Alabama/Georgia Rural Health Clinic Conference

Presented by
Cahaba Government Benefit Administrators®, LLC
Provider Outreach and Education

June 4, 2013

Disclaimer

- This resource is not a legal document. This presentation was prepared as a tool to assist our providers. This presentation was current at the time it was created.

- Although every reasonable effort has been made to assure accurate information, responsibility for correct claims submission lies with the provider of services. Reproduction of this material for profit is prohibited.

DDE User Sharing/Reassigning IDs

- User's ID and password serve as an electronic signature, and should not be shared
- Complete the Part A System Access Application at: http://www.cahabagba.com/part-a/claims/electronic-data-interchange-edi/forms/ to add or deactivate a user
- Violations will result in immediate deactivation
- Call EDI Helpdesk with questions: (866) 582-3253

Connectivity Vendor

- Effective July 1, 2013, Cahaba GBA will no longer support dial-up connections
- All electronic transactions should be routed through a Cahaba GBA approved Network Service Vendor (NSV) https://apps.cahabagba.com/providerLookups.vendorB.do
- Current user ID and password can be used
- Direct questions to the Cahaba GBA EDI helpdesk

EDI Update

- Dial-up users may experience busy signals due to reduced capacity
- Direct submitters are encouraged to begin using a Network Service Vendor as soon as possible
- A list of approved NSVs is available on our website at http://www.cahabagba.com/part-a/claims/electronic-data-interchange-edi/edi-connectivity-vendors/
- Contact the EDI Helpdesk for assistance at: (866)-582-3253

Claim Adjustments

- Cahaba will adjust claims with “through dates” on or after April 1, 2013, that processed between April 1 and April 14, 2013, with the following criteria:
  - Value Code 73
  - A deductible applied (A1, B1 or C1 Value Code) and
  - Negative reimbursement (at the line level for outpatient claims or negative reimbursement at the claim level for inpatient claims)

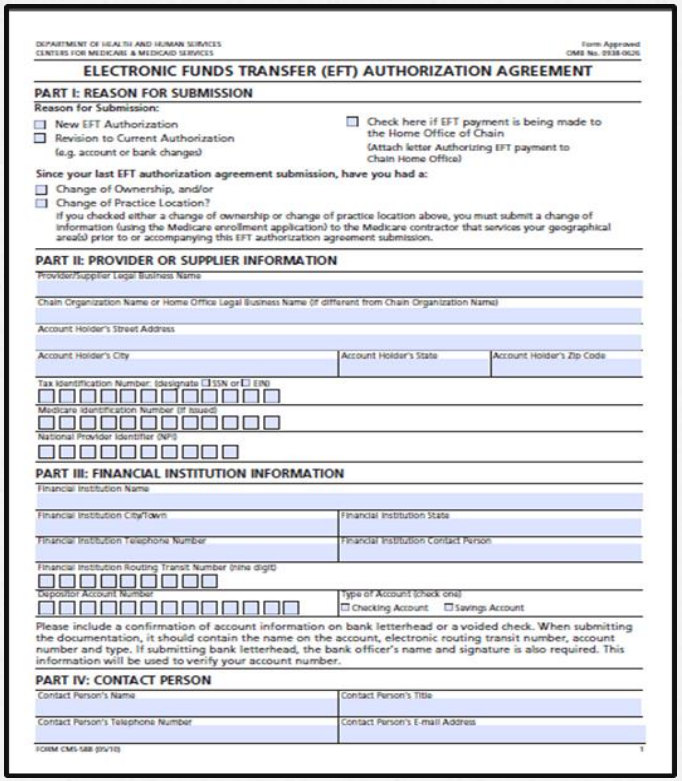
- All adjustments for previously held claims will be completed by June 30th

Revalidation Reminder

- All providers enrolled with Medicare prior to March 25, 2011, must revalidate
- Cahaba will send notices until March 23, 2015
- Complete and submit enrollment forms within 60 days
- PECOS is the preferred and easiest method to revalidate
- Do not submit an enrollment form until you receive a request to revalidate

Electronic Funds Transfer

- EFT enrollment is required at the time of:
  - Initial enrollment
  - Revalidation
  - Enrollment changes
- Complete the CMS-588 form:
  - Must contain original signature of the authorized/delegated official
  - Include voided check



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0626

ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT

PART I: REASON FOR SUBMISSION

Reason for Submission:

- ☐ New EFT Authorization
- ☐ Revision to Current Authorization (e.g. account or bank changes)
- ☐ Check here if EFT payment is being made to the Home Office of Chain (Attach letter Authorizing EFT payment to Chain Home Office)

Since your last EFT authorization agreement submission, have you had a:

- ☐ Change of Ownership, and/or
- ☐ Change of Practice Location?

If you checked either a change of ownership or change of practice location above, you must submit a change of information (using the Medicare enrollment application) to the Medicare contractor that services your geographical area(s) prior to or accompanying this EFT authorization agreement submission.

PART II: PROVIDER OR SUPPLIER INFORMATION

Provider/Supplier Legal Business Name

Chain Organization Name or Home Office Legal Business Name (If different from Chain Organization Name)

Account Holder's Street Address

Account Holder's City | Account Holder's State | Account Holder's Zip Code

Tax Identification Number (designate ☐ SSN or ☐ EIN)

Medicare Identification Number (If Issued)

National Provider Identifier (NPI)

PART III: FINANCIAL INSTITUTION INFORMATION

Financial Institution Name

Financial Institution City/Town | Financial Institution State

Financial Institution Telephone Number | Financial Institution Contact Person

Financial Institution Routing Transit Number (nine digit)

Depositor Account Number | Type of Account (check one) ☐ Checking Account ☐ Savings Account

Please include a confirmation of account information on bank letterhead or a voided check. When submitting the documentation, it should contain the name on the account, electronic routing transit number, account number and type. If submitting bank letterhead, the bank officer's name and signature is also required. This information will be used to verify your account number.

PART IV: CONTACT PERSON

Contact Person's Name | Contact Person's Title

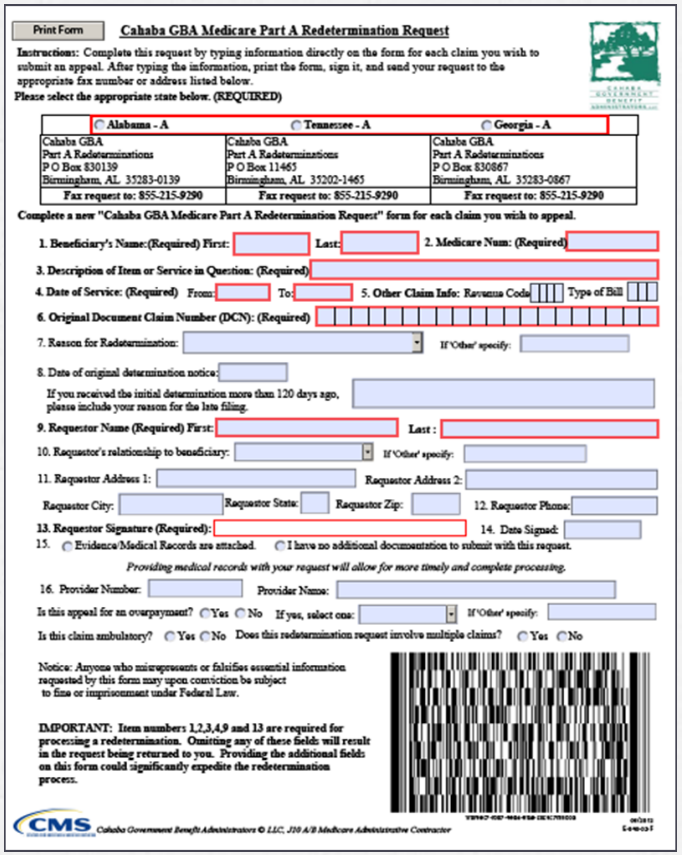
Contact Person's Telephone Number | Contact Person's E-mail Address

FORM CMS-588 (05/10) 1

http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/CMS588.pdf

Redetermination Smart Form - Reminder

- Complete all required fields (highlighted in red)
- Complete the form electronically
- Answer all questions in section 16
- Print, sign and fax



Print Form

Cahaba GBA Medicare Part A Redetermination Request

Instructions: Complete this request by typing information directly on the form for each claim you wish to submit an appeal. After typing the information, print the form, sign it, and send your request to the appropriate fax number or address listed below.

Please select the appropriate state below. (REQUIRED)

○ Alabama - A	○ Tennessee - A	○ Georgia - A
Cahaba GBA Part A Redeterminations P O Box 830139 Birmingham, AL 35283-0139	Cahaba GBA Part A Redeterminations P O Box 11465 Birmingham, AL 35202-1465	Cahaba GBA Part A Redeterminations P O Box 830867 Birmingham, AL 35283-0867
Fax request to: 855-215-9290	**Fax request to: 855-215-9290**	**Fax request to: 855-215-9290**

Complete a new "Cahaba GBA Medicare Part A Redetermination Request" form for each claim you wish to appeal.

1. **Beneficiary's Name:(Required) First:** **Last:** 2. **Medicare Num: (Required)**
3. **Description of Item or Service in Question: (Required)**
4. **Date of Service: (Required)** From: To: 5. **Other Claim Info:** Revenue Code Type of Bill
6. **Original Document Claim Number (DCN): (Required)**
7. Reason for Redetermination: If 'Other' specify:
8. Date of original determination notice:
   If you received the initial determination more than 120 days ago, please include your reason for the late filing.
9. **Requestor Name (Required) First:** **Last :**
10. Requestor's relationship to beneficiary: If 'Other' specify:
11. Requestor Address 1: Requestor Address 2:
    Requestor City: Requestor State: Requestor Zip: 12. Requestor Phone:
13. **Requestor Signature (Required):** 14. Date Signed:
15. ○ Evidence/Medical Records are attached. ○ I have no additional documentation to submit with this request.
    Providing medical records with your request will allow for more timely and complete processing.
16. Provider Number: Provider Name:
    Is this appeal for an overpayment? ○ Yes ○ No If yes, select one: If 'Other' specify:
    Is this claim ambulatory? ○ Yes ○ No Does this redetermination request involve multiple claims? ○ Yes ○ No

Notice: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine or imprisonment under Federal Law.

IMPORTANT: Item numbers 1,2,3,4,9 and 13 are required for processing a redetermination. Omitting any of these fields will result in the request being returned to you. Providing the additional fields on this form could significantly expedite the redetermination process.

CMS *Cahaba Government Benefit Administrators © LLC, J10 A/B Medicare Administrative Contractor*

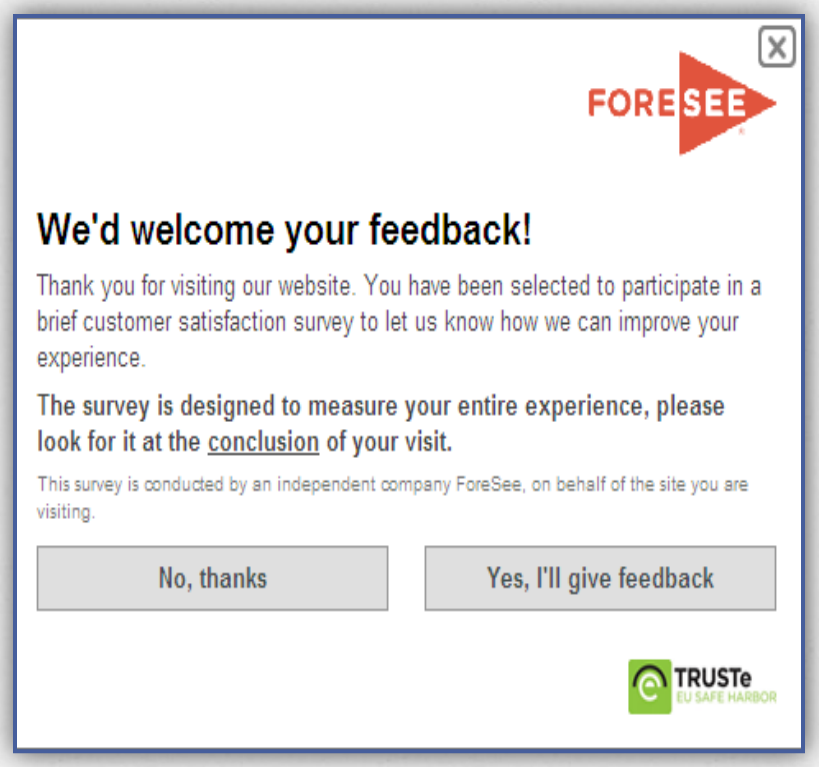
Smart Form Errors

- Incomplete or inaccurate original Document Claim Number (DCN)
- Incorrect date format submitted on the form
  - Correct date format is MM/DD/YYYY
- Mailing Smart forms instead of faxing
  - Submit Smart form via dedicated fax number
  - If mailing, complete CMS-20027
- Cover sheets should not be submitted

ForeSee

We need to hear from you!

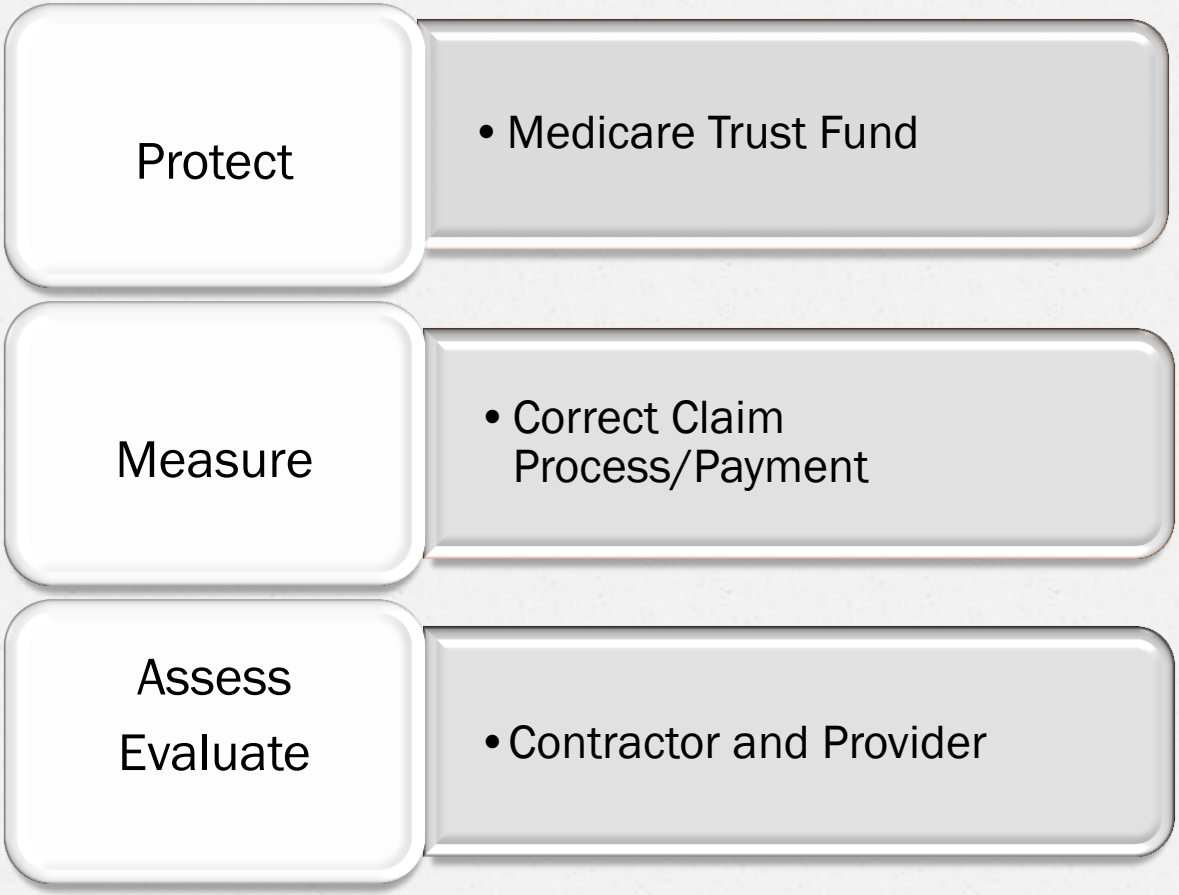
- Rate your Cahaba GBA experience
  - Quality of information
  - Freshness of content
  - Clarity of organization
  - Location of information
  - Consistency of speed
  - Overall satisfaction



Clinical Education

- Comprehensive Error Rate Testing
  - CERT Data Analysis
- CMS Signature Requirements
- CMS Resources

Comprehensive Error Rate Testing (CERT)



Part A CERT Feedback: 2013

Rural Health Clinics	Insufficient Documentation Disagree per SSA 1862(a)(1)(A) IOM Pub 100-4, Chapter 9, § 20 Method of Medicare Payment for RHC and FQHC Services PUB 100-08, Chapter 3, Â§ 3.3.2.4 - Signature Requirements	Missing: Submitted rural health clinic visit note missing signature of rendering provider. Note is typed with typed initials only. Missing legible, signed and dated clinic note. Initially received clinic note with questionable date unrelated to this claim. **Lacks MD signature on clinic note.**

CMS Signature Requirements

Change Request 6698:

- Signature Requirements for Medical Review Purposes
- Medicare requires that services provided/ordered be authenticated by the author
  - Hand written or
  - Electronic signature
- Stamp signatures are not acceptable

Rural Health Clinics (RHCs)

CMS Publication 100-07 - The State Operations Manual Appendix G – Guidance to Surveyors: Rural Health Clinics (RHCs) §491.8 Condition of Coverage: Staffing and Staff Responsibilities

1 - Physician Responsibilities

- Ascertain through written documentation, such as dates and signatures, that the physician staff member satisfactorily meets the requirement of periodically reviewing the clinic's patient records, provides medical orders, and provides medical care services to the patients.

Medical Record Documentation

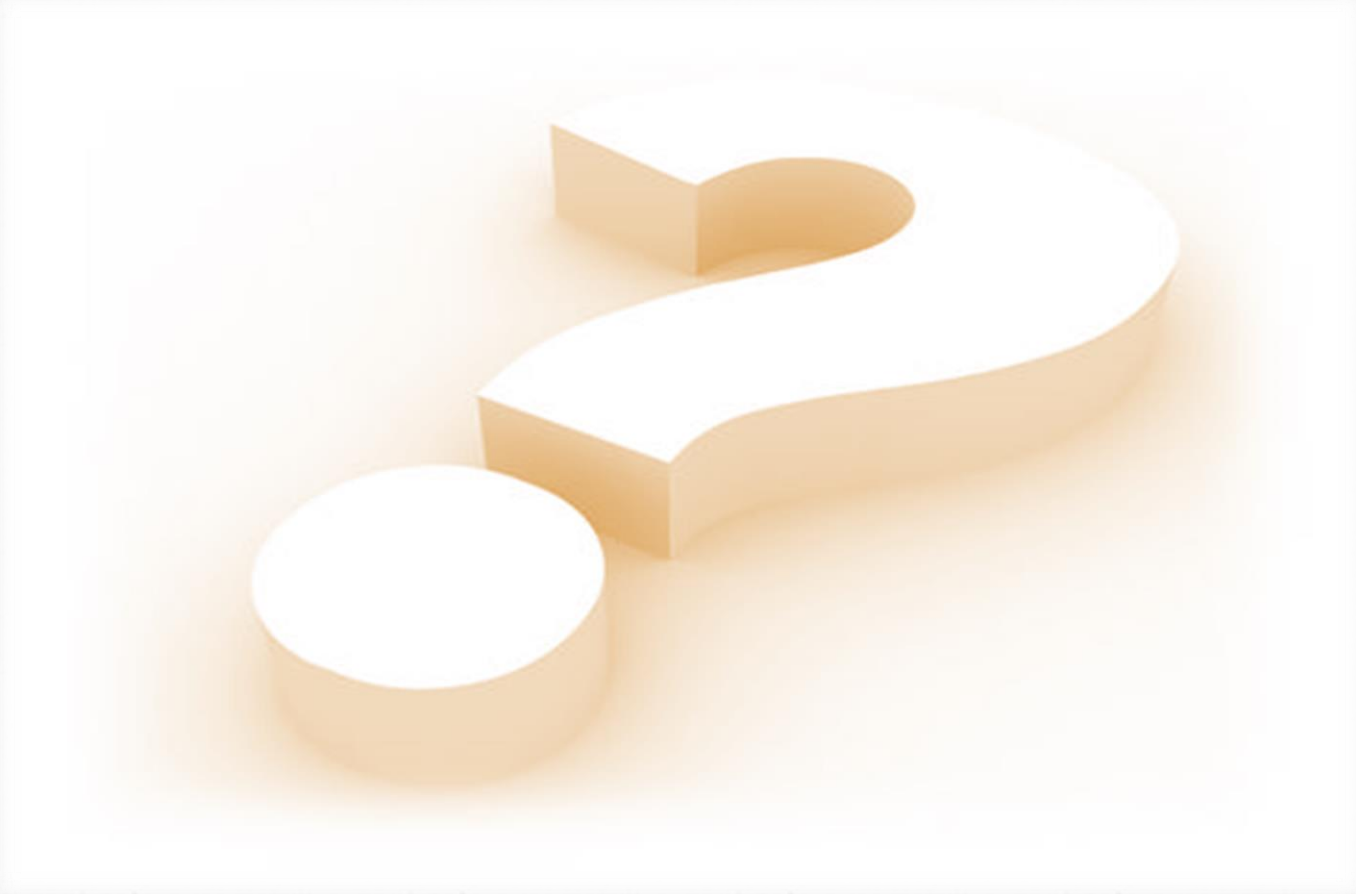
MLN Matters® Number: SE1237

Importance of Preparing/Maintaining Legible Medical Records

- General Principles of Medical Record Documentation
  Medical records should be complete and legible; and
  Medical records should include the legible identity of the provider and the date of service

- Amendments, Corrections and Delayed Entries in Medical Documentation
  Documents containing amendments, corrections, or delayed entries must employ acceptable recordkeeping principles

- Medicare Signature Requirements
  For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author. The method used shall be a handwritten or electronic signature



Provider Contact Center
Alabama, Georgia and Tennessee Providers: 1-877-567-7271