

Introduction to Medicare Part II

4/17/2025

Closed Captioning: *Auto-generated closed captioning is enabled in this course and is at best 70-90% accurate. Words prone to error include specialized terminology, proper names and acronyms.*

Today's Presenters

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Objective

After this session attendees will be able to

- Receive a more in-depth understanding of the Medicare Program
- Learn how to access Local Coverage Determinations
- How to be Medicare compliant in your office
- Know what resources to use to determine Medicare eligibility and ensure that office intake procedures are efficient



Agenda

- [Local Coverage Determinations](#)
- [National Coverage Determinations](#)
- [Preventive Services](#)
- [Medicare Compliance](#)
- [Front Office](#)
- [Applying For Medicare](#)
- [Medicare Advantage Plans](#)
- [Medigap/Supplemental Insurance](#)
- [How Do I Check Patient Eligibility](#)
- [NGSConnex](#)

Local Coverage Determinations

LCD

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

Medical Policies

Contact Us NGSConnex Subscribe for Email Updates **Part B Provider in New York (JK)** ▾

national government SERVICES HOME EDUCATION ▾ RESOURCES ▾ EVENTS ENROLLMENT APPS ▾

FEEDBACK

- Medical Policies/LCDs**
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

Local Coverage Determinations

MEDICAL POLICIES/LCDS

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.

Please note: There are many procedures for which NGS does not have an LCD/Billing and Coding Article. If your search does not return any coverage documents, then NGS does not have a local coverage statement for that procedure.

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 <i>Related terms: tilt table, sudomotor</i> | L36236 | A57024 | A54403 | 95921, 95922, 95923, 95924, 95999 |
| B-type Natriuretic Peptide (BNP) Testing <i>Related terms: congestive heart failure, acute dyspnea</i> | L33573 | A56826 | | 83880 |

Additional Medical Topics

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

Understanding the Strength
of Medical Evidence

New LCD Request Process (A56198)

- Request considered in our jurisdiction from
 - Beneficiaries residing or receiving care
 - Healthcare professionals
 - Any interested party
- Request should include
 - Language that requestor wants included in the new LCD
 - Justification supported by peer-reviewed evidence
 - Full copies of published evidence to be considered
 - Information that addresses the relevance, usefulness, clinical health outcomes or medical benefits
 - Information that fully explains the design, purpose and/or method
- Health Disparities Analysis (Recommended)
 - Include an analysis of any relevant peer-reviewed medical literature that quantifies and/or describes any health disparities related to the specific LCD Reconsideration request
 - How the requested changed may impact health disparities

New LCD Request Process

- An informal meeting may be requested for discussion of the potential LCD
- Request can be sent via email, facsimile or written letter
 - [Email: NGSnewlcdrequest@anthem.com](mailto:NGSnewlcdrequest@anthem.com)
 - Fax: 317-595-4334
 - Attention: New LCD Request
 - Mail
 - National Government Services, Inc.
 - Medical Policy Unit
 - Attention: New LCD Request
 - P.O. Box 7108
 - Indianapolis, IN 46207-7108

New LCD Request Process

- Within 60 calendar days, NGS will review the materials and determine whether the request is complete or incomplete
 - Complete
 - New LCD process will be followed
 - Response is an acknowledgement of the receipt of a complete, valid request not a determination
 - Incomplete
 - NGS will provide in writing why the request was incomplete

New LCD Request Process

- All proposed LCDs will include
 - Consultation
 - Publication of proposed LCD
 - Open meeting
 - Opportunity for public comment in writing
 - Publication of a final LCD that includes a response to public comments received
 - Notice of new policy 45 days in advance of the effective date

Article for LCD Reconsideration Process (A52842)

- Requesting a revision to a final LCD
- Submit written request
- Identify language that requestor wants added/deleted from LCD
 - Include the name of the LCD
- Copies of published authoritative evidence
- Health Disparities Analysis (Recommended)
 - Include an analysis of any relevant peer-reviewed medical literature that quantifies and/or describes any health disparities related to the specific LCD Reconsideration request
 - How the requested change may impact health disparities

LCD Reconsideration Process

- Submission of electronic request is preferred
 - Email: NGS.lcd.reconsideration@anthem.com
 - Fax: 317-595-4334
 - Mail
 - National Government Services, Inc.
Medical Policy Unit
Attention: LCD Reconsideration Request
P.O. Box 7108
Indianapolis, IN 46207-7108

Requesting Addition of ICD-10 Code

- Providers may request that an LCD be revised to add coverage for additional diagnosis codes
- Does not qualify as a reconsideration
- Can send a request to
 - [Email: NGS.lcd.reconsideration@anthem.com](mailto:NGS.lcd.reconsideration@anthem.com)
- Include clinical rationale if no peer-reviewed literature is available
 - Remember no PHI or PII can be sent electronically

LCD Open Meetings

- Held for each LCD development cycle
- Notice of meeting is posted with location and time of meetings about one month in advance
 - Medical Policies section of our website
 - Open to the public
 - In person or teleconference participation available

Medical Policy Unit Contact

- Inquiries related to medical policy, including LCDs and clinical questions
 - Submit to our Contractor Medical Director via email NGSCMD@anthem.com for clinical issues related to Medicare coverage only
- General inquiries related to Medicare coverage, local and national coverage determinations, billing and reimbursement must be directed to our Provider Contact Center
 - JK: 866-837-0241
 - J6: 866-234-7340

National Coverage Determinations

NCDs

- NCDs are policies developed by CMS
 - Same for all contractors across the country
- NCDs are made through an evidence-based process, with opportunities for public participation
 - In the absence of a national coverage policy, an item or service may be covered at the discretion of the Medicare contractors based on an LCD
 - [CMS IOM Publication 100-03, Medicare National Coverage Determinations \(NCD\) Manual](#)

NCDs

- Interested parties should submit national coverage requests and national coverage reconsideration requests through the CMS website or in writing to
- [Medicare Coverage Determination Process](#)
- Coverage and Analysis Group
Centers for Medicare & Medicaid Services
7500 Security Blvd. (Mailstop C1-09-06)
Baltimore, MD 21244

Preventive Services

MLN[®] Educational Tool Medicare Preventive Services

Overview - **Telehealth Eligible Services -** Medicare Preventive Services

× Select a Service FAQs Resources

| | | | | | | |
|--|--------------------------------|---|--|---|--|--|
| Alcohol Misuse Screening & Counseling T | Annual Wellness Visit T | Bone Mass Measurement | Cardiovascular Disease Screening Test | Cervical Cancer Screening | Colorectal Cancer Screening | Counseling to Prevent Tobacco Use T |
| COVID-19 Vaccine & Administration | Depression Screening T | Diabetes Screening | Diabetes Self-Management Training T | Flu Shot & Administration | Glaucoma Screening | Hepatitis B Screening |
| Hepatitis B Shot & Administration | Hepatitis C Screening | HIV PrEP T | HIV Screening | IBT for Cardiovascular Disease T | IBT for Obesity T | Initial Preventive Physical Exam |
| Lung Cancer Screening T | Mammography Screening | Medical Nutrition Therapy T | Medicare Diabetes Prevention Program | Pneumococcal Shot & Administration | Prolonged Preventive Services T | Prostate Cancer Screening |
| Screening Pap Test | Screening Pelvic Exam | STI Screening & HIBC to Prevent STIs T | Ultrasound AAA Screening | | | |

▲ Advance Health Equity

MLN006559 December 2024

Preventive Services Educational Tool

- Learn About Codes
- Who is Covered
- Frequency
- What the Beneficiary Pays
- ICD-10-CM Codes

Preventive Services Educational Tool Example




Select another service

Annual Wellness Visit (AWV)

Print

HCPCS & CPT Codes

-  **G0438** — Annual wellness visit; includes a personalized prevention plan of service (pps), initial visit
- G0439** — Annual wellness visit, includes a personalized prevention plan of service (pps), subsequent visit
- G0468** — Federally qualified health center (fqhc) visit, ippe or awv; a fqhc visit that includes an initial preventive physical examination (ippe) or annual wellness visit (awv) and includes a typical bundle of medicare-covered services that would be furnished per diem to a patient receiving an ippe or awv
- 99497** — Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate
- 99498** — Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)
- G0136** — Administration of a standardized, evidence-based social determinants of health risk assessment tool, 5-15 minutes

What's Changed?

Added information about E/M add-on code G2211 to the Other Notes section

ICD-10 Codes

Advance Health Equity

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Medicare Wellness Visits – IPPE/AWV

- MLN® Educational Tool: [Medicare Wellness Visits](#)

The screenshot displays the MLN Educational Tool interface for Medicare Wellness Visits. At the top, the MLN logo is accompanied by the text 'EDUCATIONAL TOOL' and 'KNOWLEDGE • RESOURCES • TRAINING'. Navigation buttons for 'Back to MLN' and 'Print' are visible. A green banner indicates 'November 2024 Updates'. The main title is 'Medicare Wellness Visits', with sub-sections for 'Quick Start', 'IPPE', 'AWV', and 'Know the Differences'. A central message states: 'Early detection saves lives. Encourage patients to get their other preventive services.' Below this is a photograph of five diverse, smiling older adults. The CMS Medicare Learning Network logo is in the bottom right corner.

Medicare Compliance

Medicare Compliance

What can we help you with?

Targeted Probe and
Educate

Comprehensive Error Rate
Testing

Fraud & Abuse

Prior Authorization

Supplemental Medical
Review Contractor

Recovery Audit

Medical Review

Comprehensive Error Rate Testing Program

- CERT program is designed to determine if MACs are processing and paying claims correctly
- Improper payments represent payments that do not meet program requirements whether intentional or otherwise and contribute to inaccurate spending of Americans' tax dollars
- Estimated overall improper payment rate for fiscal year 2024 for Medicare FFS
 - 7.66 percent, representing \$31.70 billion dollars
- Part B providers improper payment rate
 - 10.35 percent, representing \$14.19 billion dollars

Comprehensive Error Rate Testing Program

- CERT program is comprised of two contractors
 - CERT RC
 - Samples claims
 - Requests and receives all medical records
 - Reviews medical records
 - Compiles the data (using the CERT SC)
 - CERT SC
 - Calculates improper payment rates and amounts
 - Designs sampling strategy
- [Comprehensive Error Rate Testing Details](#)

Medical Review

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national government SERVICES HOME EDUCATION ▾ RESOURCES ▾ EVENTS ENROLLMENT APPS ▾

Resources > Medicare Compliance

MEDICAL REVIEW

FEEDBACK

Medical Review ^

NGS Medical Review Process

NGS Medical Review Process

Medicare contractors, like National Government Services, operate the medical review program to prevent improper payments and protect the Medicare Trust Fund. Medical reviews involve the collection and clinical review of medical records and related information to ensure that payment is made only for services that meet all Medicare coverage, coding, billing and medical necessity requirements.

Medical review identifies errors through claim analysis and/or medical record review activities. Contractors use this information to help ensure they provide proper Medicare payments (and recover any improper payments if the claim was already paid). Contractors also offer

Helpful Resources

- Targeted Probe and Educate Manual
- The preferred method to submit Medical Records is NGSConex:
 - NGSConex
 - NGSConex User Guide
- Visit our Contact Us page for other methods of submission.

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

Medical Review Target Probe and Educate

- Program is designed to help providers and suppliers reduce claim denials and appeals through one-on-one help
- TPE reviews may involve claims that have already been processed (postpayment)
 - Notification letter will include a listing of all the claims being selected
- New claim submissions (prepayment)
 - Includes a notification letter followed by separate ADRs for each claim

Key Elements of TPE



Medical Review

Includes up to three rounds of TPE review



Claim Size

Claim sample size per provider, per topic and a round of TPE review is limited to a minimum of 20 and a maximum of 40 claims



Education

Includes provider specific education focusing on improving issues

Education will be offered after each round of TPE

Medicare Provider Compliance Tips

Medicare Provider Compliance Tips

| × Select a Topic | | | | | | | |
|-------------------------|-------------------------|---------------------------------|-----------------------------------|------------------------------------|-------------------------|----------------------------|----------------------|
| Allergy Services | Ambulance Services | Ambulatory Surgical Centers | Annual Wellness Visits | Anticancer Drugs | Bacterial Cultures | Blood Counts | Canes & Crutches |
| Cardiac Pacemakers | Cataract Services | Chiropractic Services | Commodes | CORF Services | CPAP Devices | Diabetic Shoes | Diabetic Supplies |
| Echography & Sonography | Enteral Nutrition | Enteral Nutrition Pumps | ESRD Clinic Services | Evaluation & Management | Hip & Knee Replacements | Home Health Services | Hospice Services |
| Hospital Beds | Immunosuppressive Drugs | Infusion Pumps | Inpatient Rehabilitation Services | Lenses | Lipid Panels | Lower Limb Orthoses | Lower Limb Protheses |
| Manual Wheelchairs | Nebulizers | Negative Pressure Wound Therapy | Orthopedic Footwear | Ostomy Supplies | Other Lab Tests | Oxygen | Parenteral Nutrition |
| Patient Lifts | Physical Therapy | Pneumatic Compression Devices | Podiatry | Pressure Reducing Support Surfaces | Psychiatric Care | Respiratory Assist Devices | Sleep Studies |
| SNF Services | Spinal Orthoses | Suction Pumps | Surgical Dressings | TENS Units | Tracheostomy Supplies | Urinalysis | Urological Supplies |

▲ Quick Start

MLN4824456 August 2024

Front Office

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



Applying For 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

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 the costs

| | |
|---|--|
| Anthem  | MEDICARE PPO ADVANTAGE |
| Member Name: Jane Doe | Anthem Medicare Preferred Anthem Rx Network |
| Subscriber Name: Jane Doe | PCP Office Visit \$20 |
| Identification No: 123456789 | Specialist Office Visit \$20 |
| Group No: 0084567 | Emergency room \$50 |
| Plan No: 332 | Urgent Care \$50 |
| PCP not required. | |
| Begin Date: 01/01/2006 | H5529-001 |

Medicare Advantage Plans Costs

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

Medigap/Supplemental Insurance

Medigap/Supplemental Insurance

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

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

- 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
 - Other online eligibility
- Collect information
 - Ask patient, representative/family member
 - MSP questionnaire



Patient Eligibility Not Offered on the Interactive Voice Response IVR

- The IVR will no longer provide eligibility information
 - This includes Medicare Advantage Plans
 - plan name of the administering insurance company name,
 - contract number,
 - plan name, number, and
 - option code description
- CMS has instructed all MACs to remove eligibility to help protect your patients against fraud
- To obtain eligibility information for your patients you can use our free, secure internet portal, [NGSConnex](#)
- If you're not enrolled in NGSConnex, use the instructions in the Registration section of the applicable NGSConnex User Guide below to start the enrollment process
 - [NGSConnex User Guide](#) for Part B providers
- Please note, our Provider Contact Center Representatives aren't permitted to share eligibility information that can be obtained through self-service

NGSConnex

What Is NGSConnex – Free Program

- Only need Internet access and email address
- 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

Access to NGS



Access NGS Medicare

NGSMedicare gives you access to the latest Medicare education and a wide variety of Medicare tools.

Log into NGSConnex

NGSConnex, is your free, secure self-service portal to obtain beneficiary eligibility, claim status & more...saving you time and money!

[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

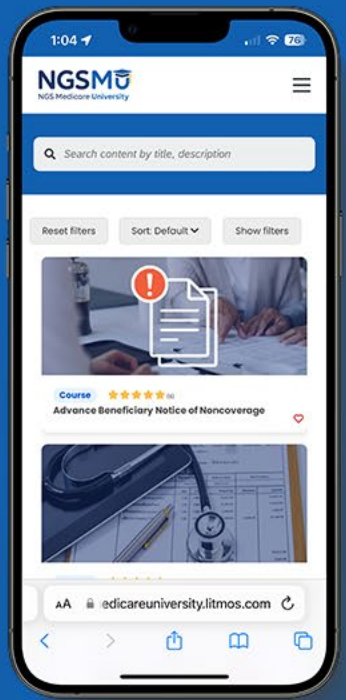
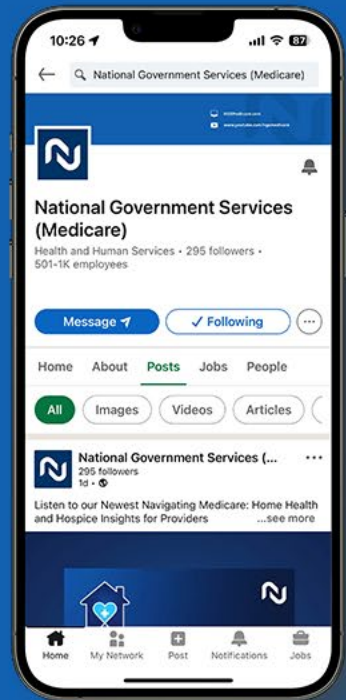
- PCC closes twice a month for training and staff development
 - Training is conducted on the 2nd and 4th Friday of each month from 11:00 a.m.–3:00 p.m. CT and 12:00 p.m.–4:00 p.m. ET
- This schedule was determined based on our lowest call volume times to reduce impact to our providers





Questions?

Thank you!



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[YouTube Channel](#)
Educational Videos

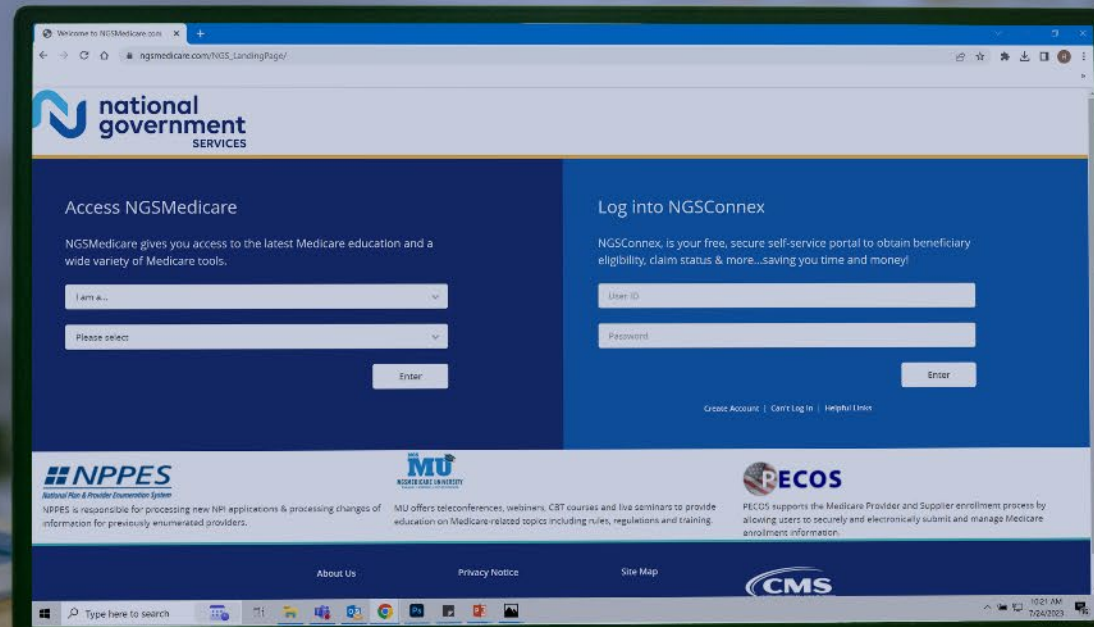


[Medicare University](#)
Self-paced online learning



[LinkedIn](#)
Educational Content

Find us online



www.NGS Medicare.com

Online resources, event calendar, LCD/NCD, and tools



[IVR System](#)

The interactive voice response system (IVR) is available 24-hours a day, seven days a week to answer general inquiries



[NGSConnex](#)

Web portal for claim information



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