Ask the Contractor Open Forum

October 10, 2019

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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CGS J15 Ask The Contractor Teleconference Open Forum

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Disclaimer

This presentation was current at the time it was published or uploaded onto the CGS website. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

This presentation was prepared as a tool to assist providers and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services.

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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.

Part A Update and Pre-Submitted Questions

Presented by Annie Scriven

DDE Recertification

- 2,995 users did not complete the annual recertification by September 30, 2019
- Deadline is extended to **November 15, 2019**
- Annual DDE Recertification Form: https://www.cgsmedicare.com/forms/annual_dde_pptn_recert_formRE.pdf

Provider-Based Billing Edits Update

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE19007.pdf

mln MATTERS®

KNOWLEDGE • RESOURCES • TRAINING

Activation of Systematic Validation Edits for OPPS Providers with Multiple Service Locations - Update

MLN Matters Number: SE19007 Revised

Related Change Request (CR) Number: 9613; 9907

Article Release Date: September 5, 2019

Effective Date: N/A

Related CR Transmittal Numbers: R1704OTN and R1783OTN

Implementation Date: N/A

Note: We revised this article on September 5, 2019, to announce a delay of full implementation until April 2020.

IRF Resources

https://www.cgsmedicare.com/parta/pubs/news/2019/09/cope13805.html

Inpatient Rehabilitation Facility Prospective Payment System Resources

The Centers for Medicare & Medicaid Services (CMS) has revised the Inpatient Rehabilitation Facility Prospective Payment System Booklet PDF , which educates IRF clinical and billing personnel on Medicare coverage and documentation requirements. In addition, CMS collaborated with the Comprehensive Error Rate Testing (CERT) Medicare Administrative Contractor (MAC) A/B Task Force to revise a web-based training (WBT) course titled, Inpatient Rehabilitation Facilities (IRFs): Improving Documentation Positively Impacts CERT. This course is available through the Medicare Learning Network Learning Management System EXT .

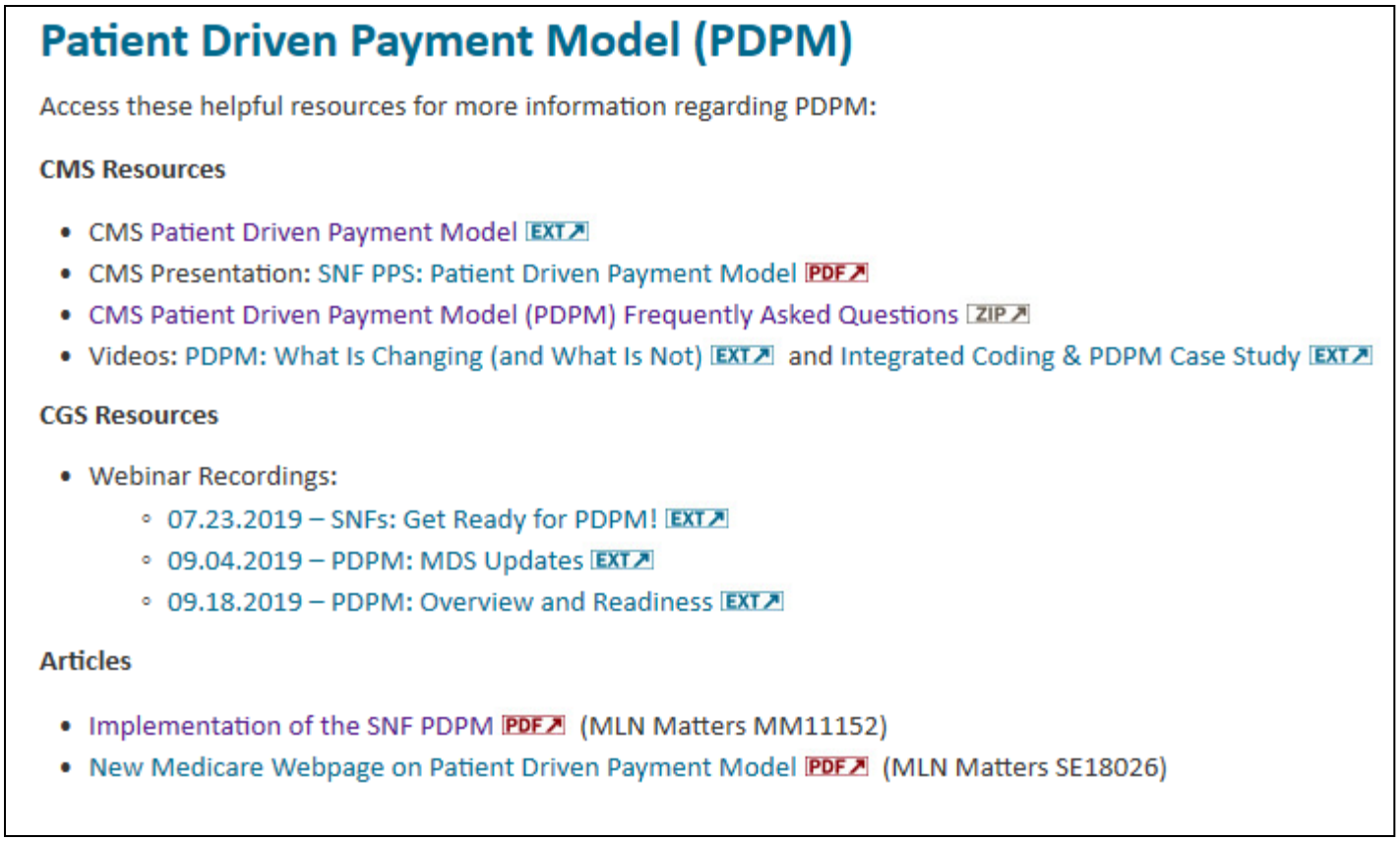
Additional IRF resources include:

- MLN Matters Article - MM11345 PDF -- Inpatient Rehabilitation Facility (IRF) Annual Update: Prospective Payment System (PPS) Pricer Changes for FY 2020
- Medicare Benefit Policy Manual Chapter 1, Section 110 PDF
- FY 2019 IRF PPS Final Rule EXT
- IRF Quality Reporting Program EXT website
- Many IRF Stays Did Not Meet Medicare Coverage and Documentation Requirements OIG Report PDF , September 2018

Please share this with your appropriate staff.

PDPM Resources

https://www.cgsmedicare.com/parta/topic/index.html#



Patient Driven Payment Model (PDPM)

Access these helpful resources for more information regarding PDPM:

CMS Resources

- CMS Patient Driven Payment Model EXT
- CMS Presentation: SNF PPS: Patient Driven Payment Model PDF
- CMS Patient Driven Payment Model (PDPM) Frequently Asked Questions ZIP
- Videos: PDPM: What Is Changing (and What Is Not) EXT and Integrated Coding & PDPM Case Study EXT

CGS Resources

- Webinar Recordings:
  - 07.23.2019 – SNFs: Get Ready for PDPM! EXT
  - 09.04.2019 – PDPM: MDS Updates EXT
  - 09.18.2019 – PDPM: Overview and Readiness EXT

Articles

- Implementation of the SNF PDPM PDF (MLN Matters MM11152)
- New Medicare Webpage on Patient Driven Payment Model PDF (MLN Matters SE18026)

New CGS Resources

- Inpatient Hospital Pre-Entitlement Claims: https://www.cgsmedicare.com/parta/pubs/news/2019/07/cope13207.html
- Device-Intensive Procedure and Device Code Search: https://www.cgsmedicare.com/medicare_dynamic/j15/device_tool/device_tool.aspx

Part A Pre-Submitted Questions

- **How do we bill when a resident is cut from skilled care, but remains in the building and is picked up skilled within 30 days?**
  - **Example:** A resident is admitted on 2.12.19 skilled and then is cut from skilled care on 3.11.19 and remained in the facility as private pay. Then was picked back up as skilled on 3.28.19. Would our claim for March have an admit date of 2.12.19 or 3.28.19 with occurrence span code 78 and condition code 57? Does the no pay claim for 3.12.19 – 3.27.19 need to be billed before we can submit the claim beginning on 3.28.19?

Please reference the CMS Medicare Claims Processing Manual (Pub. 100-04), chapter 6, section 40: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c06.pdf

Part A Pre-Submitted Questions

- **Question:** Our Part A claims in the CJR model skilled nursing 3 day rule waiver are not going through even when demonstration code 75 is in the appropriate box, which is supposed to bypass the qualifying stay rule. I have called and the rep has verified the hospital claim is on file and the code is on our claim. Yet, the claims still continue to deny. Is there an issue with these types of claims?
- **Answer:** CGS is not aware of a claims processing issue related to this type of claim. Claim example(s) are necessary to determine if there is a claim submission error or a claims processing error.

Part A Pre-Submitted Questions

- **Question:** When doing appeals, can we send documentation from a month prior and a month after claim month in review to state our case of eli?
- **Answer:** Any documentation that supports medical necessity of the services included in the redetermination request may be submitted, including documentation for dates of service not included in the request.

Part B Update and Pre-Submitted Questions

Presented by Vanessa Williams

Reopenings

https://www.cgsmedicare.com/partb/forms/gateways/reopenings.html

Countdown to Part B Clerical Reopening New Process

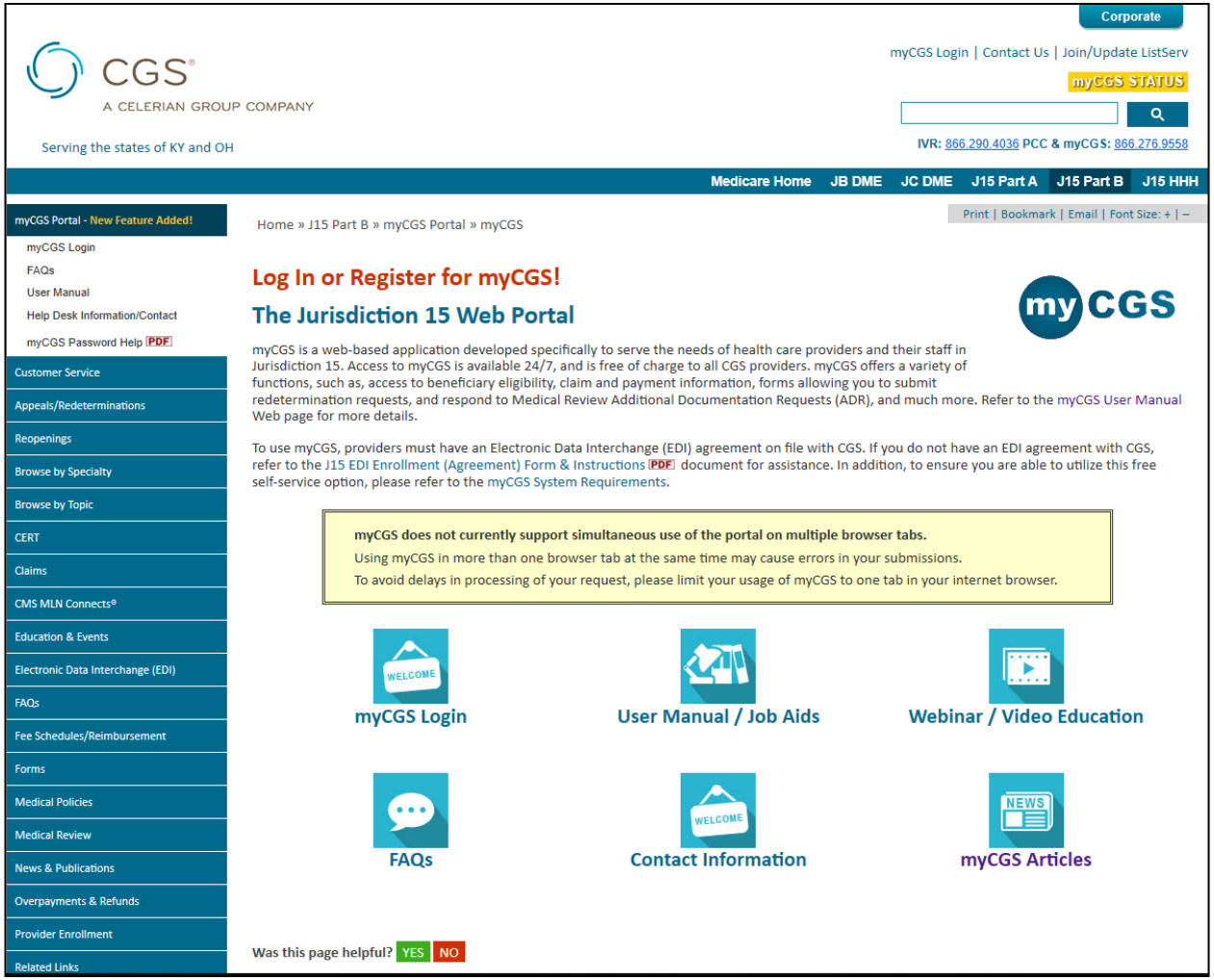
Effective October 21, 2019:

- CGS Part B Clerical Reopening will no longer accept fax submissions
  The fax line will be disabled.
- Hardcopy Reopenings will be accepted ONLY on the current form
- The Reopenings form must be typed. We suggest you access the hardcopy form online, type, and then download to print
- Submissions must be for only one claim per form
  No spreadsheets will be accepted.
- Incorrect form submissions will be returned to the provider

TIP: Consider using myCGS to submit your Reopening requests!

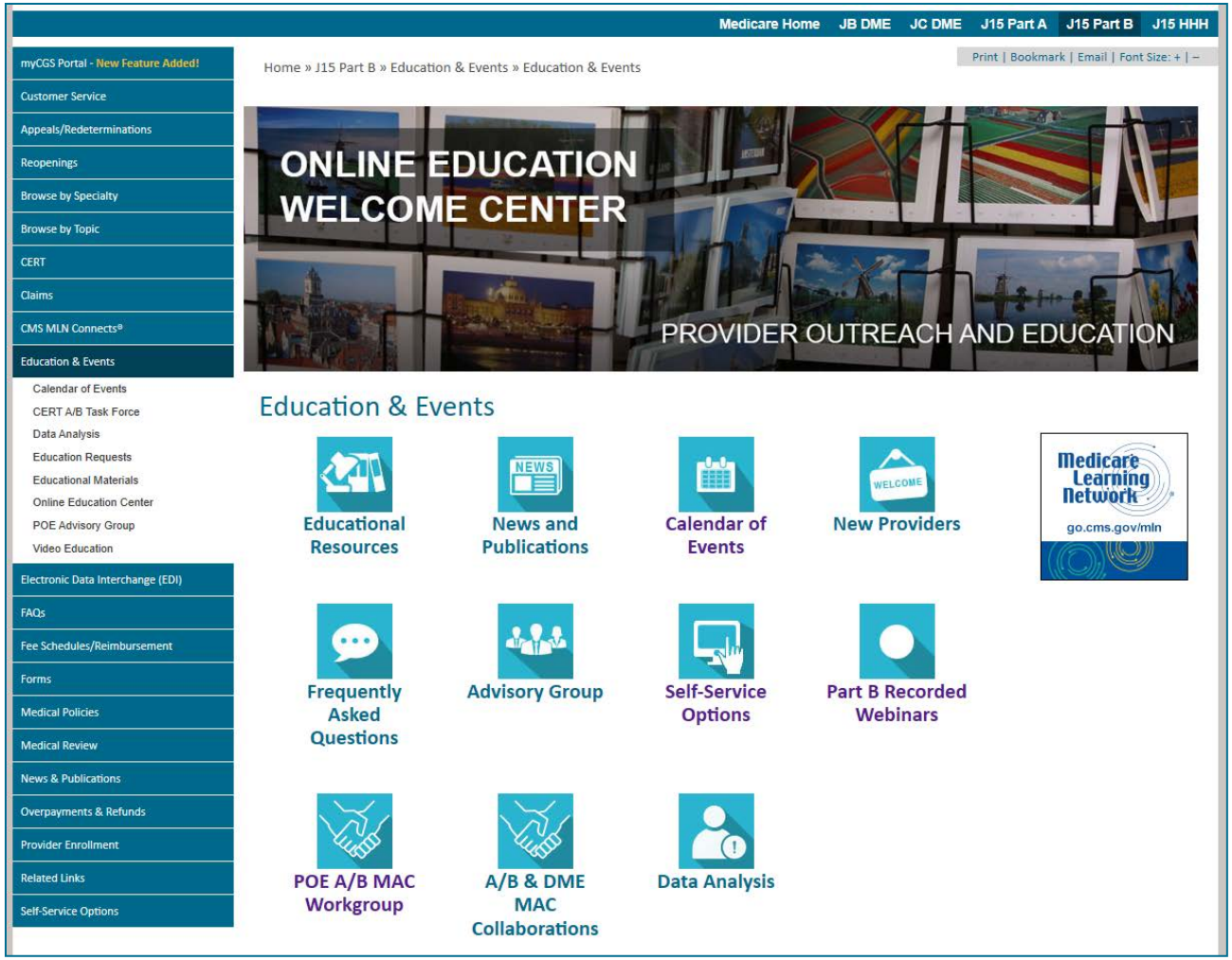
Resources

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



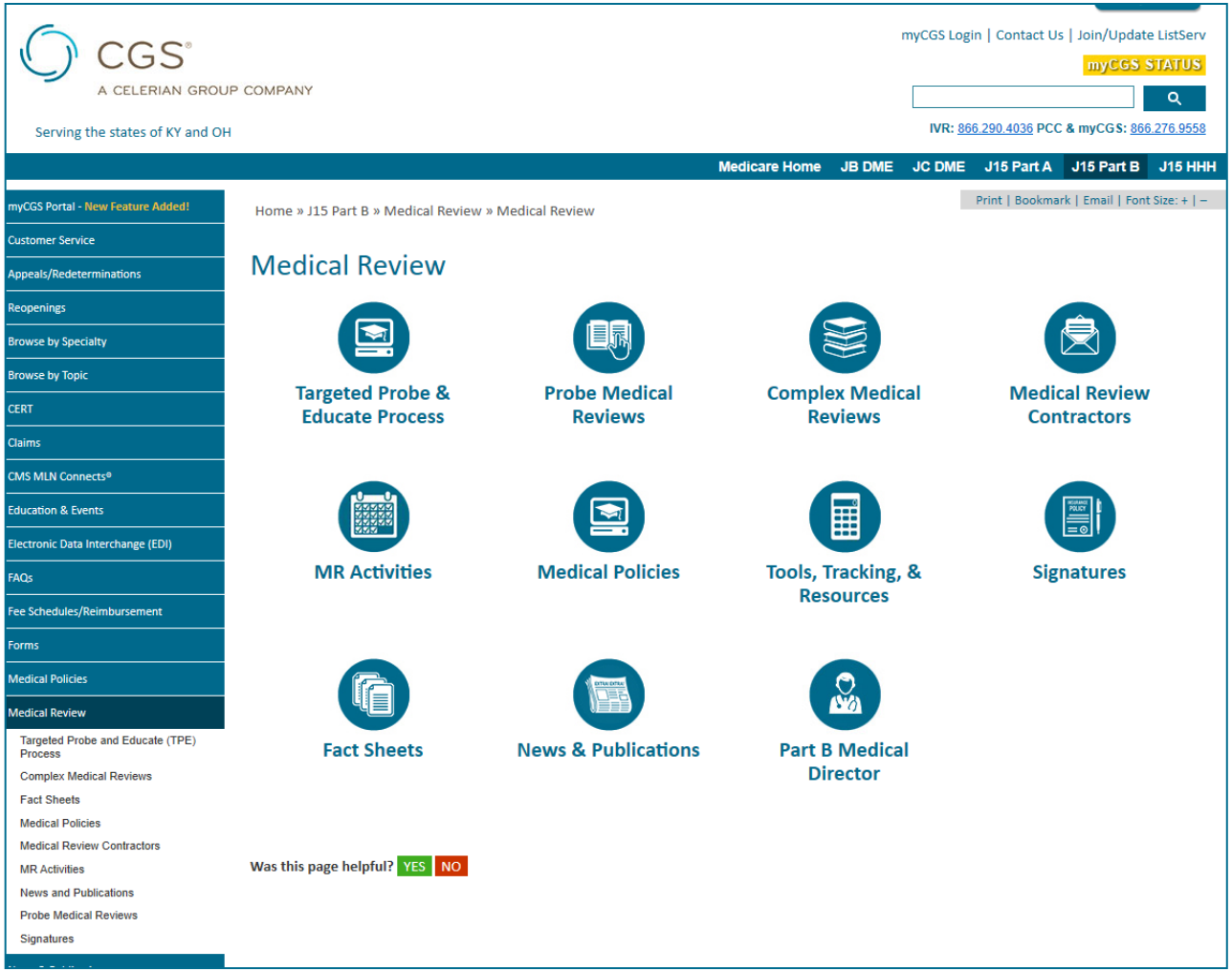
Resources

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



Resources

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



Part B Pre-Submitted Questions

- **Question:** Can I submit my claims through myCGS?
- **Answer:** Yes you can submit claims electronically through myCGS in addition to Medicare Secondary Payer Claims
  - https://www.cgsmedicare.com/partb/mycgs/mycgs_eclaims_jobaid.pdf
  - https://www.cgsmedicare.com/partb/pubs/news/2015/0215/cope28475.html

Part B Pre-Submitted Questions

- **Question:** How can I tell if my claims have been received by CGS?
- **Answer:** There are a few ways to do this.

1. Call the CGS Interactive Voice Response (IVR) system. The IVR can confirm claim status, and whether the claim is in process, on the payment floor, or paid/denied. The IVR number is 1.866.290.4036.
2. Use CGS's Web portal, myCGS at https://www.cgsmedicare.com/partb/mycgs/index.html to confirm this information (you must be a registered user to do this).
3. If claims are electronically submitted from your office, your clearinghouse/submission software may have information or a confirmation of claims being electronically submitted.

Part B Pre-Submitted Questions

- **Question:** How can I request a Provider Outreach & Education (POE) representative to come present Medicare Updates at our local meeting or conference?
- **Answer:** If you would like to request a CGS POE Representative for a meeting in your area, please e-mail your request to: J15_PartB_Education@cgsadmin.com

Targeted Probe and Educate, PDGM

Medical Review - Ronda Tipton

Questions & Answers

- **Question:** Do the TPE Audits have a point at which there will be a pause? Is this expected to continue indefinitely or is there a plan to discontinue?
- **Answer:** CGS is not aware of plans to pause or discontinue TPE at this time. TPE will continue indefinitely unless directed by CMS.

Questions & Answers

- **Question:** PDGM is the most concern for discussion for me as the intake clerk.

  I'm concerned about when we receive the referral. If they referring diagnosis is not in the grouping model, do we wait for the physician to rewrite the order? Would the assessing clinician put the primary diagnosis on the plan of care, for the more specific diagnosis, that pertains to the referring diagnosis

- **Answer:** This should be an internal agency issue on how they handle this. An RN or Therapist can't diagnosis per scope of practice.

Home Health and Hospice Updates

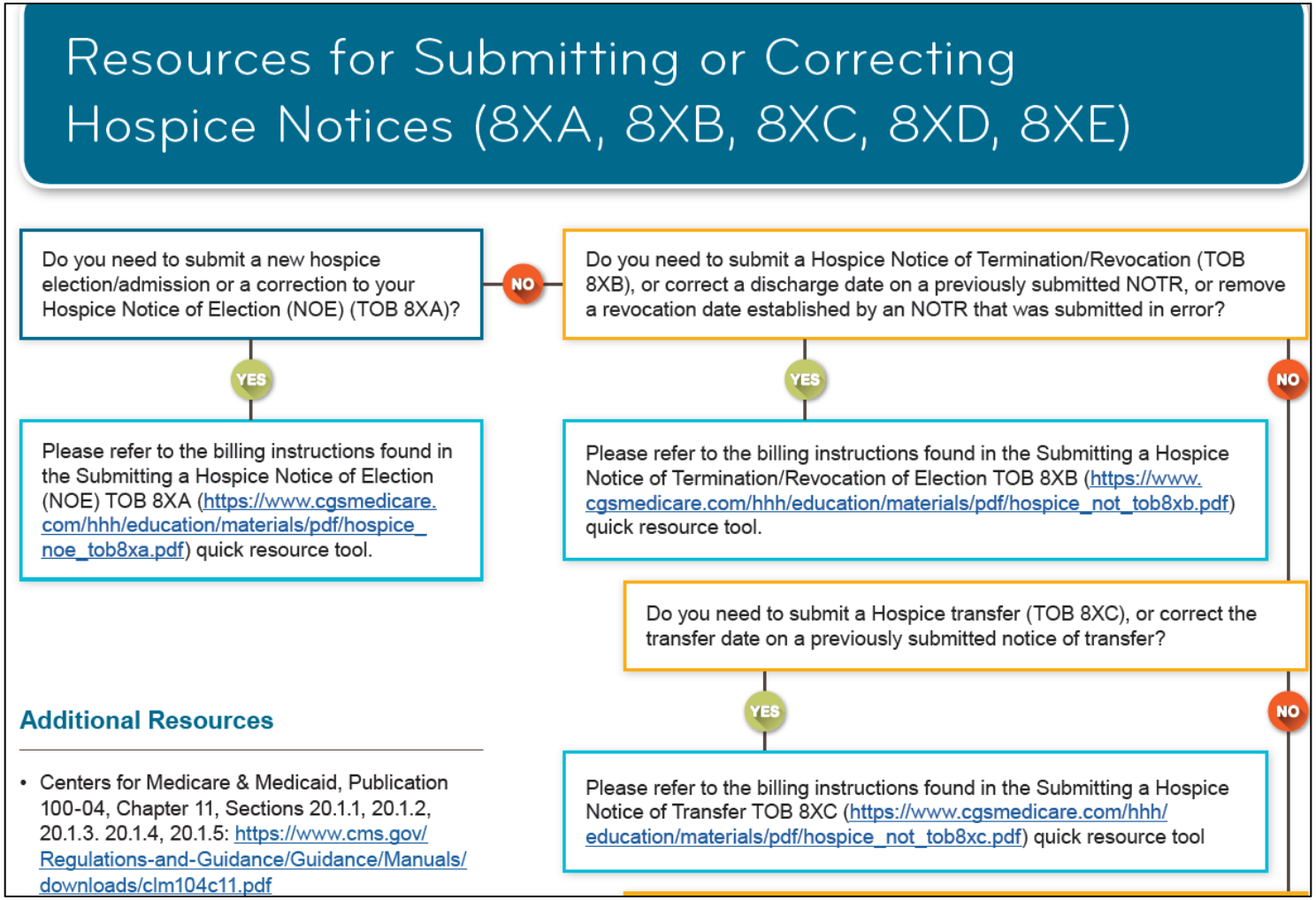
Presented by Nykesha Scales

Direct Data Entry (DDE) Recertification

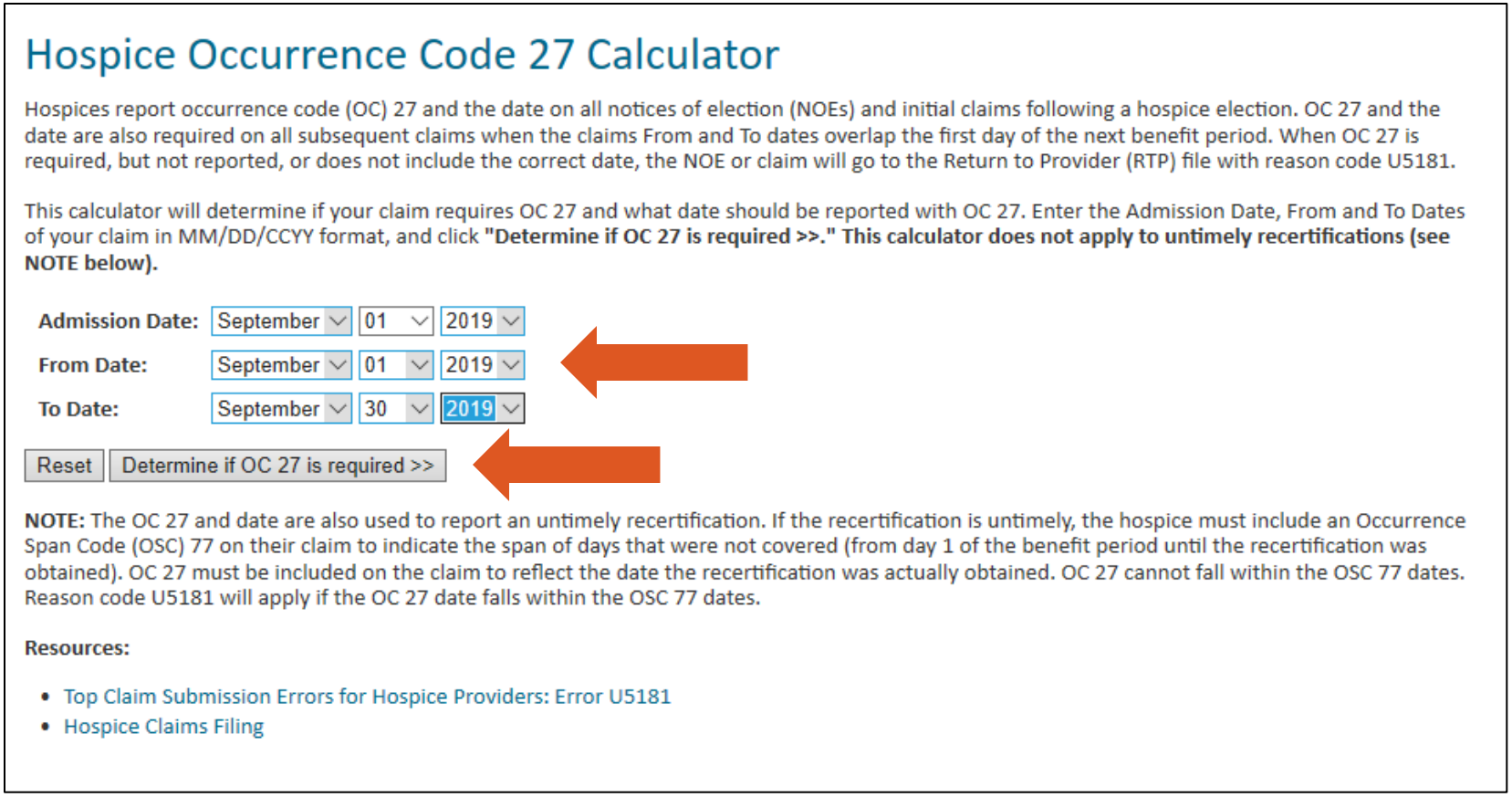
- 62% of HHH providers completed by September 30th deadline
- Deadline is extended to **November 15, 2019**
- Annual DDE Recertification Form: https://www.cgsmedicare.com/forms/annual_dde_pptn_recert_formRE.pdf

New Hospice Billing Tool

https://www.cgsmedicare.com/hhh/education/materials/pdf/hospice_sub_corr_notices.pdf



New Hospice Occurrence Code 27 Calculator



Hospice Occurrence Code 27 Calculator

Hospices report occurrence code (OC) 27 and the date on all notices of election (NOEs) and initial claims following a hospice election. OC 27 and the date are also required on all subsequent claims when the claims From and To dates overlap the first day of the next benefit period. When OC 27 is required, but not reported, or does not include the correct date, the NOE or claim will go to the Return to Provider (RTP) file with reason code U5181.

This calculator will determine if your claim requires OC 27 and what date should be reported with OC 27. Enter the Admission Date, From and To Dates of your claim in MM/DD/CCYY format, and click **"Determine if OC 27 is required >>." This calculator does not apply to untimely recertifications (see NOTE below).**

Admission Date:	September	01	2019
From Date:	September	01	2019
To Date:	September	30	2019

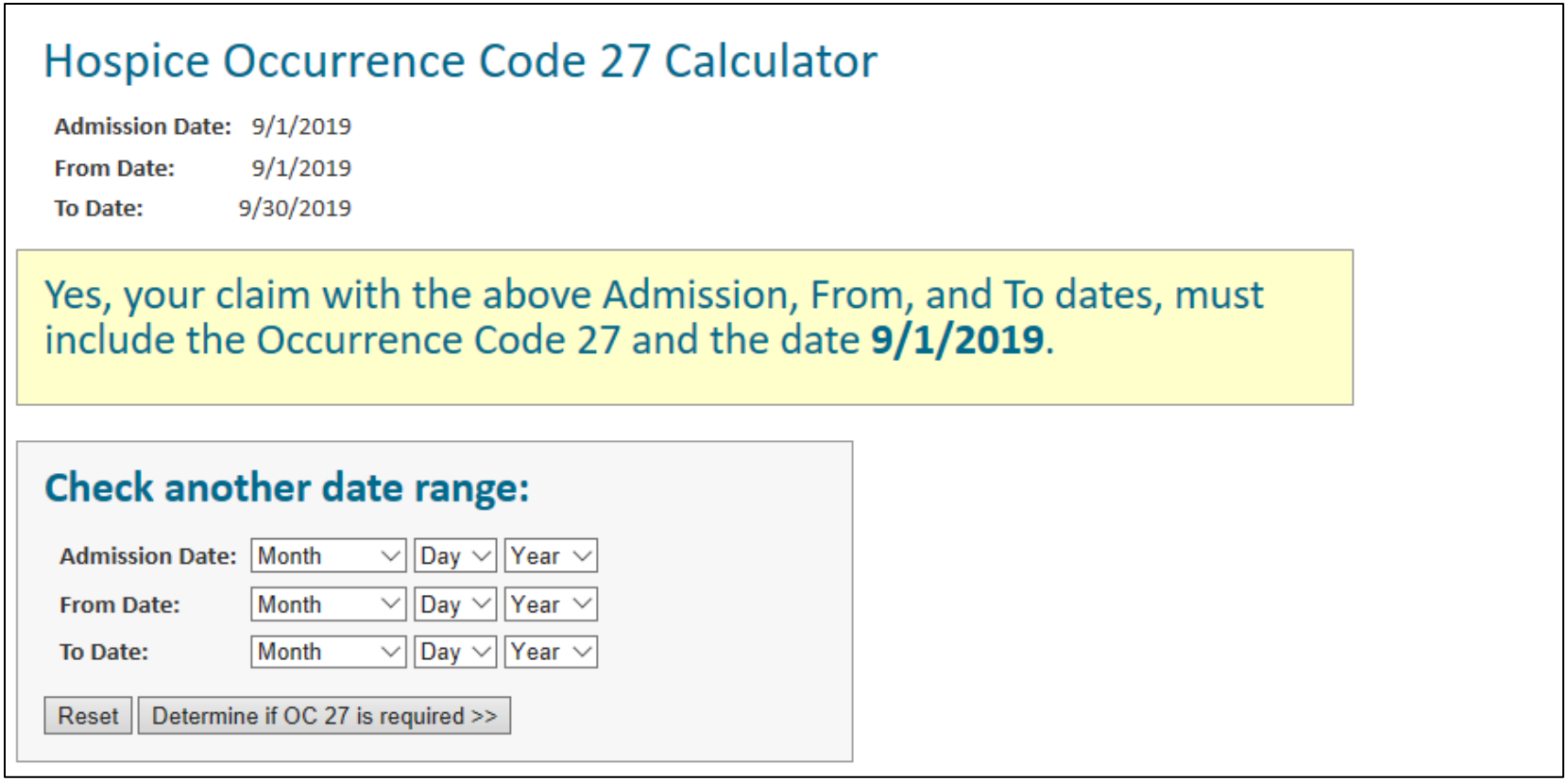
Reset | Determine if OC 27 is required >>

NOTE: The OC 27 and date are also used to report an untimely recertification. If the recertification is untimely, the hospice must include an Occurrence Span Code (OSC) 77 on their claim to indicate the span of days that were not covered (from day 1 of the benefit period until the recertification was obtained). OC 27 must be included on the claim to reflect the date the recertification was actually obtained. OC 27 cannot fall within the OSC 77 dates. Reason code U5181 will apply if the OC 27 date falls within the OSC 77 dates.

Resources:

- Top Claim Submission Errors for Hospice Providers: Error U5181
- Hospice Claims Filing

New Hospice Occurrence Code 27 Calculator



Hospice Occurrence Code 27 Calculator

Admission Date: 9/1/2019
From Date: 9/1/2019
To Date: 9/30/2019

Yes, your claim with the above Admission, From, and To dates, must include the Occurrence Code 27 and the date **9/1/2019**.

Check another date range:

Admission Date: Month Day Year
From Date: Month Day Year
To Date: Month Day Year

Reset | Determine if OC 27 is required >>

Patient-Driven Groupings Model (PDGM) Resources – HH Providers

https://www.cgsmedicare.com/hhh/education/materials/pdgm.html

- CMS PDGM Web page, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/HH-PDGM.html
- CGS PDGM Overview, https://www.cgsmedicare.com/hhh/education/materials/pdgm_overview.html
- MM11272, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM11272.pdf
- MM11081, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM11081.pdf
- https://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2019-02-12-PDGM-Presentation.pdf
- https://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2019-08-21-HH-PDGM-Presentation.pdf

C2C innovative Solutions, Inc.

Part A East – Appeals Demonstration

C2C Innovative Solutions, Inc.

Part A East - Appeals Demonstration

Telephone Discussion Demonstration & Reopening Process

- Under this Demonstration, selected suppliers will have the opportunity to participate in a recorded telephone discussion with C2C, to discuss the facts of the case and provide any additional documentation that would assist in reaching a favorable determination, and also receive feedback/education on CMS policies and requirements
- Eligible participants: Part A appeals for JH, JJ, JK, JL, JM, and JN, Home Health and Hospice (HHH) appeals in J6 and J15
  - Not eligible for the Part A Demonstration: Expedited appeals for service termination and appeals that are subject to another CMS initiative
- Elective process. Providers will receive notice from C2C when their appeal is selected for participation, or eligible Part A Providers can contact C2C if they wish to participate
- Under the Demonstration, C2C will also conduct reopenings of claims that are similar to those selected as part of the telephone discussion and are currently pending at the ALJ
- Contact Information: ADemoFeedback@c2cinc.com

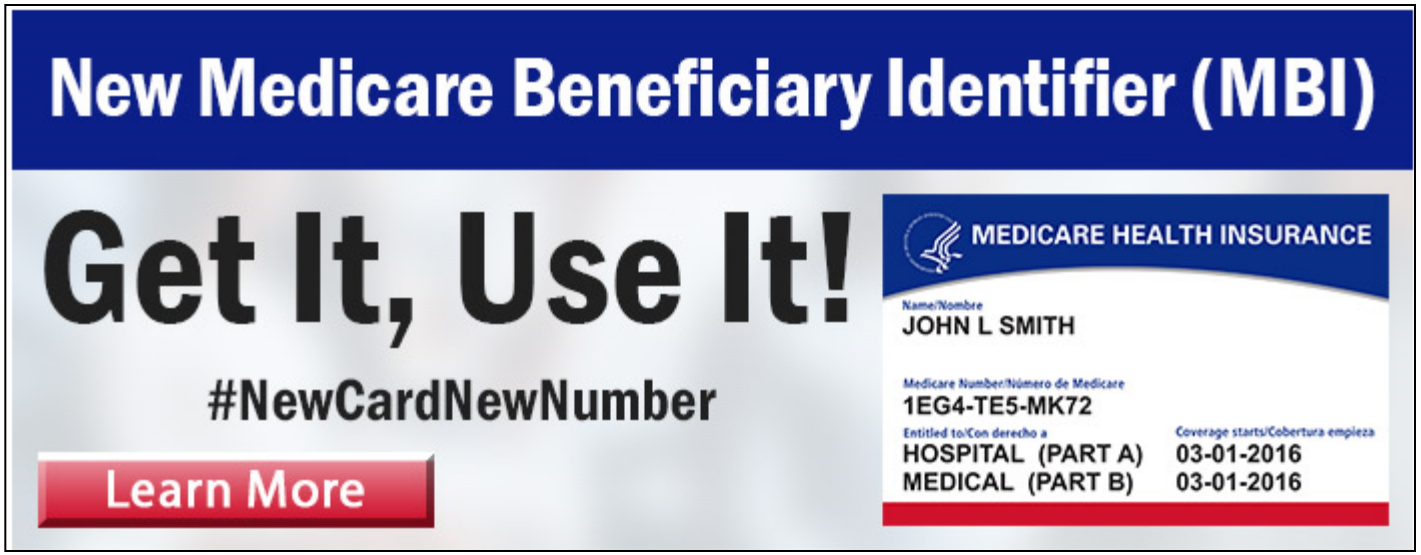
For more information please visit www.c2cinc.com/Appeals-Demonstration or https://www.cms.gov/Medicare/AppealsandGrievances/OrgMedFFSAppeals/index.html

Calendar of Events

- Be sure to check our calendar to register for upcoming events.
- https://www.cgsmedicare.com/medicare_dynamic/wrkshp/pr/hhh_report/hhh_report.aspx

Are YOU Using the MBI on YOUR Claims?

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



https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE18006.pdf

Pre-Submitted Questions Home Health & Hospice

Home Health and Hospice - Sandy Decker

Questions & Answers

- **Question:** Maryland does not require physician supervision of nurse practitioners. Will CMS be accepting nurse practitioners' signatures to certify the need for home health?
- **Answer:** Nurse practitioners or physician assistants are not allowed to sign certifications.

Questions & Answers

- **Question:** Currently we do a chart review after each certification period. If we find an order inadvertently did not get queued and sent then we wait to final bill until the order is signed and returned. With PDGM the billing moves to 30 day periods, recert/episode remains at 60 days. If we find on recertification review (every 60 days) that an order was missed in the first 30 day period that has already been billed do we need to return payment for that 30 day period, re-RAP and then final bill when the order is received?
- **Answer:** Providers would need to verify they have the orders for the 30 day period they are billing. CGS encourages providers to have a strong internal process for order verification. Conditions for billing the RAP are to have at least verbal orders received and documented and this is not changing with PDGM.

Questions & Answers

- **Scenario:** Missing narrative summary for Benefit Period 2 or lack of chosen attending physician certification due to unable to obtain one
- **Question:** Other than the case of a missing F2F, under what circumstances would a beneficiary need to be discharged and readmitted related to the cert/recertification process?
  1. In essence, if a narrative summary was missing for benefit period 2 cert but is present for benefit period 3, do those months between BP2 and 3 become non-bill or does the hospice need to administratively discharge and readmit?
  2. Claim is billed but then noticed that there is no signed attending cert and unable to obtain one
  3. Are there other circumstances?
- **Answer:** It would be an internal agency decision on how they choose to handle the scenario. As a MAC we can't tell them when to discharge and readmit.

Questions & Answers

- **Question:** When the HIC# changes, the system usually refers you to the new HIC# for the patient. If the MBI# changes, will the system direct us to the new MBI# as the HIC# did?
- **Answer:** The provider who posed the question uses Ability, so we encourage providers to check with their vendors regarding similar concerns and their readiness with the Medicare Beneficiary Identifier (MBI) Transition. However, the MBI should function as the HICN has in the past.

Questions & Answers

- **Question:** The system currently pulls up the correct HIC# for you if most of the information is correct. It shows what you keyed, invalid, and the correct HIC#. Will the system give the correct MBI if the other information is correct?
- **Answer:** The provider who posed the question uses Ability, so we encourage providers to check with their vendors regarding similar concerns and their readiness with the Medicare Beneficiary Identifier (MBI) Transition.

Questions & Answers

- **Question:** I was told ALL HIC#'s will change over to MBI's for 01.01.2020. With all the Hospice issues we are having on our claims (SIA payments due, tier level issues, etc.), if some of these are not corrected until after the first of the year and the patient is now deceased with NO MBI#, How will we get these worked? I checked to see if one of our patient's now deceased had an MBI# through the web portal and the system stated the information was invalid. I am understanding this to mean they have no MBI#.
- **Answer:** Adjustments and appeals may continue to be submitted with the HICN after the transition period.

Questions & Answers

- **Question:** If the name is spelled incorrectly and the MBI# is correct, will the system give the correct name spelling as the system currently does for HIC#'s? (suffix's, spaces, additional letters, etc..)
- **Answer:** The provider who posed the question uses Ability, so we encourage providers to check with their vendors regarding similar concerns. Be sure to verify eligibility using your system of choice.

Questions & Answers

- **Question:** Upon the system update in January 2020 using MBI only, if we adjust a claim with a HIC# will the system update this to MBI, or do we change this to the MBI before submitting our adjustment through DDE?
- **Answer:** Adjustments are one of the limited exceptions where providers may continue to use the HICN after the transition period.

Questions & Answers

- **Question:** Hospice agency addresses are updated through provider enrollment with an 855I, why is that new address information not relayed to all departments, specifically reimbursement?

  We have issues with CAP letters being sent to old addresses and they will not forward the letter to our attention indicating if the address is wrong they can't fax to us.

- **Answer:** Hospice addresses are not updated via the 855I, they are updated via the 855A. Address updates are forwarded to our internal reimbursement area. We'd need to see specific examples.

Questions & Answers

- **Question:** When will the Hospice Transfer issue with tier payments be resolved and will providers have to manually adjust the claims for the correct payments?
- **Answer:** We apologize for this inconvenience. CMS is working to resolve.

Questions & Answers

- **Question:** The CWF is indicated to be discontinued in the future. We continue to have issues where HETS only returns Hospice benefit periods from the 4 previous years. We continue to verify eligibility in CWF and find that the benefit periods are reflected correctly. Why can't HETS provide the same information. We will have missed F2F and benefit period issues if this is not resolved and CWF is retired.
- **Answer:** Change Request 11277 was to be implemented October 7, 2019, and should resolve most of these discrepancies. If you continue to encounter problems, please contact our PCC at 1.877.299.4500, Option 1.

Questions & Answers

- **Question:** We recently received an EFT payment/remittance that had several patients with SIA visits paid twice. When calling the PCC, they indicated they do not see that the charges were over paid. We can clearly see this on the remittance and were paid more than we billed. Is this an issue that will be resolved by CGS or will we have to indicate this on the credit balance report, also why would the PCC see conflicting information?
- **Answer:** The Provider Outreach and Education Team is not aware of this issue. However, anytime you're receiving conflicting information, you may request to have your call escalated or request a call back from a Tier 2 or supervisor. Please contact our Provider Contact Center again for further assistance.

Questions & Answers

- **Question:** What are the billing days for PDGM, 30 or 31 days from SOC? Prior to billing what should be present in order to bill the first 30?
- **Answer:** Home health agencies (HHAs) will need to submit a RAP at the beginning of each 30-day period and a final claim at the end of each 30-day period. Before submitting the final claim, the HHA should ensure the OASIS assessment is completed and submitted to the iQIES system and the Request for Anticipated Payment (RAP) is submitted. Refer to the CGS Home Heath Patient-Driven Groupings Model (PDGM) Web page at https://www.cgsmedicare.com/hhh/education/materials/pdgm.html for a CGS Overview.

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