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National Government Services

Fundamentals of Medicare – Part 2

Building Your Medicare Knowledge Base

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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- Presentation is available on our website
  - Accept the Attestation then in the I am a… drop-down box, select your provider type and applicable state; then click enter. On the Welcome page, click the Events tab
  - Click the Read More link to view the Presentation link
- Materials from prior webinars are available
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Objective

- Provide a basic understanding of the fundamentals of the Medicare Program

Agenda

- Medicare Part B
- Other Medicare Coverage
- Medicare Secondary Payer
- Home Health Benefit
- Noncovered Services
- Preparing Claims for Submission to Medicare
- EFT and ERA
- Fraud, Abuse and Benefit Integrity
- Provider Enrollment
- Additional Information and Resources

Medicare Part B

Did You Know

- It is very important to know whether a Medicare beneficiary has Medicare Part B coverage
  - Beneficiary has the option of selecting Medicare Part B when they first become eligible for Medicare
  - Beneficiary must have Medicare Part B to cover outpatient services
    - **Exception**: Beneficiary has other coverage that will pay for outpatient services

Medicare Part B

- Covers care outside of inpatient stay
  - Doctor’s office visits
  - Emergency room services
  - Outpatient clinic visits
  - Diagnostic and screening tests
  - Outpatient surgery

Medicare Part B

- Services provided in various locations
  - Physician's office
    - A/B MAC – Part B
      - CMS 1500 claim form or electronic equivalent
  - Facility outpatient settings
    - A/B MAC – Part B of A
      - CMS 1450 claim form or electronic equivalent
- Part B cost-sharing
  - Annual premium and deductible apply
    - Deductible is not always met during the first visit of the year
  - Coinsurance is charged based on services rendered

Preventive Services

- Not all services covered in full
  - Deductible and/or coinsurance is waived for certain preventive services
  - Deductible and/or coinsurance may apply
- May have different coverage guidelines for screening versus diagnostic testing
  - Diagnostic = patient is high risk
    - Personal or family history
    - Symptom(s) of condition
    - Reasonable suspicion of condition based on medical evaluation

Preventive Services

- Additional preventive services are periodically added to those with coinsurance and/or deductible waived
- MIPPA of 2008 allows for future payments for additional preventive services
- More preventive services may be approved through the NCD process

Other Medicare Coverage

Medicare Advantage Plans

- Balanced Budget Act of 1997 gave beneficiaries many new options
  - Medicare HMO
  - Private PFFS plans
- Eligibility requirements
  - Must have Part A and Part B
  - Does not have ESRD
  - Live in plan service area

Medicare Health Maintenance Organizations

- Private insurance companies contracted by CMS
- Same benefits as traditional Medicare plus varying additional benefits
  - Examples: Hearing aids, eyeglasses, dental care

Medicare HMOs

- Two categories of Medicare HMOs
  - Risk based
    - Beneficiaries must stay within provider network
    - HMO may deny payment if HMO regulations are not followed
  - Cost based
    - Beneficiary has freedom of choice with providers

Did You Know

- When a beneficiary selects a plan within an MAO (e.g., a Medicare HMO), all health care claims will have to be submitted to that Medicare HMO
  - Additional Information
    - CMS website for MAO Plan information
    - Medicare Advantage/Part D Contract and Enrollment Data
    - MA Plan Directory (sorted by contract number or name)

Medigap Plans

- Ten standardized plans
  - Plan A–Plan J
    - Also Medicare SELECT plans
  - Not in Massachusetts, Minnesota or Wisconsin
- Each plan has set of benefits
  - Plan A = Basic benefit
  - Plans B–J = Basic benefit plus additional benefits
- Can compare plans offered by different companies
  - Different prices, same benefits

Medicare Secondary Payer (MSP)

MSP

- Medicare beneficiary has other coverage that pays before Medicare, as required by federal law
- MSP provisions or MSP categories
  - GHP
  - Non-GHP

Did You Know

- To properly determine when another payer is primary to Medicare, providers must be familiar with the MSP provisions

GHP MSP Provisions/Categories

- Relate to beneficiary's reason for having Medicare entitlement
- If all criteria within one of these provisions has been met, then GHP is primary
- Three GHP MSP provisions
  - MSP working aged provision
  - Disabled MSP provision
  - ESRD MSP provision

Non-GHP MSP Provisions/Categories

- Do not relate to beneficiary's reason for having Medicare
- Primary when certain conditions are met
  - Federal Black Lung Program
  - PHS including research grants
  - Governmental entities
  - Workers' Compensation
  - Automobile no-fault (medical-payment or PIP)
  - Other types of no-fault (premises medical-payment)
  - Liability

Identifying Payers Primary to Medicare

- Under CMS' Medicare provider agreement, any provider that submits claims to Medicare must determine whether or not Medicare is primary payer for those services
  - Therefore, all Medicare providers are required to identify payers that are primary to Medicare
    - Have conditions/criteria for any one or more of MSP provisions been fully met?

Benefits of Identifying Payers Primary to Medicare

- Many benefits
  - Compliance with Medicare provider agreement
  - Avoid being selected for MSP hospital review
  - Improve reimbursement
  - Reduce staff time spent correcting claims

Did You Know

- Despite the MSP information that may be present in Medicare's records for a beneficiary, the information collected from the beneficiary during the MSP screening process is considered to be the most current

✓ Recent Update: MM 11945, effective12/7/2020, "Update to the Model Admission Questions for Providers to Ask Medicare Beneficiaries"

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Two Methods to Identify Primary Payers

- Provider must
  - Collect MSP information from beneficiaries by conducting MSP screening process
    - CMS IOM Publication 100-05, *Medicare Secondary Payer Manual*, Chapter 3, Section 20.2.1
  - Check for available MSP information for beneficiaries in Medicare's records
    - CWF/HETS, NGSConnex, IVR
- Both of the above must be done before submitting claims to Medicare

Online MSP Files in CWF

- If file exists, information available includes
  - MSP primary payer code or MSP VC
  - MSP effective date
  - MSP termination date, if applicable
  - Subscriber name and policy number
  - Patient relationship
  - Insurer information
  - Employer information

Determining the Proper Primary Payer

- Compare MSP information in Medicare’s records to collected MSP information
- Determine proper primary payer
  - MSP Provision conditions/criteria met?
  - Resolve conflicts
- May need to have Medicare’s records updated by BCRC
- Submit claims accordingly

If Another Payer Is Primary

- Prepare and submit claim to primary payer
  - Follow up often as Medicare timely filing applies even when Medicare is secondary
- Upon receipt of response, prepare MSP or conditional claim, if appropriate
  - Matching MSP file must be present in CWF prior to claim submission; otherwise claim will be RTP
  - If none present, BCRC must be contacted

If Medicare Is Primary

- Prepare and submit Medicare primary claim
  - Claim must have coding/remarks as to why Medicare is primary, or
  - MSP file in CWF must be updated (by BCRC) prior to claim submission; otherwise claim will be rejected
    - Existing accident-related MSP files
    - Existing GHP-related MSP files
- Tip: MSP rejected claims must be adjusted to be resolved

MSP and Conditional Claims

- MSP claims
  - Claims partially or fully paid by primary payer
- Conditional claims
  - Claims not paid by primary payer for valid reason or promptly in certain accident cases
- Submit electronically
  - Do not submit hardcopy unless you have ASCA waiver
  - **Tip:** Ensure there is an existing MSP record prior to claim submission

Common Medicare HMO/MSP Misconception

Q. When the Medicare HMO does not pay for services/charges for the beneficiary, how do we submit an MSP claim?

A. You don’t. Medicare HMO coverage takes the place of traditional Medicare coverage

- Medicare does not pay secondary to a Medicare HMO
- No claim is submitted to the traditional Medicare Program

Benefits Coordination & Recovery Center

- Report employment changes, any other insurance coverage information
- Report liability, automobile/no-fault and workers compensation case
- Add new MSP file to CWF
- General MSP questions/concerns

BCRC

- Questions regarding MSP development letters and MSP questionnaires
- Telephone inquiries to BCRC: 855-798-2627
  - Hearing/speech impaired: TTY/TDD: 855-797-2627
- Additional information
  - CMS MLN SE1416 “Updating Beneficiary Information with the Benefits Coordination & Recovery Center (formerly known as the Coordination of Benefits Contractor)”

MSP Resources

- CMS IOM Publication 100-05, *Medicare Secondary Payer Manual*
- Fiscal Intermediary Standard System/Direct Data Entry Provider Online Guide (FISS/DDE Provider Online Guide)
  - Second way to locate: NGSMedicare.com → Education → Manuals → FISS DDE Online Guide
- CMS MLN Fact Sheet: "Medicare Secondary Payer" for providers, physicians, other suppliers and billing staff; ICN 006903
- Check for upcoming MSP education
  - NGSMedicare.com → Education

Home Health Benefit

Inpatient Hospital Discharge Planning - Home Health Services

- Hospitals must
  - Have discharge planning process for all patients
  - Include discharge planning evaluation in beneficiary’s medical records
    - Evaluation must include evaluation of likelihood of beneficiary needing post-hospital services and availability of services
  - Discuss results of evaluation with beneficiary or individual acting on their behalf
- Fact Sheet: CMS’ Discharge Planning Rule Supports Interoperability and Patient Preferences

Home Health Benefit

- Skilled medical care in the beneficiary's home for treatment of an illness or injury
  - CMS Home Health Fact Sheet, ICN 908143, "Medicare Home Health Benefit"

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Home Health Coverage

- Medicare Part A or Part B
- Physician established plan of care
  - Responsible for creating, certifying and recertifying plan of care
- Need for intermittent skilled care
  - Skilled nursing care, PT, OT and SLP
- Beneficiary considered homebound
- Care provided by Medicare-certified HHA

Home Health Services Covered by Medicare

- Patient must require reasonable and necessary part-time or intermittent
  - Skilled nursing care
  - PT
  - SLP
    - OT and medical social work services must be combined with any of the above services
- Medical supplies, DME and home health aide services are other services that may be covered

Home Health Period of Care

- Unit of payment for HH PPS
- Period payment is specific to one individual homebound beneficiary
- Period pays for all covered HH care that is reasonable and necessary
  - Including routine and nonroutine supplies
- Period is only Medicare form of payment

Did You Know

- HH certification episode information is available on CWF
  - Not checking to see if beneficiary is under HH care can cause claims to not be paid by Medicare or HHA

Services Subject to Home Health Consolidated Billing

- Part-time or intermittent skilled nursing services
- Skilled therapy services (PT, OT, SLP)
- Routine and nonroutine medical supplies
- Part-time or intermittent home health aide services
- Medical social services
- Negative pressure wound therapy (NPWT) furnished using a disposable device
- Covered osteoporosis drugs as defined in [Section 1861(kk) of the Act]
- Care for homebound patients involving equipment too cumbersome to take home

Responsibilities of Providing Therapy Services

- Therapy providers
  - Must determine whether or not HH episode of care exists
  - Should ask beneficiary or representative if he/she is presently receiving HH services
- If provider learns of HH episode
  - Advise beneficiary that if he/she decides not to have services at primary HHA, he/she will be liable for services

Noncovered Services

Did You Know

- Not all services provided to Medicare beneficiaries are covered/payable under the Medicare Program
- Examples of noncovered services include, but are not limited to
  - Foot care
  - Custodial care
  - Personal comfort items
  - Cosmetic surgery
  - Dental surgery
  - Services not reasonable and necessary
- CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 16
- CMS MLN Booklet, ICN MLN906765, "Items and Services Not Covered Under Medicare"

What Is an ABN?

- Written notice given to beneficiary before services are furnished when physician, supplier, or provider believes that Medicare probably or certainly will not pay for some or all of the items or services
  - Shifts liability to beneficiary
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 30, Section 50

When Should an ABN be Issued?

- Issue ABN prior to rendering service(s) when there is an expectation of Medicare denial
  - Must state the reason provider believes services will not be covered
  - Services not reasonable/medically necessary
    - Examples: Preventive service exceeding frequency limitation
  - Care considered custodial
  - Therapy services above cap that do not qualify for therapy cap exception
- Beneficiary must comprehend contents
  - Cannot be under duress
  - Cannot be coerced
  - Informed consumer choice

Voluntary ABN

- Issuance not required for care either statutorily excluded (SSA Section 1862[a][1] and [9]) from coverage under Medicare (i.e., never covered) or care that fails to meet technical benefit requirement (i.e., lacks required certification)
  - ABN may be issued voluntarily
- Serves as courtesy to beneficiary in forewarning of impending financial obligation
  - Beneficiary should not be asked to choose an option box or sign notice

Forms

- ABN (Form CMS-R-131)
  - To deliver a valid ABN, a provider must use the most recent version of the CMS-R-131
    - Most current version contains expiration date 6/30/2023
  - Additional information on ABN
- **Note:** Additional notices are required for
  - SNF – SNFABN
  - Inpatient Hospital – Hospital-Issued Notices of Noncoverage (HINN)
  - Medicare Outpatient Observation Notice (MOON)
  - Beneficiary Notices Initiative (BNI): Additional Notices

Preparing Claims for Submission to Medicare

Did You Know

- Submitting claims correctly the first time can save time and money, and ensure timely, accurate Medicare reimbursement
- Prior to claim submission
  - Check with appropriate internal departments to ensure all services rendered are reported on the claim
  - Ensure all required data elements are entered accurately and completely

What is a Clean Claim?

- Claim does not require us to investigate or develop externally on prepayment basis
- Clean claims must
  - Be filed in the timely filing period
  - Pass all edits
  - Not require external development
  - Include all information necessary to adjudicate claim and all supporting documentation (if required)

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Timely Filing Guidelines

- All Medicare FFS claims must be filed no later than one calendar year after the date service
  - Applies to both initial submissions and adjustment claims
- Generally, start date is date of service or “From” date on claim
  - Inpatient claims timely filing is based on the date of discharge
  - Outpatient claims spanning multiple service dates: timely filing based on line item date of service

Timely Filing Exceptions

- Administrative error
- Retroactive Medicare entitlement
- Retroactive entitlement involving Medicaid
- Retroactive disenrollment from MAO plan

- Additional information: CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 1, Section 70 – Time Limitations for Filing Part A and Part B Claims

Duplicate Claim

- Definition: An exact duplicate is a claim or claim line exactly matching another claim or claim line with respect to following elements
  - MBI
  - TOB
  - NPI number
  - From and through dates of service
  - Total charges (on line or on bill)
  - HCPCS/CPT codes, or procedure code modifiers
- Results in rejection reason code 38XXX
  - Tip: Adjust claim rather then submit new claim

Double Trouble: Beware of Duplicate Submissions

- Duplicate and overlap submissions account for highest percentage of Medicare claim rejections
- To avoid duplicate submissions
  - Be aware of Medicare claim processing timeframes
  - Ensure facility’s internal billing policies in accord with Medicare regulations
  - Communicate with other areas of facility to avoid double billing
  - Identify automated claim submission processes which may result in duplicate billings

Preventing Claim Duplicates/Overlaps

- Before submitting claim for inpatient/outpatient services, review patient file to identify other inpatient/outpatient services for DOS
- Review FISS Inquiry Claim Summary screen to ensure claim not already processing
  - If so, wait for claim to finish processing, then adjust claim to add services
- Include all inpatient/outpatient services (coding, charges) for DOS on single claim

MSP and Conditional Claims

- MSP claims
  - Claims partially or fully paid by primary payer
- Conditional claims
  - Claims not paid by primary payer for valid reason or promptly in certain accident cases
- Submit electronically via 837I claim
- Do not submit hardcopy unless you have an ASCA waiver
  - **Tip:** Ensure there is an existing MSP record prior to claim submission

Submit Claim to Medicare

- Via FISS DDE or through clearinghouse
- Using 837I electronic claim form
- EDI information available online
- UB-04/CMS 1450 hardcopy claim form
  - Must have approved ASCA waiver
    - ASCA Requirements for Paper Claim Submission

Fiscal Intermediary Standard System

- National Government Services uses to process claims and maintain records
- Providers access through online computer system
  - Patient information
  - Claim status
    - Processing (“in suspense”)
    - Paid/processed
    - Rejected
    - Denied
    - Returned to provider for correction

Claims Status/Locations

- When a claim is submitted for processing, the claim will receive a status/location; the basic status/locations include
  - P B9997 – Claim processed
  - S XXXXX – Claim suspended
  - R B9997 – Claim rejected
  - T B9997 – Claim returned
  - D B9997 – Claim denied

Claim Status – Provider Action

- If claim has been returned (T B9997)
  - Log into FISS/DDE
  - Make necessary claim corrections
    - Select PF9 to resubmit claim
- If claim has been rejected (R B9997)
  - No action may be needed, determined by reason code
  - May have to resubmit (or adjust) claim, if appropriate
- If claim has been denied (D B9997)
  - Determine if an appeal is needed
  - Documentation must support services rendered

Appeals

- When a claim is denied by Medicare, the provider has the right to appeal (redetermination) the decision
  - Appeal is based on the amount in controversy
- Processed claim is considered an initial determination by Medicare; claim may be
  - Fully paid (no amount in controversy) or
  - Partially paid (some of the amount is in controversy) or
  - Fully denied (entire amount in controversy)

Who Can Submit an Appeal

- Beneficiary
  - Has the right to appeal Medicare's decision to deny or reduce payment on the basis of SSA, Section 1862(a)(1)
- Provider
  - Has the right to appeal Medicare's decision
- Additional information about Appeals
- NGSMedicare.com → Claims & Appeals → choose from the following
  - About Appeals
  - Levels of Appeals and Time Limits for Filing or
  - Reopenings for Minor Errors and Omissions

Types of Situations That Can Be Appealed

- Services determined to be not reasonable and necessary
- Application of the coinsurance provision
- Number of lifetime reserve days used
- Physician certification requirement
- Beginning and ending of a benefit period
- A determination with respect to limitations of liability provision
- CERT denials
- Recovery Auditor denials

Types of Situations That Can Be Appealed

- Amount of deductible
- Number of inpatient hospital days used toward the 190-day lifetime limitation of inpatient psychiatric hospital covered days
- Number of SNF days used
- Request for payment requirement
- Coverage of furnished items and service
- Benefit Integrity Support Center (BISC) denials
- Prepay and postpay probes

EFT and ERA

What Is EFT?

- A means of receiving your Medicare payment electronically
  - Similar to other direct deposit operations such as paycheck deposits
- Safe modern alternative to paper checks

Benefits of EFT

- Reduction in the amount of paper in your office
- Valuable time savings for staff and avoidance of hassle associated with going to the bank to deposit Medicare check
- Elimination of the risk of Medicare paper checks being lost or stolen in the mail

Benefits of EFT

- Faster access to funds
  - Many banks credit direct deposits faster than paper checks
- Easier reconciliation of payments with bank statements

What Is ERA?

- An ERA is
  - Notice of payment that explains reimbursement decisions made on processed claims
  - Outbound EDI transaction that enables providers to receive payment information in an electronic file format

Benefits of ERA

- If providers have software capability in place in their system
  - Can create an ERA file where Medicare can automatically post to accounts receivable system
  - Once system is in place, payment process is more efficient and accurate
  - Provides faster payment and claim reconciliation

Benefits of ERA

- Access to
  - All claims screen
  - Single claim screen
  - Type of bill summary screen
  - Payment screen
- Free software such as PC-Print available to create a view only
- Efficient and accurate payment posting

How to Request EFT/ERA

- EDI Enrollment
  - EDI Guided Enrollment User Guide
- Set Up Electronic Funds Transfer (EFT)
  - Complete and return Electronic Funds Transfer (EFT) Authorization Agreement (CMS-588) form
- ERA
- **Note:** EDI Enrollment process recently updated – review the entire *EDI E-Signature User Guide* before enrolling or revalidating enrollment

CMS Website on Remittance Advice

- Health Care Payment and Remittance Advice Electronic Remit Advice (ERA) and Standard Paper Remit (SPR)
- NGS article "Remittance Advice Codes: What Are They and Where to Find What They Mean"

Fraud, Abuse and Benefit Integrity

Fraud

- Fraud occurs when someone intentionally falsifies information or deceives Medicare
- Examples of fraud include, but are not limited to
  - Incorrect reporting of diagnoses or procedures
  - Billing for services not furnished or supplies not provided
  - Deliberate duplicate billing

Abuse

- Abuse occurs when providers do not follow good medical practices, resulting in unnecessary costs to Medicare
- Examples of abuse include, but are not limited to
  - Improper billing practices
  - Unbundling of services
  - Unnecessary transfers to acute and PPS exempt units

Did You Know

- Fact Sheet: 2020 Estimated Improper Payment Rates for Centers for Medicare & Medicaid Services (CMS) Programs
  - Medicare FFS improper $25.74 billion (6.27%) distributed in improper payments
  - FY 2020 Medicare FFS estimate
  - Compares to the FY 2019 estimated improper payment rate of 7.25%, representing $28.91 billion in improper payments
    - The decrease was driven by reductions in the improper payment rates for home health and skilled nursing facility claims
- CMS continues aggressive enforcement of fraud and abuse
- CMS employs multi-faceted efforts to target the root causes of improper payments, with an emphasis on prevention-oriented activities

Benefit Integrity

- It is every person's ethical responsibility to report fraudulent activity
- CMS actively investigates fraudulent and abusive billing practices
- Providers obligated by law to conform to Medicare requirements
- Ethical thin ice statements
  - "No one will ever find out"
  - "We can hide it"

Hot Tip

- Beneficiaries and others can collect rewards for reporting fraud and abuse, if their information leads directly to the recovery of Medicare money
  - Whistleblower
- Medicare Fraud & Abuse webpage

Provider Enrollment

Provider Enrollment Revalidation

- Who
  - All providers five years after initial enrollment or last revalidation
- When
  - Only when notified and before due date
  - Notices are mailed two–three months prior to due date
  - Unsolicited revalidation applications returned if received more than seven months prior due date
- What
  - Verify entire Medicare enrollment record
- Why
  - Avoid payment hold or deactivation of Medicare billing privileges by responding promptly

Provider Enrollment Revalidation

- Check PECOS
- Check CMS website
  - Medicare Provider-Supplier Enrollment – Revalidations
  - Medicare Revalidation List Tool
    - Due date will display or “TBD” (To Be Determined) if not currently due
- MLN Matters Special Edition Article SE21003 “New Provider Enrollment Administrative Action Authorities”
- MLN Matters Special Edition Article SE1617 “Timely Reporting of Provider Enrollment Information Changes
- MLN Matters Special Edition Article SE1605 Revised ”Provider Enrollment Revalidation – Cycle 2”

Additional Information and Resources

What You Should Do Now

- Share all materials with all appropriate Medicare staff who could not attend today
- Check our education calendar for teleconferences, webinars, etc.
- Sign up for Email Updates to stay apprised of the latest Medicare information and changes
- Sign up for FISS/DDE and Review Electronic Submissions
- Sign up for NGSConnex
- Sign up for ERA/EFT

NGS Resources

- CBT modules are available on Medicare University Fundamentals of Medicare Part 1 of 2 CBT Module: Catalog ID: PTA-C-0029
  - Fundamentals of Medicare Part 2 of 2 CBT Module: Catalog ID: PTA-C-0031
  - Medicare University: Available courses
- Fiscal Intermediary Standard System/Direct Data Entry Provider Online Guide (FISS/DDE Provider Online Guide)

NGS Resources

- Contact Us
- IVR
  - Part A Provider IVR User Guide, Flow Chart, Touch-Tone Card/Eligibility Checklist, Using the IVR to Avoid Top Claim Rejections and Return to Provider Errors, IVR Conversion Tools
- NGSConnex
- EFT/ERA information is available in EDI Solutions

CMS Resources

- BCRC (Formerly COBC)
  - Telephone 855-798-2627
    (Monday–Friday, 8:00 a.m.–8:00 p.m. ET)
  - Fax 405-869-3307
    - Address the fax to "Medicare - MSP General Correspondence"
  - Mailing address

    Medicare – MSP General Correspondence

    P.O. Box 138897

    Oklahoma City, OK 73113-8897
- Additional contact information

CMS Resources

- CMS website
- MLN Matters articles
- CMS Transmittals
- CMS Internet-Only Manuals (IOMs)

CMS Resources

- ABN
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 30, Sections 40 and 50
- MLN Booklet: Medicare Parts A & B Appeals Process (MLN006562)
- MLN Booklet: Medicare Billing: Form CMS-1450 and the 837 Institutional (ICN MLN006926)

CMS Resources

- CMS MLN Booklet: Items and Services that are Not Covered Under the Medicare Program (ICN MLN906765)
- Provider Compliance
  - Provider Compliance Educational Products
  - Provider Compliance MLN Matters articles
  - Archive of Medicare Quarterly Provider Compliance Newsletters
  - CERT Outreach & Education Task Force
  - CMS Provider Minute You Tube Playlist
- Provider Compliance Fast Facts
- Quarterly Provider Updates (QPU)
- Open Door Forums (ODF)

CMS Resources

- Medicare Advantage Plan Directory
- MLN Booklet: "Rural Providers & Suppliers Billing" (MLN006762)

Resources

- ICD-10 Coding Guidelines
- CMS ICD-10 website

Official UB-04 Data Specifications Manual (NUBC Manual)

- The Official UB-04 Data Specifications Manual is available from the NUBC website
- The NUBC
  - The NUBC is a voluntary, multidisciplinary committee that develops data elements for claims and claim-related transactions, and is composed of all major national provider and payer organizations (including Medicare)
  - Maintains the codes needed to complete the Form CMS-1450 (UB-04 claim) and compliant X12N 837 institutional claim
  - Is responsible for the design and printing of the UB-04 form
  - Data elements referenced in manual are also used in the electronic claim standards and the manual contains a Mapping crosswalk between the UB-04 and the HIPPA 5010 (837) electronic transaction

NGSConnex

- NGSConnex website
  - Free Internet portal provided by National Government Services, Inc.
    - Requires Internet access and an email address
  - Alternative to FISS DDE, CWF/HETS, IVR, Provider Contact Center
  - Allows providers to access: beneficiary eligibility, claim, payment information online
  - Allows providers to submit appeals, claim-specific inquiries, cost reports, credit balance reports and much more
  - Learn more
    - View videos on our YouTube Channel
    - Sign up for our NGSConnex webinars on our website

MLN Connects® National Provider Calls

- Educational conference calls on new and changing Medicare programs and policies
  - In-depth presentations by CMS subject matter experts providing the latest information on topics specific to Medicare providers and suppliers, such as ICD-10, PQRS and provider enrollment
  - Question and answer sessions with CMS experts
  - No cost to participate
  - 24/7 access to call materials (e.g., presentation slides, written transcripts, audio recordings and CMS videos on YouTube)
  - Continuing education credit for participation awarded by many professional associations and credentialing organizations
- Learn more/register for upcoming MLN Calls & Webcasts
- Bookmark this webpage for quick access to upcoming calls

MLN Connects® Provider eNews

- A weekly electronic publication containing
  - MLN Connects® National Provider Calls and other event reminders
  - CMS program updates and policy details
  - Claim, pricer, and code information
  - Medicare Learning Network® educational product announcements
- View past issues or subscribe to the CMS eNews
- **Note:** Providers who are subscribed to their MAC's Email Updates already receive the CMS eNews

To Ask a Question Using the Questions Box

Type questions here

Then click Send

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Thank You!

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

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