KMC University's
Chronicles
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CELEBRATING KATHY (KMC) WEIDNER'S FOUR DECADES OF SERVICE TO OUR PROFESSION!

DC Insights

Preventing Medical Necessity Denials - Is it Possible?

By Dr. Colleen G. Auchenbach, DC, MCS-P, CPMA

Medical necessity is a real thing - by definition anyway. We may not like the terminology since it doesn't have anything to do with technique or the appropriateness of the care we deliver. But the definition(s) of medical necessity is one of the most important to you and your practice whether a cash-based practice or one dealing with third-party payers. Medicare Part B, Medicare Advantage plans, Personal Injury, and all other third-party payers have a mandate to only pay for medically necessary care. Providers who believe they are "following the rules" still receive denials due to medical necessity. There are multiple reasons this happens, and they may differ from provider to provider, and from payer to payer.

The Definition of Medically Necessary Care

The truth is…many providers do not fully comprehend medical necessity. It is not always due to a lack of effort. We define "clinically appropriate" as all the care that providers order and render within their scope of practice. But medical necessity is defined very differently and far more narrowly by Medicare and insurance companies. Sometimes the definitions vary significantly by both third-party payers and Chiropractic licensing boards. Understanding these definitions to which providers are held accountable is one of the **most important compliance activities** a practice can undertake.

We know that Medicare's definition is as follows: ***"The patient must have a significant health problem in the form of a neuromusculoskeletal condition that necessitates treatment. The manipulative services rendered must have a direct therapeutic relationship to the patient's condition and provide a reasonable expectation of recovery or improvement of FUNCTION."*** There must be a valid expectation, at the time treatment is rendered, that improvement will occur. Through documentation, the provider must **demonstrate that improvement** has occurred, and that the functional loss has been restored to the pre-condition norms.

While we cannot list every payer's definition of what constitutes medical necessity, we can provide a simple checklist of elements that **must be included within your documentation** to support and prove medical necessity.

- Patient consultation with appropriate history
- Subjective complaints reported by the patient
- Functional deficit brought on by mechanism of injury
- Physical examination findings and tests results
- Diagnosis codes with description of condition
- Treatment plan including measurable, functional goals

Preventive Measures

Locate the Medical Review Policy (MRP). Start by finding the MRP for any payer that you are contracted with or that you bill on behalf of your patients. Review the medical necessity and/or documentation requirements for the services offered in your clinic. Look for the word ALL, as most payers require several criteria to be met and documented.

Document the Episode. As we audit records for providers, both proactively, and in defense of an audit, we see that a major reason for medical necessity issues is the apparent lack of episodic care. Chiropractic patients move through ebbs and flows during treatment, and it is best documented as "active treatment," "preventive maintenance," or "wellness care." While in the active treatment phase, there should be **clear evidence** of a foundational visit with all the items noted above. The date in Box 14 of the 1500 billing form should correspond to the **initial visit date of the episode** of care. Then, the documentation of routine office visits (ROV) in which the treatment plan is being executed should demonstrate the required progress (or lack thereof) for the episode.

Document Progress. Documenting the patient's progress, as it relates to **functional change** based on the goals established in the treatment plan, throughout the active care episode will streamline the task of satisfying medical necessity requirements for most payers. Each episode should have a beginning, a middle, and an end.

Submit Clean Claims. Reporting accurate onset dates in Box 14 and presenting correctly ordered diagnosis codes and appropriate procedure codes will provide clear communication that the patient is being properly managed.

Appropriate Discharge. Discharge from active treatment is just as important regardless of whether the patient returns for preventive maintenance or wellness care. It provides a **documented end to the active treatment** so that the next active episode is clearly delineated and more likely to meet medical necessity requirements.

Simply stated, medical necessity is the force that drives claim payment by third-party payers. **Your documentation is the element that proves your treatment was justified** and produced measurable improvement. Without proper documentation and coding, it would be fair to assume that your services will be denied as not medically necessary.

Dr. Colleen Auchenbach graduated with a Doctor of Chiropractic from Cleveland University Kansas City in December of 1998 and enjoyed practicing for over 20 years. Her interest in Medical Compliance began when she earned the 100-hour Insurance Consultant/Peer Review certification from Logan University in 2015. She has been a certified Medical Compliance Specialist-Physician since 2016 and a Certified Professional Medical Auditor since 2022. Dr. Auchenbach joined the excellent team at KMC University as a Specialist in 2020, and as a part of this dedicated team is determined to bring you accurate, current, and reliable information. You may reach her by email through info@kmcuniversity or by calling (855) 832-6562.

Coding Denials - Take a Proactive Approach

Coding denials may occur after a claim has been adjudicated by a third-party payer. In most cases, data reported on the claim caused the payer to consider it **unpayable** and as result, the claim is denied for payment. A procedure may be considered a *billable* code, but if the provider does not follow specific rules, a billable procedure quickly turns into an unpayable procedure. Denied claims are costly to a clinic. It requires precious man hours to identify the cause and follow through with appeals. A proactive approach takes time as well, but rather than costing the clinic, the complete opposite happens as reimbursement increases.

Avoiding Denials

Most providers think of billing as a moving target, as it is so hard to hit it. Once you get it right, it seems the rules change. Well, you are not far from the truth. Coding requirements do change, and payer reimbursement policies are updated quarterly. The good news is that NONE of these changes take place without notice to the public or providers.

A proactive approach is the only way to stay on top of denials. Generally, denials fall into three categories: administrative, clinical, and policy. It is vital that a clinic seriously consider all three aspects in order to successfully submit a clean claim (in other words, a payable claim). Simple steps to proactive claim submission are listed below:

- Locate the Medical Review Policy and Reimbursement policies for all network payers. Review all the services related to chiropractic and physical therapy. Take note of treatment plan requirements, visit limitations, documentation requirements, procedures considered non-covered or investigational, medical necessity qualifiers, modifier usage, and allowed diagnosis (if applicable).
- Enroll in payer updates and newsletters and schedule time to read them. Look for reimbursement or clinical policies each quarter.
- Purchase an updated coding manual for ICD-10 each year and/or become a member of an online coding resource. Review diagnosis coding updates each October.
- Obtain training on coding and documentation from a reliable source such as KMC University. We do the challenging work for you and provide updates and training on topics that impact reimbursement. Become a member today if you have not already.

If you are in over your head with denials, review the Claim Adjustment Reason Codes (CARCs) or Remittance Advice Remark Codes (RARCs). These codes often provide the 'why' for the denial. Use this information to start your research on the payer's website for an update or policy you may have overlooked. Remember, the payer will NOT tell you what code to use, so refrain from calling provider services and asking. Take advantage of the code simulation resources that most payer portals offer. If you are completely stuck, reach out to KMC University for a consultation. One of our billing experts will help you. Click on the link below to start the proactive approach.

https://kmcuniversity.com/what-we-do/

Throughout 2023, KMC University is celebrating our founder, Kathy (KMC) Weidner, for reaching an incredible milestone!

40 YEARS SERVING THE CHIROPRACTIC INDUSTRY!

To mark this momentous occasion, we're taking a stroll down memory lane. In Part I (of 4) we are bringing you some of the earliest highlights of her 40-year career. Learn how she gained her experience and, in her own words, how that shaped the development of KMC University and all we are today.

For Kathy Weidner's (Kathy Mills Chang), entry into the Chiropractic profession in 1983 was both a personal and professional milestone. Not only had she found her professional calling and passion, but she learned firsthand how Chiropractic care impacts patients. Suffering from life-long, severe asthma, she became a patient the same day she became an insurance CA. It wasn't long before her health was transformed, and her career began. From this experience, Kathy formulated her mission and higher purpose to make sure that Chiropractic is central in the healthcare arena, with its doctors earning the respect and financial rewards that are so richly deserved.

Between 1983 and 1999, Kathy built and managed multiple, high-volume chiropractic and multidisciplinary practices throughout the country, and was responsible for all daily and financial operations management. From billing and collections to patient financial management, Kathy used these years to formulate the systems she teaches and form the basis of Kathy Mills Chang (KMC) Inc. products and services.

Kathy's Personal Story

My first practice I worked in was Natural Life Centers, in Phoenix. It was Dr. John Connors, his wife Sandy, and me. The practice was a very busy practice (up to 300 visits a day... straight chiropractic). I point to this genesis of my career as a big favor to me, rather than a problem. It taught me how to think for myself, and more importantly, to research with payers when I didn't understand something. I waited on hold often, but always managed to come away from the call wiser and more educated on how insurance worked.

After 4 years there, the practice had grown to four doctors, a dozen CAs, and I ran an entire financial department in a whole separate building. The practice grew and so did I. When the chance came for a former doctor, Dr. Graham, in that practice to start his own, he invited me to help. I appreciated the fewer hours they were open.

Dr. Bob Graham started up his individual practice and I got a chance to see what it was like to start from scratch. It was a lot of sweat and effort, but he made a beautiful practice. Again, I learned important skills, like credentialing, the benefits of being in or out of network with payers, and going back to helping as a front desk CA. That was an amazing experience.

As his practice continued to grow, he added space and other doctors and CAs. After a long time waiting, we were notified in 1991 that the adoption, of our son, came through...a year earlier than we planned. I was grateful I only worked 3 days a week, but it was very tough to be away those other long days. We set about finding my replacement and I helped to train them and moved on.

I knew Dr. Ed Weathersby from church, and we often talked Chiropractic. One day, he reached out to ask if I would help him. I knew he was the President of the Arizona Association of Chiropractic and had a thriving practice nearby. On the promise of taking on the financial aspects of his practice, insurance billing and collections and making my own hours in the office, I said yes. From 1991 until 1994, I served this practice, Dr. Weathersby, and his patients. Because of his position in the State Chiropractic Association, I was asked to teach CA classes at conventions during that time. That's when the bug bit me to teach...

To be continued in the next edition of our KMC University Chronicles...

Help Desk Frequently Asked Questions

TOP 40

In celebration of Kathy (KMC) Weidner's 40th Anniversary serving the profession, we will address the Top 40 Help Desk FAQs. Each issue in 2023 will address ten questions. We all can learn from the mishaps of others. This section will hopefully help clinics nationwide avoid frustration from misinformation and/or lack of understanding.

1 *Is it best to have patients sign a Medicare ABN every year?*

According to CMS, there are **"3 triggering events** that may prompt an advance written notice of non-coverage," and an expiration date is not one of them. The events are initiations, reductions, and terminations. The one that fits most clinics is terminations since an ABN is initiated when a normally covered service (98940(41)-AT) no longer meets medical necessity as defined by Medicare. CMS states, "Terminations stop all or certain items or services. If you terminate services and the patient wants to continue getting care no longer considered medically reasonable or necessary, you must issue the notice before the patient gets the non-covered care to transfer financial liability." In most cases, active care is being terminated and the patient is transitioning to maintenance or wellness care. Therefore, you would never have a patient automatically sign a new ABN at the beginning of the year. We recommend you check out KMC University's resources on Mandatory ABNs. Additional information is available in CMS' *Medicare Advance Written Notices of Non-Coverage Booklet*

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/abn_booklet_icn006266.pdf

2 *What can I give away or discount to my Medicare patients?*

Under section 1128A(a)(5) of the Social Security Act, the OIG prohibits Medicare or Medicaid providers from offering beneficiaries inexpensive gifts or services. For enforcement purposes, inexpensive gifts or services are those that have a retail value of no more than $15 individually, and no more than $75 in the aggregate annually per patient. Therefore, coupons, exam specials, or other similar discounts should not exceed $15 per item/service or $75 annually per patient. Most likely, your exam is not going to fall into this $10-15 range, and if it does, we recommend a consultation with one of our specialists!

https://oig.hhs.gov/documents/special-advisory-bulletins/887/OIG-Policy-Statement-Gifts-of-Nominal-Value.pdf

3 *If patients run out of visits with their insurance, can we charge them the normal charge but discount the amount due? For example, on the books, the charge is $105.00, but we ask them to pay $65.00. Is this a legal way of setting up fees?*

No, this is considered a dual fee schedule. If you are stating that your fees for these services are $105, you must account for the patient paying the total amount. The only exceptions to this are any contracted fee schedules you have in place, like In-Network Participation with an insurance carrier or enrollment in a Discount Medical Plan Organization like ChiroHealth USA.

4 *My software has a Same as Last Treatment (SALT) feature. Is this okay to use for routine patient visits?*

Using the SALT feature without making any changes to the record on each individual date can be considered fraudulent record keeping and can put a doctor at risk during an audit or record review. Cloning notes are under close scrutiny as they could be produced without a physician or patient present. The unique information gathered on each patient visit is what determines whether that visit meets the medical necessity guidelines of a payer. If nothing is noted as being changed from one visit to the next, and no progress is noted, then the care is not supported.

5 *We are currently enrolled as a non-par provider with Medicare. What is the rule about charging patients when an active treatment manipulation has been denied for medical necessity? Do we, as the provider, have to eat that charge, or can we bill the patient?*

Since you are a non-participating provider with Medicare, the patient would have already paid for that visit at the time of service. Because Medicare tells you that the visit is seen as "not-medically necessary," you must refund the patient what they paid you for the CMT code only. If you also collected for other statutorily non-covered services, these do not have to be refunded. As a non-participating provider, you don't have the right to appeal unless the patient assigns that right to you. But if your Medicare bills are being denied, it screams of a much bigger problem. Are you using proper modifiers? Do you understand the difference between acute, chronic, and maintenance visits? Do you know the decision-making process that is required on a visit-by-visit basis for these kinds of patients? If not, let us help you!

6 How long do I have to complete my notes for a patient visit?

CMS expects the documentation to be "generated at the time of service or shortly thereafter. Delayed entries within a reasonable time frame (24 to 48 hours) are acceptable for purposes of clarification, error correction, the addition of information not initially available, and if certain unusual circumstances prevented the generation of the note at the time of service." Medicare has clearly stated that "reasonable" means 24 to 48 hours. As such, it is important to understand that anything beyond 48 hours could be considered unreasonable. Additional information at:

https://www.aapc.com/blog/23844-medical-record-entry-timeliness-what-is-reasonable/

7 I do therapy exercises with groups of about four people at a time. How many units per person of 97110 can I bill?

You would not select procedure code 97110 (therapeutic exercises) when working with more than one person at a time. For these circumstances, you would bill code 97150 (group therapeutic exercises) once per person, per encounter – with only one unit, as this is not a timed code. The number of minutes you spent with the group isn't relevant to billing this code. Be careful to document the service properly in each patient's healthcare record as this code does not describe the services rendered to the payer.

8 We are not in network/participating with a certain major payer, but we keep getting remits from Meritain Health with discounted fees applied. How can they apply a discount to an out of network provider?

Meritain Health is a benefits administrator or third-party administrator (TPA). They provide services for more than 2,400 plans. It is possible, although you are out of network with the unnamed major payer, you are enrolled as in-network with the TPA by means of another major payer. This is called a Silent PPO and it can be very frustrating when it happens. We recommend that you check out the Rapid Solution titled ***The Silent PPO Sting*** located in the Practice Finances section of the KMC University library. This will explain more about this payer situation and how to prevent discounts in the future.

https://learn.kmcuniversity.com/rapid-solution/the-silent-ppo-sting/

9 We are thinking about hiring a new doctor. If he is set up as cash-based only, can he see Medicare patients as long as he gets an ABN signed by the patient?

All providers who treat Medicare patients are required to be registered in the Medicare system. If you're not a registered (enrolled) provider, use of an ABN is not a protection for you, and thus you cannot collect from the patient, nor would you be able to collect from Medicare. Seeing Medicare patients for free is an inducement violation, so, as you can see, there really isn't a good option here. There has been some discussion about patients' right to elect to not disclose their information regarding their Medicare enrollment, but the patient must initiate this and request a way to exercise that HIPAA right. It can't be doctor-suggested or led, which means it can't be a policy or a requirement in your office. Medicare has a mandatory claims submission rule, so you utilize a Mandatory ABN to avoid that requirement when providing maintenance care. As a non-registered provider, you aren't allowed to use an ABN. The best option is to enroll in Medicare and choose to be non-par with Medicare, charge the limiting charge to Medicare beneficiaries, and submit claims so they can be repaid. If the provider doesn't want to do that, refer all Medicare patients to the closest registered (enrolled) Medicare provider.

10 A high percentage of our patients are enrolled in Medicare Advantage plans. Since these are not traditional Medicare patients, do I utilize the Medicare ABN form when the patient is receiving maintenance care? What can I charge the Medicare Advantage patient for maintenance care?

These are fantastic questions. Medicare Part C, also referred to as Medicare Advantage is insurance with very plan specific rules. That means you must consult each payer portal and locate the plan type (HMO, PPO, PFFS) to review the guidelines, requirements, and restrictions. We do know that the ABN form provided by CMS is NOT valid for Medicare Advantage (MA) plans. Most MA plans provide an ABN form or some type of advance notice of non-coverage form. If not, we encourage you to implement KMC University's *Patient Acknowledgement Form for Non-Covered Services.*

As for what you can charge, there isn't a simple answer. There are two things to consider: some MA plans, such as PFFS plans, have mandatory submission rules or balance billing limitations, and there is the No Surprises Act regulation for self-pay patients and/or non-covered services. We encourage your team to make it a top priority to learn about Medicare Advantage Plans. Locate the course ***Be Compliant with the No Surprises Act*** in the Compliance section of the KMC University library. It will provide all the tools you need to navigate these waters. For a quick overview of MA plans, check out the Rapid Solution in the Medicare section titled ***How to Avoid Medicare Part C Pitfalls.***

https://learn.kmcuniversity.com/courses/no-surprises-act/

https://learn.kmcuniversity.com/rapid-solution/how-to-avoid-medicare-part-c-pitfalls/

Kathy's 40th Anniversary Code of the Year

Procedure Code 97140

In honor of Kathy (KMC) Weidner's Fourth Decade serving Chiropractic, we have picked our favorite (well, not so favorite) procedure code. Over the years, this code has resulted in policy rewrites and much advocacy work by both State and National Chiropractic Associations. It is also one of the most audited codes, next to E/M, we have ever seen. How can a clinic avoid 97140 billing mishaps?

Locate the code description. CPT code 97140 is defined as – *Manual Therapy Techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, every 15 minutes.* You want to code to the highest specificity of procedures performed and documented. Do not utilize recommended codes from a vendor who is selling a device until you consult a coding manual or a professional coder.

Locate the coding guidelines. To be considered a reimbursable service, the manual therapy must be done in a separate, noncontiguous region from where spinal manipulation is performed.

Locate the payer policy. Muscle therapies are addressed in every major payer's reimbursement policy or Medical Review Policy. Identify the medical necessity criteria for all payers. No two are the same.

Consider the patient's diagnosis. The patient should have a condition that would benefit from manual therapy.

Establish a treatment plan. Create function-based goals centered around improving the patient's pain, free range of motion, and return to normal activities of daily living (ADLs). Include the frequency and duration of the proposed treatment. Indicate when the patient will be reevaluated to determine the treatment's effectiveness.

Meet all documentation requirements. The exam should support the medical necessity of this service by noting findings such as tenderness, hyper/hypotonicity of muscle fibers, decreased range of motion, edema, etc. SOAP notes must include the technique used, total treatment time, muscles and regions that were treated, who performed the service, and the patient's response to treatment.

Submit a clean (payable) claim. Utilize diagnosis pointers on the 1500 Claim Form to indicate what diagnoses are related to this service. The CMT procedure should NOT have the same diagnosis as the 97140 procedure code. Follow timed coding rules to ensure that the proper number of units are billed. Append the correct modifier to code 97140. The -59 or -XS modifier indicates that the manual therapy service was performed on a different anatomic site than a spinal manipulation.

NOTE: Most payers require use of the X-modifiers instead of the -59. Consult the Medical Review Policy or the payer's online portal.

Learn more about this code and how to appeal denials in KMC University's Rapid Solution titled ***Insight on 97140 Manual Therapy.***

https://learn.kmcuniversity.com/rapid-solution/insight-on-97140-manual-therapy/

2023 Updates

Procedure Codes

Most of the changes will not impact a Doctor of Chiropractic. The following codes have been deleted: Consultation 99241-99251 and Prolonged Services 99354-99357. There have been guideline revisions to evaluation and management codes related to inpatient hospital, prolonged services, and home residence services. If those circumstances apply to your practice, we recommend that you review these codes. As for the common E/M codes there have been small wording changes (nothing substantive) that have provided a little more clarification. Keep a look out for future training in KMC University library on this topic. We do recommend that you remove the 99211 code from your software as this code does not require a DC to be present. A DC is worth more than the 99211 code.

No Surprises Act

The requirement for physicians to work with payers to provide an Advance Explanation of Benefits (AEOB) has been placed on hold. Read more about it on KMC University's Payer Update page. NOTE: The Good Faith Estimate provision has been a requirement for all DCs since January 1, 2022. In late fall of 2022, there was documented enforcement action for providers who ignored this regulation.

https://learn.kmcuniversity.com/category/payer-updates/

HIPAA

The proposed changes to the HIPAA Privacy Rule have been in play since 2018 but no finalization of the rule as of yet. Most experts feel these rules will be finalized in early 2023. If so, there will be a need for clinics to update their policy and procedures, training process, Business Associate Agreements, as well as their Notice of Privacy Practices. We highly recommend that all clinics place HIPAA as a priority in 2023. Budget both time and money to this key component of compliance in a clinic. If you are not sure about your HIPAA status, take a moment to schedule a HIPAA Discovery Consultation with one of our Specialist at KMC University. Focus on being proactive rather than reactive in 2023.

https://learn.kmcuniversity.com/product/discovery-consultation/

Financial Hardship Forms

The annual poverty guidelines will be released in January. Keep an eye out for KMC University to upload the revised forms. We will place notification in the ***What's New*** section.

https://learn.kmcuniversity.com/2022/09/29/whats-new-in-the-library/

Upcoming Events, Seminars, and Webinars

CE Webinar | January 24, 2023
The Top Four Documentation Errors
https://register.gotowebinar.com/register/2059893680985708382

CE Webinar | February 14, 2023
Develop Clinical Rationale for Active Rehab

Parker Seminars Las Vegas | February 23, 2023
2023 Billing, Medicare, and Regulatory Updates Made Easy

CE Webinar | March 14, 2023
Documentation 101- The Life Cycle of a Patient's Chart

Check Your Inbox!

Whether it is your email inbox or snail mail, it is vital that each clinic has a dedicated process for reviewing **all communication from payers and federal authorities.** At KMC University, we see many clinics pay the penalty for not building a process to manage communications in a timely manner.

Keep A Look Out for the Following

Comprehensive Error Rate Testing (CERT) Request

Although this program was limited during the public health emergency, CMS has increased the auditing process to normal levels. If you receive such a request, you need to:

- Take note of the date of the request and respond within the "45 calendar days of the request."
- Include all documents that relate to the date of service and billing, such as ABN forms, imaging reports, outcome assessments, and initial exam findings.
- Double-check all documents for clear and legible signatures, as well as the quality of the copy (no faded documents).
- Include the bar code on the first sheet of the packet.

If you are unsure where to send the records or have questions, please see the CMS link for all the details.

Medicare Revalidation Request

In accordance with 42 CFR §424.515, to maintain Medicare billing privileges, a provider or supplier must resubmit and recertify the accuracy of its enrollment information generally every 5 years. Part A & B providers and suppliers will be issued a due date on theMedicare Revalidation List (see the CMS link provided at the end of this section).

Medicaid Revalidation

Now more than ever with the increase in Qualified Medicare Beneficiaries (QMB) patients, providers are obligated to engage with the state insurance coverage plans assigned by Medicaid. Each state has its own system but currently most send a revalidation request letter with a due date. These can be sent anytime by Medicaid within 2-5 years, not to exceed five years.

New Regulations New Requirements

Thanks to consumer empowerment on January 1, 2022, Section 116 of the Federal Consolidation Appropriations Act that addresses provider directory accuracy became effective. The No Surprises Act assigns providers the responsibility to check their provider information on all contracted payer sites. It is unclear whether reminders will be sent, but some third parties, such as Availity, are sending friendly reminders. This is a federal regulation and requires immediate attention in order to avoid fines.

Note: Provider directory updates have been a requirement for Medicare Advantage plans since 2017.

Payer Updates & Newsletters

The majority of billing errors and denials are the result of ignoring the notices from contracted payers. Most payers will notify providers 90 days ahead of time about a policy revision or code edit implementation. The main source is the Payer Update site page or Newsletter. Be proactive and sign up to receive these emails. Create a process to review them monthly.

Want to learn more? Check out the Rapid Solutions site page, *Sorting the Mail- KMC University Way.* If you are currently not setting reminders for important reimbursement related tasks, check out the Rapid Solutions titled *Your Tickler Reminder System.* Are you missing other No Surprises Act requirements? Check out the KMC University course titled *Be Compliant with the No Surprises Act* for a deeper dive into this regulation.

- https://www.cms.gov/research-statistics-data-and-systems/monitoring-programs/improper-payment-measurement-programs/cert
- https://data.cms.gov/tools/medicare-revalidation-list
- https://learn.kmcuniversity.com/rapid-solution/posting-payments-efficiently/sorting-the-mail-kmc-university-way/
- https://learn.kmcuniversity.com/rapid-solution/your-tickler-reminder-system/
- https://learn.kmcuniversity.com/courses/no-surprises-act/