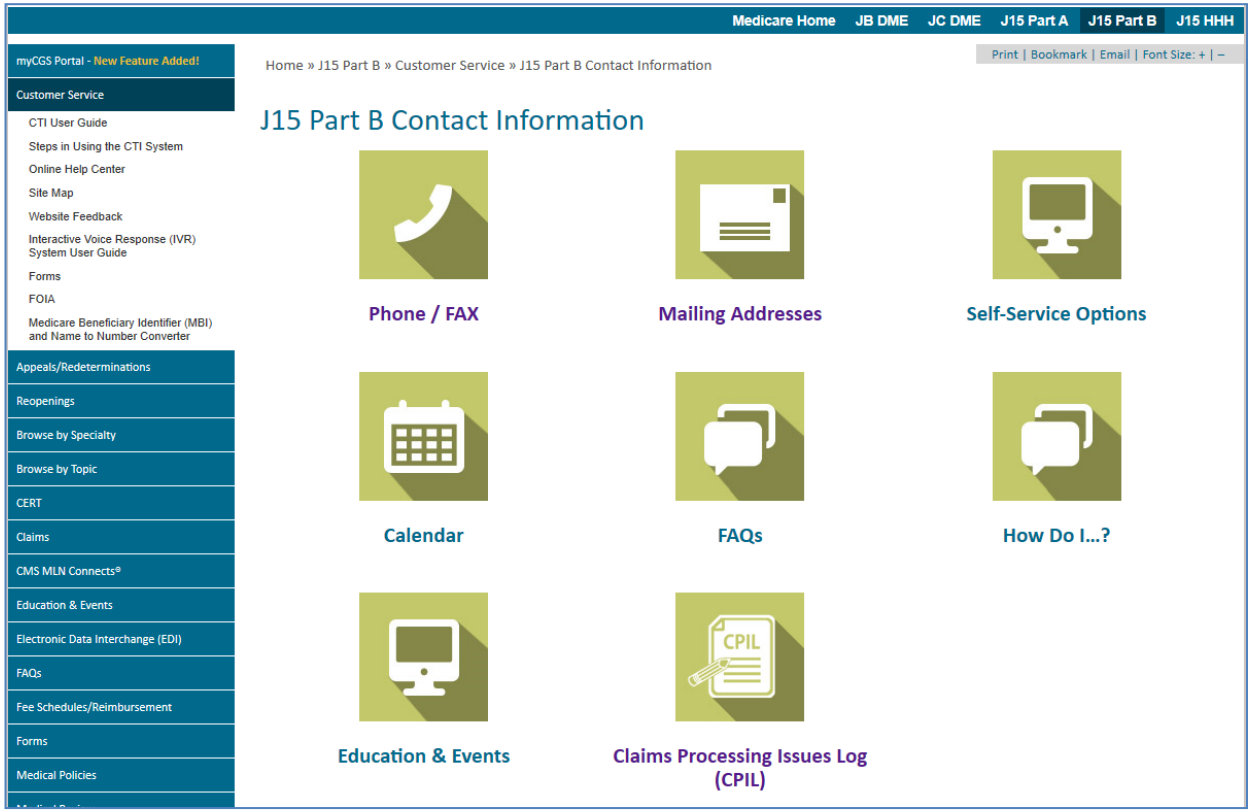
CGS Web Resources

CGS Part B Website

https://www.cgsmedicare.com/partb/index.html

CGS Customer Service

https://www.cgsmedicare.com/partb/cs/index.html



myCGS Resources

Tab	Function
Claims	Part B Medicare claims can be submitted through myCGS! You can also check the status of claims, view remark codes, and perform additional functions
Medical Review	All of your MR ADRs on one page. Also respond to pending ADRs and a number of other functions?
Remittance	View and print remittance advices (RAs)
Eligibility	With validated patient information you can check eligibility • Current/previous year's deductible • Therapy cap information • Date next eligible for the Medicare-covered preventive services • Medicare Advantage (MA) plan enrollment • Determining primary payer (MSP) and view applicable ICD-10 codes • Details on home health episodes • Hospice benefit periods • Hospital and skilled nursing facility stays • Qualified Medicare Beneficiary (QMB) status

myCGS Resources

Tab	Function
MBI Look-Up Tool	Use myCGS to obtain the patient's Medicare Beneficiary Identifier (MBI)
Financial Tools	Inquire about claims approved-to-pay and the last three checks issued
Messages	Read secure messages and alerts regarding system access and functions performed in the portal
Forms	Submit certain forms directly to CGS • Submit Redeterminations and Reopenings • Requests for eOffset (immediate offset) • Respond to Medical Review requests for documentation (ADRs) • Submit General Inquiries • Attach documentation to your requests!
ADMIN	Used by Provider Administrator to grant access to other users and unlock user accounts

CGS Web Tour

Tab	Details
Customer Service	Check this page to locate the correct phone numbers, mailing addresses, and CTI and IVR guides.
Appeals	All the resources you need to file a Redetermination of a claim including a calculator and Appeals Decision Tree.
Reopenings	Used when a claim was either paid or denied with minor errors or omissions.
Browse by Specialty	One page for all resources specific to various specialties.
Browse by Topic	Links to articles from both the CMS and CGS websites on a variety of topics.
CERT	Everything you need on the Comprehensive Error Rate Testing program.
Claims	Go here for claims-related resources including the Issues Log and the CMS 1500/ANSI Crosswalk.

CGS Web Tour

Tab	Details
CMS MLN Connects®	Official weekly CMS news directly from the Medicare Learning Network®
Education & Events	Check for upcoming educational events; data analysis resources; and links to on-demand provider education.
EDI	Tools and resources related to Electronic Data Interchange.
FAQs	Have a question? Check the Frequently Asked Questions first!
Fee Schedules/Reimbursement	Links to various fee schedules on the CMS website. Search the local Physician and ASC Fee Schedules.
Forms	Need a form? Check here first! *TIP: Don't forget myCGS!* ☺
Medical Policies	Instant access to all of our Local Coverage Determinations (LCDs)!

CGS Web Tour

Tab	Details
Medical Review	Everything you need on our current claim review strategy and resources to help you correctly document medical records.
News & Publications	Access to the monthly Part B Medicare Bulletin, recent news, and CMS articles.
Overpayments & Refunds	Everything you need to know about overpayments and what to do should you need to return money to CGS.
Provider Enrollment	Tools to help with provider credentialing and the Revalidation process.
Related Links	Links to partner organizations and other resources outside of CGS.
Self-Service Options	THE place to go for immediate access to all of the tools available to you!

Use the Search Engine!

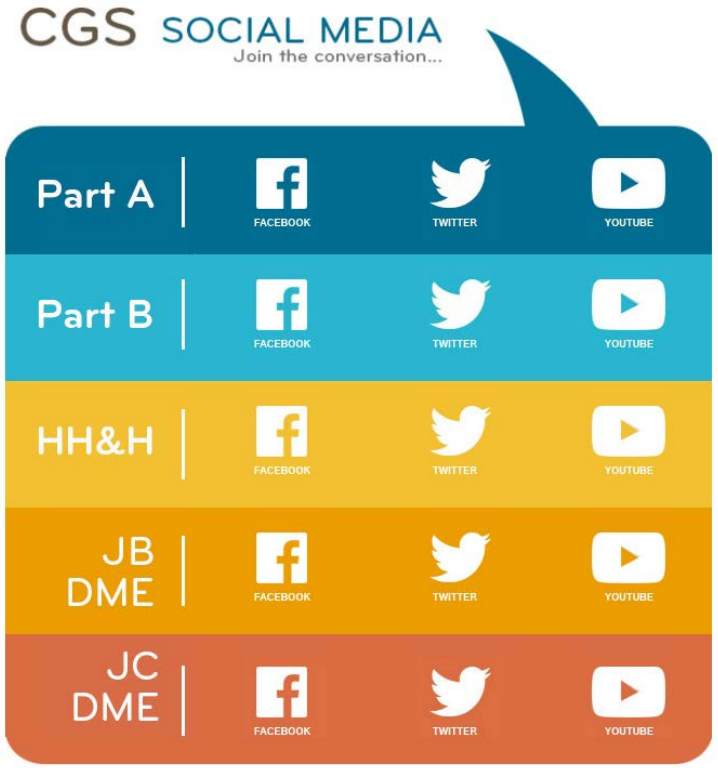
Our customer service staff is always available to help…but, save yourself some time and search the website FIRST.

- Refer to the search engine to find just want you need!
  - Check your spelling
  - Keep it simple!
  - Use quotation marks to search for a phrase
  - Sort results by relevance or by date
  - Click on links to the most popular search terms

Stay Connected!

"LIKE" us on Facebook and other social media outlets!

https://www.cgsmedicare.com/socialmedia/



CGS Web Resources

- CGS Part B Website
  - https://www.cgsmedicare.com/partb/index.html
    - Search tips! https://cgsmedicare.com/searchtips.html
- Customer Service webpage
  - https://www.cgsmedicare.com/partb/cs/index.html
- myCGS User Manual and Job Aids
  - https://cgsmedicare.com/partb/mycgs/job_aids.html
- Social Media webpage
  - https://www.cgsmedicare.com/socialmedia/

Questions?

Thanks for joining us!