J11 Part B Medicare Updates, Changes and Reminders
October 2013

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Disclaimer

The information provided in this presentation was current as of 10/10/2013. Any changes or new information superseding the information in this presentation are provided in articles with publication dates after 10/10/2013 posted on our Web site at:

www.PalmettoGBA.com/J11B

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Agenda

• Medicare Updates and Change
• Reminders
• Hot Topics
• CERT
• News to Use
• Limited Coverage Denials
• Resources

Medicare Updates and Changes
We’re Open!

• During the time that the partial government shutdown is in effect, Medicare Administrative Contractors will continue to perform all functions related to Medicare fee-for-service claims processing and payment.

Debt Ceiling
Clinical Trial Number

Effective January 1, 2014
• Clinical trial number (CTN) required for claims qualified for coverage
• Number assigned by the National Library of Medicine - [http://clinicaltrials.gov](http://clinicaltrials.gov/)
  – Same number previously voluntarily reported
  – Submit CTN when ICD-9 code of V70.7/ICD-10 code Z00.6 (in either the primary or secondary positions) and
  – Modifier Q0 and/or Q1, as appropriate (outpatient claims only) is applicable
  – Enter CTN in:
    • Field 19 of paper claim; or
    • Loop 2300 REF02(REF01=P4) of the electronic claim when a clinical trial number is used
    • Precede 8-digit clinical trial number with alpha characters CT
      • Example: CT12345678

Section 603 of the American Taxpayer Relief Act (ATRA) of 2012

Manual Medical Review (MMR) of Outpatient Therapy Claims by Recovery Auditors (RAs)

• Effective: April 1, 2013
• All outpatient therapy claims at or above the $3,700 threshold cap will be reviewed
• Medical review will be conducted separately by discipline
Section 603 of the American Taxpayer Relief Act (ATRA) of 2012

- **Two** types of reviews:
  - **Prepayment review**
    - North Carolina providers
      - Claims reviewed before the claim is processed for payment
  - **Post-payment review**
    - Virginia, West Virginia, and South Carolina
      - Claims reviewed after the claim has been processed for payment
      - Additional documentation request (ADR) sent to provider immediately after the claim is paid by the MAC with instructions to send the records to the Recovery Auditors
      - If improper payment identified, a demand letter will be sent to the provider, which clearly documents the rationale for the determination

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Section 603 of the American Taxpayer Relief Act (ATRA) of 2012

- Change to Payment Liability for Therapy Cap Denials
  - Effective: January 1, 2013
  - Switched from beneficiaries liability to provider liability
  - Medicare systems were not updated in time to accurately represent this change on provider remittance advices (RAs)
  - MACs may have already processed therapy cap denials for services provided in 2013
  - These denials incorrectly report beneficiary liability (Group Code ‘PR’) on RAs when liability legally rests with the provider (Group Code ‘CO’)

Section 603 of the American Taxpayer Relief Act (ATRA) of 2012

• Medicare’s payment amount for these claims is correct, claims will **NOT** be adjusted to correct the Group Code
• Review therapy cap denials for dates of service on or after January 1, 2013, to determine whether any payments have been collected from beneficiaries
• Refund any beneficiary payments found for these services
• Cease collecting payments for therapy cap denials unless the beneficiary was appropriately notified via an Advanced Beneficiary Notice of Non-coverage (ABN)

Ambulatory Surgery Center Payment Center

• Effective October 1, 2013
• Informs Medicare contractors about the changes to and billing instructions for various payment policies implemented in the October 2013 Ambulatory Surgery Center (ASC) payment system update
October 2013 Physician Fee Schedule Data Base

- Quarterly update to the Medicare Physician Fee Schedule Data Base (MPFSDB) released
- Effective with dates of service 1/1/2013
- Providers may request adjustments to claims affected

Quarterly Update to the Correct Coding Initiative (CCI) Edits

- Effective October 1, 2013
- Represents normal quarterly update to the CCI procedure to procedure edits
- Contractors will not search files to either retract payment or to retroactively pay claims
- Contractors will adjust claims brought to their attention
Standard Code Set Updates

- Remittance Advice Remark and Claims Adjustment Reason Codes and Medicare Remit Easy Print and PC Print Update
  - Implementation date: October 7, 2013
  - Effective date: See CMS MLN Matters Article
  - Full list of all reason and remark codes

Extended Repayment Schedule (ERS)

- Medicare contractors charged with establishing an Extended Repayment Schedule (ERS) for refunding certain overpayments
  - Formerly called an Extended Repayment Plan (ERP)
- Major change: Recoupment will be reduced from 100% to 30% on the requested overpayment while the request is under review
  - 30% recoupment applied to the outstanding overpayment in addition to the required monthly payments while plan is under review
- Full details posted to the Palmetto GBA website
New Mental Health Care Coding Changes

- Understand that all Evaluation and Management (E/M) coding and documentation rules and regulations apply to any E/M service billed by any provider including mental health care providers.
- Visit the Palmetto GBA E/M Help Center for assistance and guidance.

Flu Allowances

<table>
<thead>
<tr>
<th>Code</th>
<th>**Allowance – effective 8/1/2013 – 7/31/2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>90655</td>
<td>$17.243</td>
</tr>
<tr>
<td>90656</td>
<td>$12.398</td>
</tr>
<tr>
<td>90657</td>
<td>$6.022</td>
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<tr>
<td>90661, 90687, 90688</td>
<td>Pending</td>
</tr>
<tr>
<td>90685</td>
<td>$23.228</td>
</tr>
<tr>
<td>90686</td>
<td>$19.409</td>
</tr>
<tr>
<td>Q2035 (Afuria®)</td>
<td>$11.543</td>
</tr>
<tr>
<td>Q2036 (Flulaval®)</td>
<td>$8.579</td>
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<tr>
<td>Q2037 (Fluvirin®)</td>
<td>$14.963</td>
</tr>
<tr>
<td>Q2038 (Fluzone®)</td>
<td>$12.044</td>
</tr>
<tr>
<td>Q2039 (Flu Vaccine Adult - Not Otherwise Classified)</td>
<td>To be determined by the local claims processing contractor.</td>
</tr>
</tbody>
</table>

**Note**
Allowances not applicable when provided in a hospital outpatient department, RHC, or FQHC.
Medicare Redetermination Notice

• Beginning January 1, 2014, Medicare contractors will redact the patient’s HICNs on the Medicare redetermination notice (MRN).

• The HICNs will be redacted by replacing 5 or more values of the HICN with Xs or asterisks (*) with the last 4 or 5 digits of the HICN displayed.

New Look!

- QR or Quick Response Code
- Nice clean lines and new organization
- New Celerian branding colors and fonts incorporated into the design
Reminders

ICD-10

• On final implementation October 1, 2014, coding will change from ICD-9-CM to ICD-10
  ◦ Transition occurring throughout health care industry
  ◦ Prepare now - avoid potential reimbursement issues
  ◦ ICD-10 - date of service specific

• CMS transitioning to ICD-10 video slideshows now available on YouTube
  http://www.youtube.com/watch?v=2cSBh_h45Wc&feature=youtu.be

Logo signifies materials were developed by CMS, and are intended for general industry use
CMS-1500 Claim Form Revised

• New version – 02/12
• Changes include:
  – Ability to indicate if using ICD-9 or ICD-10 diagnosis codes on claim
  – Allows additional diagnosis codes (expands from four possible codes to 12.
• Medicare to accept revised form starting January 2014
• ICD-10 codes not accepted until 10/1/2014.

http://www.nucc.org/%5Cimages%5Cstories%5CPDF%5C1500_claim_form_2012_02.pdf?utm_medium=email&utm_source=govdelivery

DME Contractor Makes Dear Physician and Documentation Letters Available

• CGS SM the Region C DMERC makes available a series of ‘Dear Physician’ letters on the CGS SM website to assist providers ordering supplies with documentation requirements to support the medical necessity and order of medical supplies.
• http://www.cgsmedicare.com/jc/coverage/MR/Doc_Req.html
Enhancement to Initial Demand Letter Process

• To assist providers with routing demand (overpayment) letters within their office, Palmetto GBA will begin issuing initial demand letters using envelopes with a red strip on the top.
• These envelopes with a red strip will alert mailroom and other staff that the envelope contains a time sensitive request.

Medicare Covered Screening and Preventive Services

• Medicare covers many screening and preventive services
• Review the full list of covered services
• Recommend and provide those that are appropriate for your patients
• Full list including coverage, coding and billing information found in the CMS Quick Reference Guide
  
PQRS Feedback Reports

• 2012 PQRS feedback reports will be accessible for individual eligible professionals and groups who reported PQRS measures on claims or through other reporting options

• 2012 PQRS Feedback Report Users Guide

Physician Quality Reporting System

• Section 1848(a)(8) of the Social Security Act, requires CMS to subject eligible professionals and group practices who do not report data on Physician Quality Reporting System (PQRS) quality measures for covered professional services during the 2013 program year to a payment adjustment beginning in 2015
  – 2015 negative payment adjustment, -1.5% for services rendered January 1-December 31, 2015
  – 2016 negative payment adjustment, -2.0 for services rendered January 1-December 31, 2016

2012 PQRS Informal Review Period

• May request a review of your 2012 PQRS incentive payment eligibility determination
• Requests only accepted - November 1, 2013 through February 28, 2014
• CMS must receive a valid informal review request via the web-based tool
• Notification sent via email within 90 days of the submission of the original request for an informal review. (Valid requests only.)
• The informal review decision will be final, and there will be no further review or appeal.
• [Link to CMS website for more information]

Late Breaking

• Beneficiary name must match the Health Insurance Claim Number (HICN):
  – Mismatches will cause claim to reject as unprocessable.
    – Claim Reason Code – 140
    – RA Codes: MA130, MA61
• Claim must be corrected and refiled as a new claim.
Tips

• Beneficiary’s name must be submitted exactly as indicated on the Medicare card.
• Hyphens (-) and apostrophes (‘) count as a character.
• The 1st six digits of the last name must be an exact match, including spaces.
• Make sure to include any spaces in the name (ex. O BRIAN). Spaces can be difficult to see on the Medicare card.

Tips

• Electronic claims
  – Ensure EDI loop for the suffix field is populated and the suffix is not added to the beneficiary’s last name.
• Obtain correct name and Medicare HICN from the patient, their Medicare card or authorized representative, not the Provider Contact Center (PCC). Then re-file the claim with the correct information.
• In the Health Insurance Claim Number (HICN) field – **do not** insert hyphens or spaces.
Tips

• Verifying eligibility through OPS
  – OPS may require patient name be entered differently than it appears on patient’s card.

• However...when filing the claim, the name must appear exactly as it appears on the patient’s card.

Medically Unlikely Edits (MUEs)

• A MUE for a HCPCS/CPT code is the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service.

• All HCPCS/CPT codes do not have a MUE.
  – CMS publishes some MUE values on its website
  – Other MUE values are confidential and are for CMS and CMS Contractors' use only.

• MUE claim denials may be appealed with documentation to support the number of units billed.
Denial Reason and Remark Codes

- **CO-151** - Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.
- **N362** - The number of days or units of service exceeds our acceptable maximum.

http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html
Hot Topics

Taxonomy Codes

- Not required by Medicare
- Taxonomy codes submitted must be:
  - in correct location on electronic claims; and
  - valid (based on the latest National Uniform Claim Committee (NUCC) Healthcare Provider Taxonomy Codes (HPTC) code set
- Taxonomy codes meeting criteria are passed to crossover insurers
- Crossover insurers may do further validation of taxonomy codes
- Verify your clearing house is not scrubbing taxonomy codes off
Incarcerated Beneficiaries

- CMS initiated recoveries from providers and suppliers based on data that indicated a beneficiary was incarcerated on the date of service.
- CMS has since learned that the information related to these periods of incarcerations was, in some cases, incomplete for CMS purposes.
- CMS working to:
  - Restore original data on the Medicare Enrollment Data Base;
  - Identify all claims where overpayments incorrectly demanded or collected; and
  - Make changes to claims processing system utilities to effectuate the necessary changes.

*Necessary adjustments will be made to claims once CMS releases directive*

*Providers should not resubmit their claims*

Ophthalmology Code Denial

- July National Correct Coding Initiative (NCCI) edits was updated appropriately to include the ophthalmology Evaluation and Management (E/M) CPT codes 92012 and 92014.
- CMS was made aware that the claim processing system (MCS) inadvertently omitted 92012 and 92014 from the E/M range of CPT codes 99201-99499 and is not allowing the use of separately billed CPT modifiers 25, 24, and 57.
- This is causing claims to deny inappropriately when the modifiers are appended to these procedure codes.
- CMS correcting issue and inappropriately denied claims will be reprocessed by November 15, 2013.
- No action needed by providers.
Transitional Care Management (TCM)

• CMS Fact Sheet on TCM
  – Health care professionals who may furnish TCM services
  – Covered locations
  – TCM components billing guidelines
  – FAQs
  – Resources

Therapy Claim-Based Data Collection

• Implementing the Claims-Based Data Collection Requirement for Outpatient Therapy Services
  – Effective for therapy services with dates of service (DOS) on/after January 1, 2013

  • Claims will be returned/rejected for DOS on/after July 1, 2013 if required therapy claim-based data collection codes/modifiers are not submitted
Resources

CMS Transmittals (CR 8005):


CMS MedLearn Matters (SE1307):

CERT and Compliance
Compliance

- Compliance is a state of being in accordance with established guidelines, specifications, or legislation or the process of becoming so.
- Compliance is the responsibility of everyone and must be taken seriously.
- Self-test your practice for compliance with all Medicare rules and regulations!
- Take corrective action to correct known areas of vulnerability in your practice.

Who May Ask for Records?

- Zone Program Integrity Contractor (ZPIC) - AdvanceMed is the Zone 5 contractor and covers the states of Alabama, Arkansas, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Virginia, and West Virginia.
  - www.csc.com/advancemed
- Comprehensive Error Rate Testing (CERT) contractor.
- Recovery Audit Contractor (RAC).
- Connolly Consulting, Inc. – (Viant Payment Systems, Inc. serves as subcontractor.)
CERT

• Medicare contractors receive more than 2 billion claims per year.
• To help keep the Medicare program viable, CMS implemented CERT.
• CERT measures the accuracy of Medicare Fee-for-Service (FFS) payments and establishes error rates.
  – Contractor Error Rate
  – Provider Compliance Error Rate (PCER)

CERT and PCER Methodology

• CERT and PCER methodology includes:
  – Randomly selecting a sample of submitted claims
  – Requesting medical records from provider who submitted the claims
  – Reviewing the claims and medical records for compliance with Medicare coverage, coding and billing rules
Provider Compliance Error Rate (PCER)

- The PCER reflects:
  - Providers’ understanding and compliance with the Medicare rules and policies; and
  - The effectiveness of Medicare contractors’ educational programs.

- CMS compares the PCER among Medicare contractors nationwide.

CERT Error Rate

9.9%

- National CERT Error Rate

8.2%

- Palmetto GBA Error Rate

Palmetto GBA’s Target Error Rate – 0%
**Educational Focus**

**CERT**

- Evaluation and Management (E/M) Services
- Drug Services (billed to Part B)
- Laboratory Services
- Advanced Imaging Services

**E/M Errors**

- Incorrect coding: 63.20%
- Insufficient documentation submitted: 35.50%
- All Other Errors Combined: 2%

September 2013 Palmetto GBA J11 B
Jump Start Compliance

• Looking for a conversation starter to focus your next staff meeting on compliance?

• Why not use the Palmetto GBA Evaluation and Management (E/M) Weekly Tips. View a full list of the weekly tips under the ‘E/M Help Center’ on the Palmetto GBA page.
Drug Service Errors

- Insufficient documentation submitted
- Medically unnecessary
- Incorrect coding

71.40%
14.30%
14.30%

Drug and Biological Resources

Jurisdiction 11 Part B
Chemotherapy and Biologicals: Medicare Guidance

Submitting the Number of Units for Drugs and Biologicals:
- Submit the number of the dosage specified in the Healthcare Common Procedure Coding System (HCPCS) or National Drug Code (NDC) description. If the dosage given is not a multiple of the HCPCS code, round the number of units to the next highest unit in the HCPCS description.
- If the dosage provided is less than the dosage for this code specifying the minimum dosage for the drug, report the code for the minimum dosage amount.

Not Otherwise Classified (NOC) Drugs:
- When claims are submitted with HCPCS code 99696 (not otherwise classified anti-neoplastic drug), 23496 (unclassified drug), and 10646 (unclassified biological drug), the drug name, the National Drug Code (NDC) number and total dosage must be indicated. For these claims, the documentation must be included. For electronic claims, effective with version 5010 implementation, Loop 830740 99103-7 must be completed for Not Otherwise Classified (NOC) codes. The required documentation (name, dosage and NDC) may be submitted in Loop830740 23496 99103-7. If additional space is needed, Loop 23496 XTE 00 may be utilized in addition to 830740 99103-7.

Discarded Drugs:
- CMS encourages physicians to schedule patients in such a way that they can use drugs most efficiently. However, if a physician must discard the remainder of a vial or other package after administering it to a Medicare patient, the program covers the amount of drug discarded along with the amount administered. To submit a claim when a portion of the drug supplied is unused (discarded), include the total of both the unused and the used.
Laboratory Service Errors

- 77.40% Insufficient documentation submitted
- 5.30% Incorrect coding
- 11.80% Medically unnecessary
- 2% Other errors combined

Laboratory Service Resources

Jurisdiction 11 Part B

J11 PART B

TOP LINKS
- Claims Processing Issues Log
- Clinical Trials
- Dental Resolution
- DRGPOS
- Drugs & Bioequivalents
- Fee Schedules
- Frequently Asked Questions
- General
- Home Health & Hospice
- ICD-10
- Incentive Programs
- Lab Information
- Lab - Medicare Claims

September 2013 Palmetto GBA J11 B
Advanced Imaging Errors

- Insufficient Documentation: 16.60%
- Incorrect Coding: 83.30%

Types of Errors (all services combined)

- Insufficient Documentation: 0.06%
- Services Incorrectly Coded: 8.40%
- Medically Unnecessary Services or Treatment: 30%
- Other Errors (combined): 61%
Types of Errors (all services combined)

All Services Have Three Basic Errors Identified

- Insufficient Documentation
- Services Incorrectly Coded
- Medically Unnecessary Services or Treatment
- Other Errors (combined)

• Corrective action:
  – Carefully review documentation – was all necessary documentation provided?
    • Right patient
    • Right date of service
    • Reason for encounter, findings and test results
    • Assessment/diagnosis
    • Plan of care
    • Date and legible signature
    • Orders (including any necessary legible signatures)
    • How were diagnostic test results used to care for patient/decision making/plan of care
Documentation (Cont.)

- Legible signatures of observer/provider.
- Can you read the records?
- Is a key necessary to understand your provider’s abbreviations?
- Billing provider is responsible for obtaining and providing records to support their claim, even from third parties (e.g., hospitals, nursing homes, etc...).
- Does your staff know how to pull entire electronic medical record from your EHR including electronic signature?

Faxed Documentation

- Faxes & Chart Copies
  - Check quality of documentation being sent.
  - Check orientation (face-up or face-down).
  - Red ink typically does not come through on faxes.
  - Highlighting appears as a solid mark obscuring records on a fax.
Signatures

• It should be noted that while basic documentation was acceptable, many signatures were:
  – Illegible, unrecognizable handwritten signatures or initials;
  – Unsigned 'typewritten' progress notes with a typed name only;
  – Unverified or unauthorized electronic signatures; or
  – No indication of the rendering physician/practitioner.

Acceptable Signature Methods

• Records/test orders and findings:
  – Handwritten signatures or initials
  – Electronic signatures
  – Digitized signature
    • an electronic image reproduced in its identical form using a pen tablet
Electronic Signatures

• Electronic signatures usually contain date and timestamps and include printed statements (e.g., 'electronically signed by,' or 'verified/reviewed by') followed by the practitioner’s name and preferably a professional designation.
  • Example:
    • Electronically Signed By: John Doe, M.D. 08/01/2008 @ 06:26 A.
    • Digital signature – electronic method of a written signature - typically generated by special encrypted software that allows for sole usage.

Acceptable Signatures (cont.)

• Illegible signature or initials **NOT** over a typed/printed name and **NOT** on letterhead, but the submitted documentation **NOT** accompanied by:
  – Signature log; and/or
  – Attestation statement.

• Initials over a typed or printed name.
Signature Log

• A signature log lists typed or printed name of the author associated with initials or an illegible signature.
• Signature log might be included on the actual page where the initials or illegible signature are used or might be a separate document.
• If you use a signature log, be sure to submit it with your documentation.

Signature Attestation Statement

Attestation statements must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the beneficiary.

“I, [print full name of the physician/practitioner] hereby attest that the medical record entry for insert [beneficiary name and date of service] accurately reflects signatures/notations that I made in my capacity as [insert provider credentials, e.g., M.D.] when I treated/diagnosed the above listed Medicare beneficiary. I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability.”
**Unacceptable Signatures**

- **Signature stamps.** (Except when an author with a physical disability can provide proof to a CMS contractor of his/her inability to sign their signature due to their disability. CR8219)

- Reports or any records that are dictated and/or transcribed, but do not include valid signatures - 'finalizing and approving' the documents are not acceptable for reimbursement purposes.

- Corresponding claims for these services will be denied.

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**Before Appealing a CERT Denial**

- Identify the reason each service was denied
- Check the records that your office supplied
- For electronic records – was the record provided the 'final' signed report/note?
  - ‘Unapproved’ or ‘interim’ entries lacking valid signatures are not acceptable for medical reviews or appeals

- Do not resubmit the claim. The decision for denial was based upon review of medical records; therefore, claims for these services may not be resubmitted for payment consideration
CERT Help

Jurisdiction 11 Part B
GENERAL INFORMATION

The Centers for Medicare & Medicaid Services (CMS) established the Comprehensive Error Rate Testing (CERT) program to monitor and report the accuracy of Medicare fee for service (FFS) payments. The CERT program measures the error rate for claims submitted to Medicare contractors. Palmetto GBA were CERT contractors to identify areas of focus for our Provider Outreach & Education efforts. One of the major outcomes of these CERT reports is the past claim error rate (percentage of dollars paid incorrectly).

From this Web page, you may view CERT error rates by code group and provider type (specialty), articles about specific areas of concern as a result of CERT review findings and newsletters from the CERT Documentation Contractor or CMT DC. For more information about CERT:

- View public CERT reports on the CMS web site: [www.cms.hhs.gov/CERT/]
- Establish a CERT contact person for your practice: [www.CERTprovider.org]
- CMS Provider Compliance Fact Sheets & Newsletters
- Provider Compliance

FAQs: Additional Medical Review Projects and CERT
- CERT Provider Compliance Training Videos a
  13/05/2012
- Importance of Preparing/Maintaining Legible Medical Records
  13/05/2012
- Medical Record Cloning
  13/05/2012
- Introduction to CERT Web-Based Training 
  13/05/2012
- CERT Records Request Letters: Hints
  06/11/2012
- CERT Signature Denial Messages
  07/10/2012

More CERT Help

- CERT contractor Customer Service:
  (301) 957-2380

- Palmetto GBA CERT Web page
Reminder

If you can’t read it, we can’t read it!

Carefully pull and timely submit all the necessary documentation to support all services on your claim!

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CERT Help

Jurisdiction 11 Part B

GENERAL INFORMATION

The Centers for Medicare & Medicaid Services (CMS) established the Comprehensive Error Rate Testing (CERT) program to monitor and report the accuracy of Medicare fee-for-service (FFS) payments. The CERT program measures the error rate for claims submitted to Medicare contractors. Palmetto GBA uses CERT reports to identify areas of focus for our Provider Outreach & Education efforts. One of the major outcomes of these CERT reports is the paid claims error rate (percentage of dollars paid incorrectly).

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- Establish a CERT contact person for your practice: [www.certracprovider.org](http://www.certracprovider.org)
- CMS Provider Compliance Fact Facts & Newsletters
- Provider Compliance

Palmetto GBA Home / Jurisdiction 11 Part B / CERT / General...

J11 PART B

TOP LINKS
- Claims Processing Issues Log
- Fee Schedules
- Penalties
- Local Coverage Determinations
- New to Medicare

Jurisdiction 11 Part B Home
- What's New
- Browse By Specialty
- Browse By Type

FAQs:
- Additional Medical Review Projects and CERT
- Medicare Provider Compliance Training Videos
- Importance of Preparing/Maintaining Legible Medical Records
- Medical Record Clerking
- Introduction to CERT Web Based Training
- CERT Records Request Letters: Notes
- CERT Certification General Messages

September 2013 Palmetto GBA J11 B
More CERT Help

– CERT contractor Customer Service:
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– Palmetto GBA CERT Web page

Recovery Audit Contractor (RAC)

www.connolly.com/healthcare/Pages/CMSRacProgram.aspx
Recovery Audit Contractor (RAC)

- RAC sends initial letter to notify provider of error and provides contact information for questions regarding the error.
- Palmetto GBA sends overpayment demand letter to recoup monies associated with errors identified by the RAC.
- Appeals of RAC errors are submitted to Palmetto GBA and appeals should be identified as a RAC appeal when submitted.

News to Use
E/M Comparative Billing Reports

- E/M Comparative Billing Reports: Peer Code Comparison now available
- Reports based only on the Part B Extract Summary System (BESS) data between July and December 2012
- Calculate your own billing patterns and use the E/M Comparative Billing Report to see how you compare to your peers nationally and locally
- Separate file for each state

CMS Enrollment Revalidation Initiative

- Revalidation applies to all providers and suppliers enrolled prior to March 25, 2011, with no submitted changes after this date
- All revalidations to be completed by March 23, 2015
- Providers notified by mail when they must begin the revalidation process
- Providers have **60 days** from the date of the letter to submit complete enrollment forms or revalidate through PECOS
- Failure to revalidate as requested may result in the deactivation of Medicare billing privileges
**Provider Enrollment and Chain Ownership System (PECOS)**

- Looking for a faster way to enroll, revalidate, or change your enrollment information with Palmetto GBA?
- **Use the Internet-based PECOS**
  - Background information on Internet PECOS
  - Check out the *Getting Started Guide for Physicians and Non-physician Practitioners* and the *PECOS - Enrollment Example* under ‘Downloads’

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**Using PECOS**

- In order to use PECOS providers must:
  - Have an NPPES User ID and password
  - Go to Internet-based PECOS and complete, review, and submit the electronic enrollment application via Internet-based PECOS [https://pecos.cms.hhs.gov/pecos/login.do](https://pecos.cms.hhs.gov/pecos/login.do)
  - **Important**: You must electronically sign *or* print, sign and date the two-page Certification Statement and mail the Certification Statement and all supporting paper documentation to the Medicare contractor within seven days of electronic submission
Coordination of Benefits Contractor (COBC)

- Coordination of Benefit Contractor (COBC) – 1-800-999-1118
  - COBC collects, manages, and maintains other insurance coverage for Medicare beneficiaries
  - Providers may request an update to an MSP record if they have the appropriate documentation to substantiate the change
    - The documentation may need to be faxed to the COBC at 734-957-9598, or the beneficiary may need to be on the line to validate the change
  - COBC may not adjust claims or discuss specific claim determinations

Top Denials and Rejections
### Working Denials and Rejections

<table>
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<tr>
<th>Reason and Remark Code</th>
<th>Issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>CO-50, N115</td>
<td>Not Medically Necessary (LCD)</td>
</tr>
<tr>
<td>CO-B15</td>
<td>Bundled Services</td>
</tr>
<tr>
<td>PR-204</td>
<td>Noncovered Service</td>
</tr>
<tr>
<td>PR-31</td>
<td>HIC #/Name Issue</td>
</tr>
<tr>
<td>CO-50, N386</td>
<td>Not Medically Necessary (NCD)</td>
</tr>
<tr>
<td>PR-22, MA04</td>
<td>MSP</td>
</tr>
<tr>
<td>PR-170</td>
<td>Not Authorized Provider</td>
</tr>
<tr>
<td>PR-49</td>
<td>Routine/Screening Services</td>
</tr>
<tr>
<td>CO-MA01, N362</td>
<td>Frequency</td>
</tr>
<tr>
<td>CO-4</td>
<td>September 2013 Patient Modifier</td>
</tr>
</tbody>
</table>

### Help with Claim Rejections and Denials

**TOP LINKS**
- Claim Processing Issues Log
- Free Schedules
- Forms
- Incarcerated Beneficiaries
- Local Coverage Determinations

**What's New**
- Browser by Specialty
- Browser by Topic
- CERT
- CHS e-name
- EDI
- EIM Help Center
- Learning & Education
- Medical Policies
- New to Medicare
- Online Provider Services
- Publications
- Resources

**J11 PART B**

**Jurisdiction 11 Part B**

**NEWS**
- CMS e learns: August 26, 2013
  - 2013 Part A & B Fall Workshop Series: Passport to Excellence
    - Incorporated Beneficiary Claim Denials
    - Frequently Asked Questions
  - Jurisdiction 11 (J11) is Getting a New Telephone Number
- View All News for Jurisdiction 11 Part B
IT’S FREE!
• Must have an EDI agreement on file and register for access
• One administrator per group PTAN/NPI combination
• Administrator can grant access to additional staff
• Administrator controls which tabs each user may access
• Current users must ask administrators to grant access to newest features
• Access renewal required

Online Provider Services (OPS)
Online Provider System – FREE
- e-Offset
- e-Check
- Appeals
- Remittances
- Eligibility
- Claims Status
- Information (payment floor and last three checks)
Claim Processing Issue Log (CPIL)

- List of current system-related claims processing issues
- Issues have been reported to the CMS and/or MCS
- Check often for updates before contacting the provider contact center
- Located under the ‘Top Links’ section of the Palmetto GBA home page
- Sort by ‘current issues’

Correspondence Tips

- Make sure you:
  - Use the correct form
    - Palmetto GBA ‘Forms’ link provides most current forms
  - Mail/fax to the correct address/number
  - Do not combine documents that need to go to different departments in the same envelope.
  - Clearly indicate why you are sending correspondence i.e.
    - Redetermination request
    - Response to ADR letter
    - Overpayment refund
Incentive Resources

PQRS
CMS outlines measures, groups, and reporting options on the PQRS Incentive Web page.
- www.PalmettoGBA.com/J11B - select “Browse by Topic” then “Incentives”
- www.CMS.Gov/PQRS
- **Note** - when applicable, negative payment adjustments begin in 2015

eRx
- Quality Net Help Desk at (866) 288-8912
- www.cms.gov/ERXincentive/

EHR
- Visit the CMS EHR page for help on the “Path to Payment”
  - www.cms.gov/Regulations-andGuidance/Legislation/EHRIncentivePrograms/PathtoPayment.html
- Contact the EHR Information Center Help Desk for Questions concerning registration, (888) 734-6433

Electronic Transactions

Using Technology to Work Smarter Not Harder

Electronic Data Interchange (EDI) – electronic claim submission

Electronic Funds Transfer (EFT) – direct deposit

Electronic Remittance Advice (ERA) – paperless remittance advices

Medicare Remit Easy Print (MREP) – free software to convert ERAs back to a paper notice
Beginning October 1, 2013, all J11 Part A, Part B and HHH providers will have **ONE** number to dial:

855-696-0705

Consolidated Customer Service

- Use this number for:
  - Electronic Data Interchange (EDI)
  - Interactive Voice Response (IVR)
  - Provider Contact Center (PCC)

855-696-0705

One Stop Service for ALL Your Medicare Needs!

Consolidated Customer Care
Process starts with calling the IVR

Customer Service Advocate (CSA)

CSA will coordinate with other departments - Finance, Provider Enrollment, Medical Review, Appeals and Claims

Contacting Palmetto GBA

<table>
<thead>
<tr>
<th>Service</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>IVR</td>
<td>(610) 414-8333</td>
</tr>
<tr>
<td>Provider Contact Center (PCC)</td>
<td>(877) 830-3043</td>
</tr>
<tr>
<td>Telephone Reopening</td>
<td>(877) 830-5556</td>
</tr>
<tr>
<td>Electronic Data Interchange Support</td>
<td>(866) 749-4305</td>
</tr>
</tbody>
</table>

Remember these numbers consolidate on 10/1/2013
Resources

<table>
<thead>
<tr>
<th>Resources</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Palmetto GBA listserv</td>
<td><a href="http://www.PalmettoGBA.com/J11B">www.PalmettoGBA.com/J11B</a> Select E-mail Updates</td>
</tr>
<tr>
<td>Contact Us By Email</td>
<td><a href="mailto:J11.PartB@PalmettoGBA.com">J11.PartB@PalmettoGBA.com</a></td>
</tr>
<tr>
<td>Selfservice Tools (Online Provider Service (OPS))</td>
<td><a href="http://www.PalmettoGBA.com/J11B">www.PalmettoGBA.com/J11B</a> Listed under Self-service Tools</td>
</tr>
<tr>
<td>CMS listserv</td>
<td><a href="http://www.cms.gov/AboutWebsite/Email">www.cms.gov/AboutWebsite/Email</a> Updates/list.asp</td>
</tr>
</tbody>
</table>
Social Networking

New Ways to Stay Connected

Thank You for Attending.