We IMPACT Lives!

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A CELERIAN GROUP COMPANY

● Summer ● 2014

Real Help for Real Issues

PROVIDING YOU WITH THE TOOLS YOU NEED TO ADDRESS EVERYDAY BILLING PROBLEMS.

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Helping you find the information you need . . . when you need it!

It's finally here - Real Help for Real Issues.

This guide was designed for YOU – our Jurisdiction 15 Medicare providers – to have instant access to the tools you need to make your Medicare lives MUCH easier!

In this educational tool you will find the web pages used most frequently on the CGS and the Centers for Medicare & Medicaid Services (CMS) web sites. It includes easily-accessible information on key topics such as coverage, billing, provider enrollment and various payment issues to assist health care professionals in navigating the web sites.

Select a topic from the *Table of Contents* and explore!

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

New Technology: myCGS Web Portal

The myCGS Web Portal allows you instant access to helpful information about your Medicare patients and the claims you submit.

CGS is pleased to offer secure and fast access to your Medicare information through myCGS. Our self-service web portal allows you the flexibility to perform a number of Medicare inquiries and actions securely and electronically when it is convenient to YOU!

Here is an overview of what *myCGS* will allow you to do!

- CLAIMS Tab: Check the status of claims submitted to CGS
- REMITTANCE Tab: View and print remittance advices (RAs)
- ELIGIBILITY Tab: With validated patient information you can check current and previous year's deductible and therapy cap information; date next eligible to receive one of the Medicare-covered preventive services; enrollment in Medicare Advantage (MA) plan; determining primary payer to Medicare; details on home health episodes and hospice benefit periods; data on hospital and skilled nursing facility stays
- FINANCIAL TOOLS Tab: inquire about claims approved-to-pay and the last three checks issued
- MESSAGES Tab: read secure messages and alerts regarding system access and functions performed in the portal
- FORMS Tab: submit certain forms directly to CGS. Currently available - requests for Redetermination and eOffset (immediate offset)
- ADMIN Tab: used by Provider Administrator to grant access to other users

Enjoy the convenience and time saving benefits of myCGS!

Register TODAY!

SMARTER BILLING: Experience vs. Discipline

Providers with great *EXPERIENCE* bill claims based on how they have throughout their Medicare lives.

- RESULTS: Frustration with rejections and the need to resubmit claims.

Providers with great *DISCIPLINE* check myCGS before submitting claims.

- RESULTS: Claims paid right the FIRST time!

Contacting CGS

CMS requires all Medicare contractors to have a Provider Customer Service Program (PCSP) to assist providers in understanding and complying with Medicare's operational processes, policies, and billing procedures. The primary responsibility of the PCSP is to enable providers to understand, manage, and bill the Medicare program correctly.

Customer Service – 866.276.9558

- *Provider Contact Center*
- *EDI Help Desk*
- *Provider Enrollment*
- *Telephone Reopenings*
- *Overpayment/Recovery*

Interactive Voice Response (IVR)

- *866.290.4036*
- *IVR User Guide*

CGS Website www.cgsmedicare.com

- *Kentucky & Ohio Part B*
- *Part B Education & Events*

Email Inquiries

- *Online Help Center*

Facebook

- *www.facebook.com/CGSJ15*

Top Inquiries

Modifier Usage	- Refer to the *Modifier Finder Tool* for assistance o CPT modifiers 59 and 25
Additional Documentation Requests (ADRs)	- Sent when additional information needed to process a claim o Return requested documentation within 30 days o Verify signatures before sending; include attestation, if needed o Avoid sending duplicate claims
Incarcerated Beneficiaries	- Common working file (CWF) showed Medicare beneficiaries were incarcerated, resulting in claim denials and overpayment requests - Refunds have been issued; affected patients identified - Refer to FAQs for all the details - Supplemental insurers may not receive notice of adjustment
Fee Schedules and Reimbursement	- Various fee schedules available on the *Part B Fees* web page - The 2% Sequestration reduction assessed through March 2015
Outpatient Therapy Functional Reporting	- *Functional Reporting* gathers patient functional limitations during the therapy episode of care by use of non-payable G-codes and modifiers o Required at specific intervals and must be reported in order

MEDICARE CLAIMS: Know the Facts

A few *FAST FACTS* on Medicare claims:

- Medicare Part A/B enrollment: 52 million
- Medicare Advantage Enrollment: 15.7 million
- J15 Medicare FFS Enrollment: 2.8 million
- J15 Provider Enrollment: 51,000 Providers
- J15 Part A/B Claims Processed Annually: 72 million
- J15 Home Health & Hospice Claims Processed Annually (15 States): 2.3 million
- J15 Annual Payment: $22 Billion

Payment Issues: Return to Provider (RTP)

Returning an "unprocessable" claim to a provider does not mean CGS will physically return every claim submitted with incomplete or invalid information. The MA130 remark code on the remittance advice (RA) identifies an RTP (rejected) claim. Review the other reason codes for help determining reason for rejection.

Top Rejections

Incorrect Beneficiary HIC Number	- Maintain a copy of the patient's Red, White and Blue Medicare card o Submit the name and Health Insurance Claim (HIC) number as it appears on the card
Incorrect MSP Type	- When filing Medicare Secondary Payer (MSP) claims, you must include the correct MSP type for the patient. This is based on the reason Medicare is the secondary payer o TIP: *myCGS* provides this information!
Claim Not Covered by this Payer/Contractor	- Certain supplies and Durable Medical Equipment (DME) are submitted to the DMEMAC o Check the *2014 Jurisdiction List for DMEPOS* - Claims must be submitted to the correct payer when patients are enrolled with Medicare Advantage (MA) plan instead of traditional Medicare o TIP: *myCGS* provides this information!
Missing/Invalid Referring or Ordering Provider	- Phase 2 ordering/referring edits were implemented January 6, 2014 - Some services require an ordering/referring provider to be reported
Insurance Primary to Medicare	- When Medicare is secondary, the primary payer must be billed first o If corrections needed, patient must contact the *Benefits Coordination and Recovery Center (BCRC)* o TIP: *myCGS* provides this information!

Payment Issues: Claim Denials

Claim denials are also identified on the RA. To avoid denials and get claims paid the first time, utilize ALL resources available to you on the CGS web site.

Top Denials

Denials related to Local (LCDs) and National Coverage Determinations (NCDs)	- Check LCDs or NCDs prior to service to determine coverage. This will also help with execution of the *Advance Beneficiary Notice of Non-Coverage (ABN)*
Statutorily Excluded / Non-Covered Services	- Services statutorily excluded by law are never covered by Medicare o You may notify the patient by using the ABN
Provider Not Certified	- Identifiers deactivated if no response to Revalidation request within 60 days
Correct Coding Initiative (CCI)	- The National Correct Coding Initiative (NCCI) identifies code pairs that are bundled - Check CCI edits prior to claim submission o Medicare record must support use of CCI modifier o Append modifier to the Column 2 code
Global Surgery Denials	- Medicare reimburses surgeries based on a package of care - Services included in the global surgery package are not separately payable - Exceptions may be submitted with a modifier and supportive in medical record o CPT modifiers 24, 25 AND 57 (E/M); CPT modifiers 58, 78 and 79 (surgeries)

Urgent:
Issues Requiring Your Attention

Knowing how difficult it is to stay on top of important issues, please keep theses approaching deadlines and other hot topics in mind!

Hot Topics

Physician Quality Reporting System (PQRS)	- Federally-mandated quality reporting program for specific eligible professionals (EPs) - Utilize the *PQRS Job Aid* to learn more about reporting methods, selecting measures, incentives and payment adjustments (reductions) - 2014 emphasis on avoiding the 2016 payment adjustment o Choose at least 9 measures across 3 National Quality Strategy (NQS) domains report each measure for at least 50% of the EPs FFS patients • Measure-Applicability Validation (MAV) process if fewer than 9 reported o Report at least 3 measures covering one NQS domain for at least 50% of FFS patients via claims or qualified registry for the purpose of just avoiding the 2016 payment reduction • MAV process if fewer than 3 measures reported o Report at least 3 measures covering one NQS domain for at least 50% of FFS patients via qualified clinical data registry (QCDR) - Contact the *QualityNet Help Desk* at 866.288.8912 or **Qnetsupport@hcqis.org**
Value-Based Modifier	- The Affordable Care Act mandated that, by 2015, CMS begin applying a value modifier under the Medicare Physician Fee Schedule (MPFS) - Provides comparative performance information to physicians to improve the quality and efficiency of medical care o Meaningful and actionable information to physicians so they can improve care o Move toward physician reimbursement that rewards *value* rather than volume - Affects group of 100+ EPs in 2015; 10-99 EPs in 2016; 9 or fewer EPs in 2017
Electronic Health Record (EHR)	- Promotes Electronic Health Record (EHR) through incentives for the "meaningful use" of certified electronic health records technology - EHR objectives must be met in order to receive incentive - 2014 reporting period is 90 days regardless of the stage of meaningful use - Become a meaningful user to avoid 2015 payment adjustment - Option to request a hardship exception from 2015 payment adjustment by July 1, 2015 - Contact the *EHR Information Center* with questions on registration status and incentives
Provider Enrollment Revalidation	- Phase III of Revalidation process o 70% of Part B providers will receive CANARY YELLOW envelop o Application must be completed and returned within 60 days to avoid deactivation - Several resources available on the CGS web site o Top development reasons identified so providers can avoid delays o Listing of KY and OH providers sent Revalidation notice o Other provider enrollment resources
ICD-10 Implementation	- Compliance date: October 1, 2015 - Medicare providers still encouraged to prepare for ICD-10 transition o Specific resources created to assist small providers with the transition - MLN Matters article MM8691 identifies 29 NCDs that have been translated to ICD-10
3- Day Payment Window Policy	- Affects services rendered by hospital (or entity that is wholly owned or wholly operated by hospital) - Inpatient stay claim must include the technical portion of all outpatient diagnostic services and admission-related non-diagnostic services provided during the 3 days preceding admit o Medicare will pay professional component of services with separate PC/TC o Facility rate is paid on services without separate PC/TC - Use HCPCS modifier PD on services subject to this policy - Refer to CMS FAQs for additional information

Compliance Corner: Putting It All Together

There are several programs in place to facilitate the practice of proper documentation and reduce the occurrences of issuing improper payments.

Comprehensive Error Rate Testing (CERT)

The *Comprehensive Error Rate Testing* (CERT) program is designed to comply with the *Improper Payments Elimination and Recovery Act of 2010 (IPERA*). The Centers for Medicare & Medicaid Services (CMS) implemented CERT to measure improper payments in the Medicare fee-for-service (FFS) program. Contractors are charged errors, which are used to identify educational needs of the provider community.

CERT errors charged fall into one of five categories:

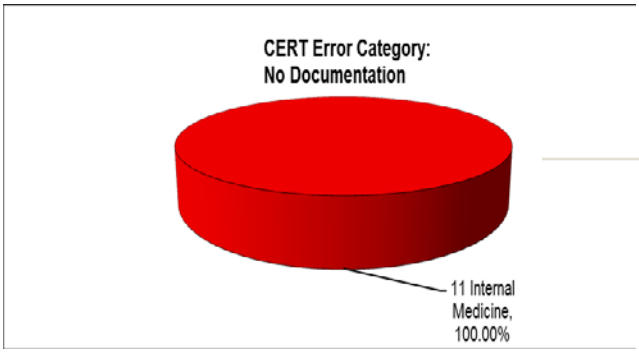
No Documentation	- Provider does not reply to CERT request for records
Insufficient Documentation	- Medicare records do not include pertinent information
Medically Unnecessary	- Clinical review finds documentation to be unsupportive of service billed
Incorrect Coding	- Service billed does not meet requirements for the level
Other	- Duplicate payment - Payment on non-covered services

Disagree with an error? ALWAYS go through the Appeal process!

CERT Top 10 States: Highest Projected Error Rates

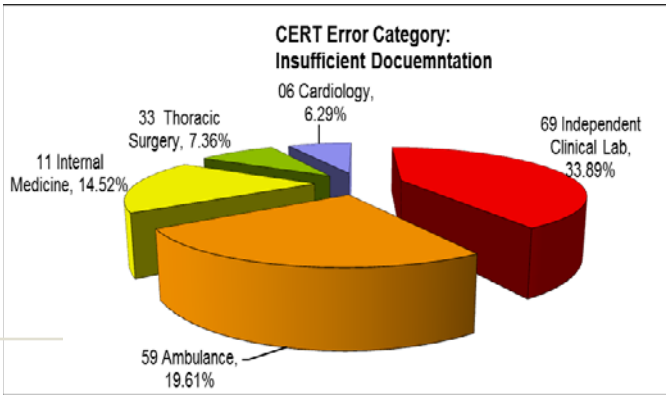
Colorado	89.4%
Virginia	42.1%
Pennsylvania	33.2%
California	30.3%
Utah	29.2%
Kansas	28.5%
Maryland	27.5%
Montana	24.2%
OHIO	**13.7%**
KENTUCKY	**13.6%**

CERT Errors Charged by Specialty



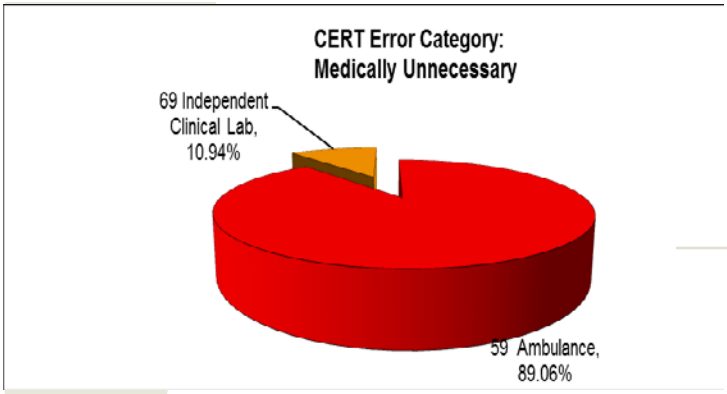
Avoid 'No Documentation' Errors

- Respond to all requests completely
- Return documentation within 75 days
- Include a copy of the bar-coded page with the request



Avoid 'Insufficient Documentation' Errors

- Be sure documentation adequately describes the service billed
- Include copies of signed orders
- Verify signatures are valid, legible and/or present
  - Submit a *Signature Attestation Statement* when necessary



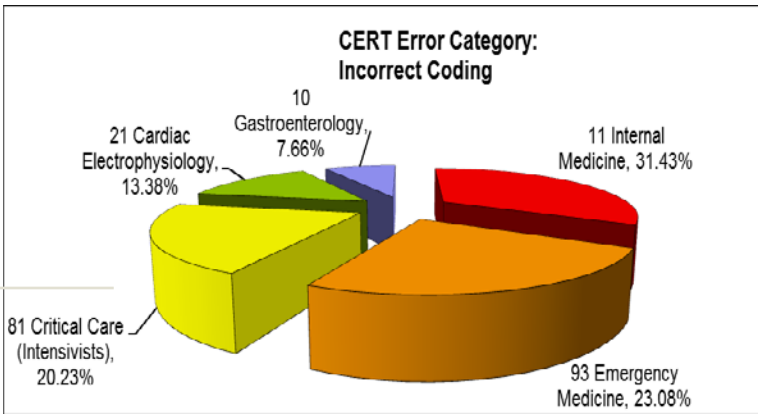
Avoid 'Medically Unnecessary' Errors

- Include all relevant medical records
- Identify the reasons surgeries and/or diagnostic tests are performed
- Always check for LCDs and NCDs to verify medical necessity is being met

Avoid 'Incorrect Coding' Errors

- Be aware of the E/M Documentation Guidelines
  - Key elements of E/M level billed must be met
  - Document time when level of service is based on time spent counseling/coordinating care
  - Always follow the *new patient* guidelines

Don't forget – You can check the status of your CERT reviews by using the CERT Claim Identifier (CID) Tool!



Recovery Auditor (RA) Program

The *Recovery Audit* (RA) program is designed to comply with the *Improper Payments Elimination and Recovery Act of 2010 (IPERA)*. The goal is to identify and correct Medicare improper payments through the efficient detection and collection of overpayments made on claims of health care services provided to Medicare beneficiaries, and the identification of underpayments to providers so that the CMS can implement actions that will prevent future improper payments in all 50 states.

Recovery Audit Facts

- Applies to Medicare fee-for-service (FFS) patients only
- RA reviews are all performed on a post-pay basis
- CMS limits the "look back" period to three years
- All reviews do not require a request for medical records
  - Automated (on-the-record) or complex (medical record request)
- Also limits the number of records requests
- All reviews are conducted by qualified staff
  - Physicians, therapists, nurses and certified coders
- CMS requires RA to obtain approval before adding issues to their purview
  - Once approved, issues must be posted on the RA web site

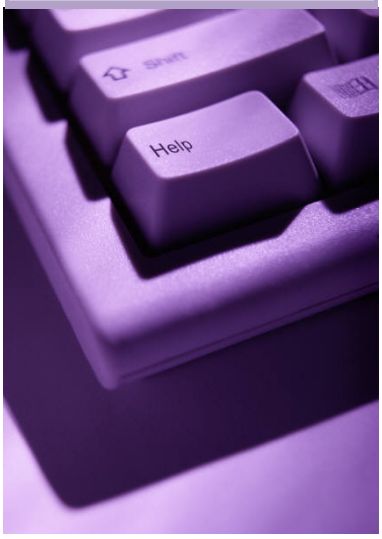
Recovery Audit Tips

- Become familiar with the RA web site
  - The J15 RA is CGI Federal, Inc.
- Access the approved issues at the *'Issues'* link
- Query the database of issues for services provided in your office
  - Make a point of checking with *Issues* log at least once each month
  - Search for *'Physician'* and *'Professional'* to find services that apply to Part B
  - Check for *Details* to learn specifics of review
    - Applicable dates of service
    - CMS references
- Perform self-audits to ensure documentation is supportive of services billed to Medicare

Additional Recovery Audit Tips

- Check the Office of Inspector General (OIG) and CERT web sites
  - Issues identified there may be added to the *approved issues* listing
- Respond to request for medical records completely and as soon as possible
  - 45-day response period
  - No response will result in a request for overpayment
- Request an Appeal if you disagree with the outcome of a review
- Questions regarding RA process? Contact the Provider Relations Coordinator for assistance

CGS Reminders To Make Things Easier!

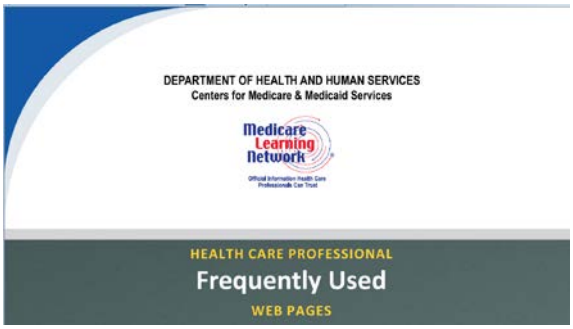


myCGS eOffset	- *eOffset* process designed to allow providers to request an "immediate offset" of a pending overpayment o A demand letter must be been received - Actual refunds cannot be processed through eOffset - To notify CGS of an overpayment, complete the *Voluntary Overpayment Refund Form*
Redeterminations	- Complete the Redetermination request form in its entirety o Better yet – SUBMIT YOUR REDETERMINATIONS THROUGH myCGS! ☺ - If requesting Redetermination due to an overpayment situation, please be sure to indicate this either in myCGS or on the actual form
Provider Enrollment	- The instructions for several sections of the CMS-855 application have been revised as a result of CR8682 o CMS-855A and CMS-855B o Delegated officials - Please be sure to share this with your credentialing staff to avoid delays
Reopenings	- A *Reopening* may be requested to correct a minor error or omission to a previously processed claim - Services requiring the review of medical records CANNOT be handled as a Reopening o This includes services that were reduced during the medical review process based on submitted documentation o Reduced services may be reconsidered by requesting a Redetermination - *SPOILER ALERT: Reopenings will be accepted through myCGS in the near future. Watch for more details!*
Medical Review	- On occasion, local coverage determinations (LCDs) are updated - Please be sure to query the LCD database on a regular basis to ensure you are following the most current policy

CMS Web Pages

Here are a number of frequently used web pages located on the CMS web site

- Medicare Home Page
- Advance Beneficiary Notice of Non-Coverage (ABN)
- Acronyms
- Change Requests (CRs) and Transmittals
- Coordination of Benefits
- Glossary
- Health Plans – General Information
- Internet-Only Manuals (IOM)
- Medicare Physician Fee Schedule Database (MPFSDB)
- Medicare Provider-Supplier Enrollment
- MLN Catalog of Products
- MLN General Information
- MLN Electronic Mailing List
- National Coverage Determinations (NCDs)
- Outreach & Education
- Physician Self-Referral
- Physician Bonuses
- Preventive Services
- Quality Incentives – General Information
- Quality Improvement Organizations (QIOs)



- Quarterly Provider Updates
- SNF Consolidated Billing
- Therapy Services

NOTES