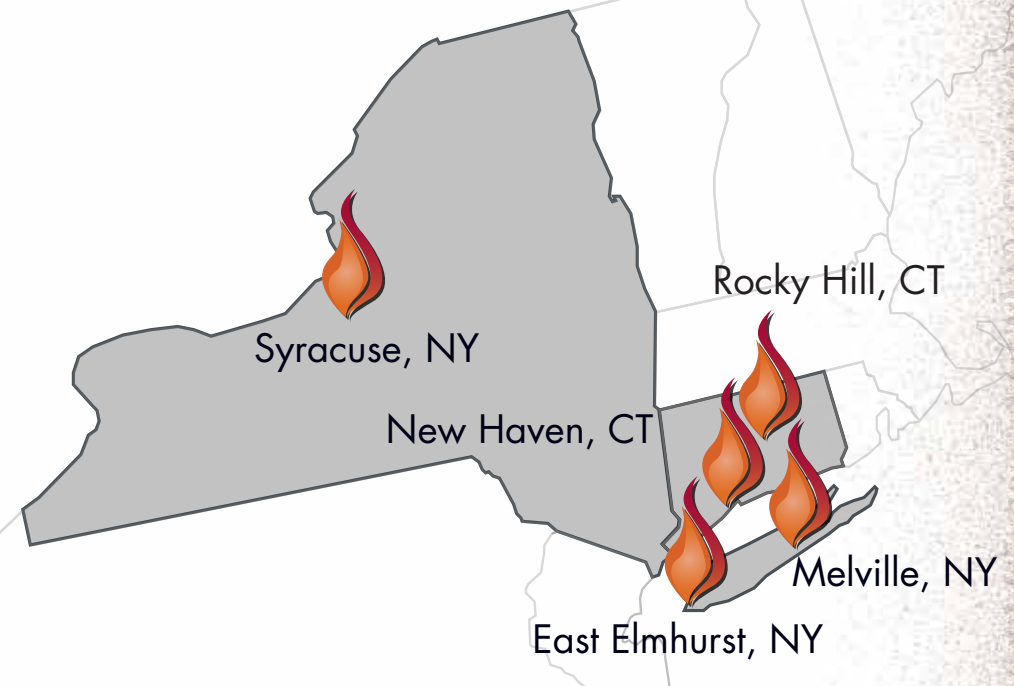


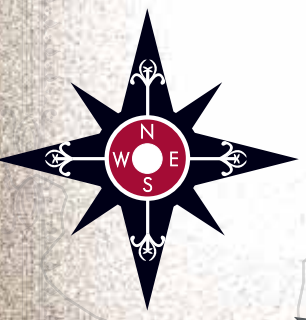


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National Government Services
Medicare Conferences 2010

 *igniting* Medicare education from place to place



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Conference Details



This year National Government Services is igniting Medicare education from place to place. We are traveling to a location near you!

In the months of May and June, National Government Services, your Jurisdiction 13 Part A and Part B Medicare Administrative Contractor, will be hosting two-day conferences in five locations throughout Connecticut and New York.

There will be over 50 courses available at these two-day educational conferences. You can earn up to six American Academy of Professional Coders (AAPC) continuing education units and six Medicare University Credits per day!

Please review the dates and locations to the right and plan on attending this exciting Medicare educational event!

Who should attend?

This conference applies to Medicare Part A and B, federally qualified health center (FQHC) providers in Jurisdiction 13 (New York and Connecticut) that have National Government Services as their Medicare administrative contractor. Home health and hospice (HHH) providers in New York are also encouraged to attend. Educational sessions are intended for Medicare billing, clinical, administrative, and registration staff.

Cost

Red Track (Part A, FQHC, HHH): \$150 per attendee

Orange Track (Part B): \$150 per attendee

Melville, NY

May 3–Red Track

May 4–Orange Track

Melville Marriott Hotel

1350 Old Walt Whitman Rd
Melville, NY 11747
www.marriott.com

New Haven, CT

May 11–Red Track

May 12–Orange Track

Omni New Haven Hotel at Yale

155 Temple Street
New Haven, CT 06510
www.omnihotels.com

Syracuse, NY

May 25–Orange Track

May 26–Red Track

Oncenter Complex

800 S State Street
Syracuse, NY 13202
www.oncenter.org

Hartford, CT

June 8–Red Track

June 9–Orange Track

Marriott Hartford Rocky Hill

100 Capital Boulevard
Rocky Hill, CT 06067
www.marriott.com

East Elmhurst, NY

June 21–Red Track

June 22–Orange Track

NY LaGuardia Airport Marriott

102-05 Ditmars Blvd.
East Elmhurst, NY 11369
www.marriott.com

Register Today at
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Red Track Schedule

Medicare Part A • Federally Qualified Health Centers • Home Health and Hospice

Schedule

7:30 a.m. to 9:00 a.m.

Events

Registration and Breakfast

9:00 a.m. to 9:15 a.m.

Welcome

9:30 a.m. to 11:00 a.m.

Session 1 Options

- Acute Care Hospital Inpatient Billing Situations
- FQHC Coverage
- Home Health Coverage/Home Health ABN
- Hospice Billing
- LCDs, NCDs, and ADRs
- Medicare Resources
- SNF Clinical Scenarios
- SNF Consolidated Billing

11:15 a.m. to 12:45 p.m.

Session 2 Options

- Acute Care Hospital Top Claim Errors
- CERT and Recovery Audit Contractor
- FQHC Billing
- Home Health Billing
- Home Health Top Claim Errors/Appeals Process
- Medicare Coverage of Outpatient Therapy Services
- MSP Fundamentals
- SNF Billing

12:45 p.m. to 1:30 p.m.

Lunch

1:30 p.m. to 3:00 p.m.

Session 3 Options

- Acute Care Hospital OPPS
- CERT and Recovery Audit Contractor
- FQHC Claims Correction Process and the Appeals Process
- Home Health Top Claim Errors/Appeals Process
- Hospice Coverage
- Medicare Appeals
- MSP Billing
- SNF Top Claim Errors

3:15 p.m. to 4:45 p.m.

Session 4 Options

- Cardiac and Pulmonary Rehabilitation Coverage Updates
- Claim Corrections and Adjustments
- MSP Billing
- Hospital Outpatient Psychiatric Services Coverage
- Preventive Services
- PECOS
- The Outpatient ABN
- SNF Clinical Overview

Orange Track Schedule

Medicare Part B

Schedule

7:30 a.m. to 9:00 a.m.

Events

Registration and Breakfast

9:00 a.m. to 9:15 a.m.

Welcome

9:30 a.m. to 11:00 a.m.

Session 1 Options

- CMS-1500 and Common Submission Errors
- CERT and Recovery Audit Contractor
- Consultation Coding Changes
- Drugs and Biologicals—Coverage and Billing for ESAs for Patients Not Receiving Renal Dialysis
- Introduction to Using the Internet-Based PECOS
- Medicare Part B Podiatry Claim Submissions—How to Avoid Common Billing Errors
- Outpatient Physical Therapy and Occupational Therapy
- The Medicare Appeals Process

11:15 a.m. to 12:45 p.m.

Session 2 Options

- Advance Beneficiary Notice of Noncoverage
- Chiropractic Medical Review and Documentation Guidelines
- Common Pitfalls of E&M Services Coding and Documentation
- Global Surgery
- Introduction to Using the Internet-Based PECOS
- Medicare Resources
- Preventive Medicine
- Show Me the Medicare Money!

12:45 p.m. to 1:30 p.m.

Lunch

1:30 p.m. to 3:00 p.m.

Session 3 Options

- Appeals
- CMS-1500 and Common Submission Errors
- Consultation Coding Changes
- Drugs and Biologicals—Coverage and Billing for ESAs for Patients not Receiving Renal Dialysis
- Medicare Resources
- Navigating the MPFSDB
- Taking the Mystery Out of MSP Part B
- The Ins and Outs of Incident-To Billing for Medicare Part B

3:15 p.m. to 4:45 p.m.

Session 4 Options

- Common Modifiers
- CERT and Recovery Audit Contractor
- EDI Process and Top Errors
- LCDs, NCDs, and ADRs
- Medicare Part B Facts about Billing for Diagnostic Radiology Services
- PQRI and Electronic Prescribing (eRx)
- Preventive Medicine
- Taking the Mystery Out of MSP Part B

Red Track course descriptions

Session 1 9:30 a.m. to 11:00 a.m.

Acute Care Hospital Inpatient Billing Situations

During this session acute care hospitals are provided with a review of various inpatient Medicare billing policies and situations, and provides the appropriate UB-04 (CMS-1450) claim coding needed so that claims can be submitted to Medicare accurately. Topics include: billing under the under arrangement policy, transfers, readmissions, leaves of absence, claims submitted for Medicare Advantage Organization plan enrollees, never events, noncovered procedures during the inpatient stay (Change Request 6547), billing under the preadmission services window policy (i.e., DRG window), and more.

Federally Qualified Health Center Coverage

During this session receive a better understanding of the application of national coverage determinations to federally qualified health centers (FQHC) and a better ability to locate and apply regulations in local coverage determinations (LCD). Also gain a working knowledge of FQHC requirements for coverage, increase your understanding of medical review and Comprehensive Error Rate Testing review of FQHC claims, and increase awareness of documentation requirements by services provided and the application of LCD requirements.

Home Health Coverage/Home Health Advance Beneficiary Notice of Noncoverage

The coverage guidelines for skilled therapy and nursing services provided under the home health benefit are reviewed during this session. Several scenarios are reviewed to explain the documentation needed to support the medical necessity of home care services. You will gain a better understanding of the coverage guidelines for skilled therapy and nursing services in home care, better understanding of the documentation necessary to demonstrate medical necessity, and understand common denial reasons. The Home Health Advance Beneficiary Notice of Noncoverage is also reviewed during this session.

(session not offered in Connecticut locations)

Hospice Billing

Be educated on the different notices and claim requirements under the Medicare hospice benefit during this session. The session focuses on the claim submission steps, as well as, the billing transactions that are used to report situations to Medicare such as elections, revocations, transfers, corrections to the Common Working File, and change of ownership. Information on how to access these notices/claims and the required fields for each of these billing transactions are provided.

(session not offered in Connecticut locations)

Medicare Part A • Federally Qualified Health Centers • Home Health and Hospice

Local Coverage Determinations, National Coverage Determinations and Additional Development Requests

A local coverage determination (LCD) and a national coverage determination (NCD) are defined and the differences between the two are described during this session. The presentation focuses not only on the nature of these tools but more importantly how to make use of them as valuable resources to aid in provider reimbursement, documentation guidelines, and in demonstrating medical necessity of services rendered and billed. This presentation takes a sample LCD and dissects it to show its value for coding recommendations, citations for research efforts, indications, and limitations of coverage. In addition, supplemental instruction articles are introduced and shown how they can augment the information found in an LCD. Lastly, there is discussion regarding additional development requests (ADR), how and when to respond to them, and where to locate information on the Fiscal Intermediary Shared System about your ADRs.

Medicare Resources

This session is designed to introduce Medicare providers and staff members to the many educational opportunities, reference materials, and other resources available to them through National Government Services and the Centers for Medicare & Medicaid Services.

Skilled Nursing Facility Clinical Scenarios

A brief overview of the skilled nursing facility (SNF) Part A benefit and seven clinical scenarios pulled from actual medically reviewed claims with analysis of each is offered during this session. The goal of the discussion is to provide information regarding coverage, medical necessity, and documentation for common clinical situations facing SNF providers. The use of a scenario and analysis allows you to visualize how information provided through documentation impacts medical necessity decisions. Review of references available and guidance on how to find them is also included.

Skilled Nursing Facility Consolidated Billing

Medicare skilled nursing facilities (SNF) are reimbursed under a prospective payment system (PPS). This payment methodology requires all entities that provide services to Medicare SNF patients to follow some very specific guidelines. Detailed instructions for the billing of services that have been designated as excluded from the SNF PPS payment methodology, as well as those services that have been determined to be included in the SNF PPS reimbursement are provided during this session. Billing examples, manual references, and Web site resources are also provided.

Session 1 9:30 a.m. to 11:00 a.m.

Red Track course descriptions

Session 2 11:15 a.m. to 12:45 p.m.

Acute Care Hospital Top Claim Errors

During this session acute care hospitals (ACH) are familiarized with the most common return to provider claims as well as rejected claims. Instructions for correcting the errors, as well as, offer tips/hints on how to prevent such errors in the future are also given. Understanding how to prevent claim errors and rejections will save time and resources for your ACH.

Comprehensive Error Rate Testing and Recovery Audit Contractor

A basic overview of both programs and the impact on the provider community and the Medicare Trust Fund are provided during this session. A discussion on how these programs interact with National Government Services Medicare Administrative Contractor and the roles each contractor plays in the Medicare Program is discussed during this session. Also discussed is current and demonstration project results, as well as, giving documentation tips and suggestions for decreasing errors.

Federally Qualified Health Center Billing

Federally qualified health center (FQHC) staff receive an understanding of the coverage and billing criteria for submission of claims to the Medicare Program during this session. The session includes the type of professionals that may bill the program, the services that are covered under the FQHC benefit, noncovered services, and preventive services. In addition, you learn the requirements for submitting FQHC claims to the fiscal intermediary.

Home Health Billing

Be educated on the reporting requirements under the Medicare home health benefit during this session. There is also a focus on the claim submission process for billing the home health request for anticipated payment and the home health final claim.

(session not offered in Connecticut locations)

Home Health Top Claim Errors/Appeals Process

During this session learn how to review, resolve, and most importantly, prevent the top claim errors from being rejected or returned to your facility due to missing, invalid, or incorrect information. Information on the appeals process is also provided.

(session not offered in Connecticut locations)

Medicare Part A • Federally Qualified Health Centers • Home Health and Hospice

Medicare Coverage of Outpatient Therapy Services

This session is a review of the coverage guidelines for outpatient therapy services. Several scenarios are reviewed to explain the documentation needed to support the medical necessity of therapy services. **Note:** This session applies to both acute care hospitals and skilled nursing facilities and does not include psychotherapy.

Medicare Secondary Payer Fundamentals

Be introduced to admissions and registration of Medicare Secondary Payer (MSP). Receive an overview of MSP including:

- what MSP is;
- what the MSP provisions are;
- what a provider's general MSP responsibilities are such as identifying and billing payers that are primary to Medicare;
- what the various types of MSP claims are; and
- what the MSP resources for providers are (e.g., National Government Services Web site, the Centers for Medicare & Medicaid Services Web site, and Internet-Only Manuals, the Coordination of Benefits Contractor, and the MSP recovery contractor).

Note: Some general billing guidelines are provided, however detailed MSP billing instructions are not.

Skilled Nursing Facility Billing

Review a number of topics that are relevant to the skilled nursing facility (SNF) billing staff during this session. Instructors address, in detail, the billing guidelines for SNF benefits exhaust claims, as well as, the requirements for the SNF no-payment claims. Medicare billing requirements for SNF beneficiaries who are enrolled in a Medicare Advantage Organization (MAO) plan are reviewed, and clarification on some current Medicare guidelines as they pertain to billing SNF claims to Medicare is provided.

Session 2 11:15 a.m. to 12:45 p.m.

Red Track course descriptions

Session 3 1:30 p.m. to 3:00 p.m.

Acute Care Hospital Outpatient Prospective Payment System

During this session, acute care hospitals are familiarized with the concepts of the outpatient prospective payment system (OPPS). This session is a useful refresher for experienced billing personnel, as well as, a good learning tool for new billing staff members or anyone who desires a better knowledge of the workings of the OPPS. Some billing reminders and scenarios are provided to help providers avoid certain return to provider claims and/or claim rejections.

Comprehensive Error Rate Testing and Recovery Audit Contractor

A basic overview of both programs and the impact on the provider community and the Medicare Trust Fund are provided during this session. A discussion on how these programs interact with National Government Services Medicare Administrative Contractor and the roles each contractor plays in the Medicare Program is discussed during this session. Also discussed is current and demonstration project results, as well as, giving documentation tips and suggestions for decreasing errors.

Federally Qualified Health Center Claims Correction Process and the Appeals Process

During this session learn how to review, resolve, and most importantly, prevent the top claim errors from being rejected or returned to your facility due to missing, invalid, or incorrect information. Information on the appeals process is also provided.

Home Health Top Claim Errors/Appeals Process

During this session learn how to review, resolve, and most importantly, prevent the top claim errors from being rejected or returned to your facility due to missing, invalid, or incorrect information. Information on the appeals process is also provided.

(session not offered in Connecticut locations)

Hospice Coverage

The medical review process, top medical review denials, documentation, and coverage issues for hospice services are reviewed during this session. First-hand information on top medical review denials and ways to avoid these denials are given. Information and steps on the progressive corrective action (PCA) process and the difference between a probe review and targeted medical review are also identified.

(session not offered in Connecticut locations)

Medicare Part A • Federally Qualified Health Centers • Home Health and Hospice

Medicare Appeals

Medicare appeals process, including the types of situations that can be appealed, the five levels of appeal, documentation, and a brief overview of recovery audit contractor appeals are reviewed during this session. When claims have been denied by Medicare, the appeal process is the only recourse the provider has to have the claim reconsidered for payment; so it is important to understand the appeals process. **Note:** This session is not applicable to home health and hospice providers.

Medicare Secondary Payer Billing

Receive an overview of how to bill Medicare as the secondary payer after the primary payer has made partial or full payment, and how to bill Medicare conditionally when the primary payer has not made payment promptly or for a valid reason. During the session, you receive detailed instructions on how to complete the appropriate UB-04 (CMS-1450) claim form locators (FL) in order to submit such Medicare Secondary Payer (MSP) and conditional claims to Medicare. The instructor reviews the claim coding that must be reported on MSP claims when the provider has received less than it was expecting to receive from the primary payer due to their application of a deductible, coinsurance, and/or co-payment. Electronic claim submission (837I) instructions are not included in the session, however references to such instructions are provided.

Skilled Nursing Facility Top Claim Errors

This session is designed specifically for skilled nursing facility (SNF) billing staff. During this session, instructors discuss the most common return to provider (RTP) claims, as well as, rejected claims that the SNFs receive from Medicare. Instructions for correcting the errors, as well as, suggestions for avoiding the claim errors and rejections are provided. Understanding how to prevent claim errors and rejections will save time and resources for your SNF and help increase your Medicare cash flow.

Session 3 12:45 p.m. to 1:30 p.m.

Red Track course descriptions

Session 4 3:15 p.m. to 4:45 p.m.

Cardiac and Pulmonary Rehabilitation Coverage Updates

Review the new Medicare coverage guidelines proposed in the Federal Register during this session. The most recent and updated information is covered and insight is given on the proposed changes.

Claim Corrections and Adjustments

Be educated on how to use the Fiscal Intermediary Standard System Direct Data Entry System to correct, adjust, and cancel Medicare claims during this session.

Medicare Secondary Payer Billing

Receive an overview of how to bill Medicare as the secondary payer after the primary payer has made partial or full payment, and how to bill Medicare conditionally when the primary payer has not made payment promptly or for a valid reason. During the session, you receive detailed instructions on how to complete the appropriate UB-04 (CMS-1450) claim form locators (FL) in order to submit such Medicare Secondary Payer (MSP) and conditional claims to Medicare. The instructor reviews the claim coding that must be reported on MSP claims when the provider has received less than it was expecting to receive from the primary payer due to their application of a deductible, coinsurance, and/or co-payment. Electronic claim submission (837I) instructions are not included in the session, however references to such instructions are provided.

Hospital Outpatient Psychiatric Services Coverage

The continuum of care for psychiatric services with emphasis on outpatient services is outlined in this session. The discussion includes information regarding incident to, covered and noncovered services, and documentation guidelines. In addition the instructor touches on billing and coding, medical review findings/claim denials, and coverage criteria. Sample scenarios are offered and will draw on audience input and interaction to illustrate documentation of active treatment, as well as, suggested content in session and progress notes. Attention is given to treatment plans and their content for audience consideration and establishing medical necessity in session/progress notes.

Preventive Services

The Centers for Medicare & Medicaid Services (CMS) is committed to promoting the appropriate use of Medicare preventive benefits. Medicare covers a broad range of services to prevent disease, detect disease early when it is most treatable and curable, and manage disease so that complications can be avoided. Unfortunately, older adults are not receiving all recommended preventive services, even with frequent visits to physician offices. Reasons for this vary, but highlight the opportunity to improve preventive care for older adults. This training session is designed to ensure that Medicare Part A providers are

Medicare Part A • Federally Qualified Health Centers • Home Health and Hospice

aware of what benefits are available, how they are administered, and how to bill them correctly. Some of the preventive services covered during this session are:

- Colorectal cancer screening
- Screening mammography
- Screening pap test and pelvic examination
- Prostate cancer screening
- Cardiovascular disease screening
- Diabetes screening
- Glaucoma screening

Provider Enrollment Chain and Ownership System (PECOS)

The Centers for Medicare & Medicaid Services (CMS) has implemented an online system whereby provider and supplier organization who are eligible to enroll in the Medicare Program may use the Internet to submit enrollment applications, view enrollment information, update enrollment information, voluntarily terminate from Medicare Program, and track the status of an application submitted via the Internet. This session highlights the top reasons that CMS-855A applications are returned to the provider, tips to avoid having the CMS-855 returned, and how to use the Internet-based PECOS.

The Outpatient Advance Beneficiary Notice of Noncoverage

Medicare delivery requirements for issuing the outpatient Advance Beneficiary Notice of Noncoverage (ABN) to Medicare beneficiaries is reviewed during this session. It is important to know when you should issue an ABN, so that facilities can be protected from unnecessary financial liability. The session also includes information on the voluntary ABN, completing the notice, and the appropriate modifiers to be used on the claim(s). **Note:** ABNs for home health or hospice providers are not reviewed during this session.

Skilled Nursing Facility Clinical Overview

This session is designed for skilled nursing facilities (SNFs) that are new to the Medicare Program or for those that may need a refresher course. Discussion includes a breakdown of the SNF Part A benefit, common denial reasons found upon medical review of records, and documentation suggestions.

Session 4 3:15 p.m. to 4:45 p.m.

Orange Track course descriptions

Session 1 9:30 a.m. to 11:00 a.m.

CMS-1500 and Common Submission Errors

A claim, whether submitted electronically or by paper, is the only way a beneficiary or a provider can receive reimbursement from Medicare. If there are discrepancies in a claim, then the provider may not receive full benefits. Information that will allow you to file claims accurately and reduce your chances of receiving “unprocessable claim” rejections are provided during this session. Medicare is prohibited by law from paying paper claims except for those from small providers and under other limited circumstances. In this session, the CMS-1500 claim form (08/05) is used to teach the attendee about claim requirements for the paper form, how to use the CMS-1500 claim form, define what unprocessable claims are, identify late filing rules, and define the requirements of filing claims on behalf of beneficiaries.

Comprehensive Error Rate Testing and Recovery Audit Contractor

A basic overview of both programs and the impact on the provider community and the Medicare Trust Fund are covered during this session. How these programs interact with National Government Services as a Medicare administrative contractor, the roles each contractor plays in the Medicare Program, current and demonstration project results, giving documentation tips, and suggestions for decreasing errors are all discussed.

Consultation Coding Changes

During this session a clear explanation of the recent changes in Part B Medicare coding and payment policy for consultation services is given. Assistance to the provider community in complying with the new guidelines that were effective January 1, 2010 is also discussed.

Drugs and Biologics—Coverage and Billing for Erythropoietin Stimulating Agents for Patients Not Receiving Renal Dialysis

The main focus of this session is to provide guidance to providers on coverage and billing of erythropoietin stimulating agents for nondialysis patients by reviewing the local coverage determination and national coverage determination. The current medical review focus on drugs and biologics and the overall finding of those medical review audits are provided as well.

Introduction to Using the Internet-Based Provider Enrollment Chain and Ownership System (PECOS)

The Centers for Medicare & Medicaid Services (CMS) has implemented an online system, called Internet-based PECOS, whereby provider and supplier organizations can submit new Medicare enrollment applications, view and update existing enrollment information, voluntarily terminate from Medicare

Medicare Part B

Program, and track the status of an application using a secure Internet application. This session demonstrates the ease and many benefits of Internet-based PECOS. Resources and tips for streamlining the Medicare enrollment process are also discussed. This is a great opportunity for any provider type to see the ease of navigating through Internet-based PECOS by following the step-by-step completion of an CMS-855I enrollment application.

Medicare Part B Podiatry Claim Submissions—How to Avoid Common Billing Errors

If you are a Medicare Part B provider billing for podiatry services, take this session to help decrease your podiatric specialty billing error rate on claim submissions to National Government Services. During this session the top podiatry billing errors are reviewed individually, describing the error and tips on how to avoid the error in future claim submissions are provided. Medical review audit findings are also discussed, and as a resource/tool, a sampling of local coverage determinations (LCD) are provided.

Outpatient Physical Therapy and Occupational Therapy

During this session, learn about the coverage and billing requirements for outpatient physical therapy and occupational therapy services as outlined in the National Government Services’ local coverage determination (LCD L26884). This session is designed for physician office billing staff and anyone interested in learning more about these services.

The Medicare Appeals Process

It is vital for providers to understand the Medicare appeals process, as when a claim has been denied by Medicare, requesting an appeal is the only recourse a provider has to have that claim reconsidered for payment in certain situations. The entire Medicare appeals process including the five levels of appeal, the types of denials that can be appealed, how to properly request an appeal, and the time frames involved when requesting an appeal are reviewed during this session.

Session 1 9:30 a.m. to 11:00 a.m.

Orange Track course descriptions

Session 2 11:15 a.m. to 12:45 p.m.

Advance Beneficiary Notice of Noncoverage

During this session, learn how to properly administer the Advance Beneficiary Notice of Noncoverage (ABN) within the office practice. This seminar is aimed at the billing staff in the physician's office or those interested in learning more about the ABN process. Some of the topics discussed include when to use an ABN, the benefits of properly issuing an ABN, how to sufficiently document that the ABN is on file, and choosing the correct modifier when an ABN is issued.

Chiropractic Medical Review and Documentation Guidelines

This session is designed to give providers During this session information on medical review denials and coverage guidelines is given and topics such as local coverage determination, top medical review denials, coverage guidelines, documentation, and Advance Beneficiary Notice of Noncoverage are explored. After attending this session, you will have an understanding of Medicare guidelines for coverage and medical necessity of chiropractic services.

Common Pitfalls of Evaluation and Management Services Coding and Documentation

Common evaluation and management (E&M) services errors identified through the process of CERT and medical review are examined and suggestions are offered for improving E&M code selection and documentation during this session.

Global Surgery

During this session, the global surgery concept and billing is reviewed. Learn how to use the payment policy indicators to identify different global surgery situations and how these indicators, as well as the proper use of modifiers, are related to billing and reimbursement under the global surgery rules.

Introduction to Using the Internet-Based Provider Enrollment Chain and Ownership System (PECOS)

The Centers for Medicare & Medicaid Services (CMS) has implemented an online system, called Internet-based PECOS, whereby provider and supplier organizations can submit new Medicare enrollment applications, view and update existing enrollment information, voluntarily terminate from Medicare Program, and track the status of an application using a secure Internet application. This session demonstrates the ease and many benefits of Internet-based PECOS. Resources and tips for streamlining the Medicare enrollment process are also discussed. This is a great opportunity for any provider type to see the ease of navigating through Internet-based PECOS by following the step-by-step completion of an CMS-855I enrollment application.

Medicare Part B

Medicare Resources

Medicare providers and staff members are introduced to the many educational opportunities, reference materials, and other resources available to them through National Government Services and the Centers for Medicare & Medicaid Services during this session.

Preventive Medicine

The Centers for Medicare & Medicaid Services (CMS) is committed to promoting the appropriate use of Medicare preventive benefits. Medicare covers a broad range of services to prevent disease, detect disease early when it is most treatable and curable, and manage disease so that complications can be avoided. Unfortunately, older adults are not receiving all recommended preventive services, even with frequent visits to physician offices. Reasons for this vary, but highlight the opportunity to improve preventive care for older adults. This session is designed to ensure that Medicare Part B providers are aware of what benefits are available, as well as, the coverage requirements and billing guidelines for these services. Some of the preventive services covered during this session are:

- Colorectal cancer screening
- Screening mammography
- Screening pap test and pelvic examination
- Prostate cancer screening
- Cardiovascular disease screening
- Diabetes screening
- Glaucoma screening

Show Me the Medicare Money!

In this session, learn about several financial incentives that Medicare is currently offering such as a two percent incentive for electronic prescribing and PQRI or learn more about the 19 billion dollars allocated for Medicare physicians who implement electronic medical records as part of the American Recovery and Reinvestment Act. We show you the Medicare money, and help your office realize the incentive potential and the many monetary benefits and practice management improvements of these initiatives. The objective is simple; it is to help you understand the many financial incentives available and how to best obtain them.

Session 2 11:15 a.m. to 12:45 p.m.

Orange Track course descriptions

Session 3 1:30 p.m. to 3:00 p.m.

The Medicare Appeals Process

It is vital for providers to understand the Medicare appeals process, as when a claim has been denied by Medicare, requesting an appeal is the only recourse a provider has to have that claim reconsidered for payment in certain situations. The entire Medicare appeals process including the five levels of appeal, the types of denials that can be appealed, how to properly request an appeal, and the time frames involved when requesting an appeal are reviewed during this session.

CMS-1500 and Common Submission Errors

A claim, whether submitted electronically or by paper, is the only way a beneficiary or a provider can receive reimbursement from Medicare. If there are discrepancies in a claim, then the provider may not receive full benefits. Information that will allow you to file claims accurately and reduce your chances of receiving "unprocessible claim" rejections are provided during this session. Medicare is prohibited by law from paying paper claims except for those from small providers and under other limited circumstances. In this session, the CMS-1500 claim form (08/05) is used to teach the attendee about claim requirements for the paper form, how to use the CMS-1500 claim form, define what unprocessible claims are, identify late filing rules, and define the requirements of filing claims on behalf of beneficiaries.

Consultation Coding Changes (Encore)

During this session a clear explanation of the recent changes in Part B Medicare coding and payment policy for consultation services is given. Assistance to the provider community in complying with the new guidelines that were effective January 1, 2010 is also discussed.

Drugs and Biologics—Coverage and Billing for Erythropoietin Stimulating Agents for Patients not Receiving Renal Dialysis (Encore)

The main focus of this session is to provide guidance to providers on coverage and billing of erythropoietin stimulating agents for nondialysis patients by reviewing the local coverage determination and national coverage determination. The current medical review focus on drugs and biologics and the overall finding of those medical review audits are provided as well.

Medicare Resources (Encore)

Medicare providers and staff members are introduced to the many educational opportunities, reference materials, and other resources available to them through National Government Services and the Centers for Medicare & Medicaid Services during this session.

Medicare Part B

Navigating the Medicare Physician Fee Schedule Data Base

During this session, an explanation as to where the Medicare Physician Fee Schedule Database (MPFSDB) is located and the steps to access it are explained. Also learn to read and understand the MPFSDB columns through actual screen shots enabling you to apply database information to your Medicare billing for successful claims processing.

Taking the Mystery Out of Medicare Secondary Payer Part B

Does it cause confusion and frustration in your office when you have to submit an MSP claim to Medicare? Are you receiving denials for improperly submitted MSP claims? Have you ever wondered how Medicare computes MSP payments made to providers? If so, you will not want to miss this seminar! This class is for those providers who already are aware of the MSP provisions and know how to identify MSP situations. During this course, attendees learn how to properly complete an MSP claim using the paper CMS-1500 claim form (or its electronic equivalent) as well as how Medicare determines provider payments and beneficiary liability for MSP claims. Upon completion of this session, you will be able to:

- properly submit MSP Part B claims both on paper and electronically;
- understand how Medicare determines MSP payment amounts;
- appropriately determine any beneficiary liability amounts; and
- forecast MSP payments for claims submitted to Medicare.

The Ins and Outs of Incident-To Billing for Medicare Part B

The requirements and situations when it is appropriate to bill incident-to services to Medicare (e.g., who can render, who can supervise incident-to services, which place of service is allowed, what types of services are or are not allowed to be rendered incident to) is reviewed during this session. The initial service, subsequent services, active participation, documentation requirements, and completing the CMS-1500 claim form items are also discussed.

Session 3 1:30 p.m. to 3:00 p.m.

Orange Track course descriptions

Session 4 3:15 p.m. to 4:45 p.m.

Common Modifiers

The proper use of the most frequently used modifiers, modifiers that identify split/shared visits, and modifiers that cause the most claim denials are reviewed during this session. An overview of the National Correct Coding Initiative (NCCI) edits, how to find the NCCI edit tables, and how/when modifiers are used in relation to NCCI are also discussed.

Comprehensive Error Rate Testing and Recovery Audit Contractor

A basic overview of both programs and the impact on the provider community and the Medicare Trust Fund are covered during this session. How these programs interact with National Government Services as a Medicare administrative contractor, the roles each contractor plays in the Medicare Program, current and demonstration project results, giving documentation tips, and suggestions for decreasing errors are all discussed.

Electronic Data Interchange Process and Top Errors

Have you ever wondered what electronic options were available for your office? Even if you are a current electronic submitter, there are other options available to you to make your office more efficient. The type of electronic transactions and how the use of them can make your office efficient, by saving time and money are covered during this session. The electronic reports you receive, the most common electronic data interchange front-end rejections, why they are occurring, and how to avoid them in the future are discussed during this session.

Local Coverage Determinations/National Coverage Determinations and Additional Development Requests

A local coverage determination (LCD) and a national coverage determination (NCD) are defined and the differences between the two are described during this session. The session focuses not only on the nature of these tools but more importantly how to make use of them as valuable resources to aid in provider reimbursement, documentation guidelines and in demonstrating medical necessity of services rendered and billed. A sample LCD is dissected to show its value for coding recommendations, citations for research efforts, indications and limitations of coverage during this session. In addition, supplemental instruction articles are introduced and how they can augment the information found in an LCD is shown. Lastly, a discussion regarding how and when to respond to additional development requests takes place.

Medicare Part B

Medicare Part B Facts about Billing for Diagnostic Radiology Services

Diagnostic radiology billing concepts and guidelines are reviewed and a better understanding of the Medicare Program billing requirements while helping to decrease claim submission billing errors are discussed during this session. The following topics are also reviewed:

- Medical necessity/local coverage determinations
- Referring/ordering physicians
- Physician self-referrals
- Billing for bilateral services
- Physician supervision of diagnostic tests
- ICD-9-CM coding for diagnostic tests
- Repeat services on the same day
- Reinterpretations
- Multiple procedures payment reduction on certain diagnostic imaging procedures
- Payment cap on the TC payment of certain imaging procedures
- Diagnostic tests subject to the antimarkup pricing limitation
- Portable x-rays
- Radiology
- The National Correct Coding Initiative

Physician Quality Reporting Initiative and Electronic Prescribing (eRx)

Be provided with the tools and resources needed to successfully implement and utilize the 2010 Medicare Physician Quality Reporting Initiative (PQRI) and Electronic Prescribing (eRx) incentive programs within the office setting during this session. Learn the benefits of each program, the changes in the programs from last year, how to properly report participation in each program, and how the incentive payments are determined.

Preventive Medicine

The Centers for Medicare & Medicaid Services (CMS) is committed to promoting the appropriate use of Medicare preventive benefits. Medicare covers a broad range of services to prevent disease, detect disease early when it is most treatable and curable, and manage disease so that complications can be avoided. Unfortunately, older adults are not receiving all recommended preventive services, even with frequent visits to physician offices. Reasons for this vary, but highlight the opportunity to improve preventive care for older adults. This session is designed to ensure that Medicare Part B providers are aware of what benefits are available, as well as, the coverage requirements and billing guidelines for these services. Some of the preventive services covered during this session are:

Session 4 3:15 p.m. to 4:45 p.m.

Orange Track course descriptions

Medicare Part B

Session 4 3:15 p.m. to 4:45 p.m.

- Colorectal cancer screening
- Screening mammography
- Screening pap test and pelvic examination
- Prostate cancer screening
- Cardiovascular disease screening
- Diabetes screening
- Glaucoma screening

Taking the Mystery Out of Medicare Secondary Payer Part B (Encore)

Does it cause confusion and frustration in your office when you have to submit an MSP claim to Medicare? Are you receiving denials for improperly submitted MSP claims? Have you ever wondered how Medicare computes MSP payments made to providers? If so, you will not want to miss this seminar! This class is for those providers who already are aware of the MSP provisions and know how to identify MSP situations. During this course, attendees learn how to properly complete an MSP claim using the paper CMS-1500 claim form (or its electronic equivalent) as well as how Medicare determines provider payments and beneficiary liability for MSP claims. Upon completion of this session, you will be able to:

- properly submit MSP Part B claims both on paper and electronically;
- understand how Medicare determines MSP payment amounts;
- appropriately determine any beneficiary liability amounts; and
- forecast MSP payments for claims submitted to Medicare.

Visit

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