national government SERVICES

NGS PROVIDER EXPERIENCE
Innovation | Education | Collaboration

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.*

NGSMU
NGS Medicare University
Meaningful | Informative | Simplified

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenters

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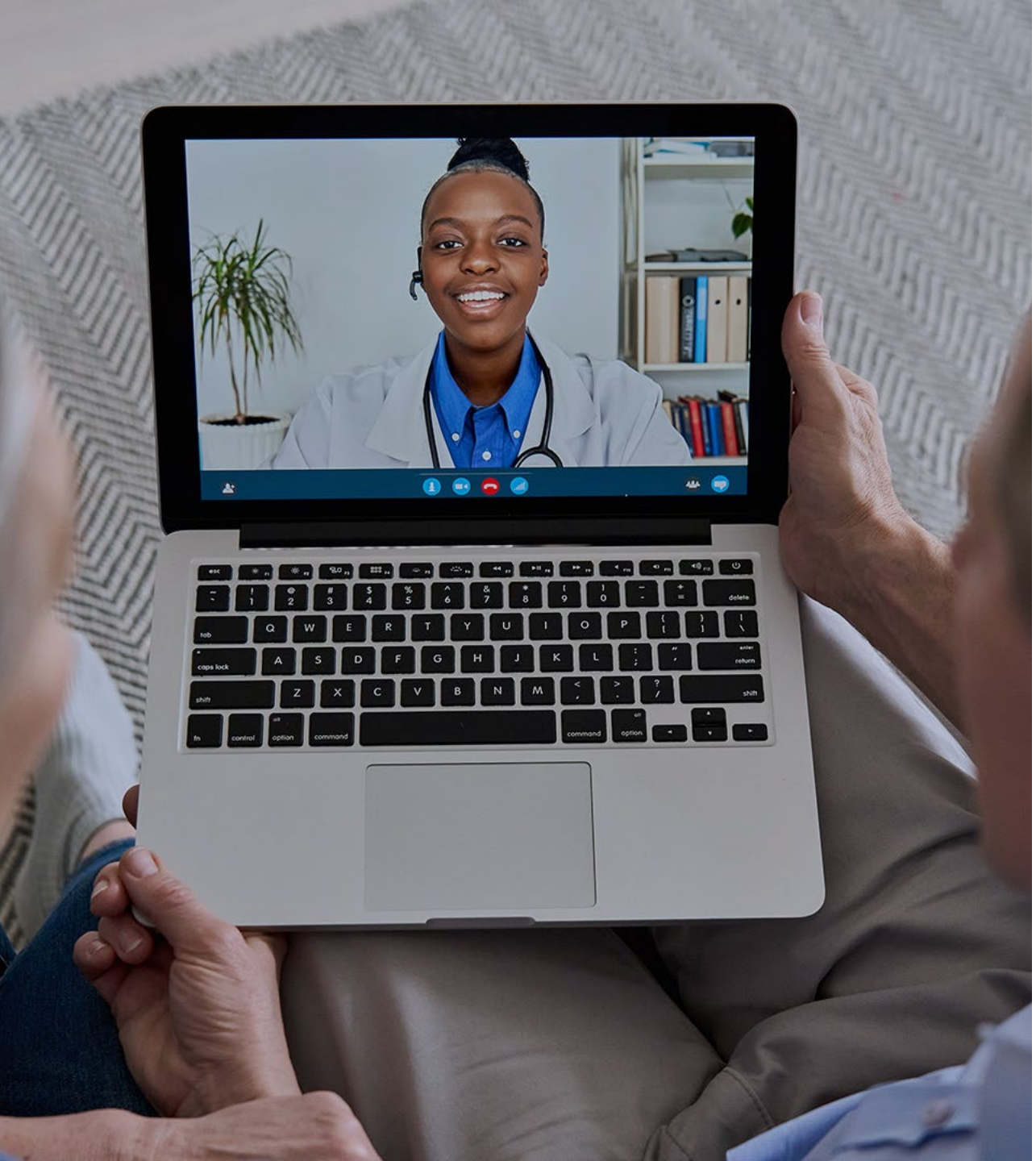


Recording

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

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

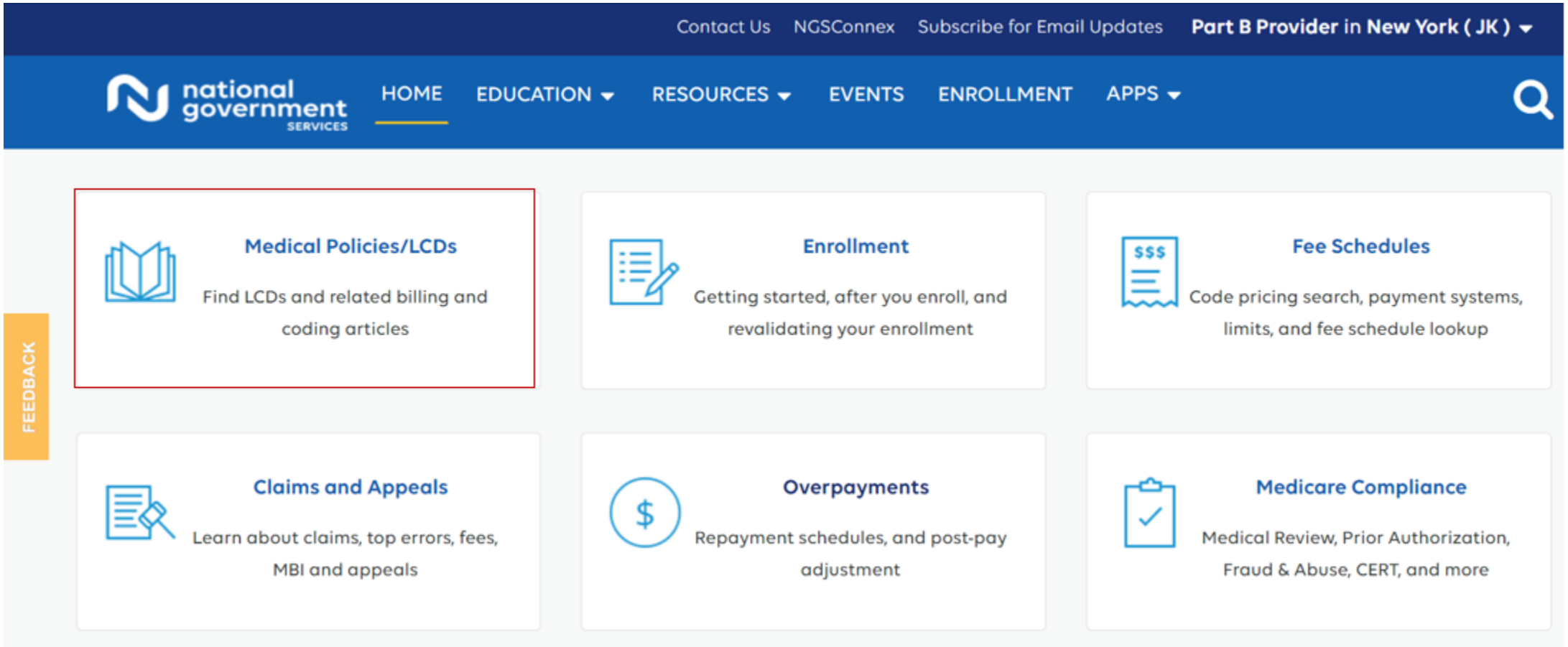
- Local Coverage Determinations
- National Coverage Determinations
- Preventive Services
- Medicare Compliance
- Front Office
- Applying For Medicare
- Medicare Advantage Plans
- Medigap/Supplemental Insurance
- How Do I Check Patient Eligibility
- NGSConnex

Local Coverage Determinations

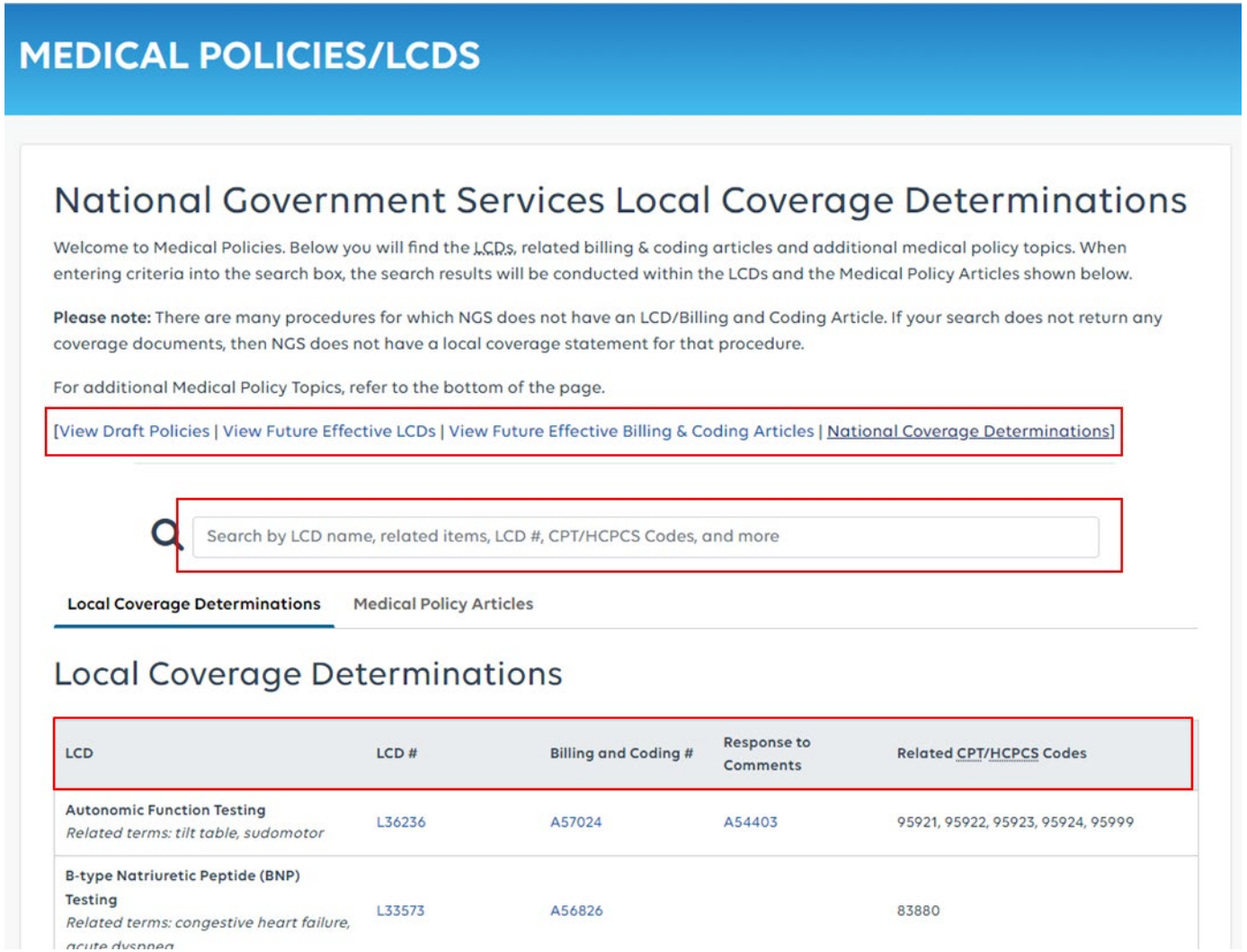
LCD

- 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



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

Additional Medical Topics

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
  - 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
- 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

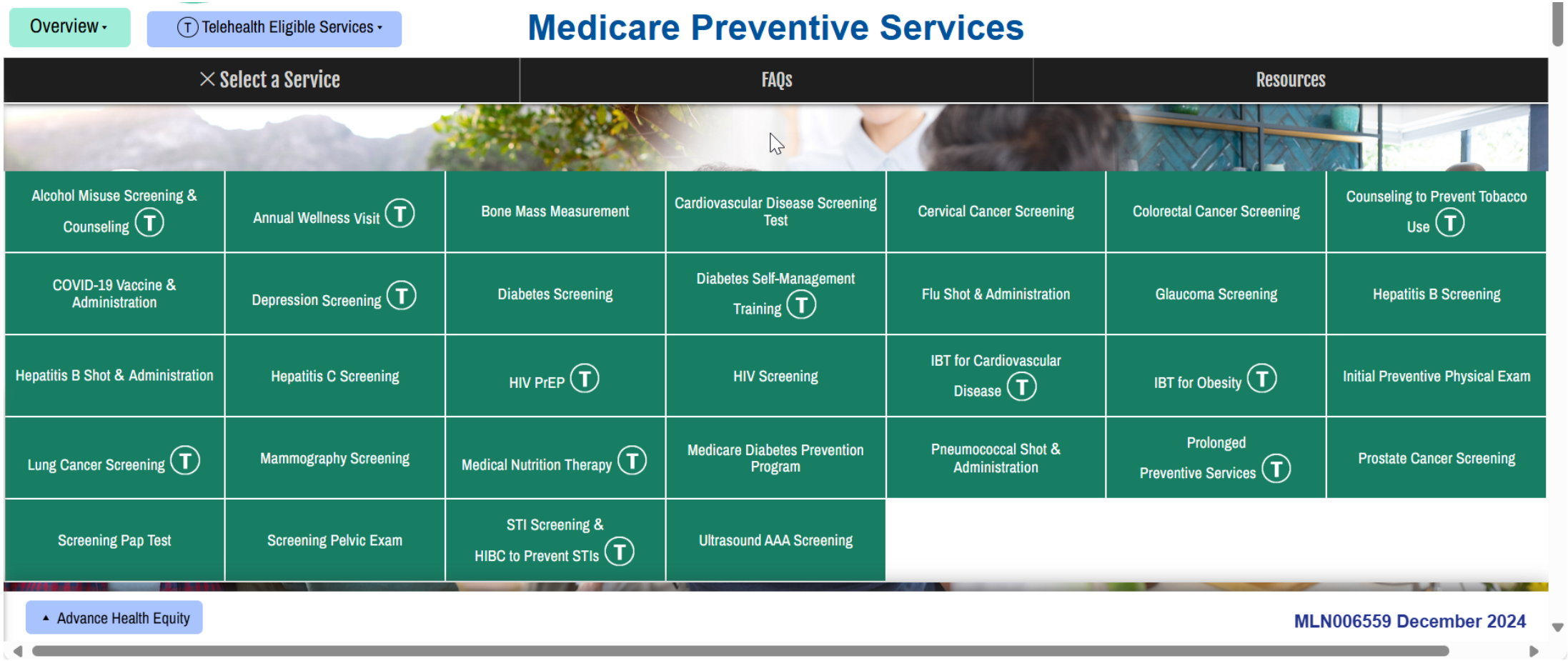
- NCDs are policies developed by CMS
  - Same for all contractors across the country
- NCDs are made through an evidence-based process, with opportunities for public participation
  - In the absence of a national coverage policy, an item or service may be covered at the discretion of the Medicare contractors 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

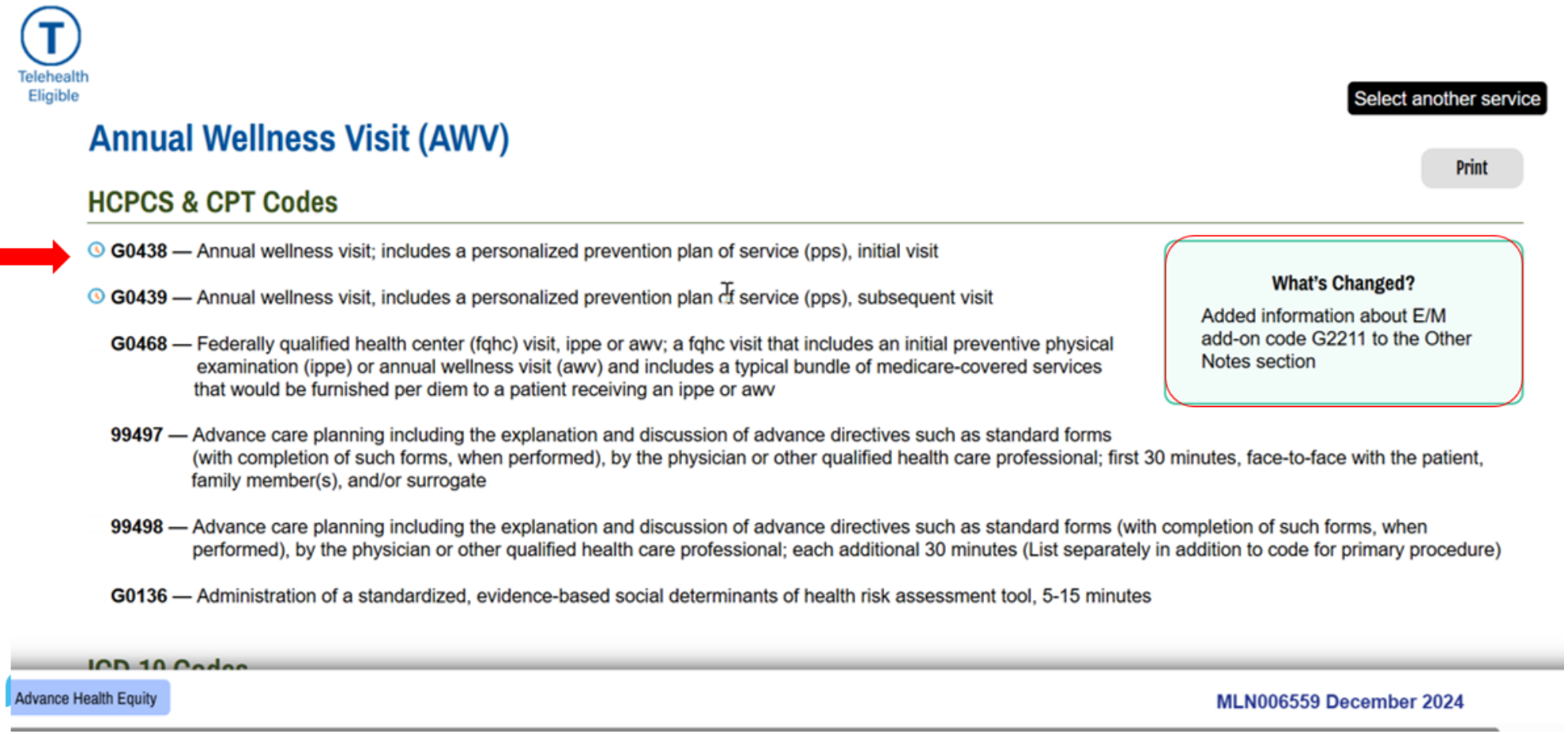
MLN® Educational Tool
Medicare Preventive Services



Preventive Services Educational Tool

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

Preventive Services Educational Tool Example

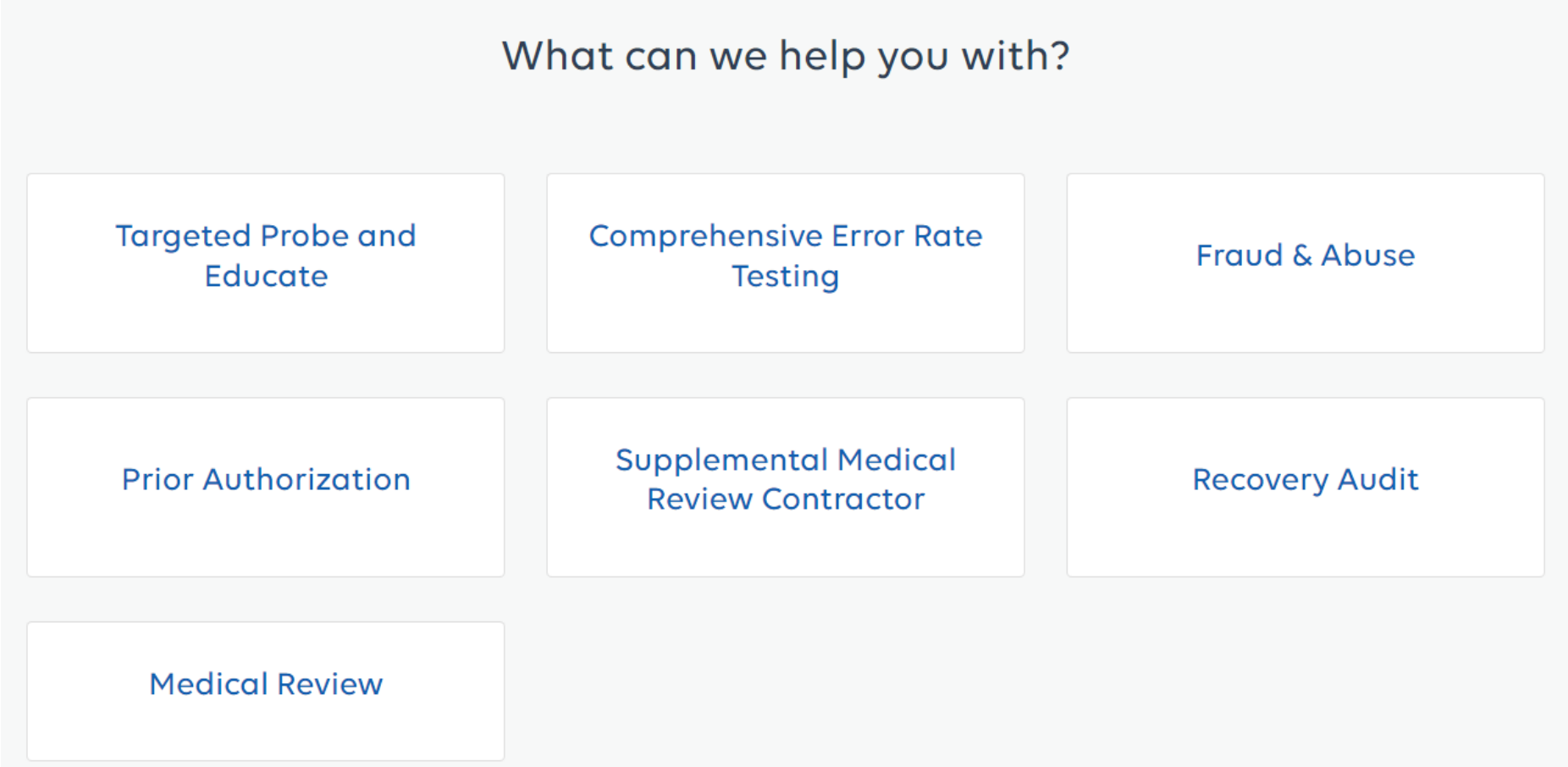


Medicare Wellness Visits – IPPE/AWV

- MLN® Educational Tool: *Medicare Wellness Visits*

Medicare Compliance

Medicare Compliance



Comprehensive Error Rate Testing Program

- CERT program is designed to determined 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

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

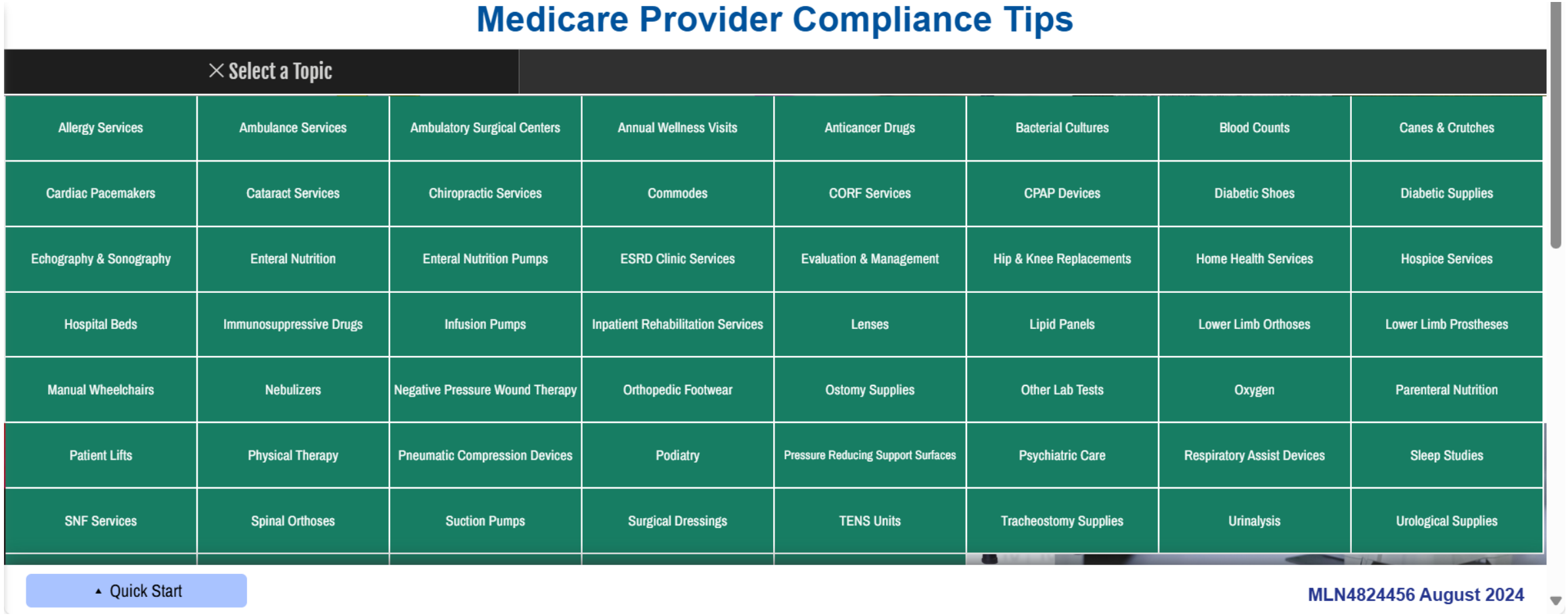
Claim sample size per provider, per topic and a round of TPE review is limited to a minimum of 20 and a maximum of 40 claims

Education

Includes provider specific education focusing on improving issues

Education will be offered after each round of TPE

Medicare Provider Compliance Tips



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

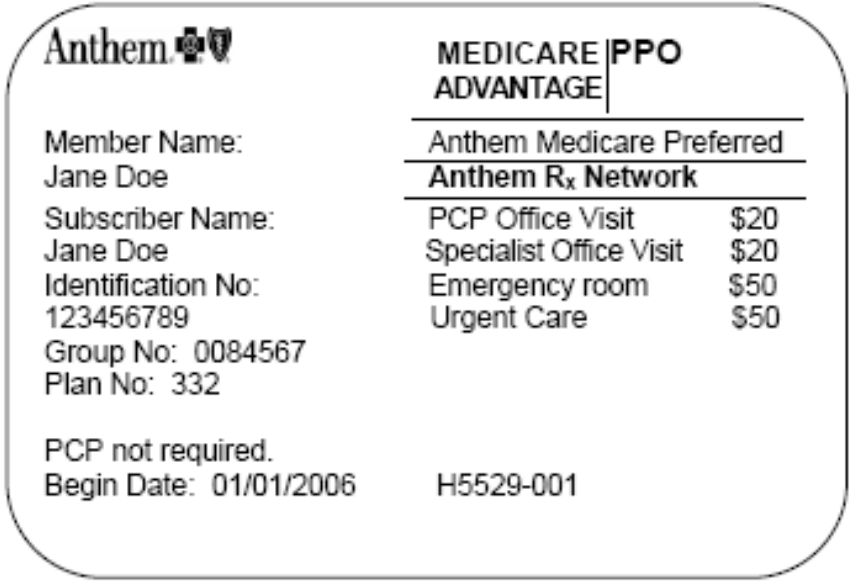
Applying for Medicare

- 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



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

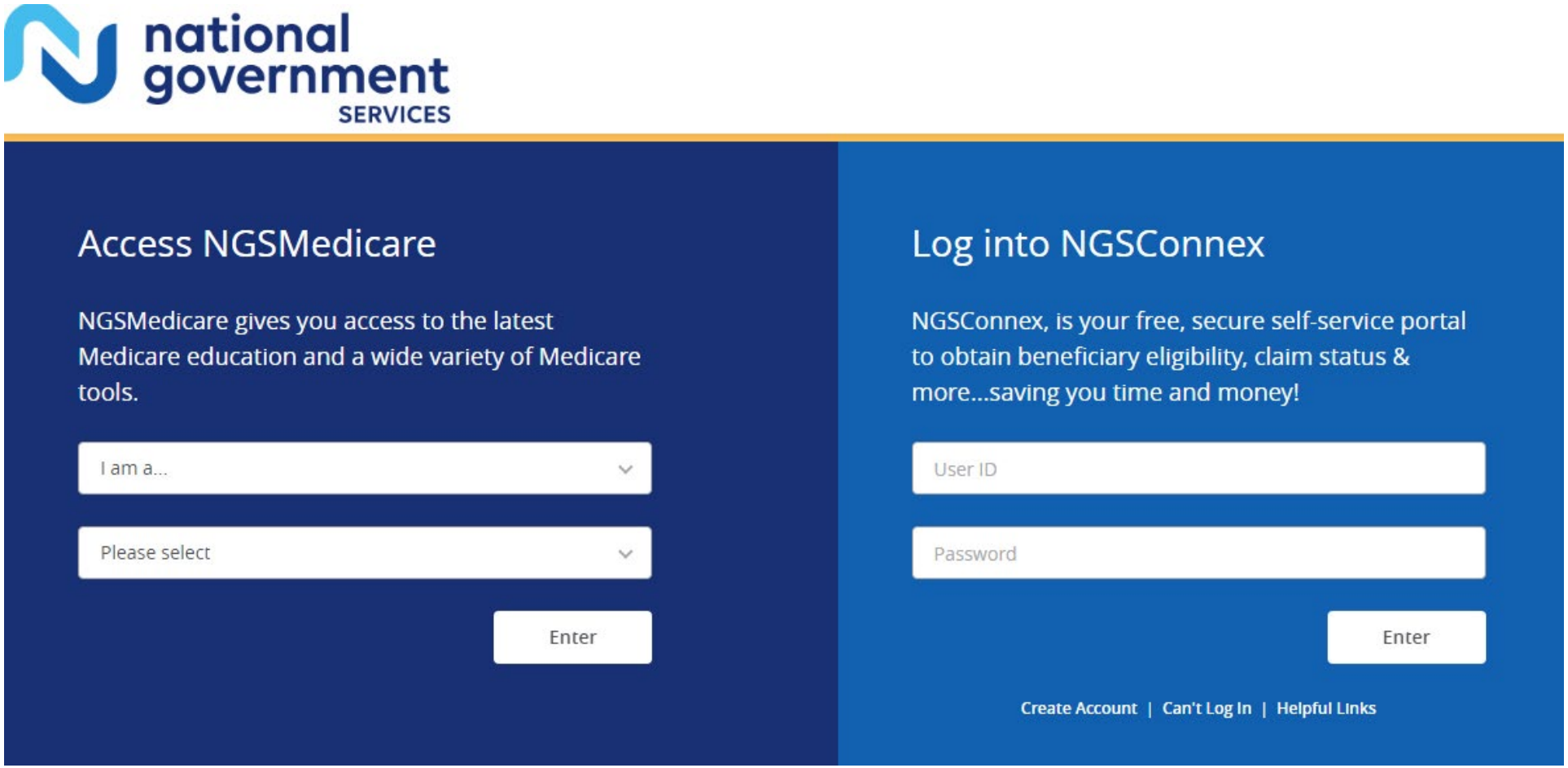
- The IVR will no longer provide eligibility information
  - This includes Medicare Advantage Plans
    - plan name of the administering insurance company name,
    - contract number,
    - plan name, number, and
    - option code description
- CMS has instructed all MACs to remove eligibility to help 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



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.

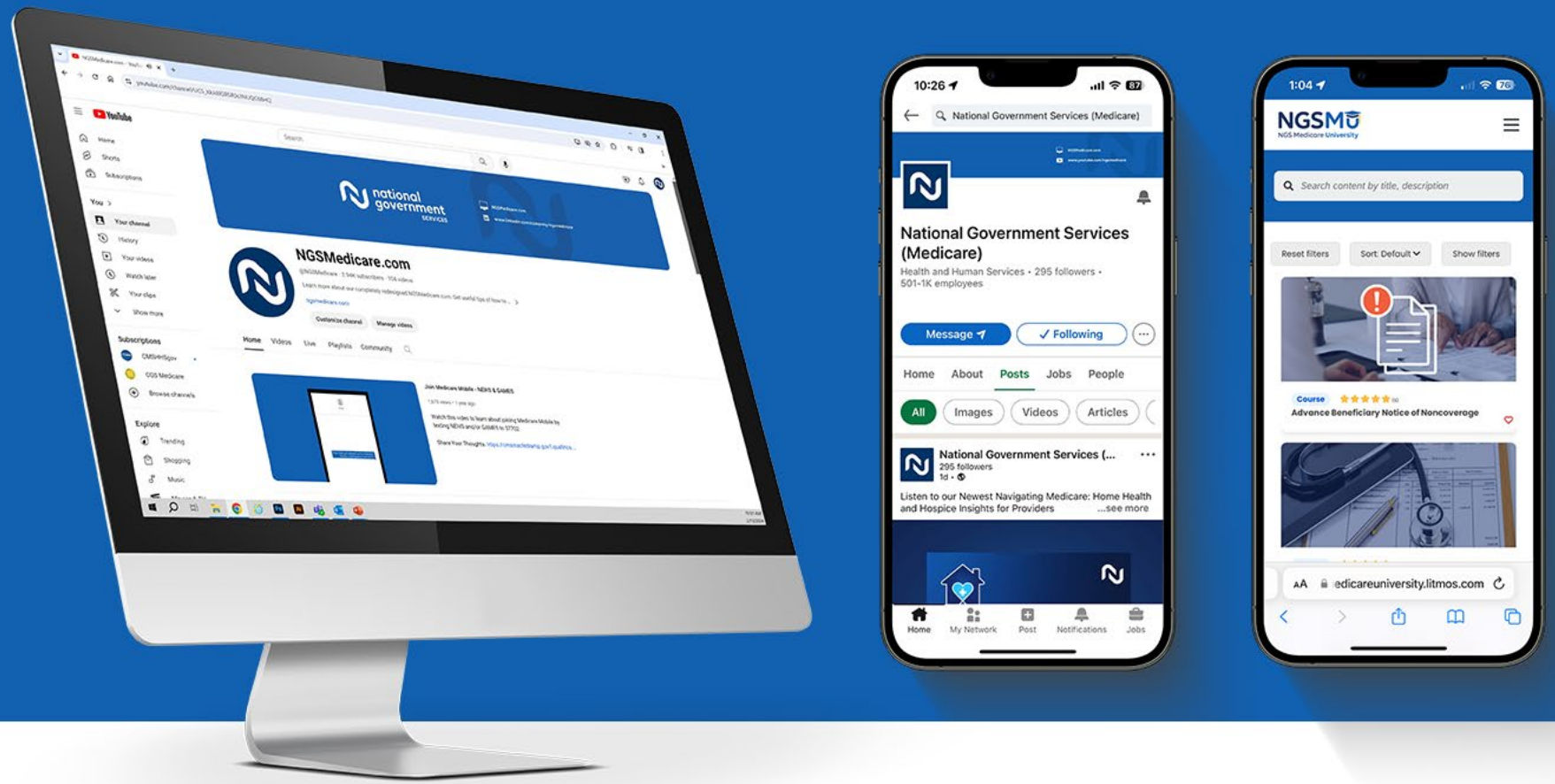
  Part B Provider Written General Inquiries
  P.O. Box 6475
  Indianapolis, IN 46206-6475
- Direct telephone line for provider enrollment J6: 877-908-8476

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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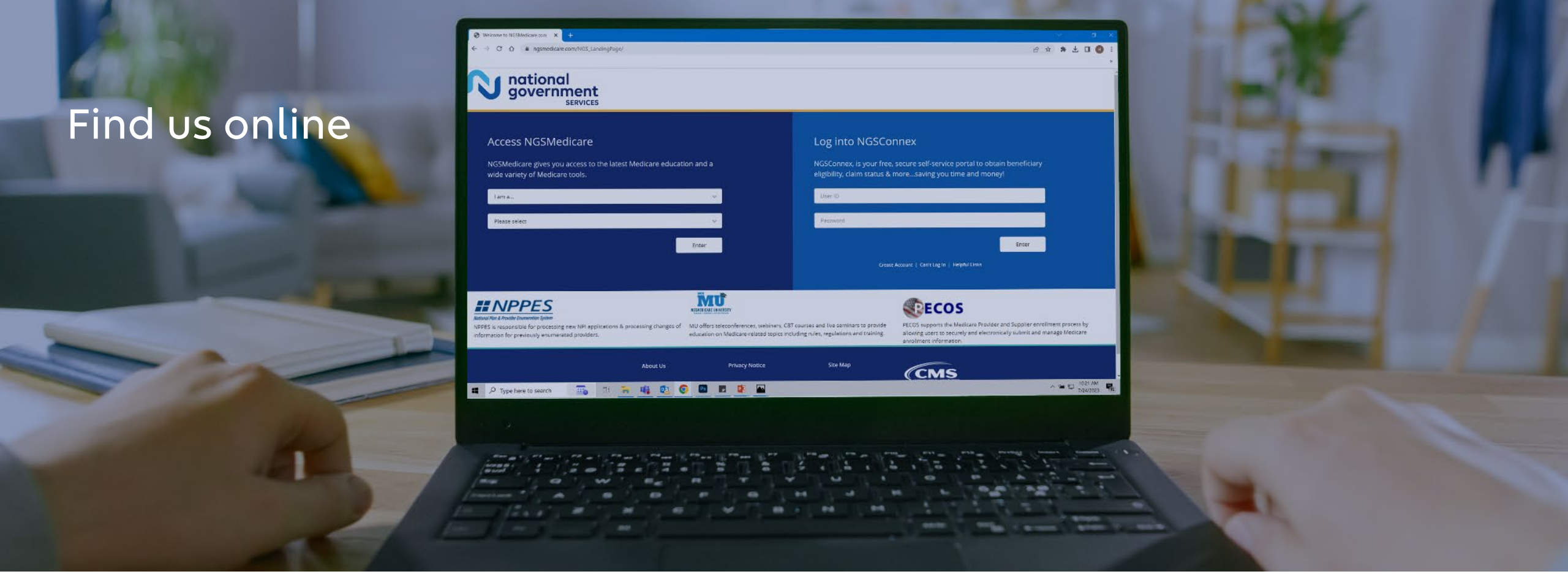

www.NGSMedicare.com
Online resources, event calendar, LCD/NCD, and tools

[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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