Integrity Matters!

Health Care Compliance Association
(HCCA) Regional Dallas/Ft Worth
(DFW) Conference

Grapevine, TX

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CMS

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Today's Presentation

- Agenda:
  - Medicare Integrity Program
  - Comprehensive Error Rate Testing (CERT) Program
  - Recovery Auditor (RA)
  - Unified Program Integrity Contractor (UPIC)
  - Supplemental Medical Review Contractor (SMRC)
  - Medicare Administrative Contractor (MAC)
  - Compliance Billing Best Practices
- Objectives:
  - Encourage developing a culture of integrity
  - Understanding the Targeted Probe and Educate process
  - Demonstrate the importance of returning ADRs
  - Explain how to research a denied claim

Acronyms

Acronym	Definition
ADR	Additional Development Request
CERT	Comprehensive Error Rate Testing
CMS	Centers of Medicare & Medicaid Services
CPT	Current Procedural Terminology
DCN	Document Control Number
DME	Durable Medical Equipment
esMD	Electronic Submission of Medical Documentation
HCPCS	Healthcare Common Procedure Coding System
HH+H	Home Health and Hospice
IOM	Internet Only Manual
NCCI	National Correct Coding Initiative

Acronyms Two

Acronym	Definition
MAC	Medicare Administrative Contractor
MIP	Medicare Integrity Program
MLN	Medicare Learning Network
MR	Medical Review
NCD	National Coverage Determination
OIG	Office of Inspector General
RA	Recovery Auditor Contractor
SMRC	Supplemental Medical Review Contractor
TPE	Targeted Probe and Educate
UPIC	Unified Program Integrity Contractor
ZPIC	Zone Program Integrity Contractor

Medicare Integrity Programs (MIP)

Medicare Integrity Program Background

- Background:
  - Health Insurance Portability and Accountability Act (HIPAA) of 1996 included a provision to establish Medicare Integrity Program (MIP)
- Purpose:
  - Addressing improper payments in Medicare fee-for-service program and promoting compliance with Medicare coverage and coding rules is top priority
- Program Overview:
  - Preventing Medicare improper payments requires active involvement of every component of CMS and effective coordination with its partners including various Medicare contractors and providers
  - CMS contracts with various types of contractors in its effort to fight improper payments and promote provider compliance in the Medicare program

Program Integrity Review Contractors

- Review contractors:
  - Comprehensive Error Rate Testing (CERT)
  - Recovery Auditors (RA)
  - Zone Program Integrity Contractors (ZPIC)
    - ✓ Now referred to as Unified Program Integrity Contractor (UPIC)
  - Supplemental Medical Review Contractor (SMRC)
  - Medicare Administrative Contractors (MAC)
- The Review Contractor Directory - Interactive Map provides access to state-specific CMS contractor contact information for all RAs, UPIC/ZPIC, SMRC, and so on:
  - Name
  - Website
  - Contact Information

Comprehensive Error Rate Testing (CERT) Program

Comprehensive Error Rate Testing (CERT)

- Background:
  - Program developed by CMS to monitor the accuracy of claims processing
- Purpose:
  - Designed to protect the Medicare trust fund and determine error rates nationally and regionally to determine if claims were paid properly under Medicare coverage, coding, and billing rules
- Program Overview:
  - Current CERT contractors:
    - ✓ CERT Review Contractor – AdvanceMed
    - ✓ CERT Statistical Contractor – The Lewin Group, Inc.
- CERT page

Comprehensive Error Rate Testing (CERT) Sampling

- Sample Selection:
  - CERT selects a stratified random sample of approximately 50,000 paid and denied claims submitted to Part A/B Medicare Administrative Contractors (MACs) and Durable Medical Equipment MACs (DMACs) during each reporting period
- CPT and/or HCPCS codes may be sampled at higher rates if:
  - Historically high error rate:
    - ✓ Certain lab
    - ✓ Special studies
- DRGs with top average high error rate may be sampled at higher rates

CERT Documentation Request

- CERT Medicare Record Requests:
  - Commonly referred to as an Additional Documentation Request (ADR)
  - The CERT Documentation contractor requests medical records from the provider or supplier that submitted the claim (several follow-up requests may be made by letter/fax/phone depending on the response/non-response)
  - Additional documentation requests are also made to the referring provider who ordered the item or service
  - If no documentation is received within 75 days of the initial request, the claim is classified as a "no documentation" claim and counted as an error
  - If documentation is received after 75 days of the initial request (late documentation), CERT will still review the claim

Sending CERT ADRs

- Documentation Requests:
  - All **first** Additional Documentation Request (ADR) letters for CERT are sent to the address on file with the National Supplier Clearinghouse (NSC) for the Medicare Administrative Contractor (MAC) for the provider/supplier that billed/submit the claim
  - All **subsequent** ADR letters can be sent to a specific correspondence address:
    - ✓ This can be provided to the CERT Customer Service Representative (CSR) by calling 888-779-7477
  - CERT Program New Processes

Part A CERT Observations

- Documentation must be submitted and complete to perform the review
- Valid physician orders are needed
- Documentation/signatures must be present and legible
- Performed procedure/service must be documented
- Therapy Services - Valid certifications and documentation must be documented to support services rendered
- Skilled Nursing Facility (SNF) – Must have a three-day qualifying stay
- Severity of illness/intensity of the service must warrant an inpatient admission to an acute level of care
- Coding errors identified: Diagnosis Related Group (DRG), discharge disposition code, Resource Utilization Group (RUG), Laboratory services, and debridement codes

Part B CERT Observations

- Insufficient Documentation:
  - Provide complete, legible medical record documentation to support the service reported to Medicare
  - Ensure medical record documentation is appropriately signed
  - Provide a valid physician order, when required (i.e. diagnostic studies, labs, therapy services, etc.)
  - Provide a treatment plan of care, when required (i.e. therapy services, chiropractic services, etc.)
- Incorrect Coding:
  - Carefully select the most appropriate level of service when reporting evaluation and management services
  - Report "total time" when reporting critical care services, discharge day management services and therapy services
  - Don't forget to report units of medication/infusion services; as well as any waste of medication
  - Report most appropriate laboratory service and provide a valid physician order for the service

CERT Observations Signatures

- Categorized as "Insufficient Documentation" errors:
  - Missing signatures
  - Illegible handwritten signatures
  - Electronic signatures not dated
  - Attestation statements do not match the date of service
- Records must be signed and dated
- Signature logs must be included to determine handwritten signatures
- Attestation statements must be completed when records are not signed
- Signatures cannot be added late to the record
- CMS Complying with Medicare Signature Requirements

CERT Identification Online Tool

- Provides status information for sampled claims using the Claim Identification Number (CID) where a decision has been made by the CERT contractor:
  - Claim in Error - CERT error was assessed or not
  - Status Date - last date that CERT updated/reviewed the case
  - Status Decision - where the claim is with the CERT Review Contractor
  - Appealed - if an appeal was initiated and the appeal status:
    - ✓ Appeals are handled by Novitas
  - Error Code- errors assessed

CERT CID Tool

CID Number : [   ] Search CID

CERT Identification Results

No data to display.

Please Note: The CERT CID is always a 7 digit number.

Medicare Integrity Programs
Recovery Auditor (RA) Contractor

Recovery Auditor (RA) Contractor Program Mission

- Background:
  - CMS uses the Recovery Audit program to detect and correct improper payments in Medicare fee-for-service program and provides information to CMS and review contractors that could help protect the Medicare Trust Fund
- Purpose:
  - To identify and reduce Medicare improper payments through the efficient detection and collection of overpayments made on claims of health care services provided to Medicare beneficiaries, and the identification of underpayments to providers so that CMS can implement actions that will prevent future improper payments

Recovery Auditor (RA) Program

- Program Overview:
  - RA review claims on a post-payment basis
  - Three (3) year time limit for the RA to review services:
    - ✓ Timeframe is based on the date of service
  - Proposed review topics are approved by CMS prior to initiation of the widespread review
  - Approved issues are posted to the RA website prior to the widespread review
  - RA utilizes the same medical policies and CMS manuals as contractors

Recovery Auditor (RA) Program Details

- Conclusion of the Review – Opening of the Discussion Period:
    - RA offers an opportunity for the provider to discuss the improper payment determination with the RA outside the normal appeal process
- RA sends a list of claims to the MAC to be adjusted for overpayments and underpayments
- Demand letters associated with the RA review will be issued by the MAC
    - If provider agrees with the RA decision:
        - ✓ Submit payment to the MAC
        - ✓ Allow recoupment of future payments
        - ✓ File for an extended repayment schedule
    - If the provider disagrees with the RA decision:
        - ✓ Fie a redetermination (appeal) within 120 days of the notice of the determination

Recovery Auditor Timeframes

- Recovery auditors have 30 days to issue their findings from receipt of medical documentation
- Medical record request limits for facilities are effective with any ADR:
    - Annual ADR Limit will be one-half of one percent (0.5%) of provider's total number of paid Medicare claims from previous year
    - ADR letters are sent on a 45-day cycle
- <u>Medicare Fee for Service Recovery Audit Program</u>

RA Contact Information

- JH Providers:
  - Cotiviti Healthcare:
    - ✓ 1-866-360-2507
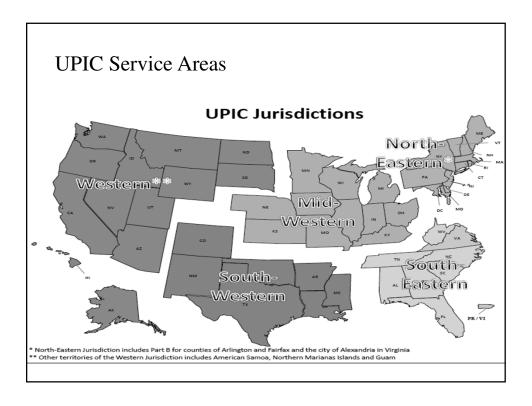
CMS Quarterly Provider Compliance Newsletter

- Provide guidance to address billing errors identified by CERT and RA
- Medicare Quarterly Provider Compliance Newsletter is a list of all CMS Compliance Newsletters:
  - Volume 9, Issue 1 – October 2018:
    - ✓ Therapeutic Shoes and Inserts for Individuals with Diabetes
    - ✓ Outpatient service overlapping or during an inpatient stay
  - Volume 8, Issue 4 – July 2018:
    - ✓ Surgical Dressings
    - ✓ Coverage of Vagus Nerve Stimulation (VNS)
    - ✓ Cataracts Once per Lifetime
    - ✓ Blood Glucose Monitor Device Bundling
    - ✓ Documentation must Support Medical Necessity of Skilled Nursing Facility Care

Medicare Integrity Programs

Unified Program Integrity Contractor (UPIC)

UPIC

- Background:
  - UPIC will combine functions previously performed by ZPIC, Program Safeguard Contractor (PSC) and Medicaid Integrity Contractor (MIC) into a single contract
- Purpose:
  - Perform fraud, waste, and abuse detection, deterrence and prevention activities for Medicare and Medicaid
- Program Overview:
  - Perform integrity related activities for:
    - ✓ Medicare Part A and B
    - ✓ Durable Medical Equipment (DME)
    - ✓ Home Health and Hospice (HH+H)
    - ✓ Medicaid
    - ✓ Medicare-Medicaid data match program (Medi-Medi)
- Operate in five geographical jurisdictions

UPIC Service Areas

UPIC Jurisdictions

* North-Eastern Jurisdiction includes Part B for counties of Arlington and Fairfax and the city of Alexandria in Virginia
** Other territories of the Western Jurisdiction includes American Samoa, Northern Marianas Islands and Guam

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UPIC Investigational Activities

- Prevent fraud by identifying program vulnerabilities
- Proactively identifies incidents of potential fraud, waste, and abuse that exist within its service area and takes appropriate action on each case
- Investigates (determines the factual basis) allegations of fraud made by beneficiaries, providers/suppliers, CMS, OIG and other sources
- Explores all available sources of fraud leads within its service area, including the state Medicaid agency
- Initiates appropriate administration actions where there is reliable evidence of fraud, including but not limited to payment suspensions and revocations
- Refers cases to OIG for consideration of civil and criminal prosecution

Contact Information

- JH Providers:
  - Qlarant

Medicare Integrity Programs

Supplemental Medical Review Contractor (SMRC)

Supplemental Medical Review (SMRC) Background

- Background:
  - SMRC performs and/or provides nationwide support for a variety of tasks aimed at lowering improper payment rates and increasing efficiencies of medical review functions
- Purpose:
  - SMRC main tasks are to perform and/or provide support for a variety of tasks aimed at lowering the improper payment rates and increasing efficiencies of medical review functions of Medicare and Medicaid programs
- Program Overview:
  - Identify provider noncompliance with coverage, coding, billing, and payment policies through research and analysis of data related to assigned task
  - As directed by CMS, perform medical review and/or extrapolation

SMRC

- Notify individual billing entities (i.e., providers, suppliers, or other approved clinician) of review findings identified and make appropriate recommendations for Provider Outreach and Education (POE) and UPIC referrals
- Contact information for all providers:
  - Noridian Healthcare Solutions, LLC (NHS)
  - 1-833-860-4133
    https://www.noridiansmrc.com/

Medicare Integrity Programs
Medicare Administrative Contractor (MAC)

Medical Review (MR)

- Novitas Solutions' MR Department is one component of overall MIP
- MR works in collaboration with other MIP contractors to minimize potential future losses to the Medicare Trust Fund
- MR activities support the primary goal of the MIP:
  - Pay claims correctly
  - Reduce the claims payment error rate
- MR pursues every opportunity, through Targeted Probe and Educate (TPE), to process claims using the Medicare approved reimbursement amount for covered, medically necessary, and correctly coded services rendered to eligible beneficiaries by legitimate providers

Targeted Probe and Educate (TPE) Background

- CR10249
  - Effective: October 1, 2017
  - Implementation: October 1, 2017
- Key Points:
  - CMS has authorized MACs to conduct the TPE review process and MACs will select the topics for review
  - MACs will focus on specific providers/suppliers:
    - ✓ That bill a particular item or service rather than all providers/suppliers billing a particular item or service
    - ✓ Who have the highest claim denial rates or who have billing practices that vary significantly from their peers:
      - ➢ Based on Data Analysis & CERT error rates
  - TPE review process includes three rounds (if warranted) of probe review with education:
    - ✓ Sample limited for each probe "round" to a minimum of twenty (20) and a maximum of forty (40) claims

Targeted Probe and Educate (TPE)

- Purpose:
  - TPE process will lower provider payment error rates
  - TPE provides opportunity to educate providers before, during and after the probe
- Program Overview:
  - TPE program will allow for time after education to correct errors before the next round occurs
  - Automated reviews and prior authorizations are not part of the TPE program

Topics For Review

- All topics for review are published on the Novitas Solutions' website with a link to education that will assist in ensuring a successful review
- These lists will be continually updated as new topics are added
- Not all providers will be subject to review:
  - Part A TPE Topics for Review
  - Part B TPE Topics for Review

Provider Notification

- Providers/suppliers selected for review will be notified with an initial letter
- ADR letters will be generated on each claim selected for review:
  - ADRs will be generated per the usual process
  - Part A providers will receive ADRs mailed to the correspondence address in FISS:
    - ✓ ADRs may also be printed or viewed in FISS
  - Part B providers will receive ADRs mailed to the correspondence address

Initial Letter and Education

- Initial letter will include:
  - Topic being reviewed
  - Reason for the selection which will be supported by data analysis
  - Number of claims requested for review
  - Documentation checklist
  - Review process
  - Contact information for the reviewer assigned to the probe
- Initial education:
  - Clinical Reviewer will call to:
    - ✓ Establish a contact person
    - ✓ Educate on the documentation requirements
    - ✓ Discuss educational tools available on our website

Additional Development Request (ADR)

- When a claim is selected for prepayment medical review, an ADR request is generated and contains necessary information for the review
  - Claims associated with the ADR are placed in a suspended location to allow time for the provider to respond to the request
- Once an ADR is received a provider should do the following:
  - Collect all requested documentation associated with the claim
  - Verify all documentation requested is included in the submission
  - Verify all documentation submitted is appropriately signed or also includes signature attestation
  - **Attach the first page of the original ADR request as the cover sheet to the records**

Provider Response to ADRs

- Provider has 45 days to respond to the contractor with medical records
- Options for sending in medical records:
  - Novitasphere (free)
  - Faxing (free)
  - esMD (cost)
  - CD/DVD submission (cost)
  - US Mail, FedEx or UPS (cost)

Sending Records via Novitasphere

- Enter Claim number (DCN or ICN)
- Utilize Browse button to select document from your files
- Utilize Add More Documentation button if documentation is located in separate files (file size limit of 200 mb total)
- Available 24 hours a day, 7 days a week

Faxing Documentation

- Original ADR request must be submitted as the cover sheet to the records
- Supporting documentation, or requested medical records, should follow the ADR letter
- Each ADR request must be faxed separately
- If pages exceed 200, another option needs to be selected for returning medical records
- Submit relevant documentation to support the date of service and services rendered to the patient
- Fax image option allows for documentation to be submitted directly to Novitas Solutions
- Available 24 hours a day, 7 days a week
- Fax ADR response to 1-877-439-5479

Sending Records via Electronic Submission of Medical Documentation System (esMD)

- Providers can submit requested ADR documentation electronically through the esMD
- Process will allow providers to submit medical documentation using secure electronic means
- Process is secure
- To sign up for esMD, visit Electronic Submission of Medical Documentation (ESMD) on CMS website

Sending Records via CD/DVD

- Sending records via password protected CD/DVD:
  - CD/DVD must be password protected
  - Send an email containing the password to:
    - ✓ SECUREPSWD@novitas-solutions.com
  - Include the following information in your email:
    - ✓ Subject - CD/DVD Password, Provider Name
    - ✓ Body of email - Provider name, Provider Number (PTAN) and the DCN/ICNs applicable to the CD/DVD, and the password
    - ✓ If you are responding to multiple MR ADR requests, clearly separate the documentation for each claim

Documentation Preparation for sending the Mail

- Do not use staples or paperclips
- Each packet should be bound with a rubber band with the appropriate ADR on top and the correct medical records
- Avoid mixing single and double-sided documents:
  - Make sure you copy both sides of the documents
- Return the medical record to the correct address listed on the ADR
- Do not include any other correspondence or claims that do not pertain to your ADR
- Documentation should be legible including physician's signatures or an attestation of signature should be included in the documentation

Sending ADR Records via US Mail

Part A State	Part A Address
Colorado, New Mexico, Texas	Medical Review JH Part A Novitas Solutions P.O. Box 3113 Mechanicsburg, PA 17055-1828
Part B State	**Part B Address**
Arkansas, Louisiana, Mississippi, Colorado, New Mexico, Texas, Oklahoma	Novitas Solutions, Inc. JH Part B ADR/Medical Records P.O. Box 3094 Mechanicsburg, PA 17055-1812

Physical Address, Overnight Delivery and Certified Mail

- For mail that cannot be sent through a P.O. Box, please submit documentation to the physical address: (includes any overnight deliveries or certified mail):
  - Novitas Solutions, Inc.
    Attention: Medical Review/Medical Records Submission
    2020 Technology Parkway, Suite 100
    Mechanicsburg, PA 17050

ADRs Not Returned

- No response counts as a denial for no records received
- Failure to respond will impact the error rate of the entire probe for the targeted provider
- Non-responders could be referred to:
  - RA
  - UPIC
  - 100% prepayment review

Intra Probe Education

- Definition:
  - Intra Probe Education is education conducted during the probe process
- Purpose:
  - Clinical Reviewer will provide Intra Probe Education to correct easily resolvable issues and eliminate the need for an appeal
  - Examples:
    - ✓ All ADR documentation is missing a required document:
      - ➢ i.e., signed order for services billed
  - Providers are given an opportunity to submit the missing documentation
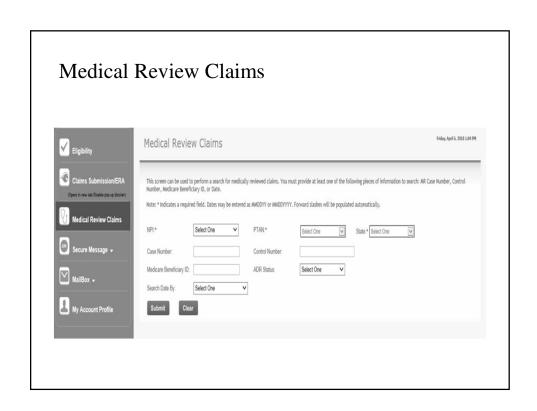
Provider Results Letter and Education

- Detailed results letter at the conclusion of each round will include:
  - Error rate and error classification
  - Detailed summary of claims denied and reasons why
  - Education information
  - Next steps in the TPE process (Major/Moderates will move to next round, Minors will not)
  - Appeal rights
  - Contact information for the Clinical Reviewer
- Post Education:
  - Will receive an educational call to discuss issues found during the probe
    - ✓ One-on-one phone call
    - ✓ Teleconference educational call
      - ➤ Contact person from provider's office should invite anyone they feel would benefit from education

TPE Results

- Providers will have 45 days between rounds to implement any changes necessary after education to correct identified billing errors
- Results for each round will be posted on the Novitas website including:
  - Common denial reasons
  - Total major, moderate and minor probe results

TPE Rounds of Review Process

TPE Process	Round 1 Initial Probe	Round 2	Round 3	CMS Corrective Actions After Round 3
Provider Notification	X	X	X	N/A
Pre-Probe Education	X	X	X	N/A
ADR request	X	X	X	N/A
Medical Review (education if necessary)	X	X	X	N/A
Results letter	X	X	X	N/A
Post-Probe Education	X	X	X	N/A
Referral (if applicable)	N/A	N/A	X	N/A
Extrapolation, referral to UPIC or RA or 100% prepay review	X	X	X	X

Medical Review Claims

Compliance Best Practices

Medical Necessity Denials

- Definition:
  - These are non-covered services deemed not reasonable or necessary by the payer
- Research:
  - Review Local Coverage Determinations (LCDs):
    - ✓ Policy Search
    - ✓ Medicare Program Integrity Manual, Pub. 100-08, Chapter 13-Local Coverage Determinations (LCD)
  - Review the National Coverage Determinations (NCDs):
    - ✓ National Coverage Determinations (NCDs) by Chapter/Section Index
    - ✓ Medicare National Coverage Determinations (NCD) Manual, Pub. 100-03
- Resolution:
  - Appeal if appropriate

Local Coverage Determination (LCD)

- Background:
  - In the absence of national policy, Medicare contractors may establish a medical coverage policy applicable to the MAC jurisdiction
- Purpose:
  - Active LCDs are a medical policy that is currently in effect
  - Novitas LCDs consist only of "reasonable and necessary" information:
    - ✓ They do not include benefit category and statutory exclusion provisions or coding instructions
  - Retired LCDs are no longer in effect because:
    - ✓ New or revised NCD is issued
    - ✓ Outdated technology with no claim volume, therefore LCD no longer providers a meaningful educational benefit
- Note: Novitas uses a separate but related article to communicate coding instructions and reasons for denial of payment

LCD Webpage

- Displays active LCDs and associated procedure codes

Medical Policy Search

- Allows providers to search policy related documents available on the Novitas website

New Instructions for Local Coverage Determinations (LCDs)

- MM 10901:
  - Implementation: January 8, 2019
- Key Points:
  - New LCDs:
    - ✓ Informal meetings are optional for customers to request information on how to submit valid new LCD request:
      - ➢ Will be conducted via teleconference
    - ✓ New LCD requests have specific requirements to be valid
    - ✓ Comment period and notice period will not change for new LCDs
  - Contractor Advisory Committee (CAC):
    - ✓ Will now be open to interested parties to observe:
      - ➢ Locations and times will be posted to our website
    - ✓ CAC members will also include non-physician healthcare professionals such as Dentist, Certified Registered Nurse Anesthetist (CRNA), Physical Therapist (PT) and Licensed Clinical Social Worker (LCSW)

New LCD Process

- LCD reconsideration request:
    - ✓ Coding updates only, such as adding diagnosis code, will be handled through revision to companion local coverage article:
        - ➤ No longer appropriate to include CPT or ICD-10 codes in LCDs instead they will be placed in billing and coding articles linked to LCD (process could take up to 1 year to complete)
    - ✓ Change in coverage will require a comment and notice period:
        - ➤ This change may delay LCD revisions for a reconsideration request

Resource Checklist

- Novitas website:
    - Look for a LCD
    - Look for a Billing & Coding Article on the Novitas Website by doing a standard search
    - Check the status indicator on the Physician Fee Schedule
- CMS website:
    - Review the NCDs
    - Search the CMS Manual for instruction
    - Review the NCCI and MUE edits on CMS website
- If no results, Reasonable and Necessary guidelines still apply

Thank You for Attending!

- Janet Hunter
  - Education Specialist, Provider Outreach and Education
  - 717-526-6343
  - Janet.hunter@novitas-solutions.com
- Janice Mumma
  - Supervisor, Provider Outreach and Education
  - 717-526-6406
  - Janice.mumma@novitas-solutions.com
- Stephanie Portzline
  - Manager, Provider Outreach and Education
  - 717-526-6317
  - Stephanie.portzline@novitas-solutions.com