

National Government Services RuralServ Newsletter July 2025

As your Medicare Administrative Contractor (MAC), National Government Services (NGS) is dedicated to working with providers in the rural areas we serve. Our goal is to keep you informed about changes to Medicare and the training opportunities available to you.

NGS RuralServ

Delivering

Education

Provider Outreach and Education

Improving Customer Experience

We are committed to improving your experience. Please watch this two-minute [video](#) that explains how each day we review comments from providers who submit surveys to let us know what is working well and how we can improve. Here are some improvements we made in the first half of 2025:

- Added a new National Correct Coding Initiative (NCCI) Lookup Tool to our NGSMedicare.com website to help providers identify when certain codes are subject to the automated code pair edits.
- Combined our Medically Unlikely Edits and National Coding Initiative web content for easier accessibility.
- Enhanced our Part B Top Claim Error Tool to indicate error type denial or rejection and improved search function.
- Added a feature to deliver Medicare redetermination notices (MRNs)/response letters through our NGSConnex portal and stop mailing hardcopy MRNs for redeterminations submitted through the portal.
- Added a notification to alert a user when a Claims or Medical Review ADR due date is within 10 calendar days of the current date.
- Enhanced our NGS Medicare University platform learning library and learning certificates.
- Expanded educational opportunities based on provider feedback.
- Shared survey responses with our Customer Service Representatives to drive improved customer experience.

Thank you for your feedback, we look forward to continuing to improve your experience.

Understanding the Submission Requirement for a Revalidation Application

According to the [42 Code of Federal Regulations Section 424.515\(b\)](#), providers and suppliers are required to submit a CMS-855 application with complete information for revalidation by a specified due date.

Once the application is received, the submission requirement is fulfilled with an acknowledgment email sent to the contact person listed in the application. The email will include the case number to follow the status of the application by using our [Check Provider Enrollment Application Status](#) tool. The provider or supplier should track the application's status and provide any additional information requested, if

necessary. After the processing is finalized, the contact will be informed of the approval, deactivation or the approval recommendation through mail, fax or email.

Interactive Voice Response System Changes Coming Soon

We're making changes to our interactive voice response (IVR) system. You'll still dial the same number, but you'll hear a new voice. Although the IVR provides instructions throughout the call, we want to point out some minor differences when using touch tone:

- To repeat, press the asterisk (*) key
- To request help, say, "help"
- To signify the end of an entry, press the pound (#) key to continue.
 - For example, when entering an NPI, press 123456789#

Please continue to check our email updates for more information.

Modifier 22 Supporting Documentation for Part B Claims

The [Centers for Medicare & Medicaid Services, Internet-Only-Manual, Publication 100-04, Medicare Claims Processing Manual, Chapter 12, Section 40.2.10](#) Unusual Circumstances states:

"Surgeries for which services performed are significantly greater than usually required may be billed with the "-22" modifier added to the CPT code for the procedure. The biller must provide:

- A concise statement about how the service differs from the usual; and
- An operative report with the claim."

NGS wants to further clarify that the statement can be a part of the operative note. The operative note should support what's in the separate statement for modifier 22 unless there's an addendum to the operative note itself. Key points include:

- Complexity of the surgery that causes it to be unusual or more difficult.
- Extra time spent on certain portions such as lysis of adhesion, control or bleeding, etc.
- For modifier 22 billed on 44180/440005 which are lysis of adhesions, how much time in excess of two hours was spent on lysis?
- Number of polyps/tumors.
- Work done in excess of the standard CPT description including complications, intensity, time.
- Generic or canned statements not supported by the operative note will not be considered for additional payment.

NGS has several ways to submit records.

- Paperwork (PWK) process for 837 electronic transactions.
 - The PWK segment is used in the [Medicare Billing: CMS-1500 & 837P](#) claims. It serves as a link between the electronic claim and supporting documentation submitted by the provider. The PWK segment is used to notify the Medicare Administrative Contractor (MAC) that additional documentation will be submitted alongside the claim. Pre-enrollment is not required. Refer to [Paperwork Segment – PWK](#) for details.

- 275 electronic transactions for attachments. You can reach out to your billing vendor for this.
 - Refer to [EDI Enrollment](#) for details
- ADR attachments may also be submitted using NGSConnex.
 - Refer to the [NGSConnex User Guide](#) for instructions

Part A Claim Error Spotlight for FQHCs: Return to Provider Reason Code W7089

Recent data analysis shows that return to provider (RTP) reason code W7089 has been consistently in the top five errors for federally qualified health centers (FQHCs).

A FQHC PPS claim (77X type of bill [TOB]) is assigned reason code W7089 when the claim contains one of the specific FQHC payment codes (G0466–G0470), but a Healthcare Common Procedure Coding System (HCPCS) code for the qualifying visit is not reported on the same day. For Medicare to pay for an FQHC encounter, a medically necessary face-to-face visit is required. Each specific FQHC payment code (G0466 - G0470) must have a corresponding service line with a HCPCS code that describes the qualifying visit.

Claims that are in RTP do not appear on your remittance advice, so it is vital to check for RTPs in FISS DDE on a routine basis, based on your facility's claim volume. Claims in RTP are not considered “received” by Medicare and must be corrected and resubmitted before processing can continue. It's important to note that claims in returned to provider (RTP) are still subject to timely filing and will be processed as provider liable if resubmitted after the timely filing period for that claim has ended.

To review and correct RTPs, you must log into Fiscal Intermediary Standard System (processing system for Part A) (FISS)/ Direct Data Entry (DDE) using your logon ID and password. Once logged in, you will see the WELCOME TO CMS screen. On this screen, key <FSS0> (zero, not O) and hit <ENTER> to get to the Main Menu. From the Main Menu, choose Claims Correction (03) to locate your RTP claims. Choose the claim you want to correct, fix the issue, and press PF9 on your keyboard to resubmit that claim. If the claim remains on the screen, there are other error(s) that need to be corrected before the claim can continue processing. Press PF1 to review the new reason code assigned to the claim.

MAP1704	NATIONAL GOVERNMENT SERVICES, #13001 UAT	ACMFAS61 12/18/19
MXG9282	CLAIM AND ATTACHMENTS CORRECTION MENU	A20201AF 11:58:07
CLAIMS CORRECTION		
INPATIENT	21	
OUTPATIENT	23	
SNF	25	
HOME HEALTH	27	
HOSPICE	29	
CLAIM ADJUSTMENTS		CANCELS
INPATIENT	30	50
OUTPATIENT	31	51
SNF	32	52
HOME HEALTH	33	53
HOSPICE	35	55
ATTACHMENTS		
PACEMAKER	42	
AMBULANCE	43	
HOME HEALTH	45	
ENTER MENU SELECTION:		

Related Content

- [Reason Code: W7089](#)
- [CMS IOM Publication 100-04, Medicare Claims Processing Manual, Chapter 9](#)
 - Section 60.2 – Billing for FQHC Claims Paid under the PPS
 - Section 70.4 – FQHC Payment Codes
- [Specific Payment Codes for the Federally Qualified Health Center Prospective Payment System \(FQHC PPS\)](#)
- [FISS DDE Provider Online Guide](#)

Medicare's Annual Wellness Visit (AWV) Telehealth Options

Ways to Improve Your Medicare Patients Access to AWV!

Did you know:

- Telehealth has the potential to expand access, reduce costs and improve a patient's health.
- Telehealth (video/audio) can improve access to AWV.
- The CMS [List of Telehealth Services](#) allows AWV using the telephone only.

For more information go to [Medicare Wellness Visits](#).

Preventive Vaccines for FQHCs and RHCs Guidance

Effective 7/1/2025, FQHCs and RHCs will bill and receive payment for all four types of Part B preventive vaccines (pneumococcal, influenza, COVID-19 and hepatitis B) and their administration at the time of service.

Summary of Changes

- Part B preventive vaccines and their administration will be billed on the UB-04 claim form (TOB 77X or 71X).
- A visit/encounter or qualifying visit code is NOT required to be reported on the same claim as these Part B preventive vaccines to receive separate reimbursement.
- Use HCPCS Level II code M0201 to bill for the additional payment for administering the vaccine to Medicare patients in their homes under certain circumstances.
- The roster billing process will be updated to allow entry for TOB 77X and 71X
- Separate payment will be made at the lesser of 95% of the AWP or the submitted charges for service lines reporting Part B preventive vaccine products when reported on TOB 77X or 71X.
- A separate payment at the lesser of the MPFS rates or the submitted charges for service lines reporting Part B preventive vaccine administration codes will also be made.
- Beneficiary coinsurance and deductible will be waived for Part B preventive vaccine products and administration.

Billing Instructions

Bill on FQHC TOB (77X) or RHC (71X) claim

- Report condition code A6
- Report appropriate administration code with revenue code 0771
 - G0008 – influenza
 - G0009 – pneumococcal
 - G0010 – hepatitis B
 - 90480 – COVID-19
 - M0201 – in-home vaccine administration (reported in addition to administration code)
- Report the appropriate Part B vaccine code with revenue code 0636
 - Influenza
 - Pneumococcal
 - COVID-19
 - Hepatitis B
- Report ICD-10-CM code: Z23

Special Instructions for FQHCs

- May be billed alone or with FQHC qualifying visit
 - If qualifying visit occurs on the same day as a preventive vaccine, report the vaccine on the claim in addition to the FQHC payment code (G-code) and qualifying visit
 - Report condition code A6 so that coinsurance is not applied to the preventive vaccine
 - If no qualifying visit occurs, submit the preventive vaccine claim (77X TOB) with the appropriate revenue codes and CPT/HCPCS codes for the administration and vaccine for payment to be made

Special instructions for RHCs

- Qualifying visit not required to be billed on vaccine claims
- RHC claims are not required to report the CG modifier on the vaccine or administration line

Cost Report

Although paid on the claim, rural health clinics (RHCs) and FQHCs must reconcile the claim payments with actual vaccine costs, and these services are ultimately reimbursed at 100% of reasonable costs through the cost report.

Related Content

- [MLN Matters® MM13923: Payment for Medicare Part B Preventive Vaccines & Their Administration for Rural Health Clinics & Federally Qualified Health Centers](#)
- [Centers for Medicare & Medicaid Services Internet-Only Manual Publication 100-04, Medicare Claims Processing Manual, Chapter 18, Section 10.2.2.2](#)
- [CMS Vaccine Pricing](#)
- [Preventive Services](#)
- [In-Home Vaccine Administration: Additional Payment](#)

NGS Part A and Part B News

- [Modifier 22 Supporting Documentation for Part B claims](#)
- [Interactive Voice Response System Changes Coming Soon](#)
- [Understanding the Submission Requirement for a Revalidation Application](#)
- [How to Complete the Paper CMS 855O Medicare Enrollment Application for Ordering/Certifying Only](#)
- [July 2025 EDI Front End Quarterly Release](#)
- [Self-Administered Drug Exclusion Update \(J6 and JK\)](#)
- [Improving Customer Experience](#)
- [National Government Services Important Update](#)
- [LCD and Billing and Coding Article Updates – 2025](#)
- [July 2025 Release "Dark Days" for the Common Working File Hosts](#)

Centers for Medicare & Medicaid Services News

- [MLN Connects® Newsletter: June 5, 2025](#)
- [MLN Connects® Newsletter: June 12, 2025](#)
- [MLN Connects® Newsletter: June 18, 2025](#)
- [MLN Connects® Newsletter: June 26, 2025](#)

Reminders

- [No Documentation Received Resulting in Increased CERT Errors](#)



- [Jurisdiction 6 and K Part A](#)
- [Jurisdiction 6 and K Part B](#)
- [Jurisdiction 6 and K FQHC/RHC](#)
- [Jurisdiction 6 and K HH+H](#)