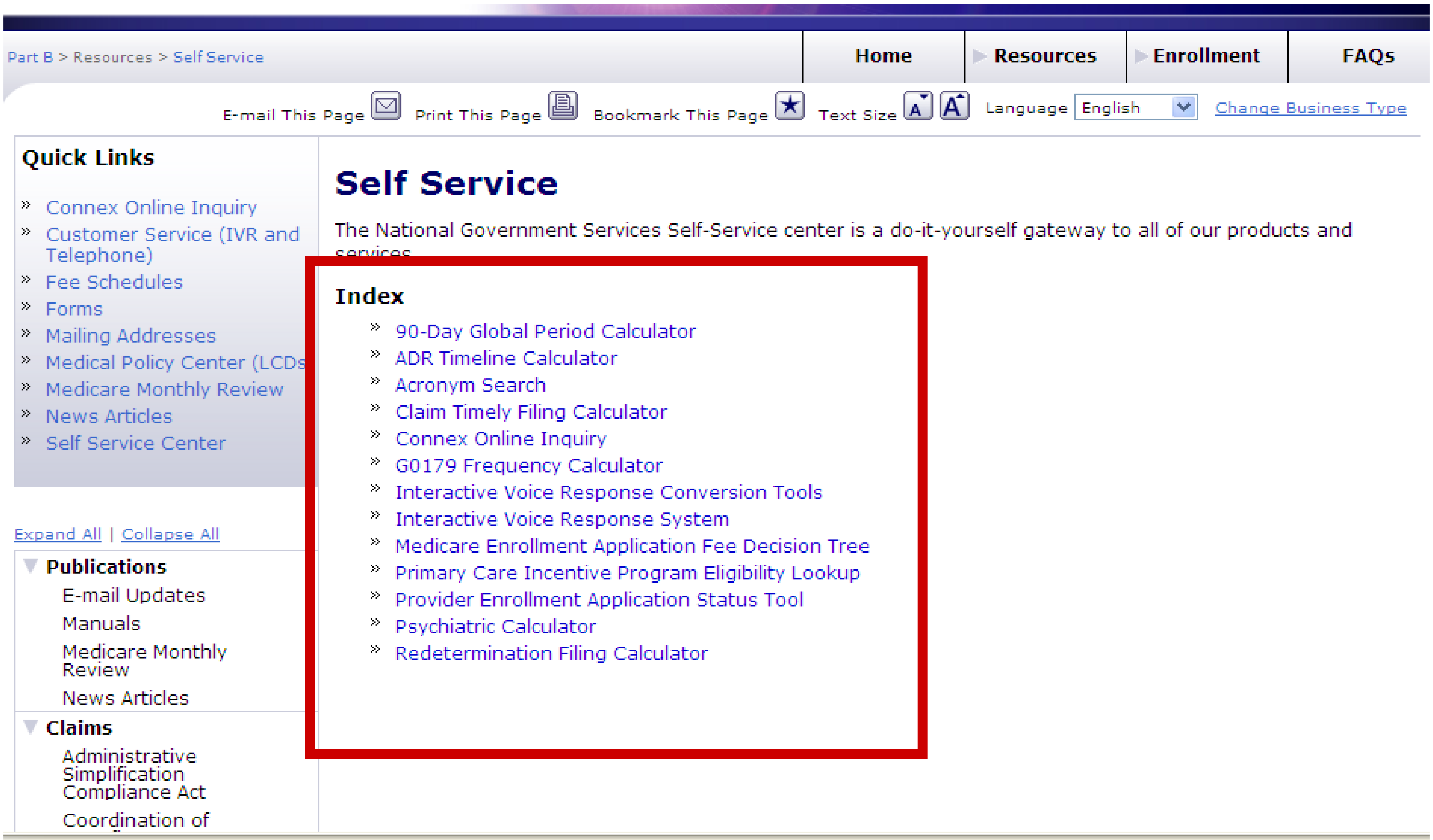
How Do I Stay on Top of Medicare Changes?

Recent Web Site Enhancements

http://www.NGSMedicare.com

New Web Site Tools!



National Government Services

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- **Publications**
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  - Clinical Education
  - Medicare University
  - POE Advisory Group
  - Training Events Calendar
  - Training Summaries
  - Welcome New Providers
- **Review Process**

Medicare Part B Home

Hot Topics

- Advanced Payment Information ***New***
- CERT Program
- Connex Online Application Now Available! ***New***
- New Site Crosswalk Tools and Communications ***New***
- Provider Enrollment Clinics Scheduled —CT and NY Dates Still Available ***New***
- HIGLAS Transition for Part B - Connecticut and New York Providers ***New***
- Welcome New Providers!

Have Your Voice Heard

Your feedback helps us make improvements to the website. Take the survey the next time you see it.

READ MORE

Latest Production Alerts

View All Production Alerts

Roster Bill Problem with CPT 90662 (Fluzone) | 12/22/2010 12:00 AM
A problem has been identified with current procedural terminology (CPT) code 90662 when submitting this CPT code on a roster bill. Providers can bill this code on a separate claim but this code cannot be submitted on a roster bill.

Reported Missing ERAs for IN/KY Providers Have Been Located and Are Being Sent | 11/19/2010 12:00 AM
Medicare Part B Indiana and Kentucky trading partners are reporting that 835 electronic remittance advices (ERAs) were not received for the dates of 10/22, 10/25, 10/26, and 10/27/2010.

Providers/Suppliers Experiencing Intermittent Issues When Calling the Contact Center |
National Government Services is currently experiencing technical issues with Contact Center phone lines.

Display Format: Select

Part B Providers

Welcome to National Government Services Event Calendar. Please use the Help button to the right for any assistance while using the Calendar. **Please Note:** All training/event times are shown in eastern time.

day week month year

subscribe download help print

May 2011

	Su	Mo	Tu	We	Th	Fr	Sa
▶	1	2	3	4	5	6	7
▶	8	9	10	11	12	13	14
▶	15	16	17	18	19	20	21
▶	22	23	24	25	26	27	28
▶	29	30	31	1	2	3	4

Display Month: Select

Advanced Search (New Search)

From: 5/1/2011

To: 5/31/2011

Location(s): Select

Keyword(s):

Submit

May 1 - 31, 2011

Start Date and Time	Event Details	Location
Wednesday, May 11, 2011		
10:30 AM - 11:30 AM	2011 Medicare Electronic Prescribing (e-Rx) Incentive Program Webinar This Webinar will provide information necessary to get started with reporting under the Medicare e-Rx Incentive program. Changes to the program for 2011 as a result of the 2011 Medicare physician fee schedule (MPFS) Final Rule will be discussed, including the payment adjustment for unsuccessful e-Rx prescribers and how to avoid the payment adjustment. The new G codes for requesting a hardship exemption will be explained.	Webinar
Wednesday, May 18, 2011		
1:00 PM - 2:30 PM	Medicare Secondary Payer (MSP) Payment for Part B Providers This session will educate providers on how Medicare calculates payment on Medicare Secondary Payer (MSP) claims submitted to Medicare.	Webinar
Thursday, May 26, 2011		
1:00 PM - 3:00 PM	Coverage of Outpatient Physical and Occupational Therapy and Recent Medical Review Results	Webinar

- New "look and feel"
- Search functionality included within the FAQs
- Topic index, including subcategories
- Display of the most popular topics, top reviewed questions, and most recently added questions
- Cross-references to related topics when viewing the FAQ search or answer page
- Cross-references to related Web site resources supporting the FAQ answers
- Feedback form for commenting on searched topics and questions
- Opportunity to comment on the helpfulness of FAQ answers and to submit new questions

Medicare University

- Educational program designed to provide a broad variety of Medicare related training
- View events on National Government Services Web site
- All teleconferences, Webinars, CBTs, and many seminars are **free**
- Registration is required
- Earn MUC Credits–self-report after training/print Report card of all training http://www.NGSMedicare.com

Education Just for J13 Providers

- Part B News Flash Webinar
- Ask-the-Contractor Teleconference (ACT)
- Minimize Errors and Maximize Revenue: Get it done right!

J13 Contact Information

J13 Contact Information

- IVR: **877-869-6504**
- Provider Contact Center: **866-837-0241**
- Fax on Demand: **866-709-1905**
- EDI Helpdesk: **877-273-4334**
- Correspondence
  National Government Services
  Part B Provider General Written Inquiries
  P.O. Box 7052
  Indianapolis, IN 46207-7052
- New Direct Telephone line for Provider Enrollment (J13): **888-379-3807**

Contacting the Telephone Reopening Unit

- TRU Line: 888-812-8905, follow prompt
- Part B TRU line hours of operation Monday–Friday, 8:00 a.m.–3:00 p.m. eastern time
- Faxes are accepted and representatives are permitted to accept more than three claims per call

EDI Helpdesk

- 877-273-4334
- Monday–Friday
- 8:00 a.m.–4:00 p.m. (eastern time) for all EDI requests
- 4:00 pm–6:00 p.m. for password resets only
- NGS_EDI_PartB@wellpoint.com

EDI Help Desk IVR System Changes

- **Press 1** to check the status of EDI enrollment forms
  - Provide the RID number, PTAN and NPI
  - Status of forms will be available 24 hours after online submission
- **Press 2** for durable medical equipment suppliers
- **Press 1** for claim status inquiry
  password reset
- **Press 3** for Part B providers:
- **Press 1** for J13, New York, Connecticut
  - **Press 1** for password reset
  - **Press 2** for all other inquiries

Help For Your Office!

What Is Connex?

- http://www.ngsconnex.com
  - Need Internet access and e-mail address
  - No cost
- Provides:
  - Claim status
  - Beneficiary eligibility
  - Financial data
  - Provider demographics
  - Ability to order remittances

NATIONAL GOVERNMENT SERVICES connex

National Government Services

Contact Us | Log Out |

Home | My Provider Profile | My Claims | Entitlement | My Financials | My User Profile

NATIONAL GOVERNMENT SERVICES connex

National Government Services

Log Out |

Home | My Provider Profile | My Claims | Entitlement | My Financials | My User Profile | User Management

Top FAQs

- **What is National Government Services Connex?**
  National Government Services Connex is an all-new Web application aimed at providers and offering them access to a wide variety of Medicare informatio...
- **When is National Government Services Connex available?**
  National Government Services Connex is accessible 24 hours a day. However, Connex will allow limited transactions during the hours of 6:00 pm to 7:00...
- **I'm a first time user of National Government Service Connex. What do I need to know?**
  If your organization does not have a local security officer (LSO), you must designate one before anyone can access data for your provider accounts in ...
- **What is a provider account?**
  A provider account is a relationship between an individual provider transaction access number (PTAN), national provider identifier (NPI), and tax iden...
- **What is an access code?**
  The access code is a unique code that activates LSO access for an individual PTAN, NPI, TIN provider account in National Government Services Connex. T...

More FAQs

Links

ngsmedicare.com

Quick Steps Job Aid | Rules of Behavior | Training Material

CMS

new functionality and scheduled outages or system down time.

New Enhancements

- Provider search options
- Reason/rejection descriptions
- Entitlement data is updated in real time obtained from CMS
- MSP insurer name and address
- Ability to request access for multiple provider accounts
- Ability to check appeal status

Record Requests/Documentation Tips

- Respond to Additional Development Request (ADR) within 30 days
- Documentation
  - Legible
  - Copy both sides
  - Signatures
  - Do not bind records together
  - Do not highlight records
  - Do not tab records
  - Make sure the ADR request matches the records sent

Records Requests/Documentation Tips

- 45th day system generated denial if records not received by the contractor
- Support all services/dates requested
  - This would include sending any and all documentation to support the coverage criteria i.e., Initial evaluation and treatment, any subsequent notes that supports the need for ongoing treatment

National Government Services

Site Search

Enter Keyword(s) | Part B | Search

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Part B > Review Process > Medical Review

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Expand All | Collapse All

Publications

- E-mail Updates
- Manuals
- Medicare Monthly Review
- News Articles

Claims

- Administrative Simplification

Responding to Additional Development Requests

Please refer to the following service-specific checklists when preparing your documentation in response to an additional development request (ADR).

- Ambulance Services
- Chiropractic Services
- Consultations
- Drugs/Biologicals/Infusions
- Electrocardiography
- Evaluation and Management Services and/or Modifier 25
- Outpatient Psychiatric Services
- Physical and Occupational Therapies and Speech Language Pathology
- Podiatry/Foot Care
- Prolonged Service Codes
- Radiology and Diagnostic Services
- Surgical Services and/or Procedures

Last Modified: 10/8/10

Signature Requirements

- Signature Requirements for Medical Documentation
  - The use of stamped signatures is not acceptable on any medical record
  - Medicare requires a legible identifier for services provided and ordered
  - Medicare will accept handwritten, electronic signatures or facsimiles of original written or electronic signatures for medical review purposes
  - The Medical Review Department will deny claims not meeting the signature requirements on records requested on additional development requests (ADR)

Submitting Duplicate Claims:

- May delay payment
  - Resubmitting your claim prior to receiving a determination not only increases administrative costs to the Medicare program but to you as well.
- Could cause you to be identified as an abusive biller; or may result in an investigation for fraud if a pattern of duplicate billing is identified
  - Although National Government Services does not believe providers are trying to deliberately receive duplicate payment by submitting duplicate claims for one service we must remind providers that this is an inappropriate billing practice.

Avoid Duplicate Claims

- Allow 29 days for paper claims and 14 days for electronic claims to be processed
- Electronic Claims Submitters should:
  - Check your EDI validation report to verify claims were received and accepted
  - Check your software system to verify claims' software system is not set up for automatic rebill every 30 days or at any other set time intervals
  - Ensure that your claims batching process is functioning properly

CMS RAC and CERT News

Mission of RAC

- The RAC's mission
- Reduce Medicare improper payments
- Identification of underpayments
- Implement actions that will prevent future improper payments

RAC Review Process

- RAC requests claims from CMS
- RAC requests claims based on data
- RAC reviews documentation (complex review) or claim (automated review) and makes determination
- Claim adjusted-over/underpayment notice

Appeal When Necessary

- Appeal process for RAC denials-same as appeal process for carrier/FI/MAC denials
  - If you disagree with the RAC determination
    - Take advantage of the RAC discussion period
    - File an appeal before the 120th day after the demand letter
      - File within 30 days of the demand letter to stop recoupment of funds

National Government Services

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Part B > Review Process > Recovery Audit Contractor

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Manuals

Medicare Monthly

Recovery Audit Contractor

- What Is the Recovery Audit Contractor Program?
- What Are the Recovery Audit Contractor Responsibilities?
- Who Are the Recovery Audit Contractors?
- How Will I Know When a Payment Determination Has Been Issued?
- What Are My Options When I Receive the RAC Demand Letter?
- How Can I Contact the Recovery Audit Contractor?
- Recovery Audit Contractor Resources

What Is the Recovery Audit Contractor Program?

The mission of the recovery audit program contractor (RAC) program is to **detect and correct past improper payments** made on health care claims for services provided to Medicare beneficiaries. The goal is to help the Centers for Medicare & Medicaid Services (CMS), Medicare carriers, fiscal intermediaries, and Medicare administrative contractors (MACs) implement actions that will **prevent future improper payments**.

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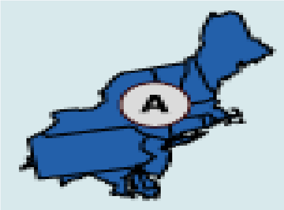
What Are the Recovery Audit Contractor Responsibilities?

Who is My RAC?

RECOVERY AUDIT CONTRACTOR	STATES SERVICED
Region A: Diversified Collection Services	 CT, DE, MA, MD, ME, NH, NJ, NY, PA, RI, VT

- Region A: VT, NH, ME, MA, RI, CT, NY, NJ, DE, MD, Washington DC, PA
- RAC Customer Care Information: 866-201-0580
  DCS Healthcare Services-Customer Service
  2815 Southwest Blvd.
  San Angelo, TX 76904

RAC Websites

- Region A: Diversified Collection Services, Inc: *www.dcsrac.com*
- RAC Web site: www.cms.hhs.gov/RAC
- RAC E-mail: RAC@cms.hhs.gov

Comprehensive Error Rate Testing

CERT

CERT

- Began 2002
- First reports November 2003
- Fee-for-Service only
- Determine a national error rate
- Measure of contractor performance
- Local, regional, and national error rate patterns

CERT Process

- Randomly select sample of claims
- Request medical records from billing provider
- Review claims along with medical records
- Determine if claim or service billed in error
- Appeal rights
- Produce reports

Review

- CERT reviews according to:
  - Local coverage determination (LCDs)
  - National coverage determination (NCDs)
  - Medicare coverage regulations

Goals

- CMS Goals for CERT
  - Reduce National Medicare Fee-for-Service Paid Claims Error Rate
  - Decrease Contractor Specific Paid Claims Error Rate
- Providers/Suppliers
  - Reduce unnecessary denials

Error Categories

- **No Documentation** – Claims are placed in this category when the provider/supplier fails to respond to repeated attempts to obtain the medical records in support of the claim
- **Insufficient Documentation** – Claims are placed into this category when the medical documentation submitted does not include pertinent patient facts
- **Medically Unnecessary** – Claims are placed into this category when claim review staff identify enough documentation in the medical records to make an informed decision that the services billed were not medically necessary based on Medicare Coverage Policies
- **Incorrect Coding** – Claims are placed into this category when providers submitted medical documentation support a lower or higher code than the code submitted
- **Other** – This represents claims that do not fit into any other category (service not rendered)

Common Errors

- **No Documentation** – No medical record received

- **Insufficient Documentation** –
  - **Physical Therapy** - Documentation received included the initial evaluation signed by the physical therapist. Missing were the order, and/or plan of care signed by the ordering physician and treatment notes.
  - Missing or illegible signatures.

- **Medically Unnecessary** –
  - **Inpatient Hospital Stay** - Payment was made for a one day inpatient hospital stay. The patient was admitted with a diagnosis of abdominal pain and stayed less than 12 hours. The patient failed to meet medical necessity criteria for an inpatient admission. Service could have been provided with the patient in an outpatient observation status.

Important Notes

- Please be sure documentation submitted is legible along with a legible physician signature or service will be denied
- Please submit records for all dates of service on the claim
- Please ensure that the medical records submitted provide proof that the service's was rendered and justification to support the medical necessity

Current CERT Findings Therapy Services

- Missing records supporting payment
  - Treatment plan
  - Missing or illegible signature
  - Documentation to support therapy exceeding the cap and the use of the KX modifier
  - No evidence of time for timed modalities
  - Documentation supports maintenance – not medically necessary

Current CERT Findings Labs & Diagnostics

- Providers with electronic ordering systems
  - Print of screen showing electronic order with statement such as “Electronically signed by”
  - One copy per provider of the protocol that describes the system and is entered by the MD with an ID and password

Current CERT Findings

- Evaluation and Management Services
  - Insufficient documentation
    - Missing progress notes
    - Missing orders for laboratory tests
    - Missing or eligible signature

CERT Appeals

- You may appeal through the normal appeal process
- You have 120 days from the date the denied claim was processed for the first level of review
- Medical records submitted to CERT will be available to the Medicare Appeals department

Resources

- CERT findings full report on the CMS Web site at http://www.cms.gov/
- Reports published
  - Select Resources and Tools
  - Select Improper Medicare Fee-for-Service Payments Report under Medicare heading
  - Select year (2011)
  - Under related links select November 2011 Report
  - Select Findings

Resources

- National Government Services Web site: http://www.NGSMedicare.com/
- CERT Web site: https://www.certprovider.com/certproviderportal/pages/default.aspx
- CERT reports: http://www.cms.gov/cert/
- Office of Inspector General reports: http://www.oig.hhs.gov/reports.asp

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Claims

- Administrative Simplification Compliance Act
- Coordination of Benefits
- Electronic Submissions (EDI)
- Fee Schedules
- HCPCS Codes
- Medicare Secondary Payer
- Top Claims Submission Errors

Coverage Determinations

Comprehensive Error Rate Testing

The Comprehensive Error Rate Testing (CERT) program is designed to determine if Medicare contractors are processing and paying claims correctly. This section will help you gain a better understanding of what the CERT program is all about and why it is so important to the Centers for Medicare & Medicaid Services (CMS) and National Government Services.

- CERT Alerts
- CERT Provider Portal Page EXT On this page you will find:
  - **CERT Newsletters:** Pertinent information from the CERT contractor
  - **Sample Letters:** Sample record request letters you may receive from CERT documentation center
  - **Provider Address Directory:** Provider contact information that CERT has for record requests with option to update
- CERT Tools
- Documentation Requirements
- Program Information

MD SIGNATURE REQUIREMENTS

Did you know the MD signature is required on orders for laboratory services, diagnostic and therapeutic procedures, therapy treatment plans, and physician progress notes? Also, if signature is not legible you will need to submit a signature key.

Please refer to the following related articles for more details:

- CMS Change Request 6698 (Revised): Signature Guidelines for Medical Review Purposes PDF
- Comprehensive Error Rate Testing Update—MD Signature Reminder (July 2010 *Medicare Monthly Review*)
- Missing or Illegible Signature Continued (September 2009 *Medicare Monthly Review*)
- Missing or Illegible Signature (August 2009 *Medicare Monthly Review*)
- MD Orders for Laboratory Services and Diagnostics (July 2009 *Medicare Monthly Review*)

Last Modified: 11/29/10

CMS Incentive Programs

CMS Incentive Program Links

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Claims

- Administrative Simplification Compliance Act
- Coordination of

CMS Incentive Program, Payment, and Remittance Advice Information

The Centers for Medicare & Medicaid Services (CMS) issues special incentive payments both quarterly and annually to eligible professionals (EP) that participate in the following incentive programs:

- Physician Quality Reporting System (PQRS) (formerly referred to as the Physician Quality Reporting Initiative or PQRI)
- E-Prescribing (ERx)
- Primary Care Incentive Program (PCIP) – (Check to see if you are eligible to receive PCIP incentive payments on the NGSMedicare.com Web site)
- Health Professional Shortage Area (HPSA) Surgical Incentive Payment Program (HSIP)
- Electronic Health Record (EHR) Incentive Programs

For details about participation in these incentive programs and the program requirements, we encourage all EPs to visit the following CMS Web sites and resources:

- **PQRS**: http://www.cms.gov/pqri/ EXT (no registration required)
- **ERx**: http://www.cms.gov/ERxIncentive/ EXT (no registration required)
- **EHR**: http://www.cms.gov/EHRIncentivePrograms/ EXT (registration required)
- **PCIP**: CMS *Medicare Learning Network (MLN) Matters* article MM7060 PDF (no registration required)
- **HSIP**: CMS *MLN Matters* article MM7063 PDF (no registration required)

Incentive Payment Information

Payments for the **PCIP** and the **HSIP** incentive programs are made on a quarterly basis and lumped into one

Medicare & Medicaid Electronic Health Record Incentive Programs Beginning in 2011

- Certification Commission for Health Information Technology (http://www.cchit.org) has tested and certified 33 EHR products that are capable of meeting the criteria supporting stage 1 meaningful use as approved by the Secretary of HHS
- Incentives: Equal to 75 percent of Medicare allowable charges for covered services furnished by EP in a year, subject to a maximum payments of: $44,000
  - 2011= $18,000
  - 2012 = $12,000
  - 2013 = $8,000
  - 2014 = $4,000
  - 2015 = $2,000

CMS Incentive Program, Payment, and Remittance Advice Information (PQRS, ERx, EHR, HSIP, PCIP)

- **Before calling National Government Services about the ERx or PQRS Program,** please ensure you have visited the Help Desk Support Web site to identify the contractor that may accurately resolve your concerns.
- Please note National Government Services is not able to answer inquiries related to the **EHR Incentive** program.

Electronic Health Record Attestation Resources

- EP participating in the EHR Incentive Program
- CMS has resources to help you attest to having met meaningful use requirements in order to receive your EHR incentive payment
  - Attestation page
  - Meaningful-use calculator
  - Webinar
  - CMS Learn Resource: 201107-46

The 2012 eRx Payment Adjustment

- The reporting period for reporting the electronic prescribing measure for purposes of the 2012 payment adjustment ended on June 30, 2011
- On May 26, 2011, CMS released a proposed rule entitled “Proposed Changes to the 2011 Electronic Prescribing Incentive Program” to address concerns stakeholders have expressed regarding the implementation of the 2012 eRx payment adjustment

The 2012 eRx Payment Adjustment

- The proposed rule proposes to do the following:
  - Allow eligible professionals until October 1, 2011 to submit a request for a significant hardship exemption
  - Modify the existing electronic prescribing measure to allow for the use of certified EHR technology as defined at 45 CFR 170.102
  - Provide the following additional significant hardships to the 2012 eRx payment adjustment:
    - Eligible professionals who register to participate in the Medicare or Medicaid EHR Incentive Program and adopt certified EHR technology
    - Inability to electronically prescribe due to local, state, or federal law or regulation
    - Limited prescribing activity; or
    - Insufficient opportunities to report the electronic prescribing measure due to limitations in the measure's denominator
- Please note that CMS is now accepting exemption requests based on the proposed significant hardship exemptions stated above until November 1, 2011.

2011 Physician Quality Reporting System Educational Resources are Now Available!

- This fact sheet provides guidance on claims-based and registry-based reporting, and describes steps that eligible professionals/practices should take prior to undertaking Physician Quality Reporting System reporting. This also provides helpful tips for eligible professionals and their billing staff
  - Physician Quality Reporting System: Satisfactorily Reporting 2011 Physician Quality Reporting System Measures – Claims and Registry Fact Sheet
- This fact sheet provides quick, easy-to-understand instructions for eligible professionals on how to satisfactorily participate in the 2011 Physician Quality Reporting System using the Preventive Care Measures Group
  - 2011 Physician Quality Reporting System: Made Simple for Reporting the Preventive Care Measures Group Fact Sheet
- This fact sheet explains the two reporting periods for the 2011 Physician Quality Reporting System: 12 months (January 1, 2011–December 31, 2011) and 6 months (July 1, 2011–December 31, 2011)
  - Physician Quality Reporting System: (Physician Quality Reporting, formerly called Physician Quality Reporting Initiative or PQRI) Reporting Periods for 2011 Fact Sheet

Major New Effort to Give Consumers and Employers Better Information About Quality of Care

- Will enable consumers and employers to select higher-quality, lower-cost physicians, hospitals and other health care providers in their area.
- See Learnsource Article PE201106-14A for more information

Incentive Payments to Primary Care Practitioners for Primary Care Services MM7060

- Primary care services furnished on or after 01/01/11 and before 01/01/16
- A 10 percent incentive payment when furnished by a primary care practitioner paid quarterly
- Primary care services
  - 99201 through 99215
  - 99304 through 99340
  - 99341 through 99350

Resources

- http://www.NGSMedicare.com
- http://www.cms.gov
- http://www.ngsconnex.com

Medicare University Credit Self-Reporting Instructions

Medicare University Self-Reporting Instructions

- To earn MUCs, you must self-report your attendance after this training event has ended:
  - Go to www.NGSMedicare.com, select your **business type** and **region**, then select **Go**
  - On the lower-right side of the page, select the **Medicare University** logo
- Alternatively, go directly to the Medicare University Web site at http://www.MedicareUniversity.com

Medicare University Self-Reporting Instructions

– Log on to the National Government Services Medicare University site
  - **Note:** You will be prompted to enter your Medicare University log on ID and password; if you don't already have one, you may obtain one at this point
– Select **Course Catalog** from the left-side menu
– Select the **Details** button for the appropriate course
  - To locate and self-report today's training event, either look for the name of the event or look for the "Catalog ID" number provided for this event

Medicare University Self-Reporting Instructions

- A new window will open providing the event description and information; select the **Enroll** button (the screen will then refresh)
- Next, select **Curriculum List** from the left side menu; locate the self-reporting course you just enrolled in and select **Go**
- A new page will open; select the **Launch** button on the new page and the course will load in a new window
- Enter the training event number and select the Submit button

Medicare University Training Event Number: 11314SBPOE15

- Topic: Medicare Part B Update
- Medicare University Credits (MUCs): 2
- # of Sessions
- Catalog Number: AA-C-00583

Thank You!