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- 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.
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Learning Outcomes

Upon completing this session, participants will be able to:

1. Understand Hospice billing requirements & guidelines
2. Analyze data to improve provider reimbursement
3. Locate CGS and CMS website resources & self-service tools

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Billing Update

JIS Provider Outreach & Education
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FY 2025 Hospice Final Rule

https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/hospice-center

https://public-inspection.federalregister.gov/2024-16910.pdf

Effective Date: 10/1/2024

CMS-1810-F

Regulation No. CMS-1810-F

Title FY 2025 Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Upda Hospice Quality Reporting Program Requirements

Display Date 2024-07-30

Publication Date 2024-08-06

The final rule went on display at the Office of the Federal Register's Public Inspection Desk on July 30, 2024 and will be available until the regulation is published on August 6, 2024. See CMS-1810-F in the "Related Links" section below.

Downloads

FY 2025 Final Hospice Wage Index

Related Links

CMS-1810-F

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Medicare Hospice Payment Policies

Rule finalizes policy to adopt most recent Office of Management and Budget (OMB) statistical area delineations, which revise existing core-based statistical areas (CBSA) based on data collected during the 2020 Decennial Census.

- https://www.cms.gov/medicare/payment/fee-service-providers/hospice/hospice-wage-index/fy-2025-final-hospice-wage-index

Hospices negatively affected by the change to their geographic wage index will only experience a maximum 5% reduction to their 2024 wage index, as there is a 5% cap on any decrease to the wage index from the prior year.

- This permanent cap, finalized in the FY 2023 Hospice Final Rule, prevents a geographic area's wage index from falling below 95% of its wage index calculated in the prior FY.

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FY 2025 Routine Annual Rate Setting Changes

The FY 2025 hospice payment update percentage is 2.9% (an estimated increase of $790 million in payments from FY 2024).

The FY 2025 payment rates for hospices that do not submit the required quality data would reflect the finalized FY 2025 hospice payment update percentage of 2.9%, minus four percentage points, which results in a -1.1% update.

The hospice payment update includes a statutory aggregate cap that limits the overall payments per individual that may be made annually to a hospice. The finalized hospice cap amount for FY 2025 is $34,465.34 (FY 2024 cap amount of $33,494.01, increased by the FY 2025 hospice payment update percentage of 2.9%).

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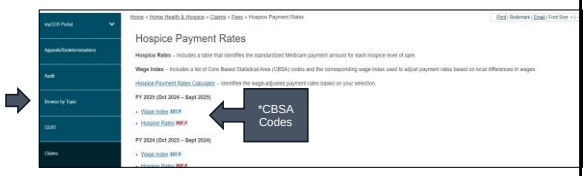
Where Can I Find Hospice Payment Rates?



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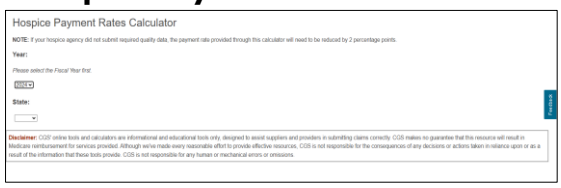
Hospice Payment Calculator



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Hospice Outcome and Patient Evaluation (HOPE)

- The rule also adopts and implements the HOPE patient-level data collection tool, beginning with FY 2025, and functionally replaces, upon implementation, the existing Hospice Item Set (HIS) structure.
  - Expected to be available October 1, 2025
- HOPE will collect data at multiple time points across the hospice stay, including admission, the HOPE Update Visit (HUV), and discharge. Compared to the HIS (which only collects data at hospice admission and discharge), HOPE will enable CMS to gather patient-level data during their hospice stay to improve patient quality of care. In addition, HOPE includes several domains that are new or expanded relative to HIS, including:
  - Sociodemographic (updated)
  - Diagnoses (expanded)
  - Symptom Impact Assessment
  - Skin Conditions
  - Imminent death

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New CMS HOPE Video

CMS is offering a 4-minute, animated explainer video for hospice providers.

This video describes HOPE, the timepoints, their data collection timeframes, and introduces the symptom follow-up visit (SFV), if triggered during a HOPE timepoint.

HOPE data collection will be required for the Hospice Quality Reporting Program (HQRP) beginning on October 1, 2025 (FY 2026)

HOPE Data Collection Timepoints Explainer Video – YouTube

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Hospice Quality Reporting Program (HQRP)

- Rule finalizes two new process measures to HQRP, expected to begin in FY 2028.
  - *Timely Follow-up for Pain Impact*
  - *Timely Follow-up for Non-Pain Symptom Impact*
- Reporting of these two measures would be through the new HOPE instrument.
- These process measures address hospice care delivery as they document whether a follow-up visit occurred within 48 hours of an initial assessment where there was an impact of moderate or severe symptoms with and without pain.

https://www.cms.gov/medicare/quality/hospice

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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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Did You Know?

Notice of Election: Commonly known as the NOE – billing transaction

Election Statement: To receive hospice services under the Medicare Hospice Benefit, the patient (or authorized representative) must elect hospice care by signing an election statement.

https://cgsmedicare.com/hhh/coverage/coverage_guidelines/election_requirements.html

Additionally, CMS is proposing regulation text changes related to clarify the requirements related to the election statement and NOE in the CoPs. These regulation text changes do not change current policy but are intended to reorganize and more clearly distinguish the separate requirements for the "election statement" and the NOE.

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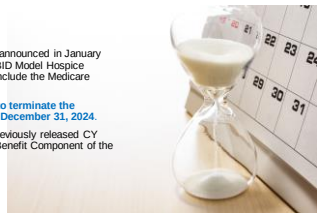
Value Based Insurance Design (VBID) – Hospice Benefit Component End Date

- **Hospice Benefit Component**
- The Centers for Medicare & Medicaid Services announced in January 2019 that beginning in CY 2021, through the VBID Model Hospice Benefit Component, participating MAOs could include the Medicare hospice benefit in their Part A benefits package.
- After careful consideration, **CMS has decided to terminate the Hospice Benefit Component as of 11:59 PM, December 31, 2024**.
- CMS will not be accepting applications to the previously released CY 2025 Request for Applications for the Hospice Benefit Component of the VBID Model.



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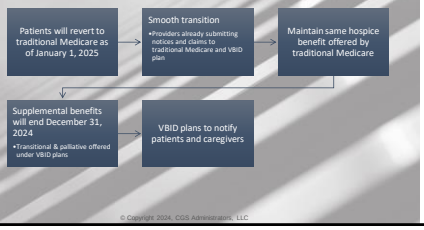
VBID Transition



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VBID Model Hospice Benefit Component Overview | CMS Innovation Center

CY2024 VBID-Hospice Technical and Operational Guidance (cms.gov)

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Hospice Certifying Physician Enrollment – Background Info

- "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."

- 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.

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Reason Code 17729

- **Subject**
  Effective June 3, 2024, (delayed from May 1, 2024), for claim "from" dates on or after this date, CMS implemented edits to enforce a new rule that would deny hospice claims if the certifying physician entered in the **Attending** field on the claim is not in the Provider Enrollment Chain and Ownership System (PECOS) as an enrolled or opted-out physician.

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Reason Code 17729 Description

The attending physician's National Provider Identifier (NPI) data on the claim does not match the PECOS Enrolled Physicians File, or the dates do not fall within the physicians effective/termination dates.

- This reason code will edit the claim's attending physician's NPI data against the PECOS Enrolled Physicians File for hospice claims, type of bill 81X and 82X (excluding 8XA, 8XB, 8XC, 8XD and 8XE) with a statement "from" date on or after June 3, 2024, and will assign when:
  - Occurrence Code 27 and associated date (hospice certification or recertification date) are present, and the Occurrence Code 27 date does not fall on or after the physician's effective date but before the termination date on the PECOS Enrolled Physicians File
  - Occurrence Code 27 and associated date are not present and the claim statement "from" date is not on or after the physician's effective date but before the termination date
  - The attending physician's NPI and/or the first four characters of the physician's last name does not match the NPI and/or the first four characters of the physician's last name

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Reason Code 17729 Resolution

The CMS Order and Referring Dataset provides information on all physicians, as well as nurse practitioners (NPs) or physician assistants (PAs) by their NPI, who are of a type/specialty that is legally eligible to order, certify and refer in the Medicare program and who have current enrollment records in Medicare. Check the dataset to ensure the attending physician entered on the claim is:

- Listed on the CMS Order and Referring Dataset with a "Y" in the hospice column. If the physician has an "N" in the hospice column, they are not eligible to certify for hospice and the claim cannot be approved for payment.
- Their NPI is correct
- Their first four (4) characters of their last name exactly matches the dataset. Ensure the first and last name are not entered in reverse on the claim.

- For initial benefit periods, complete the **Attending Physician** and **Other** fields (with the hospice certifying physician listed in the latter field) unless the patient's designated attending physician is the same as the hospice physician certifying the terminal illness
  - When the attending physician is also the hospice certifying physician, only populate the **Attending Physician** field
- For subsequent benefit periods, the hospice certifying physician may be listed in the claim's **Attending Physician** field to avoid this denial
  - Leave the **Other** field blank

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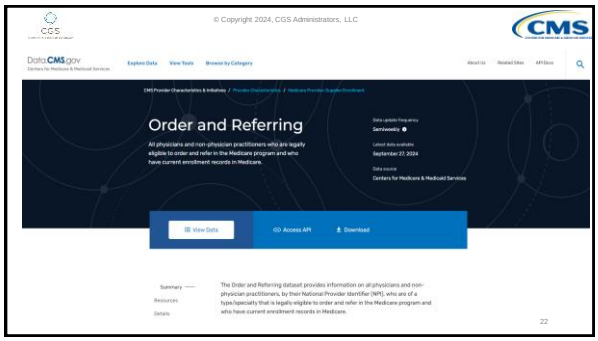
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Data.CMS.gov
Explore Data
View Tools
Browse by Category
About Us
Related Sites
API Docs
Order and Referring
All physicians and non-physician practitioners who are legally eligible to order and refer in the Medicare program and who have current enrollment records in Medicare.
Data update frequency
Semiweekly
Latest data available
September 27, 2024
Data source
Centers for Medicare & Medicaid Services
View Data
Access API
Download
Summary
Resources
Details
The Order and Referring dataset provides information on all physicians and non-physician practitioners, by their National Provider Identifier (NPI), who are of a type/specialty that is legally eligible to order and refer in the Medicare program and who have current enrollment records in Medicare.
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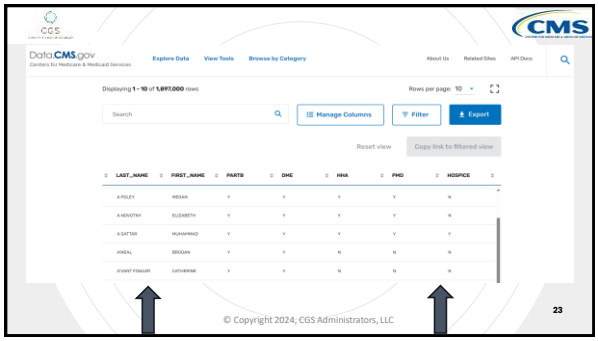
Data.CMS.gov
Explore Data
View Tools
Browse by Category
About Us
Related Sites
API Docs
Displaying 1 – 10 of 1,897,000 rows
Rows per page: 10
Search
Manage Columns
Filter
Export
Reset view
Copy link to filtered view
LAST_NAME
FIRST_NAME
PARTB
DME
HHA
PMD
HOSPICE
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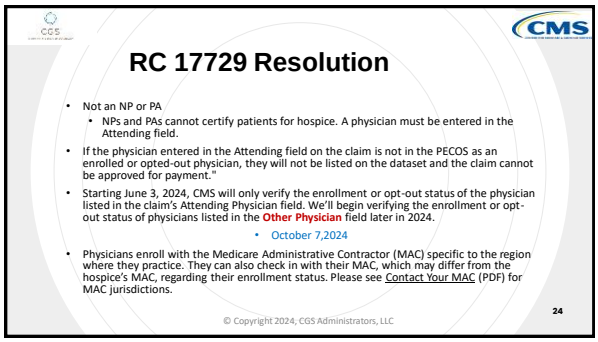
RC 17729 Resolution
Not an NP or PA
NPs and PAs cannot certify patients for hospice. A physician must be entered in the Attending field.
If the physician entered in the Attending field on the claim is not in the PECOS as an enrolled or opted-out physician, they will not be listed on the dataset and the claim cannot be approved for payment."
Starting June 3, 2024, CMS will only verify the enrollment or opt-out status of the physician listed in the claim's Attending Physician field. We'll begin verifying the enrollment or opt-out status of physicians listed in the Other Physician field later in 2024.
October 7,2024
Physicians enroll with the Medicare Administrative Contractor (MAC) specific to the region where they practice. They can also check in with their MAC, which may differ from the hospice's MAC, regarding their enrollment status. Please see Contact Your MAC (PDF) for MAC jurisdictions.
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Reason Code 17729 (Resolution)

Correction Process

1. Medicare HHH Reopening Adjustment Request Form, Medicare HHH Reopenings Adjustment Request Form (Home Health & Hospice) (cgsmedicare.com)
2. Adjustment Claim on hardcopy UB-04 claim form, with appropriate NPI and physician name, and necessary adjustment coding, Adjustments/Cancels (cgsmedicare.com).

Condition code

Document Control number (DCN) – **NOTE:** To determine the correct DCN to report on your adjustment, select the denied claim. Go to Page 02 and press F2. The DCN of the claim will appear in the upper left corner in the "DCN" field.

Remarks

Reopenings (cgsmedicare.com)

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Reason Code 17729 Resources

- https://www.cms.gov/files/document/hospice-certifying-enrollment-faqs.pdf
- https://www.cms.gov/files/document/mm13531-hospice-claims-edits-certifying-physicians.pdf
- https://cgsmedicare.com/hhh/pubs/news/2024/06/cope158325.html
- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/html/medicare-payment-systems.html
  - see "Certification Requirements" under the "Hospice Payment System and Coverage" topic

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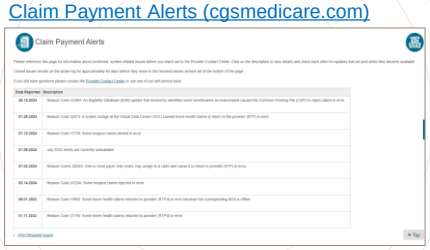
Claim Payment Alerts

Claim Payment Alerts (cgsmedicare.com)



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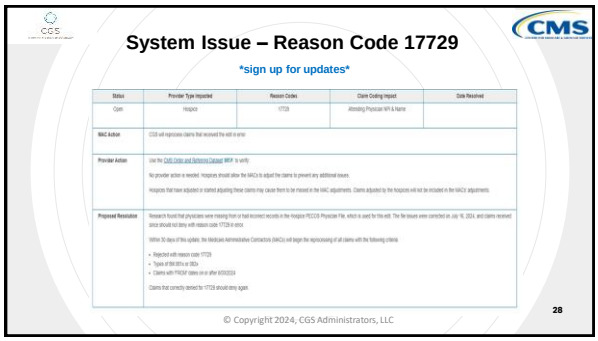
System Issue – Reason Code 17729
sign up for updates
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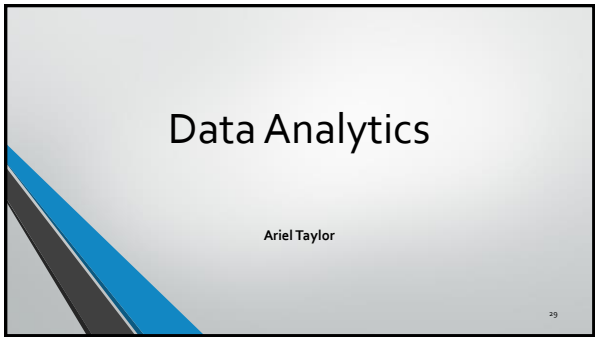
Data Analytics
Ariel Taylor
29

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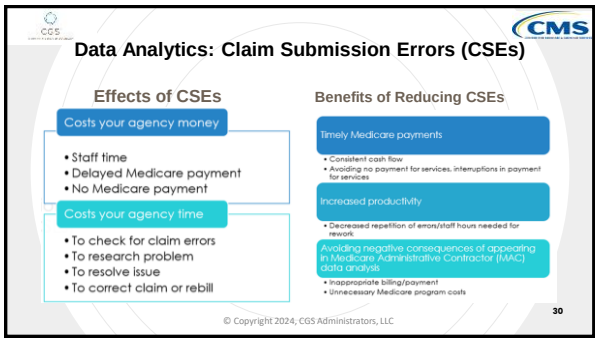
Data Analytics: Claim Submission Errors (CSEs)
Effects of CSEs
Costs your agency money
• Staff time
• Delayed Medicare payment
• No Medicare payment
Costs your agency time
• To check for claim errors
• To research problem
• To resolve issue
• To correct claim or rebill
Benefits of Reducing CSEs
Timely Medicare payments
• Consistent cash flow
• Avoiding no payment for services, interruptions in payment for services
Increased productivity
• Decreased repetition of errors/staff hours needed for rework
Avoiding negative consequences of appearing in Medicare Administrative Contractor (MAC) data analysis
• Inappropriate billing/payment
• Unnecessary Medicare program costs
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Claim Submission Error (CSE) Rate

Sept 2023-May 2024

Month	# of HH Claims Submitted	Total # of HH CSEs	HH CSE Error Rate	# 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-23	112,210	20,085	17.90%	95,634	11,375	11.97%	207,244	31,460	15.18%
Oct-23	118,827	20,912	17.60%	96,909	11,831	12.21%	215,736	32,743	15.18%
Nov-23	122,753	21,090	17.18%	98,831	12,907	13.06%	221,584	33,997	15.34%
Dec-23	117,093	20,398	17.42%	98,533	11,640	11.81%	215,626	32,039	14.86%
Jan-24	141,097	23,443	16.61%	106,035	13,808	13.02%	247,132	37,251	15.07%
Feb-24	117,334	25,664	21.87%	101,118	12,974	12.83%	218,452	38,638	17.69%
Mar-24	122,366	29,121	23.80%	99,551	16,761	16.84%	221,917	45,882	20.68%
Apr-24	129,167	23,001	17.81%	104,015	10,819	10.40%	233,182	33,820	14.50%
May-24	129,438	25,664	19.83%	106,597	14,319	13.43%	236,035	39,983	16.94%
Total	1,110,285	209,379	18.86%	906,623	116,434	12.84%	2,016,908	325,813	16.15%

June - Dec 2024

Month	# of HH Claims Submitted	Total # of HH CSEs	HH CSE Error Rate	# 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
Jun-24	113,834	19,065	16.75%	98,085	11,351	11.57%	211,919	30,416	14.35%
Total	113,834	19,065	16.75%	98,085	11,351	11.57%	211,919	30,416	14.35%

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Top 5 CSE's For Hospice
September 2024 – August 2024

Reason Code	Billing Error	# of Errors
37402	Hospice sequential billing error	8,398
17729	Attending Physician NPI & Name	7,947
U5106	NOE falls within current hospice election	4,482
U523A	The dates of service on this claim are during both a Hospice Election Period & Medicare Advantage Plan Period that is Value-Based Insurance	4,424
38200	Duplicate claim	2,839

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CGS Billing Errors – Hospice Missouri
August 2024

Reason Code	Billing Error	# of Errors
37402	Hospice sequential billing error	2,568
31689	The claim was submitted with Medicare as the secondary or tertiary payer and the dollar amount entered in the PAID AMOUNT field on the MSP Payment Inf	4,535
U5106	NOE falls within current hospice election	1,129
38200	Duplicate claim	1,158
U5181	Occ cd 27 required when certification date falls w/in DOS	619

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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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Reason Code Search and Resolution

Reason Code Search and Resolution Tool (cgsmedicare.com)

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Resources & Self-Service Tools

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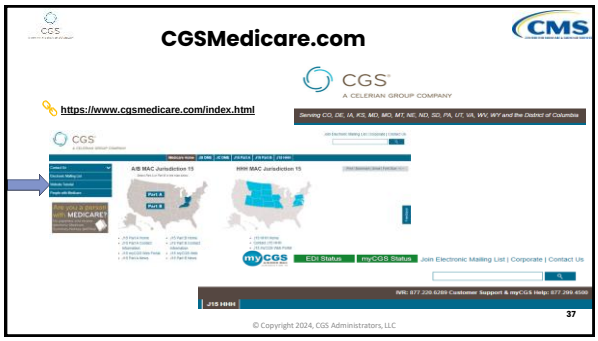
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CGS HH&H Web page
http://www.cgsmedicare.com/hhh/index.html
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CLAIMS PROCESSING ISSUES LOG
CALENDAR OF EVENTS
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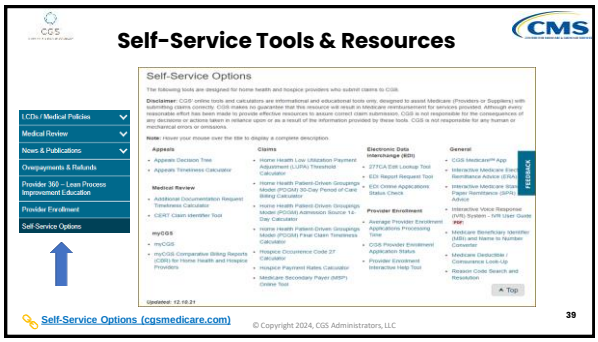
Self-Service Tools & Resources
Self-Service Options
ICDs / Medical Policies
Medical Review
News & Publications
Overpayments & Refunds
Provider 360 – Lean Process Improvement Education
Provider Enrollment
Self-Service Options
Self-Service Options (cgsmedicare.com)
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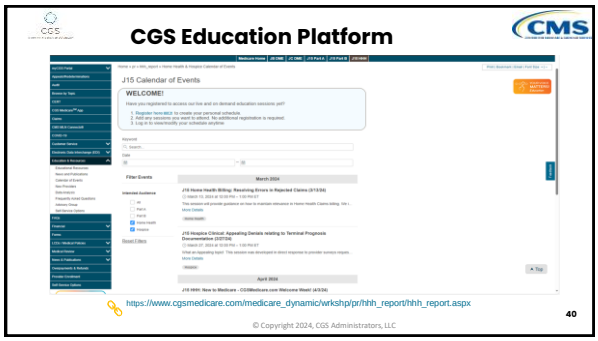
CGS Education Platform
J15 Calendar of Events
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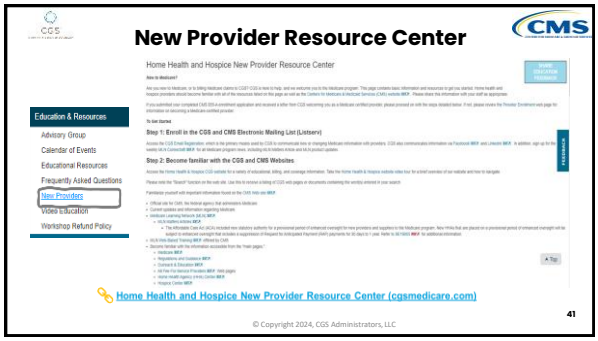
New Provider Resource Center
Home Health and Hospice New Provider Resource Center
Education & Resources
Advisory Group
Calendar of Events
Educational Resources
Frequently Asked Questions
New Providers
Video Education
Workshop Refund Policy
Home Health and Hospice New Provider Resource Center (cgsmedicare.com)
41
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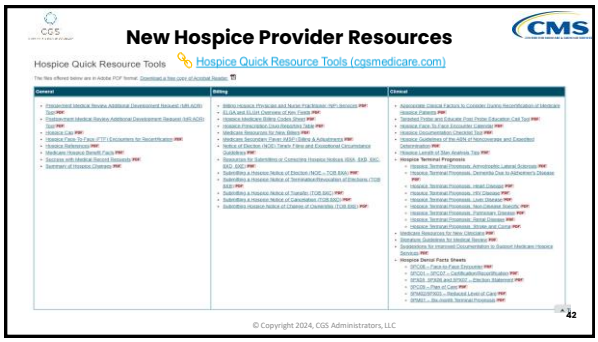
New Hospice Provider Resources
Hospice Quick Resource Tools
Hospice Quick Resource Tools (cgsmedicare.com)
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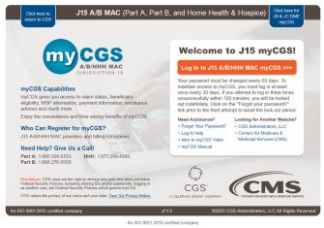
myCGS Portal



- myCGS (cgsmedicare.com)
- myCGS Tutorial Video
- myCGS User Manual (cgsmedicare.com)

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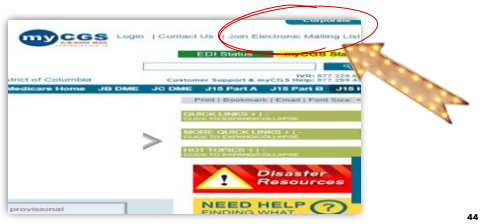
ARE YOU SIGNED UP FOR LISTSERV?



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CGS Medicare Mobile App

- CGS Medicare Mobile App

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CGS IS JUST A CLICK AWAY!
STAY CONNECTED
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https://www.cgsmedicare.com/
Follow Us on LinkedIn:
Follow Us on Facebook:
Follow Us on YouTube:
Visit the myCGS Web Portal:
SIGN UP FOR E-MAIL NOTIFICATIONS:
GET EVEN MORE RESOURCES:
Download the CGS Medicare App:
Download the CGS Medicare℠ app today!
https://www.cgsmedicare.com/email.html
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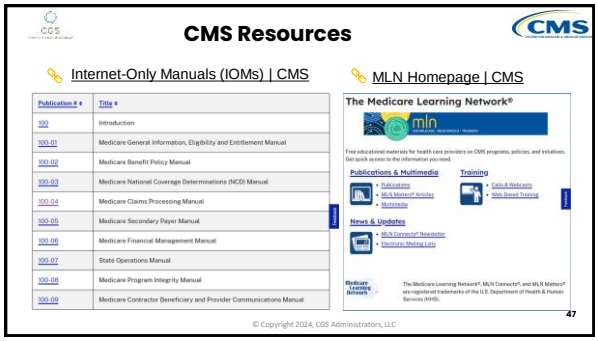
CMS Resources
Internet-Only Manuals (IOMs) | CMS
MLN Homepage | CMS
Publication # ♦
Title ♦
100 Introduction
100-01 Medicare General Information, Eligibility and Entitlement Manual
100-02 Medicare Benefit Policy Manual
100-03 Medicare National Coverage Determinations (NCD) Manual
100-04 Medicare Claims Processing Manual
100-05 Medicare Secondary Payer Manual
100-06 Medicare Financial Management Manual
100-07 State Operations Manual
100-08 Medicare Program Integrity Manual
100-09 Medicare Contractor Beneficiary and Provider Communications Manual
The Medicare Learning Network®
mln
Publications & Multimedia
Training
News & Updates
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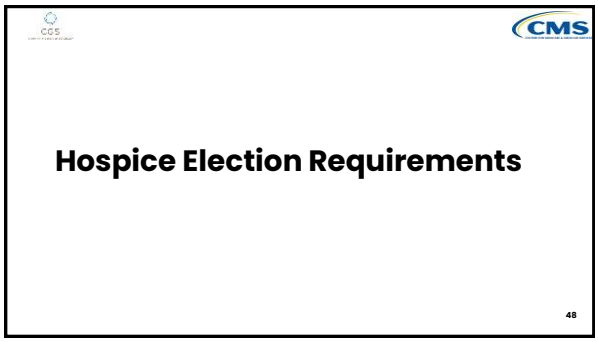
Hospice Election Requirements
48

48

Hospice Coverage Guidelines

- Medicare pays for hospice care when qualifying criteria are met and documented. It is essential for hospice agencies to have a complete understanding of these criteria, as you have the right, and responsibility, in collaboration with the physician, to decide if the beneficiary qualifies for services.
  - The agency then must understand what services are covered, and how to document these services.
- To be eligible to elect the hospice benefit under Medicare, the beneficiary must be entitled to Part A of the Medicare benefit and be certified by a physician as terminally ill.
- A beneficiary is considered to be terminally ill if the medical prognosis for life expectancy is six months or less if the illness runs its normal course.
- Hospice services are provided by various healthcare workers that make up the Interdisciplinary Group (IDG).
- The services provided by the IDG are directed by the Plan of Care (POC) that is specific for each individual beneficiary.

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c09.pdf

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Hospice Eligibility Resources

- https://cgsmedicare.com/hhh/coverage/coverage_guidelines/election_requirements.html
- https://cgsmedicare.com/hhh/coverage/coverage_guidelines/discharge_revocations_transfers.html
- https://cgsmedicare.com/hhh/coverage/coverage_guidelines/plan_of_care.html
- https://cgsmedicare.com/hhh/coverage/coverage_guidelines/cert_recert_requirements.html
- https://cgsmedicare.com/hhh/coverage/hospice_ftf_encounter.html
- https://cgsmedicare.com/hhh/coverage/coverage_guidelines/hospice_benefit_periods.html

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Election Requirements

- Please refer to the following sections of the Medicare Benefit Policy Manual (CMS Pub. 100-02), Ch. 9: 10, 20.2 and 40.1.3.1, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c09.pdf
- To receive hospice services under the Medicare Hospice Benefit, the patient (or his/her authorized representative) must elect hospice care by signing an election statement.
- Each hospice designs and prints their own election statement.
- FY 2021 Hospice Final Rule included new hospice election statement and addendum requirements **effective for all hospice elections beginning on or after October 1, 2020.**

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Which Templates Do I Use?

- As you develop your own hospice election statements and certifications of terminal illness, please review the revised:
- https://www.cms.gov/files/document/model-example-hospice-election-statement-march-2024.pdf

Model Example of Hospice Election Statement

Patient Name: _____

Hospice Agency Name: _____

Hospice Election

I, _____ (Patient Name) choose to elect the Medicare hospice benefit and receive Hospice services from _____ (Name of Hospice Agency) to begin on _____ (Start of Care Date)

(Note: The start of care date, also known as the effective date of the election, may be the first day of hospice care or a later date, but may be no earlier than the date of the election statement. An individual may not designate an effective date that is retroactive.)

Right to choose an attending physician

- I understand that I have a right to choose my attending physician to oversee my care.
- My attending physician will work in collaboration with the hospice agency to provide care related to my terminal illness and related conditions.

☐ I do not wish to choose an attending physician
☐ I acknowledge that my choice for an attending physician is:
(Please provide any information that will uniquely identify your attending physician choice.)

Physician Full name: _____

Hospice Philosophy and Coverage of Hospice Care

By electing hospice care under the Medicare hospice benefit, I acknowledge that:

- I was given an explanation and have a full understanding of the purpose of hospice care including that the nature of hospice care is to relieve pain and other symptoms related to my terminal illness and related conditions and such care will not be directed toward care. The focus of hospice care is to provide comfort and support to both me and my family/caregivers.
- I was provided information on what items, services, and drugs the hospice is to cover and furnish upon my election to receive hospice care.
- I was provided with information about potential cost-sharing for certain hospice services, if applicable.
- I understand that by electing hospice care under the Medicare hospice benefit, I waive (give up) the right to Medicare payments for items, services, and drugs related to my terminal illness and related conditions. This means that while this election is in force, Medicare will make payments for care related to my terminal illness and related conditions only to the designated hospice and attending physician that I have selected.
- I understand that items, services, and drugs unrelated to my terminal illness and related conditions are exceptional and unusual, and in general, the hospice will be providing virtually all of my care while I am under a hospice election. The items, services, and drugs unrelated to be unrelated to my terminal illness and related conditions will continue to be eligible for coverage by Medicare under separate benefits.

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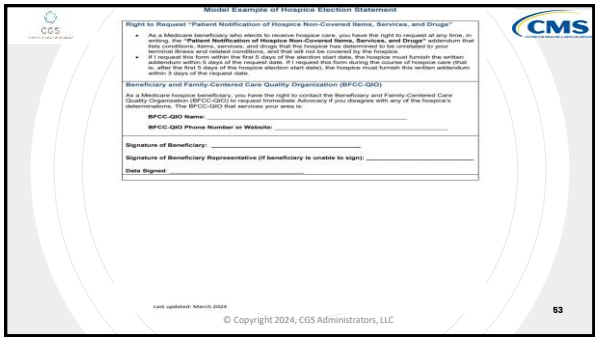

Model Example of Hospice Election Statement

Right to Request "Patient Notification of Hospice Non-Covered Items, Services, and Drugs"

- As a Medicare beneficiary who elects to receive hospice care, you have the right to request at any time, in writing, the **"Patient Notification of Hospice Non-Covered Items, Services, and Drugs"** addendum that lists conditions, items, services, and drugs that the hospice has determined to be unrelated to your terminal illness and related conditions, and that will not be covered by the hospice.
- If I request this form within the first 5 days of the election start date, the hospice must furnish the written addendum within 5 days of the request date. If I request this form during the course of hospice care (that is, after the first 5 days of the hospice election start date), the hospice must furnish this written addendum within 5 days of the request date.

Beneficiary and Family-Centered Care Quality Organization (BFCC-QIO)

As a Medicare hospice beneficiary, you have the right to contact the Beneficiary and Family-Centered Care Quality Organization (BFCC-QIO) to request Immediate Advocacy if you disagree with any of the hospice's determinations. The BFCC-QIO that services your area is:

BFCC-QIO Name: _____

BFCC-QIO Phone Number or Website: _____

Signature of Beneficiary: _____

Signature of Beneficiary Representative (if beneficiary is unable to sign): _____

Date Signed: _____

Last updated: March 2024

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What Changed in March 2024?

- Changed timeframe for addendum: "If I request this form within the first 5 days of the election start date, the hospice must furnish the written addendum within 5 days of the request date."
- Changed "BFCC-QIO Phone Number or Website"
- Changed/simplified Signature area

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Which Templates Do I Use?

https://www.cms.gov/files/document/model-hospice-election-statement-addendum-march-2024.pdf

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Model Example of "Patient Notification of Hospice Non-Covered Items, Services, and Drugs"

Please visit this website to find the BFCC-QIO for your area: https://qiconprogram.org/locate-your-qio or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Note: The 'date furnished' is defined as when the beneficiary (or representative) receives an addendum within 3 or 5 days from their request and not the date of the signature.

Signing this notification (or its updates) is only acknowledgement of receipt of this notification (or its updates) and does not constitute your agreement with the hospice's determinations.

Signature of Beneficiary: _____

Signature of Beneficiary Representative (if beneficiary is unable to sign): _____

Date Signed: _____

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What Changed in March 2024?

- Updated "Purpose of Issuing this Notification"
- Changed Signature area
  - Added/changed: "Note: The 'date furnished' is defined as when the beneficiary (or representative) receives an addendum within 3 or 5 days from their request and not the date of the signature."

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Election Statement

The hospice's election statement **must include** the following:

- ✓ Identification of the particular hospice that will provide care to the patient;
- ✓ The patient's or representative's (as applicable) acknowledgment that the patient has been given a full understanding of hospice care, ***particularly the palliative rather than curative nature of treatment***;
- ✓ The patient's or representative's acknowledgment that the patient understands that certain Medicare services are waived by the election;
- ✓ The effective date of the election, which can be the first day of hospice care or a later date, but cannot be a retroactive date;
- ✓ The patient's or representative's designated attending physician (if they have one). Include enough detail to clearly identify the attending physician. This may include, but is not limited to, the physician's full name, office address, or National Provider Identifier (NPI).

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Election Statement Requirements

Continued..

- ✓ The patient's or representative's acknowledgement that the designated attending physician was their choice.
- ✓ The signature of the patient or their representative.
- ✓ Information about the holistic, comprehensive nature of the Medicare hospice benefit;
- ✓ A statement that, although it would be rare, there could be some necessary items or services that will not be covered by the hospice because the hospice has determined that these items or services are to treat a condition that is unrelated to the terminal illness and related conditions.
- ✓ The statement would also include information about possible beneficiary cost-sharing for hospice services.
- ✓ Notification of the beneficiary's (or representative's) right to request an election statement addendum that includes a written list and a rationale for the conditions, items, drugs, or services that the hospice has determined to be unrelated to the terminal illness and related conditions and that expedited advocacy is available through the Beneficiary Family Centered Care-Quality Improvement Organization (BFCC-QIO) review if the beneficiary (or representative) disagrees with the hospice's determination.

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Change of Designated Attending Physician

- **NOTE:** If the patient/representative wants to change their designated attending physician, they must file a signed statement with the hospice.
- The statement must include the following information:
  - Identification of the new attending physician. Include enough detail to clearly identify the new attending physician. This may include, but is not limited to, the physician's full name, office address, or the NPI;
  - The date the change is effective;
  - An acknowledgement that the change in attending physician was their choice;
  - The patient's or representative's signature; and
  - The date the statement was signed.

*A hospice election statement, or statement changing the designated attending physician, that is missing any of the bulleted items above, is considered incomplete, and may result in a claim denial.

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TARGETED
PROBE &
EDUCATE
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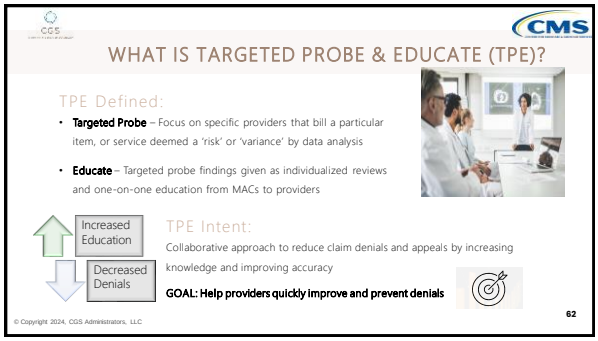
WHAT IS TARGETED PROBE & EDUCATE (TPE)?
TPE Defined:
• Targeted Probe – Focus on specific providers that bill a particular item, or service deemed a 'risk' or 'variance' by data analysis
• Educate – Targeted probe findings given as individualized reviews and one-on-one education from MACs to providers
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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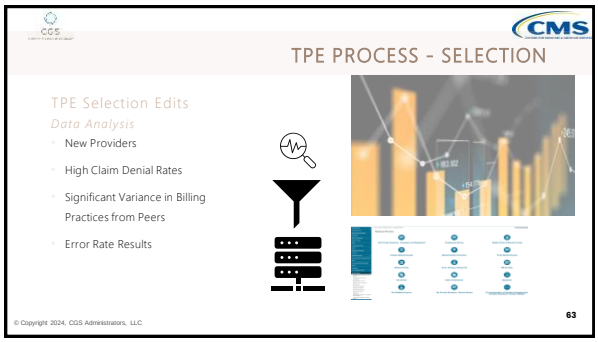
TPE PROCESS - SELECTION
TPE Selection Edits
Data Analysis
New Providers
High Claim Denial Rates
Significant Variance in Billing Practices from Peers
Error Rate Results
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TPE - CGS
myCGS TPE Edits:
Home Health and Hospice Medical Review Activity Log
Medical Review
Medical Review
Targeted Probe and Educate (TPE) Process
Complex Medical Reviews
Fact Sheets
Medical Policies / LCDs
Medical Review Contractors
MR Activities
News 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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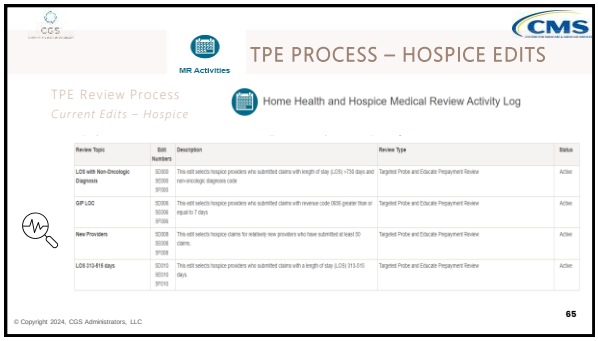
MR Activities
TPE PROCESS – HOSPICE EDITS
TPE Review Process
Current Edits – Hospice
Home Health and Hospice Medical Review Activity Log
Review Topic
Bill Numbers
Description
Review Type
Status
LOS with Non-Oncologic Diagnosis
GIP LOC
New Providers
LOS 313-515 days
Targeted Probe and Educate Prepayment Review
Active
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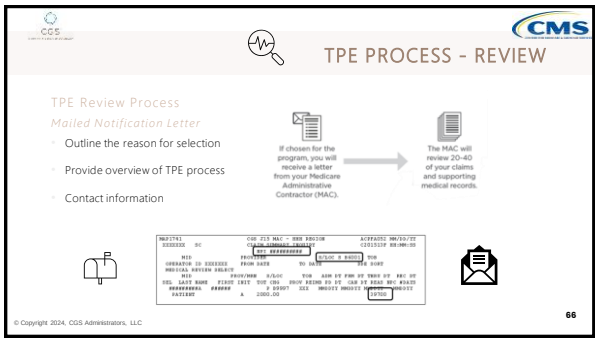
TPE PROCESS - REVIEW
TPE Review Process
Mailed Notification Letter
Outline the reason for selection
Provide overview of TPE process
Contact information
If chosen for the program, you will receive a letter from your Medicare Administrative Contractor (MAC).
The MAC will review 20-40 of your claims and supporting medical records.
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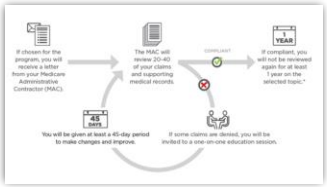
TPE PROCESS - REVIEW

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?

Claim selected for medical review

Medical review additional development request (MR ADR) is generated

- Additional medical documentation

Documentation to CGS

- Must be received within **45 calendar days**

Medical review and payment determination

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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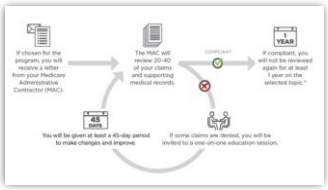
REACHING THE TPE GOAL - IMPROVEMENT

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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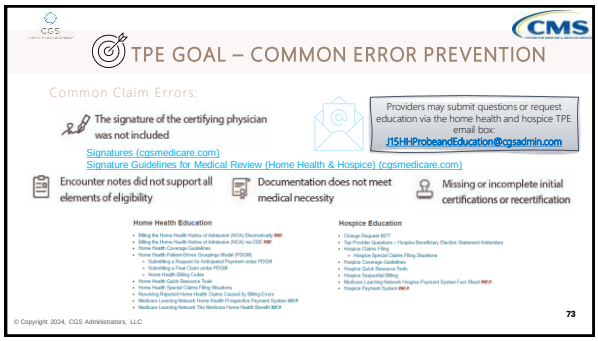
TPE GOAL – COMMON ERROR PREVENTION
Common Claim Errors:
The signature of the certifying physician was not included
Signatures (cgsmedicare.com)
Signature Guidelines for Medical Review (Home Health & Hospice) (cgsmedicare.com)
Providers may submit questions or request education via the home health and 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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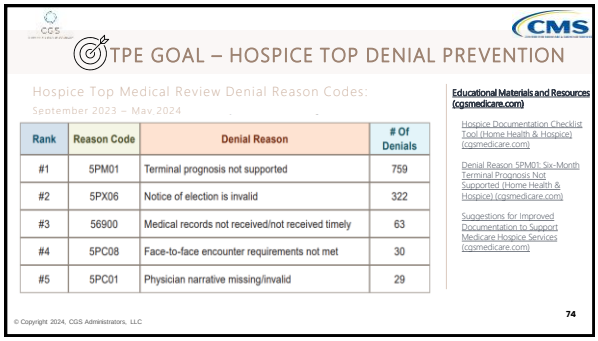
TPE GOAL – HOSPICE TOP DENIAL PREVENTION
Hospice Top Medical Review Denial Reason Codes:
September 2023 – May 2024
Rank | Reason Code | Denial Reason | # Of Denials
#1 | 5PM01 | Terminal prognosis not supported | 759
#2 | 5PX06 | Notice of election is invalid | 322
#3 | 56900 | Medical records not received/not received timely | 63
#4 | 5PC08 | Face-to-face encounter requirements not met | 30
#5 | 5PC01 | Physician narrative missing/invalid | 29
Educational Materials and Resources (cgsmedicare.com)
Hospice Documentation Checklist Tool (Home Health & Hospice) (cgsmedicare.com)
Denial Reason 5PM01: Six-Month Terminal Prognosis Not Supported (Home Health & Hospice) (cgsmedicare.com)
Suggestions for Improved Documentation to Support Medicare Hospice Services (cgsmedicare.com)
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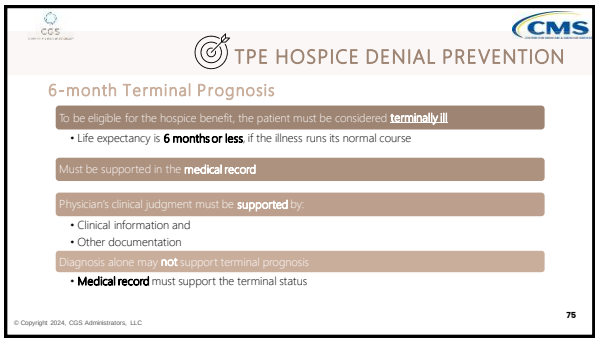
TPE HOSPICE DENIAL PREVENTION
6-month Terminal Prognosis
To be eligible for the hospice benefit, the patient must be considered terminally ill
• Life expectancy is 6 months or less, if the illness runs its normal course
Must be supported in the medical record
Physician's clinical judgment must be supported 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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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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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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https://cgsmedicare.com/hhh/medreview/hos_denial_reasons.html

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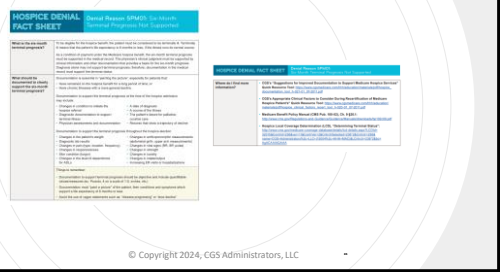
https://cgsmedicare.com/hhh/education/materials/pdf/Hospice_5pter_factsheet.pdf



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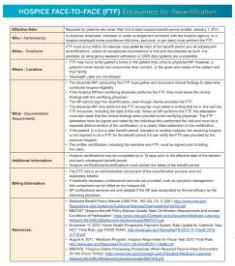
https://cgsmedicare.com/hhh/education/materials/pdf/hospice_ftf_encounters.pdf



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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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Medical Review Contractors
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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)
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