national government SERVICES

NGS PROVIDER EXPERIENCE
Innovation | Education | Collaboration

Federally Qualified Health Center Basic Billing and Reimbursement

9/10/2024

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

Disclaimer

National Government Services, Inc. has produced this material as an informational reference for providers furnishing services in our contract jurisdiction. National Government Services employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this material. Although every reasonable effort has been made to assure the accuracy of the information within these pages at the time of publication, the Medicare Program is constantly changing, and it is the responsibility of each provider to remain abreast of the Medicare Program requirements. Any regulations, policies and/or guidelines cited in this publication are subject to change without further notice. Current Medicare regulations can be found on the CMS website.

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

To provide the basic billing and coverage requirements for Federally Qualified Health Centers

Today’s Presenter

- Provider Outreach and Education Consultant
  - Mimi Vier

Agenda

- FQHC Program Basics
- FQHC PPS Billing and Reimbursement
- Billing and Reimbursement Examples
- Other FQHC Services
- Billing and Payment for Preventive Services
- References and Resources
- Questions & Answers

FQHC Program Basics

Who's Your A/B MAC?

- National Government Services (NGS)
  - J6: WI, MN, IL
  - JK: NY, CT, RI, ME, MA, VT, NH
  - NGS services FQHCs in 44 states
- FQHCs located in other states
  - New FQHCs will be under the A/B MAC assigned to their state
  - Out of jurisdiction providers (OJP) may have NGS as their A/B MAC for FQHC claims but another MAC that processes Part B claims (CMS 1500 form)
    - Billed through WI region
- Check Provider Enrollment Chain Ownership System (PECOS) enrollment

FQHC Encounters

Encounters defined

Medically necessary, face-to-face interaction between patient and core practitioner during which FQHC covered service is performed

FQHC Reimbursement per Day

Encounters with more than one health professional on same day = one encounter.

FQHC Core Practitioner

Physician, Nurse Practitioner (NP), Physician Assistant (PA), Certified Nurse Midwife (CNM), Clinical Psychologist (CP), Clinical Social Worker (CSW), Marriage and Family Counselors (MFT), Mental Health Counselors (MHC)

FQHC Encounters

- Exceptions to one FQHC PPS payment per day
  - After initial encounter the patient suffers an illness or injury requiring additional diagnosis or treatment
    - Two FQHC PPS payments may be made
  - Patient receives a medical encounter and a mental health encounter on the same day
    - Two FQHC PPS payments may be made

Visiting Nurse

- Skilled nursing services may be covered if all criteria met:
  - Patient is homebound
  - FQHC located in home health shortage area
  - Services provided under plan of treatment by NP, PA, CNM, CP, CSW
  - Furnished on intermittent basis

Dental, Podiatry, Optometry, and Chiropractic Services

- Bill for FQHC encounter furnished by dentist, podiatrist, optometrist, or chiropractor when services furnished are qualifying visits
  - Service must be within scope of practice
  - HCPCS codes must reflect actual services provided

Non-FQHC Services

- Medicare exclusions
- Group information/education/medical activities
- Services covered under Part B that are not FQHC services
  - EKG/EEG/ECG services (technical component)
  - Laboratory Services
  - DME
  - Ambulance services
  - Prosthetic devices
  - Body braces
  - Technical components of diagnostic tests

Non-FQHC Services

- Technical component of preventive services
  - Screening pap smears and screening pelvic exams
  - Prostate cancer screening
  - Colorectal cancer screening tests
  - Screening mammography
  - Bone mass measurements
  - Glaucoma screening

FQHC PPS Billing and Reimbursement

FQHC Billing

- Bill Types (77X)
  - 770 = nonpayment/zero claim
  - 771 = admit through discharge
  - 777 = claim adjustment
  - 778 = claim cancel
- DOS
  - Cannot overlap calendar years
    - Billing periods that overlap calendar years should be split into two claims

FQHC Revenue Codes

Revenue code	Description
0519	Supplemental MAO Payment
0521	Clinic encounter
0522	Home encounter
0524	Encounter for beneficiary in covered Part A SNF stay
0525	Encounter for beneficiary in noncovered Part A stay (or other residential facility)
0527	Visiting nurse service at beneficiary's home when in home health shortage area
0528	Encounter at other non-FQHC site (scene of accident)
0900	Mental health services provided by CP, CSW

Reporting Incident-To Services

- Report all services provided during encounter
- All valid revenue codes may be used except:

Revenue Code	Revenue Code
002x-024x	065x
029x	067x-072x
045x	080x-088x
054x	093x
056x	096x-310x
060x	

FQHC Payment Codes

- Identify each billable encounter using the appropriate FQHC G-code
  - G0466 – medical encounter, new patient
  - G0467 – medical encounter, established patient
  - G0468 – IPPE or AWV
  - G0469 – mental health encounter, new patient
  - G0470 – mental health encounter, established patient
- Report with billable encounter revenue code
  - 052X (medical encounter)
  - 0900 (mental health encounter)
  - 0519 (supplemental MAO payment)

Report Charges

- Set your charge for each payment code (G code)
  - Identify typical bundle of services furnished during encounter
  - Determine normal charges for those services
  - Sum of normal charges = facility charge for payment code
  - Reported in TOTAL CHARGE field of payment code line
  - Charges must be same for all patients

Billable Encounter

- Line one represents billable encounter
  - Billable encounter revenue code
    - 052X (medical encounter)
    - 0900 (mental health encounter)
  - Payment code in HCPCS field
    - G0466
    - G0467
    - G0468
    - G0469
    - G0470
  - One (1) unit
  - Payment code charge

Qualifying Visit

- Qualifying visit is reported on line two
  - Same billable encounter revenue code
  - Qualifying visit HCPCS code in HCPCS field
  - One (1) unit
  - Charges

Subsequent Claim Lines

- Incident-to services
  - Appropriate revenue code for the HCPCS code
  - Appropriate CPT/HCPCS code in the HCPCS code field
  - One (1) unit
  - Charges
  - Revenue code 001 = Total of all charges on claim (ensure calculated properly)

Billing and Reimbursement Examples

Billing Example Disclaimer

- HCPCS codes and associated charges are used for illustration purposes only
- Charges represented are not reflective of actual charges and should not be used as guidelines for setting rates
- PPS rate adjustment and payment examples reflect fictional provider in Wisconsin (AAA Healthcare)
- GAF rates posted on CMS' website for your region

Claim Example: Established Patient Medical Encounter

Rev Code	Description	HCPCS	Service Date	Service Units	Total Charges
0521	FQHC visit, established patient	G0467 Payment code	010124	1	$150.00 payment code charge
0521	Office/outpatient visit, established patient	99213 Qualifying visit	010124	1	$135.00
0300	Incident-to service	XXXXX	010124	1	$35.00
0001	Total				$320.00

FQHC PPS Reimbursement

- Based on lesser of
  - FQHC's charge for billed payment code, or
  - Adjusted PPS rate
    - PPS base rate for 01/01/2024 through 12/31/2024 = $195.99, subject to
      - GAF adjustment
      - New patient/IPPE/AWV adjustment
      - Annual increase
- Medicare reimbursement = lesser amount x 80%
- Part B coinsurance = lesser amount x 20%
  - Coinsurance waived for certain preventive services

Calculating Adjusted FQHC PPS Rates

- Apply GAF adjustment
  - Multiply PPS base rate ($195.99) by GAF
- Example: Wisconsin FQHC GAF adjustment
  - PPS base rate $195.99 x .939 (WI GAF) = $184.03

Calculating Other Payment Adjustments

- New Patient
- IPPE
- AWV (Initial or subsequent)
- Multiply GAF-adjusted PPS base rate by 1.3416 (34%)
  - Accounts for greater intensity and resource use
- Example: Wisconsin FQHC New Patient/IPPE/AWV adjustment
  - Wisconsin GAF-adjusted rate $184.03 x 1.3416 (new patient adjustment) = $246.90

Payment Example: Established Patient Medical Encounter

- Medical encounter generates PPS payment
  - FQHC payment code G0467 charge = $150.00
  - Adjusted PPS rate = $184.03
  - Reimbursement based on lesser amount = $150.00
    - Medicare payment = 80% x $150.00 = $120.00
    - Coinsurance = 20% x $150.00 = $30.00

Rev Code	Description	HCPCS	Service Date	Service Units	Total Charges
0521	FQHC visit, established patient	G0467 Payment code	010124	1	$150.00 payment code charge
0521	Office/outpatient visit, established patient	99213 Qualifying visit	010124	1	$135.00
0300	Incident-to service	XXXXX	010124	1	$35.00
0001	Total				$320.00

Claim Example: New Patient Medical Encounter

Rev Code	Description	HCPCS	Service Date	Service Units	Total Charges
0521	FQHC visit, new patient	G0466	010124	1	$250.00
0521	Office/outpatient visit, new patient	99202	010124	1	$190.00
0001	Total				$440.00

Definition of New Patient

- Beneficiary who
  - Has not received any professional medical or mental health services from any site or from any practitioner within FQHC organization within three years prior to DOS
  - Changes FQHC facilities
  - Transfers to new FQHC facility with practitioner

Payment Example: New Patient Medical Encounter

- Medical encounter generates PPS payment
  - FQHC payment code G0466 charge = $250.00
  - Adjusted PPS rate = $246.90
  - Reimbursement based on lesser amount = $246.90
    - Medicare payment = 80% x $246.90 = $197.52
    - Coinsurance = 20% x $246.90 = $49.38

Rev Code	Description	HCPCS	Service Date	Service Units	Total Charges
0521	FQHC visit, new patient	G0466	010124	1	$250.00
0521	Office/outpatient visit, new patient	99202	010124	1	$190.00
0001	Total				$440.00

Multiple Encounters on Same DOS

- May only be reported under these scenarios
  - Medical encounter and mental health encounter on same day
  - Patient suffers illness/injury that requires additional diagnosis/treatment on same day
- Report medical encounter on same DOS as IPPE/AWV as incident-to IPPE/AWV

Reporting Multiple Billable Encounters on Same DOS

- Patient has medical and mental health encounter on same DOS
  - Report second encounter on additional claim lines
    - Payment code line
    - Corresponding qualifying visit HCPCS code line
- Patient has two medical encounters on same DOS
  - Report second encounter on additional claim lines
    - Payment code line with modifier 59
    - Corresponding qualifying visit HCPCS code lines

Claim Example: Medical and Mental Health Encounter

Rev Code	Description	HCPCS	Service Date	Service Units	Total Charges
0521	FQHC visit, established patient	G0467	010124	1	$150.00
0521	Office/outpatient visit, established patient	99213	010124	1	$135.00
0900	FQHC visit, mental health established patient	G0470	010124	1	$175.00
0900	Psych evaluation	90791	010124	1	$140.00
0001	Total				$600.00

Payment Example Part One: Medical Encounter

- Medical encounter generates PPS payment
  - FQHC payment code charge of $150.00 (G0467) less than the adjusted PPS rate of $184.03
    - Medicare payment = 80% x $150.00 = $120.00
    - Coinsurance = 20% x $150.00 = $30.00

Rev Code	Description	HCPCS	Service Date	Service Units	Total Charges
0521	FQHC visit, established patient	G0467	010124	1	$150.00

Payment Example Part Two: Mental Health Encounter

- Mental health encounter generates PPS payment
  - FQHC payment code charge of $175.00 (G0470) less than adjusted PPS rate of $184.03
    - Medicare payment = 80% x 175.00 = $140.00
    - Coinsurance = 20% x $175 = $35

Rev Code	Description	HCPCS	Service Date	Service Units	Total Charges
0900	FQHC visit, mental health established patient	G0470	010124	1	$175.00

national government SERVICES

NGSMU

Claim Example: Established Patient, Two Unrelated Medical Encounters

Rev code	Description	HCPCS	Service Date	Service Units	Total Charges
0521	FQHC visit, established patient	G0467	010124	1	$150.00
0521	Office visit, established patient	99214	010124	1	$135.00
0472	Remove impacted ear wax	69210	010124	1	$30.00
0521	FQHC visit, established patient	G0467 59	010124	1	$150.00
0521	Office visit, established patient	99213	010124	1	$100.00
0001	Total Charges				$565.00

Payment Example: Each Medical Encounter

- *Each* medical encounter generates PPS payment
  - FQHC payment code charge of $150.00 (G0467) less than adjusted PPS rate of $184.03
    - Medicare payment = 80% x $150.00 = $120.00 x 2 or $240.00
    - Coinsurance = 20% x $150.00 = $30.00 x 2 or $60

Rev Code	Description	HCPCS	Service Date	Service Units	Total Charges
0521	FQHC visit, established patient	G0467	010124	1	$150.00
0521	FQHC visit, established patient	G0467 59	010124	1	$150.00

Other FQHC Services

Diabetes Self Management Training (DSMT)

- G0108 (Qualifying visit)
- One-on-one/face-to-face encounter
- All program requirements met and accredited
- Diabetes counseling or medical nutrition services provided by registered dietician may be considered as incident-to visit with FQHC practitioner
- Conducted by certified DSMT practitioner
- Coinsurance applied
- Not separately paid if provided on same day as another medical visit

Medical Nutrition Therapy (MNT)

- 97802/97803 (Qualifying visit)
- One-on-one/face-to-face encounter
- All program requirements met
- Diabetes counseling or medical nutrition services provided by registered dietician may be considered as incident-to visit with FQHC practitioner
- Provided by registered dietician or nutrition professional
- Not separately paid if provided on same day as another medical visit
- Coinsurance waived

Care Management Services (G0511)

- Billed alone or with other payable services
- 20% coinsurance based on lesser of charges or G0511 rate

General Care Management Services	HCPCS/ CPT Codes
Chronic Care Management (CCM)	99487, 99490, 99491
Principal Care Management (PCM)	99424, 99426
Chronic Pain Management (CPM)	G3002
General Behavioral Health Integration (BHI)	99484
Remote Psychologic Monitoring (RPM)	99453, 99454, 99457, 99091
Remote Therapeutic Monitoring (RTM)	98975, 98976, 98977, 98980
Community Health Integration (CHI)	G0019
Principal Illness Navigation (PIN)	G0023
PIN-Peer Support	G0140

Transitional Care Management (TCM)

- Services required following discharge from inpatient hospital setting
  - 30-day period beginning date of discharge
- Physician/NPP accepts care of beneficiary post-discharge from facility setting without gap
  - Takes responsibility for beneficiary's care
- Medical/psychosocial issues require moderate-high/complexity medical decision making

TCM Guidelines

- One TCM visit covered per beneficiary per post-discharge period
- Services provided not in post-op global period
- Only one health care professional may report TCM services
- If occurs same day as another billable visit, generally only one visit billed
  - As of 1/1/2022 bill TCM and general care management services for same patient during same time period
- Subject to Part B coinsurance

Billing for TCM Services

- DOS = day face-to-face visit takes place
- Revenue code = 0521
- Qualifying visit HCPCS codes
  - 99495 for moderate-complexity decision making
  - 99496 for high-complexity decision making
- One (1) unit
- Total charges
- 0001 total charges

Principal Care Management (PCM) Services

- PCM services describe comprehensive care management services of single high-risk disease or complex condition
  - Bill G0511 (general care management) either alone or other payable services
  - Payment rate includes PCM HCPCS G2064 and G2065
    - Change Request 12252: *Updates to Medicare Benefit Policy Manual for Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services*
    - CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 13, Section 230.2

Psychiatric Collaborative Care Model (CoCM)

- HCPCS G0512
- Can only bill once per month per beneficiary
  - Do not bill if other care management services billed for same time period by any practitioner or facility
- 70 minutes of psychiatric CoCM in first calendar month
- 60 minutes in subsequent calendar months
- Bill alone or on qualifying visit claim
- Coinsurance and deductible applied

Telehealth

- CY 2024 PFS Final Rule List of Medicare Telehealth
- FQHC is originating site (where beneficiary located)
  - Service billed separately, no other visit reported
  - Subject to Part B deductible and coinsurance
- FQHC not authorized to serve as distant site (where provider located, including their home)
  - Exception
    - Distant site telehealth services may be furnished by FQHCs through December 2024

Telehealth Billing – Originating Site

- Revenue Code 0780
- HCPCS Q3014
- Subject to Part B deductible
- FQHC G-code not required
- Qualifying visit HCPCS code not required

Telehealth: Mental Health via Telecommunications

- Mental health visits using interactive, real-time telecommunications technology
  - Report and receive payment in same way as in-person, including audio-only visits
- MLN® Matters: *SE22001: Mental Health Visits via Telecommunications for Rural Health Clinics & Federally Qualified Health Centers* effective 1/1/2025 requirements
  - In-person mental health service furnished within six months prior
  - Without use of telecommunication at least every 12 months

Telehealth: Mental Health Example

- Revenue Code 0900
- HCPCS G0469 or G0470 with modifier
  - 95 – audio-video
  - FQ or 93 – audio only
- FQHC qualifying mental health visit code

Virtual Communication Services

- At least five minutes of communication technology-based or remote evaluation services
- Patient had at least one face-to-face billable visit within previous year
- Medical discussion or remote evaluation must meet both of the following requirements
  - Condition not related to FQHC service provided within last seven days
  - Does not lead to FQHC visit within next 24 hours or soonest available appointment

Virtual Communication Services

- Can be billed alone or with other payable services
- Submit claim with HCPCS G0071
- FQHC face-to-face requirement waived
- Medicare coinsurance and deductible apply
- Virtual Communication Services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Frequently Asked Questions

Billing & Payment for Preventive Services

Billing Preventive Services

- If preventive service is only service provided, bill encounter
  - Payment code (G code) and charge,
  - Billable encounter revenue code (52X)
  - Qualifying visit HCPCS code with preventive service charge
- If performed on same day as billable encounter, report as incident-to services
  - Report preventive service on separate line
    - Appropriate revenue code (not 52X), HCPCS code and associated charges

Payment for Preventive Services

- If only service provided is preventive service exempt from coinsurance, reimbursement lesser of facility payment code charge or adjusted PPS rate
  - Medicare payment = 100%
  - Part B coinsurance = 0%
- Coinsurance waived for most preventive services
  - Prostate cancer screening, colorectal cancer screening, and DSMT are subject to 20% beneficiary coinsurance

Claim Example: Preventive Only Service

- Established patient comes to FQHC only for screening pelvic examination

Rev Code	Description	HCPCS	Service Date	Service Units	Total Charges
0521	FQHC visit, established patient	G0467	010124	1	$150.00
0521	Screening pelvic exam	G0101	010124	1	$52.00
0001	Total				$202.00

Payment Example: Preventive Only Service

- Stand-alone encounter (preventive service) generates PPS payment
  - FQHC payment code charge of $150.00 (G0467) less than PPS rate of $182.47
    - Medicare payment = 100% x $150.00 = $150.00
    - Coinsurance = $0.00

Rev Code	Description	HCPCS	Service Date	Service Units	Total Charges
0521	FQHC visit, established patient	G0467	010124	1	$150.00

Payment for Preventive Services

- Reimbursement for preventive service exempt from coinsurance and reported as incident to billable encounter
  - 100% total line-item charges for preventive services and
  - Lesser of FQHC payment code charge or adjusted PPS rate
    - Minus total line-item charges for preventive services
      - Medicare payment = 80%
      - Part B coinsurance = 20%
  - Coinsurance will not apply to preventive service charge

Claim Example: Medical Encounter & Preventive Service

- Established patient comes to FQHC for medical encounter and receives hepatitis B vaccination

Rev Code	Description	HCPCS	Service Date	Service Units	Total Charges
0521	FQHC visit, established patient	G0467	010124	1	$150.00
0521	Office/outpatient visit established patient	99212	010124	1	$120.00
0636	Hepatitis b vaccine adult three dose im	90746	010124	1	$60.00
0771	Admin hepatitis b vaccine	G0010	010124	1	$20.00
0001	Total				$350.00

Payment Example Part 1: Preventive Service

- Preventive service paid at 100%
  - Total charges for preventive service = $80.00
    - Medicare payment = 100% x $80.00 = $80.00
    - Coinsurance = 0% x $80.00 = $0.00

Rev Code	Description	HCPCS	Service Date	Service Units	Total Charges
0636	Hepatitis b vaccine adult three dose im	90746	010124	1	$60.00
0771	Admin hepatitis b vaccine	G0010	010124	1	$20.00

Payment Example Part 2: Medical Encounter

- Medical encounter generates PPS payment
  - FQHC payment code charge of $150.00 (G0467) less than adjusted PPS rate of $182.47
    - $150.00 – $80.00 (reimbursement for preventive service) = $70.00
      - Medicare payment = 80% x $70.00 = $56.00
      - Coinsurance = 20% x $70.00 = $14.00

Rev Code	Description	HCPCS	Service Date	Service Units	Total Charges
0521	FQHC visit, established patient	G0467	010124	1	$150.00

Vaccines

- Influenza, Pneumococcal, COVID-19
  - If only service provided, do not submit claim
    - Cost of vaccine and administration reported on cost report
  - If performed on same day as billable encounter, report as incident-to services
    - Report A6 Condition Code (100% reimbursement)
    - Coinsurance/deductible waived
    - Report on the cost report
- Hepatitis B vaccination
  - If provided with qualified visit, report as incident-to service
    - Coinsurance applicable
    - Payment included in qualified visit

Reference and Resources

CMS References and Resources

- Federally Qualified Health Centers (FQHC) Center
  - FQHC GAFs 1/1/24-12/31/24
  - CY 2024 Payment Rates Update to the FQHC PPS
  - FQHC PPS Payment Specific Codes
  - FQHC PPS Frequently Asked Questions
  - FQHC Preventive Services
- MLN® Booklet: *Federally Qualified Health Center* (MLN006397)
- CMS IOMs
  - Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 13 – Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services
  - Publication 100-04, *Medicare Claims Processing Manual*, Chapter 9 – Rural Health Clinics/Federally Qualified Health Centers

CMS References and Resources

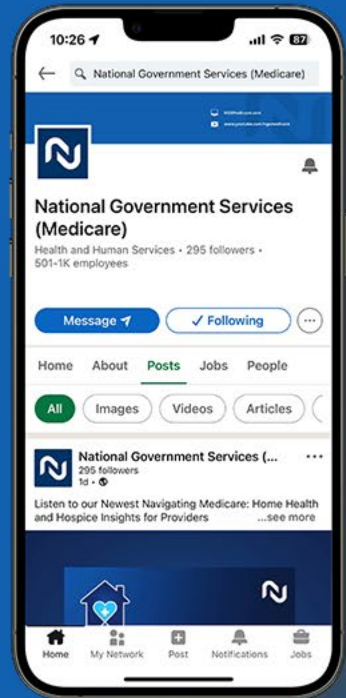
- Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs): CMS Flexibilities to Fight COVID-19
- List Telehealth Services
- MLN® Matters: *SE22001: Mental Health Visits via Telecommunications for Rural Health Clinics & Federally Qualified Health Centers*
- MLN® Booklet: *Chronic Care Management Services* (MLN 909188)
- Virtual Communication Services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHC) Frequently Asked Questions November 2022

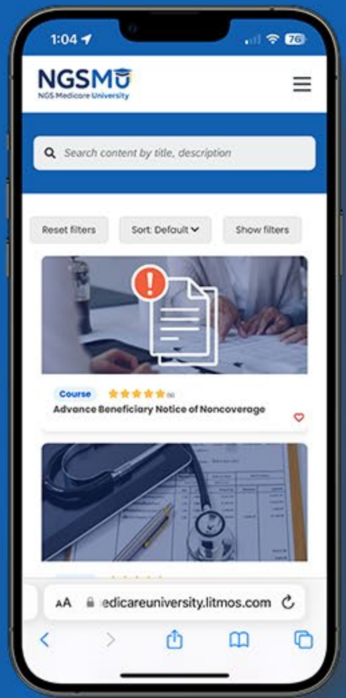
Tool: NGS FQHC PPS Calculator

- Visit our website > Resources > Fee Schedules and Pricers > FQHC PPS Calculator

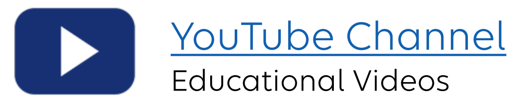
FQHC PPS Calculator: January 1, 2024 through December 31, 2024
*Complete all fields in yellow and that are immediately to the right of **.
*Do not change fields with dark borders in grey.

	1. Enter Provider Number:		
**			
	(This information is informational on the calculator and will not affect the calculation of the rate.)		
	FQHC Base Rate	$ 195.99	Per Final CR 13398 Issued 11/16/2023
	2. Select the applicable provider location. This will return the appropriate Geographic Adjustment Factor (GAF)?		
**	WISCONSIN		
	(The GAF is used to determine how the base rate is adjusted due to the geographic location of the facility. This can also be found on Page 40 of the claim record as well.)		
	PPS Rate		
	3. Is provider is eligible for a payment adjustment related to a new patient, an initial preventive physical examination (IPPE), or an annual wellness visit (AWV)?		
**	Yes	1.3416	
	(FQHCs will get a payment adjustment for claims where the patient is new to the FQHC, or if the FQHC is furnishing an IPPE, an initial AWV, or a subsequent AWV. This adjustment is calculated by mutliplying the GAF-adjusted PPS rate by 1.3416.)		
	Calculated PPS Rate		
	4. Enter the actual charges that are associated with the payment ("G") codes listed on the "Payment Adjustment" tab.		
**			
	FQHC Reimbursement*		
	(prior to Sequestration and Coinsurance)		
	*The FQHC Reimbursement is the amount of the rate that is paid to the provider prior to any coinsurance or sequestration adjustments.		





Connect with us on social media

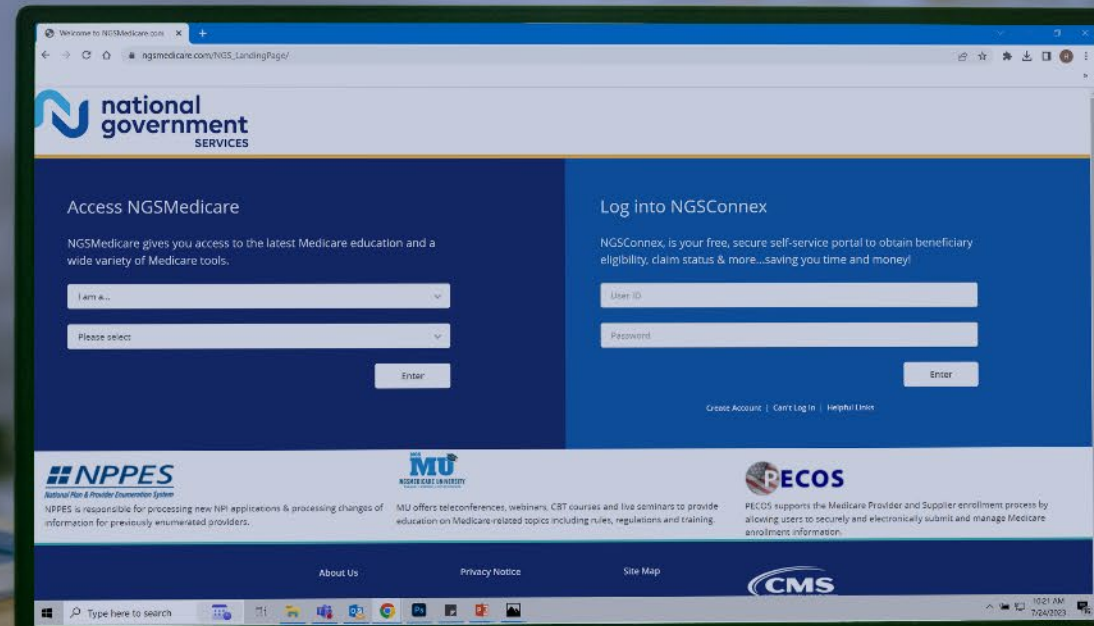


[YouTube Channel](#)
Educational Videos

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

[LinkedIn](#)
Educational Content

Find us online



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

Sign up for Email Updates
Subscribe for Email updates at the top of any NGSMedicare.com webpage to stay informed of news

Questions and Answers

Thank you!