New Provider/Front Office

10/21/2021

Today's Presenters

- Arlene Dunphy, CPC
  - Provider Outreach and Education Consultant
- Michele Poulos
  - Provider Outreach and Education Consultant

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No Recording

- Attendees/providers are **never** permitted to record (tape record or **any** other method) our educational events
  - This applies to our webinars, teleconferences, live events and any other type of National Government Services educational events

Objectives

- After this session attendees will be able to
  - Have a basic understanding of Medicare Program
  - Know what resources to use in order to determine Medicare eligibility
  - Ensure that office intake procedures are efficient

Agenda

- Jurisdictions
- NGS Website
- Medicare Enrollment Process
- Electronic Billing
- Medicare Compliance
- Medicare Part B
- Deductibles/Coinsurance/ Fee Schedule
- Local Coverage Determinations
- Claim Filing Guidelines
- Preventive Services
- Front Office (Help For the Office)
- Medigap/Supplemental Insurance/Advantage Plans
- Checking Patient Eligibility
- NGSConnex

Jurisdictions

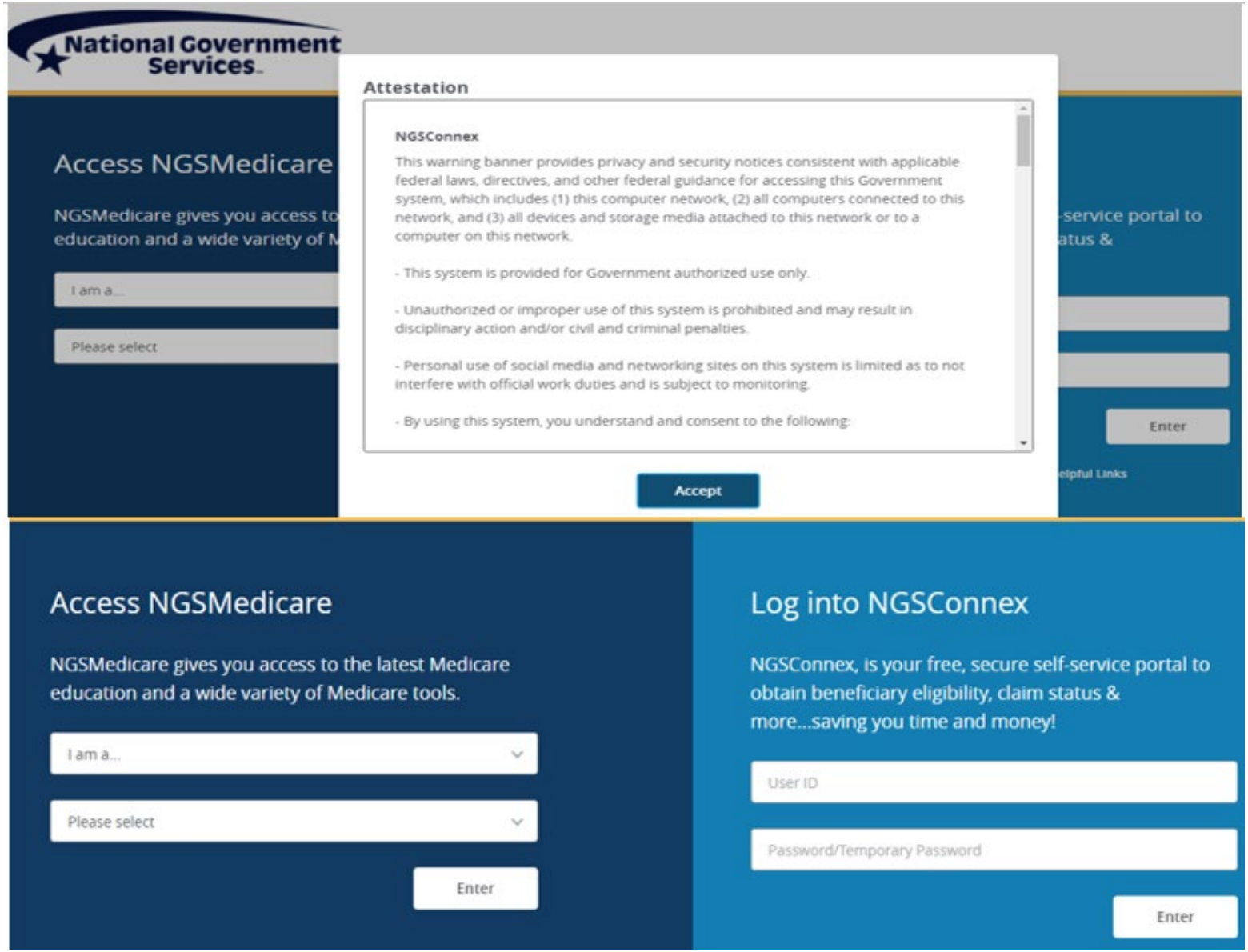
National Government Services Medicare Part A and Part B – JK/J6

- Medicare Jurisdictions
  - A/B MAC
  - HH+H
- NGS
  - Traditional Medicare Claims
  - J6: IL, WI, MN
  - JK: ME, NH, VT, MA, NY, CT, RI

NGS Responsibilities as the Part B MAC

- Processing claims
- Computing payments for services
- Making payments
- Determining medical necessity
- Informing physicians of changes in the Medicare Program
- Developing education programs

NGS Website
NGSMedicare.com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Password/Temporary Password
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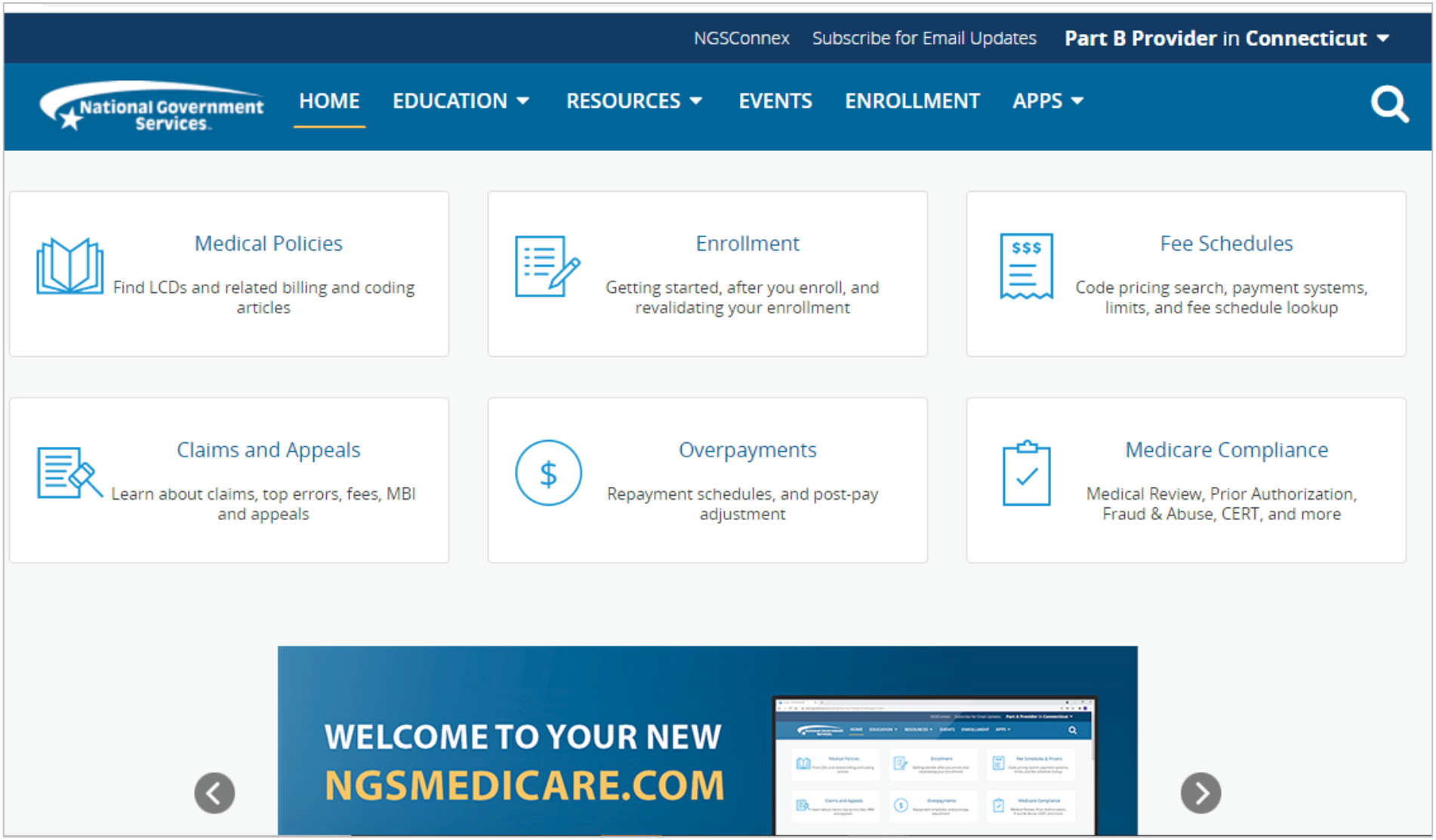
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Enrollment
Getting started, after you enroll, and revalidating your enrollment
$$$
Fee Schedules
Code pricing search, payment systems, limits, and fee schedule lookup
Claims and Appeals
Learn about claims, top errors, fees, MBI and appeals
$
Overpayments
Repayment schedules, and post-pay adjustment
Medicare Compliance
Medical Review, Prior Authorization, Fraud & Abuse, CERT, and more
WELCOME TO YOUR NEW
NGSMEDICARE.COM

NGS Website

- Fee schedules
- News articles
- LCDs
- NGSConnex
- FAQs
- Forms/mailing addresses
- Education calendar/Medicare University
- Self-service tools

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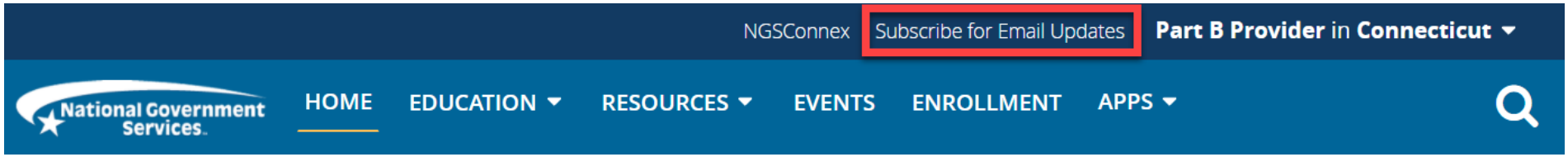
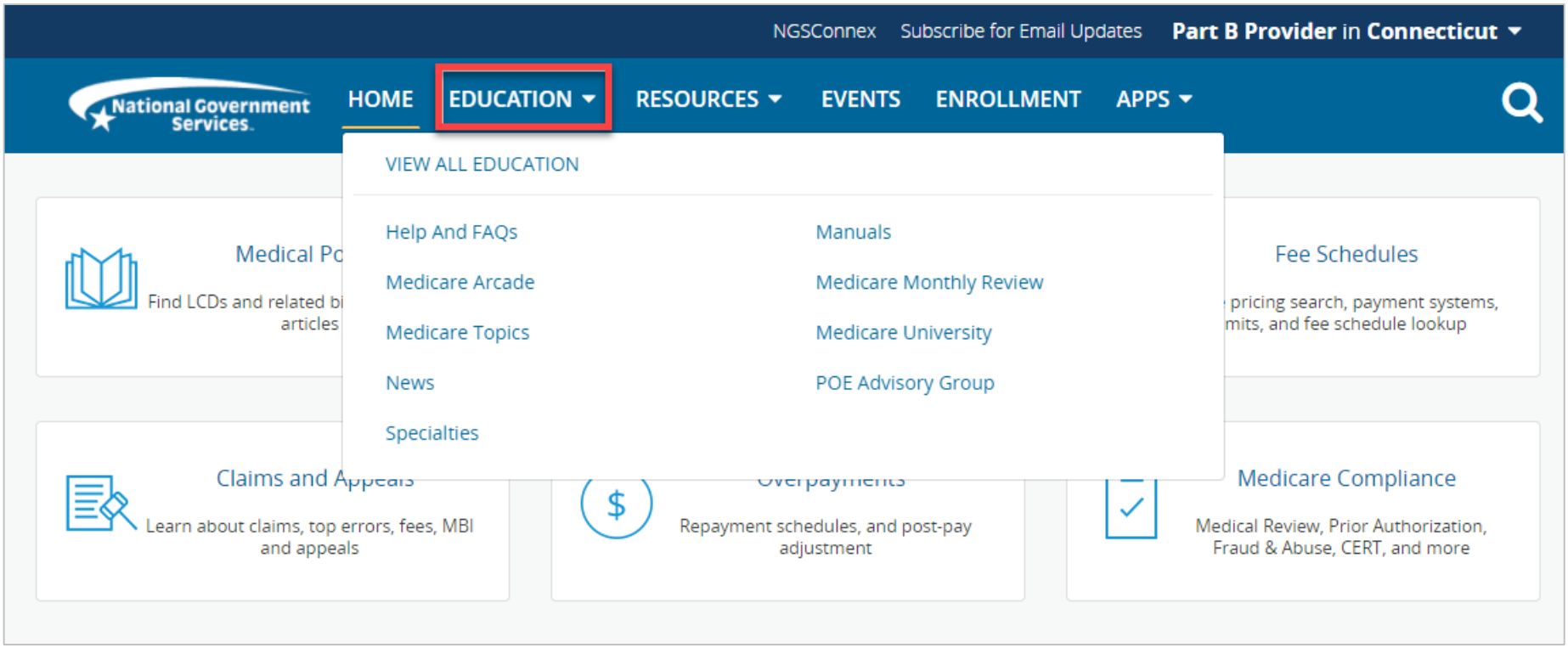


- Receive the latest changes/updates
- Request updates specific to your needs
- Search feature
- Self-service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Specialties
Manuals
Medicare Monthly Review
Medicare University
POE Advisory Group
Medical Pc
Find LCDs and related bi
articles
Fee Schedules
pricing search, payment systems,
mits, and fee schedule lookup
Claims and Appeals
Learn about claims, top errors, fees, MBI and appeals
Overpayments
Repayment schedules, and post-pay adjustment
Medicare Compliance
Medical Review, Prior Authorization, Fraud & Abuse, CERT, and more


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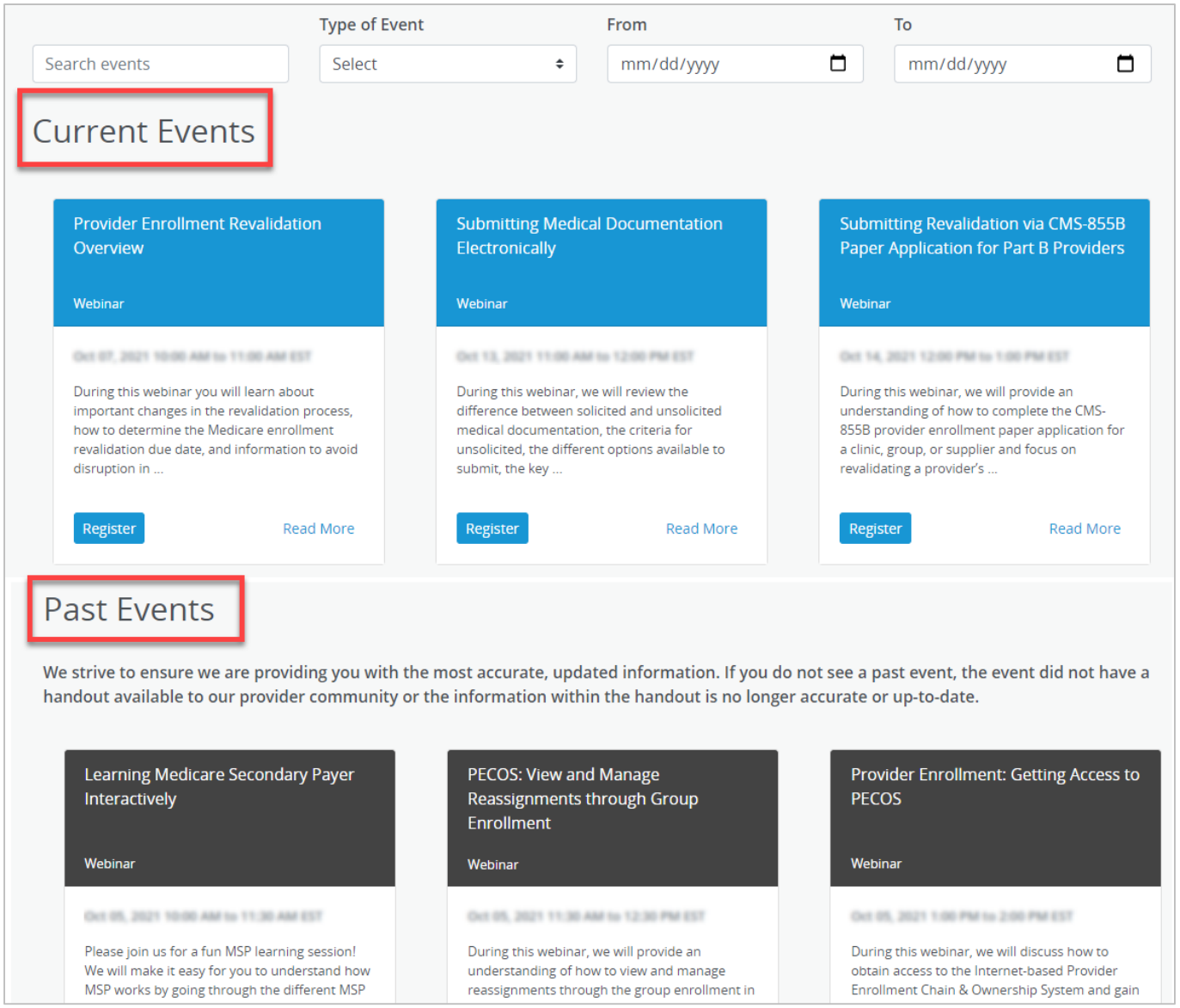
Medicare Fall 2021 Virtual Conference
Webinar
The NGS Provider Outreach and Education Team is holding our latest bi-annual virtual conference. This two full-day virtual conference will offer a variety of Part A, Part B, and FQHC-RHC sessions. There are no associated charges for this virtual conference and you may register for as many sessions as you'd like. Select the register button for a full listing of all available sessions.
Nov 09, 2021 8:30 AM EST - Nov 10, 2021 5:15 PM EST
Register
Email Us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Type of Event
Select
From
mm/dd/yyyy
To
mm/dd/yyyy
Current Events
Provider Enrollment Revalidation Overview
Webinar
During this webinar you will learn about important changes in the revalidation process, how to determine the Medicare enrollment revalidation due date, and information to avoid disruption in ...
Register
Read More
Submitting Medical Documentation Electronically
Webinar
During this webinar, we will review the difference between solicited and unsolicited medical documentation, the criteria for unsolicited, the different options available to submit, the key ...
Register
Read More
Submitting Revalidation via CMS-855B Paper Application for Part B Providers
Webinar
During this webinar, we will provide an understanding of how to complete the CMS-855B provider enrollment paper application for a clinic, group, or supplier and focus on revalidating a provider's ...
Register
Read More
Past Events
We strive to ensure we are providing you with the most accurate, updated information. If you do not see a past event, the event did not have a handout available to our provider community or the information within the handout is no longer accurate or up-to-date.
Learning Medicare Secondary Payer Interactively
Webinar
Please join us for a fun MSP learning session! We will make it easy for you to understand how MSP works by going through the different MSP
PECOS: View and Manage Reassignments through Group Enrollment
Webinar
During this webinar, we will provide an understanding of how to view and manage reassignments through the group enrollment in
Provider Enrollment: Getting Access to PECOS
Webinar
During this webinar, we will discuss how to obtain access to the Internet-based Provider Enrollment Chain & Ownership System and gain

All Education

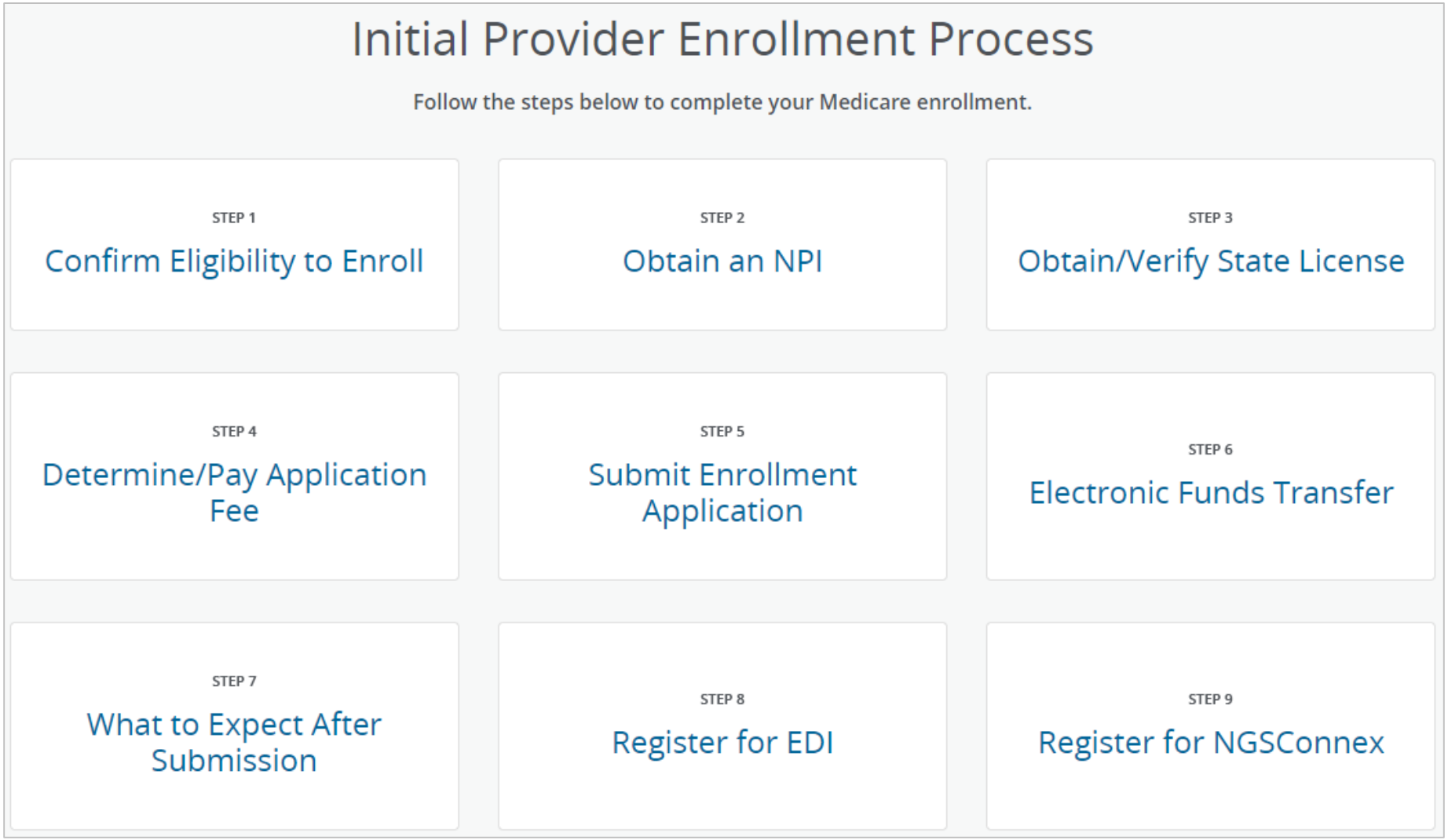
- Help and FAQs
- Medicare Arcade
- Medicare Topics
- News
- Specialties
- Manuals
- Medicare Monthly Review
- Medicare University
- POE Advisory Group

National Government Services Offers CEU Credits Through AAPC

- All NGS Part B Provider Outreach and Education attendees can receive one CEU from the AAPC for every hour of NGS education received
- If you are accredited with a professional organization other than AAPC and plan to request continuing education credit, please contact your organization not NGS with your questions concerning CEUs
- Teleconferences and webinar education
  - Upon completion of the education you will receive an email from NGS which will serve as proof of attendance
- Face-to-face education
  - A certificate of attendance will be provided at the conclusion of the event

Medicare Enrollment Process

Initial Provider Enrollment Process



Eligible Physicians

- Doctor of
  - Medicine (MD)
  - Osteopathy (DO)
  - Chiropractic (DC)
  - Dentistry (DMD) (DDS)
  - Optometry (OD)
  - Psychiatry (MD)
  - Podiatry (DPM)

Eligible Nonphysicians

- Anesthesiologist Assistant (AA)
- Audiologist (AUD)
- Certified Nurse Midwives (CNM)
- Certified Registered Nurse Anesthetist (CRNA)
- Clinical Nurse Specialist (CNS)
- Clinical Psychologist (CP)
- Licensed Clinical Social Worker (L-CSW)
- Mass Immunization Roster Biller

Eligible Nonphysicians

- Nurse Practitioner (NP)
- Occupational Therapist in Private Practice
- Physical Therapist in Private Practice
- Physician Assistant (PA)
- Psychologists Billing Independently (PsyD)
- Speech Language Pathologist (SLP)
- Registered Dietitians or Nutrition Professional (RD or NP)
- MLN® Booklet: *Advanced Practice Registered Nurses, Anesthesiologist Assistants, and Physicians Assistants*

National Provider Identifier (NPI)

- A unique **ten**-digit identification number issued to health care providers
  - Apply online on the NPPES website
  - To request a paper application
    - 800-465-3203

Internet-Based PECOS

- Provider Enrollment, Chain and Ownership System (PECOS)
- CMS Internet-based Medicare enrollment system
  - Submit new initial enrollment record
  - Make changes to existing enrollment record
  - Add or change reassignment of benefits
  - Reactivate or revalidate enrollment
  - Voluntarily withdraw
  - Track status
- Resources
  - External User Services Help Desk: 866-484-8049
    - Email: EUSSupport@cgi.com

Provider Enrollment Application Process Timeline

- Process timeline
  - All required information available
    - Internet-based PECOS application within 45 days
    - CMS-855 paper application within 60 days
- An acknowledgment notice with a case number will be faxed, mailed or emailed from NGS-PE-Communications@anthem.com to the contact on the submitted application
- If necessary, additional documentation request will be mailed or emailed with a 30-day return date
- Obtainable status
  - Interactive Voice Response System
  - Check Provider Enrollment Application Status
- Response letters may take up to seven days after the finalized application

Provider Enrollment – Revalidation

- In order to maintain Medicare billing privileges, you must resubmit and recertify the accuracy of your enrollment information every five years
  - Applies to Part B providers and suppliers
- CMS has established due dates by which you must revalidate
- Generally, this due date will remain with you throughout subsequent revalidation cycles
- Revalidation
  - Internet-based PECOS system
  - CMS-855 paper application
- Failure to submit a complete revalidation application may result in deactivation

Provider Enrollment Revalidation

- Check PECOS
- Check CMS Revalidations page
  - Medicare Revalidation List – Medicare revalidation look up tool
    - Due date will display or “TBD” (To Be Determined) if not currently due
  - MLN Matters® *SE1605 Revised: Provider Enrollment Revalidation – Cycle 2*

Participating Providers

- Enters into an agreement with the Medicare program to accept assignment for all Medicare patients
  - Direct payment
  - Accept the Medicare-approved charge amount
  - Collects only the deductible and coinsurance for covered-Medicare services
  - Listed in MEDPARD Directory
  - Mandated Medigap transfer
  - CMS-460 Medicare Participating Physician or Supplier Agreement

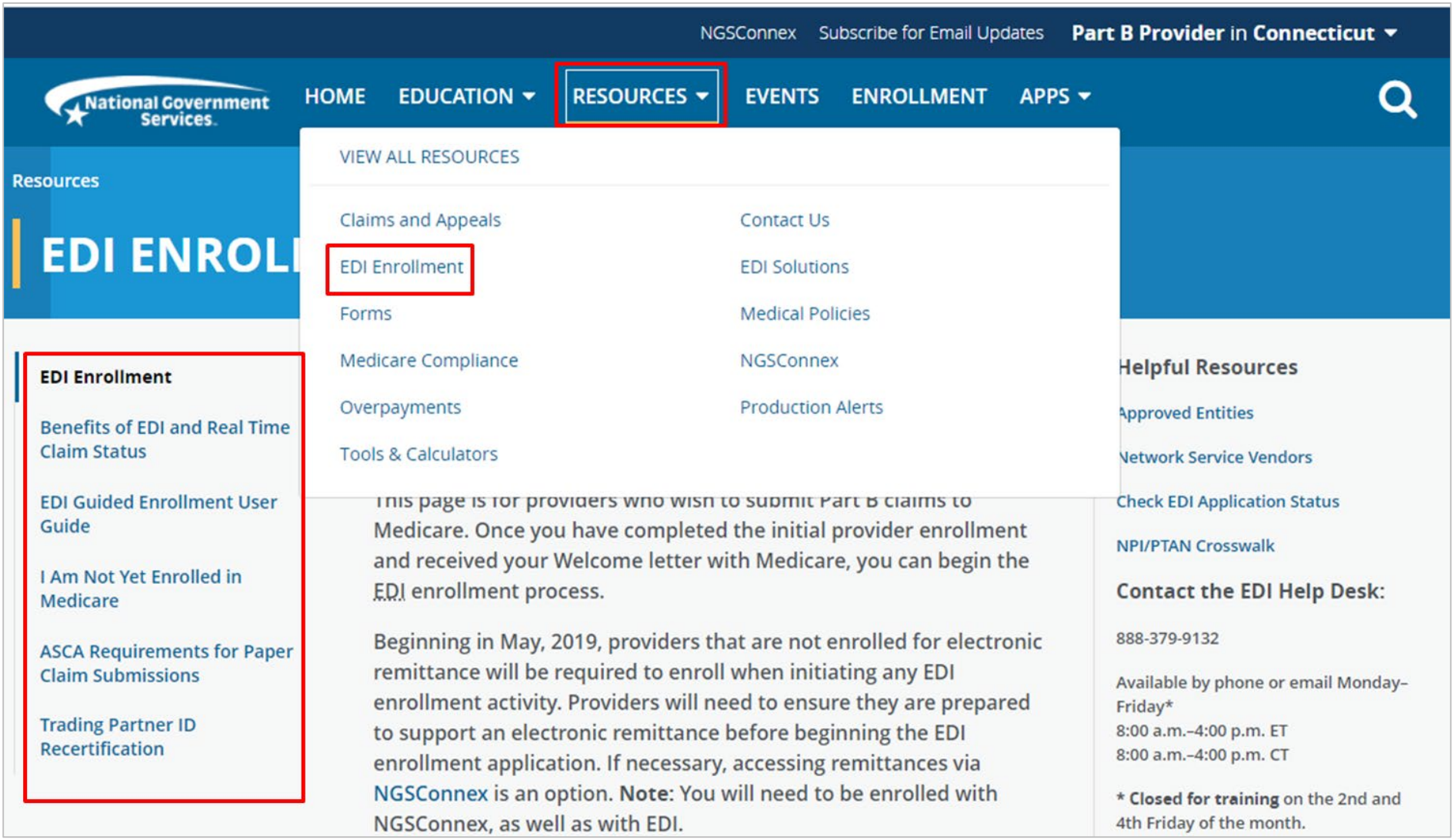
Nonparticipating Providers

- Subject to limiting charge
- **95%** of fee schedule
- New York State limit reduces charges to **105%** of Medicare nonparticipating allowance for NY providers
  - Except office and home visits

Do Not Forward Initiative

- Checks or remittances will only be sent to locations listed in the Medicare provider files
- Address changes must be made through the enrollment process

Electronic Billing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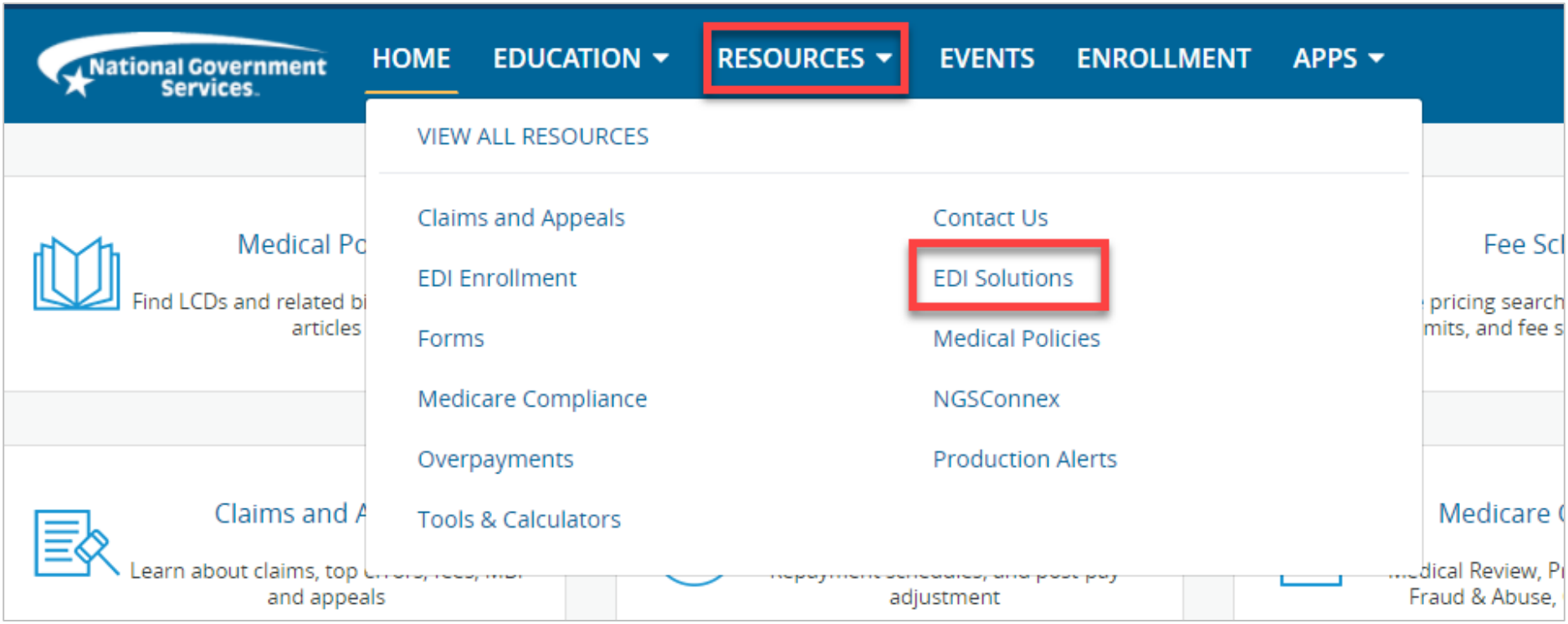
EDI ENROLL
EDI Enrollment
Benefits of EDI and Real Time Claim Status
EDI Guided Enrollment User Guide
I Am Not Yet Enrolled in Medicare
ASCA Requirements for Paper Claim Submissions
Trading Partner ID Recertification
This page is for providers who wish to submit Part B claims to Medicare. Once you have completed the initial provider enrollment and received your Welcome letter with Medicare, you can begin the EDI enrollment process.
Beginning in May, 2019, providers that are not enrolled for electronic remittance will be required to enroll when initiating any EDI enrollment activity. Providers will need to ensure they are prepared to support an electronic remittance before beginning the EDI enrollment application. If necessary, accessing remittances via NGSConnex is an option. Note: You will need to be enrolled with NGSConnex, as well as with EDI.
Helpful Resources
Approved Entities
Network Service Vendors
Check EDI Application Status
NPI/PTAN Crosswalk
Contact the EDI Help Desk:
888-379-9132
Available by phone or email Monday–Friday*
8:00 a.m.–4:00 p.m. ET
8:00 a.m.–4:00 p.m. CT
* Closed for training on the 2nd and 4th Friday of the month.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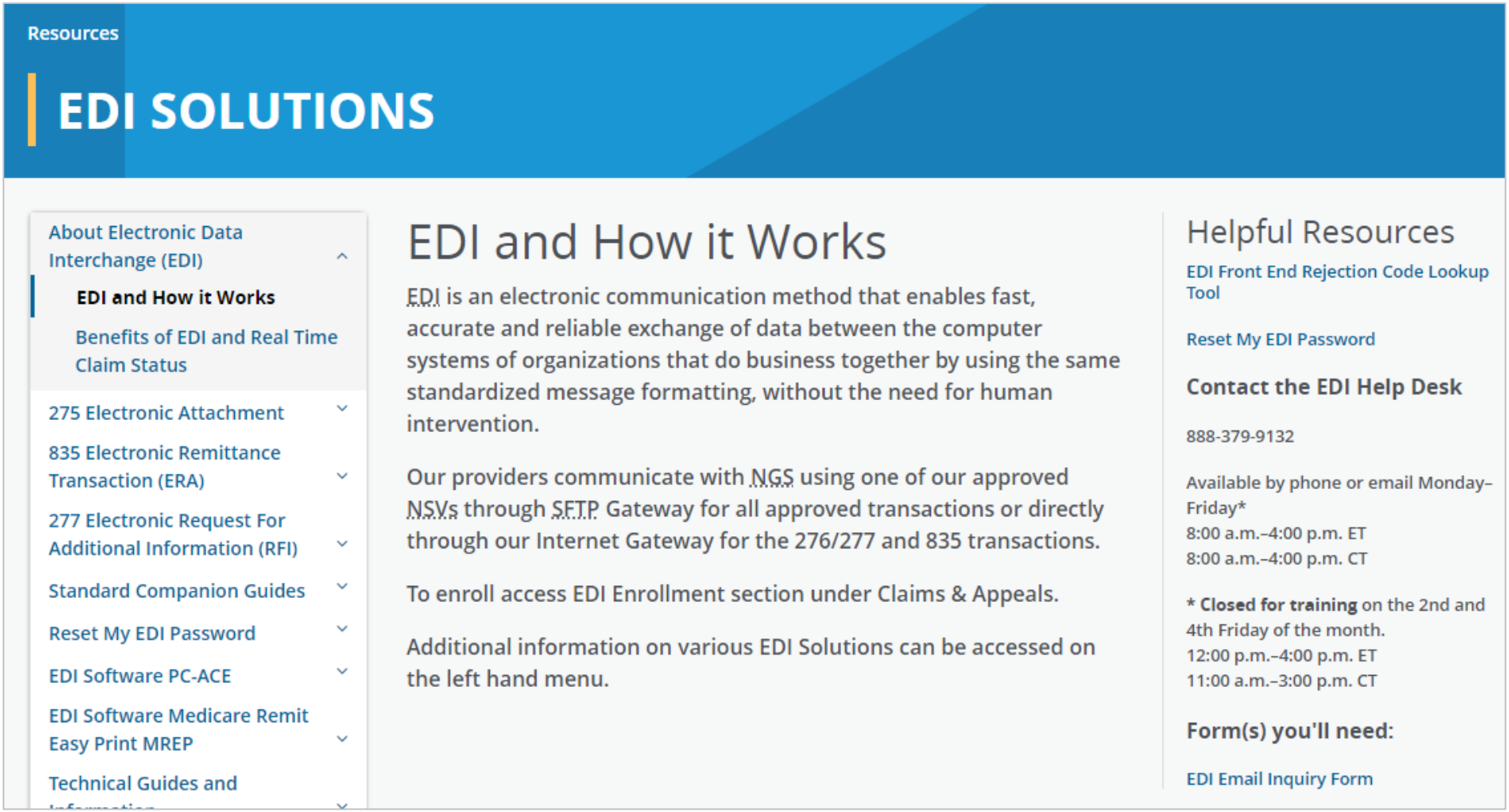
Benefits of Electronic Data Interchange

- Reduced paperwork
- Improved cash flow
- Easier monitoring of claims
- Less cost
- Less processing time
  - Electronic claims are held for 14 days (paper claims held for 29 days)


Resources
EDI SOLUTIONS
About Electronic Data Interchange (EDI)
EDI and How it Works
Benefits of EDI and Real Time Claim Status
275 Electronic Attachment
835 Electronic Remittance Transaction (ERA)
277 Electronic Request For Additional Information (RFI)
Standard Companion Guides
Reset My EDI Password
EDI Software PC-ACE
EDI Software Medicare Remit Easy Print MREP
Technical Guides and
EDI and How it Works
EDI is an electronic communication method that enables fast, accurate and reliable exchange of data between the computer systems of organizations that do business together by using the same standardized message formatting, without the need for human intervention.
Our providers communicate with NGS using one of our approved NSVs through SFTP Gateway for all approved transactions or directly through our Internet Gateway for the 276/277 and 835 transactions.
To enroll access EDI Enrollment section under Claims & Appeals.
Additional information on various EDI Solutions can be accessed on the left hand menu.
Helpful Resources
EDI Front End Rejection Code Lookup Tool
Reset My EDI Password
Contact the EDI Help Desk
888-379-9132
Available by phone or email Monday–Friday*
8:00 a.m.–4:00 p.m. ET
8:00 a.m.–4:00 p.m. CT
* Closed for training on the 2nd and 4th Friday of the month.
12:00 p.m.–4:00 p.m. ET
11:00 a.m.–3:00 p.m. CT
Form(s) you'll need:
EDI Email Inquiry Form

EDI Helpdesk Information

- Toll-Free number
  - JK: 888-379-9132
  - J6: 877-273-4334
- Hours of operation
  - Monday–Friday: 8:00 a.m.–4:00 p.m. ET
    - By phone or email
    - Closed for training the 2nd and 4th Friday of the month from 12:00–4:00 p.m. ET

PC-ACE Billing Software

- PC-ACE is a free billing software for JK/J6
- PC-ACE features
  - enter patient information
  - maintains claim payment history
  - procedure file information
  - summary report
- Network service vendor is needed

Electronic Funds Transfer and Electronic Remittance Advice

- EFT
  - Receive Medicare payments via direct deposit
  - Directly deposited and available immediately
    - EFT Authorization Agreement Form
- ERA
  - Electronic Remit Advice (ERA) and Standard Paper Remit (SPR)
    - Electronic Billing & EDI Transactions

Medicare Compliance

NGS Medical Review Process Prepayment Reviews

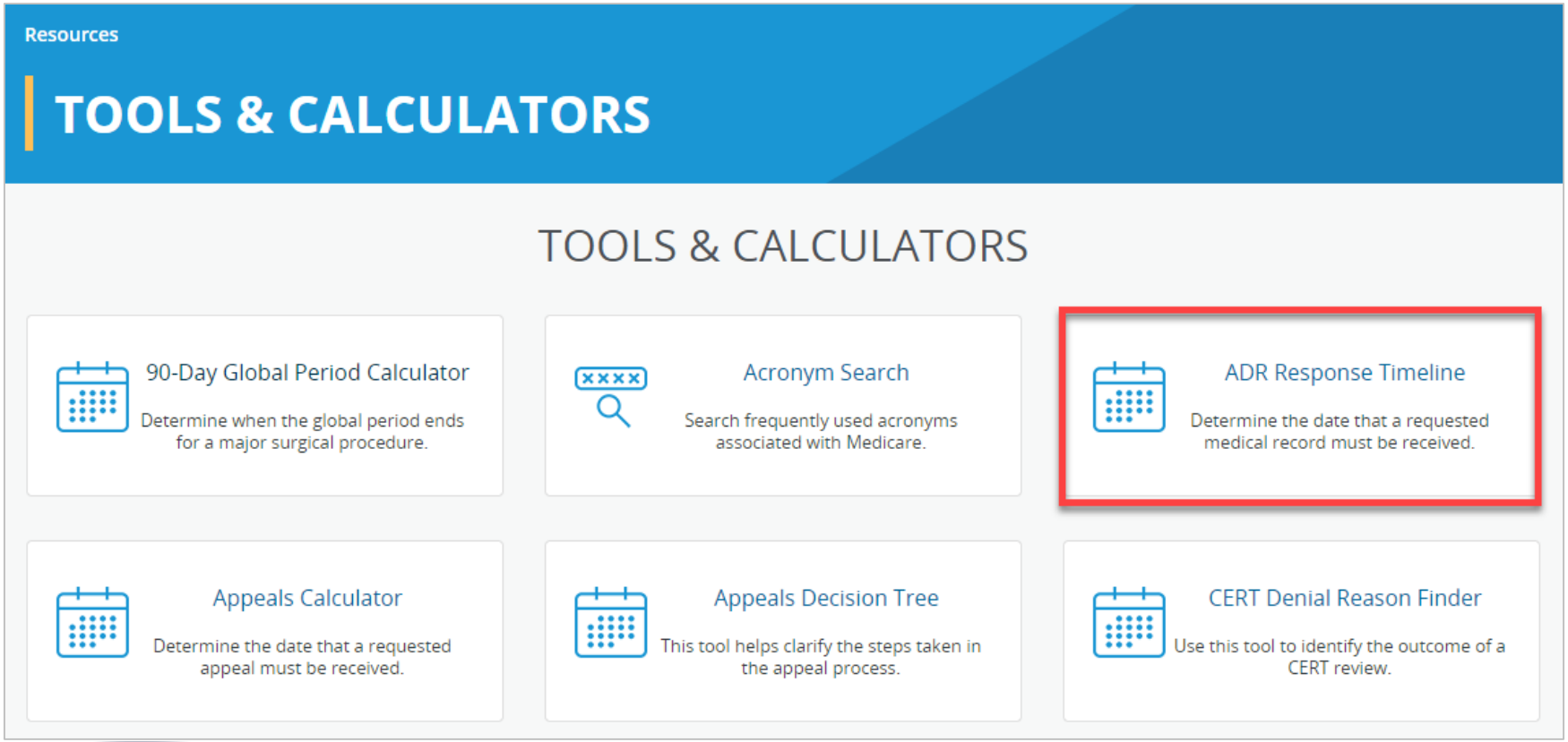
- Claims will suspend
  - ADR generated
- Respond timely and accurately
  - Within 35–40 days (CMS allows 45 days)
  - Send each response separately
  - Include all necessary records
  - Signatures and credentials

NGS Medical Review Process Postpayment Reviews

- ADR will advise you of the documentation needed
- Include all records necessary to support the services
- Do not include additional correspondence
- Records must be complete and legible
  - Including signatures and credentials

Tools & Calculators

- Additional Development/Documentation Request Timeline Calculator



Responding to ADRs

- NGS JK (CT, MA, ME, NH, NY, RI, VT)
  - Direct Fax: 315 442-4231
  - Mail:
    National Government Services, Inc.
    P.O. Box 7108
    Indianapolis, IN 46207-7108
- NGS J6 (IL, MN, WI)
  - Direct Fax: 317-595-4364
  - Mail:
    National Government Services, Inc.
    Attn: Medical Review
    P.O. Box 6475
    Indianapolis, IN 46206-6475
- NGSConnex: Through the “My Claims” tab

Targeted Probe and Educate

- Effective 10/1/2017, Medical Review transitioned all lines of business to a TPE strategy
- Includes targeted medical review and education with a potential for elevated action
- Purpose to reduce costs related to improper payments and appeals

Rounds of Review

- TPE consists of three rounds, if the provider continues to have a high payment error rate
  - Round 1 (Initial Probe)
  - Round 2
  - Round 3
- Additional rounds of review will include
  - One-on-one education with medical review after each round of review
  - Additional development request approximately 45–56 days after the education is complete
  - Detailed results letter

Documentation Request

- Round/Probe
  - ADR between 20–40 claims from the provider
    - Provider notification letter will advise your agency of how many claims will be requested
  - Provider has 45 days to respond to the contractor with medical records
    - This includes mail time and contractor processing time to a medical review location
    - Highly recommend as an internal best practice of sending documentation **within 30 days**
  - No response counts as an error
  - Notification letters and results letters will be sent out in pink envelopes

Medical Review Department

- TPE was suspended due to the PHE until 8/31/2021
- Prepayment
  - New claims will include a notification letter followed by separate ADRs
- Postpayment
  - Notification letter will include a listing of all claims being selected

Medicare Part B

How Traditional Medicare Works

- **Pays** 80% of the allowed charges-patient has 20% copayment
- **Deductible** applies
  - Some exceptions
- **Coinsurance** applies
  - Some exceptions
- Patient pays monthly premium
  - Your Medicare Costs, Medicare.gov

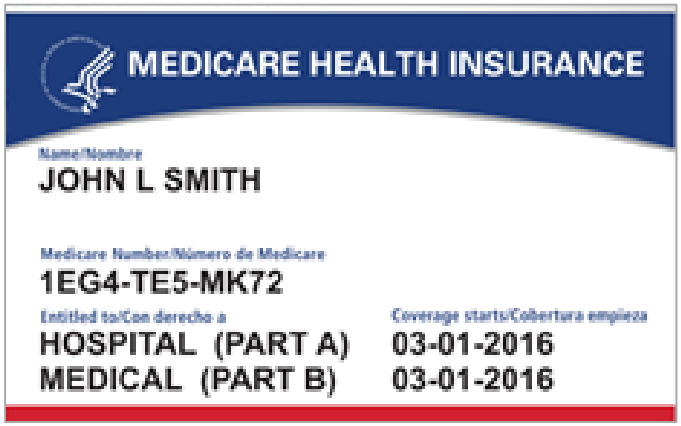
Covered Part B Services

- Ambulatory care
- Anesthesia
- Blood transfusions
- Certain medical supplies
- Certain preventive services
- Diagnostic tests
- Injectable drugs
- Medical and surgical services
- Mental health services
- Occupational therapy
- Pathology
- Physical therapy
- Radiology
- Second opinions before surgery
- Speech language therapy

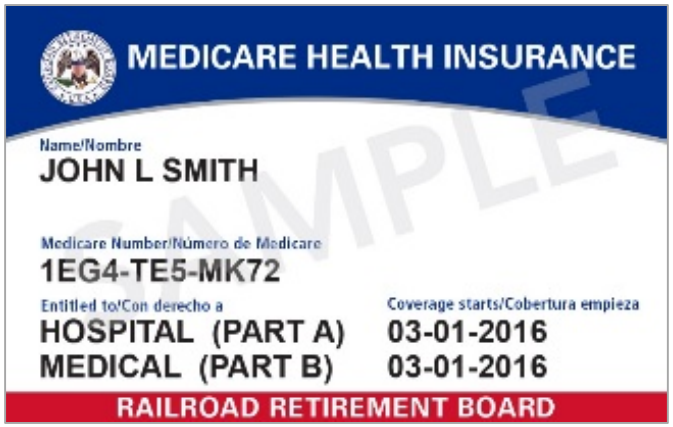
Excluded Part B Services

- Chiropractic care – except spinal manipulation
- Cosmetic surgery
- Custodial care
- Eyeglasses
- Hearing aids
- Immunizations (exceptions)
- Orthopedic shoes
- Prescription drugs
- Routine
  - Dental care
  - Eye exams
  - Foot care (exceptions)
  - Hearing exams
  - Physicals
- MLN® Booklet: *Items & Services Not Covered Under Medicare*

Medicare Card



Railroad Retiree Example



- Medicare Beneficiary Identifier (MBI)
  - Consists of 11 numbers and uppercase letters
  - Randomly generated unique MBI
- 1-800-MEDICARE on back of card
- RRB identified at the bottom

National Government Services

Deductibles/Coinsurance

Definitions

- Allowed Amount
  - The lower of the provider's submitted charge or the fee schedule allowance for the procedure
  - Payment is generally made at 80% of the approved charge
- Deductible
  - The first **$203** of approved charges for covered medical expenses is deducted per calendar year and it is the patients responsibility
- Coinsurance
  - The patient is responsible for 20% of the Medicare-approved amount in most cases
  - It can be collected at the time of the service and supplemental insurance may cover

Medicare Part B Premiums and Deductibles

2021 Premiums and Deductibles	Amounts
Monthly Part B Premium *Individual income above $88,000 up to $111,000 pay higher Part B Premium	$148.50 *$207.90
Part B Deductible	$203
Part B Coinsurance	20%
Mental Health Services	80%
Part A IH Deductible (first 60 days)	$1484
Days 61st – 90th Days	$371
Lifetime Reserve Day	$742
Skilled Nursing Facilities (21st -100th days)	$185.50

Where Can I Find Fee Schedules?

How Medicare Fee Schedules Work

- Medicare sets fees through the fee schedule
  - RVU
  - GPCI
  - Conversion factor
- Changes year-to-year and is approved by Congress
- Medicare physician fee schedule
  - MLN® Booklet: *How to Use the MPFS Look-Up Tool*

Fee Schedule Lookup

To initiate a search, select a fee schedule type from the drop-down menu, complete all required fields, then select **Search**.

Select a Fee Schedule: * Medicare Physician Fee Schedule Pricing

Result Type: *
- ○ Full Fee Schedule
- ◉ Specific To Fee Code

Date of Service: * 09/29/2021

Procedure Code: * 93000

Region: * New York (area 02)

Search

Medicare Physician Fee Schedule Pricing Fee Schedule

Procedure Code	Effective Date	State/Territory	Locality	Short Description
93000	01/01/2021	13202	02	Electrocardiogram complete

Non-OPPS Capped Payment Rates (NON-OPPS)

Modifier	NON FAC PAR	NON FAC NON PAR	NON FAC LC	FAC PAR	FAC NON PAR	FAC LC
(Details)	18.33	17.41	20.02	18.33	17.41	20.02

Non-OPPS Capped Payment Rates (NON-OPPS)

Modifier	NON FAC PAR	NON FAC NON PAR	NON FAC LC	FAC PAR	FAC NON PAR	FAC LC
(Details)	18.33	17.41	20.02	18.33	17.41	20.02

Modifier Selected: (blank)

Status	Conversion Factor	Update Factor	Work RVU	FAC PE RVU	NON FAC PE RVU
A	34.8931	1.0375	0.17	0.24	0.24
Malpractice RVU	Work GPCI	Practice GPCI	Malpractice GPCI	Reduced Therapy Amt	Endoscopic Base
0.02	1.046	1.223	2.702	0.00	99
Global Surgery	Facility Pricing	PC/TC	Preoperative Percentage	Interoperative Percentage	Postoperative Percentage
XXX	1	4	00.00%	00.00%	00.00%

Multiple Surgery	Bilateral Surgery	Assistant At Surgery	Two Surgeons	Team Surgery
6	0	0	0	0

Fee Schedule Assistance

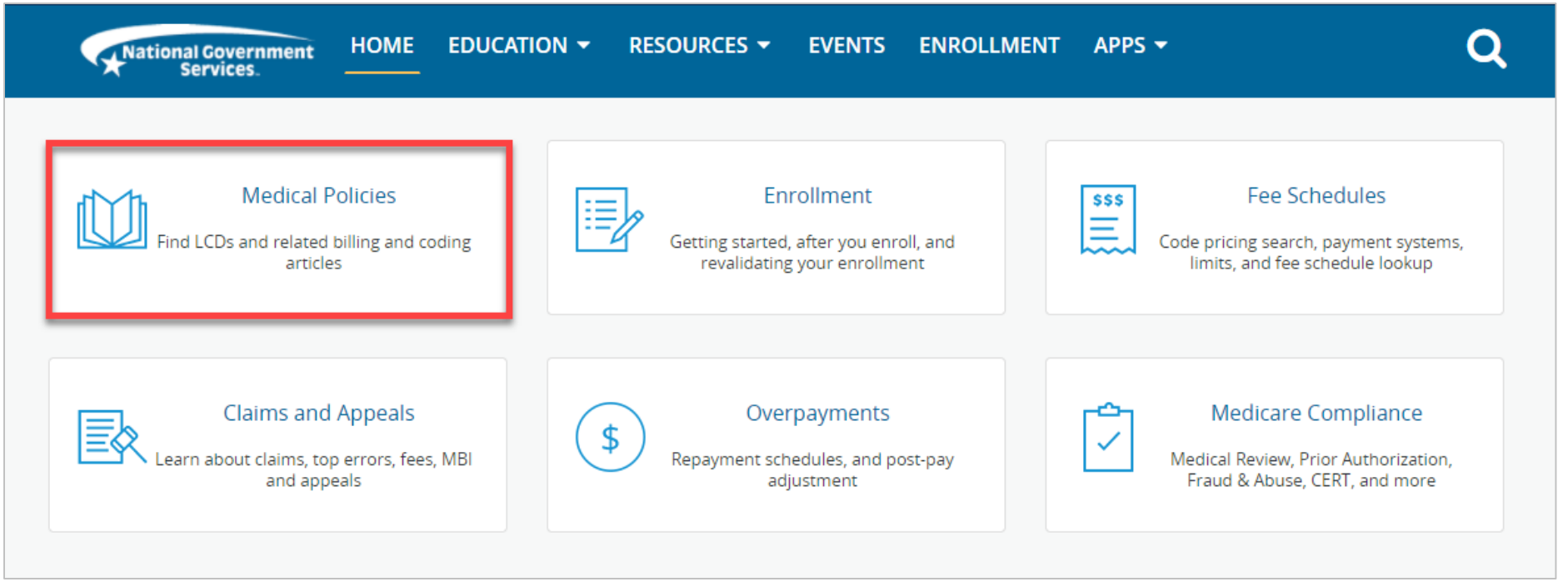
Description of Medicare Physician Fee Schedule Database Policy Indicators

- CPT/HCPCS
- Modifier
- Short Description
- Status Code
- PC/TC Indicator
- Global Surgery
- Multiple Procedure (Modifier 51)
- Bilateral Surgery (Modifier 50)
- Assistant at Surgery
- Co-surgeons (Modifier 62)
- Team Surgery (Modifier 66)
- Physician Supervision
- Diagnostic Imaging Family Indicator

Local Coverage Determinations

LCD

- Coverage Guidance
  - Indications of treatment
  - Limitations of treatment
  - Medical Necessity
- Local Coverage Article
  - Billing and coding guidance
  - Primary/secondary ICD-10-CM codes supporting medical necessity
  - Documentation requirements
  - Utilization guidelines/frequency


National Government Services
HOME
EDUCATION
RESOURCES
EVENTS
ENROLLMENT
APPS
Medical Policies
Find LCDs and related billing and coding articles
Enrollment
Getting started, after you enroll, and revalidating your enrollment
$$$
Fee Schedules
Code pricing search, payment systems, limits, and fee schedule lookup
Claims and Appeals
Learn about claims, top errors, fees, MBI and appeals
$
Overpayments
Repayment schedules, and post-pay adjustment
Medicare Compliance
Medical Review, Prior Authorization, Fraud & Abuse, CERT, and more

Resources

MEDICAL POLICIES

National Government Services Local Coverage Determinations

Welcome to Medical Policies. Below you will find the LCDs, related billing & coding articles and additional medical policy topics. When entering criteria into the search box, the search results will be conducted within the LCDs and the Medical Policy Articles shown below. For additional Medical Policy Topics, refer to the bottom of the page.

[View Draft Policies | View Future Effective LCDs | View Future Effective Billing & Coding Articles | National Coverage Determinations]

Search by LCD name, related items, LCD #, CPT/HCPCS Codes, and more

Local Coverage Determinations | Medical Policy Articles

Local Coverage Determinations

LCD	LCD #	Billing and Coding #	Response to Comments	Related CPT/HCPCS Codes
Autonomic Function Testing *Related terms: tilt table, sudomotor*	L36236	A57024	A54403	95921, 95922, 95923, 95924, 95943
B-type Natriuretic Peptide (BNP) Testing *Related terms: congestive heart failure, acute dyspnea*	L33573	A56826		83880
Biomarker Testing (Prior to Initial Biopsy) for Prostate Cancer Diagnosis *Related terms: N/A*	L37733	A56609	A56742	81539, 84153, 84154, 86316, 81479, 0005U
Biomarker Testing for Neuroendocrine Tumors/Neoplasms *Related terms: N/A*	L37851	A57059	A56247	0007M
Botulinum Toxins *Related terms: Botox, Myobloc, Dysport,Xeomin, spasticity, chemodenervation*	L33646	A52848		43201, 43236, 46505, 52287, 64611, 64612, 64615, 64616, 64617, 64642, 64643, 64644, 64645, 64646, 64647, 64650, 64653, 67345, J0585, J0586, J0587, J0588

Additional Medical Policy Topics

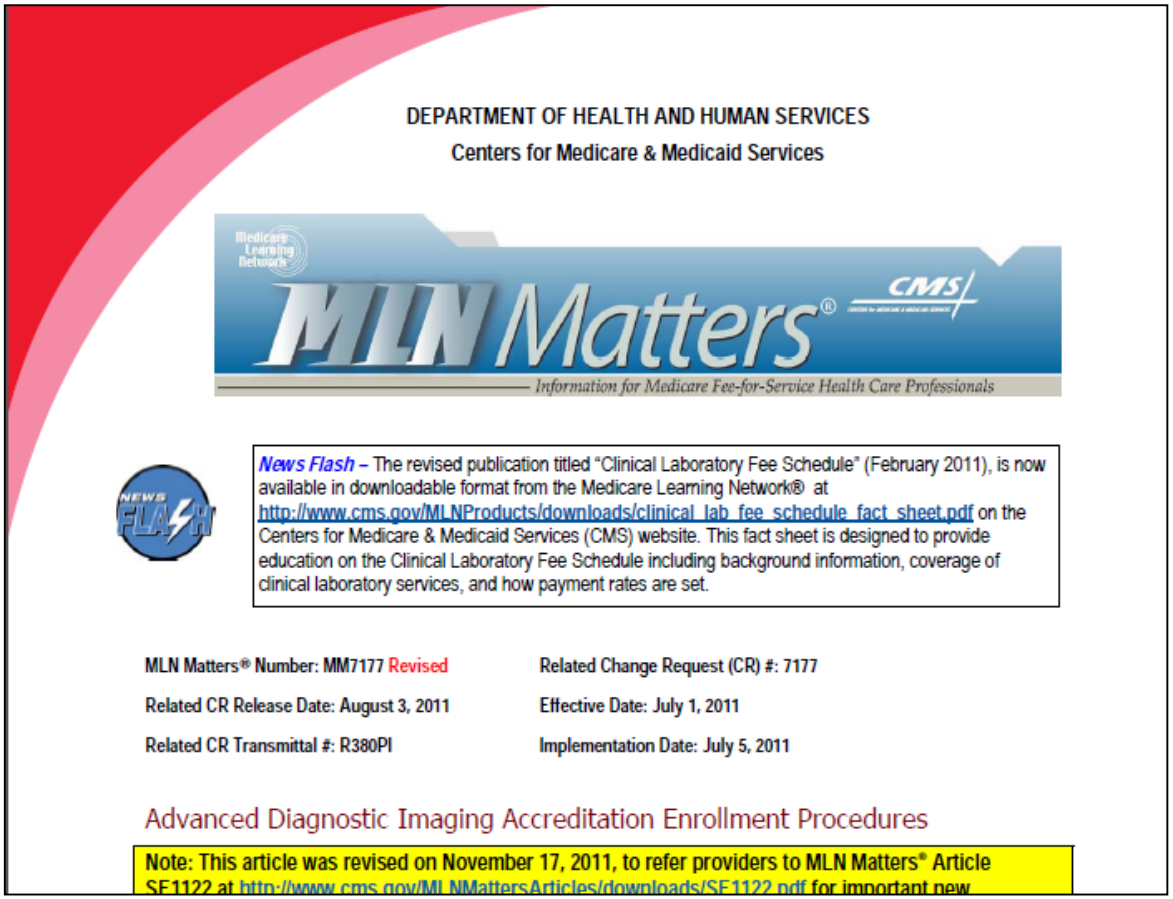
- Conflict of Interest Disclosure
- Contractor Advisory Committee (CAC)
- Investigational Device Exemption Request
- LCD Open Meetings
- LCD Reconsideration Process
- Medical Policy Contact Information
- New LCD Request Process
- Self Administered Drugs

Article for LCD Reconsideration Process A52842

- Requesting a revision to a final LCD
- Submit request via mail, email or fax
- Identify language that requestor wants added/deleted from LCD
- Copies of published evidence
- Response will be within 60 days of the day the request is received
- NGS will determine whether the request is valid or invalid and will notify the requestor of the determination

MLN Matters® Articles

- Change Request put into simple language



DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

MLN Matters® CMS

Information for Medicare Fee-for-Service Health Care Professionals

News Flash – The revised publication titled "Clinical Laboratory Fee Schedule" (February 2011), is now available in downloadable format from the Medicare Learning Network® at http://www.cms.gov/MLNProducts/downloads/clinical_lab_fee_schedule_fact_sheet.pdf on the Centers for Medicare & Medicaid Services (CMS) website. This fact sheet is designed to provide education on the Clinical Laboratory Fee Schedule including background information, coverage of clinical laboratory services, and how payment rates are set.

MLN Matters® Number: MM7177 Revised

Related Change Request (CR) #: 7177

Related CR Release Date: August 3, 2011

Effective Date: July 1, 2011

Related CR Transmittal #: R380PI

Implementation Date: July 5, 2011

Advanced Diagnostic Imaging Accreditation Enrollment Procedures

Note: This article was revised on November 17, 2011, to refer providers to MLN Matters® Article SE1122 at http://www.cms.gov/MLNMattersArticles/downloads/SE1122.pdf for important new

Claim Filing Guidelines

Ways to Submit a Claim to Medicare

- Paper claims (CMS-1500)
- EDI
- NGSConnex
- Claim filing time limitation
  - **Must** be filed within one year of the date of service
  - Limited exceptions

Tools Necessary For Coding Claims

- CPT code book
  - Numeric coding system that describes the services and procedures provided by a physician
- HCPCS code book
  - Alpha numeric coding system used by a physician to report services
- ICD-10-CM code books
  - Used to select appropriate diagnosis codes

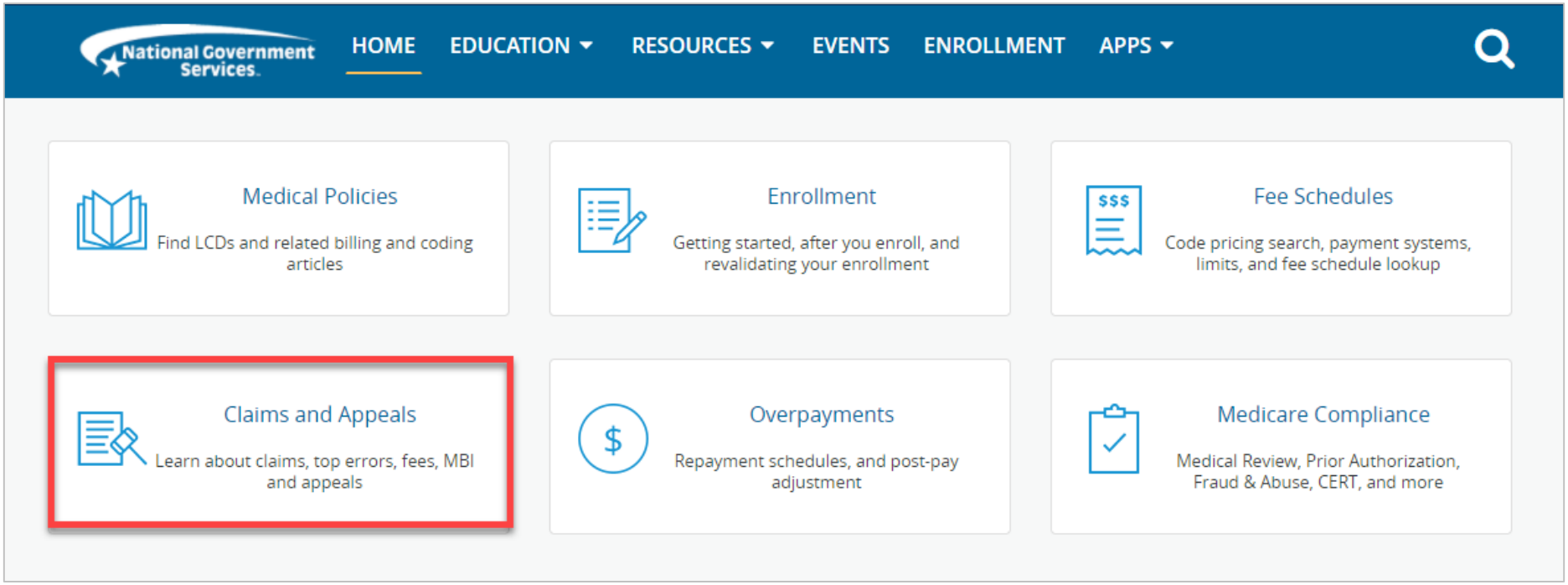
Unprocessable Claims

- Unprocessable claims
  - Claims submitted with incomplete or invalid information are returned as **unprocessable;** these claims have **no appeal rights**
- Returning a claim
  - An explanation of the errors will be provided in the form of a description or code

Avoid Duplicate Claims

- **Allow 29 days** for paper claims and **14 days** for electronic claims to be processed
- Electronic claims submitters should
  - Check your EDI validation report to verify claims were received and accepted
  - Check your software system to verify claims are not set up for automatic rebill every 30 days
  - Review your remittances

The Appeals Process



Five Levels of Appeal

	Level One	Level Two	Level Three	Level Four	Level Five
Type of Appeal	Redetermination	Reconsideration (QIC)	ALJ- Administrative Law Judge Hearing	MAC – Medicare Appeals Council	Federal Court Review
Time Limit for Filing Appeal	120 days from date of receipt of the initial determination notice	180 days from date of receipt of the redetermination decision	60 days from the date of the reconsideration (QIC decision)	60 days from date of receipt of the ALJ decision	60 days from date of receipt of the MAC decision
Amount in Controversy (monetary threshold to be met)	No minimum (none)	No minimum (none)	The amount that must remain in controversy for ALJ hearing for requests filed on or after **1/1/2021 is $180**	No minimum (none)	For requests filed on or after **1/1/2021 at least $1,760 remains in controversy**

What Is a Reopening?

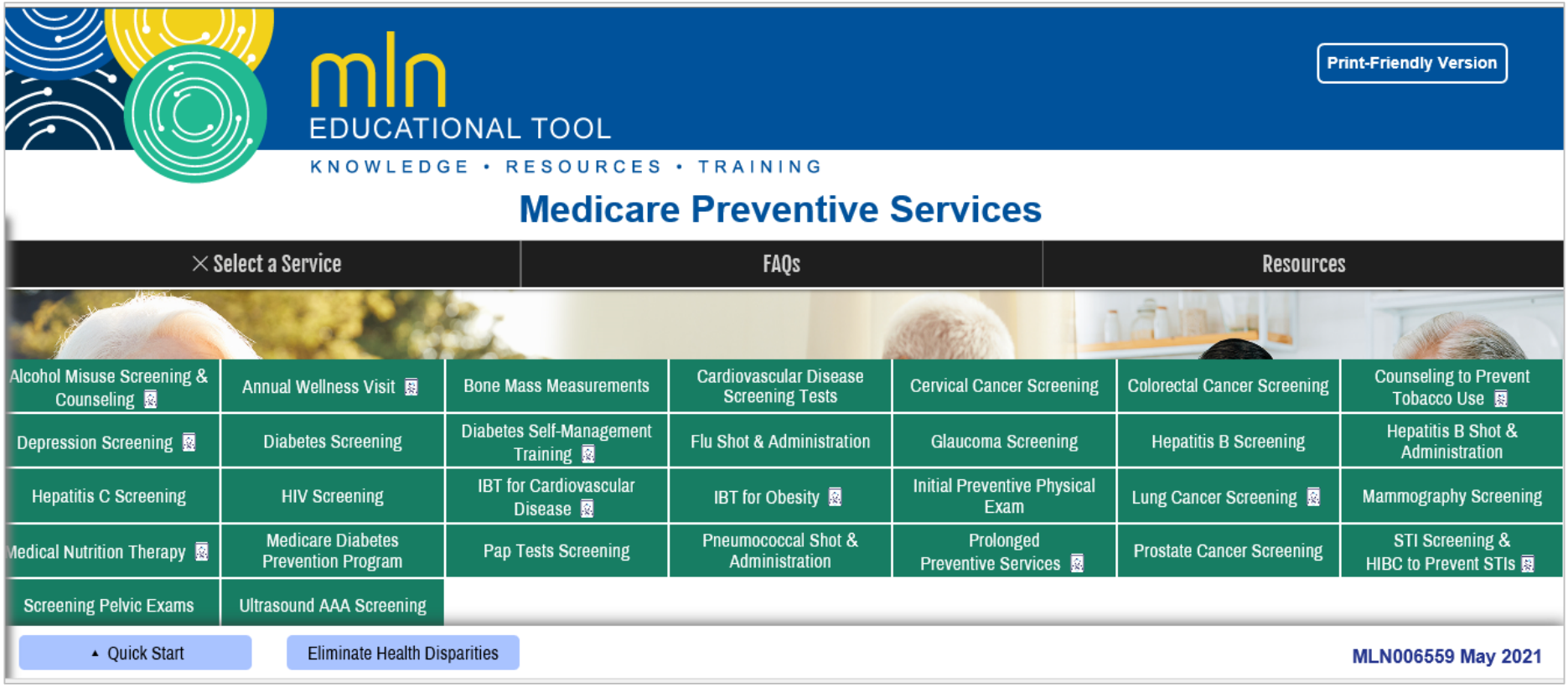
- Allows providers and suppliers to **correct clerical errors** or **omissions** without having to request a formal appeal
- A reopening can be initiated via **telephone**, in **writing** or **NGSConnex**
  - Reopenings for Minor Errors and Omissions

Contacting the Telephone Reopening Unit

- TRU Line JK: 888-812-8905
- TRU Line J6: 877-867-3418
- Hours of operation
  - Monday–Friday
    7:00 a.m.–3:00 p.m. CT/8:00 a.m.–4:00 p.m. ET
  - Closed for training the 2nd and 4th Friday of the month
    - JK: 12:00–4:00 p.m. ET
    - J6: 11:00 a.m.–3:00 p.m. CT
- Faxes accepted and representatives are permitted to accept more than three claims per call

Preventive Services

MLN Educational Tool – Preventive Services Chart (MLN006559)



Front Office

Staff

- Front office staff is key to determining what type of insurance should be billed for services
- This job is not only the collection of patient information, copying insurance cards and health information, but also **verifying insurance information with the different contractors**

Traditional Fee-for-Service Medicare

Applying for Medicare

- Beneficiary reaches 65 and notifies Social Security office to apply for Medicare Part B
- Seven month period starting with three months prior to age 65, up to three months after
- Medicare Part B is a voluntary program – Beneficiaries pay a monthly premium

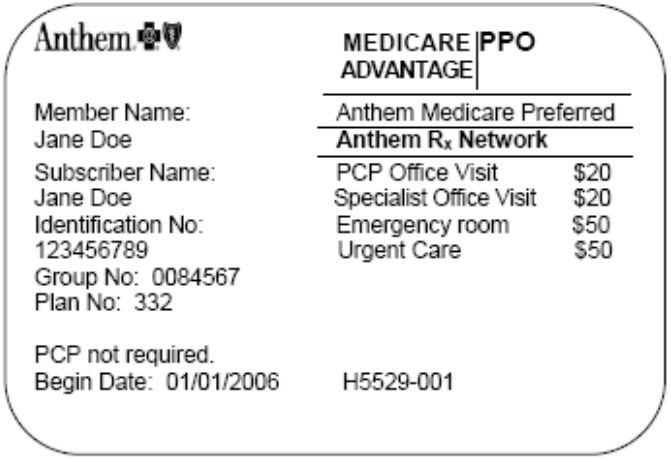
Applying for Medicare

- If beneficiary didn't sign up during initial seven-month enrollment period they can sign up from January 1–March 31 of each year
- May have to pay a higher premium for late enrollment
- If covered under a group health plan based on **current employment,** they qualify for a separate enrollment period (SEP)

Medicare Advantage Plans

Medicare Advantage Plans

- Private insurance companies approved by Medicare provide this coverage
- In most plans, you need to use plan doctors, hospitals, and other providers, or you may pay more or all of the costs



Medicare Advantage Plans

- You pay a **monthly premium** (in addition to your Part B premium), copayment or coinsurance for covered services
- Costs, extra coverage and rules vary by plan
- Your plan may require preapproval for services

Medigap/Supplemental Insurance

What Is Medigap Insurance

- Health insurance sold by private insurance companies to fill the “gaps” in traditional Medicare Plan coverage
- Some policies cover extra benefits that aren’t normally covered by traditional Medicare
- Claims will be forwarded to the Medigap carrier **once the office enters** appropriate Medigap carrier information on the claim form (OCNA)

What Is Supplemental Insurance?

- Generally a retiree benefit from their company
- They normally do not have to pay for it and it crosses automatically from the Medicare office
- Beneficiary must let Social Security office know if they have a secondary insurance to Medicare

Documenting Medicare Secondary Payer Information

- The CMS-model MSP Questionnaire can be found in the CMS IOM Publication 100-05, *Medicare Secondary Payer (MSP) Manual*, Chapter 3
- Review questionnaire with the beneficiary
  - Do not assume responses
- Document
  - Both positive and negative responses
- Develop internal policies for unable or unwilling beneficiaries
- Recommended to save MSP information for ten years from date of service

Benefits Coordination & Recovery Center

- BCRC
  - Formerly known as coordination of benefits
  - Most up-to-date and accurate beneficiary insurance information
- Customer service representatives available
  - Monday–Friday, 8:00 a.m.–8:00 p.m. ET, except holidays
    - 855-798-2627
    - TTY/TDD: 855-797-2627 (hearing and speech impaired)

How Do I Check Patient Eligibility?

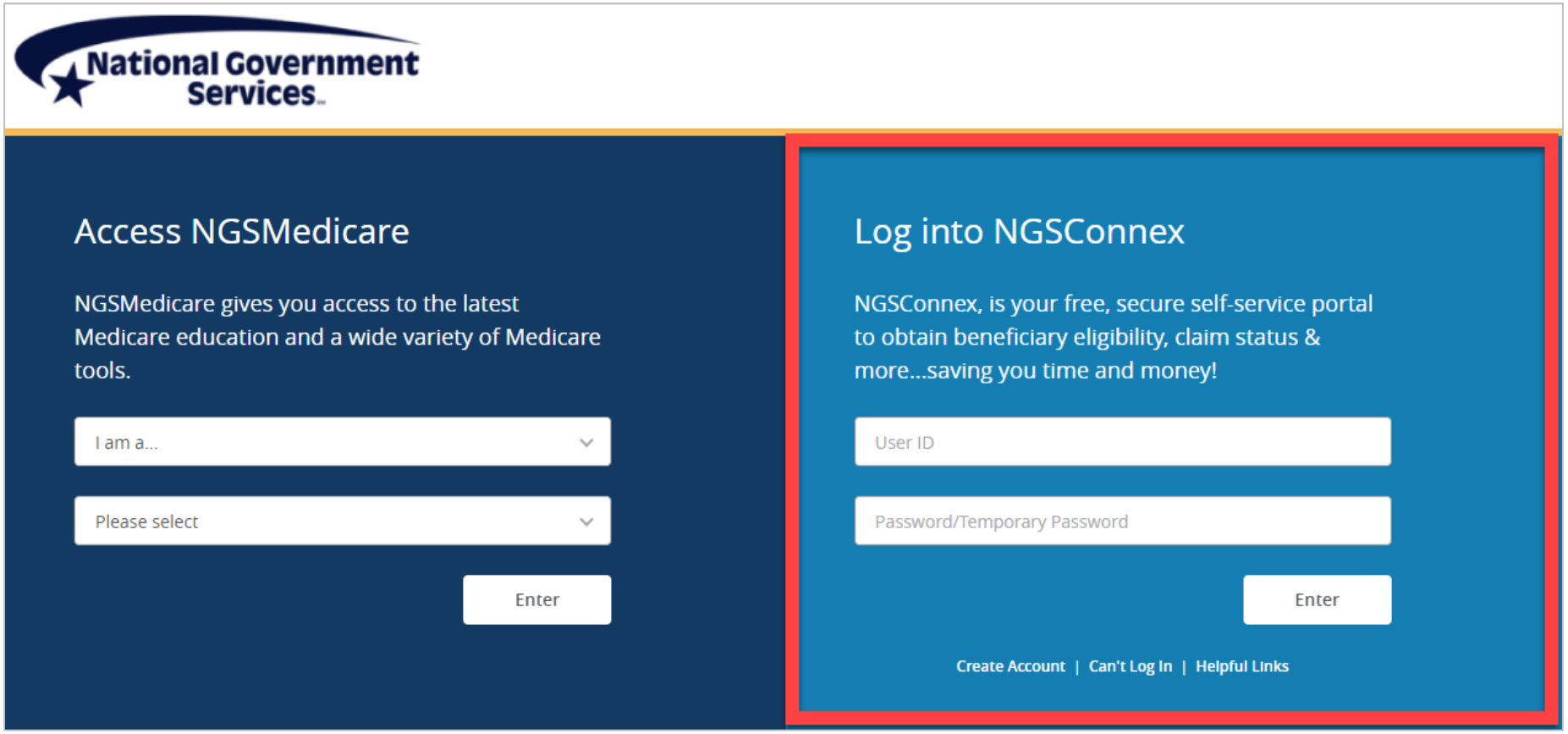
Primary Payer Identification Methods

- Check Medicare's records
  - NGSConnex
  - IVR
  - Other online eligibility
- Collect information
  - Ask patient, representative/family member
  - MSP Questionnaire

NGSConnex

What Is NGSConnex – Free Program

- NGSConnex
- Only need Internet access and email address
- Provides
  - Beneficiary eligibility/therapy caps
  - Claim status-duplicate claim status
  - Financial data/provider demographics
  - Ability to order/download duplicate remittances
  - Redeterminations/reopenings
  - Inquiries
  - Submission of medical records (ADR request)
  - Print and view appeals letters
  - Claims submission
  - Preventive services


National Government Services
Access NGSMedicare
NGSMedicare gives you access to the latest Medicare education and a wide variety of Medicare tools.
I am a...
Please select
Enter
Log into NGSConnex
NGSConnex, is your free, secure self-service portal to obtain beneficiary eligibility, claim status & more...saving you time and money!
User ID
Password/Temporary Password
Enter
Create Account | Can't Log In | Helpful Links

Hours of Availability

- NGSConnex is available 24/7
- Information obtained from the local system is only available
  - Monday–Friday: 7:00 a.m.–6:00 p.m. ET
  - Saturday: 7:00 a.m.–3:00 p.m. ET
- Not available during system upgrades or maintenance

JK Contact Information

- IVR: **877-869-6504**
- Provider Contact Center: **866-837-0241**
- EDI Helpdesk: **888-379-9132**
- Correspondence
  - National Government Services, Inc.

    Part B Provider Written General Inquiries
    P.O. Box 6189
    Indianapolis, IN 46207-6189
- Direct telephone line for provider enrollment JK: **888-379-3807**

J6 Contact Information

- IVR: **877-908-9499**
- Provider Contact Center: **866-234-7340**
- EDI Helpdesk: **877-273-4334**
- Correspondence
  - National Government Services, Inc.

    Part B Provider Written General Inquiries
    P.O. Box 6475
    Indianapolis, IN 46206-6475
- Direct telephone line for provider enrollment J6: **877-908-8476**

Provider Contact Center Training Closure

- PCC closes twice a month for training and staff development
  - Training is conducted on the 2nd and 4th Friday of each month from 11:00 a.m.–3:00 p.m. CT and 12:00 p.m.–4:00 p.m. ET
- This schedule was determined based on our lowest call volume times to reduce impact to our providers

Thank You!

- Follow-up email
  - Attendees will be provided a Medicare University Course Code
- Questions?

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