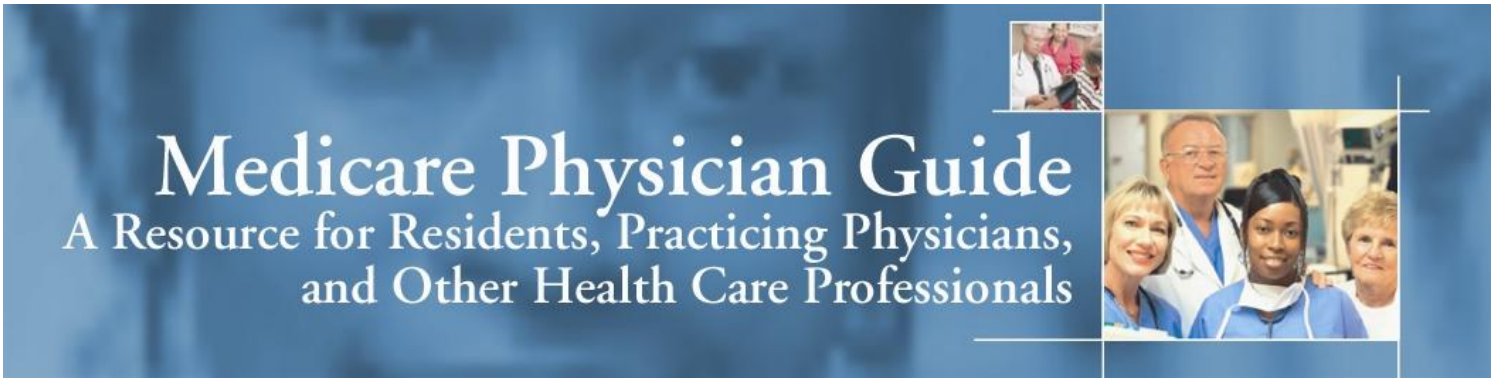

Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals

Tenth Edition – October 2008

Disclaimer

This guide 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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Medicare Learning Network

The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's web page at *http://www.cms.hhs.gov/MLNGenInfo* on the CMS website.

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Errata Sheet

To access the Errata Sheet that contains corrections or changes that have been identified regarding this publication, select the title of the publication from the list of MLN Publications located at *http://www.cms.hhs.gov/MLNProducts/MPUB/list.asp* on the CMS website.

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CHAPTER 1 – INTRODUCTION TO THE MEDICARE PROGRAM

This chapter provides information about the Centers for Medicare & Medicaid Services (CMS), the Medicare Program, organizations that impact the Medicare Program, and recent laws that impact the Medicare Program.

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 awards contracts to organizations called Medicare Contractors who perform claims processing and related administrative functions. Beginning in 2006, all Original Medicare Plan claims processing Contractors (Fiscal Intermediaries, Carriers, and Durable Medical Equipment Carriers) will be transitioned into Medicare Administrative Contractors. The Provider Call Center Toll-Free Numbers Directory, which contains Medicare Contractor contact information, can be accessed in the Downloads Section at *http://www.cms.hhs.gov/MLNGenInfo* on the CMS website.

CMS also regulates laboratory testing and surveys and certifies nursing homes, health care agencies, intermediate care facilities for the mentally retarded, and hospitals. 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 Contractors.

To find additional information about CMS, visit *http://www.cms.hhs.gov/home/aboutcms.asp* on the CMS website.

The Medicare Program

The Medicare Program was established by Title XVIII of the Social Security Act (the Act) on July 1, 1966. Medicare provides medical coverage to individuals age 65 years or older, certain disabled individuals, and individuals with End-Stage Renal Disease (ESRD).

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.

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 health insurance card and picture identification should be made for the beneficiary's medical file.

Medicare consists of the following four parts:

- Part A, hospital insurance;
- Part B, medical insurance;
- Part C, Medicare Advantage (MA); and
- Part D, prescription drug plan (PDP).

Medicare Part A and Part B

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 following a covered hospital stay;
- Some home health care; and
- Hospice care.

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.

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

Individuals residing in the U.S. (except residents of Puerto Rico) who become entitled to premium-free Part A are automatically enrolled 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. A person age 65 years or over who is not entitled to premium-free Part A must be a U.S. resident and either a citizen or an alien who has been lawfully admitted for permanent residency with five years continuous residence in this country at the time of filing in order to be entitled to Part B. Individuals who are not eligible for automatic enrollment, previously refused Part B, or terminated their Part B enrollment may enroll or re-enroll in Part B only during prescribed enrollment periods.

Medicare Part A and Part B Enrollment and Termination of Enrollment

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

- Initial Enrollment Period (IEP), which for most individuals 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 he or she attains age 65 years).
- General Enrollment Period, which takes place from January 1 through March 31 of each year. Premium Part A and Part B coverage will be effective on July 1.
- Special Enrollment Period (SEP) for the working aged and working disabled, which is when individuals may enroll who did not enroll in premium Part A or Part B when first eligible because they were covered under a Group Health Plan (GHP) based on their 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 eight-month period that begins the month the employment ends or the GHP coverage ends, whichever occurs first. Individuals with ESRD are not eligible to enroll during this SEP.
- SEP for international volunteers, which is when individuals may enroll who did not enroll in premium Part A or Part B when first eligible because they were 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 month he or she is no longer performing volunteer service outside of the U.S.
- Transfer Enrollment Period, which is when individuals who are age 65 years or over, entitled to Part B, and enrolled in a MA or Medicare 1876 cost plan may enroll in premium Part A. The individual may enroll during any month in which he or she is enrolled in the MA or Medicare 1876 cost plan or during any of the eight consecutive months following the last month he or she was enrolled in the MA or Medicare 1876 cost plan.

Once enrolled, premium Part A and Part B coverage continue until they are terminated due to one of the following:

- The individual's voluntary request;
- Failure to pay premiums;
- Part A entitlement ends (Part B will terminate at the same time) for the disabled or individuals with ESRD who are under age 65 years; or
- The individual's death.

Medicare Part A and Part B Eligibility

Medicare Part A and Part B are available to the following groups of individuals: the aged insured, the aged uninsured, the disabled, and those with ESRD, as discussed below.

1) The aged insured

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 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 he or she becomes age 65 years. If the application is filed later than that, Part A entitlement can be retroactive for only six months. For Medicare purposes, individuals attain age 65 years the day before their 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 their 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. Individuals who continue 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.

2) The aged uninsured

A second group of aged individuals who are eligible for Part A are those individuals age 65 years or older who are not insured but elect to purchase Part A coverage by filing an application at a Social Security office. Because a monthly premium is required, this coverage is called premium Part A. In addition to application and monthly premium requirements, the individual must also be a U.S. resident and either a citizen or an alien lawfully admitted for permanent residency who has resided in the U.S. continuously for at least five years as of the time 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.

3) The disabled

A disabled person 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, disabled persons who are not insured for monthly Social Security disability benefits but would be insured for such benefits if their QCs from government employment were Social Security QCs are 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. Beginning July 1, 2001, individuals whose disability is Amyotrophic Lateral Sclerosis are entitled to Medicare the first month they are entitled to Social Security disability cash benefits. If an individual recovers from a disability, Part A entitlement ends with the end of the month after the month he or she is notified of the disability termination. However, in the case of individuals who return to work but continue to suffer from a disabling impairment, Part A entitlement will continue for at least 93 months after the individual returns to work.

4) Those with ESRD

Individuals are eligible for Part A if they receive regular dialysis treatments or a kidney transplant, have filed an application, and meet one of the following conditions:

- Have worked the required amount of time under Social Security, the RRB, or as a government employee;
- Are receiving or are eligible for Social Security or Railroad Retirement benefits; or
- Are 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 of the course of dialysis if the individual engages in self-dialysis training;
- 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 C – Medicare Advantage

MA is a program through which organizations that contract with CMS furnish or arrange for the provision of health care services to Medicare beneficiaries who:

- Are entitled to Medicare Part A and enrolled in Part B;
- Permanently reside in the service area of the MA Plan; and
- Elect to enroll in a MA Plan.

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., providing another option in some rural areas. In addition, in many rural areas, beneficiaries are able to choose options such as Private Fee-for-Service Plans (PFFS), Health Maintenance Organizations, local PPOs (currently the most popular type of employer-sponsored plan), and Medicare Medical Savings Account (MSA) Plans (combines a high-deductible health plan with a MSA).

MA plans may also offer Medicare prescription drug benefits. Individuals enrolled in MA plans must receive their Medicare prescription drug benefits from their MA plan, except for MA PFFS plans that do not include drug benefits.

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

- Initial Coverage Election Period, which begins three months immediately before the individual's entitlement to both Medicare 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.
- Annual Coordinated Election Period (AEP), which occurs each year between November 15 and December 31. The Plan must accept all enrollments during this time unless it has reached its member limits.
- SEP, when, under certain circumstances, the beneficiary may change MA Plans or return to the Original Medicare Plan.
- Open Enrollment Period (OEP), during which time the beneficiary may leave or join another MA Plan if it is open and accepting new members. Elections made during this period must be made to the same type of plan (regarding Medicare prescription drug coverage) in which the individual is already enrolled. The OEP occurs from January through March of every year. If a plan chooses to be open, it must allow all eligible beneficiaries to join or enroll.

Part D – Prescription Drug Plan

The prescription drug plan provides prescription drug coverage to all beneficiaries who elect to enroll in a PDP or MA PDP.

Medicare beneficiaries may choose to join or leave a Medicare PDP during the following enrollment periods:

- The IEP for Part D is the 7-month period that surrounds the individual beneficiary's first eligibility for Part D, beginning 3 months before the month of eligibility and ending on the last day of the third month following the month eligibility began.
- AEP, which occurs each year between November 15 and December 31. The Medicare PDP must accept all enrollments during this time.

- Beneficiaries in certain circumstances may change PDP plans. The following are examples of such circumstances:
    - He or she permanently moves outside the service area;
    - He or she has both Medicare and Medicaid;
    - He or she moves into, resides in, or moves out of an institution; or
    - Other exceptions as determined by CMS.

Organizations That Impact the Medicare Program

The following organizations impact the Medicare Program:

- U.S. House of Representatives:
    - Ways and Means Committee;
    - Appropriations Committee; and
    - Energy and Commerce Committee.
- U.S. Senate:
    - Appropriations Committee;
    - Finance Committee; and
    - Energy and Commerce Committee.
- The Social Security Administration (SSA) determines eligibility for Medicare benefits and enrolls individuals in Part A and/or Part B and the Federal Black Lung Benefit Program. The SSA completes the following activities:
    - Replaces lost or stolen Medicare cards;
    - Makes address changes;
    - Collects premiums from beneficiaries; and
    - Educates beneficiaries about coverage and insurance choices.

  Contact information for the SSA is as follows:
  Website: *http://www.ssa.gov*
  Telephone: (800) 772-1213

- The Office of Inspector General (OIG) protects the integrity of HHS programs and the health and welfare of beneficiaries of those programs through a nationwide network of audits, investigations, inspections, and other mission-related functions. Additional information about the OIG can be found at *http://www.oig.hhs.gov/* on the Web.
- State Agencies survey all Medicare 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.
- CMS contracts with one Quality Improvement Organization (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. The mission of the QIO Program

is to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries. Additional information about QIOs and a link to the directory of QIOs can be found at *http://www.cms.hhs.gov/QualityImprovementOrgs/01_Overview.asp* on the CMS website.

- The State Health Insurance Assistance Program (SHIP) is a national program that offers free one-on-one counseling and assistance to people with Medicare 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 long-term care insurance; Medigap; fraud and abuse; and the Medicare, Medicaid, and public benefit programs for those with limited income and assets. Additional information about SHIPs and a link to State Health Insurance offices can be found at *http://www.cms.hhs.gov/Partnerships/10_SHIPS.asp* on the CMS website.

Recent Laws That Impact the Medicare Program

The following recently enacted laws impact the Medicare Program:

- The Medicare Improvements for Patients and Providers Act of 2008, which was enacted on July 15, 2008, includes the provision that the mid-year 2008 Medicare Physician Fee Schedule (MPFS) rate reduction of –10.6 percent will be retroactively replaced with the fee schedule rates in effect from January 2008 – June 2008, which reflect a 0.5 percent update from 2007 rates. In addition, MPFS payment rates are being revised to increase the fee schedule amounts for certain mental health services. The law also reinstated the therapy caps exceptions process for the period July 1, 2008 – December 31, 2009. Medically necessary therapy services, in excess of the therapy caps, will continue to be paid by Medicare in accordance with the exceptions process. Outpatient therapy service providers may now resume submitting claims with the KX modifier for therapy services that exceed the cap furnished on or after July 1, 2008. The law also delayed the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. Items that had been included in the first round of the DMEPOS Competitive Bidding Program can be furnished by any enrolled DMEPOS supplier in accordance with existing Medicare rules.
- The Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Extension Act of 2007 authorized the continuation of a financial incentive called the Physician Quality Reporting Initiative (PQRI) for eligible professionals to participate in a voluntary quality reporting program. Additional information about the PQRI can be found at *http://www.cms.hhs.gov/PQRI* on the CMS website.

CHAPTER 2 – 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);
- Hospice;
- Hospitals (acute care inpatient services);
- Indian Health Services Facilities;
- Inpatient Psychiatric Facilities;
- Inpatient Rehabilitation Facilities;
- Long Term Care Hospitals;
- Multiple hospital components in a medical complex;
- Organ Procurement Organizations;
- Program for All-Inclusive Care for the Elderly (PACE) providers;
- Religious Non-Medical 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);
- Clinical psychologists (CP);
- Community Mental Health Centers;
- Comprehensive Outpatient Rehabilitation Facilities;
- Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers (including pharmacies);
- End-Stage Renal Disease Facilities;
- Home Health Agencies (outpatient Part B services);
- Hospitals (outpatient services);

- Independent diagnostic testing facilities;
- Nurse practitioners (NP);
- 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;
- Physicians; and
- SNFs (outpatient services).

Physicians

The Medicare Program defines physicians to include the following:

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

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
- 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 his or her 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 (MPFS).

Practitioners

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

- Physician assistant (PA);
- NP;
- Clinical nurse specialist (CNS);
- Certified registered nurse anesthetist (CRNA);
- Certified nurse midwife (CNM);
- CP;
- Clinical social worker (CSW); or
- Registered dietician or nutrition professional.

Enrolling in the Medicare Program

Providers and suppliers must complete the following steps in order to enroll in and obtain reimbursement from Medicare:

1) Obtain a National Provider Identifier (NPI), which is a standard unique identifier for health care providers that replaces health care provider identifiers that were previously used in standard transactions and eliminates the need to use different identification numbers when conducting Health Insurance Portability and Accountability Act standard transactions with multiple plans. Providers and suppliers can apply for a NPI using one of the following methods:

- Visit *https://nppes.cms.hhs.gov* and complete the web-based application;
- Call (800) 465-3203 to request a paper application; or
- With the provider's permission, an Electronic File Interchange Organization can submit the application data.

Additional information about the NPI can be found at *http://www.cms.hhs.gov/NationalProvIdentStand* on the Centers for Medicare & Medicaid Services (CMS) website.

2) Complete the appropriate Medicare Enrollment Application. In the enrollment process, CMS collects information about the applying provider or supplier and secures documentation to ensure that the he or she is qualified and eligible to enroll in the

Medicare Program. Depending upon provider or supplier type, one of the following forms is completed to enroll in the Medicare Program:

- Form CMS-855A/Medicare Enrollment Application for Institutional Providers: Application: Application used by institutional providers to initiate the Medicare enrollment process or to change Medicare enrollment information;
- Form CMS-855B/Medicare Enrollment Application for Clinics/Group Practices and Certain Other Suppliers: Application used by group practices or 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.

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);
- Form CMS-460/Medicare Participating Physician or Supplier Agreement: Agreement to become a Part B participating provider or supplier who will accept assignment of Medicare benefits for all covered services for all Medicare beneficiaries (see the Participating and Nonparticipating Providers and Suppliers Section of this chapter for additional information about participating in the Medicare Program); and
- CMS Standard Electronic Data Interchange (EDI) Enrollment Form: Agreement executed by each provider of health care services, physician, 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 Medicare Administrative Contractors and must be completed prior to submitting EMC or other EDI transactions to Medicare.

The above forms are available at *http://www.cms.hhs.gov/CMSForms/CMSForms/list.asp* on the CMS website.

Additional forms, which may vary from state to state, may also be required in order to enroll in the Medicare Program. These forms include the following:

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

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). Contact information for SAs can be found at *http://www.cms.hhs.gov/SurveyCertificationGenInfo/03_Contact%20Information.asp* on the CMS website.

By law, in most cases Medicare must pay the provider who furnishes the service. In limited situations, however, Medicare allows physicians and practitioners who furnish services and take assignment to reassign payment to another qualified person or entity. This person or entity then bills Medicare on behalf of the physician or practitioner and receives payment for the services furnished. When a physician or practitioner authorizes someone else to bill and be paid by Medicare for services that he or she furnishes, both parties are jointly responsible for ensuring that claims filed are appropriate and reflect services actually furnished. Another exception is where a physician does not participate in Medicare and does not take assignment on the claim, in which case Medicare sends payment to the beneficiary and the physician collects the limiting charge from the beneficiary.

After all forms have been completed and signed, the enrollment packet is then mailed to the appropriate Medicare Contractor for processing. Information about where to send the enrollment packet can be found at *http://www.cms.hhs.gov/MedicareProviderSupEnroll/downloads/contact_list.pdf* on the CMS website. For most applicants, the enrollment process takes 60 days. CMS requires its Contractors to process enrollment applications within certain timeframes. Additional information about Medicare provider and supplier enrollment can be found at *http://www.cms.hhs.gov/MedicareProviderSupEnroll* on the CMS website.

Providers must report changes in their enrollment information to the Medicare Contractor as soon as possible and no later than 90 days after the reportable event by submitting the information on the same application that is used to initiate the Medicare enrollment process, with the exception of the following:

- Providers must report a change of ownership or managing interest control within 30 days; and
- DMEPOS suppliers must notify the National Supplier Clearinghouse of changes in their enrollment information within 30 days.

Participating and Nonparticipating Providers and Suppliers

There are two types of providers and suppliers in Part B of the Medicare Program: participating and nonparticipating.

1) Participating providers and suppliers:
    - Accept assignment of Medicare benefits for all covered services for all Medicare beneficiaries;
    - Receive higher MPFS 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 Physician and Other Healthcare Professional Directory.

By completing and signing Form CMS-460, the Medicare Participating Physician or Supplier Agreement, the provider or supplier has formally notified CMS that he or she wishes to participate in the Medicare Program and will accept assignment of Medicare benefits for all covered services for all Medicare beneficiaries. Assignment means that the provider or supplier will be paid the Medicare allowed amount as payment in full for his or her services. 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 PAs, NPs, CNSs, CNMs, CRNAs, CPs, CSWs, and medical nutrition therapists;
- ASC services;
- Home dialysis supplies and equipment paid under Method II;
- Drugs; 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 Contractor Open Enrollment Period, which is usually in November. During this period, participation status can be changed for 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 in which the Medicare Contractor is notified about a change in status. Once the Medicare Participating Physician or Supplier Agreement is signed, CMS rarely honors a provider 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 MPFS allowances than participating providers and suppliers for assigned or nonassigned claims;
- Are held to a limiting charge when submitting nonassigned claims (with the exception of pharmaceuticals, equipment, and supplies) and may collect up to the limiting charge at the time services are furnished, which is the maximum amount that can be charged for the services furnished (unless prohibited by an applicable State law); and
- Are not included in the Physician and Other Healthcare Professional Directory.

Below is an example of a limiting charge.

MPFS 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 MPFS allowed amount)
Limiting Charge for Procedure "X"	$218.50 ($190.00 x 1.15 = 115 percent of MPFS allowed amount)
Beneficiary Coinsurance and Limiting Charge Portion Due to Provider or Supplier	$66.50 ($38.00 + $28.50) Coinsurance – 20 percent of MPFS allowed amount ($190.00 x .20 = $38.00) **PLUS** $218.50 – Limiting charge –190.00 – Nonparticipating provider/supplier allowed amount $ 28.50 – Allowed amount

The limiting charge applies 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.

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
MPFS Allowed Amount	$100.00	$ 95.00	$ 95.00
80 Percent of MPFS 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 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;
- Doctors of osteopathy;
- Doctors of dental surgery or dental medicine;
- Doctors of podiatric medicine; and
- Doctors of optometry.

PAs, CNSs, CRNAs, CNMs, CPs, and CSWs 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.

The opt-out period is for two years unless it is terminated early or the physician or practitioner fails to maintain opt-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 service."

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.

Additional information about how to become a Medicare provider or supplier is available as follows:

- *http://www.cms.hhs.gov/medicareprovidersupenroll* on the CMS website; and
- In the Medicare General Information, Eligibility, and Entitlement Manual (Pub. 100-1) located at *http://www.cms.hhs.gov/Manuals* on the CMS website.

Promoting Cultural Competency in Your Practice

The 2000 U.S. Census confirmed that our country is becoming increasingly diverse. Racial and ethnic minorities make up 30 percent of the American population and are expected to increase to 40 percent by 2030. Some 47 million U.S. residents speak a language other than English. With the increasing diversity of the U.S. population,

providers 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 in delivering high quality, effective health care and increase patient satisfaction, improve patient compliance, and reduce racial and ethnic health disparities.

The Department of Health and Human Services Office of Minority Health and Science Applications International Corporation have developed a free interactive web-based training cultural competency course titled *A Physician's Practical Guide to Culturally Competent Care*. The course assists physicians, PAs, NPs, and pharmacists 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 course offers a variety of continuing education credit types. The course and information about cultural competency are available at *http://thinkculturalhealth.org* on the Web.

CHAPTER 3 – MEDICARE REIMBURSEMENT

This chapter provides information about Medicare claims; deductibles, coinsurance, and copayments; coordination of benefits; incentive and bonus payments; the Medicare Physician Fee Schedule (MPFS); 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 Contactors monitor compliance with these requirements. Offenders may be subject to a Civil Monetary Penalty of up to $10,000 for each violation.

In general, Medicare fee-for-service claims must be filed timely, which means that they must be filed on or before December 31 following the year in which the services were furnished. Services furnished in the last quarter of the fiscal year (FY) are considered furnished in the following FY.

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);
- 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 (some supplemental insurers who pay for these services may require a Medicare claim denial notice prior to making payment);
- He or she has opted-out of the Medicare Program by signing a private contract with the beneficiary; or
- He or she has been excluded or debarred from the Medicare Program.

Electronic Claims

As of October 16, 2003, all 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.

Electronic versions of Centers for Medicare & Medicaid Services (CMS) claim forms can be found at *http://www.cms.hhs.gov/CMSForms/CMSForms/list.asp* on the CMS website. Each provider or supplier must complete a 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. Additional information about electronic billing and EDI transactions is available at *http://www.cms.hhs.gov/ElectronicBillingEDITrans* on the CMS website. The EDI Enrollment Form is available from Medicare Contractors.

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
- Have information 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 choose to alternatively 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.

The Provider Call Center Toll-Free Numbers Directory, which contains Medicare Contractor contact information, can be accessed in the Downloads Section at *http://www.cms.hhs.gov/MLNGenInfo* on the CMS website.

Paper Claims

To find information about the limited situations in which paper claims can be submitted, visit *http://www.cms.hhs.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:

- U.S. Government Printing Office
  U.S. Government Bookstore
  Website: *http://bookstore.gpo.gov*
  Telephone: (866) 512-1800;
- Printing companies; and
- Office supply stores.

Institutional providers and suppliers use the CMS-1450, also known as UB-04, to bill Medicare Contractors. UB-04 claim forms can be ordered from:
National Uniform Billing Committee
Website: *http://www.nubc.org/guide.html* on the Web
Telephone: (800) 242-2626

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 (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
- Method II home dialysis.

Deductibles, Coinsurance, and Copayments

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 the Original Medicare Plan or a Private Fee-for-Service Plan, coinsurance is a percentage of covered charges that the Medicare 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 is paid by the beneficiary 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.

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 beneficiaries or their representatives 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, 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 Medicare 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
- Due to the physical or mental incapacity of the beneficiary, a proper claim was not filed with the primary insurer.

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.

Additional information about MSP is available as follows:

- In the Medicare General Information, Eligibility, and Entitlement Manual (Pub. 100-1) and Medicare Secondary Payer Manual (Pub. 100-5) located at *http://www.cms.hhs.gov/Manuals* on the CMS website; and
- *http://www.cms.hhs.gov/COBGeneralInformation* on the CMS website.

Coordination of Benefits Contractor

The Coordination of Benefits Contractor (COBC) performs activities that support the collection, management, and reporting of other health insurance or coverage for Medicare beneficiaries. The COBC also has responsibility for consolidation of the claims crossover process, which ensures that payers, including State Medicaid Agencies, have the opportunity to receive Medicare processed claims from one source for their use in calculating their supplemental payment. The COBC assists providers and suppliers with the following:

- Answering general questions regarding MSP;
- Verifying Medicare's primary/secondary status (note that insurer-specific information will not be released; information on payers primary to Medicare must be requested from the beneficiary prior to billing);
- Reporting changes to a beneficiary's health insurance or coverage; and
- Reporting a beneficiary's accident/injury.

If a provider or supplier submits a claim for primary payment on behalf of a beneficiary and there is information either on the claim form or in Medicare's system of records indicating that Medicare is properly the secondary payer, the claim will be denied unless the provider or supplier has submitted sufficient evidence to demonstrate that Medicare is properly the primary payer for the services provided. The beneficiary cannot be billed

when a claim is denied because a primary payer to Medicare exists. If a provider or supplier submits a claim for secondary payment on behalf of a beneficiary but there is no information in Medicare's system of records to identify the MSP situation and the claim form does not contain sufficient information to update Medicare's system of records, the COBC will investigate in an effort to obtain the required information.

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

- Initial enrollment questionnaire, which is sent to Medicare beneficiaries approximately three months before Medicare coverage begins regarding their other health insurance or coverage;
- Internal Revenue Service, 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 Medicare beneficiary;
- MSP claims investigation, which is a 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 that allow for electronic data exchange of GHP eligibility and Medicare information between CMS and employers or insurers.

COBC contact information is as follows:

Toll-free line: (800) 999-1118

General written inquiries:
MEDICARE - COB
P.O. Box 5041
New York, NY 10274-5041

Questionnaires and correspondence:
MEDICARE - COB
Data Match Project
P.O. Box 33848
Detroit, MI 48232

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

MSP Claims Investigation Project:
P.O. Box 33847
Detroit, MI 48232

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

Employer/Insurer Outreach:
P.O. Box 660
New York, NY 10274

Small Employer Exemptions:
P.O. Box 660
New York, NY 10274

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

The COBC does not process claims nor does it handle any mistaken primary recoveries or claims-specific inquiries. Medicare Contractors are responsible for processing claims submitted for primary or secondary payment and provider/supplier-related recovery. Questions concerning Medicare claim or service denials, adjustments, and billing (e.g., value and occurrence codes) should be directed to the Medicare Contractor. Inappropriate Medicare payments should be returned to the Medicare Contractor. The Provider Call Center Toll-Free Numbers Directory, which contains Medicare Contractor contact information, can be accessed in the Downloads Section at *http://www.cms.hhs.gov/MLNGenInfo* on the CMS website.

Incentive and Bonus 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 (the 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.

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. 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 within a designated full county HPSA;
2) It is not considered to fall within the county based on a determination of dominance made by the U.S. Postal Service; or
3) It is partially in a sub-county HPSA.

In these situations, the physician must utilize an AQ modifier to receive payment for claims with dates of service on or after January 1, 2006. If the ZIP code of the place of service is not on the HPSA list for automated payment, eligibility must be verified with the Fiscal Intermediary or A/B Medicare Administrative Contractor before submitting a claim with the AQ modifier.

If a physician provides services in an area that is both an eligible HPSA and an eligible Physician Scarcity Area (PSA), he or she will receive a 15 percent bonus payment on a quarterly basis. The bonus payment is based on the paid amount of the claim.

Additional information about incentive payments is available as follows:

- In Chapter 12 of the Medicare Claims Processing Manual (Pub. 100-4) – *http://www.cms.hhs.gov/Manuals* on the CMS website;
- To find the list of eligible ZIP codes – *http://www.cms.hhs.gov/hpsapsaphysicianbonuses/01_overview.asp* on the CMS website;
- To determine if an area is in a qualified HPSA – *http://www.hpsafind.hrsa.gov* and select the advanced search option; and
- To determine the census tract of the place of service – *http://www.ffiec.gov/Geocode/default.aspx* and enter the address.

Physician Scarcity Area Bonus Payment

The PSA Bonus Payment Program was created under Section 413(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 to facilitate the recruitment and retention of physicians who furnish care to Medicare beneficiaries in PSAs and was payable for dates of service January 1, 2005 through December 31, 2007. The Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Extension Act of 2007 amended Section 1833 (u)(1) of the Act, extending the payment

of the PSA bonus for dates of service through June 30, 2008. Physicians who furnish outpatient professional services in a PSA receive a five percent bonus payment. The two PSA categories are:

- Primary care, which is determined by the ratio of primary care physicians to Medicare beneficiaries; and
- Specialty care, which is determined by the ratio of specialty physicians to Medicare beneficiaries.

Determination of eligibility for the bonus payment is made based on the ZIP code where the service was furnished. If the service is furnished in an area that is on the CMS list of ZIP codes that are eligible for the PSA bonus payment, payments are automatically paid on a quarterly basis. If the ZIP code is not on the list but the area is in a county designated as a PSA, the AR modifier must be used.

For purposes of the PSA Bonus Payment Program, a primary care physician is defined as a:

- General practitioner;
- Family practice practitioner;
- General internist;
- Obstetrician; or
- Gynecologist.

A specialty care physician is defined as a physician other than a primary care physician.

The following providers are NOT eligible for the PSA bonus payment:

- Dentists;
- Chiropractors;
- Optometrists; and
- Podiatrists.

If a physician furnishes services in an area that is both an eligible PSA and an eligible HPSA, he or she will receive a 15 percent bonus payment on a quarterly basis. The bonus payment is based on the paid amount of the claim.

Additional information about bonus payments is available as follows:

- *http://www.cms.hhs.gov/hpsapsaphysicianbonuses/01_overview.asp* on the CMS website; and
- In Chapter 12 of the Medicare Claims Processing Manual (Pub. 100-4) – *http://www.cms.hhs.gov/Manuals* on the CMS website.

Medicare Physician Fee Schedule

Medicare Part B pays for physician services based on the MPFS, which lists the more than 7,000 covered services and their payment rates. Physician services include the following:

- Office visits;
- Surgical procedures; and
- A range of other diagnostic and therapeutic services.

Physician services are furnished in all settings, including:

- Physicians' offices;
- Hospitals;
- Ambulatory Surgical Centers;
- Skilled Nursing Facilities and other post-acute care settings;
- Hospices;
- Outpatient dialysis facilities;
- Clinical laboratories; and
- Beneficiaries' homes.

Payment rates for an individual service are based on three components:

1) Relative Value Units (RVU)

The three separate RVUs that are associated with the calculation of a payment under the MPFS are:

- Work RVUs reflect the relative levels of time and intensity associated with furnishing a physician fee schedule service and account for more than 50 percent of the total payment associated with a service. By statute, all work RVUs must be examined no less often than every five years.
- Practice expense (PE) RVUs reflect the costs of maintaining a practice such as renting office space, buying supplies and equipment, and staff costs. PE RVUs account for approximately 45 percent of the total payment associated with a given service.
- Malpractice RVUs represent the remaining portion of the total payment associated with a service.

2) Conversion Factor (CF)

To determine the payment rate for a particular service, each of the three separate RVUs is adjusted by the corresponding geographic cost index. The sum of the geographically adjusted RUVs is multiplied by a dollar CF. The CF is updated on an annual basis according to a formula specified by statute. The formula specifies that the update for a year is equal to the Medicare Economic Index (MEI) adjusted up or down depending on how actual expenditures compare to a target rate called the Sustainable Growth Rate (SGR). The MEI is a measure of inflation faced by physicians with respect to their

practice costs and general wage levels. The SGR is calculated based on medical inflation, the projected growth in the domestic economy, projected growth in the number of beneficiaries in fee-for-service Medicare, and changes in law or regulation.

3) Geographic Practice Cost Indices (GPCI)

GPCIs are adjustments that are applied to each of the three relative values used in calculating a physician payment. The purpose of these adjustments is to account for geographic variations in the costs of practicing medicine in different areas within the country. We are required to review, and if necessary, adjust GPCIs at least every three years.

Additional information about the MPFS is available at *http://www.cms.hhs.gov/PhysicianFeeSched/01_overview.asp* on the CMS website.

Medicare Notices

Advance Beneficiary Notice

An Advance Beneficiary Notice (ABN) is a written notice that a provider or supplier gives to a beneficiary under certain circumstances (e.g., lack of medical necessity) before items or services are furnished to advise him or her that specified items or services may not be covered by Medicare. Providing an ABN allows the beneficiary to make an informed decision about whether to receive the item or service in question. In general, 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. 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 they 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 additional information about ABNs and the ABN forms, visit *http://www.cms.hhs.gov/BNI/02_ABNGABNL.asp* on the CMS website.

Certificate of Medical Necessity and Durable Medical Equipment Medicare Administrative Contractor Information Forms

Certificate of Medical Necessity (CMN) and DME MAC Information Forms (DIF) are included with claims for certain items that require additional information (e.g., DME and PEN). Additional information about the CMN and DIF is available as follows:

- To find CMN and DIF forms – *http://www.cms.hhs.gov/CMSForms/CMSForms/list.asp* on the CMS website;

- To find Certificates of Medical Necessity – *http://www.cms.hhs.gov/MedicalReviewProcess/05_certificatesofmedicalnecessity.asp* on the CMS website; and
- Overview of the Durable Medical Equipment, Prosthetics/Orthotics, and Supplies Fee Schedule – *http://www.cms.hhs.gov/DMEPOSFeeSched/01_overview.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.

Additional information about the RA is available at *http://www.cms.hhs.gov/ElectronicBillingEDITrans/11_Remittance.asp* on the CMS website.

Medicare Summary Notice

Beneficiaries receive the Medicare Summary Notice (MSN), which lists all services or supplies that were billed to Medicare, on a monthly basis. If a beneficiary disagrees with a claims decision, he or she has the right to file an appeal. See Chapter 7 for more information about appeals. Additional information about MSNs can be found at *http://www.cms.hhs.gov/MSN/01_overview.asp* on the CMS website.

Other Health Insurance Plans

Medicare Advantage

Medicare Advantage (MA) is a program through which organizations that contract with the CMS furnish or arrange for the provision of health care services to Medicare beneficiaries who:

- Are entitled to Medicare Part A and enrolled in Part B;
- Permanently reside in the service area of the MA Plan; and

- Elect to enroll in a MA Plan.

Providers and suppliers who 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 beneficiary 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.

Additional information about MA can be found at *http://www.cms.hhs.gov/HealthPlansGenInfo* on the CMS website.

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 Medicare 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
    - 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 Medicare Part A and Part B coverage. Medicare covered services are paid first by the Medicare Program since Medicaid is always the payer of last resort.

Additional information about Medicaid can be found at *http://www.cms.hhs.gov/MedicaidGenInfo* on the CMS website.

Medigap

Medigap is a health insurance policy sold by private insurance companies to fill gaps in Original Medicare Plan coverage. A Medigap policy is not associated with a labor or union organization. Beneficiaries must be enrolled in Medicare Part A and Part B in order to purchase a Medigap policy and, under certain circumstances, are guaranteed the right to buy a 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.

Additional information about Medigap can be found at *http://www.cms.hhs.gov/Medigap* on the CMS website.

Railroad Retirement

Some Medicare beneficiaries who are retired railroad workers have supplementary medical insurance benefits from the Railroad Retirement Board. For information about Part B benefits filed on behalf of Railroad Retirement beneficiaries in the Original Medicare Plan contact:

Palmetto GBA
Railroad Medicare Part B Office
P. O. Box 10066
Augusta, GA 30999-0001
Telephone: (800) 833-4455

United Mine Workers of America

Some Medicare beneficiaries are members of the United Mine Workers of America (UMWA), which provides a health insurance plan for retired coal miners, spouses, and dependents. Paper UMWA claims should be sent to:

UMWA Health and Retirement Funds
P. O. Box 619099
Dallas, TX 75261-9741

For information regarding electronic medical claims submissions contact:

Envoy
Telephone: (800) 215-4730

Additional information about Medicare reimbursement can be found in the Medicare Claims Processing Manual (Pub. 100-4) located at *http://www.cms.hhs.gov/Manuals* on the CMS website.

CHAPTER 4 – MEDICARE PAYMENT POLICIES

This chapter discusses Medicare covered services, the incident to provision, and services not covered by Medicare.

Medicare Covered Services

In general, Medicare covered services are considered medically reasonable and necessary to the overall diagnosis and treatment of the beneficiary's condition. 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 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.

An inpatient is an individual who has been admitted to a hospital for the purpose of receiving inpatient hospital services. Generally, an individual is considered an inpatient if he or she is formally admitted as inpatient with the expectation of remaining at least overnight and occupying a bed. The individual is considered an inpatient even if he or she can later be discharged or transferred to another hospital and does not actually use a hospital bed overnight.

The physician or other practitioner responsible for an individual's care at the hospital is responsible for deciding whether he or she should be admitted as an inpatient. The physician or other practitioner should work closely with hospital staff to ensure a proper admission as an inpatient following hospital admission protocols. The physician or practitioner should also use a 24-hour period as a benchmark by ordering admission for individuals who are expected to need hospital care for 24 hours or more and treating other individuals on an outpatient basis. The decision to admit an individual is a complex medical judgment that requires the consideration of:

- The individual's medical history and current medical needs, including the severity of the signs and symptoms exhibited;
- The medical predictability of something adverse happening to the individual;
- The need for diagnostic studies that will assist in assessing whether the individual should be admitted and that do not ordinarily require him or her to remain at the hospital for 24 hours or more;
- The availability of diagnostic procedures at the time when and where the individual presents;
- The types of facilities available to inpatients and outpatients;
- The hospital's by-laws and admissions policies; and
- The relative appropriateness of treatment in each setting.

In the following situations, coverage of services on an inpatient or outpatient basis is not determined solely on the basis of length of time the individual actually spends in the hospital:

1) Minor surgery or other treatment

When an individual with a known diagnosis enters a hospital for a specific minor surgical procedure or other treatment that is expected to keep him or her in the hospital for only a limited period of time, the individual is considered an inpatient only if the physician orders an inpatient admission regardless of his or her arrival hour at the hospital, or use of a bed, or if he or she remains in the hospital past midnight.

2) Renal dialysis treatments

Renal dialysis treatments are usually covered only as outpatient services for the individual who:

- Resides at home;
- Is ambulatory;
- Has stable conditions; and
- Comes to the hospital for routine chronic dialysis treatments (not for a diagnostic workup or a change in therapy).

The following individuals who receive renal dialysis are usually inpatients:

- Those undergoing short-term dialysis until the kidneys recover from an acute illness (acute dialysis); and
- Those who have borderline renal failure and develop acute renal failure every time they have an illness and require dialysis (episodic dialysis).

An individual may begin dialysis as an inpatient and then progress to outpatient status. If noncovered services that are generally excluded from Medicare coverage are furnished in Non-Prospective Payment System hospitals, part of the billed charges or the entire admission may be denied. Appropriately admitted cases in Prospective Payment System (PPS) hospitals include the following:

- If care is noncovered because an individual does not need to be hospitalized, the admission will be denied and the Part A PPS payment will be made only under limitation on liability. Under limitation on liability, Medicare payment may be made when the provider and the beneficiary were unaware that the services were not necessary and could not reasonably be expected to know that they were not necessary. If an individual is appropriately hospitalized but receives only noncovered care (beyond routine services), the admission is denied. An admission that includes covered care, even if noncovered care was also furnished, will not be denied. Under PPS, Medicare assumes that it is paying for only the covered care furnished when covered services needed to treat and/or diagnose the illness are furnished.
- If a noncovered procedure is furnished along with covered nonroutine care, a Diagnosis Related Group change rather than an admission denial might occur. If noncovered procedures elevate costs into the cost outlier category, outlier payment will be denied in whole or in part.
- If an individual receives items or services in excess of, or more expensive than, those for which payment can be made, payment is made only for the covered items or services or the appropriate PPS amount. This provision applies to inpatient services as well as all hospital services under Medicare Part A and Part B. If items or services are requested by the beneficiary, the hospital may charge him or her the difference between the amount customarily charged for the services requested and the amount customarily charged for covered services.

If an individual requires extended care services and is admitted to a bed in a hospital, he or she is considered an inpatient of the hospital. The services furnished in the hospital will not be considered extended care services and payment may not be made unless the services are extended care services furnished pursuant to a swing bed agreement granted to the hospital by the Secretary of the Department of Health and Human Services.

Part B Services

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

- Physician services such as surgery, consultations, office visits, institutional calls;
- Services and supplies furnished incident to physician professional services;
- 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;
- Certain medical supplies used in connection with home dialysis delivery systems;
- Ambulatory Surgical Center services; and
- Preventive services.

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 non-physician practitioners (NPP) 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:

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

The direct supervision for any service, including evaluation and management (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 or included in the physician's bill

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 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;

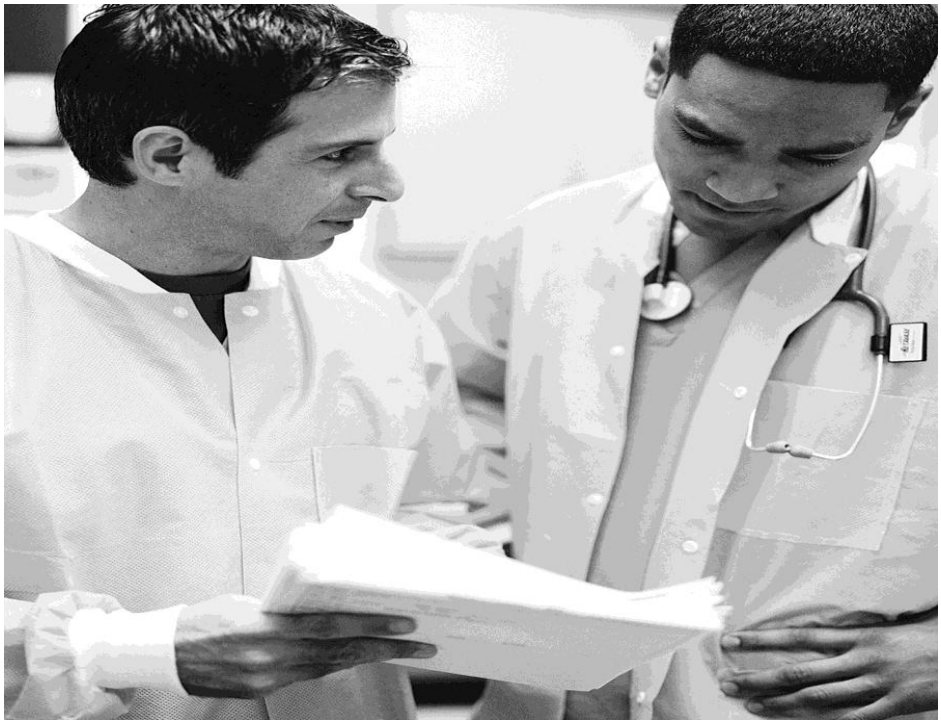
- Services that are considered not medically necessary:
    - Services furnished in a hospital or SNF that, based on the beneficiary's condition, could have been furnished elsewhere (e.g., the beneficiary's home or a nursing home);
    - Hospital or SNF services that exceed Medicare length of stay limitations;
    - 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."

Providers and suppliers should give a beneficiary an Advance Beneficiary Notice (ABN) before items or services are furnished to advise him or her that specified items or services may not be covered by Medicare. See Chapter 3 for additional information about the ABN.

Additional information about payment policies can be found in the Medicare Benefit Policy Manual (Pub. 100-2) at *http://www.cms.hhs.gov/Manuals* on the CMS website.

CHAPTER 5 – EVALUATION AND MANAGEMENT SERVICES



This chapter discusses common sets of codes and evaluation and management (E/M) documentation. It also includes the following reference materials:

- *1995 Documentation Guidelines for Evaluation and Management Services*; and
- *1997 Documentation Guidelines for Evaluation and Management Services.*

Common Sets of Codes

When billing for a patient's visit, codes are selected that best represent the services furnished during the visit. The two common sets of codes used are:

- ICD-9-CM codes; and
- Procedural or American Medical Association Current Procedural Terminology (CPT) codes.

These codes are organized into various categories and levels. It is the physician's responsibility to ensure that documentation reflects the services furnished and that the codes selected reflect those services. The more work performed by the physician, the higher the level of code he or she may bill within the appropriate category. The billing specialist or alternate source reviews the physician's documented services and assists with selecting codes that best reflect the extent of the physician's personal work necessary to furnish the services.

E/M services refer to visits and consultations furnished by physicians. Billing Medicare for a patient visit requires the selection of a CPT code that best represents the level of E/M service performed. For example, there are five CPT codes that may be selected to bill for office or other outpatient visits for a new patient:

- 99201® – Usually the presenting problem(s) are self limited or minor and the physician typically spends 10 minutes face-to-face with the patient and/or family. E/M requires the following three key components:
    - Problem focused history.
    - Problem focused examination.
    - Straightforward medical decision making.
- 99202 – Usually the presenting problem(s) are of low to moderate severity and the physician typically spends 20 minutes face-to-face with the patient and/or family. E/M requires the following three key components:
    - Expanded problem focused history.
    - Expanded problem focused examination.
    - Straightforward medical decision making.

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- 99203® – Usually the presenting problem(s) are of moderate severity and the physician typically spends 30 minutes face-to-face with the patient and/or family. E/M requires the following three key components:
    - Detailed history.
    - Detailed examination.
    - Medical decision making of low complexity.
- 99204 – Usually the presenting problem(s) are of moderate to high severity and the physician typically spends 45 minutes face-to-face with the patient and/or family. E/M requires the following three key components:
    - Comprehensive history.
    - Comprehensive examination.
    - Medical decision making of moderate complexity.
- 99205 – Usually the presenting problem(s) are of moderate to high severity and the physician typically spends 60 minutes face-to-face with the patient and/or family. E/M requires the following three key components:
    - Comprehensive history.
    - Comprehensive examination.
    - Medical decision making of high complexity.

The *Current Procedural Terminology* book may be purchased from:
American Medical Association
Website: *http://www.amapress.org*
Telephone: (800) 621-8335

Evaluation and Management Documentation

Medicare pays physicians based on diagnostic and procedure codes that are derived from medical documentation. E/M documentation is the pathway that translates a physician's patient care work into the claims and reimbursement mechanism. This pathway's accuracy is critical in:

- Ensuring that physicians are paid correctly for their work;
- Supporting the correct E/M code level; and
- Providing the validation required for medical review.

Providers may use either the *1995 Documentation Guidelines for Evaluation and Management Services* or the *1997 Documentation Guidelines for Evaluation and Management Services*. Medicare Contractors must conduct reviews using both the 1995 and the 1997 guidelines and apply the guidelines that are most advantageous to the provider.

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Additional information about E/M services is available as follows:

- E/M documentation – *http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp* and Chapter 12, Section 100 of the Medicare Claims Processing Manual (Pub. 100-4) – *http://www.cms.hhs.gov/Manuals* on the CMS website;
- *1995 Documentation Guidelines for Evaluation & Management Services* - *http://www.cms.hhs.gov/MLNProducts/Downloads/1995dg.pdf* on the CMS website; and
- *1997 Documentation Guidelines for Evaluation & Management Services* – *http://www.cms.hhs.gov/MLNProducts/Downloads/MASTER1.pdf* on the CMS website.

CHAPTER 6 – PROTECTING THE MEDICARE TRUST FUND

This chapter provides information about the Medicare medical review program, coverage determinations, and health care fraud and program abuse.

Medical Review Program

The goal of the medical review program is to reduce provider and supplier payment errors by identifying and addressing coverage and coding billing errors by:

- Analyzing data (e.g., profiling of 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 the identified errors;
- Publishing local medical review policies that provide guidance to the public and the medical community regarding payment eligibility under the Medicare statute.

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

A NCD sets forth the extent to which Medicare will cover specific services, procedures, or technologies on a national basis. A NCD is a reasonable and necessary determination made by the Secretary of the Department of Health and Human Services (HHS). Therefore, a failure to meet the terms of the NCD will make the item 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) and for which a beneficiary is given liability protection under Section 1879 of the Social Security Act if he or she did not know in advance that Medicare was prohibited from paying. An Advance Beneficiary Notice conveys this information to the beneficiary, thereby eliminating his or her liability protection. Medicare Contractors are required to follow NCDs. Prior to an NCD taking effect, the Centers for Medicare & Medicaid Services (CMS) must first issue a Manual Transmittal, ruling, or *Federal Register* Notice. If a NCD and a LCD exist concurrently regarding the same coverage policy, the NCD takes precedence.

2) Local Coverage Determination

To further define or in the absence of a specific NCD, Medicare Contractors may develop LCDs, which are coverage decisions made at their own discretion to provide guidance to the public and the medical community within a specified geographic area. LCDs cannot conflict with NCDs. LCDs are administrative and educational tools that assist providers 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 Provider Call Center Toll-Free Numbers Directory, which contains Medicare Contractor contact information, can be accessed in the Downloads Section at *http://www.cms.hhs.gov/MLNGenInfo* on the CMS website. 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 Contractor's websites.

LCDs and NCDs that may prevent access to items and services or have resulted 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 fee-for-service Medicare and Medicare Advantage);
- 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 a LCD or NCD, the beneficiary is notified about the denial and the reasons for the denial on the Medicare Summary Notice.

Information about the Medicare coverage determination process is available as follows:

- *http://www.cms.hhs.gov/DeterminationProcess/01_Overview.asp* on the CMS website; and
- In the National Coverage Determinations Manual (Publication 100-03) and Medicare Program Integrity Manual (Publication 100-08) at *http://www.cms.hhs.gov/Manuals* on the CMS website.

Health Care Fraud and Program Abuse

CMS emphasizes early detection and prevention of health care fraud and program abuse. An estimated 10 percent of Medicare costs are wrongly spent on incidences of fraud and abuse. Preventing and detecting fraud and abuse is a cooperative effort that involves:

- CMS;
- Beneficiaries;
- Medicare Contractors;

- Providers, suppliers, and other health care entities;
- State Medicaid Fraud Control Units;
- Quality Improvement Organizations;
- Department of HHS Office of Inspector General (OIG);
- Department of Justice (DOJ), including the Federal Bureau of Investigation; and
- Other Federal law enforcement agencies.

The efforts of these groups can help deter health care fraud and program abuse and protect beneficiaries from harm by:

- Identifying suspicious Medicare charges and activities;
- Investigating and punishing those who commit Medicare fraud and abuse; and
- Ensuring that money lost to fraud and abuse is returned to the Medicare Trust Fund.

Federal health care fraud generally involves a person or entity's intentional use of false statements or fraudulent schemes (such as kickbacks) to obtain payment for, or to cause another person 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 Medicare 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 Medicare payment for their health care by presenting a Medicare health insurance card or Medicare HIC number that rightfully belongs to another person.

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.

Significant Medicare Fraud and Abuse Provisions

1) False Statements and Kickbacks, Bribes, and Rebates

Under 42 U.S.C. Section 1320a-7b(a), if an individual or entity is determined to have engaged in any following activities, he or she shall be guilty of a felony and upon conviction shall be fined a maximum of $50,000 per violation or imprisoned for up to five years per violation, or both:

- Purposefully involved in supplying false information on an application for a Medicare benefit or payment or for use in determining the right to any such benefit or payment;
- Knows about, but does not disclose, any event affecting the right to receive a benefit;
- Knowingly submitting a claim for physician services that were not furnished by a physician; or
- Supplies items or services and asks for, offers, or receives a kickback, bribe, or rebate.

2) Anti-Kickback Statute

The Anti-Kickback Statute, 42 U.S.C. §1320a-7b(b), prohibits offering, soliciting, paying, or receiving remuneration for referrals for services that are paid in whole or in part by the Medicare Program. In addition, the statute prohibits offering, soliciting, paying, or receiving remuneration in return for purchasing, leasing, ordering, arranging for, or recommending the purchase, lease, or order of any goods, facility, item, or service for which payment may be made in whole or part by the Medicare Program. An arrangement will be deemed to not violate the Anti-Kickback Statute if it fully complies with the terms of a safe harbor issued by the OIG. Arrangements that do not fit within a safe harbor and thus do not qualify for automatic protection may or may not violate the Anti-Kickback Statute, depending on their facts.

3) Physician Self Referral (“Stark”) Statute

The Stark Statute, 42 U.S.C. §1395nn, prohibits a physician from making a referral for certain designated health services to an entity in which the physician (or a member of his or her family) has an ownership/investment interest or with which he or she has a compensation arrangement, unless an exception applies.

Exceptions to the prohibition on self referrals can be found in the *Code of Federal Regulations (CFR)* at CFR 411.355-357. To access the *CFR*, visit *http://www.gpoaccess.gov/cfr/index.html* on the Web. The designated health services include the following:

- Clinical laboratory services;
- Physical therapy services;
- Occupational therapy services;
- Speech-language pathology services;
- Radiology and certain other imaging services such as magnetic resonance imaging and ultrasound;
- Radiation therapy services and supplies;
- Durable medical equipment (DME) and supplies;
- Parenteral and enteral nutrients, equipment, and supplies;
- Prosthetics, orthotics, and prosthetic devices and supplies;
- Home health services and supplies;
- Outpatient prescription drugs; and
- Inpatient and outpatient hospital services.

The DOJ or a private relator can also file a suit under the civil False Claims Act (31 U.S.C. Section 3729) to recover any Federal losses due to false claims as well as additional amounts in the form of penalties and fines.

Potential Legal Actions

It is a Federal crime to commit fraud against the U.S. Government, including the Medicare Program. A provider, supplier, or health care organization that has been convicted of fraud may receive a significant fine, prison sentence, or be temporarily or permanently excluded from Medicare and other Federal health care programs. In some states, providers, suppliers, and health care organizations may also lose their licenses. Below is a discussion of some of the potential consequences of failure to comply with fraud and abuse laws.

Investigations

A Program Safeguard Contractor or Medicare Contractor Benefit Integrity unit identifies and documents potential fraud and abuse and, when appropriate, refers such matters to the OIG.

Civil Monetary Penalties

Many violations of Medicare laws and regulations are subject to the imposition of Civil Monetary Penalties (CMP). Depending on the violation, the CMP amount may be up to $10,000 per violation and exclusion from the Medicare Program may be imposed. Some examples of violations for which CMPs may apply include:

- Violation of Medicare assignment provisions;
- Violation of the Medicare physician or supplier agreement;

- Violation of an assignment requirement for certain diagnostic clinical laboratory tests and nurse-anesthetist services;
- Violations of the Anti-Kickback Statute, Stark Statue, and other fraud and abuse laws;
- False or misleading information expected to influence a decision to discharge;
- Refusal to supply rental DME supplies without charge after rental payments may no longer be made;
- Hospital unbundling of outpatient surgery costs; and
- Hospital and physician dumping of beneficiaries, either because they cannot pay or because of a lack of resources.

Denial or Revocation of Medicare Provider Billing Privileges

CMS has the authority to deny an individual 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 Authority

The OIG has the authority to exclude individuals and entities from participation in all Federal health care programs, including Medicare, Medicaid, and all other plans and programs that provide health benefits funded directly or indirectly by the U.S. (other than the Federal Employees Health Benefits Plan). No payment will be made by any Federal health care program for any items or services directly or indirectly furnished, ordered, or prescribed by an excluded or debarred individual or entity. Providers and suppliers who participate in or bill a Federal health care program generally may not employ or contract with an excluded or debarred individual or entity. In addition, excluded individuals are not eligible for Federally-insured loans, Federally-funded

research grants, and programs administered by other Federal agencies. All types of exclusions remain in effect until the individual or entity is eligible for and reinstated by the OIG. There are two types of exclusions: mandatory and permissive.

1) Mandatory exclusions

Mandatory exclusions are imposed for a minimum statutory period of five years, although aggravating and mitigating factors may justify assessment of a lengthier exclusion. Exclusions are mandated for individuals and entities who:

- Have been convicted of any type of program-related violations;
- Have been convicted of patient abuse or neglect;
- Have felony convictions related to other health care programs; or
- Have felony convictions related to certain types of controlled substance violations.

2) Permissive exclusions

The OIG may impose permissive exclusions on individuals and entities who have misdemeanor convictions that are related to:

- Health care fraud;
- Obstruction of an investigation; and
- Certain types of controlled substance violations.

These permissive exclusions typically have a benchmark period duration of three years, although aggravating and mitigating factors may justify assessment of a lengthier exclusion.

Other permissive exclusions are based on determinations made by other agencies such as licensing boards, Federal or State health care programs, and/or recommendations from payer agencies. The period of exclusion in most of these actions varies and is subject to the discretion of the OIG.

Sanctioned and Reinstated Provider and Supplier Lists

There are two types of sanctioned and reinstated provider and supplier lists: Office of Inspector General List of Excluded Individuals/Entities (LEIE) and General Services Administration Excluded Parties List System.

1) Office of Inspector General List of Excluded Individuals/Entities

The Office of Inspector General LEIE contains information about individuals and entities that are currently excluded from participation in all Federal health care programs, including the Medicare Program. The LEIE is available at *http://www.oig.hhs.gov/fraud/exclusions/listofexcluded.html* on the Web.

2) General Services Administration Excluded Parties List System

The General Services Administration Excluded Parties List System is an index of individuals and entities that have been excluded throughout the U.S. Government from receiving Federal contracts, certain subcontracts, and certain types of Federal financial and non-financial assistance and benefits. The Excluded Parties List System can be found at *http://www.epls.gov* on the Web.

Incentive Reward Program

The Incentive Reward Program encourages the reporting of information regarding individuals or entities that commit fraud or abuse and could result in sanctions under any Federal health care program. Medicare offers a monetary reward for information that leads to a minimum recovery of $100.00 of Medicare funds that were inappropriately obtained. Incentive rewards are 10 percent of the amount recovered or $1,000, whichever amount is lower.

Whistle Blower Provision

Under the Whistle Blower or *qui tam* provision of the False Claim Act, any individual who has knowledge of a false claim may file a civil suit on behalf of the U.S. Government and may share a percentage of the recovery realized from a successful action. To report suspected health care fraud or program abuse, contact:

Office of Inspector General
HHS TIPS Hotline
P. O. Box 23489
Washington, DC 20026
Telephone: (800) 447-8477
E-mail: HHSTips@oig.hhs.gov
Fax: (800) 223-8164

Additional information about protecting the Medicare Trust Fund can be found in the Medicare Program Integrity Manual (Pub. 100-8) at *http://www.cms.hhs.gov/Manuals* on the CMS website.

CHAPTER 7 – INQUIRIES, OVERPAYMENTS, AND APPEALS

This chapter discusses inquiries, overpayments, and fee-for-service appeals.

Inquiries

Medicare providers and suppliers may submit inquiries about claims, coverage, and reimbursement guidelines to Medicare Contractors either by telephone or in writing. 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. The Provider Call Center Toll-Free Numbers Directory, which contains Medicare Contractor contact information, can be accessed in the Downloads Section at *http://www.cms.hhs.gov/MLNGenInfo* on the Centers for Medicare & Medicaid Services (CMS) website.

Contractors also use automated self-help tools such as Interactive Voice Response (IVR) services, which may be available up to 24 hours a day. IVR services provide information about the following topics:

- Normal business hours;
- CSR service hours of operation;
- General Medicare Program;
- General appeal rights and the actions required to exercise appeal rights;
- Claims in process and claims completed; and
- Definitions of the 100 most frequently used Remittance Advice Remark Codes and/or Claim Adjustment Reason Codes, which appear on the Remittance Advice (RA) (as determined by each Contractor).

Overpayments

Overpayments are funds that a provider, supplier, or beneficiary has received in excess of amounts due and payable under Medicare statutes and regulations. Once a determination of an overpayment has been made, the overpayment becomes a debt owed to the Federal government. Federal law requires CMS to seek recovery of overpayments, regardless of how an overpayment is identified or caused.

Overpayments are often paid due to the following:

- Duplicate submission of the same service or claim;
- Payment to the incorrect payee;
- Payment for excluded or medically unnecessary services; or
- Payment made as the primary payer when Medicare should have paid as the secondary payer.

If Medicare pays more than the correct amount in error, providers and suppliers should make voluntary/unsolicited refunds as soon as possible, without waiting for notification. Refunds are sent to the Medicare Contractor and must include the following information:

- The provider or supplier's National Provider Number (NPI);
- The NPI of the provider or supplier who should actually be paid, if applicable;
- The beneficiary's Medicare Health Insurance Claim (HIC) number;
- The date of service;
- The amount overpaid;
- A brief description regarding the reason for the refund;
- A copy of the RA, with the claims at issue highlighted; and
- A check for the overpaid amount.

When the Federal government accepts a voluntary/unsolicited refund, it does not affect or limit its right or the right of its agencies or agents to pursue any appropriate criminal, civil, or administrative remedies that arise from or related to applicable claims.

Providers and suppliers are also responsible for timely repayment when Medicare notifies them of an overpayment. When an overpayment occurs, Medicare will send a letter which states:

- The service(s) at issue;
- Why the overpayment occurred; and
- The amount being requested.

If the overpayment is not paid within the timeframe specified in the letter, interest is assessed from the date of the letter. If no response is received from the provider or supplier within 30 days after the date of the first demand letter, a second demand letter will be sent between 31 and 45 days. If a full payment is not received 40 days after the date of the first demand letter, the Medicare Contractor will start recoupment from future payments on day 41.

If a provider or supplier disagrees with the overpayment, he or she has the right to appeal the decision. Recoupment will cease as a result of a demand letter if:

- The overpayment is determined on or after October 29, 2003; and
- A valid first level appeal request has been received.

Additional information about overpayments can be found in the Medicare Claims Processing Manual (Pub. 100-04) located at *http://www.cms.hhs.gov/Manuals* on the CMS website.

Fee-for-Service Appeals

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

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 the *Code of Federal Regulations (CFR)* at 42 CFR 405.908 (to access the *CFR*, visit *http://www.gpoaccess.gov/cfr/index.html* on the Web);
- A provider or supplier who accepts assignment of appeal rights for items or services furnished to a beneficiary; or
- A nonparticipating physician 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 §§1834(a)(18), 1834(j)(4), or 1842(l) of the Social Security Act.

A provider or supplier who is not already a party to an appeal may appeal an initial determination for services furnished to a beneficiary 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 physician 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:

- 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;
- If the party is a beneficiary, the beneficiary's Medicare HIC number;

- 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 representative may submit arguments, evidence, or other materials on behalf of the party. The representative, the party, or both may participate in all levels of the appeals process. Once both the party and the representative have signed the Appointment of Representative Form, the appointment is valid for one year from the date of the last signature for the purpose of filing future appeals, unless it has been revoked.

As noted above, a beneficiary may also assign (transfer) his or her appeal rights to a physician 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 physician 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.

After an initial claim determination is made, the appeals process is as follows:

- Redetermination by Medicare Contractor;
- Reconsideration by Qualified Independent Contractor (QIC);
- Hearing by Administrative Law Judge (ALJ);
- Medicare Appeals Council review; and
- Judicial review.

The Five Levels of Appeals

First Level of Appeal – Redetermination by Medicare Contractor

A party who is dissatisfied with the initial determination may request that a Medicare Contractor conduct a redetermination. The redetermination, which is an independent review of the initial determination, is conducted by an employee of the Contractor who was not involved in making the initial determination. A request for a redetermination must be filed within 120 calendar days of the date the notice of initial claim determination is received. If good cause is shown, the period for filing the appeal request may be extended. At this level of appeal, there is no amount in controversy (AIC) requirement. When filing the request for redetermination, parties should also submit all relevant documentation to support their assertion that the initial claim determination was incorrect. Parties must request redeterminations in writing by either completing Form CMS-20027, Medicare Redetermination Request, or by submitting a written request that includes the following:

- Beneficiary's name;
- Beneficiary's Medicare HIC number;

- Which items or services are at issue and the corresponding date(s) of service; and
- Name and signature of the party or representative of the party.

In most cases, the Contractor will issue a written redetermination notice to all parties to the appeal within 60 days of receipt of the redetermination request. If the reconsideration results in the issuance of a supplemental payment to a provider or supplier, the Contractor must also issue an electronic or paper RA.

Second Level of Appeal – Reconsideration by Qualified Independent Contractor

A party dissatisfied with the redetermination decision may request a reconsideration by a QIC. A party must file a written request for a reconsideration with the entity specified in the redetermination notice within 180 calendar days of the date the redetermination decision is received. If good cause is shown, the QIC may extend the period for filing the request. At this level of appeal, there is no AIC requirement. A party may file a written request for reconsideration by either completing Form CMS-20033, Medicare Reconsideration Request, or by submitting a written request that includes the following:

- Beneficiary's name;
- Beneficiary's Medicare HIC number;
- Which items or services are at issue and the corresponding date(s) of service;
- Name and signature of the party or representative of the party; and
- Name of the Contractor that made the redetermination.

In most cases, the QIC will issue written notice of its reconsideration decision to all parties within 60 calendar days of receipt of the request for reconsideration. In some situations (e.g., submission of additional evidence after the reconsideration request is filed), the time limit will be extended beyond 60 days. If the QIC is unable to issue a reconsideration within the applicable time limit, the QIC will notify the appellant (the party who filed the appeal request). The appellant may then file a written request with the QIC to escalate the appeal to the ALJ level. Within five days of receiving the request to escalate, the QIC will either issue a reconsideration or acknowledge the escalation request and forward the request and case file to the appropriate ALJ office. If the reconsideration results in the issuance of a supplemental payment to a provider or supplier, the Contractor must also issue an electronic or paper RA. All evidence requested by the Contractor in the redetermination decision must be submitted at the QIC reconsideration level of appeal. Failure to submit requested information at the QIC reconsideration level may lead to exclusion of such evidence at subsequent levels of appeal.

Third Level of Appeal – Hearing by Administrative Law Judge

If a party is dissatisfied with the reconsideration decision or if the adjudication period for the QIC to complete its consideration has elapsed, he or she can request a hearing before an ALJ with the Department of Health and Human Services (HHS) Office of

Medicare Hearings and Appeals. There is an AIC requirement, which will be adjusted annually in accordance with the percentage increase in the medical care component of the Consumer Price Index (CPI). The ALJ hearing may be conducted in person, via video teleconferencing (VTC) technology, or by telephone. The ALJ may also issue a decision on the record without the appearance of any parties if the decision is fully favorable to the appellant. In-person hearings may be granted upon a finding of good cause. An ALJ may also determine that an in-person hearing should be conducted if VTC technology is unavailable or special or unusual circumstances exist. A party must file a written request for an ALJ hearing with the entity specified in the QIC reconsideration notice within 60 calendar days of receipt of the QIC reconsideration notice. If a request for an ALJ hearing is not filed timely, the period for filing the request may be extended by the ALJ if good cause is shown.

To file a request for an ALJ hearing to appeal a QIC reconsideration, parties may either complete Form CMS-20034A/B, Request For Medicare Hearing By An Administrative Law Judge, or submit a written request that includes the following information:

- Name, address, and Medicare HIC number of the beneficiary whose claim is being appealed;
- Name and address of the appellant, when the appellant is not the beneficiary;
- Name and address of any designated representatives;
- Document control number assigned to the appeal by the QIC, if any;
- Dates of service for the items or services at issue;
- Reasons the appellant disagrees with the QIC's reconsideration; and
- Statement of any additional evidence to be submitted and the date it will be submitted.

When an appellant requests an ALJ hearing following a QIC reconsideration, the appellant must also send a copy of the request for hearing to the other parties to the appeal. The ALJ's 90-day timeframe to issue a decision does not start until all parties to the QIC reconsideration receive notice of the requested ALJ hearing. Generally, at the ALJ level, CMS and/or CMS Contractors may elect to either participate in the hearing or become a party to the hearing. If CMS and/or CMS Contractors choose to participate or become a party to the hearing, they will notify the ALJ and all parties within 10 days after receiving the notice of hearing. Participating in the hearing or as a party may include submitting position papers or providing testimony to clarify factual or policy issues, but does not include calling or cross-examining witnesses or being called as a witness. In addition, discovery is allowed only when CMS becomes a party to an ALJ hearing.

In most cases, the ALJ will issue a decision within 90 days of receipt of the request for hearing. The time limit may be extended for a variety of reasons, including but not limited to:

- The case being escalated from the reconsideration level;
- The submission of additional evidence that was not included with the hearing request;
- Request for an in-person hearing;
- The appellant's failure to send notice of the hearing request to other parties; and
- The initiation of discovery in cases where CMS is a party.

If the case before the ALJ was escalated from the QIC, the ALJ must issue a decision in 180 days (unless the time limit was extended for one of the reasons noted above). If the decision results in the issuance of a supplemental payment to a provider or supplier, the Contractor must also issue an electronic or paper RA. If an ALJ case is still pending at the close of the applicable adjudication timeframe, the appellant may file a written request with the ALJ to escalate the appeal to the Medicare Appeals Council level. The appellant must notify all parties to the ALJ hearing about the escalation request. Failure to send notice to all parties will toll or stop the adjudication timeframes for the Medicare Appeals Council to conduct its review.

Fourth Level of Appeal – Medicare Appeals Council Review

The appellant or any other party to the ALJ hearing may request Medicare Appeals Council review of the ALJ's decision or dismissal. The request for Medicare Appeals Council review must be filed within 60 calendar days of receipt of the ALJ hearing decision or dismissal. If good cause is shown, the period for filing the request may be extended. At this level of appeal, there is no AIC requirement. The party must file a written request for Medicare Appeals Council review by either completing Form DAB-101, Request for Review of Administrative Law Judge Medicare Decision/ Dismissal, or by submitting a written request that includes the following:

- Beneficiary's name;
- Beneficiary's Medicare HIC number;
- Specific items or services for which review is requested;
- Dates of service for the items or services at issue;
- Date of the ALJ's final action (if any) or the hearing office in which the party's request for hearing is pending; and
- Name and signature of the party or representative of the party.

The request for Medicare Appeals Council review must also identify the parts of the ALJ action with which the party requesting review disagrees and explain why he or she disagrees with the ALJ's decision, dismissal, or other determination being appealed. The Medicare Appeals Council will generally limit its review to the issues raised by the appellant and will conduct a *de novo* or new review of such issues. The appellant must also send a copy of the request for review to the other parties to the ALJ decision or

dismissal. The time limit for issuance of the Medicare Appeals Council decision does not commence until all parties are properly notified. Generally, the party requesting Medicare Appeals Council review does not have a right to a hearing before the Medicare Appeals Council. The Medicare Appeals Council will consider all of the evidence in the administrative record and either adopt, modify, or reverse the ALJ decision or remand the case to the ALJ for further proceedings. However, depending on how the appeal came before the Medicare Appeals Council, there may be opportunities for parties to submit additional evidence. Parties to Medicare Appeals Council review may request the opportunity to file briefs or other written statements discussing the facts and laws relevant to the case. A party may also request to appear before the Medicare Appeals Council to present oral argument. The Medicare Appeals Council may also dismiss a review request if the party making the request asks to withdraw the request for Medicare Appeals Council review, does not have a right to request Medicare Appeals Council review, or in certain circumstances where the beneficiary whose claim is being appealed dies.

In most cases, the Medicare Appeals Council decision, dismissal, or remand order will be mailed within 90 calendar days of submission of the request. If the decision results in the issuance of a supplemental payment to a provider or supplier, the Medicare Contractor must also issue an electronic or paper RA. If the case was escalated to the Medicare Appeals Council because the ALJ could not issue a timely decision, the Medicare Appeals Council will have 180 days to mail its decision. These timeframes may be extended under certain circumstances (for example, if a party filing a request for review fails to provide copies of the request for review to other parties to the ALJ decision or dismissal). If the Medicare Appeals Council fails to issue a decision, dismissal, or remand order within the applicable time period, the appellant may submit a request for escalation to Federal District Court. The Medicare Appeals Council will either complete the case within five days of receipt of the escalation request or within five days following the end of the applicable adjudication timeframe. If the Medicare Appeals Council is unable to complete the case, it will issue a notice to the appellant that acknowledges the escalation request and confirms its inability to issue a decision, dismissal, or remand order within the applicable timeframe. A party may then file a civil action in Federal District Court within 60 days after the date it receives notice from the Medicare Appeals Council. In certain instances, if good cause is shows, the period for filing the request may be extended. Escalation is not available regarding a request to review an ALJ dismissal.

Fifth Level of Appeal – Judicial Review

A party to an Medicare Appeals Council decision or an appellant who requests an escalation of Medicare Appeals Council review may request judicial review if the case meets the AIC requirement. The AIC amount is adjusted annually in accordance with the percentage increase in the medical care component of the CPI. Any civil action for judicial review must be filed in the District Court of the U.S. for the judicial district in which the party resides or where such individual, institution, or agency has its principal

place of business. If the party does not reside within any judicial district or if the individual, institution, or agency does not have its principal place of business within any such judicial district, the civil action must be filed in the District Court of the U.S. for the District of Columbia. The Secretary of HHS is the proper defendant in any request for judicial review of an Medicare Appeals Council decision or a case escalated to Federal District Court. Complaints filed in Federal District Court against the Secretary of HHS should also be sent to:

Department of Health and Human Services
General Counsel
200 Independence Avenue, S.W.
Washington, D.C. 20201

The District Court may either reach a final decision or remand the case to the Medicare Appeals Council or ALJ for further proceedings. Written notification regarding the District Court's decision is sent to all parties.

Liability and Appeal Decisions

Liability regarding appeal decisions is as follows:

- When an original claim determination 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 liable and must refund any monies collected from the beneficiary within 30 days of the review decision unless a valid Advance Beneficiary Notice was properly executed.
- When an original claim determination 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 determination 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 liable, a letter is sent indicating that he or she is responsible for payment.
- When an original claim determination 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, neither party will be responsible for payment.
- 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, Medicare will pay the beneficiary and request a refund from the provider or supplier.

- 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 a refund is not made within 15 days, the provider or supplier may be subject to Civil Monetary Penalties and sanctions.

Reopenings

A reopening is a remedial action taken to change a final determination or decision that resulted in either an overpayment or underpayment, even though the determination or decision was correct based on the evidence of record. A reopening allows the correction of minor errors or omissions without initiating a formal appeal. If a claim is denied because a Contractor did not receive requested documentation during medical review and the party later requests a redetermination, the Contractor must process the request as a reopening. A Contractor must also process clerical errors (including human and mechanical errors on the part of the party or Contractor), such as mathematical or computational mistakes, inaccurate data entry, or denials of claims, as duplicates. A reopening is, in general, not conducted until a party's appeal rights have been exhausted. A Contractor, QIC, ALJ, or Medicare Appeal Council's decision on whether to reopen is final and not subject to appeal. A reopening may be requested by a party or initiated by a Contractor, QIC, ALJ, or Medicare Appeals Council.

The timeframes and requirements for requesting or initiating a reopening will depend on the level at which the reopening is requested (initial determination level or one of the appeals levels) and who is initiating the reopening (a party, Contractor, QIC, ALJ, or Medicare Appeals Council). When any determination or decision is reopened and revised, a Contractor, QIC, ALJ, or Medicare Appeals Council must mail its revised determination or decision to the parties. If the reopening action results in an adverse revised determination or decision, the Contractor shall mail a letter that states the rationale for the reopening, the applicable revision, and any right to appeal.

Additional information about appeals is available as follows:

- *http://www.cms.hhs.gov/OrgMedFFSAppeals* on the CMS website;
- *http://www.cms.hhs.gov/MMCAG* on the CMS website;
- *http://www.cms.hhs.gov/MedPrescriptDrugApplGriev* on the CMS website; and
- Chapter 29 of the Medicare Claims Processing Manual (Pub. 100-4) located at *http://www.cms.hhs.gov/Manuals* on the CMS website.

Appeals forms are available at:

- *http://www.cms.hhs.gov/CMSForms/CMSForms* on the CMS website;
- *http://www.hhs.gov/dab/DAB101.pdf* on the CMS website; and
- *http://hhsstage.cit.nih.gov/omha/forms/index.html* on the Web.

REFERENCE SECTION

REFERENCE A – GLOSSARY

A

Advance Beneficiary Notice

An Advance Beneficiary Notice is a written notice that a provider or supplier gives to a beneficiary under certain circumstances (e.g., lack of medical necessity) before items or services are furnished to advise him or her that specified items or services may not be covered by Medicare.

Aged Insured
A beneficiary eligible for premium-free Part A on the basis of age. The beneficiary 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 quarters of coverage (QC) from government employment were regular Social Security QCs.

Aged Uninsured
An aged individual who is age 65 years or older, is eligible for Part A, and is not insured but elects to purchase Part A coverage by filing an application at a Social Security office.

Appeal
Complaint a beneficiary, provider of services, or supplier can make if he or she disagrees with a Medicare coverage or payment decision.

Assignment
When a provider or supplier is paid the Medicare allowed amount as payment in full for his or her services.

B

Beneficiary
Individual eligible to receive Medicare or Medicaid payment and/or services.

C

Carrier
Centers for Medicare & Medicaid Services Contactor that determines reasonable charges, accuracy, and coverage for Medicare Part B services and processes Part B claims and payments (see Medicare Administrative Contractor).

Centers for Medicare & Medicaid Services
Federal agency that administers and oversees the Medicare Program and a portion of the Medicaid Program.

Claim
A request for payment of benefits or services received by a beneficiary.

Code of Federal Regulations
Official compilation of Federal rules and requirements.

Coinsurance
Under the Original Medicare Plan or a Private Fee-for-Service Plan, a percentage of covered charges that the Medicare beneficiary may pay after he or she has met the applicable deductible.

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 that is paid by the beneficiary for each medical service.

Cost Report
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.

Department of Health and Human Services
Federal department that administers many health and welfare programs for citizens of the U.S. and is the parent agency of the Centers for Medicare & Medicaid Services.

Disabled Insured
A disabled person 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, disabled persons who are not insured for monthly Social Security disability benefits but would be insured for such benefits if their quarters of coverage (QC) from government employment were Social Security QCs are deemed to be entitled to disability benefits and automatically entitled to Part A after being disabled for 29 months.

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

End-Stage Renal Disease Insured
Individuals are eligible for Part A if they receive regular dialysis treatments or a kidney transplant, have filed an application, and meet one of the following conditions: have worked the required amount of time under Social Security, the Railroad Retirement Board (RRB), or as a government employee; are receiving or are eligible for Social Security or Railroad Retirement benefits; or are 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.

F

Fiscal Intermediary
Centers for Medicare & Medicaid Services Contractor that processes claims for services covered under Medicare Part A and most types of claims for services covered under Medicare Part B (see Medicare Administrative Contractor).

H

Health Care Fraud
Generally involves a person or entity's intentional use of false statements or fraudulent schemes (such as kickbacks) to obtain payment for, or to cause another to obtain payment for, items or services payable under a Federal health care program.

Health Professional Shortage Area Incentive Payment
A 10 percent payment made to 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 for outpatient professional services furnished to a Medicare beneficiary.

I

Incentive Reward Program
A program that encourages the reporting of information regarding individuals or entities that commit fraud or abuse and could result in sanctions under any Federal health care program.

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

L

Local Coverage Determination
A coverage decision developed by Medicare Contractors to further define or in the absence of a specific National Coverage Determination and made at the Contractor's own discretion 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; 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.

Medicare Administrative Contractor
All Medicare work performed by Fiscal Intermediaries and Carriers will be replaced by these Centers for Medicare & Medicaid Services Contractors by 2011, as mandated in Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

Medicare Advantage; Part C of the Medicare Program
A program through which organizations that contract with the Centers for Medicare & Medicaid Services furnish or arrange for the provision of health care services to Medicare beneficiaries (with the exception of individuals with End-Stage Renal Disease) who are entitled to Part A and enrolled in Part B, permanently reside in the service area of the Medicare Advantage (MA) Plan, and elect to enroll in a MA Plan.

Medicare Economic Index
A measure of inflation faced by physicians with respect to their practice costs and general wage levels.

Medicare Physician Fee Schedule
Basis for which Medicare Part B pays for physician services. Lists the more than 7,000 covered services and their payment rates.

Medicare Prescription Drug, Improvement, and Modernization Act of 2003
Comprehensive bill that was signed by President George W. Bush on December 8, 2003 that expands many parts of the Medicare Program.

Medicare Summary Notice
Notice that beneficiaries receive on a monthly basis; lists all services or supplies that were billed to Medicare.

Medigap
A health insurance policy sold by private insurance companies to fill gaps in Original Medicare Plan 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 standard unique identifier for health care providers that replaces health care provider identifiers that were previously used in standard transactions and eliminates the need to use different identification numbers when conducting Health Insurance Portability and Accountability Act standard transactions with multiple plans.

O

Office of Inspector General
Protects the integrity of Department of Health and Human Services programs and the health and welfare of beneficiaries of those programs through a nationwide network of audits, investigations, inspections, and other mission-related functions.

Overpayment
Funds that a provider, supplier, or beneficiary has received in excess of amounts due and payable under Medicare statutes and regulations.

P

Part A of the Medicare Program
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.

Part B of the Medicare Program
Medical insurance that helps pay for 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, and Ambulatory Surgical Centers; 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.

Part C of the Medicare Program; Medicare Advantage
A program through which organizations that contract with the Centers for Medicare & Medicaid Services furnish or arrange for the provision of health care services to Medicare beneficiaries (with the exception of individuals with End-Stage Renal Disease) who are entitled to Part A and enrolled in Part B, permanently reside in the service area of the Medicare Advantage (MA) Plan, and elect to enroll in a MA Plan.

Part D of the Medicare Program
Prescription drug coverage provided to all beneficiaries who elect to enroll in a Prescription Drug Plan (PDP) or Medicare Advantage PDP.

Participating Provider or Supplier
A provider or supplier who agrees to participate in Part B and accept assignment of Medicare benefits for all covered services for all Medicare beneficiaries.

Physician (Medicare)
Doctors of medicine and doctors of osteopathy, doctors of dental surgery or dental medicine, chiropractors, doctors of podiatry or surgical chiropody, and doctors of optometry. Must also be legally authorized to practice by a State in which he or she performs this function.

Physician Scarcity Area Bonus Payment
A five percent bonus payment made to physicians who furnish outpatient professional services in a Physician Scarcity Area (PSA). There are two PSA categories: primary care, which is determined by the ratio of primary care physicians to Medicare beneficiaries; and specialty care, which is determined by the ratio of specialty physicians to Medicare beneficiaries.

Practitioner (Medicare)
Any of the following to the extent that an individual is legally authorized to practice by the State and otherwise meets Medicare requirements: physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, clinical psychologist, clinical social worker, or registered dietician or nutrition professional.

Program Abuse
May be intentional or unintentional; directly or indirectly results in unnecessary or increased costs to the Medicare Program.

Prospective Payment System
Method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount.

Q

Quality Improvement Organization
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.

R

Remittance Advice
A notice of payments and adjustments that is sent to the provider, supplier, or biller.

S

Social Security Act (the Act)
Public Law 74-271 that was enacted on August 14, 1935, with subsequent amendments.

Social Security Administration
Determines eligibility for Medicare benefits and enrolls individuals in Part A and/or Part B and the Federal Black Lung Benefit Program.

Swing Bed
Bed that a small rural hospital can use for either Skilled Nursing Facility or hospital acute-level care on an as-needed basis if the hospital has obtained approval from the Department of Health and Human Services.

REFERENCE B – ACRONYMS

ABN	Advance Beneficiary Notice
AEP	Annual Coordinated Election Period
AIC	Amount in Controversy
ALJ	Administrative Law Judge
ASC	Ambulatory Surgical Center
CAH	Critical Access Hospital
CF	Conversion Factor
CFR	Code of Federal Regulations
CMN	Certificate of Medical Necessity
CMP	Civil Monetary Penalties
CMS	Centers for Medicare & Medicaid Services
CNM	Certified Nurse Midwife
CNS	Certified Nurse Specialist
COB	Coordination of Benefits
COBC	Coordination of Benefits Contractor
CP	Clinical Psychologist
CPI	Consumer Price Index
CPT	Current Procedural Terminology
CRNA	Certified Registered Nurse Anesthetist
CSR	Customer Service Representative
CSW	Clinical Social Worker

CWF	Common Working File
DIF	Durable Medical Equipment Medicare Administrative Contractor Information Form
DME	Durable Medical Equipment
DME MAC	Durable Medical Equipment Medicare Administrative Contractor
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
DOJ	Department of Justice
EDI	Electronic Data Interchange
E/M	Evaluation and Management
EMC	Electronic Media Claims
ESRD	End-Stage Renal Disease
FI	Fiscal Intermediary
FICA	Federal Insurance Contributions Act
FPL	Federal Poverty Level
GHP	Group Health Plan
GME	Graduate Medical Education
GPCI	Geographic Practice Cost Indices
HCPCS	Healthcare Common Procedure Coding System
HHS	Department of Health and Human Services
HIC	Health Insurance Claim
HPSA	Health Professional Shortage Area
ICD	International Classification of Diseases

IEP	Initial Enrollment Period
IVR	Interactive Voice Response
LCD	Local Coverage Determination
LEIE	List of Excluded Individuals/Entities
MA	Medicare Advantage
MAC	Medicare Administrative Contractor
MEI	Medicare Economic Index
MLN	Medicare Learning Network
MPFS	Medicare Physician Fee Schedule
MSN	Medicare Summary Notice
MSP	Medicare Secondary Payer
NCD	National Coverage Determination
NP	Nurse Practitioner
NPI	National Provider Identifier
NPP	Non-Physician Practitioner
OEP	Open Enrollment Period
OIG	Office of Inspector General
OT	Occupational Therapy
PA	Physician Assistant
PACE	Program for All-Inclusive Care for the Elderly
PDP	Prescription Drug Plan
PE	Practice Expense

PEN	Parenteral and Enteral Nutrition
PFFS	Private Fee-for-Service
PPS	Prospective Payment System
PQRI	Physician Quality Reporting Initiative
PSA	Physician Scarcity Area
PT	Physical Therapy
QC	Quarters of Coverage
QDWI	Qualified Disabled and Working Individual
QIC	Qualified Independent Contractor
QIO	Quality Improvement Organization
QMB	Qualified Medicare Beneficiary
RA	Remittance Advice
RO	Regional Offices
RRB	Railroad Retirement Board
RVU	Relative Value Unit
SA	State Agency
SCHIP	State Children's Health Insurance Program
SEP	Special Enrollment Period
SGR	Sustainable Growth Rate
SHIP	State Health Insurance Program
SLP	Speech-Language Pathology
SNF	Skilled Nursing Facility

SSA	Social Security Administration
SSN	Social Security Number
UMWA	United Mine Workers of America
VTC	Video Teleconferencing
WC	Workers' Compensation

REFERENCE C – CONTACT INFORMATION

Centers for Medicare & Medicaid Services

About CMS
http://www.cms.hhs.gov/home/aboutcms.asp

Administrative Simplification Compliance Act Self Assessment
http://www.cms.hhs.gov/ElectronicBillingEDITrans/05_ASCASelfAssessment.asp

All Fee-for-Service Providers
http://www.cms.hhs.gov/center/provider.asp

Ambulance Services Center
http://www.cms.hhs.gov/center/ambulance.asp

Anesthesiologists Center
http://www.cms.hhs.gov/center/anesth.asp

Appeals – Fee-for-Service
http://www.cms.hhs.gov/OrgMedFFSAppeals

Certificates of Medical Necessity
http://www.cms.hhs.gov/MedicalReviewProcess/05_certificatesofmedicalnecessity.asp

CMS Consortia
http://www.cms.hhs.gov/RegionalOffices

CMS Forms
http://www.cms.hhs.gov/CMSForms/CMSForms/list.asp

Contacts Database
http://www.cms.hhs.gov/apps/contacts

Coordination of Benefits – General Information
http://www.cms.hhs.gov/COBGeneralInformation

Documentation Guidelines for E & M Services
http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp

Durable Medical Equipment, Prosthetics/Orthotics and Supplies Fee Schedules
http://www.cms.hhs.gov/DMEPOSFeeSched/01_overview.asp

Electronic Billing & EDI Transactions
http://www.cms.hhs.gov/ElectronicBillingEDITrans

FFS ABN-G and ABN-L (Advance Beneficiary Notices)
http://www.cms.hhs.gov/BNI/02_ABNGABNL.asp

HPSA/PSA (Physician Bonuses)
http://www.cms.hhs.gov/hpsapsaphysicianbonuses/01_overview.asp

Health Care Payment and Remittance Advice
http://www.cms.hhs.gov/ElectronicBillingEDITrans/11_Remittance.asp

Health Insurance Portability and Accountability Act –
General Information
http://www.cms.hhs.gov/HIPAAGenInfo

Health Plans – General Information (Medicare Advantage)
http://www.cms.hhs.gov/HealthPlansGenInfo

Home Health Agency Center
http://www.cms.hhs.gov/center/hha.asp

Hospice Center
http://www.cms.hhs.gov/center/hospice.asp

Hospital Center
http://www.cms.hhs.gov/center/hospital.asp

Manuals
http://www.cms.hhs.gov/Manuals

MLN Matters Articles
http://www.cms.hhs.gov/MLNMattersArticles

Medicaid Program – General Information
http://www.cms.hhs.gov/MedicaidGenInfo

Medicaid Program – Contact Information
http://www.cms.hhs.gov/apps/firststep/content/medicaid-contact.html

Medicare (beneficiaries)
http://www.medicare.gov
(800) 633-4227

Medicare Contracting Reform
http://www.cms.hhs.gov/MedicareContractingReform

Medicare Coordination of Benefits Contractor
(800) 999-1118

Medicare Coverage Center
http://www.cms.hhs.gov/center/coverage.asp

Medicare Coverage Database
http://www.cms.hhs.gov/mcd/search.asp

Medicare Coverage Determination Process
http://www.cms.hhs.gov/DeterminationProcess/01_Overview.asp

Medicare Learning Network
http://www.cms.hhs.gov/MLNGenInfo

Medicare Managed Care Appeals & Grievances
http://www.cms.hhs.gov/MMCAG

Medicare Prescription Drug Appeals & Grievances
http://www.cms.hhs.gov/MedPrescriptDrugApplGriev/

Medicare Provider-Supplier Enrollment
http://www.cms.hhs.gov/MedicareProviderSupEnroll

Medicare Provider-Supplier Enrollment Contacts
http://www.cms.hhs.gov/MedicareProviderSupEnroll/downloads/contact_list.pdf

National Plan and Provider Enumeration System
https://nppes.cms.hhs.gov

National Provider Identifier Standard
http://www.cms.hhs.gov/NationalProvIdentStand

Medicare Summary Notices
http://www.cms.hhs.gov/MSN/01_overview.asp

Medicare Supplement Health Insurance (Medigap)
http://www.cms.hhs.gov/Medigap

Open Door Forums
http://www.cms.hhs.gov/OpenDoorForums

Partnering with CMS Center
http://www.cms.hhs.gov/center/partner.asp

Pharmacist Center
http://www.cms.hhs.gov/center/pharmacist.asp

Physician Center
http://www.cms.hhs.gov/center/physician.asp

Physician Fee Schedule
http://www.cms.hhs.gov/PhysicianFeeSched/01_overview.asp

Physician Fee Schedule Look-Up
http://www.cms.hhs.gov/PFSlookup

Physician Quality Reporting Initiative
http://www.cms.hhs.gov/PQRI

Physicians Regulatory Issues Team
http://www.cms.hhs.gov/PRIT

Physician Center
http://www.cms.hhs.gov/center/physician.asp

Practice Administration Center
http://www.cms.hhs.gov/center/practice.asp

Practicing Physicians Advisory Council
http://www.cms.hhs.gov/FACA/03_ppac.asp

Prescription Drug Coverage – General Information
http://www.cms.hhs.gov/PrescriptionDrugCovGenIn

Private Fee-for-Service Plans
http://www.cms.hhs.gov/PrivateFeeforServicePlans

Provider Call Center Toll-Free Numbers Directory
http://www.cms.hhs.gov/MLNGenInfo/30_contactus.asp

Provider Listservs
https://list.nih.gov

Newsroom Center
http://www.cms.hhs.gov/center/press.asp

Quality Improvement Organizations
http://www.cms.hhs.gov/QualityImprovementOrgs/01_Overview.asp

Quarterly Provider Updates
http://www.cms.hhs.gov/QuarterlyProviderUpdates

Regulations & Guidance
http://www.cms.hhs.gov/home/regsguidance.asp

Resident Training Listserv
https://list.nih.gov

State Health Insurance and Assistance Programs
http://www.cms.hhs.gov/Partnerships/10_SHIPS.asp

Survey & Certification – General Information
http://www.cms.hhs.gov/SurveyCertificationGenInfo/03_Contact%20Information.asp

Therapy Services
http://www.cms.hhs.gov/TherapyServices

Other Organizations

Administration on Aging
http://www.aoa.gov

American Medical Association Bookstore
(ICD-9-CM, CPT, and HCPCS publications)
http://www.amapress.org
(800) 621-8335

Federal Financial Institutions Examination Council (census tracts)
http://www.ffiec.gov/Geocode/default.aspx

General Services Administration
Excluded Parties List System
http://www.epls.gov

Health and Human Services Office of Inspector General
http://www.oig.hhs.gov

Health and Human Services Office of Inspector General
List of Excluded Individuals/Entities
http://www.oig.hhs.gov/fraud/exclusions/listofexcluded.html

Health and Human Services
Office of Inspector General National Hotline
(800) 447-8477

Health and Human Services
Office of Medicare Hearings and Appeals Forms
http://hhsstage.cit.nih.gov/omha/forms/index.html

Health and Human Services Office of Minority Health
Cultural Competency Continuing Education Programs
http://thinkculturalhealth.org

Health Resources and Services Administration
http://www.hrsa.gov

Health Resources and Services Administration
Health Professional Shortage Areas
http://www.hpsafind.hrsa.gov

National Uniform Billing Committee
http://www.nubc.org/guide.html
(800) 242-2626

Railroad Medicare Part B Office
(800) 833-4455

Social Security Administration
http://www.ssa.gov
(800) 772-1213

United Mine Workers
Electronic Claims Processing Information
(800) 215-4730
U.S. Census Bureau
http://www.Census.gov

U.S. Government Printing Office
Code of Federal Regulations
http://www.gpoaccess.gov/cfr/index.html

U.S. Government Printing Office
U.S. Government Bookstore
http://bookstore.gpo.gov
(866) 512-1800