FOCUS on 2024!

FINDING ANSWERS

ONGOING MEDICARE INITIATIVES

COMPREHENSIVE ERROR RATE TESTING (CERT)

UNDERSTANDING DATA

SELF-SERVICE TECHNOLOGY

CGS® A CELERIAN GROUP COMPANY

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

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.

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Objectives

- Discuss new and updated Medicare initiatives
- Provide information regarding medical record review contractors
- Provide CGS operational reminders
- Introduce resources and self-service technology options

New and ongoing initiatives include:

- *Post-COVID-19 PHE Updates*
- *Provider Based Edits*
- *Discarded Amounts of Single-Dose Drugs*
- *Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging*
- *Prior Authorization Programs*
- *Preventive Services*
- *ABN Form Renewal*
- *2024 Payment Policies*
- *Hospital Quality Initiative (HQI)*

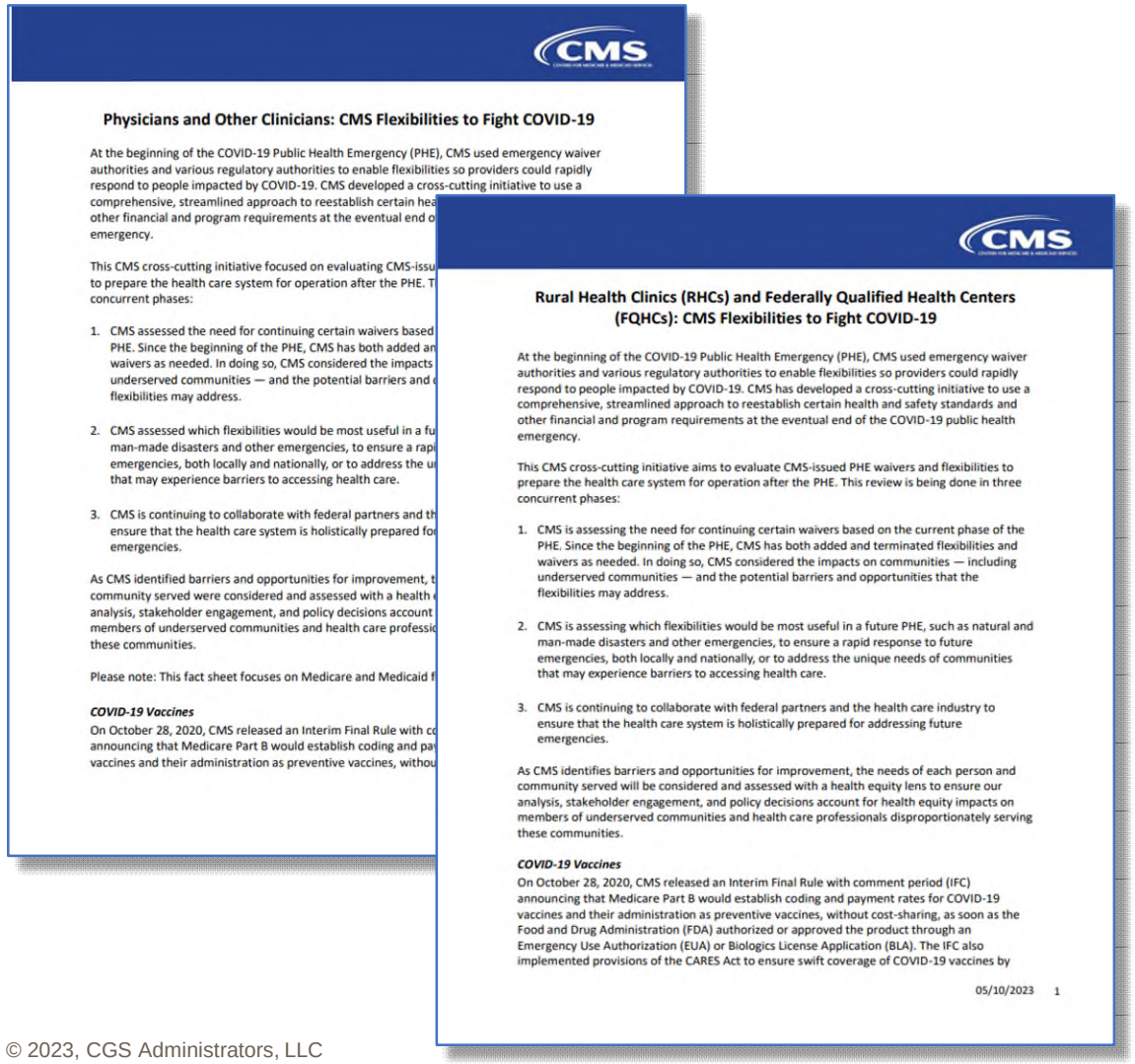
Medicare Initiatives

Post-COVID-19 PHE Updates

CMS Flexibilities

Centers for Medicare & Medicaid Services (CMS) issued emergency waivers

- At beginning of COVID-19 Public Health Emergency (PHE)
- To enable flexibilities for quick response to COVID-19
- Some still in place; others expired
  - Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19
  - Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs): CMS Flexibilities to Fight COVID-19



Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19

At the beginning of the COVID-19 Public Health Emergency (PHE), CMS used emergency waiver authorities and various regulatory authorities to enable flexibilities so providers could rapidly respond to people impacted by COVID-19. CMS developed a cross-cutting initiative to use a comprehensive, streamlined approach to reestablish certain hea other financial and program requirements at the eventual end o emergency.

This CMS cross-cutting initiative focused on evaluating CMS-issu to prepare the health care system for operation after the PHE. T concurrent phases:

1. CMS assessed the need for continuing certain waivers based PHE. Since the beginning of the PHE, CMS has both added an waivers as needed. In doing so, CMS considered the impacts underserved communities — and the potential barriers and flexibilities may address.
2. CMS assessed which flexibilities would be most useful in a fu man-made disasters and other emergencies, to ensure a rapi emergencies, both locally and nationally, or to address the u that may experience barriers to accessing health care.
3. CMS is continuing to collaborate with federal partners and th ensure that the health care system is holistically prepared fo emergencies.

As CMS identified barriers and opportunities for improvement, t community served were considered and assessed with a health analysis, stakeholder engagement, and policy decisions account members of underserved communities and health care professio these communities.

Please note: This fact sheet focuses on Medicare and Medicaid f

COVID-19 Vaccines

On October 28, 2020, CMS released an Interim Final Rule with c announcing that Medicare Part B would establish coding and pa vaccines and their administration as preventive vaccines, withou

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs): CMS Flexibilities to Fight COVID-19

At the beginning of the COVID-19 Public Health Emergency (PHE), CMS used emergency waiver authorities and various regulatory authorities to enable flexibilities so providers could rapidly respond to people impacted by COVID-19. CMS has developed a cross-cutting initiative to use a comprehensive, streamlined approach to reestablish certain health and safety standards and other financial and program requirements at the eventual end of the COVID-19 public health emergency.

This CMS cross-cutting initiative aims to evaluate CMS-issued PHE waivers and flexibilities to prepare the health care system for operation after the PHE. This review is being done in three concurrent phases:

1. CMS is assessing the need for continuing certain waivers based on the current phase of the PHE. Since the beginning of the PHE, CMS has both added and terminated flexibilities and waivers as needed. In doing so, CMS considered the impacts on communities — including underserved communities — and the potential barriers and opportunities that the flexibilities may address.
2. CMS is assessing which flexibilities would be most useful in a future PHE, such as natural and man-made disasters and other emergencies, to ensure a rapid response to future emergencies, both locally and nationally, or to address the unique needs of communities that may experience barriers to accessing health care.
3. CMS is continuing to collaborate with federal partners and the health care industry to ensure that the health care system is holistically prepared for addressing future emergencies.

As CMS identifies barriers and opportunities for improvement, the needs of each person and community served will be considered and assessed with a health equity lens to ensure our analysis, stakeholder engagement, and policy decisions account for health equity impacts on members of underserved communities and health care professionals disproportionately serving these communities.

COVID-19 Vaccines

On October 28, 2020, CMS released an Interim Final Rule with comment period (IFC) announcing that Medicare Part B would establish coding and payment rates for COVID-19 vaccines and their administration as preventive vaccines, without cost-sharing, as soon as the Food and Drug Administration (FDA) authorized or approved the product through an Emergency Use Authorization (EUA) or Biologics License Application (BLA). The IFC also implemented provisions of the CARES Act to ensure swift coverage of COVID-19 vaccines by

05/10/2023 1

Post-COVID-19 PHE Updates

Compliance Programs Post-PHE

During the PHE, flexibilities were applied across claim types. CMS announced medical review plans after PHE ends:

- CMS plans to primarily focus reviews on claims with dates of service outside of the PHE.
  - May still review DME items and services rendered during the PHE, if needed to address aberrant billing behaviors or potential fraud.
  - The Office of the Inspector General may perform reviews as well.
  - All claims will be reviewed using the applicable rules in place at the time for the claim dates of service.
- Refer to Medicare Fee-for-Service Compliance Programs for more details.

Post-COVID-19 PHE Updates

Please refer to the following resources for the most up-to-date information.

- Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19
- CMS PHE Fact Sheet
- Current emergencies | CMS
- Coronavirus Waivers | CMS
- Fact Sheet: COVID-19 Public Health Emergency Transition Roadmap | HHS.gov
- SE20011 - Medicare Fee-for-Service Response to the Public Health Emergency on COVID-19 (cms.gov)
  - NOTE: HCPCS mod CS (cost-sharing) not valid post-COVID-19 PHE

Provider Based Edits

- On **August 1, 2023**, reason codes 34977, 34978, 34984, 34985, 34986 and 34987 were activated.
- Edits validate outpatient off-campus provider department addresses submitted on claims against the service facility address on the CMS 855A Medicare Enrollment application.
- To avoid RTP'd claims:
  - Review SE19007 for details.
  - Verify service facility addresses in myCGS or DDE (Inquiry Menu Option 1D)
  - On claims for services provided at outpatient off-campus provider- based departments:
    - The provider practice location address reported on claim must be an exact match to the service facility address in PECOS
    - Appropriate modifier (PN, PO, ER) must be on applicable service lines

Provider Based Edits

- For a new practice location not enrolled or an existing address that changed, submit 855A form.
- Each address can only be designated as one type of facility. The addresses for the emergency department and the other outpatient department need to be distinct for the claims to process correctly.
- Providers have the option to update the address in PECOS to make them distinct addresses by adding suite numbers, room numbers, etc.

Reason Code Definitions

34977 - Claim service facility address does not match provider practice file address.

34978 - Off-campus provider claim line that contains a HCPCS must have a PN, PO, or ER.

34984 - Modifier ER is not present on the claim and practice location reported is a dedicated emergency department (ED).

34985 - Modifier PO is not present on the claim and a practice location is reported. Refer to SE18002.

34986 - Modifier PN is not present on the claim and a practice location is reported that has a practice effective date on/after 11/2/15. Refer to SE18002.

34987 - Condition code A7 is present on the claim and the location reported is not a Mobile Facility and/or Portable Units.

Discarded Amounts of Single-Dose Drugs

- Finalizing the definition and establishing a process for manufacturers to make refunds for payment on wastage
  - Requirements on using modifiers
    - JW mod: Used for reporting discarded amounts of drugs
    - JZ mod: Used for attesting that there were no discarded amounts
      - This modifier to be used by Jul 1, 2023, in all outpatient settings
      - Could be used beginning dates of service Jan 1, 2023, and after
        - Claims with date Jan – Jun 2023 may have been denied in error
        - All claims denied in error were auto-adjusted
    - Starting Oct 1, 2023, claims without appropriate modifier may be returned.
    - Resources
    - JW and JZ-Modifier-FAQs.pdf (cms.gov)
    - Top Provider Questions – Claim Submission (cgsmedicare.com)

Prior Authorization (PA) for Certain Hospital Outpatient Department (OPD) Services

Part A Claims Only

- Prior authorization must be requested for specific CPT/HCPCS codes for the following groups of hospital OPD services:
  - Blepharoplasty
  - Botulinum Toxin Injections
  - Cervical Fusion with Disc Removal
  - Implanted Spinal Neurostimulators
  - Panniculectomy
  - Rhinoplasty
  - Vein Ablation
  - NEW! Facet Joint Interventions for Pain Management : Dates of service Jul 1, 2023
- Check the listing for specific CPT/HCPCS codes within each group

Prior Authorization (PA) for Certain Hospital Outpatient Department (OPD) Services

Part A Claims Only *(Cont.)*

- Once the prior authorization is affirmed, a unique tracking number (UTN) is sent to the OPD.
- When the service is billed, the UTN must be added to the OPD's Part A claim.
  - Only the hospital OPD is required to include the UTN on claims, as the PA process is only applicable to hospital OPD services.
    - The Part B physician and other billing practitioners are NOT to submit the UTN.
    - Part B physician/practitioners should submit their claims as usual
    - NOTE: Claims related to/associated with services that require prior authorization as a condition of payment will be DENIED if the OPD service requiring prior authorization is not eligible for payment.
- PA OPD Services Frequently Asked Questions (FAQs)
- Part A PA OPD webpage

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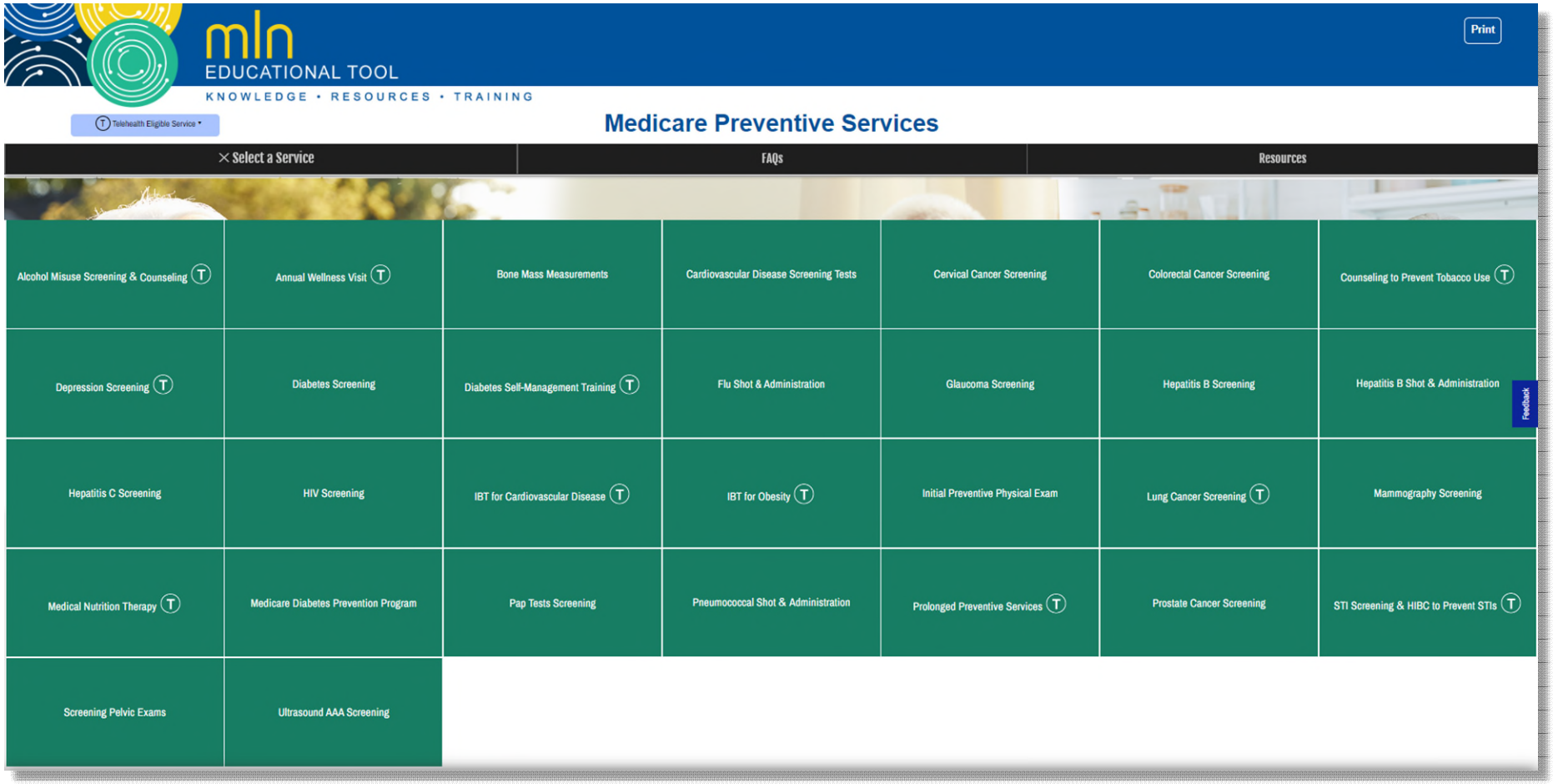
Preventive Services

Keep our seniors healthy! Offer the Medicare-approved Preventive Services!



Annual Wellness Visits Campaign!

Download the [3 Steps to Efficient, Effective, and Reimbursed Medicare Wellness Visits] flyer!

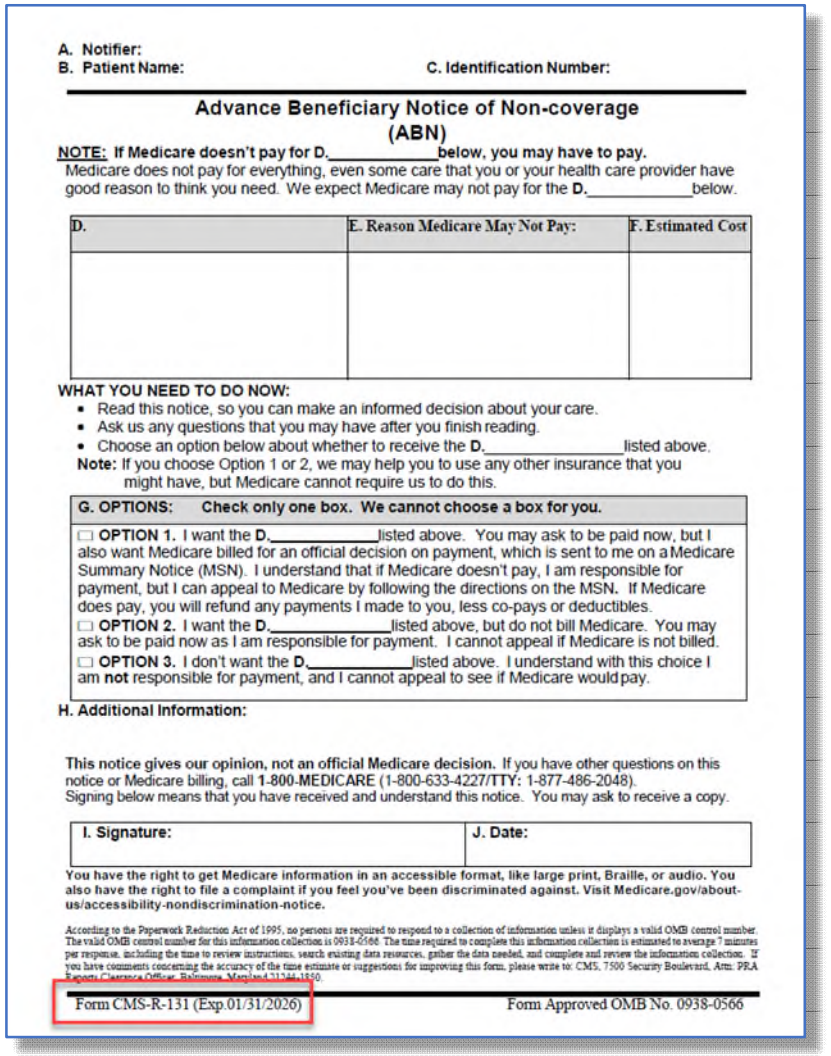
Refer to the [Medicare Wellness Visits Educational Tool] for details!

View [Medicare Wellness Visits video]!

Advance Beneficiary Notice of Non-Coverage (ABN)

Form CMS-R-131 Renewal

- The ABN, Form CMS-R-131, and form instructions have been approved by the Office of Management and Budget (OMB) for renewal.
- Use the renewed form with the expiration date of Jan 31, 2026.
- Updated form **mandatory on Jun 30, 2023**.
- Instructions remain the same.
  - Used for medical necessity situations.
  - May also be used as a reminder Medicare will not pay for statutorily excluded services.
- ABN Forms (English/Spanish and Large Print)
- ABN Form Instructions
- ABN Interactive Tutorial



A. Notifier:
B. Patient Name: C. Identification Number:

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for D._____below, you may have to pay.
Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**_____below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:
- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**_____listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**_____listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**_____listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the **D.**_____listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048). Signing below means that you have received and understand this notice. You may ask to receive a copy.

I. Signature:	J. Date:

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice.

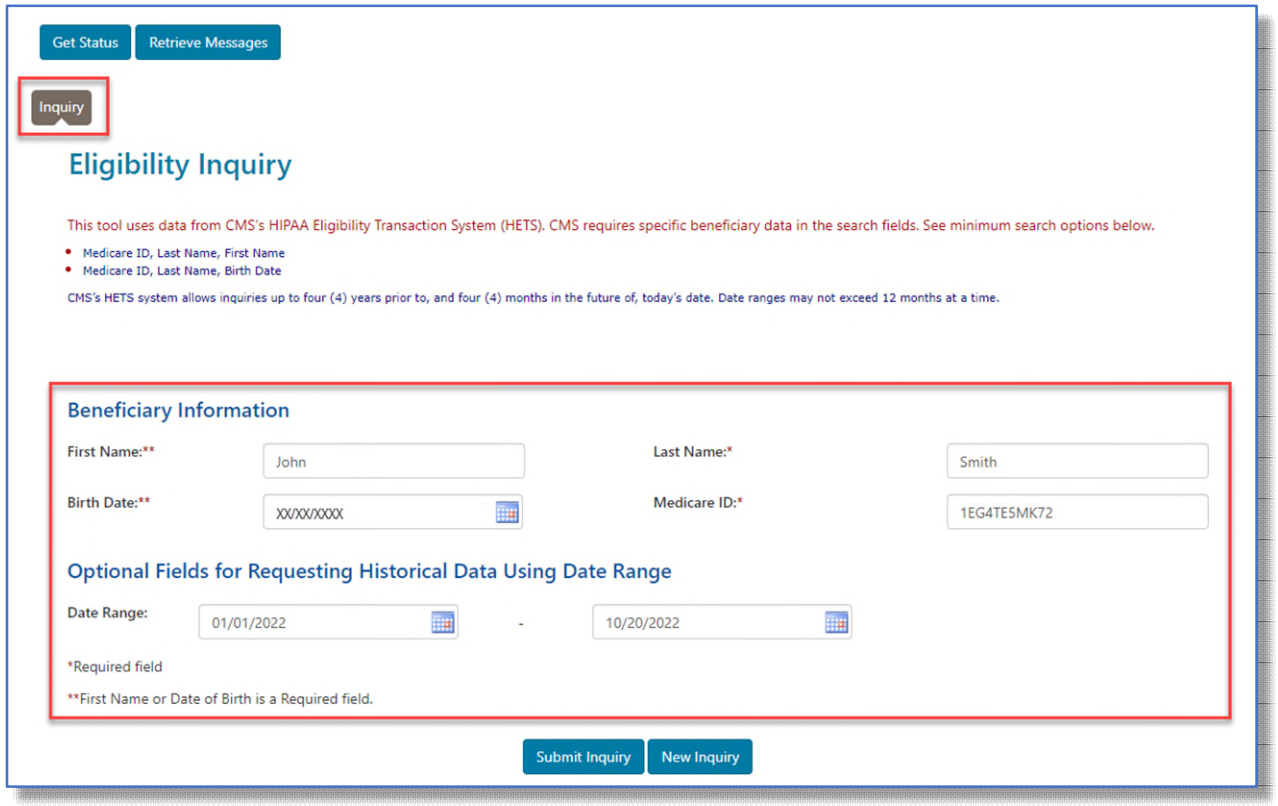
According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (Exp.01/31/2026) Form Approved OMB No. 0938-0566

Your Patient's Medicare Beneficiary Identifier (MBI) May Change

CMS reported a recent data breach

- Included patient's name, SS#, date of birth, MBI, medical history, and much more
- Estimate approx 612,000* beneficiaries impacted
- Ask your patient for their new Medicare card if you get "invalid member ID" when checking Medicare eligibility
- Use myCGS for all eligibility inquiries



*Number subject to change

CMS Final FY 2024 Part A Payment Rules

4 Part A Program Final Rules for FY 2024 Released in July 2023

- Skilled Nursing Facility (SNF) Payment System
  - Full fact sheet
- Inpatient Rehabilitation Facility (IRF) Payment System
  - Full fact sheet
  - IRF PPS webpage
- Inpatient Psychiatric Facility (IPF) Payment System
  - Full fact sheet
- Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital (LTCH) System/Rate
  - Full fact sheet
  - FY 2024 IPPS Final Rule Home Page

Medicare Patient Facility Deductibles and Coinsurances

CMS released Calendar Year (CY) 2024 Medicare monthly premiums, deductibles and coinsurances on October 12, 2023.

CMS Factsheet on 2024 Parts A & B Premiums and Deductibles

Part A Deductible and Coinsurance Amounts for Calendar Years 2023 and 2024 by Type of Cost Sharing

	2024	2023
Inpatient Hospital Deductible	**$1,632**	$1,600
Daily coinsurance for 61st-90th Day	**$408**	$400
Daily coinsurance for lifetime reserve days	**$816**	$800
Skilled Nursing Facility coinsurance	**$204**	$200

Medicare Part B Patient CY 2024 Premium and Deductibles

- The **standard** monthly premium for Medicare Part B enrollees
  - $174.70
    - An **increase $9.20** from $164.90
  - Since January 2007, the Part B premium has been based on the income of the beneficiary.
    - Individuals with AGI > $103,000 and Joint AGI > $206,000 pay higher premiums

- The annual deductible for all Medicare Part B beneficiaries
  - $240
    - An **increase of $14** from $226

CMS Factsheet on 2024 Parts A & B Premiums and Deductibles

CMS Proposed Rule Hospital Outpatient Prospective Payment System (OPPS)

On July 13, 2023, CMS issued a proposed rule for Medicare payment rates for hospital outpatient and Ambulatory Surgical Center (ASC) services provided on or after Jan 1, 2024.

- Proposed CY 2024 OPPS payment rates for hospitals that meet applicable quality reporting requirements will be updated by 2.8%.
- Proposed Hospital Inpatient Prospective Payment System (IPPS) and OPPS Payment Adjustments for the Additional Costs of Establishing and Maintaining a Buffer Stock of Essential Medicines
  - This is in response to supply issues.
- Proposed Intensive Outpatient Program (IOP) for individuals who have an acute mental illness or substance use disorder
- Proposed OPPS and ASC Payment for Dental Services

Hospital Quality Initiative (HQI)

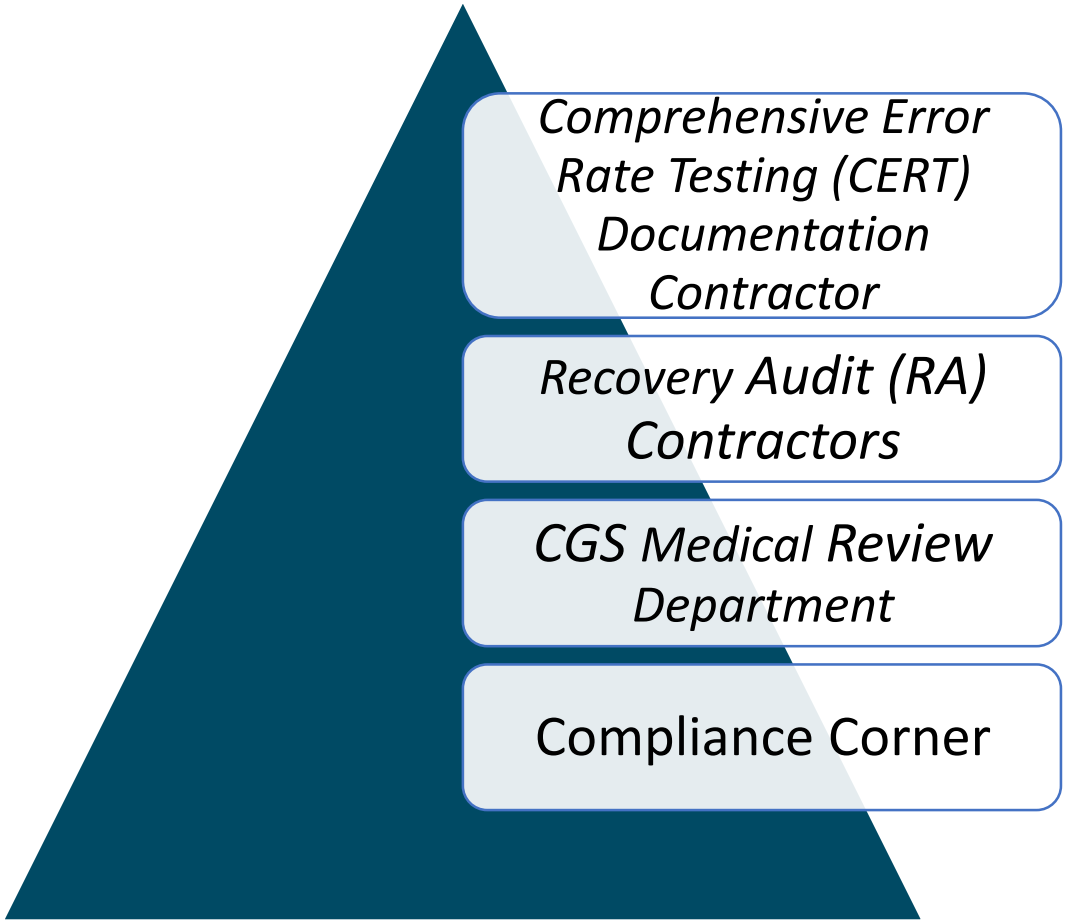
HQI established to improve the quality of care that hospitals provide and to distribute clearly defined and objective data about hospital performance to consumers.

CMS uses a variety of tools to encourage improvements in the quality of care delivered by hospitals including:

- Regulating and enforcing standards set by State survey agencies and CMS.
- Displaying hospital quality information on Web sites for consumers, including Care Compare and the Provider Data Catalog.
- Testing rewards for superior performance on certain quality measures.
- Using continual, community-based quality improvement resources through the Quality Improvement Organizations.
- Developing collaborative partnerships to leverage knowledge and resources.

Visit the CMS Hospital Quality Initiative webpage for more info!

You may receive requests for medical records.



Medicare Record Review Programs

FY 2022 CERT Improper Payment Rate

CERT improper payment rate is 7.46 percent, representing (projected amount) $31.46 billion in improper payments. (Compared to 6.26% and $25.03 billion in FY 2021)

Claim Type	Improper Payment Rate	Improper Payment Amount
Part A Providers (excluding Hospital IPPS)	8.86%	$17.13 B
Part B Providers	8.21%	$8.75 B
Part A Providers (Inpatient Hospital)	2.99%	$4.12 B
DMEPOS	25.24%	$2.19 B

The reporting period for this improper payment rate is Jul 1, 2020 through Jun 30, 2021.

NOTE: CERT Review Contractor changed name from *NCI Information Systems, Inc.* to *Empower AI, Inc.*

CERT Error Categories

Insufficient Documentation	Submitted medical records are inadequate to determine if billed services were provided, provided at the level billed, and/or were medically necessary; or when specific documentation required as a condition of payment is missing.
Medically Unnecessary	Submitted medical records contain adequate documentation to make an informed decision that services billed were not medically necessary based upon Medicare coverage and payment policies.
Incorrect Coding	Submitted medical records support a different code than what was billed; the service was performed by someone other than the billing provider/supplier; the billed service was unbundled; or patient was discharged to a site other than the one coded on claim.
No Documentation	Provider/supplier fails to respond to repeated requests for medical records or responds that they do not have the requested documentation.
Other	Errors do not fit into the previous categories (e.g., duplicate payment in error, non-covered or unallowable service, ineligible Medicare beneficiary, etc.)

CERT: Other Lines of Business (LOBs)

Avoid Part B Errors – Home Health

- Do you certify/recertify patients for Home Health?
- Provider compliance tips for Home Health
- Home Health Recertification Statement
- Home Health Referrals

Avoid Part B Errors – Hospice

- Hospice Services
- Care Plan Oversight Education Series
- Billing Hospice Physician, Nurse Practitioner (NP) and Physician Assistant (PA) Services
- Hospital-Based Hospice compliance tips

Avoid Part B Errors - DMEPOS

- CGS Part B partners with CGS DME to educate Part B providers on various documentation issues observed with ordering DMEPOS that generate CERT errors
- Education articles, videos, and recorded webinars posted on the following:
  - Therapeutic Shoes
  - Nebulizers and Inhalation Medication
  - Glucose Monitors and Supplies
  - Oxygen
  - Positive Airway Pressure (PAP) Devices
  - External Breast Prosthesis and Related Supplies
  - Your Medical Records and Ordering DMEPOS
  - Lower Limb Orthoses

Welcome to the CERT C3HUB!

Designed to provide Medicare providers, suppliers, and contractors with information about the CERT program and to facilitate coordination, collaboration, and communications between all stakeholders.

Check the C3HUB site for the following resources:

- About CERT
- Submit Records to CERT
- Letter and Contact Information
- Claim Status Search
- Attestation Letters
- Sample Request Letters
- Documentation Request Listings
- Psychotherapy Notes
- FAQs
- CMS Links

CERT A/B MAC Outreach & Education Task Force

Designed to assist in reducing the CERT error rate through consistent, accurate provider outreach and education.

- Documentation requirements for Outpatient Rehab Therapy Services
- Job aid for chiropractic services
- Documentation requirements for lab services
- Documenting therapy and rehab services
- Avoid insufficient documentation errors

CERT Videos

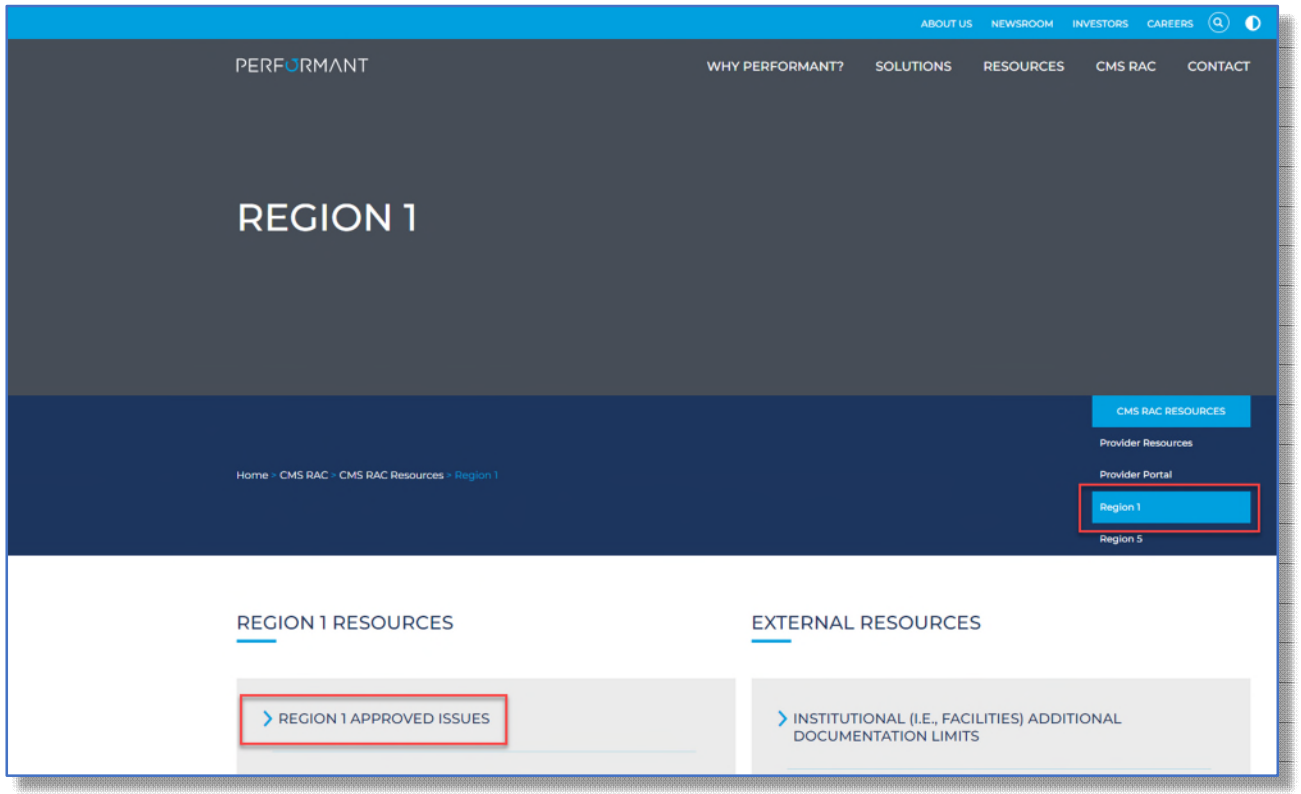
- Provider Minute: Utilizing Your MAC - YouTube
- Provider Minute: The Importance of Proper Documentation

Check here for more information

Recovery Audit (RA) Program

The Recovery Audit program was created to detect and correct past improper overpayments and underpayments made to providers.

- Performant Recovery, Inc.
- View Region 1 Resources
- Approved Issues MUST be posted
- Sample documents



RA Program
Highest Improper Payments

3rd Quarter 2023

ISSUE Number	ISSUE NAME
0004	Skilled Nursing Facility: Medical Necessity and Documentation Requirements
0001	Inpatient Hospital MS-DRG Coding Validation
0067	Inpatient Psychiatric Facility Services: Medical Necessity and Documentation Requirements
0073	Inpatient Rehabilitation Facility: Medical Necessity and Documentation Requirements

Additional issue details available on Performant website

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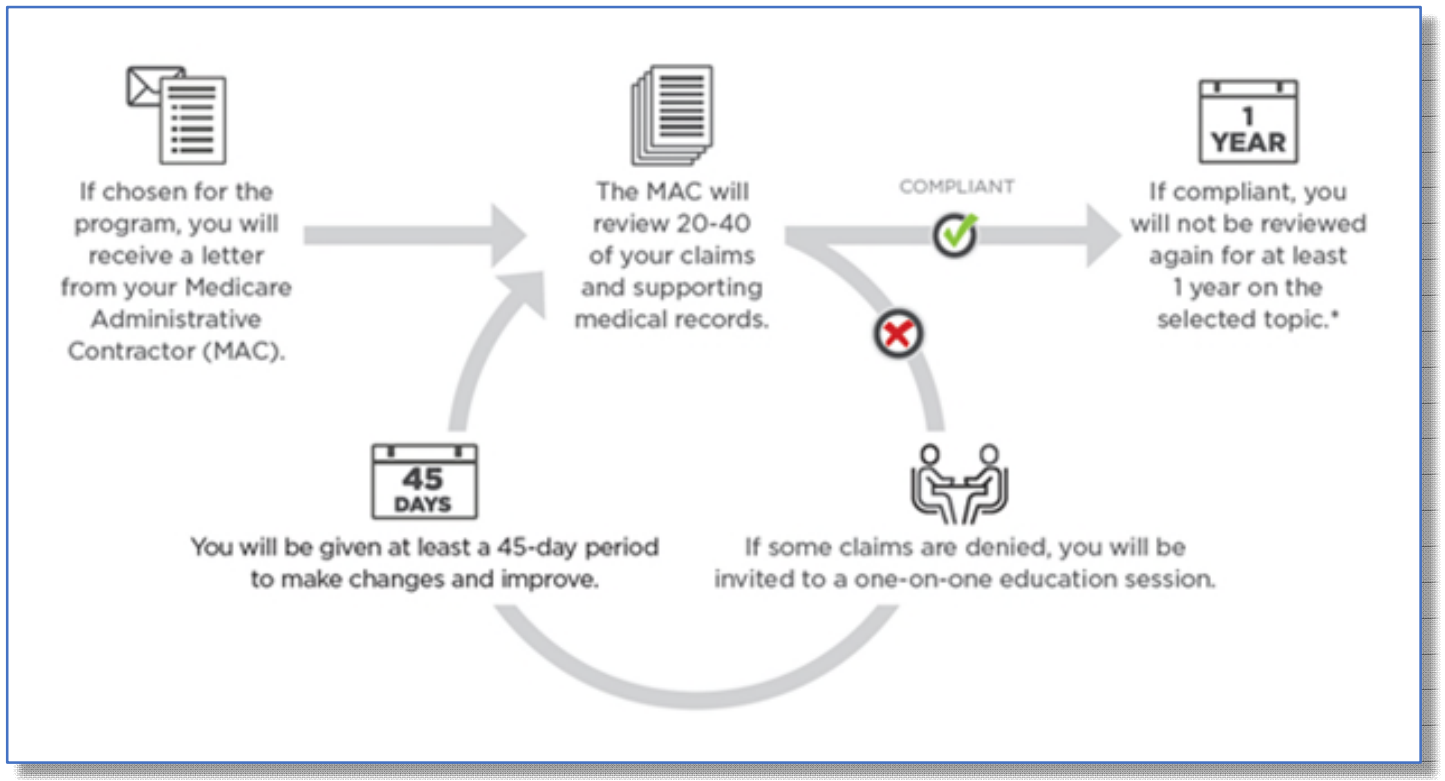
Medical Review

Reminder: Targeted Probe and Educate (TPE)

Based on data analysis of claims payment, CGS identifies areas with the greatest risk of inappropriate program payment.

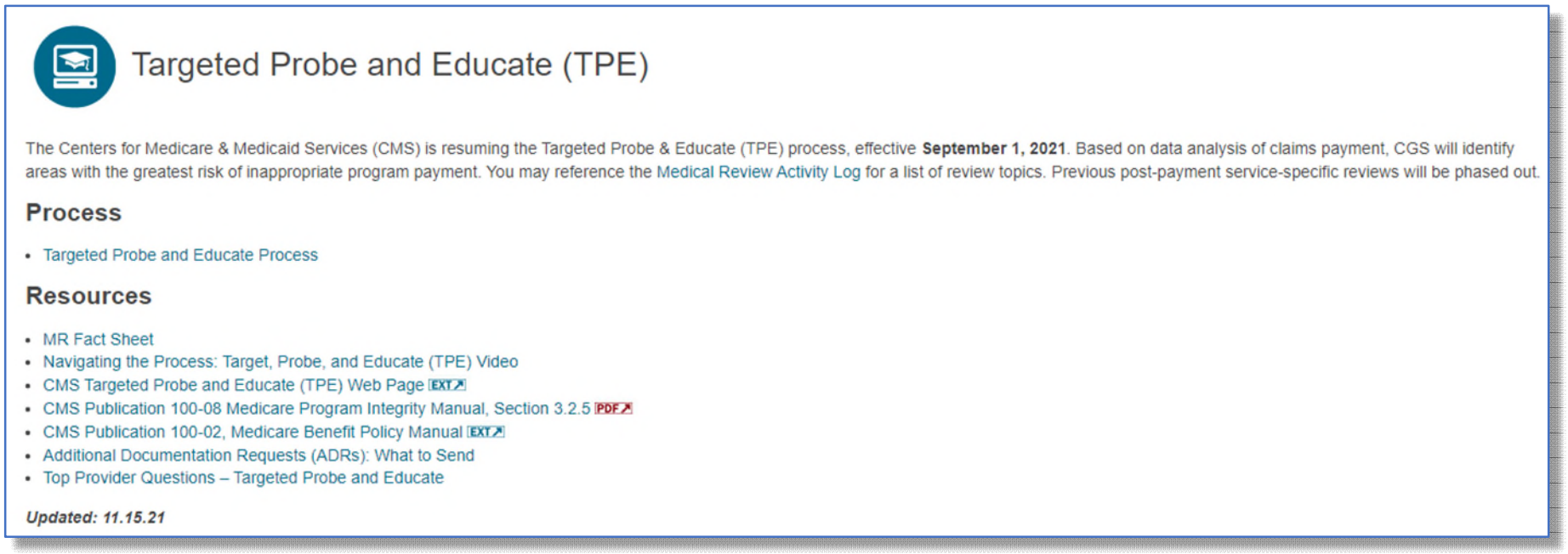


Medical Review

Reminder: Targeted Probe and Educate (TPE)

Refer to the TPE webpage for details on the process and resources. Also, don't forget how to respond to requests for additional documentation!

Part A Medical Review Activity Log



Targeted Probe and Educate (TPE)

The Centers for Medicare & Medicaid Services (CMS) is resuming the Targeted Probe & Educate (TPE) process, effective **September 1, 2021**. Based on data analysis of claims payment, CGS will identify areas with the greatest risk of inappropriate program payment. You may reference the Medical Review Activity Log for a list of review topics. Previous post-payment service-specific reviews will be phased out.

Process

- Targeted Probe and Educate Process

Resources

- MR Fact Sheet
- Navigating the Process: Target, Probe, and Educate (TPE) Video
- CMS Targeted Probe and Educate (TPE) Web Page EXT
- CMS Publication 100-08 Medicare Program Integrity Manual, Section 3.2.5 PDF
- CMS Publication 100-02, Medicare Benefit Policy Manual EXT
- Additional Documentation Requests (ADRs): What to Send
- Top Provider Questions – Targeted Probe and Educate

Updated: 11.15.21

Check LCD Articles for Billing Information

Avoid denial of services by checking the LCD and billing article first!

LCD ID	Top 10 Services Denied due to Non-Covered ICD-10 Codes – 2nd QTR 2023
Multi LCDs	Molecular Diagnostic Tests
L39038	MolDX: Molecular Syndromic Panels for Infectious Disease Pathogen Identification Testing
L33996	Vitamin D Assay Testing
L34045	Non-Invasive Vascular Studies
L34200	Removal of Benign Skin Lesions
L35891	Intravenous Immune Globulin
L33943	B-type Natriuretic Peptide (BNP) Testing
L36029	Controlled Substance Monitoring and Drugs of Abuse Testing
L37578	Micro-Invasive Glaucoma Surgery (MIGS)
L39015	Epidural Steroid Injections for Pain Management

Compliance Corner:
Documentation: Don't Forget Your Partners!

Share your documentation

CGS or other Medicare contractors may request medical records

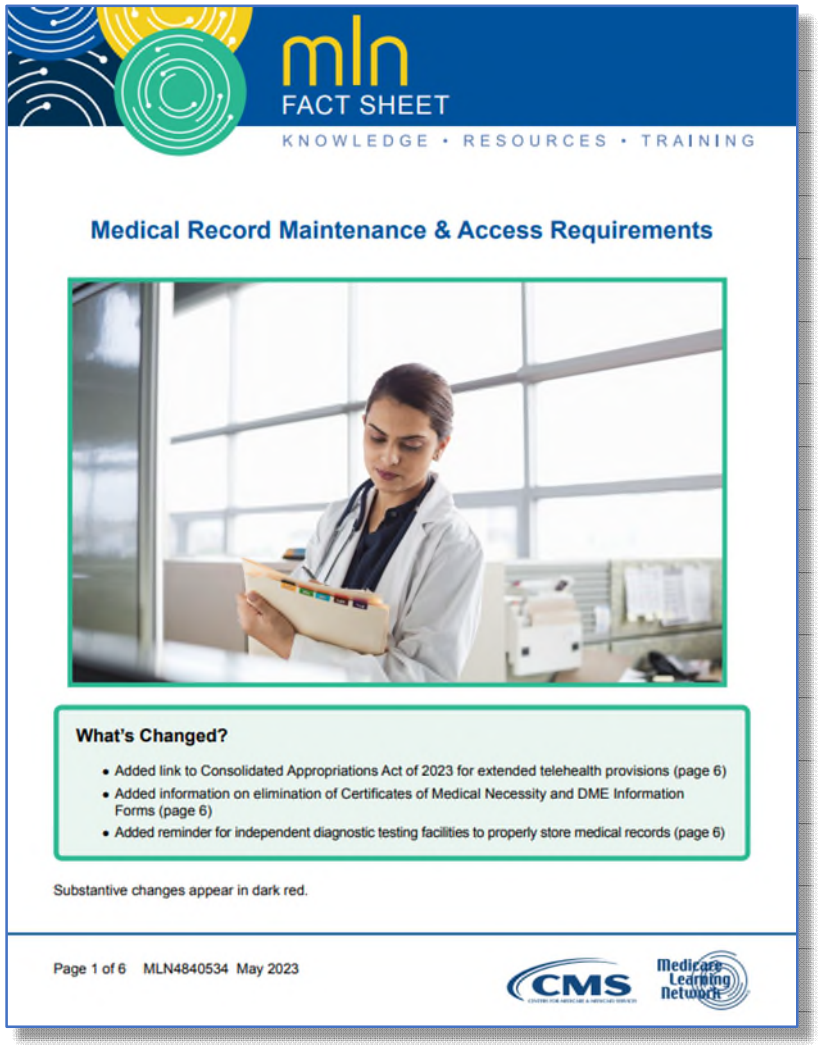
- To support the medical necessity for services based on Local Coverage Determination (LCD) requirements
- To determine the correct payment

When two separate providers collaborate to provide quality, patient care the obligation of providing, obtaining, and maintaining documentation is not the exclusive responsibility of one or the other provider.

- The treating physician should provide other providers, practitioners and facilities with documentation supporting medical necessity prior to or at the time the service is rendered.

Reference: Section 4317 of the Balanced Budget Act (BBA: SEC.4317, REQUIREMENT TO FURNISH DIAGNOSTIC INFORMATION)

Compliance Corner:
Medical Record Maintenance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FACT SHEET
KNOWLEDGE • RESOURCES • TRAINING

Medical Record Maintenance & Access Requirements

What's Changed?

- Added link to Consolidated Appropriations Act of 2023 for extended telehealth provisions (page 6)
- Added information on elimination of Certificates of Medical Necessity and DME Information Forms (page 6)
- Added reminder for independent diagnostic testing facilities to properly store medical records (page 6)

Substantive changes appear in dark red.

Page 1 of 6 MLN4840534 May 2023

CMS

Medicare Learning Network

This fact sheet gives information on updated documentation maintenance and access requirements for billing services to Medicare patients.

- It also tells you how long to keep the documentation and who is responsible for providing access.
- Includes examples and links to additional resources!

Medical Record Maintenance & Access Requirements

CGS Operational Reminders

Provider Enrollment	Claims	Appeals	Provider Contact Center

Provider Enrollment

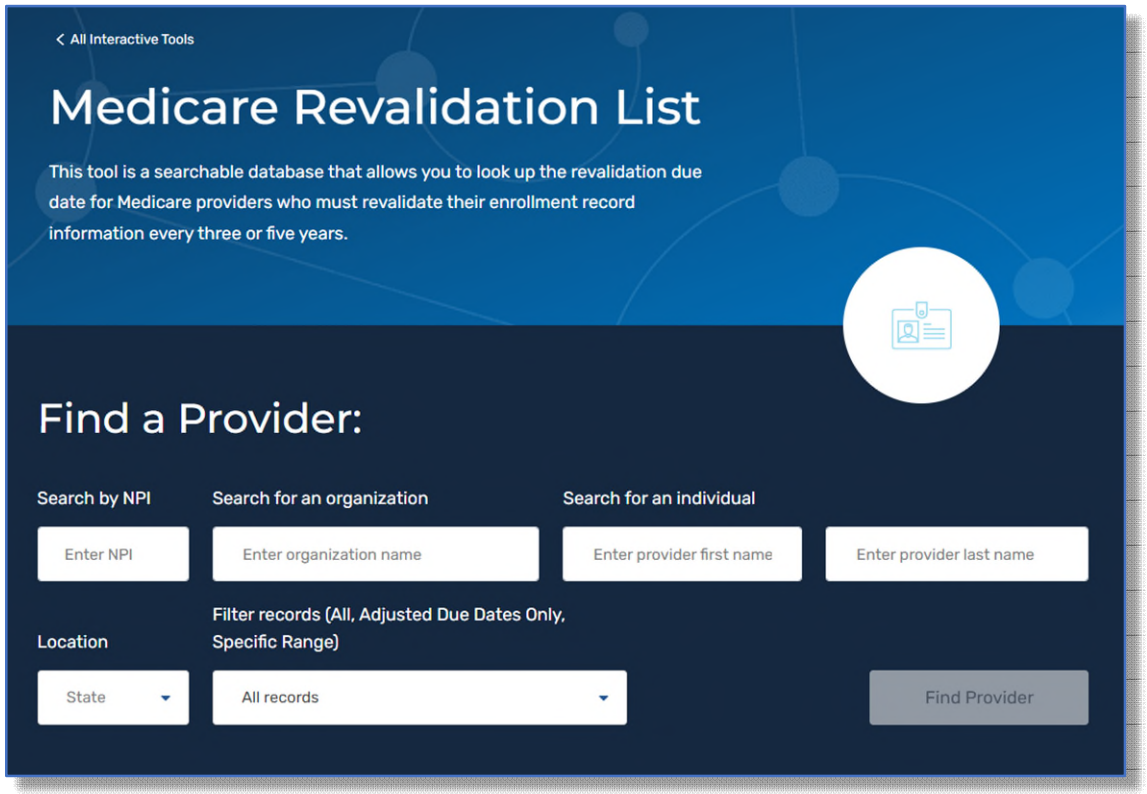
Provider Enrollment Application Fee Amount for Calendar Year 2023

- Effective Jan 1, 2023, the application fee is $688 for institutional providers that are:
  - Initially enrolling in the Medicare program
  - Revalidating their Medicare enrollment; or
  - Adding a new Medicare practice location.
- This fee is required with any enrollment application submitted from Jan 1 – Dec 31, 2023
  - NOTE: This fee does not apply to physicians, non-physician practitioners and their groups. Only to providers/suppliers that submit the following types of Medicare enrollment applications:
    - CMS-855A
    - CMS-855B (except physician and non-physician practitioner organizations)
    - CMS-855S, or
    - CMS-20134
- Refer to the Medicare Provider Enrollment MLN Education Tool for additional information.

Provider Enrollment

Provider Enrollment Revalidation

- Must revalidate Medicare enrollment every five years
- Revalidation date always the same throughout subsequent cycles
  - Always the last day of the month (e.g., Jul 30th, Aug 31st, Sep 30th)
- Check the Medicare Revalidation List for “due date”
- Avoid errors when completing apps!



Provider Enrollment

Consolidated CMS-855I and CMS-855R

- The CMS-855R will no longer be used to report reassignment information
- All data is now captured on the CMS-855I
- You must use the revised version of the CMS-855I (05/23).
- Refer to Enrollment Applications | CMS for the revised form
- **NOTE**: There is NO change in how reassignments are reported using PECOS
  - Step-by-step enrollment tutorials available at Welcome to the Medicare Provider Enrollment, Chain, and Ownership System (PECOS) (hhs.gov)

Claims

Review of Data: Top Claim Rejections and RTP Issues and how to avoid them!

Medicare Advantage (MA) plan overlap (RC U5233)

- Use myCGS to always check patient eligibility and MA information

Duplicate Service (RC 38200)

- Check the status of ALL claims before resubmitting them
- Use modifiers
- Check the Modifier Finder Tool for help with modifiers

Invalid Revenue/HCPCS Procedure Code Combination (RC 32402)

- Review the revenue and HCPCS codes for keying errors, correct, and F9/resubmit the claim.
- Use Direct Data Entry (DDE) system to view the revenue codes that are billable with a particular HCPCS code in the HCPCS inquiry screen

Appeals

Submitting Redeterminations to Appeal Other CMS Programs

- Recovery Audit Contractor (RAC)
- Comprehensive Error Rate Testing (CERT)
- Office of Inspector General (OIG)
- Supplemental Medical Review Contractor (SMRC)

Submit request for Redetermination (1st level) if you disagree with outcome

- Please wait until you receive demand letter from CGS before sending Redetermination
  - Use myCGS to send Redeterminations
- If you disagree with decision, submit request for Reconsideration (2nd level)

Provider Contact Center (PCC)

Reminder: Customer Service Representatives (CSRs) cannot assist with functions available through the *Interactive Voice Response (IVR)* or myCGS

- This includes beneficiary eligibility, claim and appeal status, offset information, etc.
  - Step-by-step instructions for the IVR and myCGS are available
  - Use the *Medicare Beneficiary Identifier (MBI) and Name to Number Converter*
- Authentication required for claim-specific inquiries and BEFORE speaking with CSR

Provider National Provider Identifier (NPI)	Provider Transaction Access Number (PTAN)
Last 5 digits of the Tax Identification Number	Beneficiary's Medicare Beneficiary Identifier
First 6 letters of the beneficiary's last name	First letter of the beneficiary's first name
Beneficiary's date of birth	

- ***Callers will be transferred back to IVR if authentication steps not completed.***

***NOTE**: Calling our PCC isn't the only way to receive immediate assistance from CGS. Use the Self-Service Options to streamline communication and enhance your productivity.* ☺

FOCUS on 2023!

CMS Resources You Can Use!

CGS is your first contact as your MAC. Check here for help with other issues.

- CMS Office of Program Operations and Local Engagement

Medicare Home Page

- Acronyms
- Change Requests (CRs) and Transmittals
- The CMS Innovation Center
- Coordination of Benefits
- Health Plans – General Information
- Internet-Only Manuals (IOM)
- Physician Fee Schedule Look-Up Tool | CMS

CMS Resources You Can Use!

The Medicare Learning Network®

- Free educational materials for providers on CMS programs, policies, and initiatives

myCGS
A/B/HHH MAC
JURISDICTION 15

CLAIMS

Submit Part B Medicare claims through myCGS! Also check the status, view remark codes, and perform additional functions.

MR DASHBOARD

View and respond to ALL your MR ADRs on one page. Includes Post-Pay ADRs!

REMITTANCE

View and print remittance advices (RAs).

ELIGIBILITY

Check eligibility, MSP status, MA plan enrollment, inpatient stays, and MORE!

MBI LOOK-UP TOOL

Use myCGS to obtain the patient's Medicare Beneficiary Identifier (MBI).

FINANCIAL TOOLS

Check the number of 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 Redeterminations, Reopenings, eOffset requests and MORE!

ADMIN

Used by Provider Administrator to grant access to other users and unlock user accounts.

MY ACCOUNT

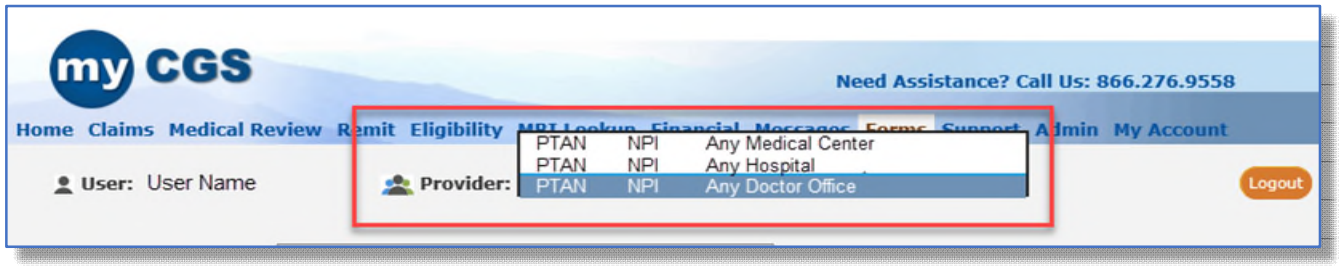
Manage functions of your account including passwords, Multi-Factor Authentication (MFA), and add providers.

FOCUS on 2023!

myCGS A/B/HHH MAC JURISDICTION 15

Choose YOUR myCGS Super ID!

Combine multiple User IDs under one master (Super) ID!

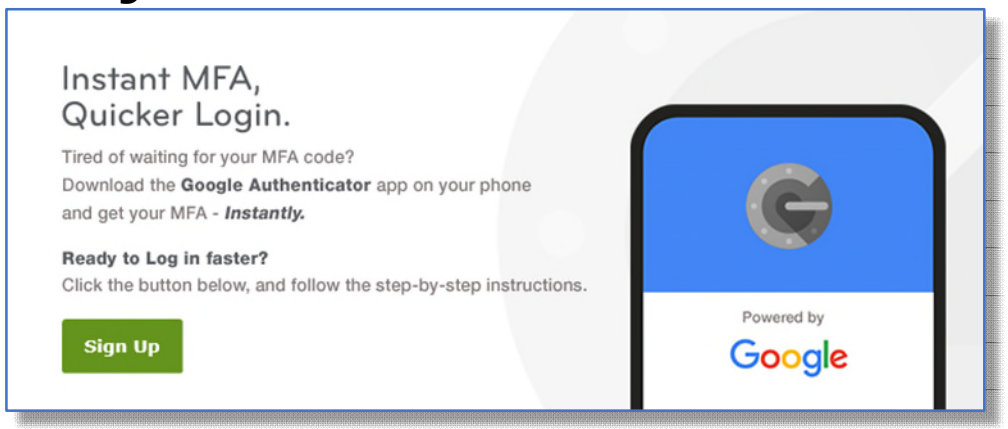


Refer to *My Account* section of the myCGS User Manual tab for more information.

Access myCGS LIGHTNING Fast!!!

Use Google Authenticator to obtain your Multi-Factor Authentication (MFA) code!

- Download from the App Store (Apple) and Android Play Store (Android).



Self-Service Options!

Additional Documentation Request (ADR) Timeliness Calculator

Determine the date documentation must be received

CMS-1500 Claim Form Instructions Tool

Identifies items of a claim form (and ANSI electronic claim)

Fee Schedule Search Tool

Access to various types of fee schedules

Online EDI Application Status Check Tool

Enter Reference Number for app status: Received, Pending, Approved, Rejected, or No Record

Medically Unlikely Edits (MUEs)

Search for the MUE assigned to CPT/HCPCS codes

Prior Authorization Decision Tree

Identifies the services that require prior authorization

Consolidated Billing

Determine correct billing for a service when the beneficiary is in a covered Part A SNF stay.

MBI and Name-to-Number Converter

Converts the beneficiary's first initial of first name, first six letters of last name, and the alpha/numeric MBI to the numbers necessary to enter on your telephone keypad.

Medicare Secondary Payer (MSP) Tool

Used to determine claim payment calculations when Medicare is the secondary payer

Reason/Remark Code Search and Resolution

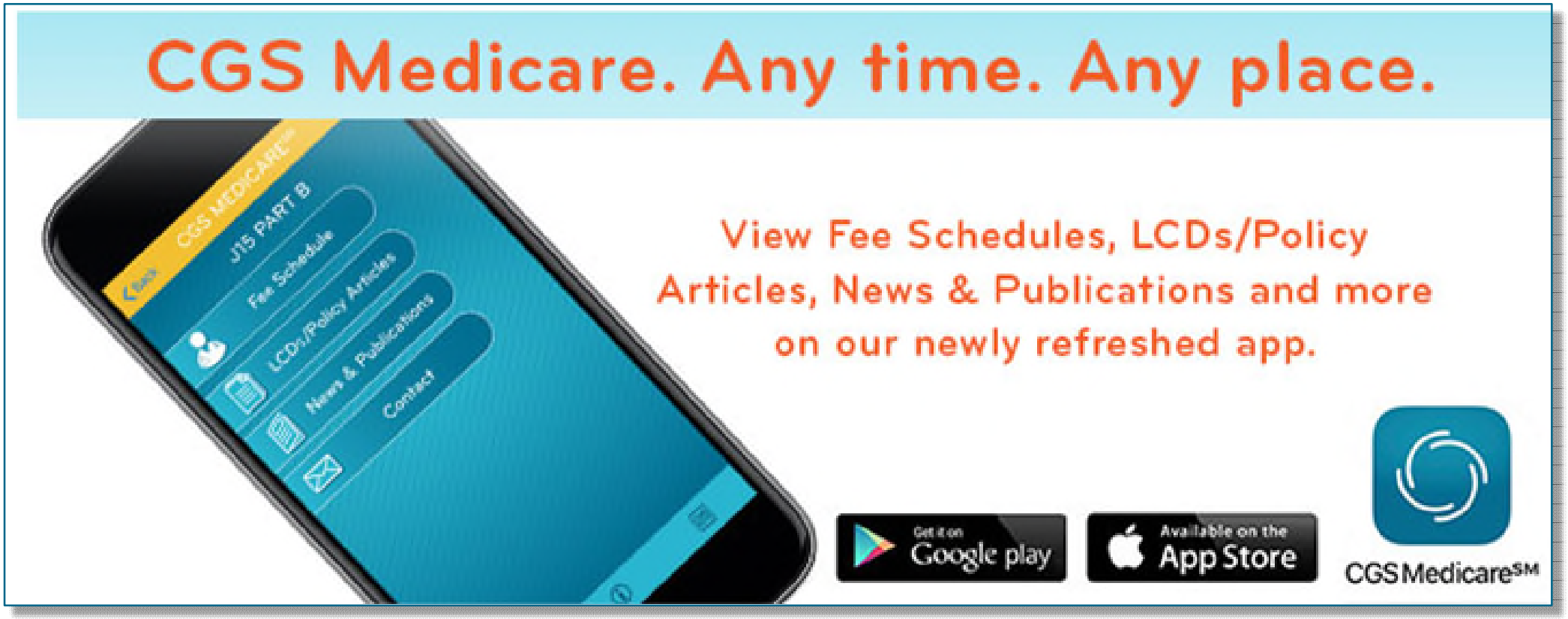
Enter the ANSI Reason or Remark Code for the denial and the possible causes and resolution.

Medicare Deductible/Coinsurance Look-Up Tool

Access deductible and coinsurance amounts for a Calendar Year.

FOCUS on 2023!

CGS Medicare App



Part A Provider Education

We are here for you, J15!

If you have a specific Medicare Part A education request, you can schedule an appointment with the POE staff at J15_PartA_Education@cgsadmin.com

FOCUS on 2023!

Your Feedback Matters!

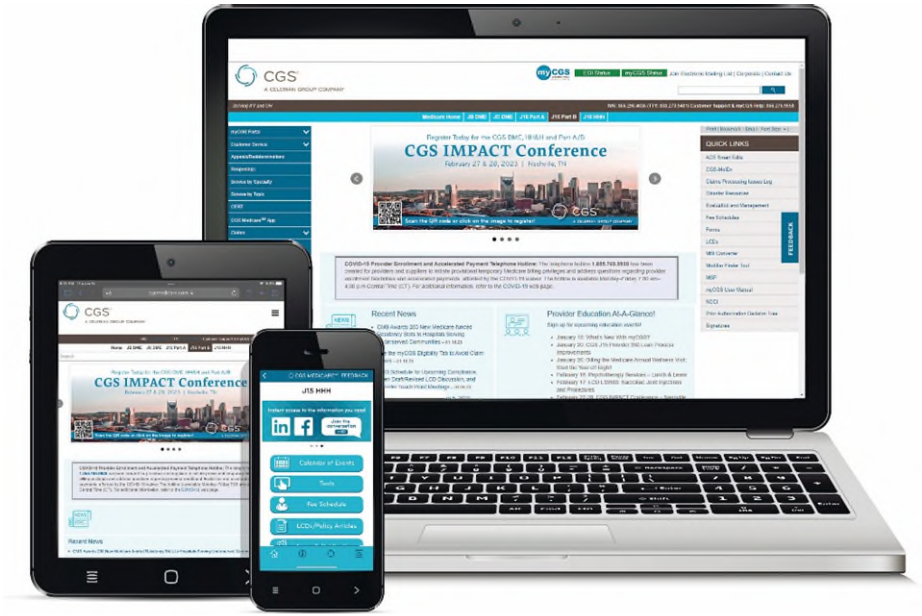
Whether it's your interaction with the website, myCGS or the Provider Contact Center, your feedback matters!

When you see the pop-up, please take a few minutes to complete the survey and share your thoughts to help CGS improve your experience.

STAY CONNECTED

CHECK OUT OUR WEBSITE:

https://www.cgsmedicare.com



GET EVEN MORE RESOURCES:

- CMS MLN Web page: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo. This includes the MLN Connects, MLN articles, and more.
- Electronic Mailing List page at: https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Electronic-Mailing-Lists
- CMS e-mail updates at: https://public.govdelivery.com/accounts/USCMS/subscriber/new?pop=t&topic_id=USCMS_7819

Follow Us on LinkedIn: @cgs-administrators-llc

Follow Us on YouTube: @cgsmedicare

Visit the myCGS Web Portal:
https://www.cgsmedicare.com/mycgs

SIGN UP FOR EMAIL NOTIFICATIONS:

By clicking on, “Join Electronic Mailing” list in the top right corner of https://www.cgsmedicare.com

Download the CGS Medicare℠ App:

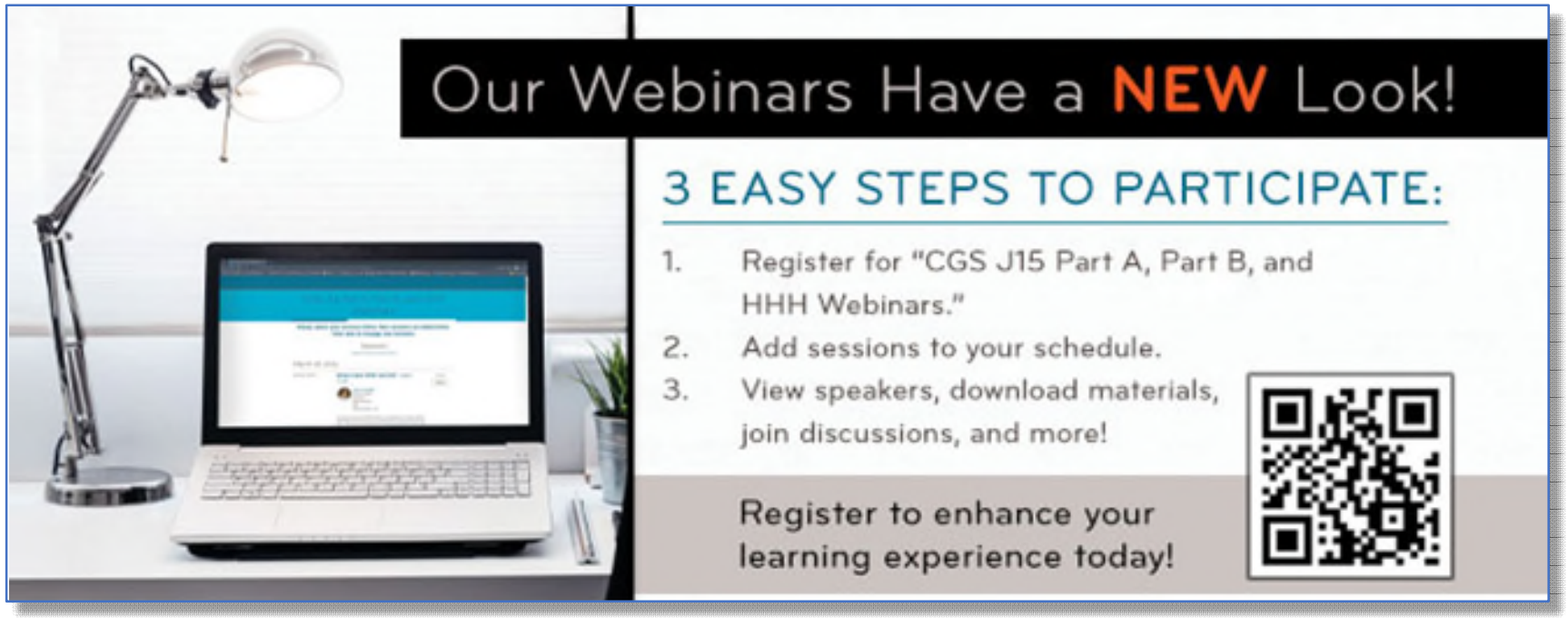
Download on the App Store

GET IT ON Google Play

Register for Cvent to Attend Events!

We have a NEW webinar platform!

Either scan the QR code or go to [Personal Information - CGS J15 Part A, Part B, and HHH Education (cvent.com)] to view events and add them to your personal schedule.



Questions???

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