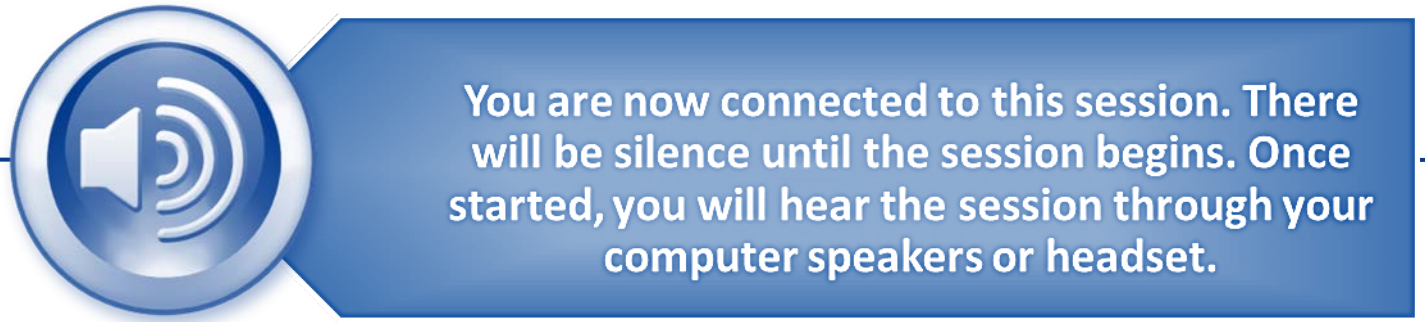
Railroad Medicare
Top Medical Review Denials



Railroad Retirement Board
Specialty Medicare Administrative Contractor (RRB SMAC)
Provider Outreach and Education

December 11, 2018

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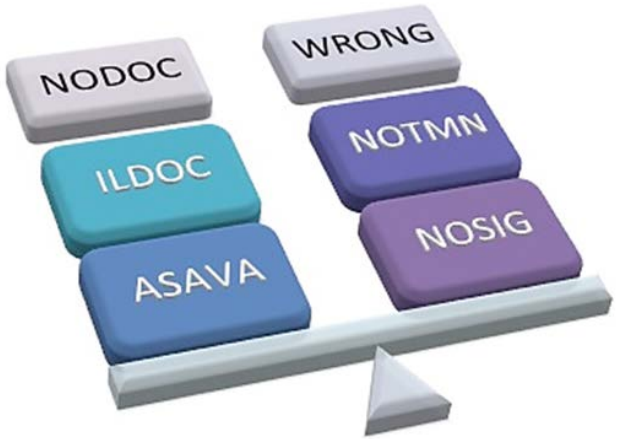
Railroad Medicare
Top Medical Review Denials



Railroad Retirement Board

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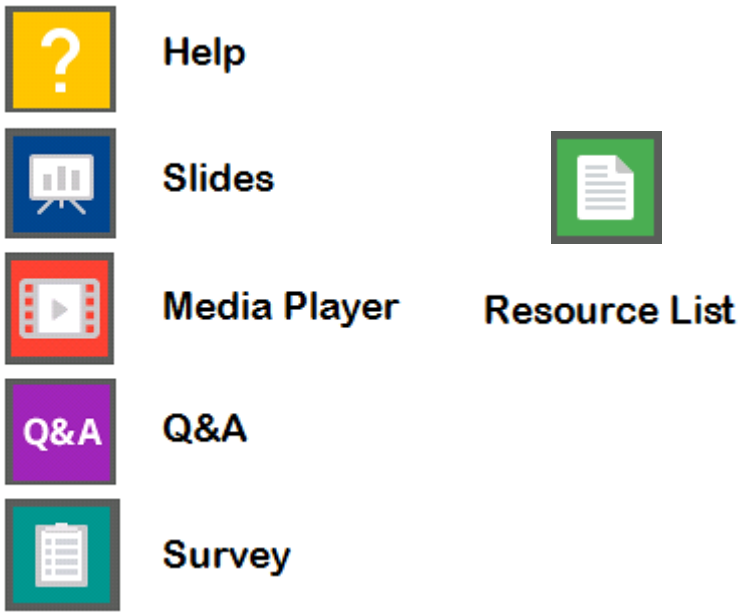
Using On24 Widgets

- Adjust volume using your computer speakers or headset.
- Use your mouse to point, click, and open a widget



Disclaimer

- The information provided in this presentation was current as of December 11, 2018. Any changes or new information superseding the information in this presentation will be provided in articles and resources with publication dates after December 11, 2018, posted on our website at www.PalmettoGBA.com/RR. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.
- This presentation was prepared as a tool to assist providers and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services.
- The Centers for Medicare & Medicaid Services (CMS) and the Railroad Retirement Board (RRB) 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 guide .
- This publication is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings.

Frequently Used Acronyms

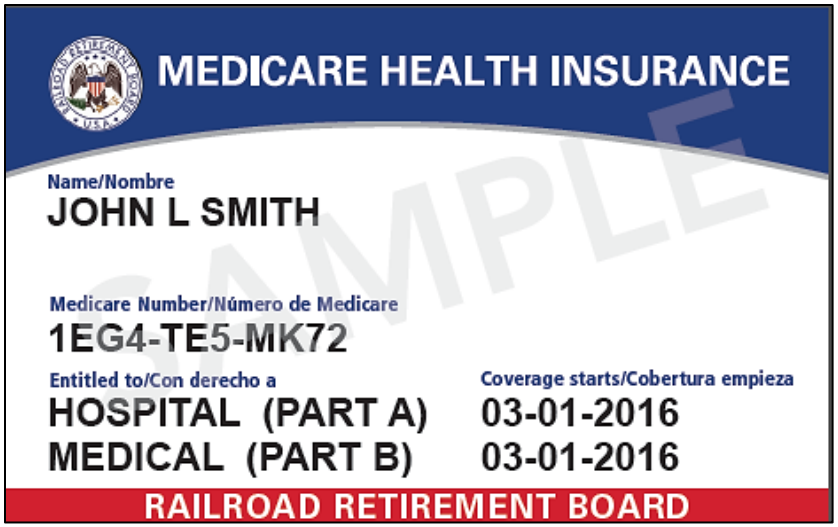
Acronym	Description
MBI	Medicare Beneficiary Identifier
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
HICN	Health Insurance Claim Number
IOM	Internet Only Manual
HCPCS	Healthcare Common Procedure Coding System
MLN	Medicare Learning Network
MR	Medical Review
RRB SMAC	Railroad Retirement Board Specialty Medicare Administrative Contractor
SSN	Social Security Number
TPE	Targeted Probe and Educate

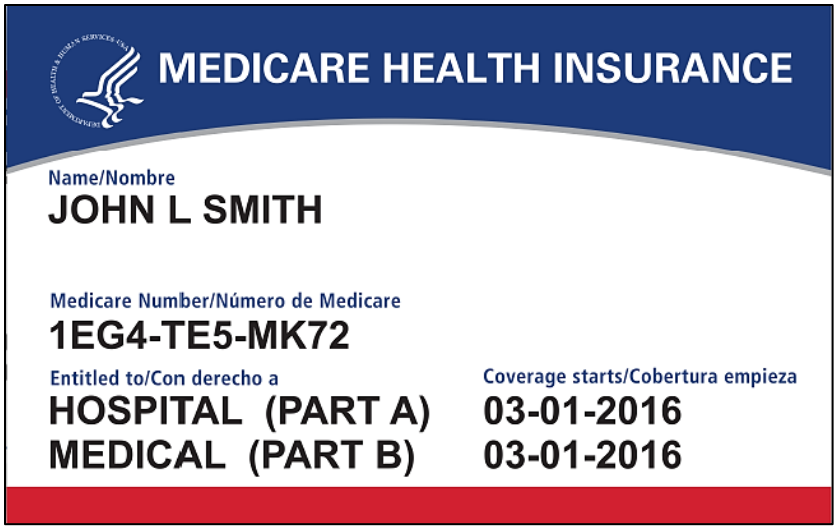
New Medicare Card Project

- Social Security Numbers (SSNs) must be removed from all Medicare cards by April 2019
- New randomly generated Medicare Beneficiary Identifier (MBI) will replace the SSN-based Health Insurance Claim Number (HICN) on new Medicare cards for transactions like billing, eligibility status, and claim status
  - CMS New Medicare Card Overview Page https://tinyurl.com/CMSNMCOverview
  - CMS New Medicare Card Provider Page https://tinyurl.com/CMSNMCProv
  - MLN Transition to New Medicare Numbers and Cards Fact Sheet https://tinyurl.com/MLN909365

New Medicare Cards with MBIs

- New Railroad Medicare cards were mailed in June 2018
- Railroad Medicare MBIs are not distinguishable from other MBIs
- Railroad Medicare cards are distinct with Railroad Retirement Board name and seal
- Electronic eligibility transaction response will identify Railroad Medicare patients





New Medicare Card Project Timeline

- **April 2018**
  - CMS began mailing new Medicare cards to people with Medicare
  - All systems & processes able to accept MBI
  - Transition Period Started: Can use either the HICN or MBI for data exchanges
  - Began returning messages in HETS responses to show when new Medicare cards have been mailed to a specific patient and when a patient qualifies for Medicare through the RRB
- **June 2018**
  - Launched provider MBI look-up tool – **Now Available in our eServices Portal**
  - RRB mailed new Railroad Medicare cards
- **October 2018**
  - Return MBI on Remittance Advice
- **January 2020**
  - Transition Period Ends: Must use the MBI on data exchanges (some exceptions)

Objectives

At the end of this presentation you will be familiar with:

- How Medical Review notifies you of a prepayment review request and of the review decision
- The Railroad Medicare Medical Review top ten denial reasons
- How to avoid those denials
- Resources to help you prepare for successful reviews

Agenda

- Medical Review and Pre-pay Additional Documentation Requests
- Top 10 Denials and How to Avoid Them
- Ensuring Your Documentation Complies with Medicare Guidelines
- Resources
- Your Questions

MEDICAL REVIEW AND PREPAY ADDITIONAL DOCUMENTATION REQUESTS

RRB SMAC Medical Review Program Goals

- Protect the Medicare Trust Fund against inappropriate payments
- Reduce payment error rate
- Identify atypical billing patterns
- Perform claim reviews to ensure provider compliance
  - Prepay reviews
    - Service specific
    - Provider specific – Targeted Probe and Educate (TPE)
  - Postpay reviews
    - Provider Specific

Additional Documentation Requests (ADRs)

Prepay ADRs include:

- Reason your claim was selected for review
- What actions you need to take
- When you need to reply
- Consequences for not replying
- Instructions for replying
- SMAC contact information

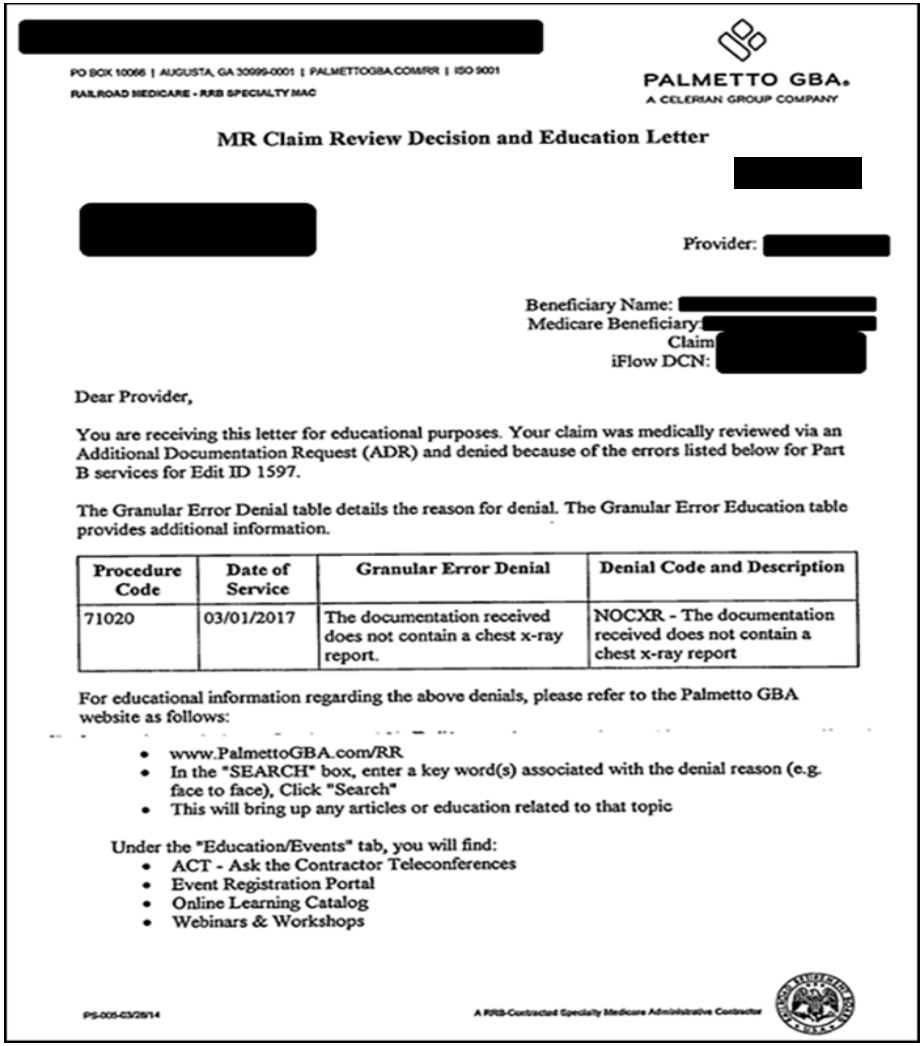
Prepay ADRs claim identification elements:

- Provider name and NPI
- Date of service
- CPT/HCPCS code
- Patient name
- Patient account number
- Encrypted MBI

See our article
'Medical Review: Additional Documentation Requests (ADRs)'

Decision and Education Letter

- Claim Review Decision and Education Letter
  - Sent when claim under prepay review is denied by Medical Review
  - Contains Granular Error Denial Table
  - Explains reason for the medical review denial determination



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MR Claim Review Decision and Education Letter

[redacted]

[redacted]

Provider: [redacted]

Beneficiary Name: [redacted]
Medicare Beneficiary: [redacted]
Claim
iFlow DCN: [redacted]

Dear Provider,

You are receiving this letter for educational purposes. Your claim was medically reviewed via an Additional Documentation Request (ADR) and denied because of the errors listed below for Part B services for Edit ID 1597.

The Granular Error Denial table details the reason for denial. The Granular Error Education table provides additional information.

Procedure Code	Date of Service	Granular Error Denial	Denial Code and Description
71020	03/01/2017	The documentation received does not contain a chest x-ray report.	NOCXR - The documentation received does not contain a chest x-ray report

For educational information regarding the above denials, please refer to the Palmetto GBA website as follows:

- www.PalmettoGBA.com/RR
- In the "SEARCH" box, enter a key word(s) associated with the denial reason (e.g. face to face), Click "Search"
- This will bring up any articles or education related to that topic

Under the "Education/Events" tab, you will find:

- ACT - Ask the Contractor Teleconferences
- Event Registration Portal
- Online Learning Catalog
- Webinars & Workshops

PS-005-03/28/14

A RRB-Contracted Specialty Medicare Administrative Contractor

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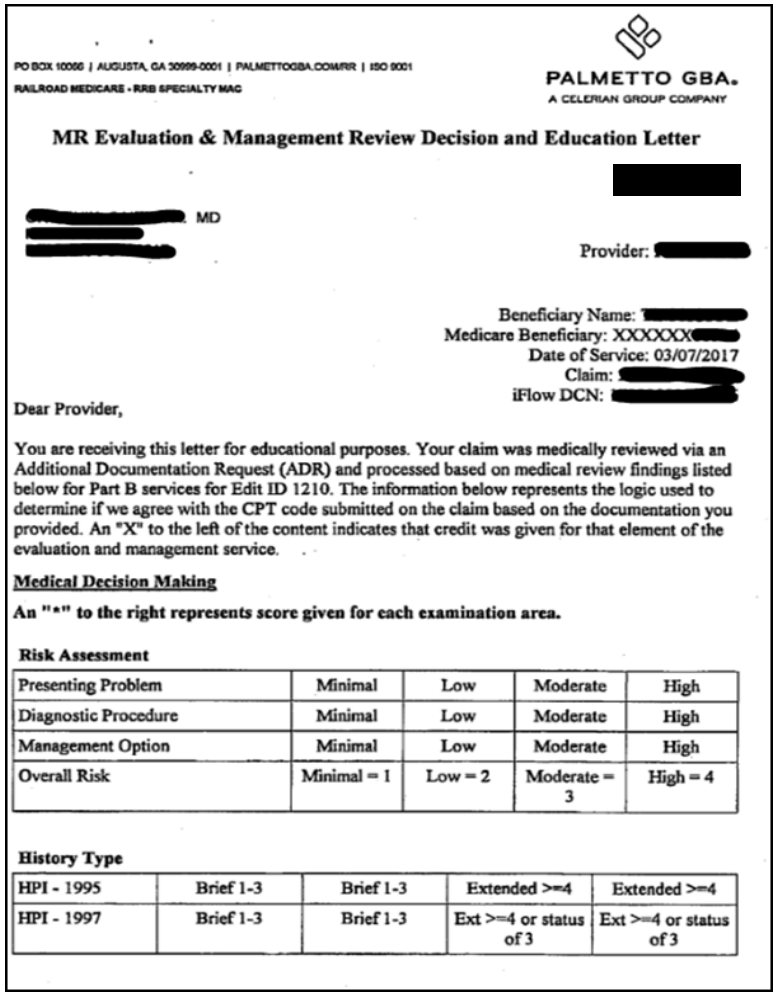
Decision and Education Letter Evaluation and Management (E/M)



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MR Evaluation & Management Review Decision and Education Letter

[redacted] MD

Provider: [redacted]

Beneficiary Name: [redacted]
Medicare Beneficiary: XXXXXX[redacted]
Date of Service: 03/07/2017
Claim: [redacted]
iFlow DCN: [redacted]

Dear Provider,

You are receiving this letter for educational purposes. Your claim was medically reviewed via an Additional Documentation Request (ADR) and processed based on medical review findings listed below for Part B services for Edit ID 1210. The information below represents the logic used to determine if we agree with the CPT code submitted on the claim based on the documentation you provided. An "X" to the left of the content indicates that credit was given for that element of the evaluation and management service.

Medical Decision Making

An "*" to the right represents score given for each examination area.

Risk Assessment

Presenting Problem	Minimal	Low	Moderate	High
Diagnostic Procedure	Minimal	Low	Moderate	High
Management Option	Minimal	Low	Moderate	High
Overall Risk	Minimal = 1	Low = 2	Moderate = 3	High = 4

History Type

HPI - 1995	Brief 1-3	Brief 1-3	Extended >=4	Extended >=4
HPI - 1997	Brief 1-3	Brief 1-3	Ext >=4 or status of 3	Ext >=4 or status of 3

- The decision and education letter for E/M codes may appear as shown here.
- The letter shows the results of E/M Review Checklist and Score Sheet Tool for levels of:
  - History
  - Exam
  - Medical Decision Making

TOP 10 DENIALS

Overall Top Denial Codes and Descriptions

Rank	Medical Review Code	Medical Review Code Description
1	Non-response	No Response to Additional Documentation Request
2	NODOC	Documentation requested for this date of service was not received or was incomplete
3	ISIGN	Information submitted contains an invalid/illegible provider signature
4	ILDOC	Information submitted deemed illegible
5	NOTMN	Payer deems the information submitted does not support medical necessity of services billed
6	BNSIG	Documentation received lacks the necessary beneficiary or authorized representative signature
7	NOORD	Documentation lacks the necessary provider order
8	BILER	Claim billed in error per provider
9	NOCXR	Documentation received lacks the necessary radiology report
10	ASAVA	Alternative services were available and should have been utilized

Reporting Period: July 1, 2018 through September 30,2018

Top 10 Denials – ASAVA (Ambulance)

#10 ASAVA – Alternative services were available and should have been utilized

- The transport report must contain medical necessity information that shows the patient traveling by other means is contraindicated.
- In any case in which some means of transportation other than an ambulance could be used without endangering the individual's health, whether or not such other transportation is actually available, no payment may be made for ambulance services.

Top 10 Denials – NOCXR (Radiology)

#9 NOCXR - Documentation received lacks the necessary radiology report

- The interpretation of a diagnostic procedure includes a written report.
- It is important to include the radiology report because:
  - When the claim is for the technical portion, the report proves the service was rendered
  - When the claim is for the professional portion, the report is the documentation of the service being billed by the rendering provider

Top 10 Denials – BILER (General)

#8 BILER - Claim billed in error per provider

- ADR response received stating the claim was billed in error due to incorrect:
  - Date of Service
  - Billed/Rendering Provider
  - Service code billed
- To avoid this denial ensure billing and coding information submitted on claim matches the service performed before claim submission

BILER (Evaluation and Management)

- Documentation submitted does not support the service was performed by the rendering provider on the claim due to:
  - Incomplete documentation to support incident-to service for outpatient/office visits
  - Incomplete documentation to support split/shared for in-patient visits

- Avoid this denial by ensuring:
  - Documentation submitted supports a face-to-face encounter
  - Documentation of a substantive portion of the E/M service by the MD as well as the NPP

Top 10 Denials – NOORD (General)

#7 NOORD – Documentation lacks the necessary provider order

- Signed provider orders, or signed progress notes that show intent to order, are required to be submitted as part of the documentation for all services that require a provider order as part of the service guidelines.
- Including services such as:
  - Radiology Diagnostic tests
  - Laboratory tests

Avoid this denial by:

- Following the CMS MLN 'Complying with Documentation Requirements for Laboratory Services' guidelines
  - Unsigned orders do not support medical necessity
  - Physicians/NPPs should sign all orders
  - Progress notes to support medical necessity must be signed or have and attestation statement from the ordering provider

NOORD (Radiology)

- Radiology interpretation report was submitted without signed order or signed progress note to show intent to order from referring provider
- Avoid this denial by ensuring the order/intent to order is submitted with the documentation in response to an ADR

Plan

- DEXA SCAN; Status:Active; Requested for:23May2017;
- US THYROID; Status:Complete; Done: 23May2017 11:01AM

Discussed with patient presentation, lab and radiology.

Recommend FNA and Bx with Afirma to the 4 cm complex left thyroid nodule.

I discussed with patient the expected results from FNA of the thyroid nodule/s with expected and percentage of possibilities including benign, malignant, insufficient and atypical or follicular neoplasm.

Ask patient to hold her baby aspirin for a week prior to FU visit. and restart it next day after the biopsy.

If TFTs refer to thyrotoxicosis, will change the plan.

Will get FT3, FT4, TSH, CMP, Phosphorus, PTH, Vit D, Mg

Will get DXA scan (including 33% radius)

Top 10 Denials – BNSIG (Ambulance)

#6 BNSIG - Documentation received lacks the necessary beneficiary or authorized representative signature

- This may occur when the submission contains:
  - Blank beneficiary signature form
  - Crew signature without receiving facility representative signature
  - Crew signature/ representative signature without documentation that patient is unable to sign for self

- Avoid this denial by:
  - Obtaining the beneficiary signature before submitting claim to Medicare
  - Ensure staff documents reason patient cannot sign (ex: dementia, injury)
  - Obtain signature from receiving facility to support transport occurred

See ‘Beneficiary Signature Requirements’ article at www.PalmettoGBA.com/RR

Top 10 Denials – NOTMN (General)

#5 NOTMN - Payer deems the information submitted does not support medical necessity of services billed

- This denial is given when the review finds:
  - The service was found not medically necessary, or
  - Medical necessity of the service not supported by the submitted documentation

- Avoid this denial by:
  - Being familiar with Medicare coverage and documentation guidelines for the service billed
  - Submitting complete documentation to support medical necessity
- The amount of necessary clinical information needed to demonstrate that all coverage and coding requirements are met will vary depending on the item/service

NOTMN (Ambulance)

- Documentation has elements of:
  - Transport destinations not covered (ER, EP)
  - A medical need for care by EMT/paramedic is not established
  - Hospital to hospital transports where services were available at the original hospital
- Avoid this denial by:
  - Being familiar with the Medicare service guidelines for the transport billed
  - Educating facilities and patients/families on coverage guidelines
  - Completing documentation to support medical necessity

NOTMN (Evaluation and Management)

Evaluation and Management code or code level requirements were not met where specific levels of documentation are necessary for the elements of:

- History
- Exam
- Medical decision making

Avoid this denial by:

- Ensuring the documentation supports the CPT levels of:
  - History
  - Exam
  - Medical decision making
- Use the CMS definitions and guidance found in the MLN 'Evaluation and Management Services' guide

NOTMN (Radiology)

Documentation missing the condition or symptoms that support medical necessity of the diagnostic test on at least one of:

- Provider order
- Clinical progress note of ordering provider
- Radiology Interpretative Report

Avoid this denial by including:

- Covered diagnosis
- Medical order or progress notes with reason for tests
- Radiology interpretive report

Bone Density Tests

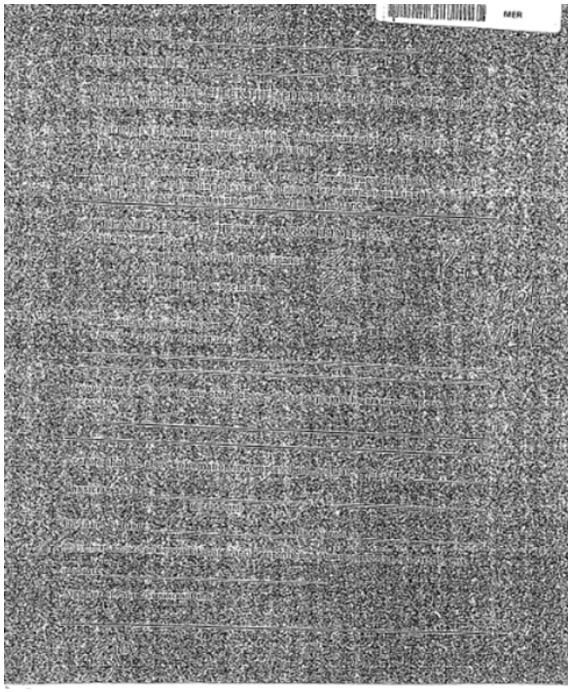
- Covered for specific conditions that place patients at risk for bone loss

Chest X-Rays

- Covered for diagnosis/treatment of medical condition

Top 10 Denials – ILDOC (General)

#4 ILDOC - Information submitted deemed illegible

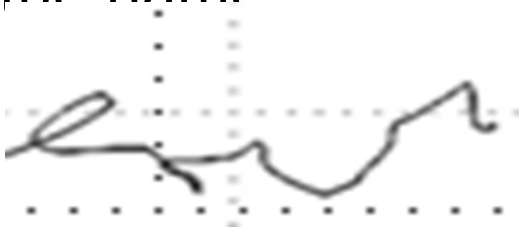


- Illegibility is usually due to:
  - Poor copy quality
  - Inscrutable handwriting
- To avoid this denial:
  - Consider uploading documentation through our eServices portal or by esMD
  - Utilize EHR when possible
  - Include a translation or transcribed notes in addition to copies of original document

Top 10 Denials – ISIGN (General)

#3 ISIGN – Invalid or Illegible provider signature

- Illegible signature:
  - Computer printed name that does not indicate 'electronic signature'
  - Signature is a "squiggle" with no printed or typed version of the name



Avoid this denial by:

- Following signature requirements
- Medicare requires that services provided/ordered be authenticated by provider
- Include the practitioner's first and last name
- We recommend you include your applicable credentials (e.g., P.A., D.O., or M.D.).

Top 10 Denials – NODOC (General)

#2 NODOC - Documentation requested for this date of service was not received or was incomplete

- **Does not mean a response to the ADR was not received**
- The documentation received was not the documentation requested
- The documentation received lacked all the required elements

To avoid this denial:

- Review the documentation requested in the ADR letter
- Make sure the documents you submit are for the correct:
  - Patient
  - Provider
  - Date of Service
  - Service

NODOC (Ambulance)

Insufficient documentation example

Included in response:

- Hospital registration face-sheet
- PCS signed by clinician
- Transport record for:
  - Same date-of-service different transport
  - Different date-of-service
  - Different patient

Missing from response:

- Runsheet for transport submitted in the claim

Avoid this denial by:

- Submitting the documentation for the transport that matches the service requested
- Considering sending notes all runs for multiple same day transports
- Submitting other elements as required

NODOC (Evaluation and Management)

- Frequently used when submitted documents lack a progress note for the date of service from the billing provider
- Submissions often consist of a note for a different:
  - Date of service
  - Patient
  - Provider

- Avoid this denial by submitting the progress note on the requested date-of-service, for the right patient, from the right provider

NODOC (Radiology)

- Frequently used when submitted documents are missing multiple elements to support the radiology service.
- To avoid this denial the submitted documents should have the frequently missing elements including:
  - Order/Progress note with intent to order
  - Radiology interpretative report
  - Signature of ordering or reading provider

Top Denial for All Services

#1 Non-response

No response to Additional Documentation Request

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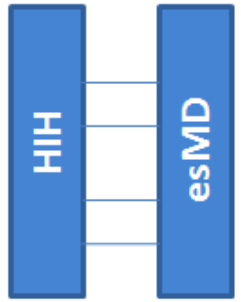
eServices

To avoid this denial:

- Respond promptly within 45 days. Claims automatically deny on the 46th day if a response is not received.
- Choose to electronically upload your response through our provider portal or through esMD, or respond by fax or by mail
- Keep your mailing address current with Railroad Medicare to ensure you are receiving all notices of pending reviews.



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ENSURING YOUR DOCUMENTATION COMPLIES WITH MEDICARE GUIDELINES

Medicare Coverage - Medical Necessity

- “Medically necessary” is defined as “health-care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.”

- The amount of necessary clinical information needed to demonstrate that all coverage and coding requirements are met will vary depending on the item/service.

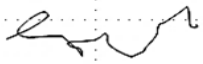
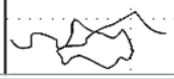
Supportive Documentation

- Make sure the documentation you submit contains the actual note for the billed service requested in the ADR
- Consider what adjunctive notes could support medical necessity (examples: labs, operative reports, etc.)
- Review and use checklists when compiling documentation

Valid Signatures

Documentation must contain a valid provider signature

- Must include a legible form of the name and credentials
- Printed or typed names must be accompanied by initials or signature of provider
- Electronic signatures must indicate it is an electronic signature
- Signature examples

Name and Credentials	Signature	Initials
Victor Frankenstein, D.O.	Dr. Victor Frankenstein	VF
Doogie Howser, M.D.	DOOGIE	DH
Dr. John Doolittle		

See ‘Medicare Medical Records: Signature Requirements, Acceptable and Unacceptable Practices’ article on www/PalmettoGBA.com/RR

Documentation Tips for Evaluation and Management Services

Your records may need to include elements such as:

- History, physical exam and medication records
- Nurses notes and procedure notes
- Operative reports and pathology reports
- Physician's orders and progress notes
- Signatures/credentials of professionals
- Any other documentation deemed necessary to support medical necessity of services

Documentation Tips for Ambulance Services

Your records need to include elements such as:

- Run sheets/Trip reports
- Provider Certification Statement (PCS), when appropriate
- Crew Signatures and Credentials
- Beneficiary Signatures
  - Or otherwise acceptable individual's signature
    - See CFR 424.36 for a complete listing of individuals who can sign on behalf of the beneficiary

Documentation Tips for Radiology Services

Your records may need to include elements such as:

- Orders
- Progress notes to support medical necessity
- Report of results
- Signatures

Responding to an ADR the Right Way

Submit medical records that are for the:

- **Right beneficiary** – is the ADR for Jon Smith or Jon Smythe
- **Right date of service** – is the ADR for 2/07/18 or 7/02/18
- **Right service** – is the ADR for the E/M visit or the Dexa scan?
- **Right order** (or intent to order) – Is that the order for the DEXA or the Chest x-ray
- **Right results/ report** – Is that the result for the test in the ADR letter?
- **Right provider** – If you have multi-provider office, check that the documentation is for the service performed and signed by same rendering provider as in the claim and on the ADR letter.

Your proactive approach…

We suggest:

- Use a tracking system or log for all medical record requests
  - Log in the request and note the due date
  - Review the request, pull the records
  - Use checklists available on the Palmetto GBA/RR website
- Review the records and authentication.
  - Ensure records support service billed
- Document in the log
  - When and what components of documentation were submitted
- Assign someone to track responses to submissions
  - Track denial trends based on the review findings
  - What are the frequent errors and how can they be address them

RESOURCES

CMS Internet-Only Manual Resources

- CMS IOM Publication 100-08, Medicare Program Integrity Manual
  - Chapter 1 – Overview of Medical Review (MR) and Benefit Integrity (BI) Programs
  - Chapter 3 – Verifying Potential Errors and Taking Corrective Actions
  - Chapter 6 – Medicare Contractor Medical Review Guidelines for Specific Services

  https://tinyurl.com/CMSIOMPIM

Medicare Learning Network® Resources

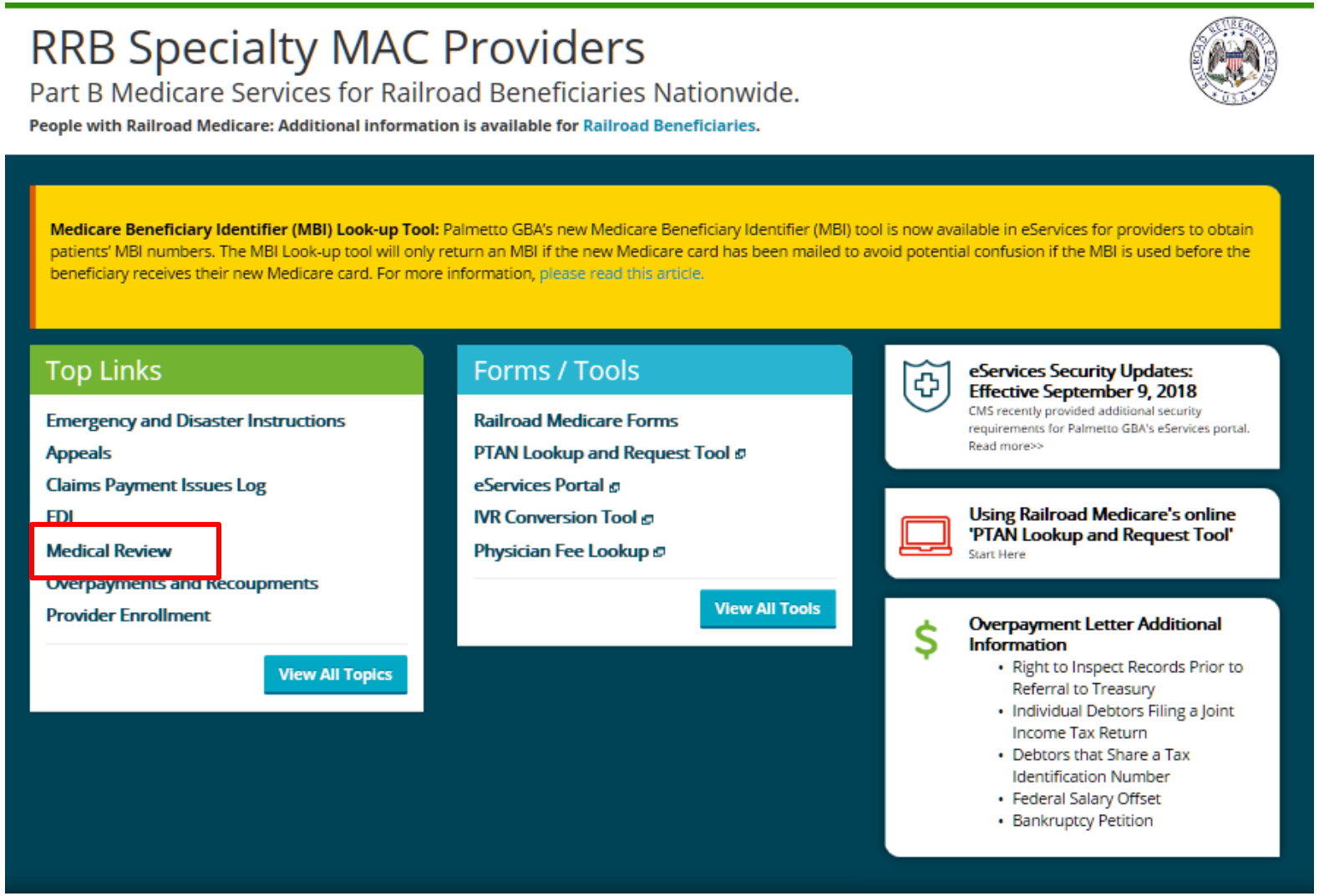
- The Medicare Learning Network® Page
  - https://tinyurl.com/MLNPage
- MLN National Provider Calls
  - National Provider Calls & Events page https://tinyurl.com/MLNCalls-Webcasts
- MLN Provider Compliance Resources
  - Complying with Medicare Signature Requirements
  - Complying with Medical Record Documentation Requirements
  - Complying with Documentation Requirements for Laboratory Services
  - Provider Compliance Tips for specific services https://tinyurl.com/MLNProvCompliance

CMS Open Door Forums

- CMS sponsors regularly scheduled ‘Open Door Forums’ providing opportunities for live dialogue between CMS and the stakeholder community at large
- Subscribe to the Open Door Forum Mailing List to be notified when forums are scheduled or when new information is posted to the website
- CMS Open Door Forums page

  https://tinyurl.com/OpenDoorForums

RRB SMAC Resources



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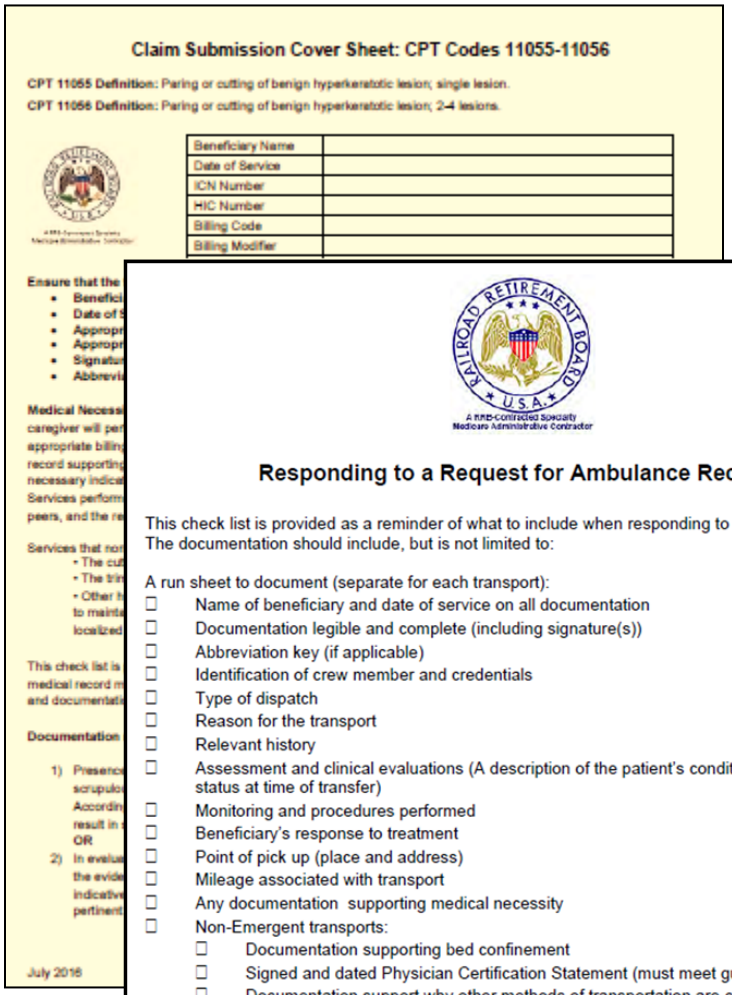
Checklists



Claim Submission Cover Sheet: CPT Codes 11055-11056

CPT 11055 Definition: Paring or cutting of benign hyperkeratotic lesion; single lesion.

CPT 11056 Definition: Paring or cutting of benign hyperkeratotic lesion; 2-4 lesions.

Beneficiary Name	
Date of Service	
ICN Number	
HIC Number	
Billing Code	
Billing Modifier	

Ensure that the

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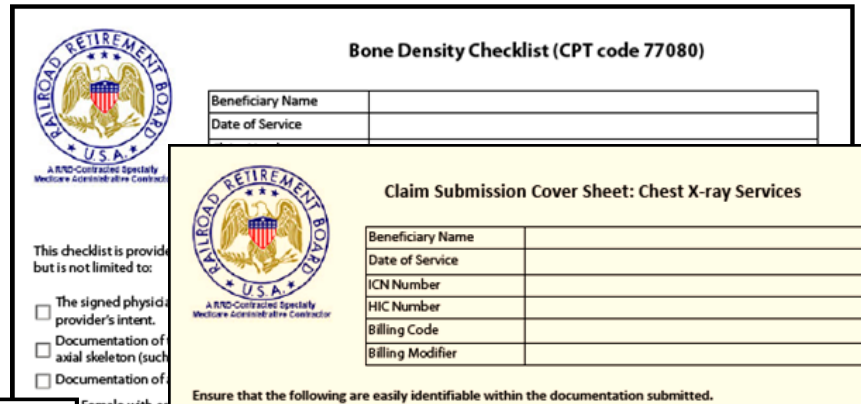
July 2016

Responding to a Request for Ambulance Records

This check list is provided as a reminder of what to include when responding to a request for records. The documentation should include, but is not limited to:

A run sheet to document (separate for each transport):

- ☐ Name of beneficiary and date of service on all documentation
- ☐ Documentation legible and complete (including signature(s))
- ☐ Abbreviation key (if applicable)
- ☐ Identification of crew member and credentials
- ☐ Type of dispatch
- ☐ Reason for the transport
- ☐ Relevant history
- ☐ Assessment and clinical evaluations (A description of the patient's condition and functional status at time of transfer)
- ☐ Monitoring and procedures performed
- ☐ Beneficiary's response to treatment
- ☐ Point of pick up (place and address)
- ☐ Mileage associated with transport
- ☐ Any documentation supporting medical necessity
- ☐ Non-Emergent transports:
  - ☐ Documentation supporting bed confinement
  - ☐ Signed and dated Physician Certification Statement (must meet guidelines)
  - ☐ Documentation support why other methods of transportation are contraindicated for the beneficiary
- ☐ Beneficiary signature or signature of his or her representative
- ☐ Hospital to hospital transports: indicate the precise reason why the required services were not available at the first hospital (services not available at the first hospital, no beds available, etc.)



Bone Density Checklist (CPT code 77080)

Beneficiary Name	
Date of Service	

This checklist is provide
but is not limited to:

- ☐ The signed physici
provider's intent.
- ☐ Documentation of
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Claim Submission Cover Sheet: Chest X-ray Services

Beneficiary Name	
Date of Service	
ICN Number	
HIC Number	
Billing Code	
Billing Modifier	

Ensure that the following are easily identifiable within the documentation submitted.

- Beneficiary Name on all documentation
- Date of Service
- Appropriate CPT code(s) Billed
- Appropriate Modifier(s) Billed

To expedite the medical review process, please indicate the page number where the following information can be located within your claim documents.

Physician's Order or Documentation that Clearly Reflects the Ordering Provider's Intent	
Documentation of Rationale of Medical Necessity That Supports Billing Code	
Interpretation of the Services (Diagnostic Test Report) with appropriate signature	
Signature of Interpreting Physician (If different from ordering physician both must be present)	
Advance Beneficiary Notice of Noncoverage (ABN), if applicable	

Important Notes:

Medical Necessity is evidenced not only by utilization of the appropriate billing CPT code and applicable CPT modifier, but also by clinical documentation in the patient's medical record supporting the diagnosis and necessity.

*** Medicare Part B covers X-rays ordered by a physician for the purpose of diagnosing a medical condition. Medicare does not cover X-rays ordered for preventive screening. No Medicare payment shall be made for items or services that are not reasonable and necessary for the diagnosis or treatment of the illness or injury or to improve the functioning of a malformed body member. ***

All submissions must include a physician's order. The physician's order must clearly document the intent/purpose for the test, order should specify a clear and valid the reason X-ray is required and supported by patient's medical history or medical examination, directional position (i.e., anterior, posterior), and the number of radiographic views to be obtained. An order does not have to be a separate, stand-alone document.

Examples of acceptable orders include but are not limited to

- a written and signed document from the treating physician, that is hand-delivered, faxed, mailed or emailed to the testing facility;
- a properly signed progress note; or
- a telephone call documented by the treating physician and testing facility in the patient's medical record.

June 2013

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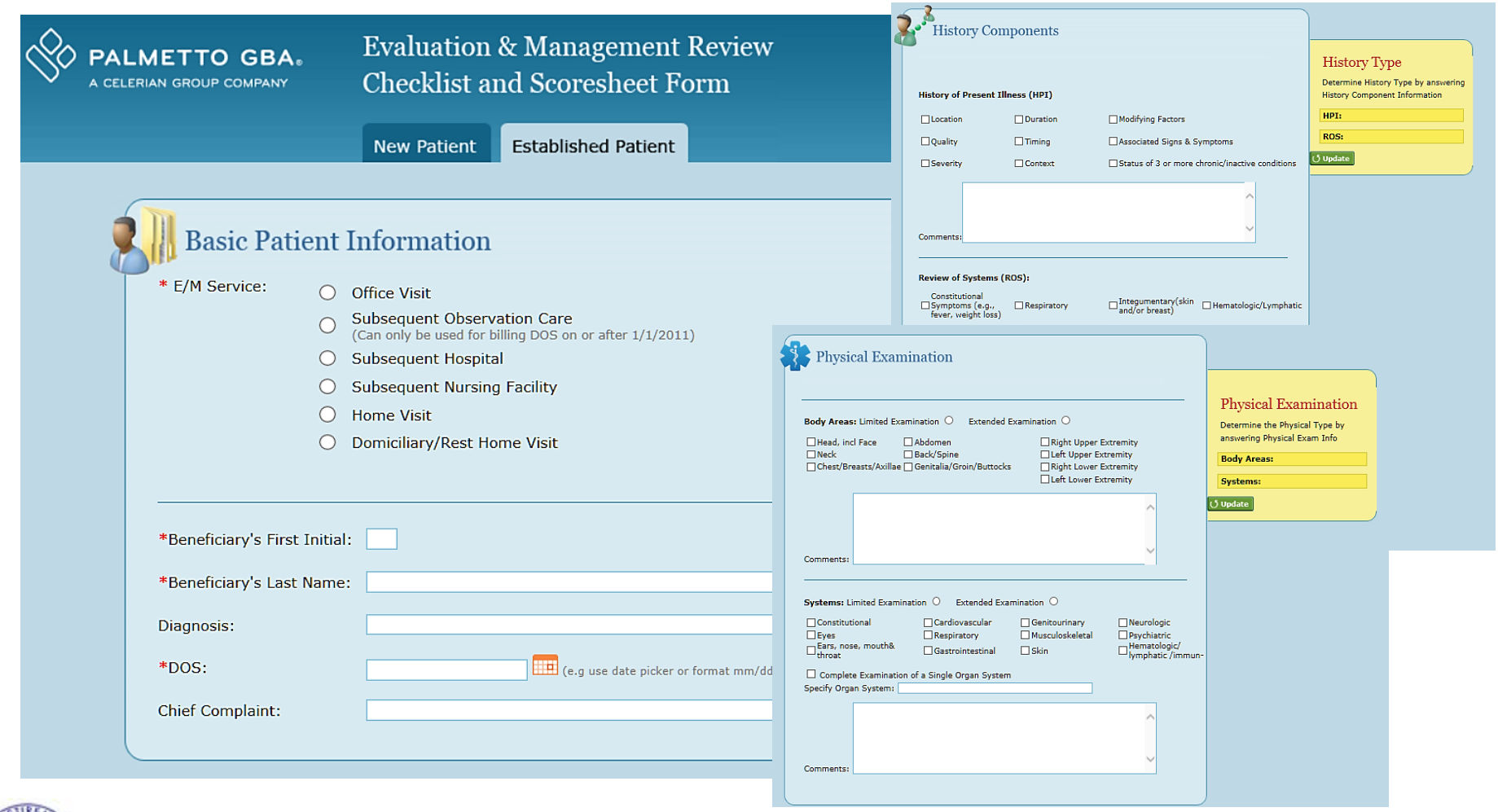
Evaluation and Management Services Checklist & Scoresheet Form



https://tinyurl.com/EM-Checklist-Scoresheet

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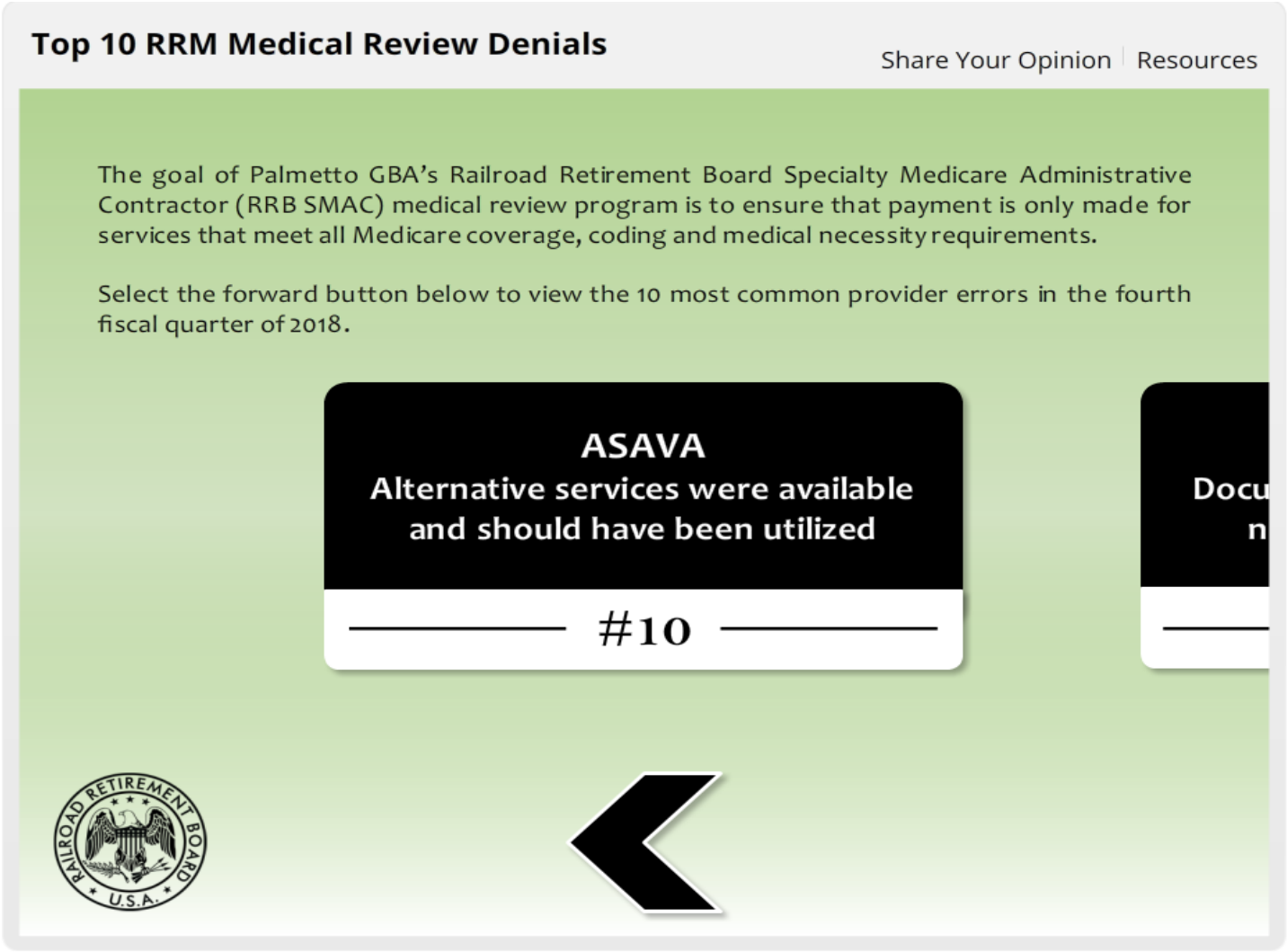
Top MR Denial Module



https://tinyurl.com/TopMRDenialModule

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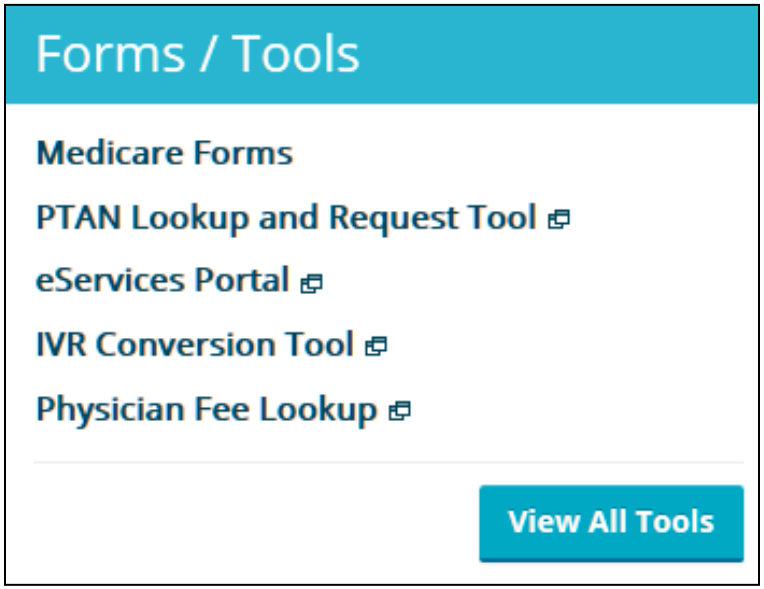
- Modifier Lookup
- MSP Lookup
- Reason/Remark Code Lookup



eServices Portal

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eServices

Look up

- Claim Status
- Patient Eligibility and Medicare Beneficiary Identifier (MBI)
- Remittance Advice

Submit

- First Level Appeals, Clerical Error Reopenings, General Inquiries
- Documentation for MR Additional Documentation Requests
- eCheck Overpayment Refunds and eOffset Requests
- Paperless eClaims

Receive

- Greenmail Notification of Pending Prepay MR ADR Requests
- Greenmail eDelivery of Medical Review and Appeals Decision Letters
- Greenmail eDelivery of General Inquiry Responses

Respond to ADRs in eServices

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eServices

- Respond to Medical Review ADRs through eServices using the MR ADR Response secure eForm
- Attach an unlimited number of PDF files to each form. Each attachment can be up to 40 MB. The total size of all attachments on each ADR eForm can be no more than 150 MB
- Track submission of your ADRs
- Must have an Electronic Data Interchange (EDI) Enrollment Agreement on file with Palmetto GBA Railroad Medicare
- Enroll for eServices at www.PalmettoGBA.com/eServices

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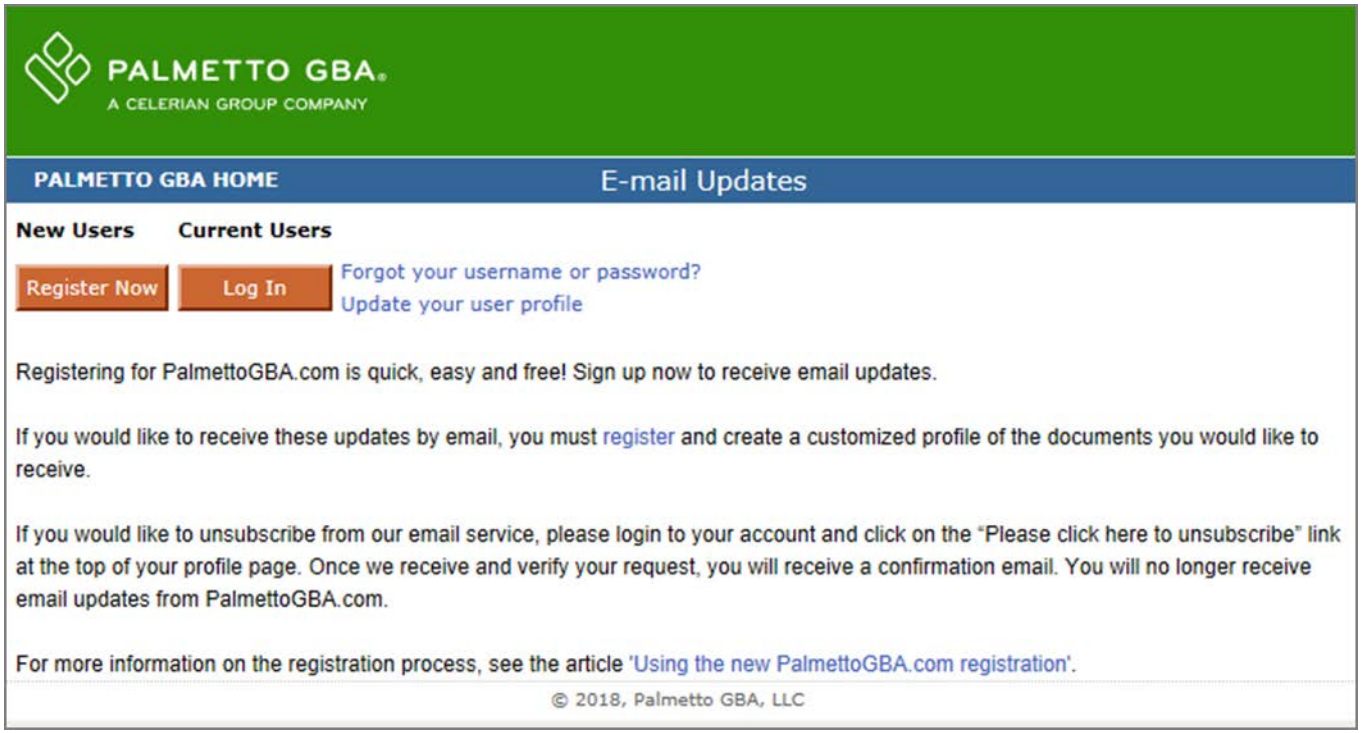

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Contact Us By Email	Medicare.Railroad@PalmettoGBA.com
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CMS Listserv	https://tinyurl.com/CMSEmailUpdates

Interactive Voice Response (IVR) System

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Questions?

Q&A Widget

Survey Widget - Please take our short survey. We appreciate your feedback.

Resource Widget

Thank you!

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