CGS MEDICARE UPDATE SPRING 2022



FINDING ANSWERS

ONGOING MEDICARE INITIATIVES

COMPREHENSIVE ERROR RATE TESTING (CERT)

Understanding Data

SELF-SERVICE TECHNOLOGY







## **Disclaimer**

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## **Objectives**

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



## Final FY 2022 Part A Payment Rules

4 Part A Program Final Rules for FY 2022 Released in July/August 2021

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



## CMS Physician Fee Schedule Final Rule

On Nov 2, 2021, CMS issued a final rule that includes updates on policy changes for Physician Fee Schedule services (PFS) on or after Jan 1, 2022:

- Expiration of the 3.75 percent payment increase provided for CY 2021 by the Consolidated Appropriations Act 2021
- CY 2022 PFS conversion factor is \$33.59
  - A decrease of \$1.30 from the CY 2021 PFS conversion factor of \$34.89.
- Split/Shared E/M Visits
  - Definition: E/M visits provided in the facility setting by a physician and an NPP in the same group.
    - The visit is billed by the physician or practitioner who provides the substantive portion of the visit.
    - By 2023, the substantive portion of the visit will be defined as more than half of the total time spent.
  - For 2022, the substantive portion can be history, physical exam, medical decision-making, or more than half of the total time (except for critical care, which can only be more than half of the total time).
  - Reported for new as well as established patients, and initial and subsequent visits, as well as prolonged services.
  - A modifier is required on the claim to identify these services to inform policy and help ensure program integrity.
  - Documentation in the medical record must identify the two individuals who performed the visit.
    - The individual providing the substantive portion must sign and date the medical record.



## CMS Physician Fee Schedule Final Rule

- Critical Care Services
  - Defined in the CPT Codebook.
  - Bundled services are not separately payable.
  - When medically necessary, can be furnished concurrently to the same patient on the same day by more than
    one practitioner representing more than one specialty.
    - Can be furnished as split (or shared) visits.
  - Critical care services may be paid on the same day as other E/M visits
    - By the same practitioner or another practitioner in the same group of the same specialty
    - Must document E/M visit was provided prior to the critical care service at a time when the patient did not require critical care
    - Must document the visit was medically necessary
    - Must document the services are separate and distinct from the critical care service provided later in the day.
    - Practitioners must report CPT modifier 25 on the claim when reporting these critical care services.
  - If unrelated, services may be paid separately in addition to a procedure with a global surgical period.
    - Patient is critically ill and requires the full attention of the physician
    - The critical care is above and beyond and unrelated to the specific anatomic injury or general surgical procedure performed
    - HCPCS modifier FT is to be used.



## CMS Physician Fee Schedule Final Rule

- Telehealth Services
  - Certain services added to the Medicare telehealth list will remain on the list through December 31, 2023
  - Services added temporarily that would have been removed in 2021, will remain through CY 2023.
  - Amending the current definition of interactive telecommunications system to include audio-only communications technology
    when used for the diagnosis, evaluation, or treatment of mental health disorders furnished to established patients in their
    homes under certain circumstances.
- Therapy Services
  - Reduced payment for outpatient PT and OT services furnished in whole or in part by a therapy assistant (PTA/OTA).
    - HCPCS modifier CQ Outpatient physical therapy services furnished in whole or in part by a physical therapist assistant
    - HCPCS modifier CO Outpatient occupational therapy services furnished in whole or in part by an occupational therapy assistant
- Allow Physician Assistants to bill Medicare directly for their services and reassign payment
- Gradually reduce coinsurance when Colorectal Cancer Screenings become diagnostic when there is a need for additional procedures during the same encounter
- Begin payment penalty phase of the AUC program either on Jan 1, 2023, or the Jan 1<sup>st</sup> that follows the declared end of the PHE for COVID-19, whichever is later

Refer to this **CMS Fact Sheet** for details of changes.



# Medicare Deductible, Coinsurance and Premium Rates for Calendar Year (CY) 2022

Part B Standard Premium

\$170.10 a month

Part B Deductible

\$233.00 a year

Pro Rata Data Amount

- \$150.66 1st month
- \$82.34 2nd month

Coinsurance

20%



## **Medicare Patient Premium and Deductibles**

# Part A Deductible and Coinsurance Amounts for Calendar Years 2021 and 2022 by Type of Cost Sharing

	2021	2022
Inpatient hospital deductible	\$1,484	\$1,556
Daily coinsurance for 61 <sup>st</sup> -90 <sup>th</sup> Day	\$371	\$389
Daily coinsurance for lifetime reserve days	\$742	\$778
Skilled Nursing Facility coinsurance	\$185.50	\$194.50



### Vaccines, Boosters, and Monoclonal Antibodies

- You may bill for COVID-19 shot administration on a single claim or <u>submit claims on a</u>
   <u>roster bill</u> for multiple patients at one time.
  - For roster, you must administer the same type of shot to 5 or more people on the same date.
  - Free PC-ACE billing software is also available for download
- Those interested in <u>becoming a mass immunizer</u> may enroll over the phone
- If you bill in three or more MAC jurisdictions, you may register as a centralized biller
  - Novitas is the MAC responsible for enrollment and claims processing
- If you participate in a Medicare Advantage Plan, submit your COVID-19 claims to original Medicare (CGS) for all patients enrolled in Medicare Advantage in 2020 and 2021.
  - If you vaccinate or administer monoclonal antibody treatment to patients enrolled in MA plans on or after January 1, 2022, submit claims to the MA Plan. Original Medicare won't pay these claims.

10

Check here for payment and HCPCS code structure.



# COVID-19 Monoclonal Antibodies: Revised Emergency Use Authorization for EVUSHELD

#### **MLN Special Edition**

On February 24, the FDA revised the emergency use authorization for tixagevimab co-packaged with cilgavimab (EVUSHELD™) to change the initial dose for the authorized use as pre-exposure prophylaxis of COVID-19 in certain adults and pediatric patients. For more information about dosage and administration, including information about dosing for patients who got the original lower dose, review the fact sheet (ZIP).

CMS created new code, Q0221, effective February 24:

- Long Descriptor: Injection, tixagevimab and cilgavimab, for the pre-exposure prophylaxis only, for certain adults and pediatric individuals (12 years of age and older weighing at least 40kg) with no known sars-cov-2 exposure, who either have moderate to severely compromised immune systems or for whom vaccination with any available covid-19 vaccine is not recommended due to a history of severe adverse reaction to a covid-19 vaccine(s) and/or covid-19 vaccine component(s), 600 mg
- Short Descriptor: Tixagev and cilgav, 600mg

Use the existing administration codes — M0220 and M0221.

<u>Visit the COVID-19 Monoclonal Antibodies webpage for more information</u>.

11



### **New HCPCS Code for Remdesivir Antiviral Medication**

New HCPCS code J0248 effective for use by all payers and is payable by Medicare in the outpatient setting for dates of service on or after December 23, 2021.

#### **CGS Claim Submission Guidance**

- VEKLURY™ (remdesivir) product code (J0248)
- ICD-10 code U07.1 (COVID-19) or J12.82 (Pneumonia due to coronavirus disease 2019)

In addition to the product code J0248, use the following CPT code for administration:

• 96365 (Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour)

#### And if needed use:

• 96366 (Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)

#### For Part A claims:

- Appropriate type of bill (TOB)
- Appropriate revenue codes

#### For Part B claims:

- Appropriate place of service (POS) code
- Refer to the NIH COVID-19 Treatment Guidelines Panel website for administration information

#### Units administered for patient:

- J0248 represents 1mg and units should be adjusted to reflect dosage administered for each patient
- Price per unit set as \$5.512 (effective from December 23, 2021 to March 31, 2022)

Claims submitted with dates of service on or after December 23, 2021, will be held until the claims processing systems are updated.

#### **MLN Special Edition**

12



### **Telehealth Services**

Access to Medicare telehealth services expanded so beneficiaries can receive services without having to travel to a healthcare facility.

Through the duration of the COVID-19 PHE:

- Medicare can pay for office, hospital, and other visits furnished via telehealth.
- These visits are considered the same as in-person visits and are paid at the same rate as regular, in-person visits.
- Medical necessity and documentation requirements still apply to all services.
- CMS requires telecommunications technology with audio and video capabilities like Facetime and Skype.
  - Exceptions including those that may be furnished using audio-only technology are on the <u>Telehealth</u>
     Services list



### Telehealth Services (Cont.)

Tips to keep in mind:

- Do not use place of service (POS) code 02 (Telehealth) for services done under the waiver.
  - Instead, use the POS code that represents the place you would have billed had the service been performed face-to-face.
  - This will allow our systems to make appropriate payment, which would be the same amount as it would
    if the service was furnished in person.
- During the PHE, CPT modifier 95 should be applied to claim lines that describe services furnished via telehealth.

Check here for practitioners that can use telehealth and other flexibilities

**COVID-19 FAQs** are also available.



## More on COVID-19!

Topic	Resource
CGS COVID-19 Webpage	Links to all resources all on one page!
CMS COVID-19 Vaccine Resources	Check here for links to toolkits and coding instructions for the vaccines and antibodies.
Toolkit on COVID-19 Vaccine for MA Plans	Toolkit for Health insurers and Medicare Advantage plans.
Medicare Billing for COVID-19 Vaccine Shot Administration	Billing instructions for various types of claims
COVID-19 Diagnostic Laboratory Tests: Billing for Clinician Services	Assessment and collection billing instructions
Reminder: Payment for Diagnostic Laboratory Tests	Lab services MUST be submitted to CGS for payment. Medicare beneficiaries are not responsible.

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## 2% Payment Adjustment (Sequestration)

### **Medicare FFS Claims: Changes**

The Protecting Medicare and American Farmers from Sequester Cuts Act impacts payments for all Medicare Fee-for-Service (FFS) claims:

- No payment adjustment through March 31, 2022
- 1% payment adjustment April 1 June 30, 2022
- 2% payment adjustment beginning July 1, 2022



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

### **Part A Claims Only**

- Effective for dates of service beginning Jul 1, 2020, prior authorization must be requested for specific CPT/HCPCS codes for five groups of hospital OPD services:
  - Blepharoplasty
  - Botulinum toxin injections
  - Panniculectomy
  - Rhinoplasty
  - Vein ablation
  - Cervical Fusion with Disc Removal (Beginning date of service Jul 1, 2021)
  - Implanted Spinal Neurostimulators (Beginning date of service Jul 1, 2021)
- Check the <u>listing for specific CPT/HCPCS codes</u> within each group

17



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

### Part A Claims Only (Cont.)

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



The 2020 Centers for Disease Control (CDC) National Diabetes Statistics Report states:

- Total: 88 million people aged 18 years or older have prediabetes (34.5% of the adult US population)
- 65 years or older: 24.2 million people aged 65 years or older have prediabetes

The MDPP is designed to help Medicare beneficiaries who have symptoms of prediabetes develop healthy habits to prevent type 2 diabetes.

 Prediabetes is a serious health condition where blood sugar levels are higher than normal, but not high enough to be diagnosed as type 2 diabetes.

The MDPP model has been expanded as a new approach to address type 2 diabetes by treating patient with an indication of pre-diabetes

- Dietary changes
- Increased physical activity
- Weight control



### Beneficiary Eligibility Requirements to Start Services:

- Medicare Part B coverage through traditional Medicare (Fee-for-Service)
- Results from one of three blood tests conducted within one year before the first core session:
  - Hemoglobin A1c test with a value of 5.7-6.4%
  - Fasting plasma glucose test with a value of 110-125 mg/dl
  - Oral glucose tolerance test with a value of 140-199 mg/dl
- A body mass index (BMI) of at least 25, 23 if self-identified as Asian.
- No history of type 1 or type 2 diabetes, with the exception of gestational diabetes.
- No End Stage Renal Disease (ESRD).



Medicare covers up to 2 years of MDPP sessions for people who are eligible.







**Months 13-24** 

**Ongoing Maintenance** 

Sessions\*

Months 0-6 **Core Sessions**  Months 7-12

- 6 monthly sessions
- Available *regardless* of weight loss and attendance
- **Core Maintenance** Sessions
- 12 monthly maintenance sessions
- People *must* achieve and maintain weight loss and attendance goals to remain eligible

21

- 16 sessions offered at least a week apart
- Available *regardless* of weight loss and attendance
  - No copay or referral
- In-person and virtual make-up sessions
- CDC-approved curriculum that includes training on dietary change, increased physical activity, and weight loss strategies

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### For CY 2022

- CMS is waiving the Medicare enrollment fee for all organizations that apply to enroll as an MDPP supplier.
  - CMS has been waiving this fee during the COVID-19 PHE for new MDPP suppliers and has witnessed increased supplier enrollment.
- CMS is shortening the MDPP services period to one year instead of two years.
  - To reduce the administrative burden and costs to suppliers
  - Improve patient access.
- CMS is restructuring payments, so MDPP suppliers receive larger payments for participants who reach milestones for attendance.

Refer to the CMS fact sheet for additional information.



### The MDPP Resources

- MDPP <u>billing and payment information</u>
- Must enroll as an MDPP Supplier separate from your current enrollment
  - If interested in enrolling, please contact us at J15\_PartB\_Education@cgsadmin.com

**NOTE**: Before enrolling as an MDPP supplier, we suggest you obtain an NPI separate from your office NPI.





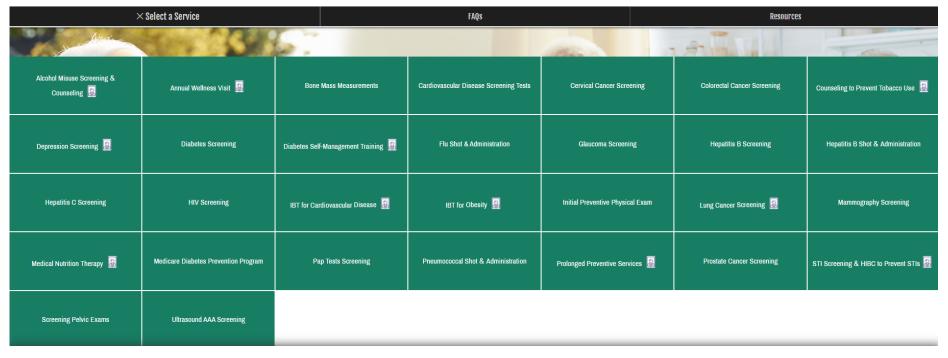
24

### **Preventive Services**

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



#### **Medicare Preventive Services**





## **Chronic Care Management (CCM) Services**

CMS recognizes CCM as a critical component of primary care that contributes to better health and care for individuals.

- Providers can be separately paid for important services while improving Medicare patients' self-management, health outcomes, and patient satisfaction.
- CCM is care coordination services done outside of the regular office visit for patients with multiple (two or more) chronic conditions and may include:
  - At least 20 minutes a month of CCM services
  - Personalized assistance from a dedicated health care professional who will work with you to create a care plan
  - Coordination of care between your pharmacy, specialists, testing centers, hospitals, and more
  - 24/7 emergency access to a health care professional
  - Expert assistance with setting and meeting your health goals



## **Chronic Care Management (CCM) Services**

### **CCM Resources**

- MLN Chronic Care Management Service Booklet
- Chronic Care Management Health Care Professional Resources
- Chronic Care Management (CPT Code 99490)





## Cognitive Assessment & Care Plan Services

Medicare covers Cognitive Assessment & Care Plan Services as a separate visit to more thoroughly assess your patient's cognitive function and develop a care plan.

Effective Jan 1, 2021:

- Medicare increased payment for these services when provided in an office setting
- Added these services to the definition of primary care services in the Medicare Shared Savings Program, and
- Permanently covered these services via telehealth
  - Use CPT code 99483 to bill for both in-person and telehealth services
- Learn more on CPT code 99483
  - How Do I Get Started?
  - Who Can Offer a Cognitive Assessment?
  - Where Can I Perform the Cognitive Assessment?
  - What's Included in a Cognitive Assessment?
  - What Care Plan Services Result from the Assessment?
  - How Do I Bill for Cognitive Assessment & Care Plan Services?
  - Resources (including a link to <u>a video on coverage, eligibility, and billing</u>)

27



# Advance Beneficiary Notice of Non-Coverage (ABN)

#### Form CMS-R-131 Renewal

- The ABN, Form CMS-R-131, and form instructions have been approved by the Office of Management and Budget (OMB) for renewal.
- Use the renewed form with the expiration date of Jun 30, 2023.
- Used for medical necessity situations.
- May also be used as a reminder Medicare will not pay for statutorily excluded services.
  - ABN Interactive Tutorial
  - ABN form and instructions

B. Patient Name:	C. Identification Number:						
Advance Beneficiary Notice of Non-coverage (ABN)							
TE: If Medicare doesn't pay for							
Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the <b>D.</b> below.							
D.	E. Reason Medicare May Not Pay:	F. Estimated					
		Cost					
LAT VOLUMEED TO DO NOW							
<ul> <li>Read this notice so you</li> </ul>	r: u can make an informed decision about your ca	re					
	nat you may have after you finish reading.						
	v about whether to receive the D	_listed above.					
	tion 1 or 2, we may help you to use any other in ave, but Medicare cannot require us to do this.	nsurance					
	one box. We cannot choose a box for you.						
OPTION 1. I want the D.	listed above. You may ask to be	naid now but I					
	an official decision on payment, which is sent to						
	derstand that if Medicare doesn't pay, I am resp						
	Medicare by following the directions on the MSN						
ooes pay, you will return any p □ OPTION 2. I want the D.	payments I made to you, less co-pays ordeduct listed above, but do not bill Med						
	sponsible for payment. I cannot appeal if Medic						
OPTION 3. I don't want the							
	nt, and I cannot appeal to see if Medicare would						
Additional Information:							
s notice dives our oninion r	not an official Medicare decision. If you have	other questions of					
	II 1-800-MEDICARE (1-800-633-4227/TTY: 1-8						
	we received and understand this notice. You a	Iso receive a copy.					
I. Signature:	J. Date:						
CMS does not discriminate in it alternative format, please cal	ts programs and activities. To request this public ll: 1-800-MEDICARE or email: <u>AltFormatRequ</u> e	cation in an est@cms.hhs.gov.					
ording to the Paperwork Reduction Act of 1995,	no persons are required to respond to a collection of information unless it dis ollection is 0938-0566. The time required to complete this information collecti	plays a valid OMB control num					
response, including the time to review instruction	is, search existing data resources, gather the data needed, and complete and re	view the information collection					
nave comments concerning the accuracy of the ti- oorts Clearance Officer, Baltimore, Maryland 2124	ime estimate or suggestions for improving this form, please write to: CMS, 7: 44-1850.	500 Security Boulevard, Atm: 1					
Form CMS-R-131 (Exp. 06/30/20	(23) Form Approved	OMB No. 0938-050					

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New program to increase the rate of appropriate advanced diagnostic imaging services furnished to Medicare beneficiaries, which include:

- Computed tomography (CT)
- Positron emission tomography PET)
- Nuclear medicine
- Magnetic resonance imaging (MRI)

Services must be furnished in the following settings:

- Physician offices
- Hospital outpatient departments (including emergency departments)
- Ambulatory Surgical Centers (ASCs)
- Independent diagnostic testing facilities



The ordering professional is required to consult a qualified Clinical Decision Support Mechanism (CDSM)

- A CDSM is an interactive tool that communicates AUC information to the user
  - Assists with treatment decision for clinical conditions
  - Confirms whether order adheres to AUC, does not adhere to AUC, or if there is no AUC applicable

Educational and Operations Testing Period is expected to last for one year

- Jan 1, 2020 Dec 31, 2022
  - CMS encourage stakeholders to use this period to learn, test and prepare for the AUC program
- Full program implementation is expected Jan 1, 2023
  - Information regarding the ordering professional's consultation with CDSM must be included with the furnishing professional's claim (G-codes and modifiers) in order for that claim to be paid



#### Examples

	24. A. DATE(s) OF SERVICE					B. PLACE OF	C.	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)					
	MM D	DD	YY	MM	DD	YY	SERVICE	EMG	CPT/HCPS		MODIF	FIER	
1													
'	01/	13/2	2021	0	1/13/2	2021	23		74261	MA			
								-					

- MA Ordering professional is not required to consult a clinical decision support mechanism due to service being rendered to a patient with a suspected or confirmed emergency medical condition
  - No G-code is billed

	24. A. DATE(s) OF SERVICE From To					B. PLACE	C.	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Cincumstances)			IES		
	MM	DD	YY	MM	DD	YY	OF SERVICE	EMG	CPT/HCPS		MODIF	FIER	
4													
	0.	1/13/2	2021	0	1/13/2	2021	11		78812	MH			

- MH Unknown if ordering professional consulted a clinical decision support mechanism for this service, related information was not provided to the furnishing professional or provider
  - No G-code is billed



### Examples

	24. A. DATE(s) OF From MM DD YY	B. PLACE OF SERVICE	C. EMG	D.PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPS I MODIFIER					
4	111111111111111111111111111111111111111	MM DD YY	SENVICE	EMG	CI IFICI S		mobil	ILIY	
	01/13/2021	01/13/2021	11		70545	ME			
9									
-	01/13/2021	01/13/2021	11		G1002				

- ME The order for this service adheres to the appropriate use criteria in the clinical decision support mechanism consulted by the ordering professional
  - Must report the appropriate non-payable G-code identifying the CDSM consulted

	24. A. DATE(s) OF From	SERVICE To	B. PLACE OF	C.	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				IES
	MM DD YY	MM DD YY	SERVICE	EMG	CPT/HCPS		MODI	FIER	
1									
'	01/13/2021	01/13/2021	11		73223	MF			
Ы									
-	01/13/2021	01/13/2021	11		G1007				

- MF The order for this service does not adhere to the appropriate use criteria in the qualified clinical decision support mechanism consulted by the ordering professional
  - Must report the appropriate non-payable G-code identifying the CDSM consulted



#### Example

	24. A. DATE(s) OF SERVICE From To MM DD YY MM DD YY			C.	D.PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPS   MODIFIER			
1								
'	01/13/2021	01/13/2021	11		78601	MG		
0								
-	01/13/2021	01/13/2021	11		G1012			

- MG The order for this service does not have appropriate use criteria in the clinical decision support mechanism consulted by the ordering professional
  - Must report the appropriate non-payable G-code identifying the CDSM consulted

#### Refer to MLN Matters® MM11268 for details

- Definitions of HCPCS modifiers and G-codes
  - All G-codes are non-payable codes used for reporting purposes only
- Applicable CPT/HCPCS codes for Advanced Imaging Procedures

Refer to <a href="CMS webpage">CMS webpage</a> for CDSMs and updates on the AUC program



# 2020 MIPS Performance Feedback and 2022 MIPS Payment Adjustments

Recently, CMS released performance feedback for clinicians included in the Merit-based Incentive Payment System (MIPS) for the 2020 performance year (PY).

- Affects CY 2022 MIPS payment adjustments
- Sign in on the Quality Payment Program (QPP) website to review your performance feedback
- 2020 MIPS Performance Feedback FAQs
- 2020 MIPS Scoring Guide

### MIPS 2021 Data Submission Period is Now Open

CMS has opened the data submission period for MIPS eligible clinicians who participated in the 2021 performance year of the Quality Payment Program (QPP). Data can be submitted and updated from now until 8:00 p.m. ET on March 31, 2022.

- Go to the Quality Payment Program webpage.
- Sign in using your QPP access credentials.
- Submit your MIPS data for the 2021 performance year or review the data reported on your behalf by a third party.



You may receive requests for medical records.

Comprehensive Error Rate Testing (CERT) Documentation Contractor

Recovery Audit (RA)
Contractors

CGS Medical Review Department

# Medicare Record Review Programs



## FY 2021 CERT Improper Payment Rate

CERT improper payment rate is 6.26% representing \$25.03 billion in improper payments. (Compared to 6.27% and \$25.74 billion in FY 20209)

Claim Type	Improper Payment Rate	Improper Payment Amount
Part A Providers (excluding Hospital IPPS)	6.3%	\$11.6B
Part B Providers	8.5%	\$8.5B
Part A Providers (Inpatient Hospital)	2.4%	\$2.6B
DMEPOS	28.6%	\$2.4B

CMS resumed CERT activities that were suspended in response to the PHE for the COVID-19 pandemic. CERT began sending documentation request letters and conducting phone calls to request medical documentation for claims in the Reporting Years (RYs) 2021 and 2022.



# **CERT Error Categories**

Insufficient

Documentation: **64.1**%

Submitted medical records are inadequate to determine if billed services were provided, provided at the level billed, and/or were medically necessary; or when specific documentation required as a condition of payment is missing.

Medically

Unnecessary: 13.6%

Submitted medical records contain adequate documentation to make an informed decision that services billed were not medically necessary based upon Medicare coverage and payment policies.

Incorrect Coding: 10.6%

Submitted medical records support a different code than what was billed; the service was performed by someone other than the billing provider/supplier; the billed service was unbundled; or the patient was discharged to a site other than the one coded on the claim.

No

Documentation: 4.8%

Provider/supplier fails to respond to repeated requests for medical records or responds that they do not have the requested documentation.

Other: 6.9%

Errors do not fit into the previous categories (e.g., duplicate payment in error, non-covered or unallowable service, ineligible Medicare beneficiary, etc.)



# **CERT: Other Lines of Business (LOBs)**

#### **Avoid Errors – Home Health**

- Do you <u>certify/recertify</u> patients for Home Health?
- Provider compliance tips for Home Health
- Home Health Recertification Statement
- Home Health Referrals
- Why isn't Mary Receiving the Home Health Care Her <a href="Physician Ordered">Physician Ordered</a>?

## **Avoid Errors – Hospice**

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



# **CERT: Other Lines of Business (LOBs)**

#### **Avoid Errors - DMEPOS**

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



# Welcome to the CERT C3HUB!

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

Check the <u>C3HUB site</u> for the following resources:

- About CERT
- Submit Records to CERT
- Letter and Contact Information
- Claim Status Search
- Attestation Letters

- Sample Request Letters
- Documentation Request Listings
- Psychotherapy Notes
- FAQs
- CMS Links



# CERT A/B MAC Outreach & Education Task Force

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

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

Check <u>here</u> for more information



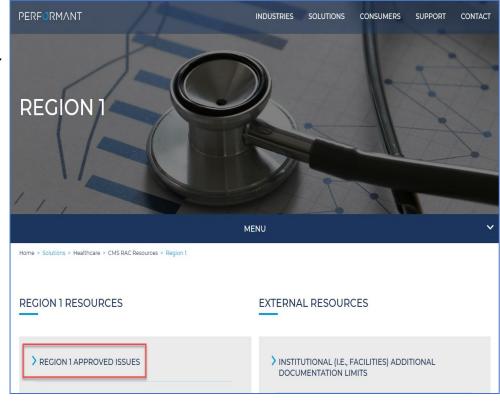
Task Force for Error-Free Medicare Claims



# Recovery Audit (RA) Program

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

- Performant Recovery, Inc. Region 1 Contractor
- View Region 1 Resources
- Approved Issues
- Sample documents
- Want to learn more about Performant? <u>View</u> recorded webinar





# RA Program Part A Most Expensive Errors

October - December 2021

Issue #	Issue Name	
0002	Cataract Removal: Medical Necessity and Coding Requirements	
0074	Drugs and Biologicals: Incorrect Units Billed (Single-Dose Vials)	
0085	Laboratory Services Rendered During an Inpatient Stay: Unbundling	
0111	Transthoracic Echocardiography: Medical Necessity and Documentation Requirements	
0161	Therapeutic, Prophylactic & Diagnostic Infusions: Incorrect Coding and Documentation Requirements	



# RA Program Most Expensive Errors

July – September 2021

CPT/HCPCS Codes	Issue	Rationale
36475	Endovenous Radiofrequency Ablation and Endovenous Laser Treatment for Lower Extremity Varicose Veins: Medical Necessity, Unbundling, and Documentation Requirements	Claims not deemed to be medically necessary will be denied based on the guidelines outlined in the policy.
99221-99223, 99231-99233, 99238-99239	Visits to Patients in Swing Beds: Incorrect Coding	If the inpatient care is being billed as inpatient hospital care, the hospital care codes apply. If the inpatient care is being billed as nursing facility care, then the nursing facility codes apply.
99221-99223, 99231-99233	Hospital Services: Excessive Units	Both Initial and Subsequent Hospital Care codes are "per diem" services and may be reported only once per day by the same physician(s) of the same specialty from the same group practice.
99304, 99305, 99306, 99307, 99308, 99309, 99310.	Nursing Facility Services: Excessive Units	The Nursing Facility Services codes represent a "per day" service. As such, these codes may only be reported once per day, per Beneficiary, Provider and date of service.
"Add-on" Codes	Add-on Codes Paid without Primary Code and/or denied Primary Code	CPT has designated certain codes as "add-on procedures". These services are always done in conjunction with another procedure and are only payable when an appropriate primary service is also billed.



# **CMS Resumes Targeted Probe & Educate Program**

CMS is restarting the <u>Targeted Probe and Educate (TPE) program</u> to help educate providers and reduce future denials and appeals. If your Medicare Administrative Contractor audits you, take advantage of the TPE education, and get up to 3 rounds of educational claim review to help you bill accurately.

The TPE Process was implemented to analyze claims payment data to identify the highest risk of issuing improper payments

- Providers who appear aberrant (based on claims data) may be subject to review
  - Up to 20-40 claims will be selected (pre or post-pay) and documentation requests sent
  - CGS has 30 days from date of receipt to review documentation and calculate error rate
  - Details of review and education provided to correct documentation issues
  - Up to three rounds of reviews possible if education provided does not result in reduced error rate
  - Case referred to CMS if error rate remains high after three rounds
- TPE findings prior to the PHE are <u>located on the TPE webpage</u>



# **Check LCD Articles for Billing Information**

<u>Local Coverage Determinations (LCDs)</u> no longer include coding/billing information. Refer to its accompanying LCD Article for allowed ICD-10 codes.

Avoid medical necessity denials by reviewing LCD Articles! (Located in last column)

LCD ID	Top 10 Services Denied due to Non-Covered ICD-10 Codes (Sep 2020 – Aug 2021)	
Multi LCDs	Molecular Diagnostic Tests	
L34200	Removal of Benign Skin Lesions	
L34045	Non-Invasive Vascular Studies	
L33996	Vitamin D Assay Testing	
L37578	Micro-Invasive Glaucoma Surgery (MIGS)	
L34348	MoIDX: Multiplex Nucleic Acid Amplified Tests for Respiratory Viral Panels	
L35891	Intravenous Immune Globulin	
L38201	Percutaneous Vertebral Augmentation (PVA) for Osteoporotic Vertebral Compression Fracture (VCF)	
L38694	Computed Tomography Cerebral Perfusion Analysis (CTP)	
L36029	Controlled Substance Monitoring and Drugs of Abuse Testing	



# **Documentation: Don't Forget Your Partners!**

#### **Share your documentation**

CGS or other Medicare contractors may request medical records

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

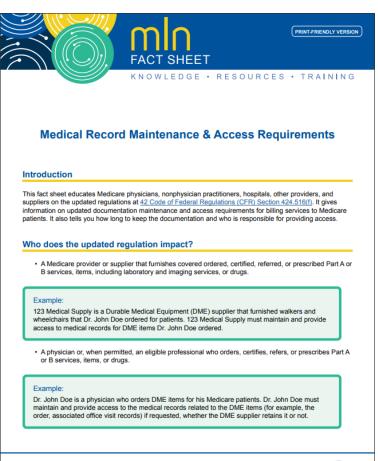
When two separate providers collaborate to provide quality patient care the obligation of providing, obtaining, and maintaining documentation is not the exclusive responsibility of one or the other provider.

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

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



## **Medical Record Maintenance**



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

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

Medical Record Maintenance & Access Requirements

Page 1 of 5 MLN4840534 April 2021





Departmental tips and updates to make your Medicare lives a whole lot easier!

- Provider Enrollment
- Claims
- Reopenings
- Appeals
- Overpayment Recovery (OPR)

# **CGS Operational Reminders**



## **Provider Enrollment**

Provider Enrollment Application Fee Amount for Calendar Year 2022

- Effective Jan 1, 2021, the application fee is \$631 for institutional providers that are:
  - Initially enrolling in the Medicare or Medicaid program or the Children's Health Insurance Program (CHIP)
  - Revalidating their Medicare, Medicaid, or CHIP enrollment; or
  - Adding a new Medicare practice location.
- This fee is required with any enrollment application submitted from Jan 1 through Dec 31,
   2022
  - NOTE: This fee does not apply to physicians, non-physician practitioners and their groups. Only to providers/suppliers that submit the following types of Medicare enrollment applications:
    - CMS-855A
    - CMS-855B (except physician and non-physician practitioner organizations)
    - CMS-855S, or
    - CMS-20134



# **Provider Enrollment**

#### Provider Enrollment Cycle 2 Revalidation

- Required to revalidate enrollment in Medicare every five years
- Revalidation date will remain throughout subsequent revalidation cycles
  - Always the last day of the month (e.g., Jul 30th, Aug 31st, Sep 30th)
- Check the Medicare Revalidation List for "due date"
- Beginning October 31, 2021, CMS will be resuming provider and supplier revalidation activities. The MACs will issue a revalidation notice to the provider and supplier at least 3 months in advance of their adjusted due date. The Medicare Revalidation Tool has also been updated to display an adjusted revalidation due date in addition to the provider or supplier's original revalidation due date. The adjusted revalidation due date will be displayed at least 3 months in advance of the provider's or supplier's adjusted due date.



# **Claims**

## CPT, HCPCS and ICD-10 Coding

- CPT and HCPCS Codes
  - 2022 claims are to be submitted with codes from 2021 CPT and HCPCS manuals
  - Codes are valid from Jan through Dec of each year
  - HIPAA requires the use of codes valid the year the service is rendered
- ICD-10-CM Diagnosis Codes
  - 2022 ICD-10-CM codes are to be used for patient encounters occurring from Oct 1, 2021, through Sep 30, 2022.
  - Updates for 2021 are available on the <u>ICD-10-CM webpage</u>.
- DMEPOS Jurisdiction Listing
  - Need help determining if a supply or DME item is billed to us or the DME MAC?
  - Refer to updates to the <u>2022 DMEPOS Jurisdiction List (ZIP)</u>



## **Part A Claims**

Review of Data: Top Claim Submission Errors (CSEs) and how to avoid them!

#### Part A

Invalid Type of Bill (TOB)

Invalid Bill Sequence

Revenue/HCPCS codes combination error

Procedure Code Invalid on Date of Service

Code claims using current CPT and HCPCS manuals

Invalid Procedure Code/Modifier Combination

Check the <u>Modifier Finder Tool</u> for help with modifiers

Missing/Incomplete/Invalid Patient Identifier

- Can't find a patient's Medicare Beneficiary Identifier (MBI)? Use the myCGS MBI Look-Up Tool!
  - Patient's first/last name, date of birth, social security number are required



# **Common Part A Claim Overlap Issues**

### Plan Coverage:

- Medicare Advantage (MA)
- Medicare Secondary Payer (MSP)

## Payment Policies (Part A only):

- Hospital bundling
- Hospital readmissions
- Leave of Absence (LOA) / interrupted stay
- Patient discharge status
- Repetitive services

## Payment Policies (Part A & B):

- 3-day / 1-day payment window
- Consolidated Billing (CB):
  - Skilled Nursing Facility (SNF)
  - Home Health (HH)
  - End Stage Renal Disease (ESRD)
- Hospice
- Place of Service (POS)



# **Avoid Claim Overlap Errors**

Verify beneficiary eligibility.

### **Patient Discharge Status Code Resources:**

- UB-04 Data Specification Manual: <a href="http://www.nubc.org">http://www.nubc.org</a>
- SE1411, "Clarification of Patient Discharge Status Codes and Hospital Transfer Policies": <a href="https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1411.pdf">https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1411.pdf</a>
- SE20025, "Review of Hospital Compliance with Medicare's Transfer Policy with the Resumption of Home Health Services and the Use of Condition Codes (A-04-18-04067): <a href="https://www.cms.gov/files/document/se20025.pdf">https://www.cms.gov/files/document/se20025.pdf</a>
- Patient Discharge Status Codes Matter: <a href="https://www.cms.gov/Medicare/Medicare-Contracting/FFSProvCustSvcGen/Downloads/Patient-discharge-status-codes-matter.pdf">https://www.cms.gov/Medicare/Medicare-Medicare-Contracting/FFSProvCustSvcGen/Downloads/Patient-discharge-status-codes-matter.pdf</a>



# **Avoid Claim Overlap Errors**

## **Utilize the CGS Part A Consolidated Billing Tool**

https://www.cgsmedicare.com/medicare\_dynamic/j15/consbill\_parta/index.aspx

## For services under arrangement, clearly establish the following:

- Admitting provider's responsibility
- Outside entity's responsibility
- Specific services
- Payment rates
- How to submit invoice
- Time frames
- Permit access to medical records as needed



## **Part B Claims**

Review of Part B Data: The main reasons we deny your claims and ways to avoid them!

Non-Covered by this Contractor

Always check patient eligibility

Duplicate Service

- Check the status of ALL claims before resubmitting them
- Submit like services on one claim
- Use modifiers

Code Submitted for Reporting Purposes

- Merit-based Incentive Payment System (MIPS)
- Appropriate Use Criteria (AUC) for Advances Diagnostic Imaging

Payment Included in Another Service Previously Adjudicated

Refer to Correct Coding Initiative (CCI) for "bundled" services

57



## **Part B Claims**

Review of Data: Top Claim Submission Errors (CSEs) and how to avoid them!

Procedure Code Invalid on Date of Service

Code claims using current CPT and HCPCS manuals

Missing/Incomplete/Invalid Patient Identifier

- Can't find a patient's Medicare Beneficiary Identifier (MBI)? Use the myCGS MBI Look-Up
   <u>Tool</u>
  - Patient's first/last name, date of birth, social security number are required

Patient Medicare Number/Name Mismatch

Maintain a copy of the patient's Medicare card

Invalid Procedure Code/Modifier Combination

Check the <u>Modifier Finder Tool</u> for help with modifiers



# Reopenings

A *Reopening* may be requested to correct a minor error or omission to a previously processed Part B claim

- Rejected claims must be corrected and resubmitted as NEW claims
- myCGS and Telephone Reopenings are also accepted!
- Time limit denials due to CGS errors or CWF updates/changes may be reopened
  - See Good Cause section of the IOM
- Medicare Secondary Payer (MSP) reopenings may be processed
  - Primary payer recoups payment due to an update in their files showing they should be secondary
  - A copy of recoupment letter or EOB must be sent within 6 months in order to be reopened



# **Provider Contact Center (PCC)**

Providers are reminded customer service representatives (CSRs) cannot assist with processes available through the *Interactive Voice Response (IVR)* 

- This includes beneficiary eligibility, claim and appeal status, offset information
- Step-by-step instructions are available
- Use the <u>Medicare Beneficiary Identifier (MBI) and Name to Number Converter</u>
  - TIP: Most of the IVR functions are also available in myCGS!
- Authentication process required for claim-specific inquiries

**NOTE**: Are you aware that CGS provides comprehensive tools to assist you in accomplishing a variety of tasks in order to save you time and streamline your processes? Calling our PCC isn't the only way to receive immediate assistance from CGS. Here are the Self-Service Options tools available to providers designed to streamline communication and enhance your productivity. ©



# **Overpayment Recovery (OPR)**

The purpose of <u>Overpayment Recovery</u> is to recover money overpaid in error to a Medicare beneficiary or provider. The funds can be recovered through a voluntary payment or through a demand letter.

There are two types of overpayments:

- Non-MSP where Medicare fee-for-service is primary, and
- MSP where Medicare fee-for-service is secondary

When you need us to send a demand letter to request an overpayment:

- Submit the request through myCGS to avoid having to mail or fax the hardcopy form (PREFERRED METHOD!)
- The <u>hardcopy forms are still available</u>, but they have been updated
  - There are now separate forms for MSP and Non-MSP requests







# **CMS Resources You Can Use!**

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

CMS Office of Program Operations and Local Engagement

#### Medicare Home Page

- Acronyms
- Change Requests (CRs) and Transmittals
- The CMS Innovation Center
- Coordination of Benefits
- <u>Health Plans</u> General Information
- Internet-Only Manuals (IOM)
- Medicare Physician Fee Schedule Database (MPFSDB)





## **CMS Resources You Can Use!**

#### The Medicare Learning Network®

 Free educational materials for health care professionals on CMS programs, policies, and initiatives

#### **Publications & Multimedia**



- Publications
- · MLN Matters Articles
- Multimedia

#### News & Updates



- MLN Connects® Newsletter
- Electronic Mailing Lists
- Social Media

#### **Events & Training**



- · Calls & Webcasts
- Web-Based Training

#### Continuing Education



Earn continuing education credit





#### **CLAIMS**

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

#### MR DASHBOARD

View and respond to ALL your MR ADRs on one page. NOTE: Now includes Post-Pay ADRs!

#### **REMITTANCE**

View and print remittance advices (RAs).

### **ELIGIBILITY**

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

### **MBI LOOK-UP TOOL**

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





## **FINANCIAL TOOLS**

Check the number of claims approved-to-pay and the last three checks issued.

#### **MESSAGES**

Read secure messages and alerts regarding system access and functions performed in the portal.

#### **FORMS**

Submit Redeterminations, Reopenings, eOffset requests and MORE!

#### **ADMIN**

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

#### **MY ACCOUNT**

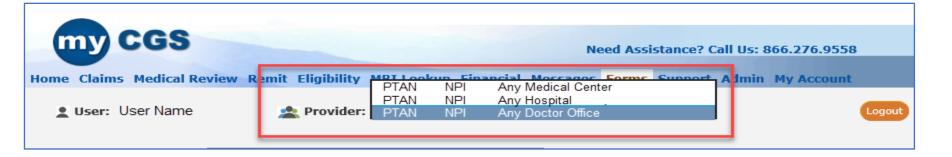
Manage functions of your account including passwords, validation Q&As, contact info, Multi-Factor Authentication (MFA).





## **Choose YOUR myCGS Super ID!**

Account Linking allows you to combine multiple User IDs under one master (Super) ID, allowing you to select one of your linked accounts with ease to perform functions available to you under that PTAN/NPI.



The FOUR easy steps to link accounts are located under the *My Account* tab in the myCGS User Manual

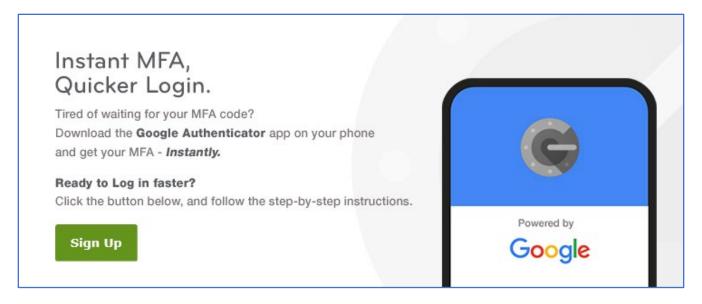




## Access myCGS LIGHTNING Fast!!!

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

Get your MFA code through the app instead of text or email



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

68





## **New Eligibility Functions!**

myCGS can now be used to check the following under the Eligibility tab:

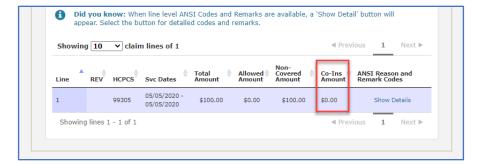
- The entitlement reason patient has benefits
  - For both Part A and Part B benefits
  - Located under the Eligibility sub-tab
- The date(s) your patient received the COVID-19 vaccine and by whom
  - Identifies immunization date, HCPCS code of vaccine and administration, and rendering provider's NPI
  - Located under the Preventive sub-tab
- Preventive sub-tab now includes a short description of CPT/HCPCS code
  - Also a new PRINT option!





## Other myCGS Enhancements!

Co-insurance now displays on the actual claim line instead of the header section



- Provider Admins now complete Account Recertification every 360 days!
  - Used to be every 90 days
  - Access from the ADMIN tab, User Listing sub-tab



70





myCGS System Requirements

**Log-In and Password Tips** 

Multiple Provider Administrators

Access the CORRECT myCGS
Web Portal

myCGS User Manual Following our system requirements will ensure you get the BEST out of myCGS!

Must log in once every 30 days!

Please be sure to have more than one provider admin in the office!

Be sure you log in from the correct line of business (i.e., Part B) web site, as our DME contracts utilize myCGS, as well.

71

Reformatted so you can find what you need!



# **Self-Service Options!**

Get IMMEDIATE help when you need it by using these tools!

#### Additional Documentation Request (ADR) Timeliness Calculator

• Help you determine the date documentation must be received

#### CMS-1500 Claim Form Instructions Tool

• Identifies each item of a claim form (and ANSI electronic claim)

#### Fee Schedule Search Tool

Access to various types of fee schedules

#### Online EDI Application Status Check Tool

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

#### Medically Unlikely Edits (MUEs)

• Use this tool to search for the MUE assigned to CPT/HCPCS codes



# **Self-Service Options!**

Get IMMEDIATE help when you need it by using these tools! (Cont.)

#### **Consolidated Billing**

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

#### MBI and Name-to-Number Converter

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

#### Medicare Secondary Payer (MSP) Tool

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

#### Reason/Remark Code Search and Resolution

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

#### Medicare Deductible/Coinsurance Look-Up Tool

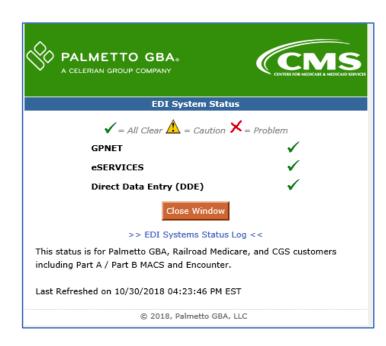
• Access deductible and coinsurance amounts for a Calendar Year



# **Self-Service Options!**

## **EDI System Status Log**

- Easy way to <u>check for any reported</u> <u>system issues</u>
  - From <u>EDI tab</u> or <u>Quick Links</u> section



## myCGS Status

- Located <u>upper-right of web site</u>
- At-a-glance notification to let you know the status of myCGS
  - GREEN means myCGS no issues
  - YELLOW means an issue was reported
  - RED means myCGS is not functioning





# **CGS Medicare App**



CGS Medicare<sup>SM</sup> App Guide



# GoToStage Video Channel!

CGS has recently made improvements to access the Part A, Part B, and the Home Health & Hospice webinar recordings. Access will be provided to all the J15 recorded webinars through <u>GoToStage Video Channel</u>.

- Webinars will display as:
  - Featured Videos
  - Recently Added
  - myCGS
  - Line-of-Business specific (A/B/HHH)
- Select the webinar and register to view
- Transcript also available





# **CGS Part A and B Provider Education**

We are here for you, J15!

If you have a specific Medicare education request, you can schedule an appointment with the CGS POE staff at

J15\_PartA\_Education@cgsadmin.com



## **Your Feedback Matters!**

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

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





# STAY CONNECTED

#### CHECK OUT OUR WEBSITE:

https://www.cgsmedicare.com/



#### GET EVEN MORE RESOURCES:

- CMS MLN Web page: <a href="https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo">https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo</a>.
   This includes the MN Connects, MLN articles, and more.
- Electronic Mailing List page at: <a href="https://www.cms.gov/">https://www.cms.gov/</a>
   Outreach-and-Education/Outreach/FFSProvPartProg/
   Electronic-Mailing-Lists
- CMS e-mail updates at: https://public.govdelivery. com/accounts/USCMS/subscriber/new?pop=t&topic\_ id=USCMS\_7819

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CGS

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#### Download Our GoMobile App:













79

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CGS MEDICARE UPDATE SPRING 2022



# Thank you for joining us!

Questions???



