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DISCLAIMER

- This presentation was prepared as a tool to assist providers and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services.
- This publication is a general summary that explains certain aspects of the Medicare Program but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings. Medicare policy changes frequently, and links to the source documents have been provided within the document for your reference.
- The Centers for Medicare & Medicaid Services (CMS) employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this guide.

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Billing Update

Nykesha Scales, MBA
J15 Provider Outreach & Education
CGS Administrators, LLC

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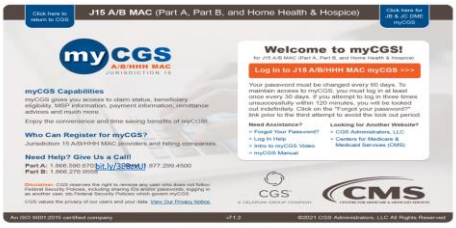
Are You Using the myCGS Portal?



https://www.cgsmedicare.com/mycgs/index.html

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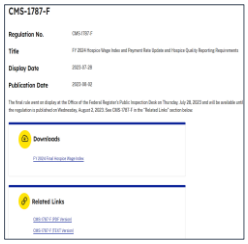
FY2024 Hospice Final Rule

- CMS-1787-F | CMS



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Medicare Hospice Payment Policies

- "Finalizing regulations' text changes related to the provision of telehealth services for Routine Home Care with the expiration of the COVID-19 PHE and for the use of telecommunications technology for the face-to-face encounter conducted by a hospice physician or hospice nurse practitioner for the sole purpose of hospice recertification through December 31, 2024."

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FY 2024 Routine Annual Rate Setting Changes

- "The FY 2024 hospice payment update percentage is 3.1% (an estimated increase of $780 million in payments from FY 2023)."
- "The hospice cap amount for FY 2024 is $33,494.01, which is equal to the FY 2023 cap amount ($32,486.92), updated by the FY 2024 hospice payment update percentage of 3.1%."

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Hospice Quality Reporting Program

- "CMS codified the HQRP data completion threshold policy at §418.312 and provided several updates relative to the development of a patient assessment instrument, titled HOPE, and future quality measures."

8

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Hospice Certifying Physician Enrollment

In response to concerns raised by commenters, we will not implement or enforce this requirement until May 1, 2024, to give unenrolled and non-opted-out physicians more time to enroll in or opt-out of the Medicare program.

- "Under our existing regulations, (1) the hospice medical director or the physician member of the hospice interdisciplinary group (hereafter the "hospice physician") and (2) the attending physician (if the beneficiary has one) must initially certify the patient's terminal condition. (For subsequent periods, only the hospice physician must do so.) As part of CMS' larger strategy to address hospice program integrity and quality of care, and under our authority under section 6405 of the Affordable Care Act, we are finalizing our proposal that these two categories of physicians must be enrolled in or opted out of Medicare for hospice services to be paid. Requiring enrollment or opt-out will allow us to screen the physician to ensure they are qualified (e.g., licensed) to certify the terminal condition."

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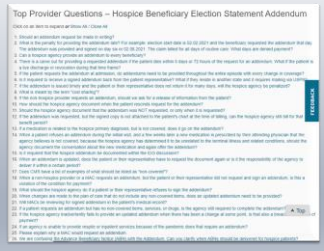
Top Provider Questions – Hospice Beneficiary Election Statement Addendum (cgsmedicare.com)



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HOSPICE QUALITY REPORTING PROGRAM (HQRP)

Hospice Public Reporting: Background and Announcements | CMS

Provider and Stakeholder Engagement | CMS

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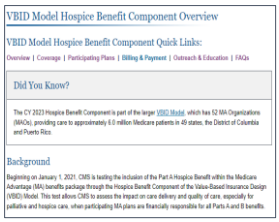
VBID Model Hospice Benefit Component Overview | CMS Innovation Center



Value-Based Insurance Design (VBID) Model Hospice Component (cgsmedicare.com)

The week of September 5, Innovation.cms.gov will be archived and no longer updated. All materials will be available on CMS.gov under Priorities
Visit beta.cms.gov to preview the site and share your feedback.

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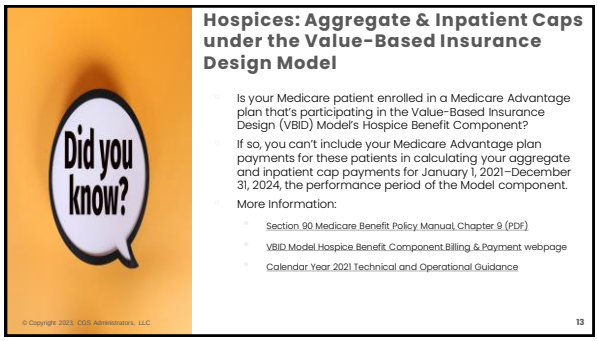

Hospices: Aggregate & Inpatient Caps under the Value-Based Insurance Design Model

- Is your Medicare patient enrolled in a Medicare Advantage plan that's participating in the Value-Based Insurance Design (VBID) Model's Hospice Benefit Component?
- If so, you can't include your Medicare Advantage plan payments for these patients in calculating your aggregate and inpatient cap payments for January 1, 2021–December 31, 2024, the performance period of the Model component.
- More Information:
  - Section 90 Medicare Benefit Policy Manual Chapter 9 (PDF)
  - VBID Model Hospice Benefit Component Billing & Payment webpage
  - Calendar Year 2021 Technical and Operational Guidance

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Data Analytics

Month	# of HH Claims Submitted	Total # of HH CSEs	HH CSE Error Rate	Sept 2022-Aug 2023 # of Hospice Claims Submitted	Total # of Hospice CSEs	Hospice CSE Error Rate	# of HH+H Claims Submitted	Total # of HH+H CSEs	HH+H CSE Error Rate
Sep-22	134,934	28,702	21.27%	94,716	11,462	12.10%	**229,650**	**40,164**	**17.49%**
Oct-22	137,960	29,448	21.35%	97,112	13,278	13.67%	**235,072**	**42,726**	**18.18%**
Nov-22	134,551	23,910	17.77%	96,095	13,770	14.33%	**230,646**	**37,680**	**16.34%**
Dec-22	134,876	25,301	18.76%	97,999	13,385	13.66%	**232,875**	**38,686**	**16.61%**
Jan-23	139,230	33,497	24.06%	102,263	12,610	12.33%	**241,493**	**46,107**	**19.09%**
Feb-23	128,733	30,644	23.80%	97,445	12,377	12.70%	**226,178**	**43,021**	**19.02%**
Mar-23	143,945	54,738	38.03%	102,391	26,652	26.03%	**246,336**	**81,390**	**33.04%**
Apr-23	121,839	21,833	17.92%	95,479	12,296	12.88%	**217,318**	**34,129**	**15.70%**
May-23	130,147	24,338	18.70%	98,563	12,205	12.38%	**228,710**	**36,543**	**15.98%**
Jun-23	128,780	24,273	18.85%	99,173	12,831	12.94%	**227,953**	**37,104**	**16.28%**
Jul-23	116,038	20,991	18.09%	94,956	12,894	13.58%	**210,994**	**33,885**	**16.06%**
Total	**1,451,033**	**317,675**	**21.89%**	**1,076,192**	**153,760**	**14.29%**	**2,527,225**	**471,435**	**18.65%**

Common Claim Submission Errors (CSEs)

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CGS Billing Errors – Hospice 9/2022 – 7/2023

Reason Code	Billing Error	# of Errors
37402	Hospice sequential billing error	21,883
38200	Duplicate claim	11,470
U523A	Patient enrolled in VBID	11,268
U5106	NOE falls within current hospice election	9,603
U5181	Occ cd 27 required when certification date falls w/in DOS	7,250

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CGS Billing Errors – Hospice– Missouri 9/2022 – 7/2023

Reason Code	Billing Error	# of Errors
37402	Hospice sequential billing error	3,942
38200	Duplicate claim	3,121
31689	Medicare Secondary Payer (MSP) claim issue w/ paid amount	2,795
U5106	NOE falls within current hospice election	1,956
U5181	Occ cd 27 required when certification date falls w/in DOS	1,664

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TOP CLAIM SUBMISSION ERRORS WEBPAGE

Hospice Top CSEs	Short Narrative
37402	Hospice sequential billing error
38200	Duplicate claim
U5106	NOE falls within current hospice election
U5181	Occurrence code 27 required when certification date falls within dates of service
34952	Service facility NPI not included
U523A	The dates of service on this claim are during both a Hospice election period and Medicare Advantage Plan Period that is Value-Based Insurance Design (VBID) Model. No resolution is required by providers. Refer to the U523A Reason Code Search and Resolution information for details.
39929	The hospice claim was rejected due to an untimely Notice of Election (NOE)
U5194	Hospice claim received for untimely NOE & occurrence span code 77 is missing or invalid
31605	The dates of services on the claim cannot be within the span code 77 dates unless the charges are non-covered
31503	The total units on the level of care lines (0651, 0652, 0655, 0656) do not equal the number of days in the billing period.

Reason Code Search and Resolution

For information about other reason codes, refer to the Reason Code Search and Resolution Web page. Note that this resource does no include a complete list of reason codes, just the most frequent.

https://www.cgsmedicare.com/hhh/education/materials/cses.html

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CGS HH&H Web page

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

CPIL CLAIMS PROCESSING ISSUES LOG

POE CALENDAR OF EVENTS

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Claims Processing Issues Log (CPIL)

Claims Processing Issues Log (cgsmedicare.com)

Date Reported	Description of Issue
08.08.2023	Some home health claims returned to the provider (RTP'd) with reason code 32103 due to an NPI Crosswalk issue. This issue occurs when an historical termination date is incorrectly applied in FISS after an application finalizes in PECOS under a current, active enrollment record.
08.02.2023	Home Health claims returned to provider (RTP'd) with reason code W7072 in error
08.01.2023	Some HH Claims Receiving Reason Code 16963 in Error
07.17.2023	Hospice Reason Code W7048 Revenue Codes Without HCPCS Codes
03.29.2023	Service Intensity Add-On (SIA) Payments Not Applying to Previous Month
02.24.2023	Some Home Health (329) claims with Condition Code 47 received Reason Code U538F
01.11.2023	Some Home Health Claims Editing for Reason Code 31755
08.02.2022	Home Health claims submitted with condition code DR (disaster related) during the COVID-19 public health emergency that are not matched to a corresponding OASIS assessment in iQIES cannot finalize.

- HHH Resolved Issues

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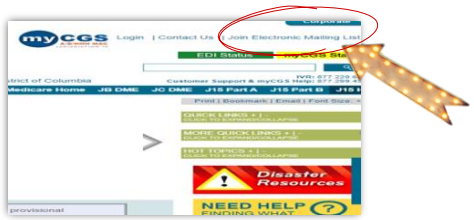
ARE YOU SIGNED UP FOR LISTSERV?



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TARGETED PROBE & EDUCATE

Katie Monzel, RN, BSN
Senior Provider Education Consultant
CGS Provider Outreach & Education

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OBJECTIVES

- Define Targeted Probe & Educate (TPE)
- Review the TPE Process
- Provide Resources and CMS guidelines to Facilitate Appropriate Reimbursement

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WHAT IS TARGETED PROBE & EDUCATE (TPE)?

TPE Defined:

- **Targeted Probe** – Focus on specific providers that bill a particular item or service deemed a 'risk' or 'variance' by data analysis
- **Educate** – Targeted probe findings given as individualized reviews and one-on-one education from MACs to providers

Increased Education

Decreased Denials

TPE Intent:

Collaborative approach to reduce claim denials and appeals by increasing knowledge and improving accuracy

GOAL: Help providers quickly improve and prevent denials

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TPE PROCESS - SELECTION

TPE Selection Edits

Data Analysis

- New Providers
- High Claim Denial Rates
- Significant Variance in Billing Practices from Peers
- Error Rate Results

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TPE - CGS
myCGS TPE Edits:
Home Health and Hospice Medical Review Activity Log
Medical Review
Medical Review
Targeted Probe and Educate (TPE) Process
Complex Medical Reviews
Fact Sheets
Medical Policies / LCDs
Medical Review Contractors
MR Activities
Laws and Publications
Postpayment Review
Probe Medical Reviews
Provider 360 (P360)
Signatures
Top Provider Questions – Evaluation & Management
Top Provider Questions – Medical Review
MR Activities
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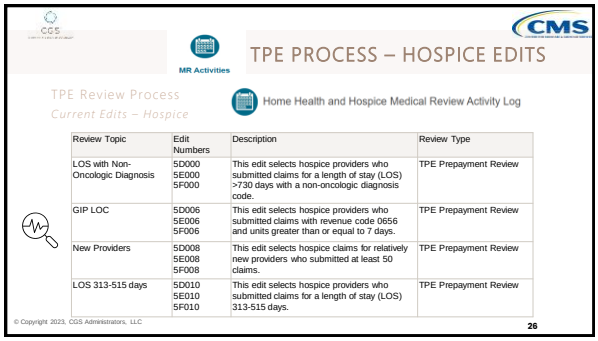
MR Activities
TPE PROCESS – HOSPICE EDITS
TPE Review Process
Current Edits – Hospice
Home Health and Hospice Medical Review Activity Log
Review Topic
Edit Numbers
Description
Review Type
LOS with Non-Oncologic Diagnosis
5D000 5E000 5F000
This edit selects hospice providers who submitted claims for a length of stay (LOS) >730 days with a non-oncologic diagnosis code.
TPE Prepayment Review
GIP LOC
5D006 5E006 5F006
This edit selects hospice providers who submitted claims with revenue code 0656 and units greater than or equal to 7 days.
TPE Prepayment Review
New Providers
5D008 5E008 5F008
This edit selects hospice claims for relatively new providers who submitted at least 50 claims.
TPE Prepayment Review
LOS 313-515 days
5D010 5E010 5F010
This edit selects hospice providers who submitted claims for a length of stay (LOS) 313-515 days.
TPE Prepayment Review
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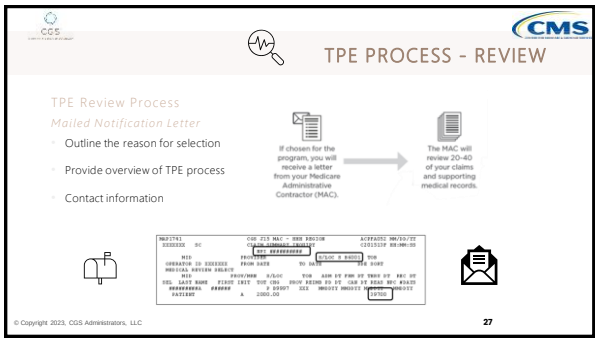
TPE PROCESS - REVIEW
TPE Review Process
Mailed Notification Letter
Outline the reason for selection
Provide overview of TPE process
Contact information
If chosen for the program, you will receive a letter from your Medicare Administrative Contractor (MAC).
The MAC will review 20-40 of your claims and supporting medical records.
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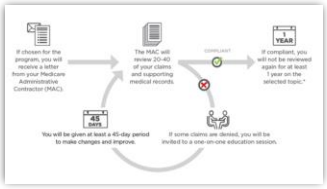
TPE PROCESS - REVIEW

TPE Review Process

Round One

- Review of 20-40 claims per provider/supplier, per item or service
- Required Additional Documentation Requests (ADRs)
- Error Rate Determined
  - No response to ADRs counts as an error when calculating the error rate



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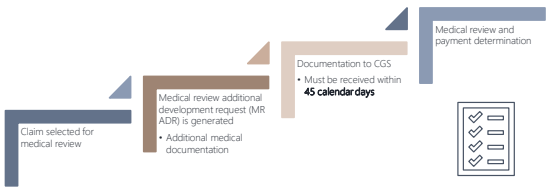
WHAT IS AN MR ADR?



CGS Home Health and Hospice Medical Review Web page
https://www.cgsmedicare.com/hhh/medreview/index.html

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Additional Documentation Requests

Length: 2:30

Course Summary: If a claim is selected for medical review, your Medicare Administrative Contractor (MAC) will request additional documentation from you to ensure payment is appropriate. When this happens, the medical review department at CGS will issue you an additional document request (ADR) with information it needs to continue processing the claim. In this video, you will learn the fundamentals of responding to an ADR, including ways to check for ADRs and tips for responding on time.

Date Recorded: 03.17.23

Additional Documentation Requests - YouTube

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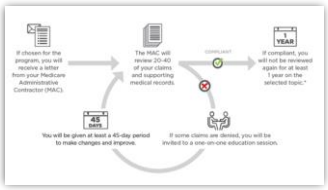
REACHING THE TPE GOAL - IMPROVEMENT

TPE Review Process

Compliant or Additional Rounds

- <25% Dollars Denied Error Rate
- 45-56 Day Improvement Period before next round of Review
- Up to Three Rounds of Review



J15HHProbeandEducation@cgsadmin.com

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TPE GOAL – MEETING THRESHOLDS

Round Results Letter

- Claims Reviewed
- Total Claims Paid
- Total Claims Denied/Reduced
- Total of nonresponse claims
- **Error rate (based on $ denied)**
- Claims Error Rate (based on number of claims)

3rd Round Threshold

This should not be a concern for most providers.

The majority that have participated in the TPE process increased the accuracy of their claims. However, any problems that fail to improve after 3 rounds of education sessions will be referred to CMS for next steps. If you did not meet the compliance threshold for Round Three, you will be referred to CMS for the next steps.

- 100% Pre-Pay Review
- Extrapolation of the % Denied and Payback
- Referral to a Recovery Auditor (ZPIC, UPIC, etc.)
- Other actions as required

Providers may submit questions or request education via the home health and hospice TPE email box: J15HHProbeandEducation@cgsadmin.com

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TPE GOAL – ADR PREPAREDNESS

myCGS ADR Checklists:

Hospice ADR Checklist – Preferred Order	Home Health ADR Checklist – Preferred Order
1.ADR letter (or FISS Page 07 screen print) and Contact Form 2.Signed election statement • Addendum(s) (as applicable) 3.Plan of care with physician certification/recertifications 4.Physician Face-to-Face documentation (for third and later benefit periods) 5.Physician orders 6.IDG reviews/POC updates **Note:** include reviews for each 15-day period to cover the billing period. This may include reviews/updates that occurred prior to the billing period. 7.Initial assessment for billing period 8.Visit notes (nursing, social worker, chaplain, etc.) 9.Physician visit notes 10.Other relevant documentation • Admission assessment	1.ADR letter (or FISS Page 07 screen print) and Contact Form 2.Physician or allowed practitioner Face-to-Face documentation • Actual encounter note or progress note • Discharge summary from inpatient stay 3.Plan of care with physician or allowed practitioner certification/recertification • If recertification, include initial certification and plan of care 4.Interim/verbal orders 5.OASIS assessment 6.Nursing visit notes 7.Therapy visit notes including evaluations/re-evaluations 8.Social work visit notes 9.Aide visit notes 10.Other relevant documentation • Any other acute/post-acute care documentation to support home health eligibility.

https://www.cgsmedicare.com/hhh/medreview/adr_process.html > myCGS step-by-step guide!

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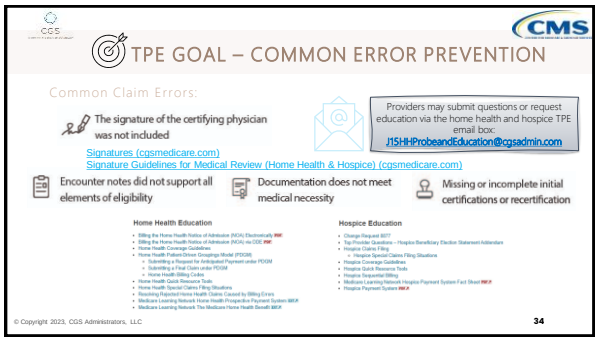
TPE GOAL – COMMON ERROR PREVENTION
Common Claim Errors:
The signature of the certifying physician was not included
Signatures (cgsmedicare.com)
Signature Guidelines for Medical Review (Home Health & Hospice) (cgsmedicare.com)
Providers may submit questions or request education via the home health and hospice TPE email box:
J15HHProbeandEducation@cgsadmin.com
Encounter notes did not support all elements of eligibility
Documentation does not meet medical necessity
Missing or incomplete initial certifications or recertification
Home Health Education
Hospice Education
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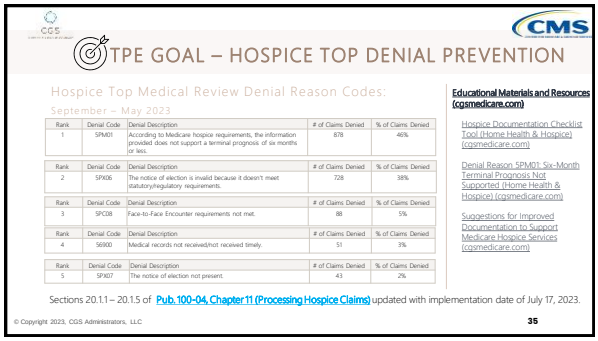
TPE GOAL – HOSPICE TOP DENIAL PREVENTION
Hospice Top Medical Review Denial Reason Codes:
September – May 2023
Rank | Denial Code | Denial Description | # of Claims Denied | % of Claims Denied
1 | SPM01 | According to Medicare hospice requirements, the information provided does not support a terminal prognosis of six months or less. | 878 | 46%
2 | SPX06 | The notice of election is invalid because it doesn't meet statutory/regulatory requirements. | 728 | 38%
3 | SPC08 | Face-to-Face Encounter requirements not met. | 88 | 5%
4 | S6900 | Medical records not received/not received timely. | 51 | 3%
5 | SP107 | The notice of election not present. | 43 | 2%
Educational Materials and Resources (cgsmedicare.com)
Hospice Documentation Checklist Tool (Home Health & Hospice) (cgsmedicare.com)
Denial Reason SPM01: Six-Month Terminal Prognosis Not Supported (Home Health & Hospice) (cgsmedicare.com)
Suggestions for Improved Documentation to Support Medicare Hospice Services (cgsmedicare.com)
Sections 20.1.1 – 20.1.5 of Pub. 100-04, Chapter 11 (Processing Hospice Claims) updated with implementation date of July 17, 2023.
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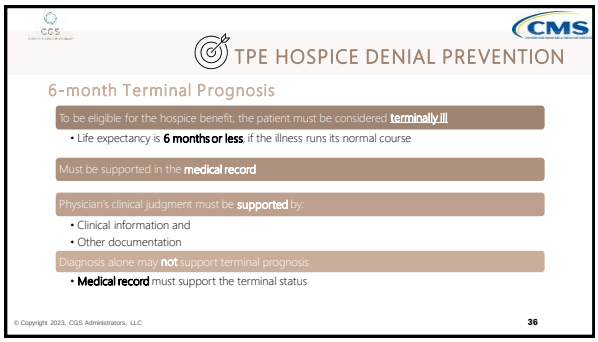
TPE HOSPICE DENIAL PREVENTION
6-month Terminal Prognosis
To be eligible for the hospice benefit, the patient must be considered terminally ill
• Life expectancy is 6 months or less, if the illness runs its normal course
Must be supported in the medical record
Physician's clinical judgment must be supported by:
• Clinical information and
• Other documentation
Diagnosis alone may not support terminal prognosis
• Medical record must support the terminal status
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TPE HOSPICE DENIAL PREVENTION

6-month Terminal Prognosis
Chronic vs Terminal

Chronically Ill
- Slowly declining disease process
- May require assistance with activities of daily living
- Can live several years as their body fails

Terminally Ill
- Disease progression significantly declining
- Trajectory of progression provides prognosis of a life expectancy of less than six months

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TPE HOSPICE DENIAL PREVENTION

6-month Terminal Prognosis
Documentation

- Be specific to that individual patient
- Document what distinguishes the patient as terminal and not chronic
- Have narrative notes to explain information noted on a checklist - use comment sections
- Distinguish between exacerbation with stabilization and exacerbation with deterioration
- Compare current to previous
- Exacerbation and resulting decline/deterioration
- Purpose and need for aggressive palliative treatments

Documentation Opportunities:
- *Appears to be losing weight*
- *Ate 50% of meal*
- *Shows "slow decline"*
- *"Stable"*
- *"Eating well"*

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TPE HOSPICE DENIAL PREVENTION

6-month Terminal Prognosis
Nursing Documentation

Typical Nursing Documentation
- Focus on identification of issues, creation of care plans based on findings and implementation of interventions and treatment plans in an effort to optimize health and achieve goals

Hospice Nursing Documentation
- Focus on patient deterioration and decline
- Good objective data
- Must support CTI that the patient has a life expectancy <6 months

Documentation Opportunities:
- *Appears to be losing weight*
- *Ate 50% of meal*
- *Shows "slow decline"*
- *"Stable"*
- *"Eating well"*

Strong Documentation:
- *Weight 142 lbs from 152 lbs at admission*
- *Intake variable, from 25-75% of meals*
- *Increased dyspnea/pain over past 2 weeks - now oxygen dependent 2L NC*

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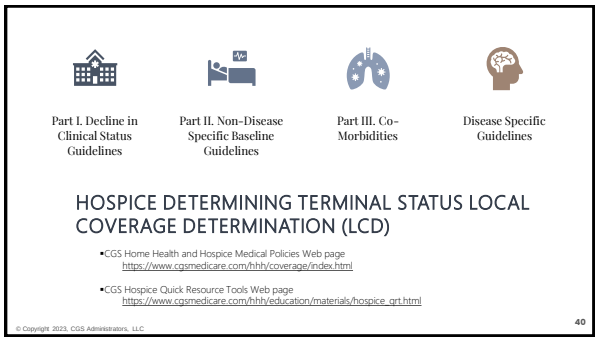
Part I. Decline in Clinical Status Guidelines
Part II. Non-Disease Specific Baseline Guidelines
Part III. Co-Morbidities
Disease Specific Guidelines
HOSPICE DETERMINING TERMINAL STATUS LOCAL COVERAGE DETERMINATION (LCD)
CGS Home Health and Hospice Medical Policies Web page
https://www.cgsmedicare.com/hhh/coverage/index.html
CGS Hospice Quick Resource Tools Web page
https://www.cgsmedicare.com/hhh/education/materials/hospice_qrt.html
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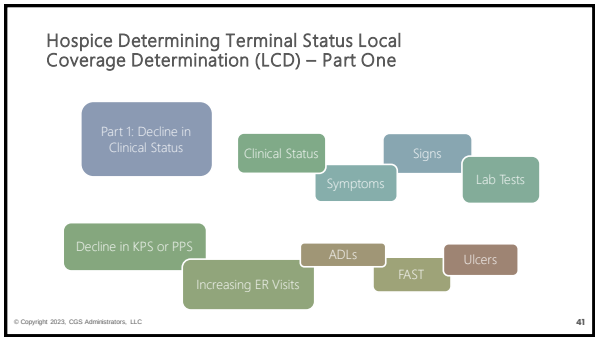
Hospice Determining Terminal Status Local Coverage Determination (LCD) – Part One
Part 1: Decline in Clinical Status
Clinical Status
Signs
Symptoms
Lab Tests
Decline in KPS or PPS
ADLs
Ulcers
FAST
Increasing ER Visits
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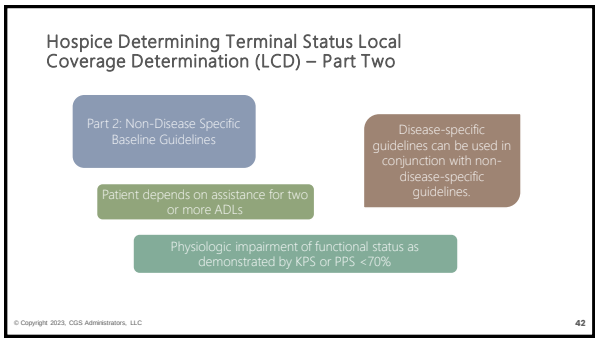
Hospice Determining Terminal Status Local Coverage Determination (LCD) – Part Two
Part 2: Non-Disease Specific Baseline Guidelines
Disease-specific guidelines can be used in conjunction with non-disease-specific guidelines.
Patient depends on assistance for two or more ADLs
Physiologic impairment of functional status as demonstrated by KPS or PPS <70%
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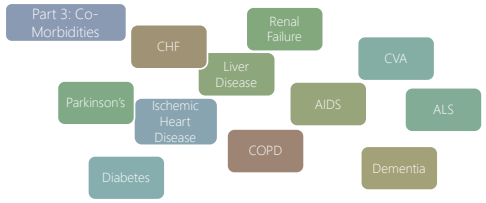
Hospice Determining Terminal Status Local Coverage Determination (LCD) – Part Three



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Common End of Life Symptoms

- Pain
- Nausea / Vomiting
- Anxiety and Depression
- Constipation and Diarrhea
- Insomnia
- Agitation, Psychosis, Delirium
- Fluid Retention
- Appetite Loss
- Infections
- Oral / Pharyngeal Secretions
- Fatigue
- Dyspnea
- Wounds & Decubitus Ulcers
- Dyspepsia

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Assessment Information to Support a Terminal Prognosis

- Vital Signs and Measurements
  - Respirations, blood pressure, pulse, temperature, pain, O2 saturation
  - Weight, L/R MAC, Abdominal Girth
  - Intake/Output
  - KPS/PPS/FAST/NYHA
    - Graphs easily illustrate change
- Skin Integrity
  - Stage 3 or 4 pressure ulcers
- Increase ADL dependence
  - Feeding
  - Ambulation
  - Continence
  - Transfer
  - Bathing
  - Dressing
- Recurrent/intractable Infection(s)
  - Pneumonia
  - Sepsis
  - Pyelonephritis or other upper urinary tract infection
  - Fever, recurrent after antibiotics
- Changes to plan of care
  - Medication adjustments
- Lab results (when available)
  - Arterial blood gases/pulse oximetry
  - CBC
  - Electrolyte balance
  - Metabolic studies
  - Prealbumin, albumin or cholesterol
  - Tumor markers
- Lucidity and Responsiveness
  - Agitation
  - Level of consciousness

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General Inpatient Care (GIP)

Beneficiary's medical condition warrants a short-term inpatient stay for pain control or symptom management that ***cannot feasibly be provided in other settings***

- ❑ Medication adjustment, observation, treatment to stabilize patient
- ❑ Intensity of care that cannot feasibly be managed in any other setting
- ❑ Services must conform with the written plan of care
- ❑ May only be provided in Medicare participating facilities
  - Hospital
  - Skilled nursing facility (SNF)
  - Hospice inpatient facility

Upon transfer to GIP level of care documentation should include both:

- ❑ A precipitating event (onset of uncontrolled symptoms or pain)
- ❑ The interventions tried in the home that have been unsuccessful at controlling the symptoms

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Documenting the Need for GIP Care

Symptom Changes

- Uncontrolled pain
- Sudden deterioration
- Uncontrolled nausea and/or vomiting
- Pathological fractures
- Unmanageable respiratory distress
- Frequent, skilled wound care
- New or increased delirium and/or agitation

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Documenting the Need for GIP Care

Pain Control

- Requiring skills of a nurse (including teaching)
- Frequent evaluation
- Frequent medication adjustment
- Aggressive treatment to control pain

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Documenting the Need for GIP Care

Other Reasons

- Medication adjustment
- Observation
- Stabilizing treatment
- Psycho-social monitoring

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POTENTIAL ISSUES WITH GIP DOCUMENTATION

- Long stays
- Inappropriate use
- No discharge planning
- Documentation not supporting GIP level of care
- Location does NOT determine level of care

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Inappropriate Use of GIP Care

- ☒ For routine admission and care plan formation
- ☒ Ongoing assessment of managed symptoms
- ☒ No available caregiver for in-home care/caregiver relief
- ☒ General fall risk and/or supervision need
- ☒ A patient in the dying process does NOT make the patient eligible
- ☒ An inpatient unit is NOT an automatic step down from the hospital

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TPE RESOURCES

- **Medicare Benefit Policy Manual (CMS Pub. 100-02, Ch. 9)**
  https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c09.pdf
- **CMS Targeted Probe and Educate Webpage**
  https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Targeted-Probe-and-EducateTPE
- **CMS Targeted Probe and Educate (TPE) Q&As**
  https://www.cms.gov/files/document/updated-tpe-qas.pdf
- **CMS Additional Documentation Request Webpage**
  https://www.cms.gov/research-statistics-data-systems/medicare-fee-service-compliance-programs/medical-review-and-education/additional-documentation-request
- **CGS Educational Materials & Resources Webpage**
  https://cgsmedicare.com/hhh/education/materials/index.html
- **CGS TPE Webpage**
  https://cgsmedicare.com/hhh/medreview/process.html
- **CGS HH&H FAQs**
  https://cgsmedicare.com/medicare_dynamic/faqs/faqshhh/j15hhh.aspx
- **CGS Home Health and Hospice Medical Review Activity Log**
  https://cgsmedicare.com/hhh/medreview/activitylog.html
- **CGS Data Analysis Webpage**
  https://cgsmedicare.com/hhh/education/data.html
- **CGS FISS DDE User Manual**
  https://www.cgsmedicare.com/fiss/index.html
- **CGS J15 Webpage**
  https://www.cgsmedicare.com/hhh/index.html
- **CGS Fact Sheets & Resources**
  https://www.cgsmedicare.com/hhh/medreview/fact_sheets.html
- **CGS Self-Service Options**
  https://www.cgsmedicare.com/hhh/tools/index.html
- **CGS Educational Resources**
  https://www.cgsmedicare.com/hhh/education/resources.html

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CGS IS JUST A CLICK AWAY!

https://www.cgsmedicare.com/email.html

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THANK YOU!

CGS Provider Contact Center: 1.877.299.4500

- **Option 1: Customer Service**
- **Option 2: Electronic Data Interchange (EDI)**
- **Option 3: Provider Enrollment (PE)**
- **Option 4: Overpayment Recovery (OPR)**

POE Mailbox: J15_HHH_Education@cgsadmin.com

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