Meeting Location(s)

This Provider Outreach and Education Advisory Group (POE AG) meeting was conducted in the Birmingham office and via webinar/teleconference.

Alabama Attendee(s)
Carol Aiken  Susan Ainsworth  Debra Freeman  Miriam McGee  Melissa Reeves
Genetics  Cardiothoracic  Multi  Cardiology  Multi
Gina Seibert  Carrie Welborn
Hemat/Oncology  Physical Therapy

Georgia Attendee(s)
Sharon Apodaco  Terry Cobb  Patricia Dykes  Gail Harrison  Regina Jones
Multi  Ambulance  Neuro Surgery  Psychiatry  Orthopedic Surgery
Trebb Putnam  Stephanie Smith  Kim-Marie Walker
Specialist  Physical Therapy  Hospital

Tennessee Attendee(s)
Roger Deversa, M.D.  Pattie Douglas  Wallace Elliott  Erin King  Kristi May
Primary Care/ Internal Medicine  Oncology  Ambulance  Urology  Orthopedics
Peggy Palmer  Dee Pratt  Fran Sorrell  Holly Steinman  Crystle Wright
Compliance Coding  Dietitian/Nutritionist  Urology  Multi  Gastroenterology

Cahaba Associates:
LaTrelle White  Renea Cloud  Paula Motes  Serena Robertson  Karen LeFan
Christie Dunagan  Leah Lewis

Welcome
The meeting was called to order at 10:00 A.M. CT /11:00 A.M. ET. Cahaba Provider Outreach and Education Consultant, Renea Cloud opened the meeting with introductory remarks. The following agenda items were discussed during the meeting:

**There was a delay in the actual start time due to operator issues. The POE staff will be working to correct these issues in future meetings. We apologize for the inconvenience caused during the meeting.**

POE AG Purpose/Member Responsibilities
Members were provided a review of the purpose and responsibilities of the POE AG. Primary functions for the POE Advisory Group include:

- **ATTEND:** Attend and participate in the majority of scheduled POE AG meetings
- **IDENTIFY:** Identify and bring forth education needs indicated by industry trends and concerns
- **ACTIVITIES:** Identify educational outreach activities
- **PLAN:** Plan educational outreach through selection of topics, educational mediums and sites

### CMS Updates

- **Medicare Administrative Contractor Satisfaction Indicator (MSI)**
  The MAC Satisfaction Indicator (MSI) is a tool used by CMS to measure provider satisfaction with the MACs from which they receive services. All Medicare providers who receive services from their Medicare Administrative Contractor (MAC) can participate. This includes Medicare fee-for-service physicians, suppliers, health care practitioners and institutional facilities who serve Medicare beneficiaries across the country. In addition to monitoring administrative contractor’s performance, CMS uses the results for monitoring trends, to improve oversight and to increase efficiency of the Medicare program. CMS uses the results into MAC incentive plans. The MSI provides contractors with more insight into how their provider communities perceive them and allows them to make process improvements based on provider feedback. The URL link to the Cahaba MSI survey was shared with the Advisory Group members.

CMS targets services provided by the MACs in the following functional areas: Provider Outreach and Education, Provider Telephone Inquiries, Claims Processing, Electronic Data Interchange (EDI) Help Desk, Reopening & Redeterminations, Provider Enrollment, Medical Review, Self-service Portal and Cost Report and Reimbursement (Part A). Members were encouraged to visit the CMS website to review previous MSI reports. For questions or comments related to the MSI survey, you can email the CMS MSI Team. The links were given during the presentation.

- **Social Security Number Removal Initiative (SSNRI)**
  The SSNRI is part of the MACRA or Medicare Access & CHIP Reauthorization Act of 2015. This section of the statute requires the removal of all social security numbers from Medicare cards. The current Health Insurance Claim number consists of a beneficiary’s social security number followed by a letter or letter and numeric suffix. A new card with a Medicare Beneficiary Identifier known as a MBI will be sent out to Medicare beneficiary’s beginning April 1, 2018. The MBI will consist of 11 characters, a mix of numerical and upper case alpha. This will be a phased process meaning the new MBI Medicare cards do not all go out at one time, they will be sent out to the beneficiaries in segments.

Since the process is going to be segmented, CMS is allowing a transition period from April 1 2018 through December 31, 2019. The transition period allows providers to use either the original Medicare number or the new MBI to submit their claims while CMS gets out the 55+ million cards to its beneficiaries. With date of services beginning January 1, 2020 all providers should bill using the new MBI.

  - **Using the HICN After SSNRI Transition Period**
    After the SSNRI transition period ends, Medicare providers may still use the HICN for:
    - **Appeals**
      - If an HICN is used on the claim, then you can use either HICN or MBI for that claim’s appeal
    - **Reports**
      - Incoming to CMS
        - Quality Reporting, Disproportionate Share Hospital data requests, etc.
      - Outgoing from CMS
        - Provider Statistical & Reimbursement Report, Accountable Care Organization Reports, etc.
    - **Retroactive Enrollment**
    - **Span-Date Claims**
      - Use the HICN if the “From Date” is before the end of the transition period (12/31/2019) for:
        - 11X-Inpatient Hospital
        - 32X-Home Health
        - 41X-Religious Non-Medical Health Care Institutions
    - **Adjustments**
      - Use the HICN for claims submitted with a HICN on the claim
• **Incoming Information Requests**
  - Inquiries, Medicare Secondary Payer information requests, requests for Medical documentation, etc.

• **Incoming Premium Payments**

A snapshot of the MBI Format Specifications was provided to the members. This information can be downloaded in a document on the CMS website at [https://www.cms.gov/Medicare/SSNRI/MBI-Format-PDF.PDF](https://www.cms.gov/Medicare/SSNRI/MBI-Format-PDF.PDF)

• **CMS Open Door Forum Materials**
  - About the SSNRI (11/1/16)
  - For Coordination of Benefits Agreement (COBA) trading partners and their associates (1/11/17)
  - For Medicare Secondary Payer (MSP) stakeholders and processes (1/11/17)

• **Beneficiary Notices Initiative (BNI)**
  Medicare beneficiaries and providers have certain rights and protections under the law related to financial liability. The Beneficiary Notice Initiative includes provider awareness about when and which types of notice should be used to inform beneficiaries of their financial liability, appeals rights, and protections. For most Part B providers that is the utilization of the Advanced Notice of Beneficiary Non-Coverage or ABN for fee-for-service providers.

  The direct link to the CMS BNI webpage is [https://www.cms.gov/medicare/medicare-general-information/bni/abn.html](https://www.cms.gov/medicare/medicare-general-information/bni/abn.html). It contains all available notices and letters for both fee-for-service and Medicare advantage plans. You can submit questions to BNImailbox@cms.hhs.gov.

• **Fee-for-Service Advance Beneficiary Notice of Noncoverage (ABN)**
  ABN Form CMS-R-131, is issued by providers (including independent laboratories, home health agencies, and hospices), physicians, practitioners, and suppliers to Original Medicare (fee for service) beneficiaries in situations where Medicare payment is expected to be denied. About every five years, the Office of Budget and Management review the ABN for continued use approval. Effective June 21, 2017, Form number 0938-0566 Expiration 03/2020 will replace the current form in use 0938-0566 03/11. No changes have been made to the form it’s self just the expiration date change. The form number information is located at the bottom of the form.

• **Merit-Based Incentive Payment System (MIPS) Participation Status Letter**
  Another new initiative made as a result of the Medicare Access & CHIP Reauthorization Act of 2015, is the new Quality Payment Program (QPP) which replaces the old Sustainable growth rate formula used by CMS to control Medicare costs.

  Calendar Year 2017 is the transition year for QPP reporting. In an effort to aid in the transition, CMS is sending out letters to medical practices to let them know if their clinicians need to report for the Merit Based Incentive Payment System or MIPS reporting period.

  CMS has reviewed Medicare claims submissions by providers and instructed the jurisdictional Medicare contractor to send letters to those that meet the MIPS reporting criteria for 2017. As a special note, if your clinician bills to more than one MAC, he/she may be referred to in multiple letters from different contractors. These letters started going out in late April 2017 and will continue through the month of May. It will be sent to the associated individual or group tax identification number and contain each clinician. Please watch for correspondence regarding participating the 2017 MIPS reporting period.
• **Quality Payment Program (QPP)**
   An overview of the QPP initiative was discussed. The QPP permits provider to participate in a quality program of their choice, the Advance Alternative Payment Models which are more specialty specific and higher performance risk for the provider or the Merit Based incentive payment system which is more generalized. Both programs offer incentive payment for meeting or exceeding the quality measure and both can impose negative payment adjustments if the quality standards are not met.

   o **Qualifying for QPP**
   For 2017, the only clinicians CMS has designated to participate in the transition year are physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetist. If your clinician type is not listed you will not be required to report, but be aware to check the reporting guidelines next year because CMS has stated they will be expanding the reporting participation lists to include other clinicians.

   If this is the first year your clinician has participated with Medicare or they do not meet the volume thresholds 30,000 dollars and more than 100 Medicare patients they will be excluded from the MIPS reporting. If you meet the APM participation guidelines, they are excluded from MIPS reporting as well.

   o **MIPS**
   Clinicians have the choice of participating as an individual or as a group. For those clinicians who are hospital based, MIPS participation is optional. Please do not confuse hospital based clinicians with hospital owned practices. A facility will not participate in 2017.

   If you are participating in MIPS, you will be required to report on the following performance categories – quality, cost, improvement activities and advance care planning. The weight of the performance will equal 100% each year and will be subject to change.

   A beneficial link that may be useful is https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MIPS-ACI-Deep-Dive-Webinar-Slides.pdf. It explains all of the reporting categories in the MIPS program.

   o **APMS**
   Advanced APM requires the participants to use certified EHR technology with at least 50% of clinicians using a Certified Electronic Health Record Technology in the first year to document and communicate clinical care. The threshold will increase to 75 percent after 2017. The payment is based on quality measure comparable to those in the MIPS program. There are no minimum numbers of measures or domain requirements except the APM must have at least one outcome measure – unless there is not an appropriate outcome measure available under MIPS.

   The Advanced APM requires the participants to bear risk and larger monetary losses. CMS states that the generally applicable financial risk standard for Advanced APMs would be that an APM must include provisions that, if actual expenditures for which the APM Entity is responsible under the APM exceed expected expenditures during a specified performance period, CMS can:
   - Withhold payment for services to the APM Entity and/or the APM Entity’s eligible clinicians;
   - Reduce payment rates to the APM Entity and/or the APM Entity’s eligible clinicians; or
   - Require the APM Entity to owe payment(s) to CMS

   **The Nominal Amount Standard**
   An APM would meet the nominal amount standard if, under the terms of the APM, the total annual amount that an APM entity potentially owes CMS or foregoes is equal to at least:
   - For QP Performance Periods in 2017 and 2018, 8 percent of the average estimated total Medicare Parts A and B revenues of participating APM Entities (the “revenue-based standard”); or,
   - For all QP Performance Periods, 3 percent of the expected expenditures for which an APM Entity is responsible under the APM (the “benchmark-based standard”).
At this time if you participate with these advanced model standards, the participants will receive a 5% lump sum bonus in years 2019 – 2024 and then start receiving higher fee schedule update starting in 2026.

- **Reporting in the Transition Year**
  MIPS participants have a choice in how much reporting they want to do in 2017. A narrative flow chart was displayed to the members. It provided the payout levels for MIPS based on the amount of reporting done by the participants. If a clinician is required to participate in the transition year and does not, he/she will incur a 4% negative payment adjustment. The MIPS system reporting requirements was shown based on an individual or group reporting.

  Website for QPP is [https://qpp.cms.gov](https://qpp.cms.gov)

- **Technical Assistance:**
  - Quality Payment Program can be reached at 1-866-288-8292 (TTY 1-877-715-6222)
  - Available Monday through Friday, 8:00 AM-8:00 PM Eastern Time
  - OR via email at QPP@cms.hhs.gov

CMS maintain information on the MACRA Quality Program, you can visit their web page for the latest presentations available on MIPS and APMs.

**Contact the Quality Payment Program Service Center**
- 1-866-288-8292
- TTY: 1-877-715-6222

You also have the ability to contact the QPP Service Center, this is the same information listed at [https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/value-based-programs/macra-mips-and-apms/quality-payment-program-events.html](https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/value-based-programs/macra-mips-and-apms/quality-payment-program-events.html). As a special note, providers have the ability to request a CMS speaker to come and talk to their group about the MACRA Merit Based and Advance payment models by submitting a request form.

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**Cahaba News & Updates**

- **99214 Target Review**
  Medical Review completed their pre-payment target review for the Evaluation and Management CPT Code 99214. A chart was provided to members showing the number of providers in each state that was asked to submit records for review. It also shows results based on the claims submission error rates.

<table>
<thead>
<tr>
<th>State</th>
<th>Number of Providers</th>
<th>Error Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>457</td>
<td>34.83%</td>
</tr>
<tr>
<td>Georgia</td>
<td>95</td>
<td>27.42%</td>
</tr>
<tr>
<td>Tennessee</td>
<td>124</td>
<td>43.59%</td>
</tr>
</tbody>
</table>

**99214 Target Review Denial Reasons**
1. Lack of timely submission of requested documentation
   - No response within 45 days after ADR letter date, MACs & Zone Program Integrity Contractors (ZPICs) shall denial the claim (PIM 100-8, Chapter 3, Section 3.2.3.8b)
2. Lack of medical necessity to support providing the service for CPT Code 99214
   - Documentation submitted did not support medical necessity for level of service billed
   - The information provided does not support the level of service as shown on the claim
   - The documentation supports a lower level of service than billed
3. Lack of documentation
   • Denied due to the lack of documentation to review for services provided on claim
   • Claims did not include the physician office notes or supportive documentation to support the service billed

AMA CPT 99214 Indications

99214 Office or other outpatient visit for the evaluation and management of and established patient, which requires at least 2 of these 3 components:
   • A detailed history;
   • A detailed examination;
   • Medical decision making of moderate complexity

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided with consistent with the nature of the problem(s) and the patient’s and/or family needs.

Usually, the presenting problems are of moderate to high severity.
Typically, 25 minutes are spent face-to-face with the patient and/or family

**The target review reveals the percentage of claims that did not contain the required elements for billing the E&M CPT Code 99214 for each state.**

99214 Tips
1. Detailed History includes:
   • Chief Complaint
   • Extended history of present illness
   • Extended review of systems
   • Pertinent past family/social history directly related to patient’s problems

2. Medical Decision Making of Moderate Complexity includes:
   • Multiple management options for diagnosis or treatment
   • Moderate amount of data to be reviewed
     • Labs
     • Diagnostic & imaging results
     • Labs or diagnostics that need to be performed
     • Other practitioner notes
   • Moderate risk of complications and/or morbidity or mortality
     • Comorbidities associated with present illness
     • Risk(s) of diagnostic procedures performed
     • Risk(s) associated with possible management options

Additional E&M Resources were discussed with the members.

- **AG Member Topic Request – Appropriate Billing of CPT Code 99211**
  - Basic 99211 Billing Guidelines
    - The patient must be established
    - The encounter must be face-to-face
    - An E/M service must be provided
      • Patient history is reviewed
      • A limited physical assessment is performed or a some degree of decision making occurred
    - Service must be separate from other services performed on the same day
    - The presence of a physician is not always required
    - No key components are required
  - CPT 99211 should not be used for:
    - Phone calls to patients
    - Drawing blood for laboratory analysis or when performing other diagnostic tests
    - Administration of medications when an injection or infusion code is submitted separately

- **AG Member Topic Request – Split/Shared E&M Service**
Split/Shared Service is a medically necessary encounter with the patient where the physician and a qualified Non-Physician Practitioner (NPP) each personally perform a substantive portion of the E/M visit face-to-face with the same patient on the same date of service.

Different Rules for Different Settings
- **Office/Clinic**
  - Split/Shared encounter between physician & NPP, the service is considered to have been performed “incident to” if the requirements are met and the patient is an established patient.
  - If “incident to” requirements are not met, the service must be billed under the NPP.
- **Hospital Inpatient/Outpatient**
  - Split/Shared encounter between physician & NPP of the same group practice, and the physician provides any face to face portion of the E/M encounter with the patient, the service may be billed under either the physician or the NPP.
  - If there was no face-to-face encounter between the patient and the physician, then the service may only be billed under the NPP.

**MLN Matters – MM9876 Revised**
An update to the release and implementation of the new influenza vaccine code that becomes effective August 1, 2017 was discussed in MLN Matters MM9876. CMS made revisions to change the release date, transmittal number and electronic address location to the Change Request. All other information remains the same.

**Multi-Factor Authentication (MFA)**
Multi Factor Authentication is the use of two or more identification factors to verify the identity of a user. One authentication factor is the password that goes along with your user id when you log into the portal. MFA requires you to provide more than one form of verification in order to prove your online user identity. This increased online security requirement was instituted by the CMS for any Medicare Contractor that provides access to protected health information. MFA has been optional for InSite users.

On May 15, 2017, it is scheduled to become mandatory. A one-time InSite user email registration is required, unless you have an email address created after the initial email authentication; however, the InSite user will be required to request a security code access daily. An explanation of how MFA works was explained to the members.

**MFA Phase-In**
- May 1 – May 14: InSite users will be required to complete the initial MFA User Email Verification
- May 15: Full implementation of MFA

**InSite Web Portal – New Release**
- New look
- InSite Icon Changes
- Respond to Medical Review Additional Documentation Request (ADR)
  - Ability to submit ADR information online
- New Tab – My History
  - Submission history for ADRs
- Eligibility Change
  - Cross-over information no longer available
- Any screen log out
- Email questions to InSite Help Desk
  - InsiteInquiries@cahabagba.com
- Part B InSite webinar scheduled May 31, 2017

**Self-Service**
A snapshot of the Cahaba Website Tools and Cahaba Help Log was displayed. The URL links for these self-service tools are located below:

- **Cahaba Website Tools**
  [https://www.cahabagba.com/part-b/tools/](https://www.cahabagba.com/part-b/tools/)

- **Cahaba Help Log**

**Helpful Reminders**

Members were reminded of the importance of the following Medicare contacts and resources:

- Comprehensive Error Rate Testing Program
  [https://www.cahabagba.com/part-b/education/comprehensive-error-rate-testing-cert/](https://www.cahabagba.com/part-b/education/comprehensive-error-rate-testing-cert/)

- Cotiviti Recovery Auditor Region 3

- Medicare Learning Network

- CMS National Training Program Series

- Foresee Survey

- 2017 Jurisdiction J MSI Survey

A question and answer session took place. Several questions were submitted via the chat area. The Part B POE team will review and respond during the next scheduled Advisory Group meeting. A list of resources and links was shared with the members.

**Workgroup Summary – February 8, 2017 Meeting**

**Assignment #1 – 2017 Medicare Expo Education**

1. Have you ever attended Cahaba’s Medicare Expo?
   - Yes 9
   - No 6

2. If you have attended a Cahaba Medicare Expo, did the class taken meet your expectations?
   - Yes (8 responses)

**Explanation for “Yes” Response**

- It covered many topics of refunds and overpayments, which is a hot topic.
- I had questions on how to escalate calls from a Medicare rep to the next level and I got the answer I needed.
- The Medical Review and the Medical Director were great. Also, Open Help Desk was wonderful!!
- Well organized, although I do agree about separating experienced and non-experienced peeps!
- Very informative. Loved being able to have one on one discussion.
- Very informative and very helpful.

**If no, Please explain and offer suggestions that would have made the session more beneficial to you** (1 response)

- Some sessions are great for everyone attending. Annual updates, latest news etc. but most everything is focused to the physician. Other specialties also are attending and we need to either have some specialty sessions for them, or offer another meeting opportunity for specialty billing etc. for ancillary services – DME. Lab, Radiology etc.

3. Please rank the following expo educational training from 1 to 5 to indicate top preference.
   1. Specialized training by Provider Type
   2. Open Help Desk – Claims, Provider Enrollment, Medical Review
   3. Guest Medicare Speaker: CMS representative, ZPIC Representative, AMA, AAPC

**Assignment #2 – POE Advisory Meetings**

- Have you participated in the Cahaba POE AG Face to Face meeting?
  - Yes (6 responses)
  - No (9 responses)

- Are you open to a Face to Face meeting via video conferencing, in which participants can interact? Do you feel this type of interaction would be beneficial? Please explain.
Face-to-face meetings would be more beneficial and would possibly help with some of the technical issues that occur during meetings (8).

Please indicate how often you feel the Advisory group should meet within a year?

- Preference for meeting four times per year (9)
- Preference for meeting three times per year (6)

**Management will review policy to meet four times a year.**

What is the most important factor when making a decision whether to attend or not a POE AG meeting? Topic, date, time, and other, please explain.

- The majority of the POE AG stated that they attend POE AG meetings because it's their responsibility and the factors above do no play a part in their attendance. Some conflicts can’t be avoided but every attempt is made to be in attendance or send a representative.

**Workgroup Assignment**

The remaining portion of the meeting was dedicated to the following topics:

- Social Media Marketing
- YouTube Educational Videos
- MAC Satisfaction Indicator Marketing
- Education Venues

As a group, members discussed the assignments and provided recommendations. Results will be submitted to management and a summary of approvals/declinations will be reported during the next scheduled meeting.

**Adjourn**

The meeting was adjourned at 12:05 p.m. Central Time/1:05 p.m. Eastern Time. Our next meeting is scheduled to be held on November 8, 2017. Please make sure to “Save the Date”!