

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare and Medicaid Services



Official CMS Information for
Medicare Fee-For-Service Providers

Medicare Physician Guide



PREFACE

This publication has been developed for Medicare Fee-For-Service (FFS) providers and suppliers. It provides the following information about the Medicare Program:

- Introduction to the Medicare Program;
- Becoming a Medicare provider or supplier;
- Medicare reimbursement;
- Medicare services;
- Protecting the Medicare Trust Fund;
- Medicare overpayments and FFS appeals; and
- Provider outreach and education.

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This publication was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

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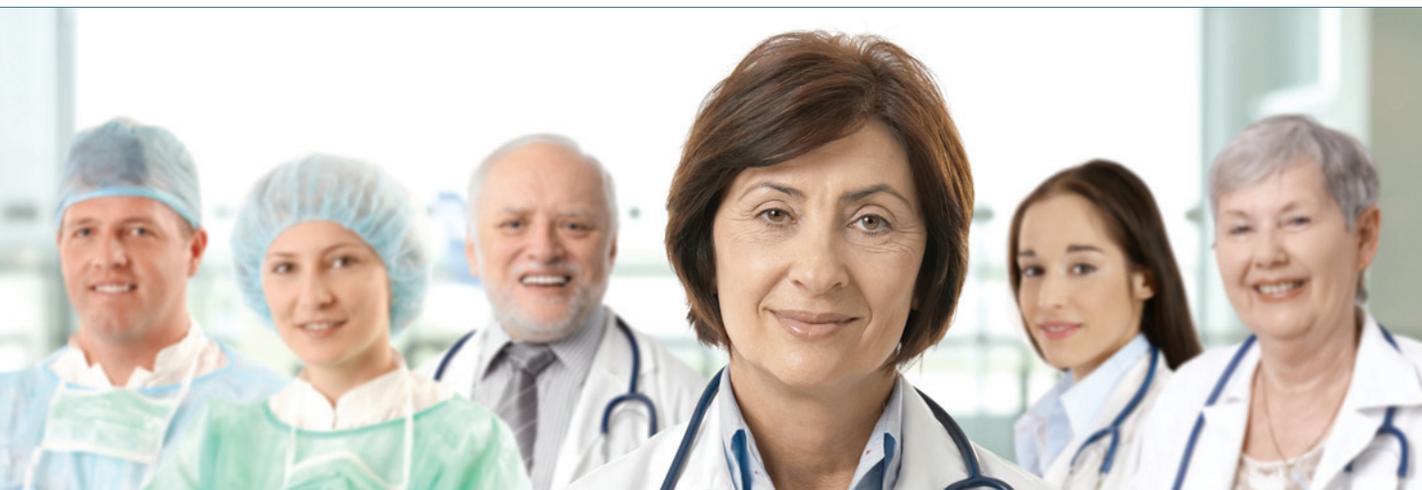
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CHAPTER ONE

INTRODUCTION TO THE MEDICARE PROGRAM

This chapter provides information about the Centers for Medicare & Medicaid Services (CMS), the Medicare Program, and organizations of interest to providers and beneficiaries.

THE CENTERS FOR MEDICARE & MEDICAID SERVICES

CMS is a Federal agency within the U.S. Department of Health and Human Services (HHS) that administers and oversees the Medicare Program and a portion of the Medicaid Program. CMS also maintains oversight for compliance with Medicare health and safety standards for laboratories, acute and continuing care providers, End-Stage Renal Disease (ESRD) facilities, hospices, and other facilities that serve Medicare and Medicaid beneficiaries.

CMS consists of a Central Office and 10 Regional Offices (RO). The Central Office is located in Baltimore, Maryland, and provides operational direction and policy guidance for the nationwide administration of the above programs. The ROs are located in major cities throughout the U.S. and support the health care provider community by:

- Conducting outreach activities;
- Establishing relationships with local and regional provider associations; and
- Helping providers and suppliers resolve disputes they may have with Medicare Contractors.

CMS awards contracts to organizations called Medicare Contractors who perform claims processing and related administrative functions. Medicare Contractors include the following:

- Fee-For-Service (FFS) Medicare Contractors;
- Medicare Advantage (MA) Plan Contractors; and
- Medicare Prescription Drug Plan (PDP) Contractors.

All FFS claims processing Contractors (Fiscal Intermediaries, Carriers, and Durable Medical Equipment Carriers) will be transitioned into Medicare Administrative Contractors by 2011, as mandated in Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

Where to Find Additional Information About the Centers for Medicare & Medicaid Services and Medicare Contractors

To find additional information about CMS, visit <http://www.cms.gov/home/aboutcms.asp> on the CMS website. To find additional information about Medicare Contractors, refer to Chapter 1 of the “Medicare General Information, Eligibility and Entitlement Manual” (Pub. 100-01) located at <http://www.cms.gov/Manuals/IOM/list.asp> on the CMS website. To find Medicare Contractor contact information, visit <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.



THE MEDICARE PROGRAM

In 1965, Title XVIII of the Social Security Act (the Act) established the Medicare and Medicaid Programs. The Medicare Program is the largest health insurance program in the U.S., with more than 47 million enrollees being entitled to benefits. Beginning in 1966, individuals age 65 years and older were able to enroll in Original Medicare. Original Medicare, also known as FFS Medicare, consists of:

- Part A, hospital insurance; and
- Part B, medical insurance.

Under FFS Medicare, eligible individuals may enroll in Part A, Part B, or both Part A and Part B. Most individuals choose to enroll in both Part A and Part B.

FFS Medicare was expanded in 1973 to include:

- Individuals who are under age 65 with certain disabilities; and
- Individuals with ESRD.

Two parts were added to the Medicare Program in 1999 and 2006, respectively:

- Part C, MA; and
- Part D, the Prescription Drug Benefit.

The four parts of the Medicare Program are discussed in more detail below.

Where to Find Additional Information About Title XVIII of the Social Security Act

To find additional information about Title XVIII of the Act, visit http://www.ssa.gov/OP_Home/ssact/title18/1800.htm on the U.S. Social Security Administration (SSA) website.

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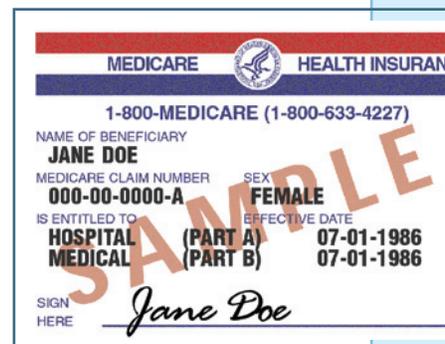
Health Insurance Cards

Office staff should regularly request the beneficiary's health insurance card and picture identification to verify that services are furnished only to individuals eligible to receive Medicare benefits. Copies of the beneficiary's health insurance card and picture identification should be made and kept in his or her medical record.

Medicare Health Insurance Card

When an individual becomes entitled to Medicare, CMS or the Railroad Retirement Board (RRB) will issue a health insurance card. The following information can be found on the health insurance card:

- Name;
- Sex;
- Medicare Health Insurance Claim (HIC) number; and
- Effective date of entitlement to Part A and/or Part B.



The HIC number on the health insurance card issued by CMS has an alpha or alphanumeric suffix and the Social Security Number (SSN), which is usually either the SSN of the insured or the spouse of the insured (depending on whose earnings eligibility is based). The HIC number on the health insurance card issued by the RRB has an alpha prefix and one or more characters and the insured's SSN, a six-digit number, or a nine-digit number.

Where to Find Additional Information About the Health Insurance Cards

To find additional information about the Medicare HIC, refer to Chapter 2 of the "Medicare General Information, Eligibility and Entitlement Manual" (Pub. 100-01) located at <http://www.cms.gov/Manuals/IOM/list.asp> on the CMS website. The respective plan will issue a membership card when a beneficiary enrolls in the MA Plan and the PDP.

Part A – Hospital Insurance

Some of the services that Part A, hospital insurance, helps pay for include:

- Inpatient hospital care;
- Inpatient care in a Skilled Nursing Facility (SNF) following a covered hospital stay;
- Some home health care; and
- Hospice care.

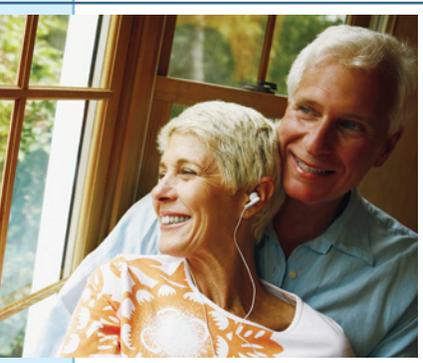
Eligibility Requirements

To be eligible for premium-free Part A, an individual must first be insured based on his or her own earnings or the earnings of a spouse, parent, or child. To be insured, a worker must have a specified number of quarters of coverage (QC). The exact number of required quarters is dependent on whether he or she is filing for Part A on the basis of age, disability, or ESRD. QCs are earned through payment of payroll taxes under the Federal Insurance Contributions Act (FICA) during the individual's working years. Most

individuals pay the full FICA tax so that the QCs they earn can be used to insure them for both monthly Social Security benefits and Part A. Certain Federal, State, and local government employees pay only the Part A portion of the FICA tax. The QCs these employees earn can be used only to insure them for Part A and may not be used to insure them for monthly Social Security benefits.

Individuals Age 65 Years or Older

To be eligible for premium-free Part A on the basis of age, an individual must be age 65 years or older and either eligible for monthly Social Security or Railroad Retirement cash benefits or would be eligible for such benefits if the worker's QCs from government employment were regular Social Security QCs. Part A for the aged individual begins with the month in which age 65 years is attained, provided he or she files an application for Part A or for cash benefits and Part A within six months of the month in which age 65 years is attained. If the application is filed later than that, Part A entitlement can be retroactive for only six months. For Medicare purposes, an individual attains age 65 years the day before his or her actual 65th birthday, and Part A is effective on the first day of the month upon attainment of age 65 years. For an individual whose 65th birthday is on the first day of the month, Part A is effective on the first day of the month preceding his or her birth month. For example, if an individual's birthday is on December 1, Part A is effective on November 1 since for Medicare purposes, he or she attained age 65 years on November 30. An individual who continues to work beyond age 65 years may elect to file an application for Part A only. Part A entitlement generally does not end until the death of the individual.



A second group of aged individuals who are eligible for Part A are age 65 years or older and are not insured but elect to purchase Part A coverage by filing an application at a SSA office. Because a monthly premium is required, this coverage is called premium Part A. The individual must be a U.S. resident and either a citizen or an alien lawfully admitted for permanent residence who has resided in the U.S. continuously for the five-year period immediately preceding the month the application is filed. Individuals who want premium Part A can only file for coverage during a prescribed enrollment period and must also enroll or already be enrolled in Part B.

Individuals Under Age 65 Years with Certain Disabilities

A disabled individual who is entitled to Social Security or Railroad Retirement benefits on the basis of disability is automatically entitled to Part A after 24 months of entitlement to such benefits. In addition, a disabled individual who is not insured for monthly Social Security disability benefits, but would be insured for such benefits if his or her QCs from government employment were Social Security QCs, is deemed to be entitled to disability benefits and automatically entitled to Part A after being disabled for 29 months. Part A entitlement on the basis of disability is available to the worker and to the widow, widower, or child of a deceased, disabled, or retired worker if any of them become disabled within the meaning of the Act or the Railroad Retirement Act.

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Beginning July 1, 2001, an individual whose disability is Amyotrophic Lateral Sclerosis is entitled to Part A the first month he or she is entitled to Social Security disability cash benefits. If an individual recovers from a disability, Part A entitlement ends at the end of the month after the month he or she is notified of the disability termination. However, if an individual returns to work but continues to suffer from a disabling impairment, Part A entitlement will continue for at least 93 months after he or she returns to work.

Individuals with End-Stage Renal Disease

An individual is eligible for Part A if he or she receives regular dialysis treatments or a kidney transplant, has filed an application, and meets one of the following conditions:

- Has worked the required amount of time under Social Security, the RRB, or as a government employee;
- Is receiving or is eligible for Social Security or Railroad Retirement benefits; or
- Is the spouse or dependent child of an individual who has worked the required amount of time under Social Security, the RRB, or as a government employee or who is receiving Social Security or Railroad Retirement benefits.

Part A coverage begins:

- The third month after the month in which a regular course of dialysis begins;
- The first month self-dialysis training begins (if training begins during the first three months of regular dialysis);
- The month of kidney transplant; or
- Two months prior to the month of transplant if the individual was hospitalized during those earlier months in preparation for the transplant.

Part A entitlement ends 12 months after the regular course of dialysis ends or 36 months after transplant.

Part B – Medical Insurance

Some of the services that Part B, medical insurance, helps pay for include:

- Medically necessary services furnished by physicians in a variety of medical settings, including but not limited to:
 - The physician's office;
 - An inpatient or outpatient hospital setting;
 - Ambulatory Surgical Centers; and
 - ESRD facilities;
- Many preventive services;
- Home health care for individuals who do not have Part A;
- Ambulance services;
- Clinical laboratory and diagnostic services;
- Surgical supplies;
- Durable medical equipment, prosthetics, orthotics, and supplies;



- Hospital outpatient services; and
- Services furnished by practitioners with limited licensing such as:
 - Audiologists;
 - Certified nurse midwives;
 - Certified registered nurse anesthetists;
 - Clinical nurse specialists;
 - Clinical psychologists;
 - Clinical social workers;
 - Independently practicing occupational therapists;
 - Independently practicing physical therapists;
 - Independently practicing speech-language pathologists;
 - Nurse practitioners; and
 - Physician assistants.



Eligibility Requirements

All individuals who are eligible for premium-free Part A are eligible to enroll in Part B. Since Part B is a voluntary program that requires the payment of a monthly premium, those individuals who do not want coverage may refuse enrollment. An individual age 65 years or older who is not eligible for premium-free Part A must be a U.S. resident and either a citizen or an alien lawfully admitted for permanent residence who has resided in the U.S. continuously for the five-year period immediately preceding the month the Part B enrollment application is filed. An individual who refused Part B and those whose Part B coverage terminated may enroll or re-enroll in Part B only during prescribed enrollment periods.

Part A and Part B Enrollment Periods

An individual who wants premium Part A and/or Part B may only enroll during one of the following prescribed enrollment periods:

- The Initial Enrollment Period (IEP) begins with the first day of the third month before the month premium Part A or Part B eligibility requirements are first met and ends seven months later (e.g., the IEP for the aged begins three months before the individual attains age 65 years and ends the third month after the month age 65 years is attained);
- The General Enrollment Period takes place from January 1 through March 31 of each year. Premium Part A and Part B coverage will be effective on July 1;
- The Special Enrollment Period (SEP) for the working aged and working disabled is when an individual may enroll who did not enroll in premium Part A or Part B when first eligible because he or she was covered under a Group Health Plan (GHP) based on his or her own or a spouse’s current employment (or the current employment of a family member, if disabled). The individual can enroll at any time while covered under the GHP based on current employment or during the

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eight-month period that begins the month after the employment ends or the GHP coverage ends, whichever occurs first. An individual with ESRD is not eligible to enroll during this SEP;

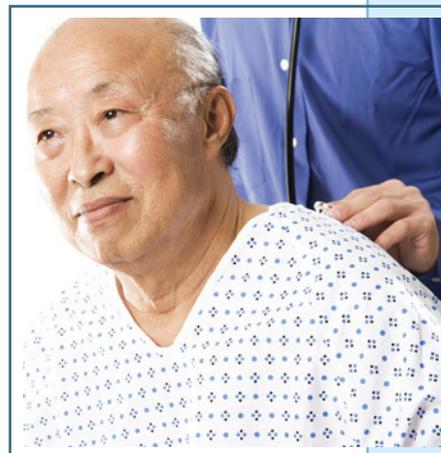
- The SEP for international volunteers is when an individual may enroll who did not enroll in premium Part A or Part B when first eligible because he or she was performing volunteer service outside of the U.S. on behalf of a tax-exempt organization and had health insurance that provided coverage for the duration of the volunteer service. The individual can enroll during the six-month period that begins the earlier of the month he or she is no longer performing volunteer service outside of the U.S., the month the organization no longer has tax exempt status, or the month the individual no longer has health insurance that provides coverage outside of the U.S.; and
- The Transfer Enrollment Period is when an individual who is age 65 years or older, entitled to Part B, and enrolled in a MA Plan may enroll in premium Part A. The individual can enroll during any month in which he or she is enrolled in the MA Plan or during any of the eight consecutive months following the last month he or she was enrolled in the MA Plan.

Premium Part A and/or Part B coverage continue until one of the following events occur:

- The individual's voluntary request for termination;
- Failure to pay premiums;
- Premium-free Part A terminates (for individuals under age 65);
- The individual's death; or
- The individual becomes entitled to premium-free Part A.

Where to Find Additional Information About Medicare Part A and Part B

To find additional information about Medicare Part A and Part B, refer to Chapter 2 of the "Medicare General Information, Eligibility and Entitlement Manual" (Pub. 100-01) located at <http://www.cms.gov/Manuals/IOM/list.asp> on the CMS website.



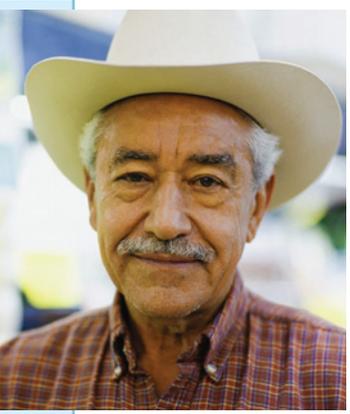
Part C – Medicare Advantage

Medicare Part C, or MA, is another health plan choice available to beneficiaries. MA is a program run by Medicare-approved private insurance companies. These companies furnish or arrange for the provision of health care services to the beneficiary who:

- Is entitled to Part A and enrolled in Part B;
- Permanently resides in the service area of the MA Plan; and
- Elects to enroll in a MA Plan.

MA Plans must cover all services that Medicare covers with the exception of hospice care, which is an elected benefit under Part A for beneficiaries who meet certain requirements. MA Plans provide Part A and Part B benefits and may also include prescription drug coverage and other supplemental benefits.

Providers and suppliers that furnish services to a Medicare beneficiary who is enrolled in a MA Plan and do not have a contract with the MA Plan to furnish the services should bill the MA Plan. Prior to furnishing services to a MA Plan enrollee under these circumstances, providers and suppliers should notify the beneficiary that he or she may be responsible for all charges for the health care services furnished.



Individuals enrolled in MA Plans must receive their Medicare prescription drug benefits from their MA Plan, with the exception of MA Private Fee-For-Service (PFFS) Plans that do not include drug benefits. Individuals with ESRD are generally excluded from enrolling in MA Plans.

Since 2006, beneficiaries have been able to enroll in regional Preferred Provider Organization (PPO) Plans throughout the U.S. In addition, beneficiaries are able to choose options such as PFFS, Health Maintenance Organizations, local PPOs, and Medicare Medical Savings Account (MSA) Plans. A Medicare MSA combines a high-deductible health plan with a medical savings account that can be used to pay for health care costs.

Election Periods

A beneficiary may choose to join or leave a MA Plan during one of the following election periods:

- The Initial Coverage Election Period begins three months immediately before the individual's entitlement to both Part A and Part B and ends on the later of either the last day of the month preceding entitlement to both Part A and Part B or the last day of the individual's Part B IEP. If the beneficiary chooses to join a Medicare health plan during this period, the Plan must accept him or her unless the Plan has reached its member limit;
- The Annual Coordinated Election Period (AEP) occurs each year between October 15 and December 7. The Plan must accept all enrollments during this time unless it has reached its member limits;
- The SEP is when, under certain circumstances, the beneficiary may change MA Plans or return to FFS Medicare; and
- The Medicare Advantage Disenrollment Period (MADP), which gives the beneficiary the opportunity to disenroll from any MA Plan and return to FFS Medicare, occurs from January 1 through February 14 of every year. Disenrollment requests made during this period will be effective the first of the following month. The MADP does not provide an opportunity to join or switch MA Plans. An individual who takes advantage of the MADP may enroll in a stand-alone PDP by February 14, and the enrollment request will be effective the first of the following month.

Where to Find Additional Information About the Medicare Advantage Plan

To find additional information about the MA Plan, refer to the "Medicare Managed Care Manual" (Pub. 100-16) located at <http://www.cms.gov/Manuals/IOM/list.asp> and

visit <http://www.cms.gov/HealthPlansGenInfo> on the CMS website. To find PFFS Plan information, visit <http://www.cms.gov/PrivateFeeForServicePlans> on the CMS website.

Part D – Prescription Drug Benefit

Part D, the Prescription Drug Benefit, provides prescription drug coverage to all beneficiaries enrolled in Part A and/or Part B who elect to enroll in a Medicare PDP or a MA Prescription Drug (MA-PD) Plan. Insurance companies or other companies approved by Medicare provide prescription drug coverage to such individuals who live in the plan's service area.

Enrollment Periods

A beneficiary may choose to join or leave a Medicare PDP or MA-PD during the following enrollment periods:

- The IEP is the seven-month period that surrounds the individual's initial eligibility for Part D, beginning three months before the month of eligibility and ending on the last day of the third month following the month eligibility began;
- The AEP occurs each year between October 15 and December 7. The Medicare PDP and MA-PDs must accept all enrollments during this time; and
- The SEP, when, under certain circumstances, a beneficiary may enroll in a Part D Plan for the first time or switch to another Part D Plan, although he or she may not disenroll altogether from the Part D Program during a SEP. The effective date of the enrollment request and duration of the SEP are determined by the circumstances that generate the SEP. The following are examples of such circumstances:
 - An individual who permanently moves outside the plan's service area;
 - An individual who enrolls in both Medicare and Medicaid, also known as a dual eligible;
 - An individual who moves into, resides in, or moves out of an institution; or
 - Other exceptions that meet "exceptional conditions" as determined by CMS.

An individual with Medicare and limited income and resources may qualify for extra help paying for Medicare prescription drug coverage costs. If the individual qualifies for extra help, he or she will receive assistance in paying for the drug plan's monthly premium, yearly deductible, and prescription copayments. Applications for extra help may be filed at the local Medicaid office or by contacting the SSA.

Some individuals may have to pay an Income Related Monthly Adjusted Amount (IRMAA). If the individual's modified monthly gross income, as reported on his or her U.S. Internal Revenue Service (IRS) tax return from two years ago (the most recent tax return information provided to the SSA by the IRS), is above a certain amount, the individual will pay an IRMAA in addition to his or her normal monthly Part D premium.

Where to Find Additional Information About the Medicare Prescription Drug Benefit

To find additional information about the Medicare Prescription Drug Benefit, refer to the



“Medicare Prescription Drug Benefit Manual” (Pub. 100-18) located at <http://www.cms.gov/Manuals/IOM/list.asp> and visit <http://www.cms.gov/PrescriptionDrugCovGenIn> on the CMS website.

ORGANIZATIONS OF INTEREST TO PROVIDERS AND BENEFICIARIES

The organizations that may be of interest to providers and beneficiaries include:

- The SSA;
- The HHS Office of Inspector General (OIG);
- State Agencies (SA);
- Quality Improvement Organizations (QIO); and
- The State Health Insurance Assistance Program (SHIP).

Each organization is discussed in more detail below.

Social Security Administration

The SSA completes the following activities:

- Determines an individual’s eligibility for Medicare benefits;
- Enrolls individuals in Part A and Part B;
- Replaces lost or stolen Medicare cards;
- Makes address changes;
- Collects premiums from beneficiaries; and
- Educates beneficiaries about coverage and insurance choices.

Where to Find Additional Information About the Social Security Administration

To find additional information about the SSA, visit <http://www.socialsecurity.gov> on the SSA website.

Health and Human Services Office of Inspector General

The HHS OIG protects the integrity of HHS programs and the health and welfare of beneficiaries of such programs through a nationwide network of audits, investigations, and other mission-related functions.

Where to Find Additional Information About the Health and Human Services Office of Inspector General

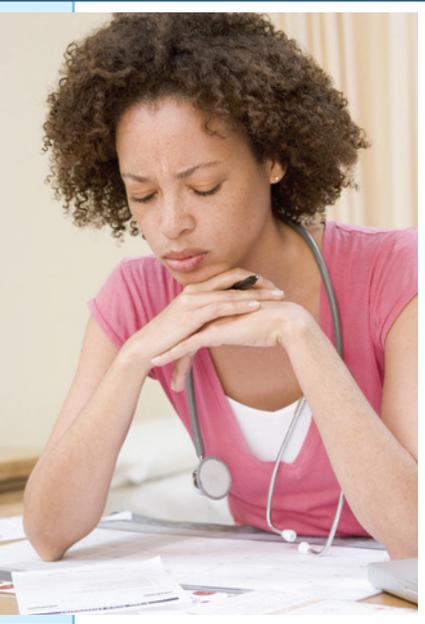
To find additional information about HHS OIG, visit <http://oig.hhs.gov> on the HHS website.

State Agencies

SAs survey all Part A and certain Part B providers and suppliers and make recommendations about their suitability for participation in the Medicare Program. SAs also assist providers and suppliers in sustaining quality standards.

Where to Find Additional Information About State Agencies

To find additional information about SAs, refer to the “State Operations Manual”



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(Pub. 100-07) located at <http://www.cms.gov/Manuals/IOM/list.asp> on the CMS website. To find contact information for SAs, visit http://www.cms.gov/SurveyCertificationGenInfo/03_ContactInformation.asp on the CMS website.

Quality Improvement Organizations

CMS contracts with one QIO in each State, Washington, D.C., Puerto Rico, and the Virgin Islands. QIOs are private, mostly not-for-profit organizations that are staffed by professionals who are trained to review medical care, help beneficiaries with complaints about quality of care, and implement improvements in the quality of care. Beneficiaries may request an expedited QIO review if they are receiving Medicare-covered services that they believe are ending too soon at one of the following:

- A hospital;
- A SNF;
- A Home Health Agency;
- A Comprehensive Outpatient Rehabilitation Facility; or
- A hospice.



Beneficiaries enrolled in FFS Medicare may contact the QIO in their State, and beneficiaries enrolled in a MA Plan may contact either their health plan or the QIO in their State regarding quality of care issues.

Where to Find Additional Information About Quality Improvement Organizations

To find additional information about QIOs, refer to Chapter 1 of the “Quality Improvement Organization Manual” (Pub. 100-10) located at <http://www.cms.gov/Manuals/IOM/list.asp> and visit http://www.cms.gov/QualityImprovementOrgs/01_Overview.asp on the CMS website.

State Health Insurance Assistance Program

The SHIP is a national program that offers free one-on-one counseling and assistance to Medicare beneficiaries and their families through interactive sessions, public education presentations and programs, and media activities. There are SHIPs in all 50 States, Washington, D.C., Puerto Rico, and the Virgin Islands. SHIP-trained counselors provide a wide range of information about the following topics:

- Long-term care insurance;
- Medigap;
- Fraud and abuse; and
- Medicare, Medicaid, and public benefit programs for those with limited income and assets.

Where to Find Additional Information About the State Health Insurance Assistance Program

To find additional information about the SHIP and a link to State Health Insurance offices, visit http://www.cms.gov/Partnerships/10_SHIPS.asp on the CMS website.



CHAPTER TWO

BECOMING A MEDICARE PROVIDER OR SUPPLIER

This chapter discusses Medicare providers and suppliers, enrolling in the Medicare Program, private contracts with Medicare beneficiaries, and promoting cultural competency in your practice.

MEDICARE PROVIDERS AND SUPPLIERS

The Medicare Program recognizes a broad range of providers and suppliers who furnish the necessary services and supplies to meet the health care needs of beneficiaries.

Part A Providers and Suppliers

Medicare makes payment under Part A for certain services furnished by the following types of entities:

- Critical Access Hospitals;
- Federally Qualified Health Centers;
- Histocompatibility Laboratories;
- Home Health Agencies (including sub-units);
- Hospices;
- Hospitals (acute care inpatient services);
- Indian Health Service Facilities;
- Inpatient Psychiatric Facilities;
- Inpatient Rehabilitation Facilities;
- Long-Term Care Hospitals;
- Multiple hospital components in a medical complex;
- Organ Procurement Organizations;
- Program of All-Inclusive Care for the Elderly (PACE) providers;

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- Religious Nonmedical Health Care Institutions (formerly Christian Science Sanatoriums);
- Rural Health Clinics; and
- Skilled Nursing Facilities (SNF).

Part B Providers and Suppliers

Medicare makes payment under Part B for certain services furnished by the following:

- Ambulance service suppliers;
- Ambulatory Surgical Centers (ASC);
- Certified nurse midwives;
- Certified registered nurse anesthetists;
- Clinical nurse specialists;
- Clinical psychologists;
- Clinical social workers;
- Community Mental Health Centers;
- Comprehensive Outpatient Rehabilitation Facilities;
- Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers (including pharmacies);
- End-Stage Renal Disease Facilities (including home dialysis);
- Home Health Agencies (outpatient Part B services);
- Hospitals (outpatient services);
- Independent Clinical Laboratories;
- Independent Diagnostic Testing Facilities;
- Mammography Centers;
- Mass immunization roster billers;
- Nurse practitioners;
- Occupational therapists in private practice;
- Other non-physician practitioners (NPP);
- Outpatient physical therapists;
- Outpatient speech-language pathology suppliers;
- PACE providers;
- Physical therapists in private practice;
- Physician assistants;
- Physicians;
- Portable X-Ray Suppliers;
- Radiation Therapy Centers; and
- SNFs (outpatient services).



Physicians

The Medicare Program defines physicians to include the following:

- Chiropractors (DC);
- Doctors of dental surgery (DDS) or dental medicine (DMD);
- Doctors of medicine (MD) and doctors of osteopathy (DO);
- Doctors of optometry (OD); or
- Doctors of podiatry (DPM) or surgical chiropody (DSC).



In addition, the Medicare physician must be legally authorized to practice by a State in which he or she performs this function. The services performed by a physician within these definitions are subject to any limitations imposed by the State on the scope of practice. The issuance by a State for a license to practice medicine constitutes legal authorization. A temporary State license also constitutes legal authorization to practice medicine. If State law authorizes local political subdivisions to establish higher standards for medical practitioners than those set by the State licensing board, the local standards are used in determining whether the physician has legal authorization. If the State licensing law limits the scope of practice of a particular type of medical practitioner, only the services within these limitations are covered.

Interns and Residents

Interns and residents include individuals who:

- Participate in approved Graduate Medical Education (GME) programs; or
- Physicians who are not in approved GME programs, but are authorized to practice only in a hospital setting (e.g., have temporary or restricted licenses or are unlicensed graduates of foreign medical schools). Also included in this definition are interns, residents, and fellows in GME programs recognized as approved for purposes of direct GME and Indirect Medical Education payments made by Fiscal Intermediaries (FI) or A/B Medicare Administrative Contractors (MAC). Receiving staff or faculty appointments, participating in fellowships, or whether a hospital includes physicians in its full-time equivalency count of residents does not by itself alter the status of “resident.”

Teaching Physicians

Teaching physicians are physicians (other than interns or residents) who involve residents in the care of their patients. Generally, teaching physicians must be present during all critical or key portions of the procedure and immediately available to furnish services during the entire service in order for the service to be payable under the Medicare Physician Fee Schedule (PFS).

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Practitioners

The Medicare Program defines practitioners as any of the following to the extent that the individual is legally authorized to practice by the State and otherwise meets Medicare requirements:

- Anesthesiologist assistants;
- Certified nurse midwives;
- Certified registered nurse anesthetists;
- Certified nurse specialists;
- Clinical psychologists;
- Clinical social workers;
- Nurse practitioners;
- Physician assistants; or
- Registered dieticians or nutrition professionals.



Where to Find Additional Information About Medicare Providers and Suppliers

To find additional information about Medicare providers and suppliers, refer to the “Medicare Benefit Policy Manual” (Pub. 100-02) and Chapter 5 of the “Medicare General Information, Eligibility and Entitlement Manual” (Pub. 100-01) located at <http://www.cms.gov/Manuals/IOM/list.asp> on the Centers for Medicare & Medicaid Services (CMS) website.

ENROLLING IN THE MEDICARE PROGRAM

In order to enroll in and obtain reimbursement from Medicare, all providers and suppliers must apply for:

- 1) A National Provider Identifier (NPI); and
- 2) Enrollment in the Medicare Program.

How to Apply for a National Provider Identifier

The NPI is a unique identification number for health care providers that is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. Covered health care providers and all health plans and health care clearinghouses must use NPIs in the administrative and financial transactions adopted under HIPAA. Providers and suppliers can apply for a NPI using one of the following methods:

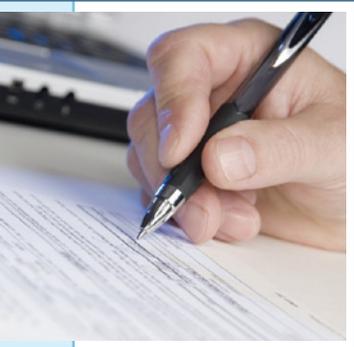
- Visiting <https://nppes.cms.hhs.gov/NPPES/Welcome.do> and completing the web-based application;
- Requesting Form CMS-10114, the NPI Application/Update Form, by calling (800) 465-3203, sending an e-mail to customerservice@npienumerator.com or sending a letter to:
NPI Enumerator
P.O. Box 6059
Fargo, ND 58108-6059; or

- Requesting that an Electronic File Interchange Organization submit application data on your behalf.

Form CMS-10114 is also available at http://www.cms.gov/NationalProvIdentStand/03_apply.asp and <http://www.cms.gov/CMSForms/CMSForms/list.asp> on the CMS website.

Where to Find Additional Information About the National Provider Identifier

To find additional information about the NPI, visit <http://www.cms.gov/NationalProvIdentStand> on the CMS website.



How to Apply for Enrollment in the Medicare Program

In the enrollment process, CMS collects information about the applying provider or supplier and secures documentation to ensure that he or she is qualified and eligible to enroll in the Medicare Program. Providers and suppliers can apply for enrollment by using either:

- The Internet-based Provider Enrollment, Chain and Ownership System (PECOS); or
- The paper enrollment process via an enrollment application (Form CMS-855).

Provider Enrollment, Chain and Ownership System Enrollment

PECOS can be used to complete the following via the Internet:

- Submit an initial Medicare enrollment application;
- View or change enrollment information;
- Track the enrollment application through the web submission process;
- Add or change a reassignment of benefits;
- Submit changes to existing Medicare enrollment information;
- Reactivate an existing enrollment record; and
- Withdraw from the Medicare Program.

After the enrollment application is submitted, the signed and dated Certification Statement and any supporting documentation is then mailed to the designated Medicare Contractor. The enrollment application cannot be processed until the Medicare Contractor receives these documents.

Paper Enrollment

Alternatively, providers and suppliers may apply for enrollment by completing and signing a paper enrollment form, which is mailed along with any supporting documentation to the designated Medicare Contractor. Depending upon the provider or supplier type, one of the following enrollment forms is completed to enroll in the Medicare Program:

- Form CMS-855A/Medicare Enrollment Application for Institutional Providers: Application used by institutional providers to initiate the Medicare enrollment process or to change Medicare enrollment information;

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- Form CMS-855B/Medicare Enrollment Application for Clinics/Group Practices and Certain Other Suppliers: Application used by group practices and other organizational suppliers, except DMEPOS suppliers, to initiate the Medicare enrollment process or to change Medicare enrollment information;
- Form CMS-855I/Medicare Enrollment Application for Physicians and Non-Physician Practitioners: Application used by individual physicians or NPPs to initiate the Medicare enrollment process or to change Medicare enrollment information;
- Form CMS-855R/Medicare Enrollment Application for Reassignment of Medicare Benefits: Application used by individual physicians or NPPs to initiate reassignment of a right to bill the Medicare Program and receive Medicare payments or to terminate a reassignment of benefits; and
- Form CMS-855S/Medicare Enrollment Application for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Suppliers: Application used by DMEPOS suppliers to initiate the Medicare enrollment process or to change Medicare enrollment information.

Additional Forms and Documentation That May Be Required

The following forms are often required in addition to the Medicare Enrollment Application:

- Form CMS-588/Electronic Funds Transfer (EFT) Authorization Agreement: Medicare authorization agreement for EFTs (for providers who choose to have payments sent directly to their financial institution); and
- CMS Standard Electronic Data Interchange (EDI) Enrollment Form: Agreement executed by each provider or supplier that intends to submit electronic media claims (EMC) or other EDI transactions to Medicare. This form is available from Medicare Carriers, FIs, A/B MACs, and Durable Medical Equipment MACs and must be completed prior to submitting EMC or other EDI transactions to Medicare.



Form CMS-460, the Medicare Participating Physician or Supplier Agreement, is also submitted if the provider or supplier wishes to enroll as a Part B participating provider or supplier. The Participating and Nonparticipating Providers and Suppliers Section below provides additional information about participating in the Medicare Program.

To access the enrollment applications, visit <http://www.cms.gov/CMSForms/CMSForms/list.asp> on the CMS website. To find information about where to send Medicare enrollment forms, visit http://www.cms.gov/MedicareProviderSupEnroll/downloads/contact_list.pdf on the CMS website.

Additional documentation, which may vary from State to State, may also be required in order to enroll in the Medicare Program. This documentation may include:

- A State medical license;
- An Occupational or business license; and
- A Certificate of Use.

Additional Requirements for Institutional Providers and Suppliers

Institutional providers and suppliers must simultaneously contact their local State Agency (SA), which determines Medicare participation requirements (certain provider types may elect voluntary accreditation by a CMS-recognized accrediting organization in lieu of a SA survey).

Reporting Changes to Information in Enrollment Records

Providers and suppliers must report most changes to information in Medicare enrollment records within 90 days of the reportable event. The following reportable events must be reported within 30 days:



- A change in ownership;
- A change in practice location; and
- Final adverse actions that include:
 - A Medicare-imposed revocation of any Medicare billing privileges;
 - Suspension or revocation of a license to provide health care by any State licensing authority;
 - A conviction of a Federal or State felony offense within the last 10 years preceding enrollment, revalidation, or re-enrollment; or
 - An exclusion or debarment from participation in a Federal or State health care program.

Where to Find Additional Information about Medicare Provider and Supplier Enrollment

To find additional information about Medicare provider and supplier enrollment, refer to Chapter 24 of the “Medicare Claims Processing Manual” (Pub. 100-04) and Chapters 10 and 15 of the “Medicare Program Integrity Manual” (Pub. 100-08) located at <http://www.cms.gov/Manuals/IOM/list.asp> and visit http://www.cms.gov/Medicare/ProviderSupEnroll/01_Overview.asp on the CMS website. To find contact information for SAs, visit http://www.cms.gov/SurveyCertificationGenInfo/03_ContactInformation.asp on the CMS website.

Participating and Nonparticipating Providers and Suppliers

There are two types of Part B providers and suppliers: participating and nonparticipating.

1) Participating providers and suppliers:

- Accept assignment of Medicare benefits for all covered services for all Medicare beneficiaries;
- Receive higher PFS allowances than nonparticipating providers and suppliers;
- Accept the Medicare allowed amount as payment in full (limiting charge provisions are not applicable); and
- Are included in the Medicare Participating Physicians and Suppliers Directory (MEDPARD).

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A provider or supplier who completes and signs Form CMS-460, the Medicare Participating Physician or Supplier Agreement:

- Is formally notifying CMS that he or she wishes to participate in the Medicare Program; and
- Agrees to accept assignment on all Part B claims for all covered services for all Medicare beneficiaries.

Assignment means that the provider or supplier is paid the Medicare allowed amount as payment in full for all Part B claims for all covered services for all Medicare beneficiaries. The provider or supplier may not collect from the beneficiary any amount other than the unmet deductible and coinsurance. The following services are always subject to assignment:

- Clinical diagnostic laboratory services and physician laboratory services;
- Physician services to individuals dually entitled to Medicare and Medicaid;
- Services of the following:
 - Anesthesiologist assistants;
 - Certified nurse midwives;
 - Certified registered nurse anesthetists;
 - Certified nurse specialists;
 - Clinical psychologists;
 - Clinical social workers;
 - Medical nutrition therapists,
 - Nurse practitioners; and
 - Physician assistants;
- ASC facility services;
- Services of mass immunization roster billers;
- Drugs and biologicals; and
- Ambulance services.



Participation is valid for a yearlong period from January 1 through December 31. Active participants receive a participation package during the Medicare Participation Open Enrollment Period, which is usually in mid-November of each year. During this period, participation status can be changed, and that change will be effective on January 1 of the following year. Providers and suppliers who wish to continue participating in the Medicare Program do not need to sign an agreement each year. The Medicare Participating Physician or Supplier Agreement will remain in effect through December 31 of the calendar year and automatically renews each year unless the participant decides to terminate the agreement during the open enrollment period. Once the Medicare Participating Physician or Supplier Agreement is signed, CMS rarely honors a provider's or supplier's decision to change participation status during the year.

2) Nonparticipating providers and suppliers:

- May accept assignment of Medicare claims on a claim-by-claim basis;
- Receive lower PFS allowances than participating providers and suppliers for assigned or nonassigned claims;
- May not submit charges for nonassigned claims that are in excess of the limiting charge amount (with the exception of pharmaceuticals, equipment, and supplies) and may collect up to the limiting charge amount at the time services are furnished, which is the maximum that can be charged for the services furnished (unless prohibited by an applicable State law); and
- Are not included in the MEDPARD.

Below is an example of a limiting charge.

PFS Allowed Amount for Procedure “X”	\$200.00
Nonparticipating Provider or Supplier Allowed Amount for Procedure “X”	\$190.00 (\$200.00 x .95 = 5 percent lower than PFS allowed amount)
Limiting Charge for Procedure “X”	\$218.50 (\$190.00 x 1.15 = 115 percent of PFS allowed amount)
Beneficiary Coinsurance and Limiting Charge Portion Due to Provider or Supplier	<p>\$ 66.50 (\$38.00 plus \$28.50) Coinsurance – 20 percent of PFS allowed amount (\$190.00 x .20 = \$38.00) PLUS \$218.50 – Limiting charge - <u>190.00</u> – Nonparticipating provider/supplier allowed amount \$ 28.50 – Additional amount that can be collected from the beneficiary</p>



Limiting charges apply to the following regardless of who furnishes or bills for them:

- Physicians’ services;
- Services and supplies commonly furnished in physicians’ offices that are incident to physicians’ services;
- Outpatient physical and occupational therapy services furnished by an independently practicing therapist;
- Diagnostic tests; and
- Radiation therapy services, including x-ray, radium, radioactive isotope therapy, materials, and technician services.

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Below is an illustration of the payment amounts that participating and nonparticipating providers and suppliers receive.

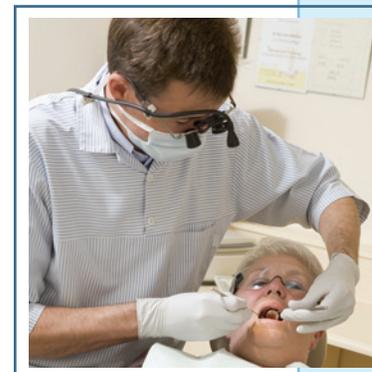
	Participating Provider/ Supplier	Nonparticipating Provider/Supplier Who Accepts Assignment	Nonparticipating Provider/Supplier Who Does Not Accept Assignment
Submitted Amount	\$125.00	\$125.00	\$109.25
PFS Allowed Amount	\$100.00	\$ 95.00	\$ 95.00
80 Percent of PFS Allowed Amount	\$ 80.00	\$ 76.00	\$ 76.00
Beneficiary Coinsurance Due to Provider/Supplier (after deductible has been met)	\$ 20.00	\$ 19.00	\$ 33.25
Total Payment to Provider/Supplier (payment for nonassigned claims goes to the beneficiary, who is responsible for paying provider/supplier)	\$100.00	\$ 95.00	\$109.25 (\$ 95.00 x 1.15 limiting charge)

PRIVATE CONTRACTS WITH MEDICARE BENEFICIARIES

The following physicians who are legally authorized to practice medicine, surgery, dentistry, podiatry, or optometry by the State in which such function or action is performed may opt-out of Medicare and privately contract with beneficiaries for the purpose of furnishing items or services that would otherwise be covered:

- Doctors of medicine and doctors of osteopathy;
- Doctors of dental surgery or dental medicine;
- Doctors of podiatry; and
- Doctors of optometry.

The following practitioners who are legally authorized to practice by the State and otherwise meet Medicare requirements may also opt-out of Medicare and privately contract with beneficiaries for the purpose of furnishing items or services that would otherwise be covered:



- Certified nurse midwives;
- Certified registered nurse anesthetists;
- Clinical nurse specialists;
- Clinical psychologists;
- Clinical social workers;
- Nurse practitioners;
- Nutrition professionals;
- Physician assistants; and
- Registered dietitians.

The opt-out law does not define “physician” to include chiropractors; therefore, chiropractors may not opt-out of Medicare and provide services under private contract. Physical therapists and occupational therapists in independent practice cannot opt-out because they are not within the opt-out law’s definition of either a “physician” or “practitioner.”



The opt-out period is for two years and can only be terminated early (no later than 90 days after the effective date of the opt-out affidavit) by a physician or practitioner who has not previously opted out. Opt-outs may be renewed for subsequent two-year periods. The physician or practitioner must opt-out of Medicare for all beneficiaries and all items or services, with the exception of emergency or urgent care situations, in which case the physician or practitioner may treat a beneficiary with whom he or she does not have a private contract and bill Medicare for the treatment. Claims for emergency or urgent care require modifier GJ, “OPT-OUT physician or practitioner emergency or urgent services.”

Medicare will make payment for covered medically necessary items or services that are ordered by a physician or practitioner who has opted-out of Medicare if:

- He or she has acquired a provider identifier; and
- The items or services are not furnished by a physician or practitioner who has also opted-out of Medicare.

Where to Find Additional Information About Becoming a Medicare Provider or Supplier

To find additional information about becoming a Medicare provider or supplier, refer to Chapters 1 and 24 of the “Medicare Claims Processing Manual” (Pub. 100-04) located at <http://www.cms.gov/Manuals/IOM/list.asp> and visit http://www.cms.gov/MedicareProviderSupEnroll/01_Overview.asp on the CMS website.

PROMOTING CULTURAL COMPETENCY IN YOUR PRACTICE

Racial and ethnic minorities are expected to make up approximately 40 percent of the U.S. population by 2030. With the increasing diversity of the U.S. population, providers

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and suppliers are more and more likely to encounter situations that require the delivery of culturally competent care, access to a vast array of language services, and supportive health care organizations. Addressing a patient's social and cultural background will assist providers and suppliers in delivering high quality, effective health care and increase patient satisfaction, improve patient compliance, and reduce racial and ethnic health disparities.

The U.S. Department of Health and Human Services (HHS) Office of Minority Health offers several free interactive web-based training cultural competency courses that assist physicians, physician assistants, nurses, and other health care professionals in preparing for the increasingly diverse patient population and furnishing the highest quality of care to every patient regardless of race, ethnicity, cultural background, or ability to speak English as their primary language. The courses offer a variety of continuing education credit types.

Where to Find Additional Information About Cultural Competency

To find additional information about cultural competency and links to the interactive courses, visit <http://thinkculturalhealth.hhs.gov> on the HHS website.





CHAPTER THREE

MEDICARE REIMBURSEMENT

This chapter provides information about Medicare claims; deductibles, coinsurance, and copayments; coordination of benefits; Medicare payment policies; Medicare notices; and other health insurance plans.

MEDICARE CLAIMS

A claim is defined as a request for payment for benefits or services received by a beneficiary. Providers and suppliers who furnish covered services to Medicare beneficiaries are required to submit claims for their services and cannot charge beneficiaries for completing or filing a Medicare claim. Medicare Contractors monitor compliance with these requirements. Offenders may be subject to a Civil Monetary Penalty of up to \$10,000 for each violation.

Exceptions to Mandatory Filing

Providers and suppliers are not required to file claims on behalf of Medicare beneficiaries when:

- The claim is for services for which:
 - Medicare is the secondary payer;
 - The primary insurer's payment is made directly to the beneficiary; and
 - The beneficiary has not furnished the primary payment information needed to submit the Medicare secondary claim;
- The claim is for services furnished outside the U.S.;
- The claim is for services initially paid by third-party insurers who then file Medicare claims to recoup what Medicare pays as the primary insurer (e.g., indirect payment provisions);

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- The claim is for other unusual services, which are evaluated by Medicare Contractors on a case-by-case basis;
- The claim is for excluded services, unless the beneficiary requests submission of a claim to Medicare (some supplemental insurers who pay for these services may require a Medicare claim denial notice prior to making payment);
- The beneficiary has signed Form CMS-R-131, the Advance Beneficiary Notice of Noncoverage (ABN), indicating that no claim should be filed for a specific item or service. The Medicare Notices section below provides additional information about the ABN;
- He or she has opted-out of the Medicare Program and entered into a private contract with the beneficiary; or
- He or she has been excluded or debarred from the Medicare Program.



Timely Filing Requirement

Before payment can be made for Medicare-covered services, claims must be filed timely. Claims with dates of service on or after January 1, 2010, must be received no later than one calendar year from the claim's date of service. Fee-For-Service (FFS) claims with service dates from October 1, 2009, through December 31, 2009, must be received no later than December 31, 2010. Claims that are filed after the specified timeframe will be denied with no appeal rights. For claims that include span dates of service, claims filing timeliness is determined as follows:

- The "Through" date is used to determine the date of service for institutional claims; and
- The "From" date is used to determine the date of service for professional claims.

There are four exceptions to the timely filing requirement, if certain conditions are met:

- Administrative error, if failure to meet the filing deadline was caused by error or misrepresentation of an employee, Medicare Contractor, or agent of the U.S. Department of Health and Human Services that was performing Medicare functions and acting within the scope of its authority;
- Retroactive Medicare entitlement;
- Retroactive Medicare entitlement involving State Medicaid Agencies and dually-eligible beneficiaries; and
- Retroactive disenrollment from a Medicare Advantage (MA) Plan or Program of All-Inclusive Care for the Elderly provider organization.

Electronic Claims

As of October 16, 2003, providers and suppliers must submit claims electronically via Electronic Data Interchange (EDI) in the Health Insurance Portability and Accountability Act format, except in limited situations.

Each provider or supplier must complete a Centers for Medicare & Medicaid Services (CMS) Standard EDI Enrollment Form and send it to the Medicare Contractor prior to submitting electronic media claims (EMC). A sender number, which is required in order to submit electronic claims, will then be issued. An organization that is comprised of multiple components that have been assigned Medicare provider identifiers may elect to execute a single EDI Enrollment Form on behalf of the organizational components to which these identifiers have been assigned.

Electronic versions of CMS claim forms can be found at <http://www.cms.gov/CMSForms/CMSForms/list.asp> on the CMS website. The EDI Enrollment Form is available from Medicare Contractors.

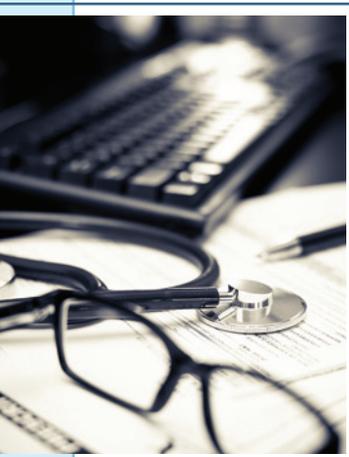
To find Medicare Contractor contact information, visit <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

Electronic Media Claims Submissions

Claims are electronically transmitted to the Medicare Contractor’s system, which verifies claim data. This information is then electronically checked or edited for required information. Claims that pass these initial edits, also called front-end or pre-edits, are processed in the claims processing system according to Medicare policies and guidelines. Claims with inadequate or incorrect information may:

- Be returned to the provider or supplier for correction;
- Be suspended in the Contractor’s system for correction; or
- Be corrected by the system (in some cases).

A confirmation or acknowledgment report, which indicates the number of claims accepted and the total dollar amount transmitted, is generated to the provider or supplier. This report also indicates the claims that have been rejected and reason(s) for the rejection.



Electronic Media Claims Submission Alternatives

Providers and suppliers who do not submit electronic claims using EMC may alternatively choose to submit claims through an electronic billing software vendor or clearinghouse, billing agent, or by using Medicare’s free billing software. Providers and suppliers can obtain a list of electronic billing software vendors and clearinghouses as well as billing software from Medicare Contractors.

Paper Claims

To find information about the limited situations in which paper claims can be submitted, visit http://www.cms.gov/ElectronicBillingEDITrans/05_ASCASelfAssessment.asp on the CMS website.

Non-institutional providers and suppliers use the CMS-1500 claim form to bill Medicare Contractors and Durable Medical Equipment Medicare Administrative Contractors (DME MAC). CMS-1500 claim forms can be ordered from printing companies, office

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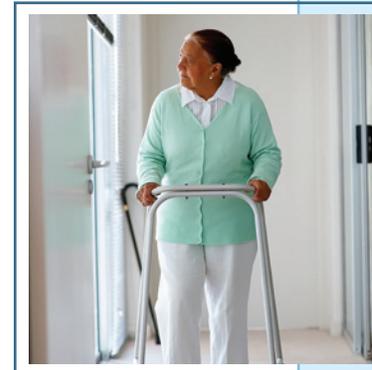
supply stores, and the U.S. Government Printing Office (GPO), U.S. Government Bookstore. U.S. Government Bookstore orders can be placed by calling (866) 512-1800 or visiting <http://bookstore.gpo.gov/collections/cms1500-form.jsp> on the GPO website.

Institutional providers and suppliers use the CMS-1450 claim form, also known as the UB-04, to bill Medicare Contractors. UB-04 claim forms can be ordered from the National Uniform Billing Committee at <http://www.nubc.org/guide.html> on the Internet.

Durable Medical Equipment, Prosthetics and Orthotics, and Parenteral and Enteral Nutrition Claims

DME MACs have jurisdiction for the following claims:

- Nonimplantable durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) (including items for home use);
- Parenteral and enteral nutrition (PEN) products (other than items furnished to inpatients covered under Part A);
- Certain oral drugs billed by pharmacies; and
- Medications delivered through infusion pumps.



Where to Find Additional Information About Medicare Claims

To find additional information about Medicare claims, refer to the “Medicare Claims Processing Manual” (Pub. 100-04) located at <http://www.cms.gov/Manuals/IOM/list.asp> and visit <http://www.cms.gov/ElectronicBillingEDITrans> on the CMS website. To find additional information about the timely filing requirement and the conditions that must be met in order to satisfy each timely filing exception, refer to Chapter 1 of the “Medicare Claims Processing Manual” (Pub. 100-04) located at <http://www.cms.gov/Manuals/IOM/list.asp> on the CMS website. To find DMEPOS and PEN claims information, visit <http://www.cms.gov/center/dme.asp> on the CMS website.

DEDUCTIBLES, COINSURANCE, AND COPAYMENTS

All providers and suppliers must collect unmet deductibles, coinsurance, and copayments from the beneficiary. The deductible is the amount a beneficiary must pay before Medicare begins to pay for covered services and supplies. These amounts can change every year. Under FFS Medicare and Medicare Advantage Private Fee-For-Service Plans, coinsurance is a percentage of covered charges that the beneficiary may pay after he or she has met the applicable deductible. Providers and suppliers should determine whether the beneficiary has supplemental insurance that will pay for deductibles and coinsurance before billing the beneficiary for them. In some Medicare health plans, a copayment is the amount that the beneficiary pays for each medical service. If a beneficiary is unable to pay these charges, he or she should sign a waiver that explains the financial hardship. If a waiver is not assigned, the beneficiary’s medical record should reflect normal and reasonable attempts to collect the charges before they are written off. The same attempts to collect charges must be applied to both Medicare beneficiaries and non-Medicare beneficiaries. Consistently waiving deductibles, coinsurance, and copayments may be interpreted as program abuse.

On assigned claims, the beneficiary is responsible for:

- Unmet deductibles;
- Applicable coinsurance and copayments; and
- Charges for services and supplies that are not covered by Medicare.

Where to Find Additional Information About Deductibles, Coinsurance, and Copayments

To find additional information about deductibles, coinsurance, and copayments, refer to Chapter 3 of the “Medicare General Information, Eligibility, and Entitlement Manual” (Pub. 100-01) and Chapter 1 of the “Medicare Claims Processing Manual” (Pub. 100-04) located at <http://www.cms.gov/Manuals/IOM/list.asp> on the CMS website.

COORDINATION OF BENEFITS

Coordination of Benefits (COB) is the process that determines the respective responsibilities of two or more payers that have some financial responsibility for a medical claim.

Medicare Secondary Payer Program

Medicare law requires that providers and suppliers determine whether Medicare is the primary or secondary payer prior to submitting a claim by asking the beneficiary or his or her representative about other health insurance or coverage. In addition, primary payers must be identified on claims submitted to Medicare. Providers and suppliers should not rely on Common Working File (CWF) information alone since Medicare Secondary Payer (MSP) circumstances can change quickly. The following secondary payer information can be found via the MSP Auxiliary File in the CWF:



- MSP effective date;
- MSP termination date;
- Patient relationship;
- Subscriber name;
- Subscriber policy number;
- Insurer type;
- Insurer information (name, group number, address, city, State, and ZIP code);
- MSP type;
- Remarks code;
- Employer information (name, address, city, State, and ZIP code); and
- Employee information (identification number).

Medicare may make payment if the primary payer denies the claim and the provider or supplier includes documentation that the claim has been denied in the following situations:

- The Group Health Plan (GHP) denies payment for services because:
 - The beneficiary is not covered by the health plan;
 - Benefits under the plan are exhausted for particular services;
 - The services are not covered under the plan;

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- A deductible applies; or
- The beneficiary is not entitled to benefits;
- The no-fault or liability insurer denies payment or does not pay the bill because benefits have been exhausted;
- The Workers' Compensation (WC) Plan denies payment (e.g., when it is not required to pay for certain medical conditions); or
- The Federal Black Lung Program does not pay the bill.

In liability, no-fault, or WC situations, Medicare may make a conditional payment for covered services in order to prevent beneficiary financial hardship when:

- The claim is not expected to be paid promptly;
- The properly submitted claim was denied in whole or in part; or
- A proper claim has not been filed with the primary insurer due to the beneficiary's physical or mental incapacity.

When payments are made under these situations, they are made on the condition that the insurer and/or the beneficiary will reimburse Medicare to the extent that payment is subsequently made by the insurer.



Where to Find Additional Information About the Medicare Secondary Payer Program

To find additional information about the MSP Program, refer to the “Medicare General Information, Eligibility, and Entitlement Manual” (Pub. 100-01) and the “Medicare Secondary Payer Manual” (Pub. 100-05) located at <http://www.cms.gov/Manuals/IOM/list.asp> and visit <http://www.cms.gov/COBGeneralInformation> on the CMS website.

Coordination of Benefits Contractor

The COB Contractor performs activities that support the collection, management, and reporting of other health insurance or coverage for Medicare beneficiaries. It identifies the health benefits available to Medicare beneficiaries and coordinates the payment process to prevent mistaken payment of Medicare benefits. The COB Contractor assists providers and suppliers with:

- Reporting employment changes or any other insurance coverage information;
- Reporting a liability, auto/no-fault, or WC case;
- MSP issues; and
- Medicare Secondary Development letters and questionnaires.

The COB Contractor determines whether beneficiaries have health insurance that is primary to Medicare through the following mechanisms:

- The Initial Enrollment Questionnaire, which is sent to beneficiaries approximately three months before Medicare coverage begins regarding their other health insurance or coverage;

- U.S. Internal Revenue Service, U.S. Social Security Administration, and CMS data match, which are completed by employers regarding GHP coverage for identified workers who are either entitled to Medicare or are married to a beneficiary;
- MSP claims investigation, which involves the collection of data regarding health insurance or coverage that may be primary to Medicare based on information submitted on a medical claim or from other sources; and
- Voluntary MSP data match agreements, which are an electronic data exchange of GHP eligibility and Medicare information between CMS and employers or insurers.

Coordination of Benefits Contractor Contact Information

COB Contractor contact information is listed below.

Telephone: (800) 999-1118

General written inquiries:

MEDICARE - COB
 P.O. Box 33847
 Detroit, MI 48232

Questionnaires and correspondence:

MEDICARE - COB
 Data Match Project
 P.O. Box 33848
 Detroit, MI 48232

MEDICARE - COB
 Small Employer Exemptions
 P.O. Box 660
 New York, NY 10274

MEDICARE - COB
 Initial Enrollment Questionnaire Project
 P.O. Box 17521
 Baltimore, MD 21203-7521

CMS c/o COB Contractor
 Workers' Compensation Medicare
 Set-Aside Arrangements Proposal/
 Final Settlement
 P.O. Box 33849
 Detroit, MI 48232

MEDICARE - COB
 MSP Claims Investigation Project
 P.O. Box 33847
 Detroit, MI 48232

The COB Contractor does not process claims for primary or secondary payment or handle any mistaken payment recoveries, claims-specific inquiries, claim or service denials and adjustments, or billing issues. These responsibilities are completed by Medicare Contractors.

MEDICARE - COB
 Voluntary Agreement Project
 P.O. Box 660
 New York, NY 10274-0660

MEDICARE - COB
 Employer/Insurer Outreach
 P.O. Box 660
 New York, NY 10274

MEDICARE PAYMENT POLICIES

Payment Systems and Fee Schedules

A variety of prospective payment systems (PPS) and fee schedules (FS) reimburse providers and suppliers for the services and supplies they furnish.

Medicare providers and suppliers receive PPS payments based on a predetermined, fixed amount that is derived based on the classification system of the service. PPSs have been developed for the following:

- Acute care hospital inpatient;
- End-Stage Renal Disease (effective January 1, 2011);
- Home health;
- Hospice;
- Hospital outpatient;
- Inpatient Psychiatric Facility;
- Inpatient Rehabilitation Facility;
- Long-Term Care Hospital; and
- Skilled Nursing Facility.

Medicare providers and suppliers are paid under a FS based on a comprehensive list of covered services and their payment rates. FSs have been developed for the following:

- Ambulance;
- Ambulatory Surgical Center;
- Clinical laboratory;
- Durable medical equipment, prosthetics, orthotics, and supplies; and
- Physician.



Incentive Payments

Health Professional Shortage Area Incentive Payment

The Omnibus Budget Reconciliation Act of 1987 established Medicare's Incentive Payment Program, which encouraged primary care physicians to work in underserved rural areas and to improve access to care for Medicare beneficiaries. It paid primary care physicians an incentive payment of five percent for services furnished to Medicare beneficiaries in Federally-designated Health Professional Shortage Areas (HPSA). Effective January 1, 1991, Congress increased the incentive payment to 10 percent and expanded eligibility to include physicians' services in both rural and urban HPSAs.

Under Section 1833(m) of the Social Security Act, physicians (including psychiatrists) who furnish care in an area that is designated as a geographic-based, primary medical care HPSA and psychiatrists who furnish care in an area that is designated as a geographic-based mental health HPSA are eligible for a 10 percent HPSA incentive payment for outpatient professional services furnished to a Medicare beneficiary. The HPSA incentive payment is available only for the physician's professional services.

If a service is billed with both a professional and a technical component, only the professional component will receive the incentive payment. The incentive payment is based on the paid amount of the claim.

If the service is furnished in an area that is on the CMS list of ZIP codes that are eligible for the HPSA incentive payment, payments are automatically paid on a quarterly basis. The list of eligible ZIP codes is updated annually and is effective for services on or after January 1 of each calendar year (CY). An area may be eligible for the HPSA incentive payment but the ZIP code may not be on the list because:

- 1) It does not fall entirely within a designated full county HPSA bonus area;
- 2) It is not considered to fall within the county based on a determination of dominance made by the U.S. Postal Service;
- 3) It is partially within a non-full county HPSA; or
- 4) Services are provided in a ZIP code area that was not included in the automated file of HPSA areas based on the date of the data used to create the file.

In these situations, the physician must utilize an AQ modifier in order to receive payment.

Physicians and psychiatrists who furnish care in a Method II Critical Access Hospital (CAH) that is located within a geographic-based primary medical care HPSA and psychiatrists who furnish care in a CAH that is located in a geographic-based mental health HPSA are eligible for the HPSA bonus payment for outpatient professional services. If the physician has assigned his or her billing rights to a Method II CAH, the CAH will receive the bonus payment.

Under the Affordable Care Act, effective for services furnished on and after January 1, 2011, general surgeons who furnish surgical services in ZIP codes that are located in a HPSA are also now eligible for a 10 percent HPSA incentive payment.



Where to Find Additional Information About the Health Professional Shortage Area Incentive Payment

To find additional information about the HPSA, visit <http://www.cms.gov/HPSAPSAPhysicianBonuses> on the CMS website, <http://hpsafind.hrsa.gov> on the Health Resources and Services Administration website, and <http://www.census.gov> on the U.S. Census Bureau website.

Physician Quality Reporting System Incentive Payment

Identified eligible professionals who satisfactorily report data on quality measures for covered Medicare Physician Fee Schedule (PFS) services furnished to Part B beneficiaries may be eligible for an incentive payment under the Physician Quality Reporting System.

Where to Find Additional Information About the Physician Quality Reporting System Incentive Payment

To find additional information about the Physician Quality Reporting System incentive payment, refer to Chapter 1 of the “Medicare Quality Reporting Incentive Programs Manual” (Pub. 100-22) located at <http://www.cms.gov/Manuals/IOM/list.asp> and visit <http://www.cms.gov/PQRS> on the CMS website.

Electronic Prescribing Incentive Program Payment

Eligible professionals who are successful electronic prescribers as defined by the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 may be eligible for Electronic Prescribing (eRx) Incentive Program payments. CMS introduced a new group practice reporting option (GPRO) for the eRx Incentive Program beginning with the 2010 eRx Incentive Program. Group practices that are successful electronic prescribers for a particular reporting period are eligible to earn an eRx incentive payment equal to a specified percentage of the group practice’s total estimated PFS allowed charges for covered professional services furnished during the reporting period. An individual eligible professional who is a member of a group practice selected to participate in the eRx GPRO is not eligible to separately earn an eRx incentive payment as an individual eligible professional under that same Tax Identification Number. Beginning in 2012, eligible professionals who are not successful electronic prescribers may be subject to a payment adjustment on their Part B PFS covered professional services. Section 132 of MIPPA authorizes CMS to apply this payment adjustment whether or not the eligible professional is planning to participate in the eRx Incentive Program.



Where to Find Additional Information About the Electronic Prescribing Incentive Program Payment

To find additional information about the eRx Incentive Program payment, refer to Chapter 2 of the “Medicare Quality Reporting Incentive Programs Manual” (Pub. 100-22) located at <http://www.cms.gov/Manuals/IOM/list.asp> and visit <http://www.cms.gov/ERxIncentive> on the CMS website.

Primary Care Incentive Payment

Under the Affordable Care Act, effective for services furnished on and after January 1, 2011, the following practitioner specialties are potentially eligible for a Primary Care Incentive Payment of 10 percent of allowed charges for Part B primary care services furnished to beneficiaries:

- Family, internal, geriatric, and pediatric medicine physicians;
- Clinical nurse specialists;
- Nurse practitioners; and
- Physician assistants.

Only those practitioners enrolled in Medicare with one of the specialties listed on the previous page **and** whose primary care services accounted for at least 60 percent of his or her allowed charges under the PFS (excluding hospital inpatient care and emergency department visits) during the designated period are eligible. Eligibility for the incentive payment is determined annually.

The following primary care services are eligible for the incentive payment:

- New and established patient office or other outpatient visits (Current Procedural Terminology [CPT] codes 99201 – 99215);
- Nursing facility care visits and domiciliary, rest home, or home care plan oversight services (CPT codes 99304 – 99340); and
- Patient home visits (CPT codes 99341 – 99350).

The incentive payment is paid on a quarterly basis and is in addition to other applicable physician incentive payments.



Electronic Health Record Incentive Program Payment

The Medicare Electronic Health Record (EHR) Incentive Program provides incentive payments to eligible professionals, hospitals, and CAHs that demonstrate meaningful use of certified EHR technology. Providers may participate in this program beginning in CY 2011. Eligible professionals under the Medicare EHR Incentive Program include:

- Chiropractors (DC);
- Doctors of dental surgery (DDS) or dental medicine (DMD);
- Doctors of medicine (MD) and doctors of osteopathy (DO);
- Doctors of optometry (OD); and
- Doctors of podiatry (DPM).

EHR incentive payments for eligible professionals are based on individual practitioners. Providers are only eligible for one incentive payment per year, regardless of how many practices or locations at which they furnish services. Hospital-based eligible professionals are not eligible for incentive payments. An eligible professional is considered hospital-based if 90 percent or more of his or her services are performed in a hospital inpatient (Place of Service code 21) or emergency room (Place of Service code 23) setting.

Where to Find Additional Information About the Electronic Health Record Incentive Program Payment

To find additional information about the EHR Incentive Program payment, visit <http://www.cms.gov/EHRIncentivePrograms> on the CMS website.

MEDICARE NOTICES

Advance Beneficiary Notice of Noncoverage

Form CMS-R-131, the Advance Beneficiary Notice of Noncoverage (ABN), is a written

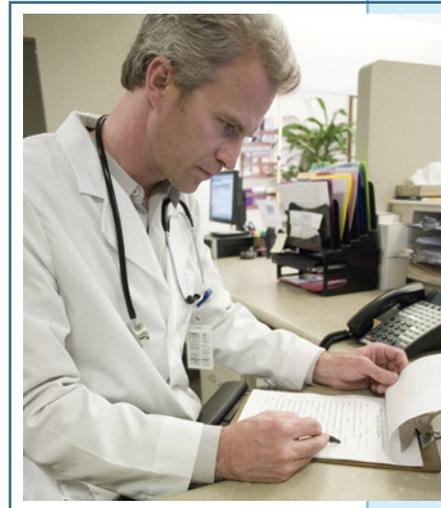
notice that a FFS provider or supplier must give to a beneficiary before providing items or services that are usually covered by Medicare, but are not expected to be paid in a specific instance (e.g., lack of medical necessity). Providing an ABN allows the beneficiary to make an informed decision about whether to receive the item or service in question. Except for items and services that are always excluded from coverage, if a provider or supplier does not provide the beneficiary with an ABN when required, the beneficiary cannot be held financially liable for the items or services if Medicare payment is denied or reduced. If the provider or supplier properly notifies the beneficiary that the items or services may not be covered, he or she may seek payment from the beneficiary. Issuance of an ABN is not required prior to providing items or services that are always excluded from coverage; however, providers and suppliers may choose to issue a voluntary ABN as a courtesy to the beneficiary to alert him or her about forthcoming financial liability. Providers and suppliers who furnish items or services to the beneficiary based on the referral or order of another provider or supplier are responsible for notifying the beneficiary that the services may not be covered by Medicare and that he or she can be held financially liable for the items or services if payment is denied or reduced. A copy of the ABN should be kept in the beneficiary's medical record.

To find Form CMS-R-131, visit http://www.cms.gov/BNI/01_overview.asp on the CMS website. To find the Certificate of Medical Necessity and DME MAC Information Forms that are included with claims for certain items that require additional information (e.g., DME and PEN), visit <http://www.cms.gov/CMSForms/CMSForms/list.asp> on the CMS website.

Remittance Advice

A Remittance Advice (RA) is a notice of payments and adjustments that is sent to the provider, supplier, or biller. After a claim has been received and processed, the Medicare Contractor produces a RA which may serve as a companion to claim payments or as an explanation when there is no payment. The RA explains reimbursement decisions, including the reasons for payments and adjustments of processed claims. The RA features valid codes and specific values that make up the claim payment. Some of these codes may identify adjustments, which refer to any changes that relate to how a claim is paid differently from the original billing. There are seven general types of adjustments:

- Denied claim;
- Zero payment;
- Partial payment;
- Reduced payment;
- Penalty applied;
- Additional payment; and
- Supplemental payment.



Medicare Summary Notice

The Medicare Summary Notice is a notice that a beneficiary receives after the provider or supplier files a claim for Part A and Part B services. It explains the following:

- What the provider or supplier billed for;
- The Medicare-approved amount;
- How much Medicare paid; and
- What the beneficiary must pay.

If a beneficiary disagrees with a claims decision, he or she has the right to file an appeal.

Where to Find Additional Information About Medicare Notices

To find additional information about Medicare notices, refer to the “Medicare Claims Processing Manual” (Pub. 100-04) located at <http://www.cms.gov/Manuals/IOM/list.asp> on the CMS website. To find additional information about the ABN, visit http://www.cms.gov/BNI/01_overview.asp on the CMS website.

OTHER HEALTH INSURANCE PLANS

Medicare beneficiaries may also be enrolled in one of the following health insurance plans:

- Medicaid;
- Medigap;
- Railroad Retirement; and
- United Mine Workers of America (UMWA).

Each plan is discussed in more detail below.



Medicaid

Medicaid is a cooperative venture funded by Federal and State governments that pays for medical assistance for certain individuals and families with low incomes and limited resources. Within broad national guidelines established by Federal statutes, regulations, and policies, each State:

- Establishes its own eligibility standards;
- Determines the type, amount, duration, and scope of services;
- Sets the rate of payment for services; and
- Administers its own program.

The following Medicare premium and cost-sharing payment assistance may be available through the State Medicaid Program:

- Payment of Part A and Part B premiums, deductibles, coinsurance, and copayments for Qualified Medicare Beneficiaries (QMB) who:
 - Have resources that are at or below twice the standard allowed under the Social Security Income Program; and

MEDICARE PHYSICIAN GUIDE

- Have incomes that are at or below 100 percent of the Federal poverty level (FPL) (subject to limits that States may impose on payment rates);
- Payment of Part B premiums for Specified Low-Income Medicare Beneficiaries who:
 - Have resources similar to QMBs; and
 - Have incomes that are below 120 percent of the FPL; and
- Payment of Part A premiums for Qualified Disabled and Working Individuals (QDWI) who:
 - Previously qualified for Medicare due to disability, but lost entitlement because of their return to work (despite the disability);
 - Have incomes that are below 200 percent of the FPL; and
 - Do not meet any other Medicaid assistance category.

QDWIs who do not meet these income guidelines may purchase Part A and Part B coverage.

Medicare-covered services are paid first by Medicare since Medicaid is always the payer of last resort.

Where to Find Additional Information About Medicaid

To find additional information about Medicaid, refer to the “State Medicaid Manual” (Pub. 45) located at <http://www.cms.gov/Manuals/PBM/list.asp> and visit <http://www.cms.gov/MedicaidGenInfo> on the CMS website.

Medigap

Medigap is a health insurance policy sold by private insurance companies to fill gaps in Medicare coverage. A Medigap policy is not associated with a labor or union organization. Beneficiaries must be enrolled in Part A and Part B in order to purchase a Medigap policy and, under certain circumstances, are guaranteed the right to buy a policy. MA Plans often cover many of the same benefits that a Medigap policy covers; therefore, beneficiaries who are enrolled in a MA Plan may not need a Medigap policy. Beneficiaries may authorize a reassignment of benefits on a claim-by-claim basis for participating providers and suppliers to file a claim for reimbursement of Medicare services and coinsurance amounts.



Where to Find Additional Information About Medigap

To find additional information about Medigap, refer to Chapter 28 of the “Medicare Claims Processing Manual” (Pub. 100-04) located at <http://www.cms.gov/Manuals/IOM/list.asp> and visit <http://www.cms.gov/Medigap> on the CMS website.

Railroad Retirement

Some beneficiaries who are retired railroad workers have supplementary medical insurance benefits from the Railroad Retirement Board.

Part B Railroad Retirement Benefits Contact Information

Part B Railroad Retirement Benefits contact information is as follows:

Palmetto GBA
Railroad Medicare Part B Office
P.O. Box 10066
Augusta, GA 30999
Telephone: (800) 833-4455



United Mine Workers of America

Some beneficiaries are members of the UMWA, which provides a health insurance plan for retired coal miners, spouses, and dependents.

United Mine Workers of America Contact Information

To find additional information about the UMWA, visit <http://www.umwa.org> on the Internet.



CHAPTER FOUR

MEDICARE SERVICES

This chapter discusses Medicare-covered services and the services that are not covered by Medicare.

MEDICARE-COVERED SERVICES

In general, Medicare-covered services are those services that are considered medically reasonable and necessary to the overall diagnosis and treatment of the beneficiary's condition and are reimbursable to the provider, supplier, or beneficiary. Services or supplies are considered medically necessary if they:

- Are proper and needed for the diagnosis or treatment of the beneficiary's medical condition;
- Are furnished for the diagnosis, direct care, and treatment of the beneficiary's medical condition;
- Meet the standards of good medical practice; and
- Are not mainly for the convenience of the beneficiary, provider, or supplier.

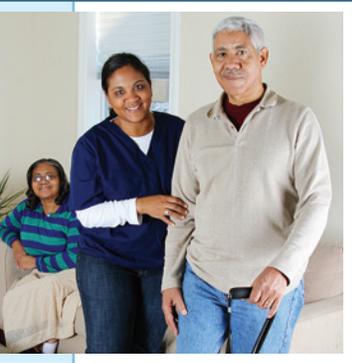
For every service billed, the provider or supplier must indicate the specific sign, symptom, or beneficiary complaint necessitating the service. Although furnishing a service or test may be considered good medical practice, Medicare generally prohibits payment for services without beneficiary symptoms or complaints.

Medicare pays for provider professional services that are furnished in:

- The U.S. (the Centers for Medicare & Medicaid Services [CMS] recognizes the 50 States, the District of Columbia, Commonwealth of Puerto Rico, Virgin Islands, Guam, Northern Mariana Islands, American Samoa, and territorial waters adjoining the land areas of the U.S. as being within the U.S.); and
- The home, office, institution, or at the scene of an accident.

Part A Inpatient Hospital Services

Subject to certain conditions, limitations, and exceptions, the following Part A inpatient hospital or inpatient Critical Access Hospital (CAH) services are furnished to an inpatient of a participating hospital or participating CAH or, in the case of emergency services or services in foreign hospitals, to an inpatient of a qualified hospital:



- Bed and board;
- Nursing and other related services;
- Use of hospital or CAH facilities;
- Medical social services;
- Drugs, biologicals, supplies, appliances, and equipment;
- Certain other diagnostic or therapeutic services;
- Medical or surgical services furnished by certain interns or residents in training; and
- Transportation services, including transport by ambulance.

Part B Services

Covered Part B services include, but are not limited to, the following:

- Physician services (e.g., surgery, consultations for telehealth services, office visits, and institutional calls);
- Services and supplies furnished incident to physician professional services;
- Outpatient (including home) dialysis services for End-Stage Renal Disease;
- Outpatient hospital services furnished incident to physician services;
- Outpatient diagnostic services furnished by a hospital;
- Outpatient physical therapy (PT) services;
- Outpatient occupational therapy (OT) services;
- Outpatient speech-language pathology (SLP) services;
- Diagnostic x-ray tests, laboratory tests, and other diagnostic tests;
- X-ray, radium, and radioactive isotope therapy services;
- Surgical dressings and splints, casts, and other devices used for reduction of fractures and dislocations;
- Rental or purchase of durable medical equipment for use in the beneficiary's home;
- Ambulance services;
- Certain prosthetic devices that replace all or part of an internal body organ;
- Leg, arm, back, and neck braces and artificial legs, arms, and eyes;
- Ambulatory Surgical Center services; and
- Certain preventive services.

Where to Find Additional Information About Medicare-Covered Services

To find additional information about Medicare-covered services, refer to the “Medicare Benefit Policy Manual” (Pub. 100-02) and the “Medicare Claims Processing Manual” (Pub. 100-04) located at <http://www.cms.gov/Manuals/IOM/list.asp> on the CMS website.

Split/Shared Evaluation and Management Services

A split/shared service is an encounter where a physician and a non-physician practitioner (NPP) each personally perform a portion of an evaluation and management (E/M) visit. Below are the rules for reporting split/shared E/M services between physicians and NPPs:

- Office/clinic setting:
 - For encounters with established patients that meet incident to requirements, report using the physician's National Provider Identifier (NPI); and
 - For encounters that do not meet incident to requirements, report using the NPP's NPI.
- Hospital inpatient, outpatient, and emergency department (ED) setting encounters shared between a physician and a NPP from the same group practice:
 - When the physician provides any face-to-face portion of the encounter, report using either provider's NPI; and
 - When the physician does not provide a face-to-face encounter, report using the NPP's NPI.

Prolonged Care

Prolonged care occurs when a physician or NPP:

- Provides direct face-to-face patient contact that is one hour beyond the usual service;
- Provides the service in an office or other outpatient setting or in an inpatient setting; and
- Bills for the service on the same day by the same provider as the companion E/M codes.

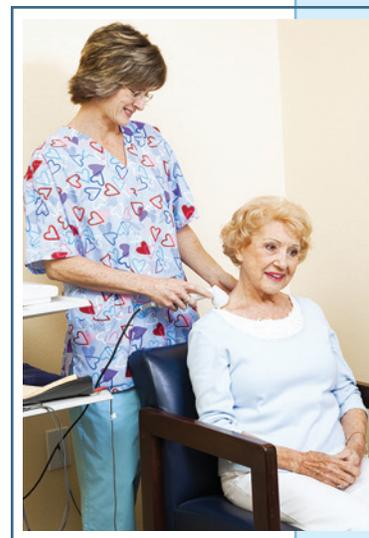
A prolonged service that is less than 30 minutes total duration on a given date is not separately payable since the work involved is included in the total work of the E/M codes. A prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately.

Global Surgery

The global surgical package includes all the usual services furnished by the physician who performs the surgery in any setting during the pre-operative and post-operative periods.

The following services related to the surgery are included in the global surgical package:

- Pre-operative visits;
- Intra-operative services;
- Complications following surgery;
- Post-operative visits;
- Post-surgical pain management;
- Supplies, with the exception of excluded items; and
- Miscellaneous services, including:



- Dressing changes;
- Local incisional care;
- Removal of operative pack, cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints;
- Insertion, irrigation, and removal of urinary catheters, routine peripheral intravenous lines, and nasogastric and rectal tubes; and
- Changes and removal of tracheostomy tubes.

The following services are not included in the global surgical package and may be paid separately:

- The initial consultation or evaluation of the medical problem performed by the surgeon to determine the need for a major surgical procedure (does not apply to minor surgical procedures);
- Services of another physician, unless a transfer of care has occurred;
- Visits unrelated to the diagnosis for which the surgical procedure is performed, unless the visits occur due to complications of surgery;
- Treatment for the underlying condition or an added course of treatment that is not part of normal recovery from surgery;
- Diagnostic tests and procedures, including diagnostic radiological procedures;
- Clearly distinct surgical procedures during the post-operative period that are not re-operations or treatment for complications, including when the decision to stage the procedure was made prospectively or at the time of the first procedure;
- Treatment for post-operative complications that require a return trip to the operating room;
- A second procedure that must be performed when a less extensive procedure has failed;
- Surgical trays for certain services performed in a physician's office;
- Immunosuppressive therapy for organ transplants; and
- Critical care services unrelated to the surgery, such as when a seriously injured or burned patient is critically ill and requires the physician's constant attendance.

Hospital Observation Services

Observation care is a well-defined set of specific, clinically appropriate services that include ongoing short-term treatment, assessment, and reassessment furnished while a decision is being made about whether the patient will require further treatment as a hospital inpatient or can be discharged from the hospital. These services are commonly ordered when a patient presents to the ED and then requires a significant period of treatment or monitoring in order to make a decision regarding admission or discharge.



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The following may bill for initial observation care:

- Physicians who order initial hospital outpatient observation services and are responsible for the patient during his or her observation care; and
- Physicians who do not have inpatient admitting privileges but are authorized to furnish hospital outpatient observation services.

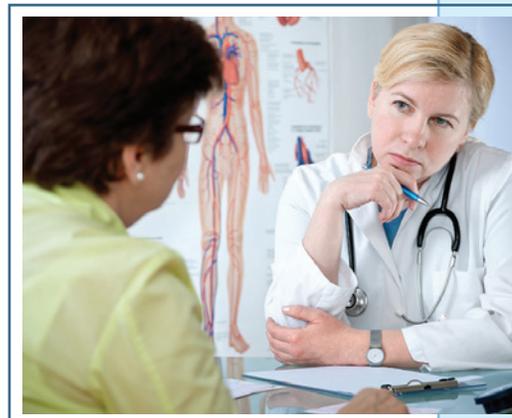
In order to bill for initial observation care, a medical observation record must be prepared in addition to any record prepared as a result of an ED or outpatient clinic encounter. This record must contain dated and timed physician's orders regarding:

- Observation services the patient is to receive;
- Nursing notes; and
- Progress notes prepared by the physician while the patient receives observation services.

Consultation Services

A consultation service is a medically necessary E/M visit that is furnished to evaluate and possibly treat a patient's medical problem(s) and can involve the following from a physician or NPP at the request of another physician or appropriate source:

- An opinion;
- Advice;
- A recommendation;
- A suggestion;
- Direction; or
- Counsel.



Effective for services furnished on or after January 1, 2010, inpatient consultation codes (Current Procedural Terminology [CPT] codes 99251 – 99255) and office and other outpatient consultation codes (CPT codes 99241 – 99245) are no longer recognized by Medicare for Part B payment purposes. However, telehealth consultation codes (Healthcare Common Procedure Coding System G0406 – G0408 and G0425 – G0427) continue to be recognized for Medicare payment. Physicians and NPPs who furnish services that, prior to January 1, 2010, would have been reported as CPT consultation codes should report the appropriate E/M visit code in order to bill for these services beginning January 1, 2010.

Incident to Provision

To be covered incident to the services of a physician, services and supplies must meet the following four requirements:

- 1) Commonly furnished in physicians' offices or clinics

Services and supplies commonly furnished in physicians' offices are covered under the Incident to Provision. Charges for these services and supplies must be included in the

physician's bill. To be covered, supplies (including drugs and biologicals) must be an expense to the physician or legal entity billing for the services or supplies.

- 2) Furnished by the physician or auxiliary personnel under the direct personal supervision of a physician

Services billed as incident to the services of a physician may be furnished by auxiliary personnel or NPPs under the required level of supervision. Auxiliary personnel are individuals who act under the supervision of a physician regardless of whether the individual is an employee, leased employee, or independent contractor of the physician or of the legal entity that employs or contracts with the physician. A physician may also have the services of certain NPPs covered as incident to his or her professional service.

These NPPs include the following:

- Audiologists;
- Certified nurse midwives;
- Certified registered nurse anesthetists;
- Clinical nurse specialists;
- Clinical psychologists;
- Clinical social workers;
- Nurse practitioners;
- Occupational therapists;
- Physical therapists; and
- Physician assistants.



The direct supervision for any service, including E/M services, can be furnished by any member of the group who is physically present on the premises and is not limited to the physician who has established the patient's plan of care. Direct supervision in the office setting means that the physician is present in the office suite and immediately available to furnish assistance and direction throughout the performance of the service.

Services furnished by auxiliary personnel outside the office setting (e.g., in a beneficiary's home or in an institution other than a hospital or Skilled Nursing Facility [SNF]) are covered incident to a physician's service only if there is personal supervision by the physician. Personal supervision means that a physician is physically in attendance in the same room during the performance of the procedure.

- 3) Commonly furnished without charge (included in the physician's bill) and are an expense to the physician

Incident to services or supplies must represent an expense incurred by the physician or legal entity billing for the services or supplies.

- 4) An integral, although incidental, part of the physician's professional service

The physician must have furnished a personal professional service to initiate the course of treatment that is being furnished by the NPP as an incidental part. There must also

MEDICARE PHYSICIAN GUIDE

be subsequent service by the physician of a frequency that reflects the physician's continuing active participation in, and management of, the course of treatment. The physician or another physician in the group practice must be physically present in the same office suite and immediately available to render assistance, if necessary. Although the rehabilitative services of PT, OT, and SLP have their own benefits under the law, it is also acceptable for these services to be billed by physicians incident to their services if the rules for both the therapy benefit and the incident to benefit are met, with one exception. The staff who provide therapy services under the direct supervision of a physician must be qualified as therapists, with the exception of any licensure requirements that may apply. For example, physical therapists must be licensed and graduates of an approved PT curriculum (unless they meet other requirements for foreign or pre-1977 training). Staff who provide PT services must be graduates of an approved PT curriculum, but not necessarily licensed.

The beneficiary's medical record should document the essential requirements for incident to services.

SERVICES NOT COVERED BY MEDICARE

The services that are not covered by Medicare include the following:

- Excluded services:
 - Acupuncture;
 - Care furnished in facilities located outside the U.S., except in limited cases;
 - Cosmetic surgery, unless medically necessary as a result of accident or injury (e.g., a car accident disfigures facial structure and reconstruction is needed);
 - Custodial care (e.g., assistance with bathing and dressing) at the beneficiary's home or in a nursing home;
 - Most dental services;
 - Hearing examinations;
 - Orthopedic shoes;
 - Routine eye care;
 - Routine foot care, with the exception of certain beneficiaries with diabetes;
 - Routine or annual physical examinations (with the exception of Initial Preventive Physical Examinations);
 - Screening tests with no symptoms or documented conditions, with the exception of certain preventive screening tests;
 - Services related to excluded services; and
 - Vaccinations, with certain exceptions;
- Services that are considered not medically necessary:
 - Services furnished in a hospital or SNF that, based on the beneficiary's condition, could have been furnished elsewhere (e.g., the beneficiary's home or a nursing home);



- Hospital or SNF services that exceed Medicare length of stay limitations;
- E/M services that are in excess of those considered medically reasonable and necessary;
- Therapy or diagnostic procedures that are in excess of Medicare usage limits; and
- Services not warranted based on the diagnosis of the beneficiary; and
- Services that have been denied as bundled or included in the basic allowance of another service:
 - Fragmented services included in the basic allowance of the initial service;
 - Prolonged care (indirect);
 - Physician standby services;
 - Case management services (e.g., telephone calls to and from the beneficiary); and
 - Supplies included in the basic allowance of a procedure.

In addition, Medicare does not pay for claims that have been rejected as unprocessable. An unprocessable claim has incomplete, missing, or invalid information that is necessary for processing the claim. Claims that have been rejected as unprocessable may be corrected and resubmitted for payment.

Providers and suppliers must give the beneficiary Form CMS-R-131, the Advance Beneficiary Notice of Noncoverage (ABN), before providing items or services that are usually covered, but are not expected to be paid by Medicare in a specific instance (e.g., lack of medical necessity). Issuance of an ABN is not required prior to providing items or services that are always excluded from coverage; however, providers and suppliers may choose to issue a voluntary ABN as a courtesy to the beneficiary to alert him or her about forthcoming financial liability. Chapter 3 of this guide provides additional information about the ABN.

Patient Name: _____ C. Identification Number: _____
Advance Beneficiary Notice of Noncoverage (ABN)
 Medicare doesn't pay for D. _____ below, you may have to pay.
 Medicare doesn't pay for everything, even some care that you or your health care provider
 might think you need. We expect Medicare may not pay for the D. _____
 E. Reason Medicare May Not Pay: _____ F. Estimated
 Cost _____
YOU NEED TO DO NOW:
 After you read this notice, so you can make an informed decision about your care.
 Ask us any questions that you may have after you finish reading. _____ listed a
 choice an option below about whether to receive the D. _____ listed a
 choice: If you choose Option 1 or 2, we may help you to use any other insurance
 that you might have, but Medicare cannot require us to do this.
OPTIONS: Check only one box. We cannot choose a box for you.
OPTION 1: I want the D. _____ listed above. You may ask to be paid now,
 but Medicare billed for an official decision on payment, which is sent to me on a letter.

Where to Find Additional Information About the Services Not Covered by Medicare

To find additional information about the services that are not covered by Medicare, refer to Chapter 16 of the “Medicare Benefit Policy Manual” (Pub. 100-02) located at <http://www.cms.gov/Manuals/IOM/list.asp> on the CMS website.

Note: The previous edition of this guide included a chapter that discussed common sets of codes and evaluation and management documentation. To access this information, please refer to the Medicare Learning Network® publication titled “Evaluation and Management Services Guide.” To access the downloadable version of this publication, visit http://www.cms.gov/MLNProducts/downloads/eval_mgmt_serv_guide-ICN006764.pdf on the CMS website. To place an order for the print version of this publication, visit <http://www.cms.gov/MLNGenInfo> on the CMS website.



CHAPTER FIVE

PROTECTING THE MEDICARE TRUST FUND

This chapter provides information about the Comprehensive Error Rate Testing (CERT) Program, the Medical Review (MR) Program, coverage determinations, and health care fraud and program abuse.

COMPREHENSIVE ERROR RATE TESTING PROGRAM

The goal of the CERT Program is to identify and measure improper payment amounts under Fee-For-Service (FFS) Medicare. A representative sample of claims is selected and reviewed to determine the level of proper versus improper payment amounts based on Medicare coverage determinations and payment policies. A national improper payment amount and corresponding error rate is projected based on results from the sample. The CERT program produces an annual report that summarizes the overall amount of improper payment across the following five major claim types:

- Part A:
 - Overall;
 - Inpatient hospital services;
 - Other inpatient hospital services (e.g., home health, hospice care, and Skilled Nursing Facilities); and
- Part B; and
- Durable medical equipment.

The CERT program may request that providers and suppliers submit medical records to verify the medical necessity for items or services furnished. Providers and suppliers may appeal a determination of improper payment and denial of payment for items or services furnished through the Medicare appeals process. Chapter 6 of this guide provides additional information about appeals.

Where to Find Additional Information About the Comprehensive Error Rate Testing Program

To find additional information about the CERT Program, visit <http://www.cms.gov/cert> on the Centers for Medicare & Medicaid Services (CMS) website.



THE MEDICAL REVIEW PROGRAM

The goal of the MR Program is to reduce payment errors by preventing the initial payment of claims that do not comply with Medicare’s coverage, coding, billing, and payment policies by:

- Analyzing data (e.g., profiling providers and suppliers, services, or beneficiary utilization) and evaluating other information (e.g., complaints, enrollment, and/or cost report data);
- Taking action to prevent and/or address identified improper payments; and
- Reducing the paid claims error rate by notifying the individual billing entities of review findings and making appropriate referrals.

Actions that may be taken to prevent and/or address identified improper payments include Progressive Corrective Action, which may involve:

- Ensuring that MR activities target identified problem areas and impose corrective actions appropriate for the severity of the infraction of Medicare rules and regulations;
- Validating claims identified as potential problems by selecting a small “probe” sample of problem claims (may be pre-payment or post-payment);
- Referring to appropriate staff for recoupment of identified overpayments;
- Referring to the Zone Program Integrity Contractor (ZPIC) or Program Safeguard Contractor (PSC);
- Evaluating the effectiveness of corrective action for post-payment review; and
- Pre-payment edits.

Where to Find Additional Information About the Medical Review Program

To find additional information about the MR Program, refer to the “Medicare Program Integrity Manual” (Pub. 100-08) located at <http://www.cms.gov/Manuals/IOM/list.asp> on the CMS website.

COVERAGE DETERMINATIONS

There are two types of coverage policies that assist providers and suppliers in coding correctly and billing Medicare only for covered items and services: National Coverage Determinations (NCD) and Local Coverage Determinations (LCD).

1) National Coverage Determination

An NCD sets forth the extent to which Medicare will cover specific services, procedures, or technologies on a national basis. An NCD is a reasonable and necessary determination made by the Secretary of the U.S. Department of Health and Human Services (HHS). Therefore, a failure to meet the terms of the NCD will make the item

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or service not reasonable and necessary, which is one of the categories of items and services Medicare is prohibited from paying under Section 1862(a)(1)(A) of the Social Security Act (the Act) and for which a beneficiary is given liability protection under Section 1879 of the Act if he or she did not know in advance that Medicare was prohibited from paying. A validly executed and delivered Form CMS-R-131, the Advance Beneficiary Notice of Noncoverage (ABN), establishes beneficiary knowledge that the item or service is non-covered, thereby eliminating his or her liability protection. Chapter 3 of this guide provides additional information about the ABN. Medicare Contractors are required to follow NCDs. Prior to an NCD taking effect, CMS must first issue a Manual Transmittal, ruling, or “Federal Register” Notice. If an NCD and an LCD exist concurrently regarding the same coverage policy, the NCD takes precedence.

2) Local Coverage Determination

To further define an NCD or in the absence of a specific NCD, Medicare Contractors may develop an LCD, which is a coverage decision made at their own discretion to provide guidance to the public and the medical community within a specified geographic area. An LCD cannot conflict with an NCD. An LCD is an administrative and educational tool that assists providers and suppliers in submitting correct claims for payment by:

- Outlining coverage criteria;
- Defining medical necessity; and
- Providing references upon which a policy is based and codes that describe what is and is not covered when the codes are integral to the discussion of medical necessity.

Providers and suppliers may submit requests for new or revised LCDs to Medicare Contractors.

The LCD development process is open to the public and includes:

- Developing a draft policy;
- Making the draft available for a minimum comment period of 45 days (if the policy requires a comment period); and
- Soliciting comments and recommendations on the draft, which health care professionals, provider organizations, and the public may electronically submit on Medicare Contractors’ websites. To find Medicare Contractor contact information, visit <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

LCDs and NCDs that may prevent access to items and services or result in claim denials can be challenged by aggrieved parties (Medicare beneficiaries or the estate of Medicare beneficiaries) who:

- Are entitled to benefits under Part A, are enrolled in Part B, or both (including beneficiaries who are enrolled in FFS Medicare and a Medicare Advantage Plan);
- Are in need of coverage for items or services that are denied based upon an applicable LCD or NCD, regardless of whether the items or services were received; and

- Have obtained documentation of the need for the items or services from his or her treating physician.

If a claim is denied by a Medicare Contractor based on an LCD or an NCD, the beneficiary is notified about the denial and the reasons for the denial on the Medicare Summary Notice.

Where to Find Additional Information About the Medicare Coverage Determination Process

To find additional information about the Medicare coverage determination process, refer to the “National Coverage Determinations Manual” (Pub. 100-03) and the “Medicare Program Integrity Manual” (Pub. 100-08) located at <http://www.cms.gov/Manuals/IOM/list.asp> and visit http://www.cms.gov/DeterminationProcess/01_Overview.asp on the CMS website.



HEALTH CARE FRAUD AND PROGRAM ABUSE

CMS, the U.S. Department of Justice, and the HHS Office of Inspector General (OIG) are charged with enforcing Federal health care fraud and program abuse laws.

Federal health care fraud generally involves an individual’s or entity’s intentional use of false statements or fraudulent schemes (such as kickbacks) to obtain payment for or to cause another individual or entity to obtain payment for items or services payable under a Federal health care program. Some examples of fraud are:

- Billing for services not furnished;
- Soliciting, offering, or receiving a kickback, bribe, or rebate;
- Violations of the physician self-referral (“Stark”) prohibition;
- Using an incorrect or inappropriate provider identifier in order to be paid (e.g., using a deceased individual’s provider identifier);
- Signing blank records or certification forms that are used by another entity to obtain Medicare payment;
- Selling, sharing, or purchasing Medicare Health Insurance Claim (HIC) numbers in order to bill false claims to the Medicare Program;
- Offering incentives to Medicare beneficiaries that are not offered to other patients (e.g., routinely waiving or discounting deductibles, coinsurance, or copayments);
- Falsifying information on applications, medical records, billing statements, cost reports, or on any statement filed with the government or its agents;
- Using inappropriate procedure or diagnosis codes to misrepresent the medical necessity or coverage status of the services furnished;
- Consistently using billing or revenue codes that describe more extensive services than those actually performed (upcoding); and
- Misrepresenting himself or herself as a Medicare beneficiary for the purpose of securing payment for health care by presenting a Medicare health insurance card or HIC number that rightfully belong to another individual.

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In general, program abuse, which may be intentional or unintentional, directly or indirectly results in unnecessary or increased costs to the Medicare Program. Many abusive practices are subsequently determined to be fraudulent. For example, if a provider or supplier ignores Medicare guidance, education efforts, warnings, or advice that abusive conduct is inappropriate and he or she continues to engage in the same or similar conduct, the conduct could be considered fraudulent.

Potential Legal Actions

Violating Federal health care fraud and program abuse laws may result in criminal penalties, civil fines, exclusion from Federal health care programs, or loss of a medical license. Below is a discussion of some of the potential consequences of failure to comply with fraud and abuse laws.

Investigations

A ZPIC or PSC Benefit Integrity Unit identifies and documents potential fraud and abuse and, when appropriate, refers such matters to the OIG.

Civil Monetary Penalties

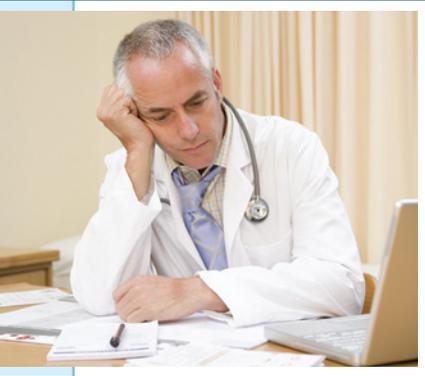
The OIG may seek Civil Monetary Penalties (CMP) for a wide variety of conduct and is authorized to seek penalties and assessments based on the type of violation at issue. Penalties range from \$10,000 to \$50,000 per violation and exclusion from the Medicare Program may be imposed. Some examples of violations for which CMPs may apply include:

- Violating Medicare assignment provisions;
- Violating the Medicare physician or supplier agreement;
- Violating the Anti-Kickback Statute;
- Providing false or misleading information expected to influence a decision to discharge;
- Presenting a claim that the individual knows or should know is for an item or service that was not furnished as claimed or is false or fraudulent; and
- Failing to provide an adequate medical screening examination for patients who present to a hospital emergency department with an emergency medical condition or in labor.

Denial or Revocation of Medicare Provider Billing Privileges

CMS has the authority to deny an individual's or entity's application for Medicare provider billing privileges or revoke a provider's billing privileges if there is evidence of impropriety (e.g., previous convictions, falsifying information on the application, or State or Federal licensure or certification requirements are not met).





Suspension of Payments

CMS has the authority to suspend payment to individuals and entities when there is reliable information that an overpayment, fraud, or willful misrepresentation exists or that payments to be made may not be correct. During payment suspensions, claims that are submitted will be processed and individuals and entities will be notified about claim determinations. Actual payments due are withheld and may be used to recoup amounts that were overpaid. Individuals and entities may submit written rebuttals regarding why a suspension of payment should not be imposed.

Exclusion from Participation

The HHS OIG is legally required to exclude from participation in all Federal health care programs individuals and entities convicted of the following types of criminal offenses:

- Fraud and any other offenses related to the delivery of items or services under the Medicare or Medicaid Programs;
- Patient abuse or neglect;
- Felony convictions for other health care-related fraud, theft, or other financial misconduct; and
- Felony convictions for unlawful manufacture, distribution, prescription, or dispensing of controlled substances.

The OIG also has the discretion to exclude individuals and entities on the following additional grounds:

- Misdemeanor convictions related to health care fraud other than Medicare or Medicaid fraud or misdemeanor convictions in connection with the unlawful manufacture, distribution, prescription, or dispensing of controlled substances;
- Suspension, revocation, or surrender of a license to provide health care for reasons bearing on professional competence, professional performance, or financial integrity;
- Provision of unnecessary or substandard services;
- Submission of false or fraudulent claims to a Federal health care program;
- Engaging in unlawful kickback arrangements; and
- Defaulting on health education loan or scholarship obligations.

Individuals and entities that are excluded from participation in Federal health care programs will not be paid for any items or services furnished, ordered, or supplied. Excluded providers may not bill directly for furnishing care to Medicare beneficiaries and their services may not be billed through an employer or a group practice. In addition, if services are furnished on a private-pay basis, orders or prescriptions given to the patient are not reimbursable by any Federal health care program.

Excluded Individual and Entity Lists

In general, providers and suppliers that participate in or bill a Federal health care program may not employ or contract with an excluded or debarred individual or entity. The HHS OIG List of Excluded Individuals/Entities (LEIE) provides information on individuals and entities that are currently excluded from participation in all Federal health care programs. To access the LEIE, visit http://oig.hhs.gov/exclusions/exclusions_list.asp on the HHS website.

The U.S. General Services Administration (GSA) Excluded Parties List System (EPLS) is an index of individuals and entities that have been excluded throughout the U.S. Government from receiving Federal contracts or certain subcontracts and certain types of Federal financial and non-financial assistance and benefits. To access the EPLS, visit <http://www.epls.gov> on the GSA website.

Incentive Reward Program

The Incentive Reward Program encourages individuals to report information regarding individuals or entities that commit Medicare fraud. Medicare offers a monetary reward for information that leads to a minimum recovery of \$100.00 of funds that were inappropriately obtained. Incentive rewards are 10 percent of the amount recovered or \$1,000, whichever amount is lower.

Health and Human Services Office of Inspector General Hotline Contact Information

To report suspected health care fraud or program abuse against Federal health care programs, the HHS OIG Hotline can be contacted as follows:

Mail:
Office of Inspector General
U.S. Department of Health and Human Services
ATTENTION: HOTLINE
P.O. Box 23489
Washington, DC 20026

Telephone: (800) 447-8477

E-mail: HHSTips@oig.hhs.gov

Fax: (800) 223-8164

Where to Find Additional Information About Health Care Fraud and Program Abuse

To find additional information about health care fraud and program abuse, refer to the “Medicare Program Integrity Manual” (Pub. 100-08) located at <http://www.cms.gov/Manuals/IOM/list.asp> on the CMS website and visit <http://oig.hhs.gov> on the HHS website.



CHAPTER SIX

MEDICARE OVERPAYMENTS AND FEE-FOR-SERVICE APPEALS

This chapter discusses Medicare overpayments and Fee-For-Service (FFS) appeals.

MEDICARE OVERPAYMENTS

A Medicare overpayment is a payment that a provider or supplier has received in excess of amounts due and payable under Medicare statutes and regulations. Once a determination of an overpayment has been made, the amount of the overpayment becomes a debt owed by the debtor to the Federal government. Federal law requires the Centers for Medicare & Medicaid Services (CMS) to seek recovery of all identified overpayments.

In general, provider or supplier overpayments occur due to:

- Duplicate submission of the same service or claim;
- Payment to the incorrect payee;
- Payment for excluded or medically unnecessary services;
- Payment for excessive or non-covered services; or
- Clerical error.

If a provider or supplier disagrees with an overpayment decision, he or she may file an appeal with the Medicare Contractor that processed the claim(s) at issue. A redetermination is the first level of appeal, in which a qualified employee of the Medicare Contractor conducts an independent review of the decision. A redetermination request must be filed within 120 calendar days from the date of the demand letter. However, in order to stop the initial recoupment process (which routinely starts on day 41 after the demand is issued), the redetermination request must be filed within 30 calendar days from the date of the demand letter. If the redetermination request is filed later

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than 30 calendar days from the date of the demand letter and recoupment has started, the recoupment process will stop when the appeal is filed. However, any recoupment already taken will not be refunded.

If a provider or supplier is still dissatisfied with the redetermination decision, he or she may request a second level of appeal or reconsideration by a Qualified Independent Contractor (QIC). A request for reconsideration by a QIC must be filed within 180 calendar days of the date the redetermination decision is received. In order to stop the recoupment process from starting, a reconsideration request must be filed within 60 days from the redetermination decision date. If the reconsideration request is filed later than 60 calendar days from the date of the redetermination decision and recoupment has started, the recoupment process will stop when the appeal request is received and validated. Any recoupment already taken will not be refunded. Thirty days after the QIC's decision or dismissal, the recoupment process will resume for any overpayment amount that has not been paid in full regardless of whether the provider or supplier requests further appeal levels.

Note: The limitation on recoupment rules described in the above paragraphs only apply to certain overpayments. The demand letter to the provider or supplier explains whether or not this limitation applies to the overpayment at issue. Where this limitation on recoupment exists and recoupment has occurred, interest will be paid to the provider or supplier for any recouped amount applied to the principal balance of the overpayment that is reversed at the Administrative Law Judge level or a subsequent level of appeal.



Interest accrues from the date of the demand and is assessed if the provider or supplier does not pay the debt in full by day 30. Interest is calculated for 30-day periods, as simple interest, at the rate in effect as of the date of the demand letter, and it is assessed for each full 30-day period that the debt is not resolved. Payments are applied to interest first and principal second. The provider or supplier may repay the debt in full at anytime.

Providers and suppliers also have an opportunity to rebut any proposed recoupment action by submitting a statement within 15 days of the demand notice that indicates why the proposed recoupment should not take place. These procedures are separate from the requirements of the limitation on recoupment process and do not replace the appeal process or toll the applicable timeframes for filing an appeal. The rebuttal process is a vehicle for the provider or supplier to inform the Medicare Contractor of a hardship, fraudulent provider number use, etc., while the appeal process is a vehicle for the provider or supplier to disagree with the actual determination.

Providers and suppliers are expected to repay an overpayment as quickly as possible. If the provider or supplier cannot refund the total overpayment within 30 days after receiving the first demand letter, an Extended Repayment Schedule (ERS) may be requested. If the request is approved, the ERS will specify the amount to be repaid, including interest, over an established timeframe.

Where to Find Additional Information About Medicare Overpayments

To find additional information about Medicare overpayments, refer to Chapter 34 of the “Medicare Claims Processing Manual” (Pub. 100-04) and Chapters 3 and 4 of the “Medicare Financial Management Manual” (Pub. 100-06) located at <http://www.cms.gov/Manuals/IOM/list.asp> on the CMS website. To find additional information about the limitation on recoupment provisions and associated interest provisions, refer to the “Code of Federal Regulations” (CFR) at 42 CFR 405.379 located at <http://www.gpo.gov/fdsys/search/home.action> on the U.S. Government Printing Office (GPO) website.



FEE-FOR-SERVICE APPEALS

A FFS appeal is an independent review of an initial determination made by a Medicare Contractor. Generally, a party to the initial determination is entitled to an appeal if he or she is dissatisfied with the determination and files a timely appeal request that contains the necessary information needed to process the request.

A party to an initial determination may be:

- A beneficiary who files a claim for payment or has a claim for payment filed on his or her behalf by a provider or supplier; or
- A provider or supplier who has accepted assignment for items or services furnished to a beneficiary that are at issue in the request for payment.

A party to a higher level appeal may be:

- The parties to an initial determination, except when a beneficiary has assigned his or her appeal rights;
- A State Agency pursuant to 42 CFR 405.908;
- A provider or supplier who accepts assignment of appeal rights for items or services furnished to a beneficiary; or
- A nonparticipating provider or supplier who does not accept assignment for items or services furnished to a beneficiary and may be obligated to make a refund pursuant to Sections 1834(a)(18), 1834(j)(4), or 1842(l) of the Social Security Act (the Act).

A provider or supplier who is not already a party to an appeal may appeal an initial determination for services furnished if the beneficiary subsequently dies, leaving no other party available to appeal the determination.

A party may appoint a representative if he or she wants assistance with the appeal. A provider or supplier may act as a beneficiary’s appointed representative. A party may appoint a representative to act on his or her behalf by completing Form CMS-1696, Appointment of Representative. A party may also appoint a representative through a submission that meets the following requirements:

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- It is in writing and is signed and dated by both the party and the individual who is agreeing to be the representative;
- It includes a statement appointing the representative to act on behalf of the party, and if the party is a beneficiary, authorizing the adjudicator to release identifiable health information to the appointed representative;
- It includes a written explanation of the purpose and scope of the representation;
- It contains the name, telephone number, and address of both the party and the appointed representative;
- It includes the beneficiary's Medicare Health Insurance Claim number (if the party is a beneficiary);
- It indicates the appointed representative's professional status or relationship to the party; and
- It is filed with the entity that is processing the party's initial determination or appeal.

A provider or supplier who furnishes the items or services being appealed may be appointed as the beneficiary's representative, but may not charge the beneficiary a fee for such representation and must waive their right to collect payment from the beneficiary for such items or services when the denial triggers the limitation on liability provisions of Section 1879 of the Act (e.g., services not medically reasonable and necessary or services considered custodial in nature).

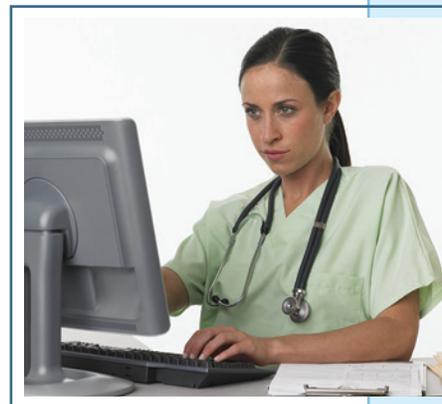
As noted above, a beneficiary may also assign (transfer) his or her appeal rights to a provider or supplier who is not a party to the initial determination and who furnished the items or services at issue in the appeal. A beneficiary must assign appeal rights using Form CMS-20031, Transfer of Appeal Rights. A provider or supplier who accepts assignment of appeal rights must waive the right to collect payment from the beneficiary for the items or services at issue in the appeal, with the exception of deductible and coinsurance amounts.

To access appeals forms, visit <http://www.cms.gov/CMSForms/CMSForms> on the CMS website and <http://www.hhs.gov/omha> on the HHS website.

Liability and Appeal Decisions

Liability regarding appeal decisions is as follows:

- When an original claim denial for both assigned and nonassigned claims is upheld on a review and the provider or supplier knew or could have been expected to know that payment for the service might be denied or reduced, he or she is held financially liable and must refund any monies collected from the beneficiary within 30 days of the review decision unless a valid Form CMS-R-131, the Advance Beneficiary Notice of Noncoverage (ABN), was properly executed. Chapter 3 of this guide provides additional information about the ABN;



- When an original claim denial for an assigned claim is upheld on a review and the provider or supplier and beneficiary could not have been expected to know that payment for the service might be denied or reduced, payment is made to the provider or supplier;
- When an original claim denial for a nonassigned claim is upheld on a review and it is found that the provider or supplier could not have been expected to know that payment for the service might be denied or reduced, he or she is notified that payment may be collected from the beneficiary. If the beneficiary is found financially liable, a letter is sent indicating that he or she is responsible for payment;
- When an original claim denial for a nonassigned claim is upheld on a review and it is found that neither the provider or supplier nor the beneficiary could have been expected to know that payment for the service might be denied or reduced, payment is made directly to the beneficiary; and
- When the beneficiary is not responsible for the payment of a service, the provider or supplier must refund any monies collected from the beneficiary. If the refund is not made within the specified time limits, the following actions may occur:
 - For an assigned claim, the beneficiary may submit a request to Medicare for indemnification from payment. A letter is sent to the provider or supplier indicating that a refund must be made to the beneficiary within 15 days for the amount actually paid, including any amounts applied to deductibles, coinsurance, and copayments. If the refund is not made within 15 days, payment is made to the beneficiary and an overpayment is assessed against the provider or supplier; or
 - For a nonassigned claim, the beneficiary may notify Medicare that the provider or supplier did not refund the amount due. A letter is sent to the provider or supplier indicating that a refund is due to the beneficiary within 15 days. If the refund is not made within 15 days, the provider or supplier may be subject to Civil Monetary Penalties and sanctions.



Where to Find Additional Information About Fee-For-Service Appeals

To find additional information about Medicare FFS appeals, refer to Chapter 29 of the “Medicare Claims Processing Manual” (Pub. 100-04) located at <http://www.cms.gov/Manuals/IOM/list.asp> and visit <http://www.cms.gov/OrgMedFFSAppeals> on the CMS website. To access the CFR, visit <http://www.gpo.gov/fdsys/search/home.action> on the GPO website.



CHAPTER SEVEN

PROVIDER OUTREACH AND EDUCATION

This chapter discusses the Medicare Learning Network® (MLN) and Medicare Contractor Provider Outreach and Education Programs.

THE MEDICARE LEARNING NETWORK

The MLN is a Centers for Medicare & Medicaid Services (CMS) program that offers providers and suppliers a variety of training and educational materials that break down Medicare policy into plain language. It delivers planned and coordinated provider education through various mechanisms including:

- National educational articles;
- Brochures;
- Fact sheets;
- Web-based training (WBT) courses;
- Videos; and
- Podcasts.

Where to Find Additional Information About the Medicare Learning Network

To find additional information about the MLN as well as links to training and educational materials, visit <http://www.cms.gov/MLNGenInfo> on the CMS website.

MEDICARE CONTRACTOR PROVIDER OUTREACH AND EDUCATION PROGRAMS

Medicare Contractor Provider Outreach and Education Programs offer providers and suppliers the following education on the fundamentals of the Medicare Program:

- National and local policies and procedures;
- New Medicare initiatives;

- Significant changes to the Medicare Program; and
- Issues identified through:
 - Analyses of provider inquiries;
 - Claim submission errors;
 - Medical review data; and
 - Comprehensive Error Rate Testing and Recovery Audit Contractors data.



Medicare Contractors use the following communication channels and mechanisms to offer providers and suppliers Medicare Program information:

- Print;
- Internet;
- Telephone;
- CD-ROM;
- Educational messages on the general inquiries line and Interactive Voice Response (IVR);
- Face-to-face instruction;
- WBT courses; and
- Presentations in classrooms and other settings.

Medicare Contractors respond to telephone, written (mail, e-mail, and FAX), and walk-in inquiries. Customer Service Representatives (CSR) are available to handle telephone inquiries continuously during normal business hours for all time zones of the geographic area serviced, Monday through Friday. Automated self-help tools (e.g., IVRs) are available 24 hours a day and provide information about the following topics:

- Hours of operation for CSR services;
- General Medicare Program;
- Specific information about claims in process and claims completed;
- Official definitions for the 100 most frequently used Remittance Codes (as determined by each Medicare Contractor); and
- Routine eligibility information.

Where to Find Additional Information About Medicare Contractor Provider Outreach and Education Programs

To find additional information about Medicare Contractor Provider Outreach and Education Programs, refer to Chapter 6 of the “Medicare Contractor Beneficiary and Provider Communications Manual” (Pub. 100-09) located at <http://www.cms.gov/Manuals/IOM/list.asp> on the CMS website. To find Medicare Contractor contact information, visit <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

GLOSSARY

A

Advance Beneficiary Notice of Noncoverage (Form CMS-R-131)

A written notice that a Fee-For-Service (FFS) provider or supplier must give to a beneficiary before providing items or services that are usually covered by Medicare, but are not expected to be paid in a specific instance (e.g., lack of medical necessity).

Assignment

When a participating provider or supplier is paid the Medicare allowed amount as payment in full for all Part B claims for all covered services for all Medicare beneficiaries.

C

Code of Federal Regulations

The official compilation of Federal rules and requirements.

Coinsurance

Under FFS Medicare and Medicare Advantage Private Fee-For Service Plans, a percentage of covered charges that the Medicare beneficiary may pay after he or she has met the applicable deductible.

Comprehensive Error Rate Testing Program

A program that identifies and measures improper payment amounts under FFS Medicare.

Consultation Service

A medically necessary evaluation and management (E/M) visit that is furnished to evaluate and possibly treat a patient's medical problem(s) and can involve the following from a physician or non-physician practitioner (NPP) at the request of another physician or appropriate source:

- An opinion;
- Advice;
- A recommendation;
- A suggestion;
- Direction; or
- Counsel.

Coordination of Benefits

The process that determines the respective responsibilities of two or more payers that have some financial responsibility for a medical claim.

Copayment

In some Medicare health plans, the amount the beneficiary pays for each medical service.

Cost Report

A report required from providers on an annual basis in order to make a proper determination of amounts payable under the Medicare Program.

Covered Service

A reasonable and necessary service furnished to Medicare or Medicaid beneficiaries and reimbursable to the provider, supplier, or beneficiary.

D

Deductible

Amount a beneficiary must pay before Medicare begins to pay for covered services and supplies.

Durable Medical Equipment

Medical equipment ordered by a physician or, if Medicare allows, a nurse practitioner, physician assistant or clinical nurse specialist for use in the home. The item must be reusable (e.g., walkers, wheelchairs, or hospital beds).

E

Electronic Health Record Incentive Program Payment

An incentive payment made to eligible professionals, hospitals, and Critical Access Hospitals that demonstrate meaningful use of certified electronic health record technology.

Electronic Prescribing Incentive Program Payment

An incentive payment that eligible professionals who are successful electronic prescribers as defined by the Medicare Improvements for Patients and Providers Act of 2008 may be eligible for.

F

Fee-For-Service Appeal

An independent review of an initial determination made by a Medicare Contractor.

Fee Schedule

Method of reimbursement in which Medicare payment is based on a comprehensive list of covered services and their payment rates.

G

Global Surgery

A package that includes all the usual services furnished by the physician who performs the surgery in any setting during the pre-operative and post-operative periods.

H

Health Care Fraud

Generally involves an individual's or entity's intentional use of false statements or fraudulent schemes (e.g., kickbacks) to obtain payment for or to cause another individual or entity to obtain payment for items or services payable under a Federal health care program.

Health Professional Shortage Area Payment

A 10 percent incentive payment that physicians (including psychiatrists) who furnish care in an area that is designated as a geographic-based, primary medical care Health Professional Shortage Area (HPSA) and psychiatrists who furnish care in an area that is designated as a geographic-based mental health HPSA are eligible for when outpatient professional services are furnished to a Medicare beneficiary.

Hospital Observation Services

A well-defined set of specific, clinically appropriate services that include ongoing short-term treatment, assessment, and reassessment furnished while a decision is being made about whether the patient will require further treatment as a hospital inpatient or can be discharged from the hospital.

I

Incentive Reward Program

A program that encourages individuals to report information regarding individuals or entities that commit Medicare fraud.

Incident to Provision

In order to be covered incident to the services of a physician, services and supplies must meet the following four requirements:

- They are commonly furnished in physicians' offices or clinics;
- They are furnished by the physician or auxiliary personnel under the direct personal supervision of a physician;
- They are commonly furnished without charge (included in the physician's bill) and are an expense to the physician; and
- They are an integral, although incidental, part of the physician's professional service.

Interns and Residents

Include individuals who:

- Participate in approved Graduate Medical Education (GME) programs; or
- Physicians who are not in approved GME programs, but are authorized to practice only in a hospital setting (e.g., have temporary or restricted licenses or are unlicensed graduates of foreign medical schools). Also included in this definition are interns, residents, and fellows in GME programs recognized as approved for purposes of direct GME and Indirect Medical Education payments made by Fiscal Intermediaries or A/B Medicare Administrative Contractors.

L

Local Coverage Determination

A coverage decision developed by Medicare Contractors at their own discretion to further define a National Coverage Determination (NCD) or in the absence of a specific NCD to provide guidance to the public and the medical community within a specified geographic area.

M

Medicaid

A cooperative venture funded by Federal and State governments that pays for medical assistance for certain individuals and families with low incomes and limited resources.

Medically Necessary

Services or supplies that:

- Are proper and needed for the diagnosis or treatment of the beneficiary's medical condition;
- Are furnished for the diagnosis, direct care, and treatment of the beneficiary's medical condition;
- Meet the standards of good medical practice; and
- Are not mainly for the convenience of the beneficiary, provider, or supplier.

Medical Review Program

A program that aims to reduce payment errors by preventing the initial payment of claims that do not comply with Medicare's coverage, coding, billing, and payment policies.

Medicare-Covered Service

A service that is medically reasonable and necessary to the overall diagnosis and treatment of the beneficiary's condition.

Medicare Learning Network®

A Centers for Medicare & Medicaid Services (CMS) program that offers FFS providers and suppliers a variety of training and educational materials that break down Medicare policy into plain language. It delivers planned and coordinated provider education through various mechanisms including:

- National educational articles;
- Brochures;
- Fact sheets;
- Web-based training courses;
- Videos; and
- Podcasts.

Medicare Overpayment

A payment that a provider or supplier has received in excess of amounts due and payable under Medicare statutes and regulations.

Medicare Part A

Hospital insurance that helps pay for:

- Inpatient hospital care;
- Inpatient care in a Skilled Nursing Facility following a covered hospital stay;
- Some home health care; and
- Hospice care.

Medicare Part B

Medical insurance that helps pay for:

- Medically necessary services furnished by physicians in a variety of medical settings;
- Home health care for individuals who do not have Part A;
- Ambulance services;
- Clinical laboratory and diagnostic services;
- Surgical supplies;
- Durable medical equipment, prosthetics, orthotics, and supplies;
- Hospital outpatient services; and
- Services furnished by practitioners with limited licensing.

Medicare Part C (Medicare Advantage)

Another health plan choice available to Medicare beneficiaries run by Medicare-approved private insurance companies that furnish or arrange for the provision of health care services to the beneficiary who:

- Is entitled to Part A and enrolled in Part B;
- Permanently resides in the service area of the Medicare Advantage (MA) Plan; and
- Elects to enroll in a MA Plan.

Individuals with End-Stage Renal Disease are generally excluded from enrolling in MA Plans.

Medicare Part D (Prescription Drug Benefit)

Benefit that provides prescription drug coverage to all beneficiaries enrolled in Part A and/or Part B who elect to enroll in a Medicare Prescription Drug Plan or a MA Prescription Drug Plan. Insurance companies or other companies approved by Medicare provide prescription drug coverage to such individuals who live in the plan’s service area.

Medicare Summary Notice

A notice that a beneficiary receives after a provider or supplier files a claim for Part A and Part B services. It explains:

- What the provider or supplier billed for;
- The Medicare-approved amount;
- How much Medicare paid; and
- What the beneficiary must pay.

Medigap

A health insurance policy sold by private insurance companies to fill gaps in Medicare coverage.

N

National Coverage Determination

A coverage policy that sets forth the extent to which Medicare will cover specific services, procedures, or technologies on a national basis.

National Provider Identifier

A unique identification number for health care providers that is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. Covered health care providers and all health plans and health care clearinghouses must use this identification number in the administrative and financial transactions adopted under HIPAA.

Nonparticipating Provider or Supplier

A Part B provider or supplier who has not indicated that he or she wishes to participate in the Medicare Program and may accept assignment of Medicare claims on a claim-by-claim basis.

P

Participating Provider or Supplier

A Part B provider or supplier who has indicated that he or she wishes to participate in the Medicare Program by completing and signing Form CMS-460, the Medicare

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Participating Physician or Supplier Agreement, and agrees to accept assignment of Medicare benefits for all covered services for all Medicare beneficiaries.

Physician Quality Reporting System Incentive Payment

An incentive payment that identified eligible professionals who satisfactorily report data on quality measures for covered Medicare Physician Fee Schedule services furnished to Part B beneficiaries may be eligible for under the Physician Quality Reporting System.

Physicians

Defined by the Medicare Program to include the following:

- Chiropractors (DC);
- Doctors of dental surgery (DDS) or dental medicine (DMD);
- Doctors of medicine (MD) and doctors of osteopathy (DO);
- Doctors of optometry (OD); or
- Doctors of podiatry (DPM) or surgical chiropody (DSC).

In addition, the Medicare physician must be legally authorized to practice by a State in which he or she performs this function.

Practitioners

Defined by the Medicare Program as any of the following to the extent that the individual is legally authorized to practice by the State and otherwise meets Medicare requirements:

- Anesthesiologist assistants;
- Certified nurse midwives;
- Certified registered nurse anesthetists;
- Clinical nurse specialists;
- Clinical psychologists;
- Clinical social workers;
- Nurse practitioners;
- Physician assistants; or
- Registered dietitians or nutrition professionals.

Primary Care Incentive Payment

Effective for services furnished on and after January 1, 2011, the following practitioner specialties are potentially eligible for a payment of 10 percent of allowed charges for Part B primary care services furnished to beneficiaries:

- Family, internal, geriatric, and pediatric medicine physicians;
- Certified nurse specialists;
- Nurse practitioners; and
- Physician assistants.

Program Abuse

In general, may be intentional or unintentional and directly or indirectly results in unnecessary or increased costs to the Medicare Program.

Prolonged Care

Occurs when a physician or NPP:

- Provides direct face-to-face patient contact that is one hour beyond the usual service;
- Provides the service in an office or other outpatient setting or in an inpatient setting; and
- Bills for the service on the same day by the same provider as the companion E/M codes.

Prospective Payment System

Method of reimbursement in which Medicare payment is made to a provider or supplier based on a predetermined, fixed amount that is derived based on the classification system of the service.

R

Remittance Advice

A notice of payments and adjustments that is sent to the provider, supplier, or biller after a claim has been received and processed. It may serve as a companion to claim payments or as an explanation when there is no payment.

S

Split/Shared Service

An encounter where a physician and a NPP each personally perform a portion of an E/M visit.

T

Teaching Physicians

Physicians (other than interns or residents) who involve residents in the care of their patients.

Timely Filing Requirement

Claims with dates of service on or after January 1, 2010, must be received no later than one calendar year from the claim’s date of service (an exception may apply if certain conditions are met).

RESOURCES

Resources for each chapter of this publication are listed below.

Chapter One

About CMS

<http://www.cms.gov/home/aboutcms.asp>

Internet-Only Manuals

<http://www.cms.gov/Manuals/IOM/list.asp>

Provider Call Center Toll-Free Numbers Directory

<http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>

Compilation of the Social Security Laws

http://www.ssa.gov/OP_Home/ssact/title18/1800.htm

Health Plans – General Information (Medicare Advantage)

<http://www.cms.gov/HealthPlansGenInfo>

Private Fee-For-Service Plans

<http://www.cms.gov/PrivateFeeforServicePlans>

Prescription Drug Coverage – General Information

<http://www.cms.gov/PrescriptionDrugCovGenIn>

U.S. Social Security Administration

<http://www.socialsecurity.gov>

U.S. Department of Health and Human Services

Office of Inspector General

<http://oig.hhs.gov>

Survey & Certification – Contact Information

http://www.cms.gov/SurveyCertificationGenInfo/03_ContactInformation.asp

Quality Improvement Organizations

http://www.cms.gov/QualityImprovementOrgs/01_Overview.asp

State Health Insurance and Assistance Programs

http://www.cms.gov/Partnerships/10_SHIPS.asp

Chapter Two

Internet-Only Manuals

<http://www.cms.gov/Manuals/IOM/list.asp>

National Plan and Provider Enumeration System

<https://nppes.cms.hhs.gov/NPPES/Welcome.do>

National Provider Identifier Standard – How to Apply

http://www.cms.gov/NationalProvIdentStand/03_apply.asp

CMS Forms

<http://www.cms.gov/CMSForms/CMSForms/list.asp>

National Provider Identifier Standard

<http://www.cms.gov/NationalProvIdentStand>

Medicare Fee-For-Service Provider Enrollment Contact List

http://www.cms.gov/MedicareProviderSupEnroll/downloads/contact_list.pdf

Medicare Provider-Supplier Enrollment

http://www.cms.gov/MedicareProviderSupEnroll/01_Overview.asp

Survey & Certification – Contact Information

http://www.cms.gov/SurveyCertificationGenInfo/03_ContactInformation.asp

U.S. Department of Health and Human Services

Office of Minority Health

<https://www.thinkculturalhealth.hhs.gov>

Chapter Three

CMS Forms

<http://www.cms.gov/CMSForms/CMSForms/list.asp>

Provider Call Center Toll-Free Numbers Directory

<http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>

Administrative Simplification Compliance Act Self Assessment

http://www.cms.gov/ElectronicBillingEDITrans/05_ASCASelfAssessment.asp

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U.S. Government Printing Office

U.S. Government Bookstore – Form CMS-1500

<http://bookstore.gpo.gov/collections/cms1500-form.jsp>

National Uniform Billing Committee

<http://www.nubc.org/guide.html>

Internet-Only Manuals

<http://www.cms.gov/Manuals/IOM/list.asp>

Electronic Billing & EDI Transactions

<http://www.cms.gov/ElectronicBillingEDITrans>

Durable Medical Equipment Center

<http://www.cms.gov/center/dme.asp>

Coordination of Benefits – General Information

<http://www.cms.gov/COBGeneralInformation>

HPSA/PSA (Physician Bonuses)

<http://www.cms.gov/HPSAPSAPhysicianBonuses>

U.S. Department of Health and Human Services

Health Resources and Services Administration – Find Shortage Areas

<http://hpsafind.hrsa.gov>

U.S. Census Bureau

<http://www.census.gov>

Physician Quality Reporting System

<http://www.cms.gov/PQRS>

Electronic Prescribing (eRx) Incentive Program

<http://www.cms.gov/ERxIncentive>

EHR Incentive Programs

<http://www.cms.gov/EHRIncentivePrograms>

Beneficiary Notices Initiative (Advance Beneficiary Notice)

http://www.cms.gov/BNI/01_overview.asp

Medicaid Program – General Information

<http://www.cms.gov/MedicaidGenInfo>

RESOURCES

Medicare Supplement Health Insurance (Medigap)

<http://www.cms.gov/Medigap>

United Mine Workers of America

<http://www.umwa.org>

Chapter Four

Internet-Only Manuals

<http://www.cms.gov/Manuals/IOM/list.asp>

**Medicare Learning Network® Publication
“Evaluation and Management Services Guide”**

http://www.cms.gov/MLNProducts/downloads/eval_mgmt_serv_guide-ICN006764.pdf

Medicare Learning Network – General Information

<http://www.cms.gov/MLNGenInfo>

Chapter Five

Comprehensive Error Rate Testing

<http://www.cms.gov/cert>

Internet-Only Manuals

<http://www.cms.gov/Manuals/IOM/list.asp>

Provider Call Center Toll-Free Numbers Directory

<http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>

Medicare Coverage Determination Process

http://www.cms.gov/DeterminationProcess/01_Overview.asp

U.S. Department of Health and Human Services

Office of Inspector General – List of Excluded Individuals/Entities

http://oig.hhs.gov/exclusions/exclusions_list.asp

U.S. General Services Administration

Excluded Parties List System

<https://www.epls.gov>

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U.S. Department of Health and Human Services
Office of Inspector General
<http://oig.hhs.gov>

Chapter Six

Internet-Only Manuals

<http://www.cms.gov/Manuals/IOM/list.asp>

U.S. Government Printing Office “Code of Federal Regulations”

<http://www.gpo.gov/fdsys/search/home.action>

CMS Forms

<http://www.cms.gov/CMSForms/CMSForms>

U.S. Department of Health and Human Services Office of Medicare Hearings and Appeals

<http://www.hhs.gov/omha>

Original Medicare (Fee-For-Service) Appeals

<http://www.cms.gov/OrgMedFFSAppeals>

Chapter Seven

Medicare Learning Network® – General Information

<http://www.cms.gov/MLNGenInfo>

Internet-Only Manuals

<http://www.cms.gov/Manuals/IOM/list.asp>

Provider Call Center Toll-Free Numbers Directory

<http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>

Note: The Reference Section of the previous edition of this guide included the “1995 Documentation Guidelines for Evaluation and Management Services” and the “1997 Documentation Guidelines for Evaluation and Management Services.” To access this information, please refer to the Medicare Learning Network® publication titled “Evaluation and Management Services Guide.” To access the downloadable version of this publication, visit http://www.cms.gov/MLNProducts/downloads/eval_mgmt_serv_guide-ICN006764.pdf on the CMS website. To place an order for the print version of this publication, visit <http://www.cms.gov/MLNGenInfo> on the CMS website.



The Medicare Learning Network[®] (MLN), a registered trademark of CMS, is the brand name for official CMS educational products and information for Medicare Fee-For-Service Providers. For additional information, visit the MLN's web page at <http://www.cms.gov/MLNGenInfo> on the CMS website.