# Medicare Updates

Western Reserve AAHAM | Annie Scriven | May 19, 2017

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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.

# Provider Enrollment Revalidation

Cycle 2

# Medicare Revalidation Lookup Tool

https://data.cms.gov/revalidation


## Medicare Revalidation List

Medicare providers must revalidate their enrollment record information every three or five years. CMS sets every provider's revalidation due-date at the end of a month, and posts the upcoming six months online. A due date of "TBD" means that CMS has not set the date yet.

**CMS offers several ways for you to view and group the revalidation dates of every provider:**

****Owing to an unforeseen delay we will be refreshing the data on May 13th ,2017****

- This data was last refreshed on **March 1st, 2017**
- Revalidation due dates included on this list range between **March 31, 2016 and September 30th, 2017**
- The next data refresh is tentatively scheduled for **May 13th, 2017**
- Affiliations now include Reassignments as well as PA Employment Relationships
- Data now includes DME Due Dates between **November 1st 2016 and September 30, 2017**
- DME Suppliers are identified on the downloadable file in a new column called **"Enrollment Type"** and are identified as **"1"**

# Medicare Revalidation Lookup Tool (Cont.)

## Search all records

*Quickly view specific providers or suppliers online.*

**Individual Last Name OR Organization Name**

**Individual First Name**

**NPI** **State**

- (•) **all records**
- ( ) **only records with due dates**
- ( ) **records due within a date range**

Search

## Online tables

Browse, search, and filter the entire list online, then save to a file. (Some advanced features of each spreadsheet are intended for data specialists)

### 1. Group practice members only
**A-D | E-L | M-R | S-Z**

Search list of all group records and their reassigned members.

### 2. Entire list of providers and suppliers

Search list of all provider and supplier enrollment records.

### 3. Reassignments and PA Employment relationships

**For data specialists**: Export this table and "join" it with Table 2 to create advanced group queries. Refer to the data dictionary (PDF) for more options.

**How to use the online tables:**

- Sort on a column by clicking its grey header
- Search with the [Find in this Dataset] search bar
- Filter the data by clicking the blue [Filter] button
- Download the file by clicking the light blue [Export] button

The Affordable Care Act requires all Medicare providers and suppliers to revalidate their Medicare enrollment information.

References: ACA Section 6401 (a), 42 CFR §424.515

# Revalidation Process

Submit your revalidation within six months of your due date or when you receive notification from CGS:

- Internet-based PECOS: https://pecos.cms.hhs.gov/pecos/login.do; OR
- Complete the appropriate CMS-855 application.
- If applicable, pay the application fee at: https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do
- Respond to all development requests from CGS timely to avoid a hold on your Medicare payments and possible deactivation of your Medicare billing privileges.
- Additional information can be found in CMS MLN Matters article SE1605: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1605.pdf

# Medical Review & Appeals

# Medical Review Contractors

- Medicare Administrative Contractor (MAC)
- Comprehensive Error Rate Testing (CERT) Contractor
- Recovery Audit Contractor (RAC)
- Supplemental Medical Review Contractor (SMRC)
- Beneficiary and Family Centered Care Quality Improvement Organization (BFCC – QIO)
- Zone Program Integrity Contractor (ZPIC)

# CGS Complex Medical Reviews





## Complex Medical Reviews

| Topic | Publication Date |
|---|---|
| Resource Utilization Group (RUG) Codes RUA, RUB and RUC: Complex Review – Ohio – Continued | 04.13.17 |
| Major Joint Replacement (Medicare Severity Diagnosis Related Group (MS-DRG) 470): Complex Medical Review – Kentucky – Continued | 02.28.17 |
| Cataract Removal (HCPCS Codes 66984, 66983, 66982): Complex Medical Review – Kentucky and Ohio – Continued | 02.28.17 |
| Spinal Injections (HCPCS Code 62311): Complex Medical Review – Ohio – Continued | 02.28.17 |
| Cardiac Rehabilitation (HCPCS Code 93798): Complex Medical Review – Kentucky and Ohio – Continued | 02.28.17 |
| Major Joint Replacement (Medical Severity Diagnosis Related Group (MS-DRG) 470): Complex Medical Review – Kentucky - Continued | 12.13.16 |
| Major Joint Replacement (Medical Severity Diagnosis Related Group (MS-DRG) 470): Complex Medical Review – Ohio - Discontinue | 12.13.16 |
| Cataract Removal (CPT Codes 66984, 66983, 66982): Complex Medical Review – Kentucky and Ohio – Continue | 12.13.16 |
| Spinal Injections (CPT Code 62311): Complex Medical Review – Ohio - Continue | 12.13.16 |
| Cataract Removal (HCPCS Codes 66984, 66983, 66982): Complex Medical Review – Kentucky and Ohio – Continue | 08.11.16 |
| Major Joint Replacement (Medical Severity Diagnosis Related Group (MS-DRG) 470): Complex Medical Review – Kentucky and Ohio – Continue | 08.11.16 |
| Outpatient Cardiac Rehabilitation with Continuous ECG Monitoring (CPT Code 93798): Probe Medical Review – Kentucky and Ohio | 08.11.16 |
| Resource Utilization Group (RUG) Codes RUA, RUB and RUC: Complex Review – Ohio – Continue | 08.11.16 |
| Spinal Injections (HCPCS Code 62311): Complex Medical Review – Ohio – Continue | 08.11.16 |
| Urinary Stent Placement (HCPCS Code 52332): Complex Review – Kentucky and Ohio – Discontinue | 08.11.16 |
| Resource Utilization Group (RUG) Codes RUA, RUB and RUC: Complex Review – Ohio Documentation Findings | 07.27.16 |

# RUG Codes RUA, RUB and RUC

- Denial rate: 34.5%
- Reasons for denial:
  - Documentation did not support medical necessity of the service
  - Medical records were not received in response to an Additional Documentation Request (ADR) within the required timeframe (45 days)
  - Documentation did not meet the criteria of the RUG code(s) billed

# Cataract Removal (CPT Codes 66982-66984)

- Denial rate: 47.2%
- Reasons for denial:
  - Documentation did not support medical necessity of the service
  - Services not documented in the medical record
    - Missing documentation included: biometry results, visual acuity exams, description of impairment of ADL's, and documentation to support cataracts as the primary cause of the beneficiary's decreased visual acuity
    - Include office notes from the ophthalmologist (per LCD L33954)
  - Medical records were not received in response to an ADR within the required timeframe (45 days)
  - According to documentation in the medical record, the service was billed in error

# Spinal Injections (CPT Code 62311)

- Denial rate: 55.8%
- Reasons for denial:
  - Documentation did not support medical necessity of the service
    - Missing documentation included: description of conservative treatments, description of impairment or neurological deficits affecting ADL's, details of previous ESI's and effects, and imaging reports to support medical necessity for treatment
    - Include office notes from any physician that are relevant to this procedure (per LCD L34807)
  - Medical records were not received in response to an ADR within the required timeframe (45 days)
  - According to documentation in the medical record, the service was billed in error

# Cardiac Rehabilitation (CPT Code 93798)

- Denial rate: 46.8%
- Reasons for denial:
  - One or more of the required components were not submitted in the medical record:
    - Physician-prescribed exercise
    - Cardiac risk factor modification
    - Psychosocial assessment
    - Outcomes assessment
    - Individualized treatment plan
  - Documentation did not support that the program was under the direct supervision of a physician
  - Medical records were not received in response to an ADR in the required timeframe (45 days)

# MR Reopening vs. Redetermination

- ADRs may be accessed via the following:
  - Mail
  - Direct Data Entry (DDE) status location SB6001
  - myCGS
- Respond to ADRs within 45 days
- If documentation is not received in response to an ADR within 45 days, CGS is unable to make a determination and must deny the claim (reason code 56900).
- If you wish to submit documentation after the claim has been denied:
  - Within 120 days of the date of denial, send the ADR and documentation to the Medical Review department and request a MR reopening
  - After 120 days of the date of denial, you may request a redetermination

# Reminder!

Medical records may be sent via:

- Mail
- Fax
- myCGS
- esMD
  - To avoid delays in processing, ensure the DCN ends in OHA (all alpha characters), not 0HA (zero instead of alpha O).

# CGS Medical Policy Resources

- CMD.Inquiry@cgsadmin.com:
  - For questions related to Local Coverage Determinations (LCDs), CMS policy interpretation and clinical questions for our Contractor Medical Directors (CMDs) and clinical staff
  - Monitored daily and a response can be expected within 14 days for providers and 30 days for consultants
  - Please do not email patient information. If referencing a claim, only the Document Control Number (DCN) may be accepted.
- J15IDE@cgsadmin.com:
  - For clinical trial submissions and related questions
  - Every effort is made to respond within 14 business days.
  - Please do not email patient information. If referencing a claim, only the DCN may be accepted.

# CERT Errors

- No documentation submitted:
  - If you send documentation in response to a CERT request, but receive another request, please contact the CGS CERT Coordinator to verify the documentation was received.
  - When billing for services performed outside of your facility and/or for services performed outside of your facility that support medical necessity of a service, it is your responsibility to obtain and include the documentation from the third party.
- No documentation to support medical necessity of lab services:
  - On the requisition, please include a written statement by the treating physician and the ICD-10 diagnosis code that explains the reason the labs are being ordered.

# CERT Errors (Cont.)

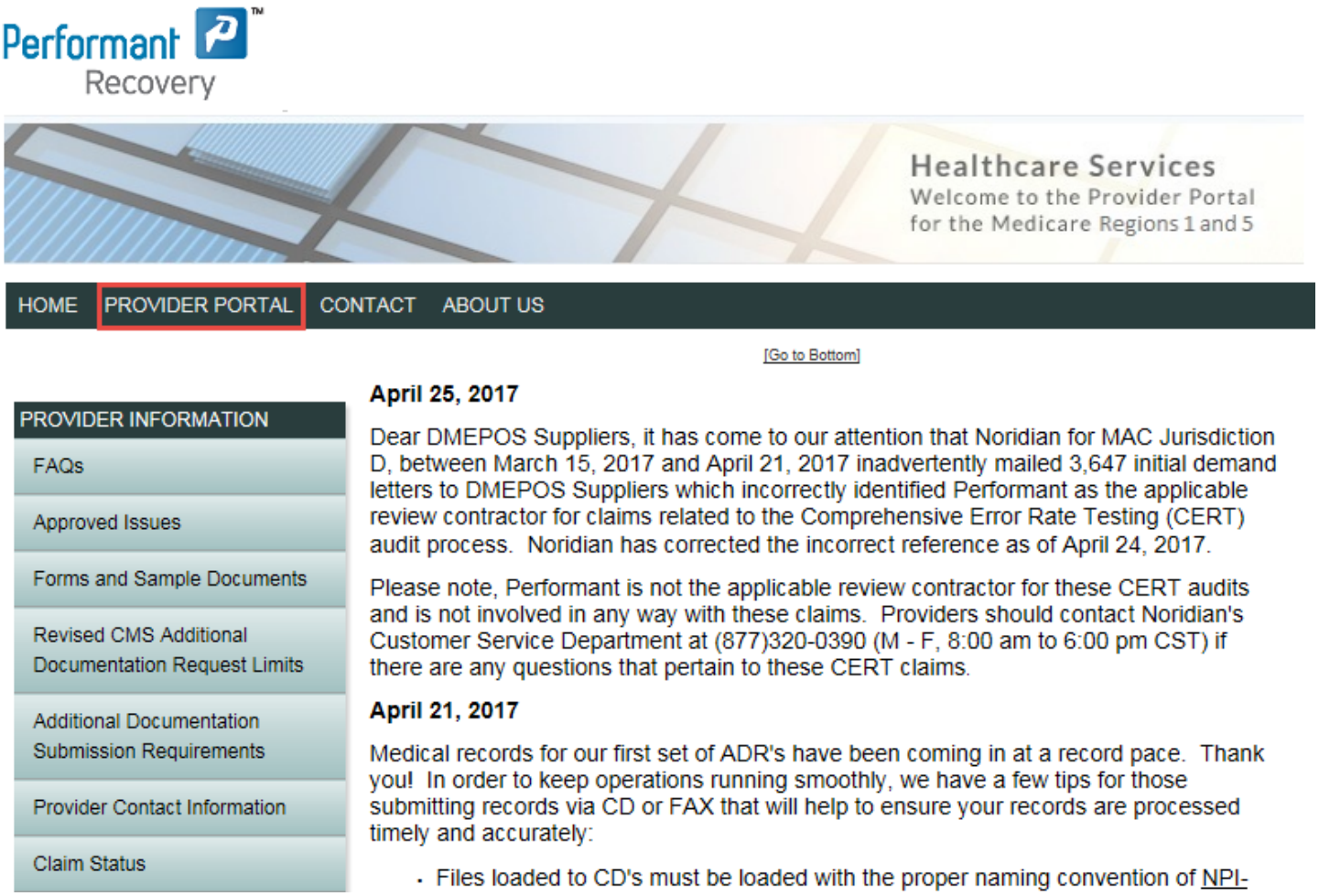
- Missing or illegible signatures:
  - Educate clinical staff to always include a legible signature.
  - Late signatures (beyond the short delay that occurs during the transcription process) are not acceptable.
  - If a signature is missing (or illegible), include an attestation statement.
  - If a signature is illegible, include the printed name and/or a signature log.
    - On your letterhead, print the provider's name and have that provider sign his/her name/initials in every variation he/she might use.
  - Review the signatures prior to sending and include a signature log and/or attestation statement where applicable.
  - CMS Medicare Program Integrity Manual (Pub. 100-08), chapter 3, section 3.3.2.4: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf

# CERT Resources

- CGS website: https://cgsmedicare.com/parta/cert/index.html
- Use the CERT Claim Identifier (CID) Tool to track the outcome of claims reviewed by CERT: https://cgsmedicare.com/medicare_dynamic/cid_tool/index.asp
- If you have questions or concerns related to a CERT review, please contact the CGS CERT Coordinator, Julene Mull:
  - Phone: 615.782.4591
  - Fax: 615.664.5961
  - Email: julene.mull@cgsadmin.com
  - Mail: Two Vantage Way, Nashville, TN 37228

# Recovery Audit Contractor (RAC)

https://www.performantrac.com/



# KEPRO Updates

Recent changes to BFCC-QIO processes:

- Beginning in April 2017, Short Stay claim reviews sample sizes:
  - 25 cases for the top 175 providers with a high or increasing number of Short Stay claims per Area
  - 10 cases for all other providers previously identified as having "Major Concerns" in the prior round of review
    - https://www.keproqio.com/twomidnight/Default.aspx
- Beginning in May 2017, bar codes, which correlate to the associated case ID, will appear at the top of all fax request documents. This document must be attached as the first sheet of each batch of records submitted to the BFCC-QIO.
  - KEPRO.Communications@hcqis.org

# Review Results Letter vs. Demand Letter

- Medical review contractors (except the CERT contractor) are required to (or may voluntarily) issue a review results letter once a determination is made.
- If a claim is reviewed by the RAC or SMRC, they must notify CGS of the determination and CGS adjusts the claim accordingly.
- When the claim is adjusted for an overpayment, a demand letter is issued.
- If you disagree with the determination, you must wait until you receive the demand letter to request a redetermination (first level of appeal). We cannot process an appeal until the claim has been adjusted to reflect the overpayment.

# Social Security Number Removal Initiative (SSNRI)

# SSNRI

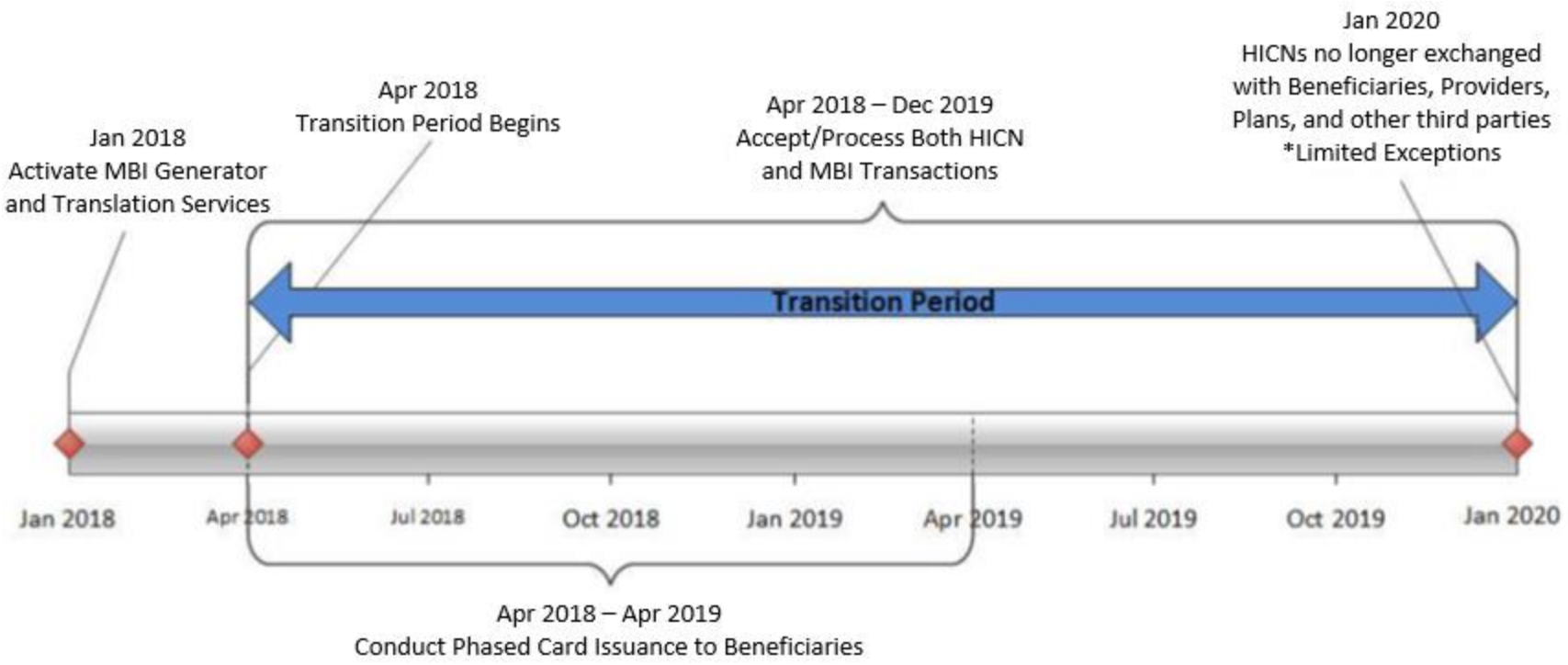
# SSNRI (Cont.)

https://www.cms.gov/medicare/ssnri/index.html

# General Information

- Social Security Numbers (SSNs) must be removed from all Medicare cards by April 2019.
- Each person enrolled in Medicare will receive a new Medicare card with a new Medicare Beneficiary Identifier (MBI) that will replace the SSN-based Health Insurance Claim Number (HICN).
- The MBI is confidential like the SSN and should be protected as Personally Identifiable Information.

# SSNRI Timeline



# SSNRI Card Issuance

**April 2018 through April 2019:**

- CMS will start issuing new Medicare cards for existing beneficiaries after the initial enumeration of MBIs.
- The gender and signature line will be removed from the new Medicare cards.
- CMS will be working in conjunction with the Railroad Retirement Board who will also issue their own cards.
- CMS will be working with states that include the HICN on their Medicaid cards to effectuate a change to remove the Medicare ID or replace it with a MBI.

# Provider Tips

- Remind your patients to bring their new Medicare cards to their appointments. CMS will be developing material to assist with this.
- Coordinate with primary care doctors or referring facilities.
- Ask your patients to contact the Social Security Administration to update their address if it doesn’t match the address you receive from the electronic eligibility transaction response.

# MBI Characteristics

- The same number of characters as the current HICN (11), but will be visibly distinguishable from the HICN
- Contain uppercase alphabetic and numeric characters
- Occupy the same field as the HICN on transactions
- Be unique to each beneficiary (e.g. husband and wife will have their own MBI)
- Be easy to read and limit the possibility of letters being interpreted as numbers (e.g. Alphabetic characters are upper case only and will exclude S, L, O, I, B, Z)
- Not contain any embedded intelligence or special characters
- Not contain inappropriate combinations of numbers or strings that may be offensive

# MBI Format

| Pos. | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Type | C | A | AN | N | A | AN | N | A | A | N | N |

**Where:**

**C** – Numeric 1 thru 9

**A** – Alphabetic Character (A...Z); Excluding (S, L, O, I, B, Z)

**N** – Numeric 0 thru 9

**AN** – Either A or N

*****NOTE: Alphabetic characters are Upper Case ONLY**

**Position 1** – numeric values 1 thru 9
**Position 2** – alphabetic values A thru Z (minus S, L, O, I, B, Z)
**Position 3** – alpha-numeric values 0 thru 9 and A thru Z (minus S, L, O, I, B, Z)
**Position 4** – numeric values 0 thru 9
**Position 5** – alphabetic values A thru Z (minus S, L, O, I, B, Z)
**Position 6** – alpha-numeric values 0 thru 9 and A thru Z (minus S, L, O, I, B, Z)

**Position 7** – numeric values 0 thru 9
**Position 8** – alphabetic values A thru Z (minus S, L, O, I, B, Z)
**Position 9** – alphabetic values A thru Z (minus S, L, O, I, B, Z)
**Position 10** – numeric values 0 thru 9
**Position 11** – numeric values 0 thru 9

# SSNRI Transition Period

**April 2018 through December 31, 2019:**

- CMS' processes and systems will be updated to accept and return the MBI as of April 1, 2018. CMS will accept, use for processing, and return to stakeholders **either** the MBI or the HICN.
- All stakeholders who submit or receive transactions containing the HICN must modify their processes and systems to submit or exchange the MBI as of April 1, 2018. Stakeholders may submit **either** the MBI or HICN.
- CMS will tell you in the message field on the eligibility transaction responses when we've mailed a new Medicare card to each person with Medicare. Your eligibility service provider can give you this information.

# SSNRI Transition Period (Cont.)

**October 2018:**

- Both the HICN and MBI will be returned on all remittance advices.
- The MBI will be located in the “changed HICN” field:
  - 835 Loop 2100, Segment NM1 (Corrected Patient/Insured Name), Field NM109 (Identification Code)

# After the Transition Period

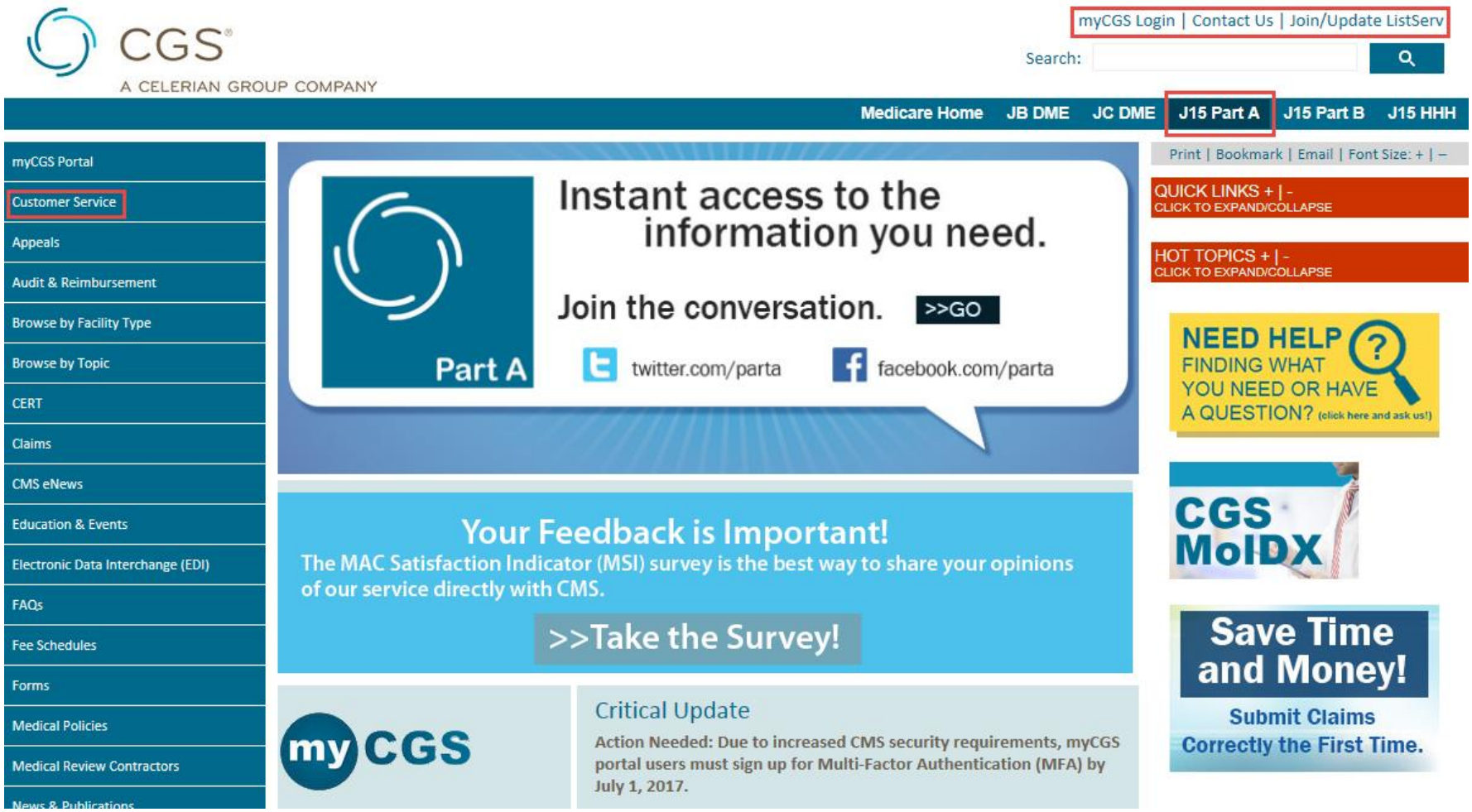
Limited exceptions for use of the HICN:

- Appeals
- Reports
- Retroactive enrollment
- Span-date claims
- Adjustments
- Incoming information requests
- Incoming premium payments

# CGS Resources

# CGS Website

https://cgsmedicare.com/



# J15 Part A Provider Contact Center (PCC)



## J15 Part A Contact Information


Phone / FAX


Mailing Addresses


Self-Service Options


Calendar

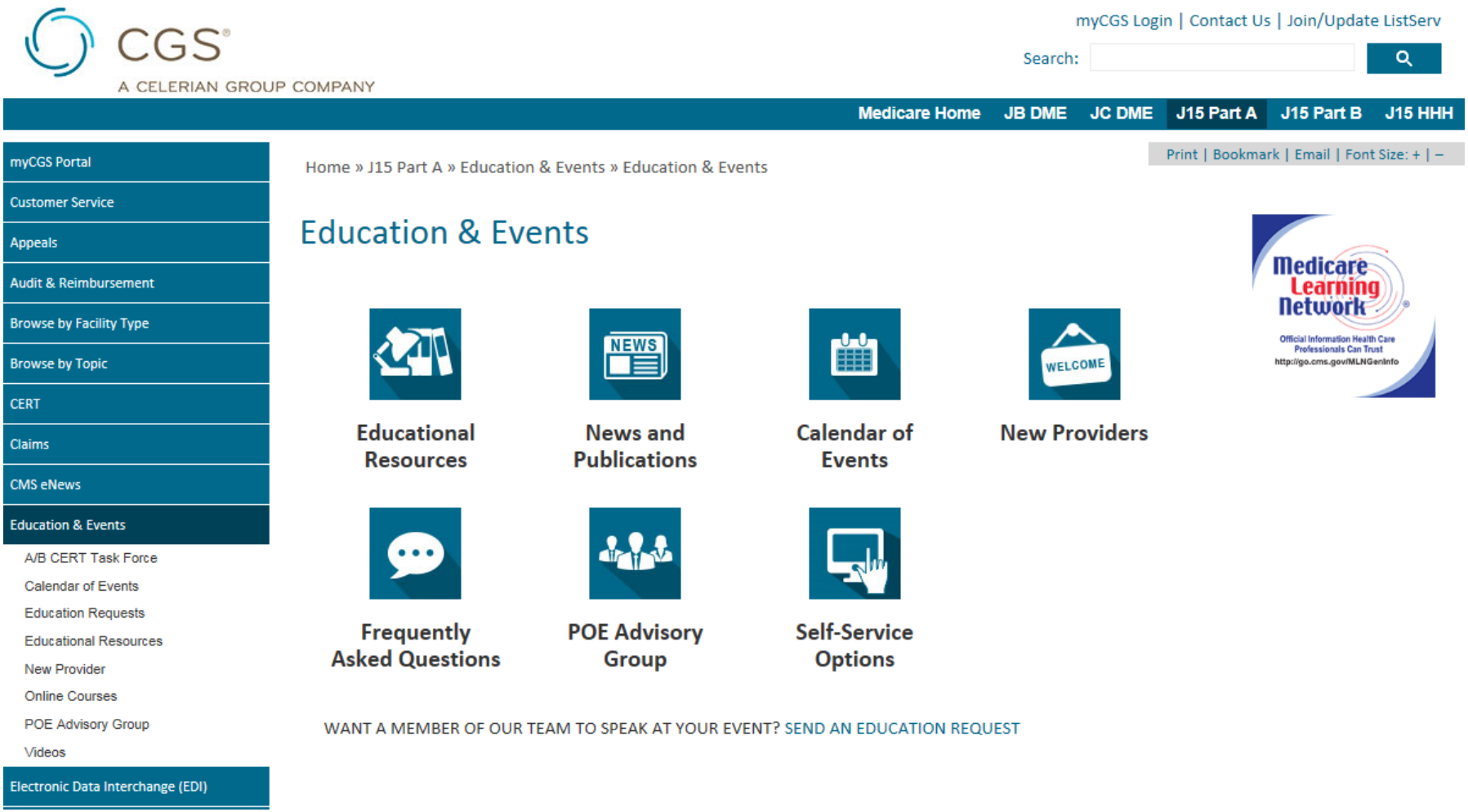

FAQs

## Phone / Fax

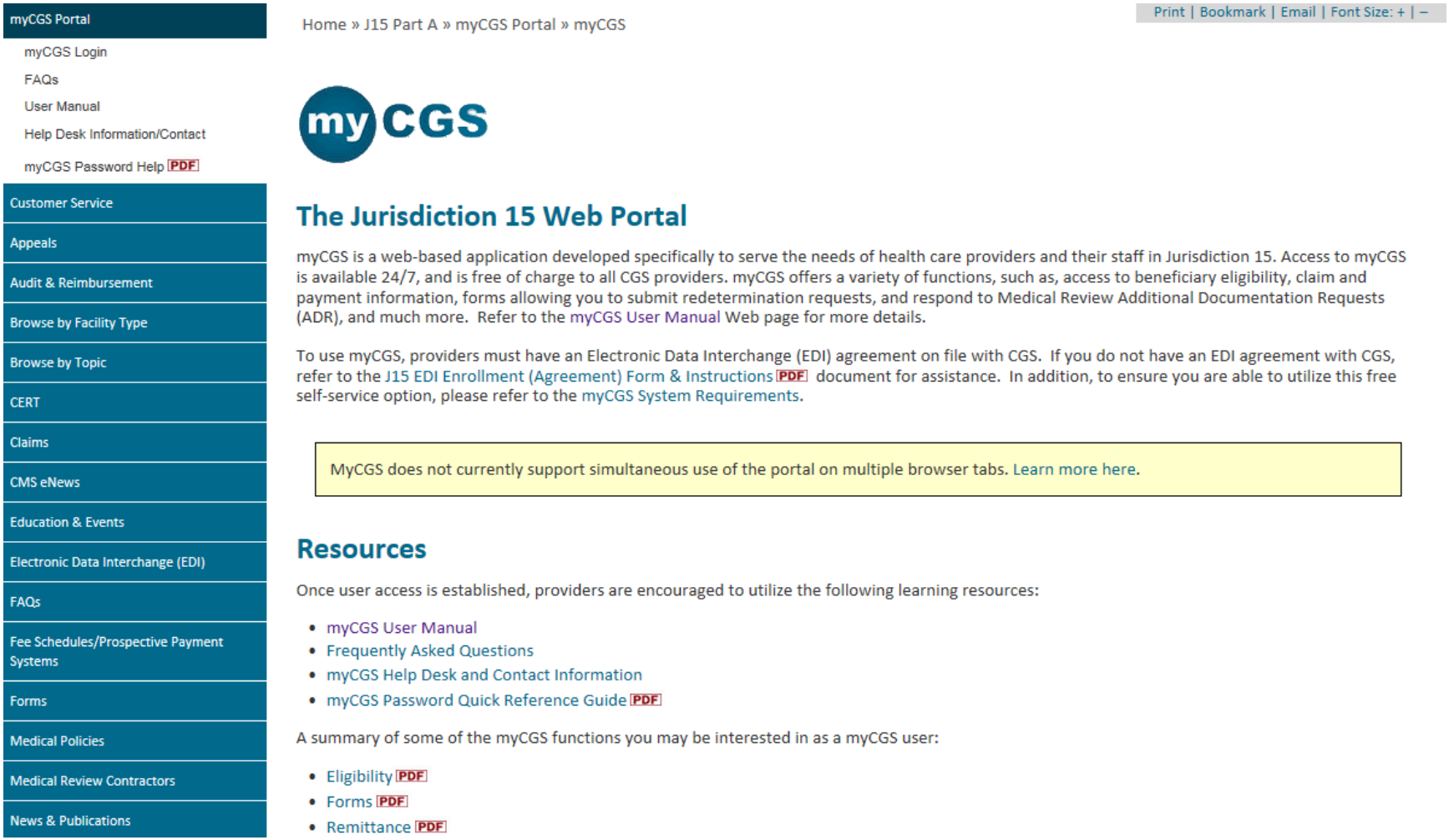
Before calling to speak with a Customer Service Representative (CSR) in the Provider Contact Center (PCC), consider using the **Self Service Tools** CGS offers.

| | | |
|---|---|---|
| **Customer Service** | Phone: 866.590.6703<br>• Option 1: Claims<br>• Option 2: Electronic Data Interchange (EDI)<br>• Option 3: Provider Enrollment (PE)<br>• Option 4: Overpayment Recovery (OPR)<br>• Option 9: General Inquiries<br>8:00 a.m. – 5:00 p.m. (EST) | Before you call, make sure you have:<br>• Your National Provider Identifier (NPI);<br>• Your Provider Transaction Access Number (PTAN);<br>• The last 5 digits of the provider Tax Identification Number (TIN); and<br>• Beneficiary's Medicare Health Insurance Claim (HIC) number, first name, last name and date of birth.<br>CTI User Guide PDF<br>Steps in Using the CTI System PDF<br>2017 Customer Service Holiday / Training Schedule PDF |
| **Telecommunications Devices for the Deaf (TTD/TTY)** | Phone: 855.294.9889 | |
| **Interactive Voice Response (IVR)** | Phone: 866.289.6501 | You will need your facility's NPI, PTAN and the last 5 digits of the provider TIN.<br>IVR User Guide PDF<br>IVR Beneficiary Name to Number Converter |

# Education & Events



# myCGS Portal



# Benefits of myCGS

- Beneficiary eligibility
- Claim status
- Payment information
- General inquiries
- Immediate offsets
- Remittance Advices
- Medical Review (MR) Additional Documentation Requests (ADRs)
- Redetermination requests and appeals status
- Credit Balance and Cost Reports

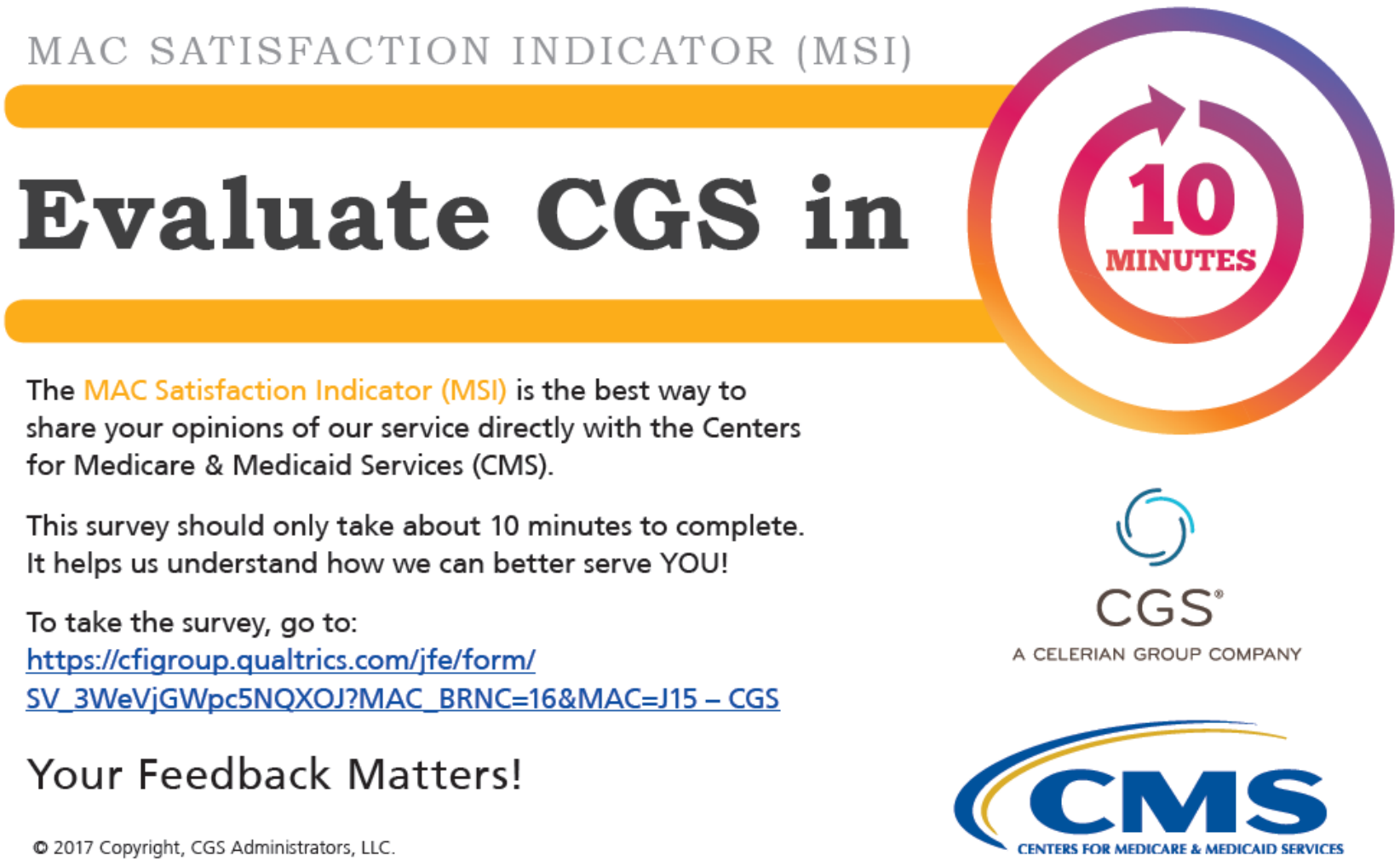

# Green Mail

- Allows immediate access to correspondence from CGS, such as ADRs and decision letters
- Notification is sent to the “Messages” tab and the registered email address.
- Your myCGS Administrator must select “Opt IN” under the “Admin” tab.
- Additional information and instructions are available at: https://cgsmedicare.com/articles/cope2948.html

# Multi-Factor Authentication (MFA)

- Effective May 1, 2017, users are required to use MFA at enrollment, password reset and account update.
- Users may also voluntarily opt in to MFA through June 30, 2017. Log in to myCGS and select the “My Account” tab.
- Effective July 1, 2017, all users will automatically be set to MFA with the email address associated with the user ID.
- Additional information and instructions are available at: https://cgsmedicare.com/articles/cope2571.html

# MAC Satisfaction Indicator (MSI)



# Medicare Updates

Thank you for attending!