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National Government Services

NGS Medicare Virtual Conference

Fall 2021

Top Reason Codes for Claim Return to Provider and Rejection

11/10/2021

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenter

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  - Provider Outreach and Education Consultant

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Objectives

- Review top reasons for claim denial, rejection and RTP
  - JK and J6 Part A claims processed March–August 2021
- Discuss how to resolve/avoid claim errors

Agenda

- Reason code review
  - Top five claim denial reason codes
  - Top five claim rejection reason codes
  - Top five claim RTP reason codes
- Adjusting/correcting a claim
- References and Resources
- Questions?

Top Claim Errors

The Cost of a Claim Error

- Staff time
  - Providers have to pay staff costs for billing and resubmitting unreimbursed Medicare claims
  - Time spent researching why a claim wasn't processed/reimbursed as expected
- Processing costs
  - Apply each time a claim is processed, whether it results in reimbursement or not
- Increased error rate
  - Don't end up on an error rate watch list

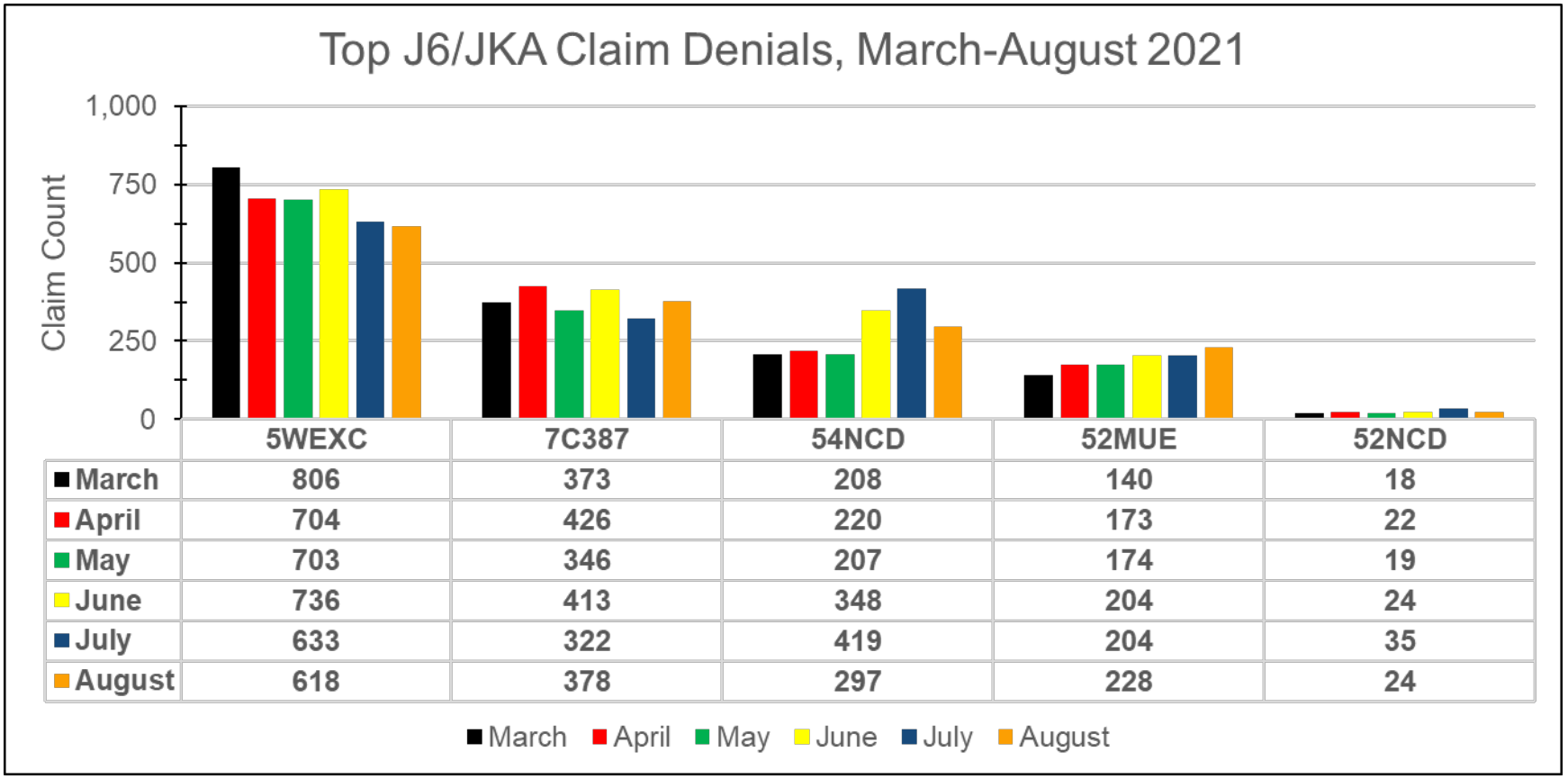
Claims Status/Locations

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

Claim Status – Provider Action

- D B9997 – denied
  - May only appeal claim determination
- T B9997 – returned to provider
  - Review reason code for claim correction instructions
- R B9997 – rejected
  - Review reason code to determine next steps
    - May have to submit new claim
    - May have to adjust rejected claim
    - No action may be necessary

Top J6/JKA Claim Denials (March-August 2021)



	5WEXC	7C387	54NCD	52MUE	52NCD
March	806	373	208	140	18
April	704	426	220	173	22
May	703	346	207	174	19
June	736	413	348	204	24
July	633	322	419	204	35
August	618	378	297	228	24

Denial 5WEXC

- As submitted, this claim does not qualify for Medicare payment due to the principal diagnosis code supplied

Denial 5WEXC

- If you disagree with the denial, you have the right to appeal
  - If additional medical circumstances exist, or if there is a more specific diagnosis code, indicate the appropriate diagnosis code(s) for the claim(s) on appeal
- Choose the most specific diagnosis code that accurately describes beneficiary's condition

Denial 5WEXC

- 5WEXC may also be issued when submitting a claim containing “noncovered” condition or excluded service
- Review CMS Internet-Only Manual Publication 100-02, *Medicare Benefit Policy Manual,* Chapter 16 - General Exclusions From Coverage

Denial 7C387

- Unacceptable ICD-10 principle diagnosis code for dental services. As submitted, this claim does not qualify for Medicare payment due to the principle diagnosis code supplied

Denial 7C387

- Medicare coverage for dental services is limited
- Review CMS Internet-Only Manual Publications 100-02, *Medicare Benefit Policy Manual*, Chapter 16, General Exclusions from Coverage and 100-04, *Medicare Claims Processing Manual*, Chapter 18, Preventive and Screening Services

Denial 52MUE

- All line items on the claim have units of service that are in excess of the medically reasonable daily allowable frequency

Denial 52MUE

- Providers should review the information on the CMS website for medically unlikely edits prior to claim submission
  - Medically Unlikely Edits
- If the units rendered are in excess of the allowed units for that service, consider whether the excess units were actually rendered and billed correctly

Denial 5ND22

- Claim contains procedure codes from CR 10865 Automatic Implanted Cardiac Defibrillators for Inpatient Claims without covered diagnosis or diagnosis pair
  - Insertion Procedure codes: 0JH608Z, 0JH609Z, 0JH638Z, 0JH639Z, 0JH808Z, 0JH809Z, 0JH838Z, 0JH839Z, 02H43KZ, 02H60KZ, 02H63KZ, 02H64KZ, 02H70KZ, 02H73KZ, 02H74KZ, 02HK0KZ, 02HK3KZ, 02HK4KZ, 02HL0KZ, 02HL3KZ, 02HL4KZ
  - Removal Procedure codes: 0JPT0PZ, 0JPT3PZ, 02PA0MZ, 02PA3MZ, 02PA4MZ, 02PAXMZ

Denial 5ND22

- Review coverage indications in NCD 20.4 for Implantable Automatic Defibrillators to determine covered diagnosis for services provided
  - Medicare Coverage Database

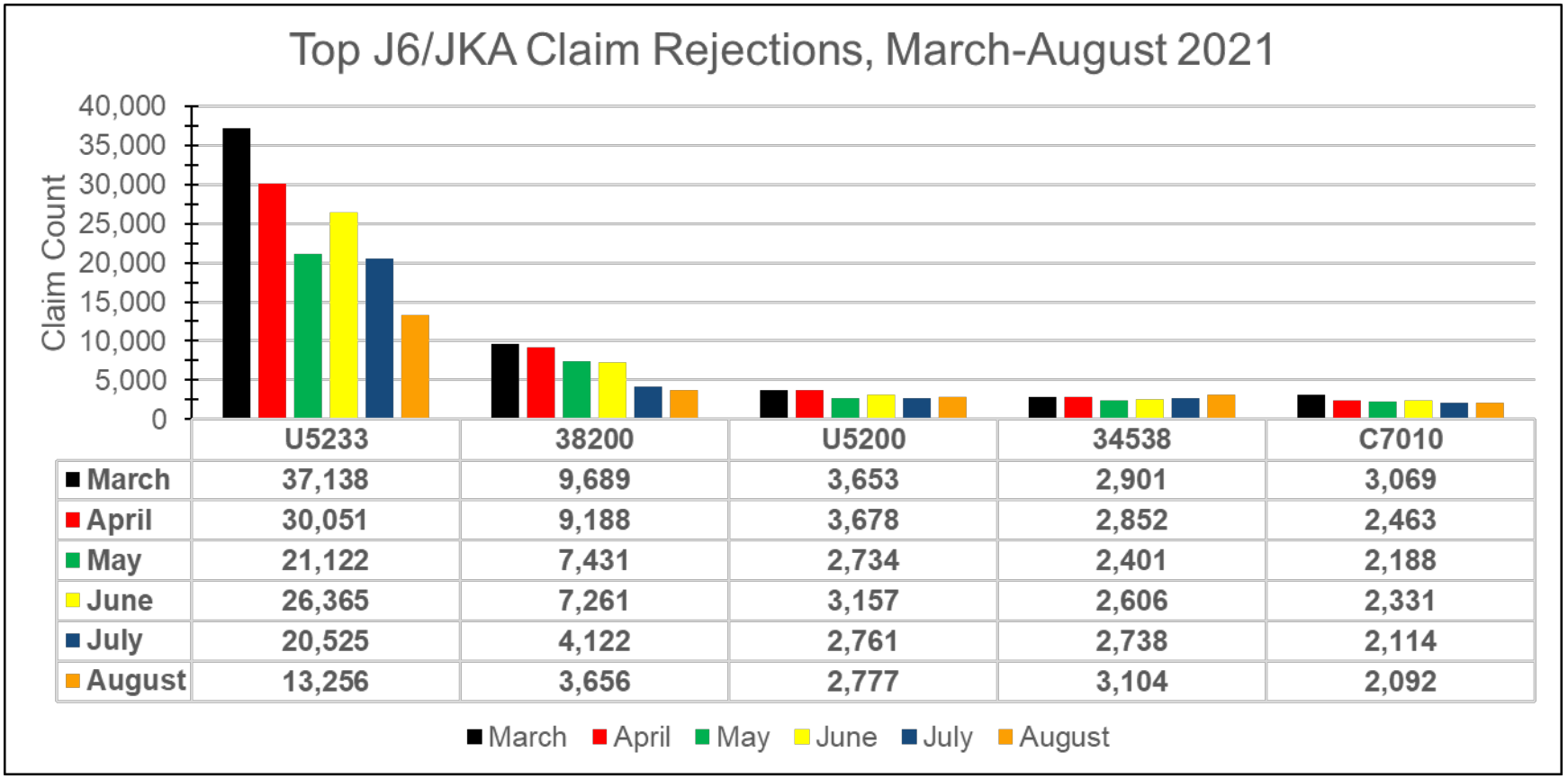
Denial 52NCD

- Line level reason code to indicate that the HCPCS on the line and a diagnosis code on the claim matched the NCD edit table list ICD-10 deny codes

Denial 52NCD

- Ensure all Medicare coverage and medical necessity requirements are met prior to billing
  - If the provider determines that Medicare will not cover the services, consider submitting the charges as noncovered
- Review CMS Medicare Coverage Database to review the NCDs and LCDs to determine the diagnosis that are covered for the services provided
  - Medicare Coverage Database

Top J6/JKA Claim Rejections (March-August 2021)



	U5233	38200	U5200	34538	C7010
March	37,138	9,689	3,653	2,901	3,069
April	30,051	9,188	3,678	2,852	2,463
May	21,122	7,431	2,734	2,401	2,188
June	26,365	7,261	3,157	2,606	2,331
July	20,525	4,122	2,761	2,738	2,114
August	13,256	3,656	2,777	3,104	2,092

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Rejection U5233

- Assigned to claims submitted to traditional Medicare for a patient who had elected a MAO plan
  - MAO plan coverage replaces traditional Medicare
- If DOS fall within MAO enrollment dates, do not submit claim to Medicare
  - Except when required for information-only claim or IME payment

Rejection U5233

- How to address this error
  - Use CWF to identify HMO beneficiary
    - Option code C
    - MAO ID
    - DOS overlap enrollment dates
  - Look up MAO details on the CMS website
    - Health Plans - General Information
  - Send claim to MAO
- Information also available in IVR, NGSConnex

```
MAP1756            NATIONAL GOVERNMENT SERVICES,#13001 UAT    ACMFA561 03/06/18
MXG9282    SC                          ACCEPTED                    C2018200 13:04:06

DATA IND 0004000000  NAME XXXXXXXXXXXXXXXX            ZIP 13205

PLAN: ENR CD
CURR PLAN: ACME HMO                CUR ID XXXXXX OPT C  ENR 030117  TERM
PRIR PLAN:                         PRI ID        OPT 0  ENR         TERM

OTHER ENTITLEMENTS OCCURRENCE CD/DATE 0          / 0

ESRD CD/DATE                /

CAT DATA: PSYCH 190  DISCHG          IND 0  DAYS USED      BLOOD

YR 89  APP           MET 00560.00  BLD 3  CO 08  FL 142  FRM          TO
IND       INT         ADM          FRM          TO            APP
ADJ IND     CALC DED             CMS  DT
YR 89  APP           MET 00560.00  BLD 3  CO 08  FL 142  FRM          TO
IND       INT         ADM          FRM          TO            APP
ADJ IND     CALC DED             CMS  DT

      PROCESS COMPLETED  ---   PLEASE CONTINUE
          PRESS PF3-EXIT  PF7-PREV PAGE PF8-NEXT PAGE
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Rejection 38200

- Claim is an exact duplicate of a previously submitted claim
  - Do not resubmit claims when they do not process/pay as you expected
- How to address this error
  - Use FISS to review claim status
    - Verify whether claim has already been submitted
    - Wait for claim to process; adjust processed claim to make updates
- Information also available in IVR, NGSConnex

Rejection U5200

- Beneficiary is not entitled to Medicare coverage for the type of services billed on the claim
  - Part A coverage must be effective for inpatient services to be covered
  - Part B coverage must be effective for outpatient services to be covered
- If DOS fall outside entitlement dates – do not submit claim to Medicare
  - Discuss other payment options

Rejection U5200

- How to address this error
  - Use CWF to identify beneficiary eligibility
    - Beneficiary must be enrolled in Part A for inpatient services
    - Beneficiary must be enrolled in Part B for outpatient and preventive services
- Information also available in IVR, NGSConnex

```
MAP1755            NATIONAL GOVERNMENT SERVICES,#13001 UAT    ACMFA561 03/06/18
MXG9282    SC                          ACCEPTED                  C2018200 13:03:33

CLAIM XXXXXXXXXX     NAME X XXXXXX  D.O.B. 061546  SEX M    INTER 58300

APP DT          REASON CD 1  DATE/TIME 20180651302  REQ ID BDMS
DISP CD 01    TYPE 3  CENT D.O.B     D.O.D
A:CURR-ENT DT 060111  TERM DT          PRI-ENT DT          TERM-DT
B:CURR-ENT DT 060111  TERM DT          PRI-ENT DT          TERM-DT

LIFE: RSRV 60  PYSCH 190

 CURRENT                   BENEFIT PERIOD DATA
FRST BILL DT  000000  LST BILL DT 000000  HSP FULL DAYS 60  HSP PART DAYS 30
SNF FULL DAYS 20  SNF PART DAYS 80  INP DED REMAIN  1340.00  BLD DED PNTS 3
PRIOR                     BENEFIT PERIOD DATA
FRST BILL DT  000000  LST BILL DT 000000  HSP FULL DAYS     HSP PART DAYS
SNF FULL DAYS     SNF PART DAYS     INP DED REMAIN          BLD DED PNTS

CURR B: YR 18  CASH 183.00  BLOOD 3  PSYCH 02200.00  PT           OT
PRIR B: YR 17  CASH 183.00  BLOOD 3  PSYCH 02200.00  PT           OT

      PROCESS COMPLETED  ---   PLEASE CONTINUE
          PRESS PF3-EXIT  PF7-PREV PAGE PF8-NEXT PAGE
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Rejection 34538

- Claim submitted as Medicare primary and there is an open MSP Working Aged record (MSP value code 12) in CWF
  - Medicare pays secondary in certain accident- and GHP-related situations and for specific funding programs
- Use MSP questionnaire to validate whether all criteria are met for coverage under specific MSP provision
  - If all criteria under MSP provision are met, do not submit claim to Medicare
    - Send to other insurer/program

Rejection 34538

- If all criteria under MSP provision are not met, Medicare is primary
- How to address this error
  - Use CWF to verify whether MSP record is open indicating other insurance coverage
    - May need to contact BCRC to update record before submitting Medicare primary claim
      - 855-798-2627
  - Submit claim to Medicare
    - Include coding/remarks on claim to indicate Medicare primary
- Information also available in IVR, NGSConnex

```
MAP1759            NATIONAL GOVERNMENT SERVICES,#13001 UAT    ACMFA561 03/06/18
MXG9282    SC                          ACCEPTED                 C2018200 13:05:28
                                MSP DATA  PAGE 1  OF 3

  EFFECTIVE DATE: 030512    SUBSCRIBER NAME: XXXXXXXXXXXX
TERMINATION DATE:              POLICY NUMBER: XXXXXXXXXXXXX
        MSP CODE: A             INSURER TYPE: H
                          PATIENT RELATIONSHIP: 01
                                 REMARKS CODES:

              INSURER INFORMATION
   NAME: PREFERRED MUTUAL INSURANCE COMPA    GROUP NO: XXX XXXXXXXX
ADDRESS: 1 PREFERRED WAY                          NAME: XXXXXXXXXXXXX

          NEW BERLIN        NY  134111800

           EMPLOYER DATA
   NAME:   XXXXXXXXXXXXX                    EMPLOYEE ID:
ADDRESS:   XXXXXXXXXXXXXX                   EMPLOYEE INFO:
           XXXXXXXXXX XX XXXXX-XXXX


       PROCESS COMPLETED  ---    PLEASE CONTINUE
           PRESS PF3-EXIT  PF7-PREV PAGE PF8-NEXT PAGE
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Rejection C7010

- Claim submitted to traditional Medicare for a patient who elected the Medicare hospice benefit and the claim does not contain a condition code 07 (zero seven)
  - Hospice coverage replaces Medicare for services related to terminal diagnosis
- If claim's DOS fall within hospice enrollment dates, determine whether services are related to terminal illness
  - If yes, do not submit claim to Medicare
    - Instead submit claim to hospice agency

Rejection C7010

- If no, send claim to Medicare reporting CC07
  - CC07 indicates service not related to the beneficiary's hospice condition (terminal illness)
- How to address this error
  - Use CWF to identify hospice beneficiary
    - View dates indicating election period
    - Review revocation indicator
- Information also available in IVR, NGSConnex

```
MAP1758            NATIONAL GOVERNMENT SERVICES,#13001 UAT    ACMFA561 03/06/18
MXG9282    SC                          ACCEPTED                C2018200 13:04:23

HOSPICE INFO FOR PERIODS 1 AND 2:

PERIOD  1 1ST  ST DATE  030118 PROV XXXXXX  INTER XXXXXX
OWNER CHANGE ST DATE            PROV          INTER
2ND ST DATE          PROV          INTER        TERM DATE
OWNER CHANGE ST DATE            PROV          INTER
1ST BILLED DT          LAST BILLED DT
DAYS BILLED       REVO IND  0

PERIOD    1ST  ST DATE          PROV          INTER
OWNER CHANGE ST DATE            PROV          INTER
2ND ST DATE          PROV          INTER        TERM DATE
OWNER CHANGE ST DATE            PROV          INTER
1ST BILLED DT          LAST BILLED DT
DAYS BILLED       REVO IND

      PROCESS COMPLETED  ---   PLEASE CONTINUE
          PRESS PF3-EXIT  PF7-PREV PAGE PF8-NEXT PAGE
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Revocation Indicators

- Codes
  - Blank/0 = No revocation on file
  - Code 1 = Revoked by beneficiary
  - Code 2 = Revoked by MAC

Adjusting a Processed/Rejected Claim

When to Adjustment a Claim

- To change details on processed/rejected claim
  - Adjustments only apply to claims in these S/LOCs
    - P B9997 (Processed)
    - R B9997 (Rejected) (limited use only)
      - Only rejected claims (R B9997) that have posted to CWF are eligible for adjustment

Introducing the Tape-to-Tape Flag

- Indicates whether claim has posted to CWF
  - Review claim page 02 - MAP171D
  - Look for “TPE-TPE” field
    - If value is “blank,” claim has posted to CWF
      - Must adjust rejected claim
    - If value is “X,” claim did not post to CWF
      - Must resubmit new claim for processing

Claim Change Reason Codes (Condition Codes) for Adjustments

Reason Code	Description
D0 (zero)	Changes to service dates
D1	Changes to charges
D2	Changes to revenue/HCPCS/HIPPS rate codes
D3	Second or subsequent interim PPS bill
D4	Changes in ICD-10-CM diagnosis/procedure code • Use for IP acute care hospital, LTCH, IRF, and SNF
D8	Change to make Medicare the primary payer
D9	Any other change (Remarks required)
E0 (zero)	Change in patient status

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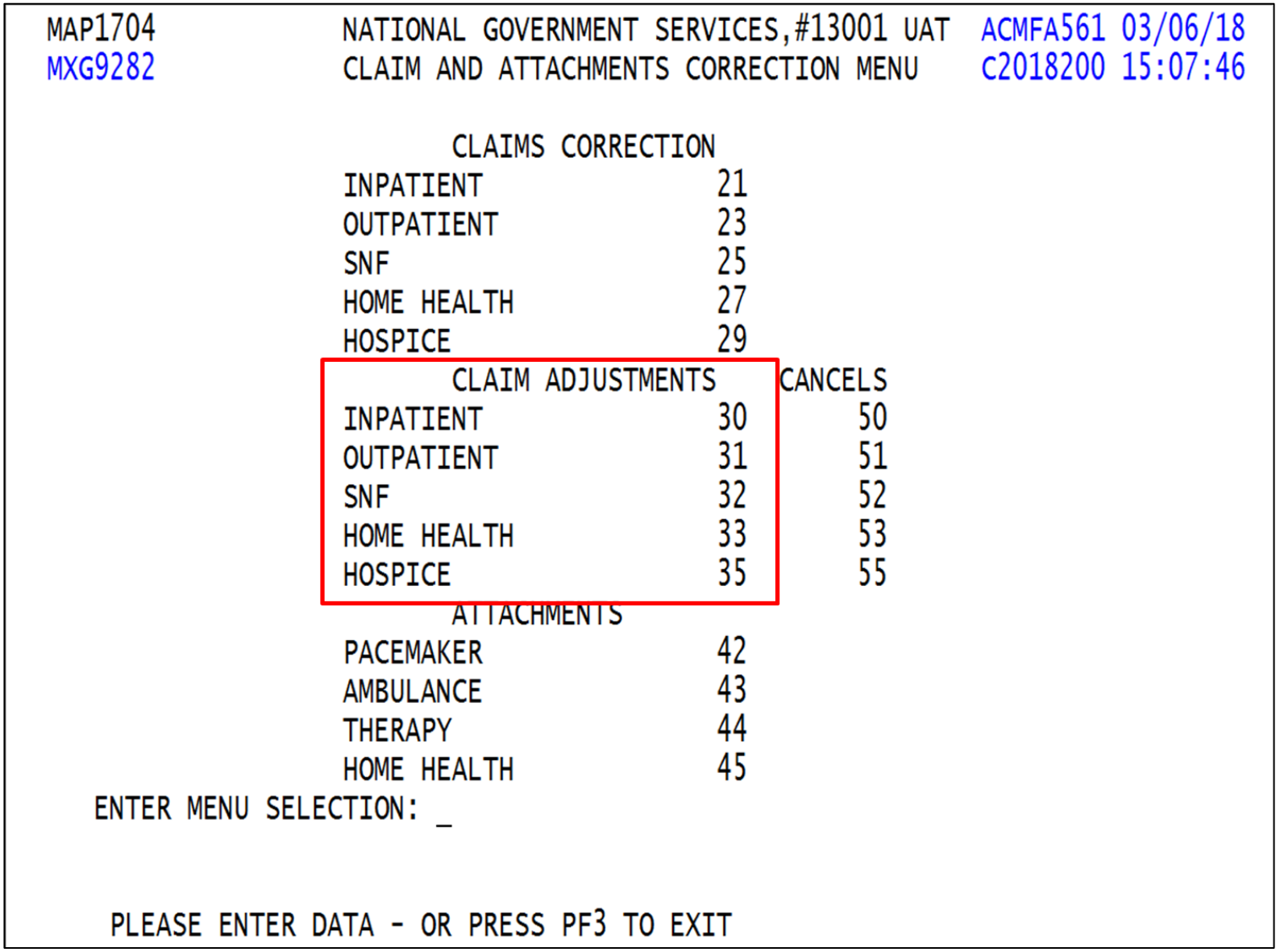
MAP1704 NATIONAL GOVERNMENT SERVICES,#13001 UAT ACMFA561 03/06/18
MXG9282 CLAIM AND ATTACHMENTS CORRECTION MENU C2018200 15:07:46
CLAIMS CORRECTION
INPATIENT 21
OUTPATIENT 23
SNF 25
HOME HEALTH 27
HOSPICE 29
CLAIM ADJUSTMENTS CANCELS
INPATIENT 30 50
OUTPATIENT 31 51
SNF 32 52
HOME HEALTH 33 53
HOSPICE 35 55
ATTACHMENTS
PACEMAKER 42
AMBULANCE 43
THERAPY 44
HOME HEALTH 45
ENTER MENU SELECTION: _
PLEASE ENTER DATA - OR PRESS PF3 TO EXIT

Step 1: Gather Required Information

- Claim change reason code
  - Describes reason why claim is changing
  - Two-digit alpha-numeric code
    - Entered on claim page one (condition code)
- Adjustment reason code
  - Describe reason for adjustment
  - Two-digit alpha code
    - Entered on claim page three in adjustment reason code field

Step 2: Access the Claim

- Log into FISS DDE
- Select Claims Correction Menu (option 03)
- Select option from Claim and Attachments Correction Menu
  - Based on processed/rejected claim type
    - Inpatient – 30
    - Outpatient – 31
    - SNF – 32
    - Home Health – 33
    - Hospice – 35

Step 2: Access the Claim

- Enter MBI and DOS
  - List of processed claims will be displayed
  - To view list of rejected claims that can be adjusted, overwrite ‘P’ in status field with ‘R’
- Select claim to be adjusted by placing ‘U’ in SEL field
  - Claim opens at page one
  - TOB automatically changes to XX7
  - System pulls in DCN from claim to be adjusted

Step 3: Make Adjustments to Claim

- On claim page one, enter claim change reason code in CC field
  - Only one claim change reason code should be reported per adjustment claim
  - If more than one applies, choose the most appropriate claim change reason code
- When reason for adjustment is to make changes to claim lines, make appropriate claim adjustments on claim page two
  - Change units, codes, rates; recalculate total charges

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Step 3: Make Adjustments to Claim

- Delete revenue code lines by placing a ‘D’ on the first position of the revenue code
  - Press the <Home> key
  - Press the <Enter> key
    - This will delete the entire revenue code line
- Add new charges by first deleting Total Charge (0001) line, adding new line(s)
- Make sure Total Charge line (0001) added and recalculated

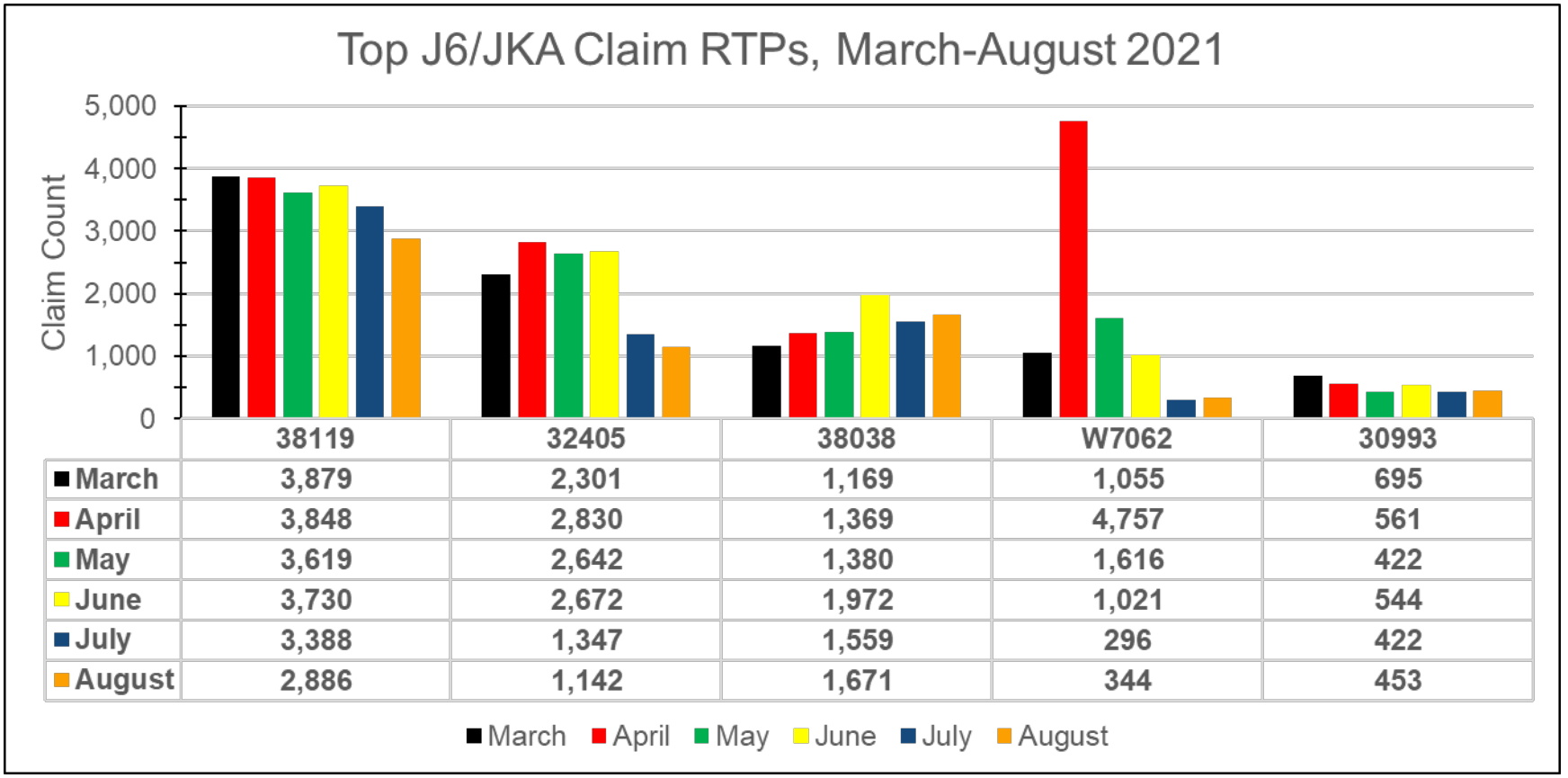
Step 3: Make Adjustments to Claim

- On claim page three, enter adjustment reason code
- On claim page four, enter remarks
  - For any situation where an adjustment requires some explanation
  - When claim change reason code D9 is used, remarks are mandatory
    - CC D9 causes claim to kick out to manual processing and remarks will be read by a claims reviewer
  - Remarks otherwise not mandatory for adjustments

Step 4: Submit and Verify Claim Adjustment

- Review changes to ensure accuracy
- Hit <F9/PF9> to resubmit claim for processing
- Verify that claim was stored correctly by going into Inquiries submenu (Option 01) and choosing Claims Summary option (Menu 12)
  - Available next day after updating claim (<F9/PF9>)
  - Key patient's MBI and from and through dates of adjustment claim
  - Adjustment should appear in 'S' Location
  - TOB = XX7

Top J6/JKA Claim RTPs (March-August 2021)



	38119	32405	38038	W7062	30993
March	3,879	2,301	1,169	1,055	695
April	3,848	2,830	1,369	4,757	561
May	3,619	2,642	1,380	1,616	422
June	3,730	2,672	1,972	1,021	544
July	3,388	1,347	1,559	296	422
August	2,886	1,142	1,671	344	453

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RTP 38119

- SNF/non-PPS inpatient claim submitted out of sequence
  - When beneficiary is an inpatient in SNF/non-PPS inpatient for several consecutive months, claims must be submitted one at a time, in sequential order
- Avoiding this reason code
  - Use CWF, IVR, NGSConnex to verify whether the prior month's claim completely processed
  - Subsequent claims in the stay should not be submitted until the prior month's claim has processed and finalized

RTP 32405

- Units billed are more than one for an automated profile, hematology profile or organ and disease panel HCPCS and the claim is for one date of service

RTP 38038

- OPPS claim overlaps claim submitted for same DOS
  - Additional E/M or ER visit rendered on same day must be submitted on one claim with proper coding
  - Separate claim can be submitted if condition code “G0” (zero) or “20” or “21” is reported on separate claim
- How to address this error
  - Review patient record to identify E/M or ER on same DOS
  - Use FISS to verify whether claim for DOS has already been submitted

RTP 38038

- Wait for claim to process and either
  - Adjust to add additional visit
    - Report modifier 27 to identify separate and distinct E/M visit on same DOS
  - Submit additional claim with appropriate coding
    - Report modifier 27 and CC G0 to identify separate and distinct E/M visit on same DOS in same revenue center
      - » Visits can be billed on single or separate claims when billing G0
- Information also available in IVR, NGSConnex

Multiple E/M Visits: Scenario One

- Mr. Smith goes to clinic of Hospital A where he is treated and released for flu-like symptoms. Later that day, Mr. Smith receives treatment in ER of Hospital A for a broken arm and is then released
  - Bill all services on one claim
    - Clinic visit: revenue code 0510 with appropriate HCPCS/CPT code and all related services
    - ER visit: revenue code 0450 with appropriate HCPCS/CPT code with modifier 27 and all related services

Multiple E/M Visits: Scenario Two

- Mr. Jones is treated for broken thumb in ER at Hospital B and released. Later that day, Mr. Jones breaks his leg and is treated and released a second time from ER at Hospital B
  - Services can either be billed together on one claim or separately on two claims
    - Both ER visits: revenue code 0450 with appropriate HCPCS/CPT code and all related services
    - Second ER visit: add modifier 27 to ER HCPCS/CPT code, report CC G0

RTP W7062

- HCPCS/CPT code not recognized by OPPS; alternate code for same service may be available
  - Check the Status Indicator (SI) on Addendum B
    - SI = E or B
  - Addendum A and Addendum B Updates

W7062

- Quarterly Integrated Outpatient Code Editor (I/OCE) Specifications
  - I/OCE Quarterly Release Files
  - The procedure code has a ‘Not recognized by Medicare for OPPS’ indicator

RTP 30993

- A claim has been submitted with a MBI and the MBI/HIC combination was not found on the MBI cache or CWF MBI Crosswalk
  - Use CWF, IVR, NGSConnex to verify MBI code is accurate

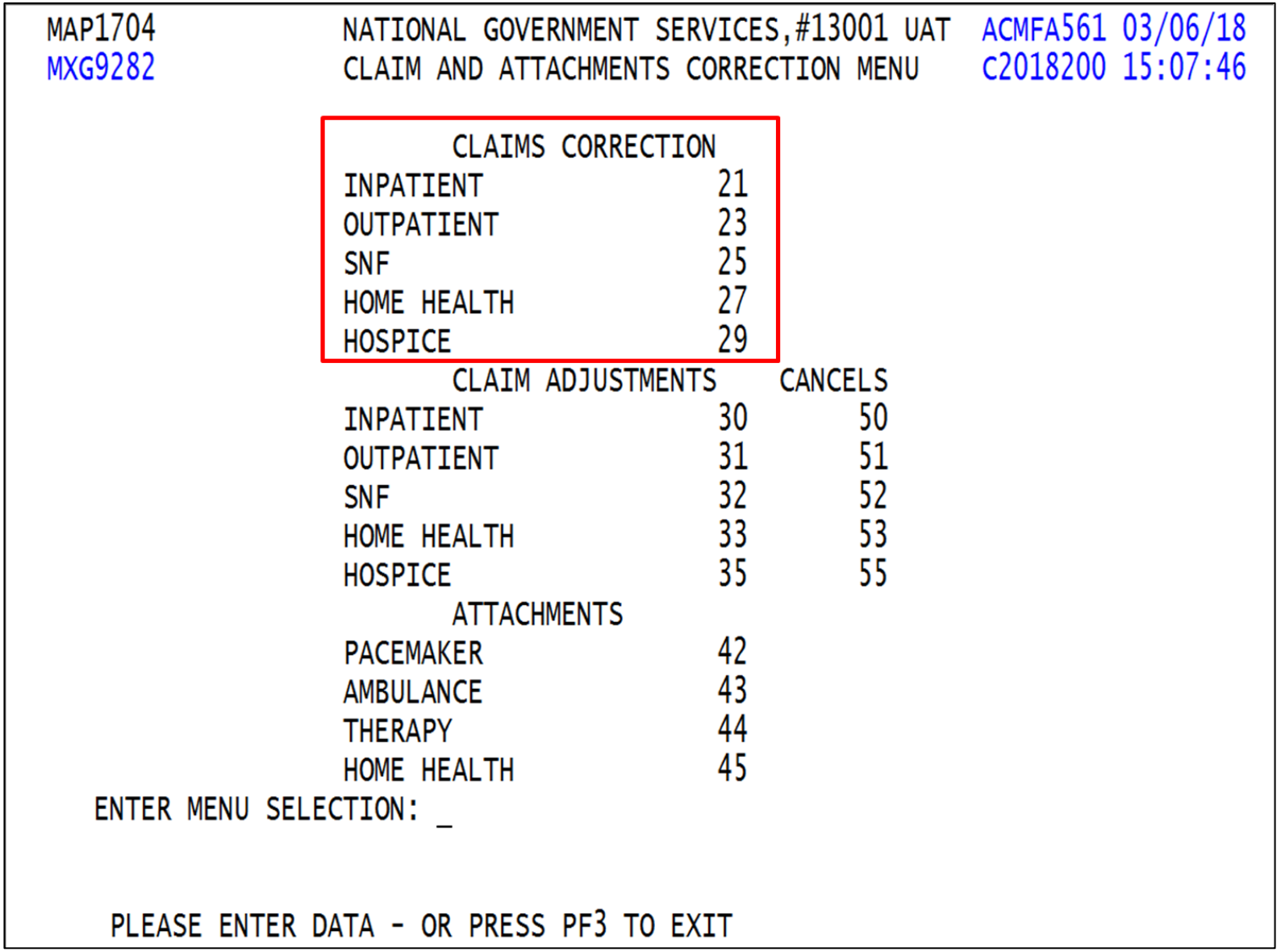
Correcting an RTP Claim

When to Correct a Claim

- To fix errors and resubmit claim without having to rekey and submit a new claim
- Claim correction only applies to claims that are RTP
  - S/LOC T B9997
- If no action is taken to resolve error that caused claim to RTP, eventually claim will drop off system without reimbursement

Did You Know

- In addition to fixing errors that caused claim to RTP, providers can make any other necessary changes to allowable fields when submitting a claim through claim correction
  - If changing fields that cannot be updated in claims correction, submit as new claim
    - MBI
    - Provider number
    - TOB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HOSPICE 29
CLAIM ADJUSTMENTS CANCELS
INPATIENT 30 50
OUTPATIENT 31 51
SNF 32 52
HOME HEALTH 33 53
HOSPICE 35 55
ATTACHMENTS
PACEMAKER 42
AMBULANCE 43
THERAPY 44
HOME HEALTH 45
ENTER MENU SELECTION: _
PLEASE ENTER DATA - OR PRESS PF3 TO EXIT

Step 1: Access the Claim

- Log into FISS DDE
  - Select Claims Correction Menu (option 03)
  - Select one of the options from Claim and Attachments Correction Menu based on RTP claim type
    - Inpatient – 21
    - Outpatient – 23
    - SNF – 25
    - Home Health – 27
    - Hospice – 29

Step 1: Access the Claim

- Enter MBI and DOS
  - List of RTP claims will be displayed
- Select claim to be corrected by placing ‘U’ in SEL field
  - Claim opens at page one

Step 2: Review Reason(s) for RTP

- On claim page one, reason code(s) listed on lower left corner
- Hit <F1/PF1> to review reason code file
  - Also available through Inquiries Submenu (01), Reason Code file (17)
- After reviewing reason code narrative, hit <F3/PF3> to return to claim

Claim Correction Tip

- If there are multiple reason codes assigned to a claim
  - Put your cursor on first character of additional reason code(s) before hitting <F1/PF1> to review the code narrative(s)
  - Or, over-key reason code to review narrative of each additional code(s)
    - Then hit <F3/PF3> to return to claim

Step 3: Make Corrections to Claim

- Changes can be made by entering/over-keying appropriate FISS DDE field
- When making changes to claim lines on claim page two, delete and rekey the line
  - Delete revenue code lines by placing a ‘D’ on first position of the revenue code
    - Press <Home> key, then press <Enter> key
      - This will delete entire revenue code line
  - Reenter units, codes, rates; recalculate charges
- Make sure Total Charge line (0001) added and recalculated

Step 4: Submit and Verify Claim Resubmitted

- Review changes to ensure accuracy
- Hit <F9/PF9> to resubmit claim for processing
- Verify that claim was stored correctly by going into Inquiries submenu (Option 01) and choosing Claims Summary option (Menu 12)
  - Available next day after correcting claim (<F9/PF9>)
  - Key patient's MBI and from and through dates of claim
  - Claim should appear with a 'S' in S/LOC field

What Happens Next

- A claim submitted through claims adjustment/correction goes through all the same system edits as an initial claim submission
- Processing of adjusting/corrected claims can be affected by
  - Recent FISS DDE updates
  - Any errors made when updating claim

Avoid Timely Filing Rejections

- Even when a claim is RTP or rejected, a provider has 12 calendar months from the DOS to resubmit the claim for processing
  - Not the date of RTP or Rejection
  - Based on clean claim receipt date
- Will result in timely filing rejections
  - These claims are provider liable

References and Resources

- NGS Website
  - Education > Manuals
    - FISS DDE Provider Online Guide
  - Claims & Appeals > Medicare Secondary Payer
  - Claims & Appeals > Top Claim Errors

IVR Resources

- NGS Website
  - Resources > Contact Us > Interactive Voice Response System
    - National Government Services Part A Provider IVR User Guide
    - Part A IVR Flow Chart
    - Part A IVR Navigation Guide
    - Part A Touch-Tone Card/Eligibility Checklist
  - Resources > Tools & Calculators > Interactive Voice Response Conversion Tools
    - Beneficiary Name to Number Converter
    - PTAN and Beneficiary Medicare Number Converter
    - IVR Conversion Tables

NGSConnex Resources

- Training materials available on NGSConnex home page
  - NGSConnex
    - Quick Steps Job Aid
    - Rules of Behavior
    - Training Material (CBT)

Thank You!

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

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