









FALL 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) websites. 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 websites.

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





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.

NOTES:

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:** NEW! Medicare claims can now be submitted through myCGS! You can also check the status of claims.
<http://www.cgsmedicare.com/pdf/mycgs/chapter2.pdf>
- » **REMITTANCE Tab:** View and print remittance advices (RAs).
<http://www.cgsmedicare.com/pdf/mycgs/chapter3.pdf>
- » **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.
<http://www.cgsmedicare.com/pdf/mycgs/chapter4.pdf>
- » **FINANCIAL TOOLS Tab:** Inquire about claims approved-to-pay and the last three checks issued.
<http://www.cgsmedicare.com/pdf/mycgs/chapter5.pdf>
- » **MESSAGES Tab:** Read secure messages and alerts regarding system access and functions performed in the portal.
<http://www.cgsmedicare.com/pdf/mycgs/chapter6.pdf>
- » **FORMS Tab:** Submit certain forms directly to CGS. Currently available - requests for Redetermination, eOffset (immediate offset) and Reopenings.
http://www.cgsmedicare.com/pdf/myCGS/chapter7_partb.pdf
- » **ADMIN Tab:** Used by Provider Administrator to grant access to other users.
<http://www.cgsmedicare.com/pdf/mycgs/chapter8.pdf>

Enjoy the convenience and time saving benefits of myCGS!

Register TODAY! <http://www.cgsmedicare.com/mycgs/index.html>

SMARTER BILLING: Experience vs. Discipline



EXPERIENCE: 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.



DISCIPLINE: 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.



Top Inquiries

Modifier Usage

Refer to the *Modifier Finder Tool* for assistance http://www.cgsmedicare.com/medicare_dynamic/modifiers_oh/search.asp

- » CPT modifiers 59 and 25
 - <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1418.pdf>
 - <http://www.cgsmedicare.com/partb/pubs/news/2013/0213/Cope21263.html>

Medicare Secondary Payer (MSP)

When Medicare is secondary, the primary payer must be billed first

<http://www.cgsmedicare.com/partb/pubs/news/2014/0314/cope24889.html>

- » Verify patient insurance information against our *MSP Job Aid* http://www.cgsmedicare.com/pdf/msp_jobaid.pdf
 - Patient or family member/representative must contact the Benefits Coordination and Recovery Center (BCRC) to make corrections to MSP records
- » **TIP:** myCGS (<http://www.cgsmedicare.com/pdf/mycgs/chapter4.pdf>) provides MSP information if you need help!

Overpayment and Recovery (OPR)

- » Requests for repayment of Medicare funds are time sensitive
- » Respond to demand letters immediately and include a copy with refund
- » **TIP:** myCGS will allow you to request an *eOffset* (immediate offset) (<http://www.cgsmedicare.com/pdf/>

[myCGS/chapter7_partb.pdf](http://www.cgsmedicare.com/pdf/mycgs/chapter7_partb.pdf)) of a demanded overpayment

- » Voluntary Refunds
 - Use the *Overpayment Refund Form* (<http://www.cgsmedicare.com/partb/forms/overpayment.html>) and complete it in its entirety
 - Identify MSP situations, when applicable
 - Include copies of remittance advices (RAs)

Duplicate Services

- » It is important to avoid submitting duplicate claims
 - If an electronic file is duplicated in error, please contact the EDI Help Desk as soon as possible
- » When responding to an additional documentation request (ADR) letter (<http://www.cgsmedicare.com/partb/pubs/news/2013/1013/cope23582.html>), do not resubmit the claim until a decision has been made
 - Claims requiring additional information may take 45 days to process
- » Always check the status of claims before resubmitting using myCGS (<http://www.cgsmedicare.com/pdf/mycgs/chapter2.pdf>) or the Interactive Voice Response (IVR) (http://www.cgsmedicare.com/partb/cs/partb_ivr_user_guide.pdf).

Patient Eligibility

Obtain patient eligibility by using myCGS (<http://www.cgsmedicare.com/pdf/mycgs/chapter4.pdf>) or the Interactive Voice Response (IVR) (<http://www.cgsmedicare.com/partb/cs/ivr.html>).

- » Maintain copies of patient Medicare cards
- » Be aware of open enrollment period (which begins October each year), as patient's coverage could change (<http://cms.hhs.gov/Center/Special-Topic/Open-Enrollment/Downloads/FINAL-Article-Medicare-Open-Enrollment-Beneficiary-2015-508.pdf>)

Customer Service: 1.866.276.9558

<http://www.cgsmedicare.com/partb/cs/contactinfo.html>

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

Interactive Voice Response (IVR):

1.866.290.4036

- » IVR User Guide: http://www.cgsmedicare.com/partb/cs/partb_ivr_user_guide.pdf

CGS Website: <http://www.cgsmedicare.com>

- » Kentucky & Ohio Part B <http://www.cgsmedicare.com/partb/index.html>
- » Part B Education & Events <http://www.cgsmedicare.com/partb/education/index.html>

E-mail Inquiries

- » Online Help Center http://www.cgsmedicare.com/partb/cs/online_help.html

Facebook:

<http://www.facebook.com/CGSJ15>



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.

Medicare Claims: Know the Fact

A few FAST FACTS on Medicare claims:

52 million

Medicare Part A/B enrollment

15.7 million

Medicare Advantage Enrollment

2.8 million

J15 Medicare FFS Enrollment

51,000 Providers

J15 Provider Enrollment

72 million

J15 Part A/B Claims Processed
Annually

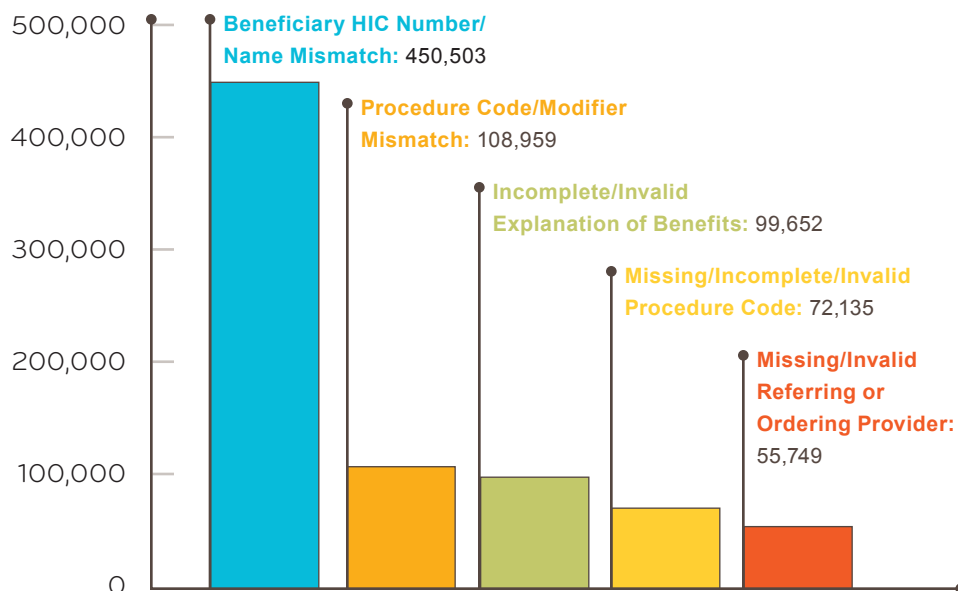
2.3 million

J15 Home Health & Hospice
Claims Processed Annually
(15 States)

22 billion dollars

J15 Annual Payment

Top Rejections



Solutions:

- » Maintain current patient records and copies of Medicare cards
 - Submit the name as it appears on the card
 - Patient must contact Social Security to make corrections or changes to their Medicare card
- » Train new staff members on website tools and other resources
 - *Modifier Finder* (http://www.cgsmedicare.com/medicare_dynamic/modifiers_ky/search.asp) tool, CPT/HCPCS books, Global Surgery (<https://www.cgsmedicare.com/partb/pubs/news/2012/1112/cope20458.html>) guidelines
- » Enter complete primary insurer information in correct electronic fields (https://www.cgsmedicare.com/pdf/MSP_JobAid.pdf)
 - Paper submitters – include complete copy of primary insurer EOB
 - Be sure primary insurer is identified on the EOB
- » Be sure to code using current CPT/HCPCS manuals
- » Phase 2 ordering/referring edits (<http://www.cgsmedicare.com/partb/pubs/news/2014/0214/cope24599.html>) were implemented January 6, 2014
 - View the CMS *Ordering/Referring File* (<http://cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/MedicareOrderingandReferring.html>) to verify practitioners reported on claims
 - Report identifies practitioners legally allowed to order/refer services for Medicare patients AND who are enrolled in PECOS



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 website.

NOTES:



Top Denials

Denials related to Local (LCDs) and National Coverage Determinations (NCDs)

Check LCDs (<https://www.cgsmedicare.com/partb/medicalpolicy/index.html>) or NCDs (<http://www.cms.gov/medicare-coverage-database/>) prior to service to determine coverage. This will also help with execution of the Advance Beneficiary Notice of Non-Coverage (ABN) (<http://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html?redirect=/bni/>).

Statutorily Excluded/Non-Covered Services

Services statutorily excluded by law are never covered by Medicare

- » You may notify the patient by using the ABN <http://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html?redirect=/bni/>

Provider Not Certified

Identifiers deactivated if no response to Revalidation request within 60 days
https://www.cgsmedicare.com/partb/enrollment/PE_Revalidation.html

Correct Coding Initiative (CCI)

- » The National Correct Coding Initiative (NCCI) identifies code pairs that are bundled <http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html?redirect=/nationalcorrectcodinited/>
- » Check CCI edits prior to claim submission <http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html>
 - Medical record must support use of CCI modifier
 - 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 <https://www.cgsmedicare.com/partb/pubs/news/2011/0711/cope15393.html>
- » Exceptions may be submitted with a modifier if supportive in medical record
 - 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 these 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) http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/PQRS_List-of-EligibleProfessionals_022813.pdf
- » Utilize the *PQRS Job Aid* to learn more about reporting methods, selecting measures, incentives and payment adjustments (reductions) http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/PQRS_OverviewFactSheet_2013_08_06.pdf
- » 2014 emphasis on avoiding the 2016 payment adjustment <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Payment-Adjustment-Information.html>
 - Choose at least 9 measures across 3 National Quality Strategy (NQS) domains report each measure for at least 50% of the EPs FFS patients http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/2014_ClinicalQualityMeasures.html
- » Measure-Applicability Validation (MAV) process if fewer than nine reported
 - 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
 - Report at least 3 measures covering one NQS domain for at least 50% of FFS patients via qualified clinical data registry (QCDR) <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Qualified-Clinical-Data-Registry-Reporting.html>
- » 2014 PQRS Interim Feedback Dashboard
 - The *2014 Interim Feedback Dashboard User Guide* (http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2014InterimFeedbackDashboardUserGuide_02-26-2014.pdf) is designed to assist eligible professionals, and their authorized users, with accessing and interpreting the 2014 interim Dashboard data.

- The Dashboard allows organizations and eligible professionals (EPs) to log-in to a Web-based tool and access their 2014 Physician Quality Reporting System (PQRS) data on a quarterly basis in order to monitor the status of claims-based individual measures.

- » Contact the QualityNet Help Desk at 1.866.288.8912 or Qnetsupport@hcqis.org <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/HelpDeskSupport.html>

Value-Based Modifier

- » The Affordable Care Act mandated that, by 2015, CMS begin applying a value modifier (<http://www.cms.gov/Medicare/Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html>) under the Medicare Physician Fee Schedule (MPFS)
- » Provides comparative performance information to physicians to improve the quality and efficiency of medical care
 - Meaningful and actionable information to physicians so they can improve care
 - 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
- » In September 2014, CMS made 2013 Quality and Resource Use Reports (QRURs) (<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2013-QRUR.html>) available to group practices and physician solo practitioners nationwide.
- » The 2013 QRURs contain quality and cost performance data for CY 2013, which is the performance period for the Value-Based Payment Modifier (VM) that will be applied to physician payments for items and services furnished under the Medicare Physician Fee Schedule for groups of 100 or more EPs in 2015.

Electronic Health Record (EHR)

- » Promotes Electronic Health Record (EHR) through incentives for the “meaningful use” of certified electronic health records technology <http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html>
- » EHR objectives must be met in order to receive incentive
- » 2014 reporting period was a 90-day period to be attested by October 1, 2014, regardless of the stage of meaningful use
- » Had to become a meaningful user to avoid 2015 payment adjustment <http://www.cms.gov/Regulations-and-Guidance/>



URGENT: Issues Requiring Your Attention

[Legislation/EHRIncentivePrograms/Downloads/PaymentAdj_HardshipExcepTipSheetforEP.pdf](#)

- » Option of request a hardship exception from 2015 payment adjustment initially had to be submitted by July 1, 2015 http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/PaymentAdj_Hardship.html
- CMS announced a new submission period for hardship exception applications for EPs and eligible hospitals, to be received by 11:59 P.M. EST November 30, 2014. This new exception period (http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/HardshipExtension_Application.pdf) is only for:
 - Those who have been unable to fully implement 2014 Edition CEHRT due to delays in 2014 Edition CEHRT availability; **AND**
 - EPs who were unable to attest by October 1, 2014, and hospitals that were unable to attest by July 1, 2014
- » Contact the EHR Information Center with questions on registration status and incentives <http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/RegistrationandAttestation.html>
 - Call the EHR Information Center at 1.888.734.6433 (option 1) to check the status of payment
 - **NOTE:** Accessing the "Attestation" section of the system without resubmitting the form could affect incentive payments



Prior Authorization for Power Mobility Devices (PMDs)

- » Beginning October 1, 2014, CMS expanded a successful demonstration for prior authorization for power mobility devices (<http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2014-Press-releases-items/2014-05-22.html>) and other DMEPOS to include Kentucky and Ohio
- Based on September 2013 claims data, monthly expenditures for certain PMDs decreased from \$12 million in September 2012 to \$4 million in August 2013 across the seven demonstration states



Provider Enrollment Revalidation

- » Phase III of Revalidation process https://www.cgsmedicare.com/partb/enrollment/PE_Revalidation.html
- » Several resources available on the CGS website
 - Top development reasons identified so providers can avoid delays https://www.cgsmedicare.com/partb/enrollment/Top_Reval_Reasons.html

60 days
Application must be completed and returned within 60 days to avoid deactivation.

- Listing of KY and OH providers sent Revalidation notice https://www.cgsmedicare.com/partb/enrollment/PE_Revalidation_Mailings.html
- Other provider enrollment resources <https://www.cgsmedicare.com/partb/enrollment/index.html>

70%
of Part B Providers will receive CANARY YELLOW envelopes.



ICD-10 Implementation

- » Medicare providers still encouraged to prepare for ICD-10 transition <http://www.cms.gov/Medicare/Coding/ICD10/index.html?redirect=/ICD10/>
- » Specific resources created to assist small providers with the transition <http://www.roadto10.org>
 - Understand the basics of ICD-10
 - Build an ICD-10 action plan to map out transition
 - FAQs
 - Clinical scenarios and documentation tips for Family Practice, Internal Medicine, OB/GYN, Orthopedics, Cardiology and Pediatrics
- » MLN Matters article MM8691 identifies 29 NCDs that have been translated to ICD-10 <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8691.pdf>

Oct 1
Compliance Date:
October 1, 2015



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 <http://www.cgsmedicare.com/partb/pubs/news/2012/0812/cope19619.html>
- Medicare will pay professional component of services with separate PC/TC
- Facility rate is paid on services without separate PC/TC
- » Refer to CMS FAQs for additional information <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/CR7502-FAQ.pdf>

Use HCPCS modifier PD on services subject to this policy.



2015 Medicare Part B Premiums and Deductibles

- » The Secretary of Health and Human Services announced the 2015 standard Medicare Part B monthly premium and deductible (<http://www.hhs.gov/news/press/2014pres/10/20141009a.html>) will remain the same as the last two years
 - 2015 standard Part B premium is \$104.90
 - 2015 Medicare Part B deductible is \$147



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.

NOTES:

Comprehensive Error Rate Testing (CERT)

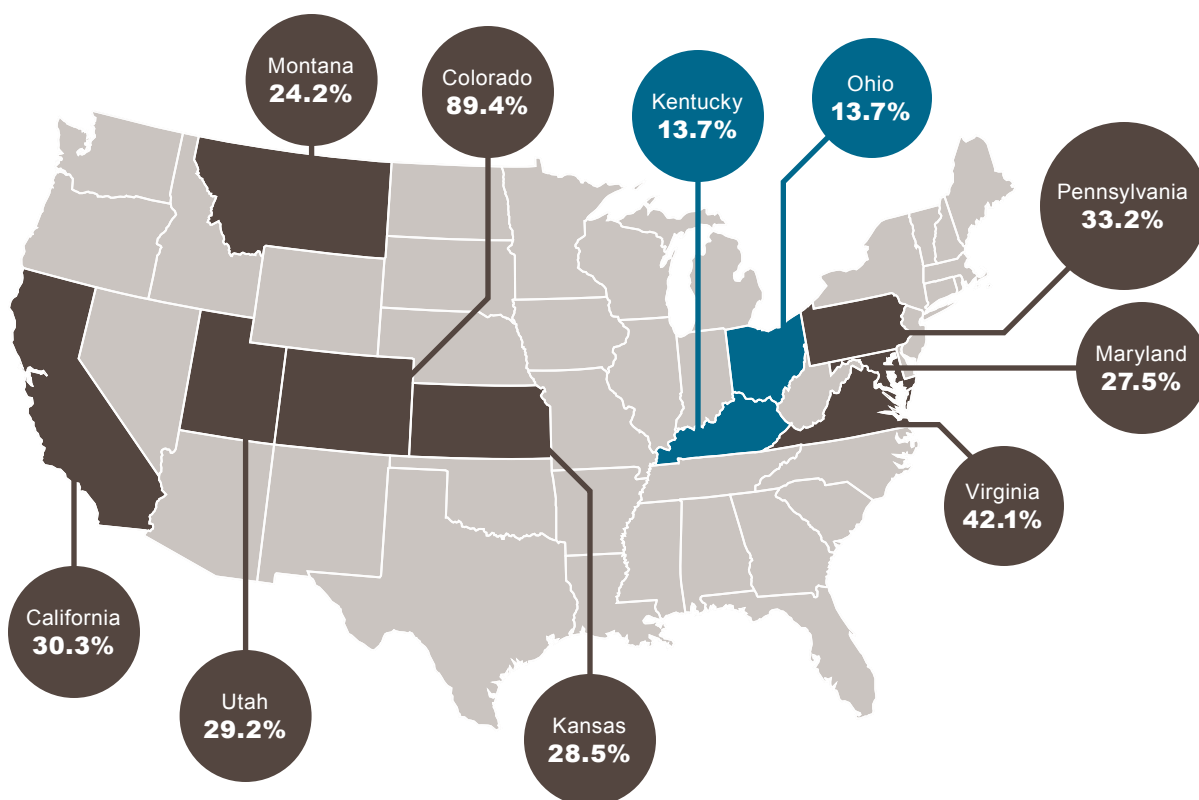


The Comprehensive Error Rate Testing (CERT) program is designed to comply with the *Improper Payments Elimination and Recovery Act of 2010 (IPERA)*. The Centers for Medicare & Medicaid Services (CMS) implemented CERT to measure improper payments in the Medicare fee-for-service (FFS) program. Contractors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

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 unresponsive of service billed
Incorrect Coding:	Service billed does not meet requirements for the level
Other:	<ul style="list-style-type: none"> » Duplicate payment » Payment on non-covered services

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

Top 10 States Highest Projected CERT Error Rates



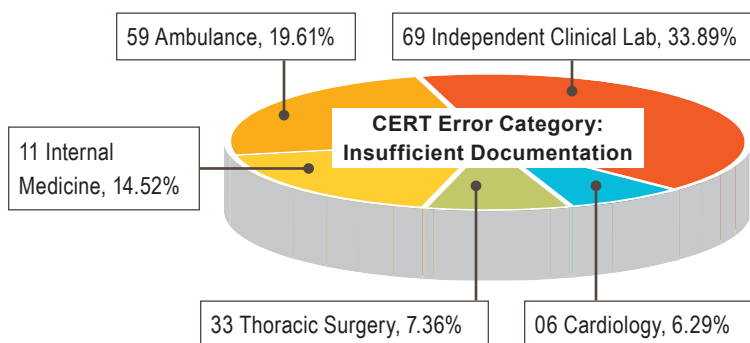
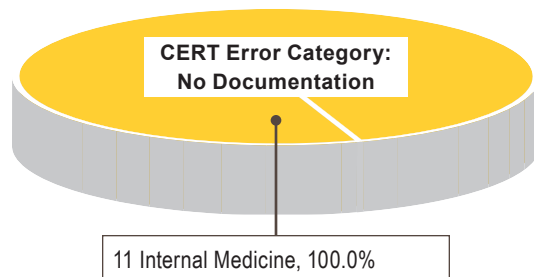
Compliance Corner: Putting It All Together

CERT Errors Charged by Specialty

Avoid “Insufficient Documentation” Errors

<http://www.cgsmedicare.com/partb/pubs/news/2014/0614/cope26009.html>

- » 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
<http://www.cgsmedicare.com/partb/pubs/news/2013/1113/cope23836.html>



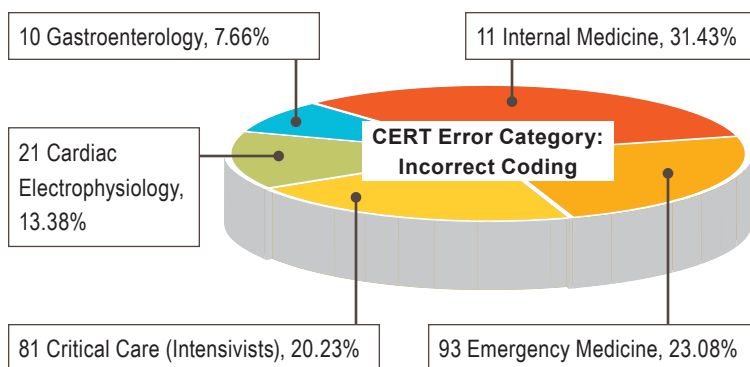
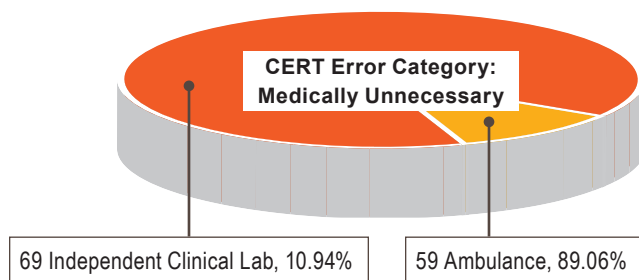
Avoid “No Documentation” Errors

http://www.cgsmedicare.com/partb/cert/review_process.html

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

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
<http://www.cms.gov/medicare-coverage-database/>



Avoid “Incorrect Coding” Errors

- » Be aware of the E/M Documentation Guidelines
<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/EMDOC.htm>
- 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
<http://www.cgsmedicare.com/partb/pubs/news/2013/1013/cope23465.html>



Compliance Corner: Recovery Audit (RA) Program

The Recovery Audit (RA) program is designed to comply with 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. <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/>



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 website

Recovery Audit Tips

- » Become familiar with the RA website
 - The J15 RA is CGI Federal, Inc. <https://racb.cgi.com/Default.aspx>
- » Access the approved issues at the “Issues” link <https://racb.cgi.com/Issues.aspx>
- » 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 websites <http://www.oig.hhs.gov/oas/cms.asp> and <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/index.html?redirect=/CERT>
 - 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 http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Recent_Updates.html

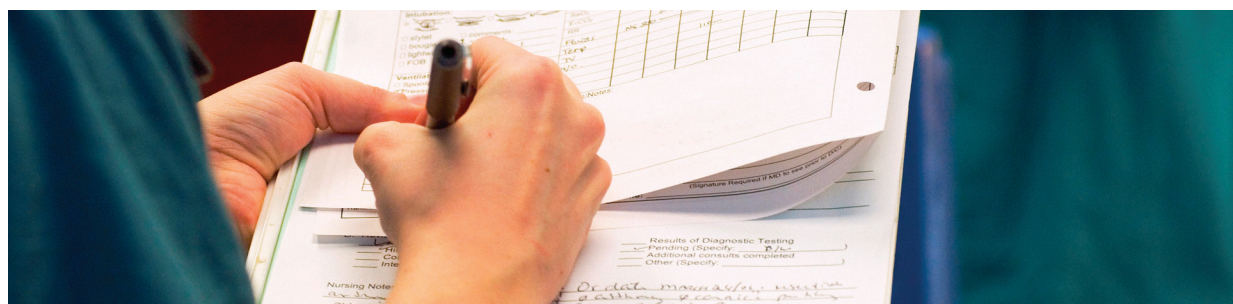


Reminders & Helps

CGS reminders to make things easier!

NOTES:

Overpayments	<ul style="list-style-type: none"> » eOffset process designed to allow providers to request an “immediate offset” of a pending overpayment http://www.cgsmedicare.com/pdf/eOffsetsJobAid.pdf <ul style="list-style-type: none"> • A demand letter must have been received » Actual refunds cannot be processed through eOffset » To notify CGS of an overpayment, complete the <i>Voluntary Overpayment Refund</i> form http://www.cgsmedicare.com/partb/forms/overpayment.html <ul style="list-style-type: none"> • Please type directly into the required fields on the Overpayment Refund Form, then print. Illegible forms may cause a delay in processing.
Redeterminations	<ul style="list-style-type: none"> » Complete the <i>Redetermination Request</i> form in its entirety http://www.cgsmedicare.com/partb/forms/gateways/redetermination.html <ul style="list-style-type: none"> • Better yet – SUBMIT YOUR REDETERMINATIONS THROUGH myCGS! http://www.cgsmedicare.com/pdf/myCGS/chapter7_partb.pdf » If requesting Redetermination due to an overpayment situation, please be sure to indicate this either in myCGS or on the actual form http://www.cgsmedicare.com/partb/pubs/news/2014/0614/cope25860.html
myCGS Password Help	<ul style="list-style-type: none"> » Allowing access to the amount of protected health information (PHI) available through myCGS requires very stringent password guidelines » To help with creating and maintaining strong passwords, use the <i>myCGS Password Quick Reference Guide</i> http://www.cgsmedicare.com/pdf/mycgs_passwordquickrefguide.pdf » Effective September 26, 2014, the password lock-out period was extended from 30 days to 60 days
Reopenings	<ul style="list-style-type: none"> » A Reopening may be requested to correct a minor error or omission to a previously processed claim http://www.cgsmedicare.com/partb/forms/gateways/reopenings.html » Services requiring the review of medical records CANNOT be handled as a Reopening <ul style="list-style-type: none"> • This includes services that were reduced during the medical review process based on submitted documentation • Reduced services may be reconsidered by requesting a Redetermination
Medical Review	<ul style="list-style-type: none"> » On occasion, local coverage determinations (LCDs) are updated http://www.cgsmedicare.com/partb/medicalpolicy/index.html » Please be sure to query the LCD database on a regular basis to ensure you are following the most current policy





Reminders & Helps

Here are a number of frequently used Web pages located on the CMS website.

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- Medicare Home Page <http://www.cms.gov/Medicare/Medicare.html>
- Advance Beneficiary Notice of Non-Coverage (ABN) <http://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html>
- Acronyms <http://www.cms.gov/apps/acronyms>
- Change Requests (CRs) and Transmittals <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/index.html>
- Coordination of Benefits <http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Coordination-of-Benefits/Coordination-of-Benefits.html>
- Glossary <http://www.cms.gov/apps/glossary/default.asp>
- Health Plans – General Information <http://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/index.html>
- Internet-Only Manuals (IOM) <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html>
- Medicare Physician Fee Schedule Database (MPFSDB) Medicare Provider-Supplier Enrollment <http://www.cms.gov/apps/physician-fee-schedule/>
- Medicare Provider-Supplier Enrollment <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html>
- MLN Catalog of Products <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Catalog.html>
- MLN General Information <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html?redirect=/MLNGenInfo>
- MLN Electronic Mailing List http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Mailinglists_Factsheet.pdf
- National Coverage Determinations (NCDs) <http://www.cms.gov/medicare-coverage-database/indexes/ncd-alphabetical-index.aspx>
- Outreach & Education <http://www.cms.gov/Outreach-and-Education/Outreach-and-Education.html>
- Physician Self-Referral <http://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/index.html>
- Physician Bonuses <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HPSAPSAPhysicianBonuses/index.html>
- Preventive Services <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/PreventiveServices.html>
- Quality Incentives – General Information
- Quality Improvement Organizations (QIOs) <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/index.html>
- Quarterly Provider Updates <http://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/index.html>
- SNF Consolidated Billing <http://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html>
- Therapy Services <http://www.cms.gov/Medicare/Billing/TherapyServices/index.html>

NOTES: