Pre-Claim Review Demonstration for Home Health Services Expands to Florida

Ask-the-Contractor Teleconference (ACT)
Nykesha Scales MBA & Sandy Decker BSN RN
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Objectives

- Discuss Demonstration Background & Goal
- Define Pre-Claim Review
- Outline Pre-Claim Review Process & Submission Methods
- Review Medicare Home Health Benefit & Documentation Requirements
- Identify Common Reasons for Non Affirmations
- Cover Resources
- Address Q&As

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DEMONSTRATION BACKGROUND

- Implemented as a result of reports and findings of extensive evidence of fraud and abuse in Medicare home health program
- Most demonstration states also identified as high-risk states that have select cities/counties under temporary moratoria on home health provider enrollment authorized under the Affordable Care Act
- Medicare improper payment rate for home health services increased from 17.3% in 2013 to 51.4% in 2014
- Fiscal Year 2015 HHS Agency Financial Report reported a further increase to 59% in 2015

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GOAL OF DEMONSTRATION

Demonstration will:

- Test improved methods for identifying, investigating, and prosecuting Medicare fraud occurring in the home health program while maintaining or improving the quality of care provided to Medicare beneficiaries
- Help make sure that applicable coverage and coding rules are met before the final claim is submitted
- Reduce the current program's reliance on the practice of "pay and chase" for inappropriate billing

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WHO IS INVOLVED?

Demonstration States: Illinois, Florida, Texas, Michigan & Massachusetts

Home Health Agencies (HHAs) providing services in these selected demonstration states

Beneficiaries using the Medicare fee-for-service benefit to receive home health services in the demonstration states

Who	When
Illinois HHAs	August 3, 2016
Florida HHAs	TBD (no earlier than April 1, 2017)
Texas HHAs	TBD
Michigan & Massachusetts HHAs	TBD
Duration of Demonstration	3 years

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WHAT IS PRE-CLAIM REVIEW?

- Pre-claim review (PCR) is a process to request a provisional affirmation of coverage by submitting documentation for review before a final claim is submitted
- PCR helps make sure applicable coverage, payment, and coding rules are met before the final claim is submitted

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Is there a Difference Between PCR & Prior Authorization?

- PCR differs from prior authorization due to the timing of review and when services begin
- Prior authorization requests must be submitted prior to the start of services and providers must wait until they have a decision before they begin to provide services
- PCR requests are submitted after initial assessments and intake procedures are completed, services have began, and prior to the submission of the final claim

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PCR Process

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PCR Specifics

- Submitting PCR request is voluntary
- However, after first three months of the demonstration in a state, if HHA provides services to a beneficiary and submits claim to Medicare Administrative Contractor (MAC) for payment without submitting a PCR request,
  - Claim will be subjected to prepayment medical review and
  - If approved for payment, the claim will be subject to a 25% payment reduction
  - Note: This payment reduction is not appealable and cannot be billed to the beneficiary
- Providers under Zone Program Integrity Contractors (ZPIC) review and Program Safeguard Contractors (PSC) review are not eligible to submit PCR requests

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Step 1: RAP Submission

A PCR request must be submitted for each 60-day episode

- Submit the Request for Anticipated Payment (RAP) when appropriate conditions are met (Medicare Claims Processing Manual, Pub. 100-04, Ch. 10, section 10.1.10.3, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c10.pdf)
- There are no changes related to submitting the RAP, or to the RAP payment
- The auto cancellation of a RAP when the final has not been submitted timely will also not change under the PCR process
- Providers are given the greater of 120 days after the start of the episode or 60 days after the paid date of the RAP to submit the final claim

Note: The PCR program does not apply to Requests for Anticipated Payment (RAPs), Low Utilization Payment Adjustments (LUPAs), demand bills with condition code 20, and no-pay bills with condition code 21.

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Type of Bills (TOBs)

PCR applies to the following TOBs:	
327	32J
329	32K
32F	32M
32G	32P
32H	32Q
32I	

32F, 32G, 32H, 32I, 32J, 32K, 32M & 32P = Adjustments initiated by CGS

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HCPCS Codes

PCR applies to the following HCPCS Codes (codes subject to change)	
G0151	G0160
G0152	G0161
G0153	G0162
G0155	G0163*
G0156	G0164*
G0157	G0299
G0158	G0300
G0159	G0493
G0494	G0495
G0496	

Includes Skilled Nursing, Physical Therapy, Occupational Therapy, Speech-Language Pathologist, Social Worker, and Aide Services

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MM9736:
Implementation of Policy Changes for the CY 2017 Home Health Prospective Payment System

Creation of New G Codes for RN and LPN in Home Health Episodes

Effective January 1, 2017, **G0163** and **G0164** are retired and replaced with four new G-codes:

1. **G0493** - Skilled services of a registered nurse (RN) for the observation and assessment of the patient's condition, each 15 minutes (the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment in the home health or hospice setting).

2. **G0494** - Skilled services of a licensed practical nurse (LPN) for the observation and assessment of the patient's condition, each 15 minutes (the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment in the home health or hospice setting).

3. **G0495** - Skilled services of a registered nurse (RN), in the training and/or education of a patient or family member, in the home health or hospice setting, each 15 minutes.

4. **G0496** - Skilled services of a licensed practical nurse (LPN), in the training and/or education of a patient or family member, in the home health or hospice setting, each 15 minutes.

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9736.pdf

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Episodes Subject to PCR Process

- PCR process applies to all 60-day episodes of care that begin on and after 'FROM' dates outlined for each demo state i.e. April 1, 2017 for FL providers
  - Initial
  - Recertification
- Discharge and readmit to the same agency within same 60-day episode of care
  - If a new admission (start of care OASIS) is required, a new PCR request must be submitted
- Transfer during a 60-day episode of care
  - Receiving HHA submits PCR request

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Step 2: Complete/Submit PCR Coversheet & Documentation

Complete PCR Coversheet and submit with the following supporting medical documentation:

- Certification/Recertification
- Face-to-Face visit encounter note
- Acute/post-acute care visit notes
- Home health plan of care (signed & dated)
- Therapy evaluations
- Outcome and Assessment Information Set (OASIS)
- Initial orders

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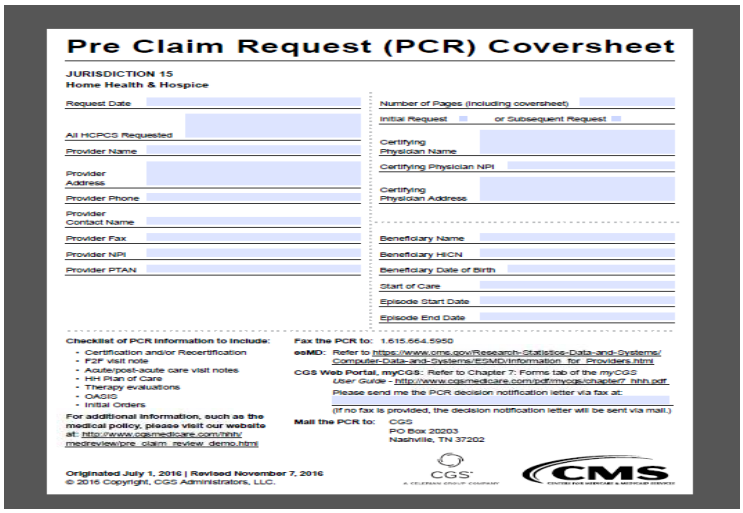
CGS PCR Coversheet

https://www.cgsmedicare.com/hhh/forms/pdf/pcr_coversheet.pdf



Pre Claim Request (PCR) Coversheet

JURISDICTION 15
Home Health & Hospice

Request Date
All HCPCS Requested
Provider Name
Provider Address
Provider Phone
Provider Contact Name
Provider Fax
Provider NPI
Provider PTAN

Number of Pages (including coversheet)
Initial Request or Subsequent Request
Certifying Physician Name
Certifying Physician NPI
Certifying Physician Address

Beneficiary Name
Beneficiary HICN
Beneficiary Date of Birth
Start of Care
Episode Start Date
Episode End Date

Checklist of PCR information to include:
- Certification and/or Recertification
- F2F visit note
- Acute/post-acute care visit notes
- HH Plan of Care
- Therapy evaluations
- OASIS
- Initial Orders

For additional information, such as the medical policy, please visit our website at: http://www.cgsmedicare.com/hhh/medreview/pre_claim_review_demo.html

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Fax the PCR to: 1.615.664.5950
eoMD: Refer to https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/ESMD/Information_for_Providers.html
CGS Web Portal, myCGS: Refer to Chapter 7: Forms tab of the myCGS User Guide - http://www.cgsmedicare.com/pdf/mycgs/chapter7_hhh.pdf
Please send me the PCR decision notification letter via fax at:
(If no fax is provided, the decision notification letter will be sent via mail.)
Mail the PCR to: CGS
PO Box 20203
Nashville, TN 37202

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PCR Request Required Elements

- Under PCR Demonstration, a HHA or beneficiary may submit a PCR request
- PCR requests must contain certain elements to be considered complete:
  - Beneficiary Information (Name, Medicare Number, Date of Birth)
  - Certifying Physician/Practitioner Information (Name, National Provider Identifier (NPI), Address)
    - Provider Transaction Number (PTAN) optional
  - Home Health Agency Information (Name, NPI, CMS Certification Number, PTAN, Address)
  - Submitter Information (Contact Name, Telephone Number)
  - Other Information
  - Required Documentation

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Other Information

- Request date
- Start of Care
- Episode Start/End dates
- Indicate if request is an initial or subsequent review
- All HCPCS requested

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DOCUMENTATION

MEDICARE HOME HEALTH DOCUMENTATION REQUIREMENTS

To qualify for the Medicare home health care benefit, the patient must:

1. Be confined to the home
2. Need skilled services
   - Intermittent skilled nursing care or physical therapy or speech-language pathology
3. Be under the care of a physician
4. Receive services under a plan of care established and reviewed by a physician
5. Had a face-to-face encounter performed by either:
   a) **Certifying physician** (must be Medicare enrolled)
   b) **Non-physician practitioner** (NPP) in collaboration with the certifying physician
   c) **Physician who cared for the patient** in an acute/post-acute facility during a recent stay and has privileges in that facility

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HOMEBOUND STATUS

Two criteria are used to determine homebound status

Criteria-One:

The patient must **either**:

- Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence.

OR

- Have a condition such that leaving his or her home is medically contraindicated.

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HOMEBOUND STATUS

Two criteria are used to determine homebound status (continued)

Criteria-Two:

- There must exist a normal inability to leave home

AND

- Leaving home must require a considerable and taxing effort

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HOMEBOUND STATUS

The patient may be considered homebound (confined to the home) if absences from the home are:

- infrequent;
- for periods of relatively short duration;
- for the need to receive health care treatment;
- for religious services;
- to attend adult daycare programs; or
- for other unique or infrequent events
- the patient may have more than one home
  - vacation home, home of caregiver, seasonal home

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HOMEBOUND STATUS

Documentation must support **homebound status** throughout

Beware of vague descriptions: "taxing effort", "unable to leave home"

Utilize **objective, measurable language**

Examples of **good documentation**:

- "After ambulating 20 feet, patient has increased dyspnea and complains of back pain."
- "Patient has unsteady gait, and must sit to rest after 10 feet of ambulation due to uncontrolled vertigo."

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PHYSICIAN RECERTIFICATION

The physician must include an estimate of how much longer skilled services will be required (preferably a timespan or interval of time)

- As part of the recertification document
- A recertification that does not include this information may result in a claim denial

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PHYSICIAN RECERTIFICATION

The achievement of a treatment goal as an estimate of how much longer a patient may need HH services is **not acceptable**

Unacceptable examples of treatment goals:

- Services will be required **until the patient can walk safely**
- Services will be required **until the ulcer heals**

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PHYSICIAN RECERTIFICATION

Acceptable examples of timespan used to convey how much longer the services will be needed:

- I **estimate** this patient will qualify for home health services for **another 60 days to continue self-feeding training**.
- I **estimate** this patient will qualify for home health services for **another 4 weeks**.

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FACE-TO-FACE WHEN?

Certifying physician must document FTF took place within

- **90 days prior to start of care (SOC),** or
- **30 days after SOC**

Reminder:

- FTF must be related to **primary reason** for home health admission
- **Exceptional** circumstance: Patient death **before** FTF can be performed

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FACE-TO-FACE FREQUENT PROBLEMS

1. The certifying physician must document the date of the face-to-face encounter.

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FACE-TO-FACE FREQUENT PROBLEMS

2. The clinical note for the face-to-face encounter must be included in the documentation submitted.

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SUPPORTING DOCUMENTATION

Examples of supporting documentation:

- Face-to-face encounter documentation
- Plan of care
- Start of care (SOC) assessment
- Certification/recertification statement
- Discharge summaries
- History and physical examination (H&P)

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HOW TO SUBMIT PCR REQUEST

Mail:

- CGS Administrators, LLC, PO Box 20203, Nashville, TN 37202

Fax:

- 1.615.664.5950

myCGS

- Step by step instructions, http://www.cgsmedicare.com/pdf/mycgs/chapter7_hhh.pdf

Electronic Submission of Medical Documentation (esMD)

- Provider information, https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/ESMD/Information_for_Providers.html

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What Happens After I submit my PCR Request?

Once the HHA submits the PCR request with the supporting documentation, CGS will:

- Review the request and supporting documentation and make a decision using existing applicable regulations, National Coverage Determination and Local Coverage Determination requirements, and other CMS policies
- Send back a decision letter affirming or non-affirming the pre-claim review request

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Review Time Requirements

- For the initial submission of the PCR request, MACs are required to make the decision and notify each submitter within ten (10) business days (excluding Federal holidays) of receipt of the request
- The submitter will be notified if the decision is provisionally affirmative or non-affirmed
- The Decision notification will contain a Unique Tracking Number (UTN)
  - UTN must be submitted on final claim
- The decision notification will be sent to the submitter based on how it was received

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Provisional Affirmed vs Non-Affirmed

A provisional affirmed decision means the claim will be paid as long as all other Medicare requirements are met.

A non-affirmed decision means the request did not demonstrate that Medicare home health coverage requirements were met.

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Non-Affirmed PCR Requests

If a pre-claim review request is non-affirmed:

1. The submitter can resolve the non-affirmative reasons described in the decision letter and resubmit the pre-claim review request.
   - Unlimited resubmissions are allowed prior to the submission of the final claim
   - Pre-claim review decisions cannot be appealed
     - Final claims processed based on non-affirmed decision are appealable
   - **or**
2. The submitter can provide the service and submit a claim:
   - The claim will be denied
   - All appeal rights are available

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PCR Resubmission Review Time Requirement

- MACs have an additional 20 business days (excluding Federal holidays) of the date received to conduct the medical review, make the decision(s), and notify the requester(s) of the decision(s)
- A notification will be sent to the submitter for each request received that provides a provisional affirmative or a non-affirmation decision
- A notification will also be sent to the beneficiary for each request received that provides a provisional affirmative or a non-affirmation decision

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What about Medicare Secondary Payer (MSP) Claims?

MSP seeking PCR

- Submit PCR request and documentation
- Submit claim to primary insurance for payment consideration
- Next, submit MSP claim to Medicare with the provisionally affirmed UTN for payment

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What about Medicare Secondary Payer (MSP) Claims?

MSP not seeking PCR

- Submit claim to primary insurance to make payment consideration
- Next, submit MSP claim to Medicare for payment consideration and the claim will stop for pre-payment review

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Final Claim Submission

- Normal data submitted on the claim is required
- TOB is 329
- Enter the 14 byte UTN provided in the PCR notification
  - ASC X12 837 5010 – Positions 19 through 32 of Loop 2300 REF02 (REF01=G1)
  - CMS-1450 (UB-04) – Form Locator 63 (positions 19-30 & last 2 characters of UTN outside the lines next to position 30, following the treatment authorization code)
  - Direct Data Entry – TREAT. AUTH. CODE field immediately following the 18-digit OASIS Matching Key code

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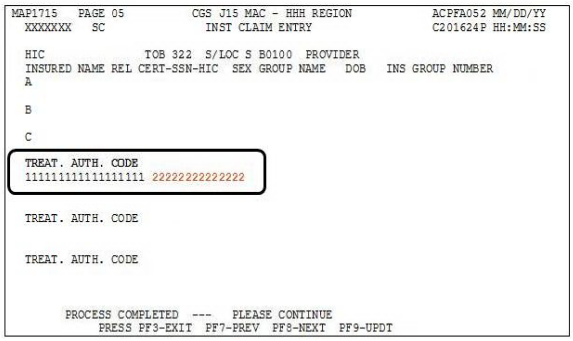
FINAL CLAIM SUBMISSION



Final claims will process based on the decision provided in the pre-claim review notification letter. If the notification letter indicated an affirm decision, the final claim will process and pay as long as all other technical and Medicare requirements are met upon claim submission. If the notification letter indicated a non-affirm decision, the final claim will be denied. Traditional appeal rights apply to non-affirmed denials.

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APPEALS

Standard appeals process applies to final claim

- There is no appeal process for non-affirmation PCR of HH services decisions
- In order to access appeal rights, the final claim should be submitted with the non-affirmed UTN which will result in a denial of the claim with the ability to appeal

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Common Reasons for Non Affirmations

#1 reason- 5HC01: The physician certification was invalid since the required face-to-face encounter was missing/incomplete/untimely.

- Refer to CMS IOM Publication 100-02, Chapter 7, Section 30.1.1 and 30.5

#2 reason- 5HH01: Documentation submitted does not support homebound status.

- Refer to CMS IOM Publication 100-02, Chapter 7, Section 30.5

#3 reason- 5HC08: The recertification estimate of how much longer skilled services are required is missing/incomplete/invalid.

- Refer to CMS IOM Publication 100-02, Chapter 7, Section 30.5.2

#4 reason- 5HY01: The medical documentation submitted did not show that the therapy services were reasonable and necessary and at a level of complexity which requires the skills of a therapist.

- Refer to CMS IOM Publication 100-02, Chapter 7, Section 40.2.1 and 40.2.2

#5 reason- 5HC09: The initial certification was missing/incomplete/invalid, therefore the recertification episode is denied.

- Refer to CMS IOM Publication 100-02, Chapter 7, Section 30.5

Medicare Benefit Policy Manual/Home Health Services, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf

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Resources

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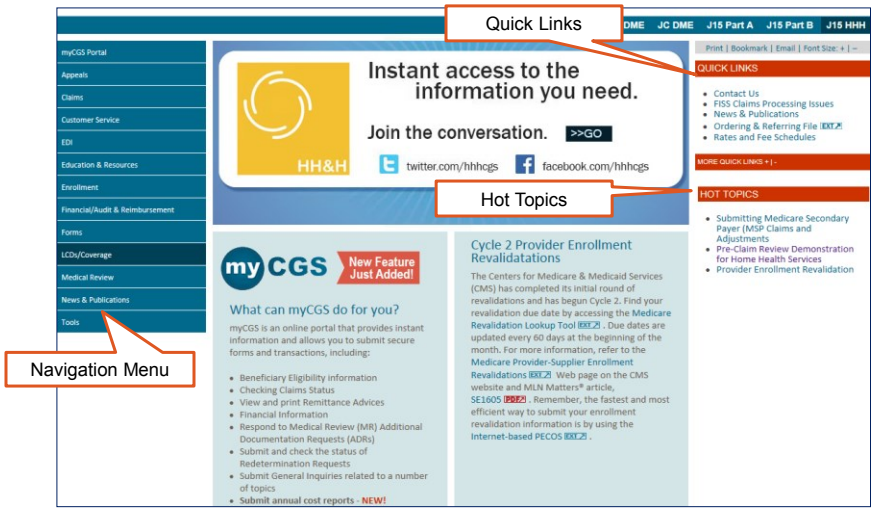
CGS HH&H Website

http://www.cgsmedicare.com/hhh/index.html



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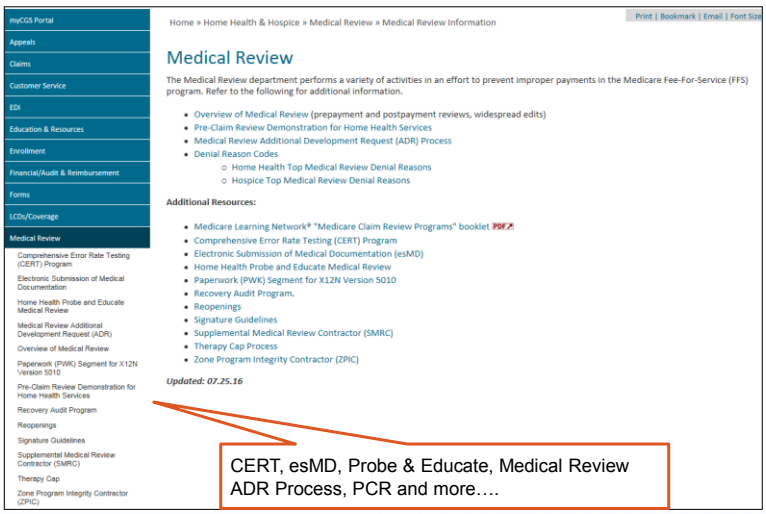
CGS Medical Review Web Page

http://www.cgsmedicare.com/hhh/medreview/index.html



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HH PCR Demonstration Fact Sheet Quick Resource Tool (QRT)

http://www.cgsmedicare.com/hhh/education/materials/pdf/hh_pcr_demo_factsheet.pdf

Home Health Pre-Claim Review (PCR) Demonstration Fact Sheet

What do HHAs need to do?	▪ Submit the Request for Anticipated Payment (RAP) as usual. No changes have been made to the RAP submission or payment process. ▪ The PCR process must occur before the final claim is submitted. ▪ Before submitting your final claim, and when you have the documentation necessary to ensure that the Medicare home health benefit coverage criteria are met, complete the Pre-Claim Review (PCR) Coversheet and submit it along with the medical record documentation to CGS. • Fax: 615.664.5950 (active August 1, 2016) • Mail: CGS Administrators PO Box 20203 Nashville, TN 37202 ▪ The Pre-Claim Review (PCR) Coversheet includes a list of the documentation you need to submit. ▪ NOTE: It is important that providers complete the Pre Claim Request (PCR) Coversheet in full. List all HCPCS codes that will be submitted on the final claim.
When will HHAs be notified of the medical review decision?	▪ A decision letter will be sent to the HHA (in the same manner as the PCR was submitted) to the HHA and the beneficiary within 10 business days of receipt. • Affirm – Medicare will pay for the home health benefit period as long as all other requirements are met • Non-affirm – Medicare will deny the home health benefit period. — Standard claims Appeal rights apply. — HHAs may resubmit the PCR with additional documentation (no limit on resubmitted PCR requests).

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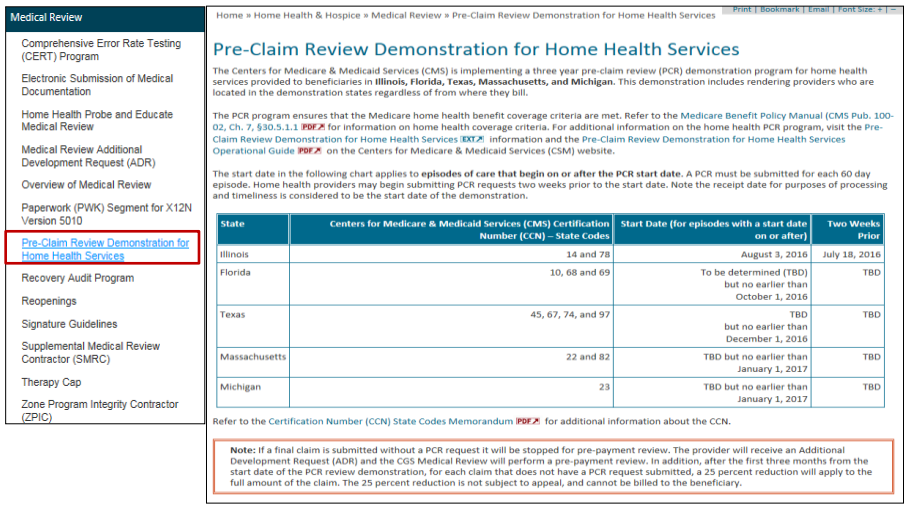
CGS PCR Web Page

HTTP://WWW.CGSMEDICARE.COM/HHH/MEDREVIEW/PRE_CLAIM_REVIEW_DEMO.HTML



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NEW: CGS HOME HEALTH PCR DEMONSTRATION LOOK-UP TOOL

http://www.cgsmedicare.com/medicare_dynamic/pcr/search.asp

Home Health Pre-Claim Review Demonstration Look-Up Tool

Print | Bookmark | Email | Font Size: + | –

The Centers for Medicare & Medicaid Services (CMS) implemented a three year pre-claim review (PCR) demonstration program for home health services, impacting home health agencies in **Illinois, Florida, Texas, Massachusetts, and Michigan.**

Enter your home health agency's Provider Transaction Access Number (PTAN) (also known as the CMS Certification Number (CCN)) in the space below. If applicable, PCR demonstration start date information for your home health agency will display. If no message displays, your home health agency is not impacted by the PCR demonstration.

Note: The start date applies to **episodes of care that begin on or after the PCR start date.**

PTAN to search: Search >>

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CGS EDUCATION & RESOURCES

HTTP://WWW.CGSMEDICARE.COM/HHH/EDUCATION/INDEX.HTML

myCGS Portal
Appeals
Claims
Customer Service
EDI
Education & Resources
- Advisory Group
- Calendar of Events
- CMS Educational Resources
- Educational Materials
- FAQs
- New Provider Resources Center
- Online Education Center
- Video Education

Enrollment
Financial/Audit & Reimbursement
Forms

Home » Home Health & Hospice » Education & Events » Education & Resources

Print | Bookmark | Email | Font Size: + | –

Education & Resources

Our overall goal is to provide our customers with effective, on time, focused education that is easily accessible, understandable, and provides the best fit for their learning needs and challenging schedule. CGS offers a variety of educational resources to keep you informed about Medicare guidelines, including:

- The **Advisory Group** assists CGS in the creation, implementation, and review of provider education strategies and efforts.
- Upcoming **Calendar of Events** includes webinars, Ask-the-Contractor Teleconferences (ACTs), and replays of live presentations.
- **CMS Educational Resources** provides access to Centers for Medicare & Medicaid Services (CMS) website resources, including transmittals (i.e., Change Requests) as well as Medicare Learning Network (MLN) articles, products catalog, and more.
- The **Educational Materials** page allows quick access to a variety of CGS educational resources, including general, billing and clinical Quick Resource Tools, a Fiscal Intermediary Standard System (FISS) Guide, and claims filing instructions and much more.
- **Frequently Asked Questions (FAQs)** provides answers related to a variety of topics. FAQs are reviewed/updated each quarter to ensure all questions are up to date.
- **...e New Provider Resource Center** page guides you through five steps to help you get familiar with the CGS and CMS websites and resources.
- **...Online Education Center** for computer based training on a variety of topics, (e.g., Electronic Data Interchange (EDI), PC-Ace Pro 32 ...ect Data Entry, and home health and hospice).
- T... ...n page includes educational video modules on informative topics that you can access anytime.

Updated: 06.0

Medicare Learning Network®
Official Information Health Care Professionals Can Trust
http://go.cms.gov/MLNGenInfo

Advisory Group, Calendar of Events, CMS Educational Resources, CGS Educational Materials, FAQs, Online Education Center (NEW PCR OEC), & Videos

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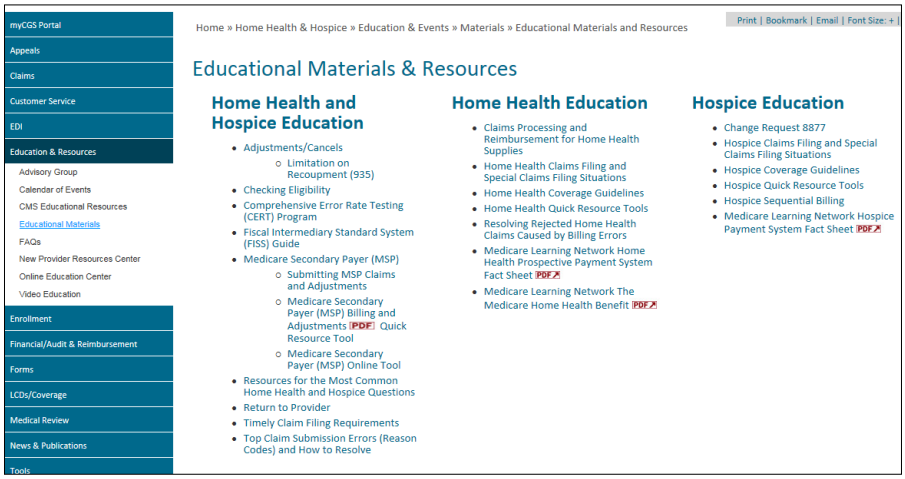
CGS EDUCATIONAL MATERIALS

HTTP://WWW.CGSMEDICARE.COM/HHH/EDUCATION/MATERIALS/INDEX.HTML



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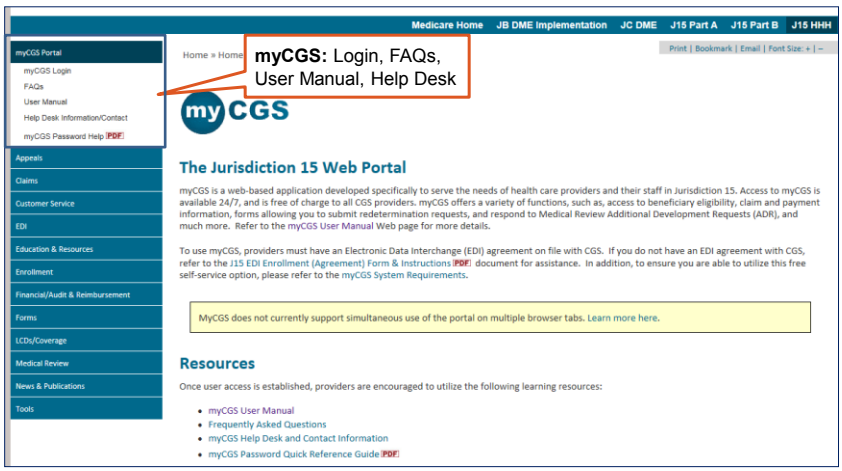
CGS HH&H WEBSITE: MYCGS PORTAL

HTTP://WWW.CGSMEDICARE.COM/HHH/MYCGS/INDEX.HTML



No costs associated with access to myCGS

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CGS HH&H Website: News & Publications

HTTP://WWW.CGSMEDICARE.COM/HHH/PUBS/INDEX.HTML

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CGS Questions?

CGS Provider Contact Center: 1.877.299.4500

Option 1: Customer Service

Option 2: Electronic Data Interchange (EDI)

Option 3: Provider Enrollment

Option 4: Overpayment Recovery (OPR)

Option 5 (now available): PCR Assistance

Twitter: http://www.twitter.com/hhhcgs

Facebook: http://www.facebook.com/hhhcgs

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